Gajewski v. Wilkie, [2014] O.J. No. 6026

Ontario Judgments

Ontario Court of Appeal

J.I. Laskin, P.S. Rouleau and G.J. Epstein JJ.A.

Heard: June 5, 2014.

Judgment: December 16, 2014.

Docket: C56661

[2014] O.J. No. 6026 | 2014 ONCA 897 | 123 O.R. (3d) 481

Between Bartosz Gajewski, Appellant, and Dr. Treena Wilkie, Respondent

(62 paras.)

Case Summary

Wills, estates and trusts law — Mental incompetency — Treatment — Consent — Appeal by Gajewski from a decision dismissing his appeal from decision of Consent and Capacity Board confirming respondent physician's finding that appellant was incapable with respect to treatment dismissed — Appellant was found not criminally responsible on account of mental disorder — Appellant denied he had delusional disorder and refused medication — Respondent's evidence, corroborated by other evidence, supported Board's conclusion that appellant was incapable with respect to treatment with antipsychotic medication — Appellant unable to apply relevant information to his circumstances and thus could not appreciate reasonably foreseeable consequences of taking or not taking proposed medication.

Appeal by Gajewski from a decision dismissing his appeal from a decision of the Consent and Capacity Board confirming the respondent physician's finding that the appellant was incapable with respect to treatment. The appellant had been found not criminally responsible on account of mental disorder at his trial on charges of assault and attempted kidnapping. He had a history of mental illness dating back to at least 2003. Although the appellant initially conceded that he had a delusional disorder, he changed his mind and believed there was no chance he had such disorder and refused medication recommended for his delusional disorder. He agreed he believed that Jehovah would prove the diagnosis of delusional disorder to be false. The appellant also testified that he believed that medication would reduce the strength of his delusional beliefs. The appellant argued that the evidence before the Board did not support the test for incapacity.

HELD: Appeal dismissed.

The respondent's evidence, corroborated by other evidence, supported the Board's conclusion that the appellant was incapable with respect to treatment with antipsychotic medication. There was a factual foundation for the respondent's conclusion that the appellant's disagreement with her was the result of the appellant's mental illness. The Board had the opportunity to observe and question the appellant. It was in a position to assess the appellant's testimony in the context of other evidence, including his documented conversations with health care workers and family members. In its reasons, the Board expressly adverted to the appellant's testimony at the hearing. The evidence supported the Board's findings that the appellant was suffering from the manifestations of a mental disorder, including entrenched false beliefs, persecutory delusions and religious preoccupation, and that he was unable to see that he was suffering from these manifestations at the time of the hearing. It was open to the Board to conclude that the appellant did not truly believe that he suffered from delusions. The appellant was not able to apply the relevant information to his circumstances and thus was not able to appreciate the reasonably foreseeable consequences of taking or not taking the proposed medication.

Statutes, Regulations and Rules Cited:

Evidence Act, R.S.O. 1990, c. E.23, s. 14

Health Care Consent Act, 1996, S.O. 1996, c. 2, Sched. A, s. 4(1), s. 10(1)

Appeal From:

On appeal from the judgment of Justice Andra Pollak of the Superior Court of Justice, dated February 6, 2013.

Counsel

Suzan E. Fraser, for the appellant.

Kendra Naidoo, for the respondent.

The judgment of the Court was delivered by

G.J. EPSTEIN J.A.

OVERVIEW

1 On March 24, 2011, the appellant, Bartosz Gajewski, was detained at the Centre for Addiction and Mental Health, in Toronto by order of the Ontario Review Board, following a verdict of not criminally responsible on account of mental disorder at his trial on charges of assault and attempted kidnapping. After the appellant refused medication recommended for his delusional disorder, a physician, the respondent, Dr. Treena Wilkie, found him incapable with respect to treatment. At a subsequent review hearing, the Consent and Capacity Board confirmed this incapacity finding.

2 Mr. Gajewski appealed the decision of the Consent and Capacity Board (the "Board") to the Superior Court. Justice Whitaker appointed an *amicus curiae* to assist Mr. Gajewski. *Amicus* advanced Mr. Gajewski's arguments and made additional submissions. In her endorsement dated February 6, 2013, Pollak J. found the Board's decision reasonable and dismissed the appeal.

3 Mr. Gajewski appeals that decision to this court. He submits that the evidence does not support the test for incapacity. He further alleges ineffective assistance of *amicus* and seeks to introduce fresh evidence to support this ground of appeal.

4 I would dismiss the appeal. In my view, the respondent's evidence, corroborated by other evidence, supports the Board's conclusion that the appellant is incapable with respect to treatment with antipsychotic medication. In my view, this appeal can be disposed of without dealing with the appellant's allegation of ineffective assistance of *amicus*.

STATUTORY TEST FOR CAPACITY

5 This appeal arises in the context of a patient's legal right to determine his or her own medical treatment. In Ontario, s. 10(1) of the *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A (the "Act"), provides that a health practitioner is precluded from administering a proposed treatment to a patient, and is required to take reasonable steps to ensure that the treatment is not administered, unless consent to the treatment is first obtained (1) from the patient, where the patient is capable with respect to the treatment; or (2) from the patient's substitute decision-maker, where the patient is incapable with respect to the treatment.

6 Section 4(1) of the Act establishes two criteria for capacity. To be "capable with respect to a treatment", a person must be "able to understand the information that is relevant to making a decision about the treatment" and must be "able to appreciate the reasonably foreseeable consequences of a decision or lack of decision." Section 4(2) provides that a person is presumed to be capable with respect to treatment. This presumption of capacity is displaced only if one or both of the s. 4(1) criteria for capacity are not met.

7 In *Starson v. Swayze*, 2003 SCC 32, [2003] 1 S.C.R. 722, at para. 78, Major J., writing for the majority, explained the two criteria for capacity to consent to a treatment, as follows:

> 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... 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.

OVERVIEW OF FACTUAL BACKGROUND

8 The appellant was born in Poland in 1971 and immigrated to Canada in 1989. He has a history of mental illness dating back to at least 2003.

9 Upon admission to the Centre for Addiction and Mental Health, ("CAMH"), on March 24, 2011, the appellant was cared for by Dr. Swayze. The doctor proposed antipsychotic medication and provided the appellant with information about the suggested treatment. At that time, the appellant denied experiencing any on-going delusions but acknowledged that he had had a fixed false belief at the time of the index offences. He agreed with the diagnosis of delusional disorder.

10 On May 20, 2011, the appellant was transferred to the minimum security unit at CAMH and into the care of Dr. Wilkie. From then to December 2011, the appellant, with some hesitation, acknowledged suffering from a delusional disorder.

11 By the end of December 2011, the appellant's view of his condition and the risks and benefits of treatment had significantly changed. As a result, over the next month, Dr. Wilkie assessed the appellant's capacity to consent to antipsychotic medication.

12 On January 31, 2012, on the basis of tests, her assessment of the appellant and a consultation with another doctor, Dr. Wilkie informed the appellant that she found him incapable of consenting to treatment. The appellant immediately expressed his wish to have a hearing before the Board.

THE BOARD HEARING

13 On February 7, 2012, the Board held a hearing to review Dr. Wilkie's finding of incapacity to consent to antipsychotic medication.

14 Dr. Wilkie testified at the hearing. She described, in considerable detail, the appellant's early insight into his medical condition and then his precipitous change of beliefs.

15 When the appellant was first admitted to CAMH on March 24, 2011, he denied that he retained any delusional beliefs regarding the victim of the index offences. But, he acknowledged that, at the time of committing the offences, he did have such delusional beliefs. He agreed with the diagnosis of delusional disorder. Upon being given information about the nature of his disorder and

medications that he should consider taking, the appellant selected a particular antipsychotic medication. At this time, the appellant's attending physician considered him capable of consenting to this treatment.

16 But the medication was not given to him. It was discovered that the appellant had abnormally high levels of liver enzymes in his blood. This symptom had to be explored, precluding treatment with the medication.

17 By the end of 2011, the appellant's liver enzymes had normalized. A specialist determined that there was no need for further investigation into the liver issue. As a result, there was more overt discussion with the appellant about starting him on antipsychotic medication. Around this time, the appellant began to express a different view of his mental illness. Treatment notes from CAMH document this change:

> * On December 12, 2011, the appellant alluded to the possibility that he had been misdiagnosed. He declined medication.
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> * On December 30, 2011, the appellant stated that he would not take medication. The appellant was anticipating an upcoming hearing before the Ontario Review Board (the "ORB"). He intimated that he would appeal his NCR status. He said that Jehovah would make sure that information came forward in due time. He stated beliefs about the victim of the index offence similar to those that apparently motivated the offence. Further, he stated that the index offence was "justifiable force".
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> * On January 3, 2012, the appellant stated that he did not believe he suffered from a delusional disorder. He refused any kind of treatment. He again expressed his belief that he had been persecuted by the victim of the index offence. He intended to challenge his NCR status. He was considering litigating against those who had wronged him, including the victim of the index offence, Dr. Wilkie and CAMH.
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> * On January 11, 2012, the appellant again stated that he was not interested in any sort of treatment, saying "Jehovah will act". He believed there was a 0% chance that he had a delusional disorder. He did not believe there would be any benefit in taking medication or any risk in not taking it.
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> * On January 31, 2012, Dr. Wilkie reviewed the appellant's recent treatment notes with him. He asserted that Jehovah would be making corrections soon, which would lead to Dr. Wilkie's going to jail and losing her license.

18 On cross-examination, Dr. Wilkie acknowledged that in a report for the ORB dated December 29, 2011, she had concluded that the appellant presented as capable of consenting to treatment with medication. Dr. Wilkie explained that, in the month between writing that report and finding the appellant lacking in capacity on January 31, 2012, she had reassessed the appellant's capacity to consent. At the end of December 2011, it became clear to her that the appellant was no longer refusing medication because of his concerns about his liver, but because he did not agree that he suffered from a delusional disorder.

19 Dr. Wilkie also expressed her view that medication would likely reduce the intensity of the appellant's delusions. Without it, his delusions would persist, as would his risk of re-offending. Dr. Wilkie also testified that, in her opinion, the appellant's mental disorder affected his ability to understand the information about the proposed treatment and his ability to apply that information to himself. As a result, in the respondent's opinion, the appellant failed both branches of the test for capacity to consent.

20 The appellant also testified at the hearing. He told the Board that he believed he had delusions. However, he also believed they were true. When asked to explain this discrepancy, he said, "I can't explain that." He agreed he believed that Jehovah would prove the diagnosis of delusional disorder to be false. The appellant also testified that he believed that medication would reduce the strength of his delusional beliefs. When asked why he had not communicated that belief to Dr. Wilkie, he stated, "That was my decision. I didn't have a valid or any reason, I just didn't do [so]."

21 During the Board hearing, the appellant spoke extensively about his concerns relating to the side effects of the proposed medication, a topic he had researched. These concerns caused him to refuse to take the medication. He said, "I am primarily concerned about my physical health."

THE BOARD DECISION

22 The panel released its decision the day after the hearing, on February 8, 2012. Written reasons followed on February 15, 2012.

23 In her reasons, the presiding Board member reviewed the evidence of the appellant's index offence and his mental disorder. She then proceeded to analyze the two branches of the test under s. 4(1) of the Act, making findings of fact in the process.

24 The Board made the following findings of fact of importance here:

* Dr. Wilkie's capacity assessment was a "process" that evolved over time;
* The appellant's evidence was inconsistent on key points;
* The appellant moved from a consistent acknowledgement of his mental disorder to a statement on January 11, 2012, that there was 0% chance that he had a mental disorder;
* By the day of the hearing, the appellant had returned to a delusional state similar to that from which he suffered in 2009 when he attempted to kidnap the victim of the index offences;
* The panel was not convinced that the appellant perceived any potential benefits from the medication; and
* The appellant viewed the world through the lens of his mental disorder.

25 With respect to the first branch of the test, the Board concluded, at p. 9, that:

> [The appellant's] distortion of his relationship with the victim [of the index offences], and his preoccupation with religion, both caused by his mental disorder, prevented him from processing, retaining and understanding the relevant information.

26 With respect to the second branch of the test, the Board concluded, at p. 10, that:

> The evidence taken as a whole, including [the appellant's] own testimony, amply supported the doctor's conclusions concerning [the appellant's] capacity. [The appellant] was unable to see that he was in fact suffering from serious manifestations of mental illness. He therefore was not able to evaluate information concerning the proposed types of medications as it related to his own circumstances, a fact which rendered him incapable to make a decision concerning them.

27 Accordingly, the Board upheld the respondent's finding that the appellant was incapable with respect to treatment with antipsychotic medication.

THE APPEAL

28 Mr. Gajewski appealed the Board's decision to the Superior Court. Prior to Mr. Gajewski's perfecting his appeal, the case management judge, Whitaker J., determined that an *amicus curiae* should be appointed.

29 Mr. Nemetz was selected as *amicus*. The appellant prepared his own factum. Mr. Nemetz filed the appellant's factum as well as one that he had written.

30 At the hearing, a discussion took place as to who would present oral argument on the appellant's behalf. Ultimately, the appellant stated that his preference "would be that Mr. Nemetz would make the arguments for me", adding, "perhaps he could use some of my arguments when he presents the case before Your Honour." The appellant further stated that had he made oral submissions, he would not have gone beyond what was written in his factum.

31 The appeal judge was not persuaded that there were any reversible errors in the Board's reasoning. She held that the Board's conclusion was within the reasonable range of possibilities and dismissed the appeal.

ISSUES

32 The appellant raises the following issues for determination by this court:

1. What standards of review apply to the Board's and the Superior Court Justice's decisions?
2. Did the appeal judge err in concluding that the Board's decision of incapacity was supported by the evidence and within the reasonable range of possibilities?
3. Should the appeal judge's decision be overturned based on the allegedly ineffective assistance of *amicus*?

ANALYSIS

ISSUE ONE: What standards of review apply to the Board's and the Superior Court Justice's decisions?

33 Determining whether the appellant was capable of making his own decision regarding treatment with antipsychotic medication required the Board to apply, and the appeal judge to review, the evidence before it to the statutory test for capacity set out in s. 4(1) of the Act. In *Starson*, at paras. 23 and 84, the Supreme Court was unanimous that this is a question of mixed fact and law that is reviewable on a standard of reasonableness. But, a reviewing court should not defer to the Board's findings if the Board has misunderstood the statutory test. See also *Dunsmuir v. New Brunswick*, 2008 SCC 9, [2008] 1 S.C.R. 190, at paras. 47-49; *Giecewicz v. Hastings*, 2007 ONCA 890, 288 D.L.R. (4th) 587, at para. 13, leave to appeal to S.C.C. refused, [2008] S.C.C.A. No. 97.

ISSUE TWO: Did the appeal judge err in concluding that the Board's decision of incapacity was supported by the evidence and within the reasonable range of possibilities?

(i) Was the respondent's evidence corroborated?

34 The appellant submits that the Board erred by not considering s. 14 of the *Evidence Act*, R.S.O. 1990, c. E.23. Section 14 states:

> An opposite or interested party in an action by or against one of the following persons shall not obtain a verdict, judgment or decision on the party's own evidence, unless the evidence is corroborated by some other material evidence:
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> 1. A person who has been found,
>
> ...
>
> iii. incapable by a court in Canada or elsewhere.
>
> 2. A patient in a psychiatric facility.

35 In *Anten v. Bhalerao*, 2013 ONCA 499, 366 D.L.R. (4th) 370, this court considered the application of s. 14 in proceedings before the Board. Writing for the court, Rosenberg J.A. held, in *obiter*, that in order for the Board to uphold a doctor's finding of incapacity, the medical evidence had to be corroborated.

36 Here, the appellant submits that the respondent's evidence was not corroborated. The appellant contends that Dr. Wilkie provided no evidence for the basis of her opinion that the appellant was incapable other than that the appellant disagreed with her. Further, the appellant asserts that there was no factual foundation for the conclusion that this disagreement was the result of the appellant's mental illness. In support of this contention, the appellant relies on the fact that it was only when he started to question Dr. Wilkie's diagnosis and the proposed medication that the respondent changed her opinion about his capacity.

37 I do not accept this submission.

38 As previously indicated, the appellant testified before the Board. In *Anten*, at para. 30, Rosenberg J.A. wrote, "I accept that in an appropriate case a physician's evidence can be corroborated, within the meaning of s. 14, by a patient's own evidence." The Board had the opportunity to observe and question the appellant. It was in a position to assess the appellant's testimony in the context of

other evidence, including his documented conversations with health care workers and family members. In its reasons, the Board expressly adverted to the appellant's testimony at the hearing. The Board described the appellant's evidence as being "consistently inconsistent on key points".

39 In addition to Dr. Wilkie's evidence, there was documentary evidence. The Board specifically referenced the fact that Dr. Wilkie sought a second opinion from a Dr. Pearce regarding the appellant's capacity to consent. Dr. Pearce met with the appellant. Dr. Pearce prepared a progress note, dated January 25, 2012, that was before the Board. In the progress note, Dr. Pearce stated that the appellant did not accept that he suffered from delusions and that "he does not have any insight into the risks and benefits of treating or not treating his mental illness." Dr. Pearce's note concludes that, in his opinion, the appellant failed both branches of the test for capacity in the Act.

40 While Dr. Pearce's note is hearsay given he did not testify at the hearing, the Board may admit hearsay evidence: *Starson*, at para. 115; *Anten*, at para. 32; *Statutory Powers Procedure Act*, R.S.O. 1990, c. S.22, s. 15. In *Starson*, at para. 115, writing for the majority, Major J. cautioned that although hearsay was admissible before the Board, the Board "must be careful to avoid placing undue emphasis on uncorroborated evidence that lacks sufficient indicia of reliability". There is no evidence here, and the appellant has pointed to none, to suggest that Dr. Pearce's hearsay evidence was lacking in reliability.

41 The documents the Board admitted into evidence also included other progress notes and a hospital report. Although these documents were primarily prepared by Dr. Wilkie, I note that the December 29, 2011, "Hospital Report to the Ontario Review Board" lists Clinical Director Padraig L. Darby as a co-author with Dr. Wilkie. In addition, the December 12, 2011, progress note was authored by a resident doctor, who met with the appellant along with Dr. Wilkie.

42 In summary, Dr. Wilkie's testimony that the appellant lacked capacity to consent was corroborated by a number of sources.

(ii) Was the Board's finding of lack of capacity a reasonable one?

43 The appellant submits that the Board erred in its application of the statutory test because the respondent failed to adduce sufficient evidence of incapacity. The appellant testified that he had weighed the pros and cons and disagreed with the respondent as to what was in his best interests. The appellant's primary consideration was his physical health and the potential adverse effects of the proposed medication.

44 The appellant also submits that the timing of the respondent's assessment undermines its credibility. In her report for the ORB, dated December 29, 2011, the respondent concluded that the appellant was capable of consenting to treatment. Just over a month later, on January 31, 2012, the respondent came to the opposite conclusion. In the appellant's view, it was only when he began to question the respondent's diagnosis and treatment plan that the respondent decided he was incapable.

45 As stated by Major J. in *Starson*, at para. 91, "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." As *Starson* illustrates, the Board must take care to ensure, in such a circumstance, that the attending physician has proven that the patient fails the statutory test for capacity. The test is not whether the treatment is, in the Board's opinion, in the patient's best interests.

46 In both *Giecewicz* and *Starson*, the focus of the analysis was the second branch of the test for capacity. I will therefore first determine whether the Board's decision with respect to the second branch was reasonable. For ease of reference, I repeat how Major J. in *Starson*, at para. 78, described the second branch:

> [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.

47 In *Starson*, at para. 79, Major J. made the following important observation:

> [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. [Emphasis added.]

48 Similarly, in *Giecewicz*, at paras. 38-40, Doherty J.A. wrote for this court:

> I have set out the evidence in some detail because, in my view, that evidence speaks to the very situation described by both Major J. and McLachlin C.J.C. in the passages from their reasons in *Starson v. Swayze* quoted above. According to Dr. Hastings, the appellant suffers from a mental disorder that in the words of Major J. ... makes her unable to apply the relevant information given to her to her own circumstances and unable to appreciate the consequence of her decisions. Dr. Hastings testified that the appellant's inability to acknowledge the existence of the condition for which he had recommended medication thoroughly undermined her ability to evaluate that information and his advice.
>
> Dr. Hastings' evidence also reveals two of the three indicators of incapacity based on an inability to appreciate consequences referred to by McLachlin C.J.C. ... Dr. Hastings opined that the appellant was unable to acknowledge the fact that the condition for which he recommended treatment may affect her (the first criterion described by McLachlin C.J.C.), and that her choice to refuse treatment was substantially based on her delusional belief system (the third criterion described by McLachlin C.J.C.).
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> The Board accepted Dr. Hastings' opinion which was virtually unchallenged. Parts of the appellant's own testimony tended to confirm that assessment. The Board did not act unreasonably in accepting his opinion.

49 In my view, the evidence supports the Board's findings that the appellant: 1) was suffering from the manifestations of a mental disorder, including entrenched false beliefs, persecutory delusions and religious preoccupation; and 2) was unable to see that he was suffering from these manifestations at the time of the hearing. Although there were moments during the hearing at which the appellant purported to accept that his beliefs about the victim of the index offences were delusions, these moments were contradicted by his other testimony and by a month of clinical observation by Dr. Wilkie and her colleagues. The appellant could provide no explanation for his shifting expression of his own beliefs. It was open to the Board to conclude that the appellant did not truly believe that he suffered from delusions. It follows from the cited passages from *Starson* and *Giecewicz* that the appellant was not able to apply the relevant information to his circumstances and thus was not able to appreciate the reasonably foreseeable consequences of taking or not taking the proposed medication.

50 There was also evidence to support the Board's finding that Dr. Wilkie's capacity assessment was a "process" that could change over time. Thus, the fact that the respondent's views on the appellant's capacity changed over the course of a month did not undermine her opinion. The evidence was that the appellant's condition might wax and wane. Moreover, until the appellant's liver enzymes had normalized, the respondent and her team at CAMH could not force the issue of the proposed medication. As a result, the question of capacity to consent to this treatment did not truly arise until late in 2011. As discussed, Dr. Wilkie's finding of incapacity was reached after a series of meetings with the appellant in late December of 2011 and in January of 2012, including a consultation with Dr. Pearce.

51 The appellant directed many of his submissions to his concern about the side effects of the proposed medication. He also asserted that the respondent had presented no evidence that the medication would ameliorate his condition.

52 As stated above, Dr. Wilkie testified that the medication would diminish the intensity of the appellant's delusions. True, she did not present the Board with anything beyond her professional opinion that the proposed medication would help the appellant. However, with respect, the appellant's submissions on the efficacy of the proposed medication are not particularly germane to the question before the Board. As stated by Doherty J.A. in *Giecewicz*, at para. 43:

> It is not the Board's task to weigh the risks and benefits of the proposed treatment or to make any determination as to the advisability of the treatment from a medical standpoint. The issue before the Board was the appellant's capacity to make the relevant decisions.

53 The only relevance of submissions relating to the benefits and side effects of the proposed medication to the question of capacity is whether the appellant has a rational justification for refusing the treatment. While I do not doubt that the appellant has a sincere, and perhaps justified, concern about potential adverse effects from the proposed medication, the rational nature of this concern cannot, on its own, overcome the preponderance of evidence that supports the reasonableness of the Board's finding of incapacity on the second branch.

54 Given my conclusion on the second branch, I do not need to consider whether the Board erred with respect to the first branch of the test. I would note, however, that in both *Starson* and *Giecewicz*, the first branch was not at issue because it was accepted that the patients were intelligent and able to process, retain, and understand the relevant information.

55 Here, Dr. Wilkie testified that:

> [I]t was clear to me that in the abstract Mr. Gajewski understood what the medication was, what the potential side effects of medication was, what the potential benefits of medication would be for another individual. But that due to the fact that he was not of the opinion that he suffered from a delusional disorder, that he was unable to apply that knowledge to himself.

56 On the basis of this testimony, I am of the view that the reasonableness of the Board's finding that the appellant lacked capacity to consent under the first branch may be in some doubt. However, as this appeal can be resolved without addressing this issue, I would not pursue it further.

57 For these reasons I would not give effect to this ground of appeal.

ISSUE THREE: Should the appeal judge's decision be overturned based on the allegedly ineffective assistance of *amicus*?

58 Ineffective assistance of *counsel* was a ground of appeal that, at law, would have been available to the appellant: *Gligorevic*, [2012] O.J. No. 721, at paras. 60-65. However, whether an argument based on ineffective assistance of *amicus curiae* is available is quite a different matter.

59 In my view, it is an issue that need not be addressed in order to determine the appeal as I have reviewed the Board's decision on the same standard of review that the Superior Court applied -- standard of reasonableness -- and have independently concluded that there is no reason to interfere with the Board's decision.

60 Nonetheless, as a serious allegation has been raised before this court, in relation to the assistance of *amicus*, I feel compelled to say that I have seen nothing in the record that gives rise to any concern about the assistance *amicus* provided the appellant.

61 It follows that I would dismiss the appellant's motion to introduce fresh evidence since the proposed evidence relates to this ground of appeal.

DISPOSITION

62 For these reasons, I would dismiss the appeal. I would make no order as to costs.

G.J. EPSTEIN J.A.
J.I. LASKIN J.A.:— I agree.
P.S. ROULEAU J.A.:— I agree.