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UNAUTHORIZED MEDICAL INTERVENTION AND INFORMED CONSENT IN THE COMMON LAW OF CANADA PRIOR TO THE SUPREME COURT'S DECISION OF REIBL V. HUGHES (1899–1980)

Preface. Since the late nineteenth century, the common law practice of various commonwealth states involving unauthorized surgery and extension of a consented surgical interference features civil actions for technical assault/battery¹ or negligence and malpractice², and occasionally, for a breach of contract under the circumstance of the fact that the extent of interference was prescribed by it³. In fact, in some cases plaintiff may sue for both, alleging that the operation was performed unconsentedly and negligently and in case not exceeding a statute of limitations, he may recover⁴. After the informed consent doctrine went into disposition, American courts actively used it but there was no uniformity upon which theory the action should be adjudicated; most courts went on with the theory of negligence, but not all⁵. In England, where the doctrine developed several decades later, the said wrong was rendered within the tort of negligence⁶ as well as battery⁷. In Scotland, failure to warn on the risks of the presupposed treatment, therapy and examination was attributed to negligence⁸. In Canada, some earlier actions filed for unconsented surgery and treatment were adjudicated on basis of battery⁹, despite at some point in the 1970s, Canadian courts attempted to distinguish it¹⁰; and in the leading case of *Reibl v. Hughes* the Supreme Court firmly discarded the battery claim attaching the subject to negligence¹¹. Some US states, as Washington D.C. recognize a separate tort in the lack of informed consent¹². Some US states modified and tapered the gist of the informed consent doctrine subjecting it to statutory limitations¹³. As the concept of intelligent consent progressed, in an action for assault/battery or malpractice, where a doctor doesn't inform his patient on the gist and potential gist fully and explicitly, especially if the methods of treatment and appliance disposed are not widely known, he'll be liable as well¹⁴. As the "exceeded consent" doctrine progressed in the common law, the doctor's failure not rather merely to obtain the consent from the patient, but instruct him properly, would be actionable upon theory of battery or medical malpractice¹⁵, or upon earlier cases both combined in a sole cause¹⁶. The abovesaid tort liability does not necessarily refer to an explicitly surgical interference as such, but to any other interference into the human's body as chiropractice¹⁷; teeth removal¹⁸; scientific experiment¹⁹ as well as disposal of personal data in scientific research²⁰ or blood transfusion²¹.

It is true, that in the earlier times, paternalist views on medical manipulations were supported by the fact that the physician has got an appropriate degree of skill and treats reasonable care for patient take any necessary decisions on, for instance, extension of the operation not taking into account whether it is emergent or not²². And it has to be intelligibly augmented, that at the very dawn of the development of common law concerning medical malpractice the rule that professional men must exercise ordinary skill and care; so, at trial their competence will be presumed unless the contrary is proved by plaintiff, was applied to physicians and surgeons as well²³; another general rule, applied and developed at quite an early date, that the doctor is expected to possess ordinary degree of skill which the people of his occupation possess and cannot be held liable only for an unsuccessful operation unless negligence is anyhow proved²⁴. The abovesaid being recognized in the United States at an earlier date, was laid down in the same manner in Canadian common law in the first half and middle of 20th century, despite much earlier authorities (though fewer than in the US) show that the Canadian rule of ordinary skill and due care is quite aged as well²⁵. The earliest cases in regard to this subject could be found in 19th century England²⁶ and United States²⁷.

A physician is entitled to perform his duties upon his best judgment in the method of treating and so is not liable for negative consequences in case of a honest mistake or a wrong diagnosis; the physician could guarantee exercising his skill and care, but cannot guarantee an explicitly positive result – this is what the US common law acknowledges as a general rule from an early date as well²⁸; on trial, the burden of proof will be put upon plaintiff to give proper evidence on physician's negligence; such frequently requires expert evidence²⁹, which is of substantial weight, but is not conclusive upon trial³⁰. However, in some US states statutes were enacted posing expert evi-

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dence to be explicitly necessary in such actions³¹. Evidence of physician's lack of skill or due care concerning treatment of some specific ailment on trial requires expert witnesses³². It was also acknowledged that surgery itself is not a precise thing to give a strict prognosis what assortment of procedures should be done for patient's treatment; therefore, the tort liability of a physician is subjected to qualifications³³. As the doctrine developed, the consent of the patient to undergo a specific operation or any other type of treatment in the sense of its "intelligence"³⁴ that was recognized as a "standard of care" and failure to obtain it under ordinary circumstances would be actionable³⁵. In Canada, the US concept of "standard of care" was approved as well at a somewhat later date, involving patient's consent to lodge his health records and other sensitive personal information as a part of his autonomy and body integrity³⁶, being an extension of the common law right to privacy³⁷. The rule of "intelligence", or more officially, "informed" consent may not only include a consent to undergo some surgery or complex conservative treatment, but upon more recent case law, may include one's right to interdict disposing of data concerning the health condition by physicians in scientific research and/or experiments; in such case, the consent is expected to be obtained in the same way it is obtained to undergo surgery and other treatment³⁸.

In its classic sense, unconsented surgery and patient's autonomy became a sort of novelty in common law jurisdictions right in the end of the 19th century. In fact, the common law footage on this subject was extremely rare back in those days, before the American cases of *Carstens v. Hanselman* and *State ex. rel. Jenney v. Housekeeper*, which were the first major authorities on unconsented surgery and both featuring husbands' suits for malpractice of surgeons while operating their wives without their consent³⁹. In both cases, courts acknowledged that the said women had a right to decide whether to undergo such treatment, or not on their own, without a special "license" from the husband. Another, much more vintage case occurring in the state of Massachusetts, *McClallen v. Adams*, was decided upon an older maxim, upon which if one lodges anybody to the skilled hands of a doctor, the latter "may know better" and so will not be liable even for thanatoid consequences deriving from the patient's condition⁴⁰. The *Carstens* and *Jenney* cases generated a prototype of a legal concept, which after a century was tentatively called "a right to patient's autonomy", or, as a 1960s penumbra called "a patient's right to know"⁴¹ which despite being a relatively new one, possesses a substantial vintage background. The "first wave" of cases concerning patient's autonomy made early commentators conclude that the patient should be the final arbiter to decide what to do with his body⁴², and thus, upon the rapidly developing common law, the physician won't be liable for non-treatment having no authority for forcible treatment under ordinary circumstances⁴³. The first modification to the announced rules concerned an unconscious state of the patient, where it would be impossible to obtain his consent. In several decades, this turn was explained to have a connexion with the widespread of general anesthesia⁴⁴. The 1920s and 1930s commentators seemed to uphold this position⁴⁵, but there was no uniformity in respect with the issue of whether the doctor, as stated in *Bennan v. Parsonnet*, could be the patient's representative to decide while the latter lies out of consciousness on the operating table⁴⁶. In that case, plaintiff went to defendant to be operated on a rupture in his left groin. After he was put under an anesthetic, one of the surgeons discovered a substantially more serious rupture in his right groin. The second operation was to be performed on the following day, but the patient declined and later brought an action for battery. The Court (opinion by Garrison, J), considered the issue of unconsciousness upon the state of which consent could not be practically obtained; it was held that while one being out of consciousness, there has to be a person acting on his behalf, and if no such person is chosen, than the doctor may be such. Being in lack of case authorities in respect with emergencies, the Court found that surgeon acted for patient's benefit and thus reversed the judgment⁴⁷. Another milestone was *Schloendorff v. The Society of New York Hospital*, a New York case, which arose two fundamental issues, namely a) liability for unauthorized surgery and the distinction of tortfeasor's acts upon theories of negligence and assault/battery; b) the liability of a non-profit or charitable body for negligent and other tortious acts done by physicians as well as other visiting staff who voluntarily operated within it's premises⁴⁸. The facts were the following: a poor woman went to a charitable hospital complaining on a stomach ailment. Within several weeks, the physicians discovered a lump appearing to be a fibroid tumor. One of the doctors advised an operation, but the others informed her that the specificities of the lump could not be traced unless a further examination is performed; she consented to it but insisted not to perform any surgery. On the next day, within the examination with ether administered, the doctors removed the tumor while the plaintiff was unconscious, so she commenced a suit alleging the operation caused a gangrene on her arm which brought to the loss of several fingers⁴⁹. Firstly the court went on to discuss charitable hospital liability and found that defendant: 1) as a corporate body, is exempt from liability since it becomes a sort of benefactor for the person accepting it waives pretensions, the payments are not commerce but are done to maintain charitable bodies; later, in New York, the same principle was applied to private and profit-making hospitals immune as well⁵⁰ (but this was not the same in other US states); 2) a charitable hospital may not be liable for its visiting staff's negligence and other tortious acts since these people are not servants in the actual sense of the word⁵¹; and thus the staff could be personally liable only. The said rule concerning the exemption from liability or a charity or other type of non-profit hospital had a reflection in both American⁵², Canadian⁵³ and English common law, as well as in Scotland⁵⁴ and other commonwealth states⁵⁵. In US, the rule was not applied in case of concluding contracts between profit-making hospitals with patients, or with other institutions where the former were to furnish medical service for people of some particular occupations, such as sportsmen or workmen – in such case, the hospital could not escape liability for its servant's negligence; in most states, the "Schloendorff rule" was not applied to profit-making infirmaries⁵⁶. The rule concerning exemption of a board from liability, nicknamed as the "Schloendorff rule" was declared abortive in *Bing v Thunig*, a 1957 New York decision, charging hospitals to be liable for the wrongs done by their employees regardless of their legal sta-

tus – be it a charitable or profit-making establishment⁵⁷. Apparently, such wrongs would include technical battery within the meaning of some unauthorized treatment or procedure as well⁵⁸. Concerning the second issue, namely the unconsented surgery, the Court outlined the following: the patient is the final arbiter of what interference could be applied to his body, in case of mature age and sound mind; thus plaintiff didn't maintain action since plaintiff didn't commence a nonsuit against physician(s) who operated on her unbeknownst to her and the hospital, upon the Hillyer-inspired rule was not liable for their acts even if such were tortious⁵⁹.

As the twentieth century progressed, the consent doctrine was upgraded with its “intelligent” side, mainly known as “informed consent”. In general⁶⁰, it is a classic consent to treatment with a 1) a patient's full comprehension of the scope and extent of the medical procedures; 2) the physician's duty to inform the patient on the scope of the treatment and “full and frank” disclosure of any hazards which might occur within the treatment; this was the key point of the cases which seemingly commenced the “informed consent” doctrine, namely *Salgo v. Leland Stanford Bd. etc. Trustees* as well as *Nathanson v. Cline*, adjudicated in 1957 and 1960 in the states of California and Kansas respectively⁶¹. These are the most outstanding, but not the first cases to arise the given issue, but the said two are ones where the Courts amalgamated the basic rules of the informed consent. Various approaches had been held by the mid- 20th century commentators concerning the topic, but I would stick to the custom view upon which, I suppose, the informed consent combines two constituents: the first is the basic consent, which was pretty much discussed in *Schloendorff* and subsequent cases; and the second is a fiduciary duty of the physician to disclose all information concerning the patient's condition and process of treatment⁶², the methods applied, potential hazards and all related issues; in fact, in a number of US cases way before the *Salgo* and *Nathanson* were adjudicated; thus, where the doctor failed to reveal such information, deceived the plaintiff or concealed the information on purpose, it was held to be actionable⁶³. The so-called “duty to warn”, mainly known to medical law by the English case of *Bolam*, could be found in other cases concerning actions for professional negligence⁶⁴; though there, the consent is not a consent given from one person to another, but a presumption of plaintiff's own due care for himself not to be injured⁶⁵. In some actions for malpractice, like, for instance, in *Ray v. Scheibert*, a 1969 Tennessee case, the issue of informed consent was blinded by the issue of physician's liability for concealing his negligence, but continuing treatment to which plaintiff impliedly consented by subjecting himself to procedures⁶⁶. The two cases mentioned hereinabove represented a newly-born model upon which the facts represented by the physician to the patient (apparently, the presupposed plaintiff in such action for malpractice/battery) lead to this “intelligent” consent⁶⁷. At federal level, the informed consent doctrine was widely observed in the outstanding case of *Canterbury v. Spence* which was adjudicated in 1972⁶⁸ though some cases involving actions for unconsented surgery and treatment occurred some decades before. In England, the common law concerning the informed consent seemed to arise around 1957; at the beginnings, it would seem more like a fiduciary or protocol duty of a physician, which, I think, could be displayed in terms of brevity as “duty to warn”, but not rather a real choice of the patient, whether to consent to some operation, or not to⁶⁹; such “right to autonomy” was not considered as a common law right until late 1980s⁷⁰. The Canadian cases on consent to treatment and the concept of informed consent will be the main subject of the next chapters of the paper, but in the matter of brevity, I have to outline that the “compound” consent theory was announced in mid-20th century⁷¹ though the full crystallization of it occurred only in the mid 1960s and the subsequent decade⁷², but in fact, the cases concerning various features of the patient's autonomy, involving the basic subject of consent to surgery occurred substantially earlier. The descent of Canadian informed consent doctrine, upon the 1970s judgments, is quite close to the United States interpretation of the doctrine⁷³; but in the 1970s, some Canadian courts tried to draw a distinction between the action against a physician for battery and negligence: an unconsented surgery would constitute a battery; whereas a doctor's failure to obtain informed consent and warn plaintiff on possible consequences would constitute negligence⁷⁴. As in the United States, this distinction, announced in *Kelly v. Hazlett*, a 1976 decision being overruled four years later, did not become uniform at once⁷⁵, but was adopted as such in *Reibl v. Hughes*⁷⁶. The Australian decisions, apart from the American and Canadian, are younger and their informed consent doctrine seems to be originating majorly from England, and to a certain extent, from Canada and United States⁷⁷. The scope of what is “informed consent” actually supposed to be is also questionable. For instance, if it creates a common law right to patient's autonomy, than it's suggested to involve the patient's right to access to his health records and seems to involve physician's duty to disclose them⁷⁸, as well as keep them confidential⁷⁹. Reviewing the subject in the United Kingdom, Mr. Dworkin called it “extended confidence” in the 1970s⁸⁰. In fact, the United Kingdom had a very tricky legacy on the subject, initially not recognizing a patient's common law right to access⁸¹, then in 1978 the House of Lords recognized it and overruled several previous decisions⁸²; at the same time, the right to access to records being in possession of municipal authorities, involving medical ones still remained qualified and restricted⁸³, the same could be attributed to the inspection of medical records by solicitors and counsels if there were foundations to regard them that they might dispose medical records outside the scope of certain legal proceedings⁸⁴. The English common law implies that some files concerning the orders for treatment and some minor internal hospital information, not generally relating to one's state of health, be it an ordinary inspection or for trial, may be privileged too⁸⁵. The Scottish common law also does not lodge a common law right for unlimited inspection and of hospital records⁸⁶, but in case it is proved to be used for trial, a court order may unveil them⁸⁷. The inhibition to reveal of patient's “medical secrets” with few qualifications, seems to be of quite vintage nature as well⁸⁸. The personal data attributing to patient are also bound to be disclosed and disseminated, be it some sensitive data in the patient's record file⁸⁹, an X-ray⁹⁰ or a photo: in an American case from Pennsylvania, *Clayman v. Bernstein*, a woman with a distorted face resulting from an unspecified illness sued to restrain a physi-

cian who took photographs of her face from their distribution and recovered; the Court said the following: “The court recognized that an individual has the right to decide whether that which is his shall be given to the public and not only to restrict and limit but also to withhold absolutely his talents, property, or other subjects of the right of privacy from all dissemination. The facial characteristics or peculiar caste of one’s features whether normal or distorted, belong to the individual and may not be reproduced without his permission”⁹¹. This was not the solitary case dealing with somewhat similar circumstances⁹².

The right to autonomy as an extension of the right to privacy: basic findings. Before I proceed to the cases involving the issue of unconsented treatment in the state of Canada I have to say a few words concerning correlation of unauthorized treatment, right to autonomy and the extension of common law right to privacy. Both of such are primarily regarded as common law rights. It would be intelligible to say that not all commonwealths have adopted a separate privacy tort, which is majorly a prerogative of the United States law; the Canadian privacy tort, if such actually may exist and is recognized both at federal and province level is questionable to subsist as a separate one. At least after courts of several Canadian provinces recognized it as such⁹³ though definitely not omnipresently⁹⁴, it was proposed to subdivide the normative-descriptive content of the term “privacy” into public and private wherein the former category would relate to criminal appeals involving unreasonable seizure or, for instance, admissibility of one’s personal data as evidence for trial⁹⁵ (however, I should remark that admissibility of surveillance-originating evidence was also put before Canadian courts in civil actions⁹⁶), while the latter is attributed to privacy violations in the way it exists in American common law, that is, in civil actions to recover damages for disclosure of one’s personal information, unconsented disposal of name, photograph or related subjects and commercial appropriation of likeness⁹⁷. A similar distinction was made by American courts as well⁹⁸. The latter category, upon the interpretation of the Supreme Court of Canada in *R. v. Dyment*, encompasses privacy in information and privacy of the body⁹⁹. As we’re concerned about the latter part of privacy violations in Canada, it has to be denoted that the tort of privacy in this state does not possess an aged history. Apart from unconsented surgery, earlier specimen of “quasi-recognitions”¹⁰⁰ of right to privacy in Canada those days has frequently involved public disclosure of private correspondence¹⁰¹, blacklisting of workmen or merchants¹⁰², mental anguish resulting from a relative’s corpse mutilation¹⁰³ as well as unauthorized autopsies or post-mortems¹⁰⁴. The tort of privacy invasion in Canada, upon a display by a number of Canadian commentators¹⁰⁵ had its best and efficient evolvement in the province of Quebec starting from middle 1960s. The outstanding Canadian cases featuring a privacy violation represent an “extended” pass-off¹⁰⁶, being a commercial appropriation of likeness by defendants¹⁰⁷; an unauthorized use of a photograph; surveillance¹⁰⁸; a combined nuisance¹⁰⁹; or basic public disclosure of private facts¹¹⁰. The extended pass-off, being sometimes referred to as “a business tort”, upon the view of Canadian commentators, doesn’t derive from common law legacy of privacy, more likely to be originating from proprietary rights¹¹¹. However, in my point of view, even regardless of the Canadian pass-off cases were later referred as privacy cases, the abovementioned position is grounded upon the commonwealth descent of the tort which initially didn’t have any connexions with privacy violations as the tort, in fact, was designed to prevent fraud, but not a privacy violation¹¹², and secondly, the leading cases on a pass-off concerning appropriation of likeness were decided upon other foundations, though it would be unfair to say that it was totally blinded: e.g. in *Henderson v. Radio Corp.*, an classic Australian privacy case, this issue was raised¹¹³ and *Krouse v. Chrysler Canada Ltd.*, one of the “leading” Canadian privacy cases¹¹⁴. However, the English authorities, namely *Tolley v. J.S. Fry & Sons Ltd.* as well as *Sim v. H.J. Heinz Ltd.* were deaf in respect with the privacy issue, both being adjudicated on grounds of libel¹¹⁵. Some commentators claimed that the Canadian law recognized a statute-originating right to privacy, but this discussion is off the point herein; what is more, some commentators claimed that the Canadian interpretation of the right to privacy may have French routes¹¹⁶. Upon the given arguments, it is quite sufficient to say that the majority of the Canadian provinces and federal courts recognize a common law right to privacy though the approaches of its descent may be somehow divergent. Upon the Supreme Court’s elucidation in *R. v. Dyment* and several earlier cases it would be intelligible to say that the right to autonomy in its scope to informed consent (as body integrity) and access to medical records (informational privacy) distinctly derives from the right to privacy. The same could be argued in the common law of the States: in *In Re Conroy*, the Supreme Court of New Jersey emphasized a correlation between plaintiff’s right to autonomy and common law right to privacy upon the view emerging from the celebrated Supreme Court decisions in *Griswold v. Connecticut* and *Roe v. Wade*¹¹⁷. In *Eichner v. Dillon* an elderly priest being in custody for his brother-in religion who after an unsuccessful surgery fell into coma, and he brought up proceedings in order to excise the latter’s life supporting systems and the Court found that such refusal of treatment rests on the constitutional right to privacy¹¹⁸. The right to withstand from supporting therapy on basis of right to privacy under circumstances similar to *Eichner* was approved in the *Quinlan* case, one of the earliest and resonant “right to die” decisions¹¹⁹. A number of other United States courts had already developed such approach in similar cases in the 1970s¹²⁰.

A *Griswold*-like position was adopted by the Supreme Court of Ireland in *McGee v. Attorney General & Another*, where the Court explicitly recognized the decision of the family to have kids deriving from “privacy of the husband and wife relationship”¹²¹. A similar view already subsists in international human rights case law deriving from the practice of the European Court of Human Rights, namely in the judgments of *Pretty v. United Kingdom*¹²², *J.W. of Moscow v. Russia*¹²³, *A., B. and C. v. Ireland*¹²⁴ as well as *Arskaya v. Ukraine*¹²⁵ where the Court adjudicated the decisions on basis of an alleged breach of right to privacy. Patient’s right to access to his personal information was also a subject of the *Gaskin* trial in the late 80s¹²⁶. The same was the conclusion of the Human Rights Committee in *Mellet v. Ireland*¹²⁷ (though it is not a court, it’s apparent that the finding of the said body would augment plaintiff’s

position at trial). What as to Australian cases, despite there has been a lot of them concerning informed consent in the last decade, they do not seem to be helpful to tie the right to privacy and the right to autonomy as I clarified above by means of Canadian, American and European Court's practice: the right to privacy hasn't received an overall recognition in Australian common law¹²⁸; the earlier Australian cases on the said subject had been adjudicated on basis of negligence¹²⁹. The same goes to New Zealand which possesses little common law on the subject¹³⁰ in spite of certainly having some common law legacy in privacy law¹³¹. The vintage and more recent United States cases concerning the patient's right to withstand the publication of his/her personal information were clearly indicated as privacy cases and patient's right not to give out this sensitive information¹³² was later regarded as a part of the right to autonomy¹³³. In Germany, in an outstanding decision on the legality and criminalization of abortions, the Federal Constitution Court considered the women's pregnancy on basis of the right to privacy but held that unless the embryo could be only a constituent of a woman's body, than the courts and legislature could not interfere, but since, upon it's thought it was not, and was considered as an independent human being, there had to be a substantial justifying cause of doing an abortion¹³⁴. Hence upon the existing case legacy it would be intelligible to conclude that the right to autonomy derives from the common law right to privacy even upon the decisions in jurisdictions who (at least partially) recognize the privacy tort.

Canadian legacy of informed consent. At present time, Canadian common law is proud to possess a handful of exclusive cases on the subject of unconsented surgery and therapy, having various influences and influencing a number of other commonwealths' law as well. The confidence of a patient-physician relationship that is of vintage nature¹³⁵, is firmly disposed in Canadian common law as well¹³⁶. It is also well settled in the Canadian common law that the doctor is expected to possess ordinary skill and cannot be the guarantor of successful treatment¹³⁷. Some learned Canadian lawyers claim that the burst of the informed consent cases in the Canadian common law broke out in the mid-to-late 1970s and the early 80s and one of the most frequent failures in the patient-physician relationship is a lack, or even let us say, absence of adequate contact between parties¹³⁸. So, is there a uniform recognition of the informed consent concept in Canada? At least, there wasn't as of 1980¹³⁹. Let the cases be subdivided into two folders: the ones being actions involving lack of a basic consent to treatment and the more contemporary ones featuring a lack of "informed" consent in the fashion of the patient as the potential plaintiff was not informed on the hazardous consequences of the treatment. Upon the conclusion of the chapter we'll conduct a brief analysis of the impact of Canadian cases on other commonwealth common law.

It would be intelligible to say that the province of Quebec did not only found the Canadian common law right to privacy, but the Quebec courts contributed a lot to the informed consent's doctrine¹⁴⁰. The earliest Canadian case recorded on the subject is *Parnell v. Springle* being adjudicated in 1899 at the Superior Court of the District of Montreal¹⁴¹. The facts were simple: a woman complained on some womb derangement and the surgeon after examining her advised to execute an operation claiming it would be a minor one. After she was put under anesthetics and the team of doctors uncovered the abdomen they noticed the deterioration condition of her reproductive organs and after negotiating the doctors decided to remove both of her ovaries to save her life. The woman claimed 1999 Dollar damages for becoming sterile but the Court found such interference would be justified as a) plaintiff unconscious and b) this was necessary for the benefit of patient¹⁴². In fact, the same inferences were made by J. in *Bennan v. Parsonnet*, one of the principal American cases on the unconsented treatment¹⁴³. The following case is *Caron v. Gagnon*, or *Caron c. Gagnon* (as it was originally reported in French) being adjudicated in Quebec as well¹⁴⁴. There, plaintiff, a young woman suffered a collapsing stroke of appendicitis and Gagnon, the physician, to whom the husband brought her, successfully operated upon it. Gagnon discovered that the ovaries were in a deteriorating condition and concluded that if not removed, the removal of the said would be compulsory very soon. The woman brought an action against the physician for becoming sterile¹⁴⁵. The doctor responded that he actually informed the husband who was alleged to have paid him and gratified Gagnon for his efforts; upon the later evidence, the husband authorized Gagnon to operate on appendicitis and fully approved his discretion, upon the fact of the ovaries removal the husband explicitly upheld the physician's judgment (see. para. 35–40). What is of particular interest, the action was filed on basis of an old negligence statute in the same fashion it was done later in *Robbins v. Canadian Broadcasting Corp.*¹⁴⁶. Moreover, in *Beausoleil*, a much later case on unauthorized anesthetic injection that brought to paralysis, *Owen, J.* referred to the same statute affirming the fault of the physician¹⁴⁷. The fact was the ovaries removal was truly an unauthorized extension of the planned surgery, but the Court admitted the doctor did well in that case as the situation was urgent and so found for defendant. This case is also presumed to have at least some French influence¹⁴⁸.

The next handful of cases featured more extended discussion on unconsented treatment and were more US and UK-influenced. The case of *Kenny v. Lockwood*, in spite of not recognizing physician's liability for the lack of informed consent was thereafter rendered as a classics of early informed consent doctrine¹⁴⁹. A number of American commentators also paid attention on this Canadian case in the digest of the US court decisions on the subject. In the *Kenny* case, a young woman having a lump on the palm which appeared to be a contracture. The physicians represented that the operation was supposed to be simple and that plaintiff would be fine within several days though had not attend the hospital for three weeks for full recovery. The action was filed for deceit/fraud. *Stoddard*, one of the surgeons being employed in the clinics admitted to conceal all conjectural hazards of the operation which appeared to be deteriorating. *Hodgins, J.*, found that there was no such fiduciary duty to disclose the said hazards especially if they may be so destructive and concluded that no fraud or deceit occurred from the side of the appellants; in his partially dissenting opinion, *Magee, J.A.* said he would find a physician's fiduciary duty to disclose the potential

risks of the operation and so would find Stoddard liable solely. The dicta on patient-physician relationship and doctor's liability for lack of informed consent in the said decision were of certain importance for Canadian common law¹⁵⁰, though a handful of case commentators found the reluctance of the Court to recognize a necessity to disclose the information to be outdated¹⁵¹, though I'm not confident to say that would be equitable to compare a 1932 decision with a 1970s or 80s decision. Besides, I'm pretty confident that the principle of non-liability for non-disclosure of quite remote and uncommon risks, at least in dentistry, that are not likely to occur aggravated by adequate physician's care still exists in modern Canadian common law¹⁵² albeit it is firmly denied in several Canadian decisions involving actions for lack of informed consent within dentistry as well¹⁵³. The principle of informed consent foreseen in *Kenny v. Lockwood* was appraised in *Hopp v. Lepp*, one of the leading Canadian cases on the subject¹⁵⁴.

The next 30s case is *Marshall v. Curry*¹⁵⁵. The facts of the case were quite sad: plaintiff, a 52-year-old sole mariner had a severe casualty in his 20s which seriously impaired his health. His spine was fractured and the injury caused other signaling problems. In his late 30s, in 1921, Marshall came to defendant and that time he was already deteriorated: apart from the old fractures he was nearly unable to control his bowel as it was already paralyzed and he wore a rubber urinal. Then, he underwent bladder treatment. Seven years passed and the plaintiff was literally rotting alive and had severe problems with his kidneys and bladder wherefrom defendant had to drain lots of pus; plaintiff underwent a number of operations and permanently resided in hospital from winter to summer 1929; in July 1929 he asked to remove a hernia; within this operation his testicle was removed unconsentedly – the plaintiff was not notified in beforehand¹⁵⁶. Plaintiff didn't sue for this act until late 1931; and defendant, upon his own testimony, recalled the 1929 hernia operation and stated he had to obliterate the inguinal canal and that upon the testicle examination, it had multiple abscesses and so it would become gangrenous anytime soon bringing to blood poisoning and apparent death in the near future. The doctor recalled several operations afterwards and claimed Marshall's health to have improved thereafter. The Court (per *Christholm, J*) agreed that extension of the operation was demanded despite no implied or an express consent was given. For the principal time in Canadian common law on the subject the Court held a pretty able discussion on surgeon's liability to unconsented surgery. Firstly, the Court observed quite an obscure (being allegedly unreported¹⁵⁷) case of *Beatty v. Cullingworth*, a 1896 Queen's Bench Division decision¹⁵⁸ which was a suit against a physician for a double ovariectomy. Then, the Court turned to American classics, *Pratt v. Davis*, an early reproductive law decision where a physician unconsentedly removed an epileptic woman's uterus not once deceiving her on what he was intending to perform as to the treatment¹⁵⁹; in fact, in *Pratt*, the Court observed the question of emergency, as well as the capacity for consent; but this remained a dictum since in the *Pratt* case the operation was not emergent and so the doctor was held to be liable; then turning to *Mohr*, *Bennan*, *Schloendorff* as well as a number of others and the two abovementioned Quebec cases. Then, at p. 274, the Court announced a set of rules upon which 1) prior consent to surgery and any examination is mandatory; 2) the consent may be express or implied, the inhibition of operation is not anyhow a consent; 3) the implied consent may derive from a set of preliminary circumstances, and the Court firmly withdrew the *Bennan* dictum upon which surgeon is a supposed representative of patient. Upon the case at bar, the Court found a) the operation was necessary upon the conditions described by the defendant and his colleagues as expert witnesses; b) the battery, even if such was proved, was barred by the statute of limitations. Therefore, plaintiff didn't prevail in action, but the case remained a valuable unit for the evolution of informed consent doctrine¹⁶⁰.

There was a number of less known unconsented surgery cases in the above said time fragment. In *Winn v. Alexander et al.*, a surgeon performed a Caesarian to a female plaintiff in 1931. Eight years after, plaintiff's health declined and within another operation, the surgeon discovered that the former physician left a sponge in her body; he was also alleged to have resected plaintiff's fallopian tubes making her thereafter unable to become pregnant; the claim was adjudicated under the doctrine of assault which enabled declaring the defendant liable, as the bar of limitations upon the Medical act was adjusted to negligence. In fact, the assault limitation was overdue as well unless there was a concealment of the cause of action, but the Court found it was; the hospital was not held to be liable on basis of *Hillyer* and a subsequent case in Canada¹⁶¹; even in spite of existing Canadian decisions disapproving it¹⁶². To our misfortune, the case report is relatively small and seems to be condensed; therefore it is impossible to say more on the gist of the said decision. Nearly to the same effect was the late 40s case of *Murray v. McMurphy* where a surgeon was sued by a woman who was a victim of an unauthorized sterilization within a caesarian. She didn't give any consent to the said manipulation and didn't anyhow asked for it; the Court made an examination of *Bennan v. Parsonett*, *Marshall v. Curry* and the *Parmley* trials which are to be discussed below and decided that as there was no urgent need to perform the said manipulation, the acts made by the surgeon constituted a trespass to person and so plaintiff recovered¹⁶³.

The 1940s–60s cases feature more firm assumptions on informed consent that was based upon American and already existing Canadian cases. Moreover, the right to autonomy was penumbally recognized in the appeal of the *Parmley* cascade of cases. The history started in early 1943 when a young woman, *Yule*, being pregnant went to the dentist, *Fred Parmley* and desired to extract two teeth, both in a badly condition. On, or about the same time she was advised to undergo tonsillectomy to which she consented; the doctor advised to postpone treatment until she would give birth to the child and perform it in a hospital; and after the birth plaintiff was advised to articulate the procedure with the tonsils removal to which she assented. *Parmley* told he would assist in arranging this and so he took his brother *Bob* employed as a hospital dentist. *Parmley's* brother was misled in the view he had to remove all the upper jaw teeth; he didn't talk to plaintiff and didn't receive any instructions from her; nor he did receive any from his brother. Believing he was authorized to do so by the fact of plaintiff's consent to undergo treatment, he removed all

upper teeth¹⁶⁴. This brought to the suit against him. The British Columbia Court (per Coady, J) went on to the question of damages for the lost teeth finding that the dentist was guilty of negligence. Defendant brought an appeal, assuming his negligence was not willful. At that trial, the evidence disclosed that the doctor didn't clearly hint his brother what teeth should he remove and so he comprehended it as he has to extract all of them. The dentist, upon his own examination found much more teeth to be decayed (see appeal, at. p. 319–320). Finally, the doctor confessed having let his brother to take out all the teeth. The Court announced the basic autonomy rule, referring to Schloendorff and Marshall dictum¹⁶⁵; and upon all the evidence introduced, both physicians were found to be negligent¹⁶⁶. The last of the triad featured an appeal to the Supreme Court of Canada. Estey, J., held that there was no authorization for the dentist to act in the way he did. The Court said: "The conclusion appears unavoidable that both of the parties hereto, particularly in the operating room, failed to recognize the right of a patient, when consulting a professional man in the practice of his profession, to have an examination, a diagnosis, advice and consultations, and that thereafter it is for the patient to determine what, if any, operation or treatment shall be proceeded with [authorities omitted]"¹⁶⁷. If I had gone so far with said case triad, I probably should cite what was said by Lord Scarman in *Sidaway v. Bethlem Royal Hospital*: "The right of "self-determination" – the description applied by some to what is no more and no less than the right of a patient to determine for himself whether he will or will not accept the doctor's advice – is vividly illustrated where the treatment recommended is surgery. A doctor who operates without the consent of his patient is, save in cases of emergency or mental disability, guilty of the civil wrong of trespass to the person: he is also guilty of the criminal offence of assault. The existence of the patient's right to make his own decision, which may be seen as a basic human right protected by the common law, is the reason why a doctrine embodying a right of the patient to be informed of the risks of surgical treatment has been developed in some jurisdictions in the U.S.A. and has found favour with the Supreme Court of Canada."¹⁶⁸ (at p. 10 there was a reference to the Supreme Court's decision in *Reibl v. Hughes* so I'm convinced that was the case impliedly referred to in the passage above). Then, having analyzed all the American rules of consent and the qualification of emergency, the Court came to a conclusion that there was no evidence that the removed teeth could not be successfully treated; the defendants were both held equally liable in a trespass to person. In fact, the House of Lords definition does not really differ from the *Parmley* one in respect with the patient's right to decide, but at the same time, the *Parmley* definition lacks the "intelligence" element on warning concerning the operation risks – that's what was augmented in *Reibl*¹⁶⁹. Still, the *Parmley* decision was invaluable for the further development of the informed consent doctrine.

The 1950s and 60s featured another handful of cases before the "eruption", as Picard called it¹⁷⁰, of "informed consent" cases stroke the Canadian courtrooms. In *Sylvester v. Crits*, a decision having a cascade of appeals¹⁷¹, a minor being at the time of the casualty at age 7–8, was given accommodation in an Ontario hospital where he was supposed to undergo a tonsillectomy. Before the operation, he was sedated and prepared for the surgery; owing to the type of operation, the doctors decided to use gaseous anesthetic being a mixture of oxygen and ether (the said was still disposed those days). Both anesthetics were lodged by means of tubes via a Maggil pipe to a special oxygen mask being supplied from an oxygen tank and a ether container, the latter being located near the boy's head. The vapor, being the mix of ether and oxygen was led to the patient's trachea to supply the anestheization; but the exact correlation of gaseous substances was not recorded or determined. Right after the induction of the blend, the boy became cyanosed which compelled the doctors to dislodge the oxygen tube from the ether container, filled in the oxygen bag with pure oxygen and then the patient's respiration went normal; but apparently the doctors needed to lodge ether back; when disconnecting the oxygen bag, there was an explosion causing severe damages to the child. Upon the existing evidence, it was caused by an electric spark setting the ether-oxygen blend which was escaping from the ether can while the Magill tube was dislodged¹⁷². The son and the father sued for negligence; the trial court found for defendant; on appeal only the anesthetist was found to be liable as the hospital was not found to be responsible for the casualty, since firstly, he was not an employee of the hospital, and secondly, it could not be blamed for foul techniques supplied to the unfortunate procedure, as evidence disclosed that the doctors were negligent in disposing the techniques; the Supreme Court affirmed the appellate court decision¹⁷³; the case comment disclosed that the doctors failed to warn the patient on the possibility of such explosion, but the informed consent issue was blinded by the subject of determining the evidence of doctors' negligence.

The next case, *Beausoleil v. Sisters of the Charity of Providence* (in French it was designated as *Beausoleil v. la Communauté des Soeurs de la Charite de la providence*, but let us dispose English names as the paper is in English), involves an anesthesia failure. The said case, being originally reported in French, features "French" routes of the Canadian informed consent doctrine as the report displays a long discussion on the proof of the physician's fault rather than an analysis of Canadian and American cases on the subject¹⁷⁴. Plaintiff was a young unmarried woman who complained on spinal ache and upon advice of an orthopedic surgeon who found a disc operation to be carried out, was hospitalized. She desired to have a general anesthetic injected and respectively told so to the operating surgeon, who advised her to say the same to the anesthesiologist. Then one Dr. Forest, the chief anesthesiologist entered the operating room and tried to convince the plaintiff to submit to the spinal anaesthesia; when Dr. Cusson, the anesthesiologist asked the staff to proceed with the general one, he was told that the spinal one had been already administered. The operation was unsuccessful which brought to permanent paralysis of the woman's legs¹⁷⁵.

Upon the evidence of witnesses; the woman didn't wish the spinal anesthesia to be administered, and that Dr. Forest talked to the plaintiff inclining her to submit the spinal as he found the general one to be more hazardous to the plaintiff. Finally she consented to it; such hazard as a blockage causing future paralysis was rare and this probably made the physicians avoid warning the plaintiff of its possibility. The Court turned to discuss the patient-physi-

cian relationship involving the scope of some unforeseen things to happen during the course of the treatment and found, upon the book of Crepeau that unconsented body interference is tortious unless done in some emergency¹⁷⁶; as Forest didn't follow the instructions given by the patient, Casey, J. stated the doctor and the hospital were liable for negligence; Rinfret, J. was of the same view basing his opinion on the Canadian cases where patients sued hospitals (or the municipalities) for negligence which were held liable¹⁷⁷. He assumed that though such complexification was not frequent, it didn't mean not to exist, and if it existed as such, it had to be foreseeable by the physicians. Turning to the question of the due care standard¹⁷⁸, the evidence of Dr. Lamoureux was examined: he told that there was a custom for an anesthesiologist to get acquainted with the patient and to learn his condition as well as body specifications (height, weight, complexion etc.) and then to speak to the doctor and decide on the anesthetics to be disposed; Forest did not do neither of this; upon a large set of other facts, he was found to be neglecting a wide range of his duties and so found to be negligent; the woman on the operating table really gave consent, but reluctantly and unwillingly: "'Do as you like' – words which denote defeat, exhaustion, and an abandonment of the will power."¹⁷⁹. Rinfret, J., Owen, J. and Casey, J. calculated the damages as 104,131.75 Dollars, a large sum as of the 1960s. Taschereau, J., dissented finding that the consent was obtained and so the fault was void, adding that the casualty by administering a spinal anesthetic was very rare though it was actively disposed in treatment both in England, United States and Canada as well saying that the lack of consent was not tortious; to this opinion joined Badaux, J.¹⁸⁰. The appeal was maintained.

The case of Beausoleil being a pre-Hopp/Reibl classics of informed consent, for some reasons, did not receive major coverage from Canadian and foreign scholars, who mainly relied on the two abovesaid cases to discuss on general rules. Another 60s case, *Halushka v. University of Saskatchewan* featured more American, as well as "domestic" approaches to the informed consent doctrine. Plaintiff, a student desiring to earn light money, decided to take part in an experiment for which he was expected to be paid 50 Dollars. Walter Halushka was brought to the University by advice of a local employment office which proposed him to become a subject of a medical test. At the anesthesia department of the University he met the doctor, appellant who told him they would like to approbate a new drug and that he would have nothing to worry about as the test was safe. Walter signed a consent form, upon which he released the examiners from any responsibility if any casualties would occur¹⁸¹. In the course of the experiment, the young man experienced a complete cardiac arrest; having nearly died, he had been unconscious for four days and was treated for around two weeks before recovering. The anesthetic that Walter had been tested on, the Fluoramar, was thereupon aborted from clinical use; after the casualty, plaintiff experienced a decline of his mental abilities and had to quit studies; all of this resulting in bringing a suit for trespass against the examiners¹⁸². Deciding the case, the Court said that the consent of the patient to undergo treatment, or a similar procedure, like in the instant case should not be as an ordinary consent (Walter surely did consent to this experiment but seemingly wasn't informed he might die in its course¹⁸³), and referred to *Parmley* and *Kenny* decisions, as well as the then-contemporary American cases¹⁸⁴; and stated that the medical research experiment standards of care would not differ from ones applicable to ordinary medical treatment; since the physicians did not disclose all the potential risks and harms, they were held liable¹⁸⁵. What is notable, the Court also made a distinction between the ordinary consent and informed one, as well as the embrace of disclosed material. Besides, the *Halushka* case was disposed as a major authority in *Koehler v. Cook*, one of the lesser frequently cited 70s cases, where the plaintiff lost smell in the course of the operation and in spite consenting to it asked on possible hazards, was told that the risk is minimal, and managed to recover¹⁸⁶.

The 60s overview would be summed up by the case of *Martel v. Hotel Dieu St-Vallier*, which was very similar to *Beausoleil* by the circumstances. Plaintiff, a 49-year-old man undertook treatment involving a haemorrhoidectomy (that is, haemorrhoid removal). In the course of the operation, plaintiff was administered a dose of caudal anesthesia. Despite the operation was carried out decently, the patient felt a failure of his lower limbs, being barely able to get up and walk. The neurological examination displayed *Martel* had paraparesis attributed to arachnoiditis of his horse tail, which was inflamed by a chemical cause. Regardless of further treatment, the ailment was not overcome and plaintiff commenced a suit against the suspected doctor and the hospital¹⁸⁷. This "suspected doctor" was apparently the anesthesiologist, who was found to be a regular employee receiving salary and accounts a percentage of the fee which patients paid for painkiller. When being hospitalized, plaintiff, as any other patient signed a paper of consent to treatment; it was found there was no special contract between plaintiff and any separate physician, who didn't consult his chosen surgeon, Dr. Emile Simard¹⁸⁸ and so the said doctor had to act as any other employee of the hospital. The plaintiff did not employ any actual anaesthesiologist by a contract so the said doctor had to act with ordinary care as any other physician. The informed consent question was not strictly touched in the said case, but the only fact was: the patient signed a paper where he lodged his consent to execute operations which were required, but it was not revealed whether the doctor told the type of drug he intended to dispose (and what would that change, if he did?). The only statement considering this, that the anesthesia was injected upon the paper *Martel* had signed and nobody consulted before administering it neither him nor his treating physician. The Court found for plaintiff, dismissing hospital's appeal and doctor's appeal declaring them both jointly and severally liable¹⁸⁹.

Before the leading cases of *Hopp v. Lepp* and *Reibl v. Hughes* were adjudicated the 70s featured a wide variety of informed consent cases experiencing a number of various doctrine influences. The 70s also featured a large discussion on whether the physician has to disclose literally any information¹⁹⁰, or this may be subjected to the mental abilities or the occupation of the plaintiff patient¹⁹¹ (but wouldn't that sound discriminatory?); or the risks to be dis-

closed should be material (meaning basically, may this damage be foreseen by the physicians upon their own experience and the existing medical practice and firm risks being known to doctors¹⁹²; or if once consent is given (tentatively, a “general” consent), it shouldn’t be given one more time even if there’s an extension of treatment (and I suspect, with quite a gross interference into plaintiff’s body)¹⁹³

A somewhat prelude of these judgments happened in *Male v. Hopmans*, a 60s decision of the Ontario Court of Justice where a man suffering from osteomyelitis was hospitalized to have his meniscus removed. He was administered neomycin, but he never consented to administering it and was not warned on any adverse impacts of this anesthetic. As a result, his hearing was severely impaired (in fact, he became deaf) and so he sued the physician for negligent treatment. It was undisputed that plaintiff gave consent to treatment, but did not assent to the said anesthetic which besides was well known for adverse impact on hearing and kidney malfunction in 10 to 20 per cent cases. The Court, however found not in the fashion of American to-date cases – Gale, C.J.H.C. said: “As to the requirement that the plaintiff ought to have been afforded an opportunity to render an informed and rational decision, I am confident that he would have been quite unable to appreciate and assess the different medical alternatives and their attendant hazards as described at the trial... [...] The final consideration is the adverse effect upon the plaintiff’s morale that might well have resulted from the detailed explanations that would have been necessary had Dr. Hopmans attempted to do what the plaintiff’s counsel now urges he should have done”¹⁹⁴. Thus, the Court found for defendant.

The late 70s case, *McLean v. Weir*, is a brother of a New Zealand case of *Smith v. Auckland Area Hospital Board*¹⁹⁵; in both cases, plaintiffs underwent angiograms and in both the consequences were deplorable – in the New Zealand case plaintiff lost a leg, and in *McLean* plaintiff became quadriplegic (in fact, the *Salgo* case being considered one of the primary informed consent cases on the record was also an action for negligence on basis on an unsuccessful angiogram¹⁹⁶). Nevertheless the facts of *McLean* were quite sad: the plaintiff was diagnosed a progressive Reynaud’s phenomenon and in order the diagnosis to be precisely determined, his physician advised plaintiff to undertake an angiogram, the purpose of which akin to an X-ray, but is to display the circulatory system. To perform this procedure, the patient has to be administered a dye intravenously. Plaintiff’s procedure presupposed inserting a multitude of catheters into the veins under local anesthesia. In early 1973, defendant performed the angiogram of the left forearm when plaintiff experienced a severe pain in his right arm; therefore procedure was immediately terminated, but the patient had already encountered an injury¹⁹⁷. It was not known what actually happened, and the medical experts assumed it had to be a catheter escape to the patient’s spinal cord (in contrast with the techniques failure in *McLean*, in *Smith v. Auckland Area Hospital Board*, the opaque dye, presumably of indecent quality obliterated the blood flow in plaintiff’s leg causing it to be removed). The medical expert witnesses testified that such awful consequences could appear, and the physician should have known of such possibility but did not warn the plaintiff. As in *Beausoleil and Halushka*, the consequences of the operation were either seldom or unexpected; the Court found that the risk of palsy was not known, or barely known by radiologists in the early 1970s and the plaintiff had already been properly informed concerning the operation; what is more, the Court concluded that the principle announced in *Kenny v. Lockwood* concerning “a duty to warn” (just like in *Bolam*) was applicable only in case of well-known hazards presupposed to occur, but not some “orphan” consequences; thus finding for defendant¹⁹⁸. This case was not followed in *Reibl v. Hughes* and *Hopp v. Lepp*. In fact, against the background of *McLean*, the *Smith*’s case looks much more prudent to modern informed consent doctrine as the physician therein was found to be liable for negligence although those complexifications from an indecent dye were also way not too frequent: at p. 247 (or alternatively, in an another report, at p. 196–197), Woodhouse, J. said the following: “The welfare of patients would not be secured if a doctor’s duty to warn about proposed treatments was to be considered in abstraction from the condition to which they were to be applied”¹⁹⁹. Therefore, it is apparent that soon or less the informed consent distinctions were to be condemned sooner or later; but in fact, this query was repeatedly brought up again²⁰⁰. In *Johnston v. Wellesley Hospital*, a case with more simple facts, plaintiff, a 20-year-old young man suffering from active acne went to the hospital to have them removed after the advice of his treating physician; the acnes were widespread on his cheeks and forehead; the procedure which was seemingly carried out imprudently causing him suffer from a multitude of scars and blisters all over his face; being a negligence case at first glance, it wasn’t entirely such, as at age 20 he still was not considered mature upon Canadian civil law and so, under ordinary circumstances, the consent of his parents would be required, but the Court decided he had enough mental capacity to decide for himself enacting the concept of “mature infant” which was majorly known upon the US case of *Bonner v. Moran*²⁰¹. Plaintiff managed to recover for negligence from the side of the hospital, but didn’t succeed in prevailing in action for assault²⁰².

In *Zimmer v. Ringrose*, being very much of traditional informed consent view, the plaintiff, a woman willing to undergo sterilization after deciding that she wouldn’t desire bearing more offsprings having already two. The doctor told her there was a swift and modern method of sterilization which didn’t require hospitalization by using a silver nitrate paste, to which she accepted though without any written consent. The procedure was carried out in March 1973, and the woman was said that the appliance of nitrate would require an another procedure some months thereafter, which was done in June 1973; in September 1973 plaintiff was found to be pregnant again, went on abortion in Edmonton and afterwards underwent a tubal ligation in October 1973 executed by the same doctor. After the procedure, plaintiff’s health declined and was stabilized only by 1975²⁰³. The medical experts’ testimony was that such method had lots of potential adverse effects and didn’t receive much clinical practice, moreover in case of pregnancy the misbirth chance tolled around 85 per cent. Thus, the Court found that the method disposed was seemingly exper-

imental and without adequate clinical support; the Court attempted to distinguish battery and negligence actions as it was initiated before²⁰⁴. In fact, the distinction used in *Zimmer* was the same as it was made in *Cobbs v. Green*: unconsented surgery is itself battery, but the failure to inform, since it became a sort of standard for professional conduct is negligence²⁰⁵. The Court outlined that the defendant may prevail in action if demonstrates he acted with prudent and generally approved medical practice²⁰⁶. Upon the given evidence defendant was found to be negligent; moreover, it was not the first trial against him: Mr. Ringrose, a gynecologist by profession seemed to experiment a lot with methods of sterilization, but all of them tragically concluded in filing lawsuits against him, namely by *Colp*²⁰⁷ and *Cryderman*²⁰⁸, besides in all of the three cases Mr. Ringrose was sued for the same method of sterilization disposed in *Colp*, *Cryderman* and *Zimmer*²⁰⁹. The facts of the other two cases did not majorly vary from *Zimmer*. In *Cryderman*, a woman desiring to be sterilized came to Mr. Ringrose and he carried out the same operation. It was not only unsuccessful, but the plaintiff became pregnant again and so had to undergo an abortion procedure (the evidence was conflicting upon which way was it performed). It was revealed that Mr. Ringrose found this “silver nitrate” method in an early 1970s medical journal and desired to approbate it, repeatedly representing it among his colleagues and fellows; perhaps before he had discovered the said method it was unknown or nearly unknown in Canada²¹⁰. The health of Mrs. *Cryderman* had declined badly. Though the case report doesn’t distinctly reveal the events concerning plaintiff’s unexpected pregnancy, it was suggested that not only the physician failed to inform her concerning his “experiments”, but he even did the abortion (via biopsy) unconsentedly. Upon *Bolam*, *Halushka* and a number of other related sources the Court found that the case at bar was the one of such nature where the informed consent is a must, especially when the procedure is highly risky, thus finding Ringrose liable²¹¹. In fact, the 60s made a number of commentators to turn their attention on medical negligence concerning experiments where the informed consent was repeatedly discussed²¹². These abovesaid cases, the Ringrose trials and *Dendaas v. Yackel*, a case very much similar to Ringrose trials also being an action for battery (but transformed by the court to a count for malpractice) for not warning the woman that the method used didn’t guarantee total sterilization²¹³, had a substantial impact on the formation of Australian common law in regard with informed consent, in particular the case of *F. v. R.*²¹⁴.

The next cases which contributed to the Canadian informed consent doctrine, being considered the leading ones (though definitely not the first ones), are *Reibl v. Hughes* and *Hopp v. Lepp*, being both adjudicated in 1980 by the Supreme Court of Canada. These cases, however did not have any extraordinary facts but were majorly known to apply a set of US general rules on the informed consent. For instance, the Canadian courts began to apply an “objective test” in actions for unconsented surgery in the fashion United States courts did slightly before²¹⁵. In *Hopp v. Lepp*, an elderly man from Alberta who was suffering from a spinal blockage was hospitalized to have an operation on a disc; defendant removed a part of the spinal disc between the 3rd and 4th lumbar vertebrae. After the said operation, a follow-up X-ray revealed that the blockage was removed, but in fact, it wasn’t completely removed as unfortunate man continued to suffer²¹⁶. Plaintiff was advised to apply to another neurosurgeon in Calgary who performed a very complicated operation known as laminectomy from the second to the fifth lumbar vertebrae of the patient, having discovered and excised lots of extruding disc material. The complexifications were discovered on basis of an extended exploration. Sadly, the plaintiff remained disabled, upon the finding that some of the root canal nerves were permanently damaged; plaintiff sued for battery and negligence, however the trial judge didn’t find enough evidence that the care of physicians could be pronounced negligent, either in diagnosis or in the performance of the operation (besides, very complicated one), or in post-operative care; no appeal from the plaintiff’s party came upon the negligence claim, it was based upon the lack of informed consent of the plaintiff and he managed to recover 15,000 Dollars²¹⁷. The Court discussed the gist of informed consent and assumed there had been Canadian legacy on the subject, but quite few in respect with “intelligent” consent; upon the evidence, the appellant physician did not disclose the elderly man neither the scope of the operation, nor that he would be the only person to deal with any conjectural complexifications if such would occur, claiming that the operation won’t be a serious one and that the plaintiff should be fine in a week or a bit longer. At the trial court the findings were that the operation did not involve the risks which could be alerted in the way it would have been suitable to do in the case of *Halushka v. University of Saskatchewan*²¹⁸. The further evidence disclosed that it was actually the principal operation of that type conducted by the doctor and that he firmly denied it could be a complicated operation advising the plaintiff and his spouse not to travel to Calgary to have the blockage removed at a Calgary clinics. The Court examined the lower court decision to find out whether there was a discussion on probable risks as well as did the plaintiff inquire on such risks; evidence disclosed that the plaintiff and physician definitely had some discussion on the topic, but it was unclear was it a general query or anything more, as observed in the *Auckland Area Hospital* case²¹⁹, frequently cited by Canadian courts and in the instance case as well; nor was it clear if these risks were different from ones existing in any similar operations²²⁰. The Court also examined the *Lockwood* trials emphasizing on the duty to disclose risks which seemingly was not developed in Canada into a system-based approach despite having such legacy²²¹ but upon the Court’s view, was much better elaborated in the United States with a well-celebrated case of *Canterbury v. Spence*. Upon the *Lockwood* trials and *Halushka*, the Court recognized the informed consent doctrine outlining a classification of risks that was elaborated in the existing US and Canadian common law; the Court also found that the “duty to warn” which might be well recognized by *Bolam*, doesn’t arise from a query but is a duty which is obligatory regardless of it²²². The Court, however found that the informed consent was not the negligent action to be sued for as there was no facts affirming that the place of the operation (Lethbridge or Calgary) could be material at all, or the plaintiff put his consent to the operation depended anyhow on the choice of the city where the operation could be performed. Moreover, the trial judge’s finding that the permanent disability could have occurred resulting from the original con-

dition of his disc, and the possibility of the fact that unless Hopp had gone to Calgary to be operated he would have suffered less damage to health was entirely conjectural, were upheld by the Supreme Court. Thus, plaintiff's action was dismissed and appeal was allowed²²³.

The next case, *Reibl v. Hughes* is one of the most outstanding leading cases on the subject in Canada. There, a man in his mid-40s being a year-and-a-half prior to his lifetime pension decided to undergo a surgery to have an occlusion of his left carotid artery removed; upon the description of the appeal and the instant case, plaintiff also suffered from repetitive headaches and hypertension (believing that the said surgery would relieve him from them as well). After being fed up with his deteriorating health in early 1969 he went to his wife's physician, one Dr. Szabo, a Hungarian by origin as the plaintiff was, who advised undergoing an examination; therein plaintiff was found to have diabetes; after the examination he proceeded to work but his deterioration of health signaled and he was later advised to go to hospital for more examinations; there after being put on a diet his condition somehow improved, but not much since he still suffered from high pressure; upon the angiogram a blockage in his left carotid artery was found and it had to be excised as the blood flow was so severed it let out only 15 per cent of ordinary blood flow through the veins leading to the brain. Before the surgery plaintiff signed the consent form²²⁴. Within the operation, or shortly after it Reibl suffered an insult remaining him half-paralyzed and impotent. Such hazards were in the "risk list" of the operation though it was not very frequent. At trial Reibl managed to succeed in action recovering a surprising sum of 225 thousand dollars but the defendants appealed. The Ontario Court of Appeals made a number of findings. On that trial expert evidence by neurosurgeons revealed that around a tenth part of such operations brought to thanatoid consequences and that the plaintiff seemingly held a conversation on the content of the operation with the doctor, but evidence was pretty much conflicting in respect with the discussion of the risks, and the Court found that although it was not clear did Hughes refer to any statistics of casualties (as of the expert evidence it was 4 % of deaths and around 10 % of insults), or he just kept on to discuss how was the operation expected to be carried out, nevertheless it was concluded that Hughes said that it was up to Reibl to decide and Reibl consented²²⁵. As I mentioned before, Reibl thought he would be relieved from headaches as well and go to work as soon as possible and the trial judge found that he misunderstood the scope of the operation (and in fact, his native language was Hungarian though he was able to speak English on a moderate level and comprehended it same but was unable to distinguish such words as "stroke"), but evidence displayed that defendant explained him that it was a confusion. Therefore, the Court found that plaintiff was anyway aware of the operation; dealing with the causes of action upon negligence and battery the Court dismissed both, as in the primary one the Court, upon a so-called "subjective test" found nothing indicated that entirely defendant's negligence provoked plaintiff's damages, and the battery claim had its defense in the fact that plaintiff actually consented to the general operation (and actually even signed some consent form, though its text was not present in the reports)²²⁶. The Court also said that the *Lockwood* trials and *Male*²²⁷ both involved issues of informed consent though not being filed for failure to disclose risks, but for negligence and battery respectively; if the latter one was of that nature, then lack of informed consent upon the Court's view couldn't be regarded as battery and would more likely to fall into the scope of negligence (majorly this was laid down upon the view of *Cobbs v. Grant*). So, the Court allowed the appeal and granted a new trial²²⁸. On the trial held at the Supreme Court of Canada, the Court found that in the conversation between plaintiff and defendant neurosurgeon the latter induced him to believe that he had better had this operation than he would rather hadn't; and within cross-examination, a substantial fragmenton of which was attached to the report, Hughes did not disclose the risks concerning the presupposed surgery or the fatality and morbidity rates which were quite hazardous to be ignored²²⁹. The Supreme Court held that the liability won't stand in battery²³⁰ but may be addressed to negligence, finding that it was a physician's duty to give the appropriate information to the patient, who didn't cope with it; the Court also used the objective test upon which the thanatoid and morbidity statistics would induce a prudent person to withstand from such operation. Thus, the Court restored the trial court's judgment finding for plaintiff²³¹. It would be quite intelligible to say that *Reibl v. Hughes* completed the formation of informed consent doctrine in Canada being truly a leading case in the state.

After the two leading Canadian cases on informed consent were adjudicated, several issues of its modification remained. Such sprung out primarily on dentistry malpractice featured a position of the Court declaring that informed consent is not obligatory for minor manipulations²³², but this was not approved in similar dentistry malpractice cases in Canada, where the courts followed the *Hopp v. Lepp* and *Reibl v. Hughes* rules of informed consent²³³. One case is however worth being discussed as it's quite of complicated nature, combining the right to privacy, right to autonomy and the issue of emergency. In *Malette v. Shulman*, a woman being a Jehovah Witness sued a doctor for an unconsented blood transfusion (in fact, it is true that people with similar religious beliefs object blood transfusion and thus there was several similar suits on "conscious" refusal of treatment, or unconsented blood transfusion²³⁴). The facts of the case were quite cunning and complicated: in 1979, the woman being already 57 years old, had been plunged into a car crash with her husband killed and herself mangled having a multitude of face and head traumas as well as suffering from a substantial blood loss; she was taken to the emergency department where she was examined by Dr. Shulman and his mate who agreed that blood transfusion would be necessary to preserve her life; one of the nurses found out a card declaring plaintiff to be Jehovah's Witness and the passage on the card stated she would not tolerate any blood transfusions under any conjectural circumstances²³⁵. Dr. Shulman had not been notified on the content of the card, but nevertheless decided to conduct transfusion; the relatives of Mrs. Malette came to the hospital and objected blood transfusion upon their beliefs even though they apparently knew in which condition the woman was. After the said procedure the plaintiff was thereafter treated without any blood

transfusions and later successfully recovered. On the first trial, defendant Shulman was found liable for battery and the learned judge found the “card” legally valid²³⁶. The Court acknowledged the right to self-determination, discussing the parity of state-interest of patient’s preservation of life and his right to autonomy in decision-making holding that the appeal should be dismissed and finding for plaintiff²³⁷. To a similar decision came the Court of Appeal (England) in the “T case” in 1993 where a pregnant woman was severely injured in a car crash, being a Jehovah’s Witness; she was also subjected to blood transfusion though it was not emergent and the Court recognized her right to withstand from treatment on basis of beliefs²³⁸. From the 1980s and 90s decisions of the English Court of Appeal it may seem that England approves maximal autonomy, if not to say independence to patient’s decision-making even in case he or a child in his custody would apparently die unless treatment is administered²³⁹; but at the same time the British courts upheld the principle to preserve child’s life unless it is firmly evaluated to be condemned to death, his further life would literally become intolerable and any amount of treatment would postpone, but not avert death²⁴⁰. The American decisions involving people with religious beliefs prohibiting blood transfusion were not uniform by their adjudication: the 1970s Federal decision of Holmes, being aggravated by the issues of survival of action (as the plaintiff deceased), his minority (20 years of age) as well as other concerns held that upon his religious beliefs he had a right to refuse treatment²⁴¹. Several US courts came to a conclusion that upon the First Amendment the person has a right to refuse medical treatment unless the state may justify the body interference in some way²⁴²; indeed, a cascade of similar cases displayed that in each of such entries has to be balanced against state interests, adopted by American courts as the following: 1) preservation of life; 2) protection of innocent third parties; 3) suicide prevention; 4) ethics preservation and maintenance²⁴³. Several US decisions, mainly the earlier ones seemed to display a substantial prevailing of state interests against patient’s religious beliefs in order to save life²⁴⁴. In fact, such cases on blood transfusion could be complexified by the circumstance the patient is a minor and the parents wouldn’t let transfusion on basis of their religious beliefs²⁴⁵. In some states, the hospitals applied for a court order to appoint a legal guardian who would allow administering blood to a person with religious beliefs inhibiting the said²⁴⁶; or applied to the court to receive an order (an “emergency writ”) to conduct it²⁴⁷. Some courts agreed that there may be a multitude of circumstances that a court may consider to allow or not allow such transfusion, or to find its performance actionable, or not, for instance, existence of dependents²⁴⁸.

Conclusions and corollary. At present time the Canadian common law truly possesses a substantial number of cases on the subject of unconsented surgery and therapy, having various impacts and influencing a number of other commonwealths’ common law as well. The carousel of domestic cases involves actions for failure to warn on the consequences of sterilization²⁴⁹; on appliance of anesthetic apparatuses and possible malfunctions of the said²⁵⁰; unauthorized administering of anesthetics which brought to paralysis²⁵¹ or other health impairments²⁵²; issues of immature consent²⁵³; nondisclosure of adverse effects of angiograms²⁵⁴; misrepresentation of the embrace of the operation²⁵⁵; nondisclosure of experiment risks²⁵⁶; unauthorized medical procedures in dentistry, such as multiple teeth removal²⁵⁷; extension of the operation involving some emergent condition²⁵⁸, and after the informed consent doctrine was adopted in *Reibl v. Hughes*, the issue of necessity of informed consent for minor and non-surgical operations (primarily in dentistry)²⁵⁹. Some cases feature French impact concerning the adjudication²⁶⁰, while the others disposed American informed consent doctrine in a blend with domestic cases²⁶¹; however upon the late 70s and early 80s the Canadian courts had enough domestic practice to adjudicate the respective cases. All in all, despite having less court decisions on the subject than in United States, the Canadian common law has got enough legacy vis-à-vis informed consent doctrine in the time fragment of 1899 and 1900.

¹ Upon the distinction originating from *Schloendorff v. New York Hospital*, 211 N.Y. 125, 129–130 (1913), in case the surgeon performs an unauthorized surgery, he’ll be liable for technical assault/battery, and it’s not a mere negligence to do this. See. *Mohr v. Williams*, 95 Minn. 261, 268–270; 1 A.L.R. 439, 439–441 (1905); *Hively v. Higgs*, 120 Or. 588, 592 (1927); *Moscicki v. Shor*, 107 Pa. Super 192, 195; 163 A. 341, 342 (1931); *Bonner v. Moran*, 126 F.2d 121, 121–122 (1941); *Rothe v. Hull*, 352 Mo. 926, 929 (1944); *Nolan v. Kechijian*, 64 A.2d 866, 866 (1949); *Chambers v. Nottenbaum*, 96 So. 2d 716, 717 (1957); *Nathanson v. Kline*, 186 Kan. 393, 402 (1960); *Gruccio v. Baxter*, 135 N.J. Super. 290, 295 (1974); *Samoilov v. Raz*, 536 A.2d 275, 277 (1987), etc. What as to an action for negligence in such case, upon *Hershey v. Peake*, 223 P. 1113 (1924), at. page 1113–1114, the action founded upon an unconsented surgery is maintainable upon the theory of negligence rather on assault/battery in case the action of the physician is *unintended* and arises from his carelessness within the said operation. The consent, however, does not exempt him from liability in case the *consented* operation was proved to be negligently executed, *Theodore v. Ellis*, 141 La. 710, 723–724 (1917). In case the patient is unconscious, and the unauthorized operation is performed in the scope of a consented operation, he may sue for assault/battery as well, and physician will be liable for it, unless an emergency (which has to be proved) occurs, *Bennan v. Parsonnet*, 83 A. 948, 949–950 (1912).

² See. *Rosenthal v. Hasbrouk*, 161 N.Y.S. 354, 354 (1916); *Delahunt v. Finton*, 224 Mich. 226, 221 N.W. 168, 169 (1928); *Gist v. French*, 136 Cal. App. 2d 247; 277 P.2d 1003, 1006 (1955).

³ See. *Burroughs v. Crichton*, 4 A.L.R. 1529, 48 App. D.C. 596, 597–598 (1919); *Frank v. Maliniak*, 249 N.Y. Supp. 514, 232 App. Div. 278, 279–280 (1931).

⁴ *Hundley v. St. Francis Hospital*, 327 P.2d 131, 135; 161 Cal. App. 2d 800, 805–806 (1958).

⁵ See. *Cobbs v. Grant*, 3 Cal. App. 3d 228, 238–238 (1973) and cases adjudicated under the theory of assault/battery and medical malpractice cited therein.

⁶ In England, one of the first reported cases to consider the subject, *Bolam v. Friern Hospital Management Committee*, [1957] 1 W.L.R. 582, 583–585., was an action for negligence. *Chatterson v. Gerson*, [1981] 1 Q.B. 432, 442–445 was filed upon the theory of trespass to person which was disapproved by the Court; Bristow, J., at p. 442–443 said that failure to obtain consent should be tried under the theory of negligence.

- ⁷ See. *Sidaway v. Bethlem Royal Hospital etc. et al.*, [1985] A.C. 871; [1985] UKHL 1, 6.
- ⁸ *Moyes v. Lothian Health Board*, [1990] S.L.T. 444, 450–451.
- ⁹ For example, see. *Marshall v. Curry*, [1933] 3 D.L.R. 260; *Mulloy v. Sang*, [1935] 1 W.W.R. 714; *Winn v. Hospital, etc.*, [1940] O.W.N. 238; *Schweizer v. Central Hospital et. al.*, [1975] 6 O.R. (2d) 606.
- ¹⁰ *Kelly v. Hazlett*, 75 D.L.R. 3d 536, para. 71, 75–78 (1976).
- ¹¹ *Reibl v. Hughes*, [1980] 2 S.C.R. 883, 888–892; 925–929.
- ¹² See. *Kozup v. Georgetown University*, 851 F. (2d) 437, 439–440 (D.C. Cir. 1988).
- ¹³ See, e.g. *Smith v. Weaver*, 22 Neb. 569, 575 (1987). There, a Nebraska statute enacted in 1976 proceeded that plaintiff could succeed in action only if he could somehow managed to prove that in an “objective test”, like in Canadian actions for negligence, a prudent person would withstand from surgery or treatment finding it dangerous thus making lack of informed consent not being itself actionable; see. 44–2820, “Action based on failure to obtain informed consent; burden of proof” and it’s case law application: *Jones v. Malloy*, 226 Neb. 559 (1987) [chiropractic casualty]; *Curran v. Buser*, 272 Neb. 332 (2006) [gallbladder removal casualty].
- ¹⁴ See. *Natanson v. Cline*, 360 P.2d 1093; 186 Kan. 393, 402–405 (1960).
- ¹⁵ *Pedesty v. Bleiberg*, 59 Cal. Rptr. 294, 251 Cal App. 2d 119, 123–124 (1967).
- ¹⁶ *Natanson v. Kline*, 187 Kan. 186, 187–188 (1960).
- ¹⁷ *Jones v. Malloy*, 226 Neb. 559, 562–565 (1987).
- ¹⁸ See, for instance, *Nelson v. Sandell et. al.*, 212 Iowa 109, 209 N.W. 440, 441 (1926); *Moscicki v. Shor*, 107 Pa. Super. 192, 183 A. 341, 341–343 (1931) as early authorities in United States on the subject.
- ¹⁹ *Halushka v. University of Saskatchewan*, 89 D.L.R. (3d) 112, para. 25–32 (1965).
- ²⁰ *Moore v. Regents of University of California*, 51 Cal. 3d. 120, 129–132 (1990).
- ²¹ See. *Holmes v. Silver Cross Hospital of Joliet, Illinois*, 340 F. Supp. 125, 129–130; 132–136 (1972); *Malette v. Shulman*, 67 D.L.R. (4th) 321, 330–336 (1987–90) *In Re T. (Adult: Refusal of Treatment)*, [1993] Fam. 95, 99–101; 113–115; see also cases cited in note 243–246 *infra*.
- ²² E.g. a dictum could be found in *Williams v. Poppleton*, 3 Ore. 139 (1870), at p. 147, where plaintiff sued a physician for negligent treatment causing his leg to be amputated. The Court had an extensive discussion on the expected degree of abilities, skill and knowledge a surgeon ought to possess not to be held liable in case the treatment is unsuccessful, and stated the following: “From these and like considerations [speaking of surgeon’s expected skills and knowledge] arise those cases and conditions so frequently alluded to by medical witnesses in the course of the trial, in which the surgeon is called upon to exercise his best judgment, and in which he is justified in changing the mode of treatment from time to time and the nature and exigencies of the case indicate a necessity, or the propriety of a change”. Later, on p. 148, the Court augmented that it might not actually mean that “doctor always knows better”, but only in the sense he would be exercising his best judgment in any particular case (see additionally e.g. *Staloch v. Holm*, 100 Minn. 276, 281 (1907).
- ²³ Concerning the unconsented surgery, the first reference to it was made in *State ex. rel. Janney et al. v. Housekeeper et. al.*, 70 Md. 162, 2 R.L.A. 587, 588 (1889). But in fact, it is a general rule in each action for professional negligence.
- ²⁴ *Cozine v. Moore*, 159 Iowa 472, 141 N.W. 424, 426 (1913); *McGuire v. Rix*, 225 N.W. 120, 122 (1929); *Hunt v. Bradshaw*, 242 N.C. 517; 88 S.E.2d 762, 765–767 (1955). On a more expanded meaning of ordinary skill and care, as well as the analysis of them, see, for instance, Milton Oppenheim, *Standard of Care of Medical General Practitioners*, 9 Clev. Mar. L. Rev. 227, 228–232 (1960).
- ²⁵ *Town v. Archer*, [1902] 4 D.L.R. 382, 388–390; *Jarvis v. International Nickel Co.*, [1929] 2 D.L.R. 842, 845–846; *Chrysler v. Pearse*, [1943] 4 D.L.R. 738, 747; *Wilson v. Swanson*, [1956] S.C.R. 804, 812–813; *Challand v. Bell*, 18 D.L.R. (2d) 150, 152–153 (1959).
- ²⁶ See *Rex v. Bateman*, 19 Cr. App. R. 8; 41 T.L.R. 557, 559 (1925) and vintage authorities cited therein.
- ²⁷ See cases cited in *Wilson v. Swanson*, [1956] S.C.R. 804, at page 813.
- ²⁸ The announced general rule on 30 Cyc. 1578 and early authorities cited therein; see also. *Nelson v. Sandell et. al.*, 212 Iowa 109, 209 N.W. 440, 442 (1926) and authorities cited.
- ²⁹ See. *Ewing v. Goode*, 78 Fed. 442, 443–444 (1897) and vintage authorities cited therein.
- ³⁰ See. *Baxter v. Snow*, 2 P.(2d) 257, 265 (1931).
- ³¹ For instance, in *Simone v. Sabo*, 37 Cal. 2d 253, 231 P. 2d 19, 21–23 (1951), plaintiff sued a physician for a negligent tooth removal involving various surgical machinery which allegedly severed the nerves, but didn’t bring expert witnesses which could approve his own testimony. The California Civil Code provisions, referred by defendant thereto required expert testimony. Instead, the defendant brought in several surgeons who testified he acted with expected care and applied decent skill. Owing to lack of evidence, the defendant had the decision.
- ³² Primarily, such expert witnesses are physicians and hospital staff. See. *Nelson v. Sandell*, 209 N.W. 440, 442 (1926); *Jackovach v. Yokom*, 237 N.W. 444, 447 (1931), and authorities cited therein.
- ³³ For means of brevity, see Gerald M. Smith, Robert J. Olinger, *Consent to Surgery*, 11 Clev. Marshall L. Rev. 241, 243–247 (1962), and a number of authorities cited therein.
- ³⁴ In a nutshell, by such “intelligence” it is meant to be that the patient conceives what is going to be performed, what are the risks and what are the conjectural adverse consequences of such operation or treatment, otherwise, upon the vast majority of US states common law it is void and actionable, *Aiken v. Clary*, 398 S.W. (2d) 668, 674–675 (1965), etc.
- ³⁵ *Gruccio v. Baxter*, 343 A.2d. 145, 135 N.J. Super. 290, 295 (1975); to the same effect goes *Reibl v. Hughes*, [1980] 2 S.C.R. 883, 925–928.
- ³⁶ *McInerney v. MacDonald*, [1992] 2 S.C.R. 138, 149; 157.
- ³⁷ See., for instance *In Re Conroy*, 486 A.2d 1209, 1222–1223 (1985) and authorities cited therein; a more detailed view upon various commonwealth state cases and international human rights case law will be expressed in the paper below.
- ³⁸ *Moore v. Regents of University of California*, 793 P. 2d 479, 51 Cal. 3d. 120, 129–131 (1990).
- ³⁹ In fact, there had been few cases on the record prior to *Housekeeper* and *Hanselman*. Such obscure entries involve *Slater v. Baker & Stapleton*, 2 Wils. 359, 361–364 (1767) [unconsented rebreach of plaintiff’s leg by two “enthusiastic” physicians attempting to experiment on a new method of fracture treatment]; *McClallen v. Adams*, 36 Mass. 333 (doctor held not to be liable for an operation not saving the life of plaintiff’s spouse, being made without his consent); *Boydsten v. Giltner*, 3 Or. 118, 124–126 (1869) [unauthorized rebreach of arm, upon lack of evidence the jury rendered verdict for defendant]. It has to be augmented that the history of medical neg-

ligence counts several centuries. An astonishing passage on this topic could be found in Mr. McCoid's treatise on a 1959 Symposium on Professional Negligence, see. Allan H. McCoid, *The Care Required of Medical Practitioners*, 12 Vand. L. Rev. 549 (1959).

⁴⁰ *McClallen v. Adams*, 36 Mass. 333, 335–336 (1837).

⁴¹ See. e.g. Donald G. Hagman, *The Medical Patient's Right to Know: Report on a Medical-Legal-Ethical, Empirical Study*, 17 UCLA L. Rev. 758, 764–767 (1970).

⁴² 1 *Kinhead on Torts* 735, 735–738 (para. 375); Taylor, *Law in its Relations to Physicians* 313, 313–315 (see. “Necessity of Consent to Surgical Operations”).

⁴³ For an example of such, see, for instance, *Littlejohn v. Arbogast*, 95 Ill. App. 605, 608 (1901) and rules announced by the court concerning consent to surgical interference (at p. 608).

⁴⁴ See. *Kennedy v. Parrott*, 243 N.C. 355, 90 S.E.2d 754, 758–759 (1956).

⁴⁵ E.g. Ralph Straub, *The Surgeon and the Unconscious Patient*, 33 Law Notes (Edward Thomson Co.) 29, 29–31 (1929).

⁴⁶ *Bennan v. Parsonett*, 83 A. 948, 949 (1913).

⁴⁷ *Bennan v. Parsonett*, 83 N.J.L.R. 20; 83 A. 948, 949–950 (1912).

⁴⁸ 211 N.Y. 125, 128–130 (1914).

⁴⁹ *Id.*, 128–129.

⁵⁰ See. *Bakal v. University Heights Sanitarium, Inc.*, 277 App. Div. 572, 575–577 (1950) (for); see also *Post et al. v. Crown Heights Hospital*, 173 Misc. 250, 257–258 (1940) (against). In *Bakal*, the Court held that unless the Appellate Court being superior to it would state otherwise, the immunity rule would not change, see *Bakal*, at p. 575. This rule, as I mentioned before, didn't really spread apart from the state of New York and was declared abortive seven years after.

⁵¹ To some extent, it was based upon an English decision, *Hillyer v. Governors of St. Bartholomew's Hospital*, [1909] 2 K.B. 820, 825–826. There, plaintiff, being a physician himself returned from Africa in bad health and applied as a non-paying patient to the Londonese hospital, a charitable body, in order to be consulted. Before the examination he was etherized and within it one of his hands was burned and the other was bruised. The Court (per Farwell, L.J.) held that defendants could not be liable as their relation is not of master and servant. What is surprising, the Court relied on an earlier American authority concerning master-servant relation concerning charitable hospitals. The *Hillyer* case was later distinguished in Scotland. In *Reidford v. Magistrates of Aberdeen*, 1933 S.L.T. 276, at page 280 it was settled that the in the scope of hospital service, a professional (a physician) could be liable in a nonsuit action for his own negligence, but the regent will not be. Within the sphere of professional medical service, it was held that there existed no actual master-servant relation. In *MacDonald et al. v. The Board of Management for Glasgow Western Hospitals, etc.*, 1954 S.C. 453, at page 456–458, this liability was said to be imposed in case of proof that the Board *itself* was negligent in some way, and the Court allowed proof, but the counsel for plaintiff didn't give justifying proof to maintain the action, see p. 457–459. This however didn't mean that a surgeon or other staff member would not be liable for his own “irregularity” (see explanatory in *MacDonald*, p. 457). Therefore, in that case the Court of Sessions approved the rule concerning the exemption of a hospital board liability for servant's negligence which was announced in various cases earlier, *Davis v. Glasgow Victoria Hospitals Board of Management*, 1950 S.L.T. 392, 394–397 (1950) and other cases cited therein; but considered the issue of board's own negligence. However, the decline of the concept in Scotland came relatively short, *Fox v. Glasgow South Western Hospitals & Another*, 1955 S.L.T. 337, 339–340 where the *Hillyer* decision was criticized and abandoned thereafter. In England, the *Hillyer* decision was severely criticized and found to be abortive even earlier, *Gold v. Essex County Council*, [1942] 2 K.B. 293, 299–300. Please note that Scottish cases cited hereinabove did not necessarily concern a non-profit hospital, whereas the *Schloendorff* rule covered only such establishments the late modification of the rule, see cases cited in *note 34 supra*, and *Bing v. Thunig*, 2 N.Y. 2d 656 (1957), at pages 666–667, where the Court declared profit-making and non-profit hospitals equally liable for the wrongs done by its staff, see *infra note 36*. Some further notes on the English views of hospital liability and standards of care are well discussed by Mr. Fleming on a 1959 Symposium on professional negligence, see. John G. Fleming, *Developments in the English Law of Medical Liability*, 12 Vand. L. Rev. 633, 635–639; 640 (1959).

⁵² Upon the timeline, revealed by Fuld, J. in *Bing*, the history of this doctrine lies in a North-American case, *MacDonald v Massachusetts General Hospital*, 120 Mass. 422, 435–436 (1876) [per Devens, J.] The sole authority referred to was an English one, being already overruled decades before by the time of *MacDonald* case occurred. See more on the said cases, A.L. Goddard, *Hospitals and Trained Nurses*, 54 L.Q.R. 553, 557–558 (1938). The pre-*Hillyer* cases were discussed in a distinct Canadian case, namely *Lavere v. Smith's Falls Public Hospital*, 35 O.R. 98; 26 D.L.R. 346, 350–354 (1915).

⁵³ In fact, Canadian courts quickly disapproved *Hillyer* and found its approach to be abortive, see. *Lavere v. Smith's Falls Public Hospital*, 26 D.L.R. 346, 360–362 (1915) [per Riddell, J.] and *Nyberg v. Provost Municipal Hospital Board*, [1927] 1 D.L.R. 969, [1927] S.C.R. 226, 229–230 [per Anglin, C.J.C.]. At the same time, other Canadian Courts followed *Hillyer* for some time: *Pierce v. Straphroy Hospital*, 27 O.W.N. 180 (1924).

⁵⁴ For the Scottish cases disapproving *Hillyer*, see cases cited and discussed in *note 51 supra*; However, in *Foot v. Shaw Stewart et. al.*, [1911] 2 S.L.T. 364, 367 the hospital was held not to be liable *ex contractu*.

⁵⁵ See *Gold v. Essex County Council*, [1942] 2 K.B. 293, 296 [argument of counsel for plaintiff] and cases cited therein. A good discussion on the said doctrine in 1866–1915 was held in *Lavere v. Smith's Falls Public Hospital*, 38 O.R. 98, 26 D.L.R. 346, 354–356 (1915), on pages I cite herein (but see also *supra note 36* on pre-*Hillyer* cases).

⁵⁶ See *Brant v. Sweet Clinic*, 167 Wash. 166, 174 (1932); *Giusti v. C. H. Weston Co.*, 165 Or. 525, 106 Pa. 2d 1010, 1012 (1941) and cases cited therein.

⁵⁷ *Bing v. Thunig*, 2 N.Y. 2d 656, 666–667 (1957) [per Fuld, J., lead opinion].

⁵⁸ See. for instance, *Martel v. Hotel Dieu St-Vallier* [1969] S.C.R. 745, 752–753. In this Canadian case, which we'll discuss in the paper, there was an issue of hospital's and anesthetist's liability for an unauthorized caudal anesthesia injection which caused plaintiff's paraparesis within a haemorrhoidectomy. There, he was found to be a regular employee and so both he and the hospital were held liable.

⁵⁹ *Schloendorff v. Society of New York Hospital*, 211 N.Y. 125, 131–135 (1914).

⁶⁰ The given definition is a pretty condensed one made up on basis of the court decisions cited hereinafter. For a more detailed description, see a decent one in Jon R. Waltz, Thomas W. Scheuneman, *Informed Consent to Therapy*, 64 N.W.U. L. Rev. 628, 630–634 (1970). Waltz and Scheuneman wittily emphasize, at page 631, that a physician while performing such a procedure, which may be somehow experimental or innovative by techniques, must not only possess ordinary skill and provide the patient with adequate care, but possess proper knowledge to conduct such procedures and dispose respective appliances.

⁶¹ *Salgo v. Leland Stanford Etc. Bd. Trustees*, 317 P.2d 170, 154 Cal. App. 2d 564, 577–578 (1957) and *Natanson v. Kline*, 350 P.2d 1093, 186 Kan. 393, 403–404; 409–413 (1960).

⁶² Such view is adopted in the celebrated case of *Canterbury v. Spence*, 464 F. 2d 772, 782 (1972). The rules and corollary deriving from the said case was repeatedly disposed within the amalgamation of custom informed consent rules in other commonwealths including England. See also fn. 15 at p. 781 and 29 at p. 782 and cases cited therein and cases cited in footnote 54 *infra*.

⁶³ For instance, see *Hudson v. Shoulders*, 11 Smith (TN) 70; 164 Tenn. 70; 45 S.W. 2d 1072, 1072–1073 (1932); *Perrin v. Rodriguez*, 153 So. 555, 557–558 (1934); *Bowman v. McPheeters*, 77 Cal. App. 2d 795, 797–798; 800–802 (1947); *Simone v. Sabo*, 231 P.2d 19, 21 (1951); *Stafford v. Shultz et al.*, 42 Cal. 2d 767, 778–780 (1954); *Guy v. Schuldt*, 138 N.E. 2d 891, 236 Ind. 101, 109–112 (1956); *Sheets v. Burman*, 322 F. 2d 277, 279–280 (1963); *Emmett v. Eastern Dispensary and Cas. Hospital*, 396 F.2d 931, 938 (1967).

⁶⁴ See remark in G. E. Maybee, *Assumption of Risk and Negligence*, 36 Can. B. Rev. 136, 136–137 (1956).

⁶⁵ In general, it is the correlation between the doctrine of “volenti non fit injuria” and professional negligence. This doctrine was not found to be a defense unless the plaintiff was proved to be explicitly aware of the extent of risk he was subjecting himself. It was quite common in actions of an injured passenger, spectator, or workman: *Letang v. Ottawa Electric Railway Co.*, [1926] A.C. 725, 730–731 (and see earlier cases cited); *Hall v. Brooklands Auto Racing Club*, [1933] 1 K.B. 205, 215–217; *Murray and Another v. Harringay Arena LD*, [1951] 2 K.B. 529, 534–535; *Wooldridge v Sumner et al.*, [1963] 2 Q.B. 43, 69–70, etc.

⁶⁶ 450 S.W. 2d 2d 578, 580–581 (1969).

⁶⁷ See *Salgo v. Leland Stanford Etc. Bd. Trustees*, 154 Cal. App. 2d 564, 578 (1957).

⁶⁸ *Canterbury v. Spence*, 487 F. 2d 772, 780–788 (1972).

⁶⁹ *Bolam v. Friern Hospital Management Committee*, [1957] 1 W.L.R. 582, 583–584; 588–590.

⁷⁰ In fact, even as of the 80s decision, *Sidaway v. Governors of Bethlem Royal Hospital etc.*, [1984] 1 Q.B. 493, 511–515, did not recognize such common law right “to autonomy”, despite a handful of American and Canadian cases affirming such right were observed. The first English decision to affirm the American and Canadian consent doctrines, where the rule similar US had been announced was *In re F*, or *F v. West Berkshire HA*, [1990] A.C. 1, at p. 69–71 [per Griffiths, L.].

⁷¹ In fact, it's difficult to stick to an exact date. In one of the most outstanding informed consent cases in Canada which was adjudicated by the Supreme Court, *Hopp v. Lepp*, [1980] 2 S.C.R. 192, at pages 196 and 201, the Court cites *Kenny v. Lockwood*, [1932] O.R. 141 (the defendant's appeal, dismissed) as well as *Parmley v. Parmley & Yule* [1945] S.C.R. 635 as the first cases to engage the informed consent doctrine. These, however, were not the principal cases on consent to surgery in Canada. All of such we'll discuss in the given paper.

⁷² See. *Hopp v. Lepp*, [1980] 2 S.C.R. 192, 195–196 and cases cited therein; also fn. 60 *infra*.

⁷³ See *McLean v. Weir*, [1977] W.W.R. 609 [annotation by Ellen P. Jacobs]; *Jodouin v. Laurentian University Hospital*, [1978] 1 A.C.W.S. 98, para. 14.

⁷⁴ See. *Kelly v. Hazlett*, 75 D.L.R. 3d 536, para. 71, 75–78 (1976); besides, a similar view was announced by US courts as well, for instance, see. *DeFilippo v. Preston*, 53 Del. 539, 173 A.2d 333, 338–339 (1961).

⁷⁵ *McLean v. Weir*, [1977] W.W.R. 609 [annotation by Ellen P. Jacobs].

⁷⁶ [1980] 2 S.C.R. 883, 888–892; 924–928.

⁷⁷ See. *Rogers v. Whitaker*, 175 C.L.R. 479, 485–492 (1992) and cases cited in *infra* note 130.

⁷⁸ See. United States: *Cannell v. Medical and Surgical Clinics etc.*, 315 N.E. 278, 279–281 (1975); *Rabens v. Jackson Park Hospital Foundation, etc.*, 40 Ill. App. 3d 113, 116–118 (1976); *Clay v. Little Co. of Mary Hospital*, 277 Ill. App. 3d 175, 178–180 (1992); Australia: *Breen v. Williams et al* [1996] H.C.A. 57, per Brennan C.J., at 14–16; Canada: *McInerney v MacDonald*, [1992] 2 R.C.S. 138, 146–153 [per Ryan, J.]. On the English cases, see passage below.

⁷⁹ In spite of data privacy being of fairly recent concerns, the issue of record-keeping in medicine seems to be a vintage one, e.g. see *Halls v. Mitchell* [1927] S.C.R. 125. There, an ex-serviceman who was discharged from the army for heart problems, desired to obtain compensation from a railroad company where he used to be employed when he suffered an iritis attack badly damaging his eyesight. When applying to a compensation board, he was rejected on basis of some earlier records suggesting he had contracted iritis earlier. He was notified that upon the evidence of several doctors he had the ailment long ago and sued one of them for defamation who allegedly reported his “fake” diagnosis to others. Dr. Mitchell, plaintiff's earlier physician found an old record of Halls complaining on iritis two years before the incident and thus reported it to one Dr. Campbell, his recent physician. Hall himself did not tell Hewitt he had iritis before. Then Mitchell applied to Dr. Hewitt, a board official, to obtain Halls' medical history. They met, checked the records and then Mitchell misspelt the diagnosis abbreviation believing it was the same malady Halls was treated earlier, and so notified the board officials thereupon (p. 130–131). The Court examined if the above stated communications with transmitting patient's personal data were privileged. Upon the English defamatory law principles, in short, such communication should have been justified by a professional duty or some overriding interest (p. 133). The communication was found to be a duty of the people mentioned hereinabove; and as a general rule, the Court stated that the personal data of the patient is under control of the patient and not the doctor, and so must not be disclosed unless a paramount necessity (p. 136, 138). At one point, it was established that not all the people examining the letters carrying the medical records were physicians; the doctor's mistake was proved and the other letters were examined (p. 143–145); finally, the Court held that the disclosure of sensitive personal data was not justified under a strict duty or “general interest of society”, and moreover, being concealed from the plaintiff; thus the Court found for plaintiff-appellant (p. 147–148). The nature of a patient-physician relationship being of confidential character seems to be originating from a well-established rule of the relationship confidence between a doctor and a patient, see also: *Kenny v. Lockwood*, [1932] O.R. 141, 155–157 *Henderson v. Johnston* [1956] O.R. 789, para. 32; *Hopp v. Lepp*, [1980] 2 S.C.R. 192, 202.

⁸⁰ Gerald Dworkin, Notes and Cases, *Access to Medical Records – Discovery, Confidentiality and Privacy*, 42 Mod. L. Rev. 88, 90 (1979).

⁸¹ See, for example, *Dunning v. United Liverpool Hospitals' Board of Governors*, [1973] 1 W.L.R. 586 (per curiam) and *Deistung v. South West Metropolitan Regional Hospital Board*, [1974] 1 W.L.R. 213, 215–217. On the same subject was *Davidson v. Lloyd Aircraft Services Ltd.*, [1974] 1 W.L.R. 1042. In that case the hospital board was not a defendant but a third party. There the medical records were disclosed, but not to plaintiff himself and to his medical adviser instead. All of the said cases were overruled by the *McIvor* decision.

⁸² *McIvor & Another v. Southern Health and Social Service Board*, [1978] 1 W.L.R. 757, 761–763 [per Diplock, L.].

⁸³ See. *Gaskin v. Liverpool City Council*, [1980] 1 W.L.R. 1549, 1551–1553 [per Denning, L. M.R.]; 1554–1555 [per Megaw, L.J.]. This case, however, did not fully embrace medical records as such. There plaintiff sought to obtain access to all his records on him

while he was in various orphanage custody. These involved medical records, but he didn't directly ask a hospital for the records. Thus, this case has to be distinguished from actions filed against hospital boards for negligence or sealing personal files. Even after the Gaskin trial at the European Court of Human Rights, the English courts denied a common law right to access to personal files being in ownership of health authorities see. e.g. *Regina v. Mid Glamorgan Family Health Services Authority & Another / Ex Parte Martin*, [1995] 1 W.L.R. 110, 115–117. There, the appeal for order to disclose health records was dismissed on basis of the foundation it would be too detrimental for the patient and in his "best interests". Basically, it was very similar to the non-disclosure arguments in the Gaskin trial, see. p. 1554 and onward; and see dictum in *Sidaway v. Benthlem Royal Hospital etc.* [1985] A.C. 871, at. p. 904 [per Templeman, L.].

⁸⁴ *Church of Scientology of California v. Department of Health and Social Security*, [1979] 1 W.L.R. 723, 733–735, etc.

⁸⁵ *Lee v. South West Thames Regional Health Authority*, [1985] 1 W.L.R. 845, 848–850.

⁸⁶ See. *Boyle v. Glasgow Royal Infirmary*, [1969] S.C. 72 (leading authority on medical records); *Connolly v. Edinburgh Northern Hospitals*, [1974] S.L.T. 53.

⁸⁷ See. *McGown v. Erskin et al.*, [1978] S.L.T. 4, 5; *Moore v. Greater Glasgow Health Board*, [1978] S.C. 123, 128–129; *Gibson, Petitioner*, [1984] S.L.T. 61, 63–64.

⁸⁸ See Alvin Hopper, *The Medical Man's Fiduciary Duty*, 7 Law Tchr. 73, 74–75 (1973). In this article, Mr. Hopper gives a brief, but a very interesting vintage common law legacy on this type of breach of confidence. I would possibly name a few more older cases on the subject, but in the terms of brevity I would agree with his position, adding that *Halls v. Mitchell* [1927] S.C.R. 125 was a exactly a common law development of data protection law and thus medical data privacy is seemingly even more vintage then *Halls*. The confidentiality of medical personal data was recognized in the 19th century in United States: *Buffalo Loan & Trust & Safe Deposit Co. v. Knights Templar & Masonic Mutual Aid Assn.*, 27 N.E. 942, 944 (N.Y. 1891). Mr. Hopper refers two "anonymous" cases in Scotland affirming confidentiality of medical records and reports, being adjudicated in 1851 and 1904 respectively (they were cited both as "AB v. CD"), while in fact their names are *Whyte v. Smith*, 14 D. 177 (No. 46); 24 S.C. 78 (1851) and *McEwan v. Watson* [1904] S.C. 213. Actually, the 1851 case in Dunlop's reports is really referred to be anonymous but the report is nearly identical to the Court of Sessions version of the case. It is true that as early as 1851 the Court of Session recognized the right of privacy as to medical records and the principle of secrecy in such personal data, see. *Whyte v. Smith*, at p. 149–150 (D) / 78–79 (C.S.). In Continental Europe, the principle of confidentiality of medical records was greatly depicted in the German case of *Günther v. Gerhard*, B.G.H.Z. 24, 72 (1957), where a man being plunged into a fight and being beaten up tried to recover money from an insurance company. As he was not severely injured, he didn't manage to recover. There was a cascade of suits against defendant and other allied persons one of which was against his physician who disclosed his medical records to third persons which were disposed to prove plaintiff was not badly injured. However, the Hildesheim regional court found that despite the breach of confidence as to major ailments would be actionable, more mediocre and light injuries were not of such nature, see p. 78–80. This case was repeatedly approved in German case law.

⁸⁹ *McInerney v. MacDonald*, [1992] S.C.R. 138, at page 150.

⁹⁰ *McGarry v. J. A. Mercier Co.*, 272 Mich. 501, 262 N.W. 296, 297–298 (1935); *Rogers v. St. Mary's Hospital of Decatur*, 149 Ill. 2d 302, 306–308; 309–310 (1992).

⁹¹ *Clayman et ux. v. Bernstein*, 38 Pa. D. & C. 543, 546 (1940, reported 1955).

⁹² See. *Feeney v. Young*, 191 N.Y. App. Div. 501, 502–503 (1920); *Bazemore v. Savannah Hospital*, 171 Ga. 257, 155 Pa. 194, 195 etc. (1930); *Griffin v. Medical Society etc.*, 7 Misc. 2d 549, 550 etc. (1939).

⁹³ For the matter of brevity, see, for instance John D.R. Craig, *Invasion of Privacy and Charter Values: The Common-Law Tort Awakens*, 42 McGill L. J. 355, 361-etc. (1997).

⁹⁴ For an able discussion on recognition and non-recognition of right to privacy in Canada upon various doctrines, see. *Jones v. Tsige*, 108 O.R. (3d) 241 (2012).

⁹⁵ See. e.g. *Attorney General for Quebec v. Rene Begin*, [1955] S.C.R. 593, 595–596 (per Kerwin, C.J.) and authorities cited therein; *Hunter et al. v. Southam, Inc.*, [1984] 2 S.C.R. 145, 158–160; *R. v. Dymont*, [1988] 2 S.C.R. 417, 431–436.

⁹⁶ See e.g. *Davis v. McArthur*, 17 D.L.R. (3d) 760, 762–764.

⁹⁷ See. *Aubry v. Vice-Versa Ltd.* [1998] 1 S.C.R. 591 para. 6–8. Basically the same was the interpretation of such distinction in *R v. Dymont*, [1988] 2 S.C.R. 417, 425–429. At page 428–429, the Court held that the other side of privacy must deal with body integrity and sensitive information concerning the plaintiff, which lies in an action for an ordinary privacy violation.

⁹⁸ E.g. *Cordell v. Detective Publications Inc.*, 419 F. 2d 989, 990 (1969). There, the Court said: "The term right of privacy is imprecise, because this beguiling expression has been used to designate many different rights of varying importance, from the Fourth Amendment freedom from arbitrary searches and seizures [...] to the right not to have one's name bruited about in gossip columns".

⁹⁹ [1988] 2 S.C.R. 417, 428–429; 436.

¹⁰⁰ The term "quasi-recognition" refers to a case where the court dealt with an action for alleged privacy violation but the suit was adjudicated on basis of libel, breach of contract, duty or confidence and other commonly known torts. Such concept was quite popular among American lawyers of the early and mid-20th century, see. John A. Callahan, *Torts – Right of Privacy – Unauthorized Radio Dramatization of Shooting*, 24 Marq. L. Rev. 170, 171 (1940). The American cases represented by Mr. Callahan were adjudicated on basis of breach of implied contract, nuisance or an unnamed "personal right" with an apparent implication on the right to privacy. The same view is shared by Mr. Simon in his article on the American common law legacy of actions for unauthorized use of photos, see. Charles Simon, *Torts – Invasion of Privacy – Unauthorized Use of Photograph*, 16 De Paul L. Rev. 255, 257 (1966). See also the passage in *Eick v. Perk Dog Food Co.*, 106 N.E. 2d 742, 347 Ill. App. 293, 299–301 (1952) concerning quasi-recognitions of right to privacy and cases cited therein. It should be denoted that these quasi-recognitions only seem to be outdated since courts in commonwealths which do not recognize a privacy tort still dispose such doctrines. For instance, in the Canadian case of *Saccone v. Orr*, 34 O.R. (2d) 317 (1981) the distinction of right to privacy from proprietary rights was reviewed. In England, where the privacy tort was still not recognized, these "quasi-recognitions" are still in fashion. For instance, in *Francome et al. v. Mirror Group Newspapers Ltd.* [1985] 1 W.L.R. 892, at. 894–895 the invasion of privacy by means of wiretapping was rendered as a trespass. In New Zealand, in *Bradley v. Wingnut Films Limited*, [1994] E.M.L.R. 195, 196–198, 201; 207–208, where a film and a newspaper article featuring a cemetery scene displayed plaintiff's grave lot with his deceased relative's names, plaintiff filed an action with a multitude of causes based on classic torts as well as invasion of privacy. The inadequacy of treating a privacy invasion by other torts, as defamation was decently reviewed by the Court. Despite the Court recognized the privacy tort may exist in New Zealand, plaintiff didn't manage to maintain the action upon the facts stated (see p. 207–208). In Australia, in *Church of Scientology v. Woodward*, [1982] H.C.A. 78, 154 C.L.R. 25 (1982), at p. 68, Mr. J. Murphy said: "If any of its [ASIO] officers acts in bad faith, uses his or her office or powers for extraneous purposes

(for example private, domestic, or partly political) or acts without due regard to those affected, then the officer is liable for misuse of office or power. Remedies may be in the traditional tort claims such as assault, trespass and defamation and the developing torts such as unjustified invasion of privacy, and outrage, or statutory remedies". Upon the abovesaid, the role of such quasi-recognitions is quite gross even nowadays in a number of commonwealth states.

¹⁰¹ *Cordingly v. Nield*, 24 Can. L. Jur. 204, 207–208 (1874).

¹⁰² *Wolfenden v. Giles*, 2 B.C.R. 279, para. 17–21 (1892).

¹⁰³ In Canada, the most outstanding vintage case was *Miner v. Canadian Pacific Railway*, 15 West L.R. 476, 3 Alb. 408, 413–415; 2 A.R.C. 1169, 1172–1173 (1911). There, the mother of a deceased young man negotiated to transport the casket with a suitcase with mourning clothes and it was erroneously taken off the train and so arrived with a delay which compelled the family to purchase new clothes and rearrange the meetings and the funeral. The Court [per Beck, J] recognized a property right in a corpse in the sense of duty to take care for it and found for plaintiff. The action was filed for negligence. See also: *Edmonds v. Armstrong Funeral Home Ltd.*, 1 D.L.R. 676 (1931); *Saleh v. Reihert*, 50 E.T.R. 143, 104 D.L.R. (4th) 384 (1993); *Bastien v. Ottawa Hospital*, 56 O.R. (3d) 397 (2001).

¹⁰⁴ *Phillips v. Montreal General Hospital*, 6 E.L.R. 477 (1908).

¹⁰⁵ See such view described in: David A. Cornfield, *The Right to Privacy in Canada*, 25 Fac. L. Rev. 103, 107–109 (1967); Harry J. Glasbeek, *Outraged Dignity – Do We Need A New Tort*, 6 Alta. L. Rev. 77, 84–85 (1968); Pierre Patenaude, *The Evolution of Right of Privacy in Quebec*, 6 Man. L. J. 283, 284–285 (1974).

¹⁰⁶ On the “extended” nature of pass-off tort as well as a brief discussion on several Canadian cases, see e.g. St. Michael Hylton and Peter Goldson, *The New Tort of Appropriation of Personality: Protecting Bob Marley’s Face*, 55 Camb. L. J. 56, 58, 61–62 (1996).

¹⁰⁷ *Racine v. C.J.R.C. Radio Capitale Ltée*, 80 D.L.R. (3d) 441 (1977); *Dowell v. Mengen Institute*, 72 C.P.R. (3d) 238 (1983).

¹⁰⁸ *Davis v. McArthur*, 17 D.L.R. (3d) 760, 763–764; *Saccone v. Orr*, 34 O.R. (2d) 317, 319–322 (1981).

¹⁰⁹ *Motherwell v. Motherwell*, 73 D.L.R. (3d) 62 (1976).

¹¹⁰ See, for instance, *Robbins v. Canadian Broadcasting Corp.*, 12 D.L.R. 35, 45 (1956).

¹¹¹ See. Robert G. Howell, *Publicity Rights in the Common Law Provinces of Canada*, 18 Loy. L. A. Ent. L. Rev. 487, 491–493 (1998).

¹¹² See, for instance, *Henderson v. Radio Corp.* [1969] R.P.C. 218, at 237–238 [per Manning, J.]

¹¹³ [1969] R.P.C. 217, at. 237 [per Manning, J].

¹¹⁴ [1971] 5 C.P.R. (2d) 20.

¹¹⁵ *Tolley v. J.S. Fry & Sons Ltd.*, [1931] A.C. 333, 337 etc.; *Sim v. H.J. Heinz Ltd.*, [1959] 1 W.L.R. 313, 315–316; 319–320.

¹¹⁶ Cornfield, *supra* at. p. 108–109 and Howell, *supra*, at. 491–492. Upon Cornfield’s reference, I can make a corollary that the “French” routes which are alleged to be incorporated into Canadian cases on the subject, seem to be displayed by the factor of admitting defendant’s fault in one way or another without designating an actual tort name, if such are disposed within the proceedings in French courts at all. Cornfield addressed this thesis towards the case of *Robbins v. Canadian Broadcasting Corporation*, 12 D.L.R. 35, at p. 40–42; 45 (1956), plaintiff, an elderly physician wrote a letter of complaint on a scandalous tabloid and was revenged by the dictator who announced plaintiff’s telephone and address within the air which made the spectators call and annoy the doctor, who later sued the TV company and managed to recover. Despite he claimed an invasion of privacy, the Court found his claim to be actionable upon the Civil Code statute enacting liability of the master for his servant’s faults. This decision would look more like a recovery based on negligence. However, rendering privacy violation as a sort of negligence could hardly apply to a case with circumstances different from it. What as to the French law, this case seemingly had somewhat similar to early French decisions concerning the right to privacy, see. e.g. F. P. Walton, *The Comparative Law of The Right to Privacy*, 47 L.Q. Rev. 219, 221–226 (1931). In fact, France is not a common law country and the cases do not constitute a major body of law, but certainly they are a body of law in this state. As of Walton, even in the late 19th and early 20th century this country possessed a substantial number of cases to form a “common law” right to privacy. Unfortunately, a part of them are hard to be found and examined. Some outstanding French cases include *Dumas c. Liebert*, S 1868 II 41, 13 A.P.I.A.L. 247 (1868) [unauthorized use of photo]; *Bonnet c. Société Olibet*, Trib comm. Seine (1882) [unauthorized reproduction of portrait]; *The Dreyfus Case*, Trib Civ. De Lyon 15 Dec. 1896, Dallez. Petr. 97, 2 page 74 [a Jewish citizen sues a Lyon bookseller for publishing a 1886 book containing the list of Jews of the city and recovers upon recognizing a property right in his name]; *Cheval c. L. Ch.*, Cour. D’Appel de Grenoble, 1 Mar. 1907, Jour. De la Cour de Grenoble, p. 151 [unauthorized use of photo]; *Hallez et al. c. Monpezat*, [1932] Gaz. Pal. 2, page. 739 [plaintiffs were put into a story depicting their conduct, recovery based on moral damages which is a French analogue of American “mental suffering”]; *Dietrich c. Société France-Dimanche*, Cour d’Appel Paris, D. 1955, page 255 [unauthorized publication of memoirs displaying plaintiff’s conduct, biography and habits, judgment for plaintiff]. Mr. Wagner represented some more interesting French cases, see generally, W. J. Wagner, *Photograph and Right to Privacy: The French and American Approaches*, 25 The Catholic Lawyer 195 (1980). Some respect to the French cases was also paid by Mr. Weeks, see. James K. Weeks, *Comparative Law of Privacy*, 12 Clev-Marshall L. Rev. 484, 495–499 (1963). Upon the cases given by Mr. Walton, Mr. Wagner and Mr. Weeks as well as the cases cited herein, it would be intelligible to say that the French case law in respect to privacy should never be underestimated only by the fact France belongs to the Continental legal system. As of Mr. Weeks’s analysis, the rules announced in early 20th century cases in France could be comparable to American ones (Weeks, at p. 497). And in fact, it would be strange if this right to privacy hadn’t developed in France, as the number of lawsuits concerning photography in France since 1851 was literally enormous and counted dozens of cases in the 19th and early 20th century, some of which were suits for unauthorized use of photographs where plaintiff was the depicted person, see. Christiane Derobert-Ratel, *Les Premier Debats Historiques sur la Contrefaçon Photographique*, Conference at Sud Toulon-Var University, (pub. 2009).

¹¹⁷ See. *In Re Conroy*, 486 A.2d. 1209, 1222–1223; 1227–1228 (1985). It is notable that, at page 1228, the Court tied the patient’s autonomy in a complicated concept of “the right to die” with the common law right to privacy as well. On the “body privacy” concept, see, for instance, *Roe v. Wade*, 410 U.S. 113, 153–154 (1973), [Per White, J].

¹¹⁸ See *Eichner v. Dillon*, 73 A.D. 2d 431, 456–462; 465–466 (1980). Please note that the fashion to recognize “the right to die” (I mean not as a derivative of right to privacy, but the right as such) is not the same as in New York in other US states and other commonwealths.

¹¹⁹ *Matter of Quinlan*, 70 N.J. 10, 39–40; 355 A.2d 647, 663 (1971).

¹²⁰ See., for instance Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 739–742 (1977). Here’s what the Court said concerning the issue: “The constitutional right to privacy, as we conceive it, is an expression of the sanctity of individual free choice and self-determination as fundamental constituents of life. The value of life as so perceived is lessened not by a decision to refuse treatment, but by the failure to allow a competent human being the right of choice” (at. p. 742).

- ¹²¹ [1974] 1 I.R. 284, 313–314.
- ¹²² [2002] ECHR 2346/02, para. 17–18 and 23. In this case, the European Court repeatedly referred to the Canadian case of *Rodriguez v. Attorney General of Canada*, [1994] 2 L.R.C. 136 and the Canadian Constitution.
- ¹²³ [2010] 302/02, para. 136.
- ¹²⁴ [2010] 25579/05, para. 167, 212–215.
- ¹²⁵ [2010] 45076/05, para. 69.
- ¹²⁶ See *Gaskin v. United Kingdom*, [1989] 10454/83, para. 34–49; see also comment in Dermot Feenan, *Common Law Access to Medical Records*, 59 Mod. L. Rev. 101, 104–105 (1996). As in the case of abortions and decision-making, the denial of access was also found to be a breach of privacy.
- ¹²⁷ [2016] No. 2324/2013, para. 3.5–3.6.
- ¹²⁸ Some commentators tend to believe that the Australian right to privacy, if it exists as such, has got relatively recent origin, see. Des Butler, *A Tort of Invasion of Privacy in Australia?*, 29 Melb. U. L. Rev. 339, 357–365 (2005). In fact, even in spite of a small legacy on the subject, I would name the following cases which may constitute the core of a privacy tort, namely: *Doodeward v. Spence*, 7 S.R. (N.S.W.) 727; 9 S.R. (N.S.W.) 107; 6 C.L.R. 406 (1907–1908) [retention of a dead deformed child's corpse in a jar and it's public exhibition]; *Rofe v. Smith's Newspaper Ltd*, 25 S.R. (N.S.W.) 4 (1924) [disclosure of facts on a "philanthropist's" machinations with charity payments]; *Henderson v. Radio Corp.* [1969] R.P.C. 218 [appropriation of dancer's likeness to advertise vinyl records]; *Commonwealth v. John Fairfax & Sons Ltd.*, [1980] H.C.A. 44 [prohibition of book sale containing highly confidential "national security" information]; *Church of Scientology v. Woodward*, [1982] H.C. 78 [wiretapping of plaintiff corporations' communications by a governmental intelligence agency].
- ¹²⁹ See *Goode v. Nash*, 21 S.A.S.R. 419, 422–423 (1979); *F. v. R.*, 29 S.A.S.R. 437, 440–442 (1982) *Gover v. State of South Australia etc.*, 39 S.A.S.R. 543, 546 etc. (1985); *E v. Australian Red Cross Society*, 27 F.C.R. 310; 99 C.L.R. 601, para. 193–195 (1991); *Rogers v. Whitaker*, 175 C.L.R. 479, 482–484; 487–488 (1992); *Young v. The Northern Territory of Australia*, 107 F.L.R. 264, 268–271 (1992).
- ¹³⁰ For instance, such view was expressed in Mrs. McLean's treatise on the informed consent doctrine evolvement in New Zealand, see. Kathryn McLean, *Children and Competence to Consent: Gillick Guiding Medical Treatment in New Zealand*, 31 V.U.W. L. Rev. 551 (2000). However, I do not really comprehend for which reason the author disposed the case of *Gillick v. West Norfolk and Wisbech Area Health Authority etc.*, [1986] A.C. 112 as a principal authority for the doctrine whereas similar cases on a minor's consent received more coverage in the United States, see. *Suver et al. v. Commonwealth*, 254 S.W. (2d) 474, 476–477 (1953); *Smith v. Seibly*, 72 Wash 2d. 16, 431 Pa. 2d 719, 722–723 (1967); *Younts v. St. Francis Hospital*, 205 Kan. 292, 469 Pa. 2d 330 (1970); *Muhlenberg Hospital v. Patterson*, 128 N.J. Super.498, 500–503 (1974); *Carter v. Cangello*, 105 Cal. App. 3d 348, 350–351 (1980); *Kozup v. Georgetown University*, 851 F 2d 437, 439 (1988); *Bendiburg v. Dempsey*, 909 F. (2d) 463, 467–468 (1990). Please note that the cases cited hereinabove were selected upon the pre-2000 scale since Mrs. McLean's treatise was published that year. What is more important, the *Gillick* case was overruled in England quite long ago and even a partially negative treatment of the opinion may cast negative light on its authority. Further, at p. 255 the author contends that New Zealand didn't have any cases to be referred to and discusses whether *Gillick* is applicable to New Zealand common law. In fact, this is not correct to say New Zealand had never faced the informed consent doctrine: the case of *Smith v. Auckland Area Health Board*, [1965] N.Z.L.R. 191 is directly on the subject. In that case, plaintiff, an elderly man was suspected an aortic aneurysm and was offered to undergo an examination which involved injecting a special dye within the aortagram; the procedure caused the blood flow in plaintiff's leg to be suppressed leaving him without the leg in the output. Before this examination, his treating physician assured that the procedure would not be hazardous and didn't warn him on the possible negative consequences. Since plaintiff was preliminarily told he would be fine in a couple of days he apparently consented to the procedure. The plaintiff subsequently sued for negligence and managed to recover. Upon the case I described above it would be erroneous to say that the New Zealand's common law has completely no legacy on the subject to be referred to. What is more, I cannot really conceive for what reason the *Gillick* case is the only authority to be relied on. Neither *Gillick*, nor, for instance, *Kozup* cases are a body of New Zealand's common law, but nothing inhibits disposing all of the said cases as authorities. Moreover, *Auckland Area Health Board* seems to be suitable for a principal informed consent case. Therefore, I would say such a position is quite obscure.
- ¹³¹ See the following: *Tucker v. News Media Ownership Ltd.* [1986] 2 N.Z.L.R. 176; *Hosking v. Runting* [2004] N.Z.C.A. 34. An able discussion on the right to privacy in New Zealand could be found in *Bradley v. Wingnut Films Ltd.* [1994] E.M.L.R. 195, at p. 206–210 [per Gallen, J.] as well as the headnote, p. 197–198.
- ¹³² See also: *Moore v Regents of University of California*, 793 P.2d. 479; 51 Cal. 3d 120, 129–132 (Cal. 1990).
- ¹³³ *McInerney v. MacDonald*, [1992] S.C.R. 138, 148; 150.
- ¹³⁴ BVerfGE 39, 1, p. 42–44 (1974).
- ¹³⁵ See e.g. *Mitchell & Another v. Homfray*, [1882] 8 Q.B.D. 587, 589; *Hopper*, supra at. 74–76.
- ¹³⁶ *Kenny v. Lockwood*, [1932] O.R. 141, 155–157 *Henderson v. Johnston* [1956] O.R. 789, para. 32; *Hopp v. Lepp*, [1980] 2 S.C.R. 192, 202.
- ¹³⁷ See. e.g. *Cardin v. The City of Montreal et. al.*, [1961] S.C.R. 655, 658.
- ¹³⁸ Ellen Picard, *Consent to Medical Treatment in Canada*, 19 Osgood Hall L. J. 140, 141 (1981).
- ¹³⁹ See. e.g. *Dendaas (Tylor) v. Yackel*, [1980] W.W.R. 272, para. 25.
- ¹⁴⁰ *Marshall v. Curry*, [1933] 3 D.L.R. 260, 272–275 [per Chrisholm, C.J].
- ¹⁴¹ Reported in 5 Rev. de Jur 74, 75–76 (1899).
- ¹⁴² *Parnell v. Springale*, 5 Rev de Jur 74, 76 (1899); see also comment in *Marshall v. Curry*, [1933] 3 D.L.R. 260, 273.
- ¹⁴³ *Bennan v. Parsonnet*, 83 N.J.L.R. 20; 83 A. 948, 949–950 (1912).
- ¹⁴⁴ 68 S.C. 155, 32.5 C.M. Ass. J. 581 (1930).
- ¹⁴⁵ *Caron v. Gagnon*, 68 S.C. 155, para. 1–3 (1930).
- ¹⁴⁶ [1958] S.C. 152, 13 D.L.R. (3d) 35, 39 [per W.B. Scott, Assoc. C. J].
- ¹⁴⁷ *Beausoleil v. Soeurs de la Charite*, 53 D.L.R. (2d) 65, 83 (1964).
- ¹⁴⁸ See. *Caron v. Gagnon*, 68 S.C. 155, para. 61.
- ¹⁴⁹ See. *Nathanson v. Kline*, 185 Kan. 393, 405–407 (1960). In fact, this case was observed by the Kansas Supreme Court as the counsel for defendants used it for defense. Moreover, the Kansas Supreme Court [per Shroeder, J] paid additional attention on the trial court decision, *Kenny v. Lockwood Clinic Ltd.* [1931], 4 D.L.R. 906, where the learned judge found the duty to inform the patient on

all potential hazards to be a fiduciary one which actually equaled the “informed consent” doctrine arising in the United States in the late 1950s. See additionally: *Halushka v. University of Saskatchewan*, 53 D.L.R. 2d 436 (1965), para. 27.

¹⁵⁰ See. *Halushka v. University of Saskatchewan*, 53 D.L.R. (2d) 432 (1965), para. 26–29.

¹⁵¹ See. Susan M.J. Chafe, *Legal Obligation of Physicians to Disclose Information to Patients*, [1991] Can. Med. Assoc. J. 681, 682 (1991).

¹⁵² At least two cases came along to such view, namely *Schinz v. Dickinson*, 31 C.C.L.T. 313, para. 6–13; 20–24 (1984) *DeFerrari v. Neville*, 42 C.C.L.T. (2d) 327, para. 11; 20–24; 29–31 (1995). As of the Schinz decision, at para. 24, the *Reibl v. Hughes* principle of overall disclosure would not be applicable in dentistry as it is not so “dramatic” as surgery and the disclosure has to be made in case the negative consequences are presupposed to be of real danger. Such view, as I mentioned in the passage upwards is definitely not uniform but is worth a reference.

¹⁵³ Against this view go *Diack v. Bardsley*, 25 C.C.L.T. 159 (1983); *Stewart v. Ross*, 64 Sask. R. 271, Q.B.No.4226.A.D.1986 (1986). The cases for and against, see the latter note supra, all were actions for negligence in dentistry for non-disclosing the risks of treatment resulting in a paraesthesia.

¹⁵⁴ [1980] 2 S.C.R. 192, 204. Here’s what the Court said: “*Kenny v. Lockwood is important as much for what it portended as for what it actually decided. It indicated that a surgeon who recommends an operation which involves known risks, that is probable risks, or special or unusual risks, is under an obligation to his patient to disclose those risks and, if he fails to do so, and injury results from one of the undisclosed or not fully disclosed risks, the patient’s consent to the operation will be held to be not an informed consent, although the operation itself was competently performed*”.

¹⁵⁵ 60 C.C.C. 136, [1933] 3 D.L.R. 260.

¹⁵⁶ *Ibid*, at p. 261–262; 263–265.

¹⁵⁷ E.g. see comment in 1 Kinkaid on Torts, section 374–375.

¹⁵⁸ In fact, though the case was not issued in regular reports, it was published in 6 Trans. in Med. L. Soc. 132 (1909). The said report gives a full reflection on what was the subject of the action and what was the decision. The case was briefly reviewed in 44 Cent L.J. 153 and [1896] BMJ 1525 (dated 21 Nov. 1896). It may be claimed that British medicine might have known consent much earlier: [1842] BMJ 427, “*Case of successful Amputation in Spreading Gangrene from Gun-Shot Wound*” (in fact, the common law had at least one specimen of such legacy, see. *Latter v. Braddell*, 50 L.J.Q.B. 448 (1881)) However, after having considered the medical case referred to in the 1842 issue I would not find myself to be confident to claim that the type of consent which was mentioned therein is the one we’re discussing here and moreover nothing hints the said medical case anticipated a lawsuit. In fact, we, lawyers may comprehend consent and it’s nature not in the same way as our medical colleagues do. For instance, see. Gerald B. Robertson, *Informed Consent in Canada: An Empirical Study*, 22 Osgoode Hall. L. J. 139 (1984).

¹⁵⁹ See. 37 Chicago Leg. N. 213 (first brief report); and 118 Ill. App. 162, at p. 174–177 (1905), original report.

¹⁶⁰ See. *Marshall v. Curry*, [1933] 3 D.L.R. 260, 274–276.

¹⁶¹ *Winn et al. v. Alexander et. al.*, [1940] D.L.R. 778, 779–781.

¹⁶² See *Lavere v. Smith’s Falls Public Hospital*, 26 D.L.R. 346, 360–362 (1915) [per Riddell, J.]; and cases cited in note 44 supra.

¹⁶³ *Murray v. McMurphy*, [1949] 2 D.L.R. 442, 444–445 [per McFarlane, J.].

¹⁶⁴ *Yule v. Parmley*, [1944] 4 D.L.R. 46, 47–48; see appeal, *Yule v. Parmley & Parmley*, [1945] 2 D.L.R. 316, 331.

¹⁶⁵ See. [1933] 3 D.L.R. 260, at p. 272 or 60 Can. C. C. 136, at p. 148–149. Practically, the Court in *Marshall* adopted the *Schloendorff* rule on consent (not to be confused by “*Schloendorff rule*” on charity body non-liability for the negligence of their employees, referred as “independent contractors”, see. *Bing v. Thunig*, 2 N.Y. 2d 656, 662–667 (1957).

¹⁶⁶ *Yule v. Parmley & Parmley*, [1945] 2 D.L.R. 316, 332–334.

¹⁶⁷ *Parmley v. Parmley & Another*, [1945] S.C.R. 635, 645–646.

¹⁶⁸ [1985] A.C. 871; [1985] U.K.H.L. 1,6.

¹⁶⁹ [1980] 2 S.C.R. 880, 896–898 etc.

¹⁷⁰ *Picard*, supra at. 140–141.

¹⁷¹ *Crits & Crits v. Sylvester*, [1956] O.R. 132.

¹⁷² *Sylvester v. Crits et al.*, [1956] S.C.R. 991, 992–995.

¹⁷³ *Ibid*, at page 996–997.

¹⁷⁴ See *Walton*, supra at p. 220–221; *Weeks*, supra at p. 495–497. The same “tort” principle applied in cases on the alleged privacy breach in France. The fault had to be proven by extensive (or at least existing and firm) evidence, and the “tort” didn’t have an exact name to be sued for. However, it would be wrong to say that French courts never use preceding cases or dicta as authorities, see, *Cheval c. L. Ch.*, Cour. D’Appel de Grenoble, 1 Mar. 1907, Jour. De la Cour de Grenoble, at p. 151–154. In that case, the Court cited a number of earlier decisions and legal literature. See additionally, Percy H. Winfield, *The Law of The Right to Privacy*, 47 L.R.Q. 23, 38 (1931). Despite Winfield invoked more attention on English, and to some extent American privacy cases, he examined more obscure specimen, such as the right to privacy in India and South Africa which possess a common law legal system, and the cases indeed contain a great research (as well as reader) interest. At p. 37–39 he briefly mentions France, but more in respect to freedom of press restrictions seemingly imposed by older French laws. For more details on sources of French cases, see note 101 supra.

¹⁷⁵ 53 D.L.R. (2d) 65, 66–67 (1964).

¹⁷⁶ It is the same general rule as it is in the United States. I guess we’ve discussed enough in *Bennan v. Parsonnet*, 83 N.J.L.R. 20; 83 A. 948, 949–950 (1912) not to cite a giant list of American cases declaring the same rule.

¹⁷⁷ See. *Cardin v. City of Montreal*, 29 D.L.R. (2d) 492, [1961] S.C.R. 655, 657–659. There, the physician and municipality were held jointly and severally liable for being unable to remove a large needle from a boy’s arm which was stuck in it as a result of a casualty when the infant swerved the arm being frightened of vaccination.

¹⁷⁸ Herein we could recall *Bolam*, but there were no direct or indirect references to it; but Dr. Lamoureux’s evidence makes me to draw a parallel with the said case, where the defendant physician emphasized that to take a patient’s consent before commencing some treatment was a kind of custom for him and others he had known of his profession, see. *Bolam v. Friern Hospital Management Committee*, [1957] 1 W.L.R. 582, 588–591. Upon the said suggestion we may make a corollary that the consent and warning the patient on the possible negative consequences of the treatment could have been a sort of “protocol duty” of doctors. In *Cobbs v. Grant*, at page 243 the Court says: “*This defendant and the majority of courts have related the duty to the custom of physicians practicing in the community*” and cites a number of cases where defendants said on cross-examination that it was a sort of custom for them. In *Reibl v. Hugh-*

es appeal, 21 O.R. (2d) 14 (1978) the defendant, upon his evidence revealed he had always explained the risks to his patients and conducted rather long talks on what he was going to perform, quote: “*The general practice is that you do your best to advise the patient of the risks involved in a procedure, particularly associated with the central nervous system because the effects can be as we see them*”. He ascertained that it was a stable practice to do so among his colleagues. Thus it seems not to explicitly derive from a legal case like those we’re discussing in the paper. In fact, *Robertson*, supra, at. p. 143-onward, conducted a questionnaire to over a thousand of surgeons of whether they heard of *Reibl v. Hughes* and how did it impact their attitude towards informing patients of potential risks and hazards of future treatment; the result was too divergent to write it in detail, but in general far not all of the respondents knew of the case. From this treatise, it is unclear of whether 1) physicians informed their patients on the risks being afraid of being sued on basis of the *Reibl v. Hughes* decision; 2) they used to inform their patients in such mode for a long time and it was a custom – the same as was referred in *Bolam* upwards, at p. 588 etc.; 3) they had enough knowledge of the informed consent doctrine from American cases, as *Salgo*, *Nathanson* etc. – basically any court decision invoking informed consent, see practitioner’s collection at 76 A.L.R. 4th 511 (1989). The given survey does not give the response to such inquiry. What could be also outstanding in the survey, is the fact that a relatively large number of surgeons were unaware of the *Reibl v. Hughes* decision and seemingly did not use the informed consent in theirs, I would better say, *medical practice*. Could the triad of cases against *Mr. Ringrose*, *Colp*, *Cryderman* and *Zimmer* have been influenced by the fact that the gynecologist who made several sterilization procedures with a non-approved, dangerous method and never warned his patients on their consequences, was simply unaware of the informed consent rule or was neglecting to follow it. Though this query may be rhetoric, the suits were all lost: see *Zimmer v. Ringrose*, 89 D.L.R. 3d 646, 658 (1978).

¹⁷⁹ 53 D.L.R. (2d) 65, 73–77 (1964).

¹⁸⁰ *Ibid*, at p. 79–83.

¹⁸¹ *Halushka v. University of Saskatchewan*, 53 D.L.R. (2d) 436, para. 1–6 (1965).

¹⁸² *Ibid*, para. 12–23.

¹⁸³ What is more interesting, the docket, 52 W.W.R. (ns) 508, features a re-typed notification of plaintiff’s consent to the experiment. The “consent form” featured a passage that Walter was explained what were the examiners desiring to do, but nothing went as to the possible risks on his health.

¹⁸⁴ Namely, *Nathanson v. Cline*, 185 Kan. 393, 407–411 (1960), with reference to *Salgo*; *Mitchell v. Robinson*, 334 S.W. (2d) 11, 17–19 (Miss. Supr. Ct., 1960).

¹⁸⁵ *Halushka v. University of Saskatchewan*, 53 D.L.R. (2d) 436, para. 1–6 (1965).

¹⁸⁶ *Koehler v. Cook*, 65 D.L.R. (3d) 765, 766–767 (1976).

¹⁸⁷ *Martel v. Hotel Dieu St-Vallier / Vigneault c. Martel*, [1969] S.C.R. 745, 747–748.

¹⁸⁸ *Ibid*, at. p. 752–753.

¹⁸⁹ *Ibid*, at. p. 753–756.

¹⁹⁰ *Halushka v. University of Saskatchewan*, 53 D.L.R. (2d) 436, para. 1–6 (1965); *Dendaas (Tylor) v. Yackel*, [1980] 109 D.L.R. (3d) 455, para. 31.

¹⁹¹ See e.g. *Cataford v. Moreau*, 114 D.L.R. 585 (1978). There, a woman, like in *Zimmer v. Ringrose*, 89 D.L.R. (3d) 646 (1978), decided to undergo sterilization and after the procedure became pregnant again, and filed an action against the physician for this. The issue of consent was only as to the fact she consented to the procedure and so sued for negligence winning over the suit. In *Zimmer* the situation was quite different, as the woman which was undergoing sterilization received a number of complexifications on her health, see *Zimmer* decision at. p. 653 etc. Same could be found in *Male v. Hopmans*, [1966] 1 O.R. 647, 650–652.

¹⁹² The main idea here was to determine, was the conjectural damage foreseeable, see, *Beausoleil v. Sisters etc.*, 53 D.L.R. (2d) 65, 70–73 (1964); *Zimmer v. Ringrose*, 89 D.L.R. (3d) 646, 650–651 (1978); in *McLean v. Weir*, 18 B.C.L.R. 325 (1980) the rarity of such cases which the physicians seemingly found immaterial to be disclosed served as a very good defense for them. As I proceed further, the Wellington Court of appeal in *Smith v. Auckland Area Hospital Board*, [1965] N.Z.L.R. 191 came to an absolutely reverse conclusion.

¹⁹³ *Halushka v. University of Saskatchewan*, 53 D.L.R. (2d) 436, para. 2 (1965); see also *Male v. Hopmans*, [1966] 1 D.L.R. 647, 650.

¹⁹⁴ *Male v. Hopmans*, [1966] 1 D.L.R. 647, 650–652.

¹⁹⁵ [1965] N.Z.L.R. 191; see note 114 *supra*. The case was also discussed in 6 Univ. Tas. L. Rev. 313, 313–315 (1966) (by P. Griffiths). It was also cited in various commonwealth state courts in cases dealing with informed consent, see, e.g. *Zimmer*, *infra* at. p. 653.

¹⁹⁶ See the facts of *Salgo v. Leland Stanford etc. Board of Trustees*, 154 Cal. App. 2d 560, 564–568 (1957).

¹⁹⁷ *McLean v. Weir*, 18 B.C.L.R. 325 (1980), para. 1–4; 8–10.

¹⁹⁸ *Ibid*, para. 21.

¹⁹⁹ *Smith v. Auckland Area Hospital Board*, [1965] N.Z.L.R. 191, 196–197. This New Zealand case, being fairly known, seemingly made a furor in various commonwealths being repeatedly cited and appraised. Even in Canada, it was well treated, see in particular *Zimmer v. Ringrose*, 89 D.L.R. (3d) 646, 653 (1978); *Hopp v. Lepp*, [1980] 2 S.C.R. 192, 201. The issue of an unauthorized angiogram without fulfilling the duty to warn was observed in a more recent Scottish case of *Moyes v. Lothian Health Board*, [1990] S.L.T. 444. There, a patient suffered an insult as a result of an angiogram and the Court of Sessions’ Outer House found it was the duty of physicians to warn on basically any negative consequences of the procedure.

²⁰⁰ See, e.g. *DeFerrari v. Neville*, 42 C.C.L.T. (2d) 327, para. 11; 20–24; 29–31 (1995).

²⁰¹ See. 126 F.2d 121, 122–123 (1941). This case was not cited by the Ontario court but the principle was entirely the same.

²⁰² *Johnston v. Wellesley Hospital*, [1971] 2 O.R. 103, 105 etc.

²⁰³ *Zimmer v. Ringrose*, 89 D.L.R. (3d) 646, 648–650 (1978).

²⁰⁴ See. *Kelly v. Hazlett*, [1976] C.C.L.T. 1, page 23; 26–28; see additionally on the issue in United States: *Cobbs v. Grant*, 8 Cal. 3d 227, 239–241 (1973). Upon the distinction between battery and negligence the following has to be stated. The rendering is way not uniform and may vary from a number of reasons, namely 1) the statute of limitations for negligence and battery; 2) existence of a definite custom in rendering such acts as a battery or negligence, as depicted in California.

²⁰⁵ 8 Cal. 3d 227, 241 (1973). The Court refers to *Natanson v. Kline*, 350 P.2d 1093, 186 Kan. 393 (1960). At page 411 the Court said: “*The primary basis of liability in a malpractice action is the deviation from the standard of conduct of a reasonable and prudent medical doctor of the same school of practice as the defendant under similar circumstances. Under such standard the patient is properly protected by the medical profession’s own recognition of its obligations to maintain its standards*”. See also *Chatterton v. Gerson*,

[1981] 1 Q.B. 432, 442–443; in that case, Bristow, J., dismissed the action based on trespass to person stating that the physician's failure to obtain the intelligent consent is a cause of action for negligence, see in detail at p. 443–445. The Court in *Reibl v. Hughes* dismissed the claim on battery and put it upon the theory of negligence as well, *Reibl v. Hughes*, [1980] 2 S.C.R. 880, 889–892. As I've previously mentioned the US courts do not uniformly accept such approach: what is the fashion in states of California, Missouri (leading opinion: *Aiken v. Clary*, 396 S.W. 2d 668, 673–674 (1965)); or Kansas won't be the elsewhere the same. For instance, in *Fogal v. Genesee Hospital*, 41 Atl. 2d. 468 (1974), see particularly at p. 471 to 473, where plaintiff's wife was severely injured (six years later died but from causes unrelated to the trial) owing to a misuse of hypothermic blankets which overcooled her body during a surgery. The action was filed for battery and adjudicated on this ground. Even in cases in respect with chiropractic casualties, courts preferred to adjudicate them not on the theory of battery but rather of negligence: *Jones v. Malloy*, 226 Neb. 559, 564 (1987).

²⁰⁶ One of the leading cases in medical negligence upon this subject in Canada is *Vancouver General Hospital v. McDaniel*, [1934] 4 D.L.R. 593. There, a woman sued the hospital for being contracted with smallpox (though it was not stated directly, she seemingly had successfully recovered) within the treatment from diphtheria as being placed in the infirmary where smallpox patients were maintained. However, the hospital managed to win over the suit proving there was no negligence on their part and the practices they applied were well established.

²⁰⁷ Originally, *Colp v. Ringrose*, Alta S.C. No. 84474, 1976 (unreported), but reported in 3 L. Med. Quarterly (Alta.) 72 (1979) [Per Lieberman, J.]. That case facts didn't substantially vary from other Ringrose trials. There a woman desiring sterilization applied to him but the physician disposing the said experimental method, didn't reveal she could become pregnant again what actually happen. Decision was for plaintiff.

²⁰⁸ *Cryderman v. Ringrose*, [1977] W.W.R. 109.

²⁰⁹ *Zimmer v. Ringrose*, 89 D.L.R. (3d) 646, 658 (1978).

²¹⁰ *Cryderman v. Ringrose*, [1977] W.W.R. 109, para. 1–13.

²¹¹ *Ibid*, para. 19–22.

²¹² See, for instance, S. M. Waddams, *Medical Experiments on Human Subjects*, 25 U.T. Fac. L. Rev. 25, 26–32 (1967). Apart from the informed consent issue and some historical overview, Waddams held quite an obscure discussion on the experiments on people in Nazi Germany as well as some issues of consent ethics.

²¹³ [1980] 5 W.W.R. 272, para. 21, etc. In that case, plaintiff managed to recover 7.500 Dollars damages.

²¹⁴ 29 S.A.S.R. 437, 440 (1982).

²¹⁵ See, for instance: *Morgenroth v. Pacific Medical Center, Inc.*, 54 Cal. App. 3d 521, 534 (1976).

²¹⁶ *Hopp v. Lepp*, [1980] 2 S.C.R. 192, 194–196.

²¹⁷ *Ibid*, at p. 195–196.

²¹⁸ 53 D.L.R. (2d) 436, 441–442 (1965).

²¹⁹ [1965] N.Z.L.R. 191, 193–194. Please note that in contrast to *Hopp v. Lepp*, the patient directly interrogated on the risks and possible harms of the angiogram and was told that he shouldn't be anxious as he "would be fine in three days".

²²⁰ 2 S.C.R. 192, 199–201.

²²¹ *Ibid*, at p. 202–203.

²²² *Ibid*, at p. 210–211.

²²³ *Ibid*, at p. 211–212. At this point, I would like to recall *Smith v. Auckland Area Hospital Board*, [1965] N.Z.L.R. 191 and make a small interlude. There, plaintiff was suffering from diabetes and went to an angiogram. The indecent dye made the blood vessels in his leg obliterate and as a result he lost the leg. But in fact, couldn't that happen as a complexification of diabetes? Such unhappy consequences are frequent among people suffering from this ailment. Or was it provoked by the faux dye? All in all, these questions were not revealed in the case report.

²²⁴ *Reibl v. Hughes*, [1980] 2 S.C.R. 880, 900–901; on appeal, 21 O.R. (2d) 14 (1978), first trial: 16 O.R. (2d) 306 (1977).

²²⁵ *Reibl v. Hughes*, 21 O.R. (2d) 14, 20–24 (1978).

²²⁶ *Reibl v. Hughes*, 21 O.R. (2d) 14, 28–32 (1978).

²²⁷ *Male v. Hopmans*, [1966] 1. O.R. 647, 650–653.

²²⁸ *Reibl v. Hughes*, 21 O.R. (2d) 14, 28–32 (1978).

²²⁹ *Reibl v. Hughes*, [1980] 2 S.C.R. 880, 925–929.

²³⁰ See p. 888–891 and Canadian cases upholding the cases for unauthorized surgery featuring an action for battery or trespass to person: *Marshall v. Curry*, [1933] 3 D.L.R. 260; *Mulloy v. Sang*, [1935] 1 W.W.R. 714; *Winn v. Hospital*, etc., [1940] O.W.N. 238; *Schweizer v. Central Hospital et. al.*, [1975] 6 O.R. (2d) 606 (this case, by a French "tort" tradition was majorly based on proving the defendant's fault rather than having an actual discussion of informed consent doctrine as such, but still occasionally referred to it); *Den-daas v. Yackel*, [1980] 5 W.W.R. 272 (filed for battery but decided upon negligence).

²³¹ *Reibl v. Hughes*, [1980] 2 S.C.R. 880, 928–929.

²³² *Schitz v. Dickinson*, 31 C.C.L.T. 313 (1984).

²³³ *Diack v. Bardsley*, 25 C.C.L.T. 159 (1983); *Stewart v. Ross*, 64 Sask R. 271 (1988).

²³⁴ See, *Holmes v. Silver Cross Hospital of Joliet*, 340 F. Supp. 125, 129–130 (1972) and cases cited therein.

²³⁵ *Malette v. Shulman et al.*, 67 D.L.R. (4th) 321, 324–327.

²³⁶ *Ibid*, at p. 327–330; lower court decision, 63 O.R. (2d) 243, 268–273 (1987).

²³⁷ *Ibid*, at p. 333–337.

²³⁸ *In Re T (Adult: Refusal of Treatment)*, [1993] Fam. 95, 102–103; 112–116; the full facts, per *Donaldson, L.*, at p. 103–106.

²³⁹ See, *In Re T (A Minor)*, [1997] 1 W.L.R. 242 (parent appealing to withdraw medical treatment by liver transplantation); see other English cases on related subjects at p. 248–251.

²⁴⁰ *In Re J. (A Minor)* [1991] Fam. 33, 40–42.

²⁴¹ *Holmes v. Silver Cross Hospital of Joliet, Illinois*, 340 F. Supp. 125, 129–130; 132–136 (1972).

²⁴² See, *In Re Boyd*, 403 A (2d) 744, 748–750 (1979) and cases cited therein.

²⁴³ See, for instance, *Public Health Trust of Dade County v. Wons*, 541 So. (2d) 96, 97; 100–101 (1989). Seemingly, the primary construction of the said state interests was at best expounded in *Satz v. Perlmuller*, 362 So. (2d) 160, 162 (1978).

²⁴⁴ See, for instance, *John F. Kennedy Memorial Hospital v. Heston etc.*, 58 N.J. 576, 279 A. (2d) 670, 672–673 (1971) [this case was repeatedly criticized thereafter]; see also.

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²⁴⁶ *Application of President and Directors of Georgetown College, Inc.*, 331 F.2d 1000, 1006–1010 (1964); *Public Health Trust of Dade County v. Wons*, 541 So. (2d) 96, 99 (1989).

²⁴⁷ See. *Application of President and Directors of Georgetown College, Inc.*, 331 F.2d 1000, 1006–1010 (1964); *Powell v. Columbian Presbyterian Medical Center*, 49 Misc. 2d 215, 267 N.Y.S.2d 450, 452 (1965).

²⁴⁸ *Application of President and Directors of Georgetown College, Inc.*, 331 F.2d 1000, 1008 (1964); *In Re Osborne*, 294 A 2d 372, 374–376 (1972); *Holmes v. Silver Cross Hospital of Joliet, Illinois*, 340 F. Supp. 125, 129–130 (1972).

²⁴⁹ *Murray v. McMurphy*, [1949] 2 D.L.R. 442; *Cryderman v. Ringrose*, [1977] W.W.R. 109; *Zimmer v. Ringrose*, 89 D.L.R. (3d) 646 (1978); *Cataford v. Moreau*, 114 D.L.R. 585 (1978); *Dendaas (Tylor) v. Yackel*, [1980] 5 W.W.R. 272.

²⁵⁰ *Crits v. Sylvester* [1965] S.C.R. 991.

²⁵¹ *Beausoleil v. Sisters etc.* 53 D.L.R. (2d) 65, 73–77 (1964); *Martel v. Hotel Dieu St-Vallier / Vigneault c. Martel*, [1969] S.C.R. 745; *Hopp v. Lepp*, [1980] 2 S.C.R. 192.

²⁵² *Male v. Hopmans*, [1966] 1 D.L.R. 647; *Koehler v. Cook*, 65 D.L.R. (3d) 765, 766–767 (1976).

²⁵³ *Johnston v. Wellesley Hospital*, [1971] 2 O.R. 103, 105 etc.

²⁵⁴ *McLean v. Weir*, 18 B.C.L.R. 325 (1980).

²⁵⁵ *Kenny v. Lockwood Clinic Ltd.* [1931], 4 D.L.R. 906.

²⁵⁶ *Halushka v. University of Saskatchewan*, 53 D.L.R. (2d) 436 (1965).

²⁵⁷ *Yule v. Parmley & Parmley*, [1945] 2 D.L.R. 316; *Diack v. Bardsley*, 25 C.C.L.T. 159 (1983); *Schitz v. Dickinson*, 31 C.C.L.T. 313 (1984); *Stewart v. Ross*, 64 Sask R. 271 (1988); *DeFerrari v. Neville*, 42 C.C.L.T. (2d) 327 (1995).

²⁵⁸ *Caron v. Gagnon*, 68 S.C. 155, para. 1–3 (1930); *Marshall v. Curry*, [1933] 3 D.L.R. 260.

²⁵⁹ See note 254 supra.

²⁶⁰ *Beausoleil v. Sisters etc.* 53 D.L.R. (2d) 65, 73–77 (1964).

²⁶¹ *Zimmer v. Ringrose*, 89 D.L.R. (3d) 646, 653–655 (1978). The earlier case, *Marshall v. Curry*, [1933] 3 D.L.R. 260, is quite much influenced by earlier American decisions.

Резюме

Литвиненко А.А. Несанкціоноване медичне втручання та інформована згода у загальному праві Канади до рішення Верховного Суду по справі *Reibl v. Hughes* (1899–1980).

Стаття присвячена дослідженню практики судів Канади у цивільних справах, предметом позову яких було несанкціоноване медичне втручання, а правовими підставами для відшкодування збитків стали делікти – професійна недбалість чи завдання позивачу фізичної шкоди. У сучасній доктрині та судовій практиці, особа не є суб'єктом лікування, а має значні права, як пацієнт, включаючи інформаційні. Ці права передбачають, серед інших, право пацієнта бути поінформованим щодо майбутнього інвазивного лікування, а отже, надати на це згоду, чи навпаки, відмовитися від нього. Доктрина інформованої згоди, що походить з позовів, поданих через несанкціоноване медичне втручання в державах англо-саксонської та континентальної систем права, має понад столітню історію в судовій практиці країн світу. В англо-саксонській системі права, зародження цієї концепції почалося в кінці XIX століття, в основному, в практиці судів США, однак вона має ряд особливостей і в судовій практиці Канади XX ст. Проміжок часу, охоплений даним дослідженням – 1899–1980 роки (від рішення по справі Парнелла, що було першим рішенням з даного питання, до рішення по справі Рейбла проти Х'юза, де Верховний Суд Канади остаточно визнав принципи необхідності інформованої згоди пацієнта в тогочасному загальному праві). У 1990-х роках принципи інформованої згоди були кодифіковані. Автор провів дослідження щодо виникнення концепції та її розвитку в Канаді у згаданому часовому відрізку до рішення по справі *Reibl v. Hughes* (1980) та досліджував витоки «права на автономію пацієнта» як розширення права пацієнта на приватність, яке існувало в судовій практиці Канади понад століття, хоч і було визнано як таке відносно недавно, навіть попри наявність чималої кількості судових прецедентів. Також автор зосередив увагу на визначенні джерел права, якими послуговувалися канадські суди в більш ранніх справах, що стосувалися несанкціонованого медичного втручання: дані джерела права включали судову практику інших держав і професійну юридичну літературу.

Ключові слова: загальне право Канади, право пацієнта на автономію, право на приватність, деліктне право, медична недбалість, інформована згода.

Резюме

Литвиненко А.А. Несанкционированное медицинское вмешательство и информированное согласие в общем праве Канады до решения Верховного Суда по делу *Reibl v. Hughes* (1899–1980).

Данная статья посвящена исследованию практики канадских судов в гражданских делах, предметом иска в которых было несанкционированное медицинское вмешательство, а юридическим основанием для возмещения ущерба истцу стали деликты – профессиональная халатность врачей или нанесение истцу физического ущерба. В современной доктрине и судебной практике, лицо не является субъектом лечения, а владеет существенными правами, включая информационные. Эти права пациента предусматривают, среди прочих, право пациента быть информированным касательно будущего инвазивного лечения и соответственно дать на это согласие или отказаться от такого лечения. Доктрина информированного согласия, которая происходит из исков, поданных из-за несанкционированного медицинского вмешательства в странах англо-саксонской и континентальной систем права, имеет более, чем столетнюю историю в судебной практике стран мира. В англо-саксонской системе права зарождение этой концепции началось в конце XIX века в основном в практике американских судов, однако она имеет ряд особенностей и в практике судов Канады XX века. Временной отрезок, который охватывает данное исследование, включает в себя 1899–1980 годы (от решения по делу Парнелла, первого судебного решения по данному вопросу, до решения по делу Рейбла против Хьюза, где Верховный Суд Канады окончательно признал принцип необходимости информированного согласия пациента в общем праве того времени). В 1990-х годах принципы информированного согласия были кодифицированы. Автор провёл исследование возникновения концепции и её развития в Канаде в оговоренном временном отрезке до решения по делу Рейбла против Хьюза (1980), и исследовал истоки «права на автономию пациента» в качестве расширения права на приватность, которое существовало в судебной практике Канады более века, хотя и было признано как таковое относительно-

но недавно, незважаючи на наявність небагато кількості судових прецедентів. Також автор зосередив увагу на визначенні джерел права, які використовувалися канадськими судами при розгляді більш ранніх справ, стосуються несанкціонованого медичного втручання: дані джерела права включали судову практику інших країн світу та професійну юридичну літературу.

Ключевые слова: загальне право Канади, право пацієнта на автономію, право на приватність, деликтне право, медична халатність, інформоване згоду.

Summary

Anatoliy Lytvynenko. Unauthorized medical intervention and informed consent in the common law of Canada prior to the Supreme Court's decision of Reibl v. Hughes (1899–1980).

The given article deals with the Canadian legacy of civil actions on negligence and technical assault or battery involving an unauthorized medical interference to plaintiff. In modern doctrine and case-law, the given concept is named "informed consent", upon which the patient is not a mere subject of medical treatment, but has a substantial set of patient rights, involving the informational ones, which includes his right to be informed on further invasive treatment and thus to be able to assent or decline it. The doctrine of informed consent, arising from actions on unauthorized medical treatment in both common law and civil law jurisdictions, has a centuryfold history in the jurisprudence. In the common-law world, it was bred in the end of the 19th century primarily in the jurisprudence of American courts, but still has its distinct peculiarities in the common law of Canada throughout the twentieth century. The span on the researched jurisprudence embraces the time period of 1899 (judgment of Parnell, which was the first case to deal with the subject) to 1980 (case of Reibl v. Hughes), where the Canadian Supreme Court has firmly recognized the principle of informed consent in the acting common law. In the 1990s, the principles of informed consent had been codified. The author has investigated on the evolvement of the concept of patient's right to autonomy in the state from the very beginning to the judgment of Reibl v. Hughes in 1980, and has researched the roots of the "right to autonomy" as an extension of the right to privacy, which has penumbally existed in Canadian jurisprudence for over a century, despite having been recognized as such relatively recently, despite an existence of various early case-law legacy. Apart from the abovesaid, the author aimed to define the authorities used by Canadian courts in the earlier cases dealing with unconsented surgery, which involves judgments from other jurisdictions as well as professional legal and medical textbooks.

Key words: Canadian common law, right to autonomy, right to privacy, tort law, medical negligence, informed consent.

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ОСОБЛИВОСТІ ВИНИКНЕННЯ ЗОБОВ'ЯЗАННЯ З ПУБЛІЧНОЇ ОБІЦЯНКИ ВИНАГОРОДИ БЕЗ ОГОЛОШЕННЯ КОНКУРСУ

Постановка проблеми. У сучасній цивілістиці поділ зобов'язань на договірні та недоговірні являє собою теоретичну догму, за якою стоять спеціальні дослідження, еволюція наукової думки та нормативно-правових положень. Однак право є «живою» матерією, яка розвивається та еволюціонує відповідно до потреб суспільства, а також економічних, політичних, технологічних та інших змін в житті людини, що відбуваються повсякденно. У зв'язку з цим цивілістичні догми або окремі їх аспекти підлягають періодичній ревізії в умовах відповідних змін.

Досить зрозумілий на перший погляд критерій диференціації цивільних правовідносин втрачає свою юридичну простоту при спробі визначити співвідношення між порядком виникнення таких правовідносин з публічної обіцянки винагороди та їх виникненням на договірній підставі. У рамках відповідної кореляції можна простежити як спільні риси обох правовстановлюючих механізмів, так і істотні відмінності між ними. Тому їх ототожнення або навпаки розмежування є передумовою, зокрема визначення перспектив удосконалення положень чинного цивільного законодавства України, принаймні, в частині збереження або доопрацювання норм, що регулюють відносини з публічної обіцянки винагороди.

Аналіз останніх досліджень і публікацій. Тематика правової природи підстав виникнення і особливостей динаміки недоговірних зобов'язань, зокрема правовідносин з публічної обіцянки винагороди, ставала предметом наукового осмислення таких вчених, як С.С. Алексєєв, І.В. Венедіктова, Є. Годєме, Н.Ю. Голубєва, І.В. Жилінкова, В.М. Ігнатенко, О.С. Іоффе, А.В. Коструба, О.О. Кот, Т.С. Ківалова, Н.С. Кузнєцова, Р.А. Майданик, В.В. Надьон, О.О. Отрадна, О.В. Подвірна, Я.М. Романюк, М.Є. Сарахман, І.В. Ткач, Р.О. Халфіна, Ю.Є. Ходико, Я.М. Шевченко, Р.Б. Шишка, О.Я. Явор, В.Л. Яроцький та ін.