Annals of Health Law

Volume 3
Issue 1 *1994*

Article 13

1994

The Efficacy of the Medical Malpractice System: A Canadian Perspective

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INTRODUCTION

This article examines the medical malpractice system in Canada and attempts to determine if the system works. This article provides a general assessment of the efficacy of the Canadian system, particularly from the patient's perspective, highlights its perceived problems, and reaches the following conclusions. First, regardless of what one believes to be the underlying purpose of the medical malpractice system, the Canadian system is not working. This is especially true from the perspective of the patient. Second, the failure of the system is due to a number of procedural and substantive reasons, but is linked primarily to problems that patients have in accessing justice. These problems are unlikely to change in the foreseeable future. Finally, although the system in Canada may be failing as a compensation scheme, Canadian law is beginning to have a significant impact on the nature of the doctor-patient relationship, and in particular on the power base underlying that relationship.

I. THE EFFICACY OF THE SYSTEM

A number of difficulties arise when trying to assess the efficacy of the Canadian medical malpractice system. One problem is the paucity of empirical data. There is fairly comprehensive and reliable data on the frequency and severity of malpractice claims in Canada published in the annual reports of the Cana-

* This article is based upon Professor Robertson's speech delivered at the Fourth Annual Comparative Health Law Conference, "Medical Malpractice: A Comparative Analysis," sponsored by Loyola University Chicago School of Law Institute for Health Law in October of 1993.

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dian Medical Protective Association ("C.M.P.A.").[1] However, no data are available on the number of medical injuries occurring in Canada each year; hence, there is no measure of the percentage of injured patients who receive compensation. As is discussed below, recent Canadian commentaries have tended to rely on data from other countries in estimating this percentage.

Another difficulty stems from regional variation. Canadian medical malpractice law is established almost exclusively at the provincial level, resulting in some quite significant differences across Canada, especially in matters of procedure and legislation. For example, as is discussed below, limitation statutes vary considerably in some parts of Canada, as do methods of assessing damages in matters such as wrongful death actions. In addition, sociological and economic variations in different provinces may have an impact on the frequency and severity of malpractice claims. These variations prevent a generalized analysis of the efficacy of the medical malpractice "system" in Canada.

A third difficulty is that the perceived defects in the present malpractice system vary depending on one's perspective.[2] What to some may appear to be a defect may seem to others to be a strength. This difference in perspective is simply part of the larger problem that there is no agreement as to the overall objectives of the present malpractice system. In other words, it is difficult to assess the efficacy of a system when its underlying purpose is unclear. As Dewees and Trebilcock emphasize in their comprehensive discussion of this theme, there are at least three different evaluative frameworks that may be used in assessing the efficacy of the tort system in general and the medical malpractice system in particular.[3] These frameworks are based on the normative goals of deterrence, corrective justice, and distributive justice. The first approach strives to minimize accident and avoidance costs by ensuring an optimum level of incentives and deterrents. Corrective justice, on the other hand, stresses moral culpability and the need to compensate those who have been injured through the fault of others. Finally, according to a distributive justice theory, medical accidents are simply an inevitable consequence of the delivery of health care, and these inev-

1. The most recent is the CANADIAN MEDICAL PROTECTIVE ASSOCIATION, NINETY-SECOND ANNUAL REPORT (1993) [hereinafter C.M.P.A. REPORT].

2. Chester N. Mitchell & Shona McDiarmid, *Medical Malpractice: A Challenge to Alternative Dispute Resolution* 3 CAN. J.L. & SOC'Y 227, 227 (1988).

3. Don Dewees & Michael Trebilcock, *The Efficacy of the Tort System and Its Alternatives: A Review of Empirical Evidence*, 30 OSGOODE HALL L.J. 57 (1992).

itable losses should be distributed among those who benefit therefrom, health care providers and, ultimately, health care consumers.

These different objectives are not wholly discrete nor are they entirely incompatible with each other. Indeed, achieving these objectives depends in large measure on a number of common factors, perhaps the most important of which is that those who are injured as a result of medical malpractice should have reasonable access to the justice system. This clear denial of access to justice, which represents a significant defect in the system, proves that the present malpractice system in Canada can be seen as a failure, regardless of what one accepts as its underlying purpose.

A. Access to Justice

According to the most recent annual report of the C.M.P.A.,[4] 1,097 new claims were initiated against its members in 1992.[5] In the same year, 306 claims were settled and 25 others resulted in a trial judgment in favour of the plaintiff. The amount of total damages paid out by the C.M.P.A. during 1992 was approximately $41 million (Can.), with legal costs of approximately $33 million (Can.).[6]

As noted above, no reliable data are available on the number of Canadians who suffer injury through medical negligence but receive no compensation. This issue was discussed in a report to the Conference of Deputy Ministers of Health entitled *Liability and Compensation in Health Care* (the "*Prichard Report*") from the Federal/Provincial/Territorial Review on Liability and Compensation Issues in Health Care (the "Prichard Review").[7] The Prichard Review, which was established in 1987 and chaired by J. Robert S. Prichard, was given a mandate to

> (1) examine and report on the issues relating to liability and compensation matters associated with health care delivered by professionals, institutions, voluntary organizations, and the Canadian Blood Supply System, (2) advise on possible legal

4. C.M.P.A. REPORT, *supra* note 1, at 18.

5. The C.M.P.A. had a membership of 55,189 physicians in 1992. *Id.* This represents approximately 96 percent of all physicians practising in Canada.

6. *Id.* at 18, 31.

7. LIABILITY AND COMPENSATION IN HEALTH CARE: A REPORT TO THE CONFERENCE OF DEPUTY MINISTERS OF HEALTH OF THE FEDERAL/PROVINCIAL/TERRITORIAL REVIEW ON LIABILITY & COMPENSATION ISSUES IN HEALTH CARE (1990) [hereinafter PRICHARD REPORT].

reforms designed to ameliorate the cost of liability claims on the Canadian public health care system, and (3) advise on the possibility of alternatives to litigation for persons disabled following an injury that occurred while they received medical attention.[8]

One of the Review's principal findings was that of all patients who suffered injury as a result of medical negligence, fewer than ten percent received any compensation from the tort system.[9] Because of the lack of Canadian data, the Prichard Review based this conclusion on data from other countries, in particular the United States and Sweden.[10] More recent studies from the United States, in particular, the Harvard Medical Practice Study, indicate that the percentage of individuals suffering a negligently caused medical injury who receive compensation is much smaller than ten percent, perhaps as low as two percent.[11] Whatever the exact figure may be, it is beyond doubt that "there is a huge gap between negligent adverse events and claims."[12] Nor is there any compelling reason to believe that data from the United States do not reflect the situation in Canada.[13] Thus, in the words of Mitchell and McDiarmid, "[i]nventing a malpractice litigation crisis also obscures the real problem, which is access to justice for injured medical patients . . . . [T]he actual crisis is that at least ninety-five percent of persons injured by medical malpractice receive no compensation."[14]

B. Reasons for Denial of Access: Procedural Issues

The reasons why so many medical accident victims do not receive compensation are varied and complex.[15] An economic barrier stems from the fact that in 1978, the Supreme Court of Canada placed a cap of $100,000 (Can.), which adjusted for inflation is now approximately $220,000 (Can.), on nonpecuniary damages for items such as pain and suffering, loss of amenities,

8. *Id.* at 35.
9. *Id.* at 5.
10. *Id.*, app. A at 98-103.
11. *See* Troyen A. Brennan, *An Empirical Analysis of Accidents and Accident Law: The Case of Medical Malpractice Law*, 36 ST. LOUIS U. L.J. 823, 847 (1992); PAUL C. WEILER ET AL., A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION (1993).
12. Brennan, *supra* note 11, at 848.
13. Indeed, because the universal health care system in Canada covers most of the health care costs associated with the patient's injuries, there is perhaps even less motivation for Canadians to commence malpractice litigation.
14. Mitchell & McDiarmid, *supra* note 2, at 229.
15. *See* PRICHARD REPORT, *supra* note 7, app. A at 103-04.

and loss of expectation of life.[16] One significant factor is undoubtedly the expense involved in this type of litigation. Though all Canadian provinces, with the exception of Ontario, permit contingency fee arrangements, this is of little comfort to potential plaintiffs whose claims are relatively modest and are unlikely to be of interest to a lawyer on a contingency basis. As the *Prichard Report* notes, legal counsel routinely discourage claims involving predicted damages of less than $100,000 (Can.).[17] Moreover, even if the claim is taken on a contingency basis, the client still faces the prospect of having to pay part of the defendant's legal costs if the claim is dismissed, since in Canada (unlike the United States) costs are normally awarded against the unsuccessful party. Thus, there is a significant financial risk involved in pursuing a medical malpractice claim and, for many, this risk represents an insurmountable barrier.[18]

Another impediment relates to limitation periods (analogous to statutes of limitations in the United States). In most Canadian provinces the limitation period in personal injury claims is two years. However, some provinces have a much shorter limitation period for medical malpractice claims, usually one year.[19] Indeed, in Saskatchewan the limitation period for claims against hospitals is only three months.[20] In most provinces, the limitation period in malpractice claims begins to run on the date on which the professional services terminate or the date on which the patient is discharged from the hospital, rather than from the date on which the cause of action arose.[21] Courts have tended to construe this provision fairly rigidly. For example, courts have held that this limitation period, unique to malpractice actions, applies whether the action is framed in negligence, con-

16. Andrews v. Grand & Toy Alta. Ltd., [1978] 2 S.C.R. 229.

17. PRICHARD REPORT, *supra* note 7, app. A at 104.

18. *See* Mitchell & McDiarmid, *supra* note 2, at 229-30.

19. This is true of Alberta, Ontario, Prince Edward Island, and Saskatchewan. *See* Limitation of Actions Act, R.S.A., ch. L-15, §§ 55(a), 56 (1980); Health Disciplines Act, R.S.O., ch. H.4, § 17 (1990); Hospitals Act, R.S.P.E.I., ch. H-10, § 13 (1988); The Medical Profession Act 1981, 1980-81 S.S., ch. M-10.1, § 72.

20. The Hospital Standards Act, R.S.S., ch. H-10, § 15 (1978).

21. This is true of Alberta, Manitoba, Newfoundland, Nova Scotia, Prince Edward Island, and Saskatchewan. *See* Limitation of Actions Act, R.S.A., ch. L-15, § 55(a) (1980); The Medical Act, R.S.M., ch. M-90, § 61 (1987); Medical Act, R.S.N., ch. M-4, § 25 (1990); Limitation of Actions Act, R.S.N.S., ch. 258, § 2(1)(d) (1989); Hospitals Act, R.S.P.E.I., ch. H-10, § 13 (1988); The Medical Profession Act 1981, 1980-81 S.S., ch. M-10.1, § 72.

tract,[22] or battery.[23] A court[24] also held that the special protection that these statutes give health care professionals[25] does not violate the Canadian Charter of Rights and Freedoms.[26]

Given a series of recent Supreme Court of Canada decisions regarding the discovery rule, the tying of the limitation period to the termination of professional services rather than to the accrual of the cause of action has a most significant effect. The Supreme Court of Canada held that, for purposes of the limitation statutes, a cause of action does not accrue until the plaintiff discovers or with reasonable diligence should have discovered the material facts upon which the action is based.[27] However, one provincial appellate court held that this discovery rule does not apply where the running of the limitation period is tied to the termination of professional services rather than to the accrual of the cause of action.[28] According to this decision, the limitation period starts to run as soon as the physician's services terminate, regardless of whether the patient knows the material facts, including the fact of injury, upon which the cause of action is based. Thus, in the words of Madam Justice Wilson of the Supreme Court of Canada, we have "the injustice of a law which statute-bars a claim before the plaintiff is even aware of its existence."[29]

22. Fishman v. Waters, 4 D.L.R.4th 760 (Man. C.A. 1983); Letiec v. Rowe, 130 D.L.R.3d 379 (Nfld. C.A. 1981); Sobon v. Kosloski, 46 Sask. R. 172 (Q.B. 1986).

23. Strachan v. Simpson, [1979] 5 W.W.R. 315 (B.C.S.C.); Hadley v. Allore, 35 C.C.L.T. 204 (Ont. H.C. 1985), *aff'd*, 43 C.C.L.T. 106 (Ont. C.A. 1988); Vincent v. Hall, 49 O.R.2d 701 (H.C. 1985), *aff'd*, (Ont. C.A. 1987); McBain v. Laurentian Hosp., 35 C.P.C. 292 (Ont. H.C. 1982).

24. Brochner v. MacDonald, 68 Alta. L.R.2d 191 (C.A. 1989).

25. Note, however, that the special limitation period may be detrimental to health care professionals by forcing plaintiffs to commence their action at an early date, perhaps before a true assessment of the merits of the case can be made. This may also encourage a "shotgun" approach to the selection of potential defendants. *See* PRICHARD REPORT, *supra* note 7, at 20, app. A at 197.

26. CAN. CONST. (Constitution Act, 1982) pt. I (Canadian Charter of Rights and Freedoms).

27. M.(K.) v. M.(H.), [1992] 3 S.C.R. 6; Central Trust Co. v. Rafuse, [1986] 2 S.C.R. 147; City of Kamloops v. Nielsen, [1984] 2 S.C.R. 2.

28. Fehr v. Jacob, [1993] 5 W.W.R. 1 (Man. C.A.). *See also* J.(A.) v. Cairnie Estate, [1993] 6 W.W.R. 305 (Man. C.A.); Scott v. Birdsell, 143 A.R. 254 (Q.B. 1993). For a more detailed discussion of this issue, see Richard W. Bauman, *The Discoverability Principle: A Time Bomb in Alberta Limitations Law*, 1 HEALTH L.J. 65 (1993); Gerald Robertson, *Fraudulent Concealment and the Duty to Disclose Medical Mistakes*, 25 ALTA. L. REV. 215 (1987); Gerald Robertson, Scott v. Birdsell: *Limitation Periods in Medical Malpractice Cases,* 32 ALTA. L. REV. 181 (1994).

29. City of Kamloops, [1984] 2 S.C.R. at 40.

C. *Reasons for Denial to Access: Substantive Issues*

In addition to the procedural obstacles relating to access to justice, there are other reasons connected with the substantive law that exacerbate the difficulty plaintiffs have in obtaining compensation by means of a medical malpractice claim.[30] The standard of care traditionally applied in malpractice cases is "that degree of care and skill which could reasonably be expected of a normal, prudent practitioner of the same experience and standing."[31] In conjunction with this test, legal doctrines such as accepted medical practice, error in clinical judgment, and "two schools of thought" have given health care practitioners a considerable degree of protection.[32] Recent case law indicates that these legal doctrines continue to have a significant impact on the outcome of medical malpractice litigation in Canada, with numerous cases being dismissed on the grounds that the defendant either acted in accordance with generally approved practice or committed only an excusable error of clinical judgment.[33] Perhaps this is why the majority of Canadian malpractice claims that go to trial are decided in favour of the defendant. For example, in 1991, physicians succeeded in forty-seven of the sixty-one cases that reached trial; in 1992, forty-eight of seventy-three cases were decided in the physician's favour.[34]

However, the Supreme Court of Canada has handed down a number of decisions in the past few years that may eventually have a significant impact in the medical malpractice field.[35] For example, in *Snell v. Farrell*[36] the Supreme Court expressed the

30. These factors are discussed in detail in Gerald Robertson, *Reform of the Law of Medical Liability: The Position in the Common Law Jurisdictions of Canada*, *in* CONTEMPORARY LAW: CANADIAN REPORTS TO THE 1990 INTERNATIONAL CONGRESS OF COMPARATIVE LAW 173 (H. Patrick Glenn ed., 1992).

31. Crits v. Sylvester, [1956] O.R. 132, 143 (C.A.), *aff'd*, [1956] S.C.R. 991.

32. *See generally* ELLEN I. PICARD, LEGAL LIABILITY OF DOCTORS AND HOSPITALS IN CANADA 153-78, 229-43 (2d ed. 1984).

33. *See* Robertson, *supra* note 30, at 174-78.

34. C.M.P.A. REPORT, *supra* note 1, at 18. In 1991, 493 cases were dismissed or disconinuted prior to trial, and 236 cases were settled; in 1992, 496 cases were dismissed or discontinued prior to trial, and 306 cases were settled. *Id.*

35. This is part of a larger trend that has seen the Supreme Court of Canada render many significant decisions in the area of tort law in the past three years, and which appears to represent a resurgence of interest in tort law on the part of Canada's highest court. *See* Lewis N. Klar, *The Supreme Court of Canada and the Law of Torts*, *in* LEGAL EDUCATION SOCIETY OF ALBERTA, UPDATE '92: WHAT'S NEW IN TORT LAW 1 (1993).

36. [1990] 2 S.C.R. 311.

opinion that trial judges in medical malpractice cases frequently apply too high a standard of proof in relation to causation, almost to the point of requiring scientific certainty. In urging a less rigid approach, Justice Sopinka stressed that causation is "essentially a practical question of fact which can best be answered by ordinary common sense rather than abstract metaphysical theory."[37] The decision in *Snell v. Farrell* is already having an impact in the lower courts, where it has assisted plaintiffs in proving causation in medical malpractice cases.[38]

Likewise, in *McInerney v. MacDonald*[39] the Supreme Court greatly expanded patients' rights of access to their own health care records, basing its decision on the fiduciary nature of the doctor-patient relationship.[40] Most recently the Court held that the doctrine of informed consent requires the physician not only to disclose material information to the patient (judged by the "prudent patient" standard),[41] but also to take reasonable steps to ensure that the patient understands this information.[42] These recent decisions may well portend an expansion in liability of the medical profession in the not too distant future.

II. Shifting the Power Base of the Doctor-Patient Relationship

Another discernible trend in Canadian medical malpractice law relates to the nature of the doctor-patient relationship, and in particular the power base underlying that relationship. In this regard it is useful to compare Canada's approach with the ap-

37. *Id.* at 328 (quoting Lord Salmon in Alphacell Ltd. v. Woodward, [1972] 2 All E.R. 475, 490 (H.L.)).

38. *See, e.g.*, Crick v. Mohan, 142 A.R. 281 (Q.B. 1993); Cherry v. Borsman, 94 D.L.R.4th 487 (B.C.C.A. 1992); Wilson v. MacKay, [1993] B.C.J. No. 739 (S.C.); Watt v. Gillanders, [1992] B.C.J. No. 1117 (S.C.); Levitt v. Carr, [1992] 4 W.W.R. 160 (B.C.C.A.), *appeal dismissed*, [1992] 6 W.W.R. lviii (S.C.C.); Lankenau v. Dutton, [1991] 5 W.W.R. 71 (B.C.C.A.), *appeal dismissed*, [1991] 6 W.W.R. lxvii (S.C.C.); Brewer v. Wade, [1992] N.B.J. No. 741 (Q.B.); Crandell-Stroud v. Adams, [1993] Nfld.J. No. 224 (S.C.); Briffett v. Gander & Dist. Hosp., 326 A.P.R. 271 (Nfld. S.C. 1992); Mahoney v. Jarvis, [1993] O.J. No. 248 (Gen. Div.); Skinner v. Royal Victoria Hosp., [1993] O.J. No. 1054 (Gen. Div.); Kenyeres v. Cullimore, [1992] O.J. No. 540 (Gen. Div.); Mann v. Jugdeo, [1993] 4 W.W.R. 760 (Sask. Q.B.).

39. [1992] 2 S.C.R. 138.

40. The fiduciary nature of the relationship was also emphasized by some of the Justices in Norberg v. Wynrib, [1992] 2 S.C.R. 224, in awarding damages against a doctor in connection with a "sex-for-drugs" arrangement which he had with a patient.

41. The Supreme Court first established this principle in Reibl v. Hughes, [1980] 2 S.C.R. 880.

42. Ciarlariello v. Schacter, [1993] 2 S.C.R. 119; *see also*, Joan Gilmour, *An Overview of Medical Malpractice in Canada*, 3 Annals Health L. 179, 191 (1994).

proach adopted in recent years by English courts, most notably the House of Lords.[43] In England, as in Canada, the concept of "generally approved practice" has figured prominently in determining the standard of care to be expected of medical practitioners. English courts routinely apply what they refer to as the "*Bolam* test,"[44] which dictates that a physician "is not guilty of negligence if [he or she] has acted in accordance with a practice accepted as proper by a responsible body of medical [practitioners] skilled in that particular art."[45] As noted above, this approach gives the medical profession considerable protection from civil liability. However, it also has the potential to do much more than this. The *Bolam* test reflects and reinforces the power of the medical community in general and the power of the individual practitioner within the doctor-patient relationship. If courts extend this test beyond purely malpractice issues into areas of health care decision making in general, the effect will be to significantly expand the power and control of the medical profession over issues that are by no means entirely clinical or scientific in nature.

This appears to be happening in England, where courts are using the *Bolam* test to analyze and resolve critical issues involving control over health care decision making. For example, in *Re F*,[46] the House of Lords held that medical treatment may be given to a mentally incompetent patient without anyone's consent, regardless of whether the situation is one of emergency, so long as the treatment is in the patient's best interests. In determining what is in the patient's best interests, the court focussed on whether the physician acted reasonably in deciding to administer the treatment; the reasonableness was judged by the traditional standard of the reasonable physician in similar circumstances. Thus, if the patient is mentally incompetent, decisions regarding the initiation, continuation, and withdrawal of treatment lie exclusively within the professional judgment of the physician. Perhaps not surprisingly, the decision in *Re F* was

43. *See also* John Hodgson, *Medical Malpractice: An Overview of the English System*, 3 ANNALS HEALTH L. 225, 228 (1994).

44. This takes its name from the leading decision in Bolam v. Friern Hosp. Management Comm., [1957] 2 All E.R. 118 (Q.B.).

45. *Id.* at 122.

46. [1990] 2 A.C. 1 (H.L.).

described by one English commentator as "medical paternalism run amok."[47]

In a similar vein, the House of Lords recently held that the question of whether artificial nutrition and hydration can be withdrawn from a patient in a persistent vegetative state is primarily a medical matter to be determined by reference to prevailing medical opinion.[48] Likewise, in the context of informed consent, England's highest court rejected the "prudent patient" standard of disclosure, preferring instead to view pre-treatment disclosure of risks and other material information as a matter of clinical judgment to be measured by the traditional standard of the reasonable physician.[49] The English trend of enhancing physicians' control over medical decision making is evident in several other areas, including access to contraceptives by minors[50] and sterilization of mentally disabled individuals.[51]

The position taken by the English courts contrasts starkly with the approach adopted by Canadian courts in recent years. The Supreme Court of Canada, as well as provincial appellate courts, have made a number of key decisions that significantly affect the balance of power within the doctor-patient relationship. For example, although the Supreme Court's adoption of the "prudent patient" test for disclosure in the context of informed consent[52] has not had a major effect on the actual outcome of malpractice cases against physicians,[53] it signals a trend of patient autonomy prevailing over medical paternalism and has the potential to af-

47. Michael A. Jones, *Justifying Medical Treatment Without Consent*, 5 PROF. NEGL. 178, 181 (1989). For another criticism, see Phil Fennell, *Inscribing Paternalism in the Law: Consent to Treatment and Mental Disorder*, 17 J.L. & SOC'Y 29 (1990); M.J. Gunn, *Treatment and Mental Handicap*, 16 ANGLO-AM. L. REV. 242 (1987); ALBERTA LAW REFORM INSTITUTE, ADVANCE DIRECTIVES AND SUBSTITUTE DECISION-MAKING IN PERSONAL HEALTH CARE, Report for Discussion No. 11, at 19-20 (1991).

48. Airedale NHS Trust v. Bland, [1993] 1 All E.R. 821 (H.L.).

49. Sidaway v. Board of Governors of the Bethlem Royal Hosp., [1985] A.C. 871 (H.L.). See the critical discussion in Harvey Teff, *Consent to Medical Procedures: Paternalism, Self-Determination or Therapeutic Alliance*, 101 LAW Q. REV. 432 (1985).

50. Gillick v. West Norfolk & Wisbech Area Health Auth., [1986] A.C. 112 (H.L.). For a detailed discussion of this case see IAN KENNEDY, TREAT ME RIGHT: ESSAYS IN MEDICAL LAW AND ETHICS 52, 61 (1988).

51. *See* Re F, [1990] 2 A.C. 1.

52. Reibl v. Hughes, [1980] 2 S.C.R. 880.

53. Plaintiffs fail in approximately eighty-two percent of cases in which they allege a lack of informed consent, primarily because of their inability to prove causation—that is, they are unable to show that a reasonable patient in the plaintiff's position would have declined the treatment if proper disclosure of the risks had been made. *See* Gerald Robertson, *Informed Consent Ten Years Later: The Impact of* Reibl v. Hughes, 70 CAN. B. REV. 423, 428 (1991).

fect profoundly the balance of power within the doctor-patient relationship.[54] Also, Canadian courts have recognized that patients have a constitutionally protected fundamental right to make their own health care decisions, including to refuse life-saving treatment.[55] Likewise, other decisions have altered this balance of power by expanding patients' rights to access their own health care records,[56] prohibiting nontherapeutic sterilization of mentally disabled individuals,[57] and recognizing the validity of advance directives even in the absence of enabling legislation.[58] It remains to be seen whether this theme will also be evident in other areas of medical decision making that have yet to be addressed by Canadian courts, such as the allocation of resources[59] and issues of medical futility.

CONCLUSION

This article outlines some of the defects in the Canadian medical malpractice system, especially those that prevent patients from accessing justice. It seems unlikely that these defects will be remedied in the near future. The Prichard Review did make a number of recommendations that sought to address the problem of access, such as revising the limitations statutes[60] and broadening the availability of legal aid for malpractice plaintiffs. The Prichard Review also recommended that a no-fault com-

54. *See* JAY KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT (1984); Margaret A. Somerville, *Informed Consent: An Introductory Overview*, *in* LAW REFORM COMMISSION OF VICTORIA, INFORMED CONSENT SYMPOSIA 2 (1986); Robertson, *supra* note 53, at 439-40.

55. Rodriguez v. Attorney Gen. of Canada, [1993] 3 S.C.R. 519; Ciarlariello v. Schacter, [1993] 2 S.C.R. 119; Reibl v. Hughes, [1980] 2 S.C.R. 880; Fleming v. Reid, 82 D.L.R.4th 298 (Ont. C.A. 1991); Malette v. Shulman, 67 D.L.R.4th 321 (Ont. C.A. 1990); Nancy B. v. Hôtel-Dieu de Québec, 86 D.L.R.4th 385 (Que. Super. Ct. 1992). In *Fleming* the Ontario Court of Appeal held that certain provisions of the Mental Health Act, R.S.O., ch. 262 (1980) (current version at R.S.O., ch. M-7 (1990)) were contrary to the Canadian Charter of Rights and Freedoms, because they infringed the patient's right to refuse psychiatric treatment.

56. McInerney v. MacDonald, [1992] 2 S.C.R. 138.

57. Eve v. Mrs. E., [1986] 2 S.C.R. 388. For a discussion of the various reactions to this decision, see Gerald Robertson, *Sterilization, Mental Disability, and* Re Eve: *Affirmative Discrimination?*, *in* DISCRIMINATION IN THE LAW AND THE ADMINISTRATION OF JUSTICE 447 (Walter S. Tarnopolsky et al. eds., 1993).

58. Fleming v. Reid, 82 D.L.R.4th 298; Malette v. Shulman, 67 D.L.R.4th 321.

59. See the interesting discussion in Robert Lee, *Doctors as Allocators: The Bald Facts*, *in* LAW, HEALTH & MEDICAL REGULATION 169, 180-87 (Sally Wheeler & Shaun McVeigh eds., 1992).

60. The recommendation was for a six year limitation period, running from the date of discovery, subject to a maximum of ten years from the date when the services were rendered. PRICHARD REPORT, *supra* note 7, at 21.

pensation scheme be introduced as an alternative to the tort system for those suffering "significant avoidable health care injuries," which system would require the patient to elect between accepting no-fault compensation or pursuing a negligence action.[61] However, in the three years since the Prichard Review issued its report, there has been no indication of any interest by the provincial governments to implement the recommendations contained in the report.

At the same time, however, it is likely that there will continue to be an escalation in the two factors that influenced the commissioning of the Prichard Review: 1) government concern over the cost of the present malpractice system and its possible negative impact on the quality of health care in Canada, and 2) the medical profession's dissatisfaction with the effect of the present system on its members. The recent trend in Canadian case law toward disempowering physicians in matters of medical decision making will certainly enhance such feelings of dissatisfaction. In time, these two factors may well force Canadian governments to give serious consideration to implementing some of the recommendations of the Prichard Review.

61. *Id.* at 28-30. For a discussion of the Prichard Review's recommendations see Bernard M. Dickens, *Implications of Health Professionals' Legal Liability*, 1 HEALTH L.J. 1 (1992).