

# FIDUCIARY LAW IN THE HOSPITAL CONTEXT: THE PRESCRIPTIVE DUTY OF PROTECTIVE INTERVENTION

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## I. Introduction

Hospitals are hazardous places. They house patients in complex environments rife with life-threatening diseases and toxic pharmaceuticals. Significant numbers of hospital patients have compromised immune systems and hence are susceptible to disease, including infectious disease. The spread of disease in hospitals is facilitated by the proximity of patients to one another and the density of the patient population. High risk, often life-threatening medical procedures, are routinely carried out. Hospital services are delivered in dynamic, fast paced environments that too often tax hospital service providers beyond their service limits. Both by virtue of their illnesses and the “realities” of hospital environments, patients are extremely vulnerable. It is not surprising, therefore, that despite significant efforts to mitigate risk, the incidence of adverse events and morbidity from adverse events in hospitals is distressingly high. In Canada, one out of every thirteen patients in non-specialized acute care hospitals experience adverse events and, annually, death ensues for thousands of Canadians.<sup>1</sup>

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1 Canadian Institute for Health Information (CIHI), *Health Care in Canada*, 2004 (Ottawa, Ont.: CIHI, 2004), at 42 reports that 7.5% of such patients experience adverse events. As to the number of deaths, see Tim Outerbridge, “Building Systemic Models for Medical Error Reporting” (2004) 12 Health L.J. 275 at para. 3 (QL) and G. Ross Baker *et al.*, “The Canadian Adverse Events Study: The Incidence of Adverse Events among Hospital Patients in Canada” (2004) 170:11 Canadian Medical Association Journal 1678. See also Michael Waite, “To Tell the Truth: The Ethical and Legal Implications of Disclosure of Medical Error” (2005) 13 Health L.J. 1 at paras. 10-15 (QL) [Waite] where he reviews a variety of studies that report different rates of adverse events. Waite concludes that despite the quantitative differences in the studies, they all conclude that medical error is a serious problem. For a U.S. study that supports Waite’s conclusion see Linda T. Kohn, Janet M. Corrigan & Molla S. Donaldson, eds., *Committee on Quality of Health Care in America*, Institute of Medicine,

Increasingly, hospitals, health care authorities, and health safety institutes are developing and implementing programs and strategies designed to mitigate hospital risk.<sup>2</sup> Legal regulation of both hospital environments and activities also contributes to the mitigation of risk. Tort law has a high profile in this task. Less important but not unimportant is fiduciary law. Together, these two bodies of judge-made law improve safety in hospitals by minimizing risk (tort law) and by requiring that service providers be dedicated to their patients' "best interests" (fiduciary law).<sup>3</sup> Recent developments in

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*To Err is Human: Building A Safer Health System*, (Washington, D.C.: National Academy Press, 1999), online: The National Academies Press <[http://www.nap.edu/html/to\\_err\\_is\\_human/exec\\_summ.html](http://www.nap.edu/html/to_err_is_human/exec_summ.html)>.

- 2 Substantial progress is being made in identifying and mitigating risk in service delivery institutions. Innovative safety programs are being introduced into hospital settings throughout Canada. These include: double checking, reporting, "just culture" and "good catch" programs. For elaboration on programs designed to mitigate risk, see *infra* notes 53 and 55. A key focus of these programs is prophylactic. Systematic changes within hospitals, including, organizational, logistical, procedural, educational, scope of practice related and changes in both communication protocols and staffing can all contribute to a reduction of morbidity and mortality. The Institute For Health Care Improvement has developed an important new communications protocol for facilitating communication between members of a health care team. See Institute for Healthcare Improvement, "SBART Technique for Communication: A Situational Briefing Model," online: IHI.org <<http://www.ihl.org/IHI/Topics/PatientSafety/SafetyGeneral/Tools/SBARTechniqueforCommunicationASituationalBriefingModel.htm>>. "Communication breakdowns between health care providers are a central feature in episodes of avoidable patient harm. For this reason, the Joint Commission has issued a new requirement in association with its National Patient Safety Goal 2, which states that facilities must implement a standardized approach to handoff communications. Because clinical teamwork often involves hurried interactions between human beings with varying styles of communication, a standardized approach to information sharing is needed to ensure that patient information is consistently and accurately imparted. This is especially true during critical events, shift handoffs, or patient transfers." For a scholarly contribution to the patient safety initiative which focuses on diagnostic error see Dr. Jerome Groopman, *How Doctors Think* (New York, N.Y.: Houghton Mifflin, 2007). Dr. Groopman sets out several types of cognitive errors which lead to mis-diagnosis.
- 3 In the context of the guardian or parent/child fiduciary relationship, the Supreme Court of Canada has held that the so-called duty of a parent or guardian

fiduciary law, buttressed by parallel developments in tort law, suggest unequivocally that fiduciary doctrine has expanded to include positive duties of disclosure and protective responsibility.<sup>4</sup> Where fiduciaries are burdened by affirmative responsibilities, much more is expected of them as guardians of their beneficiaries' interests than has historically been the case. Affirmative obligation can import a broad duty to protect beneficiaries, not only from potential misconduct of fiduciaries themselves, but from potentially harmful behaviour of third parties and even other sources of potential harm. In the health care context, such an affirmative duty has the potential to enhance the security and safety of hospitalized patients.<sup>5</sup>

Discovery and both reporting and disclosure of risk, harm and error are the *sine qua non* of an effective patient safety strategy. It is disconcerting that historically there has been and there continues to be significant reluctance to report and disclose suspicious circumstances surrounding patterns of morbidity and mortality, medical error and perhaps even misconduct perpetrated

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to act in the "best interest" of a child is more aspirational than legal. See *K.L.B. v British Columbia*, 2003 SCC 51, [2003] 2 S.C.R. 403 [*K.L.B.*]. In that case, at para. 47, the Supreme Court held that promoting the best interest of a child is a "guiding objective" or "laudable goal" which informs the discharge of fiduciary obligation but "... does not constitute a justiciable standard for determining liability in damages." It would be stretching *K.L.B.* beyond its intended limits to conclude that the Supreme Court's rejection of the "best interest" description of fiduciary duty extends beyond the guardian or parent/child relationship to all fiduciary relationships. Though somewhat debatable and subject to two qualifications, it is suggested that the duty to promote the best interests of patients continues to be an accurate description of the fiduciary duty owed by physicians (and, more generally, all professional health service providers) to their patients. For an elaboration of these points see the text at 318-322, below.

4 See discussion of this in the text at 322-336, below.

5 The potential connection between patient safety and fiduciary law has been noticed by the Health Quality Council of Alberta in its "Summary of Recommendations" of the *Review of Infection Prevention and Control and CSR Sterilization Issues in East Central Health Region*. Health Quality Council of Alberta, "Summary of Recommendations," *Review of Infection Prevention and Control and CSR Sterilization Issues in East Central Health Region* (Calgary, Alta.: Health Quality Council of Alberta, July, 2007) at 2, online: Health Quality Council of Alberta <[http://www.hqca.ca/phpBB2/files/hqca\\_summary\\_of\\_recommendations\\_july\\_25\\_2007\\_341.pdf](http://www.hqca.ca/phpBB2/files/hqca_summary_of_recommendations_july_25_2007_341.pdf)>.

by health service providers.<sup>6</sup> This article will suggest that there is a legal duty, not merely an ethical duty, to disclose and/or report misconduct, medical error and suspicious circumstances of serious health risks faced by patients. While this suggestion is not entirely novel, what may be new is the suggestion that the duty to disclose and report medical error, borne by health care professionals [HCPs], binds not only “perpetrators” of these errors but other HCPs who are aware of the “problem.” In other words, the duty to disclose and report includes a duty to whistle-blow. It is fiduciary law that spawns this extraordinary duty. The obligation to whistle-blow is derived from the broad duty of protective intervention, which, in turn, is derived from the core duty of fiducial loyalty.<sup>7</sup> Fiducial loyalty also requires disclosure/reporting of medical error outside of the context of protective intervention, that is, even where there is no apparent threat of new or continuing harm to patients.

Given the limited case law that focuses on HCPs/patient fiduciary relationships, demonstrating that a legal duty to whistle-blow exists requires a deep and critical examination of the broad body of fiduciary law. The pattern of analysis in this article is first to set out and analyse general fiduciary doctrine and then to apply this doctrine to the HCPs/patient relationships. It will be suggested that fiduciary law strongly supports the conclusion that all HCPs, including physicians, nurses, physiotherapists, occupational therapists, psychologists, social workers and others, as well as hospitals (in non-regionalised jurisdictions) and regional health care authorities themselves, are fiduciaries.<sup>8</sup> It will also be suggested that fiduciary theory clearly sup-

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6 See discussion of this in the text at 349-350, below.

7 Recent developments in tort law may have given rise to an overlapping duty of protective intervention. See discussion of this in the text at 336-342, below.

8 Whether non-professional hospital staff are also fiduciaries is an issue that is beyond the scope of this article. However, first principles, judicial *obiter* and scholarly commentary suggests that they may be. See *Re Coomber* [1911] 1 Ch. 723 at 728 where Fletcher Moulton L.J. suggests that an “errand boy” may be a fiduciary (quoted with approval in *Lac Minerals Ltd. v. International Corona Resources*, [1989] 2 S.C.R. 574 at para. 185, 61 D.L.R. (4th) 14 [*Lac Minerals*]). See also Sir Robert Megarry, “Historical Development,” *Special Lectures of the Law Society of Upper Canada 1990 – Fiduciary Duties* (Scarborough: Richard DeBoo, 1991) 1 at 11, where Megarry asks whether “humbler beings, such as secretaries and photocopy operators ...” may be fiduciaries; and see Robert Flannigan, “A Romantic Conception of Fiduciary Obligation,” Book Review of *Fiduciary Law*

ports and should support the existence of prescriptive duties, including a duty to whistle-blow.

## II. Fiduciary Theory: The Genesis of the Fiduciary Relationships

### (a) Definition and Introduction

Defining the term “fiduciary” is problematic because a definition cannot capture the subtleties of fiduciary responsibility. Nevertheless, the central idea is that a fiduciary is an actor who is “... required to look after the interests(s) of ... others with vigilance, dedication and selflessness.”<sup>9</sup> Fiduciary duty entails abnegation, that is, both loyalty and selflessness.<sup>10</sup> Within the scope of fiduciary undertakings, fiduciary duty negates the ordinary freedom of fiduciary actors to pursue self-interest. The foundational principles of fiduciary law are those which underlie and explain the genesis of fiduciary relationships. These principles inform a spectrum of interrelated fiduciary law issues with which this article is concerned, including: which HCPs are fiduciaries; what is the scope of their fiduciary obligations; are fiduciary duties merely proscriptive or also prescriptive; and what misconduct constitutes a breach of fiduciary duty.

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by L. Rotman, (2005) 84 Can. Bar Rev. 391 at 402-03 [Flannigan, “Romantic”] where it is suggested that mechanics, parking valets and taxi drivers may be fiduciaries.

9 Moe M. Litman, “Fiduciary Law and For-Profit and Not-For Profit Health Care” in Timothy A. Caulfield & Barbara von Tigerstrom, eds., *Health Care Reform and the Law in Canada: Meeting the Challenge* (Edmonton, Alta.: University of Alberta Press, 2002) 85 at 86. It follows that loyalty of the fiduciary actor is the core focus of a fiduciary relationship. Of course, loyalty is an open ended concept. To say that loyalty is central to fiduciary responsibility provides no hint of “what degree of loyalty” is expected and “in relation to what matters” is loyalty expected. In theory this uncertainty is soluble by focusing on the “reasonable expectations” of the parties. See text at 308-312, below.

10 Abnegation is defined as renunciation of one’s interest in favour of the interest of another. In a fiduciary context the renunciation occurs because of an ongoing duty of loyalty. This term is utilized and discussed by Robert Flannigan, “The Boundaries of Fiduciary Accountability” (2004) 83 Can. Bar Rev. 35 at 47 [Flannigan, “Boundaries”].

(b) The *Indicia* of Fiduciary Relationships: Does it All Boil Down to "Vulnerability"?

The starting point for identifying fiduciary relationships and, erroneously too often the end point, are the *indicia* of fiduciary relationships.<sup>11</sup> Though originally conceived of as "merely" descriptive of the common characteristics of fiduciary relationships, there is judicial disagreement about whether the *indicia* are indispensable to the creation of such relationships.<sup>12</sup> If the *indicia* are indeed essential to the existence of fiduciary relationships, then the *indicia*, which already play a prominent role in fiduciary analysis, will become even more significant. Moreover, judicial disagreements about the "*indicia*" will need to be resolved.<sup>13</sup>

Classically the *indicia* are set out in three propositions. They are: (i) fiduciaries have scope for the exercise of some discretion or power; (ii) fiduciaries can affect the legal or practical interests of beneficiaries through the unilateral exercise of their discretion or power; and (iii) beneficiaries are peculiarly vulnerable to or at the mercy of fiduciaries holding the discretion

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11 The *indicia*, set out in the text in the following paragraph, were first formulated by Justice Wilson in her dissenting opinion in *Frame v. Smith* [1987] 2 S.C.R. 99 at para. 60, 42 D.L.R. (4th) 81, as "general characteristics" which fiduciary relationships "seem to possess." They have been embraced universally in the Canadian jurisprudence. Though very useful, the *indicia* have been utilized by the judiciary as analytical panacea, which they are not, for determining whether relationships are fiduciary. That is, they have been utilized slavishly and formulaically as a test rather than as an indication of the existence of a fiduciary relationships. See *Non-Marine Underwriters, Lloyd's of London v. Scalera*, 2000 SCC 24 at para.131, [2000] 1 S.C.R. 551 where the *indicia* are explicitly referred to as a "test." And, for one of many examples of cases where courts conclude that because all the *indicia* are present, a relationship is fiducial, see *Grant v. Canada* (2006), 77 O.R.(3d) 481 at para. 35, [2006]1 C.N.L.R.1, Cullity J. Justice Cullity is no doubt correct in his ultimate conclusion that the parties relationship is fiducial but the presence of all the *indica* is not sufficient or persuasive for this conclusion. For an elaboration on this point, see the text at 308-309, below.

12 For a discussion of the indispensability of the *indicia*, see the text at 304-307, below. Though it has been suggested that only a single *indicia*, namely, vulnerability of the beneficiary, is indispensable to the creation of fiduciary relationships, it has been recognized that the *indicia* are all inextricably linked. See text accompanying notes 14-16.

13 These are discussed at 300-304, below.

or power.<sup>14</sup> Though the *indicia* take the form of discrete characteristics, the characteristics are inextricably intertwined. This point is implicit in the following uncontroversial observation made by Justice Sopinka in his dissent in *Hodgkinson v. Sims*, “Vulnerability ... may be seen as encompassing all three characteristics of the fiduciary relationship .... It comports the notion, not only of weakness in the dependent party, but of a relationship in which one party is in the power of the other ....”<sup>15</sup>

In other words, the corollary of the “peculiar vulnerability” of a beneficiary’s legal or practical interests is the fiduciary’s “unilateral” power or influence over those interests.<sup>16</sup> In essence, then, what characterizes fiduciary relationships is very considerable power or influence of fiduciaries over significant interests of beneficiaries. It follows then, that if vulnerability of beneficiaries is indispensable to the existence of fiduciary relationships, then so too is the power or influence of fiduciaries. Appreciating the relationship between the vulnerability of beneficiaries and the power of fiduciaries is important because judicial analysis constantly and seamlessly migrates between the power and vulnerability perspectives.

It has been suggested that fiduciary law is concerned with “personal” rather than “situational” vulnerability.<sup>17</sup> Personal vulnerability has been defined as “the existence of a disadvantage compelling the individual who possesses it to deal with the world on less than equal terms.”<sup>18</sup> Situational vulnerability, on the other hand, occurs when parties are placed or place themselves in circumstances where they are susceptible to harm. Though there has been some resistance to extending fiduciary protection to cases

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14 *Frame v. Smith*, *supra* note 11.

15 *Hodgkinson v. Simms*, [1994] 3 S.C.R. 377 at para.129, 117 D.L.R.(4th)161 [*Hodgkinson*]. See also Litman, *supra* note 9 at 88 where the *indicia* are described as “elastic and interrelated.”

16 The classic concern of fiduciary law is the vulnerability of beneficiaries to an improper exercise of power or discretion by the very fiduciaries upon whom beneficiaries rely. But beneficiaries are also vulnerable to external risks of harm, risks which they rely on their fiduciaries to protect them from. Prescriptive obligations of fiduciaries to provide such protection has been recognized (see the text at 322-326, below). It follows that both fiduciary power and the failure of prescriptive obligation are corollaries of the vulnerability of beneficiaries.

17 Donovan W. N. Waters, “The Reception of Equity in the Supreme Court of Canada (1875-2000)” (2001) 80 Can. Bar Rev. 620 at 678.

18 *Ibid.* at 680.

where situational vulnerability is self-incurred, particularly in cases involving commercial relationships, it seems indisputable that both forms of vulnerability co-exist comfortably within fiduciary relationships.<sup>19</sup> Clearly the parent/child and analogous fiduciary relationships are founded on the intrinsic personal vulnerability of children and dependent adults. On the other hand, the vulnerability of beneficiaries in trusts is situational. Where settlors create trusts in favour of third parties, the economic interests of the third parties in the trust are vulnerable to the unilateral power, honesty and prudence of trustees. Where settlors establish trusts for the benefit of themselves, vulnerability is self-incurred. The same is true for principals who enter into agency arrangements and business partnerships. In all of these examples, whether vulnerability is personal or situational, vulnerability exists in a fiduciary law sense.

What is important is not whether vulnerability is situational or personal but whether the vulnerability, irrespective of its source, exposes the vulnerable party to the power or influence of a fiduciary.<sup>20</sup> In other words,

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19 *Frame v. Smith*, *supra* note 11 at para. 63, Wilson J.; *Lac Minerals*, *supra* note 8 at paras. 51-53, Sopinka J. Whether the ability to avoid vulnerability should preclude someone from asserting a fiduciary relationship is a normative question. By definition it does not address the factual issue of whether vulnerability exists. Hence, if vulnerability exists, it exists irrespective of whether it is imposed or incurred. As Justice La Forest noted in *Hodgkinson*, *supra* note 15 at para. 36, "the relative 'degree of vulnerability' does not depend on some hypothetical ability to protect one's self from harm ...." As to the normative question, there are a myriad of fiduciary relationships, some in the commercial context, in which vulnerability is incurred and the fiducial character of these relationships are unquestioned. These relationships include trusts set up by settlors for their own benefit and both principal/agent and partnership relationships. The pertinent question is not whether a party could have avoided vulnerability but whether the parties have willingly opted into a (fiduciary) regime where at least one of them has dedicated themselves to the interest of the other and agreed to give up their right to pursue self-interest. The failure to avoid vulnerability, even when practical, is neither evidence that the parties intended nor evidence that the parties did not intend to opt into a fiduciary regime. While it is perfectly appropriate in some commercial contexts for fiduciary law to be sceptical about the assertion of a fiduciary relationship, this scepticism is not warranted in all cases and in any event is not informed by the post-relational vulnerability of one or both parties, even if self-incurred.

20 In the "new" era of prescriptive fiduciary duties, one might add that relevant

the vulnerability of beneficiaries and the power of fiduciary actors have legal significance for fiduciary law only within existing fiduciary relationships. This point is made by Justice La Forest in *Hodgkinson v. Simms* when he quotes Professor Weinrib's assertion that fiduciary law is concerned with vulnerability that arises from the "relative position of the parties that results from the agreement [giving rise to fiduciary relations] rather than the relative position that precedes the agreement."<sup>21</sup> Pre-relational vulnerability may explain the motivations of parties who enter into fiduciary relationships but unless that vulnerability persists and operates within a fiduciary relationship to bring beneficiaries within the power of fiduciaries, it is of no moment for fiduciary law. Of course, pre-relational vulnerability will often precede and continue to operate within a fiduciary relationship. This is evident in the guardian/dependant cases and the client/broker cases,<sup>22</sup> and also in the health provider/patient cases where anxiety over health problems, the lack of knowledge of how to solve them and other factors contribute to an individual's vulnerability. These factors can and do operate both before and after health care providers get involved. In sum, it is not vulnerability at large that fiduciary law is concerned with but vulnerability to the acts and omissions of a fiduciary actor.<sup>23</sup> Though this point may seem trite, as will be seen below, it has analytical significance. In any event, it is clear that even if personal vulnerability is a requirement of fiduciary law, it will not be an impediment to success for hospitalized patients who assert that their HCPs are fiduciaries.

The interrelationship of the various *indicia* is apparent when examined in the context of the spectrum of fiduciary relationships, including the physician/patient relationship. In trusts, agency and partnership relationships, the legal power and discretion of the fiduciary actors, trustees, agents and

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vulnerability includes susceptibility to risks of harm that a fiduciary is responsible for mitigating. See text at 322-336, below.

21 *Supra* note 15 at para. 27, quoting from Ernest J. Weinrib, "The Fiduciary Obligation" (1975) 25 U.T.L.J. 1 at 6. See also *Norberg v. Wynrib*, [1992] 2 S.C.R. 226 at para. 66, 92 D.L.R. (4th) 449 [*Norberg* cited to S.C.R.], quoting Frankel, "Fiduciary Law" (1983) 71 Calif. L. Rev. 795 at 801 to the same effect.

22 Naivety and inexperience both precede and operate within these relationships. See, for example, *K.L.B.*, *supra* note 3 at para. 38 (guardian/dependent) and *Marshak v. Branch* [2004] O.J. No. 4339, 134 A.C.W.S. (3d) 619 (Sup. Ct. J.) (broker/client).

23 See below at 322-336, below.

partners, clearly bind and affect what are almost universally vulnerable legal and economic interests of beneficiaries.<sup>24</sup> In the parent/child relationship, parents have both *de jure* and *de facto* decisional authority and profound psychological influence over their vulnerable children, particularly their “young” children. Young children are inherently vulnerable, but the decisional authority and influence (power) that parents have over their children contributes considerably to the children’s vulnerability. In professional service based fiduciary relationships, including physician/patient relationships, service providers who are fiduciary actors, at least ordinarily, have substantial influence over their patients and clients.<sup>25</sup> This is so, even though these relationships operate within consent based regimes which require free and informed choices to be made by patients and clients. In advisory and professional service relationships, important health, emotional, psychological and economic interests of patients and clients are almost always vulnerable to the powerful influence of expert fiduciary actors.

The dominance of physicians and susceptibility of patients is illustrative of the interplay of the various *indicia*. In this context, ascendancy and vulnerability stem from the physician’s superior knowledge of and experience with a highly complex and critically important body of learning, the gatekeeper functions that physicians play, the perception that physicians are objective and loyal to their patients and, as well, anxiety patients have about matters of health.<sup>26</sup> All of these factors lead patients, on a widespread basis, to seek out and ordinarily to defer to the opinions of their physicians about choice of treatment within an array of treatment options.<sup>27</sup> And, of course, treatment clearly impacts on the health, emotional and psychological interests of patients.

There is judicial disagreement about whether vulnerability is essential to the existence of a fiduciary relationship.<sup>28</sup> There is also disagreement about

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24 I say almost because one can conceive of relationships of trusts where beneficiaries are not at all vulnerable. For example, in a trust of land, where the beneficiary is a co-trustee and, in a land titles system, has caveated title on the basis of her equitable interest arising from the trust, there is no apparent vulnerability.

25 Litman, *supra* note 9 at 88.

26 *Ibid.*

27 *Ibid.*

28 See *Lac Minerals*, *supra* note 8 at para. 34 where Justice Sopinka concludes that vulnerability or dependency is “indispensable” to fiduciary relationships. In the same case, Justice La Forest explicitly disagrees at para.169. See also *Hodgkin-*

the degree of vulnerability that is either essential to or at least characteristic of such relationships. On both points, the Supreme Court of Canada appears to be equally divided. Historically, Justice Sopinka was the strongest advocate of a requirement of a high degree of vulnerability. In his view, fiduciary relationships cannot arise unless beneficiaries are “at the mercy” of their fiduciaries.<sup>29</sup> Commensurately, he described the (requisite) power of fiduciaries as “unilateral” or “total” power over their beneficiaries. This level of power has also been described as “wholesale substitution of decision-making power.”<sup>30</sup> Justice Sopinka’s concern with minimizing legal constraints on the pursuit of individual self-interest appears to be the reason why he favours significant doctrinal barriers to fiduciary responsibility. In his view, only extreme vulnerability of beneficiaries and a correlative level of power of fiduciaries justifies a duty to curb self-interest.

The leading proponent of the view that vulnerability of beneficiaries is characteristic of but not indispensable to fiduciary relationships is Justice La Forest.<sup>31</sup> In addition to disagreeing with Justice Sopinka on the necessity of vulnerability, La Forest J. takes issue with Justice Sopinka’s views on the requisite degree of vulnerability of beneficiaries. In *Hodgkinson v. Simms*, where an advisor-accountant was sued for an investment gone bad, Justice La Forest stated that it was “too restrictive” to suggest that a fiduciary relationship only exists when fiduciary power is so great as to be a “wholesale substitution of the decision making power [of beneficiaries].”<sup>32</sup> In La Forest J.’s view, “overriding influence” and “effective” power are sufficient (and preferable) indications of fiduciary power.<sup>33</sup> It may be that, in the final anal-

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*son, supra* note 15, where this difference of opinion is repeated. In *Hodgkinson*, at para. 25, Justice La Forest states that vulnerability is not “the hallmark of a fiduciary relation” but rather an “important *indicium* of its existence.” On the other hand, Justice Sopinka in *Hodgkinson* at para.131 states that vulnerability is the “hallmark to which a court looks in determining whether a fiduciary relationship exists.” No clear majority view has emerged on this important debate at the Supreme Court of Canada.

29 *Hodgkinson, ibid.* at paras.129-33.

30 This description was proffered by Justice La Forest in *Hodgkinson, ibid.* at para. 60.

31 *Supra* note 27.

32 *Supra* note 15 at para. 60.

33 *Ibid.* at para. 60 (“overriding”) and para.128 (“effective”). On the facts of *Hodgkinson*, effective and overriding power were “... such that the respondent’s

ysis, Justices La Forest and Sopinka's apparent difference of opinion on the requisite or typical degree of vulnerability/power of fiduciary actors merely has rhetorical significance. After all, from a pragmatic or functional perspective "overriding power" and "total power" are the same. However, if there is a difference between these two terms, Justice La Forest's adjectives should be preferred. This is because any difference in the level of power between overriding and total power is of no consequence. In both cases, the power is determinative.

Oddly, Justice La Forest has not explained why he regards (beneficiary) vulnerability to be merely characteristic and not a requirement of fiduciary relationships.<sup>34</sup> Be that as it may, in the context of the provision of health services his view makes considerable sense. The integrity and efficacy of the health care provider/ patient relationship is substantially enhanced by, if not completely dependant on, patient confidence in the loyalty of their service providers. Distrust impairs both the therapeutic goals and efficient operation of these relationships and that is so whether or not the patient is vulnerable. A distrustful patient is more likely to be sceptical of expert advice and, hence, less likely to make prudent decisions informed by expertise. Moreover, distrustful patients, even those who ultimately make prudent health care decisions, are more likely to incur transactional costs such as enlisting second opinions in making decisions. Moreover, vulnerability is less than an ideal concept on which to base legal duties. At least in some circumstances, evaluating whether a patient is or is not sufficiently vulnerable so as to be owed a fiduciary duty is a highly subjective and unreliable exercise, one likely to lead to the kind of strong disagreement evident in the majority and dissenting opinions in *Hodgkinson v. Simms*. Is the patient who gets multiple medical opinions *per se* non-vulnerable? If so, is the physician who is approached for a second or third opinion automatically free to engage in self-interested behaviour? Are patients who independently research their own health issues free actors and, therefore, not owed fidelity by their physicians? Are patients who are themselves physicians or nurses vulnerable? Do we really want to

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advice was *in substance* an exercise of a power or discretion reposed in him by the appellant" at para. 60 [emphasis added].

34 There are hints of his rationale throughout his judgement, in particular in his discussion of the policy reasons underlying the fiduciary concept. Even in the absence of vulnerability, fidelity may enhance the integrity and effectiveness of important social institutions. See *Hodgkinson, ibid.* at paras. 45-52 where Justice La Forest engages in a discussion of policy considerations.

formulate the law so as to encourage physicians and other fiduciary actors to evaluate the level of vulnerability of their patients and clients with a view to determining whether they may engage in self interested behaviour?

### (c) *Indicia* Analysis Applied to Hospitalized Patients

Whatever may be the resolution of the debate over the role and meaning of vulnerability in the broad body of fiduciary law, it is clear that hospitalized patients will almost always be “at the mercy” of their health care providers. By virtue of both the serious conditions that give rise to hospitalization and the fact of hospitalization itself, patients are vulnerable and completely dependant on the hospitals in whose care they are in, as well as the expertise, due diligence and fidelity of both hospital employees and independent contractors, often physicians, who provide patient services in hospitals. HCPs, whether engaged in diagnostics, treatment, rehabilitation or counselling, have specialized and sophisticated knowledge, are gate keepers with respect to important services, procedures and drugs, and are regarded by patients as objective and committed to their cause. Patients are exposed to serious risks in hospital environments and there is very little scope for them to personally take precautions to avoid these risks. Even sophisticated patients, such as specialist physicians, who suffer from the very ailments that in their professional lives they treat, are vulnerable. Like other patients, they are completely dependant on “hospital staff” to minimize the risks entailed in hospitalization, are anxious about their ailments and ordinarily rely, without reservation, on their health service providers to be dedicated to and objective about their health interests. The expectation of loyal commitment to the interests of patients is particularly important. As Justice La Forest pointed out in *Hodgkinson v. Simms*, albeit in the advisory context: “... the advisor’s ability to cause harm and the client’s susceptibility to be harmed arise from the simple but unassailable fact that the advice given by an independent advisor is not likely to be viewed with suspicion; rather, it is likely to be followed.”<sup>35</sup>

Though there is more scope for independent decision-making by physicians and other health care providers who are hospitalized as patients, many, if not most, will still be powerfully influenced by and be reliant on their health care providers. Hence, with few exceptions, the *indicia* of fiduciary relationships are not an impediment to establishing that HCPs, hospitals and

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35 *Supra* note 15 at para. 59.

health authorities are fiduciaries, even in cases where patients are themselves medical professionals.

(d) Beyond *Indicia* and Vulnerability: The Test for Determining Whether Relationships are Fiducial

Importantly, the presence of all the *indicia* is not conclusive of the existence of a fiduciary relationship. On this point there is broad agreement and the point is indisputably correct.<sup>36</sup> Pedestrians who cross roads are extremely vulnerable to the power and decision-making of motorists but clearly there is no fiduciary relationship between the parties. There is, of course, an expectation that drivers will avoid harming pedestrians and there exists a legal requirement that they drive with due care but there is no expectation of personal loyalty or allegiance by drivers to the interests of pedestrians and hence there is no fiduciary relationship.<sup>37</sup>

Even within personal relationships the presence of the *indicia* is not conclusive of the relationships being fiducial. Parties to contracts are often vulnerable to each other, yet most contracts do not create fiduciary relationships. If A relies on a contract to obtain widgets from B, widgets that are necessary for meeting a contractual commitment owed to a third party, A is highly vulnerable to any failure by B to provide the widgets. In this context, a failure of timely performance by B can give rise to expensive liability to the third party. Yet, typically, such a contract does not create a fiduciary

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36 Justice Sopinka in *Lac Minerals*, *supra* note 8 at para. 33 is explicit about this point. Referring to the *indicia* he states: "It is possible for a fiduciary relationship to be found although none of these characteristics are present, nor will the presence of these ingredients invariably identify the existence of a fiduciary relationship." The same point is implicit in Justice La Forest's statement in *Hodgkinson*, *supra* note 15 at para. 30 that "Wilson J.'s guidelines constitute *indicia* that help recognize a fiduciary relationship rather than ingredients that define it." If the *indicia* are not ingredients that define fiduciary relationships, their presence is compatible with other relationships and hence, compatible with a relationship being non-fiduciary. Indeed in *Hodgkinson*, Justice La Forest at paras. 25, 35 suggests that vulnerability can implicate a variety of legal doctrines (undue influence, unconscionability and unjust enrichment) and not just fiduciary law.

37 In *Grant v. Canada*, *supra* note 11 at para. 39 and *Laroza Estate v. Ontario* (2005), 257 D.L.R. (4th) 761 at para. 16, [2005] O.J. No. 3507 (Sup. Ct. J.), Justice Cullin observes that a duty that is owed to all cannot found a fiduciary duty.

relationship and this is so even if B is aware that the widgets are needed to supply a third party contract. While all the *indicia* are indisputably present in this contract, what is missing is a clear signal that B, the promisor, is dedicating herself to the economic and legal interests of A, the promisee.<sup>38</sup> On the contrary, the exchange of promises in this contract is all about A and B pursuing their individual self-interest and being willing to pay a specified price to each other to secure benefits under the contract. Typically, in a contract for the provision of widgets there is no undertaking by the promisor or any other basis for reasonably inferring an intent by the promisor to suppress personal self-interest in deference to the interests of the promisee (that is, to abnegate). Hence, there is nothing to prevent the promisor from having commercial dealings with a competitor of A, even if these dealings place A at a severe competitive disadvantage. The promisor, B, has bound herself to a contractual promise but not pledged herself to selflessly promote or protect the economic or legal interests of A, the promisee.

On what basis then, within relationships, may a court conclude that there have been pledges of fiduciary loyalty? This is a critical question because fiduciary relationships stem from such pledges. Three tests have been developed by the Supreme Court of Canada for determining whether relationships are fiduciary in character. They are:

- (i) an undertaking by a party (whether unilateral or as part of an agreement, or even legislatively imposed) to selflessly and exclusively dedicate oneself to the interests of another;
- (ii) a reasonable expectation of such dedication; or
- (iii) a reasonable basis for reliance on such a dedication.<sup>39</sup>

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38 *Strother v. 3464920*, 2007 SCC 24 at paras.132-144, 281 D.L.R. (4th) 640 for a discussion of contractual relationships and fiduciary duty. The critical question, set out at para. 133, is whether the contract is “a special one attracting a duty of loyalty.” Where a contracting party is an agent dedicated to promoting the interest of the other contracting party a contract is “special” in this sense.

39 See Litman, *supra* note 9 at 89, whose summary is based on the leading Supreme Court of Canada cases including: *Guerin et al. v. The Queen*, [1984] 2 S.C.R. 335 at 384, 13 D.L.R. (4th) 321 [*Guerin* cited to S.C.R.]; *Lac Minerals*, *supra* note 8 at para.163; and *Hodgkinson*, *supra* note 15 at paras. 35-36. See also *McInerney v. McDonald*, [1992] 2 S.C.R.138 at para. 128, 93 D.L.R. (4th) 415 [*McInerney*] and *Norberg*, *supra* note 21 at para. 66.

Only the first of these tests appears on its face to implicate a pledge of loyalty to the interests of another. However, as will be elaborated on below, the other two tests clearly presuppose that a pledge of fidelity has been made by and, in some instances, even for a putative fiduciary.

These three touchstones of fiduciary obligation, the undertaking, reasonable expectation and reasonable reliance tests, are closely and causally interrelated but ultimately the latter two flow from the first. Persons who reasonably rely on the fidelity of another do so because they reasonably expect that the fidelity will be accorded to them. And what makes their expectation reasonable at the outset is either conduct that can reasonably be construed (or is constructed in law<sup>40</sup>) as a pledge of loyalty or, in rare circumstances, a legislative assignment of fiduciary responsibility to an individual or entity.<sup>41</sup> Hence, despite the fact that the reasonable expectation test has gained favour and the most profile of the various touchstones,<sup>42</sup> the material event that gives rise to the creation of fiduciary obligation is the undertaking or pledge (actual or constructive) of fidelity. That is not to say that the reasonable expectation test misses the mark. Not only does reasonable expectation of loyalty flow inexorably from a pledge of fidelity but it can precede and actually give rise to an undertaking. In this regard, it has been noted that "... entry into a profession that has engendered public expectations of dedicated and selfless service to others can in itself be regarded as a pledge or undertaking to provide such service."<sup>43</sup>

Whether the focus is on reasonable expectation or a pledge of fidelity is of little import.

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40 *M (K.) v. M. (H.)*, [1992] 3 S.C.R. 6 at para. 73, 96 D.L.R. (4th) 289, La Forest J.: "I would go one step further, and suggest that fiduciary obligations are imposed in some situations even in the absence of any unilateral undertaking by the fiduciary. In the present case, however, it is sufficient to say that being a parent comprises a unilateral undertaking that is fiduciary in nature. Equity then imposes a range of obligations coordinate with that undertaking."

41 *Ibid.*, quoting from *Guerin*, *supra* note 39.

42 See for example its use in *Waxman v. Waxman*, [2002] O.T.C. 443 at para. 1225, [2002] O.J. No. 2528 (Sup. Ct. J.); *Atlantic Business Interiors Ltd. v. Hipson*, 2005 NSCA 16 at para. 47, 230 N.S.R. (2d) 76.

43 Litman, *supra* note 9 at 89.

### (e) Sources of Expectation of Fiducial Loyalty

Pledges of fidelity are rarely explicit and this is so even when prototypical fiduciary relationships such as trusts or agency are created. Rarely, if ever, do trust instruments or agency agreements advert to the fiduciary nature of the relationship between the parties, or to “fidelity,” “loyalty” or a duty of selflessness. However, both in the case of trusts and agency and, indeed, in most conventional fiduciary relationships, the *raison d’être* of the relationship is the protection or furtherance of interests of one party by another. In presumptively fiduciary relationships, including those which entail the provision of health services, this purpose is transparent and unequivocal. Throughout the spectrum of presumptively fiduciary relationships, the core task of caring for the interest of others is evident in the originating legal instruments which create the relationships, the historic manner in which these various relationships have operated and a large variety of telling contextual sources. In *Hodgkinson v. Simms*, Justice La Forest suggests that the factors that determine whether parties have a reasonable expectation that others will act as their fiduciaries include the presence or absence of “trust” and “confidence,” the sophistication of the services being provided and the level of fidelity implicated in relevant “community and industry [behavioural] standards.”<sup>44</sup> Legislation may be the source of fiduciary obligation, or at least recognize and acknowledge such obligation,<sup>45</sup> and community and industry standards can be found in professional codes of responsibility,

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44 *Hodgkinson, supra* note 15 at para. 33. I am interpreting the phrase, “complexity of subject matter,” used by Justice La Forest as referring to the sophistication of fiduciary services. Of course, many cases make reference to community and industry standards including *Lac Minerals, supra* note 8. In that case, there was disagreement between Justices Sopinka and La Forest about the propriety of using “industry standards” to determine whether a fiduciary relationship exists, with Justice La Forest arguing in favour at paras. 157-159, 164-168 and Sopinka J. arguing against at para. 48. As to community standards, see *Norberg, supra* note 21 at para. 40.

45 *Guerin, supra* note 39, where Justice Dickson attributes the Crown’s fiduciary obligation to protect Indian lands (through the surrender process) to both the “framework of the statutory scheme” [*Indian Act*] (at 376) and the *Royal Proclamation* of 1763 (at 382). Justice Wilson is more circumspect and asserts that the *Indian Act* surrender requirements do not “per se create a fiduciary obligation” but “recognize ....” (at 348) and “acknowledge” (at 349) its existence. See also *M. (K.) v. M. (H.), supra* note 40.

conduct and ethics,<sup>46</sup> as well as notorious and clearly defined industry or sector practices,<sup>47</sup> including institutional practices and policies.<sup>48</sup> All of these sources outline what one party can reasonably expect from another.<sup>49</sup>

### III. The Fiduciary Status of Physicians, Other HCPs, Hospitals & Health Care Institutions

In Canada, the confluence of the aforementioned factors have long ago, repeatedly and authoritatively resulted in the affirmation that the physician/patient relationship is fiduciary in nature.<sup>50</sup> Trust and confidence characterizes the physician/patient relationship. Strict confidentiality is generally

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46 *Hodgkinson, supra* note 15 at paras. 51-52 and *Norberg, supra* note 21 at para. 73. See also *Norberg, supra* note 21 at paras. 75, 76, 89, where Justice McLachlin makes reference to a Task Force on Sexual Abuse of Patients, commissioned by the College of Physicians and Surgeons of Ontario, to support her conclusion that physicians are fiduciaries and sexual exploitation of patients is a breach of fiduciary duty.

47 *Lac Minerals, supra* note 8 at para. 166, where Justice La Forest suggests that the significance of industry practice at issue in that case was that it informed the plaintiff Corona Ltd. that it could expect the defendant Lac to "... refrain from acting against the interests of Corona." Justice La Forest's comments on the significance of industry practice at paras. 157-159, 164-168. See *contra* Sopinka J. at para. 48, where he concludes "The practice among geologists to act honourably towards each other is no doubt admirable and a practice to be fostered, but it should not be used to create a fiduciary relationship where one does not exist."

48 As to "policy," see *Guerin, supra* note 39 at 383. Justice Dickson clearly sees Britain and Canada's continuous historic policy of protecting Indians from being exploited in transactions pertaining to their lands as a source of the Crown's fiduciary responsibility with respect to those lands. This policy and the legislation through which it was expressed was regarded as an "... historic responsibility which the Crown has undertaken, to act on behalf of Indians ...." And, of course, consistent practices reflect the content of policies, often informal or unwritten policies.

49 *Hodgkinson, supra* note 15 at paras. 32, 50.

50 The earliest Canadian authority to recognize that physicians are fiduciaries is *Rowe v. Grand Trunk Railway Co.* (1866), 16 U.C.C.P. 500 at para. 29, [1866] O.J. No. 177. More recently the Supreme Court of Canada has similarly and unreservedly held that physicians are fiduciaries. See *McInerney, supra* note 39 at paras. 19-20 and *Norberg, supra* note 21 at para. 63.

required, expected and provided.<sup>51</sup> Physicians understand that they are fiduciaries and that patients have an expectation of physician commitment to their cause.<sup>52</sup> The provision of medical service is based on highly specialized knowledge. The Hippocratic Oath, applicable codes of ethics and professional standards of practice “are replete with both explicit and implicit promises of ... fidelity [by physicians to the health interests of patients].”<sup>53</sup> And physicians who provide services in hospitals are bound by a number of hospital policies and protocols, and now legislation,<sup>54</sup> that are intended to rigorously protect and promote the health of patients by minimizing risk – including risk arising from the misconduct of health service providers.

There is good reason to believe that fiduciary obligations owed to patients extends beyond physicians to other HCPs who provide important services in hospitals, as well as to hospitals and health authorities. As will be noted below, the early trend of the case law supports this conclusion, as does the trend in hospitals and health regions of enacting policies, procedures, clinical practice guidelines and protocols intended to promote both the safety and security of patients and the integrity of institutional missions. Inceas-

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51 *McInerney, ibid.* at paras. 18-19.

52 Litman, *supra* note 9 at 85.

53 *Ibid.* at 89. See also College of Physicians and Surgeons of Alberta, *Reporting to the College: CPSA Policy* (August 2005) at “Ethical Requirements” B.1, 2, online: CPSA <<http://www.cpsa.ab.ca/publicationsresources/policies.asp>>, which impose on medical practitioners an ethical duty to whistle-blow on other medical practitioners whom they suspect are guilty of inappropriate sexual practices with a patient or other forms of “unbecoming” conduct. See also College of Physicians and Surgeons of Ontario, *CPSO Policy: Disclosure of Harm* (February 2003), online: CPSO <<http://www.cpso.on.ca/Policies/disclosure.htm>>; College of Physicians and Surgeons of British Columbia, *Resource Manual for Physicians: Ethical Duty to Report*, online: CPSBC <[https://www.cpsbc.ca/cps/physician\\_resources/publications/resource\\_manual/ethicaldutyreport](https://www.cpsbc.ca/cps/physician_resources/publications/resource_manual/ethicaldutyreport)>; College of Physicians and Surgeons of Nova Scotia, *Policies and Guidelines: Sexual Misconduct in the Physician-Patient Relationship* (March 2006), online: CPSNS <[http://www.cpsns.ns.ca/publications/sexmisconduct\\_2000.htm](http://www.cpsns.ns.ca/publications/sexmisconduct_2000.htm)>. See also *Medical Practitioners Act*, R.S.B.C. 1996, c. 285, s. 65.

54 *Protection for Persons in Care Act*, R.S.A. 2000, c. P-29 [*Protection Act Alberta*]; *Protection for Persons in Care Act*, C.C.S.M. c. P144 [*Protection Act Manitoba*]; *Adult Guardianship Act*, R.S.B.C. 1996, c. 6 (Part 3); *Adult Protection Act*, R.S.N.S. 1989, c. 2; *Adult Protection Act*, R.S.P.E.I. 1988, c. A-5; *Neglected Adults Welfare Act*, R.S.N.L. 1990, c. N-3; *Family Services Act*, S.N.B. 1980, c. F-2.2.

ingly, and laudably, written policies are being introduced for effectuating these critical goals, including disclosure of wrongdoing, whistle-blowing and protection of persons in care policies.<sup>55</sup> Of special interest to fiduciary law are conflict of interest policies which typically are applicable to all persons who provide services in hospitals, including employees, independent contractors (physicians) and even volunteers.<sup>56</sup> Implicit in these policies is an acknowledgment that patients are exposed to material risks and that the patients' best interests are of paramount value. Read as a whole, the policies clearly indicate a widespread commitment or pledge of dedicated protective service to patients on the part of hospitals and health authorities and all persons who provide services within hospitals.<sup>57</sup>

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55 By way of example only, I have perused the policies of the Capital Health Authority, whose corporate offices are in Edmonton, Alberta. Its policies take the form of corporate directives and include the following directives: "Conflict of Interest"; "Confidentiality"; "Patient/Client/Resident Abuse"; "Theft, Fraud and Similar Irregularities"; "Disclosure of Wrongdoing in Capital Health and Protection of Persons who Disclose Wrongdoing"; "Whistleblower Policy"; and "Just Culture". These policies are supplemented by other "external" policies, such as the College of Physicians and Surgeons of Alberta policy on reporting "unbecoming" conduct, *supra* note 53. See also Disclosure Working Group, *Canadian Disclosure Guidelines* (Edmonton, Alta.: Canadian Patient Safety Institute, 2008); Health Quality Council of Alberta, *Disclosure of Harm to Patients and Families: Provincial Framework* (July 2006), online: HQCA <<http://publications.hqca.ca>>. Interestingly, the Canadian Association of Occupational Therapists' *Code of Ethics* "requires" occupational therapists to abide by ethical precepts established by employers in the following terms: "CAOT expects its members to ... abide by legislative requirements and codes of ethics established by provisional occupation therapy regulatory organizations (as applicable) and other organization to which the member has obligations (e.g., employer, facility) ...." Canadian Association of Occupational Therapists, *Code of Ethics* (Ottawa, Ont.: CAOT, 2007), online: CAOT <<http://www.caot.ca/default.asp?pageid=35>>. I would like to thank the administration at Capital Health for allowing me view their corporate directives.

56 Conflict of interest policies are an important *indicia* of fiduciary duty. Capital Health Authority "Conflict of Interest" policy, requires both avoidance and disclosure of conflict of interest. It has application to "all CHA staff, contract individuals, physicians or volunteers conducting CHA business." "Conflict of Interest," *ibid.* at 3.

57 Of course, whether any particular individual or institution is in a fiduciary

Importantly, there is also a legislative trend towards enacting protection of persons in care statutes.<sup>58</sup> There is considerable variation in the various provincial enactments of this type but the Alberta and Manitoba statutes are particularly explicit in imposing on hospitals and health authorities duties to both protect patients from abuse and to provide for their safety.<sup>59</sup> The Alberta statute goes furthest by requiring that its hospitals ensure that “service providers, employees and clients” are bound by the various provisions of the Act.<sup>60</sup> In addition, the Alberta *Hospitals Act* imposes on hospital service utilization committees an obligation “to evaluate and control clinical practice in the hospital on a continuing basis for the purpose of maintaining and improving the safety and quality of patient care.”<sup>61</sup>

Though the tasks of non-physician HCPs differ from the tasks effectuated by physicians, both the roles of the non-physician providers and the regulatory environment within which they work suggest that they are “charged with the same fundamental mandate as physicians, [namely] the protection and promotion of the health interest of ... patients.”<sup>62</sup> It follows that they too are fiduciaries.<sup>63</sup> That health services are increasingly being provided by health care teams is an additional reason for painting all health service

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relationship with a patient has to be evaluated “on the facts” but it is suggested that at least very often the relationship between HCPs, as well as health care institutions, and hospitalized patients will have fiducial qualities. In the case of the Capital Health Authority, the policies are to be brought to the attention of all persons bound by the policies. With respect to some of the policies, such as conflict of interest and confidentiality, those who are bound must formally acknowledge compliance with the policies and bind themselves to continued compliance. It is important to read the policies as a whole in order to evaluate the scope of loyalty that patients can reasonably expect. *Ibid.*

58 *Supra* note 54.

59 See *Protection Act Alberta, ibid.*, ss. 1(a), 2(1), 5(1); see *Protection Act, Manitoba, ibid.*, ss. 1 (definition of abuse), 2, 3(1).

60 *Protection Act Alberta, ibid.*, s. 5(3).

61 R.S.A. 2000, c. H-12, s.16(2)(a).

62 Litman, *supra* note 9 at 88.

63 *Ibid.* See also Mark Vincent Ellis, *Fiduciary Duties in Canada*, looseleaf (Toronto: Thomson Carswell, 2000) at 10-20 citing the case of *Tannock v. Bromley* (1979), 10 B.C.L.R. 62, [1979] B.C.J. No. 2009 (S.C.) [Tannock] for the proposition that “any individual who places himself in a position as a medical advisor will be subject to the same duty of utmost good faith and fiduciary status that is owed by a physician or surgeon.”

providers with the same fiduciary brush. These teams are often headed by physicians and it seems implausible that the mission and behavioural mandate of members of a single team will diverge from the fiducial goals and obligations of physicians. While the tasks of team members will be diverse, the requirement of “single eyed” dedication to a vulnerable patient population is surely the same. Hence, from the point of view of principle, except in unusual circumstances, all analytical paths lead to the conclusion that all professional health care practitioners who work for and in hospitals are indeed fiduciaries.

Not surprisingly, the emerging case law is compatible with, if not confirmatory of the notion that a wide array of individual and institutional health care providers are fiduciaries. As noted previously, except in the most unusual circumstances, it is trite law that physicians are fiduciaries. The law with respect to non-physicians is far less developed but in a smattering of cases relating to health or health related services provided within and outside of hospitals, Canadian courts have recognized the fiduciary status of hypnotherapists,<sup>64</sup> dentists,<sup>65</sup> optometrists,<sup>66</sup> psychologists,<sup>67</sup> social workers<sup>68</sup> and even dental residents.<sup>69</sup> As well, courts have been receptive to the sug-

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64 *Tannock, ibid.*

65 *R.(J.) v. W.(E.S.)* (2001), 52 O.R. (3d) 353 at paras. 21-23, [2001] O.J. No.133 (Sup. Ct.J.).

66 *Cox v. College of Optometrists of Ontario* (1988), 65 O.R. (2d) 461, 52 D.L.R. (4th) 298 (Div. Ct.).

67 *Regina v. Matheson* (1999), 44 O.R. (3d) 557, [1999] O.J. No. 1320 (C.A.).

68 See *Justice v. Cairnie Estate* (1993), 105 D.L.R. (4th) 501 at para. 35, [1993] M.J. No. 351 (C.A.) [*Cairnie*]. See also *K.L.B. v. British Columbia*, 2001 BCCA 221 at paras. 14-24, 197 D.L.R. (4th) 431, re’g [1998] 10 W.W.R. 348 (S.C.) The British Columbia Court of Appeal left undisturbed the trial judge’s finding that social workers are fiduciaries but held at para. 24 that the trial judge erred in concluding that the social workers had breached their fiduciary duty. The Supreme Court, *supra* note 3, was silent on the issue of whether the social workers were fiduciaries.

69 See *Bulloch MacIntosh v. Brown*, 2003 CanLII 32222 (Ont. Sup. Ct.J.), Master Macleod. In this case, the plaintiff sought to amend her statement of claim, *inter alia*, by adding four dental residents, who were present at and assisted in her surgery, as defendants. In refusing to permit the amendment, Master Macleod observed that “[u]ndoubtedly there may be a fiduciary relationship between a health practitioner and a patient but dressing up a malpractice claim as a breach of fiduciary duty will be insufficient to avoid a limitation period” at para. 8.

gestion that nurses, including those who work in health care institutions, are fiduciaries.<sup>70</sup> Pleadings which allege that nurses are fiduciaries have been held to be sufficiently plausible to raise a “genuine issue to be tried.”<sup>71</sup> Similarly, the courts have also agreed that the fiduciary status of health care institutions themselves is a genuine issue to be established on the facts of each case.<sup>72</sup> In another but related context, the Supreme Court of Canada appears to have accepted that an educational institution, a School Board, is a fiduciary to its students.<sup>73</sup>

Given that the integrity of the critically important health care system and its efficacy depend on the dedication of health care providers to their patients, and a widespread public conviction that this dedication exists, there are strong principled reasons which support the notion that hospitals and health authorities, as well as the entire spectrum of HCPs working in and for these institutions, are at least ordinarily, fiduciaries. Canadian jurisprudence, while not yet going this far, seems receptive to this idea.

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70 See *Huet v. Lynch*, 2000 ABCA 97, 255 A.R. 359 [*Huet*] where the nurses in question worked in the psychiatric ward of a public hospital.

71 In *Huet, ibid.* at para. 34, Justice Wittmann notes there is “scant authority” for the proposition that nurses and other hospital staff are fiduciaries but based on a “cursory application” of the *Frame v. Smith* indicia, *supra* note 11, the “possibility cannot be ruled out.” Hence, he concluded that the fiduciary status of the defendant nurses was sufficiently credible to be part of a “genuine issue to be tried.” *Huet* appears to have been followed in *Base v. Hadley* [2006] NWTSC 4 at paras. 44-45, [2006] N.W.T.J. No. 3 (S.C.) [*Base*]. The language used by Justice Schuler in this case with respect to the fiduciary duty of nurses is, however, somewhat ambiguous. As well see *Williams v. Wai-Ping*, 2005 CanLII 16602 (Ont. Sup. Ct.J.) where Justice MacKinnon held that on the facts before him the allegation that nurses had breached their fiduciary duty was plausible.

72 *Huet, ibid.* at paras. 32, 34; *Base, ibid.* at paras. 1, 43-45. See also *Victoria General Hospital v. General Accident Assurance Co.*, [1995] 8 W.W.R. 106 at paras. 1, 5, 23, 103 Man. R. (2d) 168 (Q.B.) [*Victoria*]; *M.A.C. v. General Hospital (Grey Nuns) of Edmonton*, [1997] A.J. No. 48 at para. 19 (Q.B.) (QL). But *contra*, on the specific facts before the Court, see *Hanna v. Crouse*, 2001 SKQB 124, [2001] S.J. No. 171 at paras. 25-26. See also Litman, *supra* note 9 at 89.

73 *E.D.G. v. Hammer*, 2003 SCC 52, [2003] 2 S.C.R. 459 at paras. 22-27 [*Hammer*].

## IV. The Content of Fiduciary Obligation

What are the fiduciary duties of HCPs and health care institutions? Examining fiduciary duty in the broad context of fiduciary law and theory is helpful in shedding light on this question.

### (a) The Fiduciary Duty of "Promoting the Best Interests of Beneficiaries"

The notion that fiduciary duty entails "promoting the best interests" of beneficiaries is widely held. The Supreme Court of Canada in *K.L.B. v. British Columbia*, a case concerned with governmental liability for abuse suffered by children in foster care, noted that "a number of lower courts in Canada" have described fiduciary duty in this way.<sup>74</sup> What the Court did not say is that this same description of fiduciary duty has been embraced, on several occasions, by the Supreme Court itself. Indeed, in the context of the parent/child fiduciary relationship, the Court in the case of *M. (K.) v. M. (H.)* stated that "[t]he inherent purpose of the family relationship imposes certain obligations on a parent to act in his or her child's best interests ...."<sup>75</sup> Similarly, in the context of the physician/patient relationship, the Supreme Court, both in *Norberg v. Wynrib* and in *McInerney v. MacDonald*, has described the fiduciary duty of physicians as a duty to promote the best interests of patients.<sup>76</sup> In the latter case, in the context of a dispute about the right of a patient to access information in her medical records, the Court stated that

[a]s part of the relationship of trust and confidence, the physician *must act* in the best interests of the patient. If the physician reasonably believes it is not in the patients best interests to inspect his or her medical records, the physician may consider it necessary to deny access to the information.<sup>77</sup>

Despite the apparent acceptance of the best interest test in these cases, and in particular its acceptance in *M. (K.) v. M. (H.)* in the parent/child context, the Supreme Court of Canada in the *K.L.B.* case concluded that promoting the best interests of a child is merely a "laudable goal" or "guiding

<sup>74</sup> *Supra* note 3 at para. 43.

<sup>75</sup> *Supra* note 40 at para. 76 [emphasis added].

<sup>76</sup> *Norberg*, *supra* note 21 at paras. 64, 65, 112. For *McInerney* see text at 320-321, below.

<sup>77</sup> *Supra* note 39 at para. 28 [emphasis added].

objective” of fiduciary obligation.<sup>78</sup> For emphasis, the Court adds that the goal of promoting the best interest of children “should not be confused with” the legal obligation that parents or guardians, as fiduciaries, owe their children.<sup>79</sup> Specifically, the Court stated, “Parents should try to act in the best interests of their children....However, thus far, failure to meet this goal has not itself been elevated to an independent ground of liability at common law or equity. There are good reasons for this.”<sup>80</sup>

The reasons set out by the Court included (i) the uncertainty inherent in and subjective nature of any determination of “best interests,” (ii) the complication of the needs of other children within the family (iii) the confounding effect of “attempting to decide which of an almost infinite number of combinations of potential actions toward one’s child would best advance the child’s interests” and, given the foregoing, (iv) the Court’s concern that it is unfair to adopt a liability rule which provides no “workable standard” to guide parental conduct.<sup>81</sup> Cumulatively, these reasons are persuasive justifications for the court’s conclusion that in the parent or guardian/child context the “best interest test” should not be and is not “a legal or justiciable standard.”<sup>82</sup> Hence, it is not entirely surprising that the Court apparently changed its mind on the role of the best interest test in the context of fiduciary duty owed to children.

Might the Court go further and jettison the best interest test in other fiduciary contexts, in particular in the professional health care provider/patient context? There are good reasons to think the Supreme Court remains committed to the best interest test outside of the context of fiduciary duty owed to children. First, it is very clear in that the Supreme Court’s analysis in *K.L.B.* was specifically limited to the parent or guardian/child relationship.<sup>83</sup> Certainly, the Court did not indicate that its rejection of the “best interest” test had implications outside the parent or guardian/child fiduciary relationship. Given the significance of jettisoning the best interest test in fiduciary cases that do not involve children, it is not unreasonable to assume that the Court would have provided some indication that its analysis extended, or

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78 *M (K.) v. M.(H.)*, *supra* note 40; *K.L.B.*, *supra* note 3 at para. 47.

79 *K.L.B.*, *ibid.*

80 *K.L.B.*, *ibid.* at para. 44 [emphasis in original].

81 *K.L.B.*, *ibid.* at paras. 45-47.

82 *K.L.B.*, *ibid.* at para. 46.

83 The language in the judgement is focussed on and limited to the parent or guardian/child relationship. *K.L.B.*, *ibid.* at paras. 39, 41-47.

at least might extend, beyond the fiduciary relationship at issue in *K.L.B.* In any event, the policy reasons for rejecting the best interest test are unique to the dynamics of the parent or guardian/child fiduciary relationship and hence should be limited to that relationship. The professional health care provider/patient fiduciary relationship is illustrative of this last point.

While the application of the best interest test could cloud or even paralyse the proper, effective and ordinary operation of a family unit, the test seems entirely workable in the health care context. Health care issues tend to present themselves as discrete or at least limited issues in which carefully calculated and forward-looking decisions must be made or strategies deployed. Specific patient centred standards, protocols, evidence based alternatives, ethical and policy prescriptions and proscriptions inform health care decisions and the behavioural requirements of health professionals. In short, health care decisions involve a “limited number of alternatives” and do not entail the “almost infinite number” of alternatives that, in part, led the Supreme Court to demote the best interest test from an actual or at least apparent test to a “mere” “guiding objective.”<sup>84</sup> While the best interest standard is vague in application and provides no workable standards to guide parents in making decisions about their children, the standards, protocols, policies, ethics and evidence based knowledge that guide health professions, mitigate considerably the uncertainty that plagues the best interest test in the context of household or family dynamics.

On the other hand, just as the feasibility of the of best interest test is complicated in the parent or guardian/child relationship by needs of “other children” within the family, the fiduciary duty of health care providers, both individual and institutional, is complicated by the needs of a large number of “other” patients to whom fiduciary duty is owed. Serving “X” patient’s best interest surely precludes giving “Y” patient priority. This is because fiduciary duty requires fiduciaries to act with a singular attention to the interest of a beneficiary.<sup>85</sup> While at first sight this may seem to be an insuperable difficulty, it is clear that the duty of a fiduciary to serve the best interests of a particular beneficiary can yield to substantial and pressing priorities which include the protection of others. In *McInerney v. MacDonald*, a case which articulates fiduciary duty of physicians in terms of the best interest test, the Supreme Court of Canada indicated that a physician’s fiduciary duty can be

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84 *K.L.B.*, *ibid.* at para. 47.

85 See Litman, *supra* note 9 at 94.

superceded by reasons which are “connected with the safety of individuals or of the public ....”<sup>86</sup> While this observation is directed at the physician’s duty of confidentiality and suggests that confidentiality may in some circumstances be breached without liability, for example, with a view to protecting a person at risk of serious harm at the hands of a patient, the Court’s comments have broader import. In terms of fiduciary theory, the justification for overriding a fiduciary’s duty to promote the best interest of a particular patient is warranted when it is understood by the general population of patients that health care providers and institutions prioritize the provision of healthcare services within patient populations on the basis of factors such as the gravity and immediacy of risk, probability and extent of successful treatment and probability and severity of complications (including side effects of treatment). Since the content of and limits on fiduciary duty owed to patients is informed by the reasonable expectations of the patient population, prioritization is not legally incompatible with the duty to promote the best interests of patients. Furthermore, the ability of the health care fiduciaries to give priority to patients is analogous to the ability of trustees of discretionary trusts to allocate property to one or more beneficiaries and not others. It is indisputable that such trustees are fiduciaries with a general obligation to promote the best interests of the beneficiaries of their trusts.<sup>87</sup>

Similarly, cost containment policies may justify not acting in a particular patient’s best interest. Were it otherwise, hospitals and health authorities would face liability for refusing, for example, to implant a titanium hip rather than one comprised of a less durable and expensive material. Similarly, physicians could face liability for prescribing standard antibiotics when more potent and expensive “big gun” antibiotics can be prescribed.<sup>88</sup> Not only should reasonable cost containment policies be part of the reasonable expectations of patients, and hence circumscribe the duty to promote a patient’s best interest, but such policies must also be understood as being integral to policies that relate to prioritization of patients and the balancing

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86 *Supra* note 39 at para. 28.

87 J. E. Penner, *The Law of Trusts*, 5th ed. (Oxford: Oxford University Press, 2006) at 53-54; D. W. M. Waters, Mark Gillen and & Lionel Smith, *Waters’ Law of Trusts In Canada*, 3rd ed. (Toronto: Thompson Carswell, 2005) at 38-39, 95.

88 Imipenem, piperacillin-tazobactam are examples of the more potent variety of “big gun” antibiotics (Interview of Dr. Felix Soibelman, Department of Emergency Medicine, University of Alberta Hospital, Edmonton, Alta., Canada [n.d.]).

of their interests. In the case of big gun antibiotics, they are reserved for last resort use for reasons of both public health and economy.<sup>89</sup>

In conclusion, notwithstanding *K.L.B.*, HCPs and health care institutions continue, subject to justifiable cost containment and prioritization policies, to be bound by their fiduciary duty to promote the best interest of their patients. This duty, it is suggested, is derived from the core and variable obligation of fiducial loyalty.<sup>90</sup> Loyalty is not a fixed concept but rather exists in degrees along a continuum. Given the profound importance of human health, the duty to promote a patient's best interest is appropriately situated at the pinnacle of the continuum of fidelity.

### (b) Proscriptive & Prescriptive Fiduciary Duties

The concept of promoting the best interest of beneficiaries of a fiduciary relationship is broad enough to import both positive and negative duties. The conventional view of fiduciary duty is that it is strictly a negative duty intended to deter opportunism by fiduciaries. Traditionally, the duty has been described as an obligation to both avoid conflicts of interest (the prophylactic rule) and the duty to not make unauthorized profits, particularly at a beneficiary's expense.<sup>91</sup> The latter rule is the consequential rule to be applied when prophylaxis has failed. That the classic version of fiduciary duty is proscriptive (negative) and not prescriptive (positive) is evident from the following:

The duty is abnegation – a duty to not engage one's self-interest. There is no positive quality to the jurisdiction. There is no fiduciary duty to pursue or further the interest of beneficiaries except in the sense of putting aside one's own interest.<sup>92</sup>

And while fiduciary duty "carries with it a duty of skill and competence,"<sup>93</sup> the delivery of skill and competence is, almost always, the exclusive concern of the law of torts. Fiduciary law is concerned with a failure of con-

89 *Ibid.*

90 See text at pp. 323-324 below.

91 See *Hammer*, *supra* note 73 at para. 23, where McLachlin C.J. observes: "These are, as La Forest J. noted in *Lac Minerals* ... loyalty and the "the avoidance of a conflict of duty and interest and a duty not to profit at the expense of the beneficiary."

92 Flannigan, "Boundaries", *supra* note 10 at 47.

93 *Hodgkinson*, *supra* note 15 at para. 26.

duct that is a failure of loyalty and not a failure of either care or skill. However, it must be understood that these two forms of failure are not mutually exclusive. When infidelity is the reason for a failure of skill or care, then the failure is both a tortious wrong and a breach of fiduciary duty.<sup>94</sup> Hence, in narrow circumstances, duties which ordinarily fall into the exclusive domain of tort law can also give rise to equitable jurisdiction and relief.

It is now indisputable that Canadian law has departed from the traditional view that fiduciary duty is exclusively proscriptive. This departure has resulted in acerbic criticism by the High Court of Australia<sup>95</sup> and in Canada has led to a division of scholarly opinion. Professor Flannigan is on record as strongly opposing the recognition of prescriptive fiduciary duties.<sup>96</sup> Professor Waters has indicated that he is open to such duties but only if apt principles are developed that “determine when ... [positive duties] would be appropriate.”<sup>97</sup> With respect to the High Court, its biting criticism of the Canadian position on prescriptive duties is unreasoned. This is ironic given the gratuitous and injudicious observation made by two justices of the High Court that Canadian fiduciary law is based on “assertion” and not “analysis.”<sup>98</sup> On the other hand, Professor Flannigan does set out reasons for limiting fiduciary duty to its classic proscriptive form.

Professor Flannigan suggests that because the exclusive concern of fiduciary law is the prevention of opportunistic conduct by fiduciaries, logic impels that the sum total of fiduciary duty (expressed in the “no conflict” and “no unauthorized profit” rules) is a duty to not engage in such conduct.<sup>99</sup> While completely logical, the problem with Professor Flannigan’s claim is its premise that the exclusive concern of fiduciary law is to counteract opportunism. The wrong with which fiduciary law is concerned is broader and deeper and underlies the prohibition against opportunistic behaviour by fiduciaries. Clearly, opportunism is not inherently mischievous. Alert pursuit of self-interest, that is opportunism, is generally commendable, not condemnable. Of course, opportunism is not commendable when, in the course of

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94 See text at 343-344, below, for elaboration of this point.

95 *Breen v. Williams* (1996), 138 A.L.R. 259 at 289 (H.C.A.), Gaudron & McHugh JJ.

96 Flannigan, “Boundaries”, *supra* note 10 at 47-48, 51, 61-69.

97 Waters, *supra* note 17 at 685.

98 See Professor Flannigan’s observations in this regard, Flannigan, “Boundaries”, *supra* note 10 at 80.

99 *Ibid.* See also Flannigan, “Romantic”, *supra* note 8 at 392, 398.

fiduciary administration, it is engaged in by fiduciaries who have undertaken to loyally serve the interest of others. In that context, opportunism is an act of disloyalty by actors who have pledged themselves to serve the interests of beneficiaries. In other words, the gravamen of fiduciary misconduct is a failure of loyalty, a point which Canadian Courts have strongly and repeatedly emphasized.<sup>100</sup> It follows that foregoing opportunity is not the “end game” of fiduciary obligation but merely an example of restraint that is required of actors who have pledged their fidelity to others. As Justice Binnie explicitly put the point in his majority judgment in *Strother v. 346920*, “... the duty of loyalty ... is not fully exhausted by the obligation to avoid conflicts of interest ....”<sup>101</sup> And, importantly, while the rule against opportunism is only capable of spawning negative duties, a pledge and hence duty of loyalty has the logical capacity to spawn prescriptive requirements. Precisely what those prescriptive requirements are depend on the nature and scope of the particular fiduciary’s undertaking or pledge (or the particular beneficiary’s reasonable expectation). It is settled law that the rules that regulate fiduciary relationships are not fixed by anything other than the particular circumstances surrounding a relationship.

Prescriptive duties are actually quite common in Canadian law. The Crown in its fiduciary capacity has a duty to consult First Nations in cases where aboriginal or treaty rights may be impacted on by legislation or administrative decisions.<sup>102</sup> That fiduciaries must disclose that they are in a conflict of interest is an uncontroversial aspect of Canadian and, for that

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100 See for example *R. v. Neil*, 2002 SCC 70, [2002] 3 S.C.R. 631 at 680, 687 [*Neil*]. Much of the judgement focuses on the concept of loyalty but see in particular pages 680 and 687. See also *K.L.B.*, *supra* note 3 at para. 41, where Justice McLachlin’s description of the “common threads” that run through fiduciary law suggest, albeit not explicitly, that fiduciary law is concerned with more than merely counteracting opportunism by fiduciaries. She states that the common threads are “... loyalty and ‘the avoidance of a conflict of duty and interest and a duty not to profit at the expense of the beneficiary’” [emphasis added].

101 *Supra* note 38 at para. 56. See also his comment in *Neil*, *ibid.* at para. 19, where he describes the duty to avoid conflict as an “aspect” of the duty of loyalty.

102 *R. v. Sparrow*, [1990] 1 S.C.R.1075 at para. 82, 70 D.L.R. (4th) 385; and *Delgamukw v. British Columbia*, [1997] 3 S.C.R.1010 at para. 168, 153 D.L.R. (4th) 193. See also Sonia Lawrence & Patrick Macklem, “From Consultation to Reconciliation: Aboriginal Rights and the Crown’s Duty to Consult” (2000) 79:1 Can. Bar Rev. 252.

matter, commonwealth and American law. In *Strother*, a relatively recent decision of the Supreme Court of Canada, a lawyer was held to be in breach of fiduciary duty for failing to revisit an earlier tax opinion he had provided a client.<sup>103</sup> The Supreme Court of Canada has also held that physicians have a positive fiduciary obligation to provide patients with access to their medical records.<sup>104</sup> Moreover, as will be elaborated on below, physicians have a fiduciary duty to disclose medical errors to patients who are harmed by these errors.<sup>105</sup> With respect to non-physicians, in a series of cases dealing with sexual, physical and psychological abuse of children, Canadian courts have recognized that parents, guardians and school boards, who are not themselves perpetrators of abuse but are aware of the abuse, have a positive fiduciary obligation to prevent children in their care from being harmed.<sup>106</sup> In *K.L.B. v. British Columbia*, the Supreme Court of Canada, in *obiter*, gave its *imprimatur* to this positive duty of care when it stated that fiduciary disloyalty is perpetrated by “a parent who, wanting to avoid trouble for herself and her household, turns a blind eye to the abuse of a child by her spouse.”<sup>107</sup> In this and in another case involving sexual abuse of children, *E.D.G. v. Hammer*,<sup>108</sup> the Supreme Court of Canada explicitly adverted to the possibility that fi-

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103 *Supra* note 38 at para. 70. The lawyer was in conflict of interest because he had an economic interest in not revisiting his earlier, and at that time correct, opinion.

104 *McInerney*, *supra* note 39.

105 *Gerula v. Flores*, [1995] 126 D.L.R. (4th) 506, [1995] O.J. No. 2300 (C.A.); *Vasdani v. Sehmi*, [1993] O.J. No. 44 (Ct. J. (Gen. Div.)). See also Waite, *supra* note 1 at 15-21 and the text at 326-328 below.

106 *K.L.B.*, *supra* note 3; *Hammer*, *supra* note 73.; *L.A.J. v. H.J.* (1993), 13 O.R. (3d) 306 at paras. 22, 27, 102 D.L.R. (4th) 177 (Ct. (Gen. Div.)) (QL); *M.M. v. R. F.* (1997), 52 B.C.L.R. (3d) 127 at paras. 80-81, [1997] B.C.J. No. 2914 (QL), cited with approval in *M.B. v. British Columbia*, 2000 BCSC 735, [2000] B.C.J. No. 909, rev'd in part 2001 BCCA 227, 197 D.L.R. (4th) 385, rev'd 2003 SCC 53, [2003] 2 S.C.R. 477; *Y. (A.D.) v. Y. (M.Y.)*, [1994] 5 W.W.R. 623, [1994] B.C.J. No. 375 (S.C.) (QL); *L.T. v. R.W.T.* (1997), 36 B.C.L.R. (3d) 165 at paras. 31-41, 36 C.C.L.T. (2d) 207 (S.C.) (QL); *Cairne*, *supra* note 68 at paras. 32-37. Note that in some of these cases, for example, *L.T. v. R.W.T.*, defendants were able to avoid liability for breach of their positive duty of protective intervention because they were unaware of the potential for harm being visited on their beneficiaries but in other cases liability was established.

107 *K.L.B.*, *ibid.* at paras. 39, 49.

108 *Supra* note 73.

duciaries would be liable for their “omissions” or “inactions.”<sup>109</sup> In *K.L.B. v. British Columbia*, the Court made it clear that the juristic source of fiduciary duties owed to children is the fiduciary’s duty of loyalty and not some plenary duty to act in the “best interest” of the children.<sup>110</sup> The Manitoba Court of Appeal has also suggested that the inability of children to protect their own interests may be yet another source of prescriptive fiduciary obligation owed to children. On this point, in *Cairnie*, Scott C.J. stated, “Arguably, a court should be more ready to find a fiduciary relationship and impose a positive obligation to promote and defend the interests of the beneficiary where the child is incapable of formulating her own course of action and must rely upon the fiduciary’s judgment ....”<sup>111</sup> In the same case, Scott C.J. also suggests that prescriptive fiduciary duty may be justified “... where the relationship between the victim and the defendant gives rise to a reliance upon the special training of the defendant.”<sup>112</sup> Though in *Cairnie* the special training at issue was training as a social worker, the principle is readily transferable to professional health care practitioners

### (c) Prescriptive Fiduciary Obligations of Health Care Professionals

#### (i) *The Prescriptive Duty To Disclose Medical Error*

With respect to the duty of physicians to disclose medical error, the early cases conceive of this duty as emanating from tort law, not fiduciary law.<sup>113</sup> More than one scholar has opined that the duty to disclose medical error is merely a “logical extension” of the doctrine of informed consent.<sup>114</sup> In particular it has been argued that “... if the patient is entitled to know the risks of a procedure and what could go wrong prior to giving their consent,

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109 *K.L.B.*, *supra* note 3 at para. 45; *Hammer*, *supra* note 73 at paras. 23, 26. See also *Lac Minerals*, *supra* note 8 at para. 147, where in a commercial context Justice La Forest describes fiduciary duty as an “... obligation on one party to act or refrain from acting in a certain way” [emphasis added].

110 *K.L.B.*, *ibid.* at paras. 39, 41-49. See also *Hammer*, *ibid.* at para. 23.

111 *Supra* note 68 at para. 36.

112 *Ibid.* at para. 35.

113 See Waite, *supra* note 1 at 16-17 and, in particular, *Stamos v. Davies* (1985), 52 O.R. (2d) 10, 21 D.L.R. (4th) 507 (H.C.J.) (QL) [*Davies*]. See also Gerald B. Robertson, “When Things Go Wrong: The Duty to Disclose Medical Error” (2002) 28 Queen’s L.J. 353 (QL).

114 Waite, *ibid.* at 15; Robertson, *ibid.* at para. 8.

it follows that they would be entitled to know if something has in fact gone wrong...."<sup>115</sup>

In my view, the logic in this reasoning glosses over the limits of the informed consent rationale for the duty to disclose medical error. By definition, informed consent relates to future treatment and diagnostic options. Consent can only be informed if appropriate disclosure is made in advance of consent, let alone in advance of treatment or diagnosis. Hence, despite case law to the contrary, it is at least arguable that the informed consent doctrine can only justify a duty to disclose medical error in those instances where disclosure is material to future treatment or diagnosis.<sup>116</sup> It is not difficult to imagine such instances. For example, if a foreign body is inadvertently left in a surgical patient and removal of that body is advisable or necessary, then informed consent principles do indeed require that the error be disclosed to the patient. This is because the principles of informed consent require that patients know not only of the risks associated with the removal surgery but also the risks and consequences of non-removal.<sup>117</sup> However, the inexorable logic of the doctrine of informed consent does not require disclosure of medical error in cases where there is no possible procedure or treatment that can mitigate or eliminate the effect of the error or that can accomplish the goals, not yet realized, of the original treatment. Where neither treatment nor diagnosis is or reasonably should be in the contemplation of the parties, no consent is sought which the law requires be informed through disclosure of material risk. Nevertheless, because Canadian courts have accepted that

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115 Waite, *ibid.*

116 For an example of case law to the contrary see, *McCann v. Hyndman*, 2003 ABQB 693, 336 A.R. 360. There is little doubt that tort law's informed consent is a "convenient" doctrine through which to give effect a broad based conviction that physicians ought to be compelled to disclose medical error. However, as is suggested in the text which follows, fiduciary obligation is a much more cogent foundation for a general duty to disclose medical error.

117 The doctrine of informed consent clearly requires that patients be aware of the risks of "undergoing" and "forgoing" medical treatment. *Reibl v. Hughes*, [1980] 2 S.C.R. 880 at para. 17, 114 D.L.R. (3d) 1 (QL); *Hollis v. Dow Corning Corp.*, [1995] 4 S.C.R. 634 at para. 24, 129 D.L.R. (4th) 629 (QL) [*Hollis*]. In Ontario, the requirement is codified in legislation: see *Health Care Consent Act*, S.O. 1996, s. 2(1) [being Schedule A to the Advocacy, Consent and Substitute Decisions Statute Law Amendment Act, S.O. 1996, c-2], s. 11(2)-(3).

the duty to disclose medical error is a fiduciary duty,<sup>118</sup> physicians are bound by their duty of loyalty to their patients to disclose medical error even where informed consent principles are inapplicable. So the current state of Canadian law appears to be that the duty to disclose medical error emanates from both tort and fiduciary principles, but the latter set of principles appear to have broader application.

First principles suggest that the duty to disclose medical error extends beyond physicians to non-physician HCPs who are also fiduciaries. After all, the object of the duty to disclose medical error is not to deplete the conscience of fiduciaries but rather, as a matter of loyalty, good faith and candour, to disclose to patients that they have been harmed. It is true that Canadian physicians are currently subject to an explicit ethical obligation to disclose "harm" and that the codes of ethics of some other health care professionals, for example occupational therapists, do not contain similar obligations.<sup>119</sup> However, given that the legal duty to disclose medical error

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118 *Supra* note 105.

119 Waite, *supra* note 1 at 6-15, for a list of provincial colleges of physicians and surgeons who have disclosure of error policies. See also Canadian Medical Association, *Code of Ethics* (Ottawa: Canadian Medical Association, 2004) at para.14, online: Canadian Medical Association <<http://policybase.cma.ca/dbtw-wpd%5CPolicyPDF%5CPD04-06.pdf>>. With respect to occupational therapists, see the Canadian Association of Occupational Therapists, *Code of Ethics, supra* note 55. The ethical trend is clearly to require disclosure of harm. See for example, the *Code of ethics of physical therapists and physical rehabilitation therapists*, R.Q. c. C-26, r. 136.01, online: Canadian Legal Information Institute <<http://www.canlii.org/qc/laws/regu/c-26r.136.01/20071015/whole.html>>. Importantly, nurses, are also under an obligation to disclose harm (as well as adverse events) and this is so whether the harm or event is caused by them personally or by "physician or interdisciplinary team error." See Canadian Nurses Association, *Code of Ethics for Registered Nurses* (2002), online: Canadian Nurses Association <[http://www.cna-aicc.ca/cna/documents/pdf/publications/CodeofEthics2002\\_e.pdf](http://www.cna-aicc.ca/cna/documents/pdf/publications/CodeofEthics2002_e.pdf)>, in particular, "Nursing Values and Responsibility Statements" 8 and 9 which provide the following:

8. Nurses must admit mistakes and take all necessary actions to prevent or minimize harm arising from an adverse event.

9. Nurses must strive and prevent adverse events [including physician and interdisciplinary team error] in collaboration with colleagues on the health care team. When adverse events occur, nurses should utilize the opportunity to improve the system and prevent harm.

predated formal recognition of the ethical version of the duty, the ethical prescription is best regarded as “merely” an acknowledgment of the ethical basis of the pre-existing legal duty to disclose medical error.<sup>120</sup> This pre-existing legal duty has its source in fiduciary responsibility and, therefore, should be applicable to non-physician health care practitioners just as it is to physicians.<sup>121</sup> However, in *Shobridge v. Thomas*,<sup>122</sup> a decision of the British Columbia Supreme Court, Justice Kirkpatrick held that physicians have a fiduciary duty to disclose medical error but nurses do not. The reasoning underlying this conclusion is not expansive and in particular does not address fiduciary principles. Nevertheless, it is a significant conclusion with potential implications that go beyond the nurse/physician divide.

In *Shobridge*, Justice Kirkpatrick reasoned that the duty of the nurse defendants was merely to complete an “incident report *in accordance with hospital policy*” and that the nurses in question believed that the duty to disclose an error was a physician’s duty.<sup>123</sup> Clearly, even if *Shobridge* was correctly decided, other cases could well be decided differently where relevant hospital policies, practice guidelines and codes of ethics diverge from those that were in play in *Shobridge*. Modern conflict of interest, patient abuse, disclosure of wrongdoing and whistle-blower policies may well warrant the

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In some instances, an obligation to disclose harm or an adverse event is not set out explicitly in codes of ethics of health care workers but, based upon a reasonable interpretation of ethical prescriptions, nevertheless exists. See for example, the Canadian Society of Medical Laboratory Science, *Code of Professional Conduct* (Hamilton, Ont.: CSMLS, 2007) which provides: “Medical laboratory professionals shall take responsibility for *their* professional acts” [emphasis added], online: CSMLS <<http://www.csmls.org/english/conduct.htm>>.

120 The ethical prescription to disclose “harm” appears to go well beyond disclosure of medical error.

121 It is important that hospitals develop disclosure of harm policies with a view to ensuring both that disclosure of harm is made and that it is done in an orderly fashion. It might be, for example, that primary responsibility for informing patients that they have been harmed should be that of the attending physician and that other fiduciaries should only be required to disclose the existence of medical error to hospital administration. The ultimate responsibility for ensuring that the affected patient is informed, preferably by the attending physician, would be borne by the administration.

122 (1999), 47 C.C.L.T. (2d) 73 at para. 95, [1999] B.C.J. No. 1747 (S.C.) (QL).

123 *Ibid.* [emphasis added].

conclusion that nurses and others have a duty to disclose medical error.<sup>124</sup> Indeed, Canadian nurses are now bound by an explicit ethical obligation to report both harm and adverse events, regardless of whether they are caused by the nurses themselves, physicians or other members of an interdisciplinary team.<sup>125</sup> As well, it should be noted that the correctness of Justice Kirpatrick's analysis and conclusion in *Shoebridge* has recently been doubted in the academic literature.<sup>126</sup> The judgement in *Shoebridge* makes no reference to the English case of *Lee v. South West Thames Regional Health Authority*, let alone the reasoning in that case.<sup>127</sup> *Lee* suggests, albeit only in *obiter* and not explicitly as a matter of fiduciary law, that within hospitals the duty to disclose medical error does extend beyond physicians to other health care actors. The duty, argues *Lee*, arises out of the "hospital-patient relationship" and hence is applicable, not just to physicians, but "to hospital staff" and the relevant "hospital authority."<sup>128</sup>

On the other hand *Shoebridge* can be rationalized as a decision which responds to legitimate and important process oriented concerns relating to the disclosure of medical error or adverse incident. Clearly the process of disclosure must be appropriate and orderly. Subject to institutional policies to the contrary, attending physicians should have prime responsibility for making disclosures. Not only has case law unequivocally recognized that physicians have a duty to disclose medical error, but from the patients' perspective, physicians head health care teams that are responsible for their care. In addition, often, though by no means always, attending physicians have direct relationships with such patients. Moreover, it would be inappropriate and unseemly for multiple health service providers to each disclose errors and incidents to a patient. It follows that fiduciary actors with "secondary

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124 See the discussion immediately following.

125 *Supra* note 119.

126 Waite, *supra* note 1 at 16-21.

127 [1985] 2 All E.R. 385, [1985] 1 W.L.R. 845 (C.A. (Civ. Div.)) [*Lee*].

128 *Ibid.* at 389-90. Note as well that the analysis in *Lee* was approved of by Justice Krever in *Stamos v. Davies*, *supra* note 113 at para. 25. In terms of disclosure of error legislation, see the *Regional Health Authorities Act*, S.M.1996, c. 53, s. 53.2, which imposes a statutory duty to disclose "critical errors" on regional health authorities, health corporations and prescribed health care organizations. And in Quebec, patients ("users"), or their representatives, have a right to be informed of "any accident." See *An Act Respecting Health Services and Social Services*, Part II, Rights of Users, R.S.Q. c. S-4.2, ss. 8, 12.

responsibility" for disclosure may well discharge their duty to patients by reporting errors and adverse incidents to hospital authorities.<sup>129</sup> Such reporting should be regarded as part of a process that ensures that ultimately there will be appropriate disclosure of error made to patients, either by attending physicians or by institutional representatives. Given that HCPs in a hospital environment are numerous, it is certainly wise, if not incumbent on hospitals and health care authorities, to enact policies which ensure appropriate and orderly disclosure of medical error to patients. What these policies can provide in the hospital context, that fiduciary law cannot, is order and certainty. It is suggested that such policies, if enacted, would have the effect of regulating the manner in which HCPs meet their fiduciary obligations to disclose medical error and adverse events. They would not have the effect of negating the existence of such duties. It follows that *Shobridge*, on its particular facts, may have been correct in suggesting the nurse defendants' obligation was to prepare an incident report but this is only a description of the initial obligation of the nurses. *Shobridge* does not speak to the ultimate obligation of the nurses to disclose medical error in the event that neither the attending physician nor the hospital (or health authority) discharge their duty to disclose. Similarly, the conclusion in *Shobridge* would not absolve the hospital, to whom the report was made, from ensuring that the incident at issue was disclosed to the patient.

**(ii) The Prescriptive Fiduciary Duty of Protective Intervention**

It has already been noted that in Canada the courts have recognized that persons charged with the care of children may breach fiduciary duty by failing to protect the children. In effect these courts have fashioned a duty of protective intervention, a duty which has been formulated both in narrow and broad terms. At the narrow end of the spectrum the duty has been described as a duty to prevent assault.<sup>130</sup> The most expansive description of the duty is an obligation to protect a child from reasonably foreseeable harm.<sup>131</sup> Clearly, the broader formulation is preferable. Though the duty of protective

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129 It is noteworthy that in *Shobridge*, *supra* note 122 at para. 96, Kirkpatrick J. concludes that the nurses "... failed in their duty to file an incident report."

130 *L.A.J. v. H.J.*, *supra* note 106 at para. 22.

131 *Ibid.* at para. 28. See also *K.K. v. K.W.G.* (2006), 40 C.C.L.T. (3d) 139 at para. 38, [2006] O.J. No. 2672 (Sup. Ct. J.) (QL), where the duty is described as follows: "The fiduciary obligation not only imposes a duty to refrain from inflicting harm but also includes a duty to protect one's child from harm."

intervention has evolved in the context of sexual, physical and psychological “abuse” cases, the duty should not be either limited to these kinds of cases or otherwise narrowly circumscribed. What is important is the prevention of significant harm to children, not the nature of the harm or its source. Whether the source of potential harm is a co-fiduciary, employee, stranger or some other animate or even inanimate instrumentality is very much besides the point. Similarly, whether a threat to a child is part of a chronic pattern of abusive behaviour, recklessness or negligence, or even an isolated “accident waiting to happen”, should also not matter.<sup>132</sup> The important thing for fiduciaries in whose care children find themselves is to prevent material harm from being visited on the children. In short, when the safety and security of persons, particularly vulnerable persons, is entrusted to the care of fiduciaries, then irrespective of the nature and source of the threat, fiduciaries must take steps open to them to prevent harm. What those steps are

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132 In the context of whistle-blowing, a Canadian report has suggested that health care workers have a “duty to protect their patients against incompetent, illegal or unethical behaviour.” See Manitoba Health, *Report of the Review and Implementation Committee for the Report of the Manitoba Pediatric Cardiac Surgery Inquest* (Manitoba: Manitoba Health, 2001) at 79, online: Manitoba Health <<http://www.gov.mb.ca/health/cardiac>> [*Manitoba Report*]. Far more limited is the apparent scope of the ethical duty to whistle-blow for “unbecoming” conduct of medical practitioners set out in the College of Physicians and Surgeons of Alberta, *Reporting to the College: CPSA Policy*, *supra* note 53. The policy guide limits the duty to cases of inappropriate sexual and other “unbecoming” conduct. Whether the concept of “unbecoming” extends beyond cases implicating moral turpitude to instances of “mere negligence” is debatable. However, given that physicians who have committed medical errors have a duty to disclose these errors, moral turpitude will exist in all cases where these physicians fail to fess up. Hence, the notion that mere negligence is not “unbecoming” conduct, while perhaps correct is of no practical importance. Other whistle-blowing regimes also define broadly the circumstances in which whistle-blowing is appropriate. See, for example, the Australia, Queensland, *WhistleBlowers Protection Act 1994*, (Qld.), s. 3, which provides protection to public interest disclosures about unlawful, negligent or improper public sector conduct or, danger to public health, safety or the environment. See also *Employment Rights Act 1996* (U.K.), 1996, c. 18, s. 43B(1), online: <[http://www.opsi.gov.uk/acts/acts1998/ukpga\\_19980023\\_en1](http://www.opsi.gov.uk/acts/acts1998/ukpga_19980023_en1)> which accords protection to a broad array of disclosures including those which relate to failure of individuals to comply with legal obligations, as well as those relating to past, present and future endangerments to the health and safety of individuals.

will depend on a large variety of circumstances, not the least of which is the “means and ability” of the fiduciary.<sup>133</sup> Where fiduciaries are not exposed to significant risk, protective intervention may entail physically removing children from harms way. In cases where an evident threat to a child is a human threat, in many, if not most cases, fiduciaries will discharge their duty of protective intervention by reporting the threat to the “authorities” (whistle-blowing). Authorities include the police, social welfare agencies and, within institutions, security, administration and management personnel.

In the abuse of children cases, liability has been imposed on passive fiduciaries where their failure to act is attributable to conflict of interest. An excellent illustration is the case of *L.A.J. v. H.J.* where Justice Rutherford concluded that a mother who failed to intervene to protect her daughter from being sexually abused by the mother’s common-law husband was motivated by self interest. He stated:

Instead of pursuing means that were open to her to protect her daughter from the injurious circumstances of which she was aware, the defendant mother put her own interests above those of her daughter. She wanted to keep her husband and her daughter with her but at the expense of her daughter’s well-being.<sup>134</sup>

The pivotal role of the conflict of interest principle in these cases must not be understood as negating the existence and importance of the prescriptive duty of protective intervention. Absent this positive duty there would be no basis for imposing liability on fiduciaries in the failure to intervene cases. To illustrate this point consider a hypothetical where W and H (a couple) and T are friends. T is also a trustee, hence a fiduciary, of an investment fund for the benefit of the children of W and H. Assume that T learns that H has been abusing one of the children but because of the close friendship between T and H, T does not report the abuse to W or the authorities. T’s inaction is motivated by self-interest and allegiance to a third party, H, but T is not in breach of the conflict of interest rule precisely because there is no primary prescriptive duty of protective intervention that conflicts with his personal interest. T’s legal duties relate exclusively to trust assets and not to the children themselves. On the other hand, as the *L.A.J. v. H.J.* case illustrates, if W is aware of the abuse, but in order to protect her husband

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133 *L.A.J. v. H.J.*, *supra* note 106 at para. 27.

134 *Ibid.* at para. 29.

fails to intervene to protect the child, W will be in breach of her fiduciary duty. What this hypothetical and the foregoing discussion of prescriptive fiduciary duties demonstrate is that positive fiduciary duties clearly exist and irrespective of whether opportunistic behaviour is or is not indispensable to a finding of fiduciary liability, prescriptive duties have critical legal significance.

***(iii) The Fiduciary Duty of Protective Intervention In the Health Care Context***

The applicability of the fiduciary principles that have evolved in the children abuse cases to the hospital context is readily apparent. Patients are almost always completely reliant on hospitals and their fiduciary HCPs and healthcare institutions to shield them from and to minimize the many serious dangers that lurk in hospitals. There is little that patients can personally do to protect themselves from infection, error, negligence and, in some circumstances, misconduct of hospital staff or fellow patients. Patients are both personally and situationally vulnerable, and completely reliant on the special training, due diligence, effective power and honourable conduct of their health practitioners. Hence, the factors set out by Chief Justice Scott in the *Cairnie* case as justifying prescriptive duties are extant in a hospital context.<sup>135</sup> Moreover, it can hardly be doubted that there is a widespread and deeply held conviction that patients can expect loyal and dedicated commitment from hospitals and hospital staff. It follows that there are striking parallels between the children abuse cases and the hospital context, parallels which warrant the conclusion that professional health care providers who work in hospitals owe their patients a broad fiduciary duty of protective intervention. As noted above, this duty includes an obligation to protect patients from potential harm from a variety of sources, including harm that they may suffer at the hands of third parties. Where risk of harm emanates from third parties, protective intervention will often be discharged by whistle-blowing.

The case for the existence of a duty of protective intervention applicable to fiduciaries who deliver health services in hospitals is strengthened by a variety of contextual considerations, including applicable legislation and hospital policies. Though such policies are not binding on the courts,<sup>136</sup>

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135 See text at 326, above.

136 See *Lac Minerals*, *supra* note 8 at para. 168 where La Forest J. states "The indus-

they may be resorted to in determining the content of fiduciary responsibility. Courts have been deferential to community and industry standards of behavioural norms expressed in ethical codes, task forces, oaths of professions,<sup>137</sup> community, industry, governmental and even legislative policies,<sup>138</sup> though on occasion they have expanded fiduciary duty beyond the norms contained in these sources.<sup>139</sup> Clearly, the impact of contextual consider-

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try practice therefore, while not conclusive, is entitled to significant weight in determining the reasonable expectations of Corona, and for that matter of Lac regarding how the latter should behave.”

- 137 As to codes of ethics, see *MacDonald Estate v. Martin*, [1990] 3 S.C.R. 1235 at 1245-46, 77 D.L.R. (4th) 249, Sopinka J.; *Hodgkinson*, *supra* note 15 at 425, where it is said “... the rules set by the relevant professional body are of guiding importance in determining the nature of the duties flowing from a particular professional relationship.” With respect to task forces and oaths of professions, see *Norberg v. Wynrib*, *supra* note 21 at paras. 43, 45, 58, 73, 76, 90. Not only is it appropriate to take very seriously a profession’s judgement about the ethical mandate of its constituents but being deferential to ethical guidelines, which often are detailed, can eliminate uncertainty.
- 138 With respect to community and industry policies and standards see *Lac Minerals*, *supra* note 8 at paras. 46-48, Sopinka J. and at paras. 164-168, La Forest J. With respect to governmental and legislative policies, see *Guerin v. The Queen*, *supra* note 39 at 349, Wilson J. and at 376, 383-384, Dickson J.
- 139 Canadian Bar Association, *Code of Professional Conduct* (Ottawa: Canadian Bar Association, 2006) at 29, online: CBA <<http://www.cba.org/CBA/activities/pdf/codeofconduct06.pdf>>, which provides that “[a] lawyer who has acted for a client in a matter should not thereafter act against him ... in the same or any *related* matter” [emphasis added]. However, in *R. v. Neil*, *supra* note 100 at para. 29, the Supreme Court of Canada extended the prohibition against acting against a client, at least in some circumstances, even to “unrelated” matters. It follows, that for the purposes of fiduciary law, ethical duties set out in particular codes of ethics, may be expanded beyond the textual limits set out in the codes. If such an expansion is essential for the maintenance of public confidence in critical fiduciary institutions, such as hospitals, then the expansion is warranted. In addition and importantly, such expansion may be warranted where policies of relevant institutions, such as hospitals, set out more robust prescriptions than those set out in codes of ethics. This is because the legal duties of fiduciaries are determined by the reasonable expectation of the parties informed by the entire array of contextual sources and not just by a single source. For a brief discussion of a limited ethical duty to whistle-blow that may be expanded beyond its apparent textual limitations, see *supra* note 53 and *supra* note 131.

ations on fiduciary duty must be evaluated on a case by case basis. However, the increasing and strong emphasis on patient safety in legislative, hospital, community and public policies, bodes well for the existence of a robust duty of protective intervention applicable to hospitals, health authorities and professional health care practitioners who work in hospitals. These policies acknowledge the fiduciary role of individuals and institutions who deliver hospital services. Hence, hospitals and hospital authorities are wise to bring to the attention of their staff their collective and individual obligations to protect patients from foreseeable harm and to provide an orderly and systematic basis for providing this protection.

## V. The Tort Law/Fiduciary Law Interface

Fiduciary law is not the exclusive preserve of a positive duty of protective intervention. Both contract and tort law are capable of spawning positive duties of protection against foreseeable harm. Clearly these common law duties can and do bind fiduciaries. Recent developments in tort law suggest that there is increasing overlap between tort and fiduciary law based positive duties of care. In *Childs v. Desormeaux*, the Supreme Court of Canada, in the context of a social host liability case, laid down three broad principles where tort precepts of foreseeability and proximity may give rise to a positive duty of care.<sup>140</sup> Chief Justice McLachlin set out these three principles as follows:

The first situation where courts have imposed a positive duty to act is where a defendant intentionally attracts and invites third parties to an inherent and obvious risk that he or she has created or controls....

The second situation where a positive duty of care has been held to exist concerns paternalistic relationships of supervision and control, such as those of parent-child or teacher-student .... The duty in these cases rests on the special vulnerability of the plaintiffs and the formal position of power of the defendants.

The third situation where a duty of care may include the need to take positive steps concerns defendants who either exercise a public function or engage in a commercial enterprise that includes implied responsibilities to the public at large .... In these cases, the defen-

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140 2006 SCC 18, [2006] 1 S.C.R. 643 [*Childs*].

dants offer a service to the general public that includes attendant responsibilities to act with special care to reduce risk.

Where a defendant assumes a public role, or benefits from offering a service to the public at large, special duties arise.<sup>141</sup>

In the abstract, it is difficult to assess with precision the degree to which these three touchstones of prescriptive obligation track or duplicate positive fiduciary duties. However, in the hospital context it does appear that the *Childs*' principles give rise to very substantial, though probably not complete concordance, between tort and fiduciary notions of prescriptive obligation.<sup>142</sup> Perhaps this is unsurprising given the degree to which tort law appears to be supplementing its traditional values with the precepts, principles, values and even the vocabulary of fiduciary law.<sup>143</sup>

Within the Supreme Court of Canada there has been considerable controversy about the role of fiduciary law in cases where the common law is capable of responding to fiduciary wrongdoing. The controversy is now

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141 *Ibid.* at paras. 35-37.

142 For example, the *Childs*' principles, *ibid.*, do not seem to contemplate a general duty to disclose medical error. *Childs* seeks to protect vulnerable persons from danger or risk. Hence, when disclosure of error is unrelated to reduction or elimination of danger or risk, the *Childs* formulation is inapplicable. See the discussion in the text at 326-328, above, which elaborates on both the limits of tort law and the reach of fiduciary law in disclosure of error cases.

143 There is more than a hint of this in *Canson Enterprises Ltd. v. Boughton & Co.*, [1991] 3 S.C.R. 534 at paras. 84-86, 85 D.L.R. (4th) 129 (QL) [*Canson*], where Justice La Forest argues that the common law can and should provide relief in cases where "a person fail[s] ... to meet the trust or confidence reposed in that person." Similarly, in *Childs*, *ibid.*, at paras. 38, 40, Justice McLachlin, without adverting to equity, analyzes the touchstones of prescriptive obligation by using language and concepts that are at the core of fiduciary law. She observes that they involve "... special relationship[s] to ... person[s] in danger ... risk", the "assum[ption] ... of control of vulnerable person[s]" and "undertaking" a public service giving rise to a "reasonable expectation on the part of the public that a person providing public services ... will take reasonable precautions to reduce the risk of the activity..." [emphasis added]. McLachlin also notes that the theme that unites all three touchstones of prescriptive duty is "reasonable reliance." As noted previously in the text at 308-310, above, reasonable expectation, reliance and vulnerability are core features of fiduciary law.

approximately two decades old and has yet to be resolved. Underlying the debate is the supposition that rights and remedies should not depend on the vicissitudes of pleadings; that is, rights and remedies should not depend on whether pleadings happen to implicate equitable as opposed to common law principles.<sup>144</sup> On the merits of which body of law should apply, Supreme Court justices who favour a common law approach, over fiduciary law, do so for three main reasons. First, tort and contract law are far more developed and hence more certain than “ill defined” fiduciary law.<sup>145</sup> Second, the application of vague notions found in fiduciary law is apt to “open the floodgates to unfounded claims ....”<sup>146</sup> And, third, unlike fiduciary law, which can be “unduly harsh,” tort and contract have built in checks and balances which ensure measured and proportionate responses to wrongdoing.<sup>147</sup> Judges who prefer a common law approach acknowledge that there are cases where equity should be utilized in preference to the common law but only where the application of equity is “necessary.”<sup>148</sup> In this context, the concept of necessity is less than clear. Justice La Forest suggests that resort to equity is appropriate when equity alone can advance an important policy objective but does not elaborate.<sup>149</sup> Perhaps he is contemplating instances where deterrence of fiduciaries requires the application of the pro-plaintiff

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144 *Canson, ibid.* at paras. 84-85, La Forest J.

145 *Frame v. Smith, supra* note 11 at para. 17. See also *Lac Minerals, supra* note 8 at para. 177.

146 *Norberg, supra* note 21 at para. 96, McLachlin J.

147 *Canson, supra* note 143 at paras. 87-88, La Forest J.

148 See *Lac Minerals, supra* note 8 at paras. 27, 29, 139-40, 184, 187, 191. At para 27, Sopinka J. states that “[t]he consequences attendant on a finding of a fiduciary relationship and its breach have resulted in judicial reluctance to do so except where the application of this “blunt tool of equity” is really necessary.” Similarly at para. 29, where Justice Sopinka observes: “In my opinion, equity’s blunt tool must be reserved for situations that are truly in need of the special protection that equity affords ....” However, La Forest J. seems to have no reservations about according the plaintiff fiduciary relief even where relief can be accorded on other grounds, namely breach of confidence and unjust enrichment. See paras. 139-40, 184, 187, 191.

149 See *Canson, supra* note 143 at para. 84, where Justice La Forest states that “[o]nly when there are different policy objectives should equity engage in its well-known flexibility to achieve a different and fairer result ....” No examples of such policies are provided by way of illustration.

doctrines of fiduciary law<sup>150</sup> or instances where the breach of fiduciary duty is so egregious that the stigma associated with breach of fiduciary duty is desirable.<sup>151</sup> Remedial necessity may also justify the application of fiduciary theory in preference to the common law. In *Canson*, for example, Justice La Forest suggests that the application of fiduciary theory is warranted where the ends of justice require the application of uniquely equitable remedies such as the constructive trust.<sup>152</sup>

A rejoinder to the assertion that fiduciary law is ill defined has been conspicuously absent. It is noteworthy, however, that in *Frame v. Smith* a majority of the Supreme Court of Canada was less than sanguine about the certainty and precision of either fiduciary or tort law.<sup>153</sup> As well, Justice La Forest, a strong proponent of the use of tort law over fiduciary law, has asserted that modern fiduciary law can be "... defined and applied with some measure of precision."<sup>154</sup> While precision may not in fact be the strongest

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150 For example, the reverse onus of proof doctrine set out in *Brickenden v. London Loan & Savings Co.*, [1934] 3 D.L.R. 465 at 469, [1934] 2 W.W.R. 545 (P.C.); the hindsight doctrine discussed in *Canson*, *ibid.* at para. 55, McLachlin, J.; or equity's general tendency to disregard allegations of plaintiff misconduct or allegations that plaintiffs have contributed to their own losses. For the latter, see *Canson*, *ibid.* at paras. 23, 27, McLachlin J. and at para. 59, Stevenson J.

151 In *A. (C.) v. Crichley* (1998), 166 D.L.R. (4th) 475 at para. 85, 60 B.C.L.R. (3d) 92 (C.A.), Chief Justice McEachern recognizes that "shame and stigma" is associated with a finding of breach of fiduciary duty and hence advocates that it be restricted to appropriate cases, namely those which involve "disloyalty or dishonest[y]." After suggesting that liability for breach of fiduciary duty should be restricted to cases where fiduciaries violate trust and confidence for their direct and indirect benefit, it is noted:

This excludes from the reach of fiduciary duties many cases that can be resolved upon a tort or contract analysis, has the advantage of greater certainty, and also protects honest persons doing their best in difficult circumstances from the shame and stigma of disloyalty or dishonest[y].

See also Litman, *supra* note 9 at 108-109.

152 *Canson*, *supra* note 143 at para. 65, La Forest J. But note that in *Norberg*, *supra* note 21 at para. 141, Sopinka J. opines that "[f]iduciary duties should not be superimposed on common law duties simply to improve the nature or extent of the remedy."

153 *Supra* note 11 at paras. 10, 17, 18.

154 *Hodgkinson v. Simms*, *supra* note 15 at para. 29, La Forest J., referring to his ear-

attribute of fiduciary law, concerns about its vagueness appear overblown. This is especially so in the light of the lack of precision of the alternatives to fiduciary theory.<sup>155</sup> The same is true of the second concern that fiduciary law, owing somewhat to its vagueness, might be overly receptive to inappropriate claims of abuse of power (the floodgates argument). There is no reason to think that fiduciary law is in principle more susceptible to problems of overly expansive liability than is tort law.<sup>156</sup>

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lier judgement in *M. (K.) v. M. (H.)*, *supra* note 40 at paras. 73-74. This statement is ironic given that Justice La Forest seems clearly in the pro-common law side of the debate. This is apparent from his extensive reasons in the *Canson* case, *supra* note 143.

155 For the discussion of the vagueness of both fiduciary law and tort law, see *Frame v. Smith*, *supra* note 11 at paras. 17-18. Fiduciary law's core concepts of loyalty, undertaking, reasonable expectation and reasonable reliance, though far from precise, can hardly be said to be more vague than tort law's core concepts of reasonableness, foreseeability and remoteness. Neither body of law is capable of operationalizing its principles with mechanical rules. Clearly, owing to its relative youth as a principled body of law, fiduciary law requires development. But, as a principled body of law, there is at least a conceptual basis to guide its evolution. Unfortunately, the pre-occupation of the judiciary with the *indicia* of fiduciary relationships has contributed to the sense that fiduciary law is uncertain. Focusing, properly, on the etiological principles of "undertaking", "reasonable expectation" and "reasonable reliance" would provide conceptual guidance which would go at least some way to clarifying fiduciary law. A source of "uncertainty" in fiduciary law is the doctrine that fiduciaries may be liable for breach of fiduciary duty for conduct outside of their undertakings. See, for example, *R. v. Neil*, *supra* note 100, where the Supreme Court of Canada concluded that lawyers have a duty to refrain from acting against their client's interests even in matters that are unrelated to the lawyer's role (as defined by the lawyers retainer or, more broadly, the lawyer's mandate). The Supreme Court's concern is to impugn conduct that can result in a beneficiary developing an "understandable sense" of betrayal and which may well give rise to a loss of confidence in the integrity and efficacy of important fiducial institutions. Precisely what conduct outside of fiduciary undertaking can be impugned is very difficult to describe in any principled way other than to say that it is conduct that leads reasonable clients to feel betrayed. See *Strother*, *supra* note 38, for a decision in which the Court is very divided on the scope of fiduciary obligation.

156 In responding to the floodgates concern, Justice McLachlin in *Norberg*, *supra* note 21 at para. 97, analyses relationships which qualify as fiduciary and concludes that "[i]t is not easy to bring relationships ..." into the fiduciary "ru-

The third major criticism of fiduciary law, that it is unduly harsh, has been rejected by Justice McLachlin (and concurring judges) for two reasons. First, Justice McLachlin asserts (and demonstrates) that equity has the capacity to moderate itself in order to avoid overly harsh results.<sup>157</sup> Secondly, she suggests that in the context of fiduciary cases, it is the leniency of the common law, not equity's stringency, that is the problem. This second point requires some reading "between the lines" of her judgements in *Canson and Norberg*, though barely so. Indeed, in *Norberg*, Justice McLachlin does explicitly state that "... characterizing the duty as fiduciary [as opposed to a common law duty] does add something; indeed, without doing so the wrong done to the plaintiff can neither be fully comprehended in law nor *adequately* compensated in damages."<sup>158</sup> The inadequacy of the common law not only flows from an inability to accurately comprehend,<sup>159</sup> describe and hence respond appropriately to the egregious nature of fiduciary wrongdoing<sup>160</sup> but, perhaps more importantly, its failure to accommodate the uniquely formi-

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bric" of fiduciary law and, as well, at para. 98, that fiduciary law's "governing principles offer assurance against unlimited liability." Despite these assertions, there is widespread concern that fiduciary law is indiscriminating. In my view, this criticism fails to consider the very large number of societal relationships in which one person's mandate is to look after the interests of another and other relationships where this is the broadly held expectation. In any event, given that equity is willing to "take wisdom" wherever it is found and willing to "accept" the "insights offered by the law of tort .....", there is no reason to think that equity is more susceptible to the problem of floodgates than is the common law. *Canson, supra* note 143 at para. 8, McLachlin J.

157 See *Canson, ibid.* at paras. 27-28, where Justice McLachlin "invokes" (actually invents) a "common sense view of causation" in order to avoid a draconian result that would ensue from the application of equity's standard doctrine of "but-for" causation.

158 *Norberg, supra* note 21 at para. 95 [emphasis added].

159 From a purely conceptual perspective, Justice McLachlin in *Norberg, ibid.* at para. 95, opines that tort and contract cannot "fully comprehend" fiduciary wrongdoing and, indeed, "distort" rather than "bring [it] into focus" at para. 60.

160 It is grievous breach because it entails a breach of trust, a point not captured by nominate torts such as negligence or battery or even deceit which has application to persons dealing at arms length. In *Norberg, ibid.* at para. 87, McLachlin J. stated of Dr. Wynrib's breach of fiduciary duty that "[a] more grievous breach of the obligations, legal and ethical, which he owed her as his patient can scarcely be imagined."

dable challenges faced by vulnerable beneficiaries of detecting and proving breach of fiduciary duty.<sup>161</sup> In addition, Justice McLachlin is concerned about the inappropriate use in fiduciary analysis of common law limiting doctrines such as mitigation and “foreseeability of loss” in calculating the quantum of compensation.<sup>162</sup> In response to the majority view in *Canson* which advocates, where possible, a common law approach to fiduciary cases, but one which exempts fiduciary claims from foreseeability analysis, Justice McLachlin asks which other important and appropriate doctrines of fiduciary law will the common law adopt to redress fiduciary wrongdoing.<sup>163</sup> Underlying all of these points is a pronounced scepticism about the wisdom of jettisoning equitable doctrines that are dedicated to maintaining the integrity and efficacy of critical fiduciary institutions. These doctrines have been tailored to respond to the egregious wrong of betrayal of trust and also to counteract the pronounced and unfair barriers to proof of fiducial wrongdoing.

It may ultimately be that the outcome of the “fiduciary versus common law” debate will be of little practical consequence. This is because both the common law and equity seem willing and able, where appropriate, to borrow from each other.<sup>164</sup> However, given equity’s studied and historic preoccupation with fiduciary wrongdoing, it makes considerable sense to use it as a starting point for analysis and implant legal principles when appropriate.<sup>165</sup>

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161 *Canson, supra* note 143 at para. 8.

162 *Ibid.* at paras. 17-18, 22-23.

163 *Ibid.* at para. 8. And at para. 7, she suggests that if tort law was deployed in cases of fiduciary wrongdoing the tort of deceit would be more appropriate to utilize than the tort of negligence because, like breach of fiduciary obligation, the deceit responds to wrongs which entail “moral overtones.”

164 *Canson, ibid.* at paras. 8, 76, 83. Justice McLachlin observes at para. 8 that “... I readily concede that we [that is, equity] may take wisdom where we find it, and accept such insights offered by the law of tort, in particular deceit, as may prove useful.” Justice La Forest, in the same case at para. 76, notes that law “is not frozen in time,” and at para. 83 that “the path of equity leads to law” and finally that “the principles of law and equity over time have tended to merge.”

165 See *Canson, ibid.* at para. 8, McLachlin J. She states: “Rather than begin from tort and proceed by changing the tort model to meet the constraints of trust, I prefer to start from trust, using the tort analogy to the extent shared concerns make it helpful.”

## VI. Breach of Proscriptive and Prescriptive Fiduciary Duty

It is trite law that a mere failure of care and skill in the delivery of fiduciary services is not a breach of fiduciary duty. This is so even if the failure is a product of aggravated or gross negligence.<sup>166</sup> Breach of fiduciary duty only occurs when the impugned conduct entails disloyalty or, as it is often referred to, “breach of trust”.<sup>167</sup> Clearly, a failure to meet a standard of care or competence can occur in a myriad of ways without the slightest taint of disloyalty. Redress, in such cases, is to be found in tort law, not fiduciary law. But, importantly, as *Norberg v. Wynrib* illustrates, when negligence (or battery) is attributable to or implicates disloyalty by a fiduciary, the wrong can be and in *Norberg* was regarded to be, albeit by a minority of judges, a breach of fiduciary duty. In that case, Dr. Wynrib’s failure to counsel his addict patient to enrol in an anti-addiction program was motivated by his desire to maintain a sexual relationship with the patient. By putting his personal desires ahead of his patient’s interests, Dr. Wynrib was regarded, by Justices McLachlin and L’Heureux-Dubé, as guilty of the classic form of fiduciary disloyalty.<sup>168</sup> Other members of the Court were divided on whether Dr. Wynrib was guilty of negligence for extending the period of his patient’s addiction,<sup>169</sup> or sexual battery (the view of three of the justices).<sup>170</sup>

There is no doubt that tort and fiduciary based claims are compatible. That they are not mutually exclusive is evident from Justice La Forest’s judgement in the Supreme Court of Canada case of *M. (K.) v. M. (H.)* where he states that “[i]ncest is both a tortious assault and a breach of fiduciary duty.”<sup>171</sup> More recently, in *K.L.B.*, Chief Justice McLachlin, writing on behalf of a virtually unanimous Supreme Court of Canada (on the fiduciary

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166 *K.L.B.*, *supra* note 3 at para. 49.

167 *Ibid.* at para. 48, where Chief Justice McLachlin, writing on behalf of a virtually unanimous Supreme Court of Canada, made the following observation about the essence of breach of fiduciary duty, “The traditional focus of breach of fiduciary duty is breach of trust, with the attendant emphasis on disloyalty and promotion of one’s own or others’ interests at the expense of the beneficiary’s interests.”

168 *Supra* note 21 at 284.

169 *Ibid.* at para. 150, Sopinka J. The non-fiduciary approach was adopted by the majority.

170 *Ibid.* at para. 26, La Forest J.

171 *Supra* note 40 at para. 14.

point), briefly explored the relationship between the tort of negligence and fiduciary law. Having found the Government of Canada liable for negligence (subject to the tort claim being statute barred), she rejected the plaintiffs' assertion that the Government was also liable for breach of fiduciary duty. The rationale for rejecting the fiduciary theory was not that the tort of negligence had somehow occupied the field of liability but rather that on the facts of the case the Government was not guilty of "disloyalty ... but [rather a] failure to take sufficient care."<sup>172</sup> She elaborated on the principle as follows: "[n]egligence, even aggravated negligence, will not ground parental fiduciary liability unless it is associated with breach of trust ...."<sup>173</sup> Hence, it is clear that a single transgression can be conceptualized as both negligence and a breach of fiduciary duty. In such a case, whether analysis should proceed in tort or fiduciary law is a contentious issue that has been discussed in the preceding section of this article.

Given that disloyalty is indispensable to a breach of fiduciary duty, it is critical to determine whether a fiduciary's failure to discharge an affirmative duty is *per se* disloyal. In analysing this question, a distinction must be made between contingent and absolute prescriptive duties. With respect to contingent duties, by definition, fiduciaries are only bound to act if and when the contingency materializes. The duty of protective intervention is such a duty. In the absence of a material risk which endangers or threatens the safety of a beneficiary and knowledge of the existence of such a risk, the duty remains inchoate and, hence, cannot be the basis of liability. Other affirmative duties, for example, duties arising from specific undertakings of fiduciary actors, may be unconditional. An example of such a duty is the undertaking of the Crown to deal with First Nation lands on specified terms and conditions. This kind of undertaking was at issue in *Guerin v. The Queen* where land was surrendered by the Plaintiff band for the purpose of leasing it out as a golf course on specified terms and conditions.<sup>174</sup> The Crown, having accepted the surrender, breached its undertaking by leasing the lands on less favourable terms than those specified in the surrender. The consent of the band to the variation was not obtained or even sought. Despite the absence of any conflict of interest or any improper gain by the Crown, the Supreme Court of Canada held that the Crown had breached its fiduciary duty.

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172 *Supra* note 3 at para. 50.

173 *Ibid.* at para. 49.

174 *Supra* note 39 at 369-370.

The decision in *Guerin* has been severely criticized by numerous analysts for concluding, in the absence of any improper profit or any other apparent form of breach of loyalty or trust, that the Crown was guilty of fiducial wrongdoing. Professor Flannigan has characterized the impact of *Guerin* on Canadian jurisprudence as “profound and problematic”.<sup>175</sup> In his view, *Guerin* should be quarantined, hermetically, from the general law of fiduciary obligation and, at best, left to operate exclusively within aboriginal rights jurisprudence.<sup>176</sup> I disagree. In light of the Supreme Court of Canada’s explicit acknowledgment that fiduciary duty can be prescriptive,<sup>177</sup> *Guerin* should be understood as recognizing that disregard of a specific, important and positive fiduciary undertaking or pledge, without justification, is an actionable fiduciary wrong. It is neither unfair, nor a stretch, for fiduciary law to insist on fidelity to such undertakings. This is not to say that liability flows inexorably if positive fiduciary undertakings are not discharged. There are circumstances where a fiduciary’s failure ought to be excused. In *Guerin*, market conditions made it impossible or impractical for the Crown to discharge its specific undertaking. Had the Crown consulted with the Plaintiff Band about appropriate alternatives and effectuated the Band’s alternative wishes, liability of the Crown would have been out of the question and, for that matter, not even an issue. The problem in *Guerin* was the Crown’s unconscionable, bewildering really, disregard of its own undertaking to lease band lands on specified terms for the benefit of the Plaintiff band. Disregard of an undertaking assumed by a fiduciary is disloyal and hence a breach of fiduciary duty.<sup>178</sup> In sum, fidelity to prescriptive tasks requires more than in-

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175 *Supra* note 10 at 56.

176 *Ibid.* at 67.

177 See text at 322-326, above.

178 Flannigan, “Boundaries”, *supra* note 10 at 63, argues that characterizing the Crown’s failure to follow instructions as unconscionable is unfair and irrelevant. Coupled with the dispositive power the Crown acquired over the Plaintiff’s lands, I would suggest that the flagrant disregard of the Plaintiff’s wishes was unconscionable. As to the relevance of the Crown’s unconscionable conduct, it is suggested that unconscionable disregard of a fiduciary undertaking indisputably violates the litmus test of breach of fiduciary duty, namely disloyalty. It is not even a slight stretch for fiduciary law to insist on fidelity to the fiduciary mission. That “unconscionable disregard” of a fiduciary’s mandate is a breach of fiduciary duty may have been recognized by the Supreme Court of Canada in *Wewaykum Indian Band v. Canada*, 2002 SCC 79, [2002] 4 S.C.R. 245. In this

action. Cognizance of prescriptive duty is not too much to ask of fiduciaries. At bottom prescriptive duty requires active loyalty.

In *K.L.B.*, the Supreme Court of Canada went somewhat out of its way to indicate how the parental prescriptive fiduciary duty of protective intervention could be violated.<sup>179</sup> In a judgment concurred in by a very strong majority of the Court, Chief Justice McLachlin made some important, albeit cryptic, comments that come very close to acknowledging that parents who do nothing in the face of the sexual molestation of their children are *per se* liable for breach of their fiduciary duty. To be sure the Court did not give its *imprimatur* to the notion that a fiduciary's failure to execute a prescriptive duty is, *simpliciter*, a breach of fiduciary duty. On the contrary, the Court expressly situated the potential liability of passive parents within the conventional fiduciary principle of conflict of interest. However, what tilts the decision tantalizingly close to the notion that a fiduciary's failure to act is *per se* a breach of fiduciary duty is Chief Justice McLachlin's suggestion that parental liability for the failure to protect a child does not depend on proof of, or even awareness on the part of parents, that their inaction is motivated by a desire for personal advantage. Specifically, Justice McLachlin states:

The parent who exercises undue influence over the child in economic matters for his own gain has put his own interests ahead of the child's, in a manner that abuses the child's trust in him. The same may be said of the parent who uses a child for his sexual gratification or a parent who, wanting to avoid trouble for herself and her household, turns a blind eye to the abuse of a child by her spouse. *The parent need not, as the Court of Appeal suggested in the case at bar, be consciously motivated by a desire for profit or personal advantage;*

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regard consider the cumulative effect of paras. 76, 91 and 100. Though, *Wewaykum* deals with fiduciary duty in an aboriginal context, and affirms that the fiduciary relationship between aboriginal peoples and the Crown is *sui generis*, the Court appears to accept that non-aboriginal fiduciary law and aboriginal fiduciary law are not separate and distinct. Indeed, in *Wewaykum*, the Court refers to and applies doctrine established in non-aboriginal fiduciary cases. See in particular paras. 80 and 92, where the leading non-aboriginal fiduciary law cases are discussed and applied.

179 *Supra* note 3. The issue before the Court was that of governmental liability for sexual abuse of foster children but the Court made some important observations about the related question of liability of parents for the sexual abuse of their children.

*nor does it have to be her own interests, rather than those of a third party, that she puts ahead of the child's. It is rather a question of disloyalty – of putting someone's interests ahead of the child's in a manner that abuses the child's trust. Negligence, even aggravated negligence, will not ground parental fiduciary liability unless it is associated with breach of trust in this sense.*<sup>180</sup>

If, as appears to be the case, the parent who does not spring into action, that is at least make a good faith effort, to protect an abused child is regarded as “putting someone's interest ahead of the child,” then at least *de facto* the parent's failure to protect the child is *per se* a breach of fiduciary duty. Moreover, Justice McLachlin explicitly approves of the notion, advanced by the defendant in *K.L.B.*, that “disinterest” in potential harm to a beneficiary is a breach of fiduciary duty.<sup>181</sup> However, McLachlin provides no elaboration of the adjective “disinterest” and it remains to be seen what role it will play in future jurisprudence.

What is indisputable, and of considerable import in the hospital context, is the principle set out in *K.L.B.* that a fiduciary's failure to protect a beneficiary from abuse, and this may extend to other threats to safety, is a breach of fiduciary duty. Whether the *K.L.B.* principle is based on the notion that a failure to discharge a material affirmative duty is *per se* a breach of fiduciary obligation or is merely based on the conflict of interest doctrine set out in *K.L.B.*, is of no practical moment in both the parental context and, it is suggested, by parallel reasoning, in the hospital context.

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180 *Ibid.* at para. 49 [emphasis added].

181 In *K.L.B.*, *ibid.* at para. 39, Chief Justice McLachlin discusses each of the parties submissions regarding breach of fiduciary duty. She states: “Where the parties disagree is over the content of the duty that this fiduciary relationship imposes on the government – over what actions and inactions amount to a breach of this duty. The appellants argue that the duty is simply to act in the best interests of foster children. The government, on the other hand, argues for a more narrowly defined duty – a duty to avoid certain harmful actions that constitute a betrayal of trust, of loyalty and of *disinterest*. For the reasons that follow, I conclude that the government's view must prevail.” [emphasis added].

## VII. Breach of Prescriptive Fiduciary Duty By HCPs and Health Care Institutions

There is considerable justification for applying the *K.L.B.* liability principles, applicable to passive parents, to professional service providers in hospitals. In both the parental and hospital contexts, the fiduciary relationships are particularly intense. In both cases the beneficiaries, children and patients, tend to be extremely vulnerable. And in both cases, there is an incontrovertible expectation that the fiduciaries, parents and the professional health service providers, will protect their charges from harm. The historic practices of hospitals, their contemporary policy and practice regimes, and the legislative context in which they provide their services, clearly suggest that the role of both hospitals and health service professionals extends beyond assisting patients with the specific problems that have led to their hospitalization to protecting patients from the wide array of risks that are extant in hospital environments.<sup>182</sup> In addition, from a legal theory perspective, “clarity and integrity”<sup>183</sup> of fiduciary theory is enhanced by extending the *K.L.B.* principles, which require fiduciaries to take active steps to protect beneficiaries, into parallel fiduciary contexts, including the healthcare context. The following observation made by Justice McLachlin in *Peter v. Beblow*, a case concerned with unjust enrichment law, is as persuasive in its application to fiduciary law as it is with respect to the law of unjust enrichment:

*... the creation of special rules for special situations might have an adverse effect on the development of this emerging area of equity. The same general principles should apply for all contexts, subject only to the demonstrated need for alteration .... In short, the concern for clarity and doctrinal integrity with which the Court has long been preoccupied in this area, mandates that the basic principles governing the rights and remedies for unjust enrichment remain the same for all cases.*<sup>184</sup>

While different duties are clearly warranted in the many diverse categories of fiduciary relationships and duty may vary within each category by virtue of different expectations that inform particular relationships, the case for applying the duty of protective intervention to the hospital context

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182 See text at 313-314, above, for a brief description of hospital policies and relevant legislation.

183 *Peter v. Beblow*, [1993] 1 S.C.R. 980 at para. 24, 101 D.L.R. (4th) 621.

184 *Ibid.* [emphasis added].

is compelling. Both logic and policy strongly support the conclusion that health care fiduciaries must actively protect hospitalized patients from harm and danger and also disclose to patients and/or report to hospital authorities incidents of harm.

Both limited empirical and extensive anecdotal evidence about whistle-blowing in hospitals suggest that the principles of prescriptive duty set out in *K.L.B.* are particularly apt and needed in hospital environments. Not surprisingly, within hospitals or for that matter any environment, there is considerable reluctance to whistle-blow against colleagues. The extent of this reluctance appears to be significant, even with respect to wrongdoers who have “committed errors that have potential to cause serious harm” to patients.<sup>185</sup> Reluctance to whistle-blow appears rooted in either or both a desire to protect one’s colleagues and to avoid trouble for oneself.<sup>186</sup> A study done in the Calgary Health Region indicates that 70% of healthcare professionals who work in healthcare institutions believe medical errors go unreported and, of these respondents, 40% indicate that they are “unlikely” to report an error because of the potential embarrassment it will cause.<sup>187</sup> An additional 16% of these respondents indicate that they would not report mistakes for fear of losing their jobs.<sup>188</sup> A later survey conducted in the Edmonton Health Region reports that 77% of “allied health-care workers – those who work with doctors and nurses – said they would report potentially harmful errors, just slightly lower than the 78 per-cent provincial average.”<sup>189</sup>

There is little doubt that whistle-blowing in hospital environments is a high risk activity which can and sometimes does lead to dismissal.<sup>190</sup> A simi-

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185 Jodie Sinnema, “Creating a Quality Work Environment, Results from the HSAA 2006 Work Environment Survey” *Edmonton Journal* (24 November, 2006) reporting on Graham S. Lowe, “Creating a Quality Work Environment: Results from the HSAA 2006 Work Environment Survey” (Edmonton, Alta.: Health Sciences Association of Alberta, 2006) at 44-46, online: Health Sciences Association of Alberta <[http://www.hsaa.ca/news\\_and\\_media/other\\_publications/reports/hsaa\\_sept\\_06\\_2006.pdf](http://www.hsaa.ca/news_and_media/other_publications/reports/hsaa_sept_06_2006.pdf)>.

186 See *Manitoba Report*, *supra* note 132 at 79-80.

187 Barbara Nichols, “Just One Week After Two Calgary Dialysis Patients Died from Being Given the Wrong Drug Solution, the Health Region has Released a Survey” *Canadian Press* (25 March 2004).

188 *Ibid.*

189 *Supra* note 185.

190 Berkeley Rice, “Is whistleblowing worth it?”, online: (2006) Medical Economics

lar point is made in the *Report of the Review and Implementation Committee for the Report of the Manitoba Pediatric Surgery Inquest*, which notes: "Studies suggest that whistleblowers pay a high price in terms of their careers and their personal lives."<sup>191</sup>

One can only conclude that the very conduct which *K.L.B.* earmarks as a breach of fiduciary duty, that is disloyalty in the form of putting one's personal interest or that of a third party ahead of the interests of those to whom fiduciary duty is owed, appears to be a serious problem for patients in hospital environments. Recognizing that whistle-blowing is not only a moral obligation but a legal obligation, it is suggested, is likely to have a salutary effect in hospitals. Such a duty would contribute to the legitimization and institutionalization of whistle-blowing practices and, importantly, nudge hospitals and those who deliver hospital services to take very seriously their paramount duty of loyalty to their patients, including their duty to protect patients from undue risks, incompetent, illegal and unethical behaviour.

## Conclusion

In 1993, legal proceedings were initiated in Manitoba against a number of defendants, including the Victoria General Hospital and an employee of the hospital. The plaintiff alleged that she had been sexually abused by a former school guidance counsellor, that subsequently she had been a patient at the defendant hospital for the purpose of receiving counselling and therapy relating to the sexual abuse and that the hospital's employee, and hence (vicariously) the hospital, "... were both negligent and in breach of their fiduciary duties ... by failing to take *any* reasonable steps to protect her from the harm she was suffering at the hands of the guidance counsellor."<sup>192</sup> The

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<<http://www.memag.com/memag/content/printContentPopup.jsp?id=283068>>. See also Amy Lynn Sorrel, "Delaware physician whistle-blower wins free-speech appeal", online: (2006) 49:8 American Medical News (27 February, 2006), online: American Medical News <<http://www.ama-assn.org/amednews/2006/02/27/gvsc0227.htm>>. In some instances, of course, dismissal of whistle-blowers may be warranted. See, for example, David A. Tammello, "NY: 'whistle-blower' nurse terminated: court fails to find retaliatory termination," Hospital Law's Regan Report, (1 June, 2006), online: AllBusiness <<http://www.allbusiness.com/sector-54/professional-services-legal/1186489-1.html>>.

191 *Supra* note 132 at 80.

192 *Supra* note 72 at para. 1 [emphasis added].

thrust of the plaintiff's claim against the hospital and its employee was that these defendants had failed " ... to prevent the continuation of the abuse until it ceased in or about 1975."<sup>193</sup> The action was ultimately settled by the hospital's insurer on a confidential basis.<sup>194</sup> It is unclear whether the plaintiff could have proven that the defendants took no steps whatever to protect her from the abuse. However, assuming such proof was possible, the theory developed in this article, that hospitals and their professional employees are positively bound to protect patients, suggests that there was a plausible basis for the fiduciary claim asserted in the pleadings. Because the harm suffered by the plaintiff emanated from a source outside of the hospital, the facts of the *Victoria General Hospital* case go beyond the factual pattern that is the focus of this article. Nevertheless, depending on the content of undertakings made by the Victoria General hospital to its patients, it is possible that the scope of the affirmative duty to protect patients from harm, had sufficient breadth to include harm that is externally based.

Principle, policy, analogy, as well as the trend of the fiduciary case law, support the proposition that HCPs and healthcare institutions are fiduciaries for their patients and are legally bound to protect them from a large array of risks within and perhaps even outside of the hospital environment. Ultimately fiduciary duty is based in the concept of loyalty. The obligation of protective intervention is a broad prescriptive manifestation of the fiduciary duty of loyalty which can be discharged, depending on the circumstances, in a myriad of ways. Often, the duty will be discharged by whistle-blowing within an institution or to the authorities. Fiducial loyalty also requires that medical error be disclosed to victims of such error, even when there is no future risk of harm or prospect of further diagnosis or treatment related to the harm. Though the primary responsibility for such a disclosure ordinarily rests on attending physicians, other health care providers who are cognizant of the error, and ultimately hospitals and health care authorities, have a secondary responsibility to communicate the error to the patient.

Whistle-blowing is increasingly gaining public and governmental acceptance and has been recognized as an important, if not indispensable, mechanism for mitigating risk in hospital environments.<sup>195</sup> These environments

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193 *Ibid.*

194 *Ibid.* at para. 2.

195 It has been suggested that nurses in particular require the protection of whistle-blowing policies. See *Manitoba Report*, *supra* note 132, especially at 80-82.

are complex. Hospital whistle-blowing policies must balance a number of critically important interests, including those of good faith complainants, alleged wrongdoers, patients and also, of course, institutional interests.<sup>196</sup> It is beyond the scope of this article to address the particulars of appropriate whistle-blowing policies but clearly such policies should be explicit, at least initially generate an internal process, define the roles and responsibilities of each relevant HCP and administrative personnel, and target not only illegal and unethical conduct, but also negligence and incompetence. Without explicit recognition of a duty to whistle-blow, the culture of silence is likely to continue to compromise patient safety.<sup>197</sup>

Maintaining good morale and a positive cooperative environment within a hospital workforce is important and no small feat for institutions who seek to introduce whistle-blowing policies. A legal duty to whistle-blow within hospital environments will be viewed by some as potentially destructive and at least disruptive of a positive working environment. While this is a serious and genuine concern, the tradeoff, enhancing the safety and security of patients who face real, pervasive and much too often realized peril, is simply transcendent. No doubt, within complex hospital environments, balancing interests requires the development of thoughtful and clear policies which appropriately weigh the paramount interests of very ill and vulnerable patients with vital interests of the many fiduciaries who care for them. So long as patient interests come first and are foremost, there is little doubt that fiduciary law is receptive to this balance.

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Google searches using the term “whistle-blowing” generate hundreds of thousands of “hits” which evidence an increasing trend throughout the common law world to enact whistle-blowing policies and legislation. An “inordinate” number of these hits relate to the health care context.

196 *Ibid.* at 80, 82-84.

197 *Ibid.* at 80.