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Overview of Medical Malpractice Law in Canada

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INTRODUCTION

In Canada, as in the United States, there is a perception that the country is in the throes of a malpractice "crisis" involving both liability and insurance issues—health care providers perceive an increased exposure to or risk of legal liability for ever larger amounts of money. However, claims data from the two countries vary widely, in part because of procedural and doctrinal difference between the two legal systems. In order to assess that claim of a crisis and evaluate recent developments in medical malpractice law, this article will first explore the context in which health care is provided and the liability insurance arrangements in Canadian health care.

I. DIFFERENCES IN CONTEXT—HEALTH CARE AND LIABILITY COVERAGE IN CANADA

Under the Canada Health Act,[1] legal residents of Canada are entitled to health care. Both the federal and provincial levels of government fund the health care system through program cost-sharing.[2] For the most part, health care services are paid for out of general tax revenues, although there are also provisions for collecting some contribution to the cost of provincial health care plans from provincial residents. These arrangements vary from

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1. Canada Health Act of 1984, R.S.C., ch. C-6, § 3 (1985).

2. *Id.*, §§ 5-12; Federal-Provincial Fiscal Arrangements and Established Programs Financing Act of 1977, 1976-77 S.C., ch. 10, *amended by* 1980-81-82-83 S.C., ch. 94 [hereinafter Established Programs Financing Act].

province to province.[3] The health care program primarily covers hospital and medical care and diagnostic services.

The Canada Health Act establishes five criteria that provincial health insurance plans must meet: they must be comprehensive, universal, accessible, portable, and publicly administered.[4] The federal government enforces these requirements through the use of the carrot and stick of transfer payments, which are funds paid to the provincial governments to assist them in funding the provision of health care and education.[5] If a province fails to meet its obligations with respect to the type of health care program it is supposed to make available, then its transfer payments from the federal government can be reduced or withheld.[6] Noncompliance, then, though not illegal, is costly.

In practical terms, this means that the residents of each province have access to needed medical services, and that patients do not pay providers (physicians or hospitals) directly. The existence of provincial health insurance plans has not, however, altered either the contractual basis on which health care is

3. In Ontario, for instance, there is now an employer tax levied to pay for part of the cost of health care, which was recently extended to those who are self-employed. *See* Tom Kingisepp, *Self-employed in Ontario Face Payroll Tax Deadline*, TORONTO GLOBE & MAIL, Oct. 18, 1993, at B6. This tax replaces a system of modest premiums paid by provincial residents.

4. R.S.C., ch. C-6, § 7.

5. *Id.*, §§ 4-7. *See also* Established Programs Financing Act. The transfers are made up of a combination of tax points and cash. Despite the guarantees of universality and portability, there are variations among provinces and within individual provinces with respect to access to services and resources spent on health care. *See, e.g.*, Paul Barker, *Medicare, Meech Lake and the Federal Spending Power*, 5 CAN. J. L. & SOC'Y 111, 118-123 (1990). In R. v. S. (S.), [1990] 2 S.C.R. 254, the Supreme Court of Canada held that variation among provinces in sentencing options for young offenders did not violate constitutional equality rights where the legislation left the provincial Attorneys-General discretion in that regard. This may suggest a similar scope for variation among provincial health care plans. *See also* Finlay v. Canada (Minister of Finance), [1993] 1 S.C.R. 1080 (conditions attached to the federal government's contribution to provincial expenditures under a federal spending statute are not designed to dictate the precise terms of provincial legislation, but rather to promote legislation that achieves substantial compliance with the federal legislative objectives).

6. The incentive to comply with the Canada Health Act may be disappearing in the wake of federal government restraint measures that will result in the cash portion of its transfer payments to the provinces disappearing entirely in the near future, leaving it with no way to entice compliance or punish deviation. *See* NATIONAL COUNCIL OF WELFARE (CANADA), FUNDING HEALTH AND HIGHER EDUCATION: DANGER LOOMING 19 (1991); Reference re Canada Assistance Plan, [1991] 2 S.C.R. 526 (federal government acted constitutionally in cutting expenditures and limiting growth of payments to financially stronger provinces by statutory amendment to the Canada Assistance Plan).

delivered or the method of physician remuneration. Although there are other models of payment—for example, clinics with salaried physicians and health service organizations where physicians are paid on a capitation basis—by far the majority of physicians in Canada are paid by the provincial health insurance plans on a fee-for-service basis.

There is no upper limit on the cost or amount of needed health services that patients can receive. However, the provincial health insurance plans do not provide blanket coverage, and as financial pressures on government health care budgets grow, the list of uninsured services grows. There are also concerns that with increased financial restraints, needed medical services will not be readily available, even if they are insured.[7] In addition to insured services, there is a growing private market that provides services not insured under the provincial system.[8] Despite these exceptions and budgetary restraints, it is still fair to say that, as one author has noted, "[t]he contemporary understanding in Canada [is] of health care as a fundamental aspect of public welfare accessible to every citizen [actually, legal resident] as of right."[9]

Funding is not the only aspect of Canada's health care system that differs from that in the United States: liability insurance arrangements are different as well. Some ninety percent or more of all active civilian physicians in Canada belong to one medical defence organization, the Canadian Medical Protective Association (C.M.P.A.), a nonprofit entity owned and operated by its physician-members since 1901.[10] The C.M.P.A. is techni-

7. This has, in fact, gone beyond the point of concern to litigation. *See, e.g.*, Sallis v. Vancouver Gen. Hosp., No. 907316 (B.C.S.C. filed Nov. 8, 1990) (alleging that the wait a patient endured before needed surgery was performed to replace a worn-out artificial valve in her heart resulted in her otherwise avoidable death).

8. This would include insurance to cover prescription drugs or the extra cost of semiprivate and private hospital accommodation. There is growing concern over private offerings of otherwise publicly funded services, such as nuclear magnetic resonance imaging. *See, e.g.*, Rod Mickleburgh, *Ottawa Warns Alberta About Billing Patients*, TORONTO GLOBE & MAIL, Nov. 24, 1993, at A5.

9. Hester Lessard, *The Construction of Health Care and the Ideology of the Private in Canadian Constitutional Law*, 2 ANNALS HEALTH L. 121, 147 (1993). Health, though, is still related to economic status, and the health gap stubbornly persists. *See, e.g.*, NATIONAL COUNCIL OF WELFARE (CANADA), HEALTH, HEALTH CARE AND MEDICARE (1990); Margaret A. Shone, *Health, Poverty and the Elderly: Can the Courts Make a Difference?*, 29 ALTA. L. REV. 839 (1991).

10. 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 app. A at 58 (1990) [hereafter PRICHARD REPORT].

cally not an insurance company, as it does not sell insurance and it has the discretion to refuse claims.[11] In practice, however, it acts like an insurer in that it fully indemnifies its members against damages and legal costs associated with malpractice claims, it represents members in some professional disciplinary and other regulatory proceedings and inquests, and it provides advice on legal issues that arise in the course of medical practice.[12] There is no deductible and no cap on the settlements and awards that the C.M.P.A. will pay. Hospitals have generally shifted towards self-insurance in the past few years, and nurses recently set up a protective society similar to that of physicians.[13]

Since 1984, the C.M.P.A. has charged membership fees, which differ by the physician's area of practice and the risk associated with it.[14] Fees now range from $1,044 (Can.) per year for pathologists and medical administrators to more than $17,000 (Can.) a year for orthopedic surgeons and neurosurgeons.[15] However, provincial medical associations and governments have negotiated arrangements providing for a public contribution intended to reimburse physicians fully or partially for C.M.P.A. dues or other malpractice insurance premiums paid.[16]

When compared with the United States, concerns about a malpractice crisis in Canada seem overblown. The C.M.P.A. has a membership of more than 55,000 doctors. In 1992, 73 malpractice actions against physicians went to trial in Canada, and 48 of those were resolved in favour of the physician; in 1991, physicians prevailed in 47 of the 61 cases that went to trial.[17] In 1992, the amount of money paid by the C.M.P.A. for settlements and damage awards at trial fell 9.6 percent, from $45,613,000

11. Patricia M. Danzon, *The "Crisis" in Medical Malpractice: A Comparison of Trends in the United States, Canada, the United Kingdom and Australia*, 18 LAW, MED. & HEALTH CARE 48, 55 (1990); Gerald Robertson, *Reform of the Law of Medical Liability: The Position in the Common Law Jurisdictions of Canada*, *in* CANADIAN COMPARATIVE LAW ASSOCIATION, CONTEMPORARY LAW 173, 186 (1992).

12. PRICHARD REPORT, *supra* note 10, app. A at 58-59.

13. *Id.*, app. A at 63-64.

14. Robertson, *supra* note 11, at 186; Bernard H. Dickens, *Implications of Health Professionals' Legal Liability*, 1 HEALTH L.J. 1, 2 (1993).

15. Matt Borsellino, *Everything You Always Wanted to Know About the CMPA But Were Afraid to Ask*, MEDICAL POST, June 8, 1993, at 47.

16. Dickens, *supra* note 14, at 3; PRICHARD REPORT, *supra* note 10, app. A at 60.

17. In 1990, physicians' defences prevailed in fifty-one out of seventy-seven cases; in 1989, thirty-two of fifty-eight claims were successfully defended at trial. CANADIAN MEDICAL PROTECTIVE ASSOCIATION, NINETY-SECOND ANNUAL REPORT 18 (1993) [hereinafter C.M.P.A. REPORT].

(Can.) in 1991 (an average of $193,275 (Can.) per claim) to $41,204,000 (Can.) in 1992 (an average of $134,654 (Can.) per claim).[18] These reduced amounts are in part the result of an increase in the number of settlements, from 236 in 1991 to 306 in 1992.[19] The change from 1991 to 1992 cannot necessarily be taken as indicative of a trend; results vary dramatically on a year-to-year basis because of the relatively small absolute number of claims. Nonetheless, the perception of a "crisis"—exponential increases in awards and in the success of plaintiffs at trial—is not borne out by the claims experience. Still, it is true that Canada has seen significant increases in the frequency and severity of claims brought against physicians as well as in the rates paid for C.M.P.A. membership, which are in effect the "insurance premiums."[20]

Several procedural and doctrinal distinctions between the Canadian and United States legal systems explain in part the difference in the medical malpractice experience in the two countries.

II. Differences in Procedure

Canada's legal system in general, and the tort system in particular, operates differently than that of the United States; the procedural differences are important to understand to properly evaluate the claims experiences of both nations.[21]

18. *Id.* at 31; *see also* Ken Pole, *CMPA Settlements Down Sharply From Last Year*, Medical Post, Aug. 24, 1993, at 33.

19. C.M.P.A. Report, *supra* note 17, at 18.

20. Prichard Report, *supra* note 10, app. A at 28-31, 59. Physicians are still much more likely to be sued for malpractice in the United States than in Canada. Danzon, *supra* note 11, at 50. Danzon also suggests that, at least in 1988 when she was writing, claim severity or average payment per claim was not so different between the two countries, although she added that these figures may be misleading. Absent the deterrent effect of costs sanctions in the United States, greater numbers of minor claims may be asserted (exerting downward pressure on claim severity), while at the same time, American awards build in contingent fee payment (exerting upward pressure on claim severity). *Id.* at 56. *But see* Theodore R. LeBlang, *Medical Malpractice and Physician Accountability: Trends in the Courts and Legislative Responses*, 3 Annals Health L. 105, 105 (1994) (citing more recent figures indicating a new round of increases in the median verdict for malpractice claims for the period from 1987 through 1991 in the United States).

21. *See, e.g.*, Peter C. Coyte et al., *Medical Malpractice—The Canadian Experience*, 324 N. Eng. J. Med. 89, 92 (1991); Prichard Report, *supra* note 10, app. A at 10-11.

A. *Judge as Opposed to Jury as Trier of the Case*

A Canadian tort case is typically determined by a judge alone and not by a civil jury. Although it used to be assumed almost as a matter of course that the facts and issues in medical malpractice cases were too complex to be left to juries, this perception has now changed to the point that today a jury notice served in a malpractice action is no longer struck out as a matter of course if attacked.[22] Nonetheless, juries are still not widely chosen by plaintiffs' counsel, and even less so by defendants' counsel.

B. *Contingent Fees*

The contingency fee system is not used as widely in Canada as in the United States to determine legal fees. In fact, this system is prohibited in Ontario except in class actions. Where available, contingency fee arrangements tend to be closely and carefully regulated and supervised, and in some instances, their availability is tightly circumscribed.[23]

C. *Bearing the Cost of Litigation*

In Canada, which has adopted the British rule that costs follow the event, the loser in a civil lawsuit must compensate the winner for a portion of the latter's legal costs. In contrast, in the United States, each side generally bears its own costs. Costs do not amount to full compensation, and the proportion of the winner's legal bill covered by an award of costs decreases over time as legal fees continue to rise. Nonetheless, an award of costs can add up to a very significant amount of money that an unsuccessful defendant must pay in addition to an award of damages, or that an unsuccessful plaintiff must pay in addition to his or her own lawyer's fees.[24] The possibility of having to pay the other

22. Relative to the availability of a jury trial, in Ontario, see the Courts of Justice Act, R.S.O., ch. C-43, § 108 (1990) and ONT. R. CIV. P. 47. *See also* Soldwisch v. Toronto W. Hosp., 43 O.R.2d 449 (Div. Ct. 1993) (the practice of automatically setting aside the jury notice in a medical malpractice action is not legally supportable; the judge must decide whether retention or discharge of the jury will better serve justice to the litigants).

23. John D. Wilson, *The Costs of Medical Malpractice Litigation in Canada: Evidence and Proposals for Reform, in* PRICHARD REPORT, *supra* note 10, app. B, vol. 3, ch. 7 at 39-46.

24. ATTORNEY GENERAL OF ONTARIO, THE REPORT OF THE ONTARIO COURTS INQUIRY (ZUBER INQUIRY) 51-52 (1987). In Ontario, *see, e.g.*, Courts of Justice Act, R.S.O., ch. C-43, § 131 (1990) and ONT. R. CIV. P. 49.

side's costs can deter a party from commencing a lawsuit as well as encourage the party to settle the action.

D. Class Actions

While class actions are used to resolve allegations of a defective medical product in the United States, in many jurisdictions in Canada, class actions are effectively unavailable except in very limited circumstances. Even minor differences among claims are sufficient to disqualify them under the provincial rules governing such proceedings.[25] However, class actions have recently become more widely available in Ontario through the passage of the Class Proceedings Act, which greatly liberalized the rules governing such proceedings.[26] Under the new legislation, it is even possible to obtain some funding to assist plaintiffs in carrying a certified class action forward.[27] The ability to join together in an action and obtain financial assistance may ease some access problems. Where the claim involves a manufacturer's alleged failure to warn, the physician will typically be joined in the action either as an additional defendant or a third party since manufacturers commonly assert that any failure to warn was the physician's. With liberalized class action laws, increasing numbers of such claims may be expected. For example, recently in Ontario, a class of recipients of breast implants alleging damages against McGhan Medical Corporation and Dow Corning Inc. was certified.[28]

E. Awards

Awards for pain and suffering, which are a major component of personal injury awards in the United States, are subject to a relatively modest judicially imposed cap in Canada. In a trilogy of decisions released fifteen years ago, the Supreme Court of Canada capped nonpecuniary damages at $100,000 (Can.) (in 1978 dollars). The court reasoned that no amount of money could ever truly compensate for the nonpecuniary element of catastrophic injury although it can provide "solace," not in the sense of sympathy, but rather through "physical arrangements

25. Naken v. General Motors Can. Ltd., 144 D.L.R.3d 385 (S.C.C. 1983).
26. Class Proceedings Act, S.O., ch. 6 (1992).
27. Law Society Amendment Act (Class Proceedings Funding), S.O., ch. 7, §§ 2, 3 (1992); R.O. 771/92 (1992).
28. Bendall v. McGhan Medical Corp., 14 O.R.3d 734 (Gen. Div. 1993).

to make life more endurable" above and beyond those relating directly to the injuries.[29]

The absolute dollar amount that courts can award in nonpecuniary damages continues to be adjusted for inflation, such that by the 1990s, it was approximately $220,000 (Can.).[30] The concept of a cap, however, remains firmly in place. Total amounts awarded have also been affected by the increased sophistication of the evidence used to establish the real costs of the injury (such as lost income and cost of future care) and by the need to take into account the future income tax liability on investment income generated by the amount awarded.[31]

F. Discount Rates

Discount rates employed to convert foregone future income to present value for purposes of a lump sum award seem subject to wide variations in judicial practice in the United States; however, Ontario and other Canadian provinces follow a standardized rate.[32]

G. Punitive Damages

Punitive or exemplary damages are very rarely granted by Canadian courts, but may constitute a significant component of damage awards in the United States. In Canada, a distinction is drawn between aggravated damages and punitive damages. Aggravated damages do not supplement general damages; rather, the amount of general damages takes into account and is increased by "any aggravating features of the case."[33] Aggravated damages are still meant to compensate. On the other hand, punitive damages are not compensatory; they are awarded to punish the defendant and to make an example of him or her in order to deter others from engaging in the same or similar con-

29. Thornton v. School Dist. No. 57 (Prince George), [1978] 2 S.C.R. 267; Andrews v. Grand & Toy Alta. Ltd., [1978] 2 S.C.R. 229; Arnold v. Teno, [1978] 2 S.C.R. 287. On the advantages and disadvantages of capping damages, see Wilson, *supra* note 23, at 116-118. *See also* Samuel A. Rea, Jr., *Economic Perspectives on the Liability Crisis*, *in* LAW SOCIETY OF UPPER CANADA, INSURANCE LAW 1 (1987).

30. Bernard Dickens, *The Effects of Legal Liability on Physicians' Services*, 41 U. TORONTO L.J. 168, 173 n.267 (1991). *See also* Rea, *supra* note 29, at 7-8.

31. Rea, *supra* note 29, at 6-8.

32. On the effect of various discount rates, see *id.* at 5-6.

33. Norberg v. Wynrib, [1992] 2 S.C.R. 224, 263 (*per* La Forest, J., Gonthier and Cory, JJ., concurring).

duct.[34] The defendant's conduct must have been egregious in the extreme and morally as well as legally wrong before courts will award punitive damages.

H. Statutes of Limitations

Limitation periods in Canada are often subject to a discovery rule.[35] Further, they will be held in abeyance for minors and individuals who are decisionally incapable.[36]

I. Regional Diversity

There is a marked coherence in cases decided in the common law jurisdictions in Canada, in part because of the role played by the Supreme Court of Canada. The Supreme Court of the United States generally does not hear appeals on matters of purely state law, which includes most aspects of tort law, thus creating the potential for substantial diversity of doctrine among the states and consequent uncertainty for insurers operating in a number of state markets. Canada does not distinguish between state and federal courts in the same way as the United States does.[37] The Supreme Court of Canada sits as the highest court of appeal from each province. That does not mean that any appeal can be taken to the Supreme Court; in a civil lawsuit, leave must still be obtained.[38] However, the Court will hear appeals in disputes between private individuals if in its opinion the action raises issues of public importance that go beyond the particular dispute and the interests of the parties, or where the case

34. [P]unitive damages may only be awarded in respect of conduct which is of such nature as to be deserving of punishment because of its harsh, vindictive, reprehensible and malicious nature. I do not suggest that I have exhausted the adjectives which could describe the conduct capable of characterizing a punitive award, but in any case where such an award is made the conduct must be extreme in its nature and such that by any reasonable standard it is deserving of full condemnation and punishment.

Id. at 263-64 (citing Vorvis v. Insurance Corp. of B.C., [1989] 1 S.C.R. 1085, 1107-1108 (*per* McIntyre, J.).

35. City of Kamloops v. Neilson, [1984] 2 S.C.R. 2; Central Trust Co. v. Rafuse, [1986] 2 S.C.R. 147.

36. Papamonopoulos v. Board of Educ. for the City of Toronto, 30 D.L.R.4th 269 (Ont. C.A. 1986); Swain v. Lake of the Woods Dist. Hosp., 9 O.R.3d 74 (C.A. 1992); Martin v. Listowel Memorial Hosp., 9 O.R.3d 65 (C.A. 1992).

37. In Canada, the Federal Court has quite limited jurisdiction. *See* Federal Court Act, R.S.C., ch. F-7, §§ 17-35, *as amended by* 1990 S.C., ch. 8.

38. Supreme Court Act, R.S.C., ch. S-26, §§ 35-43 (1985).

presents issues of law or issues of mixed law and fact that are of sufficient importance to warrant its decision.[39]

In the last four years, for instance, the Court handed down decisions in cases raising a number of medical liability issues: whether a fresh informed consent had to be obtained from a patient who withdrew consent in the midst of a medical procedure;[40] who owned and could have access to a patient's medical records;[41] and which party bore the burden of proof, and how could that burden be discharged in a medical malpractice case when the expert evidence as to causation was not definitive.[42] In Canada, the Supreme Court is a real influence for uniformity and certainty in shaping doctrine with respect to medical liability.

J. Damage Calculations

Courts in Canada and in the United States may employ different methods of calculating damages for personal injuries. With respect to the issue of collateral benefits, the Supreme Court of Canada made a first attempt to limit "double recovery" in 1990. In *Ratych v. Bloomer*,[43] a five-to-four decision, the Court held that a plaintiff who continues to receive wages following an injury cannot recover lost earnings. If lost wages are provided by gift or pursuant to an insurance contract paid for by the plaintiff (a quid pro quo), or if the employer has a right of subrogation, the damages for lost wages would be recovered. This decision was an understandable response to concerns about the overall cost of compensation, and made sense on theoretical grounds because tort law seeks to ensure that an individual is compensated for the full amount of his or her losses—no more and no less. However, in practice, it is often very difficult to be sure

39. *Id.* § 40. Examples would include the trilogy of cases capping nonpecuniary damages. Thornton v. School Dist. No. 57 (Prince George), [1978] 2 S.C.R. 267; Andrews v. Grand & Toy Alta. Ltd., [1978] 2 S.C.R. 229; Arnold v. Teno, [1978] 2 S.C.R. 287.

40. Ciarlariello v. Schachter, [1993] 2 S.C.R. 119 (if a patient withdraws consent, the patient may reconsent to the procedure after all risks and changes are explained).

41. McInerney v. MacDonald, [1992] 2 S.C.R. 138 (when a patient requests medical records, a copy of the computer file must be given to the patient, even if it contains reports from other physicians; all information on which the doctor based his or her medical decisions should be made available to the patient).

42. Snell v. Farrell, [1990] 2 S.C.R. 311 (the burden is on the plaintiff to show causation; expert evidence is not required to prove certainty). *See also* Laferrière v. Lawson, [1991] 1 S.C.R. 541 (causation in law is not the same as causation in science, and it is established by a balancing of probabilities).

43. 69 D.L.R.4th 25 (S.C.C. 1990).

that the plaintiff has *not* paid a quid pro quo for the benefit, for example by accepting lower wages or some other less favourable condition of employment.[44]

Thus, Canadians may find more barriers to bringing a claim to court, and even when they succeed, they will find they are able to recover less than their American counterparts. There are also a number of substantive issues that bear on the differences in the claims experiences of the two countries as well.

III. Developments in the Substantive Law in Canada

A. The Duty of Care

In the common law jurisdictions of Canada, the ordinary laws of civil liability—the law of negligence—govern compensation for medical accidents or mishaps, although other civil wrongs such as battery, breach of contract, and breach of fiduciary duty may apply.[45] In Quebec, the civil law governs. While some elements of the common law have influenced Quebec's civil law system, and the rules of evidence are similar, the sources, methodology, and legal reasoning relied on in the civil and common law systems are fundamentally different.[46] This section will consider the developments in the substantive law in the other nine provinces and two territories of Canada, all of which are common law jurisdictions.

Generally, the legal principles that apply in determining liability for medical negligence in Canada are the same as those that govern other types of negligence claims for damages for personal injury. In broad terms, there is no great difference in the basic principles of negligence law in Canada and the United States. The plaintiff must establish that the defendant owed him

44. *Id.* at 35 (Cory, J., dissenting). Since the writing of the article, the Supreme Court retreated from this position in Cunningham v. Wheeler, [1994] 1 S.C.R. 359.

45. The applicability of recovery for battery was somewhat circumscribed by the Supreme Court of Canada in its decision in Reibl v. Hughes, [1980] 2 S.C.R. 880, where it was determined that a failure to obtain the patient's informed consent to a medical procedure sounded in negligence rather than battery. The latter is still available as an avenue for recovery if properly pleaded. *See, e.g.*, Allen v. New Mount Sinai Hosp., 28 O.R.2d 356 (H.C. 1980), *rev'd* 33 O.R.2d 603 (C.A. 1981) (allowing plaintiff to amend his complaint); Norberg v. Wynrib, [1992] 2 S.C.R. 224 (a sexual assault of a drug addicted patient is a battery).

46. Relative to civil law developments in Quebec, see Prichard Report, *supra* note 10, app. A at 17-18; Jean-Louis Baudouin, *Aperçus du droit québecois de la responsabilité civile médicale: Perspectives et prospectives*, *in id.*, app. B, vol. 1, ch. 2.

or her a duty of care, that the defendant breached this duty, and that the defendant's breach caused the plaintiff to suffer injury.[47]

The physician has a duty to exercise reasonable care in treating a patient. The plaintiff alleging medical negligence must prove that the physician's conduct fell below the applicable standard of care, described as "that degree of care and skill which could reasonably be expected of a normal, prudent practitioner of the same experience and standing."[48] Courts take into account concepts such as accepted medical practice, error of clinical judgment, and the "two schools of thought" or "respectable minority" principle in determining whether the physician has breached the standard of care.[49]

Despite the fact that changes in technology and other advances have made it more difficult for physicians to *meet* the standard of care (greater care and more skill is expected of the "normal, prudent practitioner"), the standard itself has remained essentially the same over the last two decades.[50] There has, however, been some expansion in the group of individuals to whom a duty of care is owed, although this expansion has not been uniform. For instance, it has been held that where a physician is under a statutory obligation to report to the provincial authorities any patient whom he or she considers unfit to drive, a physician who fails to report breaches the standard of care owed not only to the patient but also to the general public. An individual who is injured as a result of the patient driving has an action against the physician.[51] In provinces where physicians have discretion as to whether or not to report a patient, courts have not imposed liability for failure to report even when an accident followed.[52]

The standard of care applicable to hospitals has developed in a similar manner. A hospital may be liable in negligence either

47. ELLEN I. PICARD, LEGAL LIABILITY OF DOCTORS AND HOSPITALS IN CANADA 150 (2d ed. 1984).

48. Crits v. Sylvester, [1956] O.R. 132, 143 (C.A.), *aff'd*, [1956] S.C.R. 991; *see also* Robertson, *supra* note 11, at 175 n.8; PICARD, *supra* note 47, at 154.

49. Robertson, *supra* note 11, at 175.

50. A view shared by Robertson, *id.* at 175, 178, and in the United States by PAUL C. WEILER, MEDICAL MALPRACTICE ON TRIAL 25 (1991).

51. *See, e.g.*, Spillane v. Wasserman, 13 C.C.L. T.2d 267 (Ont. Ct. Gen. Div. 1993) (non-compliant epileptic patient suffered seizure while driving and killed a cyclist; physicians held forty percent liable for the accident for their failure to monitor the patient's compliance appropriately, failure to recognize he was unfit to drive, and failure to report).

52. C.M.P.A. REPORT, *supra* note 17, at 26-27.

directly for breaching a duty it owes to a patient or vicariously for the negligence of others. As with doctors, with respect to a hospital's direct liability, the hospital's obligations to meet the requisite standard of care have become more onerous as the scope of the hospital's duties has widened to include, for instance, liability for defects in its system to ensure proper and timely patient care.[53] With respect to vicarious liability, Canadian courts have so far held the line and continued to accept the argument that physicians (other than residents and interns) are independent contractors rather than employees of the hospital.[54] Consequently, the hospital is not vicariously liable for physician negligence. This doctrine is outmoded, particularly since, as Ellen Picard has noted, physicians are among the professionals who "facilitate the achievement of hospital objectives."[55] Still, courts have not extended hospitals' corporate responsibility, at least not yet.

B. Informed Consent

The law of informed consent has undergone the most significant doctrinal development in Canadian health law over the last fifteen years. However, the effect that these changes in theory have had on the real world, including physician behaviour and judicial decisions about liability, has been considerably muted.[56] In *Reibl v. Hughes*, a seminal informed consent decision, the Supreme Court of Canada, in determining what information a physician must disclose to a patient to assure that consent was informed, abandoned the traditional test of what a reasonable physician would disclose in favor of a test of what a reasonable person in the patient's position would want to know—that is, the physician must disclose all material risks.[57] Factors peculiar

53. Robertson, *supra* note 11, at 182; Bruce Chapman, *Controlling the Costs of Medical Malpractice: An Argument for Strict Hospital Liability*, *in* PRICHARD REPORT, *supra* note 10, app. B, vol. 3, ch. 8 at 4-6.

54. Yepremian v. Scarborough Gen. Hosp., 110 D.L.R.3d 513 (Ont. C.A. 1980). Leave to appeal to the Supreme Court of Canada was granted in this case, but a settlement was reached before the appeal could be heard. Chapman, *supra* note 53.

55. Ellen Picard, *The Liability of Hospitals in Common Law Canada*, 26 MCGILL L.J. 997, 1019 (1981). *See also* Robertson, *supra* note 11, at 183-84.

56. *See* Barry S. Wortzman, *Professional Liability—Health Care Providers*, *in* LAW SOCIETY OF UPPER CANADA, TORTS IN THE 80s 417, 423 (1983); Gerald Robertson, *Informed Consent Ten Years Later: The Impact of* Reibl v. Hughes, 70 CAN. B. REV. 423 (1991) (analyzing the basis for and outcomes in judicial decisions since *Reibl v. Hughes*).

57. [1980] 2 S.C.R. 880, 898-900. American jurisprudence has been very influential in this respect. For instance, Laskin, J., cited and relied on Canterbury v. Spence,

to the patient, such as length of time until retirement or family obligations, could affect the type of information the physician should impart to the patient. At least to some extent, then, what the patient must be told has to be tailor-made to that patient and responsive to his or her circumstances.

Reibl wrought a second change in the doctrine of informed consent, the test for causation. Unlike the subjective test for physician disclosure, courts do not consider whether *this* particular patient would have undergone the treatment if properly informed. Rather, the test is whether a *reasonable person in the patient's position* would have declined the treatment if he or she had been apprised of the relevant information.[58]

Although the decision in *Reibl v. Hughes* immediately generated much interest among lawyers and legal academic writers, its effect on physicians has been more delayed and diluted, and the outcomes in actual cases have changed little. *Reibl* was decided in 1980; a 1984 study indicated that even among surgeons aware of the decision and its importance, most had not altered their practices relative to disclosure of risks to patients.[59] Many still ranked their own views of patients' best interests well ahead of the fact that patients would probably regard the risk as relevant to their decisions to undergo treatment.[60] Evidence from a recent study suggests that physicians are now spending more time with patients discussing the risks and benefits of treatment, largely because of their fear of legal liability. However, as the author of the latter study noted, "increased quantity of interactive time does not guarantee the quality of discourse and critical information exchange."[61]

The effect of *Reibl* on the outcomes in litigation has not been striking. Most informed consent claims that go to trial do not succeed, at least not on that basis.[62] The analysis employed in the cases follows that outlined by the Supreme Court of Canada in *Reibl*. However, even where physicians failed to meet the full

464 F.2d 772 (D.C. Cir. 1972) in *Reibl*. *See also* Hopp v. Lepp, 112 D.L.R.3d 67 (S.C.C. 1980).

58. [1980] 2 S.C.R. at 899. *Reibl* was recently confirmed by the Supreme Court of Canada in Ciarlariello v. Schachter, [1993] 2 S.C.R. 119 (the critical question remains what the patient would want to know).

59. Gerald B. Robertson, *Informed Consent in Canada: An Empirical Study*, 22 OSGOODE HALL L. J. 139, 146 (1984).

60. *Id.* at 147, 159-160.

61. Bernard Dickens, *The Effects of Legal Liability on Health Care Providers, in* PRICHARD REPORT, *supra* note 10, app. B., vol. 2 at 51.

62. Robertson, *supra* note 11, at 179.

disclosure standard, courts have often found that the patient would nonetheless have gone ahead with the procedure had he or she been fully informed. The stumbling block to plaintiffs' recovery has become an inability to prove causation—that is, that with adequate disclosure they would not have consented.[63]

C. *The Doctor-Patient Relationship*

Whether plaintiffs' inability to capitalize on *Reibl* may be altered by changing characterizations of the doctor-patient relationship and the obligations it subsumes is a question raised inferentially by two recent Supreme Court of Canada decisions, *McInerney v. MacDonald*[64] and *Norberg v. Wynrib*.[65] In both cases, the judicial characterization of the doctor-patient relationship is broadened from one based solely on contract to one giving rise to fiduciary obligations on the part of the doctor, at least for particular purposes and in particular contexts. Whether these changes will be extended to the doctor-patient relationship at large is unclear as yet, although in this writer's view, it is likely that any extension of the special obligations entailed in a fiduciary relationship will be quite limited.

Norberg and *McInerney* were released within a week of each other, in June, 1992. The physician-patient relation was classified as fiduciary in nature by the whole Court in the first decision, *McInerney*,[66] and by two members of the Court in an opinion concurring as to liability in *Norberg*.[67] The remaining justices in *Norberg* found it unnecessary to consider whether the relationship was fiduciary given the type of claim that was asserted (battery).[68]

In *McInerney*, the Court had to determine whether a patient was entitled to inspect and obtain copies of all of her medical records from her physician, including those that originated with other doctors. La Forest, J., with Gonthier and Cory, JJ., concurring, held that because of the trust and confidence that the

63. Wortzman, *supra* note 56; Robertson, *supra* note 11, at 179-180. But most recently, see Hollis v. Birch, 81 B.C.L.J.2d 1 (C.A. 1993) (defendant manufacturer held liable for negligence in failing to warn since a reasonable person in plaintiff's position would not have consented to the procedure had full disclosure of the risks associated with breast implants been disclosed).

64. [1992] 2 S.C.R. 138.

65. [1992] 2 S.C.R. 224.

66. [1992] 2 S.C.R. 138, 149.

67. [1992] 2 S.C.R. 224, 271.

68. *Id.* at 249, 306.

patient places in his or her physician by virtue of the very nature of the relationship, this relationship must be considered fiduciary in character, at least for the purpose of determining the physician's obligations with respect to information received from or about a patient in confidence in the course of their professional relationship.[69] Even though the patient's records were not her *property* in the classic sense, the Court was prepared to hold that the information was still fundamentally his or her own because the patient has a "trust-like" beneficial interest in the information in the physician's possession. Thus, the physician had a fiduciary duty to provide the patient access to those records, subject to very limited exceptions when disclosure would not be in the patient's best interests or might harm third parties.[70] At the same time, the Court expressed some caution about applying a fiduciary analysis to the physician-patient relationship in general. Noting that even though the relationship was fiduciary in this context, the Court was not establishing a fixed set of rules and principles applicable in all circumstances or to all of the obligations that arise out of a relationship.[71] Thus, the relationship can be considered fiduciary for some purposes and not for others.[72] The Court shed no further light on the parameters of the physician's fiduciary obligation or the circumstances in which it might apply.

One week after *McInerney*, the Court released its decision in *Norberg v. Wynrib*, a civil action for battery. The patient sought damages for injuries she suffered as a result of a sex-for-drugs arrangement with her doctor. She was addicted to painkillers and tranquilizers, and the doctor prescribed them for her in return for sexual contact. The Court was unanimous in holding that the patient was entitled to recover damages, although each of the Court's three opinions based the plaintiff's right on different grounds.

La Forest, J., with Gonthier and Cory, JJ., concurring, focused on the presence or absence of consent, as consent is a defence to battery. Because of the marked inequality of power between the parties and the plaintiff's dependence on her doctor, which he exploited, La Forest, J., found that the plaintiff's consent to the arrangement was legally ineffective.[73] The analysis bor-

69. [1992] 2 S.C.R. 138, 149-50, 152.
70. *Id.* at 150-51, 158.
71. *Id.* at 149.
72. *Id.*
73. [1992] 2 S.C.R. 224, 250.

rowed heavily from the doctrine of unconscionability used to address the issue of voluntariness in contract law. Since a fiduciary or confidential relationship was not necessary to support a claim based on inequality of bargaining power, La Forest, J., chose to express no opinion on this point, although he noted that "such a relationship may be present."[74]

Sopinka, J., with Stevenson, J., concurring, held that the physician breached the contractual duty he owed his patient to ensure that her addiction was properly treated. With respect to the existence of a fiduciary duty, Sopinka, J., held that while certain obligations that arise from a doctor-patient relationship are fiduciary, others are contractual or based on the "neighbourhood principle" that underlies the law of negligence, adding that "[f]iduciary duties should not be superimposed on these common law duties simply to improve the nature or extent of the remedy."[75]

However, McLachlin, J., with L'Heureux-Dubé, J., concurring, based her decision firmly on the fiduciary nature of the physician-patient relationship. She contrasted the foundation and ambit of contract and tort law with those of the law of fiduciary obligations. Contract and tort law assumes that the actors are independent and equal and are concerned primarily with their own self-interest; the law balances the need to enforce obligations with the need to preserve the parties' freedom. The essence of a fiduciary relation is the inverse of self-interest: one party exercises power on behalf of another and pledges to act in the interests of the other.[76] Vulnerability on the part of one party, an assumption of power by the fiduciary that would normally reside with the vulnerable party, and an undertaking by the fiduciary to exercise that power for the vulnerable party's benefit are necessary conditions for the existence of a fiduciary relationship.[77] The physician-patient relationship exhibits all of these hallmarks. Consequently, says McLachlin, if the physician "breaks that pledge" by using "the power the patient cedes to him exclusively for her benefit . . . he is liable."[78] Although contract and tort law generally provides the appropriate analytical tools where the parties are on a relatively equal footing, a fiduci-

74. *Id.* at 249.
75. *Id.* at 312.
76. *Id.* at 272-74.
77. *Id.* at 292-93.
78. *Id.* at 293.

ary analysis can better respond to the gravamen of the wrong where there is an imbalance of power between the parties.

It remains to be seen how far and in what directions the Supreme Court will extend its initial applications of fiduciary law or its sensitivity to what La Forest, J., termed the "power-dependency" relation in future analyses of the doctor-patient relationship and the concomitant rights and duties that arise. The majority of the Court in *Norberg* was hesitant or unwilling to go beyond the interest in protecting and accessing confidential information that the Court identified in *McInerney*. Even McLachlin, J., noted that the scope of physicians' fiduciary obligations would have to be determined on a case-by-case basis, "having reference to the degree of power imbalance and patient vulnerability" in each relationship.[79] Further, the abuse of power in *Norberg* was both egregious and different in kind from that normally addressed in malpractice cases. Beyond imposing a "trust" with respect to patient records, it is unclear whether abuse will be a sine qua non of the extension of fiduciary obligations in this area.

Norberg offers a new model of the patient as a vulnerable, dependent party in an inherently unequal relationship.[80] How this will be reconciled with the model of individual autonomy and free will that forms the basis of the law requiring a patient's informed consent to medical treatment is unclear. Some critics of the doctrine of informed consent have argued that the model of individual autonomy and free will is fundamentally flawed because it is premised on the assumption that the patient is a rational, independent choice-maker giving a voluntary consent to treatment.[81] It is said that despite the great normative commitment to the model of separate selves evident in both law and modern medicine, the boundaries of self are not so impermeable as is assumed, particularly where an ill, frightened patient is concerned. Consequently, critics argue the autonomy model enables decision-makers (be they doctors or judges) to abdicate their responsibility to the patient. The autonomy model itself incorporates something of that awareness, as it is in part meant

79. *Id.* at 287.

80. As La Forest, J., noted in *Norberg*, "[a]n unequal distribution of power is frequently a part of the doctor-patient relationship." *Id.* at 258. *See id.* at 247 (La Forest, J., commented on the concept of consent in tort law operating on a presumption of autonomy and free will).

81. *See, e.g.*, ROBERT A. BURT, TAKING CARE OF STRANGERS: THE RULE OF LAW IN DOCTOR-PATIENT RELATIONS 117-18, 136 (1979).

to correct existing inequalities in power and to shore up the patient's position. However, we must question how well we are served by having just one model, a model that is a useful ideal but is not always consonant with reality.

In contrast to the uncritical acceptance of a patient's consent to or refusal of treatment evident in negligence and battery cases,[82] the opinions of La Forest and McLachlin, JJ., in *Norberg* are sensitive to the manifold meanings of and motivations for a patient's consent (albeit not to treatment in that case), and both held that the reasons for the patient's consent *are* legally relevant. In that case, the reasons vitiated the consent's legal effect. It remains to be seen whether this different perception of the nature of the doctor-patient relationship will be taken beyond that very specific context and applied to the more traditional type of malpractice case.

If the fiduciary or "power-dependency" nature of the physician-patient relationship does play a part in the analysis of the traditional malpractice case, then findings with respect to liability may be affected. For example, as McLachlin, J., pointed out in *Norberg*, defences based on the contributory negligence of the plaintiff may carry little weight, foreseeability of loss would not be a factor in determining damages, and there may be a more generous approach to remedies overall.[83] In addition, limitation periods may be longer or nonexistent.[84] Indeed, fiduciary analysis has the potential to expand the types of circumstances that would support a finding of liability and increase the amounts that plaintiffs could recover. This, taken together with the strength of current commitments to the model of patient self-determination and autonomy, make it likely that courts will maintain a conservative approach to the application of fiduciary analysis in traditional malpractice cases.

IV. Causation

Plaintiffs in complex scientific or medical cases often have a difficult time meeting the traditional standard of proof for causation. The evidence of the experts may conflict and there may

82. *See, e.g.*, Malette v. Shulman, 67 D.L.R. 4th 321 (Ont. C.A. 1990) (patient's signed card refusing blood transfusions must carry over to prevail in a later period of incompetence, even where the treatment would be life-saving).

83. [1992] 2 S.C.R. 224, 290.

84. *See, e.g.*, Limitations Act, R.S.O., ch. L.1-15 (1990); M.(K) v. M.(H), 3 S.C.R. 6, 24 (1992) (*per* La Forest, J.).

be nothing to choose between them, available scientific or statistical evidence may not meet the balance of probabilities standard employed in civil cases, or, particularly in a product liability case, the product may have been so widely manufactured and marketed that liability cannot be traced to any one defendant.

Faced with these dilemmas, Canadian courts have not widened the application of the doctrine of res ipsa loquitur, assessed fault on the basis of market share liability, or adopted the other creative (or perhaps just pragmatic) approaches that American courts have developed.[85] With regard to res ipsa loquitur, in most medical cases Canadian courts have held that the plaintiff's claim cannot be sustained for one of three reasons: the cause of the injury is unknown, the injury could have occurred without negligence, or the defendant has proffered an explanation consistent with there having been no negligence.[86]

There has, however, been some doctrinal response in Canada to the problem of proving causation. Initially, some lower courts, taking a leaf from the 1973 decision of the House of Lords in *McGhee v. National Coal Board*,[87] held that the burden of proof should shift to the party that created the risk of injury.[88] However, in *Snell v. Farrell*, a 1990 decision, the Supreme Court of Canada confirmed that the burden of proving causation in tort cases still lay with the plaintiff because adopting an alternative would have the "effect of compensating plaintiffs where a substantial connection between the injury and defendant's conduct is absent."[89] The Court noted that both the burden and standard of proof are flexible concepts, and that it had shifted

85. Snell v. Farrell, [1990] 2 S.C.R. 311, 320-322 (*per* Sopinka, J.); *see, e.g.*, Terrie A. Rymer, *The Diethylstilbestrol Dilemma*, 251 JAMA 3228 (1984).

86. *Snell*, [1990] 2 S.C.R. at 322; Hollis v. Birch, 81 B.C.L.J.2d 1, 12-14 (C.A. 1993). For an explanation of the American development and use of res ipsa loquitur in medical malpractice cases, see WEILER, *supra* note 50, at 22-23.

87. [1973] 1 W.L.R. 1 (H.L.). In that case, it could not be established whether the worker's dermatitis was the result of his employer's negligent failure to provide showers after work or of the working conditions themselves (with respect to which the employer was not negligent). The House of Lords held that it was sufficient that the employer had negligently created a risk of dermatitis and that the condition in fact materialized. The suggestion that this represented a shift in the burden of proof was disavowed by the House of Lords itself fifteen years later in Wilshire v. Essex Area Health Auth., [1988] 2 W.L.R. 557 (H.L.). Rather, the House of Lords in *Wilshire* characterized *McGhee* merely as taking a "robust and pragmatic approach to the facts." *Id.* at 569.

88. For Canadian cases following *McGhee*, see those cited in *Snell*, [1990] 2 S.C.R. at 325-26.

89. *Id.* at 327.

both in other contexts where the underlying rationales were inapplicable in the circumstances.[90] Sopinka, J., writing for the Court, was as good as his word and proceeded to flex both the standard and the burden of proof in *Snell*, although without expressly shifting either.

The *Snell* case arose as a result of the negligence of an ophthalmologist who continued plaintiff's cataract surgery in the face of retrobulbar bleeding. The plaintiff suffered atrophy of the optic nerve, which was most likely the result of a stroke in the eye attributable either to the defendant's negligence or some other, unrelated cause. The Court faced the issues of who should bear the burden of proof and how that burden could be discharged given the proclivity of medical experts to express outcomes in terms of percentages (often less than fifty percent) and their inability in some cases to form an opinion that one cause was more likely than another. In *Snell*, while the plaintiff could prove the physician's negligence and a loss suffered within the scope of the risk created by the surgery, she could not prove that the negligence definitely caused her loss.

In the view of Sopinka, J., much of the dissatisfaction with the traditional approach to causation stems from courts applying it too rigidly; legal causation is quite distinct from notions of scientific causation, and though the former can be guided by the latter, it need not be rigidly constrained by it.[91] In practical terms, in order to establish legal causation, a plaintiff does not necessarily have to be able to present medical evidence establishing negligence as the probable cause of the injury with a certainty of fifty-one percent or greater. Indeed, particularly where the facts lie peculiarly within the defendant's knowledge, as they do in many medical malpractice cases, and where, as here, the defendant's negligence in continuing the operation despite the apparent bleeding made it impossible for the plaintiff or anyone else to detect the bleeding alleged to have caused the injury, then "very little affirmative evidence" is needed by the plaintiff to justify the trier of fact in drawing an "inference of causation" in the absence of evidence to the contrary.[92] Further, even if the defendant does adduce some evidence that he or she was not negligent or that the plaintiff's injury is attributable to some

90. *Id.* at 321, 328.

91. *Id.* at 328. *See also* Laferrière v. Lawson, [1991] 1 S.C.R. 541, 606-607 (*per* Gonthier, J.).

92. [1990] 2 S.C.R. at 328-29.

other cause, that will not necessarily be fatal to the plaintiff's case, since "all evidence is to be weighed according to the proof which it was in the power of one side to have produced, and in the power of the other to have contradicted."[93] In effect, the defendant's negligence was counted against him not only per se, but also for having made it impossible for the plaintiff to prove the link between the negligence and her injury.

While the Court's conclusion that the law demands less certainty than medicine (at least with respect to causation) assisted the plaintiff in *Snell*,[94] unfortunately, the law as laid down seems to have left a great many uncertainties. How is a plaintiff to prove causation if the expert evidence is conflicting or not definitive, and with what degree of certainty? How can a defendant respond effectively? And what answer is there to Lord Wilberforce's criticism in *McGhee v. National Coal Board*, where he questions a court's ability to make legitimate inferences of fact—to "bridge the evidential gap"—when medical experts are not able to do so?[95] The distinction between *Snell*'s prescription for dealing with the issue of causation and a reversal of the burden of proof is not at all clear.

That distinction was obscured even further after the Supreme Court of Canada's decision in *Laferrière v. Lawson*.[96] In 1971, the defendant doctor recommended removal of an abnormal mass from the breast of his patient, Mrs. Dupuis. The pathology report confirmed the presence of breast cancer. The defendant never told his patient of the cancer diagnosis nor did he discuss postoperative treatment or long-term follow-up. After a few years, Mrs. Dupuis fell ill again, and in 1975, she was diagnosed with generalized cancer. She died in 1978.

93. *Id.* at 328 (quoting Lord Mansfield in Blatch v. Archer, 1 Cowp. 63, 98 E.R. 969, 970 (1774)).

94. *Id.* at 330. For a decision following *Snell*, see Rehak v. McLennan, 1992 O.J. No. 1398 (Ont. Ct. Gen. Div.) (plaintiff recovered against radiologist for missed diagnosis of dislocated shoulder joint complicating a diagnosed fracture, which delayed proper treatment, even though expert evidence as to whether plaintiff would have suffered the same extent of permanent disability if promptly treated was conflicting).

95. Snell, [1990] 2 S.C.R. at 323 (quoting McGhee).

96. [1991] 1 S.C.R. 541. The decision also provides a recent example of the application of the "respectable minority" principle in practice, as the Court held that the procedure the doctor employed—removal of the malignant tumour from the plaintiff's breast with no additional treatment by irradiation or chemotherapy—was recognized at the time, although not the standard treatment. Further, expert evidence established that at the time (1971), there was no difference in the survival rates of those who just had the lump removed and those who had the more common radical mastectomy followed by radiation and chemotherapy.

Mrs. Dupuis' estate continued the action she had commenced against the physician who removed the mass. At trial, the court held that her doctor was negligent in failing to inform his patient that she had cancer and in failing to recommend that her condition be monitored. Given that there was only a slim possibility (not probability) that her chances of survival would have been greater had she received aggressive treatment in a timely fashion, the court had to determine whether a patient could recover damages for the "loss of a chance." In other words, could the physician be found liable for negligently depriving his patient of an opportunity to recover from an illness, even if that opportunity would only have been *possible* and not *probable* absent the doctor's fault?

Carrying forward the practice of drawing inferences from less than compelling facts that it began to develop in *Snell*, the majority in *Laferrière* noted that in cases where a physician's negligence presents "a clear danger for the health and security of the patient and where such a danger materializes, it may be reasonable for a judge to assume the causal link between the negligence and the damage" unless there is evidence or a strong indication to the contrary.[97] This standard sounds remarkably like imposing liability for injury that falls within the scope of the risk created by the defendant, the approach taken in *McGhee* and rejected, at least overtly, in *Snell*. However, the Court in *Laferrière* nonetheless considered that it was adhering to traditional principles of causation.[98]

Whether or not the majority's statements signal a sub rosa shifting of the burden of proof, they did not avail the plaintiff in *Laferrière*. Gonthier, J., writing for the majority of six, held that the "loss of chance" theory should not be accepted in medical liability cases to support claims for damages for physical pain, suffering, and premature death.[99] As the plaintiff could not establish that the deceased would have lived longer or been cured if she had received earlier or different treatment, applying such a theory would undermine the traditional requirement that

97. *Id.* at 608.

98. *Id.* at 608-09.

99. *Id.* at 605-06, 608. The decision was made with respect to the civil law of Quebec. One can, however, expect a similar analysis at common law. *See* Salvatore Mirandola, *Lost Chances, Cause-in-Fact and Rationality in Medical Negligence*, 50 U. TORONTO FAC. L. REV. 258, 273 (1992). For a suggestion to the contrary, see Nicholas Rafferty, *Developments in Contract and Tort Law: The 1990-1991 Term*, 3 SUP. CT. L. REV. 2D 73, 111-17 (1992).

plaintiffs prove a causal link between the negligence and the injury, here death, on a balance of probabilities.[100] The inference the Court drew was that death was almost certainly inevitable whether or not the patient received treatment; hence, the plaintiff could not show the defendant's negligence was the cause of Mrs. Dupuis' death. The Court did, however, hold that the physician was liable for other, lesser injuries that the patient suffered: specifically, that earlier treatment might have afforded her a better quality of life and that she suffered psychologically from the defendant's failure to inform.[101] In the end, the Court reduced the damages awarded her estate from $50,000 (Can.) to $17,500 (Can.).

As a number of commentators have pointed out, a decision such as *Laferrière* does not accord with the notions of fairness or the deterrent value underlying tort law. If a patient was not likely to survive in any event, a negligent physician may escape liability even if his or her negligence led to the patient's death when the plaintiff cannot establish the necessary causal link with greater certainty than is often possible in such situations.[102] Although other types of lost chances, such as economic lost chance, are clearly recognized as compensable, courts will not compensate a plaintiff for a lost chance to recover his or her health, at least if the chance is small. On the other hand, the "loss of chance" theory could make the physician, or more accurately the C.M.P.A., a no-fault insurer, compensating patients for any injury whether or not causally connected to the physician's mistake.

CONCLUSION

It is apparent from this review of recent developments that the Canadian system for compensating patients injured by medical malpractice is slow, complex, and by no means certain—a patient who has suffered iatrogenic injury from substandard care may not be compensated for that injury even if he or she does commence a lawsuit. Although the number of actions alleging medical malpractice commenced and paid and the size of the average settlement have all increased rapidly in Canada, it is estimated that Canada's current compensation system still results

100. [1991] 1 S.C.R. at 610.
101. *Id.* at 610-11.
102. *See, e.g.*, John G. Fleming, *Probabilistic Causation in Tort Law: A Postscript*, 70 CAN. B. REV. 136, 137 (1991); Mirandola, *supra* note 99.

in financial support for fewer than one in ten victims of avoidable medical injuries.[103] Similar conclusions have been reached by recent studies in the United States, such as the Harvard Medical Practice Study commissioned by the state of New York.[104] The "malpractice crisis," then, is two-way: not only are claims and costs increasing dramatically, but the majority of victims of medical malpractice remain uncompensated.

That being the case, it is no wonder that there are calls for reform of the legal system applicable to medical liability claims. Not surprisingly, pressure to reform the system comes from both health care providers and recipients, resulting in suggested reforms that vary widely in substance and thrust. On the one side are proposals to limit the scope of claims and the time within which plaintiffs can assert them; on the other are proposals to widen both scope and time and to remove the requirement of proving fault.

Recently, a comprehensive study conducted for the federal and provincial Ministers of Health by the Federal/Provincial/Territorial Review on Liability and Compensation Issues in Health Care (the Prichard Report) made a proposal to maintain and reform present tort actions, widen the responsibility of health care institutions, and, most significantly, develop a no-fault compensation system as an alternative for persons suffering significant, avoidable medical injuries.[105] To date, this proposal has not been adopted.

In the three years between the commissioning of the Prichard Report in 1987 and its completion in 1990, the perception of a malpractice crisis in Canada faded somewhat, despite continually increasing claims and costs.[106] It is likely that the malpractice crisis has been eclipsed for now by newly pressing concerns about the need to contain rising health care costs.

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103. PRICHARD REPORT, *supra* note 10, app. A at 102. It must be recognized that this figure is an extrapolation drawn from experience in other countries, for as it points out, "[n]one of the systemic evidence on the extent of patient injury is Canadian." *Id.* at 101. As such, it suffers from the weaknesses of that type of exercise. The severity of the medical injuries included is also unclear.

104. Charlotte Gray, *Canadian Lawyer at Harvard a Mainstay Behind Calls to Change Response to Medical Malpractice*, 149 CAN. MED. ASSOC. J. 477, (1993). *See also* WEILER, *supra* note 50, at 134; PAUL C. WEILER ET AL., A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION (1993).

105. PRICHARD REPORT, note 10, app. A at 179-357.

106. Gray, *supra* note 104.

Like all eclipses, though, this one will only be temporary. Claims, C.M.P.A. dues, and amounts paid to patients will continue to increase. Many of those who have been injured by physician fault will continue to go uncompensated, as will many more who were injured in the course of treatment but without fault on the part of anyone. If this pattern continues unimpeded, which is likely given the attention now focused on other areas in the health care system, then the malpractice crisis in Canada will break out again, only in more severe form. That much seems inevitable.