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CANADIAN MEDICAL MALPRACTICE LAW IN 2011: MISSING THE MARK ON PATIENT SAFETY

COLLEEN M. FLOOD* AND BRYAN THOMAS**

INTRODUCTION

Canadian tort law, as it applies to medical malpractice, appears relatively settled from a systems perspective; there is no “burning platform” driving major tort reform in this area of the law. There are at least six factors which have contained the volume and cost of malpractice litigation in Canada, summarized here and discussed further below. First, as distinct from the U.S., non-pecuniary damages for personal injury were capped by the Supreme Court of Canada in a trilogy of cases handed down in the late 1970s.¹ Second, there is no pressure to reform from physicians, because the dominant insurance scheme, overseen by the Canadian Medical Protective Association (CMPA), effectively insulates physicians from the impact of tort liability; a finding of medical malpractice does not drive up an individual’s insurance premiums. The provinces contribute significantly to this cushioning effect, by reimbursing a significant portion of CMPA fees. Third, the CMPA has used its deep pockets to pursue what one Ontario judge recently described as a “scorched earth” policy in responding to medical malpractice claims, which has discouraged litigation.² Fourth, Canada’s rules for awarding costs contribute to this problem, by making it risky for plaintiffs to pursue uncertain claims. Fifth, the inherent difficulties in

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1. *Andrews v. Grand & Toy Alberta Ltd.*, [1978] 2 S.C.R. 229 (Can.); *Arnold v. Teno*, [1978] 2 S.C.R. 287 (Can.); *Thornton v. School Dist. No. 57 (Prince George) et al.*, [1978] 2 S.C.R. 267 (Can.). While medical malpractice liability is more costly in the U.S., its importance as a factor in the overall cost of health care is frequently overstated. The direct cost of medical malpractice liability is less than two percent of overall healthcare costs. Timothy Stoltzfus Jost, *Our Broken Health Care System and How to Fix It: An Essay on Health Law and Policy*, 41 WAKE FOREST L. REV. 537, 548 (2006).

2. *Frazer v. Haukioja* (2008), 62 C.C.L.T.3d 280, para. 2 (O.S.C.J.). At issue in this case was a nearly \$1 million claim for costs submitted by the plaintiff, in connection with a successful malpractice suit. The court explained that these high costs were the result of the defendant’s decision—with CMPA backing—to pursue a “scorched earth policy of putting the plaintiffs to the test of establishing virtually all of their claims on all issues of damages and liability.” *Id.*

establishing causation in medical malpractice cases combined with the broad defenses available for physicians further exacerbate the uphill battle facing the plaintiff patient. Finally, the tort law system treats physicians as “independent warriors,” shielding hospitals from vicarious liability for their malpractice. This is arguably problematic, because, as argued below, the deterrent effects of tort need to be targeted at the right level within the health care system.

Though there is no urgent call to reform medical malpractice tort law, one should not take this as a sign that all is well in Canada, as matters of patient safety and quality of care still remain a concern. Though Canada compares relatively well with other countries in terms of its rates of adverse events,³ over the last decade, various provinces have encountered grave systemic problems: a breast cancer diagnosis crisis in Newfoundland; concerns about the competence of Ontario’s pathologists; a pediatric care crisis in Manitoba. We argue that tort law, as it stands in 2011, misses the mark in addressing the hidden epidemic in patient safety; although we admit the paucity of robust empirical evidence makes it difficult to know whether rates of iatrogenic injury are worsening, stable or improving. There is, however, rising concern regarding the quality of care and safety of patients in privately financed and informal health care settings, e.g. in private clinics, in long-term care homes and in home care. This suggests that what we do know about the rates of adverse events in the hospital setting may be merely the tip of the iceberg. As we describe further below, Canada has attempted to address issues of safety and quality outside the courts, through regulation and the employment of preventative levers for addressing adverse events, including: quality councils, physician recertification, patient safety initiatives, and hospital accreditation. These *appear* to be positive trends, but they are rather piece-meal, and there is little evidence being collected (or planned to be collected) to assess the impact of these reforms. Proponents of patient safety are ardently opposed to a role for tort law—it is frequently identified as linked to patient safety problems—and yet as tort law presently functions it is hard to see what adverse impact it could possibly have on physician or hospital behavior, given the very low rates of litigation and the enormous hurdles that patient-plaintiffs face. Consequently, we still are left with the possibility that there is a role for reform of medical malpractice law and that such reform would contribute to better addressing patient safety issues.

3. G. Ross Baker et al., *The Canadian Adverse Events Study: The Incidence of Adverse Events Among Hospital Patients in Canada*, 170 CMAJ 1678 (2004), available at <http://www.cmaj.ca/cgi/reprint/170/11/1678> (last visited Apr. 20, 2011).

I. THE CANADIAN MALPRACTICE CONTEXT

The current state of medical malpractice law must be understood within the broader context of the Canadian healthcare system. To begin, the landscape of Canadian healthcare is shaped by the division of powers between the federal and provincial governments, as laid out in the Constitution Act of 1867.⁴ According to the Act, which sets out the responsibilities assigned to each level of government, health care does not fall solely under one jurisdiction. Instead, as the Supreme Court of Canada states in *Schneider v. The Queen*:

‘[H]ealth’ is not a matter which is subject to specific constitutional assignment but instead is an amorphous topic which can be addressed by valid federal or provincial legislation, depending in the circumstances of each case on the nature or scope of the health problem in question.⁵

Throughout the twentieth century, as responsibility for health care was absorbed by the public sector, it was necessary to mark out the roles of each level of government more carefully. While the federal government has jurisdiction over areas like quarantine, criminal law, patent regulation and spending power, the “lion’s share of responsibility for health care” is provincial.⁶

Most notably, provincial and territorial governments are charged with regulating health care insurance and the supply of hospital and physician services.⁷ Thus, publicly funded healthcare in Canada is best understood as “an interlocking set of ten provincial and three territorial health insurance plans” that provide coverage for most hospital and physician services.⁸ As each of these plans is distinct, they form a patchwork of coverage and regulation across the country. While the provinces may have the lion’s share of responsibility over healthcare, the federal government exerts influence over the provincial management of healthcare through its spending power. In order to secure health care funding from the federal government, provinces are required to adhere to five criteria set out in the Canada Health Act (comprehensiveness, universality, portability, accessibility and public ad-

4. Constitution Act, 1867, 30 & 31 Vict., c.3 (U.K.), reprinted in R.S.C. 1985, app. II, no. 5 (Can.).

5. *Schneider v. The Queen*, [1982] 2 S.C.R. 112, 142 (Can.).

6. Joan M. Gilmour, *Patient Safety, Medical Error and Tort Law: An International Comparison*, Final Report, HEALTH POLICY RESEARCH PROGRAM, HEALTH CANADA 56 (2006), available at [http://osgoode.yorku.ca/osgmedia.nsf/0/094676DE3FAD06A5852572330059253C/\\$FILE/FinalReport_Full.pdf](http://osgoode.yorku.ca/osgmedia.nsf/0/094676DE3FAD06A5852572330059253C/$FILE/FinalReport_Full.pdf).

7. *Reference re The Employment and Social Insurance Act*, [1936] S.C.R. 427, 451 (Can.).

8. HEALTH CANADA, H.C. Pub.: 5912, CANADA’S HEALTH CARE SYSTEM1 (2005), available at http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/2005-hcs-sss/2005-hcs-sss-eng.pdf.

ministration) and effectively to ensure first-dollar public funding for all “medically necessary” hospital and “medically required” physician services.⁹

The dynamics between these two levels of government are constantly at issue. One major concern is increased health care spending, resulting in part from high pharmaceutical costs. Between 1975 and 2006, while inflation-adjusted per capita spending on physician services increased 98% and spending on hospital services increased 51%, pharmaceutical expenditures increased by 338%.¹⁰ Despite references to Canada’s “single-payer” system, in reality a significant portion (approximately 30%) of health care is privately financed¹¹ and the proportion increases dramatically in specific sectors excluded from the CHA. For example, there is no requirement in the CHA for public coverage of prescription drugs consumed outside of hospital walls, nor are provinces required to provide home care or long-term care. Provincial governments voluntarily provide some coverage for certain groups, e.g. low-income and senior residents.¹² Nonetheless, the majority of Canadians must pay out of pocket, or seek private insurance, in order to have access to drugs prescribed outside of hospitals, ambulance services, hearing, vision and dental care.¹³ All of this is to say that health care financing is an issue at the forefront of public concern, and an ongoing source of tension between the two levels of government.

Along with the majority of healthcare responsibilities, the administration of justice also falls under provincial jurisdiction;¹⁴ consequently, areas like tort reform are predominantly provincial matters, meaning that there is no singular “Canadian” approach to medical malpractice reform.

A. Service Delivery, Regulation and Liability Insurance

As mentioned above, the delivery of physician and hospital services falls under the purview of the provincial governments. In general, the provinces supply publicly funded health services by contracting with physi-

9. Canada Health Act, R.S.C. 1985, c. C-6 (Can.).

10. Mark Stabile & Jacqueline Greenblatt, Institute for Research on Public Policy, IRPP Study No. 2, *Providing Pharmacare for an Aging Population: Is Prefunding the Solution?*, 9 (2010), available at http://www.irpp.org/pubs/IRPPstudy/IRPP_Study_no2.pdf.

11. Canadian Institute for Health Information, *National Health Expenditure Trends, 1975 to 2010*, at xi (2010), available at http://publications.gc.ca/collections/collection_2010/icih-cihi/H118-2-2010-eng.pdf.

12. Health Canada, *supra* note 8, at 7.

13. *Id.*

14. Constitution Act, 1867, 30 & 31 Vict., c.3 (U.K.), reprinted in R.S.C. 1985, app. II, no. 5. s. 92 (Can.).

cians—who are private, for-profit contractors— through provincial medical associations. The dominant method of payment for these private physicians has been a fee-for-service system, although this is slowly changing.¹⁵ In Canada, physicians are granted a significant degree of authority for self-regulation, and each province has a College of Physicians and Surgeons that acts as a governing body for medical doctors. The various colleges monitor and maintain standards of training and practice, investigate complaints about doctors, conduct disciplinary hearings, etc.¹⁶

Unlike physicians, hospitals are much more carefully managed and regulated by the provincial governments. Though they receive public funding, hospitals are usually non-profit private institutions, operating under provincial or territorial legislation. In addition, unlike the fee-for-service system used for physicians, hospitals are funded through annual lump sums comprised of a complex mix of historical spending, population needs and cases treated.¹⁷ Each province has its own Hospital Act and accompanying regulations that lay out the organization and operation of these publicly funded institutions and provide for extensive public control when necessary.¹⁸ This public control power was recently exercised at the Hôtel-Dieu Hospital in Windsor, Ontario following a number of serious errors in pathology and surgery. Pursuant to §9.(1) of the Hospital Act, the Lieutenant Governor in Council of Windsor appointed an external hospital supervisor to run the hospital and take over all functions of the board.¹⁹

The structure of Canada's health service delivery has shaped key features of the Canadian medical malpractice system. First, the fact that physicians are not salaried employees means that they are viewed by the law as independent professionals, with the effect that hospitals are generally not held responsible for physician negligence.²⁰ By contrast, hospitals can be held vicariously liable for negligence of nurses under their employ. As is

15. Brian Hutchinson, Julia Abelson, & John Lavis, *Primary Care In Canada: So Much Innovation, So Little Change*, 20 HEALTH AFFAIRS 3, 118 (2001), available at <http://content.healthaffairs.org/cgi/content/full/20/3/116#R8>.

16. See generally Tracey Epps, *Regulation of Health Care Professionals*, in CANADIAN HEALTH LAW AND POLICY 69 (Jocelyn Downie, Timothy Caulfield, & Colleen Flood, eds., 2007); The College of Physicians & Surgeons of Ontario, *About the College: Self Regulation and the Practice of Medicine*, available at <http://www.cpso.on.ca/aboutus/> (last visited Mar. 29, 2011).

17. For a succinct overview of funding models and decision-making processes for priority-setting within Ontario hospitals, see L. Kapiriri, O. Frithjof Norheim & D. K. Martin, *Priority setting at the micro-, meso- and macro-levels in Canada, Norway and Uganda*, 82 HEALTH POLICY 78 (2007).

18. See e.g., Public Hospitals Act, R.S.O. 1990, c.P.40 (Can.), available at http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90p40_e.htm.

19. *Province Takes Control of Hotel Dieu Hospital*, CBC NEWS, Dec. 13, 2010, available at <http://www.cbc.ca/canada/windsor/story/2010/12/13/wdr-hotel-dieu-province-steps-in.html>.

20. *Yepremian v. Scarborough General Hospital* (1980), 28 O.R. 2d 494, 496 (Can. Ont.C.A.).

discussed in more detail below, this differential recognition of liability is problematic given the mounting evidence of the need for an overall “systems” approach to preventing errors and improving safety.²¹

II. STATE AND QUALITY OF THE CANADIAN HEALTH CARE SYSTEM

Although Canada’s medical malpractice law has been relatively static in recent history, there have nevertheless been serious concerns regarding patient safety and quality of care. First, it is important to note that where there is data gathered, it is mostly with respect to adverse events within hospitals. In this regard, Canada’s rates of adverse events in hospitals compares relatively well with other countries,²² though there is nonetheless significant room for improvement.²³ In addition to hospital care, there has been growing concern about adverse events in private facilities, such as long-term care facilities²⁴ and cosmetic surgery clinics.²⁵ This section first presents some background data on the frequency of adverse events in Canadian hospitals and long-term care facilities, and then recounts several major incidents in the Canadian health care system over the past two decades.

The first Canadian adverse events study, conducted by Ross Baker and his colleagues, reached a conservative estimate that adverse events occurred in 7.5% of all hospital admissions.²⁶ Adverse events are defined as unintended injuries or complications caused by health care management, rather than by the patient’s underlying disease, that lead to death, disability or prolonged hospital stays.²⁷ To be clear, not all adverse events, nor even all *preventable* adverse events, qualify as instances of *legal negligence*. As explained below, there are standards of fault that must be met in determin-

21. Gilmour, *supra* note 6, at 60–61.

22. Baker et al., *supra* note 3, at 1685.

23. A recent initiative aimed at reducing preventable adverse events and deaths in Canadian hospitals has found significant improvements in participating hospitals during the first three years of its implementation. See Safer Healthcare Now!, *Frequently Asked Questions*, available at <http://www.saferhealthcarenow.ca/EN/about/faqs/Pages/default.aspx> (last visited Nov. 14, 2010).

24. Keir G. Johnson, *Adverse Events among Winnipeg Home Care Clients*, 9 (Sp) HEALTHCARE QUARTERLY 127 (2006); Dale Brazao & Moira Welsh, *Seniors at Risk in Retirement Home, Investigation Reveals*, TORONTO STAR, Oct. 1, 2010, available at <http://www.thestar.com/news/investigations/article/869045--seniors-at-risk-in-retirement-home-investigation-reveals> (last visited Apr. 20, 2011); Dale Brazao, *Reporter’s Diary Reveals Substandard Conditions at Retirement Home*, TORONTO STAR, Oct. 1, 2010, available at <http://www.thestar.com/news/gta/article/869047> (last visited Nov. 20, 2011).

25. Colleen M. Flood et al., *Cosmetic Surgery Regulation and Regulation Enforcement in Ontario*, 36 QUEEN’S L.J. 31, 33 (2011).

26. Baker et al., *supra* note 3, at 1685.

27. *Id.* at 1678.

ing whether negligence has occurred. Although most of the identified adverse events resulted in no physical impairment or disability, approximately 20% were estimated to have caused the death of the patient (representing around 40,000 deaths in Canadian hospitals per year).²⁸ While it must be acknowledged that adverse events are an inevitable byproduct of health care, over a third of the events identified in the study were deemed “highly preventable”—including an estimated 16,500 preventable deaths as a result of adverse events.²⁹ One especially common type of adverse event is nosocomial infection, which has drawn considerable media and scholarly scrutiny.³⁰ Nosocomial infections are infections acquired during hospital care that are not present or incubating at admission.³¹ There are approximately 235,000 nosocomial infections in Canadian hospitals each year, resulting in approximately 10,000 deaths per year, making this the fourth leading cause of death in Canada.³²

Existing research suggests that adverse events are a serious problem within hospitals, yet their true incidence is likely much greater due to underreporting. Experts agree that the Canadian Adverse Events Study—which involved a retrospective review of randomly selected hospital charts—captures only twenty-five to thirty-three percent of the total incidence of adverse events for a variety of reasons, most notably: some adverse events are simply not recorded in hospital charts; some of the randomly selected charts were not available for review, and these “missing charts” have an increased likelihood of adverse events; in the first level of review, the researchers looked for certain “triggers” before passing a chart on for second review, though there would have been some cases where adverse events occurred without these “triggers.”³³ The figures reported also do not include adverse events that occur outside of hospitals, such as in private offices, local clinics, and long-term care facilities.

It is hard to judge whether things are getting better or worse, as the lack of consistent, nationwide data collection on the occurrence of adverse events in Canada makes it impossible to assess longitudinal trends with any confidence. A study of adverse events among hospital admissions and day surgeries in Ontario, from 1992 to 1997, found “a troubling increase in the

28. *Id.* at 1681-1682.

29. *Id.* at 1681.

30. Lara Khoury & Mikhail Iokheles, *Factual Causation and Healthcare-Associated Infections*, 17 HEALTH L.J. 195, 195 (2009).

31. *Id.* at 196.

32. *Id.* at 198.

33. Interview with Peter Norton, Professor Emeritus in the Department of Family Medicine, University of Calgary (Feb. 20, 2011).

trend in hospital complication rates.”³⁴ Other studies undertaken over the years have provided snapshots of adverse event rates in specific areas: one study gathered data on *when*, during treatment, adverse events were most likely to occur at one Ottawa hospital;³⁵ another looked at complication rates after discharge from hospital;³⁶ etc. The 2004 Baker and Norton study was the first and to date last major study on adverse event rates nationwide. In the wake of Baker and Norton’s study, the Canadian Institute for Patient Safety launched a safety campaign—called Safer Healthcare Now!—whereby ninety-five healthcare institutions nationwide committed to a strategy seeking to lower adverse events by six percentage points. Data have been collected showing safety improvements through this initiative, but again, this provides only a fragmentary picture of improvements at the institutions enrolled.³⁷

Apart from empirical evidence that exists regarding hospital error, there is more anecdotal evidence of system-wide concerns with quality and safety both in the public and private health care sectors. Among the most tragic health care incidents of the past two decades were twelve pediatric cardiac surgery deaths at the Winnipeg Health Sciences Centre (HSC) in 1994.³⁸ That year the HSC pediatric cardiac program introduced the provision of surgical services, which was accompanied by a considerable personnel overhaul: a new director of pediatric cardiology and a new cardiac surgeon were hired, while three cardiologists left the program without replacement.³⁹ Within the first four months of the introduction of pediatric surgical services, five children died.⁴⁰ Mounting protests, particularly on the part of the program’s nurses and anesthesiologists, resulted in the for-

34. Dunan Hunter & Namrata Bains, *Rates of Adverse Events Among Hospital Admissions and Day Surgeries in Ontario from 1992 to 1997*, 160(11) CAN. MED. ASS’N J. 1585, 1585 (1999).

35. Alan J. Forster, Tim R. Asmis, Heather D. Clark, et al., *Ottawa Hospital Patient Safety Study: Incidence and timing of Adverse Events in Patients Admitted to a Canadian Teaching Hospital*, 170 CAN. MED. ASS’N J. 1235, 1235 (2004).

36. Alan J. Forster, Heather D. Clark, A. Menard, N. Dupuis, R. Chernish, N. Chandok et al., *Adverse Events Among Medical Patients After Discharge from Hospital*, 170 CAN. MED. ASS’N J. 345, 345 (2004).

37. Safer Health Care Now!, *Accomplishment Report, 2009*, available at <http://www.saferhealthcarenow.ca/EN/about/Overview/Documents/2009%20Safer%20Healthcare%20Now!%20Accomplishment%20Report.pdf> (last visited Apr. 20, 2011). The report does not track adverse events overall, but rather tracks achievements directly related to specific strategic initiatives, e.g. preventing adverse drug events, improving care for acute myocardial, etc.

38. Murray Sinclair, *The Report of the Manitoba Pediatric Cardiac Surgery Inquest: An Inquiry Into Twelve Deaths at the Winnipeg Health Sciences Centre in 1994*, at v (2000), available at <http://www.pediatriccardiacinquest.mb.ca/pdf/index.html> (last visited Nov. 14, 2010).

39. *Id.* at vii.

40. *Id.* at 127.

mation of an internal review committee.⁴¹ While the four-month review was underway, the program was limited to a reduced number of procedures, yet two more children died.⁴² The review recommended that the surgical program be fully reinstated in September of that year, but in the next three months five more children died, following which the program was suspended pending an external review.⁴³ As a result of this review the HSC suspended the program for six more months and issued a press release alerting the public, in particular the parents of the deceased children, to the problem.⁴⁴ Several parents demanded a public inquiry into the events, which led the province to establish the Sinclair Inquest to investigate the circumstances surrounding the deaths.⁴⁵ It was determined that at least five of the twelve deaths were preventable, and that some of the others may have been preventable.⁴⁶ Additionally, the evidence suggested that in most cases the parents were not provided with sufficient information to allow fully informed consent.⁴⁷ The Sinclair Inquest ultimately found that substandard care was partly a product of individual failures, but primarily a result of systemic issues relating to the structure of the HSC, particularly the hospital policies and procedures governing staffing, leadership, and teamwork.⁴⁸ The Report deemed the failure to replace the three cardiologists who had left the program a serious erosion in the ability of the program to operate, and identified serious flaws in the recruitment process used in the hiring of Dr. Odum, the surgeon involved in each of the cases.⁴⁹

Flashing forward ten years, from 1997–2005, another crisis has centered on breast cancer screening test errors in Newfoundland and Labrador.⁵⁰ Hormone receptor tests are critical in determining the appropriate course of treatment for breast cancer patients; if the patient's hormones stimulate the tumor, they are considered *ER/PR-positive*, and are treated

41. *Id.* at 5.

42. *Id.*

43. *Id.* at 4.

44. *Id.*

45. *Id.*

46. *Id.* at 501.

47. *Id.* at vi.

48. *Id.* at 465.

49. In particular, though Dr. Odum's credentials were outstanding, he was hired without anyone from the HSC actually seeing him perform a surgical procedure or even speaking with anyone who had seen him perform a surgical procedure. *Id.* at 467–468, 5.

50. Vik Adhopia, *Misdiagnosed: Anatomy of Newfoundland's Cancer-testing Scandal*, CBC NEWS (2008), available at <http://www.cbc.ca/news/background/cancer/misdiagnosed.html> (last visited Nov. 14, 2010); Margaret Cameron, *Commission of Inquiry on Hormone Receptor Testing, Volume 1: Investigation and Findings*, (2009), available at http://www.releases.gov.nl.ca/releases/2009/health/Volume1_Investigation_and_Findings.pdf (last visited Nov. 14, 2010).

with a hormone-blocking drug.⁵¹ This treatment is not provided to patients who test ER/PR-negative. In 2002, the retesting of one patient—at the insistence of an oncologist consulted out of province—uncovered an epidemic of errors in hormone testing across Newfoundland and Labrador.⁵² This led officials at Eastern Health—the health authority for eastern Newfoundland—to retest more than a thousand breast cancer patients who were diagnosed ER/PR-negative between 1997 and 2005. Of the 1,013 retested patients, 383 had been wrongly diagnosed.⁵³ In response, the provincial government established a Commission of Inquiry to investigate the failures.⁵⁴ The Commission determined that the quality control and quality assurance within the ER/PR testing laboratory, especially with respect to the handling and processing of tissue samples, was so minimal and haphazard as to be non-existent.⁵⁵ Had proper quality assurance and control policies been in place, and had they been followed, the testing problem would have been discovered much earlier.⁵⁶ While no death or harm to patients can be conclusively linked to the testing failures, misdiagnosed patients were denied the opportunity to access the best possible treatment for their cancer.⁵⁷ There is ongoing uncertainty as to whether all misdiagnosed patients have been informed of their flawed tests.⁵⁸

In 2009, in response to concerns about similar testing problems in Quebec, the province's pathology association sent a small number of samples to be retested at a reliable lab, which revealed that 15–20% of the hormone receptor tests sampled had false results.⁵⁹ Following those results, nearly 3,000 samples taken from 2007-2009 were sent for retesting, of which eighty-seven yielded different results than the original tests.⁶⁰

51. Adhopia, *supra* note 50.

52. Peggy Deane became known as the “index case.” Once it was discovered that she was in fact ER/PR positive she was switched onto a hormone-blocking drug, but she died four months later. *Id.*

53. Over 100 of the wrongly-tested patients are now dead. *Id.*

54. Cameron, *supra* note 50, at vii.

55. *Id.* at 146, 451.

56. *Id.* at 452.

57. *Id.*

58. Tara Brautigam, *Newfoundland Health Board Apologizes in Breast Cancer Scandal*, THE GLOBE AND MAIL, March 5, 2009, available at <http://www.theglobeandmail.com/news/national/article975202.ece> (last visited Nov. 14, 2010).

59. *1 in 5 Breast Cancer Hormone Tests Wrong, Quebec Pathologists Fear*, CBC NEWS, May 27, 2009, available at <http://www.cbc.ca/canada/montreal/story/2009/05/27/breast-cancer-quebec-hormone-tests.html> (last visited Nov. 14, 2010).

60. Special Report: The Controversy About Breast CANCER, CANADIAN CANCER SOCIETY, Dec. 19, 2009, available at http://www.cancer.ca/Quebec/About%20us/Media%20centre/Qc_nouvelle_diagnostics.aspx?sc_lang=en (last visited Nov. 14, 2010).

Similar problems have recently surfaced in Ontario, after it was discovered that a pathologist had botched cancer-screening tests, leading a surgeon at the Hôtel-Dieu hospital in Windsor to perform unnecessary mastectomies on two women who were cancer-free.⁶¹ The province undertook a review of all the hospitals that employed the pathology lab in question, finding a systemic lack of communication and cooperation between pathologists and surgeons.⁶² Investigators found, for example, that some patients had two diagnoses on file for the same ailment, and that surgeons in some cases proceeded with operations before receiving test results.⁶³ In their report, investigators urged the Ontario Ministry of Health and Long-term Care to implement province-wide standards and guidelines for pathology by the spring of 2011.⁶⁴

A. Medical Malpractice in the Domain of Privately Financed Care

Adverse events are not confined to the hospital setting. Indeed, significant problems in recent years have arisen outside of the publicly funded system, in private retirement homes, and private cosmetic surgery clinics. On the whole, governments have taken a comparatively “hands-off” approach to the regulation of privately financed care. In principle, patient safety standards should be equivalent across institutional settings.⁶⁵ In reality, however, the government and regulators appear to be primarily concerned with preventing adverse events within the Medicare system proper. Moves to regulate the private facilities have come very slowly, and only in response to crises.

One area of major concern in recent years has been the quality of care provided outside of hospitals, through home care, or in long-term care facilities and retirement homes. A recent study of home care in Winnipeg found preventable or ameliorable adverse events in 4% of the sample study.⁶⁶ Extrapolating their findings to the Winnipeg regional home care population as a whole—a population of approximately 15,000—the authors estimated a range of between 304 to 866 preventable or ameliorable ad-

61. Karen Howlett & Caroine Alphonso, *Error-prone Hospital Plagued by a Culture of Mistrust*, THE GLOBE AND MAIL, Aug. 4, 2010, available at <http://www.theglobeandmail.com/news/national/ontario/error-prone-hospital-plagued-by-a-culture-of-mistrust-report/article1661451/> (last visited Apr. 20, 2011).

62. *Id.*

63. *Id.*

64. *Id.*

65. Flood et al., *supra* note 25.

66. Johnson, *supra* note 24, at 131.

verse events annually.⁶⁷ A recent undercover report on the treatment of residents and the quality of conditions at a Toronto private retirement home also raised concerns.⁶⁸ The Toronto Star reporter, who posed as a new resident at the retirement home, observed appallingly poor sanitary conditions and in some cases profound neglect—residents left for hours in diapers, or left stranded on the floor after a fall.⁶⁹

There have also been ongoing concerns about preventable adverse events in private, for-profit clinics across Canada, particularly in the domain of cosmetic surgery. The issue made headlines in the fall of 2007, when a thirty-two year old woman died in the recovery room following a liposuction procedure at a Toronto clinic.⁷⁰ Multiple concerns came to light following this event: cosmetic surgery clinics in the province were not subject to any regime of licensing or regular inspection; GPs in Ontario were portraying themselves as “cosmetic surgeons,” despite having no formal credentials or hospital privileges in surgery; and some individual physicians had been carrying on with cosmetic surgery practices despite repeated warning signs of inadequate care. Indeed, concerns had been raised about the lax regulation of cosmetic surgery since the early 1990s, and yet it was only in 2010 that the Ontario College of Physicians took steps to seriously verify the credentials of cosmetic surgeons and inspect facilities.⁷¹ Following the 2008 death of a twenty-five year old septorhinoplasty patient, the College of Physicians of Quebec rushed to recommend reforms to the practice and regulation of cosmetic surgery in 2010, which are to be implemented within the year.⁷²

III. REDRESSING ADVERSE EVENTS THROUGH THE COURTS

Under Canadian law, adverse events may in principle be redressed through criminal, contract, and tort law remedies. However, the criminal law plays a very minor role in addressing medical malpractice, primarily because of the higher substantive and procedural standards required to impose criminal liability compared to civil liability. The Canadian Criminal Code defines criminal negligence as involving “wanton or reckless disre-

67. *Id.* at 132.

68. At least half of the retirement home’s residents need medical care that they can only get at a licensed nursing home. Brazao & Welsh, *supra* note 24; Brazao, *supra* note 24.

69. *Id.*

70. Flood et al., *supra* note 25, at 34.

71. *Id.*

72. CBC News, *Quebec Doctors Clamp Down on Cosmetic Surgery*, June 15, 2010, available at <http://www.cbc.ca/health/story/2010/06/15/mtl-college-of-physicians-cosmetic-surgery.html> (last visited Feb. 9, 2010).

gard for the lives or safety of other persons,” which the Crown must prove beyond a reasonable doubt.⁷³ Between 1900 and 2007, only fifteen physicians were prosecuted for alleged criminal negligence or manslaughter in Canada, and only *one* has been convicted.⁷⁴ In addition to being infrequently used, the criminal law is poorly equipped to deal with medical misconduct because health professionals often work collaboratively, making it difficult to assign sole responsibility and blame.⁷⁵

Canadian patients pursuing civil remedies have the option of suing in contract as well as in tort law. Claims in contract may try to allege that an implied contractual term to exercise reasonable care was breached.⁷⁶ Bringing a claim under contract law as well as tort law often makes little difference to the outcome of the case, because the standard of medical care in contract and tort is understood to be the same.⁷⁷ In some circumstances, however, there may be a benefit to suing in contract. For example, where a physician has guaranteed a specific outcome and it has not been realized, such as an aesthetically pleasing nose following rhinoplasty, damages have been awarded for breach of the contractual term in addition to those in negligence.⁷⁸ It should be noted, however, that contract law plays a somewhat more important role in Quebec, which is unique among Canada's provinces in that it has a civil law system, wherein it is established that an *intuiti personae* contract exists between patient and physician.⁷⁹ For the most part the resulting contract obligations are identical to the obligations established in tort law, with one exception: under their contractual obligations, physicians are expected to *personally* provide services, which can give rise to breach of contract where physicians delegate tasks without patient consent. In *Currie v. Blundell*,⁸⁰ for example, a surgeon allowed a surgical resident to perform heart surgery, under his direct supervision, but did not first obtain the patient's consent. The decision to delegate without

73. Criminal Code, R.S.C. 1985, c. C-46, s.220 (Can.).

74. Fiona MacDonald, *The Criminalization of Medical Mistakes in Canada: A Review*, 16 HEALTH L. J. 1, 12 (2008).

75. *Id.*

76. Ellen I. Picard and Gerald B. Robertson, LEGAL LIABILITY OF DOCTORS AND HOSPITALS IN CANADA 432 (4th ed., 2007).

77. *Worth v. Royal Jubilee Hospital* (1980), 4. L. Med.Q. 59, 67 (B.C.C.A., Can.).

78. *LaFleur v. Cornelis* (1979), 28 N.B.R.2d 569 (Q.B., Can.).

79. Robert P. Kouri & Suzanne Philips-Nootens, *Civil Liability of Physicians under Quebec Law*, in CANADIAN HEALTH L. & POL'Y 135-87 (Jocelyn Downie, Timothy Caulfield and Colleen M. Flood eds., 3rd ed., 2007).

80. [1992], 10 C.C.L.T.2d 288 (Que. S.C., Can.)

the patient's consent was criticized by the court, as a violation of the patient/physician contract.⁸¹

While adverse medical events may sometimes engage criminal or contract law concerns, the vast majority of malpractice cases proceed as tort cases—hence this will be the major focus of this section.⁸²

A. Canadian Medical Malpractice Liability in Context

Canadian doctors working in hospitals or in private practice are required to carry medical malpractice liability insurance.⁸³ The Canadian Medical Protective Association (CMPA) offers professional liability protection to approximately 95% of physicians in Canada. However, CMPA is not an “insurer” in the strict technical sense but rather a mutual defense organization that will cover a physicians’ costs if found negligent and provides advice, legal assistance, and risk management education.⁸⁴ Physicians’ premiums are not affected by their history of adverse events, which are determined solely by the type of medicine practiced and regional location.⁸⁵ In addition to CMPA premiums not being tied to physician performance, provincial governments largely cover the cost of the CMPA membership dues, in some cases up to 83%.⁸⁶ Coverage of these dues is

81. *Id.*

82. The legal characterization of the relationship between doctor and patients has changed over the past six centuries from a duty based on the doctor's status as a member of a professional calling to implied contract and finally to negligence. With the rise of the tort of negligence, the liability of doctors came to be judged by its principles. See Picard & Robertson, *supra* note 76, 1–2.

83. Stephen F. Clarke, LAW LIBRARY OF CONGRESS, *Medical Malpractice Liability: Canada*, Aug. 30, 2010, available at <http://www.loc.gov/law/help/medical-malpractice-liability/canada.php> (last visited Apr. 20, 2011).

84. Canadian Medical Protective Association (“CMPA”), *CMPA Annual Report 2009*, at 2, available at http://www.cmpa-acpm.ca/cmpapd04/docs/about_cmpa/annual_report/2009/com_ar_about_the_cmpa-e.cfm. The CMPA was founded in 1901 at the annual meeting of the Canadian Medical Association (CMA) and became a formal affiliate of the CMA in 1924. The annual general meeting of the CMPA is held in conjunction with that of the CMA. See CMPA, *A History of the Canadian Medical Protective Association 1901–2001*, available at http://www.cmpa-acpm.ca/cmpapd04/docs/about_cmpa/com_history-e.cfm (last visited Apr. 20, 2011). From the beginning, the aim of the association was to protect physicians’ reputations and ward off frivolous lawsuits through a display of sheer legal might. Quoting a 1919 report by the CMPA’s founder, Dr. R.H.W. Powell stated, “our organization does not consist in the fights we have put up or in the open success we have had but rather in the silent influence we have swayed against litigants who for a money gain have sought to blast the reputation of conscientious, painstaking and reputable practitioners knowing or suspecting that they have an easy mark and that to avoid publicity a medical man will often submit to what amounts to blackmail . . . *These litigants have found out that our Counsel stands ready to accept service of the writ and your Executive stands ready with a bank account to furnish the sinews of war . . . Dozens and dozens of cases have thus been strangled at their inception and have disappeared like dew off the grass.*” *Id.* (emphasis added).

85. Clarke, *supra* note 83.

86. Gilmour, *supra* note 6, at 55.

meant to compensate for the fact that, under Canada's single-payer system, physicians cannot pass on the cost of the insurance to patients in increased fees.⁸⁷ Yet a downside of the current scheme, arguably, is that it effectively insulates physicians from the "disincentive to risk-taking behaviour" that a tort liability regime is meant to impose.⁸⁸ The conduct of physicians is still moderated, however, by the threat of disciplinary action by the provincial self-regulating professional colleges.

It should also be noted that while the CMPA is a national organization, tort law reform is generally within the purview of the provinces, owing to the constitutional division of powers between the federal and provincial governments, explained in section 1 of this paper.

Hospitals and healthcare institutions also carry liability insurance, with many participating in the Health Insurance Reciprocal of Canada (HIROC), a member-owned non-profit insurance organization. Founded in 1987 in response to a report by the Ontario Hospitals Association calling for alternative liability arrangements, HIROC now insures over 600 institutions across Canada.⁸⁹ The premiums paid by health care institutions are to some extent loss sensitive, unlike physician premiums, which are unaffected by experience or negative history.⁹⁰

B. Empirical Trends on Medical Liability Claims

From the late 1960s to late 1980s, the frequency of tort claims quadrupled in Canada. Thus in the late 1980s, scholars were at work trying to explain the "medical malpractice explosion" in Canada.⁹¹ Yet the rate of claims has stabilized since then, ranging from 1.7 to 2.5 claims per 100 physicians annually.⁹² Indeed, the CMPA reported in 2009 that over the past ten years there has been a marked *decline* in the number of legal actions against CMPA members. The CMPA claims several factors are at

87. *Id.* Of course it is possible that faced with increased insurance premiums, medical associations would seek to increase fees earned at the next bargaining round.

88. *Stewart v. Pettie*, [1995] 1 S.C.R. 131, para. 50.

89. Healthcare Insurance Reciprocal of Canada, *Our History*, available at <http://www.hiroc.com/ourhistory.asp> (last visited Feb. 15, 2011).

90. Gilmour, *supra* note 6, at 56.

91. For an attempt to explain the rising trend throughout this period, see M. Trebilcock, D. De-wees & D. Duff, *The Medical Malpractice Explosion: An Empirical Assessment of Trends, Determinants, and Impacts*, 17 MELBOURN U.L. REV. 539 (1990). Doctrinal developments through this period can be found in J. Robert S. Prichard, *Liability and Compensation in Health Care (A Report to the Conference of Deputy Ministers of Health of the Federal/Provincial/Territorial Review on Liability and Compensation Issues in Health Care)* (1990) [hereinafter *The Prichard Report*].

92. Canada Institute for Health Information, *Health Care in Canada 2004*, available at http://secure.cihi.ca/cihiweb/products/hcic2004_e.pdf (last visited Apr. 20, 2011).

play in this decline, including “better medical care resulting in fewer adverse events, increased awareness and understanding of patient safety, enhanced risk management procedures, more effective and timely disclosure to patients, and tort reform initiatives.”⁹³

A less sanguine explanation for the low frequency and success of tort claims is that the CMPA pursues a “scorched earth” policy in countering allegations of medical misconduct, taking all measures to robustly defend claims.⁹⁴ Of the 101 civil actions against CMPA members that went to trial in 2009, plaintiffs succeeded in only nineteen, or 11%, of cases.⁹⁵ The vast majority of cases, however, never reached trial and were discontinued/dismissed/abandoned (522, or 55%) or settled (319, or 34%).⁹⁶ The CMPA’s high rate of success in defending actions is part of a consistent pattern; since 1996 their success rate has never been below 70%.⁹⁷ The CMPA is envied around the world for having contained the cost of negligence suits, but commentators such as Picard and Roberston raise concerns about the fact that *so very few* injured patients manage to secure compensation.⁹⁸

Apart from the robustness of the CMPA’s defense of claims, patient tort actions may be further chilled by the fact that under Canadian law a losing plaintiff may be ordered to pay up to two thirds of a defendant’s costs, making it risky to challenge an opponent as well-financed as the CMPA.⁹⁹ Successful litigants in Canada (plaintiffs or defendants) have a reasonable expectation of receiving an award of costs, subject to the court’s discretion and any governing rules or legislation.¹⁰⁰ Costs are generally awarded on one of two scales: partial indemnity costs (traditionally 50%) or substantial indemnity costs (traditionally 75%).¹⁰¹ The Canadian Supreme Court has held that the traditional approach to costs can be understood as advancing fairness and efficiency in the justice system by acting as a disincentive to bringing meritless claims and by making the legal system more accessible to litigants who seek to vindicate a legally sound posi-

93. CMPA, *Annual Report 2009*, *supra* note 84.

94. *Frazer v. Haukioja* (2009), 62 C.C.L.T.3d 280, para 2 (O.S.C.J., Can.); *see also* Law Library of Congress, *Medical Malpractice Liability: Canada*, Aug. 30, 2010, available at <http://www.loc.gov/law/help/medical-malpractice-liability/canada.php> (last visited Apr. 20, 2011).

95. CMPA, *Annual Report 2009*, *supra* note 84.

96. *Id.*

97. Picard & Robertson, *supra* note 76, 528–29.

98. *Id.* at 532.

99. Law Library of Congress, *supra* note 94.

100. *Id.*

101. Janet Walker & Lorne Sossin, CIVIL LITIGATION 33–36 (2010).

tion.¹⁰²In a recent Ontario case the presiding trial judge recognized the potential chilling effect of imposing costs awards against unsuccessful plaintiffs in medical negligence cases:

I believe that a cost award to the defendant in a lawsuit of this nature would send the wrong signal to plaintiffs who suffer injuries when undergoing treatment by physicians. This was a lawsuit that was supported by two eminent physicians. Proving negligence in medical malpractice lawsuits is extremely difficult. Failure to prove negligence should not always result in cost penalties. The plaintiff in this case clearly deserves the sympathy of the court. I am not prepared to award costs against him.¹⁰³

At least one author claims, however, that Canadian courts are generally hesitant to make costs orders against unsuccessful plaintiffs in medical malpractice cases absent egregious or vexatious behavior by the plaintiff.¹⁰⁴ Similarly, it is claimed that defendants often do not seek costs in cases that were brought in good faith, based on solid opinions, and well argued at trial.¹⁰⁵

While the total number of claims against physicians has been decreasing, there has been an increase in one particular type of claim: class actions.¹⁰⁶ This may help explain why although the number of cases against physicians has declined, the total amount of compensation being paid by the CMPA has been increasing. For example, in a recent class action against a hospital and physician for performing an unnecessary metroplasty surgery, the court approved a \$9.9 million settlement for a class of approximately 200 women.¹⁰⁷ If class actions continue to be settled for such large sums, alarm bells may be sounded about damages and legal expenses in the system.¹⁰⁸

102. *British Columbia (Minister of Forests) v. Okanagan Indian Band*, [2003] 3 S.C.R. 371, para.26 (Can.).

103. *Khoshmashrab v. Bent*, [2004] O.J. No. 2831, para. 204 (Can.).

104. D. Embury, *Preparing the Plaintiff for the Medical Negligence Trial*, at 4, June 7, 2006, available at http://www.torkinmanes.com/lawyers/default.asp?load=d_embury at 4 (last visited Apr. 20, 2011).

105. *Id.* at 6.

106. CMPA General Counsel, *Class Actions: On the Increase?*, April, 2008, available at http://www.cmpa-acpm.ca/cmpapd04/docs/resource_files/infosheets/2006/com_is0660-e.cfm (last visited Apr. 20, 2011).

107. *Bellaire v. Daya* (2007), O.J. No. 4819 (Can.).

108. Gerald. B. Robertson, *A View of the Future: Emerging Developments in Health Care Liability*, 1 SPECIAL ED. HEALTH L.J. 1, 12 (2008).

C. *Black Letter of Canadian Tort Law*

Medical liability in Canada has been characterized by “continuity and stability.”¹⁰⁹ There has been little major change and recent medical malpractice cases still primarily rely on legal principles developed over fifty years ago.¹¹⁰ However, as we argue above and further below, although the law in this domain may be stable it is insufficient to address the hidden epidemic of patient safety concerns.

1. Battery by Physicians

Historically, physician liability has fallen under the torts of battery or negligence. The tort of battery arises where a physician fails to obtain the patient’s consent to treatment, or obtains it through coercion, fraud or deceit, and there are no extenuating circumstances.¹¹¹ Battery is actionable without proof of damage and liability is not confined to foreseeable consequences.¹¹² However, the Supreme Court of Canada circumscribed the scope of battery in *Reibl v. Hughes*, characterizing the nature of many battery claims as more properly claims in negligence.¹¹³ Specifically, the court held that the failure of a physician to disclose material risks of a procedure does not vitiate the consent freely given by the patient.¹¹⁴ The patient in that case had consented to an internal carotid endarterectomy, but had not been warned of the 10% risk of stroke associated with the procedure. The patient suffered a serious stroke. Although on the face of it this might be characterized as a lack-of-consent case, the court held that the proper remedy for failure to disclose risks—however serious—would lie in negligence rather than battery.¹¹⁵ Since *Reibl*, medical malpractice plaintiffs have rarely succeeded in battery claims because rarely are the deficiencies in the disclosure provided so serious as to totally vitiate consent.¹¹⁶ However, empirical data demonstrates that disclosure to patients has increased in clinical practice since the *Reibl* decision.¹¹⁷ This may be due to increased focus on informed consent in the negligence case law, along with a shift in medical culture towards greater recognition of patient autonomy.

109. *Id.* at 1.

110. *Id.*

111. See *Norberg v. Wynrib*, [1992] 2 S.C.R. 226 (Can.).

112. *Id.* at para. 54.

113. *Reibl v. Hughes*, [1980] 2 S.C.R. 880 (Can.).

114. *Id.*

115. *Id.*

116. Picard & Robertson, *supra* note 76, at 191.

117. Gerald B. Robertson, *Informed Consent 20 Years Later*, HEALTH L.J. 153, 155 (2003).

2. Negligence by Physicians

Negligence is the primary category of claims against doctors and hospitals in Canada. To succeed in a negligence action, the plaintiff must demonstrate a legal duty of care, a breach of a legal standard of care, injury or loss to plaintiff that was caused by the breach, and damage not too remote to be recoverable in law.¹¹⁸ The plaintiff bears the burden of proof and must establish his or her claim on the balance of probabilities.¹¹⁹

It is generally uncontested that physicians owe a duty of care to their patients. The foundational statement outlining the standard of care owed by physicians to patients comes from the Supreme Court decision in *Crits v. Sylvester*:

Every medical practitioner must bring to his task a reasonable degree of skill and knowledge, and must exercise a reasonable degree of care. He is bound to exercise that degree of care and skill which could reasonably be expected of a normal prudent practitioner of the same experience and standing and if he holds himself as a specialist, a higher degree of skill is required of him, than of one who does not profess to be so qualified by special training and experience.¹²⁰

Physicians also owe duties to third parties in circumstances where it is reasonably foreseeable that their negligence will affect such persons. For example, doctors have been held liable to third parties injured in a car accident for a failure to report a patient's incapacity to drive to the licensing authority.¹²¹ Another foreseeable class of persons is the born-alive children of pregnant patients, whose claims in negligence become actionable upon birth.

Physicians may be liable in negligence for failing to disclose risks and alternative treatments; failing to diagnose properly; negligence in performing services; failing to disclose errors; and breaches of confidentiality.¹²² In making determinations about whether the relevant standard of care has been breached, reference to clinical guidelines, patient safety policies, and codes of conduct can be influential, in addition to expert evidence. Although these guidelines are not determinative, failure to comply is seen as suggestive of substandard care.

118. *Reibl*, 2 S.C.R. at 880.

119. *Crits v. Sylvester* (1956), 1 D.L.R. 2d 502, 508 (Ont. C.A.), *aff'd* [1956] S.C.R. 991 (Can.).

120. *Id.*

121. *Toms v. Foster* (1994), 7 M.V.R. 3d 34 (Ont. C.A.).

122. Gerald B. Robertson, *When Things Go Wrong: The Duty to Disclose Medical Error*, 28 QUEEN'S L.J. 353, 359–60 (2002).

The content of the obligation to disclose varies depending on the type of procedure. There is a trend towards finding a higher obligation of disclosure for risks relating to cosmetic and elective procedures than for required therapeutic treatments.¹²³ Physicians are also obligated to inform patients of alternative treatments,¹²⁴ but it is not clear whether the obligation extends to informing patients of treatments not available due to cost containment in their home province, but available in another region or country.¹²⁵ The legal duty of disclosure is not confined to possible risks or alternative treatments, but also requires physicians to disclose any mistakes—including their own—that a reasonable person in the patient's position would want to be informed of.¹²⁶ However, as Gibson writes, courts are much more likely to find a duty in situations where further injury is caused as a result of the mistake.¹²⁷

In addition to proving a duty and a breach of the standard of care, a plaintiff must prove causation between the act or omission (the breach) and the injury in question. The traditional test for causation in negligence is whether the injury would not have occurred “but for” the conduct of the defendant. In *Snell v. Farrell*, the Supreme Court criticized lower courts for applying a rigid conception of causation and endorsed a “robust and pragmatic approach” to determining causation in medical negligence cases.¹²⁸ The Court held that causation “need not be determined by scientific precision” and encouraged lower courts to be more willing to infer causation in the absence of contrary evidence adduced by the defendant.¹²⁹ In that case a patient suffered damage to her optic nerve following her doctor's negligent decision to continue with an operation after retrobulbar bleeding had been observed in the eye. Following the surgery, blood filled a chamber in the plaintiff's eye, remaining for nine months; at some point bleeding within the eye caused damage to the optic nerve, rendering that eye blind. Expert witnesses could not say whether the atrophied optic nerve occurred naturally or was caused by the surgery, but at any rate the defendant's neg-

123. Picard & Robertson, *supra* note 76, at 145.

124. *Videto et. al v. Kennedy*, [1981] 33 O.R.2d, 497 (Can.)

125. Timothy Caulfield & Kerry Siminoski, *Physicians Liability and Drug Formulary Restrictions*, 166 CMAJ 458, 459 (2002).

126. *Stamos v. Davies* (1985), 52 O.R.2d 10, para. 25 (Can.).

127. Elaine Gibson, *Memorandum on Duty of Disclosure in Canadian Law –Commissioned by Eastern Health for Submission to Part II of the Newfoundland and Labrador Hormone Receptor Commission of Inquiry*, [unpublished report, on file with authors], May 14, 2008.

128. *Snell v. Farrell*(1990), 2 S.C.R. 311, para 34 (Can.).

129. *Id.* at paras. 29–33.

ligence had made it impossible to detect the problem in time to address it. The Court found that it would be proper to infer causation on such facts.¹³⁰

A patient's own exercise of autonomy is an important link in establishing this chain of causation. A failure to disclose risks may not be a "but for" factor, if it can be established that a patient would have proceeded with a treatment *even if* the risks were adequately disclosed. As *Reibl* established, the question is framed by asking what a *reasonable patient* in the plaintiff's position would have chosen.¹³¹ On its face this seems to involve an objective question of fact, answered for example with testimony from other physicians, as to what their average patient would opt to do in situations comparable to the plaintiff's. Robertson has noted however that the courts have slowly shifted to consider subjective factors, very often to decide against the plaintiff: "For example, it is very common to find cases where the court describes the patient as 'assertive' or 'independent minded', and then uses this to support the conclusion that the patient had already made up their mind in favour of the treatment and hence would not have been dissuaded by disclosure of risks."¹³²

In circumstances where the "but for" test is unworkable, the Court has held that causation may be established using the "material contribution" test. Causation is made out using this test if the negligence of the defendant created a risk and the patient suffered an injury that was within the ambit of the risk created. In such cases the conduct of the defendant can be said to have materially contributed to the injury.¹³³ In the recent decision of *Resurfice Corp. v. Hanke*, the Supreme Court discussed in obiter the requirements for employing the "material contribution" test.¹³⁴ The "material contribution" may be employed in place of the presumptive "but for" test in exceptional circumstances where it is impossible to apply the "but for" test due to limited scientific knowledge.¹³⁵ Klar argues that, notwithstanding this attempt at clarification on the part of the Supreme Court, it remains unclear in what circumstances the material contribution test will be applied, and in cases decided since *Hanke* the courts have not embraced its application.¹³⁶ A restrictive application of the "material contribution" test will likely disadvantage plaintiff patients. For example, Khoury suggests that by limiting the availability of the "material contribution" test to situations of

130. *Id.* at para. 43.

131. *Reibl*, 2 S.C.R. at para. 11.

132. Robertson, *supra* note 117, at 158.

133. *Athey v. Leonati* (1996), 3 S.C.R. 458, para. 3 (Can.).

134. *Hanke v. Resurfice Corp* (2007), 1 S.C.R. 333, para. 4 (Can.).

135. *Id.* at para. 25.

136. Lewis N. Klar, *TORT LAW* 449 (4th ed., 2008).

scientific uncertainty, claims arising from health-care acquired infections may be less likely to succeed since their numerous potential causes are often scientifically understood.¹³⁷

There will be no finding of causation, however, if the physician's error only caused the plaintiff to lose a (mere) chance to avoid his or her damages. It is insufficient for a patient to show that, had a proper diagnosis been made or proper treatment given, the unfavorable outcome might not have occurred. A patient must prove that, had the proper treatment or diagnosis been made, it would be "more likely than not" that the unfavorable outcome would have been avoided.¹³⁸ For example, a cancer patient who lost a 45% chance of recovery due to misdiagnosis and delayed treatment would likely be unable to demonstrate causation. Picard and Roberston have described this as an area where "form triumphs over substance."¹³⁹

Remoteness involves an inquiry into the reasonableness of holding a defendant liable and is motivated by policy concerns that a defendant should only be held liable for what would be foreseeable to a reasonable person in the defendant's position. A determination that an injury is unforeseeable or too remote serves to limit legal liability regardless of the factual cause of the injury. In *Martin v. Inglis*, a physician was found not to be negligent in his performance of gastroplasty surgery that resulted in a gastric leak.¹⁴⁰ The trial judge held that even if the physician had been negligent, liability would not have been imposed due to the unforeseeable nature of the injury. Patients undergoing gastroplasty who survive the critical period immediately following the operation are very unlikely to suffer complications and die. The plaintiff's death fourteen and a half months after the initial operation was therefore unforeseeable.¹⁴¹

An exception to the usual limits imposed by foreseeability occurs in the case of "thin skulled" victims of negligence, where injuries are unex-

137. Khoury, *supra* note 30, at 211–213.

138. *Cottrelle v. Gerard* (2003), 67 O.R.3d 737, para. 25 (Ont. Can.)

139. Ellen I. Picard and Gerald B. Robertson, LEGAL LIABILITY OF DOCTORS AND HOSPITALS IN CANADA, 4th ed., (Toronto: Thomson Carswell, 2007) at 288; see also J. Gilmour, *The Multiple Meanings of Causation in the Supreme Court of Canada's Medical Malpractice Jurisprudence: Past, Present and Future*, in HEALTH LAW AT THE SUPREME COURT OF CANADA (J. Downie & E. Gibson eds., 2007). For more on trends in causation, see Vaughan Black, *The Transformation of Causation in the Supreme Court: Dilution and "Policyization,"* in ANNUAL REVIEW OF CIVIL LITIGATION 2002 (Todd Archibald & Michael Cochrane eds., 2003) and Colleen M. Flood, *Conundrums in Causation and Informed Medical Consent*, 23 ADVOC. Q. 217(2000).

140. *Martin v. Inglis* (2002), 218 Sask. R. 1, paras.115–16 (Sask. Can.).

141. *Id.* at paras. 133–137. The Supreme Court has recently opined at greater length on remoteness in *Mustapha v. Culligan of Canada Ltd.* (2008), 2 S.C.R. 114 (finding that a purified water company was not liable for the unforeseeable psychological damage done to the plaintiff when a fly was found in his bottled water).

pectedly severe owing to a preexisting condition. Defendants are liable for thin skulls, but not for “crumbling skulls”—cases where the preexisting condition made the injuries inevitable.¹⁴² Furthermore, as Justice Linden’s text on tort law states, “If the negligence of the defendants renders the skull of the plaintiff thin, making the plaintiff more susceptible to additional injury of sickness, the defendant is responsible for the further complications.”¹⁴³ This statement of the “thin skull rule” was applied by the Manitoba Court of Appeal to hold a physician liable not only for negligent post-operative hip surgery care, but also for the fractured femur the plaintiff sustained in a subsequent operation to address the consequence of his substandard care.¹⁴⁴

The most common defenses against claims of physician negligence are as follows: the physician followed approved practice; the physician only committed an excusable error of judgment; the patient was contributorily negligent; the action is statutorily barred. Each will be addressed in turn.

The Supreme Court clarified in *terNeuzen v. Korn* that doctors acting in accordance with a recognized and respectable practice of the profession would generally not be found to be negligent.¹⁴⁵ In reaching that decision, the court emphasized its lack of expertise and inability to second-guess the appropriateness of clinical decisions. However, when the standard is “fraught with obvious risks” such that a reasonable person without clinical skill would find it negligent, the court may find the approved practice to be negligent.¹⁴⁶ The Court cited *Anderson v. Chasney* as an example of this exception to the general rule.¹⁴⁷ After removing a child’s tonsils, the surgeon was told by the anesthetist that not all the sponges had been removed. The surgeon found no sponges, but the child later asphyxiated on one. The surgeon was held liable even though it was not the practice of the hospital at the time to count sponges, or employ ones with strings.¹⁴⁸ A failure to comply with approved practice does not necessarily mean the standard of care was breached. However, if a physician acts in accordance with a respectable body of opinion, even if not the opinion of the majority, he or she will normally avoid liability.¹⁴⁹

142. *Athey*, 3 S.C.R. at para. 35.

143. A.M. Linden, *CANADIAN TORT LAW* 350 (7th ed., 2001).

144. *Powell v. Guttman* (1978), 89 D.L.R.3d 180, para.38 (Man., Can.).

145. *terNeuzen v. Korn* (1995), 34 S.C.R. 674, para. 38 (Can.).

146. *Id.* at para. 39.

147. *Id.* at para. 45.

148. *Anderson v. Chasney* (1949), 4 D.L.R. 71 (Man., Can.), *aff’d* (1950) 4 D.L.R. 223 (SCC).

149. Picard and Robertson, *supra* note 76, at 362; see e.g., *Lapointe v. Hopital le Gardeur* (1992), 90 D.L.R. 4th 7 at para. 23 (S.C.C.).

In *Wilson v. Swanson*, the leading case on the defense of “error of judgment,” the Supreme Court held that “an error of judgment has long been distinguished from an act of unskillfulness or carelessness or due to lack of knowledge.”¹⁵⁰ Reasonableness, not perfection, is expected of doctors, and even reasonable doctors make mistakes.¹⁵¹ The defense of error of judgment is most often raised in respect of a failure to correctly diagnose a patient’s condition.¹⁵² While an initial misdiagnosis may be only an error in judgment, courts have found the failure to reconsider a diagnosis as negligent where the patient did not respond to treatment and her condition worsened.¹⁵³

The defense of contributory negligence is essentially a claim that the patient was wholly or partially the author of his or her own misfortune. In arguing that damages should be reduced, defendants will often allege an unreasonable delay on the part of a patient in seeking medical attention. Picard & Robertson contend that claims of contributory negligence rarely succeed in Canadian medical malpractice law, possibly because courts have been loathe to find patients at fault given the seemingly unequal positions of the parties.¹⁵⁴ As patients take more agency with respect to their medical care, however, it is possible that findings of contributory negligence will become more common.¹⁵⁵

All Canadian jurisdictions have legislation requiring plaintiffs to commence a civil action within a certain limitation period. Thus one of the most common defenses to a claim of medical negligence is that that action is statutorily barred because the limitation period has elapsed. Most provinces and territories have a two-year limitation period, running from when the plaintiff knew or ought to have known of the tort, for actions against physicians and other health professionals, consistent with the limitation for other claims in negligence. In the past, limitation periods for medical malpractice actions were much shorter in many jurisdictions. Apparently the preferential treatment originated in Ontario in the late nineteenth century when the Ontario legislature shortened the limitation period from the regular six years to one year for physicians. This special rule, providing additional protection to the medical profession, then spread across Canada.¹⁵⁶

150. *Wilson v. Swanson* (1956), 5 D.L.R. 2d 113, para. 23 (SCC).

151. *Felix v. Red Deer Regional Hospital Centre* (2001), 2001 ABQB 545, para. 80 (Q.B.).

152. Picard and Robertson, *supra* note 76, at 366.

153. *Bergen v. Sturgeon General Hospital* (1984), 52 A.R. 161, para. 24 (Q.B.).

154. Picard & Robertson, *supra* note 76, at 369.

155. *Id.*

156. Picard & Robertson, *supra* note 76, at 377.

Historically, the “locality” doctrine borrowed from American law provided a partial defense to claims in negligence by holding physicians in rural and/or remote communities to a lower standard of care. The doctrine is occasionally still referenced in Canadian case law, but appears now to have little to no impact on how cases are decided. This is especially so since there is no requirement in Canada that expert testimony comes from a physician within the same (or comparable) community as the defendant physician.¹⁵⁷

Although physicians may be under pressure to contain costs, *Law Estate v. Simice* suggests that limited resources cannot be a defense for physician negligence.¹⁵⁸ The case involved a patient who died after the treating physician—responding to pressures to limit the use of expensive tests—declined to order a diagnostic CT scan that would have revealed the patient’s aneurism. The court stressed in obiter that cost considerations should not affect a physician’s decision making; a physician’s duty is to his or her patient, not the financial health of the Medicare system overall.¹⁵⁹ Where resources are simply not available to a physician, due for example to the remote location of their practice, this may be a defense,¹⁶⁰ though in some cases courts have found a responsibility to refer patients to a more well-equipped treatment facility.¹⁶¹ As resource constraints increase it is possible that this question of a defense of limited resources will need to be revisited.

Motivated by a desire to reduce litigation rates and improve system quality, “apology” legislation has recently been introduced in many provinces and territories to address concerns regarding the legal consequences of apologizing. For example, the Ontario legislation provides that an apology is not admissible in any civil, administrative, or arbitration proceeding as evidence of fault or liability.¹⁶² Even if a physician’s apology includes an explicit admission of fault, the broad definition of apology in the legislation seems to preclude the use of such an admission in a negligence action. Legislation in British Columbia, Alberta, Saskatchewan, Nova Scotia and Manitoba is similarly drafted.¹⁶³ As this legislation has only been recently

157. *Id.* at 248–251; see also Ellen I. Picard and Gerald B. Robertson, LEGAL LIABILITY OF DOCTORS AND HOSPITALS IN CANADA 191–92 (3d ed., 1996).

158. *Law Estate v. Simice* (1994), 21 C.C.L.T.2d 228, para. 24 (B.C.S.C.), aff’d (1996) 4 W.W.R. 672 (C.A.).

159. *Id.* at paras. 21, 34–35.

160. *Rodych v. Krasey* (1971), 4 WWR 358 (Can.).

161. *Dillon v. Leroux* (1994), 89 B.C.L.R. 2d 376 (B.C., Can.).

162. Apology Act, 2009, S.O. 2009, c. 3, s. 2.(3) (Ont., Can.).

163. Letter from John E. Gray, Exec. Dir., Can. Med. Protective Agency, to Lorenzo Berardinetti, Chair, Standing Comm. on Justice Policy, “Re: Bill 108: Apology Act, 2008” (Jan. 5, 2009), available

enacted, there has been little or no case law to date testing its impact on negligence law.

3. Hospital Liability

Hospitals may be both directly and vicariously liable for harm caused to patients. A hospital may be directly liable for a variety of shortcomings, including: inadequate equipment; inadequate record-keeping; improper performance or supervision of staff/treatment; poor supervision of post-op care; failure to protect patients from infection; improper supervision of emergency departments; failure to establish systems necessary for safe functioning; failure to have a written protocol or internal regulations with respect to the treatment of a particular injury, or failure to follow written protocol; failure to prevent a patient from injuring themselves or other patients.¹⁶⁴

Hospitals are vicariously liable for the torts of their employees, such as nurses. Hospital vicarious liability for nurses working as part of a health care team raises interesting issues, given that nurses are health professionals with independent skills, knowledge, and judgment, but have a duty to follow the orders of physicians.¹⁶⁵ In a recent obstetrics malpractice case a rural hospital was found vicariously liable for the death of an infant.¹⁶⁶ The court determined that the nurse assisting with the delivery was negligent in failing to summon qualified help (including emergency resuscitation) in the circumstances. The treating physician displayed signs of emotional distress and panic in attempting to deal with complications that arose during the birth and did not request appropriate assistance from other medical staff.¹⁶⁷

Hospitals may, in principle, face vicarious liability for the negligence of a doctor practicing at a hospital depending on the relationship between the doctor, the hospital, and the patient.¹⁶⁸ Hospitals are vicariously liable for physicians *employed* as house staff who are under the control of the hospital, such as medical residents and interns.¹⁶⁹ However, most physicians practicing in Canadian hospitals have hospital privileges, but are paid

at http://www.cmpa-acpm.ca/cmpapd04/docs/submissions_papers/com_bill_108_apology_act-e.cfm (last visited Apr. 16, 2011).

164. Moe Littman, *Fiduciary Law in the Hospital Context: The Prescriptive Duty of Protective Intervention*, 25 HEALTH L. J. 295 (2007); Picard & Robertson, *supra* note 76, at 460–473.

165. *Id.* at 491.

166. *Skeels Estate v. Iwashkiw* (2006), 2006 Alta. L.R.4th 26, para. 258 (Alta. Can.).

167. *Id.* at para. 87.

168. *Yepremian v. Scarborough General Hospital* (1980), 28 O.R. 2d 494, para. 179 (Can. Ont., C.A.); leave to appeal allowed (1980), 120 D.L.R. 3d 337 (Can. Ont. C.A.).

169. *Id.* at para. 49.

through provincial health insurance schemes and considered to be independent contractors. These physicians are *directly liable* to their patients and hospitals are not vicariously liable for their negligence. Whether hospitals are liable for physicians other than interns and residents requires a close examination on the facts of a case. For example, some courts have held hospitals vicariously liable for the negligence of anesthesiologists,¹⁷⁰ while others have rejected such claims.¹⁷¹ Key considerations in determining whether to impose vicarious liability include whether the patient chose the physician; whether the physician is salaried by the hospital; whether the physician is integral to rather than accessory to the hospital's operation.¹⁷² The Supreme Court has recently expanded the application of vicarious liability, but these decisions have not involved hospitals.¹⁷³

Hospitals have recourse to many of the same defenses as physicians: they followed approved standard of practice, the patient was contributorily negligent, the limitations period has expired, or the injury was not foreseeable. Hospitals can also defend actions by characterizing the nature of the physician's relationship with the hospital as one of independent contractor rather than as an agent of the hospital, thereby defeating the rationale for imposing liability. A unique defense open to hospitals is that the care provided was sufficient based on the reasonable expectation of the community it serves. In *Bateman v. Dorian*, a hospital in Moncton, New Brunswick was found not to be negligent for staffing its emergency room with part-time general practitioners rather than specialists in emergency medicine.¹⁷⁴ The court held that "the non-availability of trained and experienced personnel, to say nothing of the problems of collateral resource allocation, simply makes this standard unrealistic, albeit desirable."¹⁷⁵ As mentioned earlier it is perhaps only a matter of time until a similar defense is open to physicians.

4. Government Liability

Governments may conceivably be subject to tort liability.¹⁷⁶ Despite the possibility of bringing claims against governments, Gilmour explains that in practice "they have generally been immune from liability for negli-

170. *Martel v. Hôtel-Dieu St. Vallier* (1969), 14 D.L.R. 3d 445 (S.C.C.).

171. *Toronto General Hospital v. Matthews et al.* (1972), 1972 S.C.R. 435 (Can.).

172. Picard and Robertson, *supra* note 76, at 481.

173. Gilmour, *supra* note 6, at 59.

174. *Bateman v. Doiron* (1991), 118 N.B.R. 2d 20, para. 3-4 (N.B., Can.).

175. *Id.* at para. 43.

176. Lorian Hardcastle, *Governmental and Institutional Tort Liability for Quality of Care in Canada*, 15 HEALTH L.J. 401, 431-34 (2007).

gence in their decision-making about the organization and funding of the health care system, on the basis that such decisions did not give rise to a private law duty of care, and were not amenable to a finding of negligence because they were policy and not operational decisions.”¹⁷⁷ This type of reasoning is illustrated by the Divisional Court’s decision in *Mitchell Estate v. Ontario*, a case involving allegations that hospital restructuring and health care spending decisions made by the Ontario government caused the death of a patient in an over-crowded emergency department.¹⁷⁸ In striking out the motion the Court held that “there should be no private law duty of care arising with respect to decisions affecting health care funding and hospital restructuring.”¹⁷⁹

Many of the actions against governments involve allegations by private citizens that governments failed to maintain safe systems - for instance, in response to outbreaks of Severe Acute Respiratory Syndrome (SARS) in the greater Toronto area and West Nile virus across Ontario. The Ontario Court of Appeal has struck down actions against the Ontario government emerging from injuries suffered due to infection by West Nile virus¹⁸⁰ and SARS¹⁸¹. In *Eliopoulos v. Ontario* the Court held that while the government did owe a public law duty to promote health and protect against the spread of the West Nile virus, there was no relationship of proximity between the plaintiff and Ontario capable of giving rise to a private law duty of care.¹⁸² In *Williams v. Ontario*, a proposed SARS class action, the Court held that it was “plain and obvious on the facts pleaded in the claim that Ontario did not owe a private law duty of care to the plaintiff.”¹⁸³ Even if the plaintiffs had been able to demonstrate a relationship of sufficient proximity, the court would have declined to find a duty for policy reasons, explaining that “[p]ublic health authorities should be left to decide where to focus their attention and resources without threat of lawsuits.”¹⁸⁴

Case law is not yet well developed regarding the lines between policy and operational decisions and the boundaries of private law duties of care that governments owe members of the public with respect to health care

177. Gilmour, *supra* note 6, at 62.

178. *Mitchell Estate v. Ontario* (2004), 2004 O.J. No. 3084, paras.2-3 (Ont., Can.).

179. *Id.* at para. 33.

180. *Eliopoulos v. Ontario (Minister of Health & Long-Term Care)* (2006), 217 O.A.C. 69, para. 3 (Ont., Can.).

181. *Williams v. Ontario* (2009), 95 O.R.3d 401, paras. 30-34 (Ont. Can.).

182. *Eliopoulos*, 217 O.A.C. at para. 17.

183. *Williams*, 95 O.R.3d at para. 40.

184. *Id.* at para. 35.

and public health.¹⁸⁵ Claimants may have greater success in making claims against local health authorities than the government due to more proximate relationship, greater managerial role, and more limited duties towards the public.¹⁸⁶

5. Damages

A major focus tort law reform in the United States has been a perceived need to control costs, but allegedly excessive damages awards have not been a significant issue in Canada. The Canadian Supreme Court capped damages for general non-pecuniary injuries, such as for pain and suffering, in a trilogy of cases released in 1978.¹⁸⁷ The capped amount has been adjusted for inflation over the years, and now stands around \$CAD 300,000.¹⁸⁸ To be clear, a plaintiff patient may still claim pecuniary damages, such as loss of income and health care costs not covered under the public system (as discussed below, patients are required to claim damages, in subrogation, for expenses incurred by the public insurer as a result of medical malpractice). Nonetheless, this cap on non-pecuniary losses is a major disincentive for patients to commence a malpractice action and for lawyers to specialize in or seek out malpractice cases.¹⁸⁹ A further disincentive is that the availability of punitive damages has been greatly limited by the Supreme Court. Punitive damages are only awarded in exceptional circumstances in negligence claims where there has been “high-handed, malicious, arbitrary or highly reprehensible misconduct” that departs to a marked degree from ordinary standards of decent behavior.¹⁹⁰

One may also wonder about the impact of subrogation on damages awards. All provinces and territories in Canada now have legislation requiring patients to inform the ministry of a potential claim and/or to bring a claim on behalf of the government as part of a medical malpractice action commenced by the patient.¹⁹¹ For example, Ontario’s Health Insurance Act (OHIP) requires plaintiffs to pursue a subrogated claim on behalf of OHIP for the extraordinary cost of past and, in some case, expected future health

185. Gilmour, *supra* note 6, at 59.

186. Lorian Hardcastle, *Systemic Accountability through Tort Claims Against Health Regions*, 18:2 HEALTH L.R. 40 (2010).

187. See e.g., *Andrews v. Grand & Toy Alberta Ltd.*, [1978] 2 S.C.R. 229 (Can.).

188. Stephen F. Clark, *Medical Malpractice Liability: Canada*, Law Library of Congress (Aug. 30, 2010), available at <http://www.loc.gov/law/help/medical-malpractice-liability/canada.php>.

189. *Id.*

190. *Whiten v. Pilot Insurance Co.*, [2002] 1 S.C.R. 595, para. 94 (Can.)

191. See, e.g. Health Insurance Act, R.S.O., c. H.6, s. 30-36 (1990) (Ontario); Hospitals Act, R.S.A., c. H-12, Part 5 (2000) (Alberta); Health Care Costs Recovery Act, S.B.C., C. 27 (2008) (British Columbia).

care services incurred as a result of the alleged negligence. Section 31(1) of the Act states as follows:

Any person who commences an action to recover for loss or damages arising out of the negligence or other wrongful act of a third party, to which the injury or disability in respect of which insured services have been provided is related shall, unless otherwise advised in writing by the General Manager, include a claim on behalf of the Plan for the cost of the insured services.¹⁹²

In Ontario, the Ministry of Health and Long-term Care routinely recovers the cost of publicly insured health services associated with medical malpractice, automobile accidents, and a range of other situations such as assaults, slip and falls, and manufacturing defects.¹⁹³ While recent CMPA annual reports do not provide specific information regarding the cost of subrogation, a report on tort law reform prepared by the CMA and CMPA in 2000 indicated that subrogated claims represented 4.2% of the value of total awards and settlements made by CMPA in the previous two years.¹⁹⁴ The report advocated for the elimination of subrogation respecting medical malpractice actions, claiming it was a “logical absurdity” since “virtually every dollar paid to OHIP in medical malpractice litigation originates in the Ministry of Health.”¹⁹⁵ Similar sentiments were echoed in the 2008 CMPA Annual Report, in which the CMPA argued that the elimination of subrogation would create overall savings by reducing unnecessary transaction costs.¹⁹⁶

6. Ongoing Issues and Avenues of Reform

One of the main purposes of tort law is to deter risk-taking through the imposition of potential liability.¹⁹⁷ A key challenge when using tort liability as a lever to promote patient safety is to ensure that responsibility is

192. Health Insurance Act, R.S.O., c. H.6, s. 31(1) (1990) (Ontario).

193. “Personal Injury Accidents: Recovering Health Care Costs” Ministry of Health and Long-Term Care, *available at* <http://www.health.gov.on.ca/english/public/pub/ohip/injury.html> (last visited Apr. 8, 2011).

194. Canadian Medical Association & Canadian Medical Protective Association, *CMPA Tort Reform 2000: Structures and Subrogation available at* http://www.cmpa-acpm.ca/cmpapd04/docs/submissions_papers/com_tort_backgrounder_2000-e.cfm.

195. *Id.*

196. CMPA 2008 Annual Report, *available at* http://www.cmpa-acpm.ca/cmpapd04/docs/about_cmpa/annual_report/2008/com_leadership-e.cfm.

197. There is disagreement as to whether tort law does, and ought to, serve an instrument of deterrence. For a defense of deterrence, see Michael J. Trebilcock, *Incentive Issues in the Design of No-Fault Compensation Systems*, 39 U. TORONTO L.J. 19, 19–20 (1989); but see TERENCE ISON, *THE FORENSIC LOTTERY: A CRITIQUE OF TORT LIABILITY AS A SYSTEM OF PERSONAL INJURY COMPENSATION* (London, Staples, 1967).

targeted at the appropriate level within the system. Hospitals (and arguably regional health authorities that have managerial responsibility for hospitals) are able to improve patient safety by providing better working conditions for physicians, nurses, pharmacists and other health professionals and instituting policies and procedures that will reduce error. The nature of the delivery of modern health care in hospitals is such that the present sharp distinction in Canadian law between hospital responsibility and physician responsibility is artificial. Tort law for the most part shields “blunt end” actors such as hospitals and government, and assigns liability to “sharp end” actors such as physicians practicing in hospitals.¹⁹⁸ Increasing awareness generated by the patient safety movement regarding the role of systemic factors in causing patient injury provides strong support for the expansion of hospital vicarious liability to include non-employed physicians in the future.¹⁹⁹

Another main goal of tort law is to ensure those harmed by wrongdoing are compensated for their injuries. Most tort reform initiatives in Canada over the last decade have focused on streamlining the process for resolution, and introducing structured settlements whereby damages are paid out according to a pre-determined timeline.²⁰⁰ These initiatives were encouraged in the 1990 Prichard Report to the Conference of Deputy Minister of Health, entitled *Liability and Compensation in Health Care*.²⁰¹ Progress towards achieving these goals has proceeded at a pace described as “excruciatingly slow.”²⁰² A far more ambitious recommendation considered in the Prichard Report was that Canada introduce a no-fault compensation scheme for medical injuries to supplement the existing tort regime.²⁰³

198. Even so, the structure of the current liability system provides little in the way of effective deterrence for the “sharp end” actors, as previously discussed above.

199. Gilmour, *supra* note 6, at 60–61.

200. *Canada Unlikely to Follow U.S. Malpractice Reform*, MEDICAL POST (8 Feb. 2005).

201. J.R.S. Prichard, LIABILITY AND COMPENSATION IN HEALTH CARE: A REPORT TO THE CONFERENCE OF DEPUTY MINISTERS OF HEALTH OF THE FEDERAL/PROVINCIAL/TERRITORIAL REVIEW ON LIABILITY AND COMPENSATION ISSUES IN HEALTH CARE, (Toronto: University of Toronto Press, 1990).

202. *Recent Rumbblings May Move Mountain of Malpractice Reform: Nine Years Have Passed With No Changes*, MEDICAL POST vol. 34, no. 39, pp. 1 (1998).

203. While there is no current compensation scheme for medical injuries, provincially funded disability benefits are available to qualifying individuals. For example, the Ontario Disability Support Program (ODSP) provides very basic income support to persons with a substantial disability that impairs their ability to work or care for themselves, but only those with minimal financial resources are eligible. The federally operated Canada Pension Plan (CPP) also provides a disability benefit for those under 65 who have recently contributed to the CPP through mandatory deductions from their income but are currently unable to work due to disability. The CPP disability benefit provides a very basic level of support (the maximum benefit is \$CA 1,105.99 per month). See *Ontario Disability Support Program: Income Support*, Ministry of Community and Social Services, http://www.accesson.ca/en/mcss/programs/social/odsp/income_support/index.aspx; see also

While no-fault compensation is a subject of perennial interest to Canadian legal scholars,²⁰⁴ there does not appear to be any real political momentum in this direction.²⁰⁵ Any impetus for significant change is also unlikely to come from the CMPA, given its findings in a recent report on medical liability practices that “the Canadian model appears fundamentally sound” and “may be the best available solution.”²⁰⁶

IV. PREVENTING ADVERSE EVENTS: PROFESSIONAL AND SYSTEM REFORM

A recurring theme in the literature on Canadian tort law is the slow pace and modest nature of reforms.²⁰⁷ The lack of momentum on this front should not be taken as a sign that all is rosy in Canadian health care: as explained in Part II, there have been a number of grave systemic problems in recent years, resulting in widespread calls for improvements to patient safety standards. The federal government, provincial governments, and non-governmental regulatory bodies, have pursued various strategies with a view to reducing the incidence of adverse events. What follows is a brief survey of these strategies.

A. Reforms at the Level of the Professions

1. Alternative Complaint Mechanisms

Instead of (or in addition to) bringing a claim in negligence, patients who believe they were injured or improperly treated may make a formal complaint regarding a health care provider to the appropriate self-regulating health college. In Ontario, for example, each college has a Complaints Committee, which conducts initial investigations and may refer specific allegations to the Discipline Committee for a hearing.²⁰⁸ While

CPP Disability – I want to apply, Service Canada, <http://www.servicecanada.gc.ca/eng/isp/cpp/applicant.shtml>.

204. See e.g. R. Elgie, T. Caulfield et al., *Medical Injuries and Malpractice: Is It Time For No-Fault?*, 1 HEALTH L.J. 97, 99 (1993); Colleen M. Flood, *New Zealand's No-Fault Accident Compensation Scheme: Paradise or Panacea?* 8 HEALTH L.REV. 3, 3 (1999/2000).

205. No fault insurance was later considered, and rejected, by the commission formed after Canada's tainted blood scandal—a public health crisis wherein more than 2000 individuals were infected with AIDS and hepatitis C through blood transfusions. See H. Krever, *FINAL REPORT: COMMISSION OF INQUIRY ON THE BLOOD SYSTEM IN CANADA* (Ottawa: The Commission, 1997).

206. Canadian Medical Protective Association, *Medical Liability Practices in Canada: Towards the Right Balance*, 5–7 (2005), available at http://www.cmpa-cpm.ca/cmpapd04/docs/submissions_papers/piaa/com_home-e.cfm.

207. Gilmour, *supra* note 6, at 19–26.

208. Decisions by the Ontario Complaints Committees are subject to review by the Health Professions Appeal and Review Board.

physicians in Canada are self regulating, decisions of the discipline committees of many provincial colleges of physicians are subject to public oversight through the courts, or through provincial ombudsman offices, for instance in Alberta.²⁰⁹

Some of Canada's more populous provinces have devised additional public channels for patients seeking redress for inadequate care. Under reforms introduced in 1991, the province of Quebec enacted a Patients' Bill of Rights, with complaints being heard by local health commissioners and, if unresolved at that level, escalated to the provincial Health and Social Services Ombudsman.²¹⁰ It is unclear whether Quebec's Ombudsman addresses many complaints concerning medical malpractice *per se*. In 2009, the Ombudsman primarily addressed individual and group complaints about systemic problems, relating for example to denial and delays of care, delays in the certification of long term care facilities, and ineffective triage within emergency wards.²¹¹ Ontario has not enacted a bill of patient rights, but there is nevertheless a provincial Ombudsman, whose remit encompasses decisions of the Ministry of Health and Long-Term Care—though not individual hospitals or physicians.²¹² Every year, the Ombudsman hears between 500–1000 complaints about wait times, access to care, and quality of care and other systemic issues relating to the Ministry's work.²¹³ The Alberta legislature has very recently passed the Alberta Health Act, which will see the enactment in that province of a Health Charter, to be overseen by a government appointed Health Advocate, similar to Quebec's Ombudsman.²¹⁴

209. See Alberta Ombudsman, *How We Help* (2010), <http://www.ombudsman.ab.ca/whatwedo.php> (last visited Apr. 8, 2011).

210. An Act Respecting Health and Social Services, R.S.Q., ch. 4.2 (1991) (Quebec).

211. Quebec, Le Protecteur du Citoyen, *2009-2010 Annual Report*, available at <http://www.protecteurducitoyen.qc.ca/en/major-cases-and-documentation/annual-reports/index.html#haut>. Controversy has surrounded these changes, as a leaked government document revealed that these patient rights provisions are meant to build public confidence in the system in the lead up to increased privatization. See Karen Kleiss, *Health-care Privatization Alleged by Alberta Opposition*, EDMONTON JOURNAL, Nov. 30, 2010.

212. Ontario's Ombudsman did however gain jurisdiction to investigate Hôtel-Dieu Grace Hospital when it was put under direct control of the Ministry of Health and Long-Term Care, after systemic problems were discovered in pathology services. See *Windsor Hospital Taken Over by Province*, TORONTO STAR, Jan. 5, 2011.

213. OMBUDSMAN'S ANNUAL REPORTS, <http://www.ombudsman.on.ca/en/publications-resources/annual-reports.aspx> (last visited Apr. 11, 2011).

214. Bill 17: Alberta Health Act (Dec. 2, 2010), available at http://www.assembly.ab.ca/net/index.aspx?p=bills_status&selectbill=017.

2. Revalidation/Recertification

The Code of Ethics of the Canadian Medical Association requires, among other things, that physicians “engage in lifelong learning to maintain and improve their professional knowledge, skills, and attitudes.”²¹⁵ There has recently been a push, led by the Federation of Medical Regulatory Authorities of Canada (FMRAC), to require that Canadian physicians “recertify” their qualifications on an ongoing basis, through a rigorous and standardized revalidation process.²¹⁶ Although some provincial regulators have tried to introduce new approaches to practice assessment, physician organizations are often resistant to any system seen as too burdensome or time consuming.²¹⁷ One might expect that such concerns would resonate with the public, given the general sense that the health care system is over-taxed— yet polls indicate that 87% of patients support the idea of regular, ongoing exams for physicians.²¹⁸

Some provinces, but not all, have mandated that physicians participate in an educational program— typically through the Royal College of Physicians and Surgeons’ Maintenance of Certification program or the College of Family Physicians’ Maintenance of Proficiency program— as a condition of maintaining licensure. Critics have argued that these efforts have, to date, lacked rigor—pointing out, for example, that they rely on self-reporting, and involve no external review.²¹⁹ Canadian physicians are often able to satisfy their Maintenance of Certification requirements simply by attending medical education activities, and reporting their attendance to their college, without ever being tested on what they have learned.²²⁰ It is said that Canada has not been as rigorous as other jurisdictions (e.g., the UK and the US) in the implementation of revalidation schemes.²²¹

The FMRAC has complained specifically that the provincial Colleges are not gathering sufficient evidence linking physicians’ ongoing training

215. Canadian Medical Association, *CMA Code of Ethics* (Ottawa, 2004), available at <http://policybase.cma.ca/PolicyPDF/PD04-06.pdf>.

216. Kirstyn Shaw et al., *Shared Medical Regulation in a Time of Increasing Calls for Accountability and Transparency*, 302 JAMA 18 (2009).

217. *Id.*

218. Troyen A. Brennan, et al., *The Role of Physician Specialty Board Certification Status in the Quality Movement*, 292 JAMA 1038 (2004).

219. Wendy Levinson, *Revalidation of Physicians in Canada: Are We Passing the Test?* 179:10 CAN. MED. ASS’N J. 979 (2008).

220. *Id.*

221. Shaw et al., *supra* note 216.

with their scope of practice.²²² The above-mentioned regulatory failings in the area of cosmetic surgery have been traced partly to this problem; over the years, many general practitioners expanded their scope of practice to include cosmetic surgeries, without reporting the change to their college, or undergoing any testing to verify their competence. The province of Ontario is taking steps to address this problem, but faces the challenge of assessing the qualifications of physicians who have been performing cosmetic surgeries for years, without any surgical designation.²²³

Cases of general practitioners undertaking cosmetic surgical practices plainly lie at the extreme. It is unclear whether there will be a push by the colleges to better correlate physicians' scope of practice with their credentials across the board. It has taken decades to respond to the problem of under-qualified cosmetic "surgeons" in Ontario— despite patient deaths and considerable public outrage— which suggests that the FMRAC's concerns about self-regulation may be well founded.

3. Apology Legislation

The earlier discussion of tort liability briefly described the move to enact apology legislation in several Canadian provinces. One rationale for such legislation is to break the code of silence around medical errors, allowing physicians to be honest and apologetic with patients. Receiving an apology may help the healing process for patients, but the open disclosure of errors is also argued to be important to improving patient safety overall. It is through gathering data on the occurrence of errors and near misses that systemic problems are detected and corrected.²²⁴ At the moment, only six Canadian provinces have enacted apology legislation, though there have been calls to enact similar legislation in the remaining provinces. In the meantime, the CMPA has been criticized for continuing to give "apology-chilling advice" to physicians in provinces without such legislation.²²⁵

222. FMRAC Revalidation Working Group, *Physician Revalidation: Maintaining Competence and Performance*, FEDERATION OF MEDICAL REGULATORY AUTHORITIES OF CANADA (2007), available at http://www.fmrac.ca/policy/revalidation_eng.html.

223. Flood et al., *supra* note 25.

224. Gerald B. Robertson, *When Things Go Wrong: The Duty to Disclose Medical Error*, 28 QUEEN'S L. J. 353 (2002).

225. Noni MacDonald & Amir Attaran, *Medical Errors, Apologies and Apology Laws*, 180(1) CAN. MED. ASS'N J. 11 (2009).

B. Systemic Reforms

1. Accreditation of Facilities

As indicated above, each province has its own Hospital Act, which allows for the ongoing inspection and accreditation of hospitals by provincial ministries of health. Yet there has been a lack of equivalent regulation for smaller clinics that offer privately financed care; privately financed care represents a growing portion of the overall health system, owing to “passive privatization” of Canadian health care.²²⁶ For example, in Ontario there is a massive backlog of elderly patients who require full-time nursing care and who are on wait lists for spots in government-regulated and subsidized long-term care homes. In the meantime, many take up residence in private retirement homes, which are not regulated by government—conditions in these homes are in some cases appalling.²²⁷ In the spring of 2009, the Ontario legislature passed the Retirement Homes Act, which creates a regime of licensure and inspection for these facilities.²²⁸ While seniors in the province have welcomed the change, it is worrying that the proposed regime will be one of *self*-regulation, overseen by “people with a background in the retirement-home business.”²²⁹

A very similar story can be told of the regulation of private clinics delivering non-essential care, such as elective cosmetic surgery. After years of inaction, the province of Ontario has taken steps to ensure that private clinics are subject to inspection, and that the credentials of staff are vetted.²³⁰ But again, this has been achieved through a regime of *self*-regulation, overseen by the College of Physicians and Surgeons of Ontario.²³¹ Thus there remains a disparity: hospitals delivering medically necessary care within the province are subject to direct oversight by the province’s Ministry of Health, while private clinics are subject only to self-regulation.

226. Dale Brazao, *Seniors at Risk in Retirement Homes, Investigation Reveals*, TORONTO STAR (October 1, 2010).

227. Brazao, *Seven Sad Days*, *supra* note 24.

228. Retirement Homes Act, S.O. 2010, Chapter 11 (2010) (Ontario).

229. Quoted in *Retirement Homes: Seniors need more protections* TORONTO STAR (October 3, 2010).

230. CPSO, *Out-of-Hospital Premises Inspection Program*, <http://www.cpso.on.ca/members/default.aspx?id=3756> (last visited Apr. 11, 2011).

231. *Id.*

2. Canadian Patient Safety Institute

Over the past decade, there has been recognition of the need for a comprehensive and coordinated strategy to improve patient safety. The Royal College of Physicians and Surgeons of Canada held a one-day forum on patient safety in 2001, which spawned a National Steering Committee on Patient Safety. The Committee in turn recommended the creation of the Canadian Patient Safety Institute (CPSI), tasked with promoting innovation and collaboration among governments and stakeholders, with a view to enhancing patient safety. The CPSI has been in operation since December of 2003, and has funded research, developed patient safety guidelines, and led campaigns in various targeted areas—from hand hygiene to suicide prevention.²³² To be clear, the CPSI plays only an advisory and facilitative role; it does not have the power to enforce patient safety standards on the provinces, or the power to license facilities or discipline physicians.

3. Improved Information Gathering and Dissemination

Timely information gathering and dissemination will be essential to detecting and preventing patient safety crises of the sort described above—e.g., the breast cancer screening test crisis in Newfoundland and Labrador. Regrettably, Canada has lagged behind other developed nations in its adoption of IT systems for healthcare.²³³ There have, however, been some steps taken to remedy this situation. Canada Health Infoway is a non-profit organization created by Canada's First Ministers in 2001, and funded by the federal government, which is tasked with creating a national, interoperable system of Electronic Health Records (EHRs). The country's patchwork of regulations and privacy laws is partly to blame for the long delays in designing and implementing a system of EHRs.²³⁴ There are significant concerns that the EHR system under development by Infoway is not being built with a view to facilitate *secondary* research.²³⁵ Thus it remains unclear, at this stage, to what extent this project will furnish data that can be used in improving patient safety at a systemic level.

232. CANADIAN PATIENT SAFETY INSTITUTE, <http://www.patientsafetyinstitute.ca/> (last visited Apr. 11, 2011).

233. Cathy Schoen, et al., *A Survey of Primary Care Physicians in Eleven Countries, 2009: Perspectives on Care, Costs, and Experiences*, 28 HEALTH AFFAIRS 6 (Web Exclusives): w1171-w1183 at w1175 (2009).

234. Canada, Standing Senate Committee on Social Affairs, Science and Technology, *The Health of Canadians—The Federal Role*, 6 OTTAWA: STANDING SENATE COMMITTEE ON SOCIAL AFFAIRS, SCIENCE AND TECHNOLOGY 10.4 (2002).

235. Patricia Kosseim & Megan Brady, *Policy by Procrastination*, 2 MCGILL J.L. & HEALTH 5, 6–9 (2008); see also Kimberly McGrail & Paul C. Hebert, *No More Dithering on E-health: Let's Keep Patients Safe Instead*, 182 CAN. MED. ASS'N J. 535 (2010).

A variety of smaller projects have been initiated in recent years. The National System for Incident Reporting (NSIR) is a free web-based application used by Canadian hospitals to securely and anonymously share, analyze and discuss medication/IV fluid incidents. Health Canada's program, MedEffect Canada, provides consumers, patients, and health professionals with easy access to report adverse events and obtain latest safety information on drugs and health products. Another Health Canada initiative, the Canada Vigilance Adverse Reaction Online Database, stores information reported about suspected adverse reactions to health products, such as prescription and non-prescription medication, natural health products, and radiopharmaceuticals. Lastly, the Health Council of Canada was established following the February 2003 First Ministers' Accord on Healthcare Renewal.²³⁶ The Council is to provide monitoring, public reporting and informed discussion about the performance of provincial health systems, partly with a view to improving patient safety. The majority of provinces have, in the past decade, created their own Health Quality Councils, to the same end.²³⁷

While very little information is available to the public, there is increasing interest and recognition of the importance of providing information on health quality and safety indicators to healthcare consumers. For instance, the Manitoba Physician Profile Regulation requires that the history of all licensed physicians, including medical training and disciplinary history, be available to the public.²³⁸ This initiative arose out of recommendations made by a committee reviewing the results of the Manitoba Pediatric Cardiac Surgery Inquest, as is discussed above.²³⁹ While this physician profile information is easily accessible online, it is based on self-report and is not verified by the Manitoba College of Physicians and Surgeons, limiting its usefulness.²⁴⁰

236. HEALTH COUNSEL OF CANADA, <http://www.healthcouncilcanada.ca/en/> (last visited Apr. 11, 2011).

237. See, e.g., THE BC PATIENT SAFETY AND QUALITY COUNCIL, <http://www.bcpsqc.ca/>; THE HEALTH QUALITY COUNCIL OF ALBERTA, <http://www.hqca.ca/>; THE SASKATCHEWAN HEALTH QUALITY COUNCIL, <http://www.hqc.sk.ca/>; THE MANITOBA INSTITUTE FOR PATIENT SAFETY, <http://www.mbips.ca/>; THE ONTARIO HEALTH QUALITY COUNCIL, <http://www.ohqc.ca/>; THE HEALTH QUALITY COUNCIL OF QUEBEC, <http://www.indicateurs.ca/> (all last visited Apr. 11, 2011).

238. Manitoba Physician Profile Regulation, Reg. 104/2005 (2005).

239. Gilmour, *supra* note 6, at 68.

240. See Physician Profile, COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, http://www.cpsm.mb.ca/3_1_search.php (last visited Apr. 11, 2011).

CONCLUSION

Plainly there are real and well-founded concerns about patient safety in Canada, within hospitals and within facilities that deliver privately financed care (e.g., retirement homes and cosmetic surgery clinics). What's more, the full extent of these problems is as yet partly unknown, due to the lack of ongoing data collection on adverse events across the health care system. There is no single, prevailing explanation for the system's failings to date; one can only list a variety of contributing factors and speculate as to their relative importance. From a risk reduction perspective, physicians are individually shielded from the deterrent effects of potential medical malpractice liability, thanks to the CMPA's rules for setting insurance premiums and significant subsidization of those premiums by provinces. From the plaintiff patient's perspective, there are enormous challenges to successfully litigating medical error for a number of reasons: Patients are discouraged from pursuing claims in the first place by both the CMPA's reputation for aggressive litigation of claims and Canadian rules for the awarding of costs. The inherent difficulties in establishing causation in medical malpractice cases combined with broad defenses for physicians of "accepted practice" and "excusable error of judgment" make imposing liability challenging. Finally, caps on non-pecuniary damage awards limit the possible recovery of litigants who do succeed at trial.

It is worrisome that, after cases are effectively pre-screened by these harsh disincentives, such a small proportion of claims succeed at trial. Certainly a proportion of cases are settled, thus negating the need to pursue litigation, but one still has still to question whether such a small proportion of Canadian patients have had rightful claims to damages for medical malpractice. Or have short limitation periods, unequal bargaining power, prohibitive rules on the awarding of costs, and caps on non-pecuniary damages conspired to create an access to justice problem?

A systematic review of the case law would be required in order to ascertain whether the burden of proof set out in black letter law tilts the scales against claimants in medical malpractice cases. We noted however that, for example, patients cannot recover for missed diagnoses unless they would have had a better than 50% chance of avoiding their injuries, given an accurate diagnosis. On the face of it, these do not seem very forgiving odds for plaintiffs.

Governments at both the federal and provincial levels have been more focused on strategies for the *prevention* of medical malpractice, but efforts have at times been slow, scattershot, and ineffectual. For example, patient safety issues have occurred repeatedly in the delivery of privately financed

care, and yet provincial governments and regulatory colleges have taken more than a decade to tighten regulations, typically opting for regimes of self-regulation, which may not provide optimal protection. Within this approach, steps are being taken in some provinces to ensure that physicians have adequate and up-to-date training for their scope of practice. Yet it appears that revalidation of credentials, in many cases, is nothing more than an exercise in self-reporting.

The provinces and territories, along with the federal government, seem most enthusiastic about improved information gathering and dissemination of best practice standards as a means for preventing adverse events—hence the rapid proliferation of Health Quality Councils across Canada, over the past five to ten years. This is laudable, but it is the easiest piece of the puzzle, politically. And little is being done to evaluate whether any of these reforms will result in meaningful improvements in patient safety. Governments should also be asking harder questions, concerning access to justice for victims of medical malpractice, and the expanding role of self-regulation that has accompanied the “passive privatization” of Canadian health care. Greater consideration also needs to be given to what changes in medical malpractice law would ensure that it better meets the mark of improving patient safety, for example, consideration of whether a more systems-like approach to safety would result if hospitals or regional authorities were more frequently held vicariously liable for the actions of the physicians who operate therein.