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Canadian Codes of Medical Ethics as a Source of Law

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The article discusses the codes of medical ethics which are adopted in Canada. These acts are not 'classical' normative-legal acts, since they are adopted not by legislative bodies, but rather by medical associations, and are aimed at providing rules on the professional conduct of physicians and auxiliary medical personnel; occasionally, they also feature the rules concerning the rights and duties of patients. The article's sources include the codes of medical ethics adopted in Canada, Canadian court judgments, and academic literature.
Keywords: Code of Medical Ethics, Medical Law, Canadian Law, history of Law, legal theory.

Kanados medicinos etikos kodeksai kaip teisės šaltinis

Straipsnyje aptariami Kanadoje priimti medicinos etikos kodeksai. Šie aktai nėra „klasikiniai" norminiai teisės aktai, nes juos priima ne įstatymų leidybos institucijos, o gydytojų asociacijos ir jais siekiama nustatyti gydytojų ir pagalbinio medicinos personalo profesinio elgesio taisykles; kartais jose taip pat pateikiamos pacientų teisių ir pareigų taisyklės. Straipsnio šaltiniai – Kanadoje priimti medicinos etikos kodeksai, Kanados teismų sprendimai ir akademinė literatūra.
Pagrindiniai žodžiai: Medicinos etikos kodeksas, medicinos teisė, Kanados teisė, teisės istorija, teisės teorija.

Introduction

Common Law jurisdictions use a legal precedent as a primary source of Law, though statutory legislation also regulates a considerable amount of social and legal relationships. The same relates to the sphere of healthcare, where both laws and legal precedents effectively regulate legal relationships in terms of the rights and duties of physicians, patients, the functioning of healthcare institutions, pharmacies, the liability of healthcare institutions and medical personnel for negligence, etc. As Canada

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applies a bijural legal system, the percentage of Statutory Law (e.g., several Canadian provinces possess a civil code) is more considerable than the classic Common Law states, though the role of Case Law as a source of Law is very substantial. Then, what is the place of the *code of medical ethics* in the system of the sources of Law? Again, there is no uniform answer of whether the code of medical ethics should be regarded as a source of Law, but the application of the provisions of the Canadian medical ethics codes (the *Canadian Medical Association Code of Ethics*, as well as provincial codes of medical ethics) does exist in the Canadian Case Law. In this paper, examples of applying Canadian codes of medical ethics in Case Law shall be discussed. In order to trace the changes in the *Canadian Medical Association Code of Ethics* throughout the decades, the authors chose the Code's editions of 1868, 1970s–80s (which are essentially the version of 1970 with minor changes in the forthcoming versions) and 1996, as well as the new editions of 2004 and 2018 (in the version of 2018, it is referred as the *Canadian Medical Association Code of Ethics and Professionalism*). The *CMA Code of Ethics* has undergone nineteen editions throughout its adoption in 1868 to the latest edition in 2018. For the matter of brevity of the discussion of the role of the codes of medical ethics, the authors chose the issues of the physicians' and patients' duties, as well as disciplinary violations of the physicians, occurring from various malpractices. The article will also show the role of safeguarding the patient's rights by the codes of medical ethics and the application of their provisions in disciplinary proceedings, where the doctors who were blamed for malpractice or misconduct and whose practice was suspended attempted to impugn the decisions of the executive boards in order to continue practicing medicine. It should be denoted that the CMA Code of Ethics is not the only existing code of medical ethics that is acting in Canada. The *Code of Ethics of the Canadian Dental Association* (fr. *Le Code de déontologie de l'Association dentaire canadienne*) was enacted in Canada on 16 September 1902 (Crawford, 2002, p. 2), provincial codes of ethics in dentistry are also adopted and acting; their application could be observed in several disciplinary actions, some dating back to the 1930s (*Alberta Dental Association v. Sharp*, 1930, p. 652; *Attorney-General for British Columbia v. Cowen*, 1938, p. 20). A distinct code of ethics of physicians also exists in the province of Quebec. It was originally adopted in the spring of 1980[1], and was in force until late 2002, until being replaced with its new version (Code of Ethics of Physicians, 2003). One of its most prominent examples when the provisions of the Code of Ethics of Physicians were referred to as a source of Law is the case of *A v. Children's Aid Society of Metropolitan Toronto* (1982), where the issue of consent in the case of a medical emergency was raised (A v. Children's Aid Society of Metropolitan Toronto, 1982, p. 111), and the case of *Cordeau* (1984) (Cordeau c. Cordeau, 1984, p. 201), which concerned the admissibility of evidence containing a medical secret, to which we will turn below. Upon the findings of the authors, the references to codes of medical ethics were made in cases on the following subjects:

- Informed consent and refusal to medical treatment;
- Medical confidentiality and issues relating to a legitimate disclosure of medical information, such as in court in civil proceedings;
- Disciplinary cases on professional misconduct and malpractice of physicians.

The article will consider both cases where a code of medical ethics was cited, as well as a number of cases which, despite not referring directly to a code of medical ethics, posed an ethical dilemma or a question, the answer to which was rectilinear or otherwise complex.

[1] See in detail *Cordeau c. Cordeau*, [1984] R.D.J. 201 – AZ-84122016 (Cour d'appel du Québec, le 15 mars 1984), (originally reported in French with the dissenting opinion of Nolan, J. in English).), per Nolan, J. (dissenting), at para. 44.

1. Canadian codes of medical ethics as a source of patient's rights

The Canadian Medical Association Code of Ethics was firstly enacted in 1868. It was named the *Code of Medical Ethics of the Canada Medical Association*, and has been repeatedly edited until its latest version in 2018 (Canadian Medical Association Code of Ethics and Professionalism, 2018), while being initially based upon the 1847 *American Medical Association Code of Ethics*, whereas the *Canadian Medical Association* was itself founded in 1867 (Ventresca, 2017, p. 55–56). The contents of the *Code of Ethics* considerably changed over the years as well; the Case Law, as observed in the chapter below, had been relevant from the early 20th century, starting from the case of *In re Crichton* (1906) (In re Crichton, 1906, p. 271), thereby marking a formation of a substantial body of Case Law in terms of litigation between physicians and medical associations. The first *Code of Ethics*, adopted by the *Canadian Medical Association* in September 1868, contained chapters on the duties of the physicians to the patients, and, reverse, the obligations of the patients to physicians, on the duties of physicians to each other and to the medical profession at large. The two initial chapters provided perhaps the first recorded ethical rules concerning the patient-physician relationships (*Code of Ethics of the Canadian Medical Association*, 1868). Could such provisions be seen, at least tentatively, to be applied in jurisprudence back then? The first article of the Code's 1868 version speaks of the devotedness of the doctors to come to help and treat the patients, while showing sufficient care and skill for treatment. The second article speaks of the obligation of the doctors to treat the patients with attention and humanity, as well as to express due comprehension to situations, where patients may be mentally ill. The second article is of paramount importance in terms of medical confidentiality, where it was required, that none of the communications obtained from the patients could be divulged by the physician, unless the physician is imperatively required to disclose such information. Perhaps, the provision of Art. 2 of the Code's 1868 version was the first ethical provision governing the rules of medical confidentiality in Canada. The case of *Halls v. Mitchell* (1926–28) was seemingly the first case on the record to deal with the said problem, to which we will turn below; similar issues arose concerning the preservation of confidentiality in terms of defining the admissibility of evidence on subjects containing a medical secret (e.g., cases of *Murray* (1947) and *Carter* (1974) (Murray v. Murray, 1947, p. 236; Carter v. Carter, 1974, p. 363, etc.), though, in those two cases, medical ethics codes were not mentioned directly, but, in fact, the *public interest* in medical confidentiality was; for more details, see the chapter below). The third article of the Code relates to the issue of the doctors' visits to the patients, by claiming that the visits should be regular, but doctors should, at the same time, avoid unnecessary visits to the patients (Code of Ethics of the Canadian Medical Association, 1868). Commenting upon the duty of confidentiality, referred to in the *CMA Code of Ethics* of 1868, Dr. W. M. Canniff (1881) mentioned that the relationship between the patient and the physician is of trust and confidence, and the divulgation of the medical secret would be injurious for the patient, reckoning up his own experience in avoiding answering questions relating to the health condition of his patients (Canniff, 1881, p. 248–255). The fourth article comments on the physician's necessity to avoid gloomy prognoses relating to the diseases (this issue was discussed in the case of *Carefoot* (Carefoot, In re; Medical Profession Act, In re, 1925, p. 202, etc.)), but it was mandatory for the physician to warn the patient, and the patient's relatives or friends relating to any danger to the patient's health. The physicians were recommended to avoid gloomy prognoses in order not to depress the patients as well. The fifth article forbade the physicians to abandon the patients in the case the patient's ailment was deemed as impossible to cure (in *Stark v. Council of the College of Physicians and Surgeons of Saskatchewan* (1965), the Saskatchewan Court of Queen's Bench distinguished that the abandonment of a patient in a dangerous health condition is not the same as an

omission of a patient by a physician (Stark v. Council of the College of Physicians and Surgeons of Saskatchewan, 1965, p. 157)), whereas two following articles concerned the aspects of consultations (Code of Ethics of the Canadian Medical Association, 1868). The second chapter prescribed various duties of the patients which related to the selection of the physician for the patient and the patient's family (Art. 1–3), as well as the patient's duty to communicate the cause of the disease to the physician (Art. 4), and the Code advised, that the patient "should always bear in mind that a medical man is under the strongest obligation of secrecy" (the *Code of Medical Ethics*, in respect with medical secrecy, as a legal foundation for it was also directly mentioned in the case of *Cordeau* (Cordeau c. Cordeau, 1984, p. 201, para. 25–26)). The divulgation of the patient's medical information was not only accounted as malpractice, which gave rise to an action for damages against the physician or hospital, but also caused disciplinary sanctions imposed by medical associations' disciplinary committees, whereas the physicians strived to impugn disciplinary sanctions in courts (Re Shulman and College of Physicians & Surgeons of Ontario, 1980, p. 40, etc.). The sixth article of the second chapter also underlined the necessity for the patients to be obedient to what the physician had proscribed (Code of Ethics of the Canadian Medical Association, 1868). The given provision was interpreted by Y. Ventresca as a proof of the existing paternalistic nature of the patient-physician relationships (Ventresca, 2017, p. 55–56).

The 1970–80s *Codes of Ethics of the Canadian Medical Association* (the 1970 version and the follow-ups of 1975, 1977, 1978, 1982, 1984, and 1986), by virtue of having very few differences (Comparic, Garon-Sayegh, Bensimon, 2023, p. 409), provided a considerable step in promoting the patient's rights, and also marked the reference to the patient's consent as a pre-requisite to a surgical operation or any other medical procedure. The chapter on the responsibilities of the doctors to the patients in the 1970s versions already contained a sub-chapter named *Patient Rights* (Art. 4–9), where Art. 4 provided that the physician would recognize his limitations, and, if necessary, would recommend the patient for a second opinion, and will recognize that the patient may accept, or reject any kind of proposed treatment (Art. 5). It is of interest that the term 'patient's rights' is likely to have been used for the first time in *Dufresne c. X.*, a court case adjudicated by the Superior Court of Quebec in 1960, which featured a dispute between a young woman and a dentist who decided to extract all the teeth from her lower jaw, in spite of having agreed to extract only three. Deciding upon the case, the court held that "Such a concept [of not informing the patient] denies the most sacred rights of the patient and distorts the duty of advice incumbent on the doctor" (Dufresne c. X., 1960, p. 119, para. 33). In such sense, we may find, that by the 1970s, there had been quite a multitude of informed consent-related cases in Canada, whereas probably the most known cases in respect with the legal problematics of the necessity of the patient's consent to medical treatment date back several decades, some of which one of the authors of the given article commented upon in his paper on informed consent in Canada in the period of 1899–1980 (Lytvynenko, 2021, p. 260–271). Ventresca (2017) stated that the formation of the doctrine of informed consent owing to the paternalistic nature of the patient-physician relationships, which were also anchored in the 1868 *Code of Ethics* to a major extent, is not very likely to have formed in Canada (Ventresca, 2017, p. 55–56). However, if we dig more into Case Law, we may find that all the basic principles relating to informed consent had already been formed in the Canadian jurisprudence by the 1930–40s: the first (to the best of the knowledge of the authors upon a thorough research) informed consent case could be found back in 1899 (*Parnell v. Springle*), which was adjudicated by the Superior Court of Montreal (Parnell v. Springle, 1899, p. 74), the principle of the doctor's right to conduct an extension of a previously consented operation without the consent of the patient in case of an emergency was already laid down, apart from the case of Parnell v. Springle by two other Canadian cases in the 1930s (*Caron c. Gagnon*; *Marshall v. Curry*), while some issues relating to the duty to

warn and inform the patient were already covered in *Kenny v. Lockwood* (1931) (Caron c. Gagnon, 1930, p. 155; Marshall v. Curry, 1933, p. 260; Kenny v. Lockwood, 1931, p. 141), whereas, finally, the physician's duty to inform and clarify to the patient relating to the forthcoming surgical operation was emphasized by Alberta Supreme Court in *Mulloy v. Sang* in 1935 (Mulloy v. Sang, 1935, p. 714), as well as a lawsuit for a manifestly unconsented surgical procedure (tubal ligation) in *Winn v. Alexander* in 1940 (Winn v. Alexander, 1940, p. 778, etc.). Unfortunately, the older cases did not feature a discussion of medical ethics in general terms or in terms of the *CMA Code of Ethics*, or any other code of ethics (and, in fact, the old versions of the *CMA Code of Ethics* did not discuss the patient's consent at all). However, such references could be found in the more contemporary cases. In the case of *Parcels v. Red Deer General & Auxiliary Hospital and Nursing Home Dist. No. 15* (1991), resolved by Alberta Board of Inquiry, the issue of medical ethics was referred to in terms of the principle that it was the obligation of the doctor to present the information concerning a peculiar medical procedure, which would allow the patient to make an informed choice (Parcels v. Red Deer General & Auxiliary Hospital and Nursing Home Dist. No. 15, 1991, p. 257). In another case on informed consent and the denial of medical treatment, *Nancy B. v. Hôtel-Dieu de Québec* (1992), where the plaintiff asked for a court order so that the hospital should have refrained from administering unconsented medical treatment and terminating the treatment she was being given at the time of the action, the Court referred to the *Code of Ethics of Physicians* (then acting in its 1980 version: RRQ 1981, c M-9, r.-4), clarifying that the Code gave prevalence of the freedom of choice of the patient in any medical decision relating to the patient himself/herself over the doctors' duty to safeguard the health and well-being of the patients (Nancy B. v. Hôtel-Dieu de Québec, 1992, p. 385, etc., at para. 30).

The term 'informed consent' is not directly mentioned in the 1970/75 *Codes of Ethics*, though a number of other provisions of the *Code of Ethics* refer to the consent of the patient, namely: Art. 14, Chapter *Responsibilities to the Patient* – to give consent and render such therapy as it would be in the patient's best interests, in case the patient is not able to provide the consent, and in case the person acting in patient's behalf is also absent, and Art. 17 of the Chapter *Responsibilities to the Patient* – the necessity of the physician to obtain the consent of the patient or the person acting in the patient's behalf relating to clinical research, explain its purpose and warn on the possible hazards of the procedure (Canadian Medical Association Code of Ethics, 1970, 1975, 1977); here, we may consider the case *Halushka v. University of Saskatchewan* (1965), where a young man, who was participating in an anesthetic trial, suffered a cardiac arrest, and subsequently sued the defendant on the grounds of trespassing to the person and negligence; however, no issues of medical ethics were discussed in the given case (Halushka v. University of Saskatchewan, 1965, p. 608, etc.). Nor were any issues of medical ethics directly referred to in the case *Weiss c. Solomon* (1989) which was adjudicated by the Superior Court of Quebec and which was another medical malpractice case relating to an unauthorized medical research procedure of an angiogram with the use of fluorescein, which tragically ended in the patient's death because of a cardiac arrest (Weiss v. Solomon, 1989, p. 731). It is notable that research ethics committees started to appear in Canada only in the late 1990s (Dinsdale, 2005, p. 82–83). There were other provisions relating to the patient's rights in the codes of the 1970s, namely Art. 6 provided for maintaining confidentiality of the medical information obtained from the patients, or information concerning a patient, obtained from another doctor, permitting to divulge such information only with the consent of the patient, or in cases provided by law (Canadian Medical Association Code of Ethics, 1970, 1975). In this respect, disputes mainly related to the admissibility of evidence containing a medical secret (i.e., the case of *Cordeau c. Cordeau* (1984)), or concerning a court order allowing to question medical witnesses by the plaintiff's counsel relating to the medical treatment of the plaintiff (i.e., the case

of *Hay v. University of Alberta Hospital* (1990); *Cordeau c. Cordeau*, 1984, p. 201; *Hay v. University of Alberta Hospital*, 1990, p. 176, etc.). Another notable provision is Art. 13 and 14 of the said codes, upon which, the physician was allowed, in the case of emergency, provide all necessary assistance to the patient in need, and was not obliged to ask the patient's consent, but administer the necessary treatment upon his/her own judgment, which would be in the interest of the patient (these provisions were also directly referred to in *A v. Children's Aid Society of Metropolitan Toronto* (1982)). In that case, the child's mother was placed to a psychiatric hospital, and the Children's Aid Society sought a court order to administer any necessary medical treatment to the child, including emergent treatment, and thus acting on behalf of the child. The court found that the *Society* could become empowered in this situation; the court held that, in the case the child is under the control of the *Children's Aid Society* (and, practically, with no control of the parents), the *Society* controls the child, and the court could order emergent medical treatment, if it is necessary; moreover, it would be logical to empower the *Society* to provide the necessary medical treatment when protection proceedings are pending. The court also reminded that Art. 45 of the *Criminal Code of Canada* relieved any physician from responsibility for performing an operation without the patient's consent for the benefit of the patient in case it was done skillfully and reasonably according to the health condition of the patient. The court also paid attention to the provisions of the *Code of Ethics*, according to Art. 13–14 of which, a physician in urgent cases shall render all necessary assistance to any patient when an urgency exists, and when the patient is unable to consent, the physician shall administer such therapy, as the physician believes to be in the patient's interest (*A v. Children's Aid Society of Metropolitan Toronto*, 1982, p. 111). The wording of the given provisions strongly reminds of the legal positions of the courts in earlier Canadian cases regarding the patient's lack of consent when an operation was extended to a different surgical intervention than it had been previously agreed[2].

The later versions of the *Canadian Medical Association Code of Ethics* depicted an even more patient-oriented approach, already touching such issues as biomedical research (which, as it had been mentioned previously, received a valuable precedent in the field of the medical malpractice law by relating to it in the case of *Halushka* in 1965 and *Weiss* in 1989), namely, by providing for the obligation of properly informing the people who would participate in biomedical research about the purpose of such research, probable risks and benefits, etc. (Art. 25 of the 1996 version of the *Code*, Art. 39 of the 2004 version, and Art. 9 of Sec. C of the 2018 version). The three latest versions of the *Code* attributed specific attention to the issue of informed consent and the rejection of treatment by the patient (Art. 14 of the 1996 version, Art. 23 of the 2004 version, and Art. 11 of Sec. C of the 2018 version); it is also notable that the 1996 version of the *CMA Code of Ethics* also stipulates to consider the growing engagement of minors into the process of decision-making relating to medical treatment, which was quite novel those days. The most recent versions of the *CMA Code of Ethics* provide considerable attention to the confidentiality of the patient's medical information (Art. 22–24 of the 1996 version of the *Code*, Art. 31–37 of the 2004 version, and Art. 18–21 of Sec. C of the 2018 version of the *Code*) (Canadian Medical Association Code of Ethics, 1996, 2004; Canadian Medical Association Code of Ethics and Professionalism, 2018).

It is notable that the provisions of the latest versions of the code speak about the doctor's obligation to provide the patient with a copy of his or her medical record, thus fulfilling the patient's right to get

[2] One of the best examples of such case circumstances, illustrated best by facts of the case and discussed by the court at a considerable length would be: *Marshall v. Curry* [1933] 3 D.L.R. 260 (Nova Scotia Supreme Court, May 15, 1933).

access to medical records (Art. 24 of the 1996 version, Art. 37 of the 2004 version, and Art. 19 of Sec. C of the 2018 version). In fact, the issue of the access to medical records in Canada was extensively discussed in the case of *McInerney v. MacDonald* (1992), where the Supreme Court held that that, in absence of legislation, the patient may request the records for examination, which does not stem from the patient-physician relationship; the patient's right to access the medical records is based upon the fiduciary duty of the physician, grounded upon the patient's interest in his or her medical records (*McInerney v. Macdonald*, 1992, p. 149–151). Several years earlier, in the case of *Cook v. Ip et al.* (1985), adjudicated by the Ontario Court of Appeal, the court determined that medical records in the shape of clinical notes could be produced for the needs of a lawsuit for damages (Cook v. Ip et al., 1985, p. 1).

2. Confidentiality and medical ethics

We have already discussed that it was the *CMA Code of Ethics* which likely provided for the earliest legal regulation of medical confidentiality in Canada, and the provisions, which protected the patient's medical information, were included in the forthcoming editions of the *CMA Code of Ethics* in the 20th and 21st centuries. It was accepted in the judicature of the Canadian courts that the confidentiality of medical information originated in Common Law (St. Louis v. Feleki, 1990, p. 758, para. 22). Since the late 1970s, Canadian provinces started to codify the provisions on medical confidentiality, which was also analyzed and discussed in judicature (Re Inquiry into Health Records in Ontario, 1979, p. 704). Medical confidentiality was extensively discussed in this article, but we still need to define the issue of legitimate disclosures. In the 1980s, the problem of HIV/AIDS marked the necessity of adopting new legislation relating to the legitimacy of disclosure of such information. In 1987, the *Canadian Medical Association* found that it was not unethical to make a disclosure to an 'appropriate person' with the knowledge of the patient, and, in certain situations, to make a disclosure when the public interest definitely outweighs the patient's interest. In 1989, the *Canadian Medical Association* found it appropriate that the doctor could legitimately disclose the fact of the patient's HIV-status to the patient's spouse even in spite of the fact that the patient himself or herself refused to reveal it to his or her spouse (Casswell, 1989, p. 226–229). According to Casswell (1989), the provinces of Canada adopted different legislation in terms of the physician's right or obligation to inform the close relatives of a HIV-positive patient: in some instances, a doctor could exercise such a right, whereas, in other instances, it was the physician's obligation; in British Columbia, the doctors were also required to report such cases to medical health officers (Casswell, 1989, p. 229–235). Anderson and Sadighpour also highlighted that the obligation of the physicians to health authorities concerning the need to report on HIV was not only in this type of medical issue, but that the obligation also extended to tuberculosis and viral hepatitis (Anderson and Sadighpour, 2020, p. 135). D. Y. Dodek and A. Dodek (1997) also held that the provincial legislation, obliging the physicians to report medical information relating to the HIV-status of the patients was not uniform in Canada in the 1990s (Dodek and Dodek, 1997, p. 840–842). The 2003 version of the *Code of Ethics of Physicians* (Quebec) provides more details relating to the confidentiality of medical information: Section 20 of the *Code* holds that, apart from the doctor's obligation of confidentiality, the physician must not use the medical information for the harm to the patient, and shall not disclose such medical information unless the patient has empowered the doctor to do so, or unless the Law either empowered or made it mandatory to perform such a disclosure, or when there are fair foundations for such a disclosure, which is related to the health or safety of the patient (Code of Ethics of Physicians, 2003). I. Kleinman, F. Baylis, S. Rodgers and P. A. Singer (1997) in their article on medical confidentiality relating to the *CMA Code of Ethics* denoted that the

physicians had usually and mainly breached medical secrecy in those cases where it was clear that the patient intended to cause harm to others, which mainly related to psychiatric treatment (Kleinman, Baylis, Rodgers and Singer, 1997, p. 521–524).

The case of *Halls v. Mitchell* (1926–28), known as the primary Canadian precedent in medical confidentiality, featured a reference of medical ethics in the judgment of the court of appeals: in that case, the plaintiff, an ex-serviceman, had contracted an eye disease while working on the railroad and demanded compensation under the *Workman Compensation Act*, to which he was denied, as the board found that the eye disease was a result of a venereal disease he had suffered earlier, and the physician who used to treat the plaintiff earlier wrote a letter to the *Workers Compensation Board* in which he stated that he used to treat him for a venereal disease. The plaintiff won the case on the first and third instances, while losing at the second instance (the final judgment was rendered by the Supreme Court of Canada[3]) (Halls v. Mitchell, 1927, p. 163; Halls v. Mitchell, 1928, p. 125), and a highly interesting and peculiar phrase was employed in the judgment of the *Ontario Supreme Court*: "*I do know whether the code of ethics of the medical profession would recognize such conduct as proper, but it certainly does appear extraordinary that a physician to whom a patient discloses his physical ailments should afterwards use the information so acquired to the injury of the patient, merely because the interests of his present employers so require*" (per Wright, J.) (Halls v. Mitchell, 1926, p. 209).

The case of *Murray v. Murray* (1947) raised a complicated issue on medical confidentiality on medical records relating to the treatment of venereal diseases despite the code of medical ethics was not being directly involved in the case. At that time, there was no specific legal regulation on medical confidentiality, and the institute of secrecy relating to all medical information concerning a patient was rather recognized as falling within the scope of Common Law. In a divorce lawsuit, a plaintiff claimed that he had contracted a venereal disease from his wife owing to adultery, and the defendant consented to the production of evidence from the medical records relating to her treatment which were being stored at the local Department of Health. The witness in the case, a representative of the Department, was summoned to the court in relation to the inquiry on the said medical records, and refused to provide an answer of whether the Department had actually possessed this medical record, while also objecting to the production of the medical record. The witness also produced an affidavit of the Minister of Health, where the reasons for withholding the record were explained. Firstly, the Minister of Health denoted that it would be contrary to the public interest to make the production of the medical record, regardless of the existence or non-existence of the patient's consent to it, and it would be contrary to the public interest for an officer of the Department to give information relating to such medical record and the content to it. The affidavit of the Minister of Health further proceeded that, to go otherwise, in case the medical record maintained under the *Venereal Diseases Suppression Act* (1936) (Venereal Diseases Suppression Act, 1936), could be produced for civil proceedings, then the patients would be less likely to seek medical assistance from the Department and provide the confidential information. Having examined the appropriate case and having considered the authorities, the court (per Wilson, J.) held that combatting venereal diseases is apparently a matter of public interest, and the affidavit convincingly explained the need for the confidentiality in such medical information. Therefore, the court ruled that, even without examining the documents, the medical records need not be produced in evidence, thereby ruling that it would be against the public interest to do so (*Murray v. Murray*, 1947, p. 236).

The case of *Cordeau c. Cordeau* (1984), adjudicated by the Court of Appeals of Quebec, presents the application of the *Code of Ethics of Physicians* (in its 1981 version). This was a dispute relating

[3] *Halls v. Mitchell* [1928] 2 D.L.R. 97, [1928] S.C.R. 125 (Supreme Court of Canada, February 7, 1928).

to the validity of a testament, which the appellants tried to impugn in court, and the main argument of which was that the testator was deaf and blind at the moment of drawing the said testament, and the plaintiffs doubted the validity of the testament due to finding that it may not correspond to the actual will of the testator, and hence they filed a lawsuit claiming that the will was not valid. During the trial, the doctor of the deceased was questioned in the court, and the judge raised the issue of secrecy of the doctors, since the parties of the proceedings did not raise it. The physician testified concerning the ability of the testator to hear and see, and the judge concluded that these findings were made upon the observations of the physician during the visits to the testator. When two other doctors were to be heard, the proceedings were temporarily suspended, since the judge found it necessary to study this complicated aspect of medical confidentiality, and then decided not to accept the testimony of the doctor as evidence. The court found that such a testimony would contravene Art. 9 of the *Charter of Human Rights and Freedoms* since this article, upon the conclusion of the court, inhibits disclosures of medical information by the physicians, apart from cases where the Law permits so. Hence, the testimony of the deceased testator's doctor was not accepted as evidence, which was appealed to the Quebec Court of Appeals. The court decided to allow the appeal (2 vs. 1). Upon the opinion of Turgeon, J., the wording of Art. 9 of the Charter, upon which the court was required to protect a professional secret *ex officio*, does not mean that the court must reject the doctor's testimony. This provision means that the judge should explain the witness the legal provisions and point out Art. 9 of the *Charter* and Art. 42 of the *Law on Medicine*, and medical confidentiality should be limited by the obligation of the doctor to maintain it, whereas the judge has discretional powers to compel the medical witness to give the appropriate testimony. It was emphasized that it was about the doctor's testimony in a courtroom, but not the general obligation of secrecy to the society, and the inhibition of the testator's physician to testify would contravene to the administration of justice. Hence, it was necessary for the court to know all the facts of the dispute which the court was resolving, and, for such reasons, it would be appropriate to give a restrictive interpretation of Art. 9 of the *Charter* and Art. 42 of the *Law on Medicine (Quebec)* (*Loi médicale (Québec)*, 1973). Upon the opinion of Paré, the appeal should be granted. Paré agreed with the position of the plaintiffs who hallmarked that Art. 9 of the *Charter* was incorrectly applied by the trial court, because of which, the physician was not allowed to testify concerning the blindness and deafness of the testator, while finding that Art. 42 of the *Law on Medicine (Quebec)* does not itself oblige the doctor to maintain secrecy, but only has effect on avoiding the constraint of testifying of what was revealed to the physician in confidence, thereby adding that the usual interpretation of this provision presupposed that it was up to the physician to decide of what to reveal in a courtroom in the interest of the patient. Art. 9 of the *Charter* applied in those cases where the person was bound to professional secrecy, and to such an extent to which such a person was obliged to do so. The provision of Art. 9 did not contain a list of persons bound to professional secrecy with an exception of priests, and the extent of the obligation of confidentiality was rather expounded in the laws on different professions. Paré also discussed the provision of Art. 3.01 of the *Code of Ethics of Physicians*[4] (the 1981 version acting at the time of the proceedings), which was based upon Art. 87 of the *Code of Professions*. Upon this provision, the code of ethics forbade the disclosure of medical information, which was due to the physician's negligence, but Paré denoted that this provision did not relate to the revelations concerning

[4] Art. 3.01 of the *Code of Ethics of Physicians* (Code de déontologie des médecins, RRQ 1981, c M-9, r. 4) proceeds as follows: "*The doctor must keep secret what comes to his knowledge in the exercise of his profession; he must, in particular, refrain from holding indiscreet conversations about his patients or the services provided to them or from revealing that a person has used his services, unless the nature of the case requires it.*" Hence, from the literal sense of this provision, there is no prohibition from testifying of a doctor.

a court case, and found that the testator would be interested that his will would be considered valid and, hence, Paré concluded that the said provision of the *Code of Ethics of Physicians* did not alter the meaning of Art. 42 of the *Law on Medicine*. Nolan filed a dissenting opinion due to finding that the provisions of Art. 9 of the *Charter* should be understood in a way that physicians should be exempt from testifying in relation to those subjects which they had learned in confidence. Nolan referred to the *Code of Professions (Quebec)* which had been enacted in 1973 (Code des professions (Québec), 1973), which provided that each bureau that was established within a professional corporation was to establish a specific code of professional ethics, which would, *inter alia*, establish the obligation of the person holding a certain profession, to maintain secrecy[5]. Next, in spring 1980, the *Code of Ethics of Physicians* was adopted by *Bureau de la Corporation professionnelle des médecins du Québec*. Five provisions (Art. 3.01 – Art. 3.05) related to maintaining confidentiality by doctors (in fact, there was no direct provision concerning testifying in court, whereas it was mentioned in Art. 3.04 of the Code of Ethics in which particular cases the physician could divulge the facts containing a professional secret)[6]. Upon the view of Nolan, the legislation and jurisprudence made it inadmissible to accept evidence from what came to the physician in the course of exercising the profession, while also adding that, in deciding whether the heirs of the deceased testator could release the physician from confidentiality, then none of the parties of the proceedings could do so. The appeal was allowed (2 vs. 1) (Cordeau c. Cordeau, 1984, p. 201).

3. Canadian codes of medical ethics as a source of law in disciplinary proceedings on malpractice and professional misconduct

The Canadian Case Law shows that the codes of medical ethics (mainly, the *Canadian Medical Association Code of Ethics* was cited, while, occasionally provincial codes of medical ethics were cited as well) were used as a source of Law primarily in actions by medical practitioners in order to impugn the decisions of disciplinary committees of medical associations which deleted their names from the lists of registered medical practitioners, as well as, occasionally, were cited in medical malpractice cases and cases relating to various issues of the patient's rights, such as medical confidentiality as well as consent and refusal of medical treatment. In some cases, issues of medical ethics were presumed, though not referred to directly, whereas, in many other cases, they were directly cited by the courts.

[5] The current version of the *Code* (Quebec), RLRQ c. C-26, in terms of professional secrecy states (Sec. 60.4) that the professional has to maintain secrecy, the facts containing a professional secret came during the exercise of the profession; and it is allowed to divulge such facts only in two cases: 1) when the client authorizes the professional to do so, and 2) when it is expressly established by the Law.

[6] The provisions of the *Code of Ethics for Physicians* (Code de déontologie des médecins, RRQ 1981, c M-9, r. 4) relating to medical confidentiality read as follows (translation from French):

"3.01. The doctor must keep secret what comes to his attention in the exercise of his profession; he must, in particular, refrain from holding indiscreet conversations about his patients or the services provided to them or from revealing that a person has used his services unless the nature of the case requires it.

3.02. The physician must take reasonable measures with regard to his employees and the personnel around him to ensure that professional secrecy is preserved.

3.03. The doctor must not use confidential information to the detriment of a patient.

3.04. The doctor may, however, disclose facts of which he has personal knowledge, when the patient or the law authorizes him to do so, when there is a compelling and just reason relating to the health of the patient or those around him.

3.05. Unless there is just cause, the doctor cannot reveal a serious or fatal prognosis to the patient's entourage if they forbid him to do so."

Let us examine the most outstanding cases where the codes of medical ethics were cited, or cases involving various ethical issues between patients and physicians (where codes of ethics were directly cited, or were not directly cited, but the case still involved a certain ethical problem), or between the physicians and other physicians or medical associations and hospitals. In some cases, mostly earlier ones, courts discussed how to define the 'unprofessional conduct' of physicians in disciplinary cases.

In the case of *Re Cherniak and College of Physicians and Surgeons of Ontario* (1919), the physician's (appellant's) name was deleted from the register for committing a criminal misdemeanor, for which the appellant was convicted on 15 February 1919 for giving liquor to a patient: the appellant was prosecuted before the Police Magistrate for violating the *Ontario Temperance Act* of 1916, Section 51 (Ontario Temperance Act, 1916). The appellant was fined for a misdemeanor, later impugned and failed to quash the conviction. Before the committee, the appellant stated that once, a young woman, who was complaining of cold, asked him to prescribe a quart of whiskey, but he prescribed six ounces of it and a mixture instead, and later the woman was found drunk on the street with a bottle of whiskey which belonged to the doctor. Section 31(1) of the *Ontario Medical Act* (1914) provided that the physician's name would be erased from the register had the physician committed, *inter alia*, disgraceful conduct; and Section 31(4) provided that had the physician committed a criminal offence, the physician's name would be expunged from the register even without any action by the medical council (Ontario Medical Act, 1914). The committee, and later, the medical council also found that, in respect of the appellant's conviction, the appellant conducted himself infamously, and so the appellant's name was erased from the register. The *Ontario Court of Appeals* denoted that the appeal related not to quashing the conviction, but the decision of the medical council, and that the phrase relating to the doctor's misconduct of the *Ontario Medical Act*, Section 33 (the version of the law acting at the time of the proceedings was the re-enacted law of 1897 which had been originally enacted in 1887), which was initially modelled from the *English Medical Act* (1858, c. 90), Section 29, namely: "…*guilty of any infamous or disgraceful conduct in a professional respect*." Section 31(1) could be synonymic to the one in the *English Dentists Act* (1878, c. 33, Section 13) (Dentists Act (England), 1878), upon which, the appropriate provision of the *Ontario Medical Act* (1914) was founded, whereas the *English Medical Act* reads "*guilty of infamous conduct in any professional respect*" (Medical Act (England), 1878). The Court (per Maclaren, J. A.) held the following: "*I am of opinion that our Legislature, in providing from time to time for the maintenance of discipline among the members of the various learned professions, has clearly shewn its intention that professional ethics and the rules governing the same should be interpreted and enforced by the respective members in each of the professions*." Then, upon further examination, the appellant himself claimed that had made several hundreds of liquor prescriptions, but he had not seen anything wrong with it, saying he had dispensed his own medicine this way, and his name was expunged from the register according to the council's decision in respect to his conviction. The Court (per Maclaren, J. A.) stated that the acts of the medical council were in accordance with the law. Meredith, C. J. O. also found that the appeal had to be dismissed by holding that the conviction itself would not justify respondents in finding that the appellant committed an infamous action, but, at the same time, the committee could have reached a conclusion that the appellant improperly behaved himself when he prescribed liquor to the woman who had requested it. Meredith, C. J. O. also denoted that the Legislature allowed prescribing liquor to patients in certain cases, but an abuse of such a privilege (that is, the physician's privilege to prescribe liquor to patients) could be found to be an infamous and a disgraceful act from the side of the physician in the sense of Sec. 31 of the *Ontario Medical Act* (1914). Hodgings, J. A. discussed the wording of the statutes relating to the definition of infamous conduct of the physicians within exercising their professional

capacity and found that the wording of the respective provisions of the Canadian laws differs from the English ones in the sense of being broader, and the position which was expressed in *In re Crichton* (1906) was a correct one for application. Concerning the fact that the appellant had prescribed liquor hundreds of times, upon the view of Hodgings, J. A., there was no evidence that it was made in an unlawful way, thus also coming to a conclusion that the appeal had to be dismissed, but outlining the divergences in the wording of the Canadian and the English laws. Fergusson, J. A., by dissenting, denoted that, whereas the appellant was blamed for prescribing liquor to many patients, the appellant was charged for only one such case (the circumstances of which had been described above), and the only evidence was the admission of the appellant himself who told the situation relating to the woman who had asked him for liquor; the appellant later told that he, in fact, did prescribe liquor to hundreds of patients, but all of these prescriptions were legitimate, and Fergusson, J. A. stated that there was no evidence showing that the liquor which the appellant gave to the woman was given as a beverage, and that it was unnecessary; and no evidence existed that all the other prescriptions were illegitimate, thereby finding that the appeal should be allowed, to which Magee, J. A. agreed. However, the appeal was dismissed as the majority of the judges ruled to dismiss the appeal (Re Cherniak and College of Physicians and Surgeons of Ontario, 1919, p. 43, etc.).

In the case of *Carefoot, In re; Medical Profession Act, In re* (1925) which was adjudicated by the *Saskatchewan Supreme Court*, we may observe a direct application of the medical ethics code provision. In this case, the appellant used an Abrams machine (which was then named 'Dynomizer') in order to diagnose and treat patients, and was found to be guilty of professional misconduct pursuant to Section 40 of *The Medical Profession Act* (1920) (The Medical Profession Act, 1920), and the physician's name was irrevocably removed from the register. In this case, the appellant had a certain success in reducing the penalty, and the Court ordered to restore his name on a later date. The charges for professional misconduct were formulated, in general, by firstly, using the Abrams machine (which was not accepted as a reliable diagnostic means) and secondly, in the methods of dealing with the patients while the machine was being applied), and overall. Many physicians were called to testify to express their opinion concerning the reliability of the machine which the plaintiff had used for diagnostic purposes. The disciplinary committee also observed the medical cases when the treatment applied by the appellant was found to be rather successful, and even some signs of a successful application of the Abrams machine were denoted. On the other hand, the appellant trusted the diagnostic measures to the Abrams machine, by finding it to be a proper diagnostic device, despite the vast majority of the physicians finding that it was completely unreliable. Next, evidence was presented in terms of unsuccessful cases of the appellant. He used to diagnose patients for such severe diseases as cancer and syphilis, and guaranteed a cure, which was up to the Abrams machine to select; he also used to make considerable fails while 'diagnosing' cancer and syphilis, whereas no actual signs of it had occurred, which had been proven by diagnostic means. What is more, the appellant used to provide a number of severe diagnoses simultaneously (of which there was nearly no cure, or only limited cure in the 1920s), whereas, occasionally, such gloomy diagnoses were highly overestimated or completely incorrect at all. Most of the physicians who were questioned in terms of the Abrams machine found it to be of no therapeutic value, whereas the appellant believed in the power of the machine, and there was evidence from one physician who examined the machine that it could give some positive results in treatment. The court found that the appellant could not be blamed for using the Abrams machine, and the court chose not to discuss the actual value of the device, since it was a scientific question, but, in terms of the behavior of the appellant, different conclusions were made. The physician claimed that the machine never erred in diagnosis and could find a cure for any ailment; also, the physician repeatedly diagnosed patients with

diseases which they did not actually suffer from, treated the patients from non-existing ailments and took considerable remuneration. Hence, there was substantial evidence to believe that the conduct of the appellant was unprofessional. The court also paid attention to the behavior of the appellant who repeatedly stated severe diagnoses to the patients, and referred to the *Code of Ethics of the Dominion Medical Association*, upon which, the physician should avoid giving gloomy prognostications, and it was unfavorable for the profession of a physician to propose radical cures (which, in fact, the appellant did both). At the same time, the court held that, given the fact that the appellant was a well-educated young man, it would be unfair to erase his name from the register for good, and ordered to renew his name in the register on January 1, 1927 (Carefoot, In re; Medical Profession Act, In re, 1925, p. 49).

In the case of *Re Medical Act; Re Kirby* (1964), the *Supreme Court of British Columbia* also dealt with the issue of how 'professional misconduct' should be interpreted regarding malpractice on behalf of a physician. In late August 1963, the council of the *College of Physicians and Surgeons of British Columbia* charged the appellant guilty of infamous and unprofessional conduct, and suspended his license to practice for six months; the appellant was accused in submitting claims to the *Medical Services Association* (M.S.A) as well as to *Medical Services Incorporated* (M.S.I.) for the payment for medical services which had not been actually performed by him. The counsel for the appellant claimed that all the charges were related to financial issues, but did not refer to any professional misconduct, and thus, such a claim, as he stressed, is not subject to a medical inquiry, but had to be brought before a civil court of law, as, by the charges put by the medical association, the doctor was accused of defrauding the M.S.A. and the M.S.I. The counsel for the appellant also claimed that, once, the physician had simply confused some documents, which he honestly admitted, and, in the other cases at dispute, it was entirely a matter of the interpretation of contracts of the M.S.A. and the M.S.I. relating to whether the contract clauses covered the doctor's services which include ones performed by the doctor, or the medical auxiliary staff (which refers to the nurses), or only of those services which were explicitly provided by the doctor; hence, according to the counsel, the appellant honestly believed that he could make such charges. Thus, had it been an actual error, it could be solved by the parties, and it was surely not a serious malpractice which could constitute a professional misconduct. However, earlier, the Inquiry Committee did not find the applicant's explanations to be sufficient, by underlining that, in terms of the disputed actions of the appellant, he acted knowingly (the Court reiterated the findings of the Inquiry Committee). In terms of the counsel's argument concerning the allegation that the appellant had committed nothing to charge him for infamous and unprofessional conduct, it was held that medical experts were required to assess his conduct, but, at the same time, the counsel for the respondent stated that, when the legislature entrusted the inquiry procedure to the council, it contended that the council would include such experts who would conduct a proper assessment of the physician's acts. The Court referred to two earlier case authorities in terms of defining what should be observed as infamous and disgraceful conduct (in *Re Hett and the College of Physicians and Surgeons of Ontario* (1937), the *Ontario Court of Appeal* postulated that such a standard should apply not in a general context, but in from the view of fellow professionals (Re Hett and the College of Physicians and Surgeons of Ontario, 1937, p. 582), whereas in *In re Crichton* (1906), the *Divisional Court of Ontario* held a reverse opinion by claiming that, in order to define what is professional misconduct it is necessary to conduct assessment from the view of common judgment, and not, *inter alia*, from the view of written or unwritten ethics of the medical profession (*In re Crichton*, 1906, p. 271). The Court found that there was sufficient evidence for the committee to reach a unanimous decision in respect with the appellant and thus the Court dismissed the appeal (Re Medical Act; Re Kirby, 1964, p. 688).

In the case of *Re D. and Council of the College of Physicians and Surgeons of British Columbia*

(1970), there were three issues which would pose serious ethical (notwithstanding legal) issues: a) a performance of a procedure on a minor patient without the knowledge or consent of the parents; b) impious behavior of the doctor towards the patient; c) a wayward interpretation of the institute of medical secrecy, which the physician used as a defense claiming that all details of medical procedures are under the veil of secrecy; d) concealing the actual situation with the patient's health after the medical procedure had taken place. The facts of the case were the following: the appellant impugned the decision of the Council of the *College of Physicians and Surgeons* which related to the facts of infamous conduct towards a 15-year-old female patient to whom the doctor inserted an intrauterine birth control device; the patient had previously, unbeknownst to her parents, in March 1968, came for a consultation to the physician inquiring on how to avoid pregnancy. The physician decided to insert a birth control device under general anesthesia, and this manipulation was done without the knowledge or consent of the patient's parents (however, there was no information in the case report that either the patient, or the patient's family members attempted to sue him for his acts). Next, the physician was also accused in behaving impiously towards the female patient, whereas the physician completely denied such statements. The inquiry committee, however, established that the female patient was telling the truth, and did not accept the evidence of the doctor who also introduced medical records of the patient, but these were found to be clumsily maintained. The apparatus caused bleeding and cramps of the female patient, but it was still not removed by the physician, even in spite of the fact that the female patient and her mother turned to him with the problem of health complications. The facts were established that on the third day after the insertion of the device, the female patient came to see the doctor already with her mother, and the doctor assured the patient's mother that the birth control device was no longer inside, but, in fact, it was, and the doctor was even himself not sure of whether the device was intact. The doctor did not actually remove the device, nor did the doctor notify the mother of the female patient concerning this fact. The doctor also did not ask to conduct an X-ray, which could have easily determined whether the birth control device was in the patient's body, and he did not do so. The doctor also contended that he had a substantial number of young patients seeking advice, and did not charge the female patient for the procedure, and that all the affairs between him and the female patient were under the veil of secrecy. The counsel for the appellant contended that once a doctor accepted a patient, he was bound to the code of ethics and the oath of secrecy, which would not allow divulging any information concerning the patient, even if it were the parents of the patient, but the court held that the physician could not use the oath of secrecy to defend himself in such a situation since the mother of the female patient was already involved, as she came with her daughter on the visit three days after the device had been inserted. Still, the findings of the inquiry committee were that the appellant was guilty of unprofessional behavior, and the court, by ascertaining that the committee had a better view in terms of the evidence than the given court, found that the appeal should be dismissed (Re D. and Council of the College of Physicians and Surgeons of British Columbia, 1970, p. 570).

In the case of *In re Isabey and College of Physicians and Surgeons of Manitoba* (1975), the doctor, according to the conclusions of the *Executive Committee of the Council*, committed an act of professional misconduct: from March 1970 to January 1972, the doctor collected a large sum of money from the *Manitoba Health Services Commission* for the blood counts he had never done (nor had anybody else done those under the said doctor's supervision), although one laboratory held it permissible for him to do so as the doctor had an arrangement with that particular laboratory; nevertheless, the Committee established that the practice of billing for services that had not been performed to be an unacceptable

kind of practice, and suspended the doctor's practice privileges for six months, to which the physician did not agree and impugned this decision; the *Manitoba Court of Queen's Bench*, upon hearing the case, outlined that the court's task in such a litigation is not to provide a substitution of the findings by the Committee, but to establish whether the Inquiry Committee had acted within the respective statutory provisions, and whether the physician had received an appropriate fair hearing, and whether the evidence, which had been submitted, could justify the conclusion which the Executive Committee had reached in respect with the complainant in the case at stake (as we may see, such are the court's tasks in disciplinary cases). In terms of the physician's right to a fair hearing, the evidence showed that he was definitely not deprived from it, and that the evidence showed that the physician had indeed received a large sum of money from the *Manitoba Health Services Commission* for the services he had not performed, and the physician had tried to mitigate such malpractice by claiming his professional services to the public, but the Committee found that he had actually committed a gross misconduct; the Court denoted that the physician founded his complaint on his own interpretation of a particular ethical provision; the physician believed that he had not committed any misconduct by collecting money for the services he had never performed; neither the Committee, nor the Court agreed with it. The Court found that the breach of professional ethics by the complainant, in the view of the Court, would be even more serious than the Committee had found previously. As the Court explained, as the *College of Physicians and Surgeons* was delegated an exclusive right to practice medicine in the province of Manitoba by the people of Manitoba, and had the College tolerated such practices – i.e., what kind of malpractice the complainant had committed, the people of Manitoba would lose their confidence in the College to administer the practice of medicine. The Court went further to explain that had the College tolerated such a kind of malpractice by the complainant who referred to it as a "business arrangement" (with one laboratory), such malpractice would increase, and the Court found that, by holding that such actions committed by the complainant constitute a professional misconduct, the Committee made a valuable service for administering medicine in the province of Manitoba. As to the time of the suspension, to which the physician complained, the Court found it to be adequate, and not higher than is ordinarily imposed in such cases of professional misconduct. The Court held to dismiss the appeal (In re Isabey and College of Physicians and Surgeons of Manitoba, 1975, p. 156).

Conclusions

1. Codes of medical ethics are considerably mature acts, but the question of whether it could be a source of Law has been raised very infrequently. The Canadian codes of ethics (apart from the *CMA Code of Ethics*, there exist a multitude of provincial codes of ethics) have been adopted by medical associations, and they are not legal acts which are passed and adopted by a legislative body. At the same time, their valuable nature of regulating the relationships between the physicians and the patients, as well as setting the obligations of the physicians to the public and adjusting the ethical rules of the medical profession makes them a source of Law.
2. The Canadian Case Law demonstrates that different codes of medical ethics adopted in Canada have been repeatedly cited in court decisions, and these provisions have been cited alongside legislative acts and Case Law. The references to the codes of medical ethics, upon the findings of the authors of the present research, were made in disciplinary cases on professional misconduct and malpractice of physicians, as well as in cases relating to the patient's rights.
3. It has also been found that the codes of ethics in the 1970s and 1980s already regulated some issues (i.e., the confidentiality of medical records, consent to medical treatment, treatment in the case of

emergency) relating to the rights of patients which, at that time, had been established by Common Law and were not yet codified by legislation.

4. The authors have found that the codes of medical ethics could have a bigger role in legal disputes in countries where they are lesser known and used as a source of Law since the aim of the code of medical ethics is to regulate the relationships between the patient and the physician, as well as the relationships in the sphere of healthcare upon certain moral and ethical rules, which may also become the subject of various legal disputes.

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Canadian Codes of Medical Ethics as a Source of Law

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S u m m a r y

The article discusses the Canadian codes of medical ethics as a source of Law. The heading *CMA Code of Ethics* has undergone nineteen editions since it was adopted in 1868 until its latest edition in 2018. There are also provincial codes of medical ethics, adopted by local medical and dental associations of physicians. Since its adoption, the *CMA Code of Ethics* gradually changed its content, which became more oriented towards the patient's rights and the regulation of relationships between physicians. The authors have discovered that the provisions of the codes of medical ethics (*CMA Code of Ethics*, as well as others) were occasionally applied in Case Law, when dealing with the patient's rights and in cases of the physician's disciplinary liability. It should be noted that the codes of medical ethics, adopted in Canada, were not adopted as ordinary legislative acts, but rather by associations of physicians and dentists, which makes them 'non-classical' acts. Nevertheless, these codes are considered as a complimentary source of Law, and they are occasionally cited by courts in various investigations of medical malpractice and disciplinary cases. The 1970s versions of the *CMA Code of Ethics* are also known to include the provisions concerning safeguarding the patient's rights (and, what is more notable, the use of the exact term 'patient's rights', which was also known to be used by the *Quebec Superior Court* in the case of *Dufresne c. X.* (1960), anticipating the emergence of the concept in the subsequent decades. What is more, the basics of the patient's rights had already been created in the earlier Canadian jurisprudence in medical malpractice cases on breaches of medical confidentiality (primarily known for the case of *Halls v. Mitchell* (1926–28), as well as the cases relating to unconsented surgical operations. The authors suppose that the codes of medical ethics may have a greater role in the modern medical malpractice law, and it will help solving complicated issues relating to the patient's rights, patient-physician, and physician-physician relationships.

Kanados medicinos etikos kodeksai kaip teisės šaltinis

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S a n t r a u k a

Straipsnyje aptariami Kanados medicinos etikos kodeksai kaip teisės šaltinis. CMA etikos kodekso buvo išleista devyniolika leidimų nuo tada, kai jis buvo priimtas 1868 m. iki paskutinio leidimo 2018 metais. Be šio kodekso, Kanadoje leidžiami provincijos medicinos etikos kodeksai, juos leidžia vietinės gydytojų ir odontologų asociacijos. Nuo pat CMA etikos kodekso priėmimo pamažu keitėsi jo turinys, labiau imta akcentuoti paciento teises ir gydytojų santykių reguliavimą. Autoriai išsiaiškino, kad medicinos etikos kodeksų (CMA etikos kodekso ir kitų) nuostatomis retkarčiais buvo remiamasi teismų praktikoje, sprendžiant paciento teisių ir gydytojų drausminės atsakomybės klausimus. Pažymėtina, kad Kanadoje gydytojų ir odontologų asociacijos medicinos etikos kodeksai priimami ne kaip įprasti teisės aktai, , todėl jie nėra „klasikiniai" aktai. Nepaisant to, šie kodeksai yra laikomi papildomu teisės šaltiniu, o teismai retkarčiais juos cituoja įvairiose medicininio aplaidumo ir drausmės bylose. Taip pat žinoma, kad praėjusio šimtmečio aštuntojo dešimtmečio CMA etikos kodekso versijose yra nuostatų, susijusių su paciento teisių apsauga (ir, o tai dar svarbiau, vartojamas tikslus terminas „paciento teisės", kurį taip pat žinojo Kvebeko aukštasis teismas). *Dufresne C. X* (1960) atveju, numatant šios koncepcijos atsiradimą per ateinančius dešimtmečius, be to, paciento teisių pagrindai buvo sukurti ankstesnėje Kanados jurisprudencijoje medicininio aplaidumo bylose dėl medicininio konfidencialumo pažeidimų (pirmiausia žinoma byla *Halls v. Mitchell* (1926-28), taip pat bylose, susijusios su chirurginėmis operacijomis be sutikimo. Autoriai mano, kad medicinos etikos kodeksai gali turėti didesnį vaidmenį šiuolaikinėje medicinos aplaidumo teisėje ir padėtų sprendžiant sudėtingus klausimus, susijusius su paciento teisėmis, paciento ir gydytojo bei gydytojo ir gydytojo santykiais.

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