Norberg *v.* Wynrib, [1992] 2 S.C.R. 226

Laura Norberg *Appellant*

v.

Morris Wynrib *Respondent*

and

Women's Legal Education and Action Fund *Intervener*

Indexed as: Norberg *v.* Wynrib

File No.: 21924.

1991: June 19; 1992: June 18.

Present: La Forest, L'Heureux-Dubé, Sopinka, Gonthier, Cory, McLachlin and Stevenson* JJ.

on appeal from the court of appeal for british columbia

Torts -- Battery -- Defences -- Consent -- Doctor-patient relationship -- Patient addicted to prescription drug -- Doctor suggesting sex-for-drugs arrangement -- Patient acquiescing to obtain drugs -- Whether patient's consent a defence to battery

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* Stevenson J. took no part in the judgment.

-- Whether action barred by reason of illegality or immorality -- Determination of damages.

Contracts -- Doctor-patient relationship -- Patient addicted to prescription drug -- Doctor suggesting sex-for-drugs arrangement -- Patient acquiescing to obtain drugs -- Whether breach of contract.

Trusts -- Fiduciary duty -- Doctor-patient relationship -- Patient addicted to prescription drug -- Doctor suggesting sex-for-drugs arrangement -- Patient acquiescing to obtain drugs -- Whether fiduciary relationship -- If so, whether breach of relationship.

Appellant became addicted to pain killers, and to one addictive drug in particular. She obtained the drugs from various doctors and from her sister. Eventually she began seeing the respondent, an elderly medical practitioner and, using several pretexts, obtained prescriptions for pain killers from him. At some point during this period, respondent confronted appellant about her drug usage and she admitted that she was addicted. He then made suggestions of a sexual nature by pointing upstairs where his apartment was located. Appellant then obtained the drug from other doctors but, when they reduced her supply, sought out respondent and gave in to his demands. Several instances of fondling and simulated intercourse occurred over the course of more than a year. After a time, appellant told respondent that she needed help with her addiction. Respondent advised appellant to "just quit". Appellant became the subject of a criminal investigation and respondent ceased giving her prescriptions but continued to give her pills after her visits upstairs. After

being charged with "double doctoring" -- obtaining narcotic prescription drugs from a doctor without disclosing particulars of prescriptions from other doctors -- appellant went to a rehabilitation centre on her own initiative.

Appellant sought general and punitive damages against the respondent on the grounds of sexual assault, negligence, breach of fiduciary duty and breach of contract. At trial, appellant admitted that respondent did not at any time use physical force. She also testified that he did things for her, that she "played" on the fact that he liked her and that she knew throughout the relationship that he was lonely. The action was dismissed at trial and on appeal.

At issue here was whether appellant should be allowed to recover damages.

Held: The appeal should be allowed.

Per La Forest, Gonthier and Cory JJ.: The sexual assault alleged here fell under the tort of battery -- the intentional infliction of unlawful force on another person. One defence to this tort is consent, express or implied. It has long been held that consent will be vitiated where it is obtained by force or threat of force, by fraud or deceit as to the nature of the defendant's conduct, or where it is given under the influence of drugs. The vitiating factors, however, are not limited to these. The concept of consent as it operates in tort law is based on a presumption of individual autonomy and free will. In some circumstances, a position of relative weakness can

interfere with the freedom of a person's will. Accordingly, our notion of consent must involve an appreciation of the power relationship between the parties.

In certain circumstances, consent will be considered to be legally ineffective if it can be shown that there was such a disparity in the relative positions of the parties that the weaker party was not in a position to choose freely. Ordinarily, a special "power dependency" relationship will be required. The existence of one of these special relationships, however, is not necessarily determinative of an overwhelming power imbalance. The factual context of each case must be evaluated to determine if there has been legally effective consent. The doctrine of unconscionability used to address the issue of voluntariness in contract law provides insight into the issue of consent in tort law which, to be genuine, must be voluntary.

In "power dependency" relationships, a two-step process is involved in determining whether or not there has been legally effective consent to a sexual assault. An inequality between the parties must first be proved, and then exploitation. A consideration of the type of relationship at issue may provide a strong indication of exploitation. Community standards of conduct may also be of some assistance.

There was a marked inequality in the respective powers of the parties here. The appellant was addicted to the heavy use of tranquilizers and pain killers. Her drug dependence placed her in a vulnerable position and diminished her ability to make a real choice.

An unequal distribution of power is frequently a part of the doctor-patient relationship. The respondent's medical knowledge and knowledge of the appellant's addiction, combined with his authority to prescribe drugs, gave him power over her. The second step of exploitation was also satisfied. The respondent abused his power over the appellant and exploited the information he obtained concerning her weakness to pursue his own personal interests. The sex-for-drugs relationship was markedly divergent from what the community would consider acceptable.

Respondent's assertions of compassion and interest in appellant's well-being did not square with his flagrant disregard for her need for treatment. If he were truly interested in her well-being, he would have helped her overcome her addiction. The argument that appellant took advantage of an old and lonely doctor would have had more credence had appellant initiated the sex-for-drugs arrangement.

The principle of *ex turpi causa non oritur actio* did not apply so as to bar the appellant's recovery for damages. To apply this doctrine would be to deny the appellant's claim on the same basis that she succeeded in the tort action: because she acted out of her desperation for the addictive drug. Public policy would not countenance giving to the appellant with one hand and then taking away with the other. The offence of "double-doctoring" was irrelevant here because no causative link existed between the injury and the crime. The appellant, if she had been relying on the respondent alone for her drug supply rather than "double-doctoring", would have suffered the same harm.

The tort of battery is actionable without proof of damage and liability is not confined to foreseeable consequences. Aggravated damages, where general damages are assessed taking into account any aggravating features of the case, may be awarded if the battery has occurred in humiliating or undignified circumstances. These must be distinguished from punitive or exemplary damages which are awarded to punish the defendant and make an example of him or her to deter others from committing the same tort. Here the appellant was entitled to aggravated damages for the indignity of the sexual assault. Respondent's conduct merited condemnation by the court. Although not harsh, vindictive or malicious, it was nevertheless reprehensible and it offended the ordinary standards of decent conduct in the community. Further, the exchange of drugs for sex by a doctor in a position of power is conduct that cries out for deterrence and an award of punitive damages was accordingly appropriate.

Per L'Heureux-Dubé and McLachlin JJ.: The fiduciary duty which existed here was breached. The plaintiff was entitled to recover the appropriate damages at equity.

The doctor-patient relationship can be conceptualized as a creature of contract or of tort but its most fundamental characteristic, rooted in the trust inherent in the relationship, is its fiduciary nature. The foundation and ambit of the fiduciary obligation are conceptually distinct from the foundation and ambit of contract and tort. In negligence and contract the parties are taken to be independent and equal actors, concerned primarily with their own self-interest. Consequently, the law seeks a balance between enforcing obligations by awarding compensation when those

obligations are breached, and preserving optimum freedom for those involved in the relationship in question. The essence of a fiduciary relationship, by contrast, is that one party exercises power on behalf of another and pledges himself or herself to act in the best interests of the other. When breach occurs, the balance favours the person wronged.

A fiduciary relationship is marked by the following characteristics: (1) the fiduciary has scope for the exercise of some discretion or power; (2) the fiduciary can unilaterally exercise that power or discretion so as to affect the beneficiary's legal or practical interests; and (3) the beneficiary is peculiarly vulnerable or at the mercy of the fiduciary holding the discretion or power. A physician owes his or her patient the classic duties associated with a fiduciary relationship -- "loyalty, good faith, and avoidance of conflict of duty and self-interest".

That one party in a fiduciary relationship holds power over the other is not in and of itself wrong. Wrong occurs, however, if the risk inherent in entrusting the fiduciary with such power is realized and the fiduciary abuses the power entrusted to him or her.

A fiduciary duty arises because that power or discretion may be used to affect the beneficiary in a damaging way. Fiduciary duties are not confined to the exercise of power which can affect the legal interests of the beneficiary, but extend to the beneficiary's "vital non-legal or `practical' interests". Fiduciary obligation is not confined to legal rights such as confidentiality and conflict of interest and undue

influence in the business sphere. Here, societal and personal interests which are vital and substantial are being protected, and not what have been traditionally regarded as legal interests.

The third requirement is that of vulnerability. The beneficiary of a fiduciary relationship need not be *per se* vulnerable. It is only where there is a material discrepancy, in the circumstances of the relationship in question, between the power of one person and the vulnerability of the other that the fiduciary relationship is recognized by the law. Where the parties are on a relatively equal footing, contract and tort provide the appropriate analysis.

The doctrine applied notwithstanding a number of alleged conditions of defeasibility.

The short answer to the arguments based on wrongful conduct of the plaintiff is that she did nothing wrong in the context of this relationship. She was not a sinner, but a sick person, suffering from an addiction which proved to be uncontrollable in the absence of a professional drug rehabilitation program. The law might accuse the plaintiff of "double doctoring" and moralists might accuse her of licentiousness; but she did no wrong because not she but the doctor was responsible for this conduct. He had the power to cure her of her addiction, as her successful treatment after leaving his "care" demonstrated, but instead chose to use his power to keep her in her addicted state and to use her for his own sexual purposes. An application of the clean hands maxim here amounts to nothing more than "blaming the victim".

Treating this case on the basis of breach of fiduciary duty adds a great deal, besides perhaps a duty of confidence and non-disclosure, to an action in tort or contract. The scope of the fiduciary obligation is not narrowly confined to matters akin to the duty not to disclose confidential information. Fiduciary obligations "must be reserved for situations that are truly in need of the special protection that equity affords", and the situation here is precisely one that is "truly in need of the special protection that equity affords". Given that the principles apply here to protect the plaintiff's interest in receiving medical care free of exploitation at the hands of her physician, the consequences are most significant. The defences based on the alleged fault of the plaintiff, so pressing in tort, may carry little weight when raised against the beneficiary of a fiduciary relationship. Equity has always held trustees strictly accountable in a way the tort of negligence and contract have not. Foreseeability of loss is not a factor in equitable damages. Certain defences, such as mitigation, may not apply.

Viewing the relationship at issue here as fiduciary will not open the floodgates to unfounded claims based on the abuse of real or perceived inequality of power. The ambit of the fiduciary obligation must be defined in a way that encompasses meritorious claims while excluding those without merit. The prospect of the law's recognizing meritorious claims by the powerless and exploited against the powerful and exploitive should not alone serve as a reason for denying just claims.

Damages should be assessed according to the principles which generally govern damages for breach of fiduciary duty, keeping in mind that the remedy

awarded need not be confined to that given in previous situations if the requirements of fairness and justice demand more, and that reference to the principles of assessment in contract and tort may be of assistance in so far as they are relevant. The goal of equity is to restore the plaintiff as fully as possible to the position he or she would have been in had the equitable breach not occurred. Where the traditional equitable remedies of restitution and account are not available, equity awards compensation in their stead. In awarding damages the same generous, restorative remedial approach, which stems from the nature of the obligation in equity, applies. The fiduciary, being the person with the advantage of power, assumes full responsibility and cannot be heard to complain that the victim of his or her abuse cooperated in his or her defalcation or failed to take reasonable care for his or her own interests.

Punitive damages were appropriate here.

Per Sopinka J.: Consent, either express or implied by conduct, is a defence to a claim of battery. Consent must be genuine and cannot be obtained by force, duress, or fraud or deceit as to the nature of the defendant's conduct, or under the influence of drugs. The factors relating to consent must be applied on a case-by-case basis rather than by the establishment of categories of individuals or relationships where apparent consent will never or rarely be considered valid. Certain relationships, particularly those in which there is a significant imbalance in power or those involving a high degree of trust and confidence, may require the trier of fact to be particularly careful in assessing the reality of consent.

The sexual contact, although clearly against appellant's wishes, was not without her consent. Her addiction, while it clearly inspired her willingness to engage in sexual activity, did not interfere with her ability to reason or her capacity to consent to the sexual activity which took place. The doctor did not exercise such control or authority that her submission could not be considered genuine consent. Indeed, appellant admitted to playing on respondent's loneliness. There is no basis on which to set aside the conclusion of the courts below on the issue of consent.

There is a fundamental difference between the issue of consent in tort law and the doctrine of unconscionability. The weight of academic and judicial opinion is that the doctrine of unconscionability operates to set aside transactions even though there may have been consent or agreement to the terms of the bargain. It is not that this doctrine vitiates consent; rather fairness requires that the transaction be set aside notwithstanding consent. The doctrine of unconscionability and the related principle of inequality of bargaining power are still evolving and are not yet completely settled areas of contract law. Importing the principles of unconscionability into the context of a battery claim has the potential to obscure the real question of whether, in all the circumstances, the plaintiff actually consented to the touching which constituted the alleged battery. The facts of this case are more accurately reflected by acknowledging that the appellant consented to the sexual contact and by considering the respondent's conduct in light of his professional duty towards the appellant.

Respondent's professional duty arose out of the doctor-patient relationship which is essentially based in contract. Breach, however, can be subject

to action in either contract or tort. While certain obligations that arise from a doctor-patient relationship are fiduciary in nature, other obligations are contractual or based on the neighbourhood principle which underlies the law of negligence. Fiduciary duties should not be superimposed on common law duties. Whether the appellant relies on contract or negligence, the duty to treat was not vacated by consent. The abandonment of the contractual relationship between the parties required their mutual consent supported by consideration. The doctor-patient relationship here, notwithstanding any relationship independent of it, continued and was not abandoned. Neither the parties nor the medical community had any reason to believe that the parties had mutually abandoned their contract. Even if the contract were ended, the duty subsisted independently and formed the basis of the action in tort.

The plaintiff's consent to the defendant's conduct did not excuse the defendant from the obligations of his duty. He owed a professional responsibility both to the plaintiff and to the state not to mistreat her in a medical way by extending her period of addiction without proper treatment regardless of her wishes. Absent a clear statement by the respondent to the appellant that he was no longer treating her as her physician and an unequivocal consent to the cessation of treatment, the duty to treat the appellant continued until she attended at the rehabilitation centre on her own initiative and was treated.

The appellant's claim was not barred by *ex turpi*. Its application to defeat a tort action has been rare. Emphasis is now placed on preserving the administration

of justice from the taint that would result from the approval of a transaction that a court ought not to countenance.

The sexual acts were causally connected to the failure to treat and must form part of the damage suffered by the appellant. Punitive damages, however, should not be awarded because the basis of liability is the breach of professional duty. While the sexual episodes are an element of damage, they are not the basis of liability.

Cases Cited

By La Forest J.

Considered: *R. v. Jobidon*, [1991] 2 S.C.R. 714; *W.(B.) v. Mellor*, [1989] B.C.J. No. 1393 (QL Systems); *Lyth v. Dagg* (1988), 46 C.C.L.T. 25; **referred to**: *Morrison v. Coast Finance Ltd.* (1965), 55 D.L.R. (2d) 710; *Lloyds Bank Ltd. v. Bundy*, [1975] Q.B. 326; *Waters v. Donnelly* (1884), 9 O.R. 391; *R. v. Lock* (1872), L.R. 2 C.C.R. 10; *Harry v. Kreutziger* (1978), 9 B.C.L.R. 166; *Black v. Wilcox* (1976), 70 D.L.R. (3d) 192; *Canada Cement LaFarge Ltd. v. British Columbia Lightweight Aggregate Ltd.*, [1983] 1 S.C.R. 452; *N. (J.L.) v. L. (A.M.)* (1988), 47 C.C.L.T. 65; *Vorvis v. Insurance Corporation of British Columbia*, [1989] 1 S.C.R. 1085; *R. v. McCraw*, [1991] 3 S.C.R. 72; *Stewart v. Stonehouse*, [1926] 2 D.L.R. 683; *Glendale v. Drozdzik*, [1990] B.C.W.L.D. 1839; *Q. v. Minto Management Ltd.* (1985), 15 D.L.R. (4th) 581; *Harder v. Brown* (1989), 50 C.C.L.T. 85; *Myers v. Haroldson*, [1989] 3 W.W.R. 604.

By McLachlin J.

Considered: *Frame v. Smith*, [1987] 2 S.C.R. 99; **referred to**: *McInerney v. MacDonald*, [1992] 2 S.C.R. 138; *Canadian Aero Service Ltd. v. O'Malley*, [1974] S.C.R. 592; *Lac Minerals Ltd. v. International Corona Resources Ltd.*, [1989] 2 S.C.R. 574; *Canson Enterprises Ltd. v. Boughton & Co.*, [1991] 3 S.C.R. 534; *Reading v. Attorney-General*, [1951] A.C. 507; *College of Physicians and Surgeons of Ontario v. Gillen* (1990), 1 O.R. (3d) 710; *Mazza v. Huffaker*, 300 S.E.2d 833 (1983); *Lloyds Bank Ltd. v. Bundy*, [1975] Q.B. 326; *Guerin v. The Queen*, [1984] 2 S.C.R. 335; *Pettkus v. Becker*, [1980] 2 S.C.R. 834; *R. v. Lavallee*, [1990] 1 S.C.R. 852; *Harder v. Brown* (1989), 50 C.C.L.T. 85; *Myers v. Haroldson*, [1989] 3 W.W.R. 604; *W.(B.) v. Mellor*, [1989] B.C.J. No. 1393 (QL Systems); *Szarfer v. Chodos* (1986), 54 O.R. (2d) 663.

By Sopinka J.

Referred to: *Reibl v. Hughes*, [1980] 2 S.C.R. 880; *Morrow v. Hôpital Royal Victoria* (1989), 3 C.C.L.T. (2d) 87; *Cowan v. Brushett* (1990), 3 C.C.L.T. (2d) 195; *Freeman v. Home Office*, [1984] 1 All E.R. 1036; *Lyth v. Dagg* (1988), 46 C.C.L.T. 25; *Hunter Engineering Co. v. Syncrude Canada Ltd.*, [1989] 1 S.C.R. 426; *Morrison v. Coast Finance Ltd.* (1965), 55 D.L.R. (2d) 710; *Davidson v. Three Spruces Realty Ltd.* (1977), 79 D.L.R. (3d) 481; *Harry v. Kreutziger* (1978), 95 D.L.R. (3d) 231; *Lloyds Bank Ltd. v. Bundy*, [1975] Q.B. 326; *Lac Minerals Ltd. v. International Corona Resources Ltd.*, [1989] 2 S.C.R. 574; *Girardet v. Crease & Co.*

(1987), 11 B.C.L.R. (2d) 361; *Mack v. Enns* (1981), 30 B.C.L.R. 337; *Hegarty v. Shine* (1878), 4 L.R. Ir. 288.

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APPEAL from a judgment of the British Columbia Court of Appeal (1990), 44 B.C.L.R. (2d) 47, 66 D.L.R. (4th) 553, [1990] 4 W.W.R. 193, dismissing an appeal from a judgment of Oppal J. (1988), 27 B.C.L.R. (2d) 240, 50 D.L.R. (4th) 167, [1988] 6 W.W.R. 305, 44 C.C.L.T. 184, dismissing the action. Appeal allowed.

J. J. Camp, Q.C., and *Patrick Foy*, for the appellant.

I. E. Epstein, for the respondent.

Victoria Gray, for the intervener.

//*La Forest J.*//

The judgment of La Forest, Gonthier and Cory JJ. was delivered by

LA FOREST J. -- This case concerns the civil liability of a doctor who gave drugs to a chemically dependent woman patient in exchange for sexual contact. The central issue is whether the defence of consent can be raised against the intentional tort of battery in such circumstances. The case also raises the issue whether the action is barred by reason of illegality or immorality.

Facts

In 1978, the appellant, then a modestly educated young woman in her late teens, began to experience severe headaches and pains in her jaw. She went to doctors and dentists but none of them could diagnose the cause of her excruciating pain. They prescribed various types of painkillers. However, the medication provided no relief. The headaches became worse. More and more medication was prescribed in increasing amounts and dosages. In addition to this medication, her sister, a drug addict, gave her Fiorinal, a painkiller drug. Finally in December 1978, a dentist diagnosed her difficulty as being related to an abscessed tooth. It was extracted and at last her pain was relieved.

But now the appellant had a new problem. She had a craving for painkillers. Her sister gave her more Fiorinal. In 1981, when she broke her ankle, she found a doctor who was willing to prescribe Fiorinal for her. She continued to obtain prescriptions from him until he retired. However, his replacement refused to give her more pills. She discussed the situation with her sister and in March 1982

she commenced to see Dr. Wynrib, an elderly medical practitioner in his seventies. She told him she was experiencing pain in the ankle she had broken in 1981 and asked for Fiorinal. He gave her the prescription. She kept going back to him using the ankle injury and other illnesses as a pretext for obtaining prescriptions. Her dependence on Fiorinal continued to increase as did her dependence on Dr. Wynrib. But the pretext could not continue. Later in 1982, Dr. Wynrib confronted the appellant. The appellant described this confrontation as follows:

> I had gone into his office one day and I asked him -- I asked him for a prescription of Fiorinal, and I remember that he sat back in his chair and he pulled out like the medical file and he looked at me and he asked me come on, Laura, why is the real reason you're taking the Fiorinal. I told him because it's for my back or my ankle, whatever it was that I had been asking him for, and he said -- no he said. And he looked again over my file. He said you can't be taking them for this long and not be addicted to them. Why is the real reason. And I denied it again. I said it's for the pain. And he told me that if I didn't admit to him that I was addicted to the Fiorinal that he wouldn't give me any more prescriptions. And I remember that I had started crying and I had denied [sic] to him, and he had told me to leave the office. And I wouldn't leave the office and finally I admitted to him that I was addicted to the Fiorinal.

Dr. Wynrib responded by giving the appellant another prescription.

After the appellant admitted to Dr. Wynrib that she was addicted to Fiorinal, she testified that he told her that "if I was good to him he would be good to me" and he made suggestions by pointing upstairs where he lived above his office. The appellant recognized this for what it was and sought her drugs elsewhere. She managed to secure Fiorinal through other doctors and by buying them off the street. Her tolerance and dependence grew. Eventually the other doctors reduced her

supply. She was, as she put it, desperate. Near the end of 1983 she went back to Dr. Wynrib because she knew he would give her Fiorinal. She gave in to his demands.

Initially the sexual encounters took place in the back examination room of his office. He kissed her and fondled her breasts. In time, he required her to meet him upstairs in his bedroom where he kept a bottle of Fiorinal in his dresser drawer beside the bed. She managed to stall him for awhile by asking for the Fiorinal first and then leaving after she obtained it. But this device did not work long. Dr. Wynrib told her that he would not give her the Fiorinal until she complied with his demands. The pattern was that he would tell her to undress and put the bottle of Fiorinal by his bed for her to see. Both parties would lie on the bed. Dr. Wynrib would kiss the appellant, touch her and then get on top of her. He would go through the motions of intercourse. There was no penetration, however, because he could not sustain an erection. On at least one occasion, however, he penetrated her with his fingers. He would give her pills each time she visited him in his apartment. She then would go back to his office the next day and he would write out a prescription. When the encounters began, the appellant did not want to believe what was happening. She thought he would do it once and then stop. However, the appellant testified that these incidences of simulated intercourse occurred 10 or 12 times, up to the early part of 1985.

During this period, the appellant was obtaining Fiorinal from a number of other sources: other doctors, off the street and from her sister. In February 1985, she left her job. She became depressed and no longer had the money to buy the

drugs she needed off the street. She told Dr. Wynrib that she needed help. Her evidence at trial was:

> A. . . . I remember telling him that I needed help, and he told me to just quit. He said just quit. I said I can't. The pills were on my mind all the time.
>
> Q. Did he direct you anywhere else apart from telling you to quit, giving you advice?
>
> A. No, no.

At some point in 1985, the appellant became the subject of a criminal investigation leading the RCMP to visit Dr. Wynrib in April 1985. After this visit, Dr. Wynrib told the appellant that he could no longer give her prescriptions in the office. However, he still gave her pills from the bottle in his dresser drawer when she visited him upstairs. Eventually, she was charged with the summary conviction offence of "double doctoring" under s. 3.1(1) of the *Narcotic Control Act*, R.S.C. 1970, c. N-1, as am. by S.C. 1985, c. 19, s. 198, i.e., obtaining narcotic prescription drugs from a doctor without disclosing particulars of prescriptions from other doctors. In July 1985, she went to a rehabilitation centre for drug addicts on her own initiative. She left the centre after one month and has not taken any drugs for non-medical reasons since. In September 1985, the appellant pleaded guilty to the offences for which she was charged and received an absolute discharge.

At trial, the respondent did not testify. However, the appellant admitted that Dr. Wynrib did not at any time use physical force. She also testified that he did things for her such as giving her money as well as coffee and cookies. She agreed

that she "played" on the fact that he liked her and that she knew throughout the relationship that he was lonely.

The appellant continues to attend Narcotics Anonymous and other similar programs. She has done volunteer work at the crisis and counselling centre in the area where she lives and has completed credits towards a social worker program. Her hope is to work in the area of drug rehabilitation. She daily thinks with shame and remorse about what happened with Dr. Wynrib. She returned to the rehabilitation centre for more treatment after her first child was born. She felt that she did not deserve to have a child because of what she had done with Dr. Wynrib. Her craving for drugs continues but she has learned to live without them.

Judicial History

Supreme Court of British Columbia (1988), 27 B.C.L.R. (2d) 240

At trial, the appellant sought general and punitive damages against the respondent on the grounds of sexual assault, negligence and breach of fiduciary duty.

The trial judge, Oppal J., rejected the appellant's claim of sexual assault holding that she had consented to it. At page 244, he stated:

> By apparently voluntarily submitting to the doctor's advances on the various occasions, the plaintiff gave her implied consent to the sexual contact that constitutes the alleged battery. She obviously had deep misgivings about engaging in this conduct with the defendant. Clearly, she did not wish to do so. However, at no time did she express her

> feelings to the defendant that she did not wish to engage in sexual activities with him. In fact she went along with his demands.

Oppal J. recognized that for consent to be genuine, it must not be extorted by force or threats of force, or be obtained from an individual under the influence of drugs, but he held that these factors were not present in this case. The respondent did not exercise or threaten to use force, and there was no evidence that the appellant's addiction interfered with her capacity to consent to the sexual activity or with her ability to reason.

Oppal J. next considered the appellant's claim that the respondent was professionally negligent in continuing to prescribe Fiorinal to her. He held that the respondent's continued prescribing of Fiorinal to a known addict breached the standard of care required by law. However, since the appellant was not physically injured by this conduct, her action in negligence failed.

With respect to the appellant's claim that the respondent breached his fiduciary duty by engaging in sexual relations with her and by continuing to prescribe Fiorinal, Oppal J. held, at p. 246:

> A relationship between a physician and a patient is one in which trust and confidence must be placed in the physician. Clearly, in the case at bar, the doctor breached a duty which was owed to his patient and, in the ordinary course of events, she should be entitled to damages.

Oppal J., however, went on to find that the defence of *ex turpi causa non oritur actio* was available to the respondent. In this case, both parties voluntarily

participated in an illicit relationship. Any injury the appellant sustained was a direct, natural consequence of her illegal and immoral acts.

The action was accordingly dismissed, and the appellant appealed to the Court of Appeal.

Court of Appeal (1990), 44 B.C.L.R. (2d) 47

The majority of the Court of Appeal, McEachern C.J. and Gibbs J.A., accepted, at p. 244, the trial judge's finding that the appellant "gave her implied consent to the sexual contact that constitutes the alleged battery" and that there was no evidence that her addiction to Fiorinal interfered with her capacity to consent to the sexual activity. It further agreed that the appellant was not at any time deprived of her ability to reason. In the majority's view, Oppal J. was correct in dismissing the appellant's sexual assault claim on the basis of consent.

The majority rejected, as well, the appellant's claim of breach of fiduciary duty. McEachern C.J. set forth his view in this way, at p. 52:

> If the defendant breached a duty to the plaintiff in this case it was a breach of the duty which a physician owes to his patient to treat her professionally and, unless the breach relates to an improper disclosure of confidential information or something like that, it adds nothing to describe the breach as a fiduciary one.

With respect to the appellant's claim in negligence, McEachern C.J. noted that Oppal J. found that the respondent had breached his professional duty to the

appellant. He agreed with this finding and further found that the physical harm done by the appellant's continued addiction was sufficient to support a cause of action. However, he held that the compensable period would only begin at the date the respondent became aware of her addiction, and damages would be reduced to account for the other drug sources and the appellant's own contributory negligence as a "knowing participant in her own misfortune".

At all events, the majority concluded that Oppal J. was correct in applying the principle *ex turpi causa non oritur actio* to bar the appellant's right to recover damages. McEachern C.J. stated, at p. 54:

> In my view, the plaintiff and defendant in this case were both engaged in a joint or common criminal enterprise to traffic unlawfully in a prohibited drug at least from the end of 1983. Since I have already found that the plaintiff is nevertheless entitled to proper medical treatment from the defendant, this removes at least one branch from the ex turpi principle, that is that participants in a joint criminal activity do not owe a duty of care to each other.
>
> That, however, does not exclude the other ground, namely that the court's assistance will not be furnished to a plaintiff who seeks damages for injuries resulting from illegal and immoral activity or out of an arrangement or transaction which had as one of its incidents an illegal or immoral consideration. The court, as Lord Mansfield said, will not lend its aid to such a plaintiff. In this case, of course, I rely far more heavily upon illegal than upon immoral conduct.

Locke J.A., dissenting, agreed with Oppal J. that the sexual assault claim failed because of the appellant's consent. Turning to the appellant's claim in negligence, he held that the respondent failed in his professional duty as a physician. Supplying medically unnecessary drugs to a known addict was a negligent act. There was sufficient damage to sustain the action in that the respondent's conduct

"assisted in keeping [the appellant] addicted for a year or more when she might have been receiving treatment" (at p. 60). The fact that she was subject to the disability of drug addiction for an extended period of time was foreseeable and inevitable.

Locke J.A. held that recovery on the basis of "breach of fiduciary duty" was not available. In his opinion, the evidence did not support any equitable rule operating to show the respondent in a fiduciary relationship with the appellant. He revealed her affairs to no one and he did not unduly influence her.

Locke J.A. disagreed with the majority that the maxim *ex turpi causa non oritur actio* barred the appellant's claim. Although there was joint sexual activity, there was no common purpose and there was no one criminal illegality to which both were parties. He observed that sexual intercourse between consenting adults is not a crime. Locke J.A. rejected the respondent's argument that immorality alone was sufficient to bar recovery. He held that sexual immorality is not relevant to the wrongful supply of drugs.

As to damages, Locke J.A. held that the appellant could succeed for her extended drug dependency as caused by the respondent's supply of drugs. He awarded only nominal damages of $1,000, noting that the appellant had recovered from her drug addiction except for her craving which was not the sole fault of the respondent. He held that this was not an appropriate case for punitive damages.

The court, by majority, thus dismissed the appeal.

The Appeal to this Court

The appellant then appealed to this Court. In addition to the parties, the Women's Legal Education and Action Fund appeared as intervener. At trial and in the Court of Appeal, the appellant sought recovery on a number of grounds: sexual assault, negligence, breach of fiduciary duty, and breach of contract. In this Court, however, counsel particularly stressed the assault claim and I am content to dispose of the case on this basis. The other claims would appear to give rise to difficulties that would not arise in the ordinary doctor-client case. In particular, the appellant here did not come to the doctor for treatment. Rather she intended to use him to obtain drugs. Given the manner in which I propose to deal with the case, however, it is unnecessary for me to explore these matters.

Assault -- The Nature of Consent

The alleged sexual assault in this case falls under the tort of battery. A battery is the intentional infliction of unlawful force on another person. Consent, express or implied, is a defence to battery. Failure to resist or protest is an indication of consent "if a reasonable person who is aware of the consequences and capable of protest or resistance would voice his objection": see Fleming, *The Law of Torts* (7th ed. 1987), at pp. 72-73. However, the consent must be genuine; it must not be obtained by force or threat of force or be given under the influence of drugs. Consent may also be vitiated by fraud or deceit as to the nature of the defendant's conduct. The courts below considered these to be the only factors that would vitiate consent.

In my view, this approach to consent in this kind of case is too limited. As Heuston and Buckley, *Salmond and Heuston on the Law of Torts* (19th ed. 1987), at pp. 564-65, put it: "A man cannot be said to be `willing' unless he is in a position to choose freely; and freedom of choice predicates the absence from his mind of any feeling of constraint interfering with the freedom of his will". A "feeling of constraint" so as to "interfere with the freedom of a person's will" can arise in a number of situations not involving force, threats of force, fraud or incapacity. The concept of consent as it operates in tort law is based on a presumption of individual autonomy and free will. It is presumed that the individual has freedom to consent or not to consent. This presumption, however, is untenable in certain circumstances. A position of relative weakness can, in some circumstances, interfere with the freedom of a person's will. Our notion of consent must, therefore, be modified to appreciate the power relationship between the parties.

An assumption of individual autonomy and free will is not confined to tort law. It is also the underlying premise of contract law. The supposition of contract law is that two parties agree or consent to a particular course of action. However, contract law has evolved in such a way that it recognizes that contracting parties do not always have equality in their bargaining strength. The doctrines of duress, undue influence, and unconscionability have arisen to protect the vulnerable when they are in a relationship of unequal power. For reasons of public policy, the law will not always hold weaker parties to the bargains they make. Professor Klippert in his book *Unjust Enrichment* refers to the doctrines of duress, undue influence, and unconscionability as "justice factors". He lumps these together under the general term "coercion" and states, at p. 156, that "[i]n essence the common

thread is an illegitimate use of power or unlawful pressure which vitiates a person's freedom of choice". In a situation where a plaintiff is induced to enter into an unconscionable transaction because of an inequitable disparity in bargaining strength, it cannot be said that the plaintiff's act is voluntary: see Klippert, *supra*, at p. 170.

If the "justice factor" of unconscionability is used to address the issue of voluntariness in the law of contract, it seems reasonable that it be examined to address the issue of voluntariness in the law of tort. This provides insight into the issue of consent: for consent to be genuine, it must be voluntary. The factual context of each case must, of course, be evaluated to determine if there has been genuine consent. However, the principles that have been developed in the area of unconscionable transactions to negate the legal effectiveness of certain contracts provide a useful framework for this evaluation.

An unconscionable transaction arises in contract law where there is an overwhelming imbalance in the power relationship between the parties. In *Morrison v. Coast Finance Ltd.* (1965), 55 D.L.R. (2d) 710 (B.C.C.A.), at p. 713, Davey J.A. outlined the factors to be considered in a claim of unconscionability:

> . . . a plea that a bargain is unconscionable invokes relief against an unfair advantage gained by an unconscientious use of power by a stronger party against a weaker. On such a claim the material ingredients are proof of inequality in the position of the parties arising out of the ignorance, need or distress of the weaker, which left him in the power of the stronger, and proof of substantial unfairness of the bargain obtained by the stronger. On proof of those circumstances, it creates a presumption of fraud which the stronger must repel by proving that the bargain was fair, just and reasonable. . . .

In *Lloyds Bank Ltd. v. Bundy*, [1975] Q.B. 326, at p. 339, Lord Denning M.R. took a wider approach and developed the general principle of "inequality of bargaining power":

> . . . I would suggest that through all these instances [i.e. duress of goods, unconscionable transactions, undue influence, undue pressure, salvage agreements] there runs a single thread. They rest on "inequality of bargaining power". By virtue of it, the English law gives relief to one who, without independent advice, enters into a contract upon terms which are very unfair or transfers property for a consideration which is grossly inadequate, when his bargaining power is grievously impaired by reason of his own needs or desires, or by his own ignorance or infirmity, coupled with undue influences or pressures brought to bear on him by or for the benefit of the other. When I use the word "undue" I do not mean to suggest that the principle depends on proof of any wrongdoing. The one who stipulates for an unfair advantage may be moved solely by his own self-interest, unconscious of the distress he is bringing to the other. I have also avoided any reference to the will of the one being "dominated" or "overcome" by the other. One who is in extreme need may knowingly consent to a most improvident bargain, solely to relieve the straits in which he finds himself. Again, I do not mean to suggest that every transaction is saved by independent advice. But the absence of it may be fatal.

The Court of Appeal in the instant case was unwilling to characterize the relationship between the appellant and the respondent as a fiduciary relationship. Since I am dealing with the case on the basis of the assault claim, I need not consider this point. A fiduciary or confidential relationship is not a necessary ingredient for a claim involving inequality of bargaining power, even though such a relationship may be present. This principle was stated by Boyd C. in the early Ontario case of *Waters v. Donnelly* (1884), 9 O.R. 391, at p. 401:

> . . . if two persons, no matter whether a confidential relationship exists between them or not, stand in such a relation to each other that one can take an undue advantage of the other, whether by reason of distress, or recklessness, or wildness, or want of care, and when the facts shew that

> one party has taken undue advantage of the other by reason of the circumstances I have mentioned, a transaction resting upon such unconscionable dealing will not be allowed to stand. . . . [Emphasis added.]

An inequality of bargaining power may arise in a number of ways. As Boyle and Percy, *Contracts: Cases and Commentaries* (4th ed. 1989), note, at pp. 637-38:

> [A person] may be intellectually weaker by reason of a disease of the mind, economically weaker or simply situationally weaker because of temporary circumstances. Alternatively, the "weakness" may arise out of a special relationship in which trust and confidence has been reposed in the other party. The comparative weakness or special relationship is, in every case, a fact to be proven.

As the last sentence of this passage suggests, the circumstances of each case must be examined to determine if there is an overwhelming imbalance of power in the relationship between the parties.

It may be argued that an unconscionable transaction does not, in fact, vitiate consent: the weaker party retains the power to give real consent but the law nevertheless provides relief on the basis of social policy. This may be more in line with Lord Denning's formulation of "inequality of bargaining power" in *Lloyds Bank Ltd. v. Bundy, supra*, when one takes into account his statement that it is not necessary to establish that the will of the weaker party was "dominated" or "overcome" by the other party. But whichever way one approaches the problem, the result is the same: on grounds of public policy, the legal effectiveness of certain types of contracts will be restricted or negated. In the same way, in certain

situations, principles of public policy will negate the legal effectiveness of consent in the context of sexual assault. In particular, in certain circumstances, consent will be considered legally ineffective if it can be shown that there was such a disparity in the relative positions of the parties that the weaker party was not in a position to choose freely.

There is some support in the criminal law for an approach that takes into account the relative positions of the parties. This can be seen from the definition of assault, which includes assault, sexual assault, under s. 265 of the *Criminal Code*, R.S.C., 1985, c. C-46. That provision, so far as relevant, reads:

> **265**. (1) A person commits an assault when
>
> (*a*) without the consent of another person, he applies force intentionally to that other person, directly or indirectly;
>
> . . .
>
> (2) This section applies to all forms of assault, including sexual assault . . . .
>
> (3) For the purposes of this section, no consent is obtained where the complainant submits or does not resist by reason of
>
> (*a*) the application of force to the complainant or to a person other than the complainant;
>
> (*b*) threats or fear of the application of force to the complainant or to a person other than the complainant;
>
> (*c*) fraud; or
>
> (*d*) the exercise of authority. . . . [Emphasis added.]

Although s. 265 is a statutory provision, the principles underlying it are not irrelevant to an analysis of assault at common law since the offence was derived from the

common law crimes of assault and battery (*R. v. Jobidon*, [1991] 2 S.C.R. 714, at pp. 727-28).

Section 265(3) expressly specifies the circumstances in which consent is vitiated on the basis of a coerced or ill-informed will, thereby rendering the consent legally ineffective. Although this provision was added to the *Criminal Code* in 1983 by amendment (S.C. 1980-81-82-83, c. 125, s. 19), the circumstances outlined in the provision were not new to the law. As Gonthier J. explains in *Jobidon*, *supra*, at p. 730: "[These factors] had already been part of the law previous to the proclamation of the *Code* of 1892. Any novelty of s. 244(3) [now s. 265(3)] lay in its more explicit and general expression in the *Code*, S.C. 1980-81-82-83, c. 125, s. 19." As an example of the principle enunciated in s. 265(3)(*c*), Gonthier J., at p. 740 of *Jobidon*, cites the case of *R. v. Lock* (1872), L.R. 2 C.C.R. 10, in which it was held that:

> . . . eight-year-old boys were too young to understand the nature of a sexual act with a grown man to be able to consent to it. Submission by a young child to an older, stronger person, an authority figure, would not be considered consensual. The consent would in all probability have been obtained under a coerced and ill-informed will.

The general notion of submission to an "authority" figure indicates an inequality of power between the parties such that the existence of genuine consent is questionable. Section 265(3) is an expression of the fact that in certain circumstances, considerations of public policy will negate the legal validity of consent as a defence to a charge of assault. The analogy between developments in contract law and the

issue of consent in the criminal offence of assault is referred to in *Jobidon*, *supra*, at p. 735:

> Just as the common law has built up a rich jurisprudence around the concepts of agreement in contract law, and *volenti non fit injuria* in the law of negligence, it has also generated a body of law to illuminate the meaning of consent and to place certain limitations on its legal effectiveness in the criminal law. It has done this in respect of assault. In the same way that the common law established principles of public policy negating the legal effectiveness of certain types of contracts -- contracts in restraint of trade for example -- it has also set limits on the types of harmful actions to which one can validly consent, and shelter an assailant from the sanctions of our criminal law.

There has been some recognition in the lower courts that an unequal power relationship is a relevant consideration in cases of sexual misconduct. *W.(B.) v. Mellor*, [1989] B.C.J. No. 1393 (S.C.) (QL Systems), has some similarities with the present case. There the plaintiff sued for damages in contract and tort for unwelcome sexual conduct by her doctor extending over two years. At the time the doctor-patient relationship was established, the plaintiff was in a vulnerable state owing to matrimonial, financial and personal problems. The first sexual advance occurred when the plaintiff asked the doctor for medication to help her calm down. She testified that the doctor directed her into one of his examining rooms where he said he would give her medication. In the examining room, he kissed her and touched her breasts and lower body. She "stormed out of his office" on that occasion but continued to see the doctor. When asked why, she responded that she needed medication and counselling to help her cope. The intimacy between them progressed and eventually led to intercourse. She testified that she had considered changing doctors and that she had discussed this with the defendant. However, she was afraid that he would fix her file to make her appear mentally ill. McKenzie J. found for the

plaintiff on the basis that the doctor was in breach of his fiduciary duty of care to his patient and that he breached his contract of professional services. In the course of his reasons, however, he had made the following remarks that show the effect of a power relationship on consent:

> I find that he dominated her when she was in a vulnerable state wholly to satisfy his sexual desires and with no intention to carry the relationship beyond that.
>
> On the other hand she offered little or no resistance. While she may not have welcomed the crude opening gestures of this seduction she gave him the opportunity to accomplish and perpetuate it. She could and should have left him for another doctor upon his first approach. Instead she lingered for two years to be subjected to repeated sexual acts which she apparently consented to after being excited by him. Had it not been for his initiative an affair would have been unlikely.
>
> This lady had her problems which I do not pretend to diagnose but I believe that Dr. Mellor knew what he was dealing with and from his advantageous position as her doctor he thought he could get away with what he did.
>
> Viewed in human terms they both bear responsibility for this affair -- he for initiating and perpetuating it and she for allowing him to perpetuate it. But he has special responsibilities and obligations of care imposed upon him as a doctor. He committed himself to an elevated duty of care upon entering the medical profession. This was spelled out for him in several ways and prominent among them was the Hippocratic Oath he swore.... [Emphasis added.]

Lyth v. Dagg (1988), 46 C.C.L.T. 25 (B.C.S.C.), is another lower court decision in which the defence of consent was rejected even though there was no evidence of force or threat of force and the plaintiff did not actively resist the sexual advances. This case involved a sexual relationship between a teacher and a 15-year-old student. In reaching his decision, Trainor J., at pp. 31-32, considered the following factors:

> Sexual abuse is merely one particular way in which one person can assault another. It demands careful examination of the relationship between the parties to appreciate whether both had capacity to consent, understanding the nature and consequences of the conduct, and also whether one of the parties had such a greater amount of power or control over the other as to be in a position to force compliance. This is an examination to determine whether, in all the circumstances, force was applied by one person to another and whether any consent apparently given was genuine. [Emphasis added.]

Trainor J. concluded that no genuine consent was given to the first sexual contact between the parties. The defendant "dominated and influenced" the plaintiff.

The respondent contends that *Lyth v. Dagg* is distinguishable from the present case in that it involved the sexual exploitation of a child by a teacher. I do not agree. In my view, it was the ability of the defendant to "dominate and influence" the plaintiff that was the important element in the *Lyth v. Dagg* case. This is borne out by Trainor J.'s assessment that this was more than a student-teacher relationship. He stated, at p. 32:

> . . . Dagg rose in importance and stature in the eyes of his young student. Lyth wanted to be accepted in the performing arts group which drank and smoked marijuana. He had talents in that field and was ambitious to further himself. Dagg is an intelligent person and must have perceived Lyth's devotion to his schoolwork and a keen desire to be accepted by Dagg. In those circumstances, Dagg became much more than the teacher in a student-teacher relationship. He dominated and influenced the 15-year-old Lyth, who did not want to offend Dagg or do anything which would disrupt their relationship [Emphasis added.]

An ability to "dominate and influence" is not restricted to the student-teacher relationship. Professor Coleman outlines a number of situations which she calls "power dependency" relationships: see Coleman, "Sex in Power Dependency

Relationships: Taking Unfair Advantage of the `Fair' Sex" (1988), 53 *Alb. L. Rev.* 95. Included in these relationships are parent-child, psychotherapist-patient, physician-patient, clergy-penitent, professor-student, attorney-client, and employer-employee. She asserts that "consent" to a sexual relationship in such relationships is inherently suspect. She notes, at p. 96:

> The common element in power dependency relationships is an underlying personal or professional association which creates a significant power imbalance between the parties. . . .
>
> Exploitation occurs when the "powerful" person abuses the position of authority by inducing the "dependent" person into a sexual relationship, thereby causing harm.

While the existence of one of these special relationships is not necessarily determinative of an overwhelming power imbalance, it will, at least in the ordinary case, be required.

It must be noted that in the law of contracts proof of an unconscionable transaction involves a two-step process: (1) proof of inequality in the positions of the parties, and (2) proof of an improvident bargain. Similarly, a two-step process is involved in determining whether or not there has been legally effective consent to a sexual assault. The first step is undoubtedly proof of an inequality between the parties which, as already noted, will ordinarily occur within the context of a special "power dependency" relationship. The second step, I suggest, is proof of exploitation. A consideration of the type of relationship at issue may provide a strong indication of exploitation. Community standards of conduct may also be of some assistance. In *Harry v. Kreutziger* (1978), 9 B.C.L.R. 166 (C.A.), an

unconscionable transaction case dealing with the sale of a commercial fishing boat for less than its value, Lambert J.A., at p. 177, approached the issue of unconscionability from a different angle:

> . . . questions as to whether use of power was unconscionable, an advantage was unfair or very unfair, a consideration was grossly inadequate, or bargaining power was grievously impaired, to select words from both statements of principle, the *Morrison* case and the *Bundy* case, are really aspects of one single question. That single question is whether the transaction, seen as a whole, is sufficiently divergent from community standards of commercial morality that it should be rescinded.

If the type of sexual relationship at issue is one that is sufficiently divergent from community standards of conduct, this may alert the court to the possibility of exploitation.

Application to this Case

The trial judge held that the appellant's implied consent to the sexual activity was voluntary. Dr. Wynrib, he stated, exercised neither force nor threats of force and the appellant's capacity to consent was not impaired by her drug use. The Court of Appeal agreed that the appellant voluntarily engaged in the sexual encounters. However, it must be asked if the appellant was truly in a position to make a free choice. It seems clear to me that there was a marked inequality in the respective powers of the parties. The appellant was a young woman with limited education. More important, she was addicted to the heavy use of tranquilizers and painkillers. On this ground alone it can be said that there was an inequality in the position of the parties arising out of the appellant's need. The appellant's drug

dependence diminished her ability to make a real choice. Although she did not wish to engage in sexual activity with Dr. Wynrib, her reluctance was overwhelmed by the driving force of her addiction and the unsettling prospect of a painful, unsupervised chemical withdrawal. That the appellant's need for drugs placed her in a vulnerable position is evident from the comments of the trial judge, at p. 243:

> [The appellant] stated that at first she ignored his suggestions and managed to stall him off. For a short period of time she stopped seeing him and managed to secure her drugs through other doctors. However, when the other doctors reduced her supply, she returned to Dr. Wynrib. She stated that she was desperate. She said that she complied with his demands.

And at p. 244, he added:

> She obviously had deep misgivings about engaging in this conduct with the defendant. Clearly, she did not wish to do so.
>
> . . . her willingness to engage in sexual activity was obviously inspired by the prescriptions which the doctor would provide. . . .

The appellant's vulnerability on the basis of need is also evident from the following report of Dr. Fleming of the Department of Psychiatry, Faculty of Medicine, University of British Columbia and entered as expert evidence:

> As she herself states, she wished to obtain a supply at any cost, and was willing to compromise her beliefs concerning appropriate behaviour in order to obtain supply. In the absence of dependence on and tolerance to Fiorinal it is my impression that Ms. Norberg would not have consented to have any social or sexual activity with Dr. Wynrib. On the basis of my clinical examination and the material provided it is my belief that she did so in order to obtain a supply of medication.

On the other side of the equation was an elderly, male professional -- the appellant's doctor. An unequal distribution of power is frequently a part of the doctor-patient relationship. As it is stated in *The Final Report of the Task Force on Sexual Abuse of Patients*, An Independent Task Force Commissioned by The College of Physicians and Surgeons of Ontario (November 25, 1991) (Chair: Marilou McPhedran), at p. 11:

> Patients seek the help of doctors when they are in a vulnerable state -- when they are sick, when they are needy, when they are uncertain about what needs to be done.
>
> The unequal distribution of power in the physician-patient relationship makes opportunities for sexual exploitation more possible than in other relationships. This vulnerability gives physicians the power to exact sexual compliance. Physical force or weapons are not necessary because the physician's power comes from having the knowledge and being trusted by patients.

In this case, Dr. Wynrib knew that the appellant was vulnerable and driven by her compulsion for drugs. It is likely that he knew or at least strongly suspected that she was dependant upon Fiorinal before she admitted her addiction to him. It was he who ferreted out that she was addicted to drugs. As a doctor, the respondent knew how to assist the appellant medically and he knew (or should have known) that she could not "just quit" taking drugs without treatment. Dr. Fleming stated:

> It is known that withdrawal from continuous use of short-acting barbiturates is an extremely unpleasant experience and it is natural that Ms. Norberg would attempt to maintain her supply in the absence of a comprehensive treatment program that would address her needs (pharmacological and psychological) during a withdrawal program.

The respondent's medical knowledge and knowledge of the appellant's addiction, combined with his authority to prescribe drugs, gave him power over her. It was he who suggested the sex-for-drugs arrangement.

However, it must still be asked if there was exploitation. In my opinion there was. Dr. Herbert of the Department of Family Practice, Faculty of Medicine, University of British Columbia, expressed the opinion that "a reasonable practitioner would have taken steps to attempt to help Ms. Norberg end her addiction by, for example, suggesting drug counselling, or, at the very least, by discontinuing her prescriptions of Fiorinal". However, Dr. Wynrib did not use his medical knowledge and expertise to address the appellant's addiction. Instead, he abused his power over her and exploited the information he obtained concerning her weakness to pursue his own personal interests. It seems to me that a sex-for-drugs arrangement initiated by a doctor with his drug addict patient is a relationship which is divergent from what the community would consider acceptable. The trial judge (at p. 246) stated that "Dr. Wynrib's conduct would in all likelihood be regarded by members of the medical profession and the community at large as disgraceful and unprofessional". McEachern C.J. (at p. 51) referred to the relationship as a "sordid arrangement".

There is also a body of opinion which regards sexual contact in any doctor-patient relationship as exploitative. In the opinion of the Task Force on Sexual Abuse of Patients, *supra*, at p. 12:

> Due to the position of power the physician brings to the doctor-patient relationship, there are NO circumstances -- NONE -- in which sexual activity between a physician and a patient is acceptable. Sexual activity between a patient and a doctor ALWAYS represents sexual

> abuse, regardless of what rationalization or belief system the doctor chooses to use to excuse it. Doctors need to recognize that they have power and status, and that there may be times when a patient will test the boundaries between them. It is ALWAYS the doctor's responsibility to know what is appropriate and never to cross the line into sexual activity.

Indeed, the Hippocratic Oath indicates that sexual contact between a doctor and his or her patient is fundamentally improper:

> In every house where I come I will enter only for the good of my patients, keeping myself far from all intentional ill-doing and all seduction, and especially from the pleasures of love with women or with men, be they free or slaves.
>
> (*Dorland's Illustrated Medical Dictionary* (27th ed. 1988), at p. 768.)

These observations were directed at the regulation of the doctor-patient relationship, rather than civil liability and I need not consider their precise implications in the latter context. For we are not here dealing with just a doctor-patient relationship but a doctor-drug addict relationship, and it was not just a sexual relationship but a sex-for-drugs relationship. These circumstances suggest that the appellant's consent was not genuine for the purposes of the law.

The respondent argues that the appellant exploited the weakness and loneliness of an elderly man to obtain drugs. While Dr. Wynrib, no doubt, had vulnerabilities of his own, it seems to me that the determining factor in this case is that he instigated the relationship -- it was he, not the appellant, who used his power and knowledge to initiate the arrangement and to exploit her vulnerability. The respondent's argument might be more persuasive if it had been the appellant who had suggested that she would exchange sex for drugs. I am also not convinced by

assertions that the respondent showed compassion and interest in the appellant's well-being. This does not square with his flagrant disregard for her need for treatment. If he were truly interested in her well-being, he would have helped her overcome her addiction.

The respondent argues that the position of the plaintiff is tantamount to an assertion that an addict cannot give consent. An addict, he continues, will thus not be held responsible for his or her actions. Although an addiction may indicate an inequality in power, this will not by itself render consent legally ineffective. Under the formulation I have suggested, there must also be exploitation. In *Black v. Wilcox* (1976), 70 D.L.R. (3d) 192 (Ont. C.A.), at p. 197, Evans J.A., in discussing the principle of unconscionability stated:

> . . . the Court will invoke the equitable rule that a person who is not equal to protecting himself will be protected, not against his own folly or carelessness, but against his being taken advantage of by those in a position to do so by reason of their commanding and superior bargaining position. The combination of inequality of position and improvidence is the foundation upon which the doctrine is based. [Emphasis added.]

The aim is not to absolve an addict from all responsibility; rather it is to protect an addict from abuse from those in special positions of power.

To summarize, in my view, the defence of consent cannot succeed in the circumstances of this case. The appellant had a medical problem -- an addiction to Fiorinal. Dr. Wynrib had knowledge of the problem. As a doctor, he had knowledge of the proper medical treatment, and knew she was motivated by her craving for drugs. Instead of fulfilling his professional responsibility to treat the appellant, he

used his power and expertise to his own advantage and to her detriment. In my opinion, the unequal power between the parties and the exploitative nature of the relationship removed the possibility of the appellant's providing meaningful consent to the sexual contact.

Ex Turpi Causa

In my opinion, the principle of *ex turpi causa non oritur actio* does not bar the appellant's recovery for damages. It is wise to recall the statement of Estey J. in *Canada Cement LaFarge Ltd. v. British Columbia Lightweight Aggregate Ltd.*, [1983] 1 S.C.R. 452, at p. 476, that "cases where a tort action has been defeated by the *ex turpi causa* maxim are exceedingly rare". In my view, this is not one of those "rare" cases. The respondent forced the sex-for-drugs transaction on the appellant by virtue of her weakness. He initiated the arrangement for his own sexual gratification and then impelled her to engage in it. She was unwilling to participate but did so because of her addiction to drugs. It was only because the respondent prolonged the appellant's chemical dependency that the illicit relationship was available to him. The respondent has been found liable in this appeal because he took advantage of the appellant's addiction. To apply the doctrine of *ex turpi causa* in this case would be to deny the appellant damages on the same basis that she succeeded in the tort action: because she acted out of her desperation for Fiorinal. Surely public policy would not countenance giving to the appellant with one hand and then taking away with the other.

It is true that the appellant engaged in the offence of "double-doctoring" during the period in question. However, Estey J. in *Canada Cement LaFarge Ltd.*, *supra*, p. 477, indicated that there must be a sufficient causal link between the appellant's participation in the illegal activity and the injury suffered. In my view, the offence of "double-doctoring" was irrelevant to the transaction between the appellant and the respondent. There was no causative link between the injury and the crime committed by the appellant. If the appellant had been relying on the respondent alone for her drug supply rather than "double-doctoring", she would have suffered the same harm.

In sum, I do not believe that it is in the public interest to absolve a doctor of civil liability where he deliberately abuses his position of power and influence by suggesting and pursuing a sex-for-drugs arrangement with a self-admitted drug addict. Accordingly, the *ex turpi causa* maxim does not operate in the circumstances of this case to bar relief.

Damages

The appellant asks for an award of damages which includes the following: (1) compensatory damages for wrongful supply of drugs and prolongation of addiction, (2) aggravated damages for the remorse, shame, damaged self-confidence and emotional harm caused by the continued supply of drugs and the sexual exploitation of the appellant, and (3) punitive damages for the respondent's breach of trust. The courts below were unwilling to award damages. Only Locke J.A., dissenting, would have awarded $1,000 nominal damages for the respondent's

negligence which prolonged the appellant's chemical dependence. I am concerned here, however, with damages for the sexual assault, which I have held constitutes the tort of battery at common law.

I begin by noting that the battery is actionable without proof of damage. Moreover, liability is not confined to foreseeable consequences. Aggravated damages may be awarded if the battery has occurred in humiliating or undignified circumstances. These damages are not awarded in addition to general damages. Rather, general damages are assessed "taking into account any aggravating features of the case and to that extent increasing the amount awarded": see *N. (J.L.) v. L. (A.M.)* (1988), 47 C.C.L.T. 65 (Man. Q.B.), at p. 71, *per* Lockwood J. These must be distinguished from punitive or exemplary damages. The latter are awarded to punish the defendant and to make an example of him or her in order to deter others from committing the same tort; see Linden, *Canadian Tort Law* (4th ed. 1988), at pp. 54-55. In *Vorvis v. Insurance Corporation of British Columbia*, [1989] 1 S.C.R. 1085, at pp. 1107-8, McIntyre J. thus set forth the circumstances where the defendant's conduct would merit punishment:

> . . . punitive damages may only be awarded in respect of conduct which is of such nature as to be deserving of punishment because of its harsh, vindictive, reprehensible and malicious nature. I do not suggest that I have exhausted the adjectives which could describe the conduct capable of characterizing a punitive award, but in any case where such an award is made the conduct must be extreme in its nature and such that by any reasonable standard it is deserving of full condemnation and punishment.

Although aggravated damages will frequently cover conduct which could also be the subject of punitive damages, as I noted, the two types of damages are

distinguishable; punitive damages are designed to punish whereas aggravated damages are designed to compensate. See *Vorvis*, at pp. 1098-99.

An award of damages should reflect the nature of the assault. In *R. v. McCraw*, [1991] 3 S.C.R. 72, this Court noted that a sexual assault results in a greater impact on the complainant than a non-sexual assault. Given that one can obtain considerable damages for an assault of a non-sexual nature, the appellant, in my opinion, is entitled to significant aggravated damages for the indignity of the coerced sexual assault. For example, in *Stewart v. Stonehouse*, [1926] 2 D.L.R. 683 (Sask. C.A.), the defendant was found liable for grabbing the plaintiff by the nose even though there was no evidence that the plaintiff was physically injured. The court held that the plaintiff could recover substantial damages for injury to his personal dignity. Clearly the indignity of a sexual assault outweighs the indignity of having one's nose pulled. In *McCraw*, *supra*, Justice Cory stated, at p. 85, that "[i]t is hard to imagine a greater affront to human dignity" than non-consensual sexual intercourse. Although this statement was made in the context of rape, it has relevance to the circumstances at issue here as well.

General damages (including aggravated damages in some cases) have been awarded by the lower courts in a number of recent sexual assault cases. In *N. (J.L.) v. L. (A.M.)*, *supra*, the plaintiff was repeatedly sexually abused by the common law husband of the plaintiff's mother over a period of six years beginning when the plaintiff was six. Evidence was adduced as to the actual and expected effects of the abuse. Damages were assessed at $65,000. In *Glendale v. Drozdzik*, [1990] B.C.W.L.D. 1839 (S.C.), the plaintiff was forcibly raped. After the incident, the

plaintiff became frequently depressed and suffered from post-traumatic shock syndrome. She became reclusive for almost two years, was unable to cope with work or her family, drank excessively for a time, and did not seek counselling for six months. The evidence showed that she suffered humiliation and loss of dignity. Taking into account the aggravated damages to which the plaintiff was entitled, general damages were assessed at $15,000. In *Q. v. Minto Management Ltd.* (1985), 15 D.L.R. (4th) 581 (Ont. H.C.), the landlord's employee raped the plaintiff in her apartment. The plaintiff underwent pain, suffering, indignity and humiliation and suffered emotional and psychological injury including fear, distress and anxiety and continued to do so over two years later. General damages were assessed at $40,000. In *Harder v. Brown* (1989), 50 C.C.L.T. 85 (B.C.S.C.), the plaintiff, when still a minor, was sexually assaulted a number of times over a seven-year period by the defendant, an elderly friend of her grandfather. The assaults consisted of kissing, fondling and attempted intercourse. The defendant also required the plaintiff to undress and took photographs of her during the assaults. As a result of the assaults, the plaintiff felt worthless and dirty, lost the capacity to trust people, particularly men, found it difficult to form intimate and lasting relationships, and had flashbacks and recurrent nightmares. Wood J. held that the circumstances of the case aggravated the plaintiff's general damages and awarded $40,000 general damages. *Myers v. Haroldson*, [1989] 3 W.W.R. 604 (Sask. Q.B.), was another case involving a brutal rape. After the rape, the plaintiff had difficulty in her sexual relations with her husband (fiancé at the time of the rape), experienced anxiety, insecurity, embarrassment, humiliation and loss of self-worth, lost sleep, no longer trusted men, and experienced periods of depression. General damages of $10,000 were awarded. In *Lyth v. Dagg*, the student-teacher case cited earlier, general damages of $5,000

were awarded. In *W.(B.) v. Mellor, supra*, damages of $10,000 were awarded for the additional emotional stress the defendant-doctor caused the plaintiff for two years of improper sexual conduct.

In the present case, there were repeated sexual encounters over a substantial period of time with a person in a position of power. The respondent used his power as a doctor to take advantage of the fact that the appellant was addicted to drugs. There is some distinction between this case and the rape cases cited above in that the assault here was not physically violent. However, the respondent's conduct has caused the appellant humiliation and loss of dignity as is evident from her testimony. She testified at trial that she thinks about the events with Dr. Wynrib on a daily basis and that she has felt a great deal of shame. In fact, she felt that she did not deserve to have her son because of what she had done with Dr. Wynrib. In view of the circumstances, I would award general damages of $20,000.

In several of the sexual assault cases, punitive damages were not awarded because the defendant had been convicted. An award of punitive damages in such circumstances would have amounted to double punishment. Punitive damages in the amount of $10,000 were, however, awarded in *Harder v. Brown, supra,* in the amount of $15,000 in *W.(B). v. Mellor*, *supra*, and in the amount of $40,000 in *Myers v. Haroldson*, *supra*. In awarding damages in the latter case, Osborn J. noted, at p. 614, that punitive damages are often awarded "where the tortfeasor has offended the ordinary standards of morality or decent conduct in the community, or is guilty of moral turpitude. . . . They are also awarded where the defendant's conduct amounts to arrogance and callousness". He held that the defendant's conduct attracted

punitive damages for a number of reasons including the facts that the sexual assault involved excessive force, the defendant acted arrogantly and callously in carrying out the assault, and the defendant offended the ordinary standards of morality and decency in a cold and calculating way. He concluded, at p. 614, that the defendant's conduct was

> . . . conduct needing deterrence as the predominance of sexual assaults primarily by adult males upon females in our society is real and unabating. This court is aware of the many studies and reports as will evidence the number of sexual assaults upon women in Canada, many of which go unreported, and others reported but where requisite evidence is lacking, allowing the offender to escape without penalty of law;

The question that must be asked is whether the conduct of Dr. Wynrib was such as to merit condemnation by the Court. It was not harsh, vindictive or malicious to use the terms cited in *Vorvis, supra*. However, it was reprehensible and it was of a type to offend the ordinary standards of decent conduct in the community. Further, the exchange of drugs for sex by a doctor in a position of power is conduct that cries out for deterrence. As is stated in *The Final Report of the Task Force on Sexual Abuse of Patients, supra,* at p. 80:

> The limited understanding of sexual abuse involving a breach of trust has been a major barrier to effective self-regulation. Both the actual harm and the risk of harm to other patients posed by a physician who chooses to abuse his position of power to sexually exploit and abuse are rarely identified; moreover, when harm and risk of harm are identified, both are profoundly underestimated.

An award of punitive damages is of importance to make it clear that this trend of underestimation cannot continue. Dr. Wynrib's use of power to gain sexual favours

in the context of a doctor-patient relationship is conduct that is offensive and reprehensible. In all the circumstances, I would award an additional $10,000 in punitive damages.

Disposition

I would allow the appeal and enter judgment for the plaintiff against the defendant. The plaintiff is entitled to aggravated damages in the amount of $20,000 and punitive damages in the amount of $10,000, the whole with costs throughout.

//*McLachlin J.*//

The reasons of L'Heureux-Dubé and McLachlin JJ. were delivered by

MCLACHLIN J. -- I have had the advantage of reading the reasons of my colleagues Justice La Forest and Justice Sopinka. With respect, I do not find that the doctrines of tort or contract capture the essential nature of the wrong done to the plaintiff. Unquestionably, they do catch aspects of that wrong. But to look at the events which occurred over the course of the relationship between Dr. Wynrib and Ms. Norberg from the perspective of tort or contract is to view that relationship through lenses which distort more than they bring into focus. Only the principles applicable to fiduciary relationships and their breach encompass it in its totality. In my view, that doctrine is clearly applicable to the facts of this case on principles articulated by this Court in earlier cases. It alone encompasses the true relationship

between the parties and the gravity of the wrong done by the defendant; accordingly, it should be applied.

The facts, recited in detail by La Forest J., need not detain me at length. The plaintiff was a young woman, who began under prescription to take painkillers to alleviate the pain associated with an abscessed tooth. By the time her dental problem was diagnosed and properly treated, she was addicted. Her physicians at that time did nothing to assist her in making a gradual withdrawal from the painkillers. She no longer had any medical condition which would indicate the continued ingestion of analgesics, but her craving for the drugs continued. Her drug of choice was Fiorinal, a pharmaceutical legally obtainable only on prescription, whose active ingredients include both codeine, an opiate, and butalbital, a barbiturate. Her life became one long search for the drug. It was illegal; it was hard to get. At first she was able to get it from her sister, but the best way to get it was through doctors. So the plaintiff consulted doctors, many doctors. The doctor who had been supplying her sister with prescriptions proved a fertile source, but then he retired. His replacement refused to give her more pills. She went to Dr. Wynrib with a tale of a painful ankle and asked for Fiorinal. He gave her the prescription. She kept going back for more, on the pretext of this and other illnesses. Dr. Wynrib quickly realized that she was addicted to Fiorinal and confronted her with the addiction. But he coupled the confrontation with a request: "if you're good to me I will be good to you", a request whose meaning was made clear by his pointing upstairs where he lived. The plaintiff refused and left. He continued to make similar suggestions to her and she stopped seeing him. For a while she got Fiorinal from other doctors and off the street. As the other doctors reduced both her supply and the strength of the

medication prescribed, she became, as she put it, desperate. She went back to Dr. Wynrib. She gave him what he wanted - sexual favours. He gave her Fiorinal. At one point she begged Dr. Wynrib for help. He did not advise treatment. He merely told her "to quit". The medical evidence establishes that it is virtually impossible "to quit" without the aid of a professional anti-addiction program. After being charged with the offence of "double-doctoring", the plaintiff of her own initiative went to a rehabilitation centre for drug addicts. She left the centre after one month and has not taken any drugs for non-medical reasons since.

It is not disputed that Dr. Wynrib abused his duty to the plaintiff. He provided her with drugs he knew she should not have. He failed to advise her to enrol in an anti-addiction program, thereby prolonging her addiction. Instead, he took advantage of her addiction to obtain sexual favours from her over a period of more than two years.

The relationship of physician and patient can be conceptualized in a variety of ways. It can be viewed as a creature of contract, with the physician's failure to fulfil his or her obligations giving rise to an action for breach of contract. It undoubtedly gives rise to a duty of care, the breach of which constitutes the tort of negligence. In common with all members of society, the doctor owes the patient a duty not to touch him or her without his or her consent; if the doctor breaches this duty he or she will have committed the tort of battery. But perhaps the most fundamental characteristic of the doctor-patient relationship is its <u>fiduciary</u> nature. All the authorities agree that the relationship of physician to patient also falls into that special category of relationships which the law calls fiduciary.

The recent judgment of La Forest J. in *McInerney v. MacDonald*, [1992] 2 S.C.R. 138, at pp. 148-49, a case recognizing a patient's right of access to her medical records, canvasses those authorities and confirms the fiduciary nature of the doctor-patient relationship. I can do no better than to quote the following passage from his judgment:

> A physician begins compiling a medical file when a patient chooses to share intimate details about his or her life in the course of medical consultation. The patient "entrusts" this personal information to the physician for medical purposes. It is important to keep in mind the nature of the physician-patient relationship within which the information is confided. In *Kenny v. Lockwood*, [1932] O.R. 141 (C.A.), Hodgins J.A. stated, at p. 155, that the relationship between physician and patient is one in which "trust and confidence" must be placed in the physician. This statement was referred to with approval by LeBel J. in *Henderson v. Johnston*, [1956] O.R. 789, who himself characterized the physician-patient relationship as "fiduciary and confidential", and went on to say: "It is the same relationship as that which exists in equity between a parent and his child, a man and his wife, an attorney and his client, a confessor and his penitent, and a guardian and his ward" (p. 799). Several academic writers have similarly defined the physician-patient relationship as a fiduciary or trust relationship: see, for example, E. I. Picard, *Legal Liability of Doctors and Hospitals in Canada* (2nd ed. 1984), at p. 3; A. Hopper, "The Medical Man's Fiduciary Duty" (1973), 7 Law Teacher 73; A. J. Meagher, P. J. Marr & R. A. Meagher, *Doctors and Hospitals: Legal Duties* (1991), at p. 2; M. V. Ellis, *Fiduciary Duties in Canada* (1988) at p. 10-1. I agree with this characterization.

So do I. I think it is readily apparent that the doctor-patient relationship shares the peculiar hallmark of the fiduciary relationship -- trust, the trust of a person with inferior power that another person who has assumed superior power and responsibility will exercise that power for his or her good and only for his or her good and in his or her best interests. Recognizing the fiduciary nature of the doctor-patient relationship provides the law with an analytic model by which physicians can be held to the high standards of dealing with their patients which the trust accorded

them requires. This point has been well made by Jorgenson and Randles in "Time Out: The Statute of Limitations and Fiduciary Theory in Psychotherapist Sexual Misconduct Cases" (1991), 44 *Okla. L. Rev.* 181.

The foundation and ambit of the fiduciary obligation are conceptually distinct from the foundation and ambit of contract and tort. Sometimes the doctrines may overlap in their application, but that does not destroy their conceptual and functional uniqueness. In negligence and contract the parties are taken to be independent and equal actors, concerned primarily with their own self-interest. Consequently, the law seeks a balance between enforcing obligations by awarding compensation when those obligations are breached, and preserving optimum freedom for those involved in the relationship in question. The essence of a fiduciary relationship, by contrast, is that one party exercises power on behalf of another and pledges himself or herself to act in the best interests of the other.

Frankel, in "Fiduciary Law" (1983), 71 *Calif. L. Rev.* 795, compares the fiduciary relationship with status and contract relationships, with both of which fiduciary relationships may overlap. Like a status relationship (the relationship of parent and child is perhaps the archetypical status relationship), the fiduciary relationship is characterized by dependency, but the scope of that dependency is usually not as all-encompassing and pervasive as that obtaining in a status relationship. The beneficiary entrusts the fiduciary with information or other sources of power over the beneficiary, but does so only within a circumscribed area, for example entrusting his or her lawyer with power over his or her legal affairs or his or her physician with power over his or her body. Although fiduciary relationships

may properly be recognized in the absence of consent by the beneficiary -- the consent of a child to his or her parents' acting in a fiduciary capacity for the child's benefit is not required -- they are more typically the product of the voluntary agreement of the parties that the beneficiary will cede to the fiduciary some power, and are always dependent on the fiduciary's undertaking to act in the beneficiary's interests. In this respect fiduciary relationships resemble contractual relationships. In contrast to both status and contract relationships, however,

> . . . fiduciary relations are designed not to satisfy both parties' needs, but only those of the entrustor. Thus, a fiduciary may enter into a fiduciary relation without regard to his own needs. Moreover, an entrustor does not owe the fiduciary anything by virtue of the relation except in accordance with the agreed-upon terms or legally fixed status duties. Therefore, in a fiduciary relation, the entrustor is free from domination by the fiduciary, although he may still be coerced in parallel status relation. Thus, fiduciary relations combine the bargaining freedom inherent in contract relations with a limited form of the power and dependence of status relations.
>
> Accordingly, the law of fiduciary relations should, if possible, preserve the best aspects of status and contract relations. It is desirable for the entrustor to depend on the fiduciary to satisfy certain needs. But it would not be desirable for fiduciary law to impose the relation on either party or to allow the fiduciary to abuse his power. Therefore, fiduciary law should permit the parties to enter into the relation freely and ensure that the fiduciary will not coerce the entrustor. [At p. 801.]

The fiduciary relationship has trust, not self-interest, at its core, and when breach occurs, the balance favours the person wronged. The freedom of the fiduciary is limited by the obligation he or she has undertaken -- an obligation which "betokens loyalty, good faith and avoidance of a conflict of duty and self-interest": *Canadian Aero Service Ltd. v. O'Malley*, [1974] S.C.R. 592, at p. 606. To cast a fiduciary relationship in terms of contract or tort (whether negligence or battery) is to diminish this obligation. If a fiduciary relationship is shown to exist, then the proper legal

analysis is one based squarely on the full and fair consequences of a breach of that relationship.

As La Forest J. went on to note in *McInerney, supra*, at p. 149, characterizing the doctor-patient relationship as fiduciary is not the end of the analysis: "not all fiduciary relationships and not all fiduciary obligations are the same; these are shaped by the demands of the situation. A relationship may properly be described as "fiduciary" for some purposes, but not for others". So the question must be asked, did a fiduciary relationship exist between Dr. Wynrib and Ms. Norberg? And assuming that such a relationship did exist, is it properly described as fiduciary for the purposes relevant to this appeal?

Wilson J. in *Frame v. Smith*, [1987] 2 S.C.R. 99, at p. 136, (approved by Sopinka and La Forest JJ. in *Lac Minerals Ltd. v. International Corona Resources Ltd.*, [1989] 2 S.C.R. 574, at pp. 598 and 646, and by McLachlin J., Lamer C.J. and L'Heureux-Dubé J. concurring, in *Canson Enterprises Ltd. v. Boughton & Co.*, [1991] 3 S.C.R. 534, at pp. 543-44), attributed the following characteristics to a fiduciary relationship: "(1) [t]he fiduciary has scope for the exercise of some discretion or power; (2) the fiduciary can unilaterally exercise that power or discretion so as to affect the beneficiary's legal or practical interests; (3) the beneficiary is peculiarly vulnerable to or at the mercy of the fiduciary holding the discretion or power."

Dr. Wynrib was in a position of power vis-à-vis the plaintiff; he had scope for the exercise of power and discretion with respect to her. He had the power to advise her, to treat her, to give her the drug or to refuse her the drug. He could unilaterally exercise that power or discretion in a way that affected her interests. And

her status as a patient rendered her vulnerable and at his mercy, particularly in light of her addiction. So Wilson J.'s test appears to be met. All the classic characteristics of a fiduciary relationship were present. Dr. Wynrib and Ms. Norberg were on an unequal footing. He pledged himself -- by the act of hanging out his shingle as a medical doctor and accepting her as his patient -- to act in her best interests and not permit any conflict between his duty to act only in her best interests and his own interests -- including his interest in sexual gratification -- to arise. As a physician, he owed her the classic duties associated with a fiduciary relationship -- the duties of "loyalty, good faith and avoidance of a conflict of duty and self-interest".

Closer examination of the principles enunciated by Wilson J. in *Frame* confirms the applicability of the fiduciary analysis in this case. The possession of power or discretion needs little elaboration. That one party in a fiduciary relationship holds such power over the other is not in and of itself wrong; on the contrary, "the fiduciary must be entrusted with power in order to perform his function": Frankel, *supra* at p. 809. What will be a wrong is if the risk inherent in entrusting the fiduciary with such power is realized and the fiduciary abuses the power which has been entrusted to him or her. As Wilson J. noted in *Frame*, at p. 136, in the absence of such a discretion or power and the possibility of abuse of power which it entails, "there is no need for a superadded obligation to restrict the damaging use of the discretion or power".

As to the second characteristic, it is, as Wilson J. put it at p. 136, "the fact that the power or discretion may be used to affect the beneficiary in a damaging way that makes the imposition of a fiduciary duty necessary". Wilson J. went on to state

that fiduciary duties are not confined to the exercise of power which can affect the legal interests of the beneficiary, but extend to the beneficiary's "vital non-legal or `practical' interests". This negates the suggestion inherent in some of the other judgments which this case has engendered that the fiduciary obligation should be confined to legal rights such as confidentiality and conflict of interest and undue influence in the business sphere. Wilson J. cited the following examples, at p. 137:

> ... in *Reading v. Attorney-General*, [1951] A.C. 507 (H.L.), a British soldier who was able to smuggle items past Egyptian guards because these guards excused uniformed soldiers from their inspections was held to be a fiduciary. The Crown's interest was a "practical" or even a "moral" one, namely that its uniform should not be used in corrupt ways. The soldier-fiduciary had no power to change the legal position of the British Crown, so how could the Crown's legal interests have been affected by the soldier's action? The same can be said of the Crown's interest in *Attorney-General v. Goddard* (1929), 98 L.J. (K.B.) 743, where the Crown was able to recover bribes which had been paid to its employee, a sergeant in the Metropolitan Police. In my view, what was protected in that case was not a "legal" interest but a vital and substantial "practical" interest.

The case at bar is not concerned with the protection of what has traditionally been regarded as a legal interest. It is, however, concerned with the protection of interests, both societal and personal, of the highest importance. Society has an abiding interest in ensuring that the power entrusted to physicians by us, both collectively and individually, not be used in corrupt ways, to borrow the language of *Reading v. Attorney-General*, [1951] A.C. 507 (H.L.). On the other side of the coin, the plaintiff, as indeed does every one of us when we put ourselves in the hands of a physician, has a striking personal interest in obtaining professional medical care free of exploitation for the physician's private purposes. These are not collateral duties and rights created at the whim of an aggrieved patient. They are duties

universally recognized as essential to the physician-patient relationship. The Hippocratic Oath reflects this universal concern that physicians not exploit their patients for their own ends, and in particular, not for their own sexual ends:

> The regimen I adopt shall be for the benefit of my patients according to my ability and judgment, and not for their hurt or for any wrong.... Whatsoever house I enter, there will I go for the benefit of the sick, refraining from all wrongdoing or corruption, and especially from any act of seduction, of male or female, of bond or free. Whatsoever things I see or hear concerning the life of men, in my attendance on the sick or even apart therefrom, which ought not to be noised abroad, I will keep silence thereon, counting such things to be as sacred secrets. [Quoted in Ellis, *Fiduciary Duties in Canada* (1988), at p. 10-1.]

To the extent that the law requires that physicians who breach them be disciplined, these duties have legal force. The interests which the enforcement of these duties protect are, to be sure, different from the legal and economic interests which the law of fiduciary relationships has traditionally been used to safeguard. But as Wilson J. said in *Frame v. Smith* at p. 143, "[t]o deny relief because of the nature of the interest involved, to afford protection to material interests but not to human or personal interests would, it seems to me, be arbitrary in the extreme". At the very least, the societal and personal interests at issue here constitute "a vital and substantial "practical" interest" (at p. 137), within the meaning of the second characteristic of a fiduciary duty set out in *Frame v. Smith*.

The third requirement is that of vulnerability. This is the other side of the differential power equation which is fundamental to all fiduciary relationships. In order to be the beneficiary of a fiduciary relationship a person need not be *per se* vulnerable. As Frankel put it, at p. 810:

> . . . the entrustor's vulnerability to abuse of power does not result from an initial inequality of bargaining power between the entrustor and the fiduciary.... The relation may expose the entrustor to risk even if he is sophisticated, informed and able to bargain effectively. Rather, the entrustor's vulnerability stems from the *structure* and *nature* of the fiduciary relation. [Emphasis in original.]

It is only where there is a material discrepancy, in the circumstances of the relationship in question, between the power of one person and the vulnerability of the other that the fiduciary relationship is recognized by the law. Where the parties are on a relatively equal footing, contract and tort provide the appropriate analysis. As Wilson J. put it in *Frame* at pp. 137-38:

> Because of the requirement of vulnerability of the beneficiary at the hands of the fiduciary, fiduciary obligations are seldom present in the dealings of experienced businessmen of similar bargaining strength acting at arm's length: see, for example, *Jirna Ltd. v. Mister Donut of Canada Ltd*. (1971), 22 D.L.R. (3d) 639 (Ont. C.A.), aff'd [1975] 1 S.C.R. 2. The law takes the position that such individuals are perfectly capable of agreeing as to the scope of the discretion or power to be exercised, i.e., any "vulnerability" could have been prevented through the more prudent exercise of their bargaining power and the remedies for the wrongful exercise or abuse of that discretion or power, namely damages, are adequate in such a case.

In the case at bar, this requirement too is fulfilled. A physician holds great power over the patient. The recent decision of the Ontario Court (General Division) in *College of Physicians and Surgeons of Ontario v. Gillen* (1990), 1 O.R. (3d) 710, contains a reminder that a patient's vulnerability may be as much physical as emotional, given the fact that a doctor (at p. 713) "has the right to examine the patient in any state of dress or undress and to administer drugs to render the patient unconscious". Visits to doctors occur in private: the door is closed, there is rarely a third party present, everything possible is done to encourage the patient to feel that

the patient's privacy will be respected. This is essential to the meeting of the patient's medical and emotional needs; the unfortunate concomitant is that it also creates the conditions under which the patient may be abused without fear of outside intervention. Whether physically vulnerable or not, however, the patient, by reason of lesser expertise, the "submission" which is essential to the relationship, and sometimes, as in this case, by reason of the nature of the illness itself, is typically in a position of comparative powerlessness. The fact that society encourages us to trust our doctors, to believe that they will be persons worthy of our trust, cannot be ignored as a factor inducing a heightened degree of vulnerability: see Feldman-Summers, "Sexual Contact in Fiduciary Relationships", in Gabbard, ed., *Sexual Exploitation in Professional Relationships*, at pp. 204-5. The recently issued *Final Report of the Task Force on Sexual Abuse of Patients*, commissioned by The College of Physicians and Surgeons of Ontario, makes highly instructive reading in this regard. In the words of the Task Force, at p. 79:

> Patients seek the help of doctors when they are vulnerable -- when the [*sic*] are sick, when they are needy, when they are uncertain about their physical or emotional health. The physician has the knowledge, the skills, and the expertise the patient needs to heal. The patient often suspends both judgement and personal power idealizing the doctor in order to feel secure. The physician, therefore, has more power than the patient, and this power can be used to invade sexual boundaries and to force sexual compliance. Physical force is not necessary.

Women, who can so easily be exploited by physicians for sexual purposes, may find themselves particularly vulnerable. That female patients are disproportionately the targets of sexual exploitation by physicians is borne out by the Task Force's report. Of the 303 reports they received of sexual exploitation at the hands of those in a position of trust (the vast majority of whom were physicians), 287

were by female patients, 16 by males: at p. 10. On this point see also Feldman-Summers, *supra*, at p. 195. Relying in part on the work of Morgan in *Philosophical Analysis: Permissibility of Sexual Contact Between Physicians and Patients* (Part III) -- Department of Philosophy and Centre for Bioethics, University of Toronto, the Task Force noted (at Legal Appendix, p. 2) that the power imbalance inherent in the physician-patient relationship:

> ... is exacerbated when the doctor/patient roles are combined with certain other factors relating to the personal characteristics of the parties. For example, an adult doctor and a child patient have a relationship with an even greater element of vulnerability present. The same may be argued for other groups in society, such as the handicapped and visible minorities, etc. Since the overwhelming majority of sexual abuse/impropriety cases involve female patients and male doctors, the gender dynamic cannot be ignored. Professor Kathleen Morgan has argued that the stereotypical norms of behaviour for males and females throughout society correlate to the paternalistic model of doctor/patient relationships. [Emphasis added.]

The principles outlined by Wilson J. in *Frame v. Smith* may apply with varying force depending on the nature of the particular doctor-patient relationship. For example, the uniquely intimate nature of the psychotherapist-patient relationship, the potential for transference, and the emotional fragility of many psychotherapy patients make the argument for a fiduciary obligation resting on psychotherapists, and in particular an obligation to refrain from any sexualizing of the relationship, especially strong in that context: see Jorgenson and Randles, *supra*. American courts have, as a result, imposed higher duties on psychiatrists than they have on other physicians: *Mazza v. Huffaker*, 300 S.E.2d 833 (1983). The Task Force of the Ontario College of Physicians and Surgeons has in its report also recognized the greater danger of breach of trust inherent in psychotherapeutic relationships, and has as a

consequence recommended even more stringent guidelines for appropriate psychotherapist behaviour than it has for physicians practising in other areas: at pp. 139-40. While the medical relationship between Dr. Wynrib and Ms. Norberg was not psychotherapeutic in orientation, the treatment of a patient dependent on drugs would seem to me to share many of the same characteristics, thereby rendering the addicted patient even more vulnerable and in need of the protection which the law of fiduciary obligations can afford than other patients might be.

Why then have so many of the jurists who looked at this case declined to consider it as an example of breach of fiduciary duty? The trial judge, Oppal J. ((1988), 27 B.C.L.R. (2d) 240, at. p. 246), while finding in the end that the plaintiff was barred from recovering by her own illegal and immoral acts, clearly felt the relationship was one of trust, traditionally the hallmark of a fiduciary duty:

> A relationship between a physician and a patient is one in which trust and confidence must be placed in the physician. Clearly, in the case at bar, the doctor breached a duty which was owed to his patient and, in the ordinary course of events, she should be entitled to damages.

The majority of the Court of Appeal ((1990), 44 B.C.L.R. (2d) 47), per McEachern C.J., addressed the question only in passing, stating at p. 52:

> If the defendant breached a duty to the plaintiff in this case it was a breach of the duty which a physician owes to his patient to treat her professionally and, unless the breach relates to an improper disclosure of confidential information or something like that, it adds nothing to describe the breach as a fiduciary one.

The majority went on to find that there was no compensable breach of any duty owed by Dr. Wynrib to Ms. Norberg until after such time as Dr. Wynrib discovered her addiction, and that in any event the plaintiff's conduct barred her from recovering. Locke J.A., dissenting, would have allowed the plaintiff's claim in negligence. He held that recovery on the basis of breach of fiduciary duty was not available because Dr. Wynrib had revealed Ms. Norberg's affairs to no one and did not unduly influence her, effectively confining fiduciary obligations in the doctor-patient relationship to the duty of confidence and the duty to avoid undue influence, and construing "undue influence" in such a narrow fashion that the obvious influence which Dr. Wynrib exercised over Ms. Norberg was excluded from consideration.

In this Court, La Forest J. (at p. 000) says with respect to the Court of Appeal's refusal to characterize the relationship between the parties as fiduciary simply that, "[s]ince I am dealing with the case on the basis of the assault claim, I need not consider this point." He goes on to treat the plaintiff's claim under the rubric of the tort of battery, using the equitable doctrine of unconscionable transactions to negate the defence of consent. As Sopinka J. notes, this approach is not without difficulty. First, the doctrine of unconscionable transactions has hitherto been confined to setting aside unconscionable contracts, not negating defences to tort actions. Second, where applicable, it serves not to negate the consent, but to set aside a consensual agreement on grounds of inequality of bargaining power and fairness: *Lloyds Bank Ltd. v. Bundy*, [1975] Q.B. 326 (C.A.), per Lord Denning M.R.

Having rejected, by reason of the plaintiff's consent, La Forest J.'s battery approach, Sopinka J. treats the matter simply as the contractual or tortious breach of

the physician's duty to his patient. He recognizes that some aspects of the physician-patient relationship may be fiduciary, but finds no such duty relevant to the acts alleged by the plaintiff. He adopts the conclusion of McEachern C.J., at p. 52, that "unless the breach relates to an improper disclosure of confidential information or something like that, it adds nothing to describe the breach as a fiduciary one." The only applicable duty, according to Sopinka J. (at p. 000) "is the obligation of a physician to treat the patient in accordance with standards in the profession".

I would summarize the situation as follows: the trial judge appears to have found a duty of trust and confidence and abuse thereof. None of the appellate judges who have written on the case offers a convincing demonstration of why it is wrong to characterize the relationship between Dr. Wynrib and Ms. Norberg as a fiduciary relationship; indeed none of the judgments seriously discusses the legal requirements for establishing the existence of a fiduciary duty or its breach, much less considers the facts in relation to those requirements. While the majority of the Court of Appeal and Sopinka J. suggest that the fiduciary duties to which Dr. Wynrib was subject go no further than his duties in tort or contract, they offer no basis for this suggestion in principle, policy or authority, appearing to rest their case on the assumption that the only additional duties which a fiduciary relationship could impose would be akin to the duty of confidence. This closed, commercial view of fiduciary obligations is neither defended nor reconciled with the authorities, including those of this Court. Nor can thorough consideration of the plaintiff's rights as the victim of a breach of fiduciary obligation be avoided, with respect, on the ground that it was not a live issue or argued; it has been a central issue since the trial

judge found the relationship to be one of trust, it was alluded to by all the judgments below, and it was argued before us.

I proceed then to consider the matter on the footing that the essential elements of breach of a fiduciary relationship are made out. Dr. Wynrib, in accepting Ms. Norberg as his patient, pledged himself to act in her best interests and undertook a duty of loyalty, good faith and avoidance of conflict of interest. Theirs was, as the trial judge observed, a relationship of trust, obliging him to exercise his power -- including the power to provide or refuse drugs -- solely to her benefit. The doctor breached that relationship when he prescribed drugs which he knew she should not have, when he failed to advise her to obtain counselling when her addiction became or should have become apparent to him, and most notoriously, when he placed his own interest in obtaining sexual favours from Ms. Norberg in conflict with and above her interest in obtaining treatment and becoming well.

But, it is said, there are a number of reasons why the doctrine of breach of fiduciary relationship cannot apply in this case. I turn then to these alleged conditions of defeasibility.

The first factor which is said to prevent application of the doctrine of breach of fiduciary duty is Ms. Norberg's conduct. Two terms have been used to raise this consideration to the status of a legal or equitable bar -- the equitable maxim that he who comes into equity must come with clean hands and the tort doctrine of *ex turpi causa non oritur actio*. For our purposes, one may think of the two respectively as the equitable and legal formulations of the same type of bar to

recovery. The trial judge found that although Dr. Wynrib was under a trust obligation to Ms. Norberg, she was barred from claiming damages against him because of her "immoral" and "illegal" conduct. While he referred to the doctrine of *ex turpi*, there seems to be little doubt that in equity the appropriate term is "clean hands" and consequently that is the expression I will use.

The short answer to the arguments based on wrongful conduct of the plaintiff is that she did nothing wrong in the context of this relationship. She was not a sinner, but a sick person, suffering from an addiction which proved to be uncontrollable in the absence of a professional drug rehabilitation program. She went to Dr. Wynrib for relief from that condition. She hoped he would give her relief by giving her the drug; "hustling" doctors for drugs is a recognized symptom of her illness: Wilford, *Drug Abuse, A Guide for the Primary Care Physician* (1981), at pp. 280-82. Such behaviour is commonly seen by family physicians. Patients may, as did Ms. Norberg, feign physical problems which, if *bona fide*, would require analgesic relief. They may, as Ms. Norberg also did, specify the drug they wish to receive. Once a physician has diagnosed a patient as an addict who is "hustling" him for drugs the recommended response is to "(1) maintain control of the doctor-patient relationship, (2) remain professional in the face of ploys for sympathy or guilt and (3) regard the drug seeker as a patient with a serious illness": Wilford, at p. 282.

We do not know when Dr. Wynrib first identified Ms. Norberg as a person suffering from drug addiction; we do know that he confronted her with his knowledge in the first year of their doctor-patient relationship. But whenever he became aware of the true nature of her medical condition, at that point only one form

of relief was appropriate: Dr. Wynrib, if he were to discharge properly the trust relationship he had assumed, was obliged to refuse Ms. Norberg further drugs and to refer her for professional addiction treatment. He did neither, but instead took advantage of her sickness to obtain sexual favours in exchange for the drugs she craved. While there is no doubt that he maintained control of the relationship following his realization, he did so not by retaining a professional attitude and treating Ms. Norberg as the sufferer of a serious illness who needed his help, but by exploiting his knowledge, position and the power they gave him over her to coerce her to satisfy his sexual desires. A more grievous breach of the obligations, legal and ethical, which he owed her as his patient can scarcely be imagined.

The law might accuse Ms. Norberg of "double doctoring" and moralists might accuse her of licentiousness; but she did no wrong because not she but the doctor was responsible for this conduct. He had the power to cure her of her addiction, as her successful treatment after leaving his "care" demonstrated; instead he chose to use his power to keep her in her addicted state and to use her for his own sexual purposes.

It is difficult not to see the attempt to bar Ms. Norberg from obtaining redress for the wrong she has suffered through the application of the clean hands maxim as anything other than "blaming the victim". While for the purposes of this case we need not decide whether any and all sexual contact between a doctor and his patient is a breach of the doctor's fiduciary obligation, I do note that the Task Force on Sexual Abuse of Patients, at p. 73, has recommended that <u>any</u> sexual contact between a patient and physician be sanctioned as "sexual violation" under the

Ontario *Regulated Health Professions Act, 1991* and, whether initiated by the patient or not, subject to a mandatory penalty of the revocation of the physician's licence for a minimum of five years. The philosophy which underlies this recommendation -- aptly named "Zero Tolerance" -- has already been adopted by the Council of the College of Physicians and Surgeons of Ontario. In essence, the Task Force has asked us to recognize that there is a power imbalance inherent in any doctor-patient relationship, and that that imbalance means that any sexualizing of that relationship will always be a breach of the patient's trust, and that the responsibility to at all costs avoid such exploitation rests at all times with the doctor. Such a bright, bold line approach to the question of doctor-patient sexual involvement may be appropriate to the statutory regulation of the medical profession -- on this difficult question I do not offer an opinion. But I tend not to think it appropriate to the delineation of a physician's fiduciary obligations, particularly given that the scope of such obligations can only be determined on a case by case basis, having reference to the degree of power imbalance and patient vulnerability present in the relationship under examination. Even taking a somewhat more cautious approach than that recommended by the Task Force as to when a doctor-patient relationship is characterized by sufficient power imbalance to render sexual contact between the parties a breach of the physician's fiduciary obligations, I can only agree that where such a power imbalance exists it matters not what the patient may have done, how seductively she may have dressed, how compliant she may have appeared, or how self-interested her conduct may have been -- the doctor will be at fault if sexual exploitation occurs. In the words of a victim of physician sexual exploitation heard by the Task Force, at p. 120: "Abuse is abuse, regardless of the reason the patient walked into the office".

In my opinion those words apply with full force to the relationship between Ms. Norberg and Dr. Wynrib. It matters not that she walked into his office in an attempt to obtain drugs to which she was addicted. Even if that purpose had not been merely symptomatic of her illness, but in some sense immoral, Dr. Wynrib's conduct in exploiting her dependency for his own ends would have in any event constituted a breach of that aspect of his fiduciary obligation enshrined, thousands of years ago, in the words of the Hippocratic Oath: "Whatsoever house I enter, there will I go for the benefit of the sick, refraining from all wrongdoing or corruption, and especially from any act of seduction, of male or female, of bond or free."

The matter may appear in clearer perspective if we consider an example from the paradigmatic trust situation -- that of a trustee holding a minor's estate. Assume the 14-year-old minor develops an addiction to cocaine. He asks his trustee to supply it out of the trust funds held for him. The trustee does so. Five years later, the youth enters an addiction clinic of his own volition and is successful in controlling his addiction. He sues his trustee for having dissipated his estate. Would equity say that the youth is debarred from claiming damages because of his own illegal or immoral act? I think not. The essence of trust and all fiduciary relationships is that the trustee, the person in power, assumes responsibility for the welfare of the cestui qui trust for matters falling within the scope of the trust relationship. Having assumed that responsibility, the fiduciary cannot rely on the other party's weakness or infirmity as a defence to an action grounded on his failure to discharge his fiduciary duty properly.

This brings us to a second objection to treating this case on the basis of breach of fiduciary duty -- that nothing that the law would not otherwise accord flows from categorizing the duty as fiduciary; in short, that the fiduciary obligation adds nothing, except perhaps a duty of confidence and non-disclosure, to an action in tort or contract. This appears to have been the view of the majority of the Court of Appeal below, per McEachern C.J. Sopinka J. adopts that same view. Neither authority nor principle is offered in support of this proposition.

What is really at issue here is the scope of the fiduciary obligation. The majority in the Court of Appeal and Sopinka J. would confine it to matters akin to the duty not to disclose confidential information, the situation dealt with in *Lac Minerals Ltd*. If that restriction is accepted, then they are is right; there is little reason to refer to it in this case. But I do not think that narrow view of the scope of the fiduciary obligation is correct. Accepting Sopinka J.'s statement for the majority in *Lac Minerals Ltd.* (cited by him at p. 000 of his reasons in this case) that fiduciary obligations "must be reserved for situations that are truly in need of the special protection that equity affords", I assert that the situation at issue in the present case is precisely one that is "truly in need of the special protection that equity affords". The principles alluded to by Wilson J. in *Frame v. Smith* and applied by this Court in its earlier decision in *Guerin v. The Queen*, [1984] 2 S.C.R. 335, are principles of general application, translatable to different situations and the protection of different interests than those hitherto recognized. They are capable of protecting not only narrow legal and economic interests, but can also serve to defend fundamental human and personal interests, as recognized by Wilson J. in *Frame v. Smith*.

If we accept that the principles can apply in this case to protect the plaintiff's interest in receiving medical care free of exploitation at the hands of her physician, as I think we must, then the consequences are most significant. As we have just seen, the defences based on the alleged fault of the plaintiff, so pressing in tort, may carry little weight when raised against the beneficiary of a fiduciary relationship. This is because the fiduciary approach, unlike those based on tort or contract, is founded on the recognition of the power imbalance inherent in the relationship between fiduciary and beneficiary, and to giving redress where that power imbalance is abused. Another consequence that flows from considering the matter on the basis of breach of fiduciary obligation may be a more generous approach to remedies, as I will come to presently. Equity has always held trustees strictly accountable in a way the tort of negligence and contract have not. Foreseeability of loss is not a factor in equitable damages. Certain defences, such as mitigation, may not apply.

But the most significant consequence of applying the doctrine of fiduciary obligation to a person in the position of Dr. Wynrib is this. Tort and contract can provide a remedy for a physician's failure to provide adequate treatment. But only with considerable difficulty can they be bent to accommodate the wrong of a physician's abusing his or her position to obtain sexual favours from his or her patient. The law has never recognized consensual sexual relations as capable of giving rise to an obligation in tort or in contract. My colleagues, with respect, strain to conclude the contrary. La Forest J. does so by using the contractual doctrine of relief from unconscionable transactions to negate the consent which the plaintiff, as found by the trial judge, undoubtedly gave. The problems inherent in this approach

have already been noted. Sopinka J., at p. 000, finds himself tacking damages for the sexual encounters onto the breach of the duty to treat on the ground that "[t]he sexual acts were causally connected to the failure to treat and must form part of the damage suffered by the appellant". But can damages flow from acts the law finds lawful simply on the ground they are "connected" to damages for an actionable wrong? And what of the patient whose medical needs are fully met but who is sexually exploited? On Sopinka J.'s reasoning she has no cause of action. These examples underline the importance of treating the consequences of this relationship on the footing of what it is -- a fiduciary relationship -- rather than forcing it into the ill-fitting molds of contract and tort. Contrary to the conclusion of the court below, characterizing the duty as fiduciary does add something; indeed, without doing so the wrong done to the plaintiff can neither be fully comprehended in law nor adequately compensated in damages.

A third objection raised to viewing the relationship between Dr. Wynrib and Ms. Norberg as fiduciary is that it will open the floodgates to unfounded claims based on the abuse of real or perceived inequality of power. The spectre is conjured up of a host of actions based on exploitation -- children suing parents, wives suing husbands, mistresses suing lovers, all for abuse of superior power. The answer to this objection lies in defining the ambit of the fiduciary obligation in a way that encompasses meritorious claims while excluding those without merit. The prospect of the law's recognizing meritorious claims by the powerless and exploited against the powerful and exploitive should not alone serve as a reason for denying just claims. This Court has an honourable tradition of recognizing new claims of the disempowered against the exploitive: see, for example, *Pettkus v. Becker*, [1980] 2

S.C.R. 834 (constructive trust benefiting "common law" wife whose husband had been unjustly enriched); *Guerin, supra* (aboriginal people the beneficiaries of fiduciary relationship with the Crown, which consequently has obligations with respect to dealings with land subject to aboriginal title); and *R. v. Lavallee*, [1990] 1 S.C.R. 852 (expert evidence on the psychological effects of battered wife syndrome admissible for the purposes of establishing defence of self-defence).

The criteria for the imposition of a fiduciary duty already enunciated by this Court in cases such as *Frame, Lac Minerals and Guerin* provide a good starting point for the task of defining the general principles which determine whether such a relationship exists. As we have seen, an imbalance of power is not enough to establish a fiduciary relationship. It is a necessary but not sufficient condition. There must also be the potential for interference with a legal interest or a non-legal interest of "vital and substantial `practical' interest." And I would add this. Inherent in the notion of fiduciary duty, inherent in the judgments of this Court in *Guerin* and *Canson,* is the requirement that the fiduciary have assumed or undertaken to "look after" the interest of the beneficiary. As I put it in *Canson* at p. 543, quoting from this Court's decision in *Canadian Aero Service Ltd. v. O'Malley*, *supra,* at p. 606, "[t]he freedom of the fiduciary is diminished by the nature of the obligation he or she has undertaken - an obligation which `betokens loyalty, good faith and avoidance of a conflict of duty and self-interest'". It is not easy to bring relationships within this rubric. Generally people are deemed by the law to be motivated in their relationships by mutual self-interest. The duties of trust are special, confined to the exceptional case where one person assumes the power which would normally reside with the other and undertakes to exercise that power solely for the other's benefit. It is as

though the fiduciary has taken the power which rightfully belongs to the beneficiary on the condition that the fiduciary exercise the power entrusted exclusively for the good of the beneficiary. Thus the trustee of an estate takes the financial power that would normally reside with the beneficiaries and must exercise those powers in their stead and for their exclusive benefit. Similarly, a physician takes the power which a patient normally has over her body, and which she cedes to him for purposes of treatment. The physician is pledged by the nature of his calling to use the power the patient cedes to him exclusively for her benefit. If he breaks that pledge, he is liable.

In summary, the constraints inherent in the principles governing fiduciary relationships belie the contention that the recognition of a fiduciary obligation in this case will open the floodgates to unmeritorious claims. Taking the case at its narrowest, it is concerned with a relationship which has long been recognized as fiduciary -- the physician-patient relationship; it represents no extension of the law. Taking the case more broadly, with reference to the general principles governing fiduciary obligations, it is seen to fall within principles previously recognized by this Court, and again represents no innovation. In so far as application of those principles in this case might be argued to give encouragement to new categories of claims, the governing principles offer assurance against unlimited liability while at the same time promising a greater measure of justice for the exploited.

I conclude that the wrong suffered by the plaintiff falls to be considered under the rubric of breach of fiduciary duty. The duty is established, as is the breach. The plaintiff is entitled to succeed against Dr. Wynrib and to recover the appropriate damages at equity.

Damages

The question of damages for breach of fiduciary obligation, albeit in a different context, was recently canvassed in *Canson, supra*. While the reasoning of the two main opinions diverges on the question of the extent to which analogy to tort should have limited liability in the circumstances of that case, all agreed in the result. All agreed as well that the flexible remedies of equity, such as constructive trust, account, tracing and equitable compensation, must continue to be available and to be moulded to meet the requirements of fairness and justice in specific situations. Equitable remedies, as La Forest J. asserted for the majority, should not be confined within the strictures of previous situations. Where new remedies are required, equity will recognize them.

In the case at bar, unlike in *Canson*, the question of an equivalent remedy in tort does not really arise. The action for breach of fiduciary relationship is broader in scope than any action which might be available in tort. Unlike tort, it is capable of recognizing the wrong of sexual exploitation by a fiduciary as a breach of the power entrusted to him. Moreover, it can be questioned whether, in the circumstances of this case, any action in tort lies, given that tort looks on parties at arm's length and applies defences which may well, as found in the courts below, deprive the plaintiff of her right of action. The action for breach of a fiduciary relationship is also broader than the action for breach of contract, which is confined to failure to provide proper medical treatment and does not extend to procuring sexual relations through abuse of the physician's power. In so far as the action concerns medical malpractice, principles of assessment of damages in contract and

tort may be of assistance, at least by analogy. In so far as it concerns wrongful sexual exploitation, we enter into the exclusive terrain of equity.

It therefore seems appropriate in this case to assess damages according to the principles which generally govern damages for breach of fiduciary duty, having regard to the admonition in *Canson* that the remedy awarded need not be confined to that given in previous situations if the requirements of fairness and justice demand more, and that reference to the principles of assessment in contract and tort maybe of assistance in so far as they are relevant.

As discussed in *Canson*, the goal of equity is to restore the plaintiff as fully as possible to the position he or she would have been in had the equitable breach not occurred: per La Forest J. at p. 577. Traditionally, equity made the defaulting trustee who had mismanaged a fund, for example, restore the entire fund, and would not countenance deductions for market fluctuation or failure of the beneficiary to mitigate or take appropriate care, as would the law of tort or contract. This is not a case where the traditional equitable remedies of restitution and account are available. Restoration *in specie* is not possible. And the plaintiff's loss is not economic. Where these remedies are not available, equity awards compensation in their stead: see *Canson*, *supra* at pp. 574-75. In awarding damages the same generous, restorative remedial approach, which stems from the nature of the obligation in equity, applies. The fiduciary, being the person with the advantage of power, assumes full responsibility and cannot be heard to complain that the victim of his or her abuse cooperated in his or her defalcation or failed to take reasonable care for his or her own interests.

From the principles I turn to the facts. Dr. Wynrib's breach of his duty to Ms. Norberg caused the following losses or injuries to her: (1) prolongation of her addiction; and (2) sexual violation.

Ms. Norberg's period of addiction was prolonged from the time he ought reasonably to have known that she was addicted to the time she left his care and sought help for her addiction on her own. That is a period of at least two and one-half years. The evidence establishes, and this is fully in accordance with the medical literature, that Ms. Norberg's addiction to Fiorinal was a very traumatic and damaging experience. She was desperate for the drug, desperate enough to engage in sexual activity with Dr. Wynrib which she clearly found repugnant and degrading. Her testimony with respect to the occasion when she went to Dr. Wynrib to ask for help in ending her drug use gives some idea of the character of her addiction:

> I quit my job in February of 1985, and I remember I had gone in to see him. I was getting really depressed and I no longer had the money now to buy all the drugs that I had been off of the street, and it was just getting harder to get the pills.
>
> ...
>
> ... I remember telling him that I needed help....

It will be recalled that Dr. Wynrib's response to this cry for help was to tell her to just quit, and then to continue to supply her with drugs in exchange for sexual favours. The evidence supports the conclusion that had Dr. Wynrib advised Ms. Norberg to seek treatment for her addiction, she would have done so and would have been successfully treated.

The evidence amply attests to the misery and desperation of Ms. Norberg during the period during which her addiction was prolonged by Dr. Wynrib's failure to offer the appropriate medical treatment. Part of this, her sexual degradation, must be discounted under this head, since I have considered it independently. Taking this into account, I would award an additional $20,000 for suffering and loss during the period of prolonged addiction for which Dr. Wynrib was responsible.

Second, Ms. Norberg suffered repeated sexual abuse at the hands of Dr. Wynrib. As the trial judge found, she did not want to have sexual relations with Dr. Wynrib. She submitted only because it was the only way to get the drug she desperately craved, and the deprivation of which plunged her into what was described by Dr. Fleming of the Department of Psychiatry, Faculty of Medicine, U.B.C., as the "extremely unpleasant experience" of withdrawal. Her addiction was such that (again in the words of Dr. Fleming):

> ...she wished to obtain a supply at any cost, and was willing to compromise her beliefs concerning appropriate behaviour in order to obtain supply. In the absence of dependence on and tolerance to Fiorinal it is my impression that Ms. Norberg would not have consented to have any social or sexual activity with Dr. Wynrib.

The evidence is clear that Ms. Norberg found the sexual contact degrading and dehumanizing. She avoided it for as long as she could, leaving Dr. Wynrib's care when he first suggested it. When desperation drove her back, she submitted only when her addiction rendered it absolutely necessary. The repeated sexual encounters caused her humiliation and robbed her of her dignity. The pain of those encounters will probably remain with her all her life; Ms. Norberg testified that she thinks about

the events daily, that her recollections are an unhappy reminder of her addiction and desperation. When her son was born, she felt that she did not deserve to have her baby because of what she had done with Dr. Wynrib. While the sexual encounters lack the violence of rape, the pain may be just as great because of its insidious psychological overtones. The rape victim may not, although she unfortunately often does, feel guilt. Ms. Norberg, however inevitable and excusable her participation in this activity, clearly does suffer guilt, even years after the events. The evidence suggests her self-esteem has been vitally and perhaps permanently damaged. These *sequelae*, as *The Final Report of the Task Force on Sexual Abuse of Patients* (at pp. 84-85) makes disturbingly clear, are all too typical of victims of sexual exploitation by physicians.

My colleague La Forest J. refers to a number of decisions which have considered the quantum of damages for rape and sexual assault. While one must be cautious in making such comparisons, particularly given the somewhat arbitrary basis upon which damages have been assessed in some sexual assault cases, I find the trauma caused to Ms. Norberg as a consequence of the sexual acts in many respects similar to that in *Harder v. Brown* (1989), 50 C.C.L.T. 85 (B.C.S.C.). There the plaintiff, a minor, was assaulted a number of times over a seven-year period by the defendant, an elderly friend of her grandfather. As here, the acts consisted of kissing, fondling and attempted intercourse. The defendant also caused the plaintiff to undress and be photographed. As a result, the plaintiff suffered lasting psychological trauma, including a diminished sense of self-worth and difficulty in forming intimate relationships. Wood J., as he then was, awarded general damages in the sum of $40,000. Ms. Norberg has suffered similar consequential trauma, but

bearing in mind the shorter period during which the sexual abuse occurred here, I would award $25,000 in damages for sexual exploitation.

Finally, this is in my opinion an appropriate case in which to make an award of punitive damages. In so far as reference to tort principles may be appropriate I note that punitive damages have been awarded in several sexual assault cases: see, for example, *Myers v. Haroldson,* [1989] 3 W.W.R. 604 (Sask. Q.B.) ($40,000); *Harder v. Brown, supra* ($10,000).

Quite apart from analogies with tort, punitive (or exemplary) damages are available with respect to breaches of fiduciary duty, and in particular for breaches of the sort exemplified by this case. In *W.(B.) v. Mellor*, [1989] B.C.J. No. 1393 (S.C.) (QL Systems) to which La Forest J. refers in his judgment (at pp. 20-21) a doctor was held to be in breach of his fiduciary duty when he engaged in an exploitive sexual relationship with his patient. McKenzie J. awarded the plaintiff $15,000 in punitive damages. If further authority is needed for the proposition reference can be made to the decision of Callaghan A.C.J.H.C. in *Szarfer v. Chodos* (1986), 54 O.R. (2d) 663 (Ont. H.C.), a case in which a lawyer was found to be in breach of his fiduciary duty to his client when he embarked upon a sexual relationship with his client's wife. Although Callaghan A.C.J.H.C. did not find the defendant's conduct sufficiently high handed and arrogant to warrant awarding punitive damages in the circumstances of that case, it is clear from his analysis of the issue (found at pp. 680-81) that he saw no bar to an award of punitive damages for a breach of fiduciary duty.

I find Ellis' statement, found in his text *Fiduciary Duties in Canada*, at p. 20-24, as to the circumstances which will constitute the conditions precedent for awarding punitive damages for a breach of fiduciary duty both helpful and applicable to the facts of this case:

> Where the actions of the fiduciary are purposefully repugnant to the beneficiary's best interests, punitive damages are a logical award to be made by the Court. This award will be particularly applicable where the impugned activity is motivated by the fiduciary's self-interest.

I do not think it can be seriously questioned that Dr. Wynrib's activities were both purposefully repugnant to Ms. Norberg's best interests, and motivated entirely by his own self-interest.

Punitive damages are awarded, not for the purpose of compensating the victim for her loss, but with a view to punishing the wrongdoer and deterring both him and others from engaging in similar conduct in the future. Dr. Wynrib's conduct is sufficiently reprehensible and offensive to common standards of decency to render him liable to such a punitive award. While, given his age, it is unlikely that such damages will have much utility in terms of specific deterrent effect, concerns for general deterrence militate in favour of their being granted. The Report of the Task Force of the Ontario College of Physicians and Surgeons makes it clear that the sexual exploitation of patients by physicians is more widespread than it is comfortable to contemplate. Its damaging effects extend not only to those persons who are directly harmed, but also to the image of the profession as a whole and the community's trust in physicians to act in our best interests. In this context punitive damages may serve to reinforce the high standard of conduct which the fiduciary

relationship between physicians and patients demands be honoured. This is completely in keeping with the law's role in protecting beneficiaries and promoting fiduciary relationships through the strict regulation of the conduct of fiduciaries: on this point see Frankel, *supra* at p. 816. An award of punitive damages in the present case would signal the community's disapprobation of the sexual exploitation of vulnerable patients, and for that reason ought to be made.

In considering the quantum of punitive damages I find the decision of Osborn J. in *Myers v. Haroldson, supra*, of some assistance. In that case the plaintiff had been violently raped by a man who was a stranger to her. Punitive damages in the amount of $40,000 were awarded against the defendant for the following reasons:

(1) his conduct was worthy of punishment;

(2) sexual assault is prevalent in our society and there is a consequent need for deterrence;

(3) his conduct was not only morally offensive, but also cold and calculating;

(4) his conduct was arrogant and callous, and without concern for the consequences to his victim; and,

(5) the victim's life was threatened in the course of the assault, and a child was born nine months later, whose paternity is consequently in question.

Although the circumstances of the present case are quite different from those in *Myers v. Haroldson, supra*, I find guidance in that case. The factors referred

to by Osborn J. -- blameworthy conduct, prevalence of conduct necessitating deterrence, lack of empathy for the victim and lack concern for the consequences to the victim -- are present. Most important in this case, as in *Myers*, is the need for deterrence. Dr. Wynrib is not alone in breaching the trust of his patient through sexually exploiting her; physicians, and all those in positions of trust, must be warned that society will not condone abuse of the trust placed in them. I would award punitive damages against Dr. Wynrib in the amount of $25,000.

In the result I would allow the appeal and award the plaintiff judgment for $70,000. In my opinion, this is an appropriate case in which to order costs on a solicitor and client basis. Orders as to costs are discretionary matters. In cases of fiduciary duty that discretion is often exercised to provide the successful plaintiff with costs on the more generous solicitor and client tariff: see Ellis, *Fiduciary Duties in Canada*, *supra,* at p. 20-24. An example of this tendency may be found in *W.(B.) v. Mellor, supra*, in which the exploited patient was given solicitor and client costs against the defaulting physician. I would do the same here.

//*Sopinka J.*//

The following are the reasons delivered by

SOPINKA J. -- I have had the advantage of reading the reasons of Justice La Forest. He disposes of this appeal on the basis of the battery claim. With respect, I cannot agree with his approach on the issue of consent. I am also of the view that

this case is more appropriately resolved on the basis of the respondent's duty to treat the appellant arising out of the doctor-patient relationship.

The facts of this case are substantially as set out by La Forest J. For the purposes of my reasons I wish to highlight a few crucial facts and findings by the courts below.

The appellant commenced seeing the respondent in early 1982. She admitted that she lied to him about her ankle injury and other illnesses in order to obtain Fiorinal prescriptions. Later in 1982, the respondent confronted her with his knowledge of her addiction. He made it clear to her that if she wished to continue receiving prescriptions for Fiorinal from the respondent, she would have to engage in sexual contact with him. For a short period of time she stopped seeing him and sought her drugs through other doctors. However, when these other doctors reduced her supply, she returned to the respondent. The sexual encounters initially took place in the examining room of the respondent's office and later upstairs in his home. The appellant testified that the incidents of simulated intercourse in the respondent's home took place 10 or 12 times, until some time in 1985. She admitted that at no time did the respondent use any physical force. She also agreed that she "played on him", knowing throughout this relationship that he was lonely. Oppal J. ((1988), 27 B.C.L.R. (2d) 240), found that at no time did she refuse the respondent's advances either directly or indirectly. In considering the existence and reality of consent by the appellant, he held at p. 244:

> In the case at bar it cannot be said that Dr. Wynrib either exercised force or threats of it. While Miss Norberg was addicted to fiorinal, there is no

> evidence that she was under the influence of the drug, or that her addiction interfered with her capacity to consent to the sexual activity which took place. She was not at any time deprived of her ability to reason. While her willingness to engage in sexual activity was obviously inspired by the prescriptions which the doctor would provide, nevertheless her implied consent was voluntary so that the battery claim for sexual assault must fail.

The majority of the Court of Appeal (McEachern C.J. and Gibbs J.A.) ((1990), 44 B.C.L.R. (2d) 47) accepted these findings and concluded at p. 51:

> The learned trial judge dismissed the plaintiff's action based upon assault because of her consent. With respect, this seems to me to be clearly correct. These 12 or so sexual encounters all occurred in the defendant's apartment, where she went voluntarily in order to get drugs with a clear understanding of the sordid arrangement to which she had agreed.

Locke J.A., at p. 56, agreed with the majority that the claim for sexual assault failed because of the appellant's consent:

> This consent was not brought about by force, deception or undue influence. There was no evidence of confusion brought on by drugs. Neither party was under any illusion as to what they were doing and the defence therefore succeeds.

<u>The Battery Claim and the Defence of Consent</u>

The appellant claims that the sexual contact between the respondent and herself constituted the tort of battery. As stated by Laskin C.J. for the Court in *Reibl v. Hughes*, [1980] 2 S.C.R. 880, at p. 890, the tort of battery is "an intentional one, consisting of an unprivileged and unconsented to invasion of one's bodily security".

Thus consent, either express or implied by conduct, is a defence to a claim of battery. However, that consent must be genuine. Courts and scholars have identified circumstances in which an apparent consent will not be considered valid. Consent is not genuine if it is obtained by force, duress, or fraud or deceit as to the nature of the defendant's conduct, or if it is given under the influence of drugs. See: Fleming, *The Law of Torts* (7th ed. 1987), at pp. 72-74; Linden, *Canadian Tort Law* (4th ed. 1988), at pp. 62-63.

In assessing the reality of consent and the existence and impact of any of the factors that tend to negate true consent, it is important to take a contextually sensitive approach. In relation to medical procedures, several courts have emphasized the need to consider all relevant surrounding circumstances in assessing whether there was valid consent. See, for example: *Morrow v. Hôpital Royal Victoria* (1989), 3 C.C.L.T. (2d) 87 (Que. C.A.); *Cowan v. Brushett* (1990), 3 C.C.L.T. (2d) 195 (Nfld. C.A.). Such an approach applies equally in other situations. For example, the commentary to §892B, Consent Under Mistake, Misrepresentation or Duress, of the American Law Institute's *Restatement of the Law, Second, Torts (2d)*, states in relation to duress that "[a]ge, sex, mental capacity, the relation of the parties and antecedent circumstances all may be relevant".

In my view, these factors must be applied on a case-by-case basis rather than by establishing categories of individuals or relationships with respect to which apparent consent will never or rarely be considered valid. Certain relationships, especially those in which there is a significant imbalance in power or those involving a high degree of trust and confidence may require the trier of fact to be particularly

careful in assessing the reality of consent. However, the question of consent in relation to a battery claim is ultimately a factual one that must be determined on the basis of all the circumstances of a particular case. This point was explained by the English Court of Appeal in *Freeman v. Home Office*, [1984] 1 All E.R. 1036 (leave to appeal to the House of Lords refused). The issue in that case was whether a prisoner had consented to the administration of drugs by a prison medical officer. Brown L.J. stated, at p. 1043:

> ... the sole issue raised at trial, that is to say whether the plaintiff had consented to the administration of the drugs injected into his body, was essentially one of fact.... The judge said ([1983] 3 All ER 589 at 597, [1984] 2 WLR 130 at 145):
>
> > `The right approach, in my judgment, is to say that where, in a prison setting, a doctor has the power to influence a prisoner's situation and prospects a court must be alive to the risk that what may appear, on the face of it, to be a real consent is not in fact so. I have borne that in mind throughout the case.'
>
> Essentially, however, the matter is one of fact. The judge made the positive finding that the plaintiff consented.... There was ample evidence to justify his finding of fact and accordingly the decision to which he came. It is not for this court to consider and decide this appeal on the basis of an alternative and hypothetical set of facts and circumstances.

Similarly, in *Lyth v. Dagg* (1988), 46 C.C.L.T. 25 (B.C.S.C.), which concerned an action for battery in respect of alleged sexual assaults by a teacher on a high school student, Trainor J. emphasized the importance of considering the particular relationship between the parties and all of the circumstances surrounding the alleged assault:

> Sexual abuse is merely one particular way in which one person can assault another. It demands careful examination of the relationship between the parties to appreciate whether both had capacity to consent,

> understanding the nature and consequences of the conduct, and also whether one of the parties had such a greater amount of power or control over the other as to be in a position to force compliance. This is an examination to determine whether, in all the circumstances, force was applied by one person to another and whether any consent apparently given was genuine. [At pp. 31-32, emphasis added.]

The issue then is whether, having regard to the principles which I have stated, there is any basis to set aside the findings of the courts below that the appellant consented to the sexual activity with the respondent. The appellant submits that having regard to her drug addiction and to the respondent's position of influence as her doctor, there was no genuine consent. I will consider each of these factors in turn.

With respect to the appellant's addiction, the trial judge turned his mind to this factor and concluded that although it clearly inspired her willingness to engage in sexual activity, it did not interfere with her ability to reason or her capacity to consent to the sexual activity which took place. He also noted that she was not under the influence of Fiorinal when sexual activity took place. There was evidence to support all of these findings, and I am unwilling to interfere with the trial judge's conclusion on this ground.

With respect to the doctor-patient relationship, as I have already stated, special relationships between the plaintiff and defendant should alert the trier of fact to the possibility that apparent consent is not genuine; however, the existence of a particular relationship is not determinative of the presence or absence of consent. The beneficiary of a fiduciary relationship can still consent to a transaction with the fiduciary but the court will subject such a consent to special scrutiny. There may

well be cases in which a doctor, by virtue of his or her status, exercises such control or authority over a patient that the patient's submission will not be considered genuine consent. However, in my view, that cannot be said about this case. The appellant began and continued to participate in the sexual encounters in order to obtain drugs. She acknowledged that she played on the respondent's loneliness in order to continue obtaining prescriptions. While it is clear that the sexual contact was contrary to the appellant's wishes, in my view it cannot be said that it was without her consent. I therefore do not find any basis on which to set aside the conclusion of the courts below on the issue of consent.

This is sufficient, in my view, to dispose of the battery claim. However, since my colleague La Forest J. has relied upon the principles relating to unconscionable transactions in addressing the issue of consent, I feel it necessary to explain why I do not find such an approach helpful or appropriate in this context.

As I have emphasized and as La Forest J. also observes, the factual context of each case must be evaluated to determine whether there has been genuine consent. La Forest J., at p. 000, then reasons that "[i]f the "justice factor" of unconscionability is used to address the issue of voluntariness in the law of contract, it seems reasonable that it should be examined to address the issue of voluntariness in the law of tort". There is, however, a fundamental difference between these two concepts. In the former, the court may refuse to recognize the validity of a transaction voluntarily entered into by reason of the unfair use of power by the strong against the weak. In the latter, the court is asked to saddle a party with damages for a wrong inflicted on the plaintiff. In the latter case, there is no wrong if there was

consent. In the former, the issue is not consent but whether it was fairly obtained. The factor of unconscionability would be more appropriate here if the respondent were seeking to enforce the transaction as opposed to defending himself against an allegation that he committed an intentional tort.

Accordingly, the weight of academic and judicial opinion is that the doctrine of unconscionability operates to set aside transactions even though there may have been consent or agreement to the terms of the bargain. It is not that this doctrine vitiates consent but rather that fairness requires that the transaction be set aside notwithstanding consent.

In *Hunter Engineering Co. v. Syncrude Canada Ltd.*, [1989] 1 S.C.R. 426, Dickson C.J., writing for himself and La Forest J., held at p. 462:

> Only where the contract is unconscionable, as might arise from situations of unequal bargaining power between the parties, should the courts interfere with agreements the parties have freely concluded. [Emphasis added.]

Wilson J. did not consider that case to provide an appropriate opportunity for an exposition of the doctrine of unconscionability. However, without necessarily endorsing their approaches, she referred to a number of lower court decisions which invoked the doctrine in order to provide relief. In *Morrison v. Coast Finance Ltd.* (1965), 55 D.L.R. (2d) 710 (B.C.C.A.), Davey J.A. stated, at p. 713:

> The equitable principles relating to undue influence and relief against unconscionable bargains are closely related, but the doctrines are separate and distinct.... A plea of undue influence attacks the sufficiency

> of consent; a plea that a bargain is unconscionable invokes relief against an unfair advantage gained by an unconscientious use of power by a stronger party against a weaker.

In *Davidson v. Three Spruces Realty Ltd.* (1977), 79 D.L.R. (3d) 481 (B.C.S.C.), Anderson J. stated, at pp. 492-93:

> I am of the opinion that the terms of a contract may be declared to be void as being unreasonable where it can be said that in all the circumstances it is unreasonable and unconscionable to bind the parties to their formal bargain.

In *Harry v. Kreutziger* (1978), 95 D.L.R. (3d) 231 (B.C.C.A.), McIntyre J.A. (as he then was) restated the principles set out in *Morrison*, *supra*. Lambert J.A. did not disagree with these principles. However, in his view they were not exhaustive of the circumstances in which unconscionability may operate as a ground for rescission. He stated at p. 241:

> In my opinion, questions as to whether use of power was unconscionable, an advantage was unfair or very unfair, a consideration was grossly inadequate, or bargaining power was grievously impaired, to select words from both statements of principle, the *Morrison* case and the *Bundy* case, are really aspects of one single question. That single question is whether the transaction, seen as a whole, is sufficiently divergent from community standards of commercial morality that it should be rescinded.

The final case to which I wish to make reference on this point is *Lloyds Bank Ltd. v. Bundy*, [1975] Q.B. 326. While the majority decided the case on the ground of undue influence, Lord Denning M.R. drew together several doctrines including unconscionability under the rubric of a general principle of "inequality of

bargaining power". He was careful, however, to distinguish this basis for relief from any notion of involuntariness or lack of consent, at p. 339:

> I have also avoided any reference to the will of the one being "dominated" or "overcome" by the other. One who is in extreme need may knowingly consent to a most improvident bargain, solely to relieve the straits in which he finds himself. [Emphasis added.]

This review of judicial decisions on the subject of unconscionability does not purport to be exhaustive. My point has simply been to demonstrate, firstly, that the doctrine of unconscionability and the related principle of inequality of bargaining power are evolving and, as yet, not completely settled areas of the law of contract and, secondly, that there is a substantial body of judicial opinion that either explicitly distinguishes unconscionability from the question of consent or analyzes the impugned transaction in a way that directs attention away from the question of whether a party in fact agreed or consented to a particular term.

Academic writings similarly differentiate between unconscionability and lack of consent. Professor Waters in "Banks, Fiduciary Obligations and Unconscionable Transactions" (1986), 65 *Can. Bar Rev*. 37, at pp. 48-49, discusses unconscionability as follows:

> Unlike the doctrine of undue influence, equity is not concerned in these situations with whether the mind of one party was overborne by another so that the victim's true consent was lacking; it asks the question as to whether, looked at objectively, the transaction in all the circumstances was sufficiently unconscionable that it cannot be allowed to stand.
>
> . . .

> As Professor Sheridan put it, writing in 1957, the question is whether, given the weakness of one party's bargaining position and the undervalue which he received, "a greater advantage" was obtained by the stronger party "than the current morality of the ordinary run of business allows".

See also Cope, "The Review of Unconscionable Bargains in Equity" (1983), 57 *Aust. L.J.* 279. Professor Waddams in his article "Unconscionability in Contracts" (1976), 39 *Mod. L. Rev.* 369, explained the problem with analyzing unconscionability in terms of consent at pp. 381-82:

> The use of consent theories to deal with unfair clauses in documents, signed or unsigned, has led some commentators to attempt to reduce the whole problem of unconscionability to a question of consent. I think that this approach is unhelpful, and ultimately results in a redefinition of consent in such terms that an unconscionable provision is presumed *ipso facto* not to have received assent, or "true" assent. The lack of assent becomes then not a reason for relief, but a statement of a conclusion that relief will be granted, suppressing any analysis of the criteria of unconscionability, which must be the true ground for the decision....
>
> There will be an overlap in particular cases.... But there is, I suggest, a distinction in principle between the defences of no assent and unconscionability.

Just as discussing the problem of unconscionability in terms of consent obscures the real basis for relief in these contracts cases, importing the principles of unconscionability into the context of a battery claim has the potential to obscure the real question -- whether in all the circumstances, the plaintiff actually consented to the touching which constitutes the alleged battery.

One example of how transposing unconscionability analysis into the context of a battery claim may lead courts astray is La Forest J.'s statement, at p. 000, that if the type of sexual relationship at issue is "sufficiently divergent from

community standards of conduct", this may indicate exploitation. This reasoning is drawn directly from an unconscionable transaction case, *Harry v. Kreutziger*, *supra*, in which Lambert J.A. held, at p. 241, that the key question is "whether the transaction, seen as a whole, is sufficiently divergent from community standards of commercial morality that it should be rescinded". While community standards of commercial morality may be a relevant consideration in determining whether there has been such exploitation as to warrant setting aside a commercial contract, with respect, community standards of sexual conduct have no bearing on the question of whether or not there was consent to sexual contact in a particular case.

I therefore do not find the contractual doctrine of unconscionability of assistance in attempting to answer the factual question of whether the appellant consented to sexual contact with the respondent. Furthermore, in my view, the facts of this case are more accurately reflected by acknowledging that the appellant consented to the sexual contact and by considering the respondent's conduct in light of his professional duty towards the appellant.

Breach of Duty

This professional duty arises out of the relationship of doctor-patient which is essentially based on contract. Breach of the duty can be the subject of an action in either contract or negligence. While undoubtedly, as in the case of lawyer and client, this relationship in some of its aspects involves fiduciary duties, not all facets of the obligations are fiduciary in nature.

This Court examined the principles of fiduciary duty in *Lac Minerals Ltd. v. International Corona Resources Ltd.*, [1989] 2 S.C.R. 574. In that case, I concluded for the majority on this point, at p. 596, that fiduciary obligation "must be reserved for situations that are truly in need of the special protection that equity affords". It was acknowledged, at p. 597, that "[t]he nature of the relationship may be such that, notwithstanding that it is usually a fiduciary relationship, in exceptional circumstances it is not", and further, that "not all obligations existing between the parties to a well-recognized fiduciary relationship will be fiduciary in nature". The relationship between a doctor and his or her patient is precisely of this hybrid genre. In *Lac Minerals Ltd., supra*, I also referred to the judgment of Southin J.A. in *Girardet v. Crease & Co.* (1987), 11 B.C.L.R. (2d) 361 (S.C.), which held that a solicitor's failure to use care and skill did not essentially become a breach of fiduciary duty, but rather, the breach could be founded in contract or negligence. Likewise, certain obligations that arise from a doctor and patient relationship are fiduciary in nature; however, other obligations are contractual or based on the neighbourhood principle which is the foundation of the law of negligence. Fiduciary duties should not be superimposed on these common law duties simply to improve the nature or extent of the remedy.

I therefore agree with the following statement, at p. 52, in the reasons of McEachern C.J.:

> If the defendant breached a duty to the plaintiff in this case it was a breach of the duty which a physician owes to his patient to treat her professionally and, unless the breach relates to an improper disclosure of confidential information or something like that, it adds nothing to describe the breach as a fiduciary one.

The breach of duty alleged here is the obligation of a physician to treat the patient in accordance with standards in the profession. The trial judge found that there was a breach of this duty. He stated at p. 246:

> Regardless of the nature of their relationship, it is clear that a physician has a duty to act in utmost good faith towards a patient. It is trite to say that a physician must never allow his personal interests to conflict with his professional duty. In this case Dr. Wynrib clearly did this. He was legally and ethically bound to treat his patient's drug addiction or to refer her to a drug rehabilitation centre. He did neither. Rather, he capitalized on her addiction. He showed a total disregard for the best interests of his patient.

This finding was fully supported by the evidence. One of the professional witnesses, Dr. Herbert, testified as follows:

> ... it is my opinion that a reasonable general practitioner practicing [*sic*] in British Columbia in the 1980's would have realized Ms. Norberg's addiction to Fiorinal prior to 1984. In the circumstances, a reasonable practitioner would have taken steps to attempt to help Ms. Norberg end her addiction by, for example, suggesting drug counselling, or, at the very least, by discontinuing her prescriptions of Fiorinal. In my opinion, the continued prescriptions of Fiorinal by Dr. Wynrib to Ms. Norberg after 1983, promoted and fed an addiction without medical justification.

The Court of Appeal agreed with this finding. McEachern C.J. expressly approved of the above passage from the reasons of the trial judge.

Locke J.A. also found that the respondent breached his duty as a physician. He concluded, however, that to the extent that the appellant relied on contract, it had been abandoned by mutual consent. The duty survived, however, for the purposes of the claim in negligence. In this regard, he stated at p. 58:

> Given my conclusion that the contract to heal was abandoned, one might now argue that as to anything which followed the duty was "abandoned" and the doctor owed her none. I have concluded this was not a duty which could be vacated. Even if acting as a purchaser of sex, and not in his capacity of a doctor, he owed a duty, as would anyone, not to give another a noxious substance. And as he knew the appellant's real condition -- that of addiction -- he was in purposeful -- almost malevolent -- breach of duty in giving her medically unnecessary drugs. It is this supplying of drugs that is the negligent act.

In my opinion, whether the appellant relies on contract or negligence, the duty to treat was not vacated by consent. In contract this would require the abandonment of the contractual relationship between the parties. The authorities reviewed by Locke J.A. show that this requires the mutual consent of the parties supported by consideration. I am satisfied that there was no such consent in this case.

While the parties may very well have had a relationship independent of the doctor-patient relationship, the latter relationship continued and was not abandoned. After the addiction was admitted to him in late 1982, the respondent's conduct was consistent with the continuation of a doctor and patient relationship. He ordered a series of x-rays to be taken of various parts of the appellant's body. He accepted these x-ray reports in August and November of 1984. He made gynaecological referrals for the appellant and in due course Dr. Gowd, a gynaecologist, reported to the respondent in this regard. The only conclusion to be drawn from the evidence is that the respondent continued to act as the appellant's general practitioner and the appellant continued to seek medical care from him in this capacity. Neither the parties nor the medical community had any reason to believe that the parties had mutually abandoned their contract. In fact, the conduct of both

the appellant and the respondent reinforced the existence of their doctor and patient relationship.

Moreover, even if the contract was abandoned, that did not put an end to the duty. The respondent did not change his status as a physician; nor did the appellant change her status as one who was in need of and sought treatment. This relationship continued even if technically the contract between them was terminated by mutual consent. The duty is supportable independently of contract on the basis of this relationship. Duty arising out of relationship is, of course, the basis of the law of negligence.

Both McEachern C.J. and Locke J.A. concluded that the respondent's duty to the appellant was not discharged by reason of consent to the sexual encounters. After quoting the passage from the reasons of the trial judge to which I referred above, McEachern C.J. stated at p. 52:

> I agree with the above. Further, in my opinion, the consent of the plaintiff to the conduct of the defendant does not excuse him from the obligations of that duty. He owed a professional responsibility both to the plaintiff and to the state not to mistreat her in a medical way by extending her period of addiction without proper treatment regardless of her wishes.

I agree with this conclusion. While the appellant consented to the sexual encounters, she did not consent to the breach of duty that resulted in the continuation of her addiction and the sexual encounters. The fact that a patient acquiesces or agrees to a form of treatment does not absolve a physician from his or her duty if the treatment is not in accordance with medical standards. Otherwise, the patient would be

required to know what the prescribed standard is. In the absence of a clear statement by the respondent to the appellant that he was no longer treating her as her physician and an unequivocal consent to the cessation of treatment, I conclude that the duty to treat the appellant continued until she attended at the rehabilitation centre on her own initiative and was treated.

Ex Turpi Causa

I agree with the reasons of Locke J.A. and La Forest J. that the appellant's claim is not barred by *ex turpi*. I would add the following. My colleague refers to the observation of Estey J. that the application of this maxim to defeat a tort action has been rare. Its use has been much less frequent in recent times. The courts have taken a less rigid view of its purpose. Emphasis is now placed on preserving the administration of justice from the taint that would result from the approval of a transaction that a court ought not to countenance. In this regard, I agree with the statement of Taylor J. in *Mack v. Enns* (1981), 30 B.C.L.R. 337 (S.C.), at p. 345:

> The purpose of the rule today must be to defend the integrity of the legal system, and the repute in which the courts ought to be held by law-abiding members of the community. It is properly applied in those circumstances in which it would be manifestly unacceptable to fair-minded, or right-thinking, people that a court should lend assistance to a plaintiff who has defied the law.

The views of society have changed radically in this respect. The older cases were apt to view with equal severity the misconduct of all persons who were involved in immoral or illegal transactions. I need only refer to the case of *Hegarty v. Shine* (1878), 4 L.R. Ir. 288 (Q.B.D.), in which the courts refused relief to a young

female servant who had been infected with a venereal disease by her master. I have no doubt that such a case would be viewed quite differently today. In my view, the administration of justice will suffer no disrepute in the eyes of the public by reason of this Court's lending its assistance to the appellant in this case.

Damages

The breach of duty found was that in lieu of striving to cure the appellant of her addiction, the respondent promoted it in return for sexual favours. The result was that the addiction was prolonged in lieu of treatment and the appellant was subjected to the respondent's sexual advances. The sexual acts were causally connected to the failure to treat and must form part of the damage suffered by the appellant. I would assess the damages for both these components in the amount awarded by my colleague, La Forest J. I would not, however, award punitive damages. These are inappropriate in this case inasmuch as the basis of liability is the breach of professional duty. While the sexual episodes are an element of damage, they are not the basis of liability. These sexual episodes are the basis of liability in the reasons of La Forest J. who found the respondent liable for acts of sexual assault deserving of punishment. In the view that I have taken, they are rather an element of damage for breach of duty, and an award that includes as a component aggravated damages is adequate compensation to the appellant.

I would allow the appeal with costs throughout. I would not impose costs on a scale higher than party and party which should generally be reserved for cases in which misconduct has occurred in the conduct of or related to the litigation.

Appeal allowed with costs.

Solicitors for the appellant: Ladner Downs, Vancouver.

Solicitors for the respondent: Epstein Wood Logie & Wexler, Vancouver.

Solicitors for the intervener: Bull, Housser & Tupper, Vancouver.