

CITATION: J.C. et al. v. Jugenburg et al., 2026 ONSC 3061
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SUPERIOR COURT OF JUSTICE - ONTARIO

RE: J.C. and A.C., Plaintiffs

AND:

MARTIN JUGENBURG and DR. MARTIN JUGENBURG MEDICINE
PROFESSIONAL CORPORATION, Defendants

BEFORE: Schabas J.

COUNSEL: Margaret Waddell, Karine Bedard, Kate Mazzucco, Josh Nisker, Paul Miller and
Victoria Yang, for the Plaintiffs

Nina Bombier, Paul-Erik Veel, Liza Leshchynska, Catherine Blair and Amanda
Smallwood, for the Defendants

HEARD: November 17 – 21, 24 - 28, December 1 – 5, 8 – 11, 17 and 18, 2025

REASONS FOR JUDGMENT

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Overview

[1] On December 13, 2018, the CBC investigative news show, “Marketplace”, broadcast a story about a video camera system operating at the Toronto Cosmetic Surgery Institute (“TCSI” or “the Clinic”). TCSI is a private medical clinic owned and operated by the defendants, Dr. Martin Jugenburg and his corporation, Dr. Martin Jugenburg Medicine Professional Corporation. The Clinic is located on two levels within the Fairmont Royal York Hotel in downtown Toronto where Dr. Jugenburg carries on his plastic surgery practice, providing a range of cosmetic surgical procedures including breast augmentations, liposuction, “tummy tucks”, “butt lifts” and Botox injections.

[2] In the course of an investigation into breast implant surgery offered by private cosmetic surgery clinics, two Marketplace journalists attended at the Clinic in November 2018. One of them posed as a patient. During her consultation with a nurse at the Clinic, the journalist noticed what appeared to be a surveillance camera on the ceiling of the consultation room. When asked to remove her top to have her breasts photographed, the journalist expressed concern about the camera. However, she was told there were cameras “all around” the Clinic.

[3] Marketplace contacted Ontario’s medical regulatory body, the College of Physicians and Surgeons of Ontario (“CPSO”), and the Office of the Information and Privacy Commissioner of Ontario (the “IPC”) regarding the presence of the cameras.

[4] On the same day the story aired about the cameras, December 13, 2018, the CPSO attended at the Clinic and disabled the camera system. The following day, the CPSO removed the DVRs containing footage from the camera system. The CPSO commenced an investigation into Dr. Jugenburg’s conduct.

[5] The IPC also commenced an investigation into the Clinic’s use of the cameras, eventually releasing a decision that the Clinic’s “blanket use of surveillance cameras for non-health purposes...is unacceptable” and contravened the *Personal Health Information Protection Act, 2004*, S.O. 2004, c. 3, Sched. A (“PHIPA”): PHIPA Decision 98, September 20, 2019, reported as *Toronto Cosmetic Surgery Institute (Re)*, 2019 CanLII 87820 (ON IPC) at para. 40.

[6] It was subsequently confirmed, and there is no dispute, that the Clinic had 24 surveillance cameras, located in reception and waiting areas, hallways, a staff room and workplace areas, consultation and injection rooms, and in the operating room and the post-operative recovery area. Prior to the CBC investigation, the only sign inside the Clinic warning anyone that there were surveillance cameras was on a shelf, obscured, in the Clinic operating room, stating that “this area is under video surveillance.” There were no signs anywhere else in the Clinic, including in consultation and examination rooms where patients would often be required to undress. Nor were patients informed of the cameras by Dr. Jugenburg or his staff. The only other sign about the cameras was in an elevator lobby outside the door of the Clinic on Level B which also stated, simply, “this area is under video surveillance.”

[7] This action was commenced in November 2019 under the *Class Proceedings Act, 1992*, SO 1992, c. 6 (the “CPA”). It was certified on May 10, 2021: *G.C. v. Jugenburg*, 2021 ONSC 3119, 155 O.R. (3d) 634 (the “Certification Decision”). The Court permitted the action to proceed on behalf of all patients who attended the Clinic between January 1, 2017 and December 13, 2018 (the “Class” or “Class Members”, and the “Class Period”), which is when the video surveillance system was in operation. A common issues trial was held before me in November and December 2025.

[8] The plaintiffs claim that Dr. Jugenburg and his company, in operating the video surveillance system, were negligent, breached their fiduciary duty towards patients, committed a breach of trust to the Class, and committed the tort of intrusion upon seclusion on the Class. They seek an award of aggregate damages for the tort of intrusion upon seclusion, which does not require proof of harm, and an order that a process be established to determine damages for negligence and

other torts which require proof of harm. The plaintiffs also seek an award of aggravated and punitive damages.

[9] The defendants do not dispute the negligence claim subject to proof of harm to Class Members which must be determined individually; however, the parties differ over the appropriate standard of care. The defendants submit that they should not be found liable for breach of fiduciary duty, breach of trust and for intrusion upon seclusion. They also argue that an award of aggregate damages should not be made as patients responded differently to the cameras when they were made aware of them. Some did not object or have any difficulty with them. Others, when they learned of them, were upset and felt violated, among other things.

[10] For the reasons that follow, I have reached the following conclusions:

- the defendants were negligent in operating the surveillance video system in private areas of the Clinic without the knowledge or consent of patients;
- the defendants breached their fiduciary duty towards patients by operating the surveillance video system without the knowledge or consent of patients;
- the defendants did not commit a breach of trust towards patients by operating the surveillance video system without the knowledge or consent of patients; and
- the defendants committed the tort of intrusion upon seclusion in operating the surveillance video system without the knowledge or consent of patients.

[11] I find as well that it is appropriate to make an award of aggregate damages arising from the tort of intrusion upon seclusion totalling \$21,500,000. I also find that it is appropriate to award \$1,000,000 in punitive damages. As the other torts are dependent on proof of some actual harm, counsel shall confer and provide me with a proposed process to address individual claims for damages for negligence and breach of fiduciary duty.

Trial process and presentation of evidence

Anonymization of patient witnesses

[12] At the outset of the trial, all counsel sought an extensive order limiting public access to medical records to protect patient privacy. It was contemplated by counsel that patient medical records, including photographs of patients, or parts of them, would be entered as exhibits. The draft order presented to me by counsel proposed sealing many exhibits and providing redacted copies for the public record. Counsel also sought a publication ban on the names of patients who would testify and requested that they be referred to in my Reasons by initials.

[13] Following discussion with counsel, I declined to issue a non-publication or sealing order, which I found to be unnecessary. Rather, I directed that patients could testify using only their initials, and that any exhibits which identified them should be redacted to only contain their initials. In this way, concerns about limiting access to medical records was diminished as those records could not be linked to an identifiable individual. As the trial progressed, very little in the way of medical records was presented; mostly, the records were simply patient logs showing

communications and appointments. The patients spoke about their procedures, but few if any medical records describing their treatment were entered as exhibits.

[14] Further, I prevented photographs from being adduced as exhibits. As I stated at the trial, I did not see a need to have counsel introduce, for example, intimate images of patients, which could cause harm and upset to them. If necessary, photographs could be described to me, which is all I would do in my Reasons for Judgment. Again, as it turned out, there was no need to provide the court with any photos of intimate images, or even any photographs of patients at all. Nor was it necessary to describe those images to me other than to tell me the parts of their bodies which had been photographed and whether the patients had been identified or were identifiable.

[15] The direction permitting testimony of patients by initials, and to provide the court with records redacted to only contain initials, meant that there was no publication ban or limitation on public access to any portion of the record.

[16] To the extent that my direction permitting witnesses to remain anonymous, even to me, might be seen as limit on the open court principle, in my view it would be justified under the test in *Sherman Estate v. Donovan*, 2021 SCC 25, [2021] 2 S.C.R. 75.

[17] The protection of patient confidentiality and medical records is an important public interest. The evidence from patients about their medical treatment by Dr. Jugenburg was, in most cases, highly personal and intimate, disclosure of which would go beyond mere embarrassment. Protecting their identity protected the witnesses from the “threat to their dignity... when information revealing core aspects of their private lives is disseminated”: *Sherman Estate*, at para. 73. There was no reasonable alternative to permitting them to testify anonymously and this direction was narrowly tailored. There was, as a result, no restriction on public access to any of the evidence led in the trial which meant that there was little, if any, deleterious impact on the public interest. A primary purpose of openness is to ensure that the public can scrutinize the conduct of the court. In this case, the public has access to everything that was presented to me.

The plaintiffs’ case

Patients and Clinic staff

[18] Twelve Class members, all female patients who attended the Clinic during the Class Period, were called by the plaintiffs to testify at the trial. Eleven of these patients had consultations and examinations in which they undressed, exposing their breasts and other intimate parts of their bodies. Ten of them had surgery and follow-up appointments. The twelfth patient, J.G., who was also Dr. Jugenburg’s public relations advisor, only had Botox treatment that did not involve removing her clothing.

[19] Ten of these twelve patients were unaware of the surveillance cameras until the CBC disclosed them in December 2018, or later. Other than J.L and J.G., none of them saw signs warning of the existence of the cameras. J.L. said she saw the sign in the elevator lobby and assumed it referred to cameras in the hotel, not the Clinic. J.G., who was a reluctant witness for the plaintiffs because of her ties to Dr. Jugenburg, testified that she saw a sign in a reception area, but this is inconsistent with other evidence and with the Agreed Statement of Facts which provided that there were no warning signs about the cameras in the reception areas until after the CBC

attended the Clinic in November 2018 and had notified Dr. Jugenburg that it had questions about them.

[20] The patients called by the plaintiffs (other than J.G.), gave emotional and compelling testimony about how upset they were to learn of the cameras, feeling, among other things, “violated”, “humiliated”, “shocked”, “betrayed” and “distressed not knowing where videos or pictures would have ended up.” Several talked about the anxiety they now feel, including a lack of trust in physicians and a reluctance to seek medical treatment.

[21] These witnesses also addressed the social media consent forms they were asked to sign when having treatment at the Clinic. Dr. Jugenburg’s clinic was very active on social media, promoting its activities and its favourable results with patients. These witnesses also testified about whether they received Dr. Jugenburg’s email in December 2018, following the CBC broadcast, which purported to apologize for the cameras (the “email blast”).

[22] J.G., who was Dr. Jugenburg’s public relations advisor but had also received treatment at the Clinic, testified about her interactions with Dr. Jugenburg after he was contacted by the CBC following its undercover visit. She assisted him in responding to the CBC investigation. J.G. was clearly a reluctant witness, with a loyalty to her client, Dr. Jugenburg. However, her communications with him in late 2018 were probative of several issues, including Dr. Jugenburg’s state of mind and the purpose of the cameras.

[23] One patient, J.L., got a job as a receptionist at the Clinic following her surgeries there, and was employed at the Clinic in late 2018 and in 2019. She gave evidence about Dr. Jugenburg’s response to the CBC investigation, including his reaction, his instructions to staff regarding the CPSO investigation, and the posting of signs in the reception areas.

[24] Dr. Waqqas Jalil, a plastic surgeon who worked with Dr. Jugenburg at the Clinic during the Class Period, was called to testify for the plaintiffs. Among other things, he said that prior to the CBC story he was unaware of any surveillance cameras other than in the kitchen and reception area on Level B. He was also unaware of any other cosmetic surgery clinic that had surveillance cameras in consultation or treatment spaces.

Hospital administrators

[25] The plaintiffs called two hospital administrators. They confirmed that while hospitals may have security cameras, they are generally only in public spaces such as hallways, waiting rooms and cafeterias.

[26] Jennifer Yoon, the Deputy Chief Nursing Executive and Vice-President of Quality, Patient Safety and Risk, at Humber River Hospital¹ – a large, modern hospital in Toronto where Dr. Jugenburg used to have privileges and sent patients for emergency follow-up² – confirmed that cameras are not installed in patient rooms, consultation rooms, examination rooms, washrooms, or

¹ After this matter was heard, Humber River Hospital was renamed the Hennick Humber Hospital.

² C.A. described being sent to Humber River by the Clinic after she developed a life-threatening infection following a “tummy tuck” operation at the Clinic. She underwent emergency surgery and was in the hospital for two weeks.

change rooms, because recording in those spaces is unnecessary for hospital operations and would improperly intrude on patient privacy.

[27] Cameras are used in the CT suites in hospitals where patients may get CT scans or MRIs because staff must leave the room due to, among other things, radiation exposure. These cameras allow the technician to monitor the patient while being scanned and respond if they need assistance. Operating rooms (“ORs”) at Humber River have cameras so that staff can be aware of whether the rooms are in use. I also heard that some ORs now have a “black box” camera system which is used, only with express written consent, to study systems and human factors in the OR. These uses of cameras are directly related to patient care.

[28] Thomas McHugh has held senior administrative positions in several hospitals in Ontario. He has had direct responsibility for construction and the physical attributes of hospitals, including the use of surveillance technology. He testified that surveillance cameras are not installed in patient care areas other than CT suites and, in Peterborough Regional Health Centre, a hospital with which he was familiar, seclusion rooms for patients with mental illness. Essentially, cameras are only installed where there is a specific and demonstrable operational or safety need. In the several hospitals where Mr. McHugh has worked, cameras were otherwise limited to entrances, waiting rooms, and public corridors, and were not installed in consultation rooms, treatment rooms, or operating rooms.

[29] Ms. Yoon and Mr. McHugh both testified that the existence of surveillance cameras was well-signed to inform visitors, and Mr. McHugh showed, as an example, the London Health Sciences Consent form which makes specific reference to the fact that “video surveillance is conducted in designated areas of the hospital to ensure the safety of patients, visitors, staff and affiliates, and that signage is posted to identify where surveillance is in effect.”

The plaintiffs’ expert witnesses

[30] The plaintiff called two expert witnesses, Dr. Richard Bendor-Samuel and Dr. Michelle Flaum.

[31] Dr. Bendor-Samuel is a plastic surgeon who runs a private cosmetic surgery clinic in Halifax, N.S. He gave uncontradicted evidence about the standard of care as it relates to patient privacy. Among other things, he described privacy as one of the “mainstays” of medical practice. The only justification for video surveillance would be for security, according to Dr. Bendor-Samuel. In his view, there is no security concern which would justify having surveillance cameras anywhere in a private cosmetic surgery clinic where patients have a reasonable expectation of privacy, such as washrooms, treatment rooms, consultation rooms, operating rooms, pre- and post-operative spaces, or where intimate details are being discussed between a patient and physician, including consultations where the patient is clothed. Dr. Bendor-Samuel also testified that if a clinic uses surveillance cameras, there must be signage in every room where the cameras are located to inform the patients, and patients should have the right to have them turned off.

[32] Dr. Flaum is a professor at Xavier University in Cincinnati, Ohio. She has also practised as a licensed clinical counsellor for over 20 years, diagnosing and treating emotional disorders. Dr. Flaum has expertise in “medical trauma”: trauma experienced in the medical setting, such as

trauma resulting from being diagnosed with a serious illness, experiencing a life-threatening emergency, having a frightening medical experience, or an experience with a medical professional that can cause upset and concerns about care. The effects of such trauma are seen in patients' attitudes and relationships towards health care providers. People experiencing medical trauma may have anxiety, lack of trust, and feelings of vulnerability and lack of safety, which may cause them to hesitate to seek medical treatment or not seek it at all, even when clearly needed.

[33] Dr. Flaum appears to be a pioneer in this field, publishing the first book on the topic of medical trauma as well as preparing numerous peer-reviewed articles and presentations on the subject in the United States, Canada, and elsewhere. Counsel for the defendants did not take issue with her qualifications or her ability to provide expert opinion evidence on medical trauma and the mental health impacts of adverse health care experiences, including effects of violations of patient trust, autonomy, informed consent, and privacy in medical settings.

[34] Dr. Flaum's evidence was informative and relevant to issues relating to intrusion upon seclusion and informed the evidence of the patients who reacted negatively to learning that they had been filmed by Dr. Jugenburg without their knowledge or consent.

The defendants' case

Patients and Clinic staff

[35] The defendants called seven witnesses who were patients during the Class Period. The gist of their evidence was that they saw the surveillance cameras and/or had no difficulty with them once they heard about them. Some appeared to be quite familiar with surveillance cameras which may explain why they noticed Dr. Jugenburg's cameras. Several said, among other things, that they felt that the cameras were there for their security and that they felt protected by them. One of these patients is an employee of the Clinic, having worked as a receptionist there starting in 2015 and who became a patient coordinator in 2017.

[36] Under cross-examination, most of these patients conceded that cameras should not be used in places where people disrobe or are in states of undress, such as a fitting room in a clothing store, a locker room at a gym, a washroom, or a shower.

[37] The defendants also led evidence of the range of patient responses received by the Clinic in approximately 50 emails received after Dr. Jugenburg sent out the email blast. There is no doubt that some patients were not offended by the existence of the cameras and offered their support to Dr. Jugenburg. There is also no doubt that other patients were deeply upset after learning about the cameras.

[38] The patients called by the defendants also addressed the social media consent forms they were asked to sign, and whether they received Dr. Jugenburg's email blast.

[39] Dr. Jugenburg testified for almost five full days, most of which was cross-examination. He described the operations of the Clinic and addressed the installation and use of the camera system, which he described as "security cameras." The thrust of Dr. Jugenburg's evidence in response to the claims by the plaintiffs was that he did not appreciate that the video surveillance cameras were collecting personal health information, and that he mistakenly believed that by meeting his

obligation to safeguard patient confidentiality he was also meeting his privacy obligations. I address Dr. Jugenburg's evidence in detail later in these Reasons.

[40] The defendants called two former employees of the Clinic, Kim Crawford and Melanie Petriw.

[41] Ms. Crawford was the Clinic's head nurse and the managing director of the Clinic from 2012 until her retirement in 2024. Starting in late 2016 or early 2017, she did the initial consultations with patients who were considering surgery. Ms. Crawford was known to everyone as "Nurse Kim." She was well-liked and respected by everyone who saw her.

[42] Ms. Crawford testified about the patient process, screening, obtaining information and photographs of patients, the use of photographs, and the information she would provide to patients about the procedures they were seeking. Sometimes, Dr. Jugenburg would come in for part of the initial consultations, but often she would be the only one to meet the patient along with an assistant who took notes and operated the camera used to take photographs for the patient's Electronic Medical Record ("EMR") and for Dr. Jugenburg's review.

[43] Ms. Crawford had limited involvement with patients following the initial consultation. She was not involved with obtaining social media consent or surgical consent forms and had "zero" involvement in taking photos for social media.

[44] Ms. Crawford was aware of the surveillance cameras. She said they were there to provide security – to protect staff and patients, emphasizing that the Clinic was inside a hotel and open to anyone. She said that some patients were sex workers accompanied by men who she felt raised safety concerns. She also stated that the Clinic, which is entirely private, used to accept cash from patients and would have large amounts of cash on site. She recalled one or two security incidents, including a man who came into the Clinic and took some money belonging to one of the staff. Dr. Jugenburg also testified about this incident.

[45] Ms. Crawford put up the sign in the elevator lobby area in 2012, at the request of the hotel, advising that that "this area is under video surveillance." She testified that Dr. Jugenburg used the video surveillance system to review patient-staff interactions and gave some examples of this, but said that, to her, they were security cameras. Ms. Crawford confirmed that she did not inform patients about the cameras. She was also involved when the CBC reporters came to the Clinic.

[46] Melanie Petriw also testified for the defendants. She was the Clinic's social media manager during the Class Period and gave evidence about the social media practices at the Clinic, which I address in more detail below.

Statistical and forensic evidence

[47] Two witnesses for the defendants, Matthew Maslow and Dr. Jack Berkowitz, addressed the number of patients who consented to having photographs or videos of them posted on social media – albeit without identifying them. This involved some forensic computer work by Mr. Maslow to search for the consent forms in the EMR database. Dr. Berkowitz, a statistician, generated a random and representative sample so that statistical inferences could be drawn.

[48] John Dorado, an expert in digital forensics, gave evidence about extracting and analyzing data from the devices used by Dr. Jugenburg, and from the surveillance system itself, including the DVR logs. His evidence and that of Errol Soriano, an accountant who tallied the data, addressed the amount of footage found on the DVRs and how frequently Dr. Jugenburg may have reviewed footage during the Class Period.

[49] Over the last four months of the Class Period (September through December of 2018), Soriano found 17,638 hours of recorded footage and said that 1.12 hours had been reviewed through remote playback, although he only analyzed the data presented to him by the defendants and did not conduct his own investigation. Soriano found zero hours reviewed in December 2018; however, Dr. Jugenburg contradicted this when he admitted that he reviewed footage following the CBC reporter's email about the cameras earlier that month. The 1.12 hours viewed also does not include any time Dr. Jugenburg may have spent watching live footage.

[50] Soriano also reviewed data from the EMRs to provide evidence about the number and nature of visits by patients to the Clinic during the Class Period. This is relevant to determining the number of people in the Class and the types of treatments received by them, which I address below in discussing damages.

Background Facts

Dr. Jugenburg and the Clinic

[51] Dr. Jugenburg graduated from medical school at the University of Toronto in June 2001. He completed a plastic surgery residency at the University of Manitoba in 2006 and was accredited by the Royal College of Physicians and Surgeons of Canada as a specialist in plastic surgery in 2007. Following a one-year post-graduate fellowship in New York City, Dr. Jugenburg practised plastic surgery in several locations in Toronto before opening TCSI in 2010.

[52] In 2010 the Clinic operated briefly on Level A of the Royal York Hotel, and then moved to Level B. In 2017, the Clinic expanded to include space on Level D. The Clinic is accessed by the Hotel's east elevators. Between January 2017 and December 13, 2018 (the "Class Period"), Level D was used to meet patients for initial consultations, and to treat patients who were seeking non-surgical injection treatments such as Botox injections, facial fillers and lip injections – known as the "Skinjectables Clinic." Most of the injectables services were provided by nurses or other medical professionals, not by Dr. Jugenburg. Level B was where Dr. Jugenburg's operating room was located and where he saw patients before and after surgery. Both levels had waiting rooms and reception areas. Both levels had consultation, treatment, and examination rooms.

[53] Dr. Jugenburg offered a variety of plastic surgery procedures at the Clinic. These included:

- (a) Facelifts, eyelid surgery (blepharoplasty), and neck lifts;
- (b) Breast lifts, augmentations, and reductions;
- (c) Liposuction of various areas;
- (d) Abdominoplasties (i.e. tummy tucks);

(e) Thigh and arm lifts;

(f) Labiaplasty and vaginoplasty; and

(g) Butt lifts and “Brazilian” butt lifts (a procedure whereby excess fat is taken from other parts of the patient’s body and injected into their buttocks to increase roundness).

[54] During the Class Period many people worked at the Clinic, including other plastic surgeons who saw patients and operated there, anesthesiologists, nurses, nurse injectors at Skinjectables, administrative staff, social media managers, massage therapists, and sterilization technicians.

[55] As the medical director, Dr. Jugenburg was the responsible physician for all patients who attended TCSI, including Skinjectables, and was the health information custodian of all medical records for all patients. The Clinic uses an EMR platform for clinical records of patients including clinical photographs taken as part of the treatment of patients.

Patient Treatment

[56] The evidence at the trial focused on patients seeking surgical treatment. As a private clinic operating outside the public health care system, potential patients would contact the Clinic themselves by phone or email after having heard of it from others or online. Front desk staff conducted an initial basic screening to ensure the inquiry was appropriate, usually followed by a dedicated pre-screening phone call in which a detailed medical history was taken, photographs submitted by the patient might be reviewed, and the patient’s goals and expectations might be discussed. When photos were sent, they would come to the Clinic’s general email and be saved in the patient’s EMR.

[57] During the Class Period, most initial in-person consultations were conducted by the head nurse, Ms. Crawford, who was sometimes joined by Dr. Jugenburg. Depending on the procedure, patients were asked to disrobe at the consultation for a physical examination and so that photographs could be captured of the relevant areas of their bodies. Patients were generally informed, prior to attending their initial consultation, that photos would be taken and placed in their medical file. Photographs are an integral part of the cosmetic surgery process, I was told, as they capture a patient’s baseline, progress, and outcomes. For many, having photos taken even for medical purposes was uncomfortable. As one patient put it, they are a “necessary evil.” I heard that photographs are taken at every visit and at multiple stages of care. These photographs were uploaded to each patient’s EMR.

[58] If a patient decided to proceed with surgery, a package containing consent forms and surgical information was sent to them by mail in advance. This included pre- and post-operative instructions, a general surgical consent form, a procedure-specific consent form which included a specific provision requesting patient consent to the “taking, publication and use of photography for scientific, educational, or illustrative purposes.” Patients were also sent a social media consent form, which I address in more detail below.

[59] On the day of surgery, a nurse verified that the EMR contained signed surgical consents, lab results and medical history. The nurse administered any necessary pre-operative medications. As discussed in more detail below, the social media manager also met with the patient to confirm

or obtain additional social media consent. Immediately prior to the surgery, Dr. Jugenburg confirmed the surgical plan with the patient, made surgical markings on the patient and sometimes took more photographs. When the patient entered the OR, the OR nurse would also confirm consent, including social media consent. Usually, the people present during surgery were Dr. Jugenburg, an anaesthesiologist, the OR nurse and, if there was consent, the social media manager who would film the procedure using a mobile phone, or iPhone, provided by the Clinic.

[60] After surgery, patients were transferred to a recovery room until discharge. I heard that some patients would rent a room in the Royal York Hotel for easy access to the clinic the following day. Patients attended follow-up appointments as necessary and sometimes sent photos to the clinic by email if they had concerns or questions, which would be added to the patient's EMR.

[61] Although Dr. Jugenburg was responsible for the Skinjectables Clinic, he rarely saw those patients, who were treated by nurses. Patients did not disrobe for these treatments. However, they signed a Botox consent form which included consent to having photographs taken before and after the treatment, which could be used for scientific purposes in publications and presentations.

Social media

[62] Dr. Jugenburg and his Clinic are very active on social media. The Clinic maintains a website and has accounts on social media platforms including Facebook, Instagram, Snapchat, Twitter (now X) and YouTube. Several of the Clinic's accounts use the name "Dr Six", "Dr. 6ix" or "@realdrsix". This is a nod to "the Six", which is how Toronto is known to many these days, having been popularized by, among others, the rapper Drake. However, as I learned at the trial, Dr. Jugenburg adopted many marketing and promotion techniques learned from a plastic surgeon in Miami, known as "Dr. Miami". I also heard of a plastic surgeon with a similar business in Dallas, known as "Dr. Dallas", who also has a relationship with Dr. Jugenburg. Although Dr. Jugenburg testified that he adopted the name "Dr. Six" because, he said, his name is difficult to pronounce, the use of the term is clearly for marketing purposes.

[63] The Clinic has a full-time social media manager who appears to post items on a daily basis. Dr. Jugenburg, or as he calls himself, "Dr. 6ix", is front and centre in these posts, speaking to his followers and others, describing his daily work, posting "before and after" photos of patients, and even posting videos of operations performed on patients, sometimes posting them live.

[64] Many patients learned of Dr. Jugenburg through his website and social media presence. Some described his materials on the internet as very helpful in explaining the process and the surgical procedures. Dr. Jugenburg described it as being educational, and patients were told this as well. This is correct to a point; however, the educational function could easily have been achieved by creating and posting one good video about each procedure, rather than having new material posted every day. It was clear to me that the social media activity was primarily, if not exclusively, for marketing purposes. Dr. Jugenburg was very concerned with putting material on social media to increase the number of people who viewed his posts. His full-time social media manager had no medical background and Dr. Jugenburg testified that medical education was not necessary for the social media position.

[65] Obtaining patients' consent to have their photos posted on social media appeared to get much more attention than obtaining consent to surgery. As noted, patients who decided to proceed with surgery would receive a social media consent form in the package sent to them in advance of the surgery. This form was sent in hardcopy on a sheet of paper and was titled "Social Media Consent Form." The purpose of the form was stated at the outset, as follows:

Dr. Jugenburg (Dr. 6ix) documents surgical procedures for educational purposes. These photos and videos show Dr. Jugenburg perform and explain various procedures, and are intended to educate our patients and the public about cosmetic procedures, enhance medical understanding, and create realistic expectations.

Your face and name are never exposed unless you consent otherwise.

[66] The form then listed the Clinic's social media platforms on which "photos and videos taken during surgery" would be posted. The form also contained a place to check off that one's face would not be shown and to allow patients to list any other identifiable features such as tattoos and birthmarks that they did want posted. This form also contained a box to check if a patient did not want their photos or videos posted on social media at all.

[67] Based on a review of patient files during the Class Period, 66.6% of patients completed the hardcopy Social Media Consent Form sent to them well in advance of their surgery. Of those, 57.4% authorized publication of their images on social media. This meant that about 38% of patients consented to social media on the hardcopy consent form.

[68] Dr. Jugenburg and other Clinic employees testified that the patient's choice was respected. However, this is not correct. Consent to social media, whether given or not on the hardcopy, was revisited when the patient was being prepped for surgery. As I heard from Ms. Petriw, who joined the Clinic as a social media assistant in April 2018 shortly after graduating from York University with a degree in Theatre, and who became social media manager in August 2018, she would meet with each patient just before the surgery to confirm their consent.

[69] As the social media manager, Ms. Petriw had access to patients' EMRs and would review them to see if they had submitted the hardcopy consent form. She would also have access to any photos contained in the EMRs. Regardless of whether a patient had submitted the hard copy consent form, or consented to social media or not, Ms. Petriw would meet with each patient in the surgical prep room a few minutes before their operation, often after the patient had received medication to sedate them. She would ask them about consent and show them an electronic, or digital, consent form on her computer tablet. Ms. Petriw said she would ask patients if they had any questions about social media and would try to make them feel comfortable with it.

[70] Ms. Petriw denied putting any pressure on patients to consent and said that only "occasionally" would patients who had previously declined to consent change their mind and consent just before surgery. This too is not supported by the evidence. To the contrary, the evidence supports the conclusion that patients were pressured to consent to social media.

[71] The data produced by the defendants showed that 71.4% of patients signed the electronic consent form and, of those, 98.9% consented to having images posted on social media. Thus, about

70% of patients consented when confronted with the electronic form just prior to surgery.³ This is almost twice as many people compared to those who signed the social media consent form sent to patients in the mail in advance of their surgery.

[72] The electronic form was shorter than the hardcopy form. It did not contain an option to say no, and any conditions or limitations had to be added digitally; there was no reference to tattoos or other identifying marks that could be checked off to avoid. The digital consent form would be added to the patient's EMR.

[73] I also heard that Dr. Jugenburg would also ask patients in the prep room just before surgery whether they had consented to social media, often with the social media manager present. When the patient entered the OR, the OR nurse would also ask about the patient's consent, including social media consent, which might also be in the presence of Dr. Jugenburg and the social media manager, as Ms. Petriw would be present during operations to film the procedure.

[74] It appears that the Clinic's expectation was that patients would consent. In cases where there was no consent, I was told that a "pop-up" message would be created in the patient's EMR to indicate the lack of consent.

[75] Patients who testified for the plaintiffs confirmed this pressure to consent. L.P., described feeling "pressured" to consent to social media the morning of her surgery, having already been given medication and feeling "a little groggy." She signed the consent reluctantly, feeling concerned that if she did not sign, they might not do the operation or, as she put it, "If I don't sign this, is he going to mess it up? You know, I just, it felt pressure to me."

[76] Another patient, L.J.P., testified that when she returned for a follow-up appointment and said how great she felt about the results of her surgery, Dr. Jugenburg immediately pulled out his phone and asked her to repeat what she said so he could film her statement and post it. She objected, but then described Dr. Jugenburg taking photographs of her, covering up her scars with her underwear, and telling her that he wanted to post them on Snapchat. L.J.P. refused, but Dr. Jugenburg pressed her, and she eventually agreed to repeat what she said but only have the audio recording posted. She was assured that they would not use pictures of her. However, L.J.P. discovered that before and after images of her exposed breasts were posted on Snapchat and on Instagram, with Dr. Jugenburg describing her as a "6 out of 5." L.J.P. called and emailed the Clinic, which then took the images down. She did not receive an apology. L.J.P. complained to the CPSO and sued Dr. Jugenburg.

[77] Evidence was also presented of patients who had images posted without their consent or who were identified. This included, among others, an instance in which images of a naked patient also showed her face, and another instance in which images of a patient who had a facelift were posted without her consent. Both were taken down immediately after the patients complained. Dr. Jugenburg acknowledged in cross-examination that there is ongoing litigation involving a number

³ Data analysis of 2,235 surgical patients showed that 854 consented to social media on the hardcopy form and that 1,578 consented on the electronic form.

of patients claiming non-consensual publication of their images, although I heard no direct evidence of those claims and was told that Dr. Jugenburg has denied any liability.

The surveillance camera system

[78] Dr. Jugenburg first installed surveillance cameras in the Clinic when he opened his business on Level B in 2012. Eight cameras were installed in the corners of the ceilings in the hallways, reception area, three patient rooms, the pre- and post-operative areas, the staff room and the “operating suite.” These cameras only captured video images, not sound. A separate motion detector security system was installed in the Clinic at the same time. At some point soon after installation, the surveillance system malfunctioned and remained inactive until 2017.

[79] In late 2016, the Clinic expanded onto Level D of the Royal York Hotel. As part of the build out of that space, sixteen cameras were installed in reception and waiting areas, hallways, the staff room and workspace, consultation rooms, and procedure/injection rooms. These cameras recorded both video and audio.

[80] The original eight cameras on Level B were repaired when the cameras on Level D were installed. All 24 cameras became operational on both Level B and Level D sometime in January 2017. In short, the Clinic had surveillance cameras in all treatment and consultation rooms where patients disrobed, the operating room, and in pre- and post-operative areas where patients were cared for and treated.

[81] The cameras were always on. The Level B cameras were configured to record only if motion was detected. The cameras on Level D recorded everything between 6 a.m. and 7 p.m. Outside of those hours, the Level D cameras only recorded if motion was detected.

[82] Footage from all 24 video cameras was transmitted automatically to two digital video recorders (“DVRs”). One DVR was on Level D and one on Level B. The footage was not stored in patients’ medical records. The DVRs were placed in closets within the Clinic. The closet on Level D was locked. The only people who had a key to that closet were Dr. Jugenburg and his Clinic administrator. The closet on Level B was not locked. The surveillance camera system was not connected to any alarm or security system.

[83] The footage stored on the DVRs could be accessed through an application, or “App”, on Dr. Jugenburg’s personal iPhone and iPad, and could also be accessed directly through the DVRs. The amount of footage stored varied, but after the DVRs were seized by the CPSO, several months of footage was found on them. It appears that when the DVRs’ memory reached capacity, old footage would be overridden or erased and replaced by more recent footage.

Dr. Jugenburg’s review and use of the footage from the cameras

[84] Through the App on his phone and his iPad, Dr. Jugenburg could review live or recorded footage. Dr. Jugenburg said he reviewed the footage infrequently. On occasion he watched live footage of the front desk and waiting areas to verify staff coverage at the reception area, to confirm payments, or to monitor patient flow. He used the footage to support a decision to fire a staff member when that footage showed she was not doing her job and had lied about it.

[85] Dr. Jugenburg also reviewed footage when disputes arose between patients and staff, whether over a medical issue, costs of services, or allegations of misconduct. Dr. Jugenburg's head nurse, Ms. Crawford, sometimes asked him to check footage regarding specific interactions. Occasionally, Dr. Jugenburg watched live footage at night, describing one incident when he was there overnight and was concerned that an intruder had entered the Clinic. He also described reviewing footage following a break-in to see if a suspect could be identified.

[86] At least some staff were aware that Dr. Jugenburg viewed footage. There was evidence of staff letting Dr. Jugenburg know that they would be in the Clinic on a weekend, in case he saw them when checking footage. Dr. Jugenburg's patient coordinator, who had previously been a patient, testified that some of the staff were not happy about the cameras. She also seemed to dislike them as, after a dispute between her and a patient was resolved in her favour by Dr. Jugenburg reviewing the footage, she emailed Ms. Crawford saying: "Lol in this case ... only ... thank god for these cameras."

[87] There is no evidence that anyone other than Dr. Jugenburg accessed the camera footage. Only one staff member said she was briefly shown some footage of the waiting room; otherwise, there is no evidence that anyone else saw footage from the surveillance cameras. Nor is there evidence that Dr. Jugenburg reviewed footage of patients for any prurient or voyeuristic purpose. There is also no evidence that any of the footage was ever accessed or disclosed to any third party, or "hacked." Nor is there any evidence that Dr. Jugenburg downloaded or otherwise preserved any of the footage from the camera system separate from the DVRs.

Awareness of the cameras

[88] As photographs presented at the trial showed, the cameras were not concealed. However, they were in the ceiling and went unnoticed by most people. Of the twelve Class members who testified for the plaintiff, two saw or were aware of the cameras. One, J.C., said she saw a surveillance camera, which she noticed as she left the consultation room. She said she thought it was a "really weird place for a camera", not having seen them in any other doctor's office, but thought it "must be for security after hours." She "didn't say anything to anybody because I didn't think that I would be recorded in a consultation room where I'm practically naked, right?" She decided not to go through with surgery and did not return to the Clinic.

[89] J.G., Dr. Jugenburg's public relations advisor who also received Botox treatment, testified under summons for the plaintiffs. She said she was aware of the cameras. However, this knowledge did not come from her attendance at the Clinic as a patient.

[90] The defendant called seven witnesses who were patients at the Clinic, all of whom said they saw the cameras. One of them, the patient coordinator who continues to be on staff at the Clinic, knew of the cameras in that capacity. Several others were very attentive to the presence of cameras. One, I.S., was a "camera person" who had surveillance cameras everywhere in her home. Another, A.Z. noticed the cameras were similar to ones she had in her home. S.F. worked as a manager for a large retail company where surveillance and security cameras were important. Another of the defendant's witnesses who noticed the cameras, T.F., said that when she goes into a room she looks for cameras.

[91] Some of the defendants' patient witnesses had been treated by Dr. Jugenburg on more than one occasion and were very pleased with the results. At least one claimed the cameras were "hard to miss" and another said they were "very visible", while others agreed that while they noticed them, others might not.

[92] On cross-examination, these witnesses agreed that surveillance cameras should not be placed in private spaces such as fitting rooms in stores, washrooms, or showers at gyms. One of the defendants' witnesses, when pressed, agreed that patients should at least be told of the cameras and be given an opportunity to consent or not. Another, I.S., said she would be upset if an OBGYN doctor had cameras in examination rooms and did not tell her about them.

[93] In addition to the several Class members who testified that they did not see the cameras, some staff were unaware of their presence beyond the reception areas and staff rooms.

[94] Dr. Jalil, who practiced regularly at the Clinic in 2017 and 2018, including seeing patients referred to him by Dr Jugenburg, and operating on them,⁴ testified that he was only aware of cameras in the kitchen and reception areas. He did not notice cameras anywhere else. Nor was he made aware of their existence by Dr. Jugenburg or by anyone else. He did not learn of them until the CBC story in December 2018. Dr Jalil also confirmed that he did not recall ever seeing cameras in consultation rooms, operating rooms or other treatment spaces in Ontario.

[95] Dr. Jalil testified that he asked Dr. Jugenburg about the cameras after learning about them from the CBC. Dr. Jugenburg told him they were there for security and that footage was deleted every 24 hours. At the trial, when told that one of his patients, J.K., had testified that she was upset and "felt betrayed" by the cameras, Dr. Jalil said he was deeply sympathetic to her situation and understood why patients would feel violated. When asked if he was critical of J.K. for not having seen the cameras, Dr. Jalil responded that he was not, as he "didn't notice the cameras either" even though, as he acknowledged, he was in the Clinic far more than his patients. He also stated that Dr. Jugenburg was not within that patient's circle of care.

[96] I have no reason to doubt Dr. Jalil's evidence. He continues to have a collegial and professional relationship with Dr. Jugenburg, including continuing to use the Clinic's OR from time to time. He testified under summons by the plaintiffs and his evidence was not challenged in cross-examination.

[97] There was evidence that other physicians sometimes used the Clinic's OR, but I did not hear from any of them at the trial.

[98] J.L., who worked as a receptionist at the Clinic after being a patient there and who testified for the plaintiffs, said she only knew of cameras in the kitchen and reception areas. Ms. Petriw, who was the social media manager and testified for the defence, said she was only aware of surveillance cameras in the pre-op rooms and the hallways. She was unaware of cameras in the consultation rooms or in the OR. When it was put to her that she was in the OR every working day

⁴ Within the Clinic Dr. Jalil was referred to as "Dr Fix." This was because, unlike Dr 6ix (Dr. Jugenburg), Dr. Jalil did revision surgery, operating on patients who had already had surgery, doing procedures such as breast reconstruction.

and didn't notice them there, she offered the reasonable explanation that she had no reason to notice them: "I wasn't really kind of looking up in corners or things like that."

[99] On the other hand, if a patient was sufficiently observant to see the cameras and sufficiently self-possessed to ask about them, staff, usually Ms. Crawford, would placate them with assurances that they were there for the safety of the patients and the staff. They were never turned off. The explanations given to the undercover CBC reporter when she asked about the cameras are informative on this issue:

Staff Member A: "There's cameras all around. It's just the doctor's like. We have to record everything for, like, legal purposes. Just like the dialogue and everything like that. ... Um, yeah, it's just for his personal record for legal purposes.

Staff Member B [Kim Crawford]: "Sorry about that camera thing. I know. It's in. It's all over. Um, it's to protect you too. It's just a security camera, basically. They're all, I don't know even how much he can really see out of it, and I have never seen one, so. Because I know that, he has to do it for his (unintelligible). Like if someone ever said something happened and it didn't or stuff like that."

Patient: Oh. Has it happened before?

Staff Member B: No, never.

[100] Ms. Crawford's response that nothing had happened to require review was not correct. In an email responding to a patient complaint several months earlier, Dr. Jugenburg referred to reviewing footage of a consultation. Ms. Crawford was aware of this. As I discuss later, the patient, who was a physician in the United States, also questioned the propriety of the cameras, noting to Dr. Jugenburg that in the United States written consent is required to record a patient.

[101] Another patient, L.B., was unhappy with the results of her surgery, and wanted to know whether Dr. Jugenburg had done something different than agreed. She sent an email requesting the social media footage of her surgery, to which she had consented, but was told that the Clinic had issues with their social media that day and that her surgery was not recorded. When she followed up in person, she said she "was told that they did not have any video footage of me in my surgery whatsoever." L.B. said she was never told about the surveillance cameras or the existence of footage from them which might have informed her of what happened in the OR.

[102] Accordingly, while the cameras were not hidden, they were not obvious and would not have been seen by most people, including most patients. I do not accept Dr. Jugenburg's assertion that he believed the cameras were obvious and that their visibility provided notice to people. The weight of the evidence clearly supports the opposite conclusion. Nor do I accept Dr. Jugenburg's assertion that he believed such cameras were commonplace in clinical settings. There is no evidence to support the claim that surveillance cameras are used in places where patients are treated by physicians; rather, the evidence is to the contrary.

[103] When the surveillance cameras were first installed in 2012, the Clinic was told by the hotel to put up a sign to let people know that they were under video surveillance. However, the only sign that was put up was a small notice on the ledge of a wall in a lobby area of the hotel on Level B

where the elevators were located. This was outside the main door to the Clinic. That sign simply stated: “This area is under video surveillance.” An identical small sign was found on a shelf in the operating room and was not clearly visible. These were the only signs prior to the CBC investigation.

[104] Nobody saw the sign in the OR, including Ms. Petriw and Dr. Jalil, both of whom were there frequently. This is not surprising based on the photograph of that sign shown at the trial. In any event, patients about to be anesthetized, and who may already be somewhat sedated, would not notice the sign or the cameras, let alone be able to raise concerns about the presence of the cameras in the OR. As counsel for the plaintiffs stated, it was “too little too late”, noting that “[b]y the time patients entered the OR, they had attended the Clinic on at least one prior occasion, and been through pre-operative procedures, including getting undressed and ‘marked’ in anticipation of their surgery, all the while being surveilled.”

[105] As for the sign in the lobby on Level B, all it did was tell people that the elevator lobby area was under surveillance, not the Clinic. Dr. Jugenburg claimed that this area was only used by people visiting the Clinic; however, there was evidence that others traversed that hallway and, in any event, it was clearly outside the Clinic. Most of the patient witnesses testified that they did not even see this sign. J.L., who visited the Clinic several times as a patient and then worked there beginning in 2018, quite reasonably believed that the sign in the hotel hallway referred to the hotel area being under surveillance, not the Clinic.

[106] When the Clinic expanded to Level D, no signs were put up at all. Additional signs were only added in late November or early December 2018 after the CBC disclosed that it had been to the Clinic and raised questions about the cameras.

[107] The Clinic took no other steps to inform patients of the existence of the surveillance cameras. There was no mention of them in any of the materials sent to patients before attending the Clinic for consultation, or before surgery. The consent forms, including the social media consent forms, did not refer to them, nor were staff instructed to inform patients of them. There is no evidence that any staff ever drew the surveillance cameras to patients’ attention; indeed, as noted, most of the staff were unaware of the cameras beyond the reception and staff room areas of the Clinic.

The aftermath

[108] A CBC journalist contacted the Clinic on December 6, 2018, about the cameras. She advised that she had been in contact with the IPC and the CPSO about them. On December 13, 2018, the CBC broadcast the Marketplace show about the cameras. The same day, the video camera system was disabled and secured by the CPSO, and the DVRs were removed by the CPSO the next day.

[109] On December 18, 2018, Dr. Jugenburg sent an email blast to patients that had attended the Clinic over the prior two years. The email blast, which contained the subject line “A Message from Dr. Martin Jugenburg”, stated:

I would like to inform you about an important matter involving security and patient privacy concerns.

Approximately two years ago, we installed security cameras throughout our clinic, including reception areas and examining rooms. The cameras were always visible, and signs were posted to inform our patients of the presence of video surveillance.

The video footage captured on this system was for security purposes and to protect our team and our patients. The information was stored on a highly secure IT system with access limited to me or my senior office manager.

As Canadian privacy legislation has continued to expand, both the scope of our security system and related signage should have been reviewed and updated. We have learned that we should have been more proactive in communicating the presence of the cameras through the office to you, allowing you to opt out if desired.

We did not do this, and we apologize for this oversight.

Our security system is currently disabled, and any previous recordings would be automatically deleted by the system every few weeks.

Moving forward we will ensure that any future security cameras comply with all privacy interests and expectations.

I would like to reiterate that patient safety and privacy is most important to me and my team.

We want to ensure all of our patients are provided with the best clinical care and experience when you visit our premises.

[110] Several patient witnesses said they did not receive the email blast. It was sent out by Dr. Jugenburg's administrative director at the time, Nora Rochman. Although the patient history summaries found in the patients' EMRs showed the blast having been sent, the patient history records contained many other entries that were incorrect, including, in many cases, appointments that did not occur.

[111] As the Agreed Statement of Facts puts it: "Upon receiving the email blast, some Class Members responded to voice their concerns. Some Class Members responded to voice their support. Some Class Members responded in a neutral fashion. Some Class Members did not acknowledge the notice. It is not known how many Class Members received and reviewed the email."

[112] Evidence was also led of emails received by the Clinic from patients, either in response to the email blast or following the CBC broadcast. Some were supportive, others were not. A receptionist at the Clinic at the time, J.L. (who had also been a patient), testified for the plaintiff. She said that the Clinic received many calls from upset patients and very few from supportive patients.

[113] The CPSO and the IPC both commenced investigations.

[114] Section 36(3) of the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, provides that records of proceedings, reports, documents or things prepared for or statements given at proceedings, or orders or decisions from CPSO proceedings cannot be admitted as evidence in a civil proceeding. However, “s. 36(3) does not create an evidentiary privilege relating to the information or evidence used to prepare such orders, decisions, reports, documents, things or statements”: *K.K. v. M.M.*, 2022 ONCA 72, 466 D.L.R. (4th) 559, at para. 57. Anything not specifically mentioned in s. 36(3) is “fair game” in a civil proceeding, including the fact that a complaint was made, an investigation was held, or that a decision was rendered: *K.K.*, at para. 48.

[115] From the oral testimony at the trial, I became aware that the CPSO suspended Dr. Jugenburg’s license for six months after a hearing that dealt with the surveillance cameras. No records from the CPSO proceedings were adduced as evidence at this trial and there are no details before me of what led to the six-month suspension. Although the fact that Dr. Jugenburg’s license was suspended is not an enumerated record in s. 36(3) of the *Regulated Health Professions Act* and is therefore “fair game” at this trial, it plays no role in my analysis.

[116] In January 2019, under the approval of the CPSO, the Clinic activated a much more limited video system of three cameras, located at the reception desk at Level D, reception desk at Level B, and the separate injectables reception area on Level D. Each of these cameras is programmed to only run after office hours, turning on automatically at 6:00 pm and turning off at 6:00 am. The camera faces the cash box rather than the hallway/entrance area. Signs were installed in the areas where the cameras are located, stating: “For security, these premises are under closed circuit audio/video security surveillance”.

[117] On September 20, 2019, the IPC concluded that “the Clinic’s blanket use of surveillance cameras contravened the *Personal Health Information Protection Act, 2004*.” However, the IPC stated that “in light of the steps taken by the Clinic to amend these practices”, including “ceasing the practice of collecting personal health information through the camera system” and limiting the cameras to operate only after hours and not in the “pre-operative, operating and examination rooms”, no further review needed to be conducted: *Toronto Cosmetic Surgery Institute (Re)*, 2019 CanLII 87820 (ON IPC) at para. 2.

The Common Issues

[118] This action was commenced on November 28, 2019.

[119] On May 10, 2021, Perell J. certified this action as a class proceeding in the Certification Decision. The Class was defined at para. 119 as:

All patients who attended at the Toronto Cosmetic Surgery Institute from January 1, 2017, to December 13, 2018.

[120] The certified Common Issues are outlined at para. 138 of the Certification Decision as follows:

Negligence

1. Did the Defendants, or either of them, owe a duty of care to the Class Members in the collection, retention, use, and/or disclosure of the Class Members' Personal Information?
2. If the answer to question #1 is yes, what is the applicable standard of care?
3. If the answer to question #1 is yes, did the Defendants, or either of them, breach the duty of care? If so, how?

Vicarious Liability

4. Are the Defendants, or either of them, vicariously liable for the wrongful conduct of employees or contractors of Dr. Martin Jugenburg Medicine Professional Corporation or the Toronto Cosmetic Surgery Institute?

Breach of trust and fiduciary duty

5. Did the Defendants, or either of them, owe a fiduciary duty to the Class Members?
6. If the answer to question #5 is yes, did the Defendants, or either of them, breach their fiduciary duty? If so, how?
7. Were the Defendants, or either of them, a trustee of the Class Members with regard to their Personal Information and, if so, did the Defendants, or either of them, breach the duty of trust imposed upon him, it, or them with respect to maintaining the confidentiality of the Class Members' Personal Information? If so, how?

Intrusion upon seclusion

8. Did the Defendants, or either of them, invade, without lawful justification, the private affairs or concerns of the Class Members?
9. If the answer to question #8 is yes, did the Defendants, or either of them, act intentionally or recklessly?
10. If the answer to questions #8 and #9 is yes, would a reasonable person regard the invasion of the Class Members' privacy as highly offensive causing distress, humiliation or anguish?

Damages

11. Can an award of aggregate damages be made pursuant to s. 24(1) of the *Class Proceedings Act, 1992* for the Class?
12. Does the conduct of the Defendants, or either of them, justify an award of punitive, exemplary and/or aggravated damages?

Negligence: Common Issues 1, 2 and 3

[121] Negligence is conceded, but issues relating to negligence remain in dispute. The defendants concede Common Issue 1, that they owed a duty of care to the Class Members in the collection, retention, use and/or disclosure of their personal information. This includes the personal information collected through the video surveillance system.

[122] The defendants also concede that they breached the standard of care that applied to their duty of care; however, the parties differ over the applicable standard of care and over how the defendants breached their duty, which must be addressed under Common Issues 2 and 3.

[123] The plaintiffs submit that the applicable standard of care was to not have surveillance cameras anywhere in the Clinic where patients would have a reasonable expectation of privacy, including the consultation and treatment rooms, the pre- and post-operative rooms, and the OR.

[124] The defendants put it much more narrowly, submitting that the expected standard of care required Dr. Jugenburg to install adequate signage about operation of cameras in the Clinic; to ensure that any footage was securely stored, with limited access which would overwrite within a reasonable time frame; and that if cameras operated within treatment spaces including examination rooms and ORs, to secure express consent and provide patients with an opportunity to opt out of their operation.

[125] Regarding Common Issue 3, the plaintiffs say the defendants' duty of care was breached by installing and operating surveillance cameras in those areas of the Clinic where patients had a reasonable expectation of privacy. The defendants, on the other hand, submit that their breach consisted of failing to take sufficient steps to advise Class Members that the video cameras were operating and by failing to adequately consider the privacy interests of the Clinic's patients in installing the Clinic's video camera system. However, the defendants agree that if the plaintiffs' position that the standard of care was breached by having video cameras in consultation rooms is accepted, then the defendants breached that standard of care as well.

Common Issue 1 – duty of care

[126] There is no dispute that the defendants owed a duty of care as stated in Common Issue 1. The evidence and the law support this conclusion.

[127] As a physician, Dr. Jugenburg has the obligation to act in his patients' best interests. Dr. Jugenburg admitted that trustworthiness is the cornerstone of the practice of medicine and that this includes putting the patients' interests ahead of his own – a principle that informs all aspects of a physician's practice. These duties are well-known and reflected in CPSO publications, including the CPSO Practice Guide, as Dr. Jugenburg acknowledged at the trial.

[128] Dr. Jugenburg also acknowledged that he has a duty to comply with *PHIPA* and the policies of the CPSO regarding the collection of health information and maintaining its confidentiality. The IPC ruled that the footage of patients captured by the camera system is personal health information, and that Dr. Jugenburg's "blanket use" of the cameras violated *PHIPA*.

[129] Counsel for the defendants points out that *PHIPA* is a regulatory statute which, they submit, has “no bearing on the issues.” I agree that a breach of *PHIPA* alone may not necessarily ground a civil cause of action, but *PHIPA* is relevant insofar as it creates obligations and standards for health professionals in collecting and maintaining patients’ personal health information. *PHIPA* therefore informs and supports the finding of a duty of care and informs the analysis of the standard of care expected of physicians in fulfilling that duty.

[130] The CPSO policies and guidelines regarding medical records and the confidentiality of personal health information are also informative. They include the requirement that physicians “must always obtain the patient's consent when collecting, using or disclosing personal health information (PHI), unless provided otherwise by law”, and that physicians “must be particularly diligent in protecting records” stored and accessed on mobile devices: CPSO Policy Statement #4-12, Medical Records at pp. 3 and 5.

[131] In my view, the defendants clearly owed a duty of care towards all Class Members in the collection, retention, use or disclosure of their personal information, which included collecting and retaining the personal information through the video surveillance system.

Common Issues 2 and 3 – breach of the standard of care and duty of care

[132] In assessing and applying the appropriate standard of care, the Court applies a standard of reasonableness, not perfection or infallibility. As aptly put in *Leckie v. Chaiton*, 2021 ONSC 7770 at para. 15, “[t]he standard of care is reasonable care, not a gold standard”, citing *Hillis v Meineri*, 2017 ONSC 2845 at para. 54. A physician’s conduct, the Supreme Court has said, “must be judged in the light of the knowledge that ought to have been reasonably possessed at the time of the alleged act of negligence”: *Ter Neuzen v. Korn*, [1995] 3 S.C.R. 674 at para. 34.

[133] In my view, the plaintiffs’ submission properly states the reasonable standard of care as established in the evidence, which is that physicians should not have surveillance cameras in locations where patients would have a reasonable expectation of privacy, including consultation and treatment rooms, pre- and post-operative rooms, and operating rooms.

[134] Dr. Bendor-Samuel’s uncontradicted expert evidence was clear and unambiguous in stating that it is wholly inappropriate to operate surveillance cameras anywhere in a private cosmetic surgery clinic other than where necessary for security and where there are visible signs indicating their presence. Places such as washrooms, treatment rooms, consultation rooms, operating rooms, pre- and post-operative spaces, and anywhere where intimate medical details are being discussed between a patient and physician, including consultations where the patient is clothed, are inappropriate places to have cameras.

[135] Dr. Bendor-Samuel also addressed the records created by the video cameras, stating that any photographs, images, or records of patients are personal health information and need to be secured by the physician, such as being stored on an encrypted server, and be locked up. Dr. Bendor-Samuel said any recording of patients, by photograph, video or audio recording, requires express consent of the patient.

[136] Dr. Bendor-Samuel was unaware of any physicians who put cameras in their treatment rooms. Although an email from Dr. Jugenburg to another doctor suggests that there may have been

cameras in another cosmetic surgery clinic in Toronto, I heard no evidence that cameras were placed in patient-care locations in any other clinics or doctors' offices.

[137] Dr Bendor-Samuel's evidence aligns with the evidence from the hospital administrators who said that video surveillance systems in public hospitals are generally limited to public areas and are always well-signed to inform people of the presence of the cameras. The exceptions to this limited use of camera systems are narrow and directly related to patient care. An example of this is the CT Suite where medical staff must be separated from patients being scanned, seclusion rooms for people with mental illness who need to be observed, or for teaching and quality control purposes. An example of the latter is the use of the "black box" to record surgery in an OR, which is done in order to improve patient care and only when everyone consents to the recording.

[138] The parties differ on whether it is acceptable to have surveillance cameras in treatment rooms if the patient consents. Dr. Bendor-Samuel took a hard line on this issue. His opinion was that even with consent it is inappropriate to have cameras in an examination or consultation room or in an OR at a clinic. Dr. Bendor-Samuel emphasized that patients are in a vulnerable state and that physicians need to be aware of their position of power over their patients. If there are cameras in such rooms, at a minimum the patient must be informed and be given the right to have them turned off, he said.

[139] In my view, the appropriate standard of care is not to have cameras in locations in private health clinics where patients are receiving care or consulting with medical professionals. These are locations where patients would have a reasonable expectation of privacy. The exception would be when the cameras are necessary for a medical purpose – such as a need to keep a patient under observation, or for assisting in treatment and quality of care. Those circumstances do not exist in clinics like the private cosmetic surgery clinic in this case.

[140] Nor is the standard of care necessarily met if patients are adequately informed of the presence of cameras, or if consent is obtained. People who seek medical treatment are in a vulnerable position. In this case, although many of Dr. Jugenburg's patients consented to being filmed for social media purposes, and some did so enthusiastically, others were not enthusiastic and did not consent or consented under pressure. As noted earlier, many who had previously said no to social media, consented only when confronted with a consent form just before entering the OR, raising serious concerns about the validity of such consent, and about the conduct of the defendants.

[141] But this case is not about social media consent, which did not address the surveillance cameras. No consent was sought or given for the recording of patients by the surveillance cameras; indeed, the defendants did not even make patients aware of the existence of the cameras which, for no medical reason, recorded patients in consultation and treatment rooms exposing intimate parts of their bodies and engaging in very private and personal discussions about themselves.

[142] Accordingly, the defendants breached the applicable standard of care.

Conclusions on Common Issues 1, 2 and 3

[143] The answers to Common Issues 1, 2 and 3 are as follows:

1. Did the Defendants, or either of them, owe a duty of care to the Class Members in the collection, retention, use, and/or disclosure of the Class Members' Personal Information?

ANSWER – Yes.

2. If the answer to question #1 is yes, what is the applicable standard of care?

ANSWER – The applicable standard of care is to not have cameras in locations in private health clinics where patients are receiving care or consulting with their doctors unless the cameras are present for a medical purpose – such as a need to keep a patient under observation or for assisting in treatment and quality of care – and the patient has expressly consented to the cameras and recording.

3. If the answer to question #1 is yes, did the Defendants, or either of them, breach the duty of care? If so, how?

ANSWER – Yes. The defendants breached their duty of care by recording patients in places where they were receiving medical care and consulting with their physician without their knowledge or consent and for no medical purpose.

[144] The answers to these questions do not, of course, constitute all the elements of the tort of negligence. The issues of causation and damages were not certified as common issues as they must be established on an individual or group basis in accordance with s. 25 of the *CPA*.

Vicarious Liability: Common Issue 4

[145] The defendants concede that the answer to Common Issue 4 should be yes. Dr. Jugenburg and the Clinic “generally admit that they are responsible for any conduct of employees or contractors of which evidence was led in this proceeding pertaining to security cameras at the Clinic.”

[146] This is a sensible admission. Dr. Jugenburg is the sole shareholder of TCSI, a professional corporation. He is liable for the tortious acts of the Clinic: *Business Corporations Act*, RSO 1990, c B.16, s. 3.4; *Liu v. Hao*, 2025 ONSC 1395, at para 42, aff'd 2025 ONCA 883; *Tataryn v. Diamond & Diamond*, 2021 ONSC 2624, at para 81, leave to appeal to Div. Ct. refused 2023 ONSC 2674; Health Professions Procedural Code, Schedule 2 to the *Regulated Health Professions Act, 1991*, ss, 85.11 and 85.14

[147] Dr. Jugenburg acknowledged at the trial that as the owner and medical director of the Clinic he has ultimate responsibility for the conduct of his employees. The vicarious liability of Dr. Jugenburg is consistent with the role of tort law and its goal of behaviour modification. As the Court of Appeal stated in *Weingerl v. Seo* (2005), 256 D.L.R. (4th) 1 (Ont. C.A.) at para. 51:

The policy objectives of the doctrine of vicarious liability dictate that the employer who has introduced the risk of the wrong is fairly and usefully charged with its management and minimization. There must be an incentive for those who control institutions or enterprises that engage in the intimate touching and/or treatment of

vulnerable individuals to minimize the risk of harm to patients. Finding the employer vicariously liable encourages such employers to ‘take such steps and hence, reduce the risk of further harm.’

[148] Accordingly, I conclude that Dr. Jugenburg is vicariously liable for the actions of TCSI and its employees, including nurses and others who interacted with patients. This includes the actions and inaction of the head nurse, Kim Crawford. TCSI is also vicariously liable for the actions of its employees.

[149] The answer to Common Issue 4 is yes. The defendants are vicariously liable for the wrongful conduct of employees or contractors of Dr. Martin Jugenburg Medicine Professional Corporation or the Toronto Cosmetic Surgery Institute.

Breach of Trust and Breach of Fiduciary Duty: Common Issues 5, 6, and 7

Common Issues 5 and 6 – breach of fiduciary duty

[150] The defendants concede that Common Issue 5 should be answered affirmatively. There can be little dispute that the physician-patient relationship gives rise to fiduciary obligations for a doctor, who has power over the vulnerable patient. As McLachlin J. (as she then was) stated in *Norberg v. Wynrib*, [1992] 2 S.C.R. 226, at p. 271, “the most fundamental characteristic of the doctor-patient relationship is its fiduciary nature” (emphasis in original).

[151] E.M. Morgan J. put it well when he stated in *Levac v. James*, 2021 ONSC 5971, 78 C.C.L.T. (4th) 284, at para. 145, aff’d 2023 ONCA 73:

It is now recognized that in the physician-patient relationship one party is, in effect, “at the mercy” of the other. That is, the doctor enjoys a discretionary power which can be exercised unilaterally to affect the patient’s interest, and the patient has an undeniable vulnerability to the doctor’s exercise of this discretionary power. These inherent characteristics have placed the physician-patient relationship in the category of fiduciary *per se*. Once the doctor-patient relationship is established, it alone suffices to create fiduciary duties for the doctor. [Citations omitted.]

[152] In my view, Dr. Jugenburg and his Clinic clearly owed a fiduciary duty to the Class Members, who were vulnerable patients. Dr. Jugenburg admitted that he had an obligation to protect the privacy of his patients and that he had an obligation to protect the confidentiality of their information. Trust is at the heart of the relationship between medical professionals and their patients, requiring honesty and integrity from providers of care. Patients’ interests should always prevail over the interests of the physician, nurse, or other medical professional. Dr. Jugenburg and Kim Crawford both conceded these points.

[153] Nevertheless, not all breaches of duty by a physician to a patient breach their fiduciary duty. As stated by the trial judge in *Varcoe v. Sterling* (1992), 7 O.R. (3d) 204 (S.C.), at p. 229, aff’d 10 O.R. (3d) 574 (C.A. Note), there must “be an act of betrayal which lies at the root of the relationship.” Care must be taken to not expand the concept of fiduciary breaches to situations of negligence or breach of contract. More must be established; in particular, “[w]here the conduct evinces [a] breach of trust” or there is deliberately disloyal conduct preferring one’s own interest

over another's: *K.L.B. v. British Columbia*, 2003 SCC 51, [2003] 2 S.C.R. 403, at para 48. Other cases have stated that a breach of fiduciary duty requires conduct that is "predatory" or "exploitative": *W(S) v. Doré*, [2000] O.J. No. 737 (S.C.) at para 368, although those requirements may set an unnecessarily high bar.

[154] Counsel for the defendants argue that a breach of fiduciary duty is not established simply because a physician made a "genuine mistake", as this does not give rise to dishonest or intentionally disloyal conduct. In my view this puts the test too high. A physician's "mistake" can be driven by self-interest and a disregard for their patients' interests. Assuming for the moment that Dr. Jugenburg made a "genuine mistake", he did so without regard for the interests of his patients and for his own self-interest. As I discuss below, the cameras were installed to protect Dr. Jugenburg's own interests, and for no other reason.

[155] Patients who attended the Clinic were vulnerable, seeking help regarding very intimate and personal issues, as I heard when they testified, often emotionally. They quite reasonably expected to be in a safe and trustworthy space which respected their privacy. The cameras, deliberately placed in consultation and treatment rooms without notice or consent, went well beyond a "genuine mistake."

[156] Some patients who testified for the defendants said that the cameras made them feel safer. One said that she felt "safer in spaces that are filmed" and another said she appreciated their presence because they protected both patients and medical staff. Dr. Jugenburg testified that the purpose of the cameras was for security, to deter intruders, prevent theft, and deter inappropriate conduct, and thereby make the Clinic safer for everyone. However, this is not supported by the evidence.

[157] If the purpose of the cameras was to deter intruders and theft or to make people, including patients, feel safer, they needed to know about the cameras. One sign about the existence of cameras in "this area" – an elevator lobby outside the Clinic – was woefully inadequate to inform patients or to deter intruders. The witnesses who said they felt safer were among what appears to have been a small number of patients who noticed the cameras in the ceiling of the consultation rooms, something several staff were unaware of, including Dr. Jalil.

[158] Dr. Jugenburg used the cameras to resolve patient disputes, but only when it suited him. Although, as Kim Crawford pointed out in her cross-examination, footage could also show that the patient was right, this never happened. For example, when L.B. raised concerns about what had happened during her surgery and requested to see footage of the operation, the Clinic informed her that the social media footage that day was not available. She was not told of, let alone offered, the footage from the surveillance cameras. The footage was for Dr. Jugenburg's protection, and not for the benefit of his patients.

[159] Further, Dr. Jugenburg's testimony indicated that he regarded the surveillance cameras as a tool to protect him from potential litigation. In 2019 he inquired of the contractor who installed the system whether the footage could be stored for two years, which is the limitation period in Ontario for potential claims by patients: *Limitations Act, 2002*, SO 2002, c 24, Sch B. In the same exchange with the contractor, Dr. Jugenburg also asked to upgrade the existing cameras so they would all record audio as well as video, which he said would be used to resolve disputes with

patients. He knew the cameras would record private conversations, even if there were no healthcare professionals involved, but still wanted these recordings to be preserved to protect himself.

[160] When the CBC journalist was told by Kim Crawford that the cameras had never been used to resolve a dispute with a patient, this was untrue as a few months earlier footage had been used to protect the Clinic in a dispute, of which Ms. Crawford was aware. The Clinic's patient coordinator testified of another instance when footage was used for this purpose. The footage was also used by Dr. Jugenburg to monitor the staff and clinic operations. This had nothing to do with patient safety or making the patients feel safer or more comfortable but was solely for Dr. Jugenburg's benefit.

[161] Dr. Jugenburg also took no steps to inform himself of the use of surveillance cameras in other medical settings or of the law respecting them, including his obligations under *PHIPA*. Nor did he consult the CPSO about his obligations. This inaction continued even after the patient who was a physician in the United States raised concerns about the existence of the cameras and Dr. Jugenburg's failure to obtain consent to record patients. After the CBC questioned Dr. Jugenburg about them, Dr. Jugenburg took no steps to ensure the footage was secure or encrypted to prevent unauthorized access to it.

[162] On the other hand, there is no evidence that Dr. Jugenburg installed the cameras for other nefarious purposes, such as snooping on his patients for sexual gratification. Nor is there any evidence that he shared the footage with others, and there is no evidence that the footage was improperly obtained by anyone. However, this is not the test for breach of fiduciary duty.

[163] In my view, Dr. Jugenburg's actions and inaction support the conclusion that he placed his own interests above those of his patients, and that he breached his duty of loyalty to them. His conduct is inconsistent with the trust and confidence his patients placed in him and amounts to a breach of the fiduciary duty he owed to the Class Members.

[164] The answers to Common Issues 5 and 6 are as follows:

4. Did the Defendants, or either of them, owe a fiduciary duty to the Class Members?

ANSWER – Yes.

5. If the answer to question #5 is yes, did the Defendants, or either of them, breach their fiduciary duty? If so, how?

ANSWER – Yes. The Defendants breached their fiduciary duty to the Class Members by preferring their own interests over those of the Class by installing and operating surveillance cameras and obtaining footage of patients in private medical settings without their knowledge or consent for no medical reason, but only for reasons of self-protection and self-interest. This breach also extended to the Defendants failing to properly store, secure and protect the footage or treat it as personal health information.

[165] As with negligence, this does not end the analysis. Class Members seeking damages for this tort must show that they have suffered harm from the breach of fiduciary duty. However, that is not a common issue to be decided by me at this time.

Common Issue 7 – Breach of trust

[166] This Common Issue relates to whether the defendants were trustees of the Class Members respecting their personal information and, if so, whether the defendants breached a duty of trust “with respect to maintaining the confidentiality of the Class Members’ personal information.”

[167] Dr. Jugenburg admitted that he was the custodian of the Class Members’ personal health information as designated by s. 3(1) of *PHIPA*. Plaintiffs’ counsel states, therefore, that “[i]t is not contested that he was the trustee of the Class Members’ personal health information.” However, this is incorrect, as the defendants do contest that a trust relationship existed.

[168] In my view, the defendants are correct that *PHIPA* does not create a trust-like relationship or otherwise impose a trust on personal health information. *PHIPA* imposes rules regarding the collection, use, and disclosure of personal health information, but it does not use the word “trust” or deem a trust relationship to exist. No case was drawn to my attention which has held that *PHIPA* imposes a trust in respect of personal health information.

[169] Further, the plaintiffs have failed to meet their onus to establish that a trust relationship existed at common law: *St Lawrence Cement Inc. v. 760660 Ontario Inc.*, 2008 CanLII 46323 (Ont. S.C.) at para. 33. In order for a trust to exist, the “three certainties” must be present: certainty of subject matter, certainty of object, and certainty of intention: *Corvello v. Colucci*, 2022 ONCA 159, 467 D.L.R. (4th) 693, at para. 7.

[170] Certainty of subject matter is likely established in this case. The property in issue is the video recordings of the Class Members. However, as the defendants point out, much of the subject matter has been erased or deleted. There is no retained footage prior to May 7, 2018, according to the technical experts who reviewed the data on the DVRs seized by the CPSO. On the other hand, the evidence is that all patients during the Class Period were recorded in the Clinic, and at least for a limited period of time the defendants held that property, or subject matter.

[171] The defendants argue that there is no certainty of object. They point out that “the certainty of object requirement provides that the beneficiaries of the trust must be sufficiently described to allow for trust performance”: *Rubner v. Bistricher*, 2019 ONCA 733, 50 E.T.R. (4th) 17 at para. 59, leave to appeal to S.C.C. refused, 38925 (March 19, 2020). As the footage was set up to be automatically deleted, the defendants submit that there “is no certainty that any given Class Member would actually be the beneficiary, or object, of the trust.” I do not find this convincing. The patients were all identified and identifiable to Dr. Jugenburg; the fact that the property might disappear does not mean the beneficiaries were not certain.

[172] Certainty of intention, however, is not established. This requires evidence of an intention to create a trust relationship with respect to the subject matter. As stated in *Firepower Debt GP Inc. v. TheRedPin, Inc.*, 2019 ONCA 903 at para. 11, quoting from the decision below:

Certainty of intent requires that it be clear that the donor or settlor intended to create a trust; i.e., that the settlor intended for the property in question to be held for the benefit of another. No formal document evidencing the creation of a trust is required. Nor is it necessary that the settlor use any specific language - even the use of the word “trust” is not necessarily dispositive one way or the other. The question

is one of substance - did the settlor evidence an intention that the property be held by one person for another person's benefit? This intention may be express or implied and may be determined from words or acts.

Where a trust is to be implied, however, effect must be given to inferences as to the intention of the parties which a reasonable person would draw from the words or conduct of the parties and not to any subjective or other intention which was not made manifest at the time. Certainty of intention cannot solely derive from a 'moral obligation as to what is to be done with the property.' [Citations omitted.]

[173] In this case, there is no evidence, written or oral, supporting an intention to create a trust relationship respecting the video footage. While I have found that Dr. Jugenburg had a fiduciary obligation to keep the footage confidential for the benefit of his patients, that does not create a trust. Similarly, although the IPC found that Dr. Jugenburg had a legal obligation to treat the footage as personal health information under *PHIPA*, that statutory requirement did not create a trust obligation. Accordingly, the defendants did not have a trust obligation to the Class Members with respect to the video footage obtained from the surveillance cameras.

[174] Further, and in any event, assuming there was a trust relationship, there is no evidence that Dr. Jugenburg breached that trust by failing to maintain confidentiality of the footage. Rather, the plaintiffs' claim seems rooted in Dr. Jugenburg's lack of knowledge or understanding of the system's security features, having never read the camera system manual, and having no knowledge of any breaches other than a bald assertion that the data had never been hacked or improperly accessed. This is a thin reed on which to assert a breach of trust and, in my view, is insufficient.

[175] Nor do I give any credit to the submission that the footage, or data from it, which was accessed by technical experts for purposes of defending the action, is a breach of trust. There are provisions of *PHIPA* which permit the disclosure of personal health information "for the purpose of a proceeding or contemplated proceeding in which the custodian ... is, or is expected to be, a party or witness, if the information relates to or is a matter in issue in the proceeding or contemplated proceeding": *PHIPA*, ss. 37(1)(h) and ss. 41(1). While legitimate questions were raised about the scope of access to the footage and EMRs given to the technical people, it was not a breach of trust.

[176] Accordingly, the answer to Common Issue 7 is as follows:

Were the Defendants, or either of them, a trustee of the Class Members with regard to their Personal Information and, if so, did the Defendants, or either of them, breach the duty of trust imposed upon him, it, or them with respect to maintaining the confidentiality of the Class Members' Personal Information? If so, how?

ANSWER – No.

Intrusion upon seclusion: Common Issues 8, 9 and 10

[177] The common law tort of intrusion upon seclusion was first recognized by the Court of Appeal for Ontario in 2012 in *Jones v. Tsige*, 2012 ONCA 32, 108 O.R. (3d) 241. The tort creates a limited cause of action for invasion of privacy where there has been an intrusion upon a plaintiff's

seclusion or solitude, or into his or her private affairs: *Jones*, at para. 18 citing William L. Prosser, “Privacy” (1960) 48 Cal L. Rev. 383 at 389. The tort is rooted in common law, statutes which address privacy, and the “explicit recognition of a right to privacy...underlying specific *Charter* rights and freedoms”: *Jones* at para. 46. As Sharpe J.A. stated at paras. 65 and 66 of *Jones*:

In my view, it is appropriate for this court to confirm the existence of a right of action for intrusion upon seclusion. Recognition of such a cause of action would amount to an incremental step that is consistent with the role of this court to develop the common law in a manner consistent with the changing needs of society.

...

The case law, while certainly far from conclusive, supports the existence of such a cause of action. Privacy has long been recognized as an important underlying and animating value of various traditional causes of action to protect personal and territorial privacy. *Charter* jurisprudence recognizes privacy as a fundamental value in our law and specifically identifies, as worthy of protection, a right to informational privacy that is distinct from personal and territorial privacy. The right to informational privacy closely tracks the same interest that would be protected by a cause of action for intrusion upon seclusion.

[178] Justice Sharpe went on to set out three elements to the tort, stating at para. 71 of *Jones*:

The key features of this cause of action are, first, that the defendant’s conduct must be intentional, within which I would include reckless; second, that the defendant must have invaded, without lawful justification, the plaintiff’s private affairs or concerns; and third, that a reasonable person would regard the invasion as highly offensive causing distress, humiliation or anguish.

[179] This three-part test was restated by the Court of Appeal in *Owsianik v Equifax*, 2022 ONCA 813, 164 O.R. (3d) 497, at para. 54, leave to appeal refused [2023] S.C.C.A. No. 33, as follows:

(a) the defendant must have invaded or intruded upon the plaintiff’s private affairs or concerns, without lawful excuse (the conduct requirement);

(b) the conduct which constitutes the intrusion or invasion must have been done intentionally or recklessly (the state of mind requirement); and

(c) a reasonable person would regard the invasion of privacy as highly offensive, causing distress, humiliation or anguish (the consequence requirement).

[180] It is important to observe that proof of harm is not an element of this tort. While the harm felt, or experienced, by a plaintiff may be relevant in considering the nature of the intrusion and when determining damages, harm is not required to establish liability: *Jones*, at paras. 71, 74 and 90.

Common Issue 8 – the conduct requirement

[181] The first element of the tort addresses the conduct of the defendant. It requires that “the defendant must have invaded, without lawful justification, the plaintiff’s private affairs or concerns”: *Jones*, at para. 71. This element is focused on the invasion or intrusion into the plaintiff’s privacy. It has two requirements: that there be an invasion into the plaintiff’s private affairs and that there not be a lawful justification for this invasion.

[182] Importantly, this first element of the tort does not require dissemination of private information to others. Indeed, in *Jones*, the intrusion was established by the viewing of the plaintiff’s banking information by one person who had no right to look at it.

[183] On the other hand, as the defendants note, no case has found a party liable for the mere collection of information which was never accessed, or in circumstances where the defendants did not intrude secretly, or surreptitiously. The cameras were not hidden, counsel points out, and there is no evidence of voyeurism or dissemination of the footage to anyone.

[184] As the defendants acknowledge, in general our law protects information in circumstances where an individual has a reasonable expectation of privacy regarding that information. In *R. v. Jarvis*, 2019 SCC 10, [2019] 1 S.C.R. 488, at para. 65, the Supreme Court stated the obvious, that “our society places a high value on personal privacy — that is, privacy with respect to our bodies, including visual access to our bodies.” Wagner C.J.C. continued at para. 66:

In considering the concept of informational privacy, this Court has accepted that individuals have a valid claim ‘to determine for themselves when, how, and to what extent information about them is communicated to others’. The safeguarding of information about oneself, which is also closely tied to the dignity and integrity of the individual, is of paramount importance in modern society. When a court is considering whether there is a reasonable expectation of privacy in information, the nature and quality of the information at issue are relevant. [Citations omitted.]

[185] Recently, the Supreme Court identified three factors that courts address in determining whether a reasonable expectation of privacy exists: “the claimant’s control over the subject matter, the place of the search, and the private nature of the subject matter”: *R. v. Bykovets*, 2024 SCC 6, 489 D.L.R. (4th) 1, at para. 45.

[186] In this case, the patients, or Class Members, had a reasonable expectation of privacy when in the patient consultation and treatment rooms of the Clinic. In these private, or secluded, spaces, patients share their intimate medical information and other personal information – such as, in this case, how they feel about their appearance and why they want to have cosmetic surgery – with Dr. Jugenburg and his staff. Many patients disrobe for examinations and for surgery and are photographed for treatment purposes only. Although many patients consented to the “before and after” photographs or for video made by the social media coordinator to be posted on social media (with all identifying features removed), none of this has anything to do with the footage and information gathered by the surveillance cameras for no medical purpose whatsoever, and without patients’ knowledge or consent.

[187] Counsel for the defendants argue that the information must be private vis-a-vis the intruder, such that there is no intrusion if the person is within the patient's circle of care. Counsel makes much of the fact that confidential medical information about a patient may be shared with others in the Clinic and suggests that the Clinic is "a shared zone of privacy" that diminishes the expectation of privacy of information patients provide in the consultation and examination rooms. Indeed, the defendants point out that a patient's medical records may be shared with the regulator, the CPSO, when necessary to enforce or ensure appropriate standards of care: see, e.g., *Gore v. College of Physicians and Surgeons of Ontario*, 2009 ONCA 546, 96 O.R. (3d) 241, at para. 24. In this context, the defendants submit, "the passive use of the security cameras (without any improper snooping) does not constitute an intrusion."

[188] I disagree. A doctor's office is a private place where patients must feel safe and in control of their information, including what they disclose or show, and whether and how it is recorded. Surreptitious or undisclosed recording of what occurs in such places is an intrusive act, invading the secluded space of the examination or treatment room and the privacy of the patient.

[189] In *Jarvis*, at para. 33, the Supreme Court observed that "surreptitiousness will only ever be one consideration, among many, to be taken into account in assessing reasonable expectations of privacy; it cannot be allowed to overwhelm the reasonable expectation of privacy analysis." The fact that the cameras were not concealed is therefore not determinative. As the Court observed at para. 74, "a person in a particular situation may reasonably expect to be casually observed or even stared at by others but not expect to be the focus of a permanent visual recording." The Court continued:

Recording has a greater potential impact on privacy than does mere observation, as a recording can be saved for long periods of time, replayed and studied at will, dramatically transformed with editing software, and shared with others — including others whom the subject of the recording would not have willingly allowed to observe her in the circumstances in which the recording was made.

[190] The Supreme Court recently confirmed that creating a recording of a conversation is quite different from simply having a conversation: *R. v. Campbell*, 2024 SCC 42, 498 D.L.R. (4th) 195, at para. 70. A recording captures more than what is written in a chart and more than a series of still photographs taken with consent. It is also captured electronically, making it susceptible to disclosure to third parties. Whether it is disclosed to others is irrelevant. It is the collection of the private information or images, by recording it, that is the intrusion.

[191] This point is explicitly made in *Jones*, where Sharpe J.A. stated at para. 57 that "[t]he first element indicates that the tort focuses on the act of intrusion, as opposed to dissemination or publication of information."⁵ Here, the very private information contained in the footage was collected for no legitimate purpose and without the knowledge or consent of the Class Members. In my view, this constitutes an intrusion.

⁵ In the Supreme Court's very recent decision in *Ahluwalia v Ahluwalia*, 2026 SCC 16 at para. 159, Kasirer J. observed that "the tort of intrusion upon seclusion recognized by Sharpe J.A. in *Jones* may capture the acts of stalking and surveillance." It does not require dissemination of private information to others.

[192] The defendants argue that I should not answer this Common Issue on a class-wide basis. They note that some patients saw the cameras and did not object to them, and therefore their privacy was not intruded upon. Further, some may have seen the sign in the elevator lobby, raising a need for individual inquiries of Class Members.

[193] Again, I disagree. The conduct element requires an examination of the nature of the intrusion. This is necessarily an objective test of whether the defendants' conduct intrudes into a secluded sphere where there is a reasonable expectation of privacy.

[194] The fact that some patients saw the cameras and did not object, and others did not object after learning of the existence of the cameras, is of little persuasive value. As I have reviewed earlier, those patients who saw the cameras were particularly attentive to the presence of cameras. Further, their apparent lack of concern for the cameras was undermined in cross-examination, as those witnesses acknowledged that cameras should not be placed in locations where one has a reasonable expectation of privacy, such as fitting rooms, washrooms, locker rooms and showers, and medical offices. I.S., for example, who testified for the defendants, admitted that she would object to a camera filming her without her knowledge or consent at an OBGYN's office. In short, leaving aside the motivations for these witnesses' testimony, their evidence is idiosyncratic and does not reflect the response of a reasonable person.

[195] In my view, the conduct element of the tort is met.

Common Issue 9 – the state of mind requirement

[196] The second element of intrusion upon seclusion is the state of mind requirement. In *Jones*, Sharpe J.A. stated at para. 71 that the conduct must be intentional or reckless. The Court of Appeal also discussed this standard in *Owsianik*, at paras. 59-60:

... The prohibited state of mind, whether intention or recklessness, must exist when the defendant engages in the prohibited conduct. The state of mind must relate to the doing of the prohibited conduct. The defendant must either intend that the conduct which constitutes the intrusion will intrude upon the plaintiffs' privacy, or the defendant must be reckless that the conduct will have that effect. If the defendant does not engage in conduct that amounts to an invasion of privacy, the defendant's recklessness with respect to the consequences of some other conduct, for example the storage of the information, cannot fix the defendant with liability for invading the plaintiffs' privacy.

Intention is established if the defendant meant to intrude upon the privacy of the plaintiff or knew that it was a substantially certain consequence of the act which constitutes the intrusion. Recklessness, also a subjective state of mind, refers to the realization at the time the prohibited conduct is being done that there is a risk that the conduct will intrude upon the privacy of the plaintiffs, coupled with a determination to nonetheless proceed with that conduct. The degree of recklessness required to fix liability can vary and need not be addressed in these reasons. [Citations omitted.]

[197] Counsel for Dr. Jugenburg submit that the state of mind requirement must consider whether the tortfeasor knew he would be “unlawfully” invading the patients’ privacy. Dr. Jugenburg testified that he did not think there was anything unlawful in installing and operating the cameras, so long as he maintained the confidentiality of the footage and did not disclose it to anyone else. He repeatedly testified that he misunderstood his obligation, saying that he equated confidentiality with privacy. The following exchange in cross-examination illustrates this position:

Q. And, it did not occur to you that the act of collecting it was a problem because it could lead to violations of people's privacy down the road, did it?

A. I understand that. In retrospect, I understand this. It is not what crossed my mind at the time. Because, like I said, before, to me, this was just security footage. I was just having security cameras. I understand now that it was collecting personal health information. At that time, I wasn't thinking about it in such terms. I did not consider this personal health information. I didn't realize it was such until I was told afterwards.

[198] I do not accept Dr. Jugenburg’s position, for three reasons. First, in law, the tort does not require correct knowledge of the law or knowing unlawfulness. That would create a unique mistake of law defence that must be rejected. Second, Dr. Jugenburg’s recognition that he had a confidentiality obligation with respect to the surveillance footage provides sufficient evidence to conclude that he knew, or was reckless, that he was intruding on patients’ privacy. Third, I do not accept Dr. Jugenburg’s evidence on this issue. His explanations for the cameras varied, his evidence was often self-serving, internally inconsistent, not supported by contemporaneous records, and lacked reliability and credibility. I find that Dr. Jugenburg knew exactly what he was doing and that it was wrong.

Mistake of law is no defence

[199] It is not a defence to an intentional tort that the defendant did not know the act was unlawful. For intentional torts, “[m]istake as to the legal or factual consequences of conduct does not constitute a defence if the physical consequences were intended”: *889267 Ontario Ltd. v. Norfinch Group Inc.* (1998), 6 C.B.R. (4th) 166 (Ont. Gen. Div.), at para. 23; see also *CIT Financial Ltd. v. 1153461 Ontario Inc.* (2004), 47 B.L.R. (3d) 269 (Ont. S.C.), at p. 289; *Northstar Leasing Corporation v. Two Ten Spruce Corporation* (2007), 91 R.P.R. (5th) 69 (Ont. S.C.), at para. 14; *2105582 Ontario Ltd. (Performance Plus Golf Academy v. 375445 Ontario Limited (Hydeaway Golf Club)*, 2016 ONSC 3746, at para. 20, rev’d in part on other grounds 2017 ONCA 980, 138 O.R. (3d) 562. Although these cases discuss the intentional tort of conversion, the same principle, that “ignorance of the law is no excuse”, applies to other intentional torts.

[200] A very recent illustration of this is found in the Supreme Court’s decision in *Ahluwalia*, which recognized the intentional tort of intimate partner violence, for which “the plaintiff must simply establish the defendant’s intention to engage in the impugned conduct.” It is not necessary to prove that the defendant intended to “cause a specific type of harm” or, put another way, break the law in a certain way. Rather, “consistent with intentional torts such as battery and assault”, all that must be established is “that the defendant intentionally engaged in the wrongful conduct”: *Ahluwalia* at para. 186.

[201] There is no suggestion in *Jones* or *Owsianik* that the tort of intrusion upon seclusion requires proof that the defendant knows he is breaching a statute or otherwise knows he is acting unlawfully. The knowledge or recklessness relates to the act and its consequences. This was well-put by E.M. Morgan J. in *Quantz v. Ontario*, 2025 ONSC 90 at para. 41:

The Court of Appeal has indicated that for a privacy breach to constitute this tort, the perpetrator of the breach must have acted deliberately – i.e. must have realized the danger of the impugned actions and deliberately assumed the risk of that danger. In order to establish liability, the Defendant must be shown to have been reckless in the sense of a subjective state of mind. That is, at the time of the impugned conduct the person must have turned their mind to the risk that the conduct will intrude on privacy, and then must have made a conscious determination to nonetheless proceed with the conduct. [Citations omitted.] [Emphasis added.]

[202] Morgan J.’s statement is entirely consistent with *Jones*, in which Sharpe J.A. stated at para. 59 that “[t]he defendant must either intend that the conduct which constitutes the intrusion will intrude upon the plaintiffs’ privacy, or the defendant must be reckless that the conduct will have that effect.” Nothing more is required.

[203] None of the cases cited by the defendants support the submission that the defendant must know that their action in intruding upon seclusion is “unlawful.” *Patel v. Sheth*, 2016 ONSC 6964 at paras. 109-114, for example, supports the conclusion that knowledge of the legal nature of the intrusion is not relevant as it finds intrusion upon seclusion to be made out without an express finding that the defendant knew the conduct was unlawful.

[204] The defendants’ reliance on *Owsianik* is also misplaced. *Owsianik* dealt with Equifax’s negligent storage of financial information that resulted in a data breach by a third party. The Court held that this could not amount to intrusion upon seclusion, stating that even Equifax’s “recklessness as to the consequences of its negligent storage cannot make Equifax liable for the intentional invasion of the plaintiffs’ privacy committed by the independent third-party hacker”: *Owsianik* at para. 61.

[205] This is not a case about a third party committing the intrusion. Here, Dr. Jugenburg and his Clinic committed the tortious act by intruding upon patients’ privacy by installing and operating the camera system, which collected private information in private places where the plaintiffs had a reasonable expectation of privacy.

[206] Nor must the defendant have a “nefarious intent”, as suggested by the defendants, citing *Litvin et al v. Mackenzie Financial Corporation et al*, 2025 ONSC 6138 at para. 48. In that case MacLeod R.S.J. used this term, suggesting it came from *Owsianik*. However, the word “nefarious” does not appear in *Owsianik*. MacLeod R.S.J. used the term once in discussing the findings in *Owsianik* in which he discussed a “wilfulness” standard in the context of a statutory data breach. He did not define “nefarious” in any way.

[207] In my view, the term “nefarious intent”, whatever it may mean, is not a helpful or necessary part of the state of mind required to commit intrusion upon seclusion. It is inconsistent with the

Court of Appeal decisions in *Jones* and *Owsianik* which state that knowledge or recklessness, which are well-understood concepts in our law, are sufficient.

[208] Dr. Jugenburg acted deliberately. He knew the camera system would record very private matters involving the patients. This was a “substantially certain consequence” which resulted from knowingly installing and operating the camera surveillance system. This establishes the state of mind requirement for the tort.

Dr. Jugenburg did not misunderstand his obligation

[209] Dr. Jugenburg claims that he misunderstood his obligation, saying that he equated privacy with confidentiality - that he believed that his privacy obligations meant merely keeping patients’ information confidential from third parties. Put another way, Dr. Jugenburg says he understood that he had an obligation of confidentiality because of his role as a physician, and that meeting this obligation of confidentiality protected patient privacy.

[210] However, Dr. Jugenburg agreed that the cameras collected deeply private information obtained because of his position as a physician, which had to be kept confidential, but which was not included in his patients’ medical files. He treated the videos differently from other medical information by storing them on his DVRs and accessing them on his iPhone and iPad, unlike all other information from patients which was obtained transparently, with consent, and stored securely in his EMRs, as is required. He also agreed that the footage from the surveillance cameras included private conversations between patients and their spouses or supportive friends who attended appointments with them (see, *e.g.*, the evidence of C.A.), which occurred in the absence of him or his staff and therefore was not information obtained in his capacity as a physician at all.

[211] Dr. Jugenburg knowingly breached the requirement to treat all information obtained from his patients in accordance with his professional obligation of confidentiality through his knowing and deliberate installation and operation of the surveillance cameras at his Clinic separate from his role as a medical practitioner. These cameras were entirely for his own use and served no medical purpose. Just because he is a doctor, he does not have the right to gather confidential, private information for a non-medical purpose.

[212] Dr. Jugenburg knew the surveillance cameras captured private conversations because he knew the conversations were at least subject to confidentiality requirements. He knew he was collecting this information without patients’ knowledge or consent. Whether he was mistaken about his obligations, or even what *PHIPA* said about this information, is not relevant, nor is it a defence.

Dr. Jugenburg’s evidence was not credible or reliable

[213] I also reject Dr. Jugenburg’s position because I find his evidence was not credible or reliable. Dr. Jugenburg’s explanations for the camera system - that they were for security and that he did not understand his obligations – are convenient and disingenuous after-the-fact attempts to excuse his conduct. Dr. Jugenburg’s actions and inactions, both before the cameras were discovered and afterwards, demonstrate a disregard for the interests of his patients and their reasonable expectation of privacy.

[214] Dr. Jugenburg testified for almost five days, most of which consisted of a meticulous cross-examination by Mr. Nisker. Dr. Jugenburg was impeached on several occasions which demonstrated that he misled people and was not frank with the Court. His rationales for the cameras shifted and lacked coherence. He professed a lack of memory where convenient and took positions that were inconsistent with contemporaneous records.

[215] Here are some examples.

[216] I begin with Dr. Jugenburg's credentials, found in both his curriculum vitae and what he tells prospective patients about himself on his website. Although he testified that he continually updates his website and that he ensures that his website is up-to-date and accurate, as of the date of the trial, in late 2025, Dr. Jugenburg was still telling people he had privileges at Humber River Hospital. This is false, as, according to his testimony, those privileges ceased in 2020 or 2021 when his license was suspended for six months, and he has not sought to renew those privileges.

[217] In fact, Dr. Jugenburg's curriculum vitae dated March 5, 2019, showed his privileges at Humber River had stopped in 2017. When confronted about these inconsistencies in cross-examination, Dr. Jugenburg claimed that he had "courtesy privileges" after 2017, asserting that he was "still associated with the hospital, but I wasn't practising there." He later confirmed that such "courtesy privileges" meant he could "not do much", as he could not admit a patient or practice there. At best, according to his evidence, it gave him the right to walk in, review a patient's chart and speak to the admitting physician about the patient's care, but he could not give any directions. He did not explain how this was different from any other doctor, with no privileges, who had a patient admitted to the hospital. Indeed, he testified that he now no longer has "courtesy privileges", flatly contradicting his "up to date" website.

[218] Nor does Dr. Jugenburg have privileges at any hospital, as he admitted in cross-examination. His website in 2019, however, also told patients he had "hospital privileges" at the Toronto Cosmetic Surgery Institute, which is his own clinic, and at three other cosmetic surgery clinics in Toronto: The Elements Surgery Institute, the CIBO Clinic and The Plastic Surgery Clinic. However, these are all private cosmetic surgery clinics run by individual physicians, not hospitals. No formal privilege process exists at any of them and Dr. Jugenburg's only connection to them is that he sometimes saw patients and did cosmetic surgery there prior to establishing his own business in about 2011 or 2012.

[219] Throughout the trial, Dr. Jugenburg and his counsel made a point of always referring to the cameras as "security cameras." In his direct examination, when asked about why he installed them, Dr. Jugenburg said he "thought of it as really just a simple security system there to protect all of us." At one point in his cross-examination, he said they were for security and that he "had no other reasons" for installing them.

[220] I do not accept that assertion, which makes no sense, is not supported by Dr. Jugenburg's actions, and is contradicted by his own testimony.

[221] First, if the cameras were there for needed security, it does not make sense that the cameras on Level B were left inoperative from shortly after being installed in 2012 until 2017 when they were repaired at the time the cameras on Level D were installed. Additionally, the cameras did not

set off alarms to advise of intruders after hours; Dr. Jugenburg had a separate security system for that purpose. It is an agreed fact that Level B had a motion detector security system to detect intruders, unconnected with the camera system. Nor, since there was no signage that the Clinic was under surveillance, would they have acted as a deterrent to intruders.

[222] Dr. Jugenburg asserted that the cameras could act as a “deterrent for inappropriate behaviour”, but that would also only be the case if patients and staff were aware of them. Dr. Jugenburg took no steps to achieve that. There were no visible signs in the Clinic telling patients about the cameras and several staff who testified were unaware that there were cameras in treatment and consultation rooms. As J.K. said, the security rationale is “ridiculous.”

[223] Dr. Jugenburg acknowledged that the cameras could be used to resolve disputes. In cross-examination he denied reviewing footage “to protect myself”, but the evidence showed that he reviewed footage on a number of occasions in response to patient complaints. As he put it to a colleague who ran a cosmetic surgery clinic after the CBC broadcast in December 2018:

These cameras protect me. They allowed me to dispute CBC accusations. (That got CBC pissed and they filed a complaint against me with the college....) They have helped me resolve false claims and accusations by crazy patients. They caught a burglar in our facility.

[224] When asked whether any of the patients who had complained were “crazy patients”, Dr. Jugenburg said no, that he did not have any “crazy patients.” On the other hand, in text messages with a colleague Dr. Jugenburg said that he had the cameras to “protect us from false allegations”, stating that “it only takes one to bring you down” and that “these cameras have saved my ass on several occasions.”

[225] The dispute Dr. Jugenburg had with the American physician who was treated by him led Dr. Jugenburg to review her footage. In June 2017, Dr. Jugenburg sent the patient an email which referred to him having “listened to the entire consultation.” He also said to the patient that she “appeared calm” and made other observations which could only have been based on viewing the video. In response, the patient observed: “Maybe Canada is different but in the US you have to verbally be told and sign written consent if you are being audio or video recorded during an examination.”

[226] When asked whether he did anything in response to that patient’s comment about the cameras, Dr. Jugenburg claimed not to have seen the email. I find that very difficult to accept. The patient’s email was sent directly to him in response to his personal email to her. He then forwarded the patient’s response to his nurse, Kim McDonald (now Crawford), who sent Dr. Jugenburg a responding email that specifically raised concerns about recording patients saying, among other things, “I LOVE Y(UR EMAIL. I wsa worried she would be upset with the recordign[sic].”

[227] There is also the example, discussed earlier, of the patient L.B. who requested footage of her operation and was told, falsely, that none existed. This shows that the camera system was for Dr. Jugenburg’s benefit, not for the benefit of his patients.

[228] In addition to using the footage to resolve disputes, Dr. Jugenburg said that he used the camera to monitor his staff and to monitor “patient flow.” Sometimes he even looked at the footage

“live” to see what was happening elsewhere in the Clinic. This is not for security. The reference to catching a burglar in Dr. Jugenburg’s email to a colleague is surprising. While his cameras did capture footage of one or two people who entered the clinic, one of whom stole something from a staff member, there is no evidence that anyone was “caught”, let alone caught in the facility. As I have noted, there was no connection between the camera system and the Clinic’s separate security system.

[229] The failure to post adequate signage or to inform patients of the existence of the cameras even when concerns were raised also supports the conclusion that Dr. Jugenburg knew or was reckless as to the cameras improperly invading the privacy of his patients. The only visible sign, in a hallway on one floor outside the Clinic, was completely inadequate.

[230] This raises the question, again, of how the cameras made the premises more secure, or made patients feel safer, when there was no visible signage in the Clinic informing patients, or potential intruders, of the presence of the cameras. The cameras may have been visible, but they were far from obvious. One had to be looking for them to see them, and most patients do not enter physicians’ offices looking for cameras in the ceiling.

[231] Dr. Jugenburg did not tell people about the cameras, and even many of his staff were unaware of them beyond the common spaces. If a patient questioned staff about them, “Nurse Kim”, as Ms. Crawford was known, said it was for their safety and protection, in case there was a dispute. This is what Ms. Crawford told the CBC reporter who then asked if there had been any disputes to which Ms. Crawford said, falsely, that there had not.

[232] Dr. Jugenburg’s conduct when the CBC was investigating, and after the CBC broadcast its story, also calls into question his motives, his credibility, and his sincerity. After being contacted by the CBC, Dr. Jugenburg sought public relations advice from J.G. who suggested that he meet with his staff and get them to say they are “comfortable” with the cameras, and that “it makes them feel safer, especially being in a hotel or whatever.” She also said she wanted to tell a journalist that other surgeons have cameras “for safety reasons (drugs, inappropriate visitors, emergency etc) but not sure yet.” These are rationales Dr. Jugenburg has pleaded in this case but none of those reasons were mentioned in any document prior to J.G.’s emails to him.

[233] J.G. also expressed concerns about the cameras to Dr. Jugenburg before the CBC story was broadcast. In one email to Dr. Jugenburg she said she had “always” been worried about the cameras, suggesting that she may have raised concerns about them with him previously.

[234] After the story about the cameras was broadcast, Dr. Jugenburg sent out a letter, described at trial as an “email blast”, to his patients on December 18, 2018. Dr. Jugenburg described the letter as an “apology.” The text of this letter is set out earlier in these Reasons.

[235] Dr. Jugenburg said in direct examination that his office manager, Nora Rochman, drafted the letter, although in cross-examination he prevaricated, saying variously that “she helped draft this letter for me”, “was one of the people that contributed to this letter”, that “I asked for help in drafting this letter”, and that “she drafted this letter with help.” He did at least admit that he reviewed and approved the letter before it went out.

[236] Dr. Jugenburg's attempt to distance himself from the letter may be due to the fact that the letter contained false and misleading statements and was not, in fact, an apology.

[237] The letter, described at the top as "A Message from Dr. Martin Jugenburg", told patients that about two years earlier "we installed security cameras throughout our clinic, including reception rooms and examining rooms." It went on to say that "the cameras were always visible, and signs were posted to inform our patients of the presence of video surveillance."

[238] When it was suggested in cross-examination that the reference to signs was not true, Dr. Jugenburg stated "not exactly." As I have noted, until the CBC disclosed it was investigating the cameras, there were only two signs, one outside the Clinic in an elevator lobby that made no reference to cameras inside the Clinic, and one obscured on a shelf in the OR which nobody saw, including Dr. Jalil and Melanie Petriw, both of whom worked frequently in the OR. When pressed, Dr. Jugenburg agreed that the statement "may not be perfectly accurate."

[239] The letter claimed that the footage "was stored on a highly secure IT system", which Dr. Jugenburg agreed was untrue. The letter also stated, falsely, that recordings were automatically deleted "every few weeks." It was silent on the fact that Dr. Jugenburg could access the footage on his iPhone, that he could watch events "live", or that most of the cameras recorded audio as well as video.

[240] The letter also stated:

As Canadian privacy legislation has continued to expand, both the scope of our security system and related signage should have been reviewed and updated. We have learned that we should have been more proactive in communicating the presence of the cameras through the office to you, allowing you to opt out if desired.

We did not do this, and we apologize for this oversight.

[241] This is the only apology in the letter. It is disingenuous. It is based, falsely, on an assertion that privacy legislation had changed during the time Dr. Jugenburg operated the camera system in 2017 and 2018. In cross-examination Dr. Jugenburg conceded that the law about collecting personal data from patients had not changed since 2004, claiming the change was that "I learned about privacy as confidentiality."

[242] Dr. Jugenburg's letter does not apologize to his patients for recording them without their consent, which he agreed would have made sense, if he was to apologize.

[243] The letter is also telling in what else it does not say, such as that the CPSO had removed the cameras and was investigating Dr. Jugenburg's conduct.

[244] Many of the patients who testified for the plaintiffs did not recall receiving this letter, raising questions as to how conscientious Dr. Jugenburg was in even making sure it was disseminated to his patients. He said his office manager, Ms. Rochman, sent it out, but she was not called as a witness. Given the other errors in the patient history forms which were relied on to claim that all patients received the email blast, and the lack of direct evidence as to how it was sent, I do not accept that the letter was emailed to all of Dr. Jugenburg's patients.

[245] The email blast provoked many responses from patients, some favourable and supportive of him, others were critical and angry over the surveillance. About 50 responses were collected and made an exhibit at trial. I place little weight on them since, as I note below, the determination of whether Dr. Jugenburg's conduct is tortious is not based on popularity or polling, but on objective criteria.

[246] Following the CBC broadcast, Dr. Jugenburg received an email from Dr. Oakley Smith, a plastic surgeon who sometimes used the Clinic's OR. Dr. Smith had received a call from a patient asking if her surgery had been filmed. Dr. Jugenburg replied to Dr. Smith misleadingly, stating:

We [h]ave security cameras for the facility. Her surgery was not filmed as per se. The room in general is under security footage which is automatically deleted and overwritten.

[247] When cross-examined on this statement, Dr. Jugenburg agreed that the entire surgery was filmed, but then said, incoherently: "When you say it was surgery filmed, to me that means were we filming surgery as in for social media or for clinical purposes." There is no evidence that Dr. Jugenburg ever filmed anything for "clinical purposes."

[248] Dr Jugenburg also provided inconsistent answers regarding his reaction to the CBC story. In direct examination, when explaining why he was so upset by the story, he referred to "the way this was written" by referencing "hidden cameras" which were "surreptitiously recording patients" which "created an illusion or impression that I was snooping on my patients." Yet in cross-examination, when it was suggested that the article did not say he had ulterior motives or that the cameras were hidden, he claimed not to have read the article at all.

[249] J.L., who worked as a receptionist at the Clinic in 2018 and 2019, fielded phone calls from patients after the CBC broadcast, most of whom, she said, were upset by the cameras. Dr. Jugenburg provided, in writing, a short script, instructing staff not to get into a conversation and to say, "repeatedly":

1) "We have cameras in our office for security purposes, these are NOT hidden cameras, they are clearly visible and is used for security purposes".

Any further questions please say –

2) "I cannot disclose anymore information for privacy reasons" then repeat the first line over again.

[250] J.L. described Dr. Jugenburg as seeming not to care about the impact of the camera system on patients when they were exposed by the CBC. She said that he was only concerned about his image – particularly "his stats on calls coming in and his website being viewed."

[251] Dr. Jugenburg's preoccupation with social media supports the conclusion that he placed little value on his patients' privacy. Earlier in these Reasons I reviewed the pressure placed on patients to consent to having their images posted on social media including videos of their surgery. Dr. Jugenburg and his staff devoted far more attention to obtaining consent to social media than

for the operations themselves. The evidence of L.J.P. being pressured to consent, and the Clinic then posting images without her consent, is particularly disturbing.

[252] Dr. Jugenburg’s focus on social media led to him permitting his social media director, who had no medical training, to access patients’ EMRs to view photographs and to be present in the OR for no medical reason at all. As Dr. Jugenburg testified, “there was no need for medical education for this job.” Further, as noted, there were occasions when photos of patients were posted on social media without their consent and which, in some cases, identified them. As I stated earlier, Dr. Jugenburg’s claim that the primary purpose of his social media is education is simply not credible.

[253] I found Dr. Jugenburg’s evidence to lack credibility and to be unreliable. I do not accept his after-the-fact explanations that he simply did not appreciate that what he was doing was wrong and that he somehow misunderstood or did not appreciate the difference between privacy and confidentiality. Dr. Jugenburg knew he was filming patients without their knowledge or consent. He knew that he was filming intimate, private information, for no medical purpose, or even security purpose, but to protect his own interests. His failure to disclose the existence of the camera system to his patients, even when questions were raised, and his conduct after the camera system was exposed by the CBC, including his disingenuous apology, demonstrate that he knew exactly what he was doing – invading patient privacy – and that he did not care.

Common Issue 10 – the consequence requirement

[254] The third element of the tort of intrusion upon seclusion requires a plaintiff to establish that a reasonable person would regard the invasion of privacy as highly offensive, causing distress, humiliation or anguish. This is an objective test. As Sharpe J.A. stated in *Jones* at para. 72:

Claims from individuals who are sensitive or unusually concerned about their privacy are excluded: it is only intrusions into matters such as one's financial or health records, sexual practises and orientation, employment, diary or private correspondence that, viewed objectively on the reasonable person standard, can be described as highly offensive.

[255] Earlier in his decision in *Jones*, citing American law, Sharpe J.A. stated at para. 58 that “factors to be considered in determining whether a particular action is highly offensive include the degree of intrusion, the context, conduct and circumstances of the intrusion, the tortfeasor’s motives and objectives and the expectations of those whose privacy is invaded.” See also, Leiper J. in *Trueman v. Rogers Communications Canada Inc.*, 2025 ONSC 5972 at para. 82, leave to appeal to Div. Ct. refused, 2026 ONSC 2124.

[256] In the health care context, Koehnen J. stated that “[i]t would rarely, if ever, be ‘highly offensive’ for a medical worker within a patient’s circle of care to *access* medical records” (emphasis in original): *Oliveira v. Aviva Canada Inc. et al*, 2017 ONSC 6161, 139 O.R. (3d) 618 at para. 20, aff’d 2018 ONCA 321. Nor, the Divisional Court has stated, are all unauthorized intrusions into personal health information, “however minimal and fleeting”, highly offensive: *Stewart v. Demme*, 2022 ONSC 1790, 161 OR (3d) 21, at para. 27.

[257] The defendants rely on these cases, which put constraints around what can be highly offensive, to argue that the tort should be kept narrow, as was emphasized by Justice Sharpe in *Jones*.

[258] Additionally, the defendants submit that because some patients did not find the presence of the cameras upsetting or offensive, and said the cameras made them feel safer, the law should not presume that the surveillance cameras were “highly offensive.” The defendants point out that many members of the Class only attended the “Skinjectables” part of the Clinic and did not disrobe or engage in detailed intimate conversations while being recorded. Indeed, I heard very little about the injectables part of the practice at the Clinic. Similarly, if a patient was only seeking facial cosmetic surgery, they may not have disrobed, although this does not diminish their expectation of privacy during consultations or treatment. Some patients may have attended the Clinic many times, for different reasons. As there are significant differences regarding the degree of intrusion among Class members, the defendants argue that the court should not make a Class-wide finding on this issue.

[259] In my view, the consequence requirement was rightly made a Common Issue because it calls on the court to make an objective determination. The objective standard means that the tort should not be tailored to those who are overly sensitive, as Sharpe J.A. highlighted in *Jones*, but it also means the tort should not be tailored to those who are overly relaxed about their privacy. The analysis focuses on the reasonable person, who is not overly sensitive or overly indifferent about their privacy.

[260] In this case, all Class Members were recorded having private consultations with, and in most cases receiving treatment from, a medical practitioner. This falls within one of the matters – health records – which was recognized by Sharpe J.A. in *Jones*. The degree of intrusion was serious, filming patients engaged in deeply private communications and exposing their bodies without their knowledge or consent.

[261] Evidence of the impact of the intrusion on the plaintiffs, including whether it caused distress, humiliation, or anguish, is relevant to a determination of whether a reasonable person would find the existence of the surveillance cameras highly offensive.

[262] At this trial, I heard from many Class Members about how upset they were to find that they had been video-recorded without their consent or knowledge. Many patients described how deeply personal and private their decision was to seek cosmetic surgery and described their feelings of vulnerability when being examined.

[263] Witnesses for the plaintiffs gave emotional and compelling testimony about how angry and upset they were to learn of the cameras, feeling, among other things, “violated”, “humiliated”, “shocked”, and “betrayed.” As one patient stated, Dr. Jugenburg has “got a lot of private moments on those recordings.” Another stated a frequently articulated concern of being “distressed not knowing where videos or pictures would have ended up.” One patient put it this way: “I feel if the footage is on a cell phone it is not secure” L.L. described how “disempowering” it was not to have control over intimate images of oneself, describing Dr. Jugenburg’s conduct as a “huge breach of trust.”

[264] Several patients talked about the anxiety they now feel, including a diminished or complete lack of trust in physicians and a reluctance to seek medical treatment as a result.

[265] Dr. Flaum discussed the harm such surreptitious filming can cause, noting the medical trauma and the mental health impacts arising from violations of patient trust, autonomy, informed consent, and privacy in medical settings. All of this occurred here.

[266] As reviewed earlier in these Reasons, Ms. Yoon, Mr. McHugh, and Dr. Bendor-Samuel confirmed that surveillance cameras were not installed in this manner in other healthcare facilities – clinics and hospitals - because it would constitute an unjustified intrusion into patient privacy. Dr. Jugenburg’s assertion, effectively, that there was nothing unusual about the cameras is unsupported and disingenuous.

[267] While some patients who testified for the defendants said they were not upset by the cameras and a few went so far as to say they felt safer because of them, that evidence is idiosyncratic and unpersuasive. Some of those who noticed the cameras had familiarity with surveillance camera systems. Patients who testified for the defendants agreed that cameras in other private settings, such as fitting rooms in clothing stores, restrooms, locker rooms at gyms, and other places where people disrobe, would not be appropriate, yet they were defensive of Dr. Jugenburg’s practice of filming patients without their knowledge or consent when they were undressed and having highly personal conversations in his Clinic

[268] In any event, as counsel for the plaintiffs’ notes, “class actions are not a popularity contest.” A certification is not “determined through a referendum of the class members”, as Winkler J. (as he then was), pointed out in *1176560 Ontario Ltd. v. Great Atlantic & Pacific Company of Canada Ltd.* (2002), 62 O.R. (3d) 535 (S.C.), at para. 32, aff’d 70 O.R. (3d) 182 (Div. Ct.). The Court of Appeal observed in *Levac v. James*, 2023 ONCA 73, 89 C.C.L.T. (4th) 27 at paras. 49-50, that “[t]he fact that there may have been some variation in individual experience does not preclude answering the question in common” where the same tortious action “exposed his patients to a common risk of harm.” These statements were made in the context of an appeal from a common issues trial. A similar approach was taken in *Cavanaugh v. Grenville Christian College*, 2021 ONCA 755, 72 E.T.R. (4th) 28 at paras. 74-78, where the Court of Appeal upheld a finding of systemic negligence on a class-wide basis despite some class members testifying that they did not suffer from the defendants’ practices.

[269] On the other hand, there is no evidence that the footage was disseminated to any third party. Dr. Jugenburg did not review much of the footage, and it was automatically deleted after several months. This causes counsel for the defendants to submit that any privacy breach was “ephemeral” as “a temporary collection of information that is never used cannot be highly offensive.” Additionally, they submit that the cameras were “largely recording the same kind of information that patients shared with the Clinic voluntarily and ultimately was reflected in patients’ medical charts.”

[270] This submission misses the point. The test is objective and considers whether the invasion of privacy by having the camera system at all is highly offensive. The intrusion is that Dr. Jugenburg created the recordings in the first place, capturing intimate interactions with patients without their knowledge or consent and for no medical purpose. While there was no evidence that

anyone other than Dr. Jugenburg viewed the footage, and some of it had been automatically deleted when the existence of the cameras was exposed in December 2018, that may simply be fortuitous. Further, as some patients testified, they still have concerns that the recordings of them may be stored somewhere on the internet and could possibly be accessed and disseminated. This is not an unreasonable fear.

[271] To summarize, the context and circumstances of the intrusion are serious. The filming occurred in a medical clinic, where patients expect a high degree privacy and put complete trust in the physician about their very personal and private issues. Dr. Jugenburg's motives in installing the cameras were not, as he testified, for security and safety, but to protect his own interests and be for his own benefit.

[272] While there may be differences in the degree of the intrusion between those who attended for surgery and those who only sought injections, every patient had an expectation of privacy, which was breached. This intrusion caused distress, humiliation, and anguish to many. Applying an objective test, the evidence supports the conclusion that a reasonable person would regard the invasion of privacy posed by the surveillance camera system, which recorded patients in some of their most vulnerable moments with no consent, as highly offensive.

[273] In *Jones*, Sharpe J.A. said at para. 69 that “[f]inally, and most importantly, we are presented in this case with facts that cry out for a remedy” and that “[a]ny person in [the plaintiff’s] position would be profoundly disturbed by the significant intrusion into her highly personal information”. These statements apply equally to this case. It is difficult to imagine more private information than discussions with medical professionals and loved ones, often in various states of undress, about potential medical procedures. To have video and audio of those discussions and examinations, as well as the procedures themselves, recorded without one’s consent is a situation that cries out for a remedy.

Conclusion on Common Issues 8, 9 and 10

[274] The answers to Common Issues 8, 9 and 10 are as follows:

8. Did the Defendants, or either of them, invade, without lawful justification, the private affairs or concerns of the Class Members?

ANSWER - Yes

9. If the answer to question #8 is yes, did the Defendants, or either of them, act intentionally or recklessly?

ANSWER - Yes

10. If the answer to questions #8 and #9 is yes, would a reasonable person regard the invasion of the Class Members' privacy as highly offensive causing distress, humiliation or anguish?

ANSWER - Yes

Damages: Common Issues 11 and 12

[275] The final two Common Issues are whether an aggregate damages award can be made under s. 24(1) of the *CPA* and whether the conduct of the Defendants is such that an award of punitive, exemplary and/or aggravated damages is warranted.

Common Issue 11 - aggregate damages

Should aggregate damages be awarded?

[276] Section 24(1) of the *CPA* states as follows:

(1) The court may determine the aggregate or a part of a defendant's liability to class members and give judgment accordingly where,

(a) monetary relief is claimed on behalf of some or all class members;

(b) no questions of fact or law other than those relating to the assessment of monetary relief remain to be determined in order to establish the amount of the defendant's monetary liability; and

(c) the aggregate or a part of the defendant's liability to some or all class members can reasonably be determined without proof by individual class members.

[277] Clause (a) is met here, as the plaintiffs claim monetary relief. However, the defendants argue that clauses (b) and (c) are not met.

[278] Subsection (b) requires that all issues of liability be resolved before aggregate damages can be awarded. It is common ground that aggregate damages cannot be awarded for negligence and breach of fiduciary duty as those torts, unlike intrusion upon seclusion, require proof of causation and damage. Perell J. expressly recognized this at paras. 134 and 135 of his Certification Decision, where he noted that an affirmative finding of intrusion upon seclusion would "provide the foundation for an aggregate damages award", but that an individual issues trial would be required "to attempt to perfect the negligence and breach of trust and fiduciary duty causes of action."

[279] Common Issues 8, 9 and 10 address all elements of the tort of intrusion upon seclusion. Having found that they are established, all issues of fact and law relating to liability for intrusion upon seclusion have been determined. Subsection (b) of s. 24(1) of the *CPA* is therefore met.

[280] As to subsection (c), the defendants submit that individual inquiries are still necessary to award damages to the Class Members, citing the five factors that should be considered in fixing damages set out at para. 87 of *Jones*:

(1) the nature, incidence, and occasion of the defendant's wrongful act;

- (2) the effect of the wrong on the plaintiff's health, welfare, social, business, or financial position;
- (3) any relationship, whether domestic or otherwise, between the parties;
- (4) any distress, annoyance, or embarrassment suffered by the plaintiff arising from the wrong; and
- (5) the conduct of the parties, both before and after the wrong, including any apology or offer of amends made by the defendant.

[281] Sharpe J.A. went on to specify, at para. 88 of *Jones*, that the damages awarded for intrusion upon seclusion are “symbolic or moral damages.” This characterization of the damages aligns with the fact that proof of harm is not required to make out intrusion upon seclusion. Damages relate, for the most part, to the wrongful conduct of the defendant, and the nature of the intrusion.

[282] The first factor in *Jones* focuses on the defendant’s wrongful conduct which, in this case, was having the camera system in the first place. Although there were differences between Class Members regarding the number of visits and the type of treatment, it is a feature of class proceedings that class members may have experienced the wrong differently from one another. However, the policy objectives of the *CPA*, including promoting access to justice, judicial economy and achieving behavior modification, mean that the damages will be subject to a degree of levelling: *Ramdath v George Brown College of Applied Arts and Technology*, 2015 ONCA 921, 392 D.L.R. (4th) 490, at para. 76.

[283] Here, a distinction can readily be drawn between those who only sought injection treatments, which was relatively brief and did not involve disrobing, and those who sought surgery. The fact that some may not have disrobed very much or attended the Clinic only once or twice is a variation that does not change the “nature” and “occasion” of the defendants’ conduct towards patients.

[284] Similarly, dealing with the second and fourth factors, I recognize that individual Class Members responded differently to the intrusion and were affected differently. The evidence of those who did not object to the cameras, who testified for the defendants, was not persuasive, as I have discussed above. Other reactions, from Class Members which I found reasonable and compelling, and which I accept, included anger, distress and humiliation, among other things. Some described the continuing impact on them following the disclosure of the camera system, such as anxiety, anguish and lack of trust in medical professionals to the point of avoiding treatment. Differences are to be expected, as Dr. Flaum recognized when she testified that patients may have fundamentally different reactions to the same medical event, and that there is no way to determine how individual patients react to an event without talking to them. Dr. Flaum also recognized that different patients have different reactions to events that are objectively traumatic. This is what happened here.

[285] My finding that the intrusion by the defendants was “highly offensive” and would reasonably cause distress, humiliation and anguish to Class Members provides a basis on which to quantify damages based on the defendants’ wrongdoing. Again, it is the nature of class proceedings and making awards on an aggregate basis that there is a degree of levelling of damages even though

the impact on class members differs. This accords with the point made by Belobaba J., the trial judge in *Ramdath*, who stated at para. 44 of the trial decision (2014 ONSC 3066, 375 DLR (4th) 488):

The key to understanding aggregate damages is in understanding that the measurement criterion is not what's accurate but what's reasonable. In striking a balance between accuracy (or as the [Ontario Law Reform Commission] put it, "the risk of imposing liability upon the defendants for an amount that exceeds the injury actually inflicted") and access to justice ("the possibility of denying recovery to persons who have been injured") the legislature intentionally tilted the balance in favour of access to justice. Hence the focus in s. 24(1) on whether all or part of the defendant's monetary liability can *reasonably* be determined without proof by individual class members. [Footnotes omitted.] [Emphasis in original.]

[286] Further, for those Class Members who did suffer more seriously than others, it is open to them to seek to prove that harm on an individual basis and obtain additional damages for negligence and breach of fiduciary duty as contemplated by Perell J. in his Certification Decision.

[287] Factors three and five set out in para. 87 of *Jones* do not raise differences among the plaintiffs or support a conclusion that aggregate damages are not appropriate. Although some members of the Class are or were Clinic employees, that number is very small compared to the Class as a whole, the vast majority of whom were simply patients. Dr. Jugenburg's conduct, including his purported apology after the wrong was disclosed, was similar across the Class. The fact that some received his email blast and others did not matters little, given its misleading and disingenuous content which does little to mitigate Dr. Jugenburg's wrongdoing.

[288] In *Insurance Corporation of British Columbia v. Ari*, 2025 BCCA 131, 46 C.C.L.I. (6th) 173 ["*ICBC*"], the British Columbia Court of Appeal upheld the awarding of aggregate damages in an invasion of privacy case where there was no proof of consequential harm. The case was bought under the British Columbia *Privacy Act*, R.S.B.C. 1996, c. 373; however, that law is similar to intrusion upon seclusion, as the Court noted at para. 30. Following a thorough review of the caselaw, the British Columbia Court of Appeal concluded at paras. 48-49:

...The jurisprudence on *Charter* damages and breaches of privacy makes clear that general damages may be awarded for an injury to intangible interests, even in the absence of consequential loss suffered by the plaintiff.

This is particularly clear in the case of privacy: where privacy rights are violated, there is a loss to the plaintiff, whether or not the plaintiff is ever made aware of it. The plaintiff's privacy interest—the right to control who has access to personal information—is harmed by the intrusion in a manner independent from any mental distress or upset the breach may cause. This is why "[t]he law presumes some damage will flow from the mere invasion of privacy". [Citation omitted.] [Emphasis in original.]

[289] Accordingly, I find that aggregate damages can and should be awarded in this case.

Quantification of aggregate damages

[290] The quantification of aggregate damages and punitive damages was not specifically certified as a common issue. In *Ramdath*, as in this case, the certified common issue was whether aggregate damages could be awarded; however, the trial judge quantified the aggregate damages and the Court of Appeal upheld that decision. Once liability was established, the Court held, it was open to the trial judge to quantify the damages: *Ramdath* at para. 78, citing *Pro-Sys Consultants Ltd. v. Microsoft Corporation*, 2013 SCC 57, [2013] 3 S.C.R. 477, at para. 134. The Court of Appeal was more direct in *Trillium Motor World Ltd. v. Cassels Brock & Blackwell LLP*, 2017 ONCA 544, 72 B.L.R. (5th) 177, at para. 280, stating that “a trial judge can invoke the s. 24 CPA aggregate damages remedy regardless whether aggregate damages are certified as a common issue”.

[291] In *Jones*, Sharpe J.A. stated at para. 87 that “damages for intrusion upon seclusion in cases where the plaintiff has suffered no pecuniary loss should be modest but sufficient to mark the wrong that has been done.” When *Jones* was decided in 2012, Sharpe J.A. said that he would “fix the range at up to \$20,000.” He referred to a number of cases that had awarded damages in that range, although none were class actions. In *Jones* itself, which involved the defendant looking 174 times at the plaintiff’s confidential banking records, Sharpe J.A. awarded \$10,000.

[292] In *ICBC*, a class action, damages were assessed at \$15,000 per class member for theft of personal identifying information. In *Bierman v Haidash*, 2021 SKQB 44, brought under Saskatchewan’s *Privacy Act*, R.S.S. 1978, c. P-24, a doctor improperly accessed his ex-business partner’s personal prescription medicine information and the information of several other people who were not his patients, although he said he did so only as a way to train his wife on how to assist him in finding prescription information. The court awarded damages of \$7,500.

[293] The plaintiffs rely on *Bierman* to submit that \$7,500 should be the base amount to be awarded to Class Members who attended at the Clinic for injectables. They further submit that damages for those who attended a consultation but did not have surgery should be awarded at least \$14,000 and that those who had surgery should be awarded \$28,000. In their written submissions, after citing several other awards in privacy cases in which damages ranged from \$1,700 to \$80,000, the plaintiffs submitted that damages assessed in the aggregate “should not be less than \$10,000.”

[294] The defendants, unsurprisingly, cite cases with lower damage awards. They emphasize that damages for intrusion upon seclusion are “fundamentally not about compensation”, but “about recognizing the wrong in a symbolic way.” The defendants cite *Severs v Hyp3R Inc.*, 2021 BCSC 2261, at paras. 98-103, which was a class action against a company that had “scraped” personal information about Instagram users. The defendants did not respond to the action, and the court accepted the plaintiff’s proposal of awarding just \$10 per person resulting in an aggregate award for the millions of members of the class of about \$25,000,000.

[295] The defendants also emphasize that Dr. Jugenburg did not install the camera system to “snoop” on patients, and that the “overwhelming majority” of the footage was never watched, arguing that “this is a case about one negligent act to implement a security system.” They submit that an appropriate award of aggregate damages would be \$2,500,000, suggesting \$500 for surgical

patients and \$100 for skinjectables patients. The defendants would not distinguish between those who ultimately had surgery and those who only attended a consultation.

[296] In fixing aggregate damages, I take into account that the nature of the intrusion was into highly personal and intimate private events. This is not just a data breach case. Further, while it was not motivated by a “nefarious” motive to snoop on particular individuals’ privacy, as was the case in several other privacy claims including *Jones*, the wrongful conduct arose from circumstances where the plaintiffs were highly vulnerable and had chosen to place their full trust in Dr. Jugenburg and paid him well for it.

[297] Dr. Jugenburg’s conduct also arose in a commercial context. Dr. Jugenburg charged his patients large sums of money for their treatment. The medical services provided were paid for entirely by the patients, outside the public health care system. Ms. Crawford referred to concerns about large amounts of cash being received. I heard from some patients that the amounts they were charged for Dr. Jugenburg’s services were in the tens of thousands of dollars.

[298] Addressing the factors set out in para. 87 of *Jones*, Dr. Jugenburg breached Class Members’ privacy in this highly private context repeatedly. He did so deliberately to protect his own self-interest. Patients quite reasonably felt anger, anguish, distress, and humiliation when they learned of the intrusion. Dr. Jugenburg did not apologize to his patients, and his expressions of regret at trial were, in my view, too little, too late, and insincere. These factors favour a higher award.

[299] However, very little of this footage was ever reviewed, and if so it was reviewed only by Dr. Jugenburg. Most of the footage was deleted. Only footage which existed when the camera system was uncovered remains, and it will be destroyed once all litigation is concluded. Patients who can show actual harm will have the opportunity to seek individual damages for negligence and breach of fiduciary duty, a factor not seen in other cases cited to me. These factors favour a reduced award for the “moral damages” that flow from a finding of intrusion upon seclusion.

[300] Ultimately, I give weight to the gravity of the wrong committed by Dr. Jugenburg and his Clinic. I recognize that the degree of intrusion is greater for those who attended surgical appointments than those who only received injections. Aside from J.G., the public relations advisor, I did not hear from any injectables patients. I also take into account the admonition that damages should be “modest”, while having regard to other awards.

[301] In focusing on the wrongdoing, I do not distinguish between those who had surgery and those who only attended surgical appointments, as the intrusion occurred at the consultation as well as in subsequent appointments. Nor do I draw distinctions based on the number of times patients attended the Clinic. This accords with the efficiency associated with awarding aggregate damages in class actions.

[302] In my view, having regard to awards in other cases, the nature of the intrusion and the particular facts of this case, the opportunity for individualized damages to be awarded, and the admonition that damages should be “modest”, damages for Class Members who attended surgical appointments should be fixed in the amount of \$5,000 per person. For those who attended non-surgical, or injectables, appointments, I fix damages at \$500 per person.

[303] The Class consists of approximately 7,000 patients who attended the Clinic during the Class Period. The Agreed Statement of Facts says the Class consists of 7,196 patients, but the analysis by the defendant's expert, Errol Soriano, concluded that there are 6,928 Class Members. According to Mr. Soriano's analysis, 3,648 patients attended surgical appointments, 2,805 attended non-surgical appointments, and 475 patients attended both. Mr. Soriano stated that non-surgical appointments were for patients who attended the Skinjectables clinic.

[304] Rounding out these numbers, I fix the aggregate damages at \$21,500,000. This is based on 4000 patients attending surgical appointments and 3,000 attending non-surgical appointments.

[305] Accordingly, the answer to Common Issue 11 is as follows:

11. Can an award of aggregate damages be made pursuant to s. 24(1) of the *Class Proceedings Act, 1992*?

ANSWER - Yes. Aggregate damages are fixed in the amount of \$21,500,000.

Common Issue 12 – punitive, exemplary and/or aggravated damages

[306] In *Jones*, Sharpe J.A. said he “would neither exclude nor encourage awards of punitive damages”, noting that “there are bound to be exceptional cases calling for exceptional remedies.”

[307] It is well-established that punitive damages are reserved for cases where the defendant's misconduct has been “malicious, oppressive and high-handed”, where it “offends the Court's sense of decency”: *Whiten v. Pilot Insurance Co.*, 2002 SCC 18, [2002] 1 S.C.R. 595, at para. 36, citing *Hill v. Church of Scientology of Toronto*, [1995] 2 S.C.R. 1130, at para. 196. As the Court continued at para. 36 of *Whiten*, “their objective is to punish the defendant rather than to compensate a plaintiff.”

[308] In my view, punitive damages are appropriate in this case. As I have found, Dr. Jugenburg knew exactly what he was doing – invading patients' privacy. His conduct as a physician was reprehensible. He abused his position of trust and betrayed his vulnerable patients from whom he was profiting. He installed surveillance cameras in very private places for his own benefit. Although not hidden, he did not inform, let alone seek consent from his patients or his colleagues, and few noticed the cameras. Despite Dr. Jugenburg's claim that cameras were common in medical settings, there was no support for this in the evidence, indeed the evidence was to the contrary – cameras are not used in settings where patients are examined. When the camera system was exposed, Dr. Jugenburg disingenuously claimed they were for security, and showed no remorse for his conduct.

[309] This conduct is deserving of condemnation and punishment by the Court. In my view, an award of \$1,000,000, which is the amount requested by the plaintiffs, is appropriate, and I fix punitive damages in that amount. The parties may make submissions as to how those damages should be allocated among Class Members.

[310] I decline to award aggravated damages, as those damages relate to mental distress and humiliation suffered by the plaintiffs: *Hill* at paras. 188-190. As I have noted, plaintiffs who have suffered harm of this kind can pursue individual claims in due course.

[311] Accordingly, the answer to Common Issue 12 is as follows:

12. Does the conduct of the Defendants, or either of them, justify an award of punitive, exemplary and/or aggravated damages?

ANSWER - YES. Punitive damages are fixed in the amount of \$1,000,000.

Next steps

[312] The parties shall confer regarding costs and the remaining issues. They may then contact my assistant to arrange a Case Conference to address next steps.


Paul B. Schabas J.

Date: May 26, 2026