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How Do Current Common Law Principles Impede or Facilitate Change?

by

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Contents

Highlights

- Future health care reform initiatives may not fit comfortably with existing common law malpractice principles.

- Tort and fiduciary law are primarily focussed on the interests of the patient and on the maintenance of the legal standard of care. Broader social concerns, such as equity, are not usually considered.

- Because the common law seeks, in general, to reinforce the established standard of care, it seems unlikely, at least in the short term, that Canadian courts will allow reform initiatives to erode the existing legal standard of care. As a result, physicians may feel legally compelled to ignore (consciously or unconsciously) requests to actively contain costs.

- Health care reform initiatives may create a number of unique informed consent dilemmas. For example, it is arguable that physicians have a legal obligation to disclose information about cost containment initiatives and the existence of private treatment options.

- Fiduciary law compels health care providers to focus, almost exclusively, on the best interests of the patient. As a result, fiduciary law will be relevant to any health care reform initiatives that explicitly ask physicians to integrate other factors, such as cost containment, into the clinical decision-making process.

- Possible reform options include leaving the policy concerns to be addressed by the courts or through the enactment of specific legislation to minimize or alter the nature of malpractice liability. Both approaches have limitations, however. For example, relying on the case-by-case evolution of malpractice law will not result in broadly based comprehensive reform.

- Finally, policy makers may wish to address health care reform issues as part of a broader tort reform initiative. Given the concerns highlighted in this paper, the emerging concerns associated with medical error and the ambivalent evidence supporting tort law as a mechanism of quality control, it may well be time to seriously consider the adoption of some form of no-fault scheme.

Executive Summary

Introduction

This paper provides an overview of the possible application and ramifications of malpractice jurisprudence in the context of health care reform in Canada. The changing nature of the Canadian health care system has had, and will continue to have, a tremendous impact on the practice environment for most health care professionals. Much of this change, however, does not fit comfortably with existing common law principles. This is largely because tort and fiduciary law are primarily focussed on the interests of the patient and on the maintenance of the legal standard of care. Broader social concerns, such as equity, are not usually considered. This has the potential to create a difficult policy tension. As noted by Marc Rodwin, "[Health reform] trends and views encourage the idea that rather than strive to promote only the welfare of individual patients, doctors and medical organizations must also act in the interest of the population they serve" (Rodwin 1995, 254).

Standard of Care

Historically, the common law has reinforced the established standard of care. It seems unlikely, at least in the short term, that Canadian courts will allow reform initiatives to erode the existing legal standard of care. As such, the malpractice regime will create challenges to the implementation of physician focussed reform.

Though the judiciary will undoubtedly remain sympathetic to actual scarcities of resources, conscious decisions to provide sub-standard care will be viewed with suspicion by Canadian courts. As a result, physicians may feel legally compelled to ignore (consciously or unconsciously) requests to actively contain costs and may seek ways to provide care within the publicly funded system – thus frustrating efforts to save money by initiatives such as the de-listing of services.

There is an important caveat to this conclusion, however. There are only a few cases directly on point and, as such, we can only guess how the courts will respond to future cases involving resource allocation decisions. Nevertheless, given the tone of the existing law, any near future change will likely continue to distinguish between actual scarcity and conscious decisions to contain costs.

Informed Consent

Health care reform initiatives may create a number of unique informed consent dilemmas. First, it is arguable that physicians have a legal obligation to disclose information about any cost containment initiatives that may pressure physicians to provide less, or different, health care procedures. This is something that a reasonable person in the patient's position would want to know. Second, physicians may also be required to tell patients about services that are a reasonable alternative but are not available within the public system. This may also mean that physicians have a duty to disclose information to patients about the existence of private options if

it can be conceived as something that a reasonable person in the patient's position would want to know.

As with tort law generally, informed consent principles will do little to facilitate the implementation of health care reform initiatives that are based on broader notions of social equity. More than any area of health law, informed consent is a manifestation of our society's deep reverence for personal autonomy. As such, it is concerned with providing patients with relevant information in order to allow autonomous decision making. Withholding or tailoring the provision of information in order to meet a broader social agenda conflicts directly with the ethical principles that underlie Canadian consent jurisprudence.

Fiduciary Obligations

Fiduciary obligations flow from the relationship of trust between physician and patient. Fiduciary law compels health care providers to focus, almost exclusively, on the best interests of the patient. "Loyalty is the core value of fiduciary relationships and hence the focus of fiduciary law" (Litman 2002, 91). As such, fiduciary law is clearly relevant to any health care reform scheme that explicitly or implicitly challenges the nature of this loyalty.

Fiduciary law also heightens the disclosure obligations of health care providers. In particular, it emphasizes the need to disclose information about any possible or apparent conflict of interest. As such, it is certainly possible that an application of fiduciary principles in this context would compel health care providers to disclose information about incentive schemes, such as capitation programs, that create conflicting pressures impacting treatment decisions.

Other Malpractice Issues

There are many other malpractice issues that should be considered in this context including the impact of existing common law principles on the decision making of hospitals and government, the desire to foster interdisciplinary research teams, and the growing concern regarding "medical error."

Possible Reform Options

Court Initiated Reform

One option is to leave the policy concerns outlined in this paper to be addressed by the Canadian courts. However, a case-by-case approach is unlikely to lead to a radical change in the law. Malpractice principles – and tort law in general – have, over the years, remained tremendously consistent. Incremental change, not radical revisions or paradigm shifts, is the norm. Moreover, the common law will inevitably lag behind broader social change. It is, to a large degree, a reactive mechanism. Relying on a case-by-case evolution of malpractice law will not result in broadly based comprehensive reform.

Specific Legislated Responses

Policy makers concerned about the impact of the common law on health care reform initiatives could enact legislation to minimize or alter the nature of malpractice liability. Such an approach faces a number of challenges. First, because this would likely be considered a provincial matter, each province would need to craft and enact its own legislation. There are ways to coordinate such efforts, but variation in political philosophy and in approaches to health care reform would likely result in a patchwork of regulatory responses. Second, the policy implications of limiting liability exposure through legislation should be carefully considered (e.g., what would be lost by changing the liability exposure of physicians in this context?).

Comprehensive Tort Reform (e.g., the Adoption of a No-Fault Scheme)

The most dramatic reform option would be to address health care reform issues as part of a broader tort reform initiative. By dealing with the malpractice issues associated with health care reform within a broader tort reform initiative, policy makers could specifically design a scheme to facilitate health care reform, public health work and a reduction of medical error while, at the same time, ensuring that the opportunity for patient compensation is improved. Indeed, given the concerns highlighted in this paper, the emerging concerns associated with medical error and the ambivalent evidence supporting tort law as a mechanism of quality control, it may well be time to seriously consider the adoption of some form of no-fault scheme.

"[H]ealth professionals face growing pressure to serve ends that fit awkwardly with the ideal of fidelity to patients" (Bloche 1999, 268).

Introduction

This paper provides an overview of the possible application and ramifications of malpractice jurisprudence in the context of health care reform in Canada.[1] The changing nature of the Canadian health care system has had, and will continue to have, a tremendous impact on the practice environment for most health care professionals. But, as we will see throughout this paper, much of this change does not fit comfortably with existing common law principles. This is largely because cost containment and health care reform have the potential to challenge well established legal obligations. Because tort and fiduciary law are largely focussed on the interests of the patient and on the maintenance of the legal standard of care, broader social concerns, such as social equity, are not usually considered. This has the potential to create a tension between the pressures associated with malpractice law, such as the incentive to provide more care and to remain strictly focussed on the needs of the particular patient, and the broader goals of health care reform.

This paper begins with an overview of the purpose of malpractice law and how it relates to health care reform. This is followed by a discussion of several specific areas of the common law, including the establishment and application of the legal standard of care, informed consent obligations and fiduciary law. We will see that, in general, existing common law principles will do little to facilitate health care reform and may, in some circumstances, act as a significant barrier. The paper ends with a brief discussion of a number of policy options that could be used to address the issues raised in this paper.

Context

The Purpose and Relevance of Tort Law

Though other areas of the common law are obviously relevant to the practice of health care in Canada (such as contract, fiduciary, administrative and, even, property law), health law jurisprudence has been dominated by tort law. When one thinks of "health law," one usually thinks of malpractice litigation – which is, to a large degree, simply the application of tort law in the context of health care. Indeed, many of the basic legal duties and responsibilities of health care providers in Canada – be it in relation to informed consent, confidentiality, and the provision of an appropriate level of care – have been established in the context of malpractice litigation. As such, much of this discussion paper will focus on the relevance and impact of tort principles. In addition, I will generally focus on physicians, though much of the analysis applies to other health care providers.

In general, tort law "provides a legal means whereby compensation, usually in the form of damages, may be paid for injuries suffered by a party as a result of the wrongful conduct of others." (*Hall v. Hebert* 1993; Klar 1996, 1). Tort law addresses and defines responsibility for harm and when and why a specific harm is worthy of compensation (Mariner 2001, 258). Another goal of tort law, however, is to act as a deterrent and to help establish and maintain a given standard of conduct (Klar 1996). That is, the fear of liability will cause individuals, such as physicians, to practice a certain level care – though the validity of this assumption continues to be debated (Prichard 1990; Jacobi and Huberfeld 2001). One well known Canadian study, the 1990 Prichard Report on Liability and Compensation in Health Care, concluded that "on balance, the threat of tort litigation against health care providers for negligence contributes in a positive way to improving the quality of health care provided and reducing the frequency of avoidable health care injuries" (Prichard 1990, executive summary. See also Studdert and Brennan, 2001). However, there remains little actual evidence to support the use of tort law as a means of ensuring a high quality of health care (Bovbjerg, Miller and Shapiro 2001, 369).

Relevance of Common Law to Health Care Practices and Health Care Reform

Because the common law plays a significant role in defining the rights and duties of health care providers and patients and creates an incentive to perform in a certain manner, it is essential to understand its relevance in the context of existing and possible health care reform initiatives. Malpractice lawsuits are determined on a case-by-case basis. They focus on the rights and legal duties of individual physicians and patients. While the principles of tort law obviously have social utility, the rights and duties of patients and physicians are rarely subordinated to the needs of the broader health care system. For example, as will be discussed more fully below, informed consent jurisprudence flows directly from the application of the ethical principle of autonomy (*Ciarlarliello v. Schacter*, 1993) and the needs of third parties are rarely, if ever, considered.

But many reform initiatives will necessarily involve a weighing of the needs of the general population against the needs of individuals. And because physicians remain a central and controlling element in the utilization of health care resources, health care reform initiatives will also inevitably implicate physicians (Perkel 1996, 266). But the more physicians are asked to play an active role in cost containment, the greater the potential to strain existing legal norms – particularly if health care reform alters the existing physician/patient dynamic. As noted by Marc Rodwin, "[Health reform] trends and views encourage the idea that rather than strive to promote only the welfare of individual patients, doctors and medical organizations must also act in the interest of the population they serve" (Rodwin 1995, 254). While there are undoubtedly strong policy justifications for such an approach, Canadian malpractice law is not, as least currently, equiped to handle this shift.

Impact of Malpractice Law on the Behaviour of Health Care Providers

Though it remains unclear whether, in the aggregate, fear of malpractice liability is a constructive influence on physician behaviour and the quality of care (Prichard, 1990), there seems little doubt that it has an impact on the way physicians practice. Numerous studies have found that physicians are conscious of liability concerns. In general, physicians seem to believe that malpractice pressures encourage them to provide more care – a practice often known as "defensive medicine."

To cite but a few examples of survey data on point, a 1994 survey of Canadian physicians found that 70% thought the "[r]isk of malpractice suits forces physicians to order tests that may not be required" (*Medical Post* 1994). Another study found 91% of the physicians surveyed "believed their test-ordering behaviour was affected by [a] perceived risk of litigation." (Salloum and Franssen 1993). And a study done for the Royal Commission on New Reproductive Technologies concluded that 62% of Alberta physicians said they believe that fear of law suits will lead to more PND than is medically required (Renaud 1993).

Medical Malpractice and the Legal Standard Care

In this section, I explain how the legal standard of care is established in Canada and explore the possible interaction between health care reform initiatives and the legal standard.

Establishing the Legal Standard of Care in Canada

As in many common law jurisdictions, the legal standard of care in Canada is determined by examining what "could reasonably be expected of a normal, prudent practitioner" (*Crits v. Sylvester* 1956, 508). This rule was affirmed by the Supreme Court of Canada in *ter Neuzen v. Korn* where it was held that doctors "have a duty to conduct their practice in accordance with the conduct of a prudent and diligent doctor in the same circumstances"(*ter Neuzen v. Korn* 1995, 588). National and, even, international clinical practice guidelines are becoming more common – particularly in this era of evidence based medicine. However, regardless of how well formulated, practice guidelines remain only one piece of evidence in the formulation of the legal standard of care. A case-by-case analysis remains the norm. In practical terms, this means that the standard of care is re-examined in each law suit and is generally established by the health care profession itself via the provision of expert testimony.

Because of constant innovation and improvements in clinical practice, the standard of care has generally moved forward and become increasingly stringent (Mohr 2000). As noted by Professor Robertson: "Medical knowledge and technology are constantly evolving, and what was reasonable medical practice a few years ago may not necessarily be so today" (Robertson 1999, 87). Indeed, there have been very few cases where a Canadian court has suggested that the existing legal standard of care should be lessened. There have been situations where courts have had to consider whether the legal standard of care, as established by the profession, is inappropriately low (e.g., *ter Neuzen v. Korn* 1995; *Anderson v. Chasney* 1950) or whether it was possible, in the circumstances, to meet the legal standard of care (*Bateman v. Doiron* 1991, 291), but there are few cases where the established legal standard of care was deemed too high (however, see *Elofson v. Davis*, discussed below).

Given that quality control is, rightly or not, one of the understood goals of tort law, this adherence to established standards makes sense. To allow a slippage in the standard of care would be to deem a lower quality of care as appropriate. Moreover, because the standard is established on a case-by-case basis, judges seem reluctant to have a specific injured plaintiff bear the burden of broader health policy concerns.

Relevance of Health Care Reform Strategies to Liability Issues

Of course, the judicial trend of reinforcing an established standard of care could have an important impact on any health care reform initiative that places pressure on physicians to provide less (or even different) care. The potential affect of existing tort principles is well illustrated by the British Columbia decision of *Law Estate v. Simice* (1994; see also Irvine 1994), one of the few Canadian cases where a court has had to consider the impact of cost containment

pressure on a physician's clinical decision. In this case, a patient presented in the emergency room with a headache. The patient later died of an aneurism. One of the critical issues was why a CT scan was not provided in a timely fashion. In response, one of the excuses put forward by the defendant physician for not providing the CT was that there were constraints imposed by the provincial insurance scheme on the use of such diagnostic tools. In this regard, Spencer J. stated as follows:

> [I]f it comes to a choice between a physician's responsibility to his or her individual patient and his or her responsibility to the Medicare system overall, the former must take precedence in a case such as this. The severity of the harm that may occur to the patient who is permitted to go undiagnosed is far greater than the financial harm that will occur to the Medicare system if one more CT procedure only shows the patient is not suffering from a serious medical condition.

More than in any other Canadian case, this judicial statement dramatically exemplifies the dilemma physicians and health policy decision makers face in this context. In the eyes of this judge, physicians should ignore calls for economic restraint and should focus their attention on the needs of the individual patient. Cost containment pressure will not stand as an excuse for sub-standard care.

We see a similar examination in the Newfoundland case of *McLean v. Carr* (1994) – a case which also dealt with the withholding of a CT scan. Though the judge in *McLean* comes to a conclusion similar to that in *Law Estate*, in *McLean* the judge implies that information concerning the costs of providing CT scans may have influenced his decision concerning the appropriate standard.

> The question is one of the cost effectiveness of precautions which could have been taken. It was allegedly too costly in 1987 to do a CT Scan on all head-injured patients. I was not, however, provided any evidence to establish that the cost would be prohibitive to scan, not all, but just patients whose skulls had considerable force applied and who had a resulting skull fracture. (*McLean v. Carr* 1994, 289).

An Economic "Locality Rule"?

Though controversial from the perspective of health care reform, the conclusions in Law *Estate* and *McLean* are entirely consistent with existing tort theory and case law. Indeed, to some degree, the idea of using the existence of cost containment strategies as an "excuse" for substandard care is not unlike the legal issues associated with practising medicine in a rural setting. Physicians in rural settings have often had to contend with fewer resources. In such situations, the courts have always been sympathetic to the fact that physicians may have to practice in less than ideal circumstances. In general, a physician will not be found negligent for substandard care if she did her best with the resources available.

Though not a rural setting, the case of *Bateman v. Doiron*, stands as a good example of how the courts handle situations of actual scarcity. In this case it was alleged that the hospital was negligent for staffing their hospital emergency room with family physicians instead of specialists.

The plaintiff was admitted to the Moncton hospital emergency room with chest pains and the plaintiff claimed that the defendant, who was a family physician, did not handle the situation properly. It was held if that the hospital was not negligent for using family physicians if that was all that was available. In other words, because there was an actual scarcity of the needed resource, emergency specialists, the hospital could not be held liable for not meeting the legal standard of care. "The non-availability of trained and experienced personnel, to say nothing of the problems of collateral resource allocation, simply makes this standard unrealistic, albeit desirable" (*Bateman v. Doiron* 1991, 291).[2]

However, Canadian courts have been very hesitant to allow external circumstances, such as a lack of resources, to result in an actual decrease in the standard of care. For example, the idea that courts should apply the concept of a "locality rule" – that is, varying the standard of care to accommodate those practising in rural settings – has largely been rejected by the Canadian judiciary. In the 1999 malpractice case of *Sunnucks v. Tobique Valley Hospital*, for example, the court summarized the current thinking regarding the application of the locality rule.

> The experts called by the defendant doctors referred often to the problems facing doctors in rural areas such as a lack of specialists to refer to, lack of facilities, and the long periods of being on-call, and generally being overworked. This so-called "locality rule" has been roundly criticized by both the courts and in various legal texts. The rule simply establishes that the standard of the profession depended on the acceptable conduct of the community or similar communities. The danger is that the rural-urban distinction might create a double standard based on geography allowing inferior health care to be considered adequate in some areas. The standard of care Dr. Wecker owed to the plaintiff is exactly the same as that expected of an urban doctor (*Sunnucks v. Tobique Valley Hospital* 1999, 280-1).[3]

This general reluctance on the part of common law courts to reduce the standard of care permeates much of tort law. For example, it is also reflected in the harsh approach taken to setting the standard of care for novices practising in a given profession. Despite the fact that it is important to encourage and promote new health care professionals, common law courts will not reduce the standard of care in order to soften the liability exposure of trainees. The rationale for this approach is nicely summarized by John Fleming:

> While it is necessary to encourage [beginners], it is equally evident that they cause more than their proportionate share of accidents. The paramount social need for compensating accident victims, however, clearly outweighs all competing considerations, and the beginner is, therefore, held to the standard of those who are reasonably skilled and proficient in that particular calling or activity (Fleming 1983, 105).

Implications

The existing malpractice regime will create challenges to the implementation of physician focussed reform. As we saw above, there seems little doubt that fear of liability has an impact on how health care providers practice. In general, tort law encourages the provision of more care, thus increasing the cost to the health care system. More importantly, however, if it remains the

case that health care providers will be held accountable for injuries associated with health care reform initiative, physicians may, understandably, resist (consciously or unconsciously) the implementation of cost containment initiatives that require physicians to integrate economic factors into their clinical decisions.

Liability concerns may also have other, more subtle, impacts on cost containment initiatives. For example, de-listing currently covered health care services is one mechanism (though highly criticized) that has been suggested to help control health care costs (e.g., Alberta's Report of the Premier's Advisory Council on Health 2002). Because tort liability generally encourages the provision of care, it may also encourage physicians to diagnose patients in a manner that ensures continued public coverage – thus, again, frustrating the cost containment goal. This "diagnostic drift" phenomenon was noted as one of the problems with the well known "Oregon plan" (McPhearson 1991).

In addition, it can be argued that tort law encourages more aggressive health care practices (i.e., more diagnostic tests, the provision of more medication, etc). As such, it may increase the number of iatrogenic injuries which, in turn, cause the health care system money – though, to date, there are little data on point (see Studdert and Brennan 2001).

In sum, the interaction between health care reform initiatives and medical malpractice law has the potential to create a number of unique legal and policy dilemmas. It seems unlikely, at least in the short term, that Canadian courts will allow reform initiatives to erode the existing legal standard of care. Though the judiciary will undoubtedly remain sympathetic to actual scarcities of resources, conscious decisions to provide sub-standard care will be viewed with suspicion by Canadian courts. As such, physicians may feel legally compelled to ignore (consciously or unconsciously) requests to actively contain costs and may seek ways to provide care within the publicly funded system – thus frustrating efforts to save money by initiatives such as the de-listing of services.

There is an important caveat to this conclusion, however. As noted above, there are only a few cases directly on point and, as such, we can only guess how the courts will respond to future cases involving resource allocation decisions.[4] That said, most relevant jurisprudence tells us that Canadian courts will continue to emphasize a maintenance of the standard of care and the physician's focus on the best interest of the patient. Eventually, however, tort law will need to respond to the changing health care environment. As recently suggested by one author, "[c]ourts may be reluctant at first to support such a decline in the medical standard, but ultimately, negligence law must adjust to the realities of health care economics" (Walker 2002, 7/10).

Nevertheless, given the tone of the existing law, I suspect that any future change will continue to distinguish between actual scarcity and conscious decisions to contain costs. Such a distinction fits most comfortably with the existing negligence jurisprudence. Finally, speculation about how tort law may accommodate health care reform is not terribly relevant to the immediate efforts to reform the system. Until there are more relevant Canadian cases to provide physicians with much needed guidance (Walker, 2002), health care providers will need to work with the current legal uncertainty and liability concerns.

Informed Consent in the Context of Health Care Reform

Consent and informed consent law is an important part of Canadian health law jurisprudence. It is a manifestation of our society's deep reverence for the ethical principle of autonomy and plays a central role in defining the nature of the physician/patient relationship. In this section, I review basic informed consent law and explore its relevance to and impact on health care reform in Canada.

Standard of Disclosure

Canada has a rich body of jurisprudence touching on all aspects of the consent process (Nelson 1999; Dickens 1999; and Picard and Robertson 1996). In some jurisdictions, the basic consent principles have been codified in legislation (see *Health Care Consent Act*, S.O. 1996 s. 11(1)). Other than in a few circumstances, such as in an emergency, health care providers must get a patient's consent prior to the provision of any health care procedure. In order for the consent to be legally valid, health care providers must provide patients with all material information regarding the health care procedure. In other words, the consent must be informed. The seminal Supreme Court of Canada case of *Reibl v. Hughes* defined material information as anything a reasonable person in the patient's position would want to know (*Reibl v. Hughes* 1980). Failure to provide this information constitutes negligence on the part of the physician.

Since *Reibl*, Canadian courts have had many opportunities to interpret the scope of the physician's duty. In general, this jurisprudence has consistently expanded the physician's duty of disclosure. In part, this is due to the dominant role that the principle of autonomy has played in the evolution of consent jurisprudence. In *Ciarlarliello v. Schacter*, for example, the Supreme Court of Canada declared that "the concept of individual autonomy is fundamental to the common law and is the basis for the requirement that disclosure be made to a patient" (*Ciarlarliello v. Schacter*, 1993). This focus on autonomy has caused the death of the paternalistic approach to disclosure decisions and allowed courts to focus on what a reasonable patient would want to know (Dickens 1999, 131). As such, the scope of the disclosure obligation is only rarely, if ever, mediated by external factors. Even the withholding of information for the welfare of the patient – a practice known as "therapeutic privilege" – has been largely overwhelmed by the judicial respect for autonomy (*McInerney v. MacDonald* 1992).

Disclosure Obligations in the Context of Health Care Reform

Health care reform initiatives may have an unusual impact on the informed consent process. First, it is arguable that physicians have a legal obligation to disclose information about any cost containment initiatives that may pressure physicians to provide less, or different, health care procedures (Caulfield & Ginn 1994; Miller 1992; Picard and Robertson 1996, 131-132). For example, a physician may have an obligation to tell patients of a regional health authority policy to use less diagnostic procedures. Though such information is not the traditional "medical risk" data most often associated with the consent process, it is clearly information that a reasonable person in the patient's position would want to know. Indeed, Professor Wolf has noted that "it is

hard to imagine information more material" than information about factors impacting the clinical decision making process (Wolf 1999, 1661). Likewise, physicians should disclose to patients information about any additional risks that may be associated with the implementation of a health care reform or cost containment initiative (e.g., the risks, if any, associated with being on a waiting lists).

Second, physicians may also be required to tell patients about services that are a reasonable alternative but are not available within the public system. For example, in Alberta, the recent Report of the Premier's Advisory Council on Health (2002) recommended that a number of procedures be de-listed. If the government de-lists services that a health care provider would have normally considered a treatment option, this option should still be disclosed (see *Seney v. Crooks* 1998). This may also mean that physicians have a duty to disclose information to patients about the existence of private options that may be available both within and without a given jurisdiction if it can be conceived as something that a reasonable person in the patient's position would want to know. Private options which are not substantially different, faster or more convenient may not have to be disclosed. However, if a private option is available that would allow access to a procedure that would provide treatment in a manner that would lower the risks to the patient or speed access to a medically necessary service, that private option should probably be disclosed. Again, this is something that a reasonable person in the patient's position would want to know. As suggested by Professor Dickens:

> If patients have the means to obtain indicated care in another hospital, town, province or country, physicians may be obliged to inform them, because the option may be material to patients' choice between accepting the lesser care or seeking superior care elsewhere. Physicians who do not know whether patients have such means should ask them (Dickens 1999, 133).

It is interesting to note that at least one group of physicians has decided to formally address this consent issue. Recently, the Calgary Regional Medical Staff Association circulated a form letter to all its members (Lightstone 1999). The letter was in the form of an information sheet which could be given to patients who have been placed on a waiting list for a variety of medical services (e.g., MRIs, consultations with specialists, etc.). The letter warned patients that "the waiting time for [the particular] procedure involves some risk." The letter goes on to state the following: "You may also wish to contact other centres in Alberta or the rest of Canada to determine whether the necessary services is available there sooner. You have the option of leaving the country and possibly getting the service immediately" (copy of letter on file with author). Likewise, in January, 2000, it was reported that a number of hospitals in Toronto asked patients to sign waivers "spelling out the dangers of long waiting lists for care" (The Canadian Press 2000, A9). It was suggested that the "waiver would establish, in writing, that the patient was fully aware of the health risk of joining a lengthy queue" (A9).

Though the provision of information on the existence and impact of health care reform initiatives may seem like an extreme application of the informed consent doctrine, it is clearly within the tenor of existing jurisprudence. This is information that a reasonable person in the patients' position may want to know. Moreover, there are a number of legal policy justifications for disclosure of this nature. First, this information "can empower consumers" and "encourage dialogue among consumers, physicians [and] local regulators" (Khanna, et al. 1999, 292).

Second, in some circumstances, such information may help patients choose between different providers. A patient may wish to find a physician who is not under the same constraints or who does not, for example, have a long a waiting list. As noted by Lewis, et al., "a patient may languish on a particular physician's waiting list for a long time without ever knowing that another physician could provide the needed service much sooner" (Lewis 2000, 1299). This, in turn, may encourage physicians to be more efficient in their management of resources (e.g., the management of waiting lists). Third, and most importantly, to withhold information that is potentially relevant to the provision of a health care service is to adopt a paternalistic approach which would be a stark contrast to the current philosophical and legal trend.

Implications

The application of informed consent law in this context has the potential to create a number of policy dilemmas. For example, requiring physicians to provide information about private options may facilitate the development of a "second tier." This may be particularly offensive to health care providers who are strong supporters of the public health system. For patients, hearing about private facilities from their physician could certainly be viewed as an "advertisement" for a treatment option they may not have been considering. In addition, some patients may not have the financial resources to access private options. For this sector of society, being told about unattainable private health care options could be viewed as cruel and ethically inappropriate.

These are all valid concerns. However, they do not alter the physician's legal disclosure obligations. As noted above, physicians can only rarely withhold information for the good of the patient – a concept known as "therapeutic privilege." In the case of *Meyer Estate v. Rogers*, for instance, a physician intentionally withheld information about the risks associated with contrast media. The court stated that the "therapeutic privilege" exception to the doctor's duty of disclosure should not be part of Canadian law because it has the potential to erode the requirement of informed consent (*Meyer Estate v. Rogers* 1991. See also *McInerney v. MacDonald* 1992; and *Picard & Robertson* 1996, 147-149). It is unlikely that a Canadian court would characterise the fear that a low income patient may become upset about the inability to purchase private options as a justification for the exercise of therapeutic privilege. On the contrary, the physician should not presume to know how the patient would react or use such information. Likewise, personal concern about the social consequences of providing information will likely do little to limit the physician's disclosure duties. As with other value laden issues, such as abortion, physicians must be careful not to allow personal views to interfere with their legal and ethical obligations.

Another interesting policy issue is associated with what is known as "the causation hurdle." Though Canadian consent law has placed increasingly onerous disclosure obligations on health care providers, it is still difficult for plaintiff/patients to win informed consent law suits. This is because plaintiffs must satisfy the court that "but for" the non-disclosure they would not have had the treatment (or would have had a different treatment) and, therefore, would not be injured. It has been very difficult for patients to satisfy this causation component of an informed consent law suit (*Arndt v. Smith* 1997; Nelson & Caulfield 1998; and Robertson 1991).

This causation dilemma may have a particularly odd impact in the context of "health care reform" cases. In order to illustrate the problem, let us consider how one of these cases may actually play out. If, for instance, a person is injured while on a waiting list, he or she may argue that had the physician explained the risks associated with being on a waiting list and the existence of private options, the injury would not have occurred. In this context, the court must be satisfied that "a reasonable person in the patient's position" would have opted for the private option. Applying the controversial "modified objective" test, the court would need to investigate whether the patient had the financial resources that would allow him/her to access the private option. Given the existence of the causation hurdle, Canadian courts could reasonably conclude that only plaintiffs with access to money to purchase private options can succeed in such cases.

Though this may seem perversely unjust (indeed, it compounds the inequities already present in a two tiered system), this conclusion is entirely consistent with existing case law. For example, in cases like *Mickle v. Salvation Army Grace Hospital Windsor Ontario* and *Arndt v. Smith* the courts have used very personal characteristics, such as the religious beliefs of the plaintiff, to determine this causation issue. In *Mickle*, for example, the court held that because the child's disabilities were not severe, a reasonable woman in Mickle's position would not select abortion (1998). Given this case law, it seems entirely possible that a Canadian court could use the fact that a patient/plaintiff has a low income to conclude that the plaintiff cannot satisfy the causation test – that is, that a reasonable person in the patient's position would not have opted for the private alternative.

This section will also end with the important caveat that, to date, we have had no Canadian informed consent cases directly on point. However, in other jurisdictions, particularly the US, this informed consent controversy has already led to a great deal of academic debate, case law and, even, legislation compelling disclosure of cost containment mechanisms and incentives to provide less care (Khanna, et al. 1999; Miller & Sage 1999). In addition, it seems that Canadian policy makers are already beginning to take formal action to comply with their perceived consent obligations, as evidenced by the approach taken by the Calgary Regional Medical Staff Association.

As with tort law generally, informed consent principles will do little to facilitate the implementation of health care reform initiatives that are based on broader notions of social equity. More than any area of health law, informed consent is a manifestation of our society's deep reverence for personal autonomy. As such, it is concerned with providing patients with relevant information in order to allow autonomous decision making. Withholding or tailoring the provision of information in order to meet a broader social agenda conflicts directly with the ethical principles that underlie Canadian consent jurisprudence.

Fiduciary Obligations

Fiduciary law is another area that has tremendous significance in this context. Fiduciary obligations flow from the relationship of trust between physician and patient. Indeed, fiduciary law compels health care providers to focus, almost exclusively, on the best interests of the patient. "Loyalty is the core value of fiduciary relationships and hence the focus of fiduciary law" (Litman 2002, 91). As such, fiduciary law is clearly relevant to any health care reform scheme that explicitly or implicitly challenges the nature of this loyalty.

Nature and Justifications of Fiduciary Obligations in Canada

Canada can be characterized as a country which places particularly onerous fiduciary obligations on health professionals. Unlike some jurisdictions, such as Australia, there seems little doubt that Canadian physicians are in a fiduciary relationship with their patients – at least in most situations. In *McInerney v. MacDonald*, a case dealing with a patient's right of access to her health care record, the court held that the physician/patient relationship is fiduciary in nature and that "[c]ertain duties do arise from the special relationship of trust and confidence between doctor and patient"(*McInerney v. MacDonald* 1992, 423). In the case of *Norberg v. Wynrib*, Justice McLachlin stated that "the most fundamental characteristic of the doctor-patient relationship is its fiduciary nature" (*Norberg v. Wynrib* 1992; see also *Henderson v. Johnston* 1956).

Fiduciary principles also dictate that health care providers "must avoid an appearance of conflict of interest, even when there is neither actual nor potential conflict in the classic sense" (Litman 2002, 95). For example, in the case of *Cox v. College of Optometrists of Ontario* the court held that even though there was no actual conflicting financial pressures, merely having an office in an optical companies retail space was enough to lead the court to conclude there was an inappropriate conflict of interest. Professor Litman believes that extending the application of fiduciary principles to situations where there is a mere appearance of conflict can be justified. He argues that "it has the effect of maintaining and perhaps even enhancing public confidence in the integrity of an important health-service institution where both loyalty and a perception of loyalty are essential to the efficacy of the institution" (Litman 2002, 96).

Focus on the Best Interests of the Patient

Fiduciary principles create clear barriers for health care reform initiatives that seek to integrate broader social concerns into the physician decision making process. This is particularly so if there are economic incentives in place that encourage a specific utilization pattern. This dilemma has been noted by numerous authors. For example, in the US, Perry noted that: "[T]he economic benefits and hazard of today's practice of medicine provide sundry and frequently subtle opportunities for fiduciary conflicts of interest" (Perry 1994). Recently, my colleague, Professor Litman, made the following observation:

> From the perspective of an individual patient, treatment decisions driven or influenced by cost-containment considerations are highly improper because they violate the basic

> fiduciary tenet that fiduciaries may consider only the interests of their beneficiaries in the discharge of their fiduciary responsibilities (Litman 2002, 110).

The clear conflict created by many models of health care reform initiatives has not dissuaded legal commentators from calling for an even more vigorous application of fiduciary principles in this context. Indeed, many legal scholars view fiduciary law as a needed protection against the inappropriate influences of financial incentives.

> It is part of a court's traditional function to correct for market imperfections by defining fiduciary duties to curb betrayals of trust. Despite physicians' own best efforts, pressure to curb cost may lead to erosion of their professional norm of loyalty to individual patients...(Cahill and Jacobson 2001, 431).

Disclosure of Conflicts of Interest

Fiduciary law also heightens the disclosure obligations of health care providers. In particular, it emphasizes the need to disclose information about any possible or apparent conflict of interest. For example, in the well known US case of *Moore v. Regents of the University of California* it was noted that because doctors are fiduciaries, they are legally required to inform their patients of any conflicts of interest in treating the patient, including disclosure of "personal interests unrelated to the patient's health, whether research or economic, that may affect [the doctor's] medical judgment" (1990, 485). Though there are no Canadian fiduciary law cases dealing with health care reform initiatives, disclosure of conflicts is a well understood and classic component of fiduciary law. As such, it is certainly possible that an application of fiduciary principles in this context would compel health care providers to disclose information about incentive schemes, such as capitation programs, that create conflicting pressures impacting treatment decisions. As noted by Martin and Bjerknes: "Pursuing a claim for breach of fiduciary duty, particularly in conjunction with a claim for violation of informed consent, is likely to succeed based on the long history of judicial regulation of economic conflicts of interest in fiduciary relationships" (1996, 457).

Implications

The impact of fiduciary law in this context is obvious. At a minimum, it compels the disclosure of all relevant conflicts. And, if strictly applied, fiduciary law may also prohibit physicians from providing care in situations where they are in a clear conflict of interest – such as when they may financially benefit from the provision of a privately funded "enhanced service" (Caulfield, Flood and von Tigerstrom 2000). However, it may also make it difficult to implement a wide variety of cost containment schemes. Though, again, it is difficult to predict how a Canadian court may interpret fiduciary principles in the context of a formal health care reform initiative, as with the tort principles outlined above, I believe that physician initiated "bedside rationing," an inevitable component of many cost containment schemes, will be viewed with a degree of suspicion by Canadian courts. Indeed, some commentators have suggested that we should ban all incentive mechanisms aimed at physician utilization behaviour. "Patent financial incentives that reward overcare or undercare weaken patient-physician and patient-nurse bonds

and should be prohibited" (Policy Perspective 1997, 1733). But given the key role of health care providers, especially physicians, in the control of health care budgets, how can costs be contained without such incentive schemes?

Other Malpractice Issues

Due to the limited space available, this paper has largely focussed on the impact of malpractice law on physician behaviour in relation to health care reform in Canada. However, it is important to note that common law malpractice principles will have an impact in a number of other relevant areas. Below is a brief sampling of other malpractice issues that should be considered in this context.

Group Practice, Shared Responsibilities?

Historically, the "buck stops" with the physician. That is, the majority of legal responsibilities in the delivery of health care services have generally fallen on the physician. For example, though physicians can delegate aspects of the informed consent process to a variety of other health care professionals, they remain responsible for ensuring the patient was properly informed and, even, understood the information provided. In *Ciarlarliello v. Schacter* the Supreme Court of Canada noted that "it is appropriate that the burden should be placed on the doctor to show that the patient comprehended the explanation and instructions given." (*Ciarlarliello v. Schacter* 1993, 140). Will the fact that physicians remain the focal point of legal responsibility impede attempts to create interdisciplinary health care teams?

Confidentiality Issues

Though a number of Canadian jurisdictions are introducing specific legislation (e.g., Alberta's Health Information Act), in many provinces the common law remains a dominant aspect of the law in relation to the handling of health care information (see *Canadian AIDS Society v. Ontario* 1995; *R. v. Osolin* 1993; *R v. O'Connor* 1995; and *McInerney v. MacDonald* 1992). In general, this jurisprudence places a strong and clear obligation on health care providers to maintain the confidentiality of health care information (e.g., *Peters -Brown v. Regina District Health Board* 1995). Will this law, and the emerging health information legislation, make it more difficult to implement population health initiatives? For example, population health projects often require access to a large amount of identifiable health care information. If consent is needed in order to access all identifiable health care information, as mandated by the common law, will it be feasible to undertake this work?

Medical Error

Over the past few years, there has been rising interest in the health and cost implications of "medical error." A 1999 report by the US Institute of Medicine suggested that, in the US, as many as 44,000-98,000 deaths per year could be attributed to medical error (Leape 2001, 146; and Bovbjerg, Miller and Shapiro 2001). Any comprehensive health care reform initiative will need to address this critical issue. From the perspective of this paper, it is important to note that many have argued that malpractice law may both contribute to the incidence of medical error and make it more difficult to address the problem. For example, a number of commentators have

suggested that fear of litigation may cause physicians to be less forthcoming regarding their involvement in a possible medical error, thus hurting efforts to gather detailed information about the incidence and nature of errors.

> Data on the incidence of harmful mistakes suggests that the supposed deterrent effect of medical suits alone has not been sufficient to address the problem. On the contrary, litigation may well stifle efforts to reduce error (Studdert and Brennan 2001, 227).

Contributory Negligence of Patients for "Unhealthy" Behaviour

There have been a number of Canadian decisions where patients have been found contributory negligent as a result of their unhealthy behaviour. For example, in the case of *Dumais v. Hamilton*, a physician was found liable for not appropriately disclosing the risks associated with a "tummy tuck" operation (*Dumais v. Hamilton* 1998). However, because the patient continued to smoke, the court found she had failed to mitigate her damages and, as such, was 50% liable for her injuries. Given the increasing emphasis to encourage Canadians to lead healthy lives as a way of reducing health care costs (Premier's Advisory Council on Health 2002), will the courts place more and more emphasis on patient behaviour in the assessment of malpractice claims?

Liability of Hospitals, Regional Health Authorities and Government

While I believe that Canadian physicians will likely bear a significant amount of the liability exposure in relation to health care reform initiatives, many other entities, such as hospitals, regional health authorities (RHAs) and, even, the provincial government will obviously be very involved. Indeed, though "bedside rationing" will remain an inevitable component of almost any health care reform initiative (Ubel 2002), it can be argued that these "meso" and "macro" decision makers have the greatest impact on what is available to patients and, as such, should be held liable for any decisions that results in the provision of sub-standard care.

Again, in Canada, we have very few cases directly on point. There is no doubt that hospitals and regional health authorities can be found directly negligent if a well established duty is breached (e.g., selecting competent staff) and vicariously liable for the negligence of their employees acting within their scope of employment (Picard and Robertson 1996). And, as with physicians, the courts will likely remain sympathetic to RHAs and hospitals who have to deal with an actual scarcity of resources (e.g., *Bateman v. Doirin* 1991). However, the extent to which Canadian courts will hold meso and macro decision makers liable for allocation decisions remains unclear.[5] Factors likely to be considered by courts in this context include the degree to which the decision can be characterized as a true "policy" decision, thereby rendering a public authority immune from liability, and the degree to which the harm was "forseeable" (see, for example, *Brown v. BC* 1994). In general, I believe that Canadian courts will likely show a degree of deference to public entities charged with making broad allocation decisions, as has been the case in both the US and the UK (Caulfield 1994; Jacobson 1999; Cahill and Jacobson 2001).

A thorough discussion of this important liability issue is beyond the scope of this paper (see Mariner 2001). However, the policy implications of extending liability to meso and macro decision makers should be considered as part of any tort reform initiative. For example, as with physician liability, imposing liability on meso and macro decision makers could make it more difficult to implement effective cost containment programs. As noted by Professor Jacobson: "The success of managed care cost containment innovations depends on many factors, including how courts decide litigation challenging various cost containment initiatives" (Jacobson 1999, abstract). Moreover, "[s]uch claims may deter vigorous decision making" on the part of public officials (*Decock v. Alberta* 2000, paragraph 37).

A Uniquely Canadian Dilemma?

As I have touched on throughout this paper, a number of countries have already struggled with many of these issues. And while this malpractice dilemma has led to a degree of controversy, one could certainly argue that it has not had the dramatic impact I suggest may play out in Canada if these common law issues are not appropriately considered. However, there are reasons why these legal dilemmas may be particularly problematic in the Canadian context.

First, as compared to many other common law jurisdictions, Canadian health law is especially "patient focussed." For example, in the UK and in much of the US the standard of disclosure for informed consent remains that of a "reasonable professional" (the Canadian standard is that of a "reasonable patient"). In addition, Canada's strong emphasis on fiduciary principles, perhaps the strongest in the common law world, also heighten this patient centred ethos. As noted above, it is this emphasis on the patient that, rightly or not, may cause many of the legal challenges associated with health care reform.

Second, in the US, much of the relevant common law is clouded by the complex organizational nature of their HMOs/MCOs and the application of the federal *Employee Retirement Income Security Act* (ERISA) legislation (Mariner 2001; Anderlik 1998). Among other things, the ERISA legislation limits the type of action one can bring against many MCOs. Indeed, the application of ERISA was a key issue in many of the most relevant US decisions (*Wickline* 1986; *Pegram* 2000).

Finally, unlike in the UK, many of our current legal standards have been developed in a world of fee-for-service remuneration and little administrative interference with the professional decision making process. The adoption of new forms of remuneration, new incentive schemes or new organizational frameworks will represent a significant shift for Canadian physicians. As noted throughout this paper, there is currently little Canadian jurisprudence that is capable of easily accommodating a radical shift in this area.

Possible Reform Options

The common law, and malpractice law specifically, is not the best tool for facilitating change to the existing health care system. The goals of malpractice law – that is, the compensations of injured patients and the maintenance of a high standard of care – are not necessarily congruent with, for example, cost containment. For instance, because malpractice law continues to reinforce the paramountcy of a physician's duty to her patients, it does little to facilitate the introduction of broader health care reform initiatives. Simply put, tort law is not designed as a tool for effectuating broadly based social reform.

However, malpractice law is a powerful social force. Given its impact on health care provider behaviour, policy makers must consider whether some degree of tort reform is necessary and/or desirable. For example, it is possible that a reform initiative that reduced physician liability exposure would make cost containment initiatives easier to implement. However, what other social goals would be compromised by such a reform scheme? Below, I briefly outline a number of reform options for addressing the concerns raised in this discussion paper.

Court Initiated Reform (e.g., Case-by-Case Evolution of Tort Malpractice Law)

One option is to leave the policy concerns outlined in this paper to be addressed by the Canadian courts. That is, we could rely on the case-by-case evolution of malpractice principles in the hope that the judiciary will develop new methods of resolving the policy concerns inextricably linked to health care reform. Indeed, as noted by Walker above, some type of judicial accommodation is inevitable (Walker, 2002) as Canadian courts must, at some level, respond to the changes occurring in the health care system.

Though a case-by-case approach may lead to a radical change in the law, it seems highly unlikely. Malpractice principles – and tort law in general – have, over the years, remained tremendously consistent (Mariner 2001, 258). Incremental change, not radical revisions or paradigm shifts, is the norm. As suggested by Professor Mariner, in relation to US health care reform law, we are "not likely to find salvation in new theory" (Mariner 2001, 270). This is not to say that the courts are unaware of the policy issues relevant to cases in this area. In one US study of over 480 cases involving managed care issues, the authors found that in 56% of the cases the courts raised at least one policy issue.

> Judges are actively considering the policy implications of their decisions. This does not mean that the courts are actually formulating health care policy. But it does suggest that the judiciary is well aware of the policy conflicts at stake and is willing to consider them in the decision-making process (Jacobson, Selvin and Pomfret 2001, 286).

However, even in the US, where there have been a larger number of health care reform cases, no radical shift in tort law has emerged. It is true that courts throughout the world have shown a substantial degree of deference to those entities making broader allocation decisions, including MCOs in the US, but there has been little or no change in the basic malpractice principles as they apply to individual health care providers. Moreover, as noted elsewhere, there

are, to date, few Canadian cases on point. Despite numerous headline grabbing stories about possible liability concerns (Priest 2000) and oft cited cases, such as the *Law Estate v. Simice*, Canadian courts have yet to grapple with many of the issues raised in this paper. This means the evolution of Canadian tort law in response to health care reform, if an evolution is going to happen at all, has not even begun.

Finally, it should be noted that the common law will inevitably lag behind broader social change. It is, to a large degree, a reactive mechanism. Before a specific issue can be addressed it must be brought before the courts by an individual seeking compensation. Relying on a case-by-case evolution of malpractice law will not result in broadly based comprehensive reform. Though a rich and complex source of legal principles, malpractice jurisprudence is developed in a largely ad hoc manner. There is no nationally coordinated approach.

Specific Legislated Responses

Of course, the common law can be altered by the enactment of legislation. Policy makers concerned about the impact of the common law on health care reform initiatives could enact legislation to minimize or alter the nature of malpractice liability. For example, though not enacted for the purpose of facilitating health care reform, ERISA legislation has greatly limited the liability exposure of MCOs in the US. Similarly, a number of US jurisdiction have also enacted legislation in order to protect patients from the effects of aggressive cost containment initiatives. For instance, "[r]equirements to disclose financial incentives have been enacted in many states and are included in recent reforms to Medicare and Medicaid." (Miller and Sage 1999, 1424).

Such an approach faces a number of challenges. First, because this type of legislation would likely be considered a provincial matter, each province would need to craft and enact its own legislation. There are ways to coordinate such efforts, but variation in political philosophy and in approaches to health care reform would likely result in a patchwork of regulatory responses (as we have seen with provincial variation in the emerging health care reform legislation).

Second, the policy implications of limiting liability exposure through legislation should be carefully considered. As noted above, a number of scholars have suggested that the accountability associated with malpractice law helps to maintain a high standard of care and encourages all health care decision makers – from physicians to regional health authorities – to consider the needs of individual patients (Litman 2002; Cahill and Jacobson 2001; Prichard 1990). In addition, using legislation to limit liability exposure would make it even more difficult for patients to receive compensation. Indeed, the Prichard Report concluded that:

> [O]nly about 250 injured patients annually receive any compensation from the liability and compensation system and that this represents only a modest percentage (less than 10 percent) of those suffering negligent injury (Prichard 1990, principle finding 5).

Legislation that further inhibited the ability of patients to obtain compensation would only make this situation worse.

Comprehensive Tort Reform

The most dramatic reform option would be to address health care reform issues as part of a broader tort reform initiative. Over the past few decades, many authors have noted the general failings and inefficiencies of the existing medical malpractice system (e.g., Jacobi and Huberfeld 2001; Harvard Medical Practice Study, 1990). A number of countries, such as New Zealand and Sweden, already have medical no-fault systems (Elgie, Caulfield and Christie 1993). And, as a result, the adoption of a no-fault system continues to be considered.

> The central premise of this model is that patients need not prove negligence to access compensation. They must prove only that they have suffered an injury, that it was caused by medical care, and that it meets whatever severity or other threshold criteria apply. (Studdert and Brennan 2001)

The cost of medical malpractice insurance, though still not as high as in the US, is also relevant to this discussion. For some medical disciplines, such as in the area of obstetrics, the cost can be extremely high and in some jurisdictions the expenses are paid for, at least in part, through public dollars, thus adding to the overall cost of the health care system.

By dealing with the malpractice issues associated with health care reform within a broader tort reform initiative, policy makers could specifically design a scheme to facilitate health care reform, public health work and a reduction of medical error while, at the same time, ensuring that the opportunity for patient compensation is improved. Indeed, given the concerns highlighted in this paper, the emerging concerns associated with medical error, the rising cost of medical malpractice insurance and the ambivalent evidence supporting tort law as a mechanism of quality control, it may well be time to seriously consider the adoption of some form of no-fault scheme.

There are, of course, numerous challenges associated with the implementation of a no-fault scheme. For example, as with almost any legislative initiative impacting private law, it would need to be done on a province-by-province basis – thereby making it more difficult to remain nationally consistent. In addition, there are issues around the economic and administrative efficiencies of a no-fault system (however, it can certainly be argued that it could be at least as efficient as the existing fault based approach) (Bovbjerg and Sloan 1998; Elgie, Caulfield and Christie, 1993). Finally, despite a lack of strong data supporting the deterrent effect of tort law, there is concern we would lose the quality control benefits currently associated with the malpractice system. Indeed, this seems to be the primary reason that, in 1990, Prichard recommended that we maintain tort actions against health care providers (Prichard 1990).

The Need for More Research

While tort law may not be an effective health care reform tool, existing common law principles should not be viewed simply as a barrier to constructive social change. There are good reasons why tort and fiduciary law have placed such a strong emphasis on the health care provider's obligation to the patient. And the judiciary's continued deference to the ethical

principle of autonomy, which lies at the heart of much of this common law, is the result of centuries of socio-political development. Before steps are taken to erode or alter these well established social norms – for example, through the adoption of a no-fault scheme – Canadian society needs to carefully consider the long term trade-offs. Do we really want to reduce the impact of autonomy in the context of health care decision making? Would a lessening of the physician's fiduciary obligations result in a concomitant and detrimental reduction in the relationship of trust so essential to the health care setting? Of course, there is already a great body of literature considering medical ethics in this context (see, for example, Project Bibliography, Caulfield and von Tigerstrom, 2002, 272), but I believe more Canadian work is essential, particularly in relation to tort reform.

We also need more research on the actual social benefits and harms of malpractice jurisprudence. Since the 1990 Prichard Report, very little empirical work has been done on this tremendously expensive system.

> Given how much reliance society places on legal mechanisms to promote safety and the very large expense of liability systems, it is rather stunning that there is so little scientific evidence on how effectively liability and discipline perform (Bovbjerg. Miller and Shapiro 2001, 369).

Notes

1 I have had the opportunity to consider many of the issues discussed in this paper in a variety of different articles and book chapters, including: T. Caulfield, "Malpractice in the Age of Health Care Reform" in Barbara von Tigerstrom and Timothy Caulfield, eds. *Meeting the Challenge: Health Care Reform and the Law* (University of Alberta Press, 2002); T. Caulfield and K. Siminoski, "Physician Liability and Drug Formulary Restrictions" (2002) 166 Canadian Medical Association Journal 458; T. Caulfield and G. Robertson, "Cost Containment Mechanisms in Health Care: A Review of Private Law Issues" (1999) 27 Manitoba Law Journal 1; and T. Caulfield and D. Ginn, "The High Price of Full Disclosure: Informed Consent and Cost Containment in Health Care" (1994) 22 Manitoba Law Journal 328. This paper has been informed by and builds on these previous publications. I will not reference them again in this paper.

2 However, even if physicians are not liable for cost containment initiatives that cause an actual scarcity in resources, such situations may, nevertheless, create other legal challenges. For instance, physicians may need to become increasingly sensitive to the lack of resources available within a given jurisdiction. As noted by Robertson: "Lack of resources or equipment is also relevant in the context of the doctor's duty to refer. A doctor who does not have access to particular equipment or testing may be negligent in failing to refer the patient to another facility which does, or possibly in failing to inform the patient that it is available in another facility" (Robertson 1999, 89).

3 However, see *Elofson v. Davis* (1997), 49 Alta L.R. (3d) 327 (QB). To my knowledge, this is the only recent case where the locality rule has been explicitly accepted – largely in the hope that a reduced standard of care will encourage more physicians to practice in rural communities.

> The law recognizes and reflects public policy that a less stringent standard applies to a rural medical general practitioner. ... [T]he rural general practioner is badly needed in the rural areas of Canada, and in this case rural Alberta; and it is likely that if the rural practitioner was held to a higher standard, it would seriously increase the existing deterrent to rural practice (para 56 (QL)).

The case is also important as it represents one of the rare examples of a Canadian court, at least in a malpractice setting, lowering the standard of care in order to address a specific population health concern. Given the tone of recent jurisprudence relevant to the locality rule, this case must be viewed as an exception to the general rule reflected in *Sunnucks*. Nevertheless, from the perspective of this paper, the case is an interesting example of external policy concerns persuading the court to alter the legal standard.

4 In fact, the lack of relevant jurisprudence is quite surprising. Other than *Law Estate* and *McLean*, both 1994 decisions, there have been no other cost containment decisions. Given the huge cuts to the health care system that occurred in the mid-90s, I expected a large number of similar decisions. It is possible that the relevant cases have been litigated but settled prior to trial.

5 It is worth noting that it is certainly possible to sue government officials in relation to allocation decisions. In the well publicized case of *Decock v. Alberta* (2000) the Alberta Court of Appeal held that Premier Klein and the Minister of Health, Shirley McClellan, could be named in a malpractice law suit. In the case, the plaintiffs allege that "Klein and McClellan had a duty to ensure that they were provided with reasonable and proper medical care, attention and treatment, which duty was breached" (*Decock* 2000, paragraph 6). Of course, it is far from clear whether the plaintiffs will succeed.

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