A VIEW OF THE FUTURE: EMERGING DEVELOPMENTS IN HEALTH CARE LIABILITY

Gerald B. Robertson*

I. Introduction

In keeping with the "visions" theme of the conference, the purpose of this paper is to discuss the future of health care liability in Canada. What significant changes (if any) are likely to occur in this area in the foreseeable future?

The first section of the paper examines the past, and takes the position that there have been very few (if any) doctrinal changes of any real significance in health care liability over the last 50 years. In light of this one might suppose that there is no reason to expect that there will be any in the next 50 years. However, the second section of the paper explores a number of factors and developments which may combine to produce a significant re-emergence of interest and momentum in replacing the present system with one of no-fault compensation.

II. The Past

History tells us that before we can look forward, we must first look back. Our vision of the future is informed by our understanding of the past. In the area of health care liability, the past (certainly the recent past) speaks of continuity rather than change, of reaffirmation rather than reform. Although there have been many interesting and important developments in health care liability over the past few decades, none achieves what can reasonably be described as involving radical or fundamental change.

Evidence of the continuity and stability of the law in this area is found in most of the recent medical malpractice cases. Typically one finds that the core principles of law applied by the court are articulated by reference to cases decided over 50 years ago. Thus, for example, the key issue of the

---

* Gerald B. Robertson, Q.C., LL.B., LL.M., Professor of Law, University of Alberta. This is a slightly updated version of the paper presented at the Visions: National Health Law Conference (November 2007).

standard of care to be applied to physicians continues (almost invariably) to be defined by reference to the 1956 decision in *Crits v. Sylvester*, in particular the following passage:

> Every medical practitioner must bring to his task a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. He is bound to exercise that degree of care and skill which could reasonably be expected of a normal, prudent practitioner of the same experience and standing, and if he holds himself out as a specialist, a higher degree of skill is required of him than of one who does not profess to be so qualified by special training and ability.[1]

Likewise, the important distinction between error of judgment and negligence continues to have a significant impact on the outcome of medical malpractice litigation in Canada.[2] However, once again this is a principle which has been well established for many decades. Though now often supported by reference to the 1992 decision of the Supreme Court of Canada in *Lapointe v. Hôpital Le Gardeur*,[3] that decision merely reaffirms what the Supreme Court said in 1956 in the leading case of *Wilson v. Swanson*.[4] The continuing and significant influence which the concept of error of judgment has in modern day medical malpractice litigation offers strong support for the view that, in essence, very little has changed in this area over the last 50 years.

So too with the defence of approved practice. The decision of the Supreme Court of Canada in *ter Neuzen v. Korn*[5] makes it clear that, absent very exceptional circumstances, a doctor will not be found to have been negligent if he or she acted in accordance with a recognized and respectable practice of the profession.[6] As with "error of judgment," this principle continues to play a key role in the outcome of medical malpractice litigation. However, though

---

1 [1956] O.R. 132 at 143, 1 D.L.R. (2d) 502 (C.A.), aff'd [1956] S.C.R. 991, 5 D.L.R. (2d) 601 [*Crits* cited to O.R.].

2 See generally Ellen I. Picard & Gerald B. Robertson, *Legal Liability of Doctors and Hospitals in Canada*, 4th ed. (Toronto: Thomson Carswell, 2007) at 364-367 [Picard & Robertson].

3 [1992] 1 S.C.R. 351, 90 D.L.R. (4th) 7 [*Lapointe*].

4 [1956] S.C.R. 804, 5 D.L.R. (2d) 113. See also *St. Martin v. Dupont*, [1922] S.C.J. No. 1 at para. 30 (QL).

5 [1995] 3 S.C.R. 674, 127 D.L.R. (4th) 577 [*ter Neuzen*].

6 See generally Picard & Robertson, *supra* note 2 at 355-364.

it is now usually discussed by reference to the *ter Neuzen* decision, its roots are much older than this. *ter Neuzen* merely reaffirms what the Supreme Court of Canada decided in 1950,[7] and indeed the origins of the defence of approved practice in Canada probably date back to the 19th century.[8]

Another key principle in this area, one which is emphasized in many of the recent cases, is the importance of avoiding the danger of "hindsight." As was stated by Madam Justice L'Heureux-Dubé, when judging a doctor's actions "courts should be careful not to rely upon the perfect vision afforded by hindsight."[9] It is essential that a defendant-physician be judged by the standards of the profession applicable at the date of the treatment, rather than those applicable at the date of the trial.[10] Although this principle has been reaffirmed by the Supreme Court of Canada in a number of modern cases,[11] it has a well established pedigree dating back many years. Its importance is perhaps best captured in Lord Denning's famous dictum in 1954 in *Roe v. Minster of Health*, that "we must not look at the 1947 accident with 1954 spectacles."[12]

One possible exception to the underlying premise of this paper – that there have been very few (if any) changes of any real significance in health care liability over the last 50 years – is the doctrine of informed consent.[13] The principle which lies at the heart of that doctrine – the fundamental right of the patient to be free from unwanted medical treatment – is, of course, not new. Though reaffirmed by the Supreme Court of Canada on numerous

---

7 *Anderson v. Chasney*, [1949] 4 D.L.R. 71, [1949] 2 W.W.R. 337 (Man. C.A.), aff'd [1950] 4 D.L.R. 223, [1950] S.C.J. No. 50 (S.C.C.).

8 See for example, *Jackson v. Hyde* (1869), 28 U.C.Q.B. 294, [1869] O.J. No. 74 (Q.B.).

9 *Lapointe*, *supra* note 3 at para. 28.

10 See Picard & Robertson, *supra* note 2 at 240-241.

11 See for example, *Lapointe, supra* note 3; *ter Neuzen, supra* note 5.

12 [1954] 2 Q.B. 66 at 84, [1954] 2 All E.R. 131 (C.A.) [*Roe*].

13 Some might suggest that another exception is the recognition of the fiduciary nature of the doctor-patient relationship, as seen in cases such as *McInerney v. MacDonald*, [1992] 2 S.C.R. 138, 93 D.L.R. (4th) 415 and *Norberg v. Wynrib*, [1992] 2 S.C.R. 226, 92 D.L.R. (4th) 449. However, although there has certainly been a renewal of interest in the fiduciary relationship between doctor and patient, its existence has been well established for many years: see for example, *Kenny v. Lockwood*, [1932] O.R. 141, [1932] 1 D.L.R. 507 (C.A.); *Halushka v. University of Saskatchewan* (1965), 53 D.L.R. (2d) 436, 52 W.W.R. 608 (Sask. C.A.).

occasions in recent years,[14] its origins date back to at least the turn of the last century, as evidenced by Mr. Justice Cardozo's famous (and oft-quoted)[15] statement in 1914 that "every human being of adult years and sound mind has a right to determine what shall be done with his own body."[16] However, the evolution of the principles of informed consent and the physician's duty of disclosure, and in particular the Supreme Court of Canada's adoption of the "reasonable patient test" as the standard of disclosure,[17] is probably the most important doctrinal development in Canadian health care liability in modern times. Even though that development is not having much impact on the actual outcome of medical malpractice litigation – patients are unsuccessful in over 80% of informed consent cases which go to trial[18] – there is some evidence that it has had a very real impact on medical practice.[19] In addition, it also has a powerful symbolic value in reformulating the power balance underlying the doctor-patient relationship.[20]

Subject, therefore, to the possible exception of informed consent, it is submitted that the underlying premise of the paper is valid and supported by the case-law. Though many interesting doctrinal developments have occurred in health care liability in Canada in the past 50 years, this area has not undergone fundamental or significant change. Essentially it has been a

---

14 See for example, *Starson v. Swayze*, [2003] 1 S.C.R. 722, 225 D.L.R. (4th) 385; *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519, 107 D.L.R. (4th) 342; *Ciarlariello Estate v. Schacter*, [1993] 2 S.C.R. 119, 100 D.L.R. (4th) 609; *Reibl v. Hughes*, [1980] 2 S.C.R. 880, 114 D.L.R. (3d) 1 [*Reibl* cited to D.L.R.]; *Hopp v. Lepp*, [1980] 2 S.C.R. 192, 112 D.L.R. (3d) 67.

15 Including the Supreme Court of Canada in *Reibl, ibid.* at 10.

16 *Schloendorff v. Society of New York Hospital*, 211 N.Y. 125 at 129, 105 N.E. 92 (C.A. 1914).

17 *Reibl*, *supra* note 14.

18 Gerald B. Robertson, "Informed Consent 20 Years Later" [2003] Health L.J. 153; Gerald Robertson, "Informed Consent Ten Years Later: The Impact of Reibl v. Hughes" (1991) 70 Can. Bar Rev. 423.

19 "The Effects of Legal Liability on Health Care Providers" by Bernard M. Dickens, in *Report of the Federal/Provincial/Territorial Review on Liability and Compensation Issues in Health Care*, vol. 2 (Toronto: University of Toronto Press, 1990) at App. B (Chairman: J.R.S. Pritchard) [Dickens]; "Report of the Survey of the Impact of Medical/Legal Liability on Patterns of Practice" by Frank Sellers, *ibid.* [Sellers].

20 See Picard & Robertson, *supra* note 2 at 125.

period of "more of the same." Which leads to the question: is there any reason to suppose that the future will be any different?

III. The Future

Although an examination of the past might lead us to conclude that there is no reason to expect any fundamental change in the foreseeable future in health care liability, there are some signs to the contrary. In particular, it is submitted that there are a number of factors and recent developments which may combine to produce a significant re-emergence of interest and momentum in replacing the present system with one of no-fault compensation.

It should be emphasized that a discussion of the many arguments for and against no-fault compensation falls outside the scope of this paper.[21] The purpose of the paper is not to argue for or against the replacement of the present system of health care liability with one of no-fault compensation, but rather to suggest that there is some reason to believe that the future may see a renewed interest in that debate.

The last time there was any significant and sustained interest in the possibility of replacing the present health care liability system with one of no-fault compensation was in the late 1980's and early 1990's, around the time of the publication of the report of the Prichard *Review on Liability and Compensation Issues in Health Care*.[22] Although one of the recommendations of the Pritchard Report was that a no-fault compensation scheme should be introduced for "significant avoidable health care injuries," as an alternative to the present tort system (with the patient having the option of choosing between the two systems),[23] nothing ever came of that recommendation.

The history surrounding the Pritchard Review demonstrates that fundamental change in this area (or at the very least, serious consideration of the need for fundamental change) requires a sense of "crisis," including financial crisis. It is clear that the Pritchard Review was created because there was a perception on the part of major stakeholders, such as government, health

---

21 For a comprehensive discussion of this topic, see Joan M. Gilmour, *Patient Safety, Medical Error and Tort Law: An International Comparison* (Ottawa, Ont.: Health Canada, 2006) [Gilmour].

22 *Report of the Federal/Provincial/Territorial Review on Liability and Compensation Issues in Health Care*, vol. 1 (Toronto: University of Toronto Press, 1990) (Chairman: J.R.S. Pritchard).

23 *Ibid.* at 28-31.

care professionals and institutions, and the Canadian Medical Protective Association [CMPA], that there was a medical malpractice "crisis" in Canada. This perception was fuelled by a dramatic increase in both the number of lawsuits being commenced against health professionals and the amount of damages being awarded, as well as a marked increase in the annual fees levied by the CMPA on its members.

In the years following the Pritchard Report, the feeling of "crisis" has diminished. One of the main reasons for this is that there has been a significant and continuing reduction in the number of lawsuits brought against Canadian doctors. Specifically, in the last ten years there has been a 35% decrease in the total number of legal actions brought against CMPA members, and almost a 50% reduction in the number of actions per 1,000 members.[24] CMPA annual fees have also fallen sharply in recent years, adding to the diminishing sense of "crisis." For example, CMPA fees for obstetricians in Ontario have gone from $86,244 in 2005 to $50,508 in 2008, and cardiac surgeons in Ontario have seen a decrease in fees from $21,564 to $9,768 during the same period.[25] It is perhaps not surprising that the CMPA, one of most prominent voices in favour of change at the time of the Prichard Review, now considers the present system to be a "world-class model."[26]

At the same time, however, the CMPA itself has counselled against complacency that a "crisis" will not return. It cites, for example, the situation in countries such as the United States, where "medical malpractice litigation has spiked dramatically, to the extent that more than half of the states south of the border are in crisis,"[27] as well as problems in the United

---

24 Canadian Medical Protective Association, *2006 Annual Report* (Ottawa, Ont.: Canadian Medical Protective Association, 2007) at 8, online: Canadian Medical Protective Association <http://www.cmpa-acpm.ca> [CMPA, *2006 Report*].

25 Picard & Robertson, *supra* note 2 at 530; Canadian Medical Protective Association, *Fee Schedule for 2008* (Ottawa, Ont.: Canadian Medical Protective Association, 2007), online: Canadian Medical Protective Association <http://www.cmpa-acpm.ca>.

26 Canadian Medical Protective Association, *The Medical Liability Environment Outside Canada* (Ottawa, Ont.: Canadian Medical Protective Association, 2006), online: Canadian Medical Protective Association <http://www.cmpa-acpm.ca>.

27 Canadian Medical Protective Association, *2003 Annual Report* (Ottawa, Ont.: Canadian Medical Protective Association, 2004) at 6, online: Canadian Medical Protective Association <http://www.cmpa-acpm.ca>.

Kingdom.[28] In addition, although the number of claims against Canadian doctors has steadily declined, the amount of damages (and legal expenses) paid out continues to rise. As noted in the CMPA's most recent Annual Report:[29]

> This Report demonstrates that while the number of new legal actions commenced against Canadian physicians has been decreasing over time, the awards and settlement costs associated with these actions have been increasing. In 2006, the CMPA paid out its highest ever amount for awards and settlements. Accordingly, when the declining number of cases would suggest that costs should be stabilizing, they continue to rise.[30]

There are some emerging developments which have the potential to reignite a feeling of "crisis" (including financial crisis) and which may lead to a renewed interest in replacing the current system with one of no-fault compensation. The first such development is the rise of the patient safety movement, and the importance which it attaches to ridding the present system of its "culture of blame" in order to achieve meaningful progress in protecting and enhancing patient safety. For example, the Canadian Patient Safety Institute has stated that "In Canada, as in most western countries, a culture of blame persists which discourages disclosure of adverse events, and the learnings that could be shared from those events."[31] Likewise, the

---

28 See United Kingdom, Department of Health, Sir Liam Donaldson, *Making Amends: A Consultation Paper Setting Out Proposals for Reforming the Approach to Clinical Negligence in the NHS* (London: Department of Health, 2003), online: Department of Health <http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4010641>. Aspects of this report are discussed in J. K. Mason & G. T. Laurie, *Mason & McCall Smith's Law and Medical Ethics*, 7th ed. (Oxford: Oxford University Press, 2006) at 9.3-9.15, and in Gilmour, *supra* note 21 at 117-142.

29 CMPA, *2006 Report, supra* note 24 at 1.

30 A possible explanation for this is that the number of meritorious claims has remained constant, and the decline in overall claim frequency reflects fewer weaker claims being brought: see Picard & Robertson, *supra* note 2 at 529.

31 Canadian Patient Safety Institute, *A New Era: Creating a Culture of Safety – Annual Report 2005* (Edmonton, AB.: Canadian Patient Safety Institute, 2006) at 3, online: Canadian Patient Safety Institute <http://www.patientsafetyinstitute.ca>.

Canadian Healthcare Association has observed that "The crucial first step in managing and reducing adverse events then must be to reframe the events; to remove the stigma of error and the culture of 'judgment and blame' and replace it with one of 'learning for quality improvement'."[32]

That sentiment has already produced some (albeit relatively modest) legal change, such as the introduction of "apology laws" in some Canadian provinces, which prevent an apology being admitted in evidence as an admission of liability.[33] As the patient safety movement continues to build momentum, we may well see calls for much more fundamental change to remove the "culture of blame" from the system. Indeed, organizations such as the Health Council of Canada have already called for a re-examination of the issue of no-fault compensation,[34] and this was also one of the recommendations in Professor Gilmour's comprehensive report on patient safety and medical liability, published by Health Canada in 2006.[35]

---

32 Canadian Healthcare Association, *Patient Safety and Quality Care*: *Action Required Now To Address Adverse Events – A Backgrounder* (November 2002) at 19, online: Canadian Healthcare Association <http://www.cha.ca>. See also Canadian Nurses Association, *Position Statement – Patient Safety* (Ottawa, Ont.: Canadian Nurses Association, 2003), online: Canadian Nurses Association <http://www.cna-aiic.ca/CNA/documents/pdf/publications/PS70_Patient-Safety_en.pdf> (referring to the need for "a paradigm shift from a culture of individual blame to a culture of safety"). For a detailed discussion of this issue see Joanna K. Weinberg, "Medical Error and Patient Safety: Understanding Cultures in Conflict" (2002) 24 Law & Pol'y 93.

33 See, for example, *Apology Act*, S.B.C. 2006, c. 19; *Apology Act*, S.M.. 2007, c. 25 [in force February 6, 2008]; *Evidence Act*, S.S. 2006, c. E-11.2, s. 23.1 [en. 2007, c. 24, s. 2]. For an excellent discussion of this, see Tracey M. Bailey, Elizabeth C. Robertson & Gergely Hegedus, "Erecting Legal Barriers: New Apology Laws in Canada and the Patient Safety Movement: Useful Legislation or a Misguided Approach?" (2007) 28 Health L. Can. 33.

34 Health Council of Canada, *Health Care Renewal in Canada: Clearing the Road to Quality, Annual Report To Canadians 2005* (Toronto: Health Council of Canada, 2006) at 56, online: Health Council of Canada <http://www.healthcouncil canada.ca>. However, the CMPA is not in favour of the introduction of no-fault compensation: see Canadian Medical Protective Association, *Medical Liability Practices in Canada: Towards the Right Balance* (Ottawa, Ont.: Canadian Medical Protective Association, 2005), online: Canadian Medical Protective Association <http://www.cmpa-acpm.ca>.

35 Gilmour, *supra* note 21 at 42 (Recommendation 6).

The patient safety movement is, in part, a reaction to the growing evidence that a significant number of patients suffer harm as a result of "adverse events" during their medical care. The leading study in Canada, published in 2004,[36] indicates that 7.5% of Canadians suffer an "adverse event" while in hospital,[37] and those adverse events are associated with between 9,000 and 24,000 preventable deaths every year. Of course not all of these incidents would be attributable to negligence, but it is reasonable to assume that a large number would be. When one takes into consideration that only 917 lawsuits were commenced against Canadian doctors in 2006,[38] and that only approximately one-third of these are likely to receive any compensation,[39] this underscores what some commentators believe to be the real medical malpractice "crisis", namely, that only a tiny fraction (perhaps as few as 2%) of people who suffer injury as a result of medical negligence actually receive any compensation.[40] If the research data continue to show such a high incidence of patient harm caused by adverse events, this may well focus attention on the inefficiency of the present system in failing to provide compensation to those who are entitled to it, and hence reignite interest in an alternative system such as no-fault compensation.

Another development relates to the vicarious liability of hospitals for the negligence of their medical staff. The leading decision is *Yepremian v. Scarborough General Hospital*,[41] which affirms the principle that a hospital is

---

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

37 The Baker study, *ibid.* at 1679, defined "adverse event" as "an unintended injury or complication that results in disability at the time of discharge, death or prolonged hospital stay and that is caused by health care management rather than by the patient's underlying disease process." A similar definition is found in Canadian Patient Safety Institute, *Canadian Disclosure Guidelines* (Edmonton, AB.: Canadian Patient Safety Institute, 2008) at 30, online: Canadian Patient Safety Institute <http://www.patientsafetyinstitute.ca> ("An event which results in unintended harm to the patient, and is related to the care and/or services provided to the patient rather than to the patient's underlying medical condition.").

38 CMPA, *2006 Report*, *supra* note 24 at 7.

39 See Picard & Robertson, *supra* note 2 at 529.

40 *Ibid.* at 531-532.

41 (1980), 28 O.R. (2d) 494, 110 D.L.R. (3d) 513 (C.A.).

not vicariously liable for the negligence of its physicians (because they are not employees), nor does the hospital owe its patients a non-delegable duty to provide non-negligent treatment.[42] This principle has been reaffirmed in many recent decisions.[43] However, in a series of cases involving intentional wrongdoing such as sexual assault, the Supreme Court of Canada has reformulated the legal and policy bases underlying vicarious liability,[44] and in so doing has emphasized the importance of the concept of "enterprise liability".[45] In the words of Chief Justice McLachlin:

> Vicarious liability is based on the rationale that the person who puts a risky enterprise into the community may fairly be held responsible when those risks emerge and cause loss or injury to members of the public. Effective compensation is a goal. Deterrence is also a consideration. The hope is that holding the employer or principal liable will encourage such persons to take steps to reduce the risk of harm in the future. Plaintiffs must show that the rationale behind the imposition of vicarious liability will be met on the facts in two respects. First, the relationship between the tortfeasor and the person against whom liability is sought must be sufficiently close. Second, the wrongful act must be sufficiently connected to the conduct authorized by the employer. This is necessary to ensure that the goals of fair and effective compensation and deterrence of future harm are met.[46]

This emphasis on the connection between the negligence of the individual defendant and the corporate enterprise may well lead the Supreme Court of Canada, when the opportunity arises, to conclude that, as in Eng-

---

42 For a detailed discussion of the *Yepremian* decision, see Ellen Picard, "The Liability of Hospitals in Common Law Canada" (1981) 26 McGill L.J. 997.

43 See generally Picard & Robertson, *supra* note 2 at 476-485.

44 *E.B. v. Order of the Oblates of Mary Immaculate in the Province of British Columbia*, 2005 SCC 60, [2005] 3 S.C.R. 45; *John Doe v. Bennett*, 2004 SCC 17, [2004] 1 S.C.R. 436 [*John Doe*]; *K.L.B. v. British Columbia*, 2003 SCC 51, [2003] 2 S.C.R. 403; *Jacobi v. Griffiths*, [1999] 2 S.C.R. 570, 174 D.L.R. (4th) 71; *Bazley v. Curry*, [1999] 2 S.C.R. 534, 174 D.L.R. (4th) 45.

45 For a critique of these cases see J.W. Neyers, "A Theory of Vicarious Liability" (2005) 43 Alta. L. Rev. 287; Attila Ataner, "How Strict is Vicarious Liability? Reassessing the Enterprise Risk Theory" (2006) 64 U. T. Fac. L. Rev. 63.

46 *John Doe, supra* note 44 at para. 20.

land,[47] the physician's connection with the "enterprise" and "organization" of the hospital justifies imposing vicarious liability on the hospital for the negligence of the physician.[48] If this were to happen, it would likely have a very significant impact on the legal costs involved in medical malpractice litigation if hospitals were named as a defendant every time one of their physicians was sued. It would also create increased tension and conflict between physicians and hospitals on issues such as professional autonomy and independence, and institutional control over the physician's practice,[49] which (coupled with the escalation in defence costs) might in turn lead to increased dissatisfaction with the current fault-based system.

The last factor which should be mentioned is the remarkable increase in the number of class actions being brought against health care institutions and professionals. Particularly over the last few years, numerous class actions have been certified in cases of medical liability,[50] many of them involving very considerable amounts of money. For example, in 2001 the CMPA settled one class action for $29.5 million,[51] and in December 2007 an Ontario court approved a $9.9 million settlement in a medical negligence class action against a hospital and one of its physicians.[52] As noted above, the CMPA in its most recent Annual Report emphasized that the amount of damages and

---

47 See in particular *Cassidy v. Ministry of Health*, [1951] 2 K.B. 343, [1951] 1 All E.R. 574 (C.A.); *Roe*, *supra* note 12.

48 In her report, *supra* note 21 at 32, Professor Gilmour recommended that provinces should consider enacting legislation to impose liability on hospitals for the negligence of non-employed physicians treating patients on-site.

49 See the discussion in Gilmour, *ibid.* at 31.

50 See, for example, *Anderson v. Wilson* (1999), 44 O.R. (3d) 673, 175 D.L.R. (4th) 409 (C.A.), leave to appeal to S.C.C. refused [1999] S.C.C.A. No. 476; *Birrell v. Providence Health Care Society (c.o.b. Providence Health Care)*, 2007 BCSC 668, [2007] 12 W.W.R. 673, leave to appeal granted 2008 BCCA 14, [2008] B.C.J. No. 53; *Doucette v. Eastern Regional Integrated Health Authority*, 2007 NLTD 138, 271 Nfld. & P.E.I.R. 39; *Healey v. Lakeridge Health Corp.* (2006), 38 C.P.C. (6th) 145, [2006] O.J. No. 4277 (Sup. Ct. J.); *Rideout v. Health Labrador Corp.*, 2007 NLTD 150, 270 Nfld. & P.E.I.R. 90; *Rose v. Pettle* (2004), 23 C.C.L.T. (3d) 21, 43 C.P.C. (5th) 183 (Ont. Sup. Ct. J.).

51 Canadian Medical Protective Association, *2005 Annual Report* (Ottawa, Ont.: Canadian Medical Protective Association, 2006) at 19, online: Canadian Medical Protective Association <http://www.cmpa-acpm.ca>.

52 *Bellaire v. Daya*, (2007), 49 C.P.C. (6th)110, 162 A.C.W.S. (3d) 371 (Ont. Sup. Ct. J.).

legal expenses which it has paid on behalf of its members has increased significantly in recent years.[53] If the trend towards more class actions in medical liability cases continues, this will undoubtedly exacerbate that rise in damages and legal expenses, once again raising the possibility of a perceived "crisis" in the system.

IV. Conclusion

While an examination of the past suggests that the law relating to health care liability in Canada will likely continue relatively unchanged in the foreseeable future, some recent developments portend the renewal of a sense of "malpractice crisis," and if this happens there may well be a significant reemergence of interest and momentum in replacing the present system with one of no-fault compensation.

53 CMPA, *2006 Report, supra* note 24 at 1.