IN THE MATTER OF A REFERENCE PURSUANT TO THE HEPATITIS C 1986-1990 CLASS ACTION SETTLEMENT AGREEMENT
(Parsons v. The Canadian Red Cross et al.
Court File No. 98-CV-141369)

BETWEEN

Claimant File 1400858

- and -

The Administrator

(On a motion to oppose confirmation of the decision of Judith Killoran, released September 9, 2005)

Reasons for Decision

WINKLER J.:

Nature of the Motion

1. This is a motion to oppose confirmation of the decision of a referee appointed pursuant to the terms of the Settlement Agreement in the Hepatitis C litigation for the class period January 1, 1986 to July 1, 1990. The Claimant made a claim for compensation pursuant to the Agreement which was denied by the Administrator charged with overseeing the distribution of the settlement monies. The Claimant appealed the denial to a referee in accordance with the process set out in the Agreement. The referee upheld the decision of the Administrator and denied the appeal. The Claimant now opposes confirmation of the referee's decision by this court.

Background

2. The Settlement Agreement is Pan-Canadian in scope and was approved by this court and also approved by courts in British Columbia and Quebec. (See *Parsons v. The Canadian Red Cross Society* (1999), 40 C.P.C. (4th) 151 (Ont. Sup. Ct.)). Under the Agreement, persons infected with Hepatitis C through a blood or specified blood product transfusion, within the period from January 1, 1986 to July 1, 1990, are entitled to varying degrees of compensation depending primarily on the progression of the Hepatitis C infection.

Facts

3. The Claimant seeks compensation for expenses that he incurred in relation to treatment administered by a naturopath.

4. On October 20, 2006, I released Reasons for Decision concerning the Claimant's appeal. At that time, I declined to make a final order. Instead, I requested written submissions from the Joint Committee, Fund Counsel and the Claimant concerning the scope of the term "generally accepted" as it is used in the context of section 4.06 of the Transfused HCV Plan (the "Plan"), and who should bear the onus in proving whether a treatment or medication is "generally accepted".

5. Mr. William Dermody was appointed to make submissions on the Claimant's behalf. I have received written submissions from each of the parties, and I have taken these submissions into consideration. Although I outlined the pertinent facts to this appeal in my earlier Reasons, I do so again here for convenience.

6. On April 12, 2001 the Claimant was approved for compensation under the terms of the Settlement Agreement. On March 2, 2005, he submitted a request to the Administrator for the reimbursement of the naturopathic treatment, totaling $6,658.15. He also requested reimbursement for $1,985.59 in travel expenses.

7. The Claimant received the naturopathic treatment after requesting a referral from his treating physician. The naturopath administered intravenous injections, consisting of vitamins, minerals, antioxidants and homeopathic solutions. The Claimant believes that this treatment resulted in significant improvements to his health.

8. The Administrator denied his request for reimbursement on the grounds that the treatment that he received was not reimbursable under the Plan. The Claimant appealed.

9. As part of the appeals process, Fund Counsel wrote to the Claimant's treating physician and asked whether the treatment administered by the naturopath was "generally accepted by the medical community for the treatment of HCV or conditions due to the infection with HCV". The physician stated the following in reply: "In response to your query about whether they are generally accepted by the medical community, I would say they are not."

10. The Claimant's appeal was heard before a referee on September 9, 2005. The referee upheld the Administrator's decision not to provide compensation. The Claimant has appealed the referee's decision.

Standard of Review

11. In a prior decision in this class proceeding, the standard of review set out in *Jordan v. McKenzie* (1987), 26 C.P.C. (2d) 193 (Ont. H.C., aff'd (1990), 39 C.P.C. (2d) 217 (C.A.) was adopted as the appropriate standard to be applied on motions by a rejected claimant to oppose confirmation of a referee's decision. In *Jordan,* Anderson J. stated that the reviewing court "ought not to interfere with the result unless there has been some error in principle demonstrated by the [referee's] reasons, some absence or excess of jurisdiction, or some patent misapprehension of the evidence."

Analysis

12. To qualify for a reimbursement for the cost of treatment, the Claimant must satisfy the requirements set out in section 4.06 of the Plan:

> 4.06 - An Approved HCV Infected Person who delivers to the Administrator evidence satisfactory to the Administrator that he or she has incurred or will incur costs for generally accepted treatment and medication due to his or her HCV infection which are not recoverable by or on behalf of the claimant under any public or private health care plan is entitled to be reimbursed for all reasonable past, present or future costs so incurred, to the extent that such costs are not costs of care or compensation for loss of services in the home, provided:
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> a. the costs were incurred on the recommendation of the claimant's treating physician; and
> b. if the costs are incurred outside of Canada, the amount of compensation cannot exceed the lesser of the amount of compensation payable if the costs had been incurred in the Province or Territory where the claimant resides or is deemed to reside and the actual costs.

13. Section 4.06 is further informed by the Court Approved Protocol entitled "Uninsured Treatment and Medical Expenses and Out of Pocket Expenses (Sections 4.06 and 4.07 of the Transfused and Hemophiliac HCV Plans)" (the "CAP"). The relevant provisions from the CAP are as follows:

> 1. For the purpose of this CAP, Treating Physician means a medical doctor who is or was treating the HCV Infected Person in respect of his/her HCV infection or conditions due to his/her infection with HCV.
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> ...
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> 3. In consultation with a physician(s) in one or more of the medical specialties listed on Tran 2/Hemo 2 Form ("HCV Medical Specialist") the Administrator shall compile a list of medications and treatments which are recommended or prescribed for treatment of HCV and for conditions due to the infection with HCV which are generally accepted by the medical community (the "HCV Medication List"). This list shall be periodically updated at the Administrator's discretion.
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> 6. Where reimbursement is claimed for items which are not on the HCV Medication List, the Administrator shall require the Claimant to supply a form completed by the HCV Infected Person's Treating Physician confirming that he/she prescribed or recommended the treatment or medications for treatment of the HCV infection or conditions due to the infection with HCV. If the Treating Physician is an HCV Medical Specialist, the Treating Physician must confirm that the treatments or medications prescribed or recommended are generally accepted by the medical community for the treatment of HCV or conditions due to the infection with HCV. If the Treating Physician is not an HCV Medical Specialist, the Administrator shall consult an HCV Medical Specialist to determine whether the items are generally accepted by the medical community for the treatment of HCV or conditions due to the infection with HCV.

a) The Scope of "Generally Accepted"

14. Section 4.06 of the Plan provides that a Claimant will be reimbursed for treatment that (i) has been recommended by his or her treating physician and (ii) is "generally

accepted". As noted above, I have requested submissions on the scope of "generally accepted"

15. Mr. Dermody, counsel for the Claimant, argues that in order for a treatment to be "generally accepted", it must simply be reasonable or legitimate given the Claimant's circumstances. He argues that the language of the Plan does not require that the treatment be "generally accepted by the medical community", only that the costs were incurred on the recommendation of the Claimant's treating physician.

16. The Joint Committee argues that the proper context for the words "generally accepted" is the medical community, and that the Fund should not bear the cost of treatment unless it is efficacious.

17. Fund Counsel argues that what constitutes "generally accepted" is a question to be determined by a medical expert with specialist training in the area of HCV. In the alternatively, Fund Counsel argues that it is a factual determination to be made by the Administrator, and on appeal, by the referee, taking into account the circumstances of the Claimant, the extent to which the treatment has been tested, studied, and found to be effective and safe.

18. In weighing the submissions before me, I have considered the Divisional Court's analysis in *Flora v. Ontario Health Insurance Plan (General Manager)* 83 O.R. (3d) 721 (Ont Div Ct), aff'd [2008] O.J. No. 2627 (CA). In that case, the court considered the significance of the phrase "generally accepted in Ontario", which forms part of section 28.4(2) of *Ontario Regulation 552* (the "Regulation") of the *Health Insurance Act*, R.S.O. 1990, c. H.6 ("HIA").

19. In *Flora,* the appellant appealed the decision of the Health Services and Review Board, which upheld the decision of the Ontario Health Insurance Plan ("OHIP") to deny the appellant reimbursement for the cost of a liver transplant. The appellant had undergone the treatment in England.

20. The basis for the Board's decision to deny reimbursement was its interpretation and application of section 28.4(2) of the Regulation. Under section 28.4(2), treatment was not an insured service, i.e. the appellant was not entitled to reimbursement, if the treatment was not "generally accepted in Ontario as appropriate for a person in the same medical circumstances as the insured person". After hearing evidence from several Ontario physicians, the Board found that the appellant was not a suitable candidate for a liver transplant under the criteria applied in Ontario. Consequently, the Board found that the procedure he underwent in England was not "generally accepted in Ontario" and, consequently, reimbursement was not permitted under section 28.4(2).

21. On the appeal Epstein J.(as she then was), speaking for the court, interpreted section 28.4(2) as follows:

> [99] The wording of s. 28.4 of the Regulation clearly establishes that the purpose of the provision is to extend public health care funding to those treatments obtained outside of Canada that would

> have been provided to insured persons in Ontario, but cannot be because of a life-threatening delay, or because equivalent procedures are not performed in Ontario…
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> [100] OHIP determines whether the regulatory requirement is satisfied based upon the particulars of an applicant's case and the medical evidence as to the general acceptance in Ontario of the treatment for a patient in those circumstances. This determination is a factual one that considers the specifics of the individual's case, clinical considerations, and professional and ethical standards…
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> [101] It is reasonable to limit the funding of out-of-country medical care to those treatments "generally accepted in Ontario as appropriate for a person in the same medical circumstances as the insured person". This limitation ensures that funding of out-of-country medical treatments is provided fairly and equally in a manner that upholds Ontario's medical and ethical standards, while protecting vulnerable Ontario patients in a responsible, cost-effective manner.
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> …
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> [103] There is no internationally or globally recognized standard of health care. OHIP relies upon the opinions of Ontario physicians, the qualifications of whom are regulated, in determining what is generally accepted as appropriate treatment for a patient. The "generally accepted in Ontario" standard ensures that out-of-country funding is provided only to those treatments that are regarded in Ontario as safe and effective.
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> [104] Additionally, the "generally accepted in Ontario" standard limits public funding of medical treatments to those procedures that Ontario doctors have determined are of some clinical value... [Emphasis added]

22. While section 28.4(2) of the Regulation at issue in *Flora* is differently worded than the provision in section 4.06 of the Plan – with the additional qualification "in Ontario", nevertheless the court's analysis is of assistance in respect of the issues before this court.

23. In *Flora,* the court found that the determination of what was "generally accepted in Ontario" was "a factual one that considers the specifics of the individual's case, clinical considerations, and professional and ethical standards", and that reimbursement for medical treatment was limited to treatments that are "safe and effective" and "of some clinical value". In my view, section 4.06 of the Plan engages similar considerations.

24. I am not persuaded by the submissions of the Claimant that the medical community is not the proper context for section 4.06. The language clearly positions the section within the scope of the medical community. First, it requires that a Claimant's treating physician recommend the treatment or medication. Second, medication and treatment are, by their very nature, a central subject matter of the medical community. Sections 3 and 6 of the CAP specifically reference the "medical community".

25. Therefore, the medical community is the proper context for the term "generally accepted". However, with that said, I cannot accept the submission by Fund Counsel that the question of whether a particular treatment is "generally accepted" must be answered at the sole discretion of a medical expert with specialist training in the area of HCV. Section 4.06 clearly states that evidence is to be provided to the Administrator and that such evidence "must be satisfactory to the Administrator". Whether a treatment or

medication is "generally accepted" by the medical community is a factual determination for the Administrator to make based on the evidence before it.

26. The Joint Committee and Fund Counsel (in its alternative argument) argue that unless a given treatment or medication is efficacious, the Fund should not bear the cost of it. This argument is consistent with the Divisional Court's analysis in *Flora;* and I find it a compelling one.

27. The language of section 4.06 aims to limit the amount of compensation payable to a Claimant to treatment and medication that are "generally accepted" by the medical community. The funds available under the Plan are finite. The Plan should not be required to reimburse Claimants for medications and treatments that lack objectively demonstrated evidence as to efficacy and safety.

28. In summary, the proper context for the term "generally accepted" is the medical community; and Claimant should only be reimbursed for medication and treatments that are safe and efficacious.

b) The Onus in Proving What is "Generally Accepted"

29. Counsel for the Claimant states that the onus to establish what is "generally accepted" rests with "the Plan" but concedes that the cooperation and participation of the Claimant in providing satisfactory evidence is expected.

30. The Joint Committee argues the onus lies with the Administrator, noting that this requirement is consistent with the CAP, particularly sections 3 and 6.

31. Fund Counsel states that, pursuant to the CAP, the onus lies with the Administrator to complete a list of medications and treatments that are generally accepted by the medical community; and, in respect of any treatments or medications not listed on the HCV Medication List, the Claimant bears the onus of obtaining the opinion of his or her treating physician on whether the treatment is "generally accepted". However, in circumstances where the Claimant's treating physician is not an HCV specialist, the onus shifts back to the Administrator to secure an opinion from an HCV specialist.

32. Fund Counsel also points to section 12 (formerly section 10) of the CAP, which holds that the Administrator shall pay the reasonable fees to a treating physician for completing forms in relation to a claim for compensation.

33. In my view, the submissions of Fund Counsel correspond with the language of the Plan and, in particular, section 6 of the CAP. The Claimant is already required to obtain from his or her treating physician a completed form indicating that the treatment or medication was recommended by the treating physician. If the treating physician is an HCV specialist, requiring the Claimant to provide information from his or her treating physician concerning whether the treatment or medication is "generally accepted" by the medical community as provided in paragraph 6 of the CAP is not unreasonable. In

scenarios where the Claimant's physician is not an HCV specialist, the burden lies with the Administrator. In either scenario, the Administrator shall pay the reasonable fees incurred by a treating physician.

34. I would, however, add the following step to the process. In circumstances where an HCV specialist has stated that the treatment is not "generally accepted" by the medical community, the matter is not necessarily concluded. Instead, the onus then shifts from the Administrator to the Claimant to provide persuasive evidence to the contrary. As noted above, whether or not the treatment or medication is "generally accepted" is a factual determination for the Administrator or, on the appeal, for the referee to make; it is not a determination to be made solely by an HCV specialist. In circumstances where an HCV specialist has informed the Administrator that the treatment in question is not "generally accepted" by the medical community, the Claimant should be afforded the opportunity to provide persuasive evidence to the contrary.

c) The Claimant's Appeal

35. I turn now to the Claimant's appeal. In order to satisfy section 4.06 of the Plan, the treatment that the Claimant received must be "generally accepted" by the medical community. It must also have been recommended by the Claimant's treating physician.

36. The Claimant's treating physician stated that the homeopathic treatment administered to the Claimant was not "generally accepted" by the medical community as treatment for HCV or conditions due to an infection with HCV. Consequently, in accordance with the above analysis, at that point, the onus shifts from the Administrator to the Claimant. It is therefore incumbent upon the Claimant to provide persuasive evidence that the treatment he received was "generally accepted" by the medical community.

37. Counsel for the Claimant argues that the treatments for HCV remain in flux. He argues that prior to receiving the homeopathic treatment, the Claimant was experiencing a decline in his health due to his HCV infection, and that following the treatment his health improved to the point that he was able to live independently. Counsel for the Claimant argues that the treatment was not fanciful, or without any scientific, medical or physiological foundation. He argues that no one has questioned the reasonableness or efficacy of the treatment and that the costs are not exorbitant.

38. Unfortunately, the Claimant's evidence does not rise beyond a subjective or anecdotal account concerning the treatment that he received. Anecdotal evidence – a personal account by the Claimant that he found a particular form of treatment beneficial – in these circumstances in my view does not rise to the standard of "persuasive evidence". Accordingly, the Claimant is not entitled to a reimbursement for the cost of the naturopathic treatment pursuant to the terms of the Settlement Agreement.

39. The Claimant's treating physician provided a referral to the naturopath but only in response to the Claimant's request. It is therefore arguable whether the first requirement

under section 4.06 of the Plan has been met. Given that the Claimant has failed to meet the second requirement under section 4.06, it is not necessary to make a ruling on whether the first requirement has been met.

40. The Claimant's claim for reimbursement of travel expenses must also fail. Section 4.07 contemplates the reimbursement of travel expenses, but only where such expenses relate to the "seeking of medical advice or generally accepted medication or treatment". The treatment received by the Claimant was not "medical advice" and, as already indicated, the Claimant has failed to establish that the treatment was "generally accepted."

Result

41. In my view, the referee committed no errors in principle, with respect to jurisdiction or by misapprehending the evidence before her. Accordingly, the referee's decision is confirmed.

Winkler J.

July 23, 2013

Released: