

Starson v. Swayze: The Supreme Court Speaks Out (Not all That Clearly) on the Question of “Capacity”

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Objectives: The decision in *Starson v. Swayze* interpreting the “understanding” requirement for capacity in the Ontario Health Care Consent Act (HCCA) provoked concern and criticism from psychiatric quarters. This article seeks to explain the decision and its implications for Ontario and other provinces.

Method: The majority and minority opinions in the *Starson* case, and 4 cases decided in Ontario since *Starson*, were closely analyzed. The literature on capacity was examined. The decision’s constitutional implications were considered.

Results: Patients need not be able to understand that their condition constitutes an illness to be found capable of consenting to or refusing treatment. The focus should be on their ability to understand that they are affected by the condition’s manifestations. A patient’s “best interests” are not relevant to the capacity determination. The majority opinion departed from the traditional role accorded to a patient’s denial of illness in determining capacity. Contrary to the views of some commentators, the Court’s discussion of the actual benefits and risks of the treatments prescribed for *Starson* had no bearing on the capacity issue. Three of the post-*Starson* cases examined complied with the Court’s holding; one did not. The majority’s distinction regarding what patients must be able to understand about their condition is likely not a “principle of fundamental justice” under the Canadian Charter of Rights and Freedoms (the Charter). The right of the capable patient to refuse treatment and the irrelevance of the patient’s best interests likely do constitute such principles.

Conclusions: Patients in Ontario cannot be found incapable because they deny they are ill. Ability to recognize the manifestations of their condition suffices. This distinction is probably only binding in Ontario. The capable patient’s right to refuse treatment and the irrelevance of the patient’s best interests likely are binding throughout Canada.

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Clinical Implications

- In Ontario, the Ontario Consent and Capacity Board (the Board) determinations of capacity will have to focus on the patient’s ability to recognize the manifestations of his or her condition rather than on whether the patient denies that he or she is ill.
- Consideration of the patient’s best interests will have to be avoided in determining a patient’s capacity.
- The right of the capable patient to refuse treatment and the principle that the patient’s best interests are irrelevant to the capacity determination will likely have to be respected throughout Canada.

Limitations

- The conclusions and clinical implications above are based on the author’s analysis of the decision in *Starson v. Swayze* and his analysis of the constitutional implications of that decision. They are thus dependent on the accuracy of these analyses, which accuracy will ultimately be dependent on the future decisions of the Supreme Court.

Key Words: *Starson*, Ontario Health Care Consent Act, capacity, denial of illness, manifestations of condition, best interests, autonomy

Psychiatry and the law are moving toward agreement on one principle: except in situations of emergency, capable psychiatric patients—those who are able to understand the information they are receiving and able to appreciate the foreseeable consequences of accepting or refusing treatment—have the right to make that treatment decision for themselves, whether they are voluntary or involuntary patients. Legislation in 4 provinces (British Columbia, Newfoundland and Labrador, New Brunswick, and Saskatchewan), however, continues to allow the capable patient's refusal of treatment to be overridden either by a psychiatrist or by a court.¹ p 178–179 The constitutionality of such legislation is seriously in doubt, as will be noted later in this article.

Agreement on the principle of the capable patient's right to refuse treatment has not come without reservations, inasmuch as many psychiatrists tend to see the legal principle of autonomy, on which the right to refuse is based, as incongruent with "true autonomy," which, they maintain, involves "the choices of the healthier self. . . and that self's long-term autonomy."² p 12; 3 Some psychiatrists also express concern over the possibility that harm caused by delays in treatment will accrue to involuntary patients seeking review of findings of incapacity from courts and review boards, especially since it is rare for incapacity findings to be overturned on review.⁴ Moreover, it is likely that many psychiatrists continue to see the patient's right to refuse treatment as a protection of his or her "right to rot."⁵

An open and greater source of contention between the 2 professions is the question of what the "understanding criterion" of the capacity definition requires—what information the patient has to understand to be considered capable to accept or refuse treatment—and to what extent a consideration of the patient's best interests figures into the determination of capacity. The difference of opinion on the best interests question has been a particular "point of friction between psychiatry and law."⁶ p 814

In the 2003 case of *Starson v. Swayze*,⁷ the Supreme Court of Canada made its first foray into these issues regarding capacity. The Court was called on to interpret the capacity provision of the Ontario Health Care Consent Act (HCCA),⁸ wherein capacity is defined in terms of the individual's ability both "to understand the information that is relevant to making a decision about treatment" and "to appreciate the reasonably foreseeable consequences of a decision or lack of decision."⁸ s 4(1)

The Court, which was split 6 to 3 in its decision, issued 2 opinions. In an opinion written by Justice Major, the majority held, as had both the Ontario Superior Court⁹ and the Ontario Court of Appeal,¹⁰ that the determination of the Ontario Consent and Capacity Board (the Board) that "Professor" Starson was

incapable to refuse treatment was unreasonable and had to be set aside.

Reactions to the decision from the psychiatric profession ranged from the relatively mild "it will continue to be more difficult to provide treatment for involuntary patients who are severely mentally ill"¹¹, p 2 to the strong response of Dr Richard O'Reilly of the Department of Psychiatry at the University of Western Ontario:

[Persons] who have delusions—fixed false beliefs—that the Pope works for them, that they are going to marry Joan Rivers and that Pierre Trudeau was killed by aliens [all beliefs Starson reportedly held], cannot appreciate that anti-psychotic medication can free them of these mistaken beliefs and thus [are] not capable of consenting to or refusing this treatment. Somehow all the courts [in the Starson case] have contrived to ignore this simple fact.¹² p 51

What legal principles the *Starson* case stands for, the case's implications for the future, and whether these concerns and criticisms of the judgment are justified, are the subjects of this article.

The Facts and Evidence in the Case

At the time the case was heard, all parties except Starson believed that he suffered from bipolar disorder (a diagnosis that has since been changed to schizoaffective disorder).¹³ Whatever the nature of his illness, Starson refused the treatment plan proposed for him—neuroleptic medication, mood stabilizers, antianxiety medication, and antiparkinsonian medication.⁹ para 3 He denied having bipolar disorder or any other form of mental illness. As a result of his denial of illness, his treating psychiatrist judged him to be incapable of making a treatment decision. Starson then applied to the Board for a review of that determination, and after a hearing, the Board confirmed the finding of incapacity.

Starson had graduated in 1976 from Ryerson Polytechnical Institute with a degree in electrical engineering and had gone to work for an international electrical engineering company, eventually rising to the position of national sales manager. By the late 1980s, having become deeply interested in physics, he was developing ideas about antiprotons and antigravity.¹² With a physics professor at Stanford University, Professor H Pierre Noyes, he coauthored an article in 1991 entitled "Discrete Anti-Gravity." Professor Noyes filed a letter with the Board in the 1999 hearing stating that he was "much impressed" and "excited" by Starson's ideas, even if they were unconventional.⁹ para 28 Although many of his ideas had been found to be invalid, he was generally considered by his peers to be "extraordinarily intelligent," to the point that "although [he was] not by university training a professor, he

was allow[ed] to use the title as recognition of his accomplishments.”^{7, para 65} In the media, he was called Canada’s Beautiful Mind, a reference to John Nash in the book and Hollywood film by that name.¹²

Starson had indicated at the Board hearing that his primary reason for refusing medication was its “dulling effect on his thinking, which prevented his work as a physicist.” He stated that he preferred the symptoms of his condition to the effects of the medication.^{7, para 92,102}

Nobody disputed Starson’s brilliance. However, since 1985, when he was 29, Scott Starson, born Scott Jeffery Schutzman, had been in and out of mental institutions in Canada and the United States. During most of his hospitalizations, he was diagnosed with bipolar disorder. Throughout this time, it was not disputed by anyone—except Starson himself—that he suffered from long-standing mental illness and that “without medication his condition was likely to continue to deteriorate.”^{7, para 4} In an article published in *MD Canada*¹² following the Supreme Court’s decision, Starson was described by a writer who had interviewed him as having textbook symptoms of mania (“his speech was a gusher of disjointed, disorganized ideas, tangents of thought that looped around each other with no landing point”) with delusions (for example, “claimed involvement in the deaths of 3 people, including *Star Trek* creator Gene Roddenberry” and that he was the greatest scientist in the world) and hallucinations (“at times he had side conversations with imaginary people”) and as having a questionable comprehension of “the nature of what the Supreme Court had done.”^{12, p 40}

Starson’s illness had also caused him to come into contact with the criminal law. On several occasions he had uttered death threats against acquaintances and strangers, resulting in criminal charges being filed against him.^{7, para 2} His hospital confinement at the time of the Starson litigation had in fact come about because his treating psychiatrist filed a criminal charge of death threats against him, a charge which the psychiatrist had admitted to the Board was made for the purpose of having Starson found not criminally responsible on account of mental disorder and involuntarily hospitalized—a strategy that the Superior Court judge questioned on ethical grounds.^{9, para 4.6} The strategy proved effective when Starson was in fact found not criminally responsible and, after a hearing before the Ontario Review Board that concluded “the accused suffers from a serious mental disorder and is a significant threat to public safety,” was ordered to be confined at the Centre for Addiction and Mental Health, Queen St Division.^{9, para 2; 13, p 50}

At his capacity hearing before the Board, Starson was found incapable on account of his denial that he suffered from any mental illness. As summed up by one of the doctors testifying

before the Board, given that Starson did not understand that he had a mental illness, “it was impossible . . . to explore with him benefits of medication obviously because that would be tied to an understanding of the need to take them.”^{7, para 33} In the Board’s words, “without acknowledgment that he has some type of mental disorder and that his behaviour is being affected by that disorder, [Starson] . . . cannot understand the potential benefits of the medication proposed.”^{7, para 20}

The Supreme Court’s Judgment

As the Supreme Court iterated in its majority and minority opinions in Starson, owing to the law’s presumption that persons, including psychiatric patients, are “capable to decide to accept or reject treatment,” the onus was on the attending physician to establish Starson’s incapacity.^{7, para 13,77} Chief Justice McLachlin, writing the opinion for the 3-Justice minority, felt that onus had been satisfied. Echoing the Board’s sentiments, she wrote that as a result of his being in “almost total denial of mental disorder, . . . Starson lacked [the ability] to understand and acknowledge his condition. One cannot appreciate the benefits of treatment unless one understands and appreciates the need for treatment.”^{7, para 28,39}

There are several tests for capacity found in the literature. One that is prominent and “probably much in clinical use” is whether the reasons for the patient’s decision are “rational,” that is, “whether the patient’s decision is due to or is a product of mental illness.”^{14, p 281} According to another prominent test, specifically, the one adopted in the Ontario HCCA, the patient’s ability to understand the information about treatment, “is probably the most consistent with the law of informed consent.” The patient’s decision making need not be rational; “unwise choices are permitted.”^{14, p 281} Under both of these tests, the patient’s denial of illness traditionally has been viewed as a primary factor leading to a judgment of incapacity, both clinically^{15, p 18} and under the case law prior to Starson.^{16,17} In her statement quoted above, Chief Justice McLachlin was endorsing this traditional view.

The majority of the Supreme Court, however, departed from this traditional position. In arriving at their decision, the majority relied heavily on a report written for the Ontario Ministry of Health in 1990 by Professor David Weisstub.¹⁸ Stressing “the desirability of allowing individuals the greatest possible measure of control of their lives” and their concomitant “right to act ‘unreasonably’ and to make foolish decisions should they choose,”^{18, p 66} Weisstub had argued that, since psychiatry is not an exact science and thus “dissident interpretations of information” can occur, the focus of the “understanding” criterion in the Ontario HCCA definition of capacity should not be on whether “the patient agree[s] with the specific diagnostic label” applied to his or her condition or to its labelling as an “illness.”^{18, p 229} Instead, it should be on the

"broader manifestations of the illness. [The] requirement for understanding," Weisstub continued, "[should] focus on the objectively discernable manifestations of the illness rather than the interpretation that is made of the manifestations."¹⁸, p 250, fn 443

Speaking for the majority, Justice Major agreed with these arguments, noting that although Starson had denied he was mentally ill, he acknowledged that he had "mental problems [in the past] that were difficult, almost impossible to . . . handle" and had "exhibited symptoms . . . that would be considered manic" and that he "need[ed] therapy" to help him deal with his problems.^{7, para 93} According to Justice Major,

[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 regarding the cause of that condition. [Only] if the patient's condition results in him being unable to recognize that he is affected by its manifestations, [will he] be unable to apply the relevant information to his circumstances, and unable to appreciate the consequences of his decision [with regard to accepting or refusing treatment].^{7, para 79}

Later in his judgment, he added:

[The Board] appeared to be overly influenced by its conviction that medication was in Professor Starson's best interest . . . [Its] conception of the patient's best interests is irrelevant to [the capacity] determination.^{7, para 76,91}

These 2 passages in the majority's judgment, in this writer's opinion, represent the holding in the case. As a result, in Ontario, the Board cannot base a finding of incapacity on a patient's denial of his or her illness, nor can it consider its conception of the patient's best interests as a factor in that capacity determination.

The Lack of Evidence as to the Benefits of the Treatment and the Risks of Nontreatment

Two sections of the majority's judgment were devoted to the insufficiency of the evidence produced at the Board hearing to establish both the benefits of the treatment prescribed for Starson and the risks of nontreatment. Owing to this, counsel for the Schizophrenia Society of Canada and a member of the Ontario Crown Law Office have each claimed that the Supreme Court's decision was based on "a lack of proper evidence" and that the "only principle" resulting from the case was that it is irrelevant to the issue of capacity whether treatment is in the best interests of the patient.¹¹

That the Starson decision established the principle that the patient's perceived best interests are irrelevant to the capacity

determination is no doubt correct. That this is the only principle issuing from the case is, however, mistaken.

Considerations of the efficacy of the treatment, while vital to the Board's decision to impose treatment against a patient's wishes as a matter of sound clinical practice, have no relevance to the question of the patient's capacity. The only consideration that bears on capacity is whether the patient is able to understand the information received regarding the proposed medication's effectiveness and to appreciate the foreseeable consequences of his or her decision. In Chief Justice McLachlin's words, "The issue in the [capacity] 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."^{7, para 36} As a leading article on the capacity question put it, in the law's view,

what matters in [the ability to understand test of capacity] is that the patient is able to comprehend the elements [of benefits and risks that] are part of treatment decision making. How the patient weighs these elements, values them, or puts them together to reach a decision is not important.^{14, p 281}

Receiving effective treatment might be in a patient's best interests but that, again, has no bearing on the issue of capacity.

Arguably, the Starson majority could have articulated more clearly the relevance of their discussion of the insufficiency of the evidence. As it stands, that discussion has led some to view the majority's holding narrowly and may have obscured the point of Professor Weisstub's report, endorsed by the majority, that capacity depends on a patient's recognition that he or she is affected by a condition's manifestations and not on acceptance that he or she has an illness.

The Repercussions: Post-Starson Cases in Ontario

Since the Supreme Court delivered its judgment in Starson, there have been 4 findings of incapacity by the Board that were judicially reviewed. In 3 of the cases,¹⁹⁻²¹ evidence was presented at the hearings of the patients' failure "to acknowledge the symptoms of their illness" and to admit that they were "affected by the condition's manifestations." In addition, evidence was presented that the treatment refused was beneficial and that patients' conditions were deteriorating. Psychiatrists before the Board had, in other words, "covered all the bases" of the Starson majority judgment.

Not surprisingly, in all 3 cases, the Ontario Superior Court upheld the Board's determination of incapacity.

A fourth case, *T.S. v. O'Dea*,²² is arguably the most significant inasmuch as it supports the narrower view of the Starson decision. Unlike the preceding 3 cases, evidence was placed

before the Board that although TS denied he had the condition diagnosed—“paranoid illness”—he recognized that he had “difficulty sometimes controlling his impulses and gets angered very easily” and “admits he has paranoid ideation” and that he hears voices. He believed the treatment would not “provide relief for his symptoms,” but that he “can get better just by isolation and peace and quiet.”^{22, para 8–9,30}

Evidence was also presented to the Board by 3 doctors as to “the benefits of the medication” and that without medication his “condition would continue to deteriorate.”^{22, para 30,32,36} Evidence of the efficacy of the treatment, in other words, was presented.

In concluding that the patient was incapable, the Court appeared not to consider the patient’s acknowledgement of the manifestations of his illness and in fact, citing a pre-Starson decision,²³ noted that the patient “denies [his] illness.”^{22, para 41} The Court concluded, “There was sufficient evidence before the Board to show that the [patient] was unable to weigh the foreseeable risks and benefits of a decision or lack of a decision.”^{22, para 40} In the opinion of this writer, the Court’s decision is inconsistent with the majority ruling in Starson and, as such, is wrong.

The Applicability of the Starson Decision Outside Ontario: The Charter Question

Starson was a decision interpreting the Ontario HCCA definition of capacity. Whether the Supreme Court’s interpretation of that definition applies to different definitions in the other provinces depends on whether the error the Board made in basing Starson’s incapacity on his denial of illness violates “principles of fundamental justice” within the meaning of Section 7 of the Charter. The Supreme Court did not rule on this constitutional issue, noting that the constitutional issue had not been raised on the appeal.

The Quebec Court of Appeal was confronted with this issue in the 2004 case, *M.B. c. Centre Hospitalier Pierre-LeGardeur*.²⁴ A woman, aged 45 years and suffering from multiple sclerosis, had been taken to the hospital after she was found by her son lying on the floor of her apartment, helpless and in her excrement. She sought to leave the hospital and return to her apartment, which was not equipped for a person with her physical handicap. She had minimized her functional difficulties and attributed her fall to fatigue and to the lighting conditions in her apartment. She was found by her treating physicians to be incapable of refusing care in the facility required by her state of health.

The trial court upheld the finding of incapacity (under Quebec law there is no intervening board determination).²⁵ On appeal to the Court of Appeal, MB’s counsel, citing the Starson decision, argued that the trial court judge had incorrectly used

MB’s denial of her illness as a factor in deciding she was incapable.^{24, para 37} The question of applying the Starson decision outside Ontario was thus squarely presented.

Quebec—which strangely has no legislative definition of capacity—by judicial decision¹⁷ has adopted the 5 criteria for capacity in the Nova Scotia Hospitals Act,^{26, s 52(2)} 2 of which read: “whether or not the person . . . understands the condition for which the treatment is proposed” and “whether or not his ability to consent is affected by his condition.” Both of these criteria are inconsistent with the analysis of capacity contained in the Starson majority judgment.

In upholding the finding of incapacity of the trial court judge, the Court of Appeal stated flatly:

[In Starson, the Supreme Court] was called upon to interpret the criteria [in the Ontario HCCA]. It is therefore crucial to exercise great prudence prior to importing concepts into Quebec law which have been developed in a highly different legislative context. . . . [T]he principles laid down in Starson do not prohibit an analysis using the five-question test [for capacity] set forth [under the Nova Scotia Hospitals Act.] They are simply there to guide the judge in a review of these questions.^{24, para 42–43}

The Court continued:

The criteria contained in the five questions adopted [from the Nova Scotia Hospitals Act] are not cumulative. The court must consider these criteria as a whole in order to determine whether . . . the patient actually understands the parameters of the decision that he or she is making. It would be erroneous [as held in the Starson decision] to conclude that a person is incapable simply because the care refused is in his or her interest.^{24, para 45–46}

Although it never mentioned the Charter explicitly, the Court by implication held that Quebec’s courts, and hence psychiatrists practising in Quebec, are not constitutionally bound by the Starson ruling. In the opinion of this writer, the Court got the constitutional issue largely right.

The right of capable psychiatric patients to refuse treatment was held to be a “principle of fundamental justice” under Section 7 of the Charter in the 1991 case of *Fleming v. Reid*,²⁷ in which the Ontario Court of Appeal held that a board decision to override a capable refusal of treatment was “arbitrary and unfair.”^{27, p 319} While, as noted, the Supreme Court in Starson did not consider the constitutional issue, both the majority and minority opinions referred to the capable patient’s right as “fundamental” to his or her “dignity, autonomy and right to self-determination”^{27, para 6,75}—language presaging a positive decision by the Court under Section 7 of the Charter. If this

turns out to be the case, any legislation allowing a capable patient's right to refuse to be overridden, as does that of the 4 provinces noted at the outset of this article, would be unconstitutional.

It is a more complex and different question, however, whether the principles set out in *Starson* for determining what constitutes that capacity are also principles of fundamental justice. Here, I will venture only to make some brief observations. First, the *Starson* majority's distinction between a person understanding that he or she has an illness and understanding that he or she is affected by its manifestations, while a binding interpretation of the Ontario HCCA, is probably too fine a distinction to qualify as a principle of fundamental justice applicable throughout Canada. Nor does it seem that legislation such as that of the Nova Scotia Hospitals Act, which includes denial of illness as a factor in the determination of capacity, can be dismissed as arbitrary. Moreover, 3 members of the Supreme Court, including the Chief Justice, rejected the distinction as a matter of interpreting the Ontario HCCA, and it would be a most unusual state of affairs if their rejection of the distinction was subsequently found to violate principles of fundamental justice.

On the other hand, provincial court decisions or legislative definitions that incorporate the best-interests factor in the capacity determination, as does the legislative definition of capacity in Alberta,²⁸ must be considered highly suspect constitutionally, especially if the best-interest factor is given decisive weight. The entire Court in *Starson* held emphatically that the doctors' and Board's view of what is in the patient's best interests "is irrelevant" to the capacity determination. Inclusion of a best-interests criterion would render most patients who rejected treatment incapable and thus undermine the value of autonomy enshrined in the Charter. It is thus exceedingly doubtful that any inclusion of "best interests" as a factor in the determination of capacity will hold up under constitutional scrutiny.

Conclusion

Presently, *Starson* is still hospitalized.²⁹ In a talk before the University of Calgary's Faculty of Law on the "Challenges of Mental Illness,"³⁰ Chief Justice McLachlin referred to the "cruel paradox" of the *Starson* decision. *Starson*'s "liberty to refuse treatment," she said, had resulted in the loss of his liberty to be treated and ultimately released from the hospital—a point not dissimilar to the previously noted argument in psychiatric quarters that the decision of a person with mental illness to refuse treatment involves no "true autonomy" but rather the choice of "the unhealthy self."^{2, p 12; 3}

As appealing as the Chief Justice's criticism of the majority's judgment might appear, her statement represents a minority position within the Court. As a matter of law, the Board and

courts in Ontario are bound by the majority's holdings that, first, a patient need not accept the diagnostic label given to his or her condition or its characterization as an illness but that, rather, it suffices for a finding of capacity that the person recognizes that he or she suffers from the symptoms or manifestation of the condition; and, second, the best interests of the patient have no bearing on the capacity determination. The majority's judgment cannot be construed as based only on the inadequacy of the evidence presented on the effectiveness of the treatment.

Moreover, as one law academic has astutely observed, "[T]he patient who can admit that she is agitated, pacing, or scared has every reason to accept treatment that her doctors say will help those symptoms abate [and] it is not clear that we need to make the patient admit to the illness."^{2, p 192,193} That some patients like *Starson* might nevertheless still opt for a treatment other than that which their doctors prescribed, or even refuse treatment outright, does not detract from the value of the legal principle of autonomy underlying the majority's decision.

As a result, psychiatrists in Ontario and the Board, on review, cannot base a finding of incapacity on the patient's denial of his or her illness. However, it is at least arguable that the distinction between a patient's recognition of the manifestations of his or her condition and acceptance of those manifestations as an illness is not binding under the Charter on the procedures in provinces like Quebec where requirements for capacity materially differ from Ontario's. Provisions that include the patient's denial of illness as a factor in the capacity determination, in other words, likely remain valid in that province. Best-interests factors included in provincial definitions of capacity, however, are a different matter. They are unlikely to survive constitutional review.

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Résumé : Starson c. Swayze : la Cour suprême se prononce (pas très clairement) sur la question de « capacité »

Objectifs : La décision dans Starson c. Swayze qui interprète l'exigence de « compréhension » à l'égard de la capacité dans la *Loi de 1996 sur le consentement aux soins de santé* de l'Ontario a provoqué des inquiétudes et des critiques dans les milieux psychiatriques. Cet article cherche à expliquer la décision et ses implications pour l'Ontario et les autres provinces.

Méthode : Les opinions de majorité et dissidentes dans la cause Starson, et les 4 causes jugées en Ontario après Starson, ont été analysées en détail. La documentation sur la capacité a été examinée. Les implications constitutionnelles de la décision ont été étudiées.

Résultats : Les patients ne sont pas tenus d'être capables de comprendre que leur état constitue une maladie pour être jugés capables de consentir à un traitement ou de le refuser. L'accent devrait être mis sur leur capacité de comprendre qu'ils sont affectés par les manifestations de leur état. « L'intérêt » du patient ne concerne pas la détermination de la capacité. L'opinion de majorité dérogeait au rôle traditionnel accordé au déni de la maladie par le patient dans la détermination de la capacité. Contrairement aux opinions de certains commentateurs, la discussion de la Cour des avantages et des risques réels des traitements prescrits n'avait aucun rapport avec la question de la capacité. Trois des causes ultérieures à Starson examinées se conformaient à la position de la Cour, et l'une pas. La distinction de la majorité concernant ce que les patients doivent être capables de comprendre de leur état n'est probablement pas un « principe de justice fondamentale » en vertu de la *Charte canadienne des droits et libertés* (la *Charte*). Le droit du patient capable de refuser un traitement et la non-pertinence de l'intérêt du patient constituent probablement de tels principes.

Conclusions : Les patients de l'Ontario ne peuvent pas être jugés incapables parce qu'ils nient être malades. L'aptitude à reconnaître les manifestations de leur état suffit. Cette distinction n'est probablement exécutoire qu'en Ontario. Le droit du patient capable de refuser un traitement et la non-pertinence de l'intérêt du patient sont vraisemblablement exécutoires dans tout le Canada.