



Medico-legal handbook for physicians in Canada

THE CANADIAN MEDICAL PROTECTIVE ASSOCIATION



This handbook provides insight into basic legal concepts and underlying principles that govern physicians in their practices

Seventh Edition

The Canadian Medical Protective Association (CMPA) provides medico-legal protection to physicians licensed to practise medicine in Canada.

As the principal provider of medical liability protection in Canada, the CMPA is committed to protecting the professional integrity of physicians and promoting safer medical care. To fulfill this mandate, the CMPA provides a range of services to members in both English and French including medical liability protection, advice and assistance, risk management and education, and publications.

This handbook is available on the CMPA website at cmpa-acpm.ca

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Introduction

Medicine and the law

This handbook provides insight into basic legal concepts and underlying principles that govern physicians in their practices. It also offers physicians a greater understanding of the standards and requirements imposed on them by law. This will better equip physicians to recognize and avoid medico-legal difficulties. It is important to highlight that some of the legal principles addressed in this document arise out of the common law system, which applies to all provinces and territories in Canada, except for Québec. Civil law in Québec has its own legal principles. Similarities exist nevertheless in the application of these two legal traditions in Canada.

The interaction between law and medicine permeates almost all aspects of a physician's practice and, of course, goes far beyond events or mishaps that might give rise to litigation. This diversity is reflected in the fact that each year the CMPA receives thousands of inquiries from its members about practice-related issues, including the application and interpretation of provincial or territorial statutes that impinge on the practice of medicine in ever-increasing numbers.

Members can contact the CMPA for advice on a broad range of medico-legal issues arising from their professional work in Canada. They receive the benefit of advice from people who understand their situation — experienced medical officers who are physicians with clinical practice backgrounds in various practices and specialties. These medical officers are available to provide advice and, when warranted, arrange further legal assistance for matters arising from a member's professional work, including the following:

- civil legal actions
- regulatory authority (College) complaints, investigations, and disciplinary hearings
- coroners' inquests or other fatality inquiries
- billing audits or inquiries
- hospital privilege matters
- criminal proceedings
- some general contract or research contract matters
- privacy legislation breaches and privacy complaints
- human rights complaints

When members face a medico-legal action, they are eligible for assistance in the form of legal representation, and payment of legal costs, judgments, or settlements to compensate patients where it is determined those patients have been harmed by negligent care or malpractice. The CMPA works with an independent general counsel and with selected legal firms in each province (provincial counsel) to ensure that members have the support necessary to achieve the best possible outcome.

Legal proceedings

The Canadian legal system

Generally speaking, activities are governed by two sources of law: the law created by statute, either federally, provincially, or territorially; and the common law developed by judgments rendered in legal actions that have proceeded through the courts. In Québec, the common law is replaced by a codified system of civil law, but for the most part the underlying principles of medico-legal jurisprudence are similar in common law provinces and territories.

There are also two types of legal actions: civil and criminal. A civil action involves the resolution of disputes between two or more parties by resort to the litigation process. Today this often includes mediation. Criminal actions involve the prosecution of an individual charged with committing an offence as defined by statute, usually the federal *Criminal Code*. There are also quasi-criminal offences set out in other federal statutes (for example, the *Controlled Drugs and Substances Act*) as well as in several provincial and territorial statutes.

Civil and criminal actions are heard by much the same courts, although the jurisdiction of some courts is split into civil and criminal divisions. The accused in a criminal action often has a right to elect trial by jury. An absolute right to a jury is only available to plaintiffs in a civil action in Saskatchewan. Jury trials in civil actions have been abolished in Québec. Traditionally, civil actions in the remaining provinces and territories are heard by a judge alone, but in recent years there has been an increasing trend toward jury trials.

A defendant in a civil action may be found liable if the essential elements of the claim are established on a balance of probability, while the accused in a criminal action will not be found guilty unless the charge is proven beyond a reasonable doubt. A defendant found liable in a civil action must pay an amount of money awarded to the plaintiff in damages. The accused found guilty in a criminal action may be fined, imprisoned, or both.

The plaintiff or defendant in a civil action, and the Crown or the accused in a criminal action, may appeal any judgment rendered. The Court of Appeal will not interfere with the decision, however, unless the court is satisfied there has been an error in law or the decision is plainly unreasonable and unjust when reviewing the evidence as a whole. While the accused in a criminal action may appeal to the Supreme Court of Canada without permission (depending on the circumstances), a party in a civil action must obtain the leave (permission) of the court to appeal the judgment of a provincial or territorial Court of Appeal to the Supreme Court of Canada. It is, however, becoming increasingly difficult to obtain such leave (permission); it is only granted when one clearly demonstrates to the court that an aspect of the case is of national importance.

The litigation process

A number of events might alert the physician to impending litigation:

- A clear error is made (for example, an operation on the wrong patient or on the wrong part of the body).
- A serious and unexpected mishap occurs in the course of treatment.
- The patient is dissatisfied. This should raise a red flag in the mind of the physician. Many legal actions are commenced by disgruntled patients who feel their physician did not give them enough time or attention; these patients may then attribute a result that is less than perfect to the carelessness of the physician rather than being an acceptable complication or outcome.
- A complaint is made to the regulatory authority (College) or provincial or territorial medical board.
- A decision is made to hold an inquest or other investigation into the death of a patient.

The most common announcement of an impending legal action, however, is the receipt of a letter from a lawyer on behalf of the patient. Some of these letters simply request copies of the medical records and may include general questions for the physician about the treatment rendered, the complication that occurred and the current prognosis for the patient. If the lawyer is forthright, the letter will also advise that a legal action is being considered or has already been commenced against the physician, and suggest that the defence organization or insurance company should be contacted.

Pleadings

Often there is no warning whatsoever about an impending legal action until the physician is served with a notice of action or its equivalent. Service of the notice of action is usually accomplished when a document is delivered personally to the defendant physician by a bailiff or other process server. A notice of intent to defend or appearance must be filed into the court on behalf of the defendant physician within strict time limits, so it is very important that physicians notify the CMPA immediately when served with any legal document pertaining to their medical practice.

In some provinces and territories the legal action is initiated by a statement of claim, which is again almost always served upon the defendant physician personally. In Québec, this document is called a *Requête introductive d'instance* (motion to institute proceedings) and follows a formal demand letter. In the remaining jurisdictions, the statement of claim usually accompanies the notice of action. The statement of claim sets out in a concise manner the facts and particulars upon which the plaintiff is relying to establish a cause of action or alleged wrongdoing against the defendant. It is not unusual for the statement of claim to include allegations that challenge the defendant physician's competence and reputation.

A statement of defence is the answer prepared on behalf of the defendant to the allegations, set out in the statement of claim. In essence, this response sets out the facts, allegations, and denials upon which the defendant intends to rely in refuting the claim asserted by the plaintiff. While again there are time limits for the filing of a

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statement of defence, an accommodation is almost always reached between lawyers to allow time to obtain records and information necessary to prepare it. During this time, the defendant physician will be asked to provide legal counsel with a narrative account and copies of the office records concerning the patient. Often the defendant doctor will also find it valuable to meet with defence counsel to discuss the case. In Québec, the statement of defence is generally filed later in the proceedings, once examinations have been held.

On occasion, a cross-claim may be included in the statement of defence to raise the allegation or argument that a co-defendant in the legal action is responsible in whole or in part for the claim being asserted by the plaintiff; therefore, the defendant is entitled to contribution or indemnity from the co-defendant respecting any damages that might be awarded. Similarly, a third party claim, or claim in warranty in Québec, may be initiated on behalf of the defendant against a person or party not already named in the original action, again on the basis that this person or party is responsible in whole or in part for the claim being asserted; therefore, the defendant is entitled to contribution or indemnity for any damages awarded.

Countersuits

Upon receipt of a statement of claim, some physicians immediately seek to commence an action in defamation or to initiate a countersuit against the plaintiff or the plaintiff's lawyer or both. Unfortunately, allegations set out in a statement of claim are privileged and therefore cannot form the basis of an action in defamation against the plaintiff or the lawyer.

The availability of a countersuit is also extremely limited. To succeed in a medico-legal countersuit, the physician must prove the following:

- The patient and the patient's lawyer had no basis whatsoever to commence or continue the initial medico-legal action against the physician and that the action was brought without any foundation or investigation whatsoever.
- The medico-legal action against the physician has been dismissed on its merits by the court in favour of the physician.
- The medico-legal action was instituted and continued with the malicious intent of the patient or the lawyer to cause specific harm to the physician.
- The physician did in fact sustain direct damage to the practice as the result of the medico-legal action. The loss of professional reputation, litigation expenses, the loss of income, and other expenses while defending oneself do not qualify as damages in this regard.

These hurdles have prevented the countersuit from being an effective response to the frivolous legal action.

Adopting a vigorous defence is a much more effective and expeditious manner of dealing with clearly unwarranted legal claims, which are often quickly abandoned or concluded by means of a dismissal order.

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Litigation proceedings

Many legal actions seem to stall once pleadings have been exchanged; indeed, many are simply abandoned at this stage. For those actions that proceed, the defence counsel carefully investigates the claim by obtaining copies of all relevant hospital and medical records, discussing the file thoroughly with the defendant physicians, and obtaining preliminary expert opinion. These steps may take months, even a year or more.

Preliminary applications may be made to the court from time to time for directions or a determination on a point of law. These usually proceed in the absence or even without the knowledge of the physician.

One of the most important stages in the litigation process, and the next step in the legal proceedings, is conducting Examinations for Discovery. This pre-trial examination allows legal counsel to question each other's client under oath before a court reporter who prepares a transcript of the questions and answers.

In some jurisdictions, legal counsel may conduct an Examination for Discovery of individuals not included in the legal action, such as another treating physician or an expert witness. In most jurisdictions however, such Examinations for Discovery or interviews of other treating physicians may only take place, if at all, pursuant to a court order.

The individual being examined is usually subjected to detailed questioning as to any knowledge, information, and belief concerning the facts and issues in dispute in the legal action. It is extremely important that these examinations be taken seriously. The physician is expected to diligently prepare by reviewing very carefully all the medical records pertaining to the patient. As well, the physician must co-operate fully and be available to meet with legal counsel. It is extremely difficult to back away at any subsequent trial from an answer given during Examinations for Discovery. Legal actions are often won or lost at this stage.

Increasingly, mediation is being introduced into the litigation process. In Ontario, for example, there are mandatory mediation requirements even before discoveries may be complete. Often legal counsels for the parties simply agree to voluntarily participate in mediation. In a somewhat similar vein, it is common in some jurisdictions to use pre-trial conferences with a judge, usually one other than the judge who will preside at trial. Both mediation and pre-trial conferences attempt to reach agreement on issues in dispute to facilitate resolution or at least shorten any trial.

The culmination of these legal proceedings, which can span 4 to 6 years, is the trial of the action. In Québec, parties have 180 days to file a legal action, although this deadline is often extended. Several months, indeed even several years, can pass between the time an action is ready for trial and the commencement of trial. As noted earlier, in most provinces and territories trials are traditionally heard by a judge alone, without a jury. There is, however, a trend on the part of lawyers acting for patients to seek a jury trial. In jurisdictions where juries are permissible, whether or not there should be a jury must be decided on the merits and circumstances of each case, particularly the complexity of the points to be decided and the medical or scientific evidence to be anticipated.

The trial of medico-legal actions seems to be taking longer and longer, often weeks or months. It is, of course, necessary for the defendant physician to be in court for most, if not all, of this time, which produces considerable hardship. The trial judge almost always takes the case under advisement at the conclusion of the trial and the Reasons for Judgment are usually not delivered for some months. Each party may appeal the judgment to the Court of Appeal in the jurisdiction. Again, there is a delay while the lawyers prepare factums and transcripts of the evidence adduced (introduced) at trial before the appeal is heard. The physician may, but need not, be present at the hearing of the appeal. There may be an additional delay while the Court of Appeal deliberates before rendering judgment.

If any party is not satisfied with the judgment of the Court of Appeal, they may seek leave (permission) to appeal the case to the Supreme Court of Canada. In the unlikely event that leave is granted, there will be additional delays before the appeal can be heard and final judgment is rendered.

Settlement

The CMPA's primary interest and concern has always been, and continues to be, protecting the professional integrity of its member physicians. For this reason, a vigorous defence is always mounted for a member who has not been careless or negligent and for whom a successful defence is possible. It is a firm principle that no settlement will be reached on the basis of economic expediency. However, when a review of the medical facts reveals that shortcomings in a physician's work have resulted in harm to a patient, the CMPA will arrange for a financial settlement that is fair to all concerned. When the claim is clearly indefensible, a settlement is negotiated as early as possible. For the most part, however, settlements are not effected until after Examinations for Discovery to allow the evidence and credibility of the parties to be assessed, and expert opinion to be obtained as to whether or not the work of the defendant doctor is defensible.

To put this in perspective, approximately 65% of all actions commenced against physicians are dismissed or abandoned short of trial. Each year between 25 and 30% of all cases are settled. Most of the 5 to 10% of cases that proceed to trial are successfully defended.

Statutes of limitation

At one time the limitation period during which a civil action had to be initiated against a physician commonly ran from the date of the termination of medical services giving rise to the claim. Thus, the patient had 1 or 2 years from the date of last treatment to commence the action. In the early 1970s much was written about how this special interest legislation favoured the medical profession and prejudiced the patient, particularly when the patient was unaware of the potential negligence on the part of the physician within that time period.

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Today it is universal for the limitation provisions respecting actions against physicians to incorporate a discovery principle, in which the time for commencing an action against a physician does not start until the patient knew or ought to have known the facts upon which the action is based. The discovery principle can extend the limitation period significantly, particularly when the court is prepared to interpret the aspect of constructive knowledge to require that the patient has received appropriate expert opinion.

Statutory provisions in several jurisdictions specifically require that the running of the limitation period must be postponed when the plaintiff is under a disability, either by being under the age of majority or mentally incompetent. The result can, of course, extend the limitation period to upwards of 20 years, and longer for patients suffering from a mental disability.

A number of provinces and territories have placed a cap on the length of time a patient may have to initiate an action against a physician. The outside time limit in British Columbia and Prince Edward Island, for example, is 6 years from the day the patient had a cause of action against the physician. In Alberta it is 10 years and it is 15 years in Saskatchewan and Ontario. These caps do not apply, however, while a patient is below the age of majority or is suffering from a serious mental disability.

The CMPA has vigorously argued that prolonged and uncertain limitation periods pose problems for physicians in terms of the need to store records for long periods of time, the availability of witnesses, and so on. It may be argued that this is true for any type of litigation, but when actions involve medical matters, the problems are particularly difficult. Most important, because of rapid changes in medical science, it becomes very difficult for courts to fairly assess a physician's work respecting the applicable standard of care if that work was done a decade or more earlier.

The table on page 8 is a summary, by province and territory, of the limitation periods for commencing actions against physicians (effective January 2010 — see this table on the CMPA website for any subsequent amendment to the applicable limitation period).

Limitation period

Province/ Territory	Basic limitation period	Postponement for disability (Infancy or mental incompetence)
British Columbia	2 years from knowledge of facts but no more than 6 years from cause of action	postponement until termination of disability
Alberta	2 years from knowledge of facts but no more than 10 years after the claim arose	postponement until termination of disability
Saskatchewan	2 years from knowledge of facts but no more than 15 years from cause of action	postponement until termination of disability
Manitoba	2 years from termination of professional services subject to discretion of the court to extend time up to 30 years	postponement until termination of disability (up to 30 years max.)
Ontario	2 years from knowledge of facts but no more than 15 years from cause of action	postponement until termination of disability
Québec	3 years from the date of fault or from date of knowledge of facts	prescription does not run against persons if it is impossible for them to act by themselves or to be represented by others
New Brunswick	the longer of 2 years from termination of professional services or 1 year from knowledge of facts *Legislation has been enacted but not yet brought into force which would amend the limitation provisions in New Brunswick to be the same as currently apply in Ontario.	postponement until termination of disability, then action must be commenced within 1 year
Nova Scotia	2 years from termination of professional services subject to an additional 4 years at the discretion of the court	postponement until termination of disability, again subject to additional 4 years at the discretion of the court
Prince Edward Island	the longer of 2 years from the alleged negligence or knowledge of facts; but no more than 6 years from the termination of treatment, except in the case of fraudulent concealment or a retained foreign body	postponement until termination of disability, then action must be commenced within 2 years
Newfoundland and Labrador	2 years from knowledge of facts, but no more than 10 years from date of treatment	postponement until termination of disability, then action must be commenced within 1 year
Yukon	2 years from knowledge of facts	postponement until termination of disability
Northwest Territories	2 years from knowledge of facts	postponement until termination of disability
Nunavut	2 years from knowledge of facts	postponement until termination of disability

Cause of action

A cause of action refers to the set of facts or alleged faults that, if established, give rise to the claim for damages. More than one cause of action can arise out of the same situation and may be advanced under one or more of the following headings.

Assault and battery

The Supreme Court of Canada has restricted such a claim to those non-emergency situations where the physician has carried out surgery or treatment on the plaintiff without consent, or has gone well beyond or departed from the procedure for which consent was given. An assault and battery may also be committed where fraud or misrepresentation is used to obtain consent. These claims are, for the most part, now restricted to errors where the wrong operation is performed on a patient or an operation is performed on the wrong patient.

False imprisonment

These claims arise when patients are restrained or confined against their will and without reasonable cause or lawful authority. There have been very few actions for false imprisonment, most of which are brought by patients against psychiatrists and psychiatric institutions.

Defamation or injury to reputation

This claim is based upon a statement, written or oral, that tends to bring the plaintiff into ridicule or contempt or that causes the plaintiff to be shunned, avoided, or discredited. There have been very few actions for defamation, yet physicians still fear such claims, particularly when required to give critical comments about a colleague or patient. These concerns are unnecessary; not only is the truth of the statement a full defence, in most instances the statement is probably also protected by qualified privilege. The defence of qualified privilege protects a person whether or not the words are in fact true provided that, in all of the circumstances, there was a duty upon the individual to make the comments and in so doing the individual acted fairly. The duty may only be a moral one and, to have acted fairly, it must be demonstrated that the individual made the statement honestly and in good faith, without malice.

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Breach of contract

In provinces and territories that are subject to common law, these claims are made when it is alleged that the physician has breached an expressed or implied term of the agreement that arises out of the physician-patient relationship, usually an allegation that the physician failed to achieve the result guaranteed. This occurs most often in the context of cosmetic surgery. A claim for breach of contract is also advanced when it is alleged that the physician, or someone for whom the physician is responsible in law, has disclosed confidential information about the patient without proper authorization and in the absence of being required to disclose the information by law. In Québec, the concept of the medical contract has a more general application where a direct physician-patient relationship has been established. The existence of a medical contract

in that province does not necessarily impose an obligation of result to the physician, although the physician may have an obligation of means.

Informed consent

It is not unusual for a claim to be asserted on behalf of the plaintiff alleging that, in obtaining consent, the physician failed to provide all the information about the nature and anticipated effect of the proposed procedure, including the significant risks and possible alternatives that a reasonable person would wish to know in determining whether to proceed. The notion of informed consent is entrenched in many codes of ethics and in legislation, in particular in the Québec Civil Code. This notion and, more particularly, the switch to the reasonable patient standard of disclosure, was discussed by the Supreme Court of Canada in 1980. The new standard was worrisome for physicians, creating great uncertainty about what was expected of them. It would appear, however, that physicians have come to appreciate the need for more detailed explanations to be given to their patients and are finding the requirements of informed consent are not imposing as stringent a hardship as once feared. The successful defence of such actions is assisted by the overriding requirement, also introduced by the Supreme Court of Canada, that to succeed, the plaintiff must demonstrate that in the face of full disclosure, a reasonable person in the patient's place would have refused the procedure. It is this aspect that defeats most claims alleging lack of informed consent.

Negligence, malpractice, and civil liability

The majority of legal actions brought against physicians are based on a claim for negligence or malpractice. These actions involve an allegation that the defendant physician did not exercise a reasonable and acceptable standard of care, competence, and skill in attending upon the patient and, as a result, the patient suffered harm or injury.

Fiduciary duty

Courts have long recognized that the physician-patient relationship is built on trust; this relationship of trust is recognized in the concept of fiduciary duty. Physicians' fiduciary duty means they must act with good faith and loyalty toward the patient and never place their own personal interests ahead of the patient's. Claims of a breach of fiduciary duty are most often brought when it is alleged that the physician has abused the trust within the physician-patient relationship by having an inappropriate sexual relationship or committing sexual misconduct. However, fiduciary duty may be asserted regarding any duty imposed by law arising from the physician-patient relationship. The hallmarks of a fiduciary duty are: an imbalance of power between the parties (often found by courts to exist between doctors and patients), an ability in the stronger party to affect the weaker party's financial or other interests, and a particular vulnerability on the part of the weaker party. Fiduciary duties are increasingly alleged by plaintiffs who consider the legal right or remedy to be inadequate or otherwise unavailable on the facts of the case.

Professional misstatement

The court at times has allowed a claim of negligent misrepresentation against a physician arising from a medico-legal report found to contain a professional misstatement or erroneous opinion as to the patient's prognosis. The elements of negligent misrepresentation, as determined by the Supreme Court of Canada, include a special or professional relationship between the parties; the representation or opinion must be untrue, inaccurate, or misleading due to the negligence of the professional; the receiver must have relied on the misrepresentation or erroneous opinion; and as a result of such reliance, the individual must have suffered damages. When providing a medico-legal report or expert opinion, physicians must take care to remain within their area of practice or specialty and avoid vague statements or speculation as to prognosis.

Liability for the acts of others

Generally speaking, individuals are personally liable for negligent acts or malpractice they commit. This is called direct liability. Individuals may also be held liable for the negligence or malpractice of their employees or agents. This is called vicarious liability or liability based on *respondeat superior* (let the principal answer).

It follows that physicians may be held liable for the work of any health professional in their employ. A physician who practises in a partnership is also jointly and severally liable for negligent acts or malpractice committed by any partner in the course of the partnership business.

In the hospital setting, the hospital is vicariously liable for the negligent acts or malpractice of nurses, physiotherapists, and other healthcare providers it engages as employees or agents of the hospital. Generally, physicians on the medical staff of a hospital are engaged or granted privileges as independent contractors and not employees of the hospital. There is therefore no vicarious liability on the hospital for the negligence or malpractice of physicians on the medical staff.

Responsibilities of heads of departments and chiefs of staff

Physicians have expressed concern about potential liability they might incur when accepting positions as head of a department or chief of staff. There have been very few legal actions to date where the role of a physician as head of a department or chief of staff has been a focal point in the litigation. This is not to say there is no risk of liability, rather it is to put the magnitude of the risk in perspective.

As head of a department or chief of staff, physicians function as officers of the hospital. They work hand-in-hand with the administration to help carry out the broad duties owed by the hospital to patients. Those duties extend to the selection, organization, and monitoring of both professional and non-professional staff, as well as the acquisition and maintenance of appropriate facilities and equipment to reasonably ensure that patients receive adequate and proper care.

There have been very few legal actions to date where the role of a physician as head of a department or chief of staff has been a focal point in the litigation.

The specific duties and responsibilities of heads of departments and chiefs of staff are often set out in the provincial or territorial *Hospitals Act* or its Regulations (in Québec, the Act respecting health services and social services) and in the hospital's by-laws. Generally, physicians in these positions are expected to

- Exercise responsibility for the general clinical organization of the hospital.
- Supervise all professional care given to all patients within the hospital.
- Report to the Medical Advisory Committee (in Québec, the Council of Physicians, Dentists and Pharmacists) respecting medical diagnosis, care, and treatment provided to the patients and outpatients of the hospital.
- Exercise responsibility for the organization and implementation of clinical review programs and encourage continuing medical education.
- Intervene in the management of the patient when becoming aware that a serious problem in diagnosis, care, or treatment exists and appropriate steps are not being taken by the attending physician.
- Participate in the appropriate committees of the hospital.

The head of a department or the chief of staff is not expected to be a guarantor of the work of other members of the medical staff or other healthcare providers.

There is sometimes fear the head of a department or the chief of staff might be held responsible for any mishap caused by any other member of the medical staff or any other healthcare provider over whom it may be said they have administrative or supervisory responsibilities. It is always difficult to speculate about the extent to which legal liability might devolve in any hypothetical situation. Much depends on the circumstances of each case. Nevertheless, the head of a department or the chief of staff is not expected to be a guarantor of the work of other members of the medical staff or other healthcare providers.

More specifically, the liability of heads of departments or chiefs of staff does not extend to their being held liable simply for the negligence or malpractice of some other member of the medical staff or other healthcare providers, including medical students or residents. Liability is only engaged if they fail to act reasonably in carrying out the duties assigned to them by legislation and the by-laws of the hospital, or if they fail to intervene when they know, or ought to know, that a patient may come to harm without intervention.

Damage awards

Damages are awarded to a patient as a result of either a successful legal action against the defendant physician(s) or as a negotiated settlement of the claim.

Incidence

Interestingly, in the last decade there has been a steady decrease in the number of legal actions brought against physicians. This is thought to be due in part to better medical care resulting in fewer adverse events, increased awareness and understanding of patient safety measures, and enhanced risk management procedures. It is useful, nevertheless, to review the factors which contribute to the commencement of a legal action against a physician, as follows:

- There has been a change in public attitude toward the fallibility of the physician. Patients are no longer likely to consider that any complication or unsatisfactory result was simply unavoidable in spite of the best efforts of the physician.
- Public awareness of recent advances in medicine often leads to unrealistic expectations such that people equate complications and poor results with negligent treatment.
- There is a school of thought that the courts should place the burden of loss, particularly when it is large or tragic, on the party most able to bear it: an insured hospital or a physician with liability protection. The perception has developed that, at least in some cases, the courts strain to find liability without apparent fault.
- Counsel for the patient may be encouraged to initiate or continue with some legal actions due to an unrealistic standard of care advocated by expert consultants retained on behalf of the patient.
- It is thought that the loss of more traditional areas of litigation (e.g. motor vehicle actions to no-fault insurance) and the ever-increasing number of new lawyers may give rise to increased litigation. Any such influence does not appear to be measurable, at least to date.
- The most frequent factor is a lack of adequate communication between the physician and the patient. Patients are most likely to sue when they feel they have not been kept informed about their progress or complications. Physicians are therefore encouraged to foster and maintain good communication with their patients.

Size of awards

It is a concern that while the frequency of medico-legal actions has stabilized, there has been a substantial increase over the same time frame in the court award of damages and in the amount of settlements negotiated in favour of patients.

The reasons for this increase in damages are multi-factorial. Certainly, the more complex medical and surgical treatment methods become, the greater the risk of more serious complications. As well, advances in medicine have resulted in the resuscitation and long-term survival of patients who may otherwise have died. Unfortunately, some of these patients will remain severely and permanently disabled. Items of damages for cost of future care and loss of income therefore loom large, and in the case of compromised babies often amount to millions of dollars.

One of the major factors giving impetus to the rise in the size of awards was the decision of the Supreme Court of Canada in 1978 that detailed the manner in which courts must proceed in assessing damages. No longer could global sums be awarded recognizing in only a general way the harm that may have been done to the plaintiff. The courts are now required to assess each item of damages separately, with the total often adding up to a substantial figure. Individual amounts must now be calculated for each of the following items:

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- General or non-pecuniary damages

These are intended to compensate the injured party for pain and suffering, loss of amenities, and loss of enjoyment of life. The proper approach to this item is functional, in the sense of providing the injured person with reasonable solace for his/her misfortune.

In 1978, the Supreme Court of Canada established an upper cap of \$100,000 for general damages. With inflation, this upper limit has now increased to in excess of \$335,000. This maximum award is to apply only in the most catastrophic of cases where the individual has suffered severe injuries, such as quadriplegia, and is fully aware of the extent of such injuries. Other claims are scaled down from this amount.
- Cost of past medical care and other special damages or pecuniary damages

These relate to expenditures incurred by or on behalf of the patient for medical expenses, hospitalization, medical supplies, transportation costs, household assistance, and the like, made reasonably necessary as a result of the harm or injuries sustained by the patient.

This item also includes any subrogated claim the provincial or territorial healthcare agency may seek to advance for reimbursement of medical and hospital expenses incurred by the province or territory on behalf of the patient.
- Future medical and hospital care

The calculation of these amounts can vary enormously depending on the nature of future care needs for the injured patient and the anticipated duration of such care. The courts have demonstrated a propensity, based on the opinion of rehabilitation experts, to favour a home-care environment for the seriously disabled, including compromised babies. This often necessitates home modification or even acquisition of a new home and employment of specialized attendant care. The cost may well exceed \$200,000 a year; with ever-increasing life expectancies for the disabled, this lump sum amount for future care often amounts to millions of dollars.

The calculation of the cost of future care is done on a self-extinguishing basis, such that the entire amount of the capital sum set aside will be used up by the time the last payment for future care is made. While the fund for future care is discounted to current values to reflect the anticipated investment income it will generate over the years, the reality is that some of this investment income will be lost through taxation. The argument is therefore made that the fund will be exhausted too soon if the disabled patient is also required to use the money to pay the income tax on investment earnings generated by the fund. The courts have been persuaded that there must be a gross-up on the lump sum award to provide additional funds to pay income tax. The calculation of this gross-up has at times increased the lump sum award for future care by 50% or more.
- Loss of past or future income or loss of earning capacity

The amount of these claims varies according to the nature of work and the length of time the patient is disabled or kept out of the workforce. In some instances the

patient may be too young to be working, or may be temporarily unemployed. In these cases there is no established loss of income but rather a loss of earning capacity. In calculating loss of earning capacity the court will look to the patient's level of education, and employment experience or expectations. For injured infants, the courts will look to other factors including the education and occupation of the parents and average wage statistics.

The Supreme Court of Canada has repeatedly held that the loss of income is to be calculated using the gross amount of the patient's income and not the net income the patient receives after paying income taxes, even though the patient is not required to pay income tax on an award for loss of income.

Patients who are off work due to a medically-related injury often continue to receive income through collateral sources such as employee benefits, disability insurance, unemployment insurance, and welfare benefits. The Supreme Court of Canada has again held that no deduction is to be made to account for such collateral source payments when calculating the patient's loss of income. This method of calculating loss of income, based on the gross earnings of the patient and the failure to account for collateral source benefits received while disabled, may well serve as a disincentive for any patient to return to work. Unfortunately, any change in these methods of calculating loss of income will require legislation.

- Pre-judgment interest

The patient is entitled to an award of interest calculated on all items of damages except awards of future care and loss of income. Pre-judgment interest dates back to the commencement of the action. Bearing in mind that many legal actions take 5 years or more to proceed through the courts, this item can also serve to inflate damage awards significantly.

- Claims on behalf of family members

These awards are intended to compensate for additional services performed and to recognize the loss of guidance, care, and companionship other members of the patient's family suffered as a result of the disability of the patient.

As well, family members are entitled to claim for loss of financial support where the patient has died as a result of the medical injury. These amounts are calculated on an apportionment of the net after-tax income of the deceased that the family member might have expected to receive.

- Exemplary and punitive damages

Patients will occasionally advance such a claim to punish the defendant physician. These claims are almost never successful. Such an award will only be made where the misconduct of the physician is so malicious, oppressive, and high-handed that exemplary or punitive damages are necessary to serve as a deterrent. In Québec, the infringement of rights protected under the Québec Charter can justify the award of punitive damages.

While the majority of legal claims brought against CMPA members are successfully defended, it is anticipated that damages awarded to patients in a judgment or settlement will continue to rise. The two aspects most responsible for this increase are the claims for loss of income and earning capacity and the cost of future care.

While the majority of legal claims brought against CMPA members are successfully defended, it is anticipated that damages awarded to patients in a judgment or settlement will continue to rise.

Structured settlements

Substantial savings may be achieved in the cost of future care through greater use of structured settlements, whereby an annuity is purchased to provide a guaranteed tax-free stream of payments to ensure the injured patient receives the necessary future care and attention for life. The savings flow from favourable impaired life ratings often available for pricing annuities, as well as the avoidance of a tax gross-up calculation on the capital amount awarded or allocated for future care.

Structured settlements also benefit the patient. There is the certainty and stability of payments into the future as the annuity is non-assignable. A capital amount or lump sum paid to the patient is vulnerable to misinvestment or misuse and may therefore be dissipated well before the future monetary requirements to provide care to the patient are exhausted. A structure may also offer flexibility, with the annuity being tailored to vary the stream of payments to take anticipated changes in economic conditions or the patient's circumstances into account. Finally, a structure provides security into the future, as the annuity payments are not attachable in bankruptcy.

Although there is encouragement within legislation or rules of court in several provinces and territories to use structures, the courts are not generally empowered to require structured payments when awarding damages for future care. Stricter legislation or rules are required to forcefully take advantage of the benefits of structured settlements to plaintiffs and defendants.

The expert consultant

The expert consultant assists and advises the court through the expression of expert opinion as to what constitutes a reasonable standard of conduct, skill, and knowledge in the circumstances of a particular case. Above all else, the expert is expected to be impartial. It is not the role of the expert to act as an advocate for any party.

Physicians asked to act as an expert consultant must honestly self-evaluate whether they are appropriately qualified to provide the necessary opinion in the circumstances of that case. The potential expert may feel that another physician of greater or different experience, or another specialty, is more suitable to assess the work of the defendant physician. Physicians should not fall into the trap of believing that only leading specialists are qualified to act as expert consultants. In fact, an experienced general practitioner is best qualified to speak of the work of another general practitioner.

The expert must be guided by personal experience and what is perceived to be the usual or acceptable practice of colleagues in similar circumstances. Careful consideration must also be given to the education, experience, and other qualifications of the defendant physician, as well as to the equipment, facilities, and other resources that were available. It has been suggested that, as a final check, the expert consultant should ask whether the complication or result may have happened to any other physician even when being reasonably careful. If so, the defendant physician should not be considered to have been in breach of the appropriate duty of care toward the patient.

Physicians should not fall into the trap of believing that only leading specialists are qualified to act as expert consultants.

The expert consultant should remember that, in formulating an opinion about the quality of past medical care, it is a luxury to be able to review all the facts in retrospect. Allowances must be made to adjust for this advantage. It is equally important for the expert consultant to ensure the work of the physician is assessed according to the standards of practice applicable at the time of the event. The standards of practice change quickly and it would be unfair to review the work of the physician in the light of later practice.

In recent years concerns have been raised about the emergence of a counsel of perfection being advocated by some expert witnesses who are called to give evidence on behalf of the plaintiff. These expert consultants seem to apply a textbook standard in assessing the work of the defendant physician. There is doubt whether these expert consultants or, for that matter, physicians in general are able to adhere to these high standards on all occasions.

The following are some of the possible reasons for this counsel of perfection:

- The term expert may be misinterpreted and cause consultants to prepare so thoroughly and to become so knowledgeable that they lose sight of the more moderate level of skill and knowledge generally held by their colleagues.
- The experts may be prompted by pride and fear that they may face criticism of their own practices unless they advocate an optimum standard of care and skill.
- The expert consultant may be influenced by a personal practice which introduces a higher standard of care than is generally adhered to by members of that particular specialty or other type of practice.
- There is a view, particularly in the United States, that some experts tailor their evidence to advocate on behalf of the party who retained them.

The most common reason for unrealistic expert opinion appears to relate to the failure of many expert consultants, perhaps most, to appreciate or understand their role in the legal process. It bears repeating that the function of the expert consultant is to advise the court as to the proper standard of care against which the defendant physician is to be judged. The standard is not one of excellence or perfection, but rather that level of care and skill that could reasonably be expected of a physician with similar training and in similar circumstances to those of the defendant physician.

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The expert report

There is no obligation to act as an expert at the request of legal counsel for the plaintiff or defendant in a legal action; physicians are free to do so as a matter of choice. Physicians assuming the role of an expert should possess the appropriate expertise and experience to provide the specific expert opinion being requested. Always, as an expert, the physician should ensure that legal counsel has provided all the relevant documents for review so the physician is aware of all of the pertinent facts and issues on which to base an opinion. These documents should include the legal pleadings, all relevant medical records of the patient's treatment, transcripts of the evidence from examinations for discovery, and, where appropriate, the reports of other experts. The expert should always pay careful attention to, and follow the directions of, the instructing legal counsel.

Experts should raise with the instructing lawyer, at the outset, the issue of payment for reviewing documents and preparing the expert report. This discussion should extend to the time the expert might be required to devote to prepare for an attendance at any trial of the action. Following this discussion, the expert might write to the instructing lawyer setting out the terms and conditions of the retainer and the payment arrangements.

There is no established format for presenting an expert report, but most legal counsel find it helpful if the expert organizes the report using key headings where possible. For example:

- **Address the report to the lawyer or individual who requested it, never To Whom It May Concern.**
- **Refer to the purpose of the report.** Indicate whether the expert has been retained to provide an opinion on the standard of care or approved practice ("You have requested my opinion as to whether the medical treatment rendered the patient met the level expected for standard care"), on the issue of causation ("You have asked me to comment on the diagnosis of the medical condition and whether earlier treatment would have affected the outcome"), or on the assessment of disability ("This report is prepared following my independent medical examination of the patient").
- **State qualifications and experience.** Although the expert will likely have to provide a complete curriculum vitae to instructing counsel, it is helpful to include a paragraph summarizing the most pertinent details. For example, "I am a (name of specialty) and obtained my Fellowship from the Royal College of Physicians and Surgeons of Canada in (year). I have practised as a (name of specialty) in (name of city) for the last 30 years and was, until recently, chief of surgery at the local hospital and former chairman of the department of surgery at the faculty of medicine."
- **Include required information.** In an increasing number of jurisdictions, experts are being expressly required to include certain information in their legal reports, including an acknowledgement of their duty to provide opinion evidence for the court that is fair, objective, non-partisan, and related only to matters that are within the expert's area of expertise.
- **Specify the documentation that was reviewed in preparing the report.** This should be a complete list of all the relevant materials received from the instructing lawyer and reviewed in preparing the report. The dates of any medical examinations of the patient should also be included in the list. Reference might also be included to any specific literature or research data upon which the expert may have relied.
- **Outline the relevant patient history.** A narrative may have been provided by the instructing lawyer but the expert should prepare a personal medical summary of the chronology as confirmed by the relevant medical records.
- **State any assumptions used in preparing the report** and include any photographs, diagrams, calculations, or other research data used.

- **Describe any medical examination or functional inquiry.** Any medical examination, diagnostic investigation, or functional assessment of the patient should be reviewed in detail.
- **Summarize and conclude.** This will normally involve the analysis and opinion of the expert on the issue in question. In a medical negligence claim, for example, the expert should identify and comment on the failures, if any, in the medical care rendered and whether such deficiencies caused any direct harm or injury to the patient. There is also a trend to require experts to not only state their own opinion, but as well, to comment on and distinguish alternative or competing opinions relating to the issues being addressed.

Guidelines for giving evidence

Physicians may be required to testify in court, before a disciplinary committee or at some other tribunal, such as a coroner's inquest. Often they will be asked to give evidence as the attending physician who has first-hand factual information about the care and management of the patient. Generally such witnesses should not be asked questions intending to solicit an opinion about the work of others. If physicians are called to give evidence as expert consultants, their testimony will be expected to include an opinion on issues relating to standard of care and causation.

Here are some guidelines to consider prior to and while testifying:

Preparing

- Review all pleadings, medical records, statements, and transcripts relevant to the proceedings.
- With the help of counsel, identify and become familiar with all exhibits that will be presented to you during your testimony.
- Explore with your counsel the anticipated testimony of other witnesses to understand the theory of the case and be prepared to explain any inconsistencies that might arise.
- Review with counsel the evidence you will be expected to provide.
- Confirm with counsel the exact date, time, and place you will be required to attend to give evidence, and what records or other material you should bring with you.

Testifying

- Dress neatly.
- Be well rested; this will make it easier to stay in control and be attentive.
- Always tell the truth in a direct and straightforward manner.
- Listen carefully to every question and wait until the question is completed before you answer. If you do not understand a question, ask counsel to repeat or rephrase the question.
- Answer only the question that is asked; do not speculate or volunteer information.

If physicians are called to give evidence as expert consultants, their testimony will be expected to include an opinion on issues relating to standard of care and causation.

- Speak loudly and clearly, using positive and direct answers to each question; where possible use your own words, in language that will be understood by the court or tribunal.
- Maintain your composure and do not lose your temper or argue with legal counsel regardless of the vigour with which questions are asked.
- If an objection is made by counsel to any question or answer, stop and wait for the court or tribunal to rule on that objection.

These guidelines are of necessity quite general. If physicians have questions about the procedure or the facts of any case, they should raise their concerns with legal counsel well in advance of being called to give evidence.

Non-resident patients

From time to time, physicians practising in Canada are called on to provide professional services to patients who are not ordinarily resident in Canada. Many such patients are visitors or tourists who are in need of urgent or emergent care. At an increasing rate, however, such patients are individuals, mostly United States residents, who have travelled to Canada specifically to receive medical care and attention.

Non-resident patients who may be dissatisfied with the professional medical services received in Canada may seek to bring any medico-legal action against the Canadian physician in the foreign territory where they (patients) reside. An issue will then arise as to whether the foreign court should accept jurisdiction or defer such that the action must be brought in Canada. The more it appears that a non-resident was encouraged or invited to attend in Canada for medical care or attention, the more it appears that arrangements for such care or treatment were made while the patient was in the foreign jurisdiction, the more elective the care or treatment provided, or the more it appears that foreign funding was involved, the greater the likelihood the foreign court will permit the legal action to proceed in that jurisdiction.

Canadian physicians attending non-resident patients in Canada may take steps to encourage any subsequent medico-legal action being brought in Canada by requiring the non-resident patient to submit to the jurisdiction and law of the province in which the care or treatment is given.

Before treating a non-resident patient (with the exception of emergency cases), all physicians should have that patient sign the Governing Law and Jurisdiction form. There are occasional revisions to the form; when this occurs, CMPA members are advised.

Obtaining a patient's signature on this form is not an iron-clad guarantee of preventing legal action in a foreign jurisdiction, but remains a powerful argument in successfully restoring jurisdiction to Canada.

If a patient refuses to sign the form, physicians put themselves at risk if they carry the professional relationship any further.

For more information on this topic, refer to the CMPA article entitled "Treating non-residents of Canada" on our website (cmpa-acpm.ca).

Before treating a non-resident patient (with the exception of emergency cases), all physicians should have that patient sign the Governing Law and Jurisdiction form.

Medico-legal principles and duties

Negligence, malpractice, and the standard of care

It has often been said that medicine is not an exact science and that a physician does not guarantee satisfactory results or the patient's renewed good health. Untoward results may occur in medical procedures even when the highest degrees of skill and care have been applied. Taking for granted that the law does not demand perfection, what standard of care must a physician exercise in order not to be considered negligent?

Consistently over the years, the majority of medico-legal actions brought against physicians have been based on a claim for negligence or malpractice. Allegations of negligence or malpractice extend not only to acts the physician is said to have committed in error, but also to steps it is suggested the physician should have taken but failed to take. Indeed, this latter category, the alleged omission on the part of the physician, constitutes the bulk of claims for negligence or malpractice.

In jurisdictions subject to common law (all provinces and territories except Québec), four elements must be established or proven for any legal action based upon a claim for negligence to be successful:

1. There must be a duty of care owed towards the patient.
2. There must be a breach of that duty of care.
3. The patient must have suffered some harm or injury.
4. The harm or injury must be directly related or caused by the breach of the duty of care.

In Québec, the elements required to evaluate the liability are derived from different sources, but the issues to be decided by the court are similar.

These elements are explored below.

Duty of care

In common law jurisdictions, it is established that the duty of care imposed on a physician arises naturally out of the physician-patient relationship. In Québec, this duty arises out of the principles of general civil liability. Accepting a patient creates a duty, an obligation, to attend upon the patient as the situation requires and as circumstances reasonably permit. The physician also has an obligation to make a diagnosis and to advise the patient of it. While this may seem onerous, the physician is not expected to be correct every time, rather is merely expected to exercise reasonable care, skill, and judgment in arriving at a diagnosis. It is important to caution, however, that due regard be given to appropriate differential diagnoses when warranted.

Another duty imposed by the physician-patient relationship requires the physician to properly treat the patient in accordance with the current and accepted standards of practice. Further, the physician has an obligation to refer the patient or to obtain consultation when unable to diagnose the patient's condition, when the patient is not responding to treatment, or when the required treatment is beyond the competence or experience of the physician. In the same vein, referral or coverage arrangements must be made when the physician will not be available to continue to treat the patient. There is also a duty upon physicians to adequately instruct patients about both active treatment and follow-up care. This applies not only to return appointments and referrals for lab tests or consultations, but also to clinical signs and symptoms that might signal a complication requiring the patient to seek immediate medical care.

Breach of duty

In determining whether a physician has breached a duty of care toward a patient, the courts consider the standard of care and skill that might reasonably have been applied by a colleague in similar circumstances. In this regard, the courts have stated that:

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

The appropriate measure is therefore the level of reasonableness and not a standard of perfection.

The appropriate measure is therefore the level of reasonableness and not a standard of perfection. The courts have also recognized that it is easy to be wise in hindsight, therefore they must guard against judging a physician in retrospect. In addition, legal actions often take years to arrive at trial and medical standards may change in the interim. It is important that the appropriate standard be determined with reference to the circumstances and the reasonable standard of care as it applied at the time of the alleged negligence. The court ascertains this reasonable standard by means of expert evidence at trial.

Given that the physician is to be judged according to the standards ordinarily met by physicians of similar training and experience, it should not be surprising that any alleged breach of duty might be refuted where evidence is adduced (introduced) that the physician's conduct was in conformity with the practice of his colleagues. The Supreme Court of Canada has affirmed, however, that in very limited circumstances of a non-technical nature, the court may make a finding that the approved practice is itself unacceptable or negligent. A successful defence might also be expected where there are alternative approaches available and if the care and treatment provided were in keeping with that which might have been provided by at least a respectable minority of competent physicians in the field.

It has long been held that physicians are not in breach of their duty toward a patient simply because they have committed an honest error of judgment after a careful examination and thoughtful analysis of a patient's condition. The courts have attempted to distinguish an error of judgment from an act of unskilfulness or carelessness due to a lack of knowledge. As Lord Denning stated:

"It is so easy to be wise after the event and to condemn as negligence that which was only a misadventure. We ought always to be on our guard against it, especially in cases against hospitals and doctors. Medical science has conferred great benefits on mankind, but these benefits are attended by considerable risks. We cannot take the benefits without taking the risks."

Harm or injury

To establish negligence or malpractice, it is not enough for the patient to merely demonstrate that the physician has breached a duty of care toward the patient in one way or another. It must also be demonstrated that the patient has suffered some harm or injury. Many occasions arise in medical practice when a breach of the standard of care occurs, but fortunately no adverse result is suffered. An example might be a fracture that is perhaps missed at the time of the initial review of the X-ray but is later detected before any harm resulted to the patient.

Causal connection

The patient must also establish that there is a relationship, or causal connection, between the alleged breach of duty and the stated harm or injury. This issue often becomes the crux of a legal action. Until recently, in provinces or territories subject to common law, when the cause of the complication was not readily evident, counsel for the plaintiff would attempt to bridge the gap by resorting to the maxim *res ipsa loquitur* or "the thing speaks for itself." The Supreme Court of Canada has now stated that using this maxim to establish causation is inappropriate. Medical science has not yet reached the stage where the law ought to presume that all treatment afforded a patient must have a successful outcome and that anything less suggests negligence or malpractice.

The Supreme Court of Canada has upheld that the traditional elements of a legal action in negligence apply to professional liability cases and affirmed that the plaintiff must establish, on a balance of probabilities, that the alleged breach of duty caused or contributed to the injury sustained. The Supreme Court has gone on to state, however, that the trial judge is entitled to adopt a robust and pragmatic approach to the facts so as to adopt a common sense inference of causation even in the absence of positive or scientific proof being adduced (introduced) by the plaintiff.

On occasion, the plaintiff may be unable to establish a probable causal connection between an alleged breach of duty and a complication sustained, as there may be other factors that could also have caused or contributed to the same result and for

Medical science has not yet reached the stage where the law ought to presume that all treatment afforded a patient must have a successful outcome and that anything less suggests negligence.

which the physician could not be faulted. The Supreme Court of Canada has held that where such multiple factors are distinct and separate, such that each factor on its own was sufficient to cause the injury, the plaintiff must comply with the traditional requirement to establish, on a balance of probability, that the physician's breach of duty caused the outcome. The court held, however, that the plaintiff would not be held to such a strict standard where there were multiple factors present, but it was not possible to distinguish between the various causes and, indeed, all the factors combined to create the one outcome. In such circumstances the plaintiff might succeed by establishing that the physician's breach of the standard of care materially contributed, that is to say, contributed in more than a *de minimis* manner, to the occurrence of the injury. Such situations will hopefully be rare and the traditional balance of probability test for causation will continue to be used in the majority of medico-legal actions.

Consent

There is a very basic proposition recognized by the courts that every human being of adult years and of sound mind has the right to determine what shall be done with his or her own body. This general principle is that of the inviolability of the person in Québec. Therefore, subject to certain exceptions, such as an emergency or a court order, a physician must obtain a valid and informed consent before any treatment is administered to a patient.

An emergency nullifying the requirement to obtain consent only exists where there is imminent and serious danger to the life or health of the patient and it is necessary to proceed immediately to treat the patient. The concept of emergency treatment also extends to instances where the patient requires treatment to alleviate severe suffering. The convenience of the physicians, the healthcare team, and the hospital, however, must not be included as determining factors in declaring proposed treatment to be emergent.

Consent plays such a major role in the physician-patient relationship that the CMPA has published a booklet offering an overview of the law of consent as it pertains to medical management: *Consent: A Guide for Canadian Physicians* is available on our website. A print version is also available on request.

The law on consent will continue to evolve, either through the refinement of future court decisions or through legislation enacted by the provinces or territories. In the meantime, the following suggestions may help physicians meet the legal standards applicable to the law of consent:

- Discuss with the patient the nature and anticipated effect of the proposed treatment, including the significant risks and available alternatives.
- Give the patient the opportunity to ask questions.
- Tell the patient about the consequences of leaving the ailment untreated. Although there should be no appearance of coercion by unduly frightening patients who refuse treatment, the courts now recognize there is a positive obligation to inform patients about the potential consequences of their refusal.

- Be alert to and deal with each patient's concerns about the proposed treatment. It must be remembered that any patient's special circumstances might require disclosure of potential although uncommon hazards of the treatment when ordinarily these might not seem relevant.
- Exercise cautious discretion in accepting waivers, even if the patient waives all explanations, has no questions, and may be prepared to submit to the treatment whatever the risks.

Substitute decision

An individual who is able to understand the nature and anticipated effect of proposed treatment and available alternatives, including the consequences of no treatment, is competent to give valid consent. While it was once thought that a patient had to be of the age of majority to give consent, age is no longer the deciding factor.

It is also well accepted that a person suffering from mental incapacity may still retain sufficient mental ability to give valid consent to medical treatment. Again, it depends on whether the patient is able to adequately appreciate the nature of the proposed treatment, its anticipated effect, and the alternatives. Therefore, many individuals who are mentally incapable or who are in psychiatric facilities continue to be capable of controlling and directing their own medical care, including the right to refuse treatment.

There is legislation in several provinces and territories that provides a means to obtain substitute consent when the patient is incapable of giving valid consent by reason of immaturity or mental disability. Typically such legislation sets out and ranks a list of individuals, usually family members, who are authorized to give or refuse consent to treatment on behalf of an incapable person. These substitute decision-makers must act in compliance with any prior expressed wishes of the patient, or in the absence of any expression of will, in accordance with the best interests of the patient.

Legislation exists in most provinces and territories that specifically empowers a patient to execute an advance directive as to future care in the event the patient later becomes incapacitated or unable to communicate such wishes. An advance directive may contain explicit instructions relating to consent or refusal of treatment in specified circumstances, sometimes referred to as a living will.

Age of majority

All jurisdictions have enacted legislation to establish an age of majority. In British Columbia, New Brunswick, Nova Scotia, Newfoundland and Labrador, and the territories, that age is 19 years. In the remaining provinces the age of majority is 18 years. It was once thought that patients had to reach the age of majority before they could give proper consent to treatment. In more recent years, the patient's ability to comprehend explanations given, rather than the chronological age, has become the important determinant in obtaining valid consent from young people. It is now widely recognized that many young patients reach the age of discernment before the age of majority. This subject is explored in the CMPA booklet *Consent: A Guide for Canadian Physicians*. The Civil Code of Québec generally establishes the age of consent

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at 14 years, below which the consent of the parent or guardian or of the court is necessary for the purposes of proposed treatment.

Sterilization of the mentally incapable patient

In a judgment dated October 23, 1986 in the case of "Eve" the Supreme Court of Canada declared that sterilization should never be authorized to be carried out on mentally incapable persons for non-therapeutic purposes. The irreversible and serious intrusion of a sterilization procedure on the basic rights of the individual is simply too great to allow the court to act on the basis of possible advantages which, from the standpoint of the individual, are highly debatable. If non-therapeutic sterilization of the mentally incapable patient is to be accepted as desirable for any general social purposes, provincial and territorial governments must enact appropriate legislation. This decision of the court must be interpreted to also prohibit the capability of a parent or guardian to consent to the sterilization of a mentally incapable child for non-therapeutic reasons. In Québec, the authorization of the court is necessary to submit a mentally incapable person of full age to care that is not required by his/her health condition and that could present serious risks to his/her health or cause severe and permanent damage.

The court emphasized that utmost caution must be exercised in deciding when therapeutic sterilization procedures might be appropriate for mentally incapable persons, even for medical reasons. When medical benefits are marginal they must be weighed carefully against what is seen as a grave intrusion on the physical and mental integrity of the mentally incapable patient. The court referred to a case in British Columbia where a hysterectomy was ordered performed on a seriously mentally incapable child because the child's phobic aversion to blood might seriously affect her when menstruation began. The court noted that this case was at best dangerously close to the limits in justifying a therapeutic sterilization. It is wise for physicians asked to sterilize a mentally incapable person to consult with a psychiatrist to assess the mental status of the patient, including the prognosis, and in questionable cases to consult with a colleague. It is very important to document and record all these discussions and consultations so the rationale for the procedure can be confirmed at a later date.

Refusal of treatment (blood transfusions)

It is a basic principle of medical practice that physicians may do nothing to or for a patient without valid consent. In particular, the doctor cannot substitute his will for that of the patient despite the best of intentions or the reasonableness of the proposed treatment. It has also been generally accepted that a person of sound mind has the right to refuse treatment even though refusal may well lead to an avoidable death. It has even been suggested that the right of a competent patient to refuse treatment may well be protected by the *Canadian Charter of Rights and Freedoms*.

An Ontario action, affirmed on appeal, dealt with circumstances where the doctor administered blood transfusions to an unconscious adult Jehovah's Witness who carried a card prohibiting blood transfusion. The physician considered the transfusions necessary to save the patient's life. The court held that the physician should have respected the wishes of the patient as affirmed by the family members in attendance at the time.

It is clear, however, that parents do not have the authority to refuse needed treatment on behalf of their children. Provincial and territorial child welfare legislation generally defines a child to be in need of protection to include situations when the parent or person having charge of the child refuses to consent to medical treatment required to cure, prevent, or alleviate physical harm or suffering on the part of the child. This section is invoked when parents who are Jehovah's Witnesses refuse to consent to blood transfusions being administered to their child. The procedure in such instances is to report the situation to the child welfare authorities who will then arrange for a hearing to have the child declared in need of protection and placed in their custody so they might consent to the proposed treatment over the objections of the parents, or to obtain authorization from the court.

It is of interest that in other recent cases the courts have upheld parental refusal to consent to chemotherapy that may have had limited success in prolonging the life of their child.

End-of-life decisions

It is the traditional role, even legal duty, of physicians to provide medical care and treatment to patients. However, the medical profession accepts that there are conditions of ill health and of impending inevitable death for which continued treatment might be considered entirely inappropriate. The experience of many physicians, however, is that these treatment decisions become particularly difficult in the context of end-of-life care, as ethical factors and clinical judgment often collide with the wishes of the patient or his/her family. Indeed, it is not uncommon for controversy to arise in situations where a physician believes a certain treatment should be withheld or withdrawn on the basis of medical futility, yet the patient, his/her family, or substitute decision-maker demands such treatment. These situations usually arise in the context of a do-not-resuscitate (DNR) order or in situations where the attending physicians are of the opinion that continued attempts to treat the terminal patient would be completely ineffective and therefore life-sustaining treatment should be withheld or withdrawn.

- Do-not-resuscitate orders

The Canadian Medical Association takes the position that it is appropriate, medically and ethically, for a physician to write a DNR order for terminally ill patients whose death seems imminent and inevitable.

Competent patients have the absolute right to make decisions about their treatment. This extends to decisions not to resuscitate; therefore, physicians contemplating such an order should discuss this with the patient. When the patient is not competent, the appropriate substitute decision-maker and, where permitted, the appropriate members of the patient's family should be included in the process leading to a decision to issue a DNR order.

It is important that the basis of any decision to issue a DNR order not be, or even be seen to be, arbitrary. The reasoning and criteria to be applied by the physician should be sufficiently firm and clear so any decision can be effectively supported should it later be subject to question. While there need not be unanimity among colleagues, there must be at least a substantial body of opinion in the medical profession that would support both the reasoning and criteria applied and the decision made by the physician. Where appropriate, the attending physician may wish to consult with colleagues for support of the DNR order. The Canadian Medical Association and others have issued a joint statement that outlines a protocol for healthcare professionals regarding resuscitated intervention for the terminally ill.

- Withholding/withdrawal of medical treatment

While it is undisputed that a physician must respect any known wishes of a patient not to receive a particular procedure or treatment, it is less clear whether a patient (or the appropriate substitute decision-maker) has a positive right to demand that a specific form of treatment be given, even though the physician may disagree. However, recent case law demonstrates a trend to give greater weight to the views of the patient and the substitute decision-maker (usually the family) regarding end-of-life decisions. Thus, for example, cultural and religious considerations of the family may well influence treatment decisions, or at least the timing of the same.

It is well established that the wishes and best interests of the patient are paramount when making end-of-life decisions. Physicians should also be familiar with the recommendation and requirements contained in any relevant College policies regarding end-of-life care and withholding or withdrawing life sustaining treatment.

Where conflict arises in respect of these complex decisions, physicians may attempt to reach some form of consensus with the patient, his/her family, or substitute decision-maker about the goals of continued treatments and what is likely to be achieved. Often these discussions may include religious and other family advisors, as well as involvement and consultation with physician colleagues. In those rare circumstances where consensus is still not achieved, it may be necessary to make an application to the court (or another administrative body) for directions. In every case, members are encouraged to contact the CMPA for specific advice whenever there is a disagreement with a patient, family member, or substitute decision-maker regarding recommended treatment decisions for end-of-life care.

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- Physician assisted suicide

In a well publicized case in 1993, the Supreme Court of Canada considered the rights of a 42-year-old mother with amyotrophic lateral sclerosis to choose, once she reaches the stage of being unable to enjoy her life, to commit physician assisted suicide. The court considered the interests of the patient under the *Charter of Rights*, balanced against the interests of society and upheld the validity of the prohibition against assisted suicide as set out in the *Criminal Code of Canada*. The court concluded that the prohibition on giving assistance to commit suicide serves to protect and maintain the respect for human life. The protection is grounded on a substantial consensus among Western countries, medical organizations, and the Law Reform Commission of Canada to the effect that the prohibition against assisted suicide without exception is necessary in order to protect the sanctity of life and those who are most vulnerable in our society.

Informed discharge

Although not strictly an element of the pre-operative consent process, the courts have elaborated on the duty or obligation of physicians to properly inform patients in the post-operative or post-discharge period. Thus a physician must conduct a full discussion with a patient of the post-treatment risks or complications, even statistically remote ones, that are of a serious nature. The purpose is to inform the patient of clinical signs and symptoms that may indicate the need for immediate treatment such that the patient will know to visit the physician or return to the hospital or facility.

Confidentiality and privacy

Communications between a patient and a physician are confidential and must be protected against improper disclosure. Physicians are therefore under restraint not to volunteer information about the condition of their patients or any professional services provided without the consent or authorization of the patient or as otherwise may be required or permitted by law.

Any improper disclosure of confidential information about a patient renders the physician vulnerable to disciplinary proceedings before the College of Physicians and Surgeons or other authority in the province or territory as well as a potential civil action that may be commenced on behalf of the plaintiff for damages. Complaints or claims for breach of confidence most often originate with the inadvertent, even the best-intentioned, release of medical information to a friend or relative of the patient without proper authorization, or unguarded discussion between healthcare providers in an elevator or other public place.

Consent to disclose information

There are situations where a physician may properly divulge confidential information about a patient. These exceptions are examined below.

Expressed consent

A physician may clearly disclose confidential information when authorized or directed by the patient to do so. The physician should obtain the written authorization of the patient when the information to be released may be sensitive in nature or where the information is to be forwarded to a third party such as the patient's employer or insurer, or legal counsel retained by or on behalf of the patient.

It is particularly important that there be a clear understanding between the physician and the patient about the release of medical information when the patient is being examined at the request of another person, such as a prospective employer or insurer. The patient must understand, and should acknowledge in writing, that a report of the examination will be forwarded to this other party, perhaps without a copy being made available to the patient.

Implied consent

The patient's authorization for the release of information may be reasonably implied in certain circumstances. Such implied consent is often relied upon for consultations or discussions among members of the healthcare team and for discussion with family members. If there is a later dispute, the onus is on the physician to demonstrate there was a reasonable basis for assuming implied consent.

The physician called as a witness

A physician summoned or subpoenaed to give evidence in legal proceedings, including those in any court or before any board or tribunal, must answer all questions asked when under oath. Only communications between lawyers and their clients are fully privileged and protected from disclosure, even in court.

A physician who refuses to answer questions asked under oath may be held in contempt of court and fined or even sent to jail. The courts do have some discretion, however, particularly in the areas of mental health and family relations, to excuse a physician from answering questions where the potential harm caused by the disclosure of the confidential medical information may be greater than any benefit to be gained by such disclosure.

Search warrants and court orders

Generally, there is no obligation to provide the police with clinical or personal information about a patient suspected of committing a crime. In fact, in order to comply with the requirements of confidentiality, physicians should respond to routine police inquiries about a patient by asking the police to obtain a search warrant for the production of the patient's chart. Physician and hospital administrators must comply with the demands of a search warrant. Before producing the original chart to the

police, steps should be taken to copy the patient's chart so that it is available for the purpose of treating the patient.

There is also no general obligation to report patients suspected of having committed a crime (see Duty to warn section below). Recently, however, 5 provinces (Saskatchewan, Manitoba, Ontario, Québec, and Nova Scotia) have enacted legislation that requires all hospitals and healthcare facilities that treat a person for a gunshot wound to disclose that information to the local police service. The legislation in Saskatchewan and Manitoba also extends the reporting obligation to stab wounds. Of particular interest, the legislation in Québec also permits but does not oblige physicians to report to police suspicious behaviour of patients whom they reasonably believe may endanger their own safety or the safety of another person by the use of a firearm. The information to be disclosed should be limited to that which is necessary to facilitate police intervention.

Physicians often receive requests for copies of the patient's office record from a third party. Physicians should not comply with such requests unless they have the written authorization of the patient or they are provided with a court order requiring the release of such records.

Statutory requirements

There are statutes in every province and territory as well as federal statutes that require a physician to divulge information obtained through the physician-patient relationship. In many instances the physician is not only required to report confidential information to a public authority but, as well, the physician may be prosecuted, fined, or imprisoned for failing to fulfil this statutory obligation.

The most notable statutory requirements pertain to the reporting of suspected child abuse, patients who are unfit to drive, and patients suffering from designated diseases, as well as reports to workers' compensation boards and the completion of certificates under the *Vital Statistics Acts*.

Duty to warn

There are occasions when a physician's duty to society may outweigh the obligation of physician-patient confidentiality, thereby justifying the voluntary disclosure of information about a patient to the appropriate authority. In a landmark decision, the Supreme Court of Canada confirmed the existence of a public safety exception to physician-patient confidentiality. The court held that, in appropriate circumstances, danger to public safety can provide a justification for the disclosure of privileged or confidential information. Courts are to consider the following factors in determining if physician-patient confidentiality should be displaced:

- There is a clear risk to an identifiable person or group of persons.
- The risk is one of serious bodily harm or death.
- The danger is imminent.

The Supreme Court of Canada stated that these factors will often overlap and vary in importance and significance depending on the circumstances of each case, but they all must be considered. The test appears to be objective. Therefore, the question is whether a reasonable person, given all the facts, would consider the potential danger to be clear, serious, and imminent.

In this case, the court was only required to state that disclosure in the public interest is permissible for public safety, and expressly avoided the issue of whether there exists an actual duty to warn. However, it is possible this decision will lead to formal recognition of such a duty. Therefore, a failure to warn could soon form the basis of an action in tort and grounds for a finding of professional misconduct.

The principle arising out of the decision by the Supreme Court of Canada, which is also recognized in certain legislative texts, permits physicians to disclose otherwise confidential physician-patient information to the relevant authorities in the interest of public safety. This disclosure should be limited to information necessary to protect public safety. Physicians are encouraged in individual situations to seek specific advice and counsel as to the appropriateness and scope of disclosure of information relevant to public safety.

Privacy

In addition to the long-standing obligations of confidentiality and security in the provision of patient care, a physician must now also comply with obligations established under privacy legislation. While the various statutes contain minor differences, privacy legislation governing the collection, use, and disclosure of personal information (including health information) is now applicable in each jurisdiction across Canada. Physicians should become aware of the privacy legislation applicable in their province or territory and accommodate it within their type of practice. In some provinces, physicians working in hospitals have different obligations than physicians working in private practice.

The fundamental principle of all privacy legislation is an individual's right of control over the collection, use, and distribution of their personal information, including health information. Consent is the cornerstone of an individual's control and, subject to certain legislated exceptions, personal health information should not be collected, used, or disclosed without the individual's consent. While the method of obtaining a patient's consent may be implicit or explicit, it must always be informed and voluntary and may be amended or withdrawn at any time.

Most often, personal health information is collected for the purposes of treating an individual's injury or illness. Generally, when a patient seeks treatment, a physician may reasonably assume that implied consent has been provided by the patient for the collection and use of personal health information for the purpose of treatment. Further, unless the individual has expressly withheld or withdrawn consent, it is permissible for the physician to rely upon this implied consent to share the personal health information with other healthcare professionals involved in treating the same injury or illness.

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If circumstances are such that implied consent cannot be reasonably assumed, then a physician is obligated to discuss with their patient the purpose for which personal information is being collected and how such information is to be used or disclosed to others. Physicians should always obtain and document new and specific consent if they intend to use, or disclose an individual's personal information for any purpose other than that for which the information was first collected.

Most privacy statutes provide a list of exceptions where personal information may be collected, used, or disclosed without the individual's consent. While the exceptions vary, most statutes permit collection, use, and disclosure without consent where the information is required:

- for use in legal proceedings
- to prevent a risk of serious harm to the health and safety of the individual or others
- to contact an individual's relatives or next of kin
- to comply with a subpoena or a provision of another statute

In a number of privacy statutes, there are also special provisions relating to the use of personal health information for research purposes.

Privacy legislation reinforces a patient's existing right of access to personal information contained in his/her medical records. While a fee may be charged for such access requests, physicians should be aware that the amount of the fee may be governed by statute, regulation, or College guidelines. Clarification should be sought. Patients may also be permitted to challenge the accuracy of factual information contained in their medical records. The opinions of treating or consulting physicians are not subject to amendment. In circumstances where corrections are made, it may prove prudent to not delete any aspect of the existing record but rather append the correct information to the record with a clear note of explanation. There are limited circumstances where a physician can deny an individual's request for access, including when disclosure may present a risk of harm to the individual or reveals personal information about a third party.

Most privacy statutes provide for the appointment of an enforcement officer, such as an information and privacy commissioner. Enforcement officers may have the power to investigate complaints, initiate investigations, and make recommendations and orders regarding an organization's privacy compliance. In some cases, breaches of privacy legislation may result in penalties and fines.

Physicians should become aware of the applicable administrative duties regarding personal information management. It may be necessary to designate an employee to act as a privacy officer to monitor compliance with privacy legislation. The privacy officer may also be charged with responding to access requests and complaints. While the CMPA will provide advice and assistance with many privacy matters, we will not assist physicians with becoming compliant in their practice environment; however, the Canadian Medical Association and some provincial medical associations have excellent toolkits to assist physicians with privacy compliance.

More information on privacy issues is available on the CMPA website (cmpa-acpm.ca).

Medical records

Access to medical records

In June 1992, the Supreme Court of Canada rendered a judgment on a patient's right to access the medical records compiled in the office of a physician.

The court concluded that the medical record maintained by the physician is, in the physical sense, owned by that physician. The court also affirmed the well-recognized duty of physicians to hold the information in the medical record confidential, unless otherwise directed by the patient or authorized by law.

The remaining and more controversial issue, however, was whether the patient had the right to examine and obtain copies of all documents in the physical medical record. Mr. Justice La Forest examined the fiduciary aspect of the physician-patient relationship and concluded that the information about the patient was held by the physician in a trust-like manner. He considered that the information in the record remained in a fundamental way the patient's own. The patient has a basic and controlling interest in such information.

The court held that the significant beneficial interest of the patient in the medical record was sufficient to extend the fiduciary duty of the physician to grant the patient direct access to the medical record. The crucial aspects of the judgment are as follows:

- The physical medical records are the property of the physician.
- A patient is entitled, upon request, to examine and receive a copy of the complete medical records compiled by the physician in administering advice or treatment to the patient, including records prepared by other physicians that the physician may have received.
- The patient is not entitled to examine or receive copies of any information or material received or compiled by the doctor outside of the physician-patient relationship.
- A patient's general right of access to medical records is not absolute. Physicians may exercise discretion not to disclose any information they reasonably believe is likely to cause a substantial adverse effect on the physical, mental, or emotional health of the patient or harm to a third party. The court stated that patients should have access to the medical records in all but a small number of circumstances.
- A patient should have access to the medical record in the ordinary course unless there are compelling reasons for non-disclosure. The onus is on the physician to justify a denial of access to the information or records.
- A patient may apply to the court for a review of any refusal by a physician to disclose all or part of the medical record. If the court is not satisfied that the physician acted in good faith, it may not only order production, but also grant the patient appropriate relief by way of costs.

This judgment represents a significant departure from the previously-held view that the patient's right to information in the medical chart is limited to a summary report of the care and management afforded the patient by the physician. Physicians must recognize and adapt to the court's decision.

Retention of records

Physicians and healthcare institutions are required by law in each province and territory to maintain a treatment record for each patient. In most jurisdictions, the legislation specifically details the information to be recorded in the patient's chart. This legislative requirement is premised on the understanding that maintaining complete and accurate medical records is necessary to ensure a consistent treatment plan for the patient. Records are also invaluable to the physician who is the subject of a complaint or civil action by a patient. Because patients usually do not keep concurrent notes of the events, the physician's notes, if reasonably detailed and made at the time or shortly after each visit, are often considered to be the most accurate and reliable record of a consultation.

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This table is a summary, by province or territory, of the minimum legislative requirements or recommendations respecting the retention of records (effective January 2010 — see this table on the CMPA website for any subsequent amendment to the applicable limitation period).

Province/ Territory	Physicians	Hospitals
British Columbia	7 years from date of last entry or the age of majority, whichever is the latest. (<i>Health Professions Act</i>)	primary documents*: 10 years from most recent day of discharge. Secondary documents**: 6 years from date of discharge (<i>Hospitals Act</i> regulations)
Alberta	10 years following date of last service or in the case of minor, 10 years or 2 years past age 18, whichever is longer (recommended by the College)	10 years from date of discharge or 2 years past age 18 if minor; where microfilming employed, originals may be destroyed after 1 year. (<i>Hospital Act</i> regulations)
Saskatchewan	6 years following date of last entry; 2 years past age 18, or 6 years after date last seen, whichever is later (<i>College bylaws</i>)	10 years from date of discharge or if minor, until age 19, whichever is longer. Period may be extended as deemed necessary by hospital. Where microfilming employed, paper copy of records must still be retained for 6 years. (<i>Hospital Standards Act</i> regulation)
Manitoba	10 years following date of last entry or 10 years past age 18 in case of minor. (<i>College By-law 1, article 29.5</i>)	30 years (recommended by the (now defunct) Manitoba Health Organization). Each hospital required to set a retention period. (<i>Personal Health Information Act, s. 17(1)</i>)
Ontario	10 years after date of last entry or if minor, until 10 years after patient reaches or would have reached age 18 (<i>Medicine Act</i> regulations)	10 years from date of last visit or 10 years past age 18 if minor (<i>Public Hospitals Act</i> regulations)

Continued

Province/ Territory	Physicians	Hospitals
Québec	5 years following date of last entry; 10 years for operation reports for major surgeries, anatomopathology reports, and genetic tests. Genetic tests must be kept for another period of 10 years unless they have been remitted to the person concerned by these reports or another copy is available. (Professional Code regulation)	varies from hospital to hospital (Archives Act, s. 7)
New Brunswick	10 years after date of last entry; or 2 years past age 19 if minor; or 2 years after death of patient (College guideline)	6 years after date of discharge; or if minor, for 6 years or until age 21, whichever is longer (Public Hospitals Act regulations)
Nova Scotia	10 years after date of last visit or 10 years past age 19 if minor (recommended by College)	primary documents*: 20 years following date of discharge. Secondary documents**: 7 years following discharge; or if minor, 7 years past age of majority (N.S. Dept. of Health Guidelines)
Prince Edward Island	10 years after date of last entry or 10 years past age 18 if minor (recommended by the College)	20 years following date of discharge or 5 years from death of patient. Photographed records: 50 years for photographs and 2 years for the chart; if minor, retention period does not commence until age 18 (<i>Hospital Management Regulations</i> , s. 41, 43, 44)
Newfoundland and Labrador	10 years after date of last entry or 2 years past age of majority, whichever is longer (recommended by College)	30 years following date of discharge; where microfilming employed, paper records can be destroyed, but if scanned paper records must still be kept for 6 years (government guidelines)
Yukon	not less than 6 years from date of last entry (Medical Professions Act Regulation) 10 years (recommended by Yukon Medical Council as per advice of the CMPA)	Primary documents*: 10 years from most recent day on which patient discharged. Secondary documents**: 6 years (Hospital Act regulations)
Northwest Territories/ Nunavut	10 years (in accordance with recommendation of the medical association)	usually 6 years following date of discharge or 2 years past age 19 if minor (may vary with hospital policy)

* *Primary documents: documents signed by physicians that are of value for the continuing care of a patient (e.g history, physical examination, operative reports, etc.)*

** *Secondary documents: documents that are important at the time of care, but are not of vital medical importance for future care (e.g nurses' notes, vital signs records, consent, etc.)*

How long, then, should medical records be kept to ensure their availability in the event of litigation or a complaint by the patient? The most prudent approach is to retain the medical records until the anticipated expiry of the limitation period to commence an action. Physicians should also be aware of the minimum legislative requirements respecting the retention of medical and hospital records in their province or territory. In the absence of legislative requirements, some jurisdictions have issued recommendations about the retention of records that are considered to adequately protect both patients and physicians. For medico-legal purposes it is recommended that the physician's records about patients be kept secure and intact for a period of at least 10 years following the date of the patient's last visit. It may be appropriate that the records of at least some newborns and children be kept for several years after the child should have reached the age of majority.

Electronic records

Many physicians are now moving from storing patient information in traditional paper-based records to an electronic version of the record (electronic medical records or EMRs). EMRs may be simple office-based systems or shared records that connect health professionals through a network. Many hospitals and health authorities have also implemented electronic health record systems (or EHRs) in their institutions. EHRs are generally a compilation of core health data from multiple sources and may be comprised of many different records submitted by numerous providers and organizations.

There are a number of important factors to be considered in the transition from paper-based patient records to an electronic version of such medical records:

- The selection of an appropriate system and software program is the crucial first step, both as to suitability to the needs of the physician's practice, and as well for compatibility with the systems of other healthcare providers and healthcare institutions and facilities.
- Physicians are encouraged to consult widely with colleagues and to seek professional assistance from a variety of sources, including qualified service providers, information technology experts, provincial, territorial, or national medical associations and any local physician technology support programs.
- Physicians should consult personal legal counsel and seek advice from provincial, territorial, and national medical associations before entering into any formal agreement to purchase or lease hardware equipment and to obtain an appropriate software licence to operate the system.

While the rules surrounding the use of paper records are generally understood by all physicians, the rules are less clear when dealing with electronic records systems. From a medical liability perspective, the key issues that must be considered in the

context of electronic records are ownership and stewardship of data, privacy and consent, access to and accuracy of information, and secondary use and evidentiary requirements. Physicians should refer to the CMPA's paper, *Electronic Health Records: A Medical Liability Perspective*, and the *Electronic Records Handbook* for a more comprehensive overview of the technological and medico-legal issues associated with the implementation and use of electronic records.

Important legislation

Provincial and territorial legislation plays an important role in medical practice. Here are highlights of some of the most important aspects of such legislation.

Reporting patients unfit to drive

There is a statutory duty in all jurisdictions related to reporting patients unfit to drive. The relevant legislation in Alberta, Québec, and Nova Scotia is discretionary such that physicians are permitted to breach confidence and report a patient who they believe may have a medical condition that renders the person unable to operate a motor vehicle. Conversely, the legislation in Saskatchewan, Manitoba, Ontario, New Brunswick, Prince Edward Island, Newfoundland and Labrador, and the territories is mandatory and requires physicians to report any patient who, in their opinion, has a medical condition that may make it dangerous for the person to drive. Indeed, failure to report in these latter jurisdictions constitutes an offence.

In British Columbia, physicians are required to report only a patient who, in their opinion, has a medical condition that makes it dangerous to drive and the patient continues to drive after being warned of the danger by the physician.

Physicians have been involved in several actions brought on behalf of an injured party in a motor vehicle accident alleged to have been caused in part by the medical disability of another person who should not have been allowed to continue driving. Physicians have been found liable for failing to report, notably in those provinces and territories with mandatory requirements.

Physicians have been found liable for failing to report, notably in those provinces and territories with mandatory requirements.

It is therefore important for physicians to fulfil their statutory duties in a diligent yet sensible manner, reporting those patients who they believe have a medical condition that might reasonably make it dangerous to drive. In the cases to date, the courts have been greatly influenced by the Canadian Medical Association booklet *Determining Medical Fitness to Drive: A Guide for Physicians*. Physicians are encouraged to be familiar with, and use, these guidelines when assessing a patient's fitness to operate a motor vehicle and in deciding about the need to report a patient.

Reporting child abuse

Every province and territory has enacted legislation requiring physicians to report children in need of protection, including instances of suspected child abuse, to the child welfare authorities or the equivalent in the province or territory. For most jurisdictions the duty to report applies to children under 16 years of age but in Alberta, Manitoba, Québec, and the Yukon it is 18 years. It is also 18 years of age for the reporting of sexual abuse in Saskatchewan. The age is 19 years in British Columbia for all purposes. The duty to report is mandatory even though the information reported may be confidential. Failure to report constitutes an offence. Physicians are protected against legal action for making the required report, provided the report was not made maliciously or without reasonable cause.

Blood alcohol samples

The *Criminal Code* was amended in 1985 to allow for the taking of blood samples in certain situations. The police may request a person to provide a blood sample when they believe, on reasonable and probable grounds, that the person has operated a car, boat, or aircraft while impaired during the preceding 2 hours and the person is incapable, by reason of a physical condition, of providing a breath sample or it would be impractical to obtain such a sample. If the individual refuses to comply without reasonable excuse, he commits an offence. Physicians should not attempt to obtain a blood sample from a patient in these situations without the patient's consent.

A blood sample may also be taken from a person on the basis of a warrant issued by a Justice of the Peace in appropriate circumstances. These warrants may be issued where the Justice of the Peace is satisfied there are reasonable grounds to believe the person has been driving while impaired within the previous 2 hours and was involved in an accident resulting in death or bodily harm to any person. The Justice of the Peace must also be satisfied on the basis of medical opinion that the person is unable to consent to the taking of the sample by reason of any physical or mental condition resulting from the consumption of alcohol, the accident or any other occurrence associated with the accident, and that taking the sample will not endanger the life or health of the person. All this information may be relayed by telephone to the Justice of the Peace, who may instruct that a facsimile warrant be completed by the police. In these situations, the physician takes the blood sample on the basis of the warrant and not on the basis of consent by the patient.

Physicians are not obliged to comply with the police request to take a blood sample. However, any physician who assists the police in taking a blood sample, either by consent or pursuant to a warrant, is protected from criminal or civil liability for anything necessarily done with reasonable care and skill in taking the sample.

Mental health legislation — involuntary admission

There is legislation in all jurisdictions governing mental health that provides specifically for involuntary confinement in, or admission to, a psychiatric institution.

There is legislation in all jurisdictions governing mental health that provides specifically for involuntary confinement in, or admission to, a psychiatric institution. Generally, a physician may complete an application for an individual to be conveyed to a psychiatric facility for assessment if the physician has recently (within days) examined the person and the physician is satisfied that the stated criteria warranting such assessment have been met. The legislation further provides that, once at the psychiatric facility, the individual must be examined by one or more psychiatrists, again within a strict time frame, usually measured in hours. If the mental disorder and the appropriate criteria are confirmed, a certificate of involuntary admission is issued. These certificates are usually valid for a number of days and must be renewed periodically following appropriate examinations of the patient. The legislation in some jurisdictions also provides for procedures whereby the patient may apply to a review board to consider if the certificate of involuntary admission or its renewal was proper and necessary.

At one time, the criteria for psychiatric assessment and involuntary admission were extremely broad, relating solely to the issue of whether or not the individual suffered a mental disorder. Gradually the criteria were made more restrictive and required that the

individual not only suffer from a mental disorder but also present a danger or safety risk of self-harm or harm to others. Generally speaking, these remain as part of the criteria in most jurisdictions.

In some jurisdictions, the criteria for psychiatric assessment and involuntary admission of individuals were further narrowed by adding the elements of urgency and the need for a higher degree of the potential danger. Ontario was the first jurisdiction to enact serious harm and imminence criteria for involuntary admission. However, in Ontario, an amendment to the *Mental Health Act* repealed the imminence criterion. The New Brunswick legislation requires the recent behaviour of the individual to represent “a substantial risk for imminent physical or psychological harm to himself or others” before a patient can be involuntarily admitted. Similarly, the Northwest Territories and Nunavut require “serious bodily harm” or “imminent and serious physical impairment”; the Yukon lists “serious mental or physical impairment” as one of its criteria; Manitoba uses “grave and immediate danger” to warrant a patient's involuntary admission.

More recently, some provinces have broadened the involuntary admission process by providing alternatives to the harm criterion. Where a patient does not meet the harm criterion, but the attending physician is of the opinion that the patient is likely to suffer deterioration in psychological health without treatment, this deterioration is sufficient to justify the patient's involuntary admission. The *Mental Health Services Act* in Saskatchewan requires a patient to be suffering from a mental disorder likely to cause harm to the person or others, or to be suffering substantial mental or physical deterioration before being detained as an involuntary patient. British Columbia and Manitoba have enacted similar alternative criteria to involuntary admission. Ontario has also recently broadened the criteria in its *Mental Health Act* to allow for the involuntary admission of patients who have a history of successful treatment and who are at risk of suffering mental deterioration.

The *Canadian Charter of Rights and Freedoms* has enshrined the security of the person and the right for an individual not to be arbitrarily detained or imprisoned or to be subjected to cruel and unusual treatment. Legislative enactments, in particular the *Mental Health Acts*, are therefore being scrutinized to determine if their involuntary admission provisions, which deprive individuals of their liberty, may be justified in a free and democratic society.

The tendency of the courts is to interpret the legislation strictly. Yet psychiatry is not an exact science, therefore it can be difficult to form the definite or precise opinion demanded by the criteria in mental health acts before an individual may be subjected to involuntary admission. It can be suggested only that physicians continue to exercise their judgment and opinion honestly and in the best interests of the patient and others. When in doubt as to whether the appropriate criteria have been met for involuntary admission, the physician should seek a consultation with a colleague. It has been our experience that while the courts have from time to time set aside a certificate of involuntary admission, they have been very reluctant to find liability against the physician who has acted reasonably and in good faith. Physicians should be cautious to not only comply with the requirements and criteria set out in the relevant legislation when certifying a patient for involuntary admission, but also to document the clinical findings and rationale for the certification in the patient record.

It can be suggested only that physicians continue to exercise their judgment and opinion honestly and in the best interests of the patient and others.

Medical certificates

Physicians are often asked to provide certificates of medical fitness for their patients in many different settings. Examples include work-related issues, applications for insurance coverage or other benefits, the ability to participate in a specified activity, etc. There is a legal obligation on physicians to complete such certificates for their patients; in fact, most provinces have legislation that makes it an act of professional misconduct to fail to complete them. For example, in Ontario, regulations under the *Medicine Act, 1991* contain, as one of the definitions of professional misconduct, the following:

Professional misconduct: Failing without reasonable cause to provide a report or certificate relating to an examination of treatment performed by the member within a reasonable time after the patient or authorized representative has requested such a report or certificate.

It is important for physicians to appreciate that the completion of the certificates for patients is a medical act and therefore invokes all the same legal responsibilities and requirements that apply to medical treatment generally. Physicians must therefore adhere to the appropriate standard of care in completing the medical certificates. In addition, physicians must appreciate that a third party will rely on the representations made by the physician in the medical certificate and therefore any erroneous or unfounded opinion expressed by the physician may be subject to liability related not only to the patient, but also the third party. It is recommended that, when completing medical certificates, physicians should keep in mind the following:

- The intent and purpose of the form.
- The expressed written consent of the patient should be obtained and care should be taken not to disclose more information than is covered by the patient's authorization.
- If the medical clearance is to be directed towards some form of employment or leisure activity, the physician should have some knowledge of the particulars of that job or activity.
- The medical record of the patient should be carefully reviewed to ensure that any statements made are, to the best knowledge and belief of the physician, accurate and based upon current clinical information.
- On occasion, it may be necessary to carry out an independent medical evaluation — an examination or assessment of the patient — to obtain the information or to form the belief necessary to complete the certificate.

Physicians may be requested by patients to complete medical certificates or forms to enable the patient to exercise a right or obtain a benefit pursuant to some federal or provincial legislation. For the most part, physicians should treat these requests in the same manner as for any other medical certificate.

Concern has been expressed regarding the scope of certain medical certificates, particularly in connection with the federal *Marijuana Medical Access Regulations* and the federal *Firearms Act*. In both instances, the danger is that the medical certificate or forms may require physicians to provide an opinion or assessment that may well be outside their knowledge or expertise.

Regulations to access marijuana

These regulations, which make it possible for some patients to legally obtain marijuana for medical purposes, came into force on July 30, 2001. The regulations were subsequently amended on June 7, 2005. Patients are now divided into two categories, depending on their condition. For each category, a different medical declaration is required (these forms can be found on Health Canada's website at hc-sc.gc.ca.)

Category 1 — Patients suffer from symptoms treated within the context of compassionate end-of-life care or specified symptoms associated with cancer, AIDS/HIV, multiple sclerosis, spinal cord injury or disease, epilepsy, or severe forms of arthritis, or associated with the medical treatment of those conditions.

Category 2 — Patients suffer from debilitating symptoms other than Category 1 symptoms and that are associated with a medical condition or with the treatment of that condition.

Although many aspects of the declarations that were of concern when the regulations were first published have now been changed, there remain parts of the declarations that may be of concern for some physicians.

Although physicians are no longer required to recommend the daily dosage of marijuana and the form and route of administration, Part 3 of the declarations does require the physician to indicate in grams the proposed daily amount of dried marijuana and the form and route of administration. Although the Regulations stipulate that the physician is only required to indicate the dosage and form and route of administration that the applicant intends to use, it is likely that patients will seek their physician's advice on this matter. Physicians are referred in the declaration to a fact sheet about marijuana and daily amounts. Any physician who is not comfortable providing this advice to patients and whose patient does not have a particular request with respect to dosage or form and route of administration, may consider declining to complete Part 3 of the declarations.

Part 5 of the medical declaration for Category 2 applicants requires the signing physician, if the physician is not a specialist, to declare that: (1) the applicant's case has been assessed by specialists, (2) the physician's area of specialization is relevant to the treatment of the applicant's medical condition, (3) the specialist concurs that conventional treatments for the symptom are ineffective or medically inappropriate for the treatment of the applicant, and (4) the specialist is aware that the marijuana is being considered as an alternative treatment for the applicant. It would be preferable if the declaring physician attached a document from the specialist attesting to the matters set out above, rather than the declaring physician making declarations on behalf of the specialist.

Patients are now divided into 2 categories, depending on their condition. For each category, a different medical declaration is required

Although the regulations have been improved and are now less onerous for physicians, physicians should nonetheless make an assessment whether they are capable of making the declarations required. Physicians who believe in good faith that the medical condition of the patient might benefit from marijuana may choose to complete the declarations in their entirety, if they consider themselves qualified to do so. The physician should carefully explain to the patient why he or she is unable to complete the entire declaration and keep a record of that discussion. Physicians who have a concern about completing the portion of the declaration on the form and route of administration and the daily amount of dried marijuana (where their patient has no specific intention in this regard) could complete all the other portions of the declarations that do not pose any difficulty.

It is recommended that physicians ask their applicant patients to sign a release from liability with respect to the application process and the patient's use of marijuana (a template release form is available).

Note that a number of Colleges have published statements or clinical guidelines regarding the prescription of marijuana. It is important that physicians seek advice from their College to fully understand the implications of these statements or clinical guidelines before providing a medical declaration pursuant to the regulation and asking their patients to sign the form of release prepared by the CMPA.

Firearms Act

Section 5 of the *Firearms Act* describes the criteria for eligibility to acquire a licence to possess a firearm and includes the factors as to whether the applicant "has been treated for a mental illness ... that was associated with violence or threatened or attempted violence ... against any person; or has a history of behaviour that includes violence or threatened or attempted violence ... against any person." In consideration of these factors, the provincial firearms office is authorized to make inquiry of anyone who may provide relevant information as to whether the applicant is eligible to possess or acquire a firearm. Often this process includes a medical certificate or form that a physician is requested to complete on behalf of a patient who has applied for a firearms licence.

Although there is no statutory format, the certificate or declaration typically includes a question requesting the physician to provide an opinion as to whether the patient has a medical condition or exhibits violent tendencies that should prevent the purchase or possession of firearms. More pointedly, physicians are often asked to provide an opinion as to whether there is a risk to the patient or public safety by the patient having the ability to lawfully possess or purchase firearms. Many physicians may not feel qualified or capable of providing an opinion on these issues, recognizing the reliance that might be placed on the certificate and the potential exposure to liability should the opinion later be found to be unwarranted and harm results to the patient or others. Such physicians should simply decline to provide an opinion in response to these questions. The physician may, however, be able to complete other aspects of the certificate or declaration related to any medical diagnosis or condition of the patient.

The CMPA has produced articles on independent medical evaluations, medical marijuana, and firearms (available at cmpa-acpm.ca).

Risk management

Disclosure and reporting of adverse events

Physicians are encouraged to consult the CMPA booklet *Communicating with your patient about harm: Disclosure of adverse events*, which provides extensive advice on communicating with patients when an unanticipated poor clinical outcome has occurred during care.

The CMPA has historically advised physicians about the significance of disclosing adverse events to their patients. Indeed, physicians have an ethical, professional, and legal obligation to disclose adverse events. The CMPA uses the Canadian Patient Safety Institute (CPSI) definition of an adverse event as an event that results in unintended harm to the patient, and is related to the care and services provided to the patient, rather than to the patient's underlying medical condition. The information disclosed to the patient should be limited to the known facts at that time, e.g. the clinical information about what has happened and the clinical nature of the patient's condition as it now exists. A physician should not speculate about what happened. If the physician does not know how or why the event occurred, it is acceptable to state this. The physician should refrain from blaming others or commenting on the care provided by others. Although the physician should express genuine concern and regret for what has happened, the use of words that express or imply legal responsibility (such as negligence or fault), or reference to failing to meet the standard of care, should be avoided.

If practising within a hospital or institution, physicians will also likely have an obligation to report adverse events to a designated person or committee. Most healthcare institutions have policies guiding the reporting of adverse events or close calls. The CMPA uses the CPSI definition: a close call is an event with the potential for harm that did not result in harm because it did not reach the patient due to timely intervention or good fortune.

It is important to recognize that disclosing adverse events to patients and reporting such events to third parties (e.g. hospital administration or quality improvement committee) are separate and distinct processes. While the disclosure of adverse events to patients is an integral part of individual patient care, the reporting of adverse events is generally part of a much broader quality improvement initiative aimed at identifying and addressing systemic problems. The overall goal is to improve patient safety. The CMPA generally advises physicians to ensure that any reporting takes place under the auspices of a properly constituted quality improvement committee so that the information generated through the quality improvement process will be protected, to the extent possible, from being used in subsequent legal, regulatory, or other proceedings. The CMPA booklet *Learning from adverse events: Fostering a just culture of safety in Canadian hospitals and healthcare institutions*, further describes the requirements and processes for reporting adverse events and close calls, and the best approach for reviewing these events. A complementary position paper by the CMPA,

Reporting and responding to adverse events: A medical liability perspective, addresses policy issues associated with the reporting of, and response to, adverse events.

Interprofessional (collaborative) care

In response to the considerable resource problems facing our healthcare system, it is becoming increasingly common for healthcare to be delivered through interprofessional (collaborative) practice teams. Today's reality is that physicians are increasingly working with — and relying on — other healthcare professionals when treating patients. Evolving models for healthcare delivery mean that other health professionals are playing an increasingly significant and valuable role in the care of patients. While interprofessional care is an important contributor to improving patient access to healthcare, physicians should be aware of the unique liability risks associated with this type of healthcare model. As discussed in the CMPA publication, *Collaborative care: A medical liability perspective*, these risks can be mitigated when all health professionals have adequate liability protection and by delineating the roles and expectations of each health professional.

The concern over adequate liability protection stems from the potential application of joint and several liability in circumstances where a legal action is commenced by a patient against numerous members of the interprofessional care team. In most Canadian jurisdictions, the principle of joint and several liability operates to permit a plaintiff to pursue any one defendant for the full amount of the award, even though there may be other co-defendants found liable in the action. Although the court may assign fault in varying degrees between the co-defendants, the plaintiff is entitled to seek full recovery of damages from one of those defendants — even if only found to be 1% responsible for the harm caused the patient, for example. It is then up to that defendant to pursue the other defendants for their respective share of the damages awarded to the patient. This task is greatly facilitated if all of the members of the interprofessional care team have adequate medico-legal protection or insurance. Adequate liability protection also ensures that patients will receive appropriate compensation in the event of a finding of negligence against any single member of the interprofessional care team.

Clearly delineated roles and expectations will also allow the interprofessional care team to effectively and efficiently deliver quality healthcare to patients. Written policies should be established for each member of the team on issues such as the role of each member, documentation and communication between members of the team, responsibility for follow-up care, and ultimate authority on treatment decisions in particular instances. Distinctly defined scopes of practice for each team member will also assist in minimizing the accountability risks within interprofessional care.

Scarcity of resources

The courts have yet to fully address how the scarcity of healthcare resources will affect the standard of care expected of physicians. To date, the courts appear more willing to consider the scarcity of resources when evaluating whether the facilities and staffing were reasonable in the circumstances. The courts, however, appear less ready to accept an economic defence to justify withholding treatment or services from a patient for reasons of overall resource or cost containment.

Duty of hospital

Generally speaking, it is the responsibility or duty of hospitals to ensure adequate staffing and co-ordination of personnel and other resources. Hospitals will be directly liable to the patient for damages sustained as a result of improper protocols or lack of adequate facilities and paramedical personnel.

The courts have, however, given favourable recognition toward economic realities in making allowances for the scarcity of resources when determining whether the facilities and staffing were adequate under the circumstances. For example, a 1991 decision of the New Brunswick Court of Queen's Bench, affirmed on appeal, the "non-availability of trained and experienced personnel, to say nothing of the problems of collateral resource allocation" were considered when evaluating what community standard was to be expected of the hospital that staffed its emergency department with general practitioners due to the unavailability of emergency physicians.

Resources were also considered in a Nova Scotia judgment in determining whether the standard of care was met by the hospital. In that case, it was stated that a hospital was not negligent in its system of anaesthesia coverage of a cardiovascular intensive care unit. The court, in making this determination, examined the coverage available in other intensive care units in Canada and stated that "no hospital could afford to have anaesthesia residents always at hand, waiting around without other responsibilities until such time as a patient might have occasion to require their services." This case demonstrates that not only might the fact of scarce resources be considered by a court, but so will the custom in other similar hospitals respecting staffing.

Interestingly, the British Court of Appeal addressed the issue of insufficient resources leading to inadequate care in a 1993 case and came to a different conclusion. The infant plaintiff had suffered brain damage as a result of the hospital's alleged inadequate system for providing emergency obstetrical care. The case considered the liability of a hospital with two separate facilities or campuses and the organization of services between them. The emergency services were available only at one site and the health authority argued it could not be expected to do more with the limited resources available. The court rejected this aspect of the hospital's defence, stating, "it was not necessarily an answer to allegations of unsafety that there were insufficient resources to do everything that they would like to do."

If a Canadian court were to adopt this approach, a hospital might not be successful in raising as a defence that it was doing its best with limited resources and that it should not be faulted for providing some service rather than none under such circumstances.

The courts have given favourable recognition toward economic realities in making allowances for the scarcity of resources when determining whether the facilities and staffing were adequate under the circumstances.

Duty of physicians

Restructuring, funding cutbacks, and cost containment have resulted in physicians facing the dilemma of being asked to meet the standard of care toward their patients with fewer and often inadequate resources. Once a physician-patient relationship has been established, the physician owes a duty to do what is in the patient's best interest. In the event of a choice between a physician's duty to a patient and that owed to the medical care system, the duty to the patient must prevail. To date, the courts appear unwilling to accept a defence based solely on cost containment to justify withholding treatment or services from a patient. In a British Columbia case relating to the alleged failure of the physicians to have diagnosed the patient's aneurysm earlier, the court commented:

"I understand that there are budgetary problems confronting the health care system. I respectfully say it is something to be considered by those who are responsible for the provision of medical care and those who are responsible for financing it. I also say that if it comes to a choice between a physician's responsibility to his or her individual patient and his or her responsibility to the medicare system overall, the former must take precedence in a case such as this. The severity of the harm that may occur to the patient who was permitted to go undiagnosed is far greater than the financial harm that will occur to the medicare system if one more CT scan procedure only shows the patient is not suffering from a serious medical condition."

A similar issue relating to the alleged delay in ordering a CT scan was considered in a case in Newfoundland and Labrador. The court refused to give way to arguments of cost effectiveness in the absence of detailed and convincing evidence that the cost in routinely carrying out CT scans in the particular circumstances was prohibitive.

While the courts do not appear willing to apply a lower standard of care for physicians based on cost considerations alone, some relief has been afforded physicians in circumstances where, for economic or other reasons, clinical resources are simply not available. Thus, in a recent case involving the alleged breach of the standard of care for failing to conduct further investigations before discharging the patient who later died due to a dissected aortic aneurysm, the court stated:

"The court must take into account the availability and cost of procedures, medication and equipment to the attending physician at the time when the cause of action arose. This consideration will affect the standard of care in that a doctor cannot reasonably be expected to provide care which is unavailable or impracticable due to scarcity of resources."

It is to be expected that the courts will continue to address resource issues to better define the appropriate standards of care for physicians. In the meantime, physicians who are left to grapple daily with increasing pressure from government officials and hospital administrators to ration the use of healthcare resources might consider the following advice:

- In keeping with the Canadian Medical Association Code of Ethics to collaborate with others in promoting fair access to healthcare, physicians should participate in establishing guidelines and criteria regarding the allocation or rationing of limited resources. As in other matters, the standard of care expected of a physician is determined by reference to the reasonable conduct of peers in similar circumstances. Physicians should therefore seek a consensus among colleagues and, where appropriate, seek advice from specialty organizations as to what might constitute appropriate guidelines or criteria for prioritizing patients.
- Physicians might also discuss with the patient, as part of the consent process, limitations in availability of healthcare resources and the reasonable alternatives available to the patient, including seeking treatment elsewhere.
- Finally, if physicians have concerns about lack of resources or protocols in their hospital that might adversely affect patient care, they should make every effort to draw those concerns to the attention of the appropriate authorities and to work toward resolution of the problem.

All such efforts and discussions should be appropriately documented.

Future considerations

Several studies have been conducted on professional liability, with resultant reports calling for reorganization of the courts and introduction of mechanisms for alternative dispute resolution. Perhaps the most comprehensive is the 1990 Federal, Provincial, Territorial Review on Liability and Compensation Issues in healthcare chaired by J. Robert S. Prichard, then Dean of Law at the University of Toronto. There are three principal recommendations in the resultant report:

- Tort actions against healthcare providers should be maintained and enforced.
- Responsibility of healthcare institutions for the quality of care provided in and by them should be increased.
- An alternative the no-fault compensation system might be considered for avoidable healthcare incidents that cause serious personal injuries.

There is an increasing need for tort reforms, either by legislation or through the courts, to stabilize the issues of liability and quantum in professional liability cases.

At the moment, there is very little enthusiasm to introduce even a limited no-fault compensation plan. There are, however, several initiatives to amend the present judicial system to improve case management and to introduce mediation as an alternative means of resolving the legal action. In an attempt to stem escalating damages, extensive submissions are now being made to strengthen the ability of the courts to order the use of structures for future care. Similarly, submissions are also being made to persuade provincial and territorial ministries of health not to exercise rights of subrogation for reimbursement of medical, hospital, and other social care expenses incurred on behalf of patients involved in professional liability cases.

The changing nature of medical practice challenges the law in many ways, particularly related to the use of technology. Early forays into telemedicine were primarily designed as pilot projects to address the extraordinary needs of very remote communities. Telemedicine or telehealth initiatives are now much broader in scope and may change the way medicine is practised. Technology has raised concerns about security and privacy, electronic medical records, healthcare information networks, and even the nature of the physician-patient relationship. The use of information in communication technologies, particularly related to the Internet, has raised questions about risk and possible new areas of liability for physicians. One example is vulnerability to legal actions in the multiple foreign jurisdictions where individuals (patients) accessing medical information or advice via the Internet might reside. Many questions remain unanswered, as the law has not had sufficient opportunity to formulate answers to these new and novel issues.

The CMPA is keeping a close watch on the changing face of medical practice and the law so it can identify areas of potential risk and work with appropriate partners to develop strategies physicians can use to reduce adverse outcomes for themselves and their patients.

The CMPA offers its members timely advice on current and emerging issues in its regular publications and on its website. Members who are in doubt about any medico-legal issue are encouraged to contact the CMPA for assistance.



The CMPA: providing value to members

As the principal provider of medical liability protection in Canada, the CMPA is committed to protecting the professional integrity of physicians and promoting safer medical care. To fulfill this mandate, the CMPA provides a range of services to members in both English and French, including:

PROTECTION

- Occurrence-based medical liability protection
- On behalf of physician members, appropriate compensation to patients proven to have been harmed by negligent medical care

ADVICE AND ASSISTANCE

- Physician-to-physician contact
- Medico-legal advice from experienced physicians
- Member-oriented services and assistance on professional issues

RISK MANAGEMENT AND EDUCATION

- Accredited, evidence-based risk management education including presentations, symposia, and regional conferences with CME credit
- eLearning
- Sharing of evidence-based research to improve the safety of medical care

PUBLICATIONS

- *CMPA Perspective*, published quarterly
- Print and web-based handbooks and reports on medico-legal issues

PUBLIC POLICY

- Expert input into policy development, including legislation and regulations, and patient safety initiatives
- Presentations, submissions, publications, and stakeholder engagement

FOR INFORMATION AND ADVICE: 1-800-267-6522 OR 613-725-2000

FOR EDUCATIONAL SESSIONS: education@cmpa.org

FOR WEB-BASED EDUCATION, INFORMATION, AND TRANSACTIONS: cmpa-acpm.ca