

GOVERNMENTAL AND INSTITUTIONAL TORT LIABILITY FOR QUALITY OF CARE IN CANADA

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The past half century has been marked by the expansion of the law of torts and, especially, responsibility for negligence. No citation of authority is necessary to show that, in order to meet new situations in a rapidly changing society, Courts have greatly expanded the concept of the duty owed to others by persons and institutions. [T]he responsibilities of the hospital to the patient have expanded greatly in breadth and depth in this century.... Public expectations that hospitals will provide total care and make all arrangements are influencing courts in determining the responsibilities of hospitals. If the hospital is to bear more responsibility for the doctor, present systems and organization may have to be reviewed.¹

These quotations express the need of the common law to evolve and reflect societal changes in health care, the perspective of the dissenting judge, Blair J., in the seminal Canadian case on hospital liability, *Yepremian v. Scarborough General Hospital*.² However, the majority of Canadian courts do not support Blair J.'s view and have allowed health sector tort law to remain stagnant, failing to recognize major changes in the health care system. Historically, physicians were perceived as solely responsible for patient injuries, while hospitals merely provided a location for a physician to practice and nursing staff to assist the physician in this endeavour. The patient had limited legal relations with the hospital itself and consequently, the hospital owed the patient few legal obligations. The duties imposed on the hospital corresponded to its limited role in the delivery of health care – the provision of competent staff and the maintenance of an adequate facility.

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1 *Yepremian v. Scarborough General Hospital*, (1980) 28 O.R. (2d) 494 at para. 144 (C.A.) [*Yepremian*], quoting Ellen I. Picard, *The Legal Liability of Doctors and Hospitals in Canada* (Toronto: Carswell 1975).

2 *Supra* note 1.

But over the last 100 years, medical care has fundamentally changed, becoming more complex, technologically advanced and specialized. The hospital is no longer merely a place where a doctor treats a patient, but a sophisticated facility designed to provide a plethora of services from a wide variety of health professionals. For example, in the case of emergency services, a patient expects treatment from the hospital's emergency team – whatever combination of physicians, nurses, and other practitioners with which the hospital chooses to staff the emergency room. The patient also knows she may have contact with other practitioners and that radiologists, pathologists or pharmacists may be involved in her treatment. Given this matrix of care, it is natural for a patient not to look solely to one's own physician for care, but to the hospital itself. Hospitals and other institutions have responded to the complexity of modern medicine by taking on a greater role in organizing and managing the delivery of services, and coordinating the diverse staff and programs. Organization and management has extended to activities related to quality of care, such as forming quality-control committees and creating policies relating to patient outcomes.³

Similarly, the role of provincial governments in health care has undergone a significant transformation, as part of a larger trend towards state involvement in social services.⁴ Historically, its primary role was public health and limited funding of health services for the destitute.⁵ The transformation in the state's role began with it undertaking the financial responsibility for physician and hospital services for all citizens, and then extended to a number of other programs, such as mental health services and prescription drug costs for certain residents.⁶ But as publicly funded health care became en-

3 For example, see Calgary Health Region, Regional Policy 1451, "Admission of Patients to Over-Capacity Inpatient Beds" (19 January 2001), online: Calgary Health Region Policies <http://www.calgaryhealthregion.ca/policydb/ShowPolicy?policy_id=1451>, discussed in greater detail in Part Two, *infra*.

4 See generally Raymond B. Blake & Jeffrey A. Keshen, eds., *Social Fabric or Patchwork Quilt: The Development of Social Policy in Canada* (Peterborough: Broadview Press, 2006).

5 See generally E. Vayda, R.G. Evans & W.R. Mindell, "Universal Health Insurance in Canada: History, Problems, Trends" (1979) 4 *Journal of Community Health* 217.

6 The evolution in governmental health care funding is discussed in Colleen Flood, "The Structure and Dynamics of Canada's Health Care System" in Jocelyn Downie, Timothy A. Caulfield & Colleen Flood, eds., *Canadian Health Law*

trenched in the Canadian identity, government increased its involvement in the governance, management and administration of the system. Motivated by its enormous public investment in health care and growing public concern and expectations,⁷ the state has developed an interest in issues such as quality of care and patient outcomes. Governments now take an active role in setting the overarching policies that guide the way the system operates and evolves.

Over the course of the 1990s (earlier for Quebec and in the past few years in Ontario), governments adopted a reform pathway loosely referred to as “devolution,” which has served to alter the relationship between government, hospitals, other institutions, and the recipients of health care services. Although there is provincial variation in implementation, scale, and the range of responsibilities devolved, the thrust of reform has been to devolve some managerial and administrative authority away from provincial governments to the newly-created institutions – regional health authorities, district health authorities, and (in Ontario) local integrated health networks (LIHNs).⁸

Despite the greater involvement of provincial governments and institutions such as regional health authorities in the governance, management and administration of health care, there has been little change in the common law jurisprudence. The common law continues to hold physicians primarily liable for failures in quality of care, and to deem physicians independent of the institutions within which they work, despite the important roles assumed by both provincial governments and institutions in such areas as funding, policy-setting, organization, coordination, management and regulation, all of which impact patient care. This failure of the common law to

and Policy (Markham: Butterworths, 2002). Universal insurance for hospital services began in 1947 in Saskatchewan, with the other provinces following. Insurance for physician services was later added.

7 In this regard, see the recent report on the Canadian health care system: Canada, Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada* (Canada: 2002) at 9 [Romanow Report].

8 For a general history of regionalization, see J. Lomas, G. Veenstra & J. Woods, “Devolving Authority for Health Care in Canada’s Provinces: 1. An Introduction to the Issues” (1997) 156 CMAJ 371. With regard to Ontario’s LHINs, see generally Ontario, “About Local Health Integration Networks”, online: Local Health Integration Networks <<http://www.lhins.on.ca/english/main/aboutLHINs.asp>>.

evolve to reflect systemic changes is particularly surprising, given the proliferation of literature demonstrating that many patient injuries are attributable to systemic causes, and that institutions are in a better position to recognize and rectify these problems.⁹ Due to the changes in the role of institutions in health care and a growing recognition of the role these entities play in patient safety, corresponding legal accountability should receive careful consideration by Canadian courts.

In Part One, I examine the literature on medical error and patient safety, focusing on the systemic roots of adverse events. While physicians are often deemed liable for errors causing patient injury, many errors are in fact caused or contributed to by the system in which that clinician works, a system which is a the cumulative product of decisions taken at the institutional and governmental level. Part Two explores the role of governments and institutions in health care, specifically commenting on their roles post-devolution. In particular, systemic actors have asserted a significant role for themselves in quality of care. Part Three discusses the approach of Canadian courts in imposing liability on systemic actors. Their approach has been relatively static over time, despite changes in both the complexity of medical care and its resultant organization and reform initiatives such as devolution. Part Four goes on to discuss some of the possible rationales for limiting liability. However, I conclude that Canadian courts should reconsider their approach, as a result of important changes in the health care system.

1. Systemic Roots of Patient Injuries

Reports of patient injuries have increased significantly in recent years, raising public awareness of medical errors, and prompting further study of patient safety.¹⁰ In 2003, Jesica Santillan, a seventeen-year-old girl born with restrictive cardiomyopathy, received a heart-lung transplant at Duke University, “one of the Meccas for transplant technology”¹¹ by a surgeon considered one

9 See *e.g.* Committee on Quality of Health Care in America, Institute of Medicine, *To Err is Human: Building a Safer Health System* (Washington: National Academy Press, 2000).

10 Gautham Suresh, “If It’s in the paper, It Must Be True: Newspaper Reporting of Pediatric Medication Errors” (2006) 117.6 *Pediatrics* 22 81.

11 Robert M. Wachter & Keveh G. Shojania, *Internal Bleeding: The Truth Behind America’s Terrifying Epidemic of Medical Mistakes* (New York: Rugged Land, LCC, 2004) at 251-67.

of the brightest in his field. Jessica's Mexican parents raised the initial \$5,000 to smuggle their daughter into the United States, and a charity raised the additional \$500,000 to pay for the surgery. Jessica died after receiving a heart and lungs of the wrong blood type.¹²

A number of studies suggest that medical errors are responsible for staggering numbers of patient injuries and deaths. The Institute of Medicine Committee on Quality of Health Care in the United States (US) reported in 2000 that between 44,000 and 98,000 deaths from medical error in a single year.¹³ This death rate is higher than the number of deaths from motor vehicle accidents, breast cancer, or AIDS.¹⁴ Moreover, this figure does not include deaths from preventable adverse events in outpatient care, home care or self-care.¹⁵ A 2004 Canadian study found an overall adverse event rate of 7.5 percent.¹⁶ In other words, of the almost 2.5 million annual hospital admissions, approximately 185,000 are associated with an adverse event. More importantly, of these adverse events, close to 70,000 were preventable.¹⁷

There is legal scholarship making important contributions to the study of medical error. However, much of this literature focuses on reforming the law governing the actions of individual practitioners – for example literature relating to error reporting and its accompanying privilege¹⁸ – or the reform of the medical malpractice system.¹⁹ This paper takes a different perspective,

12 *Ibid.* In another widely publicized case discussed by these authors, fifty-one-year-old Willie King had one of his legs amputated at a Florida hospital due to complications from diabetes. However, doctors amputated the wrong leg, leaving him confined to a wheelchair after undergoing amputation of the originally intended diseased leg.

13 Marilyn M. Rosenthal & Kathleen M. Sutcliffe, eds., *Medical Error: What Do We Know? What Do We Do?* (San Francisco: John Wiley and Sons, Inc., 2002) at x, citing Committee on Quality of Health Care, *To Err is Human*, *supra* note 9.

14 *Ibid.*

15 *Supra* note 13.

16 G. Ross Baker *et al.*, "The Canadian Adverse Events Study: The Incidence of Adverse Events Among Hospital Patients in Canada" (2004) 170 CMAJ 1678 at 1678.

17 *Ibid.*

18 *Human: Building a Safer Health System* (Washington: National Academy Press, 2000). See *e.g.* Michael Waite, "To tell the Truth: The Ethical and Legal Implications of Disclosure of Medical Error" (2005) 13 Health L.J. 1.

19 See *e.g.* Joan Gilmour, *Patient Safety, Medical Error and Tort Law: An International Comparison* (Ottawa: Health Canada, 2006).

and considers the possibility of increasing the tort liability of systemic actors to reflect their roles in patient safety.

a. Causes of Patient Injuries

The underlying causes of errors are complex, but there is a growing body of research suggesting that responsibility for many adverse events attributed to health care professionals should more appropriately lie with decision-makers at higher levels. Rosenthal and Sutcliffe argue that 85 percent of errors are attributable to systems rather than individuals.²⁰ Similarly, Byers and White comment that “[i]t is important to recognize that there are many unseen or invisible systems and processes that contribute to an error, and blaming a person does little to resolve the latent errors, which will persist until the next person makes the same error.”²¹

Rosenthal and Sutcliffe usefully group the systemic causes for error into organizational and institutional factors.²² Major organizational factors include:

1. Team factors,²³ which include such issues as communication barriers and the various professionals involved in patient care, loosely organized with unclear lines of authority.²⁴
2. Work environment and organizational design.²⁵
3. Processes and practices.²⁶
4. Financial resources or constraints,²⁷ which include policies, procedures and decisions at higher levels that govern the allocation and management of resources, people equipment, space and time.²⁸

20 *Supra* note 13 at 122.

21 Jacqueline Fowler Byers & Susan V. White, *Patient Safety: Principles and Practice* (New York: Springer Publishing Company, Inc., 2004) at 30.

22 *Supra* note 13 at 175.

23 *Ibid.*

24 Patrice L. Spath, ed., *Error Reduction in Health Care: A Systems Approach to Improving Patient Safety* (San Francisco: Jossey-Bass, 2000) at xxii.

25 *Supra* note 13 at 175.

26 *Supra* note 13.

27 *Supra* note 13.

28 Charles Vincent, ed., *Clinical Risk Management: Enhancing Patient Safety*, 2nd ed. (London: BMJ Books, 2001) at 325.

5. Leadership and culture, such as support for patient safety and the values instilled by leaders.²⁹

Examples of the second type of errors, institutional errors, include:

1. The economic and regulatory context.³⁰ For example, opportunities and constraints in the external environment, as well as societal and cultural factors condition the decisions of hospital leaders and managers at the organizational level.³¹
2. National health standards.³²
3. The complexity of health care delivery, including the management of sophisticated technology and powerful drugs, the wide diversity of patients and their varying needs, and the simultaneous performance of multiple processes.³³

Another important factor to consider is the fact that errors at the systemic level have greater consequences than the errors of individual practitioners. According to Rosenthal and Sutcliffe, the higher in a hierarchy an

29 Byers & White, *supra* note 21 at 30-37. A number of authors discuss this factor, such as Paul B. Hoffman & Frankie Perry, eds., *Management Mistakes in Healthcare: Identification, Correction and Prevention* (Cambridge: Cambridge University Press, 2005) at 4-8. These authors give a number of examples of managerial level errors: tolerating an incompetent manager for an inordinate amount of time, failing to address substandard clinical performance by a practitioner, allowing a low-volume organ transplant program to continue for non-clinical reasons, using insufficiently trained lower skilled personnel, or deferring funding of essential but mundane equipment.

30 *Supra* note 13 at 175.

31 *Supra* note 28 at 325.

32 *Supra* note 13 at 175.

33 *Supra* note 24 at xxii. It is important to acknowledge that issues relating to the complexity of health care delivery, such as the sophistication of technology, are not entirely within the control of systemic actors, but are attributable to the changing nature of medicine itself. However, systemic actors certainly make decisions relating to the sophistication of technology, such as which technologies to fund and adopt, how they are tested for safety and efficacy, how staff are trained in the use of such technology, and the location of the technology and the setup of ancillary equipment and services within the institution.

error occurs, “the more likely it is that the error will be magnified, the more likely it is that the error will be compounded with other errors, and the more likely it is that the error will be disastrous.”³⁴ In addition, high level errors are likely to be more far-reaching “because the higher an error is when it occurs, the more likely it is to be disseminated through amplifying power of the organization,” and are likely to be more complex “because higher-level errors are more likely to pick up and combine with smaller, lower-level errors that, by themselves, would not have produced anything untoward.”³⁵

b. Preventing Patient Injuries

Recent scholarship suggests that not only are many injuries caused or contributed to by systemic conditions, but that the focus for safety improvements should be at the systematic level, as these actors are in the best position to address patient safety. Rosenthal and Sutcliffe note a number of weaknesses inherent in human nature, for example difficulty attending carefully to several tasks simultaneously, difficulty recalling detailed information quickly, and poor computational ability, activities which are inherent to health care.³⁶ It is difficult to change these weaknesses inherent in human nature.³⁷ Addressing patient safety at the systemic level allows these human weaknesses to be anticipated and guarded against, by making it difficult for providers to err and preventing multiple providers from making the same errors. In this regard, Nolan notes that “although we cannot change the aspects of human cognition that cause us to err we can design systems that reduce error and make them safer for patients.”³⁸

c. Specific Cases of Medical Errors

I now turn to some specific cases of inquiries into medical errors that illustrate the role of systemic actors in patient injuries. Instead of analyzing a single death, these inquiries focus on the deaths of multiple patients and the common causal factors for injuries, many of which are systemic in nature.

34 *Supra* note 13 at page 185.

35 *Supra* note 13.

36 *Supra* note 13 at 188.

37 In this regard, Spath notes that human nature can only be moderated, not eliminated, *supra* note 24 at 7.

38 Thomas W. Nolan, “System Changes to Improve Patient Safety” (2000) 327 *BMJ* 771 at 771.

The Winnipeg inquiry explored twelve pediatric cardiac surgery deaths that occurred in 1994 at the Health Science Centre (HSC). Dr. Joseph Odim performed all twelve surgeries. Despite this, the Inquiry concluded that the actions of systems actors contributed to these deaths:

While some of the problems that the program faced related to the abilities and conduct of specific individuals, other problems were largely systemic in nature. These systemic problems related to the structure of the HSC, in particular to hospital policies and procedures governing staffing, leadership, teamwork, communication, decision-making and quality assurance. Weaknesses in all of these areas led to problems in the procedures and outcomes of the program.³⁹

As with the errors literature discussed above, this report affirmed that actors at the systems level should implement safeguards to address and anticipate human nature, stating that it is:

...unrealistic to believe that human error can be totally eliminated. More importantly, it is impossible to design a system that relies totally on everyone doing the tasks assigned to them properly. Allowances must be made for the possibility that errors will be committed and mechanisms to address that possibility must be put into place.⁴⁰

The inquiry listed numerous specific systemic causes for the patients' deaths. Using Rosenthal and Sutcliffe's error typology discussed above, it found both organizational and institutional errors. With regard to team factors, the inquiry noted divisiveness between the pediatric and adult surgery programs, the latter of which was much larger and had its concerns better addressed.⁴¹ Another organizational factor, work environment, also created problems. For example, fluctuating operating room temperatures made it

39 Manitoba, *The Report of the Manitoba Pediatric Cardiac Surgery Inquest: An Inquiry into Twelve Deaths at the Winnipeg Health Sciences Centre in 1994* (Manitoba: 2000) at 465 [Winnipeg inquiry].

40 *Ibid.* at 487.

41 For example, while the sole pediatric surgeon provided coverage for services for adult surgery, the adult surgeons did not provide similar coverage, resulting in the pediatric surgeon being on call "literally 24 hours a day, seven days a week," *ibid.* at 111.

difficult to control the patients' temperatures, a critical issue in pediatric anesthesia.⁴²

The recruitment issues experienced at the Health Science Centre illustrates the third of Rosenthal and Sutcliffe's organizational factors, processes and practices. For example, in conducting the reference check on Dr. Odim, no one in Winnipeg spoke with the people most recently involved in his training, and no one observed him performing surgery.⁴³ In addition, the inquiry found that those responsible for staff replacements were slow to begin recruitment, took too long to find replacements, relied on inadequate staff recruitment processes, and failed to take appropriate steps to address issues such as caseload when positions were vacant for long periods of time.⁴⁴

At the governmental level, one of the problems contributing to recruitment and retention was the compensation of pediatric heart surgeons. This problem illustrates the institutional factor of economic and regulatory environment. The inquiry noted that when the fee schedule for doctors was originally set, pediatric cardiac surgery was a limited field, and as a result, fees paid to surgeons for pediatric procedures were lower than for adult procedures.⁴⁵ In addition, the number of pediatric cases was considerably lower than the number of cases a surgeon operating on adults could perform and bill for, resulting in a much higher income for those treating adults.⁴⁶ This lower income was one of the reasons given for the departure of the predecessor to Dr. Odim.⁴⁷

Similar to the case in Winnipeg were the deaths of a number of children over a period of 12 years at the Bristol Royal Infirmary, and the subsequent inquiry into these deaths. This inquiry similarly found that both government and institutions contributed to these injuries: "to a very great extent, the flaws and failures of Bristol were within the hospital, its organization and culture, and within the wider NHS as it was at the time."⁴⁸ Much like the Winnipeg inquiry, the Bristol inquiry also identified a number of issues il-

42 *Ibid.* at 110.

43 *Ibid.* at 120-23.

44 *Ibid.* at 467.

45 *Ibid.* at 111.

46 *Ibid.* at 111.

47 *Ibid.* at 111.

48 Department of Health, *The Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984-1995, Learning from Bristol* (United Kingdom: 2001) at 9.

lustrating the organizational and institutional errors discussed by Rosenthal and Sutcliffe. Those authors, and many others, recognize that institutional culture and the attitudes of those in charge are critical to quality of care.⁴⁹ In giving evidence before the Inquiry, the Director of Cardiac Services said that the Chief Executive of the Trust, “was known for saying ‘don’t give me your problems, give me your solutions.’”⁵⁰ Furthermore, he called it a “fact” that only clinicians could identify defects in clinical performance, and management was merely to provide the facilities to allow the exercise of clinical freedom.⁵¹ The inquiry report concluded that these types of attitudes at the leadership level affected quality of care at Bristol.⁵²

The report also pointed to difficulties at the broader systemic level. For example, the Department of Health designated neonatal and infant cardiac surgery a supra regional service, which entails national planning and funding, and the provision of the service at specific designated centres. There was evidence that this designation was “doomed from the start,” “arbitrary,” and the criteria for supra regional services was never met in some of the supra regional centres.⁵³ Furthermore, “the proliferation of supra regional centres meant that the criterion based on volume of cases could not be met.”⁵⁴ Given the affects of systemic actors on patient safety, literature discussing the role of systemic actors in patient injuries should receive careful consideration by the courts in considering institutional and governmental liability in future health sector cases.

49 *Supra* note 13 at 182. In this regard, see also Leape et al., “Promoting patient safety by preventing medical error” (1998) 280 *Journal of the American Medical Association* 1444 at 1444, where the authors argue that to increase patient safety, a culture needs to be established where injury prevention is everyone’s responsibility. Similarly, in their textbook on healthcare organizations, Scott et al., acknowledge the existence of an institutional culture and of the influence of that culture over actors within the organization. W. Richard Scott, Marin Ruef, Peter J. Mendel & Carol A. Caronna, *Institutional Change and Healthcare Organizations: From Professional Dominance to Managed Care* (Chicago: University of Chicago Press, 2000) at 170-171.

50 *Supra* note 48 at 68.

51 *Ibid.*

52 *Supra* note 48 at 266.

53 *Supra* note 48 at 106.

54 *Ibid.*

2. Governmental and Institutional Roles in Quality of Care

I now turn to a broader discussion of the roles of government and institutions in the health care system, with a view to further illustrating their ability to impact patient outcomes. Another basis for reconsidering the legal obligations of systemic actors is the role they have carved out for themselves in quality of care through their organization of the health care system. Systemic actors, whose involvement in quality of care was previously limited, now organize and manage the system in a manner that gives them a significant ability to impact quality of care. This section discusses these issues in light of the recent movement towards devolution, using Ontario and Alberta as examples.⁵⁵ The law does not currently reflect the significant role of systemic actors in quality of care, with the courts generally failing to consider the impact of institutions and government on patient outcomes.

a. The Role of Government Post-Regionalization

Before discussing examples of the ways in which systemic actors affect patient safety, it is important to mention the recent health system reform of devolution, and how it affects the allocation of responsibility for quality of care. Governments across Canada premised regionalization upon the devolution of authority from the provincial governments to regional health authorities.⁵⁶ Despite the rhetoric of power transfer, provincial governments have not devolved all of their responsibilities relating to quality of care, and

55 I focus my analysis on the provinces of Ontario and Alberta as they have approached devolution in significantly different manners, with Alberta creating health regions and Ontario implementing Local Health Integration Networks (LHINs). These two approaches result in entities with different roles in the health care system, and perhaps different resulting legal responsibilities, although the situation with respect to the latter remains uncertain as the courts have yet to hear a case with a LHIN defendant. In addition, while Alberta implemented regionalization policies at the same time as the majority of the other provinces, Ontario has only looked to devolution more recently, allowing Ontario's approach to reflect on the advantages of the approach of other provinces and take into consideration the possible disadvantages associated with regionalization.

56 Lomas, Veensta & Woods *supra* note 6 at 371. In Ontario, "the government intends to devolve a good deal of power and authority to the LHINs, leaving the Ministry of Health and Long Term Care (MOHLTC) to function as a head office, providing more strategic direction": Ontario, "LHIN Bulletin No. 11" online:

retain critical oversight roles in their respective health care systems.⁵⁷ Moreover, it is not clear to what extent government in fact devolved administrative and managerial responsibility to regional health authorities.⁵⁸ In addition, although Tuohy argues that regionalization did not significantly change the overall structural balance or institutional mix in the health care system, she argues that it did involve a greater degree of state activism.⁵⁹ This activism is important, as it illustrates how devolution, despite its predication on the transfer of authority, was as an assertion of government control in the health care system.⁶⁰ The control of government in health care is key to both the argument in this section that governments and institutions have a

Ontario Ministry of Health and Long Term Care <http://www.health.gov.on.ca/transformation/lhin/050205/lhin_bul_11_050205.html>.

- 57 For example, in Alberta, “[t]he Minister, aided by the department, various advisory bodies and directed by government as a whole, sets policy for health care. The department of Health and Wellness implements and ensures compliance with policy. The Minister and the department also works with ministers and their departments of health across the country on national policies and initiatives.” Alberta, “About Us: Minister and Department”, online: Alberta Health and Wellness <<http://www.health.gov.ab.ca/about/minister.html>>.
- 58 For example, governments retain a great deal of control over the administrative and managerial decisions available to health regions through their control of the largest items in the health care budget. In this regard, the Mazankowski report notes: “Regional health authorities have an important role to play in delivering health services but their budgets are almost completely determined by government, the expectations are set by government, and they are accountable to government.” Alberta, Report of the Premier’s Advisory Council on Health, *A Framework for Reform* (Alberta: 2001) at 21 [Mazankowski report].
- 59 Carolyn Hughes Tuohy, *Accidental Logics: The Dynamics of Change in the Health Care Arena in the United States, Britain, and Canada* (New York: Oxford University Press, 1999) at 100.
- 60 In this regard, Hurley *et al.* comment that regionalization is the most extensive round of reform since the inception of Medicare: Jeremiah Hurley, Jonathan Lomas & Vandna Bhatia, “When Tinkering is Not Enough: Provincial Reform to Manage Health Care Resources” (1994) 37 Can. J. Pub. Admin. 490 at 491. One can contrast this to the historical situation, in which few organizational changes were made to the delivery of physician and hospital services, but rather the government insured them as they were, as noted by Carolyn Hughes Tuohy, “The Costs of Constraint and Prospects for Health Care Reform in Canada” (2002) 21 Health Affairs 32 (Proquest).

role in managing and organizing the health care system, and thus affecting patient safety, and my later argument that courts have been too restrictive in deciding that the government's involvement in the health care system is primarily policy setting.

The result of changes in the organization and delivery of health care, along with changes in the nature of health care itself, is that both governments and health regions or LHINs, have a significant ability to affect the quality of health care received by patients. In what follows, I give examples of specific ways in which these systemic actors are involved with, or their decisions impact, patient outcomes and quality of care.

b. The Questioning of Clinical Wisdom

As previously discussed, medical errors are typically attributed to the professionals most immediately involved in patient care. This stems from a number of reasons – professional independence, medical paternalism, the idea that the doctor knows best, and a historical lack of involvement in clinical judgement on the part of systemic actors. However, in recent years there has been an increased awareness of the subjectivity of clinical judgement. This is reflected, for example, in evidence of variations in clinical care,⁶¹ which has paved the way for systemic actors to take a role in quality of care.

In this regard, Hanlon argues that managers were previously concerned with stewardship and appeasing professionals, but have now become focused on what physicians do and why they do it, and a greater emphasis is placed on measuring the relationship between input and outputs.⁶² This concern with clinical care has manifested in a number of systemic initia-

61 See *e.g.* James Kennedy, Hude Quan, William A. Ghali & Thomas E. Feasby, "Variations in Rates of Appropriate and Inappropriate Carotid Endarterectomy for Stroke Prevention in 4 Canadian Provinces" (2004) 171 CMAJ 455; Shi Wu Wen, Shiliang Lui, Sylvie Marcoux & Dawn Fowler, "Trends and Variations in Length of Hospital Stay for Childbirth in Canada" (1998) 158 CMAJ 875.

62 Neil T. Hanlon, "Sense of Place, Organizational Context and the Strategic Management of Publicly Funded Hospitals," (2001) 58 Health Policy 151 (Science-Direct). According to Hurley et al., *supra* note 61 at 493, the desire to manage medical discretion was one of the justifications for regionalization. He argues that "determining medical need is not as objective as once imagined and the delivery of medical services responds to a host of factors beyond patient need." Similarly, Johnson argues that government intervention has curtailed physician autonomy and that hospitals exert greater control over the manner in which

tives relating to the supply and demand of health care, both of which are largely driven by physician decisions. For example, some provinces have de-listed services,⁶³ restricted the granting of billing numbers to physicians,⁶⁴ and provided of incentives for doctors to practice in under-serviced areas.⁶⁵

In addition, increased interest by systemic actors in the use of clinical practice guidelines and evidence-based medicine illustrates their concerns with the appropriateness of clinical care. For example, the Alberta government recently formed an advisory panel with the responsibility of “developing principles and criteria to guide decisions on public funding, and assessing whether services or treatments were safe, have demonstrated benefits, and are effective.”⁶⁶

c. Management and Coordination of Care

Government and institutions have also entrenched significant roles for themselves within the health care system which physicians are not able to perform. Robinson notes:

physicians provide treatment, Linda B. Johnston, “Playing Doctor: Who Controls the Practice of Medicine?” (1992) 66 St. John’s L.R. 425 at 426.

63 See *e.g.* Jennifer Dales, “Delisting Chiropractic and Physiotherapy: False Saving?” (2005) 172 CMAJ 166.

64 For example, in *Wilson v. British Columbia (Medical Services Commission)*, [1989] 2 W.W.R. 1 (C.A.), the B.C. courts heard a challenge to physician billing number restrictions.

65 See *e.g.* M. O’Reilly, “Medical Recruitment in Rural Canada: Marathon Breaks the Cycle” (1997) 156 CMAJ 1593; N. Robb, “Nova Scotia Hopes to Solve Recruitment Problem with Joint Effort from MDS, Government” (1996) 155 CMAJ 1615.

66 Alberta, *The Burden of Proof: An Alberta Model for Assessing Publicly Funded Health Services* (Alberta: Alberta Health, 2003) at 1. In addition, there are entities such as the Canadian Agency for Drugs and Technologies in Health, whose mandate includes “[i]mpartial, rigorous, evidence-based reviews of the clinical effectiveness, cost effectiveness, and broader impact of drugs, health technologies, and health systems.” This agency also has the mandate to review the clinical and cost effectiveness of new drugs, and identify and promote evidence-based best practices in pharmaceutical prescription and use. Canadian Agency for Drugs and Technologies in Health, online: <<http://www.cadth.ca/index.php/en/home>>.

[T]he hospital historically has contested with the physician for the role of coordinating medical care. The physician has always held the clinical skills and the patient's trust, but lacked financial resources, managerial capabilities and a strategic orientation. Over the course of the twentieth century, hospitals have nurtured these strengths and achieved growing recognition from insurers, regulators and purchasers as the locus of organization in this ever larger and more complex industry.⁶⁷

As providers became more specialized and hospital services became more complex, institutions perform a critical role in managing and coordinating these various programs. As discussed, failures in coordination create opportunity for patient injuries.⁶⁸

This ability to impact patient care through management and coordination is not only a product of the specialization and complexity of modern medicine, but of regionalization. Regionalization increases the ability to coordinate and manage a greater number of services, with regions coordinating a broader spectrum of services and programs. In contrast, hospital boards historically merely administered services under their roof, while a myriad of other organizations managed other health services. Now that fewer entities coordinate and integrate services, institutions are more instrumental in the totality of care received by the patient.⁶⁹ As there is continued movement towards integrating services under institutions, the importance of organiza-

67 James C. Robinson, *The Corporate Practice of Medicine: Competition and Innovation in Health Care* (Berkeley: University of California Press) at 178. Although this quotation is in reference to the US medical system, the comments are also applicable in Canada, where various developments, such as the complexity of care and the numerous professionals and programs within hospitals has allowed hospital managers and executives to establish themselves as the locus of organization.

68 For example, the Winnipeg inquiry noted the problems in coordinating the adult and pediatric surgery programs

69 In this regard, Malcom recognizes the connection between integration and responsibility, arguing that while it was historically possible to blame another portion of the system for inadequacies, this is difficult with districts responsible for the full range of services. John Malcom, "Lessons From Regionalization in Canada" in John L. Dorland & S. Mathwin Davis, eds., *How Many Roads?: Regionalization & Decentralization in Health Care* (Kingston: Queen's University School of Policy, 1996) at 108.

tion and coordination, and the role of systemic actors in quality, will only become more important.⁷⁰

d. Policy Setting in Quality

In addition to the above-mentioned actions and roles resulting in a significant ability impact patient safety, government and institutions have also explicitly set policies relating to quality of care. Such policies affect the management and care of patients – formerly the exclusive domain of physicians. An example of an institutional policy clearly related to quality of care is the Calgary Health Region policy entitled “Admission of Patients to Over-Capacity Inpatient Beds.”⁷¹ The reason for this policy is:

The risk to patient safety and patient outcome is greater in those patients waiting with undetermined diagnosis in the waiting room than those patients who may be moved to an over capacity bed in the facility.⁷²

This statement illustrates recognition by systemic actors that factors other than clinical judgement may affect patient care. Long waits, which the policy acknowledges create risks to patient safety, have multiple causes, many of which are systemically determined. For example, emergency room staffing levels are dependent on institutional policies relating to scheduling and hiring. Furthermore, the number of practitioners available for institutions to hire is dependent on governmental decisions on compensation and medical school class sizes.

70 This is likely to continue, with recent proposals for health system reform advocating integrative reforms. For example, the Fyke Report, Saskatchewan, Commission on Medicare, *Caring for Medicare: Sustaining a Quality System* (Regina: Government of Saskatchewan, 2001), discusses interdisciplinary teams and networks of hospitals. Similarly, the Romanow report, *supra* note 5, advocates integrating prevention and promotion as a central focus of primary care, and breaking down barriers between providers, facilities and different sectors of the health care system,

71 Although the policy does not define “over capacity beds,” it suggests that these are specifically-designated beds which are only used when regularly used inpatient units reach full capacity.

72 *Supra* note 3 at 1.

Significantly, this policy does not specify the admission of patients to over capacity beds in broad terms, but gives specific directions to physicians on how to manage these patients. In this regard, the policy states that a patient may only be admitted to an over-capacity bed when patient care is compromised, and any one of a list of the following specific conditions exist for more than one hour: there are no more than ten patients waiting for admission across all of the region's acute care sites; there are no more than five patients awaiting admission at any one site; or there are no more than three patients awaiting admission within a single clinical service at one site.⁷³

At the governmental level, there are also policies and programs relating to quality. For example, in Ontario, in its efforts to reduce wait times and improve access to primary care, the Ministry appointed a Health Results Team whose mandate addresses quality. This team is involved with wait time strategies, including government targeting specific procedures – selected cancer services, hip and knee replacements, selected cardiac services, cataract surgery, and MRI and CT procedures.⁷⁴ Although the quality of care, or at least the access to care, for patients receiving the targeted services may improve, these decisions may negatively affect the care received by other patients through the diversion of resources from other programs. Despite the explicit role taken in quality of care by systemic actors, as illustrated by their policies, which impact patients and influence practitioners' treatment decisions, this role has received limited consideration by the courts.

e. Legislation and Quality of Care

Legislation also articulates a specific role for institutions and governments in quality of care. However, the courts have yet to consider these provisions and their impact on the legal responsibilities of systemic actors. This section contrasts more recent pieces of health care legislation with their predecessor statutes, which were of a more corporate nature. This comparison illustrates the evolution in the role of systemic actors from merely passively paying for and operating health care facilities, to an involvement in quality of care.

Alberta's *Regional Health Authorities Act* provides that regional health authorities are responsible for promoting and protecting population health and

⁷³ *Ibid.*

⁷⁴ Ontario, "Health Results Team," online: Ontario Ministry of Health and Long Term Care <<http://www.health.gov.on.ca/transformation/hresults.html>>.

working towards disease and injury prevention, assessing health needs of their regions, determining priorities for services and allocating resources, ensuring that reasonable access to quality services, and promoting service provision in a manner that is responsive to need and supports integration.⁷⁵ This provision is significant because it involves the government mandating an integrated system of care with much of the delivery concentrated in a single entity. In addition, the word quality appears in the legislation as an explicit responsibility. Similarly, Ontario's legislation indicates that LHIN are to plan, fund and integrate the local health system, which includes activities relevant to quality of care: "to promote the integration of the local health system to provide appropriate, co-ordinated, effective and efficient health services."⁷⁶

In contrast to this more recent legislation, Alberta's *Hospitals Act* contained three parts: the organization of general and auxiliary hospital districts, which dealt with the mechanics of establishing districts and financing issues; the operation of approved hospitals, which regulated staffing issues such as bylaws and privileges; and the hospitalization benefits plan, which addressed the benefits insured persons were entitled to.⁷⁷ The only provision relevant to monitoring care was the establishment of a hospital services utilization review committee, with the powers to "conduct a review of a continuing nature of the utilization of all services."⁷⁸ However, it is significant that there was no mention of accompanying responsibilities to monitor the quality or efficacy of services. The only requirements relating to quality place that responsibility on physicians and enforce the role of the hospital board as merely a manager. For example, the legislation states that "the board of each approved hospital shall cause to be kept by the attending physician a record of the diagnostic and treatment services provided in respect of each patient in order to assist in providing a high standard of medical care."⁷⁹ Ontario's previous legislative structure was similarly of a more corporate nature, primarily addressing issues relating to the physical hospital facility,⁸⁰

75 R.S.A. 2000, c. A-10, s. 5.

76 *Local Health Systems Integration Act*, S.O. 2006, c. 4, s. 5(a).

77 R.S.A. 1980, c. H-11.

78 *Ibid.* at s. 30.

79 *Ibid.*, at s. 40(1).

80 *Public Hospitals Act*, R.S.O. 1990, c. P-4, s. 11, 23. Although this legislation is still in force today, it is accompanied by the legislation noted above that discusses issues of quality of care.

financing,⁸¹ hospital bylaws,⁸² and the appointment of staff.⁸³ The discussion of quality of care was limited, with s. 8 giving the Lieutenant Governor in Council the power to appoint persons to investigate and report on the quality of management and administration of a hospital, the quality of care and treatment of patients in a hospital, or other matters relating to the hospital, where it is in the public interest to do so.⁸⁴ Notably, this provision does not place any quality of care obligations on the hospital, but rather merely gives the government the power to conduct a review at its discretion.

There are also legislative provisions relating to the role of government in health care. For example, Alberta's *Health Care Protection Act* provides: "it is the responsibility of the Government of Alberta to provide leadership and support in the delivery of quality health services in order to maintain and improve the health of Albertans."⁸⁵ In addition, it states that "the Government of Alberta is committed to the pursuit of excellence in the health system in Alberta through the efficient delivery of quality publicly funded services based on high standards, best practices and effective patient outcomes."⁸⁶ Although the legislation does not specifically mention quality of care, it is relevant that the government explicitly commits itself to supporting high standards, best practices, and patient outcomes, which are all in the interests of improving quality of care. In Ontario, the focus for government in health sector legislation is on integration, which is set out as a collaborative role between LHINs and government, with the preamble noting that the people of Ontario and the government "recognize the need for communities, health service providers, local health integration networks and the government to work together to reduce duplication and better co-ordinate health service delivery to make it easier for people to access health care."⁸⁷

Because these are broad policy objectives, rather than specific legislative duties, I do not argue these aspirations relating to quality should necessarily be used to impose greater liability. However, by carving a role for itself and health regions in quality of care and explicitly articulating it in legislation,

81 *Ibid.* at s. 5, 25-28.

82 *Ibid.* at s. 12.

83 *Ibid.* at s. 35-43.

84 *Ibid.* at s. 9.1(1)(e).

85 R.S.A. 2000, c. H-1, preamble.

86 *Ibid.*

87 *Supra* note 77 at preamble (e).

government acknowledges that it does have a role in the care received by patients, which should receive consideration by courts.

3. Quality of Care and the Law in Canada

Despite changes in the health care system and a recognition of the role systemic actors play in patient injuries, Canadian courts have cautiously approached the idea of holding government and institutions liable for these injuries. In this section I examine the relevant legal doctrines for imposing institutional liability – vicarious liability for the acts of physicians, and a direct duty on institutions to provide non-negligent medical care.

a. Institutional Liability

i. Direct Duties

In Canadian jurisprudence, courts may use direct duties owed by the hospital to the patient to find liability. Although the law imposes a number of direct duties on institutions, which have undergone a gradual expansion, there has not been an expansion to include a duty to provide non-negligent medical care. The earliest duties, dating back nearly 100 years, were to select competent staff and to provide proper equipment and facilities.⁸⁸ More recent obligations include the duty to provide proper supervision and to establish systems necessary for the safe operation of the hospital.⁸⁹ This affirmative duty to take proactive measures relating to patient safety is the closest Canadian courts have come to a duty to furnish a patient with non-negligent medical care.⁹⁰ However, cases imposing a duty to establish safe

88 Ellen Picard, “The Liability of Hospitals In Common Law Canada” (1981) 26 McGill L.J. 997 at 997.

89 Ellen I. Picard & Gerald B. Robertson, *Legal Liability of Doctors and Hospitals in Canada*, 4th ed. (Toronto: Thomson Canada Limited, 2007) at 463. In a quotation adopted by a number of Canadian courts, the authors note: “[a] hospital has the responsibility for establishing such systems as are required for the coordination of personnel, facilities, equipment and records so that the patient receives reasonable care,” cited, for example, in *Wild v. Salvation Army Maternity Hospital* (1998), (171) N.S.R. (2d) 204 at para. 44 (S.C.).

90 Examples of this line of caselaw include *MacPhail v. Desrosiers*, [1998] N.S.J. No. 353 at para. 16 (C.A.), in which liability was imposed for failure to follow a policy prohibiting a woman from driving after receiving an abortion; *Comeau v. Saint John Regional Hospital*, [2001] N.B.J. No. 450 at para. 2 (C.A.), where

systems are limited in number, and the courts have only imposed this type of liability in the clearest of cases. Additionally, the courts' analysis does not typically extend beyond the interaction between patients and the providers most directly involved with their care to look at the deeper systemic roots for patient injuries.⁹¹

Illustrative of the restrictive approach to institutional liability is the seminal Canadian case, *Yepremian v. Scarborough General Hospital*.⁹² This case, heard by the Ontario Court of Appeal in 1980, has been followed across Canada, almost without exception, for the past 26 years. The plaintiff, Yepremian, attended at an emergency department where the internist failed to diagnose and treat his diabetes, culminating in cardiac arrest and brain damage. Although the majority of the Court of Appeal acknowledged that hospitals do owe direct duties to patients, they refused to find that the defendant hospital owned a duty to ensure the provision of competent medical treatment. In this regard, the majority decision stated:

the Yepremians had every right to expect that a large public hospital like Scarborough General would provide whatever was required to treat seriously ill or injured people, but I do not think it follows that the public is entitled to add the further expectation: "and if any doctor on the medical staff makes a negligent mistake, the hospital will pay for it."⁹³

a hospital was liable for failure to enforce a policy requiring internists to consult with emergentologists in diagnosis and discharge; *Braun Estate v. Vaughan*, [2000] M.J. No. 63 at para. 11 (C.A.), which found an affirmative duty to have policies for reviewing test results; and *Martin v. Listowel Memorial Hospital*, [1998] O.J. No. 3126 at para. 60 (Gen. Div.), which deemed a hospital liable for failure to have policies or procedures for nurses to follow when admitting premature mothers.

91 For example in *Braun Estate v. Vaughan, ibid.*, the Manitoba Court of Appeal imposed liability on a doctor and a hospital for a failure to notify a patient of test results. Although the Court found that both defendants ought to have follow-up procedures for test results, this finding focuses on the most immediate cause for the patient's injury and does not delve into deeper systemic problems that may have contributed to the injury.

92 *Supra* note 1.

93 *Supra* note 1 at para. 53.

Although not without academic criticism,⁹⁴ most courts have followed *Yepremian* without appropriate reflection on the changes in the relationship between patients and hospitals in general, or on the facts of the specific case before them. For example, *Zeledon v. Kelowna General Hospital*⁹⁵ was a motion by the defendant doctors and hospital to have the case dismissed for want of a cause of action, a high burden for a defendant to meet. Despite this, the discussion of the law of direct institutional duties was limited, with the British Columbia Supreme Court summarily concluding that the reasoning in *Stewart v. Noone*, another British Columbia Supreme Court decision analyzing *Yepremian* “applies to this case.” *Zeledon* states “[n]o court in Canada has ever found before that [a non-delegable duty of care]...exists, and with great respect to the trial Judge, I am not persuaded by his reasons that there is such a duty.”⁹⁶

ii. Vicarious liability

The other doctrine to impose institutional liability is vicarious liability, or liability for hospital employees. Institutions are vicariously liable for the majority of health care professionals, such as nurses⁹⁷ and residents,⁹⁸ but except in rare cases,⁹⁹ doctors are independent contractors.

94 See *e.g.* Picard, *supra* note 90.

95 [1996] B.C.J. No. 2868 (S.C.). See also *Jaman Estate v. Hussain*, [2001] M.J. No. 548 (Q.B.), *rev'd* [2002] M.J. No. 283 (C.A.), and *Locke v. Smith*, [2000] O.J. No. 2726 at para. 2., *aff'd* [2002] O.J. 2173 (C.A.), in which the Superior Court of Justice cited *Yepremian*, and with little further analysis concluded “in essence there is no ‘non-delegable duty of care’ owed by hospitals to patients, in the law of Ontario.”

96 *Ibid.* at paras. 51-52.

97 See *e.g.* *MacDonald v. York County Hospital et al.* (1974), 1 O.R. (2d) 653 (C.A.).

98 See *e.g.* *Aynsley v. Toronto General Hospital*, [1972] S.C.R. 435, *Murphy v. St. Catharines General Hospital* (1964), 41 D.L.R. (2d) 697 (H. Ct.). However, see also *Comeau v. Saint John Regional Hospital*, *supra* note 90 at para. 33, in which the Court stated that “[w]hile I agree that with the proper evidentiary foundation resident doctors can be considered employees of a hospital, I do not share the view that such was the case here.

99 In this regard, there is a limited line of Quebec caselaw. However, all of these cases are older, all involve anaesthetists, and they have received little attention in modern cases since *Yepremian*. In *Martel v. Hotel-Dieu St.-Vallier*, (1969), 14 D.L.R. (3d) 445 at 451, the Supreme Court of Canada found that “[t]he anaesthetist in this case gave his services as he was obliged to do under his contract of

Canadian courts, in determining institutional liability in health care, focus their discussion on the factors of remuneration and control, and tend to provide little analysis or reasoning for their categorization of doctors as independent contractors. For example, in *Comeau v. Saint John Regional Hospital*, the Court of Appeal noted that the trial judge did not set out the evidence relied upon to conclude the doctors were not employees and stated:

It was clear that although Mr. Comeau did not retain any of [the doctors]...upon his arrival at the emergency room, all physicians were provided to him and he paid for their services through Medicare. There was also evidence that the doctors who treated Mr. Comeau as a patient had been granted the usual hospital privileges, that they were not paid by the Hospital and the manner in which they performed their work was not generally supervised by the Hospital, nor were they acting under the orders or control of the Hospital when performing their tasks as providers of medical services.¹⁰⁰

Given the complexity and fact sensitive nature of the determination of vicarious liability, this analysis fails to explore the issue in any level of detail.

In contrast to these cursory discussions based on factors remuneration and control, the Supreme Court of Canada advocates an approach that analyzes these factors on a case-by-case basis:

The liability of a hospital for the negligent acts or omissions of an employee vis-à-vis a patient, depends primarily upon the particular

employment with the hospital, as did the other members of the staff.... The fact that he was a specialist changes nothing." Similarly, in *Beausoleil v. Soeurs de la Charitie de la Providence*, (1964), 53 D.L.R. (2d) 65, the Quebec Court of Appeal found that because the hospital held the anaesthetist out as its doctor and paid him a salary for his duties as chief anaesthetist, that he was a hospital employee. However, other cases, such as *Aynsley v. Toronto General Hospital*, *ibid.* deem anesthesiologists independent contractors.

100 *Supra* note 90 at para. 30. Similarly, in *Crnkovic v. Stockdill*, [1998] B.C.J. No. 3187, the British Columbia Supreme Court granted an application to dismiss the plaintiff's claim alleging negligence against the Langley Memorial Hospital as the employer of an anaesthetist and a surgeon. The Court based this on the fact that doctors billed services directly to the Medical Services Plan, and that the hospital exercised no control over the medical services or clinical judgment. Although these are appropriate factors to take into consideration, the analysis of this issue was rather brief.

facts of the case, that is to say, the services which the hospital undertakes to provide and the relationship of the physician and surgeon to the hospital.¹⁰¹

Despite this statement, recent cases have rejected that vicarious liability is a relevant question for consideration by not allowing it to proceed to trial.¹⁰² The courts often base this finding on *Yepremian*.¹⁰³ For example, the court *Lafond v. Fabian* commented that in *Yepremian*, it was held that hospitals:

do not control the clinical decision making of physicians and that physicians are independent contractors for whom Defendant Hospitals are not vicariously responsible. For that reason there can be no liability on the part of the hospital in respect to their relationship for the Defendant Physicians.¹⁰⁴

Although these interpretations of the finding in *Yepremian* are correct, courts should not merely rely on that decision, but should engage in a more detailed examination of the facts of the case before them. This is particularly true given the fact that the *Yepremian* decision is 26 years old, it is from the Ontario Court of Appeal rather than the Supreme Court of Canada, and was issued prior to significant health system reforms.

In addition, the courts often fail to seriously analyze and consider whether the factors of remuneration and control might constitute an employment relationship in a particular case. Both of these factors have undergone changes in recent years, arguably necessitating fresh analysis by the courts. Originally, the law refused to impose vicarious liability because patients personally retained and paid physicians, and the hospital merely furnished the facility. Although the courts recognize that patients no longer

101 *Aynsley v. Toronto General Hospital*, supra note 100 at 224.

102 See e.g. *Kratochvil v. Burnett*, [2000] M.J. No. 275 (Q.B.).

103 See also *Grizzle v. Scarborough General Hospital*, [1998] O.J. No. 3137 at para. 20 (Gen. Div.), in which the court merely stated: “[t]he hospital is not vicariously liable for the doctor’s negligence: *Yepremian v. Scarborough General Hospital*.” Similarly, in *Smith v. Dodds*, 1998 CanLII 4351 at para. 7, with little analysis other than mentioning *Yepremian*, the British Columbia Supreme Court found that “[i]t is clear in law, that the defendant hospital is not vicariously liable for the actions of the independent physician who treats a patient in the hospital’s premises.”

104 2004 CarswellOnt 2709 at para. 18 (Master).

pay physicians directly, they continue to deny claims of vicarious liability. Moreover, the nature of the employment relationship is profoundly changing with an increasing number of physicians becoming salaried, often paid directly by institutions.¹⁰⁵

Health care institutions also exercise more control over physicians now than was the case historically. For example, as discussed, institutions have various institutional policies relating to the quality of care and treatment rendered to patients.¹⁰⁶ Courts have acknowledged a legal duty on physicians to follow these institutional policies.¹⁰⁷ In addition to a failure by the courts to reconsider the issue of vicarious liability in light of the changes in the health care system, these cases also apply an outdated test, which focuses on remuneration and control, for determining employee versus independent contractor status. In recent years, the Supreme Court of Canada has stated that there is no universal test, and courts should examine the total relationship between the parties. This includes factors such as control, whether the worker provides his or her own equipment and hires his or her own helpers, the “degree of financial risk taken by the worker,” the “degree of responsibility for investment and management” held by the worker, and the worker’s opportunity for profit from the work.¹⁰⁸

A number of the factors listed by the Supreme Court favour an employment relationship. For example, the institution furnishes the physician with equipment and hires the staff to assist. In addition, the physician working within a hospital has no degree of financial risk. With regard to the factor of responsibility for management, while physicians frequently have roles in hospital management, the institution is predominantly responsible for organizing and overseeing the complex management structure.

Picard suggests that a more appropriate test for vicarious liability is to assess whether the physician is an integral part of the institution, making it possible for the institution to fulfill its duties and obligations.¹⁰⁹ Although the

105 Shelley Martin, “Fee-for-service v. Salary: The Debate is Heating Up” (2003) 169 CMAJ 701, notes that data indicates the proportion of physicians receiving over 90 percent of their professional income from fee-for-service payments has declined from 68 percent in 1990 to 57 percent in 2003.

106 *Supra* note 3.

107 See e.g. *MacPhail v. Desrosiers*, *supra* note 90.

108 671122 *Ontario Ltd. v. Sagaz Industries Canada Inc.*, [2001] S.C.R. 983 at para. 44, quoting *Market of Social Security*, [1968] 3 All E.R. 732 (Eng Q.B.) at 737-38.

109 *Supra* note 90 at 1017.

Supreme Court of Canada has found that there is no single test to be applied in determining vicarious liability,¹¹⁰ they affirmed the use of the organizational test in non-medical contexts.¹¹¹ Employing this test, more Canadian physicians would be employees of the institution, as hospitals are no longer structured entirely around doctors and their services, and patients may receive treatment from a number of practitioners other than physicians. In addition, persons such as administrators making allocation and staffing decisions may also affect the care received by the patient. Therefore, the physician is often arguably a member, albeit an important one, of a team providing treatment to patients.¹¹²

iii. Cases Suggestive of Greater Institutional Responsibility

Although Canadian jurisprudence tends to limit institutional liability, there are a handful of cases where courts demonstrate a more sophisticated understanding of the health care system. For example, the court in *Lachambre v. Nair* recognized that health care is a complex enterprise requiring institutional coordination, stating: “[w]here a patient in a hospital is treated by more than one specialty, the hospital owes a duty to ensure that proper coordination occurs and that the treatment program operates as a unified and cohesive whole.”¹¹³ Similarly, the dissent of Blair J. in *Yepremian* discusses the evolution of health care:

This direct duty arises from profound changes in social structures and public attitudes relating to medical services and the concomitant changes in the function of hospitals in providing them. It is obvious that as a result of these changes the role of hospitals in the delivery of medical services has expanded.¹¹⁴

110 *Supra* note 108.

111 *Co-op Insurance Assn v. Kearney*, [1956] S.C.R. 106.

112 Courts in other jurisdictions have been more receptive to these arguments. For example, in the United States, courts have used the doctrine of agency to impose liability.

113 [1989] 2 W.W.R. 749 at 768 (Sask. Q.B.). Similarly, in *Braun v. Vaughn*, *supra* note 90 at para. 49, Scott, C.J.M. concluded that the hospital had an “obligation to provide a reasonable a practical ‘safe system’ including the coordination of services between physician, patient and the institution.”

114 *Supra* note 1 at para. 192. Similarly, in Houlden J.A.’s decision, at para. 202, he notes the evolution of a system of universal health care in Canada, the mobility

However, these rare recognitions of health system changes are typically *obiter* in nature and these courts do not explore the possible systemic causes for the negligence that occurred, but merely acknowledge the complexity of the health care system.

In Canada, the only pending case suggestive of a potential re-evaluation of institutional liability is *Jaman Estate v. Hussain*, a decision by the Manitoba Court of Appeal to allow a plaintiff's claim to proceed to trial.¹¹⁵ The judgement took a relatively progressive view, noting that *Yepreman* was decided on a 3-5 split with persuasive minority decisions, and that the Supreme Court of Canada had granted leave to appeal in *Yepreman*, which the plaintiff discontinued only after a substantial settlement.¹¹⁶ In addition, the court in *Jaman* showed a more sophisticated understanding of the nature of modern medical care. In this regard, Twadle J. noted that in cases involving large city hospitals it may be correct to infer that a plaintiff has a choice of doctors. However, in smaller centres (as was the case in *Jaman*) patients have no real choice and rely on the hospital holding itself out as a source of emergency care.¹¹⁷ Despite the prospects for this claim leading to a reconsideration of hospital liability, nothing has been reported on the case in the past five years, suggesting that the parties may have settled.

of the population, and the "ever-increasing fragmentation of the medical profession," with the result that the public relies less on the family doctor and more on hospitals, concluding that "hospitals have recognized this change in their function by the provision of family, out-patient and various other clinics, as well as by the posting of signs and symbols to indicate the location of hospital facilities."

115 *Jaman Estate v. Hussain*, [2001] M.J. No. 548 (Q.B.), rev'd [2002] M.J. No. 283 (C.A.).

116 *Ibid.* at paras. 10-11, citing *Yepreman et al. v. Scarborough General Hospital et al.* (No. 2) (1981), 31 O.R. (2d) 384 (H.C.J.). This decision notes that this settlement was for almost \$2 million. Some academics have expressed the opinion that if this case had proceeded to the Supreme Court of Canada, the decision of the Ontario Court of Appeal may have been reversed. See e.g. Bruce Chapman, "Controlling the Costs of Medical Malpractice: An Argument for Strict Hospital Liability" (1990) 28 Osgoode Hall L.J. 523 at 530; and G. Sharpe, *The Law and Medicine in Canada* (Toronto: Butterworths, 1987) at 122.

117 *Jaman Estate, ibid.* at para. 14.

b. Governmental Liability

Although there have been a number of cases addressing hospital liability for patient injury, there are relatively few addressing government liability in the health sector, despite its integral and pivotal role. Additionally, the reported tort decisions with governmental defendants are not final determinations on the merits of the cases, but are motions by defendants to dismiss the claims for want of a cause of action or class certification motions. To date, courts have shown a reluctance to impose tort liability on government, with the majority of these claims being struck in whole or in part before trial, particularly the more recent claims.¹¹⁸ In this section I argue that both the test for striking claims before trial and the test for governmental liability are applied too restrictively in health sector claims, in contrast to other cases alleging governmental tort liability.

i. Application of the Test to Strike Claims

The high burden required to strike a claim is set out by the Supreme Court of Canada in *Hunt v. Carey Canada Inc.*:

The requirement that it be “plain and obvious” that some or all of the statement of claim discloses no reasonable cause of action before it can be struck out, as well as the proposition that it is singularly inappropriate to use the rule’s summary procedure to prevent a party

118 *Decock v. Alberta*, [2000] A.J. No 419, 2000 ABCA 122, leave to appeal to S.C.C. granted [2000] S.C.C.A. No. 301 and *Marble (Litigation Guardian of) v. Saskatchewan* (2003), 236 Sask R. 14, were allowed to proceed to trial, although in the later the government was released from liability on the basis of a settlement agreement. A number of cases arising from the SARS outbreak were allowed to proceed, but a number of the allegations were struck: *Williams v. Canada (Attorney General)* (2005), 76 O.R. (3d) 763 [Williams], *Jamal Estate (Trustee of) v. Scarborough Hospital* (2005), 34 C.C.L.T. (3d) 271, *Larozza v. Ontario* (2005), 34 C.C.L.T. (3d) 264, and *Abarquez v. Ontario* (2005), 34 C.C.L.T. (3d) 249. In addition, the claims in *Mitchell Estate v. Ontario*, 2002 CarswellOnt 1728, (2004), 71 O.R. (3d) 571 (Div. Ct.) and *Eliopoulos v. Ontario (Minister of Health and Long Term Care)* [2004] O.J. No. 3035 (Sup. Ct. Just.), (2005) 76 O.R. (3d) 36 (Div Ct), [2006] O.J. No. 4400 (C.A.) [Eliopoulos] were struck in their entirety, and in *Cilinger v. Centre Hospitalier de Chicoutimi*, [2004] O.J. No. 3035 (Sup. Ct. Just.), aff’d [2004] R.J.Q. 2943 (C.A.) [Cilinger], the Quebec Court of Appeal refused to certify the class action against the provincial government.

from proceeding to trial on the grounds that the action raises difficult questions, has been affirmed repeatedly in the last century.¹¹⁹

The Supreme Court went on to state that “[c]omplex matters that disclosed substantive questions of law were most appropriately addressed at trial where evidence concerning the facts could be led and where arguments about the merits of a plaintiff’s case could be made.”¹²⁰ Quoting from the British Columbia Court of Appeal, the Court further stated that “[i]f the action involves investigation of serious questions of law or questions of general importance, or if the facts are to be known before rights are definitely decided, the Rule ought not to be applied.”¹²¹

Health sector claims would certainly meet these criteria. For example, few could dispute that in light of the potential scope of a pandemic that the questions that arose in *Williams v. Canada (Attorney General)*¹²² are of general importance. This case was a class action alleging tort liability for the government’s response to SARS. Similarly, the complexity inherent in health ministries is clear when contrasting the decisions in *Eliopoulos v. Ontario (Minister of Health and Long Term Care)*, a case arising from the government’s response to the West Nile Virus,¹²³ and *Just v. British Columbia*, which arose when a boulder fell on the plaintiff’s car on the highway.¹²⁴ In the former the Court listed a plethora of individuals involved in the government’s decisions around the Virus: the Ministries of Health, the National Steering Committee for West Nile Virus, the Canadian Cooperative Wildlife Health Centre, local boards of health, neighboring provinces, and the Center for Disease Control. In contrast, in the latter case, the decision-making process involved two engineers responsible for inspecting slopes and making recommendations regarding their stability, and a rock work section composed of a crew which performs remedial work which is supervised by an engineer.¹²⁵

119 [1990] 2 S.C.R. 959 at para. 18. A number of the health sector claims specifically affirm this articulation of the test, see e.g. *Eliopoulos v. Ontario (Minister of Health and Long Term Care)*, *ibid.* at para. 8 and *Williams v. Canada (Attorney General)*, *ibid.* at para. 2.

120 *Hunt v. Carey*, *ibid.* at para. 17.

121 *Ibid.* at para. 28, quoting *Minnes v. Minnes* (1962), 39 W.W.R. 112 at 122.

122 *Supra* note 118.

123 *Supra* note 118.

124 [1989] 2 S.C.R. 1228 [*Just*].

125 *Ibid.* at para. 4-5.

ii. Application of the Test for Governmental Tort Liability

The Supreme Court of Canada laid out the test for governmental tort liability in *Just*.¹²⁶ First, a court must ask whether the plaintiff has established that the defendant owes a duty of care, by establishing sufficient foreseeability and proximity.¹²⁷ Once the duty of care is established, it must be determined whether there are factors to limit the duty owed. This is generally a question of whether the decision was a policy decision, for which government will not be liable, or an operational decision, for which liability may result.¹²⁸ Although a detailed exploration of the courts' application of this test is beyond the scope of this paper, this section discusses the policy/operational dichotomy to illustrate the courts' strict application of this test in health sector cases.

Decisions involving financial, economic, social or political factors are considered policy decisions, and thus beyond the scope of judicial review. Generally, the classification of a decision as budgetary will typically result in its characterization as policy, due to the comments of the Supreme Court of Canada in *Just*: "[a]s a general rule, decisions concerning budgetary allotments for departments or governmental agencies will be classified as policy decisions."¹²⁹ Although it is difficult to envision many governmental decisions which do not somehow involve resource allocation or budgetary allotments, the non-health sector jurisprudence shows a greater willingness to look beyond the financial aspects of governmental decisions.

Just involved the inspection of slopes above highways and the removal of rocks that carried a risk of falling onto the road. In this case, the Supreme Court of Canada found that the government made a policy decision involving budgetary considerations in settling on a plan to inspect slopes visually and conduct further inspections where warranted. However, the carrying out of inspections were "manifestations of the implementation of the policy decision to inspect,"¹³⁰ and thus suitable for judicial review, despite the fact

126 *Ibid.*

127 As set out in *Anns v. Merton London Borough Council*, [1978] A.C. 728 at 752 (H.L.).

128 Although the initial articulation of the test contemplates a broad consideration of factors which may limit the duty owed, the jurisprudence generally restricts itself to discussing the policy/operational dichotomy.

129 *Supra* note 124.

130 *Ibid.* at para. 31.

that budgetary policy decisions “will have an effect upon the frequency of inspections and the manner in which they may be carried out.”¹³¹

In contrast, the health sector claims seem to regard the involvement of government in health care as restricted to budgetary involvement, despite the role government has clearly taken in issues beyond the financing of the health care system. For example, the Court of Appeal in *Eliopoulos* stated: “In deciding how to protect its citizens from risks of this kind that do not arise from Ontario’s actions and that pose an undifferentiated threat to the entire public, Ontario must weigh and balance the many competing claims for the scarce resources available to promote and protect the health of its citizens.”¹³² This fails to look beyond these initial resource determinations to analyze the implementation of the government’s decisions.

The approach of the lower courts in *Eliopoulos* better reflects the jurisprudence of the Supreme Court. Although the Superior Court of Justice acknowledged that “it is not the role of the courts to dictate how public funds should be spent,” this “does not mean, however, that the courts may not review any decision involving money.”¹³³ Specifically with regard to the facts of the case, and analogous to the reasoning of Supreme Court of Canada in *Just*, the Court concluded:

The defendant cannot suggest that the government would create a detailed operational manual for dealing with WNV [West Nile Virus] without having made the necessary budgetary decisions for the implementation of the Plan.... If the government has committed to

131 *Ibid.* at para. 33. This is similar to *Brown v. British Columbia (Minister of Transportation and Highways)*, [1994] 1 S.C.R. 420 in which the Supreme Court of Canada classified the decision to maintain a summer and winter road maintenance schedules as policy, as it involved “classic policy considerations of financial resources, person and, as well, significant negotiations with government unions.” However, the Court went on to consider whether the manner in which the sanding was carried out under the summer schedule was negligent, despite the fact that the manner in which the sanding was carried out would certainly involve some budgetary considerations.

132 *Supra* note 118 at para. 32. This comment also seems to conflate the proximity analysis with the policy/operational analysis, as the Court refers to the group of persons affected by the risk. In addition, they differentiate between the government creating the risk and protecting from the risk, which relates to whether a duty is owed under the first stage of the analysis.

133 *Ibid.* at para. 51.

and planned for the taking of certain steps, it cannot sidestep liability by claiming that implementation involves money.¹³⁴

In this case, the plaintiffs referred to the government's document *West Nile Virus: Surveillance and Prevention in Ontario*,¹³⁵ which described as an operational document detailing in the steps the government intended to address the disease.¹³⁶ The Superior Court of Justice agreed, noting:

[u]ndoubtedly, the research, fact finding, negotiations, and determining of strategies may have led to the formulation of the Plan and were part of the policy-making process. The Plan was a final statement of those policy decisions and a detailed plan on how to carry out those policy decisions at the operational level.¹³⁷

There could thus be negligence in the manner in which the plan was carried out, similar to the Court's finding in *Just* that there could be negligence in the manner in which the plan relating to the inspection system was carried out.

In contrast, the Court of Appeal's decision in *Eliopoulos* does not differentiate between the creation of a plan and liability for its implementation in the same fashion as the Court in *Just*. In this regard, the Court of Appeal found that any operational duties created by the plan resided with local authorities and boards of health, rather than government.¹³⁸ The notion of operational duties is found nowhere in the Supreme Court of Canada jurisprudence. Instead, once there is a policy decision, there may be negligence in its implementation. In addition, these comments of the Court of Appeal

134 *Ibid.* The Court goes on to cite *Just*, stating that in that case, Cory J. "made it clear that the courts may scrutinize expenditures, or the lack of them, when looking at the operational aspects of governmental actions or decisions." It is important to remember that while *Just* was a trial decision, *Eliopoulos* was a motion to strike, and thus the plaintiff had a much lower burden to meet.

135 *West Nile Virus: Surveillance and Prevention in Ontario* (Toronto: Ontario Ministry of Health and Long Term Care, 2001), online: Ontario Scholars Portal <<http://ozone.scholarsportal.info/bitstream/1873/7112/1/10295917.pdf>>.

136 *Supra* note 118 at para. 39.

137 *Ibid.* at para. 49.

138 *Ibid.* at para. 22.

neglect considerations of whether these entities may be government agents or even employees.¹³⁹

The broad categorization of governmental decisions as budgetary also occurred in *Cilinger v. Centre Hospitalier de Chicoutimi*, a class action certification proceeding by women alleging they did not receive radiation treatment in a reasonable length of time.¹⁴⁰ In this case, the plaintiffs attributed their delays in treatment to budgetary controls, control of personnel and professionals, and other regulatory controls.¹⁴¹ The court recognized that the government makes high-level decisions relating to funding, specifically, the amount of the yearly budget for health care, the allocation of this amount between hospitals, and the determination of the use of these funds.¹⁴² However, the court did not consider the possibility of government's involvement beyond decisions relating to the hospital's budget, despite the fact that the plaintiffs made claims with regard to control of personnel and professionals, and other regulatory controls. In addition, the court refers to a number of governmental policies relating to breast cancer, but does not discuss their implementation.¹⁴³

4. Limits of Systemic Liability

As discussed in the previous sections, Canadian courts have been reluctant to impose tort liability on systemic actors, despite changes in their roles in the health care system. Unfortunately, the courts in these cases are rarely

139 Although this may not have been specifically plead, the courts, including the Supreme Court, have not been restrictive in this aspect of pleadings, allowing the assumption that general allegations against government may be carried out by their employees. For a general discussion on this issue see *Williams, supra* note 118.

140 *Supra* note 118.

141 *Ibid.* at para. 81.

142 *Ibid.* at para. 111.

143 1992 policy which indicated government's intention to reduce breast cancer mortality by 15% by 2002 (*supra* note 118 at para. 82), a 1992 report by a ministerial committee on cancer services which mentioned a further report of a working group concerning hospital's radiotherapy needs (*supra* note 118 at para. 83), a 1997 consultative committee report "Quebec program to fight against cancer" relating to human resources (*supra* note 118 at para. 84), and a 1999 committee to remedy operating difficulties and waiting lists (*supra* note 118 at para. 85).

clear on their reasons for these limits. For example, in the governmental liability cases, the courts do not generally discuss the policy reasons for limiting governmental liability under the second stage of the tort liability test, the stage at which the court is to consider reasons to limit the governments' duty to the plaintiff, despite the fact that these reasons are most likely what is actually driving their decision to strike these claims. Instead, the courts strike these claims by applying the policy/operational dichotomy and the test for striking claims more restrictively to health sector claims than claims arising from the government's decisions in other sectors. Even if the courts ultimately decide that systemic liability should be limited, they should do this through an explicit consideration of the reasons for these limits, rather than through applying these tests strictly.

The exception to this is *Eliopoulos*, where the decision reflects on the reasons for limiting governmental liability. In this regard, the trial decision noted the governmental defendant's objections to increasing systemic liability: it would give rise to indeterminate liability, lead to the judicial creation of a compensation or insurance scheme, and impede proper governance in the public interest.¹⁴⁴ The Court of Appeal elaborated on the third of these duties:

to impose a private law duty of care...would create an unreasonable and undesirable burden on Ontario that would interfere with sound decision-making in the realm of public health. Public health priorities should be based on the general public interest. Public health authorities should be left to decide where to focus their attention and resources without the fear or threat of lawsuits.¹⁴⁵

Unfortunately, these considerations were raised on a motion to strike, without the benefit of a full factual record, which is arguably required to consider complex questions of social policy, government priorities, and the governmental decision-making process.

Although these are certainly serious concerns, particularly the risk of interfering with sound decision-making in health care, the tests for institutional negligence and governmental tort liability contain internal limits to address these policy concerns. For example, expanding hospital liability to include a direct duty to provide non-negligent medical care would be

144 *Supra* note 118 at para. 53.

145 *Ibid.* at para 33.

limited by the requirement of causation – that the patient would not have been injured but for the negligence of the hospital. With regard to government, one of the main limits internal to the test for governmental liability is the policy/operational dichotomy. This dichotomy provides a policy realm where government is insulated from exercising its discretion. However, unlike the courts' typical finding to date, not all governmental decisions are policy.

When combined with the fact that the common law has the means to limit widespread liability, the reasons for considering greater legal accountability of systemic actors outweigh the policy considerations listed above. As discussed in the first two sections of this paper, systemic actors have taken a role in the quality of care received by patients and their decisions have a large impact on patient outcomes. Despite this, practitioners bear almost full legal responsibility for patient injuries. Shifting some of the accountability from practitioners to systemic actors would thus better reflect the reality of modern health care. In addition, it would better reflect public expectation. The fact that a number of tort lawsuits against government have been commenced in the past few years clearly shows that patients are looking to the law to impose remedies on systemic actors for their injuries. Finally, imposing greater legal accountability at the systemic level could encourage improvements in patient safety at the systemic level.

Although beyond the scope of this paper, it is also significant that increased systemic liability has not spelled disastrous results for health care decision-making in other jurisdictions. For example, both Britain and the United States impose greater liability at the systemic level, despite historically employing a conservative approach similar to Canada. However, the common law in these jurisdictions has eroded these limits, reflecting a greater understanding of the complexity of modern health care and the impact systemic actors have on patient outcomes. For example, in imposing liability in *Darling v. Charleston Community Memorial Hospital*, the court stated:

The conception that the hospital does not undertake to treat the patient, does not undertake to act through its doctors and nurses, but undertakes instead simply to procure them to act upon their own responsibility, no longer reflects the fact. Present-day hospitals, as their manner of operation plainly demonstrates do far more than furnish facilities for treatment. They regularly employ on a salary basis a large staff of physicians, nurses and internes, as well as administrative and manual workers, and they charge patients for medical care and treatment, collecting for such services, if necessary, by legal action. Certainly, the person who avails himself of "hospital

facilities” expects that the hospital will attempt to cure him, not that its nurses or other employees will act on their own responsibility.¹⁴⁶

In the United States, the doctrine of agency is generally used to impose systemic liability. A doctor will be the hospital’s agent, and thus the hospital’s legal responsibility when “a hospital holds out a physician as its agent or employee, and a patient accepts treatment from that physician in that reasonable belief that it is being rendered on behalf of the hospital.”¹⁴⁷ Although this test would certainly be met in a number of Canadian cases, such as *Yepremian*,¹⁴⁸ where the patient attended at the emergency room in need of medical assistance and was assigned a doctor by the hospital, Canadian courts have not considered agency in the health context.

British courts have also imposed greater legal accountability at the systems level. For example, in *Roe v. Ministry of Health*, the Court of Appeal commented:

I consider the anaesthetists were members of the “organization” of the hospital: they were members of the staff engaged by the hospital to do what the hospital itself was undertaking to do. The work which Dr. Graham was employed by the hospital to do was work of a highly skilled and specialized nature but this fact does not avoid the application of the rule of “respondeat superior.”¹⁴⁹

Similar to the American cases, there is British jurisprudence illustrating a sophisticated understanding of the systemic nature of patient injuries. In *Collins v. Hertfordshire County Council*, a surgeon ordered a drug over the telephone, which was misheard, and resulted in a fatality.¹⁵⁰ The pharmacist dispensed the drug without further inquiry or requiring the written instructions of a qualified physician, and the surgeon who ordered the drug over the telephone dispensed it without checking it to ensure it was what he ordered. In reflecting on this chain of events, the Court commented: “If the system which was in operation at the hospital had not been as utterly defec-

146 143 N.E.2d 3 at 8 (Ill. 1957).

147 Shafeek Sanbar, *Legal Medicine*, 6th ed. (St. Louis: Mosby, 2004) at 380.

148 *Supra* note 1.

149 [1954] 2 All E.R. 131 (C.A.) at 141.

150 [1947] 1 All E.R. 633.

tive and dangerous as I think it was, the anaesthetic which was presented to him could not have been presented to him."¹⁵¹

Conclusion

Historically, patient safety was solely within the purview of clinicians, with quality of care activities consisting primarily of clinical departments meeting to discuss particular cases. The hospital merely provided a facility within which doctors practiced medicine, and government funded this endeavour. Tort law reflected this state of affairs, with physicians bearing almost sole legal responsibility for patient injuries.

Medicine has evolved, becoming more complex and specialized. Accompanying these changes was an evolution of the modern hospital into a technologically advanced facility designed to provide a plethora of services from a wide variety of health professionals. Hospitals responded by taking on a greater role in organizing and managing the delivery of services, and coordinating the diverse staff and programs. The focus has shifted to include not only the business aspects of the hospital operation, but activities related to quality of care.

With more sophisticated treatment available and complex hospitals increasingly expensive to operate, governments' financial stakes in health care increased. As this occurred, so did the entrenchment of Medicare in the Canadian identity, and a concomitant rise in the public's expectations of government. These changes resulted in an expansion of government's role in health care to include governance, management and administration. In addition, similar to the institutional interest in quality of care, government took an active role in the clinical aspects of care.

These roles in the organization and management of the health care system have given governments and institutions the ability to greatly effect quality of care. Furthermore, they have asserted roles for themselves in quality of care through policy-setting and legislation. Despite the greater involvement of these systemic actors in the governance, management and administration of health care in Canada, all of which directly affect patient care, there has been little change in the tort law jurisprudence, which continues to hold physicians primarily liable for failures in quality of care.

151 *Ibid.*

In addition to the active role that systemic actors have taken in quality of care is an increasing recognition of the impact that systems have on patient injuries – systems that are the cumulative product of decisions taken at the institutional and governmental level. It is clear from this literature that although the most easily ascertainable causes of patient injuries are the actions of the practitioners most immediately involved in providing treatment, the systems within which those providers work also cause and contribute to injuries. Research also shows that many of the most effective means of preventing errors are at the systemic level. Again, the courts give little consideration to this body of literature.

While there are good policy reasons not to shift liability entirely from physicians to systemic actors, the common law has internal limits to this liability in cases where it is warranted. In addition, the courts need to be explicit about the ways in which these reasons are playing into their decisions, rather than merely applying the law more restrictively in health sector cases than cases arising in other sectors. While liability should not completely shift from practitioners to systemic actors, courts should reconsider the legal relationships between patients and those at the systems level, given significant developments in the organization of the health care system and a growing recognition of the roles governments and institutions play in patient safety.

