Dr. Russel Fleming *Appellant*

v.

Professor Scott Starson a.k.a. Scott Jeffery Schutzman *Respondent*

and

Schizophrenia Society of Canada, Centre for Addiction and Mental Health, Mental Health Legal Committee and Mental Health Legal Advocacy Coalition *Interveners*

Indexed as: Starson v. Swayze

Neutral citation: 2003 SCC 32.

File No.: 28799.

2003: January 15; 2003: June 6.

Present: McLachlin C.J. and Gonthier, Iacobucci, Major, Bastarache, Binnie, Arbour, LeBel and Deschamps JJ.

ON APPEAL FROM THE COURT OF APPEAL FOR ONTARIO

Physicians and surgeons ---- Medical treatment -- Consent ---- Ontario Consent and Capacity Board -- Patient refusing consent to proposed medical treatment for bipolar disorder -- Physicians finding patient not capable of making treatment decision -- Board's confirmation of incapacity overturned on judicial review -- Whether reviewing judge properly applied reasonableness standard of review to Board's finding of incapacity -- Whether reviewing judge correctly found that Board misapplied statutory test for capacity -- Health Care Consent Act, 1996, S.O. 1996, c. 2, Sch. A.

Since 1985 the respondent has frequently been admitted to mental institutions in the United States and Canada and has most often been diagnosed as having a bipolar disorder. His recent admission to hospital arose after he was found not criminally responsible for making death threats and the Ontario Review Board ordered his detention for 12 months. The respondent's physicians proposed treatment for his bipolar disorder that included neuroleptic medication, mood stabilizers, anti-anxiety medication and anti-parkinsonian medication. The respondent refused to consent to this medication and the attending physician found him not capable of deciding whether to reject or accept the proposed medical treatment. The Ontario *Health Care Consent Act, 1996* permits a person to be treated without consent on grounds of lack of capacity, defined as a lack of the ability "to understand the information that is relevant to making a decision about the treatment . . . and . . . to appreciate the reasonably foreseeable consequences of a decision or lack of decision". The respondent applied to the Ontario Consent and Capacity Board for a review of the physician's decision and the Board's confirmation of incapacity was subsequently overturned on judicial review at the Superior Court of Justice. The Court of Appeal upheld the findings of the reviewing judge.

Held (McLachlin C.J. and Gonthier and LeBel JJ. dissenting): The appeal should be dismissed.

Per Iacobucci, Major, Bastarache, Binnie, Arbour and Deschamps JJ.: The *Health Care Consent Act, 1996*, presumes a person is capable to decide to accept or reject medical treatment; therefore, patients

with mental disorders are presumptively entitled to make their own treatment decisions. The presumption of capacity can be displaced only by evidence that a patient lacks the requisite elements of capacity provided by the Act. Capacity involves two criteria: first, a person must be able to understand the information that is relevant to making a treatment decision and second, a person must be able to appreciate the reasonably foreseeable consequences of the decision or lack of one. The legislative mandate of the Consent and Capacity Board is to adjudicate solely upon a patient's capacity and the Board's conception of the patient's best interests is irrelevant to that determination. The question under review, namely the Board's determination of capacity, is a question of mixed fact and law: the Board must apply the evidence before it to the statutory test for capacity. In the absence of any error of law, this question is relatively fact-intensive. Applying the pragmatic and functional approach to this question, it is clear that reasonableness is the appropriate standard of review.

In this case, the reviewing judge applied the proper standard of review and correctly held that the Board's finding was unreasonable. The Board's determination of incapacity turned on two findings: that the respondent was in "almost total" denial of a mental disorder, and that he failed to appreciate the consequences of his decision. A careful review of the evidence demonstrates that there is no basis for either of these findings. Although the patient did not conceive of the condition as an illness, he was quite aware that his brain did not function normally. There was also no evidence that the proposed medication was likely to ameliorate the respondent's condition. Moreover, the respondent appreciated the intended effects of the medication. The Board's conclusion that treatment would improve his chances at future review board hearings is entirely speculative. There was no basis for the Consent and Capacity Board to find that a possible benefit of treatment would be the resumption of the respondent's work as a physicist. Lastly, the respondent was never asked at the hearing whether he understood the possibility that his condition could worsen without treatment. Consequently, there is no support for the Board's ultimate finding of incapacity.

In addition, the Board misapplied the statutory test for capacity. The interpretation of this legal standard is a question of law. No deference is owed to the Board on this issue and a correctness standard of review is to be applied. Although the Board found the respondent failed to appreciate the risks and benefits of treatment, it neglected to address whether the reasons for that failure demonstrated an inability to appreciate those risks and benefits. Furthermore, the Board's reasons indicate that it strayed from its legislative mandate, which was to adjudicate solely upon the patient's capacity. The wisdom of the respondent's treatment decision is irrelevant to that determination. The Board improperly allowed its own conception of the respondent's best interests to influence its finding of incapacity.

Per McLachlin C.J. and Gonthier and LeBel JJ. (dissenting): The Consent and Capacity Board properly applied the law and nothing in its reasons suggests that it strayed from the question of the respondent's capacity to make medical decisions on his own behalf. The Board's preliminary expression of sympathy for the respondent's actual situation was merely an expression of concern and does not show that the Board focussed on the respondent's best interests rather than on his capacity.

The issue in this case is not whether the Board's conclusion was the best conclusion on the evidence, but rather whether it is among the range of conclusions that the Board could reasonably have reached. Only if the Board's conclusion is unreasonable having regard to the whole of the evidence can it be set aside. Here, the Board's conclusion that the respondent lacked capacity to make treatment decisions was firmly anchored in the evidence and cannot be characterized as unreasonable. The Board's finding that the respondent's denial of his illness was "almost total" is amply supported in the evidence. While the Board never suggested that the respondent denied all his difficulties and symptoms, it did suggest, entirely accurately, that the respondent did not see his symptoms and difficulties as an illness or a problem relevant to the proposals for treatment. The Board was entitled to conclude from the evidence that the respondent was in denial about his mental illness generally, and not just about the specific diagnosis. This denial was compounded by the respondent's inability, because of his delusional state to understand the information relevant to making a treatment decision, as required by the Act. There was also ample evidence to support the Board's finding that the respondent was unable to appreciate the foreseeable consequences of treatment and refusing treatment because he lacked the ability to appreciate (1) the possible benefits of the proposed medication; (2) the fact that absent medication it is unlikely he will ever return to his previous level of functioning and his condition may continue to deteriorate; and (3) the relationship between lack of treatment and future dispositions by the Review Board. Given the evidence and the Board's application of the correct legal tests, there is no basis upon which a court of judicial review can set aside the Board's decision.

Cases Cited

By Major J.

Distinguished: *R. v. Owen*, [2003] 1 S.C.R. 779, 2003 SCC 33; **referred to:** *T. (I.) v. L. (L.)* (1999), 46 O.R. (3d) 284; *Fleming v. Reid* (1991), 4 O.R. (3d) 74; *E. (Mrs.) v. Eve*, [1986] 2 S.C.R. 388; *Koch (Re)* (1997), 33 O.R. (3d) 485; *U.E.S., Local 298 v. Bibeault*, [1988] 2 S.C.R. 1048; *Canada (Director of Investigation and Research) v. Southam Inc.*, [1997] 1 S.C.R. 748; *Pushpanathan v. Canada (Minister of Citizenship and Immigration)*, [1998] 1 S.C.R. 982; *Dr. Q v. College of Physicians and Surgeons of British Columbia*, [2003] 1 S.C.R. 226, 2003 SCC 19; *Law Society of New Brunswick v. Ryan*, [2003] 1 S.C.R. 247, 2003 SCC 20.

By McLachlin C.J. (dissenting)

R. v. Owen, [2003] 1 S.C.R. 779, 2003 SCC 33; *Khan v. St. Thomas Psychiatric Hospital* (1992), 7 O.R. (3d) 303.

Statutes and Regulations Cited

Criminal Code, R.S.C. 1985, c. C-46, Part XX.1, s. 672.54 [ad. 1991, c. 43, s. 4].

Health Care Consent Act, 1996, S.O. 1996, c. 2, Sch. A, ss. 1, 4(1), (2), 10(1)(b), 21, 70(2), 71(3), 73(2), 75, 80(1) [am. 2000, c. 9, s. 48], (9), (10).

Mental Health Act, R.S.O. 1990, c. M.7, s. 20(1) to (5).

Statutory Powers Procedure Act, R.S.O. 1990, c. S.22, s. 15(1).

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Roth, Loren H., Alan Meisel and Charles W. Lidz. "Tests of Competency to Consent to Treatment" (1977), 134 *Am. J. Psychiatry* 279.

Weisstub, David N. *Enquiry on Mental Competency: Final Report*. Toronto: Queen's Printer for Ontario, 1990.

APPEAL from a judgment of the Ontario Court of Appeal (2001), 201 D.L.R. (4th) 123, 146 O.A.C. 121, 33 Admin. L.R. (3d) 315, [2001] O.J. No. 2283 (QL), dismissing an appeal from a judgment of the Superior Court of Justice (1999), 22 Admin. L.R. (3d) 211, [1999] O.J. No. 4483 (QL). Appeal dismissed, McLachlin C.J. and Gonthier and LeBel JJ. dissenting.

Leslie McIntosh and *Diana Schell*, for the appellant.

Anita Szigeti, as *amicus curiae*.

Daphne G. Jarvis and *Barbara J. Walker-Renshaw*, for the intervener the Schizophrenia Society of Canada.

Written submissions only by *Janice E. Blackburn* and *James P. Thomson*, for the intervener the Centre for Addiction and Mental Health.

Marshall A. Swadron and *Aaron A. Dhir*, for the interveners the Mental Health Legal Committee and the Mental Health Legal Advocacy Coalition.

The reasons of McLachlin C.J. and Gonthier and LeBel JJ. were delivered by

THE CHIEF JUSTICE (dissenting) --

I. Introduction

1 The issue in this case is whether the Ontario Consent and Capacity Board acted unreasonably in finding that Scott Jeffery Schutzman (who prefers to be called "Professor ⇐**Starson**⇒" or simply "⇐**Starson**⇒") is incapable by reason of mental illness of consenting to treatment under the *Health Care*

Consent Act, 1996, S.O. 1996, c. 2, Sch. A ("*HCCA*"). I agree with Major J. that the test for capacity requires more than mere intellectual ability, and I agree on the standard of review applicable to the Board's decision. However, I do not agree that the Board's conclusion that Professor **Starson** lacked capacity to decide what treatment he should receive was unreasonable. Unlike my colleague Major J., I conclude that the Board applied the law correctly and that there was ample evidence before the Board to support a finding of incapacity. I would therefore allow the appeal.

2 Professor **Starson** is an exceptionally intelligent man who in earlier years did remarkable work in physics and still counts leading physicists among his friends. He suffers from long-standing mental illness. He has been in and out of mental hospitals in the United States and Canada, since at least 1985. His illness has led to erratic behaviour; his tendency to utter death threats against acquaintances and strangers has repeatedly brought him into conflict with the criminal law and is the reason for his current detention. Professor **Starson** entertains delusions of varying severity. He talks about plans to run the "**Starson** Corporation" from inside his current inpatient unit; insists that he is "leading on the edge of efforts to build a starship"; claims to be a world-class skier and arm-wrestler; and has asserted that he is the greatest scientist in the world and communicates with extra-terrestrials. While Professor **Starson** would not agree, his illness appears to have progressed and his condition has deteriorated.

3 Professor **Starson** has received medication for his mental illness in the past. It successfully reduced his delusions. But it had side effects that Professor **Starson** did not like. The most serious of these was Professor **Starson**'s complaint that the medication dulled his mind and diminished his creativity. As a consequence of his past experiences with medication, Professor **Starson** has set his mind against all further treatment by medication. He categorically asserts that "no benefits exis[t] for medication", and refuses all treatment except psychoanalysis.

4 Professor **Starson**'s doctors have told him that new medications are available which promise much better results, with reduced negative side effects. They have also explained to him that without medication, his condition is likely to continue to deteriorate. Professor **Starson**, however, continues to refuse treatment by medication. Professor **Starson**'s doctors have concluded that in his present condition, he does not understand the benefits of treatment with the new medications, nor does he appreciate that without treatment his condition will probably continue to deteriorate. Faced with this conclusion, which would open the door to imposed medication, Professor **Starson** applied to the Consent and Capacity Board for a determination that he is capable under the *HCCA* and can therefore refuse treatment. The Board found that Professor **Starson** is not capable. On appeal, Molloy J. set aside the Board's decision as unreasonable. The Ontario Court of Appeal confirmed her decision.

II. Standard of Review

5 I agree with my colleague Major J. that the Board's interpretation of the law is reviewable on a standard of correctness. On the application of the law to the facts, I agree that the Board's decision is subject to review for reasonableness. The legislature assigned to the Board the task of hearing the witnesses and assessing evidence. Absent demonstrated unreasonableness, there is no basis for judicial interference with findings of fact or the inferences drawn from the facts. This means that the Board's conclusion must be upheld provided it was among the range of conclusions that could reasonably have been reached on the law and evidence. As Binnie J. states in *R. v. Owen*, [2003] 1 S.C.R. 779, 2003 SCC 33 (released concurrently), at para. 33: "If the Board's decision is such that it could reasonably be the subject of disagreement among Board members properly informed of the facts and instructed on the applicable law, the court should in general decline to intervene." The fact that the reviewing court would have come to a different conclusion does not suffice to set aside the Board's conclusion.

III. The Legal Definition of Capacity

6 The *HCCA* confronts the difficult problem of when a mentally ill person may refuse treatment. The problem is difficult because it sets in opposition fundamental values which we hold dear. The first is the value of autonomy -- the ability of each person to control his or her body and consequently, to decide what medical treatment he or she will receive. The second value is effective medical treatment -- that people who are ill should receive treatment and that illness itself should not deprive an individual of the ability to live a full and complete life. A third value -- societal protection -- comes into play in some cases of metal illness. Where the mentally ill person poses a threat of injury to other people or to him-- or herself, it may be justified to impose hospitalization on the basis that this is necessary in the interests of public safety: see s. 672.54 of the *Criminal Code*, R.S.C. 1985, c. C-46, which permits courts and Boards to impose hospitalization on an accused person found not criminally responsible on account of mental disorder, and ss. 20(1) to 20(5) of the Ontario *Mental Health Act*, R.S.O. 1990, c. M.7, which permit the involuntary hospitalization of mentally ill persons under certain circumstances. Professor **Starson**

was under a twelve-month hospital detention order pursuant to these *Criminal Code* provisions at the time of the application, having been found not criminally responsible for making death threats. However, the application with which we are concerned did not rely on public safety, so this value does not affect this appeal.

7 Ordinarily at law, the value of autonomy prevails over the value of effective medical treatment. No matter how ill a person, no matter how likely deterioration or death, it is for that person and that person alone to decide whether to accept a proposed medical treatment. However, where the individual is incompetent, or lacks the capacity, to make the decision, the law may override his or her wishes and order hospitalization. For example, young children generally lack capacity to make medical decisions because of their age; thus their parents or guardians, not they, decide what medical treatment they should receive. Where mental illness deprives a person of the ability to make a decision about medical treatment, the law may permit that person's wishes to be overridden. This result flows from s. 4(1) of the *HCCA*.

8 There is no easy answer to the question of when a mentally ill person should be held incapable of making decisions concerning his or her medical treatment. Different societies have drawn different lines at different times. The applicable law in Ontario permits a mentally ill person to be hospitalized without consent on grounds of public safety (*Criminal Code* and *Mental Health Act*) and lack of capacity (s. 4(1) of the *HCCA*), defined as a lack of the ability "to understand the information that is relevant to making a decision about the treatment . . . and . . . to appreciate the reasonably foreseeable consequences of a decision or lack of decision". Moreover, as discussed in greater detail below, the definition of capacity offered in the *HCCA* is broad; incapacity is not confined to lack of rational ability to understand, but extends to lack of ability to "appreciate" or judge.

9 The Ontario legislature's decision to permit a mentally ill person's decision to refuse treatment to be overridden where public safety is not threatened reflects the value of promoting effective medical treatment of people suffering from mental illness. The *HCCA*'s definition of capacity offers a way out of the dilemma that is created when treatment for an illness is dependent on consent, which in turn is not forthcoming because of the illness. The way out of the dilemma lies in recognizing that the focus should be not only on consent but on capacity to consent. The policy of the law is that where a person, due to mental illness, lacks the capacity to make a sound and considered decision on treatment, the person should not for that reason be denied access to medical treatment that can improve functioning and alleviate suffering. Rather, that person's incapacity should be recognized and someone else appointed to make the decision for him or her.

10 At the same time, the *HCCA* preserves the value of individual autonomy. Mental illness is not conflated with incapacity. Mental illness without more does not remove capacity and autonomy. Only where it can be shown that a person is unable to understand relevant factors and appreciate the reasonably foreseeable consequences of a decision or lack of decision can treatment be imposed.

11 The *HCCA* represents a careful and balanced response to the problem of accommodating the individual autonomy of the mentally ill person and the aim of securing effective treatment for mentally ill people. It says that when a mentally ill person lacks the capacity to sufficiently understand and appreciate his or her situation, authorized treatment may be imposed. This response is doubtless influenced by increased appreciation of the suffering and loss occasioned by non-violent mental illness, and the ever-expanding treatment options available as our understanding of mental illness increases. Whatever the explanation, the fact is that the legislature has chosen a test based on a nuanced conception of incapacity that includes both the ability to understand and appreciate, to be applied by the specialized Board. The courts must respect this choice.

12 Against this background, I come to the test for incapacity. Section 4(1) of the *HCCA* provides:

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.

13 I would summarize the four important points as follows:

1. The person is presumed to be competent and the standard of proof for a finding of incapacity is a balance of probabilities.

2. The test relates to the capacity or ability to understand and appreciate, not actual understanding and appreciation.

3. The first component of the test for capacity is that the person be "able to understand the information that is relevant to making a decision about the treatment" at issue.

4. The second component of the test is that the person be "able to appreciate the reasonably foreseeable consequences of a decision or lack of decision".

14 The second point, that the test relates to a person's capacity or ability to understand and appreciate, is reflected by the use of the word "able" in relation to "understand" and "appreciate". It means that a person cannot be found to lack capacity on the basis of lack of information about his or her illness or the fact that he or she holds contrary views to a prescribed diagnosis: see Professor D. N. Weisstub, *Enquiry on Mental Competency: Final Report* (1990), at p. 249.

15 While the difference between ability to understand and appreciate and actual understanding or appreciation is easily stated, it may be less easy to apply in practice. Capacity is an abstract concept. The primary means of ascertaining capacity or ability, in any context, is to look at what an individual in fact says and does. It follows that it is not an error for the Board to inquire into the actual understanding or appreciation of the person in question. At the same time, the fact that the person's actual conclusion does not agree with that of other people, for example medical experts, does not in itself demonstrate lack of understanding or capacity. In this connection, Professor Weisstub, *supra*, App. V, at pp. 421-22 states:

The test clearly refers to the ability of the patient, although there is a strong feeling that the distinction between actual understanding and the ability to understand one's situation is merely a theoretical point. While it may generally be true that actual understanding is an appropriate guide of the ability to understand, the distinction could still be important, for example, for patients who would be able to understand their situation if sedated somewhat less, or, of course, for those who have not received complete information about their situation.

16 The first component of the test for capacity is that the person be "able to understand the information that is relevant to making a decision about the treatment" at issue. The person must be capable of intellectually processing the information as it applies to his or her treatment, including its potential benefits and drawbacks. Two types of information would seem to be relevant: first, information about the proposed treatment; and second, information as to how that treatment may affect the patient's particular situation. Information relevant to the treatment decision includes the person's symptoms and how the proposed treatment may affect those symptoms. The patient must be able to acknowledge his or her symptoms in order to be able to understand the information relevant to a treatment decision. Agreement with a medical professional's diagnosis *per se*, or with the "label" used to characterize the set of symptoms, is not, however, required.

17 The second component of the test is that the person be "able to appreciate the reasonably foreseeable consequences of a decision or lack of decision". The appreciation test has been characterized as more stringent than a mere understanding test, since it includes both a cognitive and an affective component: R. Macklin, "Some Problems in Gaining Informed Consent from Psychiatric Patients" (1982), 31 *Emory L.J.* 345. To be capable, a patient must be able not only to understand the relevant information, but also to "appreciate the reasonably foreseeable consequences of a decision or lack of decision": s. 4(1) of the *HCCA*. "An understanding criterion focuses on a patient's ability to acquire information, while appreciation focuses on the patient's ability to evaluate information": Berg et al., *Informed Consent: Legal Theory and Clinical Practice* (2nd ed. 2001), at p. 102. Appreciation seizes upon the ability of the person who is able to understand the facts (the first component) to weigh or judge and thus evaluate the foreseeable consequences of accepting or refusing treatment (the second component). Arbour J.A. (as she then was) described this distinction as follows in *Khan v. St. Thomas Psychiatric Hospital* (1992), 7 O.R. (3d) 303 (C.A.), at p. 314 (citing a Review Board's comment): "there are situations where a person may understand in an intellectual sense the subject-matter in respect of which consent is requested and further understand the nature of the illness for which treatment is proposed and understand the treatment proposed, but his or her ability to appreciate the same as it relates to themselves may be impaired by the mental disorder".

18 Commentators have identified three "common clinical indicators" of a person's ability to appreciate the consequences of accepting or declining treatment: "whether the person is able to acknowledge the fact that the condition for which treatment is recommended may affect him or her; whether the person is able to assess how the proposed treatment and alternatives, including no treatment, could affect his or her life or quality of life; [whether] the person's choice is not substantially based on a delusional belief": B. F. Hoffman, *The Law of Consent to Treatment in Ontario* (2nd ed. 1997), at p. 18. These indicators provide a useful framework for identifying what "ability to appreciate" means in concrete terms.

19 Like understanding, appreciation does not require agreement with a particular conclusion, professional or otherwise. A patient may look at the pros and cons of treatment and arrive at a different

conclusion than the medical experts. Nor does it amount to a "best interests" standard. A patient who is capable has the right to refuse treatment, even if that treatment is, from a medical perspective, in his or her best interest. It is crucial to guard against interpreting disagreement with a particular diagnosis or proposed treatment plan as itself evidence of incapacity. But just as it is important to protect patients' capable wishes to refuse treatment, so is it important to ensure that patients who are not capable of making treatment decisions receive appropriate treatment.

IV. Application to the Facts

20 The Consent and Capacity Board, composed in this case of a psychiatrist, a lawyer and a community member, heard from Professor **Starson**, two of his physicians and his solicitor. It also read letters written by Professor **Starson**'s friends and acquaintances affirming their belief in his mental capacity. Based on this evidence, the Board found: (1) "[C]lear and cogent evidence was presented that the patient is suffering from a chronic mental disorder, likely a bipolar disorder with psychotic features" (TO-98/1320, January 24, 1999, at p.15); (2) Professor **Starson**'s denial that he has any type of mental illness "is almost total" (p. 16); (3) without acknowledgment that he has some type of mental disorder and that his behaviour is being affected by that disorder, Professor **Starson** "cannot understand the information provided to him . . . because he cannot relate it to his particular disorder" (p. 17); (4) Professor **Starson** "cannot understand the potential benefits of the medication" proposed (p. 17), and "seems unable to appreciate that efforts will be made to reduce the incidence of past side effects by using more benign medications" (p. 18); (5) "[w]ithout some treatment, it is unlikely [Professor **Starson**] will ever return to his previous level of functioning" (p. 17); to the contrary, "the literature is clear that an untreated Bipolar Disorder is likely to result in further deterioration over time" (p. 17).

21 From all this, the Board concluded that, despite Professor **Starson**'s high level of cognitive functioning, his manic and delusional symptoms prevent him from being able to understand the relevant information and to appreciate the nature of his condition and the reasonably foreseeable consequences of refusing the proposed course of treatment.

22 The first question is whether the Board applied the proper legal test. Here the Board was required to be correct. In my view, it was. First, the Board's reasons make it clear that it was considering Professor **Starson**'s capacity, not the wisdom of his decision to refuse treatment. The Board referred to Professor **Starson**'s actual understanding and acknowledgement. But this was in relation to the ultimate question of whether he was able to understand his illness and the benefits and disadvantages of medication. The Board reasoned that the absence of understanding and acknowledgement of his condition rendered Professor **Starson** unable to understand the factors relevant to making a decision about treatment and unable to appreciate the consequences of lack of treatment. This was not an error, as Molloy J. suggested ((1999), 22 Admin. L.R. (3d) 211 (Ont. S.C.J.) at para. 74). Rather, it followed the accepted approach to ascertaining ability: see Hoffman, *supra*, at p. 18. As for the Board's preliminary expression of sympathy for Professor **Starson**'s actual situation, this should be taken for what it is -- an expression of concern. It does not show that the Board focussed on the wisdom of refusing treatment rather than on Professor **Starson**'s capacity.

23 The remaining question is whether the Board's conclusion that Professor **Starson** lacked capacity under s. 4(1) of the *HCCA* was unreasonable. The issue here is not whether the Board's conclusion was the best conclusion on the evidence. It is rather whether it is among the range of conclusions that the Board could reasonably have reached. Only if the Board's conclusion is unreasonable, having regard to the whole of the evidence, can it be set aside.

24 It is said that the Board acted unreasonably: (1) in concluding that Professor **Starson**'s denial of his illness was "almost total" and (2) in concluding that Professor **Starson** lacked the ability to appreciate the consequences of refusing treatment. These errors are said to render the Board's ultimate conclusion of incapacity unreasonable. In fact, the Board's conclusions on these matters find ample support in the evidence.

A. *Professor **Starson**'s Denial of his Illness*

25 I turn first to the Board's conclusion that Professor **Starson**'s denial of his illness was "almost total". Before addressing the question of what the Board found in this respect and whether the record supported it, it should be pointed out that a conclusion of denial or lack of acknowledgement of one's condition is one of the three "common clinical indicators" of inability to appreciate the consequences of accepting or declining treatment under s. 4(1) of the *HCCA*: Hoffman, *supra*. The Board properly recognized this and grounded its conclusions on Professor **Starson**'s incapacity in large part on his inability to acknowledge the condition for which treatment was recommended.

26 With respect, Molloy J., whose conclusions were endorsed by the Court of Appeal and by my colleague Major J., seems to have misunderstood the Board's assertion that Professor **Starson**'s denial of his illness was "almost total". Molloy J. took this to mean that he did not accept that he had any mental problems of any sort. Interpreting the phrase in this manner, Molloy J. concluded that since the evidence shows some awareness of mental abnormality, the Board erred.

27 The evidence of Professor **Starson**'s physicians, and in particular Dr. Swayze, was that Professor **Starson** was in denial of his disorder. But this evidence was not intended to convey that Professor **Starson** denied all aspects of his mental illness. The Board acknowledged that Professor **Starson** was aware of the fact that his mind functioned differently. Professor **Starson** acknowledged in the Board hearing that he had "exhibited the symptoms of these labels that you give". He realized that he had mental problems and had difficulty dealing with others, and indeed was prepared to accept psychotherapy to address these problems. What the Board found was that he denied suffering from a mental disorder: "Despite overwhelming evidence to the contrary he continues to deny that he has a mental disorder". It reached this conclusion in the following context, at pp. 16-17:

> The patient's denial is almost total. He did concede when questioned by Dr. Swayze, that he might have had some difficulties, but these have not led to any threats towards others. This was contrary to the evidence presented and his acknowledgment to Dr. Swayze when questioned, was in contradiction to total denial in the past to both Dr. Swayze and Dr. Posner of the presence of any disorder. Thus, even the small concession to Dr. Swayze of some past difficulties when he was questioned did not seem to be a significant acknowledgement of the existence of the illness.
>
> Accepting that a patient "should not simply be deemed incapable because he or she does not agree with the diagnosis," the Board correctly responded that "the issue is more complex" and what is required is "that the patient understand that he or she has a mental disorder of some type, if the evidence establishes the presence of a disorder" (p. 16). It was only then and in this sense, that the Board stated that "[t]he patient's denial is almost total," expressly adding in the same sentence that Professor **Starson** "did concede . . . that he might have had some difficulties, but [that] these have not led to any threats towards others" (p. 16).

28 The Board's appraisal, including its conclusion of "almost total" denial of a mental disorder, is fully supported by the record. The Board never suggested that Professor **Starson** denied all his difficulties and symptoms; indeed, it expressly acknowledged this. The Board did suggest, entirely accurately, that Professor **Starson** did not see his symptoms and difficulties as an illness or a problem relevant to the proposals for treatment.

29 I cite only a few excerpts from the record to show that evidence existed upon which the Board could reasonably have concluded Professor **Starson** was in denial about his mental disorder. His doctors testified that:

> Dr. Swayze:
>
> -His understanding was that indeed, he did not and has not suffered from any psychiatric disorder, particularly not from a mood or psychotic disorder.
>
> -Professor **Starson** claims that "[h]e has no disorder".
>
> Dr. Posner:
>
> -He does not understand "that he has a mental illness".
>
> -He did "not understand in any way, shape or form that he had a mental illness . . .".
>
> -He has exhibited a "complete lack of understanding of him having his own mental illness".

30 Professor **Starson** refused to answer directly whether he was mentally ill or not. However, his evidence at other points supports denial of mental illness: "I did have mental problems 13 years ago that were difficult, almost impossible for me to handle. What I differ on is that the cause of these problems was not a mental illness". His medical charts indicated that, when asked about his opinion as to whether he suffered from a disorder, he responded "I have no opinions. You are a religion. I have the perfect scientific mind. Only you people say I have an illness".

31 The Board was amply entitled to conclude from this evidence that Professor **Starson** was in denial about his mental illness generally, and not just about the specific diagnosis.

32 This denial was compounded by Professor **Starson**'s refusal to acknowledge any benefits of medication whatsoever, even in the abstract. Although I base my opinion that the Board's conclusion was reasonable primarily on Professor **Starson**'s clear lack of appreciation of the foreseeable consequences of refusing treatment, he also appears to have lacked the ability to understand the information relevant to making a treatment decision, as required by the *HCCA*. Like a cancer patient advised to undergo chemotherapy or a diabetic advised to inject insulin, a mentally ill patient advised to take antipsychotic medication must be able to understand its benefits and drawbacks in order to be deemed capable of making a treatment decision. This, in turn, requires a willingness to consider, whether or not he or she chooses to follow, the scientific evidence regarding its effectiveness. The record suggests that Professor **Starson** not only refused to do this, but was in fact unable to because of his delusional state.

33 By way of example, I cite the following passages from the record:

Dr. Swayze:

We then attempted to review, or I attempted to review the risks and benefits of those medications and was, once again, quickly interrupted: All chemicals are rejected with the understanding by myself that that inferred that there were no medications which were amenable or appropriate for a bipolar disorder or psychotic episode and that there was no consideration, that those would be appropriate under any circumstances.

I've attempted to focus on the issue of the benefit of those medications. "None exist." Then canvass the area of risk involved in rejecting medications and was told, in no uncertain terms, that once again the medications were chemicals. They should be rejected and that there was no risk of rejecting them, as they would, in fact, inflict injury upon any person foolish enough to accept them. [Emphasis added.]

Dr. Posner:

I wanted to try to appeal to his formerly objective side by explaining to him that two patients [he said he knew who died from taking Haldol] does not make a fact. Two patients are two observations. You know, in science, when we're trying to gather data in psychiatry, when we're trying to gather data on the effects and the mal-effects of neuroleptic medications or anything, we look at population data, we look at collections of many different reports of adverse side effects. And yes, you could find any medication at all that had two deaths associated with -- although one might argue, so close to home -- he might have overemphasized those in his own mind.

But he shocked me to pieces on that one, metaphorically, that is and [he] explained that Haldol was a toxic agent. It killed people. We killed people, he went on, with Haldol. This was part of the religion or -- the religion of psychiatry's way of . . . . And he didn't really go on after that. We sort of finished things up.

But it convinced me that not only did he not understand in any way, shape or form that he had a mental illness, but that it was impossible at this point to explore with him benefits of medications obviously because that would be tied to an understanding of the need to take them, or a treatment go. But also to explore in any way side effects, negative adverse effects. [Emphasis added.]

34 The Board could reasonably have concluded from the evidence before it that Professor **Starson**, despite his high intelligence in the area of physics, was unable to understand the information relevant to a treatment decision involving his mental health.

B.*Professor **Starson**'s Inability to Appreciate the Consequences of Refusing Treatment*

35 Nor did the Board err in its conclusion that Professor **Starson** lacked the ability to appreciate the reasonably foreseeable consequences of accepting or refusing treatment. Here again, Molloy J.'s analysis, with respect, seems to misread the Board's conclusion as asserting that the proposed medications promised a cure and Professor **Starson**'s resumption of scientific work, and then to argue that the record does not support this. My colleague Major J. likewise emphasizes at para. 98 that it was unclear whether the proposed treatment would "facilitate a `normal functioning level'".

36 This, with respect, misses the point. The issue is not the efficacy of the proposed treatment or what would be in the patient's best interests, but the capacity of Professor **Starson** to make decisions about treatment under s. 4(1) of the *HCCA* -- whether Professor **Starson** is able "to appreciate the reasonably foreseeable consequences of a decision or lack of decision". As a practical matter, capacity hearings will arise when doctors believe that treatment would improve a patient's functioning. However, the issue in the hearing is not the merits of medication or other treatment, but the patient's ability to understand and appreciate the benefits and drawbacks of treatment or lack thereof.

37 There was ample evidence in the record to support the Board's conclusion that Professor **Starson** was unable to appreciate the reasonably foreseeable consequences of accepting or refusing treatment. I cite some of the evidence below:

Dr. Swayze:

[He] does not understand the ramifications on himself, does not appreciate that there are treatment options which are legitimate, nor does he appreciate the risks of rejecting those.

Dr. Posner:

-I feel he is not capable to make consent -- to make treatment decisions on his own behalf in any way, shape or form. Professor **Starson** cannot even be engaged in a discussion of a mental illness as it pertains to him. He can't be engaged in the use of medications as they pertain to him.

-[A]ll of the above virtually rules out discussing the consequences or appreciating the consequences of not taking medications.

-. . . Professor **Starson**, despite the fact that he may be able to reiterate and he's got a good memory, I don't have any doubt, CPS-like side effects, I don't believe that he has any appreciation whatsoever of what those side effects could mean in terms of him. And I don't think he has the ability to engage in a discussion of any sort that would allow him to become more knowledgeable in that area. I mean, at least argue on a rational basis. No, I don't think he could do that.

So I don't think he meets any of the sort of criteria for capability of making treatment decisions and I don't think he's -- I don't even think he's close on any of them.

-. . . I can say that none of that intelligence [in physics] bears any -- has any role in his understanding -- has not contributed to his understanding of mental illness. In fact, in an indirect way, all that intelligence may be reinforcing his delusional system. He may be using it to perpetuate things. Maybe at a faster or more impressive rate than the average delusional patient.

One of the things about delusions is that when you develop these kinds of illnesses, you can't effectively evaluate what happens on around you, so you begin to construct your own reality. Sometimes you borrow it from the Bible, from science fiction, from whatever source. Sometimes, especially if you're smart enough, if you've got enough raw intelligence, you build it yourself, perhaps on a skeleton of something else. And I think that's where the intelligence has gone. I don't think it's certainly gone into understanding that he has a mental illness. [Emphasis added.]

38 These medical conclusions were well-founded in more particular evidence. The Board concluded that on the evidence before it, Professor **Starson** was not able to appreciate the consequences of deciding to refuse treatment because of his lack of ability to appreciate three things: (1) the possible benefits of the medication; (2) the fact that absent medication it is unlikely he will ever return to his previous level of functioning and his condition may continue to deteriorate; and (3) the relationship between lack of treatment and future dispositions by the Ontario Review Board (under the *Criminal Code*, Part XX.1). I will discuss each of these conclusions in turn, showing how the evidence supported them.

39 The first finding is that Professor **Starson** lacked the ability to appreciate "the possible benefits" of treatment. The Board correctly framed the issue not in terms of whether Professor **Starson** accepts that a particular treatment will benefit him (as Molloy J. suggests) but whether he is able to appreciate "the possible benefits" of treatment. The Board's reasons for concluding that Professor **Starson** lacked this ability go back to his inability to understand and acknowledge his condition. One cannot appreciate the benefits of treatment unless one understands and appreciates the need for treatment. As a result of this inability Professor **Starson** simply cannot, to use the Board's phrase, "relate [the treatment] to his particular disorder" (p. 17). There are two aspects here: the ability to appreciate and the possible benefits of treatment. I have already reviewed the evidence on lack of ability to appreciate treatment matters. On the second aspect, Molloy J. correctly points out that the record does not indicate promises by Professor **Starson**'s doctors of a total return to normal functioning. There was evidence before the Board showing a reasonable prospect of improvement with the proposed treatment, with fewer negative side effects. The fact that doctors did not guarantee a cure did not make unreasonable the Board's conclusion that Professor **Starson** was incapable of appreciating the reasonably foreseeable consequences of treatment. There was ample evidence that the newer medications might yield positive benefits with fewer negative side effects. The following are unchallenged references to the evidence, as reproduced by the Board:

-Doctor Swayze emphasized that there is a window of opportunity at last to treat the patient. (p. 6)

-[I]t was [Dr. Swayze's] proposal to treat the patient with newer neuroleptic (antipsychotic) medication which would produce less side effects than in the past. (p. 7)

-When it was suggested that the patient was concerned that the medication would slow down his brain, [Dr. Swayze] responded it was not his intention to blunt the patient's thinking beyond what was required to stabilize his condition. (pp. 7-8)

-[O]ther than when Haldol (an older neuroleptic medication) had been administered there had never been an adequate trial of any other medication. (p. 9)

-[Dr. Swayze] did not believe that the medications would not help because there were volumes of evidence in the literature o[n] the efficacy of treatment. (p. 8)

40 I conclude that the record amply supports the Board's conclusion that Professor **Starson** was incapable of appreciating the foreseeable benefits of treatment by more modern medication.

41 Secondly, the Board concluded that Professor **Starson** was unable to appreciate the likelihood that without treatment his mental condition would worsen.

42 My colleague Major J., accepts that there was evidence before the Board from Dr. Posner supporting this conclusion although he characterizes it as "scant" (para. 105). He also argues that the fact that Professor **Starson** was not questioned on this at the hearing precluded the Board from concluding that he did not appreciate the risks of non-treatment (para. 105). With respect, I cannot agree on either count.

43 Characterizing the evidence as "scant" does not detract from the fact that the evidence was before the Board and provided its inferences were reasonable, the Board was entitled to rely on it. In fact, a review of the record shows that both doctors who testified shared the view that without treatment, Professor **Starson**'s condition was likely to deteriorate, and that there was no contrary evidence. I reproduce only some of the evidence.

Dr. Swayze:

-I could only characterize [this as] . . . essentially an unremitting disorder.

-My worry is that this [condition] will remain unremitting, that there will be fluctuating degrees, however his baseline will not return, i.e. prior degree of functioning and stability that likely has not been there since the early `80s.

-[T]his charting is ominous. It would suggest to me a chronic, unremitting course which likely would be a future for Professor **Starson**, should he not receive treatment.

Dr. Posner:

-. . . I don't agree that the disorder has been a steady psychotic state. In fact, it's been a progressive psychotic state and there are a lot of very good pieces of evidence to support that.

-What [this threat to a hospital worker] means to me is that the illness has taken on another dimension. If provocation of . . . that objectively small or innocent of a degree could have evoked that kind of explosion, that concerns me, because ten or fifteen years ago, I don't believe it would have.

-[T]he literature from bipolar disorder shows that untreated . . . mania . . . can and often does progress in severity, so it's not a question of maintaining the status quo. If you sit still and do nothing, harm will happen at a physiologic level, evidenced by the worsening of his state, as perceived by others.

44 As related by the Board, Dr. Posner testified that Professor **Starson**'s illness had been "steadily progressing" since 1994. Prior to 1994, the patient had produced a number of publications which "appeared credible". After 1995, "there were questions as to the validity of his references suggesting that his thinking had changed". Dr. Posner felt that "the illness had progressed from a hypomanic state to one of greater irritability". Dr. Posner then stated that an individual "who could have made an enormous contribution to society was now lost in a psychotic world" (pp. 8-9).

45 Dr. Posner testified that colleagues had noted deterioration and that in general "untreated Bipolar Disorder tends to deteriorate with time" (p. 9). This evidence, coupled with the evidence of Professor **Starson**'s denial of illness, provided an ample basis for the Board's conclusion that Professor

Starson was unable to appreciate the likelihood of deterioration absent treatment. The fact that Professor **Starson** was not questioned directly on the relationship between treatment and future deterioration does not detract from the strength of this evidence. Because Professor **Starson** denied any negative impact of his mental condition, questioning him about further deterioration would have been pointless. It is clear on the evidence that Professor **Starson** simply adheres to the view that he continues to function well without medication, contrary to all the objective evidence.

46 In addition to his physicians' testimony, there is evidence from Professor **Starson** himself supporting the Board's conclusion that he does not appreciate that failure to receive treatment will likely result in prolonged hospitalization and further deterioration of his mental condition. Professor **Starson** insisted that, without treatment, he would "go back to [his] life even better than it was before". He dismissed any suggestion that his hospitalization could be prolonged by either the Consent and Capacity Board or the Review Board as a "hypothetical situation that will not occur". His unresponsiveness is palpable throughout the record; when Dr. Swayze asked him about his manic symptoms, he replied: "they might not be beneficial for somebody else, but no one is doing what I'm doing. I'm leading the edge. I'm trying to define physics that will eventually enable us to build a starship. Okay? That's what anti-gravity is all about".

47 The evidence supports the view that Professor **Starson**'s delusional state had rendered him unable to appreciate that, without the proposed treatment, his mental condition will not improve, and will likely deteriorate. The Board was entitled to take all of this evidence into account in reaching a conclusion on whether or not Professor **Starson**, despite his intellectual ability, lacks the ability to relate treatment information to his own situation and to weigh the risks and benefits of treatment in a considered fashion. The Board concluded, on the evidence, that he does not.

48 Finally, the Board found that Professor **Starson** "seemed unable to relate the consequences [of no treatment] . . . to future dispositions by the Ontario Review Board" (p. 17). While the evidence amply supported the Board's conclusion of incapacity absent this consideration, this was a further indication of Professor **Starson**'s inability to appreciate the consequences of refusing treatment. Given the pattern of escalating threats by Professor **Starson**, the likelihood was that, without the proposed treatment, the Review Board would be "more and more hesitant to release the patient into the community" (p. 17). Yet, Professor **Starson** persisted in the belief that he would continue to `beat the system' as he had previously under Lieutenant-Governor's warrants (p. 17). This supported the conclusion that Professor **Starson** was not able to appreciate how treatment related to his life situation.

49 In summary, the Board had before it ample evidence to support the conclusion that Professor **Starson**, while he might have been highly intelligent, was unable, because of his delusional state, to understand the information relevant to treatment or to appreciate the benefits of the proposed newer medications; to appreciate the likelihood of deterioration without treatment; and to appreciate his future prospects under the Review Board, absent treatment. The Board's conclusion was firmly anchored in the evidence and cannot be characterized as unreasonable.

C. *Whether the Board Based its Decision on Professor **Starson**'s "Best Interests"*

50 In addition to challenging the Board's conclusions on the evidence, my colleague Major J. asserts that the Board erred in that it did not base its conclusion on capacity, but on its own view of what was in Professor **Starson**'s best interests.

51 With respect, I must demur. Nothing in the Board's reasons suggests that it strayed from the question before it -- Professor **Starson**'s capacity to make medical decisions on his own behalf. The Board addressed the inquiry at the outset as one involving the criteria "required for an individual to be capable with respect to treatment" and then proceeded to inquire into "capacity" (pp. 15-16 (emphasis added)). The key to capacity in this case, as discussed, was Professor **Starson**'s ability to appreciate the disorder, its consequences, and possible treatments.

52 Pursuing this, the Board discussed this question at length. Repeatedly it referred to the fact that the evidence showed Professor **Starson** "cannot relate [information] to his particular disorder"; that "the patient is unable to weigh the possible benefits of the medication"; that "the patient seemed unable to relate the consequences with respect to future dispositions by the Ontario Review Board"; that "[t]he patient seems unable to appreciate that efforts will be made to reduce . . . side effects"; that "[h]e does not appreciate the consequences of a decision to refuse medication" (pp. 17-18 (emphasis added)). After a brief discussion of outside evidence, the Board then moved directly to its conclusion at pp. 18-19:

> For the above reasons, the Board confirmed that the patient is not capable with respect to the

treatment proposed by the attending physician. . . .

53 It is thus clear that the Board was concerned with capacity throughout and that its conclusion was driven by evidence relevant to capacity and that alone. Not once does the Board refer to the best interests of the patient. As a preliminary matter, before entering into its analysis, the Board stated that it viewed Professor **Starson**'s current situation with "great sadness" and stated that "[u]fortunately, his potential has been disrupted time and time again by admission to psychiatric facilities" (p. 15). But the Board expressly recognized that this was preliminary to analysis as to capacity, not part of that analysis. It began this brief passage with the words: "Before commenting with respect to the specific criteria required for an individual to be capable" (p. 15). With the greatest of deference, this preliminary comment cannot be elevated to the error of deciding the case on the basis of best interests instead of capacity.

D.*Summary*

54 Having concluded the analysis, it may be useful to summarize where my colleague and I agree and where we part company.

55 On the facts, my colleague Major J. and I agree that there was evidence that Professor **Starson** suffered from serious mental illness; that he accepted he had symptoms of mental illness which had created difficulties for him in the past and for which he was prepared to accept psychotherapy; that he did not agree with his physicians on the diagnosis of this illness; and that without the proposed medical treatment, he might continue to deteriorate. We also agree that Professor **Starson** did not wish to accept the proposed medication-based therapy because of the effects of previous drug therapy, in particular the fact that it dulled his intellectual functioning.

56 On the law, my colleague and I agree that it would be erroneous for a Board to find incapacity simply because the patient does not accept the doctors' diagnosis or because treatment is in the best interests of the patient.

57 The central differences between my colleague and me appear to be two: whether there was evidence to support the Board's conclusion on capacity; and whether the Board erroneously applied a best interests standard.

58 In my respectful view, the evidence amply supports the Board's findings of Professor **Starson**'s inability to understand the information relevant to treatment and to appreciate the reasonably foreseeable consequences of a decision or lack of decision. Nor, in my view, did the Board erroneously apply a "best interests" standard; rather it remained focussed on the question of capacity throughout. Given this evidence and the Board's application of the correct legal tests, I see no basis upon which a court of judicial review can set aside its decision.

V.Conclusion

59 I conclude that the Board applied the law correctly and that its conclusion that Professor **Starson** lacked capacity within the meaning of s. 4(1) of the *HCCA* is amply supported by the evidence and is reasonable.

60 I would allow the appeal and restore the Board's decision.

The judgment of Iacobucci, Major, Bastarache, Binnie, Arbour and Deschamps JJ. was delivered by

61MAJOR J. -- The adult respondent, who prefers to be called Professor **Starson**, refused medical treatment proposed by his psychiatrist for a bipolar disorder. The Consent and Capacity Board of Ontario ("Board") held that Professor **Starson** lacked the capacity to make this decision.

62 The Board's ruling was overturned on judicial review. The principal issues in this appeal are whether the reviewing judge applied the appropriate standard of review to the Board's decision, and whether she correctly interpreted the statutory test for capacity provided by the *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sch. A ("Act").

63 I have concluded that the reviewing judge properly held that the Board's finding of the respondent's incapacity was unreasonable, and that the Board misapplied the statutory test. The Board placed primary importance on what it believed to be in the respondent's best interests at the expense of failing to adequately consider the critical aspect of this appeal, that is, whether Professor **Starson** had the capacity to make up his own mind as to whether he wanted medication or not.

64 This decision was made by him when he was able to recognize that his condition required

treatment. He knew as well that the doctors were optimistic that new medication would improve his condition although medication had been unsuccessful in the past. His choice, which he was entitled to make, was to remain as he was and to continue psychiatric therapy, in spite of his condition and the hope of others. I would dismiss the appeal.

I.Factual Background

65 By all accounts, Professor **Starson** is an extraordinarily intelligent and unique individual. Although he lacks any formal training in the subject, it is beyond dispute that his driving passion in life is physics. He has published several papers in the field: see a paper co-authored with Professor H. P. Noyes of Stanford University, entitled "Discrete Anti-Gravity" (1991). Professor Noyes is said to have described the respondent's thinking as "ten years ahead of his time". Although the respondent is not by university training a professor, his peers in the academic community allow him to use the title as recognition of his accomplishments.

66 Unfortunately, since 1985 the respondent has frequently been admitted to mental institutions in the United States and Canada. He has most often been diagnosed as having a bipolar disorder. Professor **Starson** has never caused physical harm to himself or to others, with the exception of reacting against unwanted forcible medication. His most recent admission to hospital arose after he was found not criminally responsible for making death threats. The Ontario Review Board ("ORB") ordered his detention for 12 months.

67 The respondent's physicians proposed treatment for his bipolar disorder. It included neuroleptic medication, mood stabilizers, anti-anxiety medication and anti-parkinsonian medication. He refused to consent to this medication. The respondent acknowledges that he has mental health problems, but will not agree that he suffers from an illness. He claims that his full mental functioning is critical to his scientific pursuits. He believes that all previous medication of a similar kind has significantly dulled his thinking and thereby prevented his work as a physicist. Although to him his life is generally very happy, medication has invariably made him miserable in the past.

68 The attending physician found Professor **Starson** not capable of deciding whether to reject or accept the proposed medical treatment. Professor **Starson** applied to the Board for a review of that decision. The Board's confirmation of incapacity was subsequently overturned on judicial review at the Ontario Superior Court of Justice. The Ontario Court of Appeal upheld the findings of the reviewing judge. That decision is appealed by the chief psychiatrist of the hospital in which Professor **Starson** currently resides.

II.Relevant Statutory Provisions

69 The following statutory provisions are relevant:

Health Care Consent Act, 1996, S.O. 1996, c. 2, Sch. A

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.

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

80. (1) A party to a proceeding before the Board may appeal the Board's decision to the Superior Court of Justice on a question of law or fact or both.

. . .

(9) The court shall hear the appeal on the record, including the transcript, but may receive new or additional evidence as it considers just.

(10) On the appeal, the court may,

(a)exercise all the powers of the Board;

(b)substitute its opinion for that of a health practitioner, an evaluator, a substitute decision-maker or the Board;

(c)refer the matter back to the Board, with directions, for rehearing in whole or in part.

III.Judicial History

70 The Board based its decision (TO-98/1320, January 24, 1999) of the respondent's incapacity to decide on the proposed medical treatment primarily on the views of the attending psychiatrists, and "largely discounted" evidence provided by his friends and colleagues, which contradicted the evidence of the psychiatrists. The Board gave little weight to Professor **Starson**'s testimony. It ultimately held that despite cogent evidence of a mental disorder, the patient is in "almost total" denial of his illness. The Board noted that without an acknowledgement of illness, the patient cannot relate information to his own particular disorder, and therefore cannot understand the consequences of a decision to either refuse or consent to medication. It also noted that the respondent failed to appreciate the risks and benefits of a treatment decision. As a result, the Board concluded that Professor **Starson** was incapacitated.

71 At the Ontario Superior Court of Justice ((1999), 22 Admin. L.R. (3d) 211), Molloy J. reversed the decision of the Board. She held that its decision had to be reviewed on a standard of reasonableness: see *T. (I.) v. L. (L.)* (1999), 46 O.R. (3d) 284 (C.A.). She found that the Board's conclusion that Professor **Starson** was in total denial of his illness was unreasonable in light of the evidence. In addition, there was no evidentiary foundation to support many of the Board's findings that Professor **Starson** suffered from delusions. She observed that the Board had unreasonably disregarded the evidence of Professor **Starson**'s friends and colleagues, that it drew insupportable inferences in regard to Professor **Starson**'s criminal activity based on vague hearsay evidence, and that the factual foundation for the alleged benefits of treatment was fundamentally flawed.

72 Molloy J. also held that the Board failed to consider the extent to which Professor **Starson**'s psychiatric disorder and alleged delusions affected his ability to understand information or appreciate the consequences of treatment. Such failure, she said, amounted to a misapplication of the legal test for capacity. Finally, she found that the Board had misapprehended Professor **Starson**'s reasons for rejecting the proposed treatment, and had ultimately allowed its subjective assessment of Professor **Starson**'s best interests to improperly influence its decision. Molloy J. concluded that there was no basis upon which the Board could reasonably find that the presumption of Professor **Starson**'s capacity had been displaced.

73 The Ontario Court of Appeal unanimously agreed with the reviewing judge: (2001), 33 Admin. L.R. (3d) 315. The court confirmed the standard of review as reasonableness, and concluded that Molloy J. properly applied that standard. The court based its agreement on three considerations in the record. First, the respondent clearly recognized that he has mental problems. Second, no evidence was led that demonstrated that any of his previous medications had helped him. Third, and significantly, his refusal to accept treatment was based primarily upon the detrimental effects of treatment on his scientific work. The court decided that although the respondent's refusal to consent to the proposed treatment might not objectively be in his best interests, there was no evidentiary basis to find incapacity and so his decision to reject treatment was one he was entitled to make.

IV.Issues

74 The appeal raises the following issues:

1 Did the reviewing judge properly apply a reasonableness standard of review to the Board's finding of incapacity?

2 Did the reviewing judge correctly find that the Board misapplied the statutory test for capacity?

3 Did the reviewing judge err in her approach to hearsay evidence?

4 Did the Court of Appeal err in its refusal to admit new evidence?

V.Analysis

A.*The Health Care Consent Act, 1996*

75 The right to refuse unwanted medical treatment is fundamental to a person's dignity and autonomy. This right is equally important in the context of treatment for mental illness: see *Fleming v. Reid* (1991), 4 O.R. (3d) 74 (C.A.), *per* Robins J.A., at p. 88:

Few medical procedures can be more intrusive than the forcible injection of powerful mind-altering drugs which are often accompanied by severe and sometimes irreversible adverse side effects.

Unwarranted findings of incapacity severely infringe upon a person's right to self-determination. Nevertheless, in some instances the well-being of patients who lack the capacity to make medical decisions depends upon state intervention: see *E. (Mrs.) v. Eve*, [1986] 2 S.C.R. 388, at p. 426. The Act aims to balance these competing interests of liberty and welfare: see B. F. Hoffman, *The Law of Consent to Treatment in Ontario* (2nd ed. 1997), at p. 3. Neither party raised the constitutionality of the Act as an issue in this appeal.

76 The legislative mandate of the Board is to adjudicate solely upon a patient's capacity. The Board's conception of the patient's best interests is irrelevant to that determination. As the reviewing judge observed, "[a] competent patient has the absolute entitlement to make decisions that any reasonable person would deem foolish" (para. 13). This point was aptly stated by Quinn J. in *Koch (Re)* (1997), 33 O.R. (3d) 485 (Gen. Div.), at p. 521:

The right knowingly to be foolish is not unimportant; the right to voluntarily assume risks is to be respected. The State has no business meddling with either. The dignity of the individual is at stake.

In this case, the only issue before the Board was whether Professor **Starson** was capable of making a decision on the suggested medical treatment. The wisdom of his decision has no bearing on this determination.

77 The law presumes a person is capable to decide to accept or reject medical treatment: s. 4(2) of the Act. At a capacity hearing, the onus is on the attending physician to prove that the patient is incapable. I agree with the Court of Appeal that proof is the civil standard of a balance of probabilities. As a result, patients with mental disorders are presumptively entitled to make their own treatment decisions. Professor D. N. Weisstub, in his *Enquiry on Mental Competency: Final Report* (1990), at p. 116 ("Weisstub Report"), notes the historical failure to respect this presumption:

The tendency to conflate mental illness with lack of capacity, which occurs to an even greater extent when involuntary commitment is involved, has deep historical roots, and even though changes have occurred in the law over the past twenty years, attitudes and beliefs have been slow to change. For this reason it is particularly important that autonomy and self determination be given priority when assessing individuals in this group.

The Board must avoid the error of equating the presence of a mental disorder with incapacity. Here, the respondent did not forfeit his right to self-determination upon admission to the psychiatric facility: see *Fleming v. Reid*, *supra*, at p. 86. The presumption of capacity can be displaced only by evidence that a patient lacks the requisite elements of capacity provided by the Act.

78 Section 4(1) of the Act describes these elements as follows:

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.

Capacity involves two criteria. First, a person must be able to understand the information that is relevant to making a treatment decision. This requires the cognitive ability to process, retain and understand the relevant information. There is no doubt that the respondent satisfied this criterion. Second, a person must be able to appreciate the reasonably foreseeable consequences of the decision or lack of one. This requires the patient to be able to apply the relevant information to his or her circumstances, and to be able to weigh the foreseeable risks and benefits of a decision or lack thereof. The Board's finding of incapacity was based on their perception of Professor **Starson**'s failure in this regard.

79 Before turning to an analysis of the reviewing judge's decision, two important points regarding this statutory test require comment. First, a patient need not agree with the diagnosis of the attending physician in order to be able to apply the relevant information to his own circumstances. Psychiatry is not an exact science, and "capable but dissident interpretations of information" are to be expected: see Weisstub Report, *supra*, at p. 229. While a patient need not agree with a particular diagnosis, if it is demonstrated that he has a mental "condition", the patient must be able to recognize the possibility that he is affected by that condition. Professor Weisstub comments on this requirement as follows (at p. 250, note 443):

Condition refers to the broader manifestations of the illness rather than the existence of a discrete diagnosable pathology. The word condition allows the requirement for understanding to focus on the objectively discernible manifestations of the illness rather than the interpretation that is made of these

manifestations.

As a result, a patient is not required to describe his mental condition as an "illness", or to otherwise characterize the condition in negative terms. Nor is a patient required to agree with the attending physician's opinion regarding the cause of that condition. Nonetheless, if the patient's condition results in him being unable to recognize that he is affected by its manifestations, he will be unable to apply the relevant information to his circumstances, and unable to appreciate the consequences of his decision.

80 Secondly, the Act requires a patient to have the ability to appreciate the consequences of a decision. It does not require actual appreciation of those consequences. The distinction is subtle but important: see L. H. Roth, A. Meisel and C. W. Lidz, "Tests of Competency to Consent to Treatment" (1977), 134 *Am. J. Psychiatry* 279, at pp. 281-82, and Weisstub Report, *supra*, at p. 249. In practice, the determination of capacity should begin with an inquiry into the patient's actual appreciation of the parameters of the decision being made: the nature and purpose of the proposed treatment; the foreseeable benefits and risks of treatment; the alternative courses of action available; and the expected consequences of not having the treatment. If the patient shows an appreciation of these parameters -- regardless of whether he weighs or values the information differently than the attending physician and disagrees with the treatment recommendation -- he has the ability to appreciate the decision he makes: see Roth, Meisel and Lidz, *supra*, at p. 281.

81 However, a patient's failure to demonstrate actual appreciation does not inexorably lead to a conclusion of incapacity. The patient's lack of appreciation may derive from causes that do not undermine his ability to appreciate consequences. For instance, a lack of appreciation may reflect the attending physician's failure to adequately inform the patient of the decision's consequences: see the Weisstub Report, *supra*, at p. 249. Accordingly, it is imperative that the Board inquire into the reasons for the patient's failure to appreciate consequences. A finding of incapacity is justified only if those reasons demonstrate that the patient's mental disorder prevents him from having the ability to appreciate the foreseeable consequences of the decision.

B.*The Decision of the Reviewing Judge*

82 Molloy J. reversed the Board's decision on two bases: first, that the Board's finding of incapacity was unreasonable based on the evidence before it, and second, that the Board erred in its application of the statutory test for capacity. The appellant agrees that the standard of review is reasonableness, but then submits that the reviewing judge misapplied both the reasonableness standard and the statutory test. I disagree.

(1)Standard of Review

83 The accepted approach to judicial review was established in *U.E.S., Local 298 v. Bibeault*, [1988] 2 S.C.R. 1048, and expanded upon in *Canada (Director of Investigation and Research) v. Southam Inc.*, [1997] 1 S.C.R. 748, and *Pushpanathan v. Canada (Minister of Citizenship and Immigration)*, [1998] 1 S.C.R. 982. In summary, the Court has adopted a pragmatic and functional approach that supplants the earlier jurisdictional approach: see *Dr. Q v. College of Physicians and Surgeons of British Columbia*, [2003] 1 S.C.R. 226, 2003 SCC 19, at para. 21. The pragmatic and functional approach requires a court to weigh a series of factors in order to discern the standard of review applicable to the particular issue under review. The factors to be considered are the existence of a privative clause or statutory right of appeal, the relative expertise of the tribunal; the purpose of the statute and provision, and the nature of the question at issue: see *Pushpanathan*, *supra*, at paras. 29-38, *per* Bastarache J. As stated in *Dr. Q*, *supra*, at para. 26, those factors, which may not necessarily be exclusive, should be considered in their totality and not applied mechanically. Against this framework, we can determine whether the appropriate standard of review in this case is correctness, reasonableness or patent unreasonableness.

84 The question under review is the Board's determination of capacity. This is a question of mixed fact and law: the Board must apply the evidence before it to the statutory test for capacity. In the absence of any error in law, this question is relatively fact-intensive: see *Southam*, *supra*, at paras. 35-37. Applying the pragmatic and functional approach to this question, it is clear that reasonableness is the appropriate standard of review.

85 On the one hand, the Act provides a broad right of appeal to the Ontario Superior Court of Justice on a question of fact or law or both: s. 80(1). The court is given broad powers of review: it may exercise all the powers of the Board, substitute its opinion for that of the Board, or refer the matter back to the Board for rehearing: s. 80(10). As well, capacity hearings are primarily adjudicative in nature. The Board's sole task is to determine the patient's capacity to consent. This matter is important to a patient's autonomy. Each of these factors counsels against a deferential standard of review: see *Dr. Q*, at paras. 27 and 32.

86 On the other hand, the Board is likely to enjoy some measure of institutional expertise with respect to determinations of capacity. The Act does not specify any minimum qualifications for Board members, apart from instances in which a member sits alone: ss. 71(3) and 73(2). The statute merely stipulates that members are to be appointed by the Lieutenant Governor in Council: s. 70(2). However, unlike the usual reviewing court, Board members are likely to have acquired experience over the course of their appointments in dealing with assessments of capacity. The Board is uniquely positioned to hear the *viva voce* evidence of the patient and physicians. These factors suggest that determinations of capacity should generally be entrusted to the relative expertise of the Board: see *Dr. Q*, *supra*, at paras. 29 and 38.

87 As well, a principal aim of the Act is to facilitate treatment for incapable patients: s. 1. To achieve this aim, determinations of capacity must be made expeditiously to avoid delays in treatment. The Act ensures that the Board is well-suited to this task. The Board is required to begin a hearing within seven days of receiving an application and must decide the application by the day after the hearing ends: s. 75. If a party requests reasons for the Board's decision, the Board must provide such reasons within two business days of the request. A court's *de novo* review of the Board's findings would immeasurably delay the outcome of treatment decisions. Such delay would frustrate the Act's purpose.

88 These countervailing factors call for review of the Board's determination of capacity on a reasonableness standard. The standard of reasonableness "involves respectful attention, though not submission" to the Board's reasons: see *Law Society of New Brunswick v. Ryan*, [2003] 1 S.C.R. 247, 2003 SCC 20, at para. 49. An unreasonable decision is one that "is not supported by any reasons that can stand up to a somewhat probing examination": see *Southam*, *supra*, at para. 56.

89 The sole issue, then, is whether the reviewing judge properly applied this standard. In my view, it is clear that she did. Molloy J. expressly adverted to a reasonableness standard at the outset of her reasons. Her analysis demonstrates that she remained faithful to this standard throughout her decision. Indeed, the appellant could not point to one instance in which the reviewing judge's analysis was suggestive of a less deferential standard of review.

90 Moreover, the evidence amply supports the reviewing judge's decision. The Board's determination of incapacity turned on two findings: that the patient was in "almost total" denial of a mental disorder, and that he failed to appreciate the consequences of his decision. Putting aside, for the moment, the issue of whether the Board properly applied the capacity test, a careful review of the evidence demonstrates that there is no basis for either of the above findings.

91 In my view, the Board's reasons, as stated earlier, appear to be overly influenced by its conviction that medication was in Professor **Starson**'s best interest. The Board arrived at its conclusion by failing to focus on the overriding consideration in this appeal, that is, whether that adult patient had the mental capacity to choose whether to accept or reject the medication prescribed. The enforced injection of mind-altering drugs against the respondent's will is highly offensive to his dignity and autonomy, and is to be avoided unless it is demonstrated that he lacked the capacity to make his own decision.

92 As a result of its focus on the respondent's best interests, the Board disregarded clear evidence of his capacity. Professor **Starson** acknowledged that he suffered from a mental condition, and appreciated the purpose of the proposed medication and the possible benefits suggested by the doctors. He had tried other treatments in the past to no avail. The evidence did not suggest that enforced treatment was likely to improve his condition. Professor **Starson** preferred his altered state to what he viewed as the boredom of normalcy. His primary reason for refusing medication was its dulling effect on his thinking, which prevented his work as a physicist. Although the Board found that he failed to appreciate the possibility that his condition could worsen, the respondent was never asked about this. Given that he acknowledged the negative impacts of his illness and the need for treatment, it was unreasonable to conclude without further inquiry that he was unable to appreciate that possibility.

(a)*Acknowledgement of Disorder*

93 The reviewing judge observed, at para. 31, that there is no support for the Board's finding that Professor **Starson**'s denial of his condition was "almost total". As she noted, at para. 30, Professor **Starson** expressly acknowledged before the Board that he displays symptoms of a bipolar disorder:

> I certainly have exhibited the symptoms of these labels that you give . . . and certainly I have exhibited things that would be considered manic.

Professor **Starson** also stated that he had "mental problems 13 years ago that were difficult, almost impossible . . . to handle". While he did not believe that these problems were the result of mental illness, as noted above he is not required to recognize his condition in such terms. When asked by the

attending physician whether the mental problems had been resolved, Professor **Starson** answered "no", and that those are problems that "through Dr. Posner, I will learn how to deal with . . . once I work it out with Dr. Posner". He also stated that due to his need for therapy, he would not leave the hospital at that time even if he were permitted to do so. Finally, he acknowledged that his own perception of reality differed from that held by others. This understanding was confirmed, as Molloy J. noted at para. 32, by letters from the patient's long-term friends.

94 It is true that Dr. Swayze expressed the view that the respondent was in denial of his disorder. The Board failed, however, to scrutinize the reasons for that view. Dr. Swayze stated that he had great difficulty eliciting Professor **Starson**'s opinion regarding his condition. He ultimately inferred that he had no awareness of the condition based upon the patient's statement that "[o]nly you people say I have an illness". This statement demonstrates only that Professor **Starson** did not accept the characterization of his unique mental functioning as an illness. The basis for the attending physician's conclusion, therefore, was premised on a misapprehension of the relevant legal test. In fact, Dr. Swayze later appeared to accept that Professor **Starson** is aware that his mental functioning is not normal:

> His personal situation, his ability to function in the community has been extremely hampered and in no way has this disorder and its manifestations, which at times Professor **Starson** seems to be quite comfortable and enthusiastic about, have not been to benefit, they've only been to detriment. [Emphasis added.]

An interesting question is how Professor **Starson** could be "quite comfortable and enthusiastic" about his disorder and its manifestations without being aware of its existence.

95 As a result, Molloy J. properly concluded that there was no reasonable basis upon which the Board could decide that the patient was in almost total denial of his condition. On the contrary, the evidence demonstrates that although the patient did not conceive of the condition as an illness, he was quite aware that his brain did not function normally.

(b)*Ability to Appreciate Consequences of Treatment Decision*

96 The Board also found that the patient failed to appreciate both the benefits of treatment and the risks of non-treatment. These are considered in turn.

(i) Benefits of Treatment

97 The Board concluded that the patient failed to appreciate the foreseeable benefits of treatment, which it defined as "improvement in his delusional state, improved prospects before the Ontario Review Board in the future, and a possible resumption of his goals in the scientific field" (p. 18). These conclusions, as Molloy J. observes at para. 60, are not supported by any basis in the record.

98 There was no evidence that the proposed medication was likely to ameliorate Professor **Starson**'s condition. Dr. Swayze testified that it was "unclear" whether treatment would facilitate a "normal functioning level", and that treatment in the past had never enabled Professor **Starson** to function adequately. Dr. Posner noted that in general, only 60 percent of patients treated with neuroleptics respond favourably to new treatment. The evidence does not suggest that Professor **Starson** would fall into that category. He stated that medication attempts "have always been the most horrible experiences of my life". The end goal of the proposed treatment was to place Professor **Starson** on mood stabilizers. Both Professor **Starson** and Dr. Swayze confirmed that he had tried different mood stabilizers in the past. The respondent testified that he had "been through all the treatment [and] it hasn't worked".

99 Furthermore, Professor **Starson** appreciated the intended effects of the medication: "I've been through these chemicals that they propose before -- and I know the effects and what they want to achieve is slow down my brain, basically . . . ". The attending physician agreed that the purpose of the medication was to slow down Professor **Starson**'s brain to a normal range:

> If by that he refers to slowing down (inaudible) speech, or racing thoughts, or intrusive thoughts, which would be characteristic elements in a manic episode, then that is my intention. If it is to blunt him beyond what would be put (inaudible) of a normal range of mood and thought process without psychosis, then that is my intent.

The respondent's stated position on medication was that "should the individual think the medications are helping them, by all means then the individual should be on the medications". As noted, however, his past experience led him to believe that the medication would not help him. Although Professor **Starson** did not believe the medication would affect his sense of reality, there was no clear

evidence, as the reviewing judge observed, with respect to the nature and extent of Professor **Starson**'s delusions or "as to what delusions the medication would eliminate or control" (Molloy J., at para. 61).

100 There was also no evidence that treatment would improve the patient's prospects before the ORB. The Board, as Molloy J. observed at para. 62, is not suited to predict "the future determination of a wholly separate administrative tribunal which must apply different criteria and a different legal test". Neither Dr. Swayze nor the Board had even received the ORB's reasons for decision. In these circumstances, the Board's conclusion that treatment would improve Professor **Starson**'s chances at future ORB hearings is entirely speculative.

101 Most importantly, the Board appears to have entirely misapprehended the respondent's reasons for refusing medication. The Board acknowledged only that he had "some antipathy to the medication as a result of suffering side effects in the past" (p. 17). In *Fleming v. Reid*, *supra*, Robins J.A. observed, at p. 84, that neuroleptic medication carries with it "significant, and often unpredictable, short term and long term risks of harmful side effects". Professor **Starson** clearly appreciated the extent of these risks. However, it was the intended purpose of the medication that he primarily objected to.

102 Professor **Starson** stated that the medication's normalizing effect "would be worse than death for me, because I have always considered normal to be a term so boring it would be like death". The evidence indicates that the dulling effects of medication transformed Professor **Starson** "into a struggling-to-think `drunk'", a result that precluded him from pursuing scientific research. Professor **Starson** stated unequivocally that every drug he had previously tried had hampered his thinking. As a result, there was no basis for the Board to find that a possible benefit of treatment would be the resumption of his work as a physicist. The evidence, in fact, suggests just the opposite. It is apparent from the record that Professor **Starson** values his ability to work as a physicist above all other factors. It is clear that he views the cure proposed by his physicians as more damaging than his disorder.

(ii)Risks of Non-Treatment

103 The Board also found that the respondent "does not appreciate the consequences of a decision to refuse medication, that is the likelihood that his mental disorder will worsen" (p. 18). There was speculation that his condition had begun to deteriorate, but little evidentiary basis to gage the validity of that speculation. Dr. Swayze noted that since "manic episodes tend to resolve spontaneously, treated or otherwise", he initially had believed that the patient's condition would improve. He ultimately concluded that the record of Professor **Starson**'s prior hospitalizations would suggest "a chronic, unremitting course", but he did not express a belief that the condition was deteriorative.

104 Dr. Posner disagreed, and stated that he felt the evidence suggests "a progressive psychotic state". In contrast to Dr. Swayze, he noted that the literature suggests that untreated mania "can and often does progress in severity". Dr. Posner felt that the patient "is in control a good, but not complete, percentage of the time". However, he observed that Professor **Starson** had not published in journals in the three or four years preceding the hearing, and that conversations with other psychiatrists suggested that Professor **Starson** was relatively more irritable than he had been in the past. As a result, he felt that the patient's condition was likely to worsen. However, as Dr. Posner noted, it was unclear whether medication could impede the condition's deterioration.

105 Putting aside this scant evidentiary basis, Professor **Starson** was never asked at the hearing whether he understood the possibility that his condition could worsen without treatment. The presumption, of course, is that a patient has the ability to appreciate the consequences of a treatment decision. The onus is not on Professor **Starson** to prove this ability. As noted above, Professor **Starson** was alert to the presence of a mental condition and the need to be in hospital to treat that condition. In light of his awareness of the need for treatment, it was unreasonable for the Board to conclude, without further inquiry, that the respondent failed to appreciate the possibility that his condition could worsen.

106 In summary, there was no basis to find that Professor **Starson** lacked awareness of his condition or that he failed to appreciate the consequences of treatment. In the absence of these findings, there was no support for the Board's ultimate finding of incapacity. As a result, Molloy J. correctly set aside the Board's decision.

107 I disagree with the conclusion of my colleague, McLachlin C.J. Her reasons, with respect, appear to disregard the bulk of Professor **Starson**'s testimony. Absent is the candid acknowledgement by him of his mental problems, his obvious appreciation of the intended purpose of the medication, the admitted uncertainty by the doctors that treatment would improve Professor **Starson**, the failure in

the past of mood stabilizers, which was the end goal of the proposed treatment (see para. 98), and his rationale for refusing the medication.

108 The respondent recognized the need for treatment as evidenced by his express request to remain in hospital to work through his problems with Dr. Posner. Although McLachlin C.J. accepts that the respondent was aware of his condition and its manifestations, she concludes that his denial of illness renders him incapable. The conclusion of his incapacity is founded on his disagreement with the diagnosis of his physicians. In my respectful view, this was the error the Board made. The conclusion of the Board adopted by McLachlin C.J. comes from an appraisal of the patient's best interests rather than whether the evidence established his capacity to decide.

(2)The Board's Misapplication of the Capacity Test

109 Although the above findings are sufficient to dispose of the appeal, Molloy J. also observed that the Board misapplied the statutory test for capacity. I agree with that conclusion.

110 The interpretation of the legal standard for capacity is a question of law: see *Southam*, *supra*, at para. 35. No deference is owed to the Board on this issue. As noted above, the broad statutory right of appeal and adjudicative nature of the proceedings militate against deference. Furthermore, courts clearly have relative expertise on general questions of statutory interpretation. One of the stated purposes of the Act is to provide for the consistent application of its rules: s. 1. Consistency requires courts to ensure that individual panels do not diverge in their interpretation of statutory provisions. Finally, this question of law has broad application and need not be resolved anew on each appeal. A correctness standard of review on this issue will not impede the expeditious treatment of patients.

111 The Board found that Professor **Starson** failed to appreciate the risks and benefits of treatment, but neglected to address whether the reasons for that failure demonstrated an inability to appreciate those risks and benefits. Molloy J. observed, at para. 74:

> The Board's . . . conclusions appear to be based on its perception that Professor **Starson** *failed* to understand the information or appreciate the consequences as evidenced by his refusal to agree that he should have the recommended treatment, rather than any evidence that his mental disorder prevented him from being *able* to understand and appreciate. [Emphasis in original.]

As noted above, a patient's failure to recognize consequences does not necessarily reflect an inability to appreciate consequences. It is critical that the Board determine whether the reasons for a patient's failure to appreciate consequences demonstrate that the patient is unable, as result of his condition, to appreciate those consequences. In this case, the Board stated that the patient failed to appreciate the consequences of treatment with regard to future dispositions by the ORB. However, neither of the psychiatrists who testified had discussed any of these possible consequences with the patient. Professor **Starson**'s perceived failure in this regard might have simply reflected the psychiatrists' failure to inform him of the potential consequences.

112 Furthermore, as noted above, the Board's reasons indicate that it strayed from its legislative mandate to adjudicate solely upon the patient's capacity. The Board stated at the outset of its reasons that "it viewed with great sadness the current situation of the patient" (p. 15), and later noted that "his life has been devastated by his mental disorder" (p. 16). Putting aside the fact that the respondent entirely disagreed with those statements, the tenor of the comments indicate that the Board misunderstood its prescribed function. The Board's sole task was to determine the patient's mental capacity. The wisdom of Professor **Starson**'s treatment decision is irrelevant to that determination. If Professor **Starson** is capable, he is fully entitled to make a decision that the Board, or other reasonable persons, may perceive as foolish. The Board improperly allowed its own conception of Professor **Starson**'s best interests to influence its finding of incapacity.

113 I conclude that Molloy J. correctly decided that the Board misapplied the legal test for capacity.

C.*Evidentiary Issues*

114 The appellant raises two other arguments: that the reviewing judge erred in her approach to hearsay evidence, and that the Court of Appeal erred in its refusal to admit new evidence.

(1)Hearsay Evidence

115 The appellant argues that the reviewing judge wrongly interfered with the Board's discretion to determine the weight of hearsay evidence regarding previous threats made by the patient. This finding was tangential to the reviewing judge's decision and had no bearing on her disposition of the case. As a

result, the issue is of no consequence to the outcome of the appeal. In any event, there was no error in the reviewing judge's approach to the hearsay evidence. As she observed, there is no doubt that such evidence is admissible before the Board: see the *Statutory Powers Procedure Act*, R.S.O. 1990, c. S.22, s. 15(1). Hearings must be conducted in an expeditious manner to ensure that treatment decisions can be made without undue delay. To fulfill that mandate, the Board will often be forced to rely on hearsay evidence to become fully informed of a patient's circumstances. The weight to be accorded to such evidence is normally a matter that is left to the discretion of the Board. Nonetheless, the Board must be careful to avoid placing undue emphasis on uncorroborated evidence that lacks sufficient indicia of reliability, a fact it failed in this case to observe.

(2)New Evidence on Appeal

116 The appellant brought a motion before the Court of Appeal to hear new evidence. The evidence concerned Professor **Starson**'s current mental status and a subsequent disposition order by the ORB. Section 80(9) of the Act provides as follows:

> The court shall hear the appeal on the record, including the transcript, but may receive new or additional evidence as it considers just.

117 The appellant provided this Court with no details of the evidence that it sought to admit. As a result, there is no measure to assess the Court of Appeal's decision to reject it.

118 A patient's capacity may fluctuate over time. The Board's decision is specific to the patient's capacity at the time of the hearing. A finding that Professor **Starson** is capable may have an important effect on future treatment decisions. If he subsequently becomes incapacitated, the attending physician needs consent to treatment from his substitute decision-maker: see s. 10(1)(b) of the Act. If the substitute decision-maker knows of a prior capable wish that is applicable to the circumstances, consent must be given or refused in accordance with that wish: s. 21. Consequently, the Board's previous determination that Professor **Starson** was capable may be relevant to whether he had expressed wishes that are applicable to future circumstances. If so, he has the right to have that capacity recognized in law, so that sufficient recognition may be accorded to any wishes expressed at that time.

119 Accordingly, on judicial review under the *Health Care Consent Act, 1996*, a court's task is to determine the reasonableness of the Board's finding in relation to the patient's capacity at the time of the hearing. New evidence relating to the patient's deterioration after the time of hearing is irrelevant to that determination. This is to be contrasted with the situation dealt with in *R. v. Owen*, [2003] 1 S.C.R. 779, 2003 SCC 33, released concurrently, in which fresh evidence of the deterioration of the mental condition of a person held not criminally responsible on account of mental disorder was ruled properly admissible on the issue of whether the individual should receive an absolute discharge or be further detained as a significant risk to public safety. In this case there is no issue of public safety. If a patient's condition worsens after a capacity hearing, it is open to the attending physician to make another finding of incapacity, which the patient can again challenge before the Board. In light of the relative expertise of the Board on factual determinations of capacity, and the expeditious manner in which it is able to deal with hearings, the Board is clearly the most appropriate forum for new evidence to be examined.

VI.Conclusion

120 The reviewing judge properly held that the Board's finding of incapacity was unreasonable, and that the Board misapplied the statutory test for capacity. There is no basis to find that either of the courts below erred on the evidentiary issues that were raised by the appellant. Accordingly, I would dismiss the appeal.

Appeal dismissed, MCLACHLIN C.J. *and* GONTHIER *and* LEBEL JJ. *dissenting.*

Solicitor for the appellant: Attorney General of Ontario, Toronto.

Solicitors appointed by the Court as amicus curiae: Hiltz Szigeti, Toronto.

Solicitors for the intervener the Schizophrenia Society of Canada: Borden Ladner Gervais, Toronto.

Solicitors for the intervener the Centre for Addiction and Mental Health: Paterson MacDougall, Toronto.

Solicitors for the interveners the Mental Health Legal Committee and the Mental Health Legal Advocacy Coalition: Swadron Associates, Toronto.