Proof of incapacity: analysis of CIUSSS de L’Ouest-de-L’île-de-Montréal (ST. Mary’s Hospital Center) c. R.C.

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PROOF OF INCAPACITY: ANALYSIS OF CIUSSS DE L’OUEST-DE-L’ÎLE-DE-MONTRÉAL (ST. MARY’S HOSPITAL CENTER) c. R.C.[1]

Summary

The authors comment on this decision rendered on September 20, 2024, in which the Court of Appeal ruled on the capacity to consent to care in the presence of a psychiatric disorder. The Court of Appeal overturned the first instance decision, which had found the respondent capable of refusing treatment with antipsychotic medications even though he had refuted his diagnosis, because he understood the benefits that antipsychotic medications could afford him and refused to take them because of their side effects. The Court of Appeal rather concluded that the trial judge had misapplied the five criteria to be used to assess whether a person is capable of consenting to care, particularly in the context where (i) the trial judge’s conclusion ran counter to the uncontradicted opinion of an expert; and (ii) there was much evidence supporting the fact that the respondent was incapable of making an informed decision.

INTRODUCTION

In this case, the Centre intégré universitaire de santé et de services sociaux de l’Ouest-de-l'Île-de-Montréal (the “CIUSSS”) appealed a decision rendered by the Superior Court on March 14, 2024, dismissing its application for an authorization to provide care to R.C., a 51-year-old man. The Superior Court had concluded that the CIUSSS had not proven that the respondent was incapable of consenting to care. The Court of Appeal was thus called upon to review the trial judge’s answer

to the first question (incapacity to consent) in the analytical framework surrounding the test that has now been used for three decades.[3]

THE FACTS

R.C. has a complex medical history. He was hospitalized several times between 2007 and 2019 for mental health issues, including suicidal ideation and personality disorders. In 2021, he was admitted to the CHUM for COVID-19-related complications having resulted in brain damage caused by hypoxia. From 2022 onwards, he made repeated visits to the emergency room, often to obtain benzodiazepines, leading him to become addicted. Even though he adhered to treatment with antipsychotic medication for a time, R.C. stopped taking his medication because of undesirable side effects.

In January 2024, after an episode of confusion, he was taken to hospital where he was diagnosed with late-onset schizophrenia. However, R.C. refuted the diagnosis, claiming that his health problems were caused by an artificial intelligence device he believed had been implanted in his body. The psychiatrists who assessed him concluded that he was incapable of consenting to care.

On February 16, 2024, the CIUSSS filed an application for authorization to re-hospitalize R.C. and administer antipsychotic medications, despite his categorical refusal.

After analyzing the evidence, which essentially consisted of R.C.'s testimony and that of the CIUSSS psychiatrist, the Superior Court concluded that R.C. understood the nature of his condition and the benefits of the proposed treatment, despite his refusal to accept his diagnosis. The Court was of the opinion that the CIUSSS psychiatrists, in their analysis of R.C.'s capacity, had erroneously and repeatedly carried over his rejection of the diagnosis in a cascading fashion in their analysis of the five criteria from the decision in A.G.,[4] thereby making the same error as the one that the Court of Appeal had identified in the M.H. decision.[5] Despite the absence of a second opinion on R.C.'s capacity, the Superior Court had determined that he was able to consent to his care. According to the trial judge, in keeping with the teachings of the Court of Appeal in the F.D. decision,[6] he therefore lacked jurisdiction to order care. For this reason, he dismissed the application for an authorization to provide care.

THE COURT OF APPEAL'S DECISION

The Court of Appeal began by reiterating the five criteria for assessing a person's capacity, namely:

> Does the person understand the nature of the illness for which treatment is proposed?
> Does the person understand the nature and purpose of the treatment?
> Does the person understand the risks and benefits involved in undergoing the treatment?
> Does the person understand the risks involved in not undergoing the treatment?
> Is the capacity to consent to treatment affected by the patient's illness?[7]

It pointed out that the criteria are not cumulative and that it is incumbent upon the trier to assess them as a whole.[8] Moreover, the mere fact that a person refuses care that would be in their best interest is not enough to conclude that the person is incapable,[9] nor is their mere rejection of their diagnosis.[10]

In this case, the Court of Appeal considered that the Superior Court judge had committed a palpable and overriding error making its intervention warranted. It stated that the trial judge was *obliged* to express an opinion on whether the evidence proffered was sufficient, adding that the judge had a proactive role to play in protecting the interests of the person involved. If the trial judge felt that a point that had not been the subject in a genuine adversarial debate raised a problem in his view, it was up to him to ask questions.[11]

Subsequently, the court took extracts from the evidence consisting of a psychiatric report and the testimony of its author and went on to note that the evidence did not allow the trial judge to conclude that R.C. was capable of consenting or refusing the proposed treatment plan, on the contrary. Based on the same evidence, the Court declared R.C. incapable of consenting to care and sent the case back to the Superior Court so that it could determine whether there was indeed categorical refusal and assess the terms of the treatment plan sought.

AUTHORS' COMMENTS

This decision of the Court of Appeal follows approximately 20 other decisions[12] respecting orders authorizing care handed down by this same court, which have all further established and clarified the guiding principles surrounding such orders since the F.D. decision of 2015.[13] These successive decisions have not only added to case law, they have refined the assessment criteria and legal requirements pertaining to applications for authorization to provide care. Such a development in case law shows that the courts are committed to circumscribing complex healthcare situations. Doing so involves striking a balance between the rights to freedom and self-determination and the protection of those who are vulnerable or otherwise unable to consent.

On July 6, 2015, the Court of Appeal of Quebec marked a decisive turning point where orders authorizing care are involved by rendering a decision that sent a clear message to the Superior Court, namely *F.D.* c. *Centre universitaire de santé McGill (Hôpital Royal-Victoria).*[14] In that decision, an analytical framework was established to ensure compliance both with the provisions of the law and the spirit of the law. Since then, the Court has handed down some 20 other significant decisions, each shedding additional light. The guiding principles derived from these decisions can be summarized under the following themes:

Rights relating to the judicial process

Every person has the fundamental right to contest an application for a order authorizing care, to be heard and to be represented.[15]

The judge must proactively protect the user's interests and ensure that they are represented by a lawyer.[16]

Scope of the care plan

Requiring a definite care plan does not mean dictating which medication should be administered in a limitative way.[17]

A judge may remove certain substances from a treatment plan if they deem that to be in the patient's best interest.[18]

It is crucial to draw a distinction between preventive care and a treatment plan that includes various alternatives as the situation evolves.[19]

For a future hospitalization clause to be valid, there must be a reasonable foreseeability of hospitalization.[20]

When a patient is to be placed, the application for authorization must indicate where they are to be placed.[21]

Physical restraint may only be used if it is necessary to avoid serious harm, and must be limited to the minimum.[22]

A parent's refusal to consent to a treatment plan may not be warranted if the plan is in the child's best interests.[23]

Duration of the authorization

When the person concerned is not cooperating and access to their previous medical records is not available, the judge must be especially careful in assessing whether the proposed care plan is legal, in particular in terms of its duration and scope.[24]

The duration of the care order should be as short as reasonably possible, without compromising the effectiveness [25]

of the treatment.
When a future hospitalization is contemplated, the judge must take into account the time required to stabilize the patient.[26]
The 30-day period for a future hospitalization should not be considered an absolute limit, as a longer period may be deemed necessary after a thorough analysis.[27]

The evidence

The mere fact that a relationship exists between an expert and a party does not make the expert's testimony inadmissible: The circumstances surrounding the expert's role must be reviewed.[28]
An expert who does not know a patient's reasons for refusing treatment is not deemed to have breached their duty to inform.[29]
An expert may testify to reported facts without the possibility of anyone opposing them; however, this does not mean that reported facts are proven, as the rules of evidence remain stringent in this context.[30]
An expert report may suffice as testimony; the judge need not require the patient's testimony if the patient cannot understand the issues at hand.[31]
Applications for safeguard orders may be unsuccessful where there is no expert report and it is not demonstrated that the matter is urgent.[32]

This review highlights the significant advances that the courts have made in overseeing applications for orders authorizing care and protecting vulnerable people. The analytical framework established in the F.D. decision remains relevant, and subsequent decisions have further refined its questions.

The decision that the Court of Appeal handed down in *Centre intégré universitaire de santé et de services sociaux de l'Ouest-de-l'Île-de-Montréal* c. *R.C.* is milestone in the jurisprudence on court orders authorizing care. By overturning the lower court's judgment, the Court of Appeal reaffirmed the need for a thorough assessment of the capacity to consent, emphasizing that the work of medical teams and applications made by healthcare institutions are important to ensure appropriate care. This decision not only underscores the fact that it is important to protect the rights of users, but also that the work of the court is crucial, for it must ensure that the criteria are met without substituting its opinion for that of the experts heard.

CONCLUSION

The decision discussed in this paper is part of a series of decisions that have clarified and enhanced the guiding principles established since the F.D. decision was handed down in 2015.[33] The Court of Appeal has provided valuable guidelines for judges, institutions and healthcare professionals to use in their assessment of applications for authorization to provide care. Through a careful review of the circumstances of each case, the courts have shown that they are committed to effectively circumscribing complex health situations by ensuring that institutions have the tools they need to respond appropriately.

Lastly, we must recognize that while progress has been made, there are still unresolved issues that need to be addressed. Recent court decisions, including the one that led to the R.C. decision,[34] illustrate the importance of constant dialogue between those involved in the legal aspect of cases and those dealing with clinical realities. As jurisprudence continues to develop, paying close attention to future developments will be key to ensuring that healthcare institutions can act effectively in consideration of patients' needs.

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1. 2024 QCCA 1231.
2. *F.D.c. Centre universitaire de santé McGill (Hôpital Royal-Victoria),* 2015 QCCA 1139.
3. See the landmark decision, *Institut Philippe Pinel de Montréal* c. *A.G.*, 1994 CanLII 6105 (QC CA).
4. *Institut Philippe Pinel de Montréal* c. *A.G.*, 1994 CanLII 6105 (QC CA).
5. *M.H.* c. *Centre intégré universitaire de santé et de services sociaux de la Capitale-Nationale*, 2018 QCCA 1948, para. 57.

6. *F.D.* c. *Centre universitaire de santé McGill (Hôpital Royal-Victoria),* 2015 QCCA 1139.
7. This decision, para. 13; with reference to *Institut Philippe Pinel de Montréal* c. *A.G.*, 1994 CanLII 6105 (QC CA), pp. 28 to 33.
8. This decision, para. 14; with reference to *M. B.* c. *Centre hospitalier Pierre-le*-Gardeur, 2004 CanLII 29017 (QC CA), para. 45; *M.C.* c. *Service professionnel du Centre de santé et de services sociaux d'Arthabaska-et-de-L'Érable,* 2010 QCCA 1114, para. 13.
9. This decision, para. 14; with reference to *M. B.* c. *Centre hospitalier Pierre-le-Gardeur*, 2004 CanLII 29017 (QC CA), para. 46.
10. This decision, para. 14, with reference to *Starson v. Swayze*, 2003 SCC 32, para. 79 and *M.H.* c. *Centre intégré universitaire de santé et de services sociaux de la Capitale-Nationale*, 2018 QCCA 1948, paras. 61–62.
11. This decision, para. 18.
12. We have excluded the following decisions from our analysis: *Bédard* c. *Centre intégré universitaire de santé et de services sociaux du Nord-de-l'Île-de-Montréal*, 2023 QCCA 508; *M.G.* c. *Centre intégré universitaire de santé et de services sociaux de la Capitale-Nationale*, 2019 QCCA 203; *S.F.* c. *CIUSSS de Centre-Ouest-de-l'île-de-Montréal – Hôpital général juif – Sir Mortimer B. Davis,* 2021 QCCA 1531; *P.L.* c. *Centre intégré de santé et de services sociaux de la Montérégie-Centre*, 2018 QCCA 318; *N.G.* c. *Sir Mortimer B. Davis Jewish General Hospital*, 2021 QCCA 1892; *F.D.* c. *Centre intégré universitaire de santé et de services sociaux de la Capitale-Nationale,* 2017 QCCA 1206.
13. *F.D.c. Centre universitaire de santé McGill (Hôpital Royal-Victoria),* 2015 QCCA 1139.
14. Ibid.
15. *M.H.c. Centre intégré universitaire de santé et de services sociaux de la Capitale-Nationale,* 2018 QCCA 1948, paras. 68 and 69.
16. *A.N.* c. *Centre intégré universitaire de santé et de services sociaux du Nord-de-l'île-de-Montréal,* 2022 QCCA 1167 , para. 30.
17. *Centre intégré universitaire de santé et de services sociaux de la Capitale-Nationale* c. *D.M.,* 2017 QCCA 1333, para. 25.
18. *Centre intégré universitaire de santé et de services sociaux du Saguenay-Lac-Saint-Jean c. O.G.*, 2018 QCCA 345, paras. 15 and 16.
19. *C.R.c. Centre intégré de santé et de services sociaux du Bas-St-Laurent*, 2017 QCCA 328, para. 28.
20. *G.J.* c. *Centre intégré de santé et de services sociaux de Laval*, 2021 QCCA 1944, paras. 24 to 26.
21. *Centre intégré universitaire de santé et de services sociaux de la Mauricie-et-du-Centre-du-Québec (CIUSSS MCQ)* c. *J.B.*, 2017 QCCA 1638., paras. 30 to 35.
22. *X.Y.c. Hôpital général du Lakeshore*, 2017 QCCA 1465, para. 20.
23. *A.P.* c. *Centre hospitalier universitaire Sainte-Justine,* 2023 QCCA 58, para. 19.
24. *L.C.* c. *Centre hospitalier de l'Université de Montréal (CHUM),* 2015 QCCA 1139, paras. 4 and 5.
25. *D.A.* c. *Centre intégré de santé et de services sociaux des Laurentides,* 2016 QCCA 1734, para. 31.
26. *T.F.* c. *CIUSSS de l'Est-de-l'île-de-Montréal* , 2022 QCCA 1306, para. 25.
27. *N.M.* c. *Centre intégré de santé et de services sociaux de la Montérégie-Centre,* 2022 QCCA1567, para. 17.
28. *M.G.* c. *Centre intégré universitaire de santé et de services sociaux du Centre-Sud-de-l'Île-de-Montréal ,* 2021 QCCA 1326, para. 11.
29. *Centre intégré universitaire de santé et de services sociaux de l'Ouest-de-l'île-de-Montréal (Douglas Mental Health University Institute)* c. *I.A.,* 2023 QCCA 1100, para. 30.
30. *Institut universitaire en santé mentale Douglas c. W.M.*, 2016 QCCA 1081, para. 5
31. *A.D.* c. *Centre intégré universitaire de santé et de services sociaux du Centre-Sud-de-l'île-de-Montréal,* 2023 QCCA 1240, paras. 50, 56–57.
32. *A.F.* c. *Centre intégré de santé et de services sociaux des Laurentides,* 2021 QCCA 928, para. 50.
33. *F.D.* c. *Centre universitaire de santé McGill (Hôpital Royal-Victoria),* 2015 QCCA 1139.
34. *CIUSSS de l'Ouest-de-l'Île-de-Montréal (St. Mary's Hospital Center)* c. *R.C.*,2024 QCCA 1231.