SUPREME COURT OF YUKON

Citation: *M.S.Z.* v. *Dr. M.,* 2008 YKSC 73

Date: 20081001
S.C. No. 06-A0096
Registry: Whitehorse

Between:

M.S.Z.

Plaintiff

And

DR. M.

Defendant

Before: Mr. Justice L. F. Gower

Appearances:

Susan Roothman and André Roothman — Counsel for the Plaintiff
Nigel L. Trevethan — Counsel for the Defendant

REASONS FOR JUDGMENT

INTRODUCTION

[1] This is an action by the plaintiff, M.S.Z., for medical battery, claiming that the defendant, Dr. M., performed a tubal ligation on her without her consent. More specifically, Ms. Z. claims that, because she was sexually sterilized by Dr. M. without her consent, then the medical battery constitutes a sexual assault. She claims general, special, and aggravated damages as a result.

[2] Dr. M. says that he performed the tubal ligation after completing a Caesarean section on Ms. Z., and that both procedures were performed with her consent. In particular, Dr. M. says that Ms. Z. had requested a tubal ligation at the same time as her

intended Caesarean section on several occasions prior to the surgery. Dr. M. also says that Ms. Z. has incorrectly pleaded her claim as "sexual assault", when her allegations, although denied, can only give rise to an action for medical battery at best. Further, as her claim for medical battery was commenced after the two year limitation period, it is statute barred.

[3] A pre-trial order was made, at the request of Ms. Z., prohibiting the publication or broadcast of any information which could disclose the identity of the parties.

ISSUES

[4] The following issues arise in this trial:

1. Is the plaintiff's action barred by the *Limitation of Actions Act*?

2. If the plaintiff's claim is not statute barred, then did she consent to the tubal ligation?

3. Is there a further requirement upon Dr. M. to prove that the plaintiff provided her "informed consent" to the tubal ligation?

4. If Dr. M. is liable, what are the plaintiff's damages?

SUMMARY OF THE FACTS

[5] Ms. Z. is presently 33 years old and has been in a relationship with her common law spouse, K.G., for approximately ten years. They have two children, J., 13 years old, who is a child from Ms. Z.'s previous relationship, and B., who is 8 years old and is the biological child of Ms. Z. and K.G. Both J. and B. were delivered by Caesarean section (alternatively, "C-section"). Ms. Z. also delivered two other children by C-section, who

died shortly after birth. Both were complicated pregnancies and both children were born prematurely on January 2, 2002 and December 30, 2002, respectively.

[6] Dr. M. is a physician who qualified as a specialist in obstetrics and gynaecology in 1981 and has practiced in the Yukon since 1994. He was one of Ms. Z.'s treating physicians during her last three pregnancies. These pregnancies were complicated by Ms. Z.'s insulin-dependant Type I diabetes, which she has had since childhood. Dr. M. delivered Ms. Z's second child, B., by C-section. During her third and unplanned pregnancy, Ms. Z. was again referred to Dr. M. by her family physician. She was admitted to Whitehorse General Hospital ("W.G.H.") for a rupture of membranes and loss of amniotic fluid on December 10, 2001, and remained in hospital for seven days bed rest. Ms. Z. was discharged on December 17, 2001, but re-admitted on January 8, 2002 for a spontaneous rupture of membranes and vaginal bleeding. Ms. Z. was transferred to the Royal Columbian Hospital in British Columbia, where an emergency Caesarean section was performed by Dr. Waterman on January 9, 2002. A live infant boy was delivered at 25 weeks gestation, but died shortly after birth.

[7] On October 25, 2002, Ms. Z. was again referred to Dr. M. for management of her fourth, and again unplanned, pregnancy. An examination showed that she had lost most of the amniotic fluid around the fetus. Dr. M. transferred Ms. Z. to the B.C. Women's Hospital for further assessment, where she was seen by Dr. L. on November 15, 2002. Dr. L.'s prognosis for the fetal outcome was poor and he estimated her chances of successfully delivering a live infant to be in the 25-30% range.

[8] On December 30, 2002, Ms. Z. attended at the Whitehorse General Hospital fully dilated at 29 weeks gestation, with the fetus in breech position. Dr. M. performed a

Caesarean section and a tubal ligation, with a family physician assisting. An infant boy was delivered in poor condition and died soon after birth.

[9] On May 13, 2005, Ms. Z. was referred to Dr. M. for consultation about a possible reversal of the tubal ligation. Ms. Z. was seen by Dr. M.'s partner in medical practice, on July 27, 2005, to discuss a possible reversal.

[10] Ms. Z. commenced this lawsuit on October 18, 2006.

ANALYSIS

1. Is the plaintiff's action barred by the *Limitation of Actions Act?*

[11] Dr. M. says that Ms. Z.'s claim was not commenced within the two year limitation period in the *Limitation of Actions Act*, R.S.Y. 2002, c. 139, and is therefore statute barred. The relevant portions of that *Act* are as follows:

> 2(1) Subject to subsection (3), the following actions shall be commenced within and not after the times respectively hereinafter mentioned
>
> …
>
> (d) …actions for trespass to the person, assault, battery … whether arising from an unlawful act or from negligence, …within two years after the cause of action arose…
>
> …
>
> (3) The following actions are not governed by any limitation period and may be brought at any time
>
> (a) a cause of action based on misconduct of a sexual nature, including without limitation, sexual assault,
>
> (i) when the misconduct occurred while the person was a minor, and
>
> (ii) whether or not the person's right to bring the action was at any time governed by a limitation period;

> (b) a cause of action based on sexual assault, whether or not the person's right to bring the action was at any time governed by a limitation period." (my emphasis)

[12] If Ms. Z.'s claim gives rise only to a cause of action in battery, more specifically, medical battery, then it is barred because it was not commenced within two years after the date the cause of action arose. That date was, at the latest, on January 2, 2003, when Ms. Z. claims she was informed the tubal ligation had been done. Whether or not a claim is statute barred is not subject to the discretion of the court. If the action was not brought within the time period specified in the *Limitation of Actions Act*, then that is the end of the matter: *Grayson* v. *Canada Safeway Limited*, [1981] 2 W.W.R. 321 (B.C.C.A.) at p. 323.

[13] Ms. Z.'s counsel submits that sexual sterilization without consent constitutes a "sexual assault" and that there is no time limitation on when that cause of action can be commenced. In support of this submission, counsel relies exclusively on the case of *D.E. (Guardian ad litem of)* v. *British Columbia,* 2005 BCCA 134. *D.E.* was an appeal by 18 former patients of a Provincial Mental Hospital claiming that three former superintendents of that institution abused their public office in recommending the sterilization of the patients by tubal ligations and vasectomies, under the authority of the *Sexual Sterilization Act*, S.B.C. 1933, c. 59, which was repealed in 1973. The surgeries were carried out between 1933 and 1968. The trial judge had found that the ultimate limitation period of 30 years in s. 8(1)(c) of the *Limitation Act*, R.S.B.C., 1996, c. 266 applied, as the patients' claims arising from their sterilization did not constitute a "sexual assault". Therefore, one of the issues before the British Columbia Court of Appeal was whether or not the cause of action was based in sexual assault, as the British Columbia legislation, like Yukon's,

provided that no limitation period applied to a cause of action based on “sexual assault” (s. 3(4)(l) of the B.C. *Act*). The other issue on the appeal was whether there was evidence that the former superintendents committed the tort of misfeasance in a public office by wrongly and knowingly exercising their discretion under s. 4(1) of the *Sexual Sterilization Act*, in recommending the sexual sterilization of a number of the appellants.

[14] Mr. Justice Donald, with whom Huddart J.A. agreed, considered the misfeasance issue at length. Indeed, the bulk of his reasons (paras. 1–69) dealt with that question and only in the final nine paragraphs did Donald J.A. address the limitation issue. There, he recognized that the appellants’ actions would be barred by the ultimate 30 year limitation period, unless they could characterize their cause of action as based on sexual assault. At para. 72, he stated:

> “There does not seem to be much doubt that an unlawful sterilization is an assault. I think that it is also clear that if the sterilization was procured by an improper recommendation, the cause of action brought against the person making the recommendation is based on an assault. The real controversy is whether the assault is a sexual assault within the meaning of s. 3(4)(l) of the Limitation Act.”

[15] At para. 73, Donald J.A. noted that the trial judge used an objective test in resolving the above question and relied on *R.* v. *Chase*, [1987] 2 S.C.R. 293 in concluding that a reasonable observer would not see the “sexual or carnal context” of these assaults. Donald J.A. disagreed with the trial judge in that approach. He referred to *R.* v. *K.B.V.*, [1993] 2 S.C.R. 857, where the Supreme Court restored the verdict of a trial judge who had found a father guilty of sexually assaulting his small son by grabbing his genitals as a form of discipline. Donald J.A. interpreted *K.B.V.* as holding that there need not be a carnal element or an aspect of sexual gratification in an act for it to be

sexual in nature. He then went on to express his opinion, at para. 74, that "the sexual nature of sterilization is beyond argument" and that "state actors took away an essential facility of the patients' sexuality." Later, at para. 78, Donald J.A. said that the central question posed by *R.* v. *Chase* was whether "the sexual integrity of the victim is violated" and that "[s]ince procreation is an integral part of a person's sexuality, I do not know how it can be reasonably said that an unlawful sterilization is not such a violation."

[16] Donald J.A. also addressed *Arishenkoff* v. *British Columbia*, 2004 BCCA 299, which was a case involving a number of children who were apprehended from Doukhobor parents in the 1950s. There were allegations of physical and sexual assaults upon the children while they were in the custody of the state. One of the plaintiffs, P., alleged physical abuse, but not sexual abuse. At trial, P.'s claims were dismissed as being statute-barred. P. argued that the distinction between victims of non-sexual child abuse and those of sexual child abuse constituted discrimination under the *Charter*. In dismissing this argument, the Court of Appeal in *Arishenkoff* quoted from Hansard, where the Attorney General, in proposing the amendment to remove limitation periods from child sexual abuse, cited delays resulting from fear of disclosure and suppression of memory as a reason why a time limit is unjust. In the result, the Court of Appeal held that there was a legitimate distinction between child victims of sexual abuse and those suffering other forms of non-sexual abuse, and that the amendments to s. 3 of the British Columbia *Limitation Act,* eliminating the limitation period for child sexual abuse "provides a particular benefit tailored to alleviate a particular harm" (at para. 137).

[17] Donald J.A. further noted that s. 3(4)(l) of the British Columbia *Limitation Act* was added two years after the provision discussed in *Arishenkoff* [s.3(4)(k)] and, unlike that

section, is not limited to children. He acknowledged the argument made by the respondent that the sterilization of the plaintiffs did not occur in circumstances where one would expect delays in reporting to occur, as is the case with sexual abuse. However, ultimately Donald J.A. did not find *Arishenkoff* helpful and stated, at para. 77, that while "children are weak and vulnerable" and may not report abuse soon after a triggering event, "so are mental patients, indeed in many ways they are more vulnerable than children."

[18] The respondent in *D.E.* also argued that if this type of sexual sterilization constitutes sexual assault, then any surgical errors involving a reproductive or sexual organ could constitute a sexual assault. Donald J.A. dismissed that argument, stating, at para. 75:

> "…medical negligence is not assault. However, where a surgeon operates on a reproductive or sexual organ without any lawful authority, I see no injustice in fixing liability for sexual assault. "

[19] With great respect, this conclusion does not completely answer the concern raised by the respondent. Donald J.A. commented earlier, at para. 72, that "an unlawful sterilization is an assault" (my emphasis), and therefore could give rise to a claim in battery, which is a form of assault, in the sense that it is a non-consensual trespass to the person. While such claims may also give rise to a cause of action in "medical negligence", they would not necessarily be restricted to such a cause of action. Consequently, in my respectful opinion, there would be a possibility of great injustice if courts adopt the proposition that physicians performing procedures on reproductive or sexual organs without consent are liable for "sexual assault", as it would result in potential absurdities in the application of limitation periods to actions for medical battery.

Specifically, claims for medical battery based on medical procedures performed without consent on a reproductive or sexual organ would be exempted from the application of any limitation period, while claims for medical battery involving other body parts would be subject to the two year limitation period under s. 2(1)(d) of the Yukon *Limitation of Actions Act*. Further, courts may be required to determine whether a given organ or body part is reproductive or sexual in nature, for example, the male breast, the prostate, or even the brain. This would also give rise to the very real possibility that certain medical specialists, such as those in obstetrics/gynaecology and urology, will have to defend claims of battery indefinitely, while other physicians focusing on other parts of the body will have the benefit of the two year limitation defence.

[20] In *N.C.* v. *Blank*, [1998] O.J. No. 2544 (Ont. Court of Justice), the court considered the policy rationales for limitation periods at paras. 101, 103 and 105:

> "101. In *M.(K.)* v. *M.(H.)*, *supra*, La Forest J. explores the three main policy rationales for limitation periods: (1) the need on the part of a defendant that after the passage of a certain amount of time, he or she will not be held to account for past conduct; (2) the desire to foreclose claims based on stale evidence; and (3) the desire to encourage potential litigants to pursue their rights in a timely fashion. He concludes that they have little bearing in establishing limitation periods in cases of incest; and I conclude likewise in regard to cases of sexual abuse of a client by a therapist.
>
> …
>
> 103. Limitation periods exist to meet the valid concerns of defendants; however, the court must apply limitation periods in a manner that is fair to plaintiffs. It is patently unreasonable to require a plaintiff to commence an action before the plaintiff realizes he or she has a cause of action. That lack of realization can result from many factors, such as a lack of knowledge of who was responsible for the damages suffered or a lack of appreciation that injuries of the magnitude justifying legal recourse were suffered. (See *Peixeiro* v. *Haberman*, [1997] S.C.J. 31).

…

> 105. The fact that in some cases of sexual assault a full appreciation of the harm done and the source of that harm can only be gained by the victim "after lengthy therapy or several therapeutic relationships" was recognized by McLachlin J. in *M.(K.)* v. *M. (H.)*, *supra* at p. 340."

[21] Excerpts from Hansard illustrate that the intention of the Yukon legislature, in removing limitation periods for causes of action based upon "sexual assault" and "sexual misconduct", was to recognize that sexual assault victims often suffer psychological trauma which renders them incapable of acting with the diligence expected of other types of victims. However, there is no suggestion at all that legislature intended to exclude a class of medical battery claims (for performing procedures on reproductive or sexual organs without consent) from the operation of the limitation period in s. 2(1)(d) of the *Limitation of Actions Act*. I refer here to Hansard excerpts from November 5 and 9, 1998, respecting Bill No. 59 – an *Act to Amend the Limitation of Actions Act.* On November 5, at the second reading of the Bill, the Honourable Ms. Moorcroft, then Minister of Justice, commented:

> "The reasons why childhood survivors of sexual assault and sexual misconduct may fail to bring timely actions against their abusers are complicated. It depends in large part on the dynamics of sexual abuse. There is the harm arising from the abuse itself, such as anxiety, remorse, shame, feelings of inferiority and negative self-esteem. There is also the harm arising after the fact and lasting well into adulthood, including depression, exaggerated mistrust, anger, hostility, intense guilt and self-destructive behaviour, such as addictions or even suicide.
>
> This picture shows why victims of childhood sexual abuse have difficulty in bringing actions against their abusers within the prescribed limitation periods. Memories can become blocked. Victims may have little or only subconscious knowledge of the abuse, or may recall it but cannot confront it. Memories may be

> suppressed. Victims may recall the event but avoid doing so until it's less dangerous to recognize the abuse. Whatever the defensive mechanism adopted, each is a survival strategy likely to result in a gradually diminishing or indefinitely delayed stress reaction.
>
> The picture is not significantly different for survivors who suffered sexual assault as adults.
>
> …
>
> Mr. Speaker, we must take this step. We must make clear that sexual abuse will not be tolerated and we must show that its victims will be heard. **The reality of survivors is that almost all of them are unable to comply with the current limitation period. It may take years to recognize and appreciate the critical relationship between the abuse they experienced and the profound effect it's had on their lives.**
>
> While courts are becoming more receptive to arguments that address the plight of these victims, it's important that we don't leave barriers in place, barriers that have the effect of denying victims their day in court. **The simple fact is that limitation periods were not drafted with victims of sexual abuse in mind. It's time to revisit that omission and to help in the healing process.** (my emphasis)

On November 9, during debate on the Bill, the Minister added:

> The removal of the limitation of actions is designed to make it possible for victims of sexual assault or sexual misconduct to bring forward an action and not be subjected to the existing two – year time period. Other jurisdictions in Canada have brought this forward. **We want to make sure that the force of law is available to survivors of sexual abuse through civil remedies."** (my emphasis)

[22] In my view, victims of medical battery do not suffer from the same types of trauma, disabilities or frailties commonly experienced by sexual abuse victims. Thus, it is reasonable to expect that the victims of medical battery should be able to commence their actions within the two year limitation period.

[23] While decisions of the British Columbia Court of Appeal are of great persuasive value in the Yukon, as the members of that Court also sit on the Yukon Court of Appeal, strictly speaking, its decisions are not binding upon this Court. Consequently, with great respect, I choose not to follow the majority in *D.E.* for the following reasons.

[24] First, the focus of *D.E.* was on the potential liability of the former superintendents for having recommended sexual sterilization. It was not upon the potential liability of the physicians who performed those operations. This may explain why the 'absurd consequence' argument set out above was not fully considered by Donald J.A.

[25] Second, to the extent that Donald J.A. noted the rationale for the removal of limitation periods for child sexual abuse and the argument that the sterilizations in *D.E.* did not occur in circumstances where one would expect delays in reporting to occur, he seemed to dismiss *Arishenkoff* for the policy reason that mental patients who were wrongfully sterilized should be afforded the same protection as child sexual abuse victims. However, that rationale fails to account for the potentially large class of patients of sound mind who claim to be victims of medical battery involving sexual or reproductive body parts. According to *D.E.*, this class would have an unlimited opportunity to make claims, when all other victims of nonsexual medical battery must bring their claims within two years.

[26] Third, Donald J.A. gave no consideration to the case of *Reibl* v. *Hughes*, [1980] 2 S.C.R. 880, where Chief Justice Laskin, speaking for the Supreme Court of Canada, was dealing with medical battery and made no distinction between surgeries related to sexual or reproductive organs and surgeries related to some other body part. At pp. 890–891,

Laskin C.J. said:

> "…In my opinion of battery in respect of surgical or other medical treatment should be confined to cases where surgery or treatment has been performed or given to which there has been no consent at all or where, emergency situations aside, surgery or treatment has been performed or given beyond that to which there was consent.
>
> This standard would comprehend cases where there was misrepresentation of the surgery or treatment for which consent was elicited and a different surgical procedure or treatment was carried out. See for example *Marshall* v. *Curry* [1933] D.L.R. 260 60 C.C.C. 136 **(consent given to operation to cure hernia; doctor removes patient's testicle; action in battery)**; *Murray* v. *McMurchy* [[1949] 2 D.L.R. 442.] **(consent given to a caesarian operation; doctor goes on and sterilizes the patient; doctor liable for trespass to the person)**; *Mulloy* v. *Hop Sang* [[1935] 1 W.W.R. 714.] (doctor told to repair hand and not to amputate; performs amputation; held liable for trespass); *Winn* v. *Alexander and the Soldiers' Memorial Hospital* [[1940] O.W.N. 238.] **(consent given to caesarian; doctor goes further and sterilizes the patient)**; *Schweizer* v. *Central Hospital et al.* [(1974), 53 D.L.R. (3d) 494.] (patient consented to operation on his toe; doctor operated on back instead (spinal fusion); doctor liable for trespass to the person). (my emphasis)

As can be seen, all of the examples in this passage, including those on sexual body parts, are classified as constituting battery or trespass to the person and not sexual assault.

[27] Lastly, a number of cases since *Reibl* v. *Hughes* have said that a physician who sterilizes a patient by tubal ligation without consent commits battery. None of those decisions found the physician liable for sexual assault:

> *Johnson* v. *Boyd*, [1996] B.C.J. No. 3003 (C.A.)
> *Parotta* v. *Yeung*, [2003] BCSC 1305
> *Hadley* v. *Allore*, [1988] 63 O.R. (2d) 208 (C.A.)
> *Adan* v. *Davis*, [1998] O.J. No. 3030 (Prov. Ct.)
> *Kanis* v. *Sinclair*, [1989] B.C.J. No. 606 (S.C.)

Indeed, I have not discovered any case which has relied upon *D.E.* for the proposition that a non-consensual medical procedure on a sexual or reproductive organ constitutes a sexual assault.

[28] On the other hand, Saunders J.A. delivered a persuasive dissenting judgment in *D.E.* At para. 83 she agreed with the trial judge's interpretation of *R.* v. *Chase*, as applied to the facts in *D.E.*, that:

> "…no sexual or carnal context would have been apparent to anyone involved in the sterilization of the plaintiffs. From the perspective of the physicians performing them, the sterilizations were strictly medical procedures authorized by the Board of Eugenics. From the perspective of the superintendents who recommended them, the sterilizations were surgeries performed as a means of birth control authorized by statute…"

[29] Saunders J.A. also gave greater weight to the comments of the Attorney General in Hansard from 1992 when the amendment to the B. C. *Limitation Act* was enacted to remove the limitation period for "misconduct of a sexual nature" upon children. In 1994, the Attorney General again spoke about the present s. 3(4)(l), which removed the limitation period for sexual assault involving adult victims. At para. 88 Saunders J.A. quoted part of the Attorney General's remarks to the legislature:

> "Section 1 [present s. 3(4)(l)] will allow adult victims of sexual assault to pursue civil legal action at any time. This amendment recognizes that many factors may operate to prevent adult victims of sexual assault from bringing legal action within the limitation periods in the current act. The victim may believe that the abuser has done nothing wrong, particularly in relationships of trust, dependency or authority. The victim may be living in fear of the abuser or may be psychologically incapable of confronting the assault within the limitation period. This amendment ensures that these factors do not result in the victim losing the opportunity to seek redress through a civil action."

Those remarks are very similar to the ones I quoted above from the Yukon legislature in relation to the equivalent amendments to our legislation.

[30] Saunders J.A., at para. 90, also went on to consider the wording of paras. 3(4)(k) and 3(4)(l). She noted that para. (k) refers to "misconduct of a sexual nature including … sexual assault":

> "…That is, sexual assault is a species of misconduct of a sexual nature, a subset of that larger body of wrongs. The phrase "misconduct of a sexual nature" thus helps to define the term "sexual assault" as used in s. 3(4)(k). At a minimum, it includes a degree of personal moral failure. The provision in issue in this case includes the same phrase "sexual assault". In interpreting the phrase we may consider that the legislators intended like words in the section to bear like meaning." (my emphasis)

The wording of s. 2(3)(a) and (b) of the Yukon *Limitation of Actions Act*, is virtually identical to that of its British Columbia equivalent. Therefore, the interpretation of Saunders J.A. above is equally applicable to the Yukon legislation.

[31] Further, Saunders J.A. considered *Reibl* v. *Hughes*, and noted, at para. 91, that it referred to cases involving operations which affected patients' reproductive ability or genitalia as "battery" claims. Saunders J.A. also acknowledged *Non-Marine Underwriters, Lloyd's of London* v. *Scalera,* 2000 SCC 24, which recognized that "sexual battery" is a subset of the general tort of battery. She also observed that, although the *Limitation Act* refers to sexual assault, with respect to the facts in *D.E.* "we are more correctly dealing with alleged sexual battery".

[32] Finally, Saunders J.A. dealt with *R.* v. *K.B.V.,* cited above, where the offender had disciplined his young son by grabbing his genitals. There, the Supreme Court held that "it was clearly open to the trial judge to conclude from all the circumstances that the assault was one of a sexual nature and … that the sexual integrity of the appellant's son was

violated." Of course, *R.* v. *K.B.V.* came after *R.* v. *Chase*, which Saunders J.A. quoted at para. 93, as describing sexual assault in the following terms:

> "The landmark cases on sexual assault are *R.* v. *Chase*, [1987] 2 S.C.R. 293, and *R.* v. *K.B.V.* (1992), 71 C.C.C. (3d) 65 (Ont. C.A.), appeal dismissed, [1993] 2 S.C.R. 857. In *R.* v. *Chase* McIntyre J. described sexual assault in these terms:
>
> > [11] Applying these principles and the authorities cited, I would make the following observations. Sexual assault is an assault within any one of the definitions of that concept in s. 244(1) of the Criminal Code which is committed in circumstances of a sexual nature, such that the sexual integrity of the victim is violated. The test to be applied in determining whether the impugned conduct has the requisite sexual nature is an objective one: Viewed in the light of all the circumstances, is the sexual or carnal context of the assault visible to a reasonable observer" (*Taylor*, [1985] A.J. No. 821, per Laycraft C.J.A., at p. 269). The part of the body touched, the nature of the contact, the situation in which it occurred, the words and gestures accompanying the act, and all other circumstances surrounding the conduct, including threats which may or may not be accompanied by force, will be relevant (see S.J. Usprich, "A New Crime in Old Battles: Definitional Problems with Sexual Assault" (1987), 29 Crim. L.Q. 200, at p. 204.) The intent or purpose of the person committing the act, to the extent that this may appear from the evidence, may also be a factor in considering whether the conduct is sexual. If the motive of the accused is sexual gratification, to the extent that this may appear from the evidence, it may be a factor in determining whether the conduct is sexual. It must be emphasized, however, that the existence of such a motive is simply one of many factors to be considered, the importance of which will vary depending on the circumstances." (my emphasis)

[33] In *R.* v. *K.B.V.*, the Supreme Court discounted the importance of sexual gratification as a factor. It did not expressly state that the absence of a carnal context could not be considered in the analysis. Rather, as Osborne J.A. put it for the majority in the Ontario Court of Appeal (1992), 71 C.C.C. (3d) 65 (Ont. C.A.), at para. 10:

> "… A sexual assault does not require sexuality and, indeed, may not even involve sexuality. It is an act of power, aggression and control. In general, sexual gratification, if present, is at best a footnote."

One can readily imagine the types of scenarios Osborne J.A had in mind with these words, but it seems to me they are wholly inapplicable to the facts in *D.E.*

[34] Rather, the comments of Saunders J.A., at para. 96 of *D.E.*, seem more appropriate:

> "…the term "sexual assault" used in connection with a cause of action carries with it an aspect of sexual or carnal behaviour or, failing that as in the unusual case of *R.* v. *K.B[V.]*., an aspect of overt aggression or other misconduct involving the sexual integrity of the recipient." (my emphasis)

Saunders J.A. concluded, at para. 97, that:

> "…the aspect of sexual or wrongdoing on the part of the medical personnel that would elevate the surgeries from assaults (or battery) to sexual assault is in my view, absent. The complaint is of "medical battery"…"

I agree with this reasoning.

[35] Accordingly, I conclude that Ms. Z's claim is one of medical battery and not sexual assault. As such, the two year limitation period in s. 2(1)(d) of the *Limitation of Actions Act* applies.

[36] Ms. Z. admits that, on the date of her discharge from the W.G.H. on January 2, 2003, she was told that Dr. M. had performed a tubal ligation on her at the same time as her C-section on December 30, 2002. Consequently, she had a full appreciation of the harm done and the source of that harm as of January 2, 2003. Therefore, she should have commenced her action by no later than January 2, 2005. She failed to do so and her claim is now statute barred.

2. If the plaintiff's claim is not statute barred, then did she consent to the tubal ligation?

Background

[37] In the event that I am wrong in finding that Ms. Z.'s claim is statute barred, I will go on to address the issue of whether she consented to the tubal ligation.

[38] The Supreme Court of Canada recognized in *Ciarlariello* v. *Schacter* (1993), 100 D.L.R. (4th) 609, at para. 39, that a patient has autonomy over their bodily integrity:

> "…This encompasses the right to determine what medical procedures will be accepted and the extent to which they will be accepted. Everyone has the right to decide what is to be done to one's own body. This includes the right to be free from medical treatment to which the individual does not consent. This concept of individual autonomy is fundamental to the common law and is the basis for the requirement that disclosure be made to a patient. If, during the course of a medical procedure a patient withdraws the consent to that procedure, then the doctors must halt the process. This duty to stop does no more than recognize every individual's basic right to make decisions concerning his or her own body."

Thus, medical treatment administered without consent, save in exceptional circumstances, constitutes the tort of battery. The onus of establishing that there has been consent is on the physician who performed the medical procedure.

[39] To be clear, although the onus is on Dr. M. to prove that Ms. Z. consented to the tubal ligation, he is not required to show that Ms. Z. gave her written consent to that procedure. Dr. von Dadelszen was qualified as an expert in obstetrics, including the management of high risk pregnancies and the consent process involved in obtaining medical consents for Caesarean sections and tubal ligations. His written report included the following:

> "At the time of a true obstetric emergency at 29 weeks' gestation, with a breech presentation and full dilation, the gathering a of written consent of any form is not always manageable, and, …may not fully reflect the verbal interaction. Dr. M.'s contemporaneous written record states that he was requested to perform the tubal ligation, and had gained informed consent – he was certain enough of that to reassure a nursing colleague that verbal consent had been obtained at the time that clarification was requested. The nature and substance of this discussion…reflect the more than adequate nature of this interaction." (my emphasis)

[40] In *Reibl* v. *Hughes*, cited above, the Supreme Court of Canada concluded that actions for medical battery should be confined to cases where there was no consent at all, where the treatment went beyond the scope of the consent, or where the consent was obtained by misrepresentation or fraud. Further, the Court went on to say that the failure of a physician to disclose the attendant risks of a procedure is a breach of the duty of care which goes to negligence rather than to battery. In other words, a failure to obtain "informed consent" is not a test of the validity of the consent which a defendant physician must prove when sued for medical battery. Chief Justice Laskin made this clear, at pp. 891 and 892 [S.C.R.]:

> "In situations where the allegation is that attendant risks which should have been disclosed were not communicated to the patient and yet the surgery or other medical treatment carried out was that to which the plaintiff consented (there being no negligence basis of liability for the recommended surgery or treatment to deal with the patient's condition), I do not understand how it can be said that the consent was vitiated by the failure of disclosure so as to make the surgery or other treatment an unprivileged, unconsented to and intentional invasion of the patient's bodily integrity. I can appreciate the temptation to say that the genuineness of consent to medical treatment depends on proper disclosure of the risks which it entails, but in my view, unless there has been misrepresentation or fraud to secure consent to the treatment, a failure to disclose the attendant risks, however serious, should go to negligence rather than to battery. Although such a failure relates to an informed choice of submitting to or refusing recommended and appropriate treatment, it arises as the breach of an anterior duty of due care, comparable

> in legal obligation to the duty of due care in carrying out the particular treatment to which the patient has consented. It is not a test of the validity of the consent. " (my emphasis)

[41] Ms. Z. testified that she did not consent to the tubal ligation and that she did not have the capacity to consent. She does not allege that her consent was obtained by Dr. M. through misrepresentation or fraud. Dr. M. testified that Ms. Z did consent to the procedure, on more than one occasion, and that he would not have performed the operation without her consent. Thus, my determination as to whether or not consent was given turns on the credibility of the parties and the other witnesses who testified at the trial.

[42] My analytical approach to the question of credibility must begin by observing the comments of the British Columbia Court of Appeal in *Faryna* v. *Chorney*, [1952] 2 D.L.R. 354. That case advises trial courts to consider the context of the factual matrix in assessing credibility; that is, to examine the consistency of a given piece of evidence with the probabilities that exist in the surrounding circumstances. At p. 357, the Court held that:

> "The credibility of interested witnesses, particularly in cases of conflict of evidence, cannot be gauged solely by the test of whether the personal demeanour of the particular witness carried conviction of the truth. The test must reasonably subject his story to an examination of its consistency with the probabilities that surround the currently existing conditions. In short, the real test of the truth of the story of a witness in such a case must be its harmony with the preponderance of the probabilities which a practical and informed person would readily recognize as reasonable in that place and in those conditions…"

This analytical approach was applied by Kelleher J. in *Ward* v. *Mackie,* 2004 BCSC 1019, and *Raina* v. *Shaw,* 2006 BCSC 832.

[43] I must also keep in mind the law regarding evidence of invariable practice. In *Belknap* v. *Meakes*, (1989) 64 D.L.R. (4th) 452, Seaton J.A., speaking for the British Columbia Court of Appeal, said at p. 465–466:

> "If a person can say of something he regularly does in his professional life that he invariably does it in a certain way, that surely is evidence and possibly convincing evidence that he did it in that way on the day in question."

[44] In *Raina* v. *Shaw*, cited above, Kelleher J. made a similar comment, at para. 72:

> "…Professionals often testify about what they asked or told a client or patient based on their invariable standard practice. It is an admissible substitute for present recollection and can be convincing evidence."

Ms. Z.'s Evidence

[45] The plaintiff was 27 years old when the tubal ligation was done on December 30, 2002. At the time of the trial she was employed as a department manager with a major retail store in Whitehorse. She was born and raised in Manitoba, and while living in that province she worked as a nurses' aide in a seniors' home and at the Health Sciences Centre in Winnipeg on the surgical ward. She is partially qualified as a licensed practical nurse. She did not appear to be someone who is unsophisticated or unintelligent. However, I agree with Dr. M.'s counsel that there were a number of frailties in her evidence, such as her inability to recall critical details, the inconsistencies between her evidence and that of other witnesses and the documentary evidence, the improbability of some of her testimony and her occasional dishonesty with some of her health care providers.

Plaintiff's Lack of Recollection

[46] Dr. M. testified that there were three occasions on which Ms. Z. indicated her consent to the tubal ligation. The first was during her appointment with him on October 28, 2002. The second was during a follow-up appointment on November 4, 2002. The third was on December 30, 2002, immediately preceding the C-section and tubal ligation surgery. Therefore, the evidence of the parties about their conversations on each of these three occasions is critical to my determination of the issue of consent. In addition, there were two other witnesses who testified about their dealings with Ms. Z. at Whitehorse General Hospital on December 3, 2002, and their evidence is similarly critical.

[47] Regarding the appointment on October 28, 2002, in direct examination, Ms. Z. was shown the letter from her family physician, Dr. A., to Dr. M., dated October 25, 2002, in which Dr. A. said she was referring Ms. Z. to Dr. M. for consultation relating to her fourth unplanned pregnancy. Dr. A. noted in that letter that it had been suggested to Ms. Z. in the spring of 2002 "to have a tubal ligation". When Ms. Z. was asked whether she discussed the issues raised in Dr. A.'s letter with Dr. M., she replied affirmatively, but gave no specific evidence about the date that discussion occurred. She recalled Dr. M. discussing her diabetes and asking her about having a tubal ligation. However, with respect to the tubal ligation, Ms. Z. she said she told him that she wasn't sure if she did or did not want it done.

[48] Ms. Z. gave no direct evidence about the appointment of November 4, 2002. She did volunteer some evidence about an appointment with Dr. M. where she discussed her

consultation with Dr. L. in Vancouver, but that had to have been after November 15, 2002, which was the date of Dr. L.'s consultation.

[49] It was only in cross-examination that Ms. Z. said she remembered having her first appointment with Dr. M. on October 28, 2002 regarding the fourth pregnancy. She said that she was "pretty sure" that Dr. M. asked her about having a tubal ligation and that they discussed her fourth pregnancy as being "so soon after the last pregnancy", which tragically ended in an emergency C-section and the death of that child in January 2002. That was the extent of her recollection of the appointment of October 28, 2002. As a result, by her own admission, she cannot contradict the evidence of Dr. M. as to the nature of the discussions which took place between them on that occasion.

[50] Ms. Z. was also cross-examined about the appointment on November 4, 2002. It was suggested to her that this was arranged to discuss with Dr. M. the results of an ultrasound examination a few days earlier. It was further suggested that Dr. M. was planning to transfer her to a hospital in Vancouver for a more detailed assessment and that he told her he was going to include in a letter to the Vancouver physician information about her desire for a tubal ligation. Ms. Z. testified that she did not recall that discussion. Again, this prevents her from contradicting Dr. M.'s evidence on those discussions that day.

[51] As for the events on December 30, 2002, Ms. Z. testified that she had no recollection of any events at the hospital after being wheeled to the elevator from the maternity ward, en route to the operating room, except perhaps for the anaesthetist telling her "we've got to put you out". The next thing she remembered was waking up in either the operating room or the recovery room after the operation. As a result, she was

not able to contradict what Dr. M. may have said or not said to her, and what she said or did not say in response, prior to the operation.

Inconsistencies and Improbabilities

[52] Ms. Z. testified that she told Dr. M. at "every appointment" with him regarding the fourth pregnancy, that she was unsure about having the tubal ligation done. In particular, she said that she told Dr. M. if there was something wrong with the baby then she did not want the tubal ligation, but that if the baby was okay (i.e., delivered successfully), then she would consider it. She further testified that she repeated these same instructions to her family physicians, including Drs. A. and K., at "every single appointment" with them. This evidence is inconsistent with the notes and recollections of Drs. M., A. and K., who each testified that they received no such instructions. Also, all three doctors testified that if Ms. Z. had provided these instructions, they would have documented them in their respective notes.

[53] Ms. Z. also testified that, at no time did Dr. M. explain anything to her about the details of a tubal ligation, including the risks and the various surgical options involved. This seems improbable and somewhat inconsistent, given her evidence that Dr. M. continually mentioned the tubal ligation at "pretty much every appointment" she had with him during the fourth pregnancy. It is also externally inconsistent with Dr. M.'s evidence that he did discuss with Ms. Z. the immediate and long term risks of her pregnancy versus the tubal ligation, as well as the types of tubal ligation procedures which could be performed. Dr. M. recalled that he went into his "routine discussion" with Ms. Z. about the matter. He also testified that it was his invariable practice to discuss this information with any patient interested in a tubal ligation.

[54] Ms. Z. signed two consent forms upon her admission to W.G.H. on December 30, 2002. One is a “Consent for Admission to Hospital” form, which has the time typed in, presumably by a receptionist, as “0123”, or 1:23 a.m. The other form is entitled “Consent to Operate or Other Procedure and Consent to Anaesthesia” and has a time inserted in hand writing as “0130”, or 1:30 a.m. In addition, the W.G.H. “Pre-Operative Checklist” shows that her pre-operative vital signs were taken at 1:30 a.m. Finally, the “Operating Room Nursing Record” shows that Ms. Z. was taken into the operating theatre at 2 a.m., which is consistent with the “Anaesthetic Record”, showing that the surgery commenced at approximately 2:10 a.m. All this information is inconsistent with the evidence of Ms. Z. that she arrived at the hospital sometime between 11:30 p.m. and 12 midnight on December 29, 2002 and went into the operating “pretty quick” after her arrival at the hospital. She further testified that she was “adamant” that she did not sign any consent forms for the operation until *after* the surgery.

[55] Ms. Z. testified that, while she was recuperating from the operation in the hospital, she asked her attending nurses five or six times each day various questions about what was involved in having a tubal ligation, what the details of the operation were, how big the incision was, how much time she would need to take off work in recovery, and other related questions. She also maintained that she had not yet discovered that the tubal ligation had already been performed. Ms. Z. said she was “sure” that she had raised these questions with the nurses on every occasion that they came in to attend to her needs over her stay in hospital from December 30, 2002 to January 2, 2003. She further testified that it was only on leaving the hospital, on January 2, 2003, that she told one of

her nurses that she did not think she would have it done, to which the nurse replied “he already tied them [her fallopian tubes] during the C-section”.

[56] This is inconsistent and improbable in at least two respects. If Ms. Z. had asked the nurses such questions as frequently as she claims, one would logically expect that at some point prior to her discharge, one of the nurses would have alerted Ms. Z. to the fact that the tubal ligation had already been performed. This evidence is also externally inconsistent with the fact that there are no nurses’ notes, or any other medical notes, to support this assertion. If Ms. Z. was as unusually fixated on the topic of a tubal ligation as her evidence would indicate, then again one would logically expect that to be reflected somewhere in the medical records. Thus, Ms. Z.’s evidence about the questioning of the nurses, as well as her evidence that she was not told by any nurse that the procedure had been performed until she actually was leaving the hospital, is inconsistent with the factual matrix of the surrounding circumstances.

[57] Ms. Z.’s testimony was to the effect that she was surprised to learn about the tubal ligation when she was discharged from W.G.H. on January 2, 2003, because she had not consented to the procedure. She said that her spouse, K.G. was with her at the time and also heard the nurse tell Ms. Z. about the tubal ligation. She testified that both she and, particularly, K.G. were “quite mad” about the news, and that K.G. had quite a few “colourful words” to say about it. This is inconsistent with the testimony and notes of Dr. K., who met with Ms. Z. shortly afterwards on January 9, 2003. The doctor’s notes of that appointment include the following comments:

> “… she thinks she’s doing reasonably well. They had a memorial service for family at the gravesite on January 5. Her mother-in law had wanted a huge potlatch but this had happened in January with their previous baby that had died and [M.] and [K.] did not want this

> to happen. Therefore there was some tension over this in the family but they did have things go the way they wanted them to in the end and she's very happy about this. She had a tubal ligation at the same time as the C-section…she seemed emotionally very stable today, did not seem upset…" (my emphasis)

[58] Ms. Z. also testified that, post-operatively, after discovering that the tubal ligation had in fact been performed, she asked each of her attending physicians why the procedure had been done without her consent. In particular, she referenced the following appointments with:

- Dr. K., on January 9, 2003;
- Dr. A., on February 10, 2003;
- Dr. A., on October 23, 2003;
- Dr. G. and Dr. O'K., on May 13, 2005; and
- Dr. K., on February 1, 2006.

In summary, she testified in cross-examination that at "pretty much every appointment" she raised the issue of the non-consensual tubal ligation. Later, she said that the tubal ligation was an issue "in every appointment". This is externally inconsistent with the testimony of Drs. A., K. and G. and is not reflected anywhere in their notes of those specific appointments, or indeed in the notes of any of their appointments with Ms. Z. Each of the doctors further testified that, had such concerns been expressed by Ms. Z., they would have documented them in their notes.

[59] In cross-examination, Ms. Z. testified that, after her third unsuccessful pregnancy, she had asked questions of her various health care providers about the possibility of a tubal ligation, but "nobody ever gave answers" to her questions. Given the tenor in the

testimony of all of the attending physicians in this trial, as well as the two expert witnesses, that testimony would seem to be highly improbable.

Dishonesty

[60] Ms. Z. was also, at times, dishonest with her health care providers. In particular, she failed to tell the doctors or nurses at the W.G.H. about the physical abuse she suffered from her common-law partner, K.G., just before she was admitted on December 10, 2001, and again on January 8, 2002, when she was suffering from a severe loss of amniotic fluid. This was despite her knowledge that the doctors were searching for a possible cause for that problem and despite the fact that she was in W.G.H. for a full seven days. When she was transferred to the Royal Columbian Hospital in Vancouver on January 8, 2002, she admitted that she made up a story about falling down the stairs. Once again, even though she was at the hospital from January 9 to 15, 2002, she did not tell any of her attending health care providers of the truth of the K.G.'s physical abuse.

Ms. Z.'s Circumstances

[61] The factual matrix of Ms. Z.'s personal circumstances is consistent with Dr. M.'s testimony that she did in fact want a tubal ligation. Some examples of these circumstances from the evidence are as follows:

- Ms. Z. was extremely distressed by the loss of her third child and asked Dr. W. in Vancouver for a tubal ligation shortly afterwards.
- Ms. Z. pursued the discussions about a possible tubal ligation with Dr. A. in 2002.

- Ms. Z. testified in cross-examination that, at some point in the spring of 2002, she decided to have the tubal ligation, but then learned that K.G. was possibly ill with prostate problems, which she though might interfere with their ability to have further intercourse or might render K.G. infertile. As a result, she changed her mind, because she thought the tubal ligation might be an unnecessary procedure. However, Ms. Z. later discovered that her concerns about K.G. in that regard were unfounded.
- At times Ms. Z. suffered from violent physical abuse by K.G., which abuse was a factor in the loss of Ms. Z.'s third child.

The Documentary Evidence

[62] The documentary evidence confirms that there were frequent requests by Ms. Z. for a tubal ligation and that there were no complaints from her post-operatively about the procedure being done without her consent. However, there are statements from Ms. Z. to her family physicians that, while she originally wanted the tubal ligation, she began to have doubts about her decision in that regard and ultimately suggested that she was not of sound mind when she consented. Following are examples of some of the more relevant documents:

1. January 17, 2002 - Dr. A. noted that Ms. Z. asked for a tubal ligation at the time of the C-section in Vancouver, but the obstetrician there [Dr. W.] suggested that she wait.
2. April 25, 2002 - Dr. A. noted "…Dr. [M.] has recommended a tubal ligation but she feels she is unlikely to have intercourse with [K.] [being ill] and also thinks it would be logistically hard to even have day surgery with [K.] being ill and 2 young children at home…I really think she should have a tubal ligation when possible…"

This is consistent with Dr. A.'s testimony that she discussed the procedure with Ms. Z. at that time. It is also consistent with Ms. Z.'s testimony that, at some point in the spring of 2002, she decided that she wanted to have a tubal ligation, but then changed her mind because of K.'s illness.

3. October 15, 2002 - Dr. A. noted on Ms. Z.'s British Columbia Antenatal Record "*needs T.L. @ time of repeat c/s".

Although Dr. A. conceded on cross-examination that she did not specifically recall receiving instructions from Ms. Z. to perform a tubal ligation at that time, she assumed that she must have received those instructions because she made this note in the Antenatal Record and said that she very likely had discussed with Ms. Z. the fact that tubal ligations are most often done at the time of C-sections.

4. October 28, 2002 - Dr. M. noted in his two page letter reporting to Dr. A. about his consultation with Ms. Z. on that day "…she is

> adamant about having her tubes tied at the end this pregnancy regardless of the outcome…" (my emphasis)

This is consistent with Dr. M.'s testimony that he specifically recalled the appointment on October 28, 2002. He said there was a lengthy discussion with Ms. Z. on that occasion about the possibility of a tubal ligation and that Ms. Z. told Dr. M. about the trauma of her third pregnancy and her conversation with Dr. W. in Vancouver. Ms. Z. told Dr. M. that she could not go through that again, because it was too traumatic. According to Dr. M., after further discussion about the risk of the tubal ligation being minimal if performed at the same time as the C-section, and the various types of tubal ligations and other related information, Ms. Z. indicated to him that, regardless of the outcome of the fourth pregnancy, she wished to proceed with the tubal ligation because she was "absolutely certain" she did not want any further children. This was the reason Dr. M. gave for using the word "adamant" in his letter to Dr. A. He said that he intended to reflect the extraordinary circumstances of the previous pregnancy and the high risk of a poor outcome with the fourth pregnancy. He also wanted to ensure Ms. Z. was "certain" about having the tubal ligation performed during the anticipated C-section for that pregnancy.

In her closing arguments, Ms. Z.'s counsel stressed that Dr. M. admitted he "deviated" from his routine practice in documenting Ms. Z.'s consent to the tubal ligation. However, as I understood this evidence, it was given in the context of the above letter to Dr. A., following the October 28, 2002 appointment, and that what Dr. M. was referring to was his failure to specifically note in that letter the extensive discussion he had with Ms. Z. about the procedure. Rather, he somewhat succinctly stated only the conclusion that she

was “adamant” about having it done. What I heard Dr. M. say about this in cross-examination was as follows:

> “I did deviate from my routine in this particular case with documentation. My usual routine is to indicate that I discussed the issue with the patient.”

In my view, this does not undermine his credibility on the issue of this consent.

5. November 14, 2002 - there is a further note in Ms. Z.’s British Columbia Antenatal Record regarding the history of her third pregnancy “*was supposed to get t/l”.

This is consistent with Ms. Z.’s testimony that she had made a decision in the spring of 2002 to have a tubal ligation performed.

6. December 30, 2002 - Dr. M. made a “Case History” note of his examination of Ms. Z. on that date. The note includes the following:

   “….Patient wishes T.L. Discussed this during pregnancy & again now. Adamant about no further pregnancies regardless of outcome this time. Plan C/s/T.L. w Filshie Clips”

This is consistent with Dr. M.’s testimony that he wrote this note after his meeting with Ms. Z. in the holding room outside the operating theatre, but before Ms. Z. was put under anaesthetic. Ms. Z.’s counsel pointed out that there is no time stated on the note and implied that it may have been written after the surgery in order to cover up the fact that no consent was obtained from Ms. Z. for the tubal ligation beforehand. I reject that argument. First, Dr. M. was not seriously challenged in cross-examination about the

point. Second, the note also makes a reference to Ms. Z.'s vital signs and heart rate. This is consistent with Dr. M. having examined Ms. Z. briefly just prior to the operation. Thirdly, the language of the note is consistent with it being prospective, rather than retrospective:

- the patient "wishes" tubal ligation
- "discussed [tubal ligation] again now"
- "regardless of outcome this time"
- the "plan" was to perform a C-section and tubal ligation.

Finally, there is a post-operative note made by Dr. M. on the same date at "0400", or 4 a.m., immediately after the surgery, which is consistent with the former note being made before the surgery.

7. December 30, 2002 - there is an Operating Room Nursing Record which includes the following:

> "Note: Dr. [M.] informed prior to procedure that the patient has not signed an operative consent for Bilateral Tubal Sterilization with Filshie clips".

This is consistent with Dr. M.'s testimony, as I understood it, that it is a requirement of the hospital for emergency surgeries to obtain consents for all intended procedures. He said the nurses would have been aware of this requirement and that would be the reason why they informed him of the lack of a signed consent for the tubal ligation. Rather, the only signed consent which the nurses had was for the C-section. It also consistent with Dr. M.'s testimony that, upon being informed of the problem by the nurse, he in turn indicated

that he had just discussed the tubal ligation with Ms. Z., that Ms. Z. was very clear about her intention to proceed and that the nurse was content to see the reference to Ms. Z.'s consent in Dr. M.'s pre-operative Case History note, just discussed above.

Ms. Z.'s counsel argued here that the Operating Room Nursing Record stated that Dr. M. was informed "prior to" the surgery that Ms. Z. had not signed a consent for the tubal ligation, and that this was inconsistent with Dr. M.'s testimony that all of Ms. Z.'s medical records should have been available to the surgical team. Thus, went the argument, if Dr. M. completed his Case History note before the surgery, then the nurses should have seen it and there would have been no reason for the Nursing Record note that Dr. M. was advised that no written consent had yet been obtained. This argument presupposes a perfectly linear progression of events, which is unrealistic in an emergency situation such as this. The tenor of the evidence of Drs. M. and K. and Nurse C. is that the several members of the surgical team were all very busy going about their respective duties in preparation for this surgery. Time was very much a factor and a lot of things were happening concurrently. It is therefore not surprising that a nurse noted the absence of a signed consent to the tubal ligation because she had not yet seen Dr. M.'s Case History note, which he logically would have discussed with the nurse upon the concern being raised.

8. December 30, 2002 – "Operative Report" prepared by Dr. M.
   This was dictated on the same date as the surgery and includes the following:

   "…the patient was adamant about having a tubal ligation with the Caesarean section. We had talked

about this during the pregnancy. She had wanted a tubal ligation after her last delivery, even though the baby succumbed, as she didn't want to go through that again. Again, she was adamant on this occasion that she just does not want any more children." (my emphasis)

9. January 2, 2003 - "Discharge Summary" prepared by Dr. M. This was dictated on January 24, 2003, and includes the following:

   "…The patient also was very adamant about having a tubal ligation. She had previously been consulted regarding the potential poor neo-natal outcome on this occasion, but despite that the patient was adamant. She did not want to go through this again. She does have 2 living children at home, who are healthy. We therefore performed a tubal ligation with Filshie clips…" (my emphasis)

10. January 9, 2003 - Dr. K. noted that she met with Ms. Z. on that day (as discussed above) and that she seemed "emotionally very stable" and did not seem upset. (my emphasis)

11. February 10, 2003 - Dr. A. noted that she met with Ms. Z. on that day, and that "…Her husband and mother-in-law are,

amazingly, disputing her decision to have a tubal ligation…" (my emphasis)

12. November 28, 2003 - Dr. G. met with Ms. Z. on that date and noted:

> "…she's not very sure she's happy about the tubal ligation. She says at that point she was pretty sure she wanted it done but now she's not very sure and she feels that the whole pain is related to that…generally she appears well…she has good insight into her problem….this was over 50 minute consult." (my emphasis)

13. May 13, 2005 - Dr. G. met with Ms. Z. on that date and noted:

> "…She had a tubal ligation after her C-section in 2002. She states that she was not of sound mind @ the time she made that decision & is wanting a reversal. She states that she's been requesting this for years but no one has listened to her. She states that her & her partner who have been together for 8 years, for the past 3 years have been considering another child if possible." (my emphasis)

14. November 28, 2003 to May 13, 2005 - Dr. G. had five appointments with Ms. Z. and made no reference in her notes to Ms. Z. raising any concern about the tubal ligation.

15. February 1, 2006 - Dr. K. met with Ms. Z. on that date and noted Ms. Z. was having "relationship difficulties" with K.G.:

> "She states that he [K.G.] is quite controlling. He does not physically or verbally abuse her, but is quite controlling." (my emphasis)

16. April 18, 2006 - Dr. A. met with Ms. Z. on that date and noted:

> "She spent at least 10 min. discussing her thoughts about possibly achieving another pregnancy…she says she does want a baby at times but not at others. Her husband does seem to be driving the whole agenda…" (my emphasis)

17. June 29, 2006 - Dr. A. met with Ms. Z. on that date and noted:

> "1) review of possible tubal reversal. On this visit & the last [M.] describes her concern & that of her husband about the circumstances of her tubal ligation. Afterwards I looked in the chart & saw that Dr. [B.] had explored this issue on July 27, 2005. His letter is informative. I pointed out to [Ms. Z.] that her likelihood of a successful pregnancy outcome was very, very small…" (my emphasis)

18. February 13, 2007 - Dr. A. met with Ms. Z. on that date and noted:

> "She has reviewed her chart with her lawyer. She says that Drs. [M.] and [B.] made some very negative

> comments about her, for instance “that I shouldn’t be allowed to procreate”. Listened sympathetically but told [Ms. Z.] that I too felt that a tubal ligation would be in her best interest because of her very high risk of having further pregnancies leading to fetal demise. After the appointment I did a careful review of her file and I could really not find any disparaging remarks by either obstetrician to this effect…Lawsuit regarding tubal ligation underway.” (my emphasis)

[63] All of this evidence is consistent with Dr. M.’s testimony that he clearly had obtained Ms. Z.’s consent to the tubal ligation before performing the procedure. It further indicates that Ms. Z. was experiencing pressure from her spouse and mother-in-law about having made that decision. Over the course of time, Ms. Z. came to doubt the wisdom of the decision, and then convinced herself that she was not of sound mind when she made it. She now alleges, in this lawsuit, that she did not provide her consent at all.

The Plaintiff’s Capacity to Consent

[64] Ms. Z.’s counsel did not plead the issue of capacity in her amended statement of claim. Nor did she expressly refer to this issue in her trial brief. However, the issue arose during Ms. Z.’s evidence and her counsel pursued the issue in her closing oral submissions, claiming that Ms. Z’s ability to consent was “completely compromised” by her pain following her admission to the hospital.

[65] I agree with Dr. M.'s counsel that, having raised the issue, there is an evidentiary burden on Ms. Z. to prove she was incapable of consenting to the tubal ligation. In my view, her evidence falls short in that regard.

[66] Ms. Z. testified that during the day before the surgery she felt uncomfortable "not myself" and that she had pains in her lower back. She said that those pains got worse and worse, to the point where she could barely walk. She called her girlfriend to drive her to the hospital. On arrival at the hospital, she was put in a wheelchair and sent straight to the maternity ward. The nurse helped her to change and to go the bathroom. She felt a lot of pressure and it hurt to lay down. Ms. Z. further testified that she was in a "tremendous" amount of pain after her admission to the hospital. She said "I felt like my hips were going to explode" and that she "screamed" at the hospital staff as she was being wheeled from the maternity ward to the elevator, en route to the operating room, "because it hurt so much".

[67] She recalled being examined by Dr. K. prior to the surgery, but not by Dr. M. Consequently, on cross-examination she agreed that she could not comment on any discussion which may or may not have taken place with Dr. M. In particular it was put to her that Dr. M. would say that he saw her in a holding area adjacent to the operating room, that he confirmed he would do the C-section and tubal ligation and that Ms. Z. told him that she wanted a tubal ligation done along with the C-section. She agreed that she could not recall any such conversation and therefore could not comment upon it. While Ms. Z.'s lack of recall here is arguably consistent with her claimed incapacity, her other evidence as to the degree of her pain is inconsistent with the evidence of Dr. M., Dr. K. and Nurse C.

[68] Dr. K. was initially called to treat Ms. Z. upon her admission to hospital on December 30, 2002. She recalled some of the details of that occasion. She talked with Ms. Z., checked her vital signs and did a pelvic exam. After determining that Ms. Z. was fully dilated and that the baby was in a breech position, she called Dr. M. and the paediatrician and told the nurses to get ready for a C-section. She spoke with Ms. Z. about what was going to take place. The only medication Ms. Z. was receiving at that time was a steroid to help with the fetus' lungs. There is no evidence that it would have had any impact upon Ms. Z.'s capacity. Dr. K. testified that Ms. Z. was "clear and lucid" and "quite stoic". She said that she spent "some time" with Ms. Z. pre-operatively and also assisted during the surgery. She testified that if she did have concerns regarding Ms. Z.'s ability to communicate, she would have discussed that with the attending nurses and documented it. She did neither. Dr. K. was not shaken on cross-examination.

[69] M. C. testified that she is a registered nurse and a qualified midwife. She had 18 years experience as a nurse and midwife prior to coming to the Yukon in 1998. She worked as a nurse on the maternity ward at W.G.H. from 2000 – 2004 and was on-call on December 30, 2002. She recalled dealing with Ms. Z. Her responsibilities included getting Ms. Z. ready for surgery by administering an intravenous tube and catheter, by monitoring her vital signs, and by assisting with the fetal monitor. She said that she was "constantly interacting" with Ms. Z. in preparation for the surgery and that Ms. Z. said to her that this had already happened to her once in Vancouver and she never wanted to go through it again. Nurse C.'s impression was that she was determined to go ahead with the tubal ligation. She said that Ms. Z. "seemed to be clear headed, she knew what was

happening, she was not in a lot of distress because she was in premature labour and the contractions are not as severe as in full labour".

[70] Ms. Z.'s counsel submitted that Nurse C. was not credible, suggesting that her ability to recall the details of that morning was limited at best. I find no basis in the evidence for that submission. On the contrary, Nurse C. impressed me as an objective, careful, and competent professional with a very good memory.

[71] The evidence of both Dr. K. and Nurse C. corroborates that of Dr. M. that Ms. Z. was lucid and had the capacity to consent to the tubal ligation. Dr. M. testified that the steroid (betamethizone) administered to Ms. Z. prior to his pre-operative consultation with her would have had no impact on her capacity to consent. He also said that while Ms. Z. was undergoing periodic contractions, between those contractions, "she was lucid and stoic, oriented". He said he had no concerns at all regarding the clarity of her wishes.

[72] On cross-examination he acknowledged that in obtaining a patient's consent, the patient should have the capacity to understand the decision being made and the decision should be voluntary. He acknowledged that voluntarinous could "potentially" be compromised in circumstances where the patient is in severe pain. When asked whether Ms. Z. was in severe pain following her admission to hospital and prior to the surgery he answered "No, she was having moderate contractions". He was then asked about his evidence at his examination for discovery where the following was said:

> "Q: So, if she is saying that she was in real severe pain, you don't agree with that?
>
> A: No, I agree with that, because labour pains can be very intense; and in fact, she had a dehiscence, so that might actually contributed to the pain. [as written]"

(Dr. von Dadelszen earlier testified that “dehiscence” is a condition where, as the uterus contracts, muscle fibres can come apart in the area of the incision from the previous C-section and ultimately lead to uterine rupture.) Dr. M. said that, while his discovery evidence was correct, it is not inconsistent with his evidence that she was only undergoing “moderate contractions” at that time, which in turn is corroborated by Nurse C.

[73] In addition, there was further evidence from Dr. M.’s examination for discovery read into the record surrounding the question and answer just quoted above. That evidence was as follows:

> “Q So, when a patient ends up in the holding area, they’re already medicated at that time?
>
> A No.
>
> Q No?
>
> A She had no medication. She had betamethasone [as written], which is a steroid that we give to try to – when she came in to try to rapidly mature lung function to assist the baby’s first hours of life, first days of life; but in fact, it wouldn’t have had any impact on this particular baby, because the time was too short, but no other medications or sedation.
>
> Q You are aware of the fact that when she was there, it was a breech baby?
>
> A Yes.
>
> Q What would you say – on a scale of one-to-10 – what would be the pain the woman experiences when sort of in that situation that she was?
>
> A She would start to feel some pelvic pressure, I assume. Pain, labour-related pain is extraordinarily variable from woman-to-woman. It can be extremis, meaning out of control, and you’re unable to even speak to them; or it’s controllable, meaning that they have contractions, and they’re in significant pain during contractions, but once a contraction is over, they’re actually very lucid and easy to communicate with.
>
> Q But when you think back, M. specifically at that specific stage, what would you say? In what condition was she?

A She minded her contractions when they came, but she was lucid and clear-thinking between contractions.

Q So, if she is saying that she was in real severe pain, you don't agree with that?

A No, I agree with that, because labour pains can be very intense; and in fact, she had a dehiscence, so that might actually contributed to the pain.

Q So, do you really think that she was in a position to give consent at that stage?

A If, in fact, that was the only time that we had to discuss a tubal ligation, then that would not have constituted an appropriate consent. The consent was based on my previous discussions with the patient, as well as the discussions at that time."

[74] I also note there were absolutely no concerns about Ms. Z.'s capacity expressed by either of the experts who reviewed extensive materials in preparing their respective opinions, which included the records of Dr. M., the records of Whitehorse General Hospital and the examination for discovery transcripts of both Dr. M. and Ms. Z.

[75] In *Johnston* v. *Boyd*, [1996] B.C.J. No. 3003 (C.A.), the British Columbia Court of Appeal was dealing with a case very similar on its facts to the one at bar. There, the plaintiff claimed that she never agreed to a tubal ligation in the course of an emergency C-section when her fourth child was born. The two defendant doctors claimed that she consented and signed a consent form for the C-section and the tubal ligation. During the pregnancy, the plaintiff told one of the doctors she did not want any more children. The plaintiff had been in labour for 18 hours and had inhaled nitrous oxide for three hours. The trial judge accepted the doctors' evidence that the plaintiff consented to the procedure performed upon her. One of the appellant's grounds of appeal was that the trial judge erred in holding that she was capable of granting consent in the

circumstances. Hollinrake J.A., delivering the judgment for the Court, ultimately upheld the trial judge on this point, and stated at paras. 13 and 14:

> "…The appellant says that she was clearly in stressful circumstances when her consent was given and the law should not protect the doctor who asserts consent by his patient when that consent is obtained in the circumstances that prevailed in this case. The plaintiff's position is set out in her factum as follows:
>
> > It is further submitted that a woman who has been in labour for over 18 hours, who has been inhaling nitrous oxide for over 3 hours, and who has just been informed that an emergency Caesarean section is required to prevent a tragedy, is not mentally capable of giving her consent to a complex operation with long-term ramifications.
>
> I cannot accept that the policy of law should lead to the conclusion that as a matter of law, where there is no emergency and the patient is in stressful conditions a consent can never be a defence to a claim in battery. The issue before the Court in cases such as this is whether there was in fact consent. No doubt in many cases the facts will lead the trier of fact to conclude there was no binding consent. I think that is a question of fact. Here, as a matter of fact the trial judge found there was consent and one that was binding on the appellant. Referring to the evidence of Mrs. Crompton the trial judge said and I repeat:
>
> > She confirms other testimony that the plaintiff, far from being in a state rendering her incompetent to consent, was behaving normally and rationally and gave her real agreement to the procedure." (my emphasis)

[76] It must also not be forgotten that Dr. M. maintains that Ms. Z. consented to the tubal ligation during her earlier appointments with him on October 28 and November 4, 2002. Ms. Z. provided no evidence about her incapacity on either of those occasions.

The Plaintiff's Submissions on Timing

[77] Ms. Z.'s counsel suggested in closing argument that there was insufficient time on December 30, 2002, for Dr. M. to travel from his home in the subdivision of Pineridge to

W.G.H. and have a consultation with Ms. Z. before she went into surgery. Dr. M. testified that he lives 10 or 11 kilometres away from the hospital and that it normally takes him about 12–13 minutes to drive that distance. He said that he received the call from the hospital at approximately 1:30 a.m. Therefore, he would have arrived at the hospital at about 1:45 a.m.

[78] Ms. Z.'s counsel also points to the "Anaesthetic Record", which indicates that the anaesthesia start time was at 1:45 a.m. and suggests that Ms. Z. must have been in the operating room at that time and about to undergo surgery. However, Dr. M.'s counsel argued that not all of the players would necessarily have synchronized the respected time pieces relied upon by each of them. Further, he points to the fact that the Anaesthetic Record also indicates that the actual administration of the anaesthetic did not take place until 2:05 or 2:10 a.m. Further, the Operating Room Nursing Record indicates that the Ms. Z. was not brought into the operating theatre until 2:00 a.m.; that the anaesthetic start time was also at 2:00 a.m.; and that the surgery start time was at 2:11 a.m. Thus, on the face of it, if Dr. M. arrived at the hospital at about 1:45 a.m., he would have had about 10 or 15 minutes to speak with Ms. Z. before she was taken into the operating room. This is consistent with Dr. M.'s testimony that he spent about ten minutes with Ms. Z. prior to the surgery to reaffirm her desire for the tubal ligation.

[79] In summary, I am satisfied that the evidence indicates there was sufficient time for Dr. M. to obtain Ms. Z.'s consent, that Ms. Z. had the capacity to consent, and that she did in fact consent to the tubal ligation on December 30, 2002. I further find that she verbally consented to this procedure during her appointments with Dr. M. on October 28 and November 4, 2002.

3. Must Dr. M. prove "informed consent"?

[80] Section 43(1)(a) of the *Health Act*, S.Y. 2002, c. 106, states:

> "Clients have the right
> a) to be treated only in accordance with their informed consent"

While s. 43(1) has been repealed by the *Care Consent Act*, R.S.Y. 2003, c. 21, which was proclaimed in force April 29, 2005, it was in force on December 30, 2002.

[81] Ms. Z.'s counsel failed to plead reliance upon the *Health Act* in her amended statement of claim. Nor has she pled the lack of "informed consent" in the context of medical negligence, as referred to in *Reibl* v. *Hughes*. Therefore, strictly speaking, she should not be raising this issue at trial. However, both counsel addressed the issue in their closing submissions, so I will attempt to resolve it here.

[82] As I understand the submissions of Ms. Z.'s counsel, the "informed consent" in the *Health Act* is something different from "informed consent" in the context of medical negligence. In her trial brief, Ms. Z.'s counsel referred to the latter as follows:

> "Informed consent refers to the attending physician's duty to disclose all material information, including alternative treatment and risks of medical treatment or surgical procedures to a patient and to make sure that the patient understands the information."

She then went on to state:

> "Informed consent meaning informed choice should be distinguished from the doctrine of informed consent, as used in case law, meaning a failure to disclose and the consequences of such a failure."

However, Ms. Z.'s counsel also stated:

> "Consent to medical treatment should be informed consent through necessary disclosure of relevant information. Informed consent is

> pertinent in this case before the Court because the plaintiff has pursuant to the relevant section in the *Health Act*, the statutory right to be treated only in accordance with her informed consent."

[83] I was confused by these submissions and consequently spent a fair amount of time discussing them with Ms. Z.'s counsel during their closing submissions. Further to those discussions, the plaintiff's counsel filed a "Consent Diagram" as an explanatory aid to their submissions. However, I confess that my confusion in this regard was not alleviated by that diagram.

[84] Ms. Z.'s counsel further submitted that the consent which must be proved by Dr. M. in defence to a claim of medical battery, or sexual assault, must be a "valid consent". Here she referred me to *Trainor* v. *Knickle,* [1996] P.E.I.J. No. 55 (S.C.), at para. 126, where Matheson J. said:

> "The requirements to a valid consent are set out by Madam Justice Picard at p. 53 of her text Legal Liability of Doctors and Hospitals in Canada (2nd ed. Carswells 1984) as:
>
> (a) given voluntarily;
>
> (b) given by a patient who has capacity;
>
> (c) referable both to the treatment and the person who is to administer that treatment; and
>
> (d) given by a patient who is informed. [as written]"

However, it must be remembered that *Trainor* v. *Knickle* was an action for medical negligence and is therefore distinguishable from the case at bar.

[85] Ms. Z.'s counsel similarly relied on *Adan* v. *Davis*, [1998] O.J. No. 3030 (Gen. Div.) in support of the proposition that disclosure of the nature of the procedure and the attendant risks is an element of a valid consent. However, disclosure of attendant risks would seem to import the notion of informed consent in the medical negligence context,

which Ms. Z.'s counsel concedes is not at play here. Further, *Adan* was also an action for medical negligence and is therefore distinguishable on that basis.

[86] At the end of the day, Ms. Z.'s counsel submitted that a "valid consent" requires:

1. that the patient have the capacity to consent;
2. that the consent is provided voluntarily; and
3. that there be disclosure of the nature of the procedure, the attendant risks and the options to the procedure.

I accept that the type of consent required as a defence to an action in medical battery is logically premised on it being one which is voluntary, as an involuntary consent would be no consent at all. Similarly, it is logical that the patient should have the capacity to provide their consent, since a lack of capacity would essentially vitiate the voluntariness of the consent. I can even accept that there is an element of disclosure in the medical battery context, insofar as the physician must inform the patient what procedure is to be performed in order for the patient to provide their consent to that procedure. However, I disagree that the consent which must be proved in defence of a battery claim, must include disclosure of attendant risks and options to the proposed procedure. In my view, that type of disclosure only arises within the doctrine of informed consent, in the context of medical negligence, as described in *Reibl* v. *Hughes*, and has no applicability to this case.

[87] I repeat that the consent required for a defence to a claim of medical battery is one which pertains to the actual procedure performed and not one secured through misrepresentation or fraud. A failure to provide a patient with an opportunity to make an "informed choice" is effectively the corollary of a failure to obtain an informed consent.

There is no real distinction between the two concepts, despite the submissions of Ms. Z.'s counsel to the contrary. Further, both concepts relate solely to the issue of medical negligence and the absence of either is a not test of the validity of the consent in a medical battery context. I repeat the quote from *Reibl* v. *Hughes*, above, at p. 892 [S.C.R.]:

> "…a failure to disclose attendant risks, however serious, should go to negligence rather than to battery. Although such a failure relates to an informed choice of submitting to or refusing recommended and appropriate treatment….It was not a test of the validity of the consent."

[88] What then is the effect of s. 43(1)(a) of the *Health Act* in this case? I conclude it has no application at all. The section refers to "clients" and not "patients" and there is nothing in the *Act* to indicate that it was intended to have an impact on the legal elements of the doctor-patient relationship. Further, the *Health Act* provides no statutory remedy to "clients" who claim to have been treated without their informed consent. Rather, it seems clear from both the preamble to the *Act* and the Hansard excerpt at the time of its enactment that it was framework legislation designed to link together the *Mental Health Act*, the *Hospital Act*, and the *Health Insurance Act*, in the Yukon government's attempt to develop a comprehensive public policy with respect to the delivery of health and social services throughout the Yukon. There is no suggestion that the legislation was intended to abrogate the well-established common law distinction between medical battery and medical negligence set out in *Reibl* v. *Hughes*.

[89] I hasten to add here that, even if I am wrong about this issue, I am satisfied that Dr. M. has proven that he did have an extensive conversation with Ms. Z. on October 28, 2002 about the attendant risks of the tubal ligation being done at the same time as the

anticipated C-section, about the various types of tubal ligation procedures, and about the risks associated with not having the tubal ligation done. Although he had a specific recollection of that appointment, he referred to this as his "routine discussion" on tubal ligations, which is significant given his evidence that he performs 30 to 40 such procedures per year. In short, I find that the consent Ms. Z. provided both then and just prior to the surgery was indeed informed consent.

CONCLUSIONS

[90] Given the length of these reasons, I will summarize my conclusions as follows:

1. The plaintiff does not have a cause of action for sexual assault under s. 2(3)(b) of the *Limitation of Actions Act*. Rather, her cause of action is for battery, and more specifically for medical battery, which is subject to a two year limitation period. That limitation expired prior to the commencement of this action and therefore the action is statute barred.

2. Even if Ms. Z.'s cause of action is not statute barred, Dr. M. has proven on a balance of probabilities that she consented to the tubal ligation on three occasions: October 28th, November 4th and December 30, 2002. Ms. Z. has failed to establish that she did not have the capacity to provide her consent or that her consent was involuntary. On the contrary, I find that she was lucid just prior to the surgery and subject to the moderate contractions of premature labour. Ms. Z. has also failed to establish that there was insufficient

time for Dr. M. to consult with her and to obtain her consent to the tubal ligation. Therefore, her action in medical battery must fail.

3. Dr. M. is not required to prove that he obtained Ms. Z.'s informed consent to the tubal ligation, as she did not sue Dr. M. for medical negligence and the *Health Act* has no application to this case. However, if I am wrong in this conclusion, I find that Dr. M. did obtain Ms. Z.'s informed consent in any event.

[91] Given the length of these reasons to this point, and my conclusions thus far, I feel it is unnecessary for me to deal with the issue of damages, notwithstanding that Ms. Z.'s counsel addressed the issue briefly in her closing oral submissions and Dr. M.'s counsel did so rather more extensively in his written argument.

[92] Costs are awarded to the defendant.

Gower J.