CITATION: Barker v. Barker, 2017 ONSC 3397
COURT FILE NO.: CV-00-199551
DATE: 20170601

ONTARIO
SUPERIOR COURT OF JUSTICE

BETWEEN:

REGINALD BARKER, JEAN-PAUL BELEC, ERIC BETHUNE (formerly Jean-Jacque Berthiaume), JOSEPH BONNER, WILLIAM BRENNAN, STEPHEN CARSON, ROY DALE, MAURICE DESROCHERS by the Estate Trustee LORRAINE DESROCHERS, DONALD EVERINGHAM, JOHN FINLAYSON, ROBERT FROST, TERRY GHETTI, ROBERT HABERLE, BRUCE HAMILL, ELDON HARDY, WILLIAM HAWBOLDT, DANNY A. JOANISSE, RUSS JOHNSON, STANLEY KIERSTEAD, DENIS LEPAGE, CHRISTIAN MAGEE, DOUGLAS McCAUL, WILLIAM A. McDOUGALL, BRIAN FLOYD McINNES, ALLEN McMANN, LEEFORD MILLER, JAMES MOTHERALL, MICHAEL ROGER PINET, EDWIN SEVELS, SAMUEL FREDERICK CHARLES SHEPHERD and SHAUNA TAYLOR (formerly Vance H. Egglestone)

Plaintiffs

– and –

ELLIOTT THOMPSON BARKER, GARY J. MAIER and HER MAJESTY THE QUEEN IN RIGHT OF ONTARIO

Defendants

Joel P. Rochon, Peter R. Jervis, Suzanne E. Chiodo and *Lisa M. Fenech* for the Plaintiffs

William D. Black and *Sam Rogers* for the Defendants Elliott Thompson Barker and Gary J. Maier

Sara Blake and *Meagan Williams* for the Defendant Her Majesty the Queen in Right of Ontario

HEARD: May 16-17, 2017

PERELL, J.

REASONS FOR DECISION

> I will use treatment to help the sick according to my ability and judgment, but never with a view to injury and wrong-doing. Neither will I administer a poison to anybody when asked to do so, nor will I suggest such a course. Similarly, I will not give to a woman a pessary to cause abortion. But I will keep pure and holy both my life and my art. I will not use the knife, not even, verily, on sufferers from stone, but I will give place to such as are craftsmen therein.
>
> Into whatsoever houses I enter, I will enter to help the sick, and I will abstain from all intentional wrong-doing and harm, especially from abusing the bodies of man or woman, bond or free. And whatsoever I shall see or hear in the course of my profession, as well as outside my profession in my intercourse with men, if it be what should not be published abroad, I will never divulge, holding such things to be holy secrets. [*Hippocratic Oath*, 5th century BC]

> ...If the process were one of eradicating a set of disapproved ideas and washing in different social values, then we would be committing offences as grievous as those involved in setting up the Third Reich – indeed, the more sinister, because of their subtlety. On the other hand, if our patients did not choose to deviate from society's norms, but rather were driven to such deviations by internal unresolved conflicts, then we should help them to resolve such conflicts by every means at our disposal, including force, humiliation, and deprivation, if necessary. Physical force brought the patient to our hospital, physical force maintains him there, and this force will not be lifted until he changes his behaviour in a recognizable way. [E.T. Barker, M.D (Assistant Superintendent, Ontario Hospital, Penetanguishene) and M.H. Mason (patient – Intensive Treatment Unit, Ontario Hospital, Penetanguishene), *Buber Behind Bars* (1968), 13 *Canadian Psychiatric Assoc. Journal* 61.]

A. Introduction and Overview

[1] The Plaintiff Shauna Taylor, formerly Vance Egglestone, was and is an involuntary patient at the Mental Health Centre in Penetanguishene, Ontario, where she was originally detained in January 1976, at the Oak Ridge Division.

[2] In 2000, pursuant to the *Class Proceedings Act, 1992*, S.O. 1992, c. 6, Ms. Taylor commenced a proposed class action against the Defendants Dr. Elliott Thompson Barker, Dr. Gary J. Maier, and the Province of Ontario (Her Majesty the Queen in Right of Ontario) ("the Crown"), which operated Oak Ridge.

[3] In 2001, Danny Joanisse, who as teenager was detained as an involuntary patient at Oak Ridge, was added as a co-Plaintiff to the proposed class action.

[4] Between 1966 and 1983 (*i.e.*, between 51 and 34 years ago), Drs. Barker and Maier oversaw the Social Therapy Unit at Oak Ridge. During those 17 years, Ms. Taylor, Mr. Joanisse, and the putative Class Members, all of whom were patients at Oak Ridge, underwent three programs designed by Dr. Barker for the Social Therapy Unit.

[5] In the proposed class action, the Plaintiffs sued: (1) the Defendants for breach of fiduciary duty; (2) Drs. Barker and Maier for assault and battery; and (3) the Crown for negligence in respect of its failure to supervise Drs. Barker and Maier.

[6] Without alleging that it was a separate cause of action, the Plaintiffs also alleged that the Defendants had contravened common law principles and international law norms relating to the use of torture and cruel, inhumane, or degrading treatment and punishment.

[7] The basic allegation against Drs. Barker and Maier is that in the interests of research, they engaged in degrading and abusive human experimentation that could not be justified on medical or scientific grounds and that had severely deleterious effects on the patients at Oak Ridge. It is to be noted that in the Statement of Claim, there was no malpractice or medical negligence claim, as such, advanced against Drs. Barker and Maier. And, although bad faith might be inferred from the material facts pleaded, neither bad faith, malice, nor improper purpose was expressly pleaded against them.

[8] Right from the outset of the action, the Defendants raised the issue that the Plaintiffs' causes of action were statute-barred.

[9] Thus, in 2001, when Ms. Taylor brought the motion to add Mr. Joanisse, the Defendants opposed the motion and argued that his claim was statute-barred. Justice Cumming, however, granted the motion to add Mr. Joanisse and held that the limitation issue should be dealt with on a proper record. In 2003, during the certification motion, the matter of limitation periods was mentioned but not resolved by Justice Cullity. In 2006, after the unsuccessful appeal of the order refusing certification, Ms. Taylor and Mr. Joanisse brought a motion to continue the action as a multi-plaintiff proceeding, and once again, the matter of limitation periods was mentioned but not resolved by Justice Cullity. In 2013, the co-Plaintiffs brought a motion to add five more plaintiffs, and, once again, the Defendants opposed the joinder and submitted that the new Plaintiffs' claims were statute-barred. On the joinder motion, I held that it was not plain and obvious that the Plaintiffs' claims were statute-barred, and I allowed the joinder.

[10] The Defendants now bring a summary judgment motion to resolve once and for all the issue of whether the claims of the 31 co-Plaintiffs in the multi-plaintiff proceeding are statute-barred.

[11] During the hearing of the summary judgment motion, the Plaintiffs accepted, as they have throughout the action, that there is no free-standing tort of infliction of torture, but they asserted that their claims for breach of fiduciary duty, and battery; and negligence were not statute-barred.

[12] During the course of the argument at the hearing, I advised the parties that I was of the view that there were four ways of deciding the Defendants' motion; namely: (1) grant the motion and dismiss the Plaintiffs' action; (2) adjourn the motion for additional evidence on matters for which there were genuine issues requiring a trial but which issues might be resolved by employing the forensic resources of the summary judgment rule; (3) dismiss the motion and direct that the matter of whether the Plaintiffs' actions were statute-barred be decided at trial; or (4) dismiss the Defendants' summary judgment motion but grant a notional cross-motion by the Plaintiffs for a partial summary judgment dismissing the Defendants' limitation period defence and ordering the action to proceed for a determination of the merits of the claims for breach of fiduciary duty, battery, and negligence.

[13] During the course of reviewing the facts and the law while writing these Reasons for Decision, I came to the conclusion that there was a fifth way of deciding the Defendants' summary judgment motion. The fifth way was to grant a notional cross-motion by the Plaintiffs for a partial summary judgment of their claim for breach of fiduciary duty and ordering a trial or additional summary judgment motions to prove victimization, harm, causation of harm and to quantify the individual Plaintiffs' damages, if any.

[14] For the reasons that follow, I have decided that the fifth way is the fair and just way to decide the summary judgment motion. A summary of my reasons for granting a partial summary judgment is that in 2000 when Ms. Taylor commenced the proposed class action, s. 28 of the *Class Proceedings Act, 1992* suspended the running of any not already expired limitation periods for her and the putative Class Members (now the co-Plaintiffs). The question then is what causes of action, if any, were extant in 2000. The answer to that question is that Ms. Taylor's and the putative Class Members' claims for breach of fiduciary duty were extant and not statute-barred when the action commenced. All of the Plaintiffs suffer or suffered from some form of serious mental illness and they are among the most disadvantaged, ostracized, and vulnerable members of society, and they were in a fiduciary relationship with the Defendants, and the Defendants breached their fiduciary duties to them. In 2000, there was no limitation period for a breach of fiduciary duty claim under the former *Limitations Act, infra,* and the Defendants' breach of fiduciary duty claim was separate and not subsumed within any statute-barred claims for battery or negligence. When, in 2006, the proposed class action was re-constituted as a multi-plaintiff action, the breach of fiduciary duty claim remained extant. Although the individual Plaintiffs must prove victimization, harm, causation of harm, and the monetary amount of their damages, if any, there is no *laches* nor substantive defence to the Plaintiffs' respective breach of fiduciary duty claims.

[15] There is no substantive or technical defence to the breach of fiduciary duty claim because the three programs designed by Dr. Barker and implemented by the doctors and other employees of Oak Ridge - even if designed and implemented in good faith and even if the programs could be proven to be in some way therapeutic – were torture and a degradation of human dignity. It is an inexcusable breach of fiduciary duty for a physician to torture a patient.

B. Procedural Background

[16] On October 25, 2000, Ms. Taylor, then Mr. Egglestone, commenced a proposed class action on behalf of:

> (a) All individuals who were incarcerated at Oak Ridge division of the Penetang Psychiatric Hospital in Penetanguishene, Ontario [hereinafter "Penetanguishene"] between 1968 and 1979 and who participated in the Motivation, Attitude, Participation Program ("MAPP") or, where such individuals are deceased, the personal representatives of the estates of the deceased individuals;
>
> (b) All individuals who were incarcerated at Penetanguishene between 1968 and 1979 and who participated in the Total Encounter Capsule Program (the "Capsule") or, where such individuals are deceased, the personal representatives of the estates of the deceased individuals; and,
>
> (c) All individuals who were incarcerated at Penetanguishene between 1968 and 1979 and who participated in Defence Disruptive Therapy ("DDT") or, where such individuals are deceased, the personal representatives of the estates of the deceased individuals.

[17] In 2001, Justice Cumming added Mr. Joanisse as a co-Plaintiff. See *Egglestone v. Barker*, [2001] O.J. No. 1617 (S.C.J.).

[18] In 2003, Ms. Taylor and Mr. Joanisse moved for certification of their action as a class action. Justice Cullity dismissed the motion. In declining to certify the proceedings, Justice Cullity found that although there were causes of actions and although there were common issues of law and fact, the Plaintiffs had not demonstrated that a resolution of those issues would advance the proceedings. See *Egglestone v. Barker*, [2003] O.J. No. 3137 (S.C.J.), aff'd [2004] O.J. No. 5433 (Div. Ct.), leave to appeal to the Court of Appeal denied on May 18, 2005.

[19] In 2006, pursuant to s. 7 of the *Class Proceedings Act, 1992*, Ms. Taylor and Mr. Joanisse moved for an order permitting the action to continue as an ordinary action with an amended Statement of Claim that would join individuals from the putative Class Members as co-Plaintiffs. Justice Cullity granted the motion. See *Joanisse v. Barker*, [2006] O.J. No. 5902 (S.C.J.).

[20] On October 12, 2006, an amended Statement of Claim was delivered.

[21] On January 7, 2015, the Plaintiffs issued their Second Fresh as Amended Statement of Claim.

[22] In the reconstituted multi-plaintiff action, the Plaintiffs allege that the medical treatment they received, which was known as social therapy, was unethical and illegal. The Plaintiffs state that they were the subjects of experimentation and torture. In advancing their claim, among other international treaties, the Plaintiffs rely on the *United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, December 10, 1984, [1987] Can. T.S. No. 36 (entered into force 26 June 1987), which is part of Canada's international human rights obligations.

[23] In 2013, the Plaintiffs brought a motion to remove nine Plaintiffs and to add five additional Plaintiffs to the action. The Defendants objected to the joinder on the grounds that the claims were statute-barred. I concluded that at that juncture of the proceedings, it could not be determined whether the claims were statute-barred.

[24] More particularly, I concluded that pursuant to the transition provisions of the *Limitations Act, 2002*, S.O. 2002, c. 24, Sched. B, the former limitation periods found in the *Medical Act, infra,* the *Health Disciplines Act, infra,* the *Mental Hospitals Act, infra,* or the *Mental Health Act, infra,* might arguably apply to the claims of the five Plaintiffs; however, it was not plain and obvious that these limitation periods did apply; therefore, the five Plaintiffs should be joined without prejudice to the Defendants' right to plead that the claims are statute-barred. Accordingly, I granted the Plaintiffs' motion to amend their Statement of Claim to add the additional Plaintiffs. See *Barker v. Barker,* 2013 ONSC 7381.

[25] The action proceeded to examinations for discovery, and in 2016, at a case management conference after most of the Plaintiffs were examined and arrangements were being made for examinations of Drs. Barker and Maier, the Defendants asked for a date for a summary judgment motion on the issue of whether the Plaintiffs' claims were statute-barred.

[26] I granted the request for a summary judgment motion, and I scheduled the motion now before the court. I did so on terms. I froze the record for the motion and limited the evidentiary record to the facts in the Statement of Claim that were to be taken to be proven for the purposes of determining whether the co-Plaintiffs' claims were statute-barred.

[27] For the eventuality that the motion would not be successful, I ordered the Plaintiffs to set the action down for trial, which they have done, without prejudice to their right to bring a motion for a summary trial being a hybrid of transcript and *viva voce* evidence.

[28] In their factums for the summary judgment motion, the Defendants submitted that the Plaintiffs' claims were all statute-barred under several special and general limitation period statutes.

[29] In their responding factum for the summary judgment motion, the Plaintiffs made four alternative arguments. First, they submitted that their claims were not barred by any limitation period pursuant to the retroactive application of s. 16 (1)(h.2) of the *Limitations Act, 2002.* Second, they denied that their claims were statute-barred under the several special and general limitation period statutes. Third, they submitted that if any statutory limitation period applied, the limitation period has not yet begun to run due to the Plaintiffs' mental incapacity. Fourth, they submitted that if any statutory limitation period applied, the claims were not statute-barred due to the doctrines of discoverability and, or continuance of injury or damage.

[30] I foreshadow to say that I shall decide this motion based on the Plaintiffs' second argument. It is, therefore, unnecessary for me to comment on the merits of their other three arguments, which confront numerous difficulties, beginning with the serious problem that the Plaintiffs never delivered a Reply to the Defendants' Statement of Defence. It is a trite and fundamental principle that a party cannot have a judgment for a claim or defence that is not pleaded. A court cannot determine an issue not identified by the parties in the pleadings, and a judgment cannot be based on a claim or a defence not pleaded: *Rodaro v. Royal Bank of Canada* (2002), 59 O.R. (3d) 74 (C.A.); *Garfin v. Mirkopoulos*, [2009] O.J. No. 2038 (C.A.); *Mercer v. Gray*, [1941] O.R. 127 (C.A.).

C. Factual Background

1. Introduction

[31] The following factual background is taken from the material facts contained in the Defendants' Statements of Defence and from the Plaintiffs' Second Fresh as Amended Statement of Claim, which, as noted above, are to be taken as proven for the purposes of the summary judgment motion to determine the application, if any, of various special and general limitation periods. In making findings of fact, however, I do not include matters of argument and pleaded legal conclusions.

[32] In describing the factual background, I begin by noting that throughout the 17 years of this action, the Defendants have never disputed the allegations of what occurred and the nature of what the Plaintiffs experienced at Oak Ridge. What has been disputed is whether the programs developed for the Social Therapy Unit at Oak Ridge were beneficial mental health care and reputable scientific experiments in psychology based on credible and ethical scientific research or whether the programs were torture and unethical experimentation on humans.

2. Oak Ridge and the Defendants

[33] Oak Ridge, which opened in 1933, was an institution designated under the *Mental Hospitals Act, infra.* It was a physically separate unit of the Ontario Hospital, Penetanguishene. It was a Schedule 1 psychiatric facility designated under the *Mental Health Act, infra.* Oak Ridge was administered by the Ministry of Health, a Ministry of the Crown. Between 1966 and 1983, Oak Ridge was the only facility in Ontario for the custody and treatment of dangerous or unmanageable mentally ill patients. Typically, the patients of Oak Ridge had extensive criminal records that included violent crimes including abduction, pedophilia, rape, assault and murder. The patients suffered from a variety of psychiatric illnesses including personality disorders, schizophrenia, sexual deviation, and organic brain disorders.

[34] Dr. Barry Boyd, now deceased, was the Superintendent or Officer in Charge of Oak Ridge from 1960-1974, and its Medical Director from 1974 to 1978. He established the Social Therapy Unit at Oak Ridge. Dr. Boyd hired the Defendants, Drs. Barker and Maier, who were employees of the Crown.

[35] Oak Ridge included the Social Therapy Unit or STU (wards E, F, G, and H). The Defendants plead that the Social Therapy Unit was a therapeutic community based on principles that were recognized and accepted in psychiatry and related disciplines at the time. They plead that the intensive therapy programs in the Social Therapy Unit were predicated on the concepts that patients needed to undergo self-discovery and to take responsibility for their own behaviour. The programs involved a shift away from a custodial model where patients were never expected to be released into society and were treated with sedatives, tranquilizers, electroshock, and psychosurgery.

[36] Dr. Barker was licensed to practice medicine by the College of Physicians and Surgeons, and he had a specialty in psychiatry. From 1966 and 1972, he was Assistant Superintendent and Clinical Director of the Social Therapy Unit. Between 1972 and 1978, he worked part-time at Oak Ridge conducting court-ordered assessments. Between 1978 and 1979, he resumed administering the Social Therapy Unit.

[37] Dr. Barker developed intensive therapy programs to treat patients at Oak Ridge. He believed that intensive therapy was an alternative to what otherwise would be lengthy incarceration. Dr. Barker published papers on the topic of human experimentation with mind-altering drugs and with intense group therapy methods where patients would be involved in treating each other. He authored the following papers, among others: (a) *The Insane Criminal as Therapist* (with M.H. Mason) (1968), 10 *The Canadian Journal of Corrections* 4; (b) *Buber Behind Bars* (with M.H. Mason) (1968), 13 *Canadian Psychiatric Assoc. Journal* 61; (c) *Defence Disruptive Therapy* (with M.H. Mason and J. Wilson) (1969), 14 *Canadian Psychiatric Assoc. Journal* 355; (d) *LSD in a Coercive Milieu Therapy Program* (with M.F. Buck) (1977), 22 *Canadian Psychiatric Assoc. Journal* 311; and, (e) *The Total Encounter Capsule* (with Alan J. McLauchlin) (1977), 22 *Canadian Psychiatric Assoc. Journal* 355.

[38] Dr. Maier was licensed to practice medicine by the College of Physicians and Surgeons, and he had a specialty in psychiatry. He completed his residency at Oak Ridge between 1972 and 1973, and on about July 1, 1973, was appointed Clinical Director of the Social Therapy Unit. He served in this position until about June 30, 1978, with an interruption for one year during 1976-1977.

[39] Following the departure of Drs. Barker and Maier, Dr. Julia Reilly, another psychiatrist, was the Director of the Social Therapy Unit, and she continued until 1983. Dr. Reilly was a duly licensed psychiatrist employed by the Crown as Unit Director from September 1980 to 1986.

[40] Dr. Tate was a duly licensed psychologist employed by Oak Ridge from 1976 to 1978. Drs. Boyd, Reilly, and Tate are not defendants but are the subject of allegations or mentioned in the Statement of Claim.

[41] The Crown is the employer of the physicians at Oak Ridge and is vicariously liable for them.

[42] The programs developed by Dr. Barker to treat the patients at Oak Ridge utilized among other techniques: solitary confinement, group confinement in close quarters; sensory deprivation,

physical force and constraint, discipline and punishment, the administration of hallucinogens and delirium-producing drugs, including LSD (lysergic acid diethylamide, a drug that produces hallucinations, delusions, and psychotic behaviour), and brain-washing techniques developed by the CIA (Central Intelligence Agency) in the United States.

[43] There were three main programs: (1) DDT (Defence Disruptive Therapy); (2) MAPP (Motivation, Attitude, Participation Program); and (3) the Capsule Program (Total Encounter Capsule Program). The programs were provided by Drs. Barker and Maier pursuant to the *Mental Hospitals Act, infra* and the *Mental Health Act, infra.*

[44] Under the DDT, a patient was administered combinations of hallucinogenic, delirium producing, psychosis producing, or mind-altering drugs including combinations of: alcohol, dexamyl-tofranil, Dexedrine, dextroamphetamine, imipramine, LSD-25, largactil, methedrine, nozinan, ritalin, scopolamine, and sodium amytal.

[45] The idea behind this program was that drugs would disrupt the defence mechanisms of the criminally insane so that they confront their illnesses and the underlying personality disorders. The drugs were used to remove the unconscious psychological processes (defence mechanisms) that interfered with self-discovery. In his paper, *Defence Disruptive Therapy*, Dr. Barker described the phenomena as follows:

> ... It has been found that patients experience more anxiety for periods of up to two months following the termination of treatment. They seem less well defended, more sensitive, restless and troubled, undergoing changes of behaviour in which they frequently turn to their peers for support. Needless to say, for our polished, confident but insightless psychopaths and schizophrenics, such an experience appears to spur them to examine their assumptions about themselves and the world. Our experience suggests that subsequent courses of DDT increase the degree and duration of the anxiety experience. We think also the more prolonged and complete the period of delirium, the more are these delayed effects displayed. .... It is possible that the drug-induced random experiencing of events and nullified interpersonal sanctions represent a partial desocialization process, more useful than simple retraining as a prelude to resocialization.

[46] MAPP was a form of re-education that involved regimen, study, discipline, and punishment. The patient lived under a set of rules and was required to study papers and write examinations on interpersonal communication. The patient was not permitted to leave the program unless he had completed 14 days without unauthorized talking or movement. A disruptive patient at Oak Ridge was forced to sit on a bare Terrazzo floor with his feet straight out in front of him in the attention position. His hands would be either cuffed or placed in front. He was confined to a space of approximately three square feet in which he would be allowed to move only four times during a four-hour session. Standing was not permitted, and failure to comply with the non-movement orders and other directives resulted in the individual being verbally confronted, heavily sedated with Nozinan or Largactil, put in restraints, or placed in solitary confinement for days at a time.

[47] In 1978, the Ombudsman of Ontario commissioned Drs. Butler, Rowsell, and Long to investigate the Social Therapy Unit at Oak Ridge and to evaluate the treatment programs, including the MAPP. The result of the investigation was a public report entitled *An Evaluative Study of the Social Therapy Unit, Oak Ridge Division, Penetanguishene Mental Health Centre.* The Ombudsman adopted the Report.

[48] The authors of the Report, who spent 36 hours at the Centre over a course of three days, described the MAPP program as follows:

Admission is on a basis of behaviour that demonstrates a severe relapse to the members of the Social Therapy Unit. Generally speaking, this is acting out, such as making threatening remarks or striking somebody; or acting displaying suicidal behaviour. It can be prescribed for undermining (undesirable destructive words or actions). Should a man not mix or talk or generally interact for more than what is thought to be a desirable period of time, he will go to M.A.P., where he will have to interact. There was considerable discrepancy as to whether ordinary criticism or exasperation expressed in the course of group work or ward committees, would qualify one for this treatment. Overall admission here is on the basis of behaviour the group does not accept. All patients know the broad categories of such behaviour or, if they do not, that the purpose of the M.A.P. program is to make sure that they will.

The M.A.P. rules speak for themselves. There is no casual talk, in fact, the man may speak only in a group to matters which are considered relevant. The groups last all day with breaks. During the group, he sits on the terrazzo floor with his feet straight out in front of him in the attention position, his fingers are intertwined and he is given a square area of about three square feet in front of him within which he may look. He must respond positively "feedback" positively, and participate in the prescribed M.A.P. way. He may use nothing but good English. He may move only four times during a session of about four hours, and then only after being given permission to do so by the "teacher". In the group in which we sat, a staff member was present. One patient flinched every now and then and we noticed his hands were slightly swollen. During a break, in response to our questions, he told us his cuffs were too tight. He was not allowed to move or to loosen them. As required, his tone was positive as if he appreciated his plight. The cuffs were of the standard automobile safety belt material with buckles. The patients wore the "baby doll." This is a long untearable strip of quilted material going from front to back with a hole for the man's head, similar in design to a poncho, but open at each side and fastened by ties on the edges.

Later in the day we spoke to several people, some of whom had been on the list of those who had contacted the Ombudsman's office. It seemed to them that M.A.P. was beneficial and more humane than it had been in the past. There were tales of brutality by various people, but never independently corroborated. The possibilities of abuse are considerable. There were dark stories of people being choked, being given injections of tranquillizers and then lifted from the ground and bounced on the floor when they became dozy, being made to stand cuffed, and then having their feet kicked out from under them. The most seemingly offended person, however, still had good things to say about this program in what seemed to be a spontaneous way to us. It was said to be vital to the function of the Unit, not only by the staff but several patients that we spoke to. Safeguards against abuse are dealt with below.

In order to leave M.A.P. a patient has to have fourteen consecutive perfect days. A perfect day involves: no slips of the tongue, no unauthorized moving, no keeping others waiting, no lack of participation, a satisfactory demonstration of motivation, attitude and participation. This means perfect posture, deportment and language. Behaviour, feeling and thinking are all studied by the group and are continually under discussion and observation. Should the person not participate he is put in a room by himself, after generous discussion of his defects, and left there until he wishes to participate. He cannot, of course, hope to leave until he does resume an active part in the group, yet he is still fed and bedded. The visitor is left with the impression that he would be there forever. The threat this place holds is of mental torment it seems, not physical torture. There is at least two weeks of provocation, confrontation and having to face one's weaknesses or severe personal anxieties. The patient feels a steady and imminent threat of being broken mentally, yet he must maintain acceptable standards of posture, deportment and language, as mentioned earlier.

The M.A.P. program is a remorseless re-educative experience which carries a heavy psychological burden. Referral to it is so flexible as to be capable of abuse and release from it is difficult. Any patient at any stage in his career at Oak Ridge can be sent to it. On the positive side, it provides a very valuable learning experience in self-control and in group support. All members are continually helping each other to find other ways of behaving or living with their uncomfortable feelings more successfully. It is worth repeating that the psychopathic personality and the borderline personality get into trouble through lack of self-control or delaying immediate gratification of feelings, as well as their inability to share deep feelings with others and allow

> others to reach them. In this setting, not only can this take place, but it must. Many ex-patients have said that M.A.P. was entirely responsible for their success.
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> This program evolved over the course of time in the development of the Social Therapy Unit. It was the product of patient committees and is repeatedly given credit by patients. That it could be abused is very easy to see.
>
> ....
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> The M.A.P. program is clearly a rigorous one, which has been highly beneficial. It must be monitored and reviewed constantly. The mental rigors are not greater than those voluntarily undertaken in the community by certain drug addicts or psychiatric patients. Psychoanalysis, individual psychotherapy, tranquillizers, brain operations, and shock treatments for such patients as these does no good but perhaps demonstrable harm. As noted, a great many patients have stated that this program has been crucial to their recovery.

[49] In the Capsule Program, the patient was placed in a specially constructed, soundproof, windowless, but continuously lighted room, eight feet by ten feet in size, furnished only with a soft rug over a foam floor. There were washing and toilet facilities, which consisted of an open toilet and wash basin, but no towels were provided. Beds were not provided, and the patients slept on the floor. A group of up to seven patients were confined in the room to remain for many days at a time. The patients were totally removed from contact with the outside world. They were stripped nude and often chained to one another. They were fed through liquid food dispensers – four straws through the wall – and received no solid foods. They were drugged with Dexamyl, Tofranil, LSD, and other hallucinogens. The room was continuously lit, and the patients were temporally disoriented and sleep deprived. The room was under constant observation, either through a one-way mirror in the ceiling or by closed circuit television with a high-quality audio amplifying system.

[50] In his paper, *The Total Encounter Capsule, supra*, Dr. Barker described the room in which the patients were confined as follows:

> After eight months' experience with the operation of the Sunroom program, the Total Encounter Capsule was designed. It was to function as a place of undisturbed security where a small group of voluntary patients could focus upon issues they felt important enough to warrant the exclusion of the usual physical and psychological distractions, and the possible risks of suicide or homicide that might attend extremely intense personal encounters.
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> The Capsule is a specially constructed, soundproof, windowless, but continuously lighted and ventilated room, eight feet by ten feet, with a soft rug-over-foam floor, which provides the basic essentials - liquid food dispensers, washing and toilet facilities - and in which it is possible for a group of up to seven patients to live for many days at a time, totally removed from contact with the outside. The Capsule group is under constant observation, either through a one-way mirror in the ceiling and/or by closed circuit television, and a high-quality audio amplifying system.
>
> Patient observers, trained specifically for this full-time job, work eight hour shifts, and have a wide variety of duties. They must keep a continuous supply of liquid foods - soups, milkshakes, tea, coffee, cocoa – available to the group, regulate the temperature of the Capsule to comfortable levels at all times, record on video tape any interaction that is deemed significant enough to replay for the participants or staff, keep a continuous written record of events as they unfold, and intervene if it appears that physical acting out is imminent.
>
> It was decided, as the ground rules for the first groups were being drawn up, that the patients would participate in the Capsule without clothes. This move was prompted by the experience of Paul Bindrim, a psychologist working in California, who felt that uncovering of the private parts of one's body might facilitate the uncovering of the private parts of one's mind, and partly because the fear that clothing might be used in a dangerous manner.

[51] Dr. Barker believed that the use of force is legitimate in treating patients for illnesses that they did not recognize in settings in which they will be incarcerated until they change. In his paper, *Buber Behind Bars*, under the heading "Coercion and the goad to freedom," Dr. Barker had the following to say about the use of force in the programs at Oak Ridge:

> To make the statement that patients should not be allowed any unhelpful experience is of course to stumble into the thorny question of coercion and non-acceptance. Those who feel with Carl Rogers, that even to evaluate is to corrupt the helping relationship, might object to suggestions that to use force - is to make such a relationship possible; that to repeatedly and without compromise thrust a person's illness before his eyes - is to sustain such a relationship; that to insist upon a person's examining his own behaviour - is to make him free. Approaches of that sort seem to run counter to many of psychiatry's most cherished notions.
>
> To what extent is force legitimate in treating patients who are incarcerated because of illnesses that they do not recognize, or for which they wish to receive no treatment? We think that when one is confronted with such persons, one must first decide if such imprisonment is warranted and if it is not, the task is to 'treat' society rather than the patient. But in situations where patients are quite properly being held against their will until they change, it seems humane and helpful to use force, at least to the point of increasing their range of choice, of increasing their awareness of themselves, and others, to the point where, as far as can be determined, what they do, they self-consciously choose to do. The validity of force depends on this assumption. If the process were one of eradicating a set of disapproved ideas and washing in different social values, then we would be committing offences as grievous as those involved in setting up the Third Reich – indeed the more sinister, because of their subtlety. On the other hand, if our patients did not choose to deviate from society's norms, but rather were driven to such deviations by internal unresolved conflicts, then we should help them to resolve such conflicts by every means of our disposal, including force, humiliation, and deprivation, if necessary. Physical force brought the patient to our hospital, physical force maintains him there, and this force will not be lifted until he changes his behaviour in a recognizable way.
>
> In our opinion, there is no question that the treatment necessary to produce some remission of the illnesses suffered by most Oak Ridge patients would be impossible on a voluntary basis.
>
> True, it seems evident that in the traditional autocratic hospital, the use of force is antitherapeutic in most cases. However, it may be that the effect of force depends upon the motivation for its use, the way in which the motivation is conveyed from the agent to the patient, and the way in which it is perceived by the patient. If communication is maximized, coercion may be therapeutic, particularly when it is exerted by peers rather than authority figures. Our feeling was that force could most usefully be employed in treatment, particularly the treatment of the asocial and antisocial personality disorders; and that as communication approaches a maximum, the permissible use of force approaches a maximum.

[52] The authors of the report for the Ombudsman reported that they were satisfied that the treatment programs of the Social Therapy Unit were understood by the patients and applied humanely and that the patients and society generally benefitted greatly from the work of the Social Therapy Unit. The authors described the MAPP as a stressful but therapeutic treatment program under which "the hardened shell of the psychopath may give way to a unique and maturing sharing of kindness and concern." The main finding of the authors was that Oak Ridge was an exciting program and "here, the impossible is apparently happening – psychopaths are being treated with success." The authors criticized the "perversity that this Hospital, which should be the flag carrier for the Ministry of Health, has recently had its funds cut to below the acceptable level ...."

[53] The authors of the Ombudsman's Report saw a remorseless re-educative experience of discipline as a way to make psychopaths kind and caring. They drew a distinction between mental torment and physical torture. They apparently agreed with the views of Dr. Barker that

force, humiliation, deprivation, and offences more sinister and grievous than those involved in setting up the Third Reich would help the patients to resolve the internal conflicts that had driven them to deviate from society's norms.

[54] Notwithstanding these views, I find as a fact that applied humanely or not, to experimentally administer drugs to patients in the manner of the DDT program or to punish them in the manner of the MAPP program or to strip them, drug them, chain them nude one to another, feed them only liquids through a straw through a wall, deprive them of sleep and confine them for extended periods of time in a crowded continually lit room with no privacy and with a humiliating location for their personal hygiene and health for the purpose of changing their personality and behaviour in the manner of the Capsule program is to grossly violate their human dignity and human rights and to torture them both mentally and physically.

[55] And, I find as a fact that for a physician to implement the DDT program, the MAPP program, and the Capsule program is to breach a fiduciary duty and to obliterate the 2,500-year-old Hippocratic Oath, which is an ethical obligation: to abstain from abusing the bodies of man or woman, bond or free; to never administer or suggest the administration of a poison; to keep pure and holy the art of healing; and to use treatment to help the sick but never with a view to injury and wrong-doing.

3. The Plaintiffs' Experiences at Oak Ridge

[56] Reginald Barker (born 1946), who has an extensive psychiatric history and criminal record, was transferred to Oak Ridge pursuant to a Lieutenant Governor's warrant having being found not guilty by reason of insanity on a charge of murder. He spent 10 years at Oak Ridge between 1968 and 1978. He was prescribed the DDT program.

[57] After being found not criminally responsible by reason of insanity on a charge of murder, Jean-Paul Belec (born 1950), who has an extensive criminal record, spent 7 years at Oak Ridge between 1972 and 1979. He experienced the Capsule program on three occasions and was given LSD and scopolamine. He experienced the MAPP on several occasions and was prescribed the DDT program.

[58] Eric Bethune (formerly Jean-Jacque Berthiaume) (born 1948), who has an extensive psychiatric history and criminal record, was admitted to Oak Ridge in 1965 (age 17) for a psychiatric assessment and was discharged in September 1969 after being found fit to stand trial. While at Oak Ridge, he experienced the Capsule program and the DDT program.

[59] Joseph Bonner (born 1954), who has an extensive psychiatric history and criminal record, was admitted to Oak Ridge in 1971 (age 17) and was detained for 10 months, 7 months of which were in solitary confinement. He was also in the Capsule program and was prescribed the DDT program.

[60] William Brennan (born 1954), who has an extensive psychiatric history and criminal record, was admitted to Oak Ridge in September 1973 and was detained there for one month and again for three years from May 1974 to May 1977. He experienced MAPP on several occasions. He was in the Capsule program on at least two occasions and administered drugs under the DDT program.

[61] Stephen Carson (born 1958), who has an extensive psychiatric history, was admitted to Oak Ridge in January 1978 on a Warrant of Remand having being charged, among other things,

with assault. He was detained for one year, eight months of which he experienced the MAPP.

[62] Roy Dale (born 1952), who has an extensive psychiatric history and criminal record, was admitted to Oak Ridge in 1972 for 30 days and then for five years from 1974 to 1979. He experienced the MAPP and in 1974 he was in the Capsule program for 14 days. He was prescribed the DDT program on numerous occasions.

[63] Maurice Desrochers (born 1962) was at Oak Ridge from September 1980 to January 1985. He was admitted on a Lieutenant Governor's warrant following the murder of his mother and the attempted murder of his father. He experienced the MAPP in 1981 and 1982.

[64] Donald Everingham (born 1946), who has an extensive psychiatric history and criminal record, was admitted to Oak Ridge on a Warrant of Remand after being charged, among other things, with abduction, forcible confinement, rape, and attempted murder. He was detained in Oak Ridge in 1975, where he remains to this day. He was a subject of the MAPP, the Capsule program, in 1976 and 1977, and the DDT program.

[65] John Finlayson (born 1936), who has an extensive criminal record of violent crime, was admitted to Oak Ridge after being found not guilty by reason of insanity on a charge of murder of a young boy. He was detained at Oak Ridge from March 1974 until 1979. He experienced the Capsule program and the DDT program.

[66] Robert Frost (born 1956, now deceased), who has an extensive criminal record, was admitted to Oak Ridge in 1972 (age 16), where he spent six months until transferred to a penitentiary. During his time at Oak Ridge, he experienced the MAPP. He alleges that he was strangled with a towel by staff and injected with Nozinan. While at Oak Ridge, he was prescribed the DDT program.

[67] Terry Ghetti (born 1945), who has an extensive criminal record, was admitted to Oak Ridge in 1973, where he remains to this day. He was admitted after being found not guilty of murder and manslaughter by reason of insanity. He experienced MAPP in 1976 and 1977. He was in the Capsule program in 1973, 1974, and 1976. He was prescribed the DDT program on three occasions, each lasting seven weeks.

[68] Robert Haberle (born 1953), who has an extensive psychiatric history, was admitted to Oak Ridge in 1973 after threatening, with a knife, doctors at the Clarke Institute of Psychiatry. He and was detained for two years. During his detention, he was placed in the Capsule program for approximately five months.

[69] Bruce Hamill (born 1956), was first admitted to Oak Ridge in 1977 on a Warrant of Remand after having been charged with first degree murder. In 1978, he was readmitted having being found not criminally responsible for murder by reason of insanity. He was in Oak Ridge until December 1980 and then again in March 1993 to date. He experienced MAPP on several occasions and was placed in the DDT program during his first confinement at Oak Ridge.

[70] Eldon Hardy (born 1945), who has an extensive psychiatric history and criminal record, was at Oak Ridge from 1972 to 1979 after being found not criminally responsible by reason of insanity. He experienced the MAPP, the DDT program, and the Capsule program.

[71] William Hawboldt (born 1942), who has an extensive psychiatric history and criminal record, was at Oak Ridge from January 1975 to February 1975, September 1975 to November 1980, summer 1982 to January 1989. He experienced MAPP for 45 days in 1976 and again in

1998. He was in the DDT program in 1975, 1976, and 1977.

[72] Mr. Joanisse (born 1956) was admitted to Oak Ridge as an involuntary patient the day before his 15th birthday. In September 1973, he was found not guilty of murder by reason of insanity. He was detained at Oak Ridge periodically; that is: May 27, 1971 to March 1 1972; March 26, 1972 to January 30, 1979; May 9, 1979 to December 3, 1980; April 9, 1981 to January 28, 1982; September 6, 1983 to March 6, 1997; June 16, 1999 to October 2005. He was placed in the MAPP on seven occasions each lasting from one to four weeks in duration. He was under the DDT program from time to time. He was in the Capsule program on two occasions in October 1971.

[73] Russ Johnson (born 1947) was admitted to Oak Ridge in August 1977 and remains there to this day. He was originally admitted on a Warrant of Remand and was subsequently found not guilty of murder and attempted murder by reason of insanity. He was in the MAPP on several occasions in 1978 and 1979. He was also in the DDT program from 1978 to 1980.

[74] Stanley Kierstead (born 1952) was admitted to Oak Ridge in 1967 (age 15) on a transfer from a training school where he had been admitted because of a history of arson, cruelty to animals and threatening children. He was detained at Oak Ridge for three years until he was discharged to another psychiatric hospital. While at Oak Ridge, he was placed in the Capsule program and experienced the MAPP and the DDT program on several occasions.

[75] Denis LePage (born 1946), who has an extensive criminal record, was at Oak Ridge in 1966 (1 month), 1977 (2 months), 1978 (1 month), between July 1983 and February 1992, and from May 1995 to date. At various times, he was in the penitentiary and at various times he was at Oak Ridge having been found not guilty of charges by reason of insanity. He was placed in the MAPP in 1978 (1.5 months), 1978 (1 month) and 1980 (6.5 months). He was placed in the DDT program from time to time.

[76] Christian Magee (born 1948), who has an extensive psychiatric history and criminal record, was at Oak Ridge in 1976 (2 months), 1977 (3.5 months) and from December 1977 to date. He was found not guilty of rape and murder by reason of insanity and was transferred to Oak Ridge on a Lieutenant Governor's Warrant. He was in the MAPP on three occasions. He was in the DDT program from time to time.

[77] Douglas McCaul (born 1953), who has an extensive criminal record of very violent crimes, was at Oak Ridge between December 1976 to January 1981 and between May 1988 to date. He was found not guilty by reason of insanity for kicking a woman to death. He was in the MAPP in 1978 and placed in the Capsule program for eight days in 1978. He was in the DDT program in 1977 and 1988.

[78] William A. McDougall (born 1950), who has an extensive psychiatric history and criminal record, was at Oak Ridge between September 1978 to December 1981 and was in the MAPP on two occasions. [It is not clear whether the claim against Mr. McDougall is still extant because the Defendants plead that the claim was dismissed for delay in 2014.]

[79] Brian Floyd McInnes (born 1958) was at Oak Ridge on three occasions between 1976 and 1978 and experienced the MAPP, the Capsule program, and the DDT program.

[80] Allen McMann (born 1959) was admitted to Oak Ridge in September 1975 (age 16) and remained there until January 1978. He was placed in the MAPP on several occasions for periods over two months. He was placed in the Capsule program on two occasions for 10-14 day

sessions. He was placed in the DDT program from time to time.

[81] Leeford Miller (born 1954), who has an extensive criminal record, was admitted to Oak Ridge in 1977 and was confined there from 1977 to 1983, 1984 to 1985, 1992, and 1996 to date. He was found guilty of murder by reason of insanity. He was in the MAPP program on two occasions each lasting for more than a month. He was in the DDT program from 1978 to June 1981.

[82] James Motherall (born 1950), who has a criminal record for violent crime, was detained at Oak Ridge from May 1973 to June 1976. He was in the Capsule program on three occasions and in the DDT program from time to time.

[83] Michael Roger Pinet (born 1953), who has an extensive psychiatric history and criminal record, was first admitted to Oak Ridge in 1971 (age 17) and detained between March 1971 to February 1972, May 1977 to January 30, 1984, October 1985 to August 1995, and August 2000 to date. He was in the MAPP on three occasions: April 1978 (3 weeks); December 1978 to January 1979 (5 weeks), and July 1980 (3 weeks). He was placed in the Capsule program six times between 1971 and 1977. He was placed in the DDT program from time to time..

[84] Edwin Sevels (born 1943) was at Oak Ridge in 1978 and remains there. He experienced the MAPP.

[85] Samuel Frederick Charles Shepherd (born 1951), who had an extensive psychiatric history and criminal record, was first admitted to Oak Ridge in 1972 for sixty days and readmitted in March 1973 until July 1973. He was placed in the Capsule program for 11 days and was in the DDT program for three weeks.

[86] Ms. Taylor (born 1956) was admitted to Oak Ridge in January 1976 and remained there until February 1979 to return again in January 1981 where she was detained until 1986. She returned to Oak Ridge in 1995. She was placed in the MAPP from: May 18, 1976 to June 26 1976; May 15, 1978 to June 5, 1978, and January 19, 1978 to February 24, 1978. She was originally admitted to Oak Ridge on a Warrant of Remand after being found not guilty of insanity for rape. She was in the Capsule program in December 1976 for two weeks and in June 1977 for 11 days.

4. The Pleaded Causes of Action

[87] The Plaintiffs plead that the infliction of physical force on them during the three programs without their *bona fide*, free, willing and informed consent constituted the tort of battery.

[88] The Plaintiffs plead that consent to administer the three programs was rarely solicited and that when it was solicited, any consents were invalid having been obtained under duress, coercion, or intimidation. Further, the Plaintiffs plead that any consents were obtained without the patients being advised of the risks associated with the programs and that there was no scientifically proven value to the programs.

[89] The Plaintiffs plead that Drs. Barker and Maier were negligent and breached a duty of disclosure in failing to provide truthful information about the experimental nature of the programs and that the Crown breached its duty of care to review and supervise its agents at Oak Ridge.

[90] The Plaintiffs plead that Drs. Barker and Maier had a fiduciary relationship with the patients at Oak Ridge and breached their fiduciary obligations in that they, among other things: (a) conducted unethical human experimentation within the confines of a maximum-security facility; (b) subjected the Plaintiffs to mind-altering experimentation, inhumane treatment and psychological and physical abuse and torture; (c) treated the Plaintiffs with force and humiliation; and (d) conscripted the Plaintiffs without obtaining their *bona fide* consent or alternatively obtained ineffective consents under coercive circumstances.

[91] The Plaintiffs plead that the Crown, through its agents, owed and breached a fiduciary duty to the Plaintiffs. The fiduciary duty was based on the vulnerability of the Plaintiffs arising from the power imbalance inherent in the maximum-security environment.

[92] The Plaintiffs plead that the acts of the Defendants violated fundamental standards with respect to biomedical research involving human beings contrary to accepted common law principles and international law norms and constituted torture and cruel, inhumane, degrading treatment, or punishment in violation of the common law and international law. The Plaintiffs plead that the Defendants violated the prohibition against torture.

[93] The Plaintiffs plead reliance on: (a) *The Nuremberg Code;* (b) *The Universal Declaration of Human Rights,* G.A. res. 217 (III), December 10, 1948, U.N.Doc. A/810 (1948); (c) *The International Covenant on Civil and Political Rights* (1976), 999 UNTS 171, [1976] CTS 47; (d) *Convention against Torture and Other Cruel, Inhuman Punishment*, Dec. 10, 1984, G.A. rs. 39/46, UN GAOR, 39th Sess., Supp. No. 51, art I; and (e) *World Medical Association of Helsinki Ethical Principles for Medical Research Involving Human Subjects,* adopted by the 18th WMA General Assembly in June 1964 and amended at the 52nd WMA General Assembly in October 2000.

D. Statutory Provisions

[94] The Plaintiffs' claims are based on events that occurred between 1966 and 1983. Under the transition provisions of the *Limitations Act, 2002*, s. 24 (3), which is the current statute of limitations, no proceeding shall be commenced in respect of statute-barred claims, and the Defendants submit that all of the Plaintiffs' claims expired during the 1960s, 1970s, and 1980s under the limitation periods of the formerly applicable statutes, of which there are six; namely:

- (1) the *Health Disciplines Act, 1974*, S.O. 1974, c. 47, s. 17; R.S.O. 1980, c. 196, s. 17
- (2) the *Limitations Act*, R.S.O. 1960, c. 214, s. 47; R.S.O. 1970, c. 246, s. 47; R.S.O. 1980, c. 240, s. 45
- (3) the *Medical Act*, R.S.O. 1960, c. 234, ss. 43, 48
- (4) the *Mental Health Act, 1967,* S.O. 1967, c. 51, s. 58; R.S.O. 1970, c. 269, s. 58; R.S.O.1980, c. 262, s. 62
- (5) the *Mental Hospitals Act*, R.S.O. 1960, c. 236, s. 10; R.S.O. 1970, c. 270, s. 10; R.S.O. 1980, c. 263, s. 10
- (6) the *Public Authorities Protection Act,* R.S.O. 1960, c. 318, s. 11; R.S.O. 1970, c. 374, s. 11; R.S.O. 1980, c. 406, s. 11.

[95] The Defendants also rely on the doctrine of *laches*.

[96] The Plaintiffs deny that their claims are statute-barred and with respect to their battery claim, they also rely on the recent and retroactive amendments to the *Limitations Act, 2002*. The Plaintiffs, in resisting the defence that their claims are statute-barred submit that the limitation period did not run during their mental incapacity. The Plaintiffs also rely on the doctrines of discoverability and, or continuance of injury or damage. As I have already mentioned above, I shall only address the Plaintiffs' argument that their claims are not statute-barred under the former special and general limitation statutes that may have applied up until 2000 when Ms. Taylor commenced her proposed class action.

[97] Before providing the details of the six statutes that may be applicable to bar the Plaintiffs' claims, it must be said, and it must be kept in mind during the analysis that follows, that for over a century, the Ontario Legislature and legislatures across the country, have intended to provide doctors and other healthcare practitioners with very extensive protection for actions by their patients about claims arising from professional practice and from providing medical treatment or services.

[98] As examples of where claims against doctors have been found to be statute-barred, see: *Miller v. Ryerson* (1892), 22 O.R. 369 (Div. Ct.) (treatment causing deafness in child); *Boase v. Paul*, [1931] O.R. 625 (C.A.) (unconsented extraction of teeth); *McBain v. Laurentian Hospital* [1982] O.J. No. 2289 (H.C.J.) (foot surgery without consent); *Fishman v. Waters* (1983), 4 D.L.R. (4th) 760 (Man. C.A.) (disfigurement from cosmetic surgery); *Vincent v. Hall* (1985), 49 O.R. (2d) 701 (H.C.J.) (arm amputation without consent of burn victim); *Martin v. Perrie*, [1986] 1 S.C.R. 41 (removable of suture 10 years after surgery); *Hadley v. Allore* (1988), 63 O.R. (2d) 208 (C.A.) (unauthorized tubal ligation); *Clark v. Naqui* (1989), 63 D.L.R. (4th) 361 (N.B.C.A.) (unauthorized surgery); *Perez (Litigation Guardian of) v. Salvation Army of Canada* (1997), 37 O.R. (3d) 447 (Gen. Div.), aff'd (1998), 42 O.R. (3d) 229 (C.A.) (unattended psychiatric patient at hospital smashing window and falling to death); *Beatty v. Waters*, 2002 MBQB 100 (Master) (unauthorized type of breast implant); *Soper v. Salvation Army Scarborough Grace Hospital*, [2009] O.J. No. 427 (SCJ) (unattended psychiatric patient smashing window and injuries misdiagnosed and mistreated).

[99] The *Medical Act* was passed to provide "special protection" for physicians and to safeguard them from professional negligence or malpractice claims: *Miller v. Ryerson, supra,* at p. 372; *Hadley v. Allore, supra,* at p. 211; *Martin v. Perrie, supra,* at pp. 50-51. The language of the statutes is very broad, and the case law holds that it was meant to cover any cause of action in any way based upon the relationship of doctor and patient, regardless of the manner in which the cause of action is framed: *McBain v. Laurentian Hospital, supra,* at para. 32.

[100] In *Boase v. Paul, supra*, which involved the comparable limitation statutes protecting dentists, and where through mistake the defendant dentist extracted all of the plaintiff's diseased upper teeth and not just the one that the plaintiff wished extracted, Justice Hodgins approved the definition of malpractice from *Mozley & Whiteley's Law Dictionary,* (3rd ed.) (1908) as "improper or unskillful management of a case by a surgeon, physician, or apothecary, whereby a patient is injured; whether it be by neglect, or for curiosity and experiment." Justice Hodgins stated:

> But I think that, apart from definitions, the pith of the enactment is to give protection to professional men who are registered members of the Royal College of Dental Surgeons, after the lapse of six months, against liability for mistakes, negligence or improper treatment of a patient if the cause of action arose out of or in the course of professional services either requested or

> rendered under an implied contract, or under a mistaken interpretation of that express or implied contract."

[101] In the same case, Justice Middleton stated:

> I agree with my brother Hodgins that the statute operates to protect the defendant against this action. I think the intention of the Legislature was that any action should be brought within a limited period when it was in any way based upon the relation of dentist and patient. If there is any actionable wrong after that relationship is established, it falls under the head of "negligence or malpractice".

[102] The general limitation statute potentially applicable to the Plaintiffs' claims was the *Limitations Act*, *supra,* which was in force until it was replaced by the *Limitations Act, 2002* which provided a six-year limitation period for negligence. Section 45 of the *Limitations Act* stated:

> 45. (1) The following actions shall be commenced within and not after the times respectively hereinafter mentioned: ...
>
> (g) an action ... upon the case other than for slander, within six years after the cause of action arose;
>
> ....
>
> (j) an action for assault, battery, wounding or imprisonment, within four years after the cause of action arose;

[103] The *Public Authorities Protection Act*, *infra,* a special limitation period statute, provides a six-month limitation period for claims against public authorities. Section 11 states:

> 11. No action, prosecution or other proceeding lies or shall be instituted against any person for an act done in pursuance or execution or intended execution of any statutory or other public duty or authority, or in respect of any alleged neglect or default in the execution of any such duty or authority, unless it is commenced within six months next after the cause of action arose, or, in case of continuance of injury or damage, within six months after the ceasing thereof.

[104] The *Medical Act, supra* which was in force between 1887 and 1974, provided a one-year limitation period from the termination of professional services. Section 48 of the *Medical Act* stated:

> 48. No duly registered member of the College is liable to any action for negligence or malpractice, by reason of professional services requested or rendered unless such action is commenced within one year from the date when in the matter complained of such professional service terminated.

[105] The *Health Disciplines Act, supra,* replaced the *Medical Act* and was in force between 1974 and 1991. The *Health Disciplines Act* continued the protection for members of the College providing professional service but replaced the absolute limitation period of the *Medical Act* with a one-year limitation period from the date when the patient knew or ought to have known the facts upon which he or she alleged negligence or malpractice. Section 17 of the *Health Disciplines Act, 1974* provided:

> 17. No duly registered member of a College is liable to any action arising out of negligence or malpractice in respect of professional services requested or rendered unless such action is commenced within one year from the date when the person commencing the action knew or ought to have known the fact or facts upon which he alleges negligence or malpractice.

[106] The *Mental Health Act*, *supra*, which was in force between 1968 and 2004, provided a six-month limitation period from the date of the action complained of. Section 58 of the *Mental Health Act, 1967* stated:

> 58. All actions, prosecutions or other proceedings against any person or psychiatric facility for anything done or omitted to be done in pursuance or intended pursuance of this Act or the regulations shall be commenced within six months after the act or omission complained of occurred and not thereafter

[107] The *Mental Hospitals Act*, which was in force between 1935 and 2004, provided a six-month limitation period from the date of the action complained of. Section 10 (later s. 9) of the *Act* provided:

> 10 (1) No action, prosecution or other proceeding shall be brought or be instituted against any officer, clerk, servant or employee of the Department, or the Public Trustee, or against any other person for an act done in pursuance or execution or intended execution of any duty or authority under this Act or the regulations, or in respect of any alleged neglect or default in the execution of any such duty or authority, without the consent of the Attorney General.
>
> (2) All actions and prosecutions against any person for anything done or omitted to be done in pursuance of this Act shall be commenced within six months after the act or omission complained of has been committed, and not afterwards.
>
> ....

E. Jurisdiction to Grant Summary Judgment

[108] The Defendants seek a summary judgment dismissing the action on the basis that there is no genuine issue requiring a trial because the action is statute-barred having been commenced in the case of each plaintiff after the expiry of the applicable limitation period.

[109] Although the Plaintiffs did not bring a formal cross-motion for summary judgment, in their factum, the Plaintiffs requested that the Defendants' summary judgment motion be dismissed with a ruling dismissing their limitation period defence.

[110] The court does not require a cross-motion for summary judgment when it can decide the issue that is the subject matter of the motion for summary judgment: *King Lofts Toronto I Ltd. v. Emmons*, 2014 ONCA 215, aff'g 2013 ONSC 6113. On a summary judgment motion, a successful respondent cannot choose to have a trial; where a motion for a summary judgment leads to the conclusion there is no genuine issue for trial, the adverse party should be granted judgment: *MacDonald v. Chicago Title Insurance Company of Canada*, 2014 ONSC 7457; *Kassburg v. Sun Life Assurance Company of Canada*, 2014 ONCA 922 at paras. 50-52

[111] As foreshadowed at the outset of these Reasons for Decision, and as I shall next explain, it is my conclusion that there is no genuine issue requiring a trial that the Plaintiffs' breach of fiduciary duty claim is not statute-barred nor is it barred by the defence of *laches*. Moreover, it is my conclusion that the Plaintiffs are entitled to a partial summary judgment of their claim for breach of fiduciary duty subject to a trial or additional summary judgment motions to prove victimization, harm, causation of harm and to quantify the individual Plaintiffs' damages, if any.

F. Discussion and Analysis

[112] For the purposes of testing the limitation periods relied on for the summary judgment motion, the Defendants accept that the Plaintiffs can prove their causes of action. However, the Defendants submit that even if the Plaintiffs were to prove the allegations in the Statement of Claim, all of their claims, which involve events that occurred between three to five decades ago, are statute-barred.

[113] For the purposes of the analysis that follows, I am going to focus on the Plaintiffs' breach of fiduciary duty claim. I agree with the Plaintiffs' argument that their claim for breach of fiduciary duty is not statute-barred. I disagree with the Defendants' argument that there is no claim for breach of fiduciary duty that is not encompassed by the malpractice or other tort claims that are statute-barred.

[114] The Defendants make the categorical argument that a breach of fiduciary duty claim against a physician or a medical institution is encompassed by what is a statute-barred claim for: (1) negligence or malpractice by reason of professional services (*Medical Act* or *Health Disciplines Act*); (2) anything done or omitted to be done in pursuance of the *Mental Health Act*; (3) an act done in pursuance or execution or intended execution of any duty or authority under the *Mental Hospitals Act*; (4) assault, battery, wounding or imprisonment (*Limitations Act)*; (5) an action for negligence (action on the case, *Limitations Act*); (6) an act done in pursuance or execution or intended execution of any statutory or other public duty or authority (*Public Authorities Protection Act)*, or (7) an act in respect of any alleged neglect or default in the execution of any statutory or other public duty or authority (*Public Authorities Protection Act)*.

[115] It is only a slight oversimplification to say that the Defendants' argument is that if there is a physician-patient relationship, then any wrongdoing by the physician associated with professional services or medical treatment causing harm to the patient, including a breach of fiduciary duty is categorically a subset of the malpractice or other tort claims and, therefore, subject to the limitation periods that would be applicable to those tort claims. I foreshadow to say that as the discussion below will reveal, Justice McLachlin, as she then was, rejected a similar argument by Justice Sopinka in the important case of *Norberg v. Wynrib,* [1992] 2 SCR 226, discussed below.

[116] In my opinion, the case at bar is an example of a case where the Defendants' breach of fiduciary duty is not subsumed by the tort claims be they claims for assault, battery, wounding, negligence, malpractice by reason of a professional service, or for acts or omissions in pursuance of duties or authority under the *Mental Health Act,* the *Mental Hospitals Act*, or the *Public Authorities Protection Act*. In the immediate case, there is a genuine and discrete breach of fiduciary duty claim, which, as it happens, up until the coming in force of the *Limitations Act, 2002,* in 2004, did not have any limitation period. Thus, subject to the doctrine of *laches*, which I would not apply because of, among other things, the egregiousness of the breach of fiduciary duty, the Plaintiffs' breach of fiduciary duty claim is not statute-barred.

[117] The nature of my disagreement with the categorical nature of the Defendants' argument can be demonstrated by an analogy. A lawyer, who is categorically in a fiduciary relationship with his or client, does not breach his fiduciary duties by negligently drafting a separation agreement for the client; the malpractice would be a wrongdoing by a person in a fiduciary relationship but not a breach of fiduciary duty. Equity is not needed for the fiduciary's negligent draftsmanship and equity has no role to play. However, the lawyer would genuinely breach his fiduciary duties if he disclosed or misappropriated confidential information received by the client during the course of the retainer to draft the separation agreement. Continuing with the lawyer and client analogy, if the lawyer hired to draft the separation agreement prepared a perfectly fine agreement but during the course of the lawyer-client relationship sexually assaulted the client, then as a matter of civil liability, the client would have a discrete tort claim for a sexual assault and also a free-standing breach of fiduciary duty claim.

[118] The above analysis can be supported by an examination of the case law, to which I now

turn, beginning with a general discussion of the nature of a breach of fiduciary duty claim.

[119] The elements of a claim for breach of fiduciary duty are: (1) a fiduciary relationship; (2) a fiduciary duty; and (3) breach of the fiduciary duty: *Canadian Aero Services Ltd. v. O'Malley*, [1974] SCR 592; *Guerin v. The Queen*, [1984] 2 SCR 335; *Frame v. Smith*, [1987] 2 SCR 99; *Lac Minerals Ltd. v. International Corona Resources Ltd.*, [1989] 2 S.C.R. 574; *Canson Enterprises Ltd. v. Boughton & Co.*, [1991] 3 SCR 534; *Hodgkinson v. Simms*, [1994] 3 SCR 377; *Galambos v. Perez*, 2009 SCC 48; *Alberta v. Elder Advocates of Alberta Society*, 2011 SCC 24. The general obligations of a fiduciary are obligations of loyalty including the duties to keep the beneficiary's information confidential (a duty of confidentiality), to not keep secrets from the beneficiary (a duty of disclosure) and a duty to avoid conflicts of interest (good faith and acting in the interests of the beneficiary).

[120] Generally speaking, fiduciary relationships are of two types. First, fiduciary relationships can be categorical because the law has historically regarded particular types of relationship as fiduciary and as requiring the supervision of equity. Second, a fiduciary relationship can arise *ad hoc* because the circumstances of a particular relationship require the supervision of equity.

[121] In the case at bar, the Defendant physicians categorically had a fiduciary relationship with the Plaintiffs who were their patients at Oak Ridge because physicians, like trustees, lawyers, partners, priests, parents, guardians of children, and teachers, are categorically fiduciaries. In the case at bar, the Crown had a fiduciary relationship with the Plaintiffs either vicariously as the employer of the Defendant physicians or directly as being the operator of a mental health facility. I need not decide whether the Crown had an *ad hoc* fiduciary relationship based on the indicia for such a relationship. In any event, for the purposes of testing the Defendants' limitation period defence, it can be taken that the Defendants had a fiduciary relationship with the Plaintiffs and attendant fiduciary duties that were breached. The Defendants submit, however, that the Plaintiffs' claims for breach of fiduciary duty are subsumed or encompassed by statute-barred claims for breach of the common law and that equity has no role to play in the circumstances of the case at bar.

[122] How equity may have a role to play in determining the civil responsibilities and liabilities of a physician that are independent from the duties provided by statute and the common law is demonstrated by *McInerney v. MacDonald*, [1992] 2 S.C.R. 138. This case has several important lessons for the case at bar.

[123] The issues in *McInerney v. MacDonald* were whether Ms. MacDonald had a property interest in her personal medical records or whether the records were the property of her physicians, one of whom was Dr. McInerney, or if Ms. MacDonald did not have an ownership interest in her medical records, then did she, nevertheless, have an enforceable right to examine and obtain copies of all the documents in the physicians' medical records.

[124] In deciding the case for the Supreme Court of Canada, Justice La Forest accepted that the physicians or the medical institution compiling the records owned them, and then he called on equity to resolve the issue of whether the patient had an enforceable right to a copy of the records. Justice La Forest characterized the nature of the physician-patient relationship as fiduciary and as imposing a duty of disclosure on the physicians, and thus *McInerney v. MacDonald* is frequently cited as authority that physicians have fiduciary obligations.

[125] After Justice La Forest characterized the physician-patient relationship as fiduciary, he made several points that are particularly important to resolving the issues in the case at bar. At

paras. 20-21 of his decision, he made the important points that while there are some fiduciary duties that are part of any fiduciary relationship, the scope of a fiduciary's obligations had to be tailored to the nature of the particular fiduciary relationship. He said that fiduciary relationships and fiduciary obligations are not all the same; he stated:

> 20. In characterizing the physician-patient relationship as "fiduciary", I would not wish it to be thought that a fixed set of rules and principles apply in all circumstances or to all obligations arising out of the doctor-patient relationship. As I noted in *Canson Enterprises Ltd. v. Boughton & Co.*, [1991] 3 SCR 534, 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. That being said, certain duties do arise from the special relationship of trust and confidence between doctor and patient. Among these are the duty of the doctor to act with utmost good faith and loyalty, and to hold information received from or about a patient in confidence. ...
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> 21. The physician-patient relationship also gives rise to the physician's duty to make proper disclosure of information to the patient; see *Reibl v. Hughes*, [1980] 2 SCR 880, at p. 884; and *Kenny v. Lockwood, supra*, at p. 155. The appellant concedes that a patient has a right to be advised about the information concerning his or her health in the physician's medical record. In my view, however, the fiducial qualities of the relationship extend the physician's duty beyond this to include the obligation to grant access to the information the doctor uses in administering treatment.

[126] The point made by Justice La Forest that a relationship may properly be described as fiduciary for some purposes, but not for others, is important to the case at bar. I shall return to this point below when I discuss *Norberg v. Wynrib, supra*. In *McInerney v. MacDonald,* Justice La Forest placed the physician's fiduciary duty to disclose information to the patient in the context of the physician's other fiduciary duties that he identified, including the duty of the physician to keep the patient's information confidential and the duty of the physician to act with utmost good faith and loyalty. At paras. 28-29, Justice La Forest made several points, once again, particularly important to the case at bar, about how equitable duties are contextual and not absolute and about the nature of equity's intervention which is also flexible and contextual; he stated:

> 28. While patients should, as a general rule, have access to their medical records, this policy need not and, in my mind, should not be pursued blindly. The related duty of confidentiality is not absolute. In *Halls v. Mitchell, supra*, at p. 136, Duff J. stated that, *prima facie*, the patient has a right to require that professional secrets acquired by the practitioner shall not be divulged. This right is absolute unless there is some paramount reason that overrides it. For example, "there may be cases in which reasons connected with the safety of individuals or of the public, physical or moral, would be sufficiently cogent to supersede or qualify the obligations *prima facie* imposed by the confidential relation". Similarly, the patient's general right of access to his or her records is not absolute. The patient's interest in his or her records is an equitable interest arising from the physician's fiduciary obligation to disclose the records upon request. As part of the relationship of trust and confidence, the physician must act in the best interests of the patient. If the physician reasonably believes it is not in the patient's best interests to inspect his or her medical records, the physician may consider it necessary to deny access to the information. But the patient is not left at the mercy of this discretion. When called upon, equity will intervene to protect the patient from an improper exercise of the physician's discretion. In other words, the physician has a discretion to deny access, but it is circumscribed. It must be exercised on proper principles and not in an arbitrary fashion. Where a person, in this case a doctor, is under a fiduciary duty to inform another, equity acts *in personam* to prevent that person from acting in a manner inconsistent with the interests of the person to whom the duty is owed. As stated by Dickson J. (as he then was) in *Guerin v. The Queen*, [1984] 2 SCR 335, at p. 384:
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> > ... where by statute, agreement, or perhaps by unilateral undertaking, one party has an

> obligation to act for the benefit of another, and that obligation carries with it a discretionary power, the party thus empowered becomes a fiduciary. Equity will then supervise the relationship by holding him to the fiduciary's strict standard of conduct.
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> 29. I hasten to add that, just as a relationship may be fiduciary for some purposes and not for others, this characterization of the doctor's obligation as "fiduciary" and the patient's interest in the records as an "equitable interest" does not imply a particular remedy. Equity works in the circumstances to enforce the duty. This foundation in equity gives the court considerable discretion to re-fuse access to the records where non-disclosure is appropriate.

[127] For present purposes, the points to note and to carry forward into the analysis that follows are that when a doctor is under a fiduciary duty, equity acts *in personam* to prevent the doctor from acting in a manner inconsistent with the interests of the patient to whom the duty is owed and that equity will intervene to protect the patient from an improper exercise of the physician's discretion.

[128] Justice La Forest's decision in *McInerney v. MacDonald* featured prominently in *Norberg v. Wynrib, supra*, a civil case for damages brought by Ms. Norberg, a former drug-addicted patient, against Dr. Wynrib, her former physician, who provided her with drugs in exchange for sex. In three judgments, all of the justices (Justices La Forest, L'Heureux-Dubé, Sopinka, Gonthier, Cory, and McLachlin; Justice Stevenson took no part in the judgments) considered the role of the claim for breach of fiduciary duty in the context of a physician-patient relationship. The *Norberg v. Wynrib* decision is another important decision for resolving the problems of the case at bar.

[129] All of the justices in *Norberg v. Wynrib* accepted that a physician is in a fiduciary relationship with his or her client, and thus, *Norberg v. Wynrib* is another authority on this point. Where the justices of the Supreme Court differed in their analysis (they agreed in the result) is whether and to what extent the law about breach of fiduciary duty was relevant to what was a claim by Ms. Norberg for the intentional tort of battery, for which consent, express or implied, is a defence.

[130] In this regard, Justice La Forest (Justices Gonthier and Cory concurring), whom it should be recalled wrote the judgment in *McInerney v. MacDonald,* was of the view that the power and dependency imbalance of the relationship between a physician and a patient was relevant to Dr. Wynrib's defence that Ms. Norberg had consented to the sexual activity. Justice La Forest, however, did not decide the case on the basis of a breach of fiduciary duty by Dr. Wynrib; rather, Justice La Forest used a two-step process to determine whether there was a legally effective consent to what would otherwise be a sexual assault or battery. The first step was proof of an inequality between the parties that would ordinarily occur within the context of a special power dependency relationship, of which the fiduciary relationship between a physician and patient was an example. The second step was the proof of exploitation by the person in the dominant position. Justice La Forest summarized his approach to the case in para. 48 where he stated:

> 48. 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.

[131] Justice Sopinka, writing for himself, did not agree with the approach taken by Justice La

Forest. Justice Sopinka reasoned that the case was more appropriately resolved on the basis of Dr. Wynrib's common law duties as a doctor treating a patient. Justice Sopinka concluded that Dr. Wynrib did have a defence to Ms. Norberg's battery claim, because he reasoned that the consent defence to battery had to be determined on a case-by-case basis and he said that a fiduciary relationship was not determinative of the presence or absence of genuine consent. Rather than deciding the case on the basis of battery or breach of fiduciary duty, Justice Sopinka concluded that Dr. Wynrib was liable for malpractice; i.e., for breach to treat the patient in accordance with standards in the profession. At para. 140 of his decision, Justice Sopinka stated:

> 140. 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 SCR 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 BCLR (2d) 361 (SC), 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.

[132] Justice McLachlin, as she then was, (Justice L'Heureux-Dubé, concurring) disagreed with the approaches of both Justice La Forest and Justice Sopinka. Justice McLachlin said to look at the events that occurred over the course of the relationship between Dr. Wynrib and Ms. Norberg from the perspective of tort or contract was to view that relationship through lenses which distort more than they bring into focus. In her opinion, only the principles applicable to fiduciary relationships and their breach captured the essential nature of Dr. Wynrib's wrongdoing. She stated at paras. 63, 65, 67-68 of her decision:

> 63. 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 fiduciary 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.
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> ....
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> 65. 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 relation-ship 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.
>
> ....
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> 67. 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.
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> 68. As La Forest J. went on to note in *McInerney, supra*, at p. 149, characterizing the doc-tor-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?

[133] Justice McLachlin went on to conclude that Dr. Wynrib had breached his fiduciary duties to Ms. Norberg. Justice McLachlin stated at para. 83 of her judgment:

> 83. 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.

[134] In an argument that is especially telling in the circumstances of the case at bar, Justice McLachlin rejected Justice Sopinka's view that the regulation of a physician's duties in physically harming a patient could be determined just by the common law that regulated a physician's duty of care to a patient. Thus, she stated at paras. 93-95:

> 93. 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.* .... 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.* 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 SCR 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*.
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> 94. 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.
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> 95. 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. 317, finds himself tacking dam-ages 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.

[135] Pausing here, it should be recalled that the case at bar, like *Norberg v. Wynrib,* involves the tort of battery and a claim for breach of fiduciary duty. Applying the lessons learned from *Norberg v. Wynrib* to the circumstances of the immediate case, it may be observed that the approaches of Justice La Forest and Justice Sopinka, while recognizing that physicians have a fiduciary relationship with their patients, would have the breach of fiduciary duty claim in the case at bar subsumed by the claims in tort. However, in my opinion, Justice McLachlin's approach, which Justice La Forest originated in *McInerney v. MacDonald* and which he returned to in *K.M. v. H.M., infra,* discussed next, is the correct approach to be applied to the circumstances of the immediate case. Applied to the circumstances of the immediate case, the approach of Justice McLachlin yields a free-standing and not statute-barred claim for breach of fiduciary duty.

[136] What happened at Oak Ridge from 1966 to 1983 was a situation in need of the special protection that equity affords. If the professional standards at the time justified patients being tortured as being humane treatment, this is precisely the circumstance where equity historically would be engaged because the common law is inadequate to respond to wrongdoing. As Justice McLachlin observed in *Norberg v. Wynrib*, equity is capable of protecting not only narrow legal and economic interests, but can also serve to defend fundamental human and personal interests. As Justice La Forest observed in *McInerney,* equity will intervene to protect the patient from an improper exercise of the physician's discretion.

[137] Outside of the context of physician-client fiduciary relations, there are cases where the courts have treated the breach of fiduciary duty claim as separate from the tort claim with different limitation provisions, although the claims both arise from the same underlying facts. One of those cases is *K.M. v. H.M.*, [1992] 3 SCR 6, which case supports the conclusion that I

have reached in the case at bar.

[138] The facts of *K.M. v. H.M.* were that between the ages of 8 and 16, K.M. was sexually assaulted by her father. She reported the incest to her mother and others but, alas, she was not believed. Years later, after attending a self-help group for incest victims, K.M., then 26 years old, sued her father for damages arising from the incest. She sued in tort and also for breach of fiduciary duty. The jury found that the she had been sexually assaulted and awarded her $50,000, but the trial judge, in a decision upheld by the Ontario Court of Appeal, dismissed her action as statute-barred. The Supreme Court of Canada reversed the judgments of the courts below. Justice La Forest (Gonthier, Cory and Iacobucci concurring) held that incest is a tortious assault and a breach of fiduciary duty.

[139] In the view of Justice La Forest, the tort claim in *K.M. v. H.M.*, although subject to a limitation period, was not statute-barred because the limitation period did not begin to run until K.M. was reasonably capable of discovering the wrongful nature of the defendant's acts and the nexus between those acts and the her injuries, which presumptively occurred only when K.M. entered therapy. The breach of fiduciary duty claim was not limited by statute in Ontario, and this breach stood with the tort claim as a basis for recovery by the appellant.

[140] Justices McLachlin and L'Heureux-Dubé agreed with Justice La Forest with the qualification that discovery of the tort claim was a question of fact and a presumption that the claim was discovered when a therapeutic relationship began was not necessary. Justice Sopinka agreed with Justice La Forest with the same qualification as Justices McLachlin and L'Heureux-Dubé and with a qualification with respect to any shifting of the burden of proof. Thus, the court in *K.M. v. H.M.* was unanimous about Justice La Forest's approach to the breach of fiduciary duty claim.

[141] In a passage that is particularly pertinent to the issues in the case at bar and that reiterates the theme that the claim in equity may add rights and remedies not available in tort, at paras. 70-71 of his decision, Justice La Forest explained why it was necessary to treat the breach of fiduciary duty claim as a free-standing claim notwithstanding that K.M. was entitled to a judgment based on the tort claim; he stated:

> 70. Consequently, it is left to this Court to consider the question of fiduciary duty. In my view, the issue must be addressed even though the tort action has survived the limitations defence. It was fully argued by the parties, and there may well be cases where the limitations statute cannot be circumvented but where the fiduciary claim is unaffected by the statute. Moreover, the equitable remedy available to the appellant may vary from the common law award established by the jury. The importance of considering any equitable cause of action has recently been stated by Justice McLachlin in *Norberg v. Wynrib*, [1992] 2 SCR 226, at pp. 290-91:
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> > 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.
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> In *Norberg*, McLachlin J. and I differed on the path to be followed in upholding recovery. She chose the route of the fiduciary claim whereas I preferred the route afforded by common law tort of battery because in the circumstances of that case there might be difficulties concerning the applicability of fiduciary obligations, an issue I did not find it necessary to decide. I could do this because I did not consider the common law molds to be ill-fitting in that case. Nor, as I will attempt to demonstrate, do I think they are ill-fitting in the present circumstances. Nonetheless, I

> agree with my colleague that a breach of fiduciary duty cannot be automatically overlooked in favour of concurrent common law claims. The point is simply stated by Cooke P. of the New Zealand Court of Appeal in *Mouat v. Boyce*, unreported March 11, 1992, at p. 11: "For breach of these duties, now that common law and equity are mingled the Court has available the full range of remedies, including damages or compensation and restitutionary remedies such as an account of profits. What is appropriate to the particular facts may be granted."
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> 71. In the present case, the lower courts have not ruled on the question of fiduciary obligation. As such, this Court must assume the role of finder of fact in equity, but in this case that burden poses no difficulty. We have a jury's verdict on the fact of sexual assault, and it is easy enough to apply that finding to the equitable claim. What remains is the legal issue of whether the assaults constitute a breach of fiduciary duty. ...

[142] If the above arguments that there is a role for a free-standing claim for breach of duty in the immediate case are correct, then subject to the matter of the defence of *laches*, in my opinion, subject to proof of victimization, harm, causation of harm and the quantification of damages, each of the Plaintiffs has a claim for breach of fiduciary duty. It is an inexcusable breach of fiduciary duty for a physician to torture a patient and torture is what occurred at Oak Ridge.

[143] As for *laches*, it is an equitable defence that denies an equitable remedy because of the plaintiff's harmful delay in seeking the equitable remedy, in this case the remedy of compensation. In *K. M. v. H. M.*, *supra* Justice La Forest described *laches* as a defence available to resist an equitable claim if the defendant can demonstrate that the plaintiff, by delaying the commencement or prosecution of his or her case, has either: (a) acquiesced in the defendant's conduct; or (b) caused the defendant to alter his or her position in reasonable reliance on the plaintiff's acceptance of the *status quo*, or otherwise permitted a situation to arise which it would be unjust to disturb. The court examines the justice or injustice of granting an equitable remedy in circumstances when it was not promptly pursued.

[144] In the case at bar, the Plaintiffs cannot be said to have acquiesced to being tortured and they did not cause the Defendants to alter their position in reliance on the Plaintiffs' acceptance of their circumstances at Oak Ridge. Particularly in circumstances where there is no substantive defence to the breach of fiduciary duty apart from disproving that a particular Plaintiff can complete his cause of action by showing injuries caused by the breach of fiduciary duty, it is not unjust to permit the Plaintiffs' claim to proceed.

[145] Further, if the above arguments that there is a free-standing claim for breach of duty in the immediate case are correct, then these arguments distinguish or negate the cases relied on by the Defendants and disprove the Defendants' categorical argument that a breach of fiduciary duty connected with the provision of medical services is encompassed by the limitation periods for the tort claims.

[146] In my opinion, the limitation period statutes designed to protect physicians from claims arising from providing treatment and professional services, which may protect experimental treatments that prove harmful, do not encompass an action based on breach of fiduciary duty where the act of professional practice or experimentation is torture. The cases that give a wide definition to the scope of malpractice actions, even the few cases that consider breach of fiduciary duty as instances of malpractice, were not dealing with what Dr. Barker proudly thought to distinguish from "offences as grievous as those involved in setting up the Third Reich."

[147] The case at bar is at some considerable difference from determining whether unconsented surgery, treatment causing deafness, the removable of a suture post-surgery, disfigurement from

cosmetic surgery, unattended psychiatric patients smashing windows and injuring themselves, or the extraction of too many rotten teeth are encompassed by malpractice and subject to a limitation period defence.

[148] For an example of how their authorities are inapplicable or distinguishable, in support of their argument in the immediate case, the Defendants rely on *B.H. v. Dattani* (2010), 315 DLR (4th) 705 (Sask. CA), but, in my opinion, the case is distinguishable. The facts were that at age 13 B.H. was impregnated by her father. She attended Dr. Dattani, her family doctor, then Dr. Sheridan, an abortion counsellor, and Dr. Smith, who performed an abortion. Six years after she reached maturity, B.H. sued the doctors, whom she alleged knew that she did not consent to the abortion, for assault and battery. She also sued the doctors for breach of fiduciary duty for their failure to report the sexual abuse by her father to the authorities. The Saskatchewan Court of Appeal upheld the decision of the motions judge that the breach of fiduciary duty claim was statute-barred under s. 72 of Saskatchewan's *Medical Profession Act, 1981,* S.S. 1980-81, c. M.-10.1, which imposed an absolute limitation period of two years "in any action arising out of the provision of professional services."

[149] In the Court of Appeal, Justice Richards held that s. 72 applied to the fiduciary obligations claim. At paras. 34-37, he explained his reasoning, and he stated:

> 34. The key reality in this appeal is that no one, including the Doctors, suggests s. 72 of *The Medical Profession Act, 1981* applies to any and every possible claim brought by a patient or former patient against his or her physician. By way of only one perhaps obvious example, the section would be clearly inapplicable to an action arising from circumstances where a physician, driving negligently, strikes a pedestrian who happens to be his or her patient. ... As a result, the challenge in resolving this aspect of the appeal concerns the identification of the line between those situations where s. 72 applies and those where it does not.
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> 35. The key to this puzzle lies in the nature of the connection between the act or omission of the physician which is said to give rise to liability and the medical services provided by the physician. Section 72 refers to claims "arising out of the provision of professional services." This suggests the act or omission complained of by the patient must be rooted in the diagnosis, treatment or other medical services performed by or on behalf of the physician. In other words, the act or omission must be bound into what the physician did or should have done *qua* physician in the course of assisting the patient.
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> 36. This sort of approach satisfactorily explains the result in cases like *Erkelens v. Ledger* [[1997] 2 WWR 597 (Man. QB) (misinformation about insurance coverage for anxiety disorder)] and *B.(D). v. Beesley* [(2000), 144 Man. R (2d) 227 (QB) (sexual assault by doctor on patient)] because in neither of these situations did the injury in question result from the provision of medical services to the plaintiff. It also works more generally to prevent s. 72 from being applied in a way which overshoots its legislative purpose. That purpose was not to cloak physicians with a special limitation period in respect of every sort of possible claim brought against them by their patients. In general terms, it was to ensure that claims amounting to complaints about how physicians act in their professional roles are brought forward expeditiously after the treatment ends.
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> 37 In the present case, B.H. says the Doctors owed a fiduciary obligation to her. She alleges that obligation existed because of her physician-patient relationship with them. She goes on to assert, in effect, that one dimension of this fiduciary relationship was a duty on the part of the Doctors to advise the authorities of the abuse. Accepting all of this for the purpose of the Rule 188 application, it is difficult to see how B.H.'s claim for failing to report the abuse does not arise "out of the provision of professional services." The basic thesis of her claim is that, as a necessary aspect of her relationship with the Doctors *qua* physicians, the Doctors were obliged to contact the authorities.

[150] In *B.H. v. Dattani*, Justice Richards recognizes that sometimes, but not always, will a doctor's fiduciary obligations arise out of the provision of professional services and that the purpose of s. 72 of Saskatchewan's *Medical Profession Act, 1981* was not to cloak physicians with a special limitation period in respect of every sort of possible tort or fiduciary duty claim brought against them by their patients. Just as Justice Richards accepted that s. 72 would not capture a doctor's breach of fiduciary duty for having sexual relations with a patient during the course of providing professional services, I do not regard torturing a patient during the course of providing professional services as captured by any of several limitation periods relied on by the Defendants in the case at bar.

[151] In the case at bar, I appreciate that the Crown and Drs. Barker and Maier may have been acting in good faith, and I am prepared to assume that to be the case because *mala fides* was not expressly pleaded, although the deemed-to-be-proved facts in the Statement of Claim may suggest otherwise, and I appreciate that apart from professional renown and advancement, there was no self-serving gratification for the Defendant physicians at the expense of the Plaintiffs but, in my opinion, that does not negate the circumstance that it is a breach of a physician's ethical duty to physically and mentally torture his patients even if the physician's decisions are based on what the medical profession at the time counts for treatment for the mentally ill.

[152] In the different context of determining the constitutional validity of the assault provision of the *Criminal Code* that excludes from that crime reasonable physical correction of children by their parents and teachers, in *Canadian Foundation for Children, Youth and the Law v. Canada (Attorney General)*, 2004 SCC 4 at para. 106, Justice Binnie said that few things are more demeaning and disrespectful of fundamental values than to withdraw the full protection of the *Criminal Code* against deliberate, forcible, unwanted violation of an individual's physical integrity.

[153] I would say much the same thing about withdrawing the protection of equity from the patients of Oak Ridge who have already lost their freedom. In the case at bar, there is a free-standing breach of fiduciary duty claim that at the time of the commencement of this action was not statute-barred.

G. Conclusion

[154] For the above reasons, I dismiss the Defendants' summary judgment motion, and I grant the Plaintiffs a partial summary judgment for breach of fiduciary duty.

[155] I order a trial or additional summary judgment motions to prove victimization, harm, causation of harm and to quantify the individual Plaintiffs' damages, if any. I direct the Plaintiffs to schedule a case conference to set a schedule for the completion of the action.

[156] If the parties cannot agree about the matter of costs, they may make submissions in writing beginning with the Plaintiffs' submissions within 20 days of the release of these Reasons for Decision followed by the Defendants' submissions within a further 20 days.

Perell, J.

Released: June 1, 2017

CITATION: Barker v. Barker, 2017 ONSC 3397
COURT FILE NO.: CV-00-199551
DATE: 20170601

ONTARIO
SUPERIOR COURT OF JUSTICE

BETWEEN:

REGINALD BARKER, JEAN-PAUL BELEC, ERIC BETHUNE (formerly Jean-Jacque Berthiaume), JOSEPH BONNER, WILLIAM BRENNAN, STEPHEN CARSON, ROY DALE, MAURICE DESROCHERS by the Estate Trustee LORRAINE DESROCHERS, DONALD EVERINGHAM, JOHN FINLAYSON, ROBERT FROST, TERRY GHETTI, ROBERT HABERLE, BRUCE HAMILL, ELDON HARDY, WILLIAM HAWBOLDT, DANNY A. JOANISSE, RUSS JOHNSON, STANLEY KIERSTEAD, DENIS LEPAGE, CHRISTIAN MAGEE, DOUGLAS McCAUL, WILLIAM A. McDOUGALL, BRIAN FLOYD McINNES, ALLEN McMANN, LEEFORD MILLER, JAMES MOTHERALL, MICHAEL ROGER PINET, EDWIN SEVELS, SAMUEL FREDERICK CHARLES SHEPHERD and SHAUNA TAYLOR (formerly Vance H. Egglestone)

Plaintiffs

– and –

ELLIOTT THOMPSON BARKER, GARY J. MAIER and HER MAJESTY THE QUEEN IN RIGHT OF ONTARIO

Defendants

REASONS FOR DECISION

PERELL J.

Released: June 1, 2017