THE ROLE OF TORT LIABILITY IN IMPROVING GOVERNMENTAL ACCOUNTABILITY IN THE HEALTH SECTOR

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A thesis submitted in conformity with the requirements for the degree of Doctor of Juridical Science

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Abstract

Over the past decade, concerns with the accessibility and quality of health services have led several individuals to bring tort claims against provincial governments. Unlike other types of health sector legal cases, which have been the subject of much commentary, this thesis provides the first treatment of the tort cases against governmental defendants. To date, Canadian courts have not been receptive to these claims, striking nearly all of them on pre-trial motions, on the basis that government defendants did not owe the plaintiffs a duty of care.

In order to situate the health sector tort claims within the judiciary’s broader approach to governmental liability, I compiled a dataset of all tort cases against Canadian governmental defendants from the past decade. My dataset indicates that judges have dismissed more health sector tort claims than those arising from nearly all other sectors of government activity, even accounting for other explanatory variables. I also develop a framework to categorize the judicial approaches to the test for establishing a duty of care. Canadian judges now generally conduct a comprehensive analysis of the closeness and directness of the parties’ relationship and the policy implications of tort liability in determining whether a defendant owes a plaintiff a duty of care. However, judges adjudicating health sector claims fail to appreciate the government's modern role in the health sector and are almost singularly concerned with the policy implications of their decisions.
I conclude with two policy recommendations. First, I argue that judges should more frequently permit these claims to proceed beyond the pre-trial dismissal stage to a full trial, in order to evaluate the policy concerns both for and against governmental liability with the benefit of a full evidentiary record. Second, I argue that judges should more frequently permit health sector tort claims to proceed beyond the duty of care stage of the negligence analysis to an assessment of whether the government met the standard of care. While this approach would allow judges to scrutinize the reasonableness of the government’s decisions, improving transparency and potentially motivating an improved decision-making process, it would not necessarily lead to widespread liability.
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INTRODUCTION

Historically, physicians bore sole responsibility for the quality of health care services, while hospitals merely furnished a location to practice medicine and nursing staff to assist in this endeavor. From Canada’s inception through the first half of the twentieth century, the role of provincial governments in the health sector was also narrow, with the state providing limited funding for specific health services and for low-income populations. Governments also delivered certain health services, primarily mental health and public health programs. The minor role that hospitals and the government played in the health sector meant that these actors owed few legal obligations to patients.

In the second half of the twentieth century, there were significant changes in the roles of the various health system actors—governments, hospitals, health care professionals, patients, and newly-created regional entities—and the relationships between these actors. Beginning with the implementation of Medicare in 1966, the responsibilities of provincial ministries of health underwent a significant expansion, culminating in three major functions in the health sector—insurer, policy-maker, and manager. Several pressures contributed to these changes, including escalating health system costs, the increasing complexity of medical care, growing public expectations, and concerns with the appropriateness and safety of health services. In what follows, I explore the government’s expanding role in the health sector and the effect of this change on the state’s legal relationship with its citizens. Specifically, I argue that the government’s growing regulation of clinical decision-making and the health service delivery system creates an increasingly close nexus between patient injuries and government decisions.

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1 Throughout, unless otherwise noted, I use the general term “government” to indicate Canadian provincial governments and the ministries to which they have delegated responsibility for the health sector.
2 Medical Care Act, 1966, SC 1966-67, c 64. This legislation set out the scheme for insurance for universal physician services.
3 I describe these pressures in detail in Section A, below.
This is relevant to the legal test for establishing a duty of care, which, as I discuss below, requires a close and direct relationship between the parties.

A substantial body of health policy literature indicates that there are gaps in accountability at all levels of the health system.\textsuperscript{4} Concerns with the sustainability of the health system, access to and quality of health services, and the government’s expanded role in the health sector have all contributed to increased calls for improving accountability within provincial ministries of health. With the government investing an ever-increasing portion of tax dollars into the health care system,\textsuperscript{5} the public has come to expect reasonable access to quality health care services. When the system fails to fulfill this expectation, the public seeks to hold the government to account, as evidenced by numerous legal claims against government defendants, frequent health sector complaints to provincial ombudspersons, public demands for commissions of inquiry into patient injuries, and aggrieved citizens turning to the media to expose their grievances about the health system.\textsuperscript{6} Due to the relative advantages and disadvantages of the various accountability mechanisms and the different types of government decisions captured by each, I argue that a multi-pronged approach is necessary to achieve effective health sector accountability.

\textsuperscript{4} I briefly discuss this literature in Section B, below, and explore it in detail in Chapter Two.
\textsuperscript{5} Data from the Canadian Institutes for Health Information indicate that total health expenditures were forecast to reach $200.5 billion in 2011. Total health expenditures were expected to consume 11.6 percent of the gross domestic product in 2011. Canadian Institute for Health Information, \textit{National Health Expenditure Trends, 1975 to 2011} (Ottawa: CIHI, 2011) at xv, online: Canadian Institute for Health Information <http://secure.cihi.ca/cihiweb/products/nhex_trends_report_2011_en.pdf>. In 2010, the Ontario government reported that it was spending 42 percent of total program spending in health care costs, and projected that this would rise to 50 percent “in the near future” (Ontario Ministry of Finance, \textit{Ontario’s Long-Term Report on the Economy} (Toronto: Ministry of Finance, 2010) at 44). Based on current trends, a report by TD Economics projected that “[i]f health care spending roars ahead at 6.5% per annum while total spending is contained to 4% growth, then health care would comprise 80% of total program spending by 2030, up from 46% today. Everything else the government does, including providing education for its residents would have to be squeezed into the remaining one-fifth” (TD Economics Special Report, \textit{Charting a Path to Sustainable Health Care in Ontario} (Toronto: TD Financial Group, 2010) at 4).
\textsuperscript{6} I summarize health sector tort claims against governmental defendants in Section C, below, and explore them in greater detail in Chapters Three and Four. In Chapter Five, I discuss the other mechanisms by which citizens seek to hold governments accountable.
Over the past decade, a number of plaintiffs have filed tort claims alleging governmental negligence in the discharge of its health sector responsibilities, for example, for its management of disease outbreaks, its oversight over medical devices and health services, and its role in contributing to long wait times for health services. Despite the importance of the legal issues raised in these cases and the significance of health as a fiscal and policy issue, there is a paucity of literature examining health sector tort claims against the government. This stands in stark contrast to other types of health sector claims, particularly claims invoking the Canadian Charter of Rights and Freedoms, which are the subject of extensive legal commentary. In what follows, I explore the potential for tort law to improve governmental health sector accountability. In particular, I argue that increased judicial scrutiny of ministry of health decisions has the potential to facilitate accountability, as the government will be called upon to explain its decision-making process and the factors it considered in that process, and to justify the trade-offs it made between competing programs and interests.

Despite the potential for tort law to facilitate health sector accountability, which I discuss in detail below, Canadian courts have struck nearly all of the negligence claims against government defendants, either on a motion to dismiss for lack of a cause of action or a refusal to certify a class action. In striking these claims, the courts have adopted an outdated view of the government’s health sector role, by focusing largely on its financial responsibilities and ignoring its modern managerial responsibilities. In addition, policy considerations favoring judicial restraint, particularly concerns over the reallocation of scarce health sector resources and

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institutional competence to adjudicate matters of complex social policy, have dominated the courts’ duty of care analysis. Although there are certainly legitimate policy concerns with governmental tort liability, the courts must balance these concerns against countervailing policy considerations that favor judicial scrutiny of ministry of health decisions, such as the role of tort law in improving accountability. Furthermore, judges must be cautious in foreclosing a plaintiff’s legal remedies on a pre-trial motion, in the absence of a full factual record to aid the court in comprehensively assessing the policy concerns for and against tort liability.⁹

This reluctance to disrupt health sector decision-making stands in contrast to the judiciary’s approach to claims arising from other sectors of governmental decision-making, many of which proceeded to trial. In addition, in most tort claims against governmental defendants, Canadian judges conduct a comprehensive analysis of the closeness and directness of the parties’ relationship and the policy implications of tort liability in determining whether a defendant owes a plaintiff a duty of care. In contrast, judges adjudicating health sector claims are almost singularly concerned with the policy implications of their decisions. In the remainder of this introduction, I set out the major themes that I address in this thesis and then lay out the specific organization of the chapters.

**Part One: Outline of Major Themes**

The first major theme that I discuss is the evolving role of provincial governments in the health sector and the effect of this change on the legal relationship between the state and its citizens. Second, I describe the gaps in health sector accountability and the important role

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⁹ According to the seminal Supreme Court of Canada decision on the pre-trial dismissal of claims, although a court must read a plaintiff’s claim generously and accept all facts as proven, “the potential for the defendant to present a strong defense should not prevent the plaintiff from proceeding.” *Hunt v Carey Canada Inc.* [1990] 2 SCR 959 at para 33 [*Hunt v Carey*].
played by the courts in improving governmental accountability. Finally, I turn to discuss health sector tort claims more specifically. In that section, I discuss my criticisms of the judiciary’s refusal to permit cases to proceed to trial and to impose a duty of care on governmental defendants.

A. The Government’s Evolving Role in the Health Sector

Until the latter half of the twentieth century, the involvement of Canadian provincial governments in the health sector was generally restricted to the provision of some mental health and public health services, and the provision of limited funding for health care services and subsidies for the purchase of private insurance for low-income individuals. There was minimal governmental regulation of either the cost or the quality of health care services.\(^{10}\) Professional self-regulatory bodies and the medical staff structure within hospitals asserted primary jurisdiction over the regulation of the quality of health care services through licensure and hospital privilege regimes.\(^{11}\) The increasing standardization of medical education in North America following the 1910 Flexner Report also led to significant improvements in the quality of health care services and lent legitimacy to professional self-regulation.\(^{12}\) Similarly, prior to

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\(^{10}\) Unless otherwise noted, I use the term health care services or medical services to refer to physician and hospital services. I refer to other services, such as mental health and public health services, more specifically. Collectively, I use the term health services.

\(^{11}\) These bodies regulate quality through controlling entry requirements into the profession—self-regulatory bodies restrict entry though licensure requirements and the Medical Advisory Committees of hospitals control entry to the medical staff through the credentialing and privileging processes. These bodies also regulate quality through discipline—revocation of licenses by self-regulatory bodies or recommendations to suspend or revoke hospital privileges by Medical Advisory Committees. Finally, the medical staff structure regulates quality through morbidity and mortality reviews of patient injuries (retrospective reviews of health professional treatment decisions designed to prevent future adverse events) and the oversight of physicians by Department Chiefs and the Chief of the Medical Staff.

\(^{12}\) The Flexner Report was a commentary on the state of medical education in the early 1900s. It triggered standardization, organizational reforms, and curriculum modifications. Prior to the report, many medical schools were operated on a for-profit basis, with a focus on making money rather than improving the quality of medical education. Abraham Flexner, *Medical Education in the United States and Canada* (New York: The Carnegie Foundation for the Advancement of Teaching, 1910).
Medicare, there was no governmental regulation of the cost of medical services, but rather doctors determined their own fees, and patients paid for care out-of-pocket or through insurance plans, which were generally administered by physicians. During the Great Depression in particular, there was also considerable reliance on physician charity, with many doctors providing medical services on a pro bono basis or in exchange for goods or services, while many patients went without medical care.¹³

Beginning in the late 1940s, a number of factors created a window of opportunity for Canadian provincial governments to assume the role of health system insurer: the increased efficacy of and resulting demand for medical services;¹⁴ post-World War II prosperity and the expansion of the welfare state;¹⁵ and the example of Saskatchewan, a province that had successfully surmounted opposition on the part of the medical profession to implement universal health insurance for hospital services.¹⁶ Motivated by the federal government’s offer to share

¹³ Ken MacTaggart, “The First Decade: The story of the birth of Canadian Medicare in Saskatchewan and its Development During the Following Ten Years” (1972) 106:11 CMAJ 1234.
¹⁴ Recognizing the importance of access to health services, a number of provincial governments had already started to subsidize the purchase of private insurance. Medical practitioners, who feared that government insurance would harm their autonomy, supported these state subsidies. Ibid.
¹⁶ Saskatchewan had a premier, Tommy Douglas, who was deeply committed to public insurance. He would have lost his leg due to a childhood affliction of osteomyelitis, as his parents could not pay for surgery. However, a doctor provided the care for free, as he believed that Douglas was a good teaching case for his medical students. Furthermore, Douglas’ party, the Co-operative Commonwealth Federation (predecessor to the New Democratic Party), had a significant majority of the seats in the legislature. There was also high public support for the government’s involvement in health care, as Saskatchewan had been particularly impoverished during the Great Depression. However, the province did endure a physician’s strike and resulting public opposition after the introduction of universal hospital insurance. Walter Stewart, Tommy Douglas (Toronto: McArthur & Company, 2004). For an extensive discussion of the historical events leading to medical insurance in Saskatchewan, see the seven-volume series of articles in the Canadian Medical Association Journal by Ken MacTaggert, “The First Decade: The Story of the Birth of Canadian Medicare in Saskatchewan and its Development During the Following
costs with participating provinces, all Canadian provinces implemented universal insurance for hospital services. Universal insurance for physician services followed a similar path in the 1960s. Although the government’s role as health system insurer demanded a significant financial commitment, the state remained a passive payer, merely reimbursing the cost of services organized and delivered by hospitals and physicians. Physician autonomy, the doctor-patient relationship, health professional self-regulatory jurisdiction over quality, and the hospital organizational structure initially remained unchanged by universal insurance for hospital and physician services. Tuohy refers to the relationship of accommodation between the government and physician interests as the “fundamental bargain” upon which Medicare was founded.

By the late 1980s, serious concerns had emerged over the sustainability of Medicare. Decades of expansion encouraged by federal cost-sharing resulted in excess hospital capacity, fee-for-service physician reimbursement caused supplier-induced demand for medical services,

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17 Hospital Insurance and Diagnostic Services Act, SC 1957, c 28.

18 Medical Care Act, supra note 2. The Medical Care Act and the Hospital Insurance and Diagnostic Services Act were later subsumed into the Canada Health Act, SC 1984, c C-6. This federal-provincial cost-sharing arrangement became a point of contention between the two levels of government, as the federal government’s financial contribution decreased over time, leaving the provinces with an extremely expensive program that was politically infeasible to abandon. For a discussion of federalism issues in Canadian health care, see e.g. Steven Lewis, “The Bog, the Fog and the Future: Five Strategies for Renewing Federalism in Health Care” (2002) 166:11 CMAJ 1421 and Carolyn Hughes Tuohy, “The Costs of Constraint and Prospects for Health Care Reform in Canada” (2002) 21:3 Health Aff 32. The Canada Health Act sets out five main conditions that the provinces must meet in order to qualify for federal funding, including portability, universality, comprehensiveness, public administration, and accessibility. In addition, the Act prohibits user fees and extra billing for medically necessary services. However, the federal government has largely failed to enforce these conditions. See e.g. Sujit Choudhry, “Bill 11, the Canada Health Act and the Social Union: The Need for Institutions” (2000) 38 Osgoode Hall LJ 39.


20 According to Canadian Institute for Information data, total health expenditures (in current dollars) were approximately $12.2 billion in 1975, $22.3 billion in 1980, $39.8 billion in 1985, and $61 billion in 1990. Health spending as a percentage of gross domestic product rose from 7 percent to 9 percent over this same time period. Supra note 5 at 118.

21 Although the demand for medical services may be less elastic than other goods, there is a correlation between health service supply and utilization. David Reisman, Health Care and Public Policy (Cheltenham: Edward Elgar Publishing Limited, 2007) at 57.

and costly advances in medical technology led to rapidly escalating costs. Governments responded to these concerns by expanding their health sector role through the implementation of cost-containment policies. These policies targeted the supply of health services (for example, governments restricted the number of billing numbers granted to doctors, capped physician incomes, restricted medical school class sizes, and capped hospital global budgets). Provinces also sought to curb the demand for health services, for example, by delisting certain services from public insurance plans. However, for a variety of reasons, including physician opposition to restrictions on billing numbers and budget caps, public and health professional outcry against service de-listings, and the ongoing technological sophistication (and thus cost) of medical services, governmental policies achieved very modest success in containing escalating health care expenditures. As the terms of the federal/provincial cost-sharing arrangement gave the federal government no means of controlling its share of health care spending, it similarly sought to curb spending by abolishing the existing cost-sharing arrangement and shifting to a combination of transfer payments and tax points assigned to the provinces.

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24 In Ontario, the Ministry of Health and Long-Term Care and the Ontario Medical Association collaborated on several initiatives to save costs through de-listing services from the public plan. For a discussion of these initiatives, see Colleen M Flood & Joanna N Erdman, “The Boundaries of Medicare: Tensions in the Dual Role of Ontario’s Physician Services Review Committee” (2004) 12 Health LJ 1.
25 Although unsuccessful, several physicians challenged these billing number restrictions on the basis that they violated the section 7 Charter right to security of the person, which they argued included financial security resulting from employment. For example, see Waldman v British Columbia (Medical Services Commission) 1999 BCCA 508.
26 For a discussion on the process by which services were de-listed and the subsequent court challenges by the public and by members of health professions whose services had been de-listed, see Colleen M Flood & Joanna Erdman, The Boundaries of Medicare: The Role of Ontario’s Physician Services Review Committee, IRPP Working Paper Series no. 2004-02 (Montreal: Institute for Research on Public Policy, 2004).
28 For a discussion of the federal government’s shifting financial commitment to Medicare, see Steven Lewis et al, “The Future of Health Care in Canada” (2001) 323 BMJ 926. The authors note that by 1995, through some negotiated and some unilateral changes, the federal government’s 50 percent contribution was reduced to 16 percent.
Motivated by the ongoing need to control costs, along with emerging concerns respecting the appropriateness and safety of health care services, provincial governments further expanded their role in the health sector in the 1990s to become involved in managing clinical decision-making and the delivery of health care services. They also undertook a significant reorganization of the health care system through regionalization. Canada was not unique in this shift towards regionalization. Other countries that had expanded health care funding during the post-World War II rise of the welfare state, such as the Britain and the United States, also responded to sustainability and quality concerns with integrative organizational reforms.

(according to the provinces) or 32 percent including tax points (according to the federal government). The transfer payment portion of the federal contribution was grouped together with other social programs (post-secondary education and welfare) in the Canadian Health and Social Transfer, but these programs have since been disaggregated into the Canada Health Transfer and the Canada Social Transfer.

29 According to Canadian Institute for Health Information data, total health expenditures (in current dollars) were approximately $39.8 billion in 1985, $61 billion in 1990, $74.1 billion in 1995, and $98.6 billion in 2000. Health spending as a percentage of gross domestic product rose from 8.2 percent to 9.2 percent over this same period. Supra note 5 at 118.

30 There is inter-provincial variation in the configuration of health regions, for example, their size and the scope of their responsibility for services delivered outside of hospitals (such as public health services and long-term care). For a general introduction to regionalization and the issues arising from this reform, see Jonathan Lomas, John Woods & Gerry Veenstra “Devolving Authority for Health Care in Canada’s Provinces: An Introduction to the Issues” (2001) 156:3 CMAJ 371. There is also a range in the names given to devolved entities, including health regions, regional health authorities, or health districts. Throughout, I refer to these entities collectively as regional health authorities (RHAs). I generally discuss Ontario’s regional entities, Local Health Integration Networks separately, due to significant differences in the scope of responsibilities given to these entities (for example, the fact that LHINs did not assume the responsibilities of hospital boards). However, I use the term regional entities to include both LHINs and RHAs collectively.

31 For example, the British government has experimented with a number of reorganizations, generally with a view to facilitating integration. The current structure of the NHS consists of strategic health authorities under the Department of Health, with various types of trusts under the jurisdiction of strategic health authorities. Trusts are responsible for determining the needs of their population and securing the provision of services for that population. For example, primary care trusts provide primary care services and purchase other health services on behalf of their populations. They are tasked with ensuring the availability of services “including hospitals, dentists, opticians, mental health services, NHS walk-in centers, NHS Direct, patient transport (including accident and emergency, screening and pharmacies. They are also responsible for getting health and social care systems working together for the benefit of patients.” “About the NHS: Authorities and Trusts”, online: National Health Service <http://www.nhs.uk/NHSEngland/thenhs/about/Pages/authoritiesandtrusts.aspx#primary>. Similarly, the U.S. movement towards managed care was integrative, as it consolidated financing and delivery functions. There was also service integration, as managed care organizations expanded from physician services to include, for example, dental and vision services. Hospitals also integrated through cooperative agreements, joint ventures, or as the members of multi-hospital organizations, and hospital networks expanded their services in acquiring outpatient clinics, nursing homes and physician groups. Phoebe Lindsay Barton, Understanding the US Health Services System (Chicago: Health Administration Press, 2003) at 109 and 250-252.
Similar to those other countries, in Canada, the goals of integration were to cut costs through the elimination of health service and administrative duplication, and to enhance quality by facilitating continuity of care. The creation of devolved entities—perhaps the most transformative health system reform since the implementation of Medicare itself—represented a significant assertion of governmental control, as regionalization generally involved replacing the boards of private hospital corporations, which had governed hospitals for many decades, with government appointees. Regionalization involved a complete reconfiguration of the health care delivery system by the state, with little evidence as to its anticipated benefits. Although rhetoric of power transfer accompanied regionalization, the decision-making authority of regional entities was constrained by the governmental retention of important health sector responsibilities. For example, provinces continued to negotiate the schedule of insured services and reimbursement rates with physicians and retained responsibility for determining the pharmaceuticals included in provincial pharmaceutical insurance plans, instead of devolving these significant health system cost drivers to regional entities.

The government also exerts significant control over regional health authorities and hospitals, for example, by requiring approval of hospital bylaws, mandating ministerial

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32 Although a few provinces initially experimented with elected board members (see e.g. Steven J Lewis et al, “Devolution to Democratic Authorities in Saskatchewan: an Interim Report” (2001) 164:3 CMAJ 343), all provinces subsequently shifted to government appointees (see e.g. Alberta’s Regional Health Authority Membership Regulation, Alta-Reg 164/2004, s 3(1): “The Minister shall appoint all of the members of a regional health authority”). Tuohy describes the power to appoint boards as “a permanent expansion in the scope of formal state authority.” Supra note 19 at 180.

33 In this regard, Leatt et al note that “[t]o date, there has been little evaluation of the outcomes of the move to regional health authorities” Peggy Leatt, George H Pink, & Michael Guerriere, “Towards a Canadian Model of Integrated Healthcare” (2000) 1:2 Healthcare Papers 13 at 18.


35 See e.g. British Columbia’s Hospitals Act, RSBC 1996, c 200, s 2(2), which states that the “bylaws of rules of a hospital, including medical staff bylaws, are not effective until approved by the minister.” Furthermore, under s 42, the “minister may require that the bylaws or rules of a hospital…be revised in a manner satisfactory to the minister
approval for the exercise of many hospital and RHA board powers, subjecting RHAs and hospitals to extensive reporting requirements, and requiring the adoption of specific hospital governance practices. Accountability agreements between ministries of health and RHAs detail specific performance obligations, such as safety indicators and acceptable readmission rates, and health service delivery specifications, such as service volumes. These activities all go well beyond the government’s traditional role of merely fixing health care budgets. Despite

in order to meet changing conditions and policies, and to provide for greater uniformity and efficiency in all matters concerning the administration and operation of hospitals.”

36 For example, under Ontario’s Public Hospitals Act, RSO 1990, c P-40, s 4, a hospital must obtain ministerial approval to incorporate a hospital, amalgamate hospitals, add buildings to a hospital, and sell or otherwise dispose of hospital land. Under Ontario’s Local Health System Integration Act, SO 2006, c 4, a LHIN requires approval to transfer or encumber property, borrow or lend money, invest money, create a subsidiary, indemnify any person from liability guarantee the payment of money, directly provide health services, receive money from any person other than the Crown, act in association with an entity that conducts fundraising, make charitable donations, register as a charity, or enter into an agreement for the provision of services outside Ontario (s 6).

37 For example, under Manitoba’s Regional Health Authorities Act, CCSM c R-34, authorities must submit a plan for approval (s 24). This plan must state objectives and priorities for the provision of services (incorporating provincial objectives and priorities), describe how the authority proposes to carry out its responsibilities and measure its performance, include a comprehensive financial plan, and address other matters the Minister requires. Authorities must also provide any reports, returns, statistical information, and financial information the Minister requests (s 30, s 40). In addition, authorities must submit an annual report describing its activities (including the services provided and their costs), the health of the population, financial statements, and other information required by the Minister (s 38).

38 For example, the Ontario government recently amended regulations to prohibit members of the clinical staff or hospital employees from voting if they are members of a hospital board, Hospital Management Regulations, RRO 1990, Reg 965, s 2(2). According to the Excellent Care for All Act, SO 2010, c 14, hospitals must tie executive compensation to hospital performance targets (s 9(1)).

39 Although the Ontario government is not a party to LHIN/service provider accountability agreements, the Ministry leads the negotiation process, which includes determining service volumes and performance targets (respecting, for example, the acceptable rates of readmission for selected case mix groups, the percentage of full time nurses, and the percentage of chronic care patients with pressure ulcers). “Hospital Planning and Accountability: Status of the 2007/2008 HAPS/HAA Negotiation Process”, online: Ontario Ministry of Health and Long-Term Care <http://www.health.gov.on.ca/english/providers/project/hosp_plan/neg_process.html>. Under the agreement between Ontario and the Toronto Central LHIN, the Ministry may determine (in consultation with the LHIN), the hospitals that will provide Hospital Programs (core services and some specialized services), hospital volumes for these programs, and service delivery models for those services (at 11-12). For Provincial Strategies (emerging services in pilot or developmental phase), LHINs must incorporate the performance indicators, volumes, and service delivery models determined by government (at 13). For services covered by the provincial Wait Time Strategy, LHINs must incorporate the specifications (providers, volumes, funding levels, and other conditions) set out by the Ministry (at 14). The Ministry sets performance targets (relating to wait times, readmissions, alternate level of care days, and avoidable emergency room visits) for which LHINs are held accountable (at 49-50). “Ministry-LHIN Accountability Agreement”, online: Toronto Central LHIN <http://www.torontocentrallhin.on.ca/uploadedFiles/Public_Community/Board_of_Directors/Accountability_Agreement/Toronto%20Central%20Consolidated%20MLAA%202008_Aug1st.pdf>.
these changes, the courts continue to focus on the government’s financial responsibilities in adjudicating health sector claims.

Provincial governments also have the authority to appoint individuals to inspect or investigate concerns within RHAs or hospitals, or, most intrusively, to assume the administrative responsibilities of their boards. The Ontario government has appointed individuals with “the exclusive right to exercise all of the power of the [hospital] board” on several occasions, with those appointees implementing wide-ranging changes. For example, a government-appointed supervisor at Cambridge Memorial Hospital served for ten months, during which time he developed and implemented a new financial plan, appointed a board chair, recruited new board members, amended the corporate and medical staff bylaws, and recommended a new candidate for Chief of the Medical Staff. This type of direct managerial control over matters that were, for many decades, issues of internal hospital governance creates a much closer nexus between patient injuries and governmental decision-making than was historically the case. The courts have failed to consider these changes in the relationship between patients and the government in determining whether the parties have a sufficiently close and direct relationship to ground a duty of care.

In addition to the management of previously independent hospitals, governments in Canada and abroad are turning to reforms aimed at controlling physician decision-making. This is a significant shift from the status quo, as physicians have been zealous protectors of their autonomy, invoking arguments about the necessity of maintaining the integrity of the doctor-

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40 Hospitals Act, RSA 2000, c H-12, s 8 s 26, s 27, s 29.
41 Public Hospitals Act, supra note 36, s 9.
patient relationship and the specialized nature of medical knowledge. Although cost-containment continues to be a significant explanatory factor for governmental involvement in clinical decision-making, as I discuss below, the quality of medical care is also under increasing scrutiny, due to evidence of inappropriate care (as demonstrated by clinical practice variation) and high rates of patient injuries. The emphasis of governmental policy-making is thus shifting from cost-containment to a desire to also achieve improved value for money. The increasing state scrutiny of quality of care is motivating deeper engagement by government with the provision of health care services, which, for reasons I describe in Chapter Four, is more amenable to tort liability than its traditional budgetary function.

Numerous studies reveal significant variation in health service utilization, in the absence of clinical or demographic factors to explain these differences. Data regarding caesarean sections are often invoked to illustrate this clinical practice variation. For example, a recent British Columbia study showed that caesarean section rates vary dramatically throughout the province—from 16.1 percent to 27.5 percent—even after adjustments for patient medical condition and preferences. Numerous other studies confirm clinical practice variation for a

43 In his seminal work on the sociology of professions, Freidson discusses the special character of knowledge that distinguishes professions from other occupations. Eliot Freidson, *Professionalism Reborn: Theory, Prophecy, and Policy* (Chicago: University of Chicago Press, 1994). Physicians resisted the efforts of other actors to encroach on medical knowledge. For example, the evidence-based medicine movement was commonly denounced as “cookbook medicine,” and an impediment to the ability of physicians to account for the individual needs and idiosyncrasies of patients. Stefan Timmermans & Aaron Mauck, “The Promises and Pitfalls of Evidence-Based Medicine” (2005) 24:1 Health Aff 18.


46 Gillian Hanley, Patricia Janssen & Devon Greyson, “Regional Variation in the Cesarean Delivery and Assisted Vaginal Delivery Rates” (2010) 115:6 Obstetrics & Gynecology 1201. This study also showed that Cesarean section rates have increased dramatically over the past two decades, without corresponding improvement in maternal or perinatal outcomes.
wide spectrum of health services and medical conditions.\textsuperscript{47} These high rates of potentially inappropriate health services motivated provincial governments to create bodies to disseminate clinical practice guidelines and other evidence-based practice tools. One such body is the Ontario Health Quality Council, whose mandate includes monitoring and reporting on health system outcomes, supporting continuous quality improvement, and promoting evidence-based health care through recommendations to health care organizations concerning standards of care and to the Minister concerning funding.\textsuperscript{48}

Although the mere dissemination of evidence is unlikely to attract tort liability, the government is now going further than the provision of information to health professionals and is exerting an increasing level of control over the treatment decisions of physicians. For example, recent legislation requires Ontario’s hospitals to appoint a quality committee to monitor and report to the board on quality of care (“with reference to appropriate data”), make recommendations regarding quality improvement, ensure that best practices information is distributed within the hospital, and oversee the preparation of annual quality improvement plans.\textsuperscript{49} If the government continues on this current trajectory and further erodes physician autonomy, for example by prescribing clinical practice guidelines that health professionals must apply, individuals who are injured through the application of those guidelines could commence a claim in tort against the government.

Provincial ministries of health are also exploring the realignment of health professional financial incentives with a view to fostering cost savings and encouraging appropriate care. For

\textsuperscript{47} \textit{Supra} note 45.

\textsuperscript{48} \textit{Excellent Care for All Act, supra} note 38, s 12.

\textsuperscript{49} \textit{Excellent Care for All Act, supra} note 38, s 2, s 4. The Health Quality Council of Alberta’s responsibilities similarly include measuring, monitoring and assessing patient safety and health service quality; identifying effective practices and making recommendations for the improvement of safety and quality; and assisting in the implementation and evaluation of strategies designed to improve safety and quality (\textit{Health Quality Council of Alberta Regulation}, Alta Reg 130/06, s 7(2)).
example, over the past few decades, an increasing number of Canadian physicians have shifted to salaries from fee-for-service reimbursement.\textsuperscript{50} Governments in Canada and abroad are now also exploring the benefits of pay-for-performance models of physician compensation,\textsuperscript{51} including primary care practitioner financial incentives for preventive or other evidence-based services.\textsuperscript{52}

\textsuperscript{50} Data indicate that in 2005/2006, 21.3 percent of all payments to physicians for clinical services were made through alternative payment programs (defined as payment methods other than fee-for-service). This was an increase of 12.6 percent since 2004/2005. Canadian Institutes for Health Research. \textit{Physicians in Canada: The Status of Alternative Payment Programs 2005-2005} (Ottawa: CIHI, 2008) at 5. Although the evidence is mixed, some studies suggest that alternative payment models positively affect clinical care (by removing financial disincentives for health professional to provide preventive care) and health care costs. For example, one study indicated that physicians reimbursed on a fee-for-service basis conduct more patient visits than physicians remunerated by other methods. Rose Anne Devlin & Sisira Sarma, “Do Physician Remuneration Schemes Matter? The Case of Canadian Family Physicians” (2008) 27 J Health Econ 1168.

\textsuperscript{51} Governments in Canada and abroad are also exploring the benefits of pay-for-performance at the hospital level. For a general discussion of hospital reimbursement methodologies, see Jason Sutherland, \textit{Hospital Payment Policy in Canada: Options for the Future} (Ottawa: Canadian Health Services Research Foundation, 2011). As this paper notes, the primary source of revenue for Canadian hospitals are global budgets (a fixed amount of money distributed to each hospital to pay for all hospital-based services for a year). In many provinces, the budget is determined through historical spending patterns and hospital lobbying, rather than the type and volume of services provided. In contrast, activity-based funding pays hospitals based on service volume, adjusted by the characteristics of the patients treated. The main advantage of this remuneration method is its incentive for cost-efficiency (assuming that hospitals are permitted to retain some or all of their surplus). Episode-based payment means that hospitals are remunerated for the costs of patient episodes of clinical care (for example, a surgical procedure). These payments include all of the services provided to a patient for that episode (from pre-admission to post-acute care). This approach has the potential to encourage cost-efficiency and more appropriate service volumes. Although remuneration rates for episodes of care could be based on historical rates or hospital average rates, policy-makers have discussed the possible implications of setting these rates based on performance. Pay-for-performance methodologies can either reward process (for example, paying hospitals on would it cost to treat a particular condition according to clinical practice guidelines) or outcomes (for example, paying hospitals based on mortality or avoidable readmission rates). For an example of the former see Robert Wood Johnson Foundation, “Prometheus Payment: On the Frontlines for Health Care Payment Reform” (2009), online: RWJF <http://www.rwjf.org/files/research/66748.pdf>). For an example of the latter, see the Centers for Medicare and Medicaid policy refusing to upgrade patients’ diagnostic codes (and thus hospital reimbursement rates) when patients contract a hospital-acquired infection or other avoidable adverse event. RL Fuller et al, “Estimating the Costs of Potentially Preventable Hospital Acquired Complications” (2009) 30:4 Health Care Financing Rev 17.

\textsuperscript{52} In a literature review, Petersen et al concluded that five of six studies relating to physician-level financial incentives and seven of nine studies of provider group incentives found partial or positive effects on measures of quality. Laura A Petersen et al, “Does Pay-for-Performance Improve the Quality of Health Care?”(2002) 145 Ann Intern Med 265. Policymakers are also examining the potential for gain-sharing through accountable care organizations to incentivize more cost-effective treatment decisions. Accountable care organizations have three characteristics: providers are accountable across the entire continuum of care for a defined patient population, financial incentives rewarding quality improvement and slow spending growth, and the integration of performance measurement. Some proponents of ACOs see gain-sharing as a crucial part of the model, whereby providers have a financial incentive to provide more efficient care. For a comprehensive discussion of ACOs see Stephen M Shortell, Lawrence P Casalino & Elliott Fisher, \textit{Implementing Accountable Care Organizations} (Berkeley: University of California, 2010). The recent round of health reform in the United States incorporated this delivery system reform into the American health care system. Louise G Trubek, Barbara J Zabawa & Felice Borisy-Rudin, “Adopting Accountable Care Through the Medicare Framework” Seton Hall L Rev (forthcoming, 2012).
Governments not only seek to indirectly influence health professional treatment decisions by modifying financial incentives but, more intrusively, are directly involved in determining what services patients will receive in certain circumstances. Provincial ministries of health are increasingly scrutinizing whether expensive new diagnostic services and pharmaceuticals are sufficiently cost-effective to warrant inclusion in provincial health insurance plans. For example, in Ontario, only certain medical conditions are eligible for publicly funded positron emission tomography scans (PET scans), which cost up to $2000 each.\(^{53}\) The requirement that new health services must be cost-effective in order to attract public funding was a departure from the status quo, whereby new services were typically added to the schedule of insured services as a matter of course. Furthermore, doctors were historically able to provide insured services to their patients at their own discretion.

Another catalyst for the government’s expanded health sector involvement was the patient safety movement. A landmark 1999 study by the Institute of Medicine indicated that up to 98,000 patients died each year in the United States due to medical error.\(^{54}\) Using a conservative methodology, a 2004 Canadian study found similarly alarming medical error rates—70,000 preventable adverse events per 2.5 million annual hospitalizations.\(^{55}\) These

\(^{53}\) The categories of patients who qualify for PET scans include those with certain cancers or cardiac conditions, those who are part of a clinical trial to test the efficacy of scans for additional medical conditions, and patients whose physicians apply for special approval. “Pet Scan Primer: A Guide to the Implementation of Positron Emission Tomography Imaging in Ontario” at ii, online: Cancer Care Ontario <http://www.cancercare.on.ca/common/pages/UserFile.aspx?fileId=13626>. There is no publicly available data on the prevalence of special approval applications or the percentage of applications that are successful.

\(^{54}\) Committee on Quality of Health Care in America, To Err is Human: Building a Safer Health System (Washington, DC: Institute of Medicine, 1999) [To Err is Human].

\(^{55}\) G Ross Baker et al, “The Canadian Adverse Events Study: the incidence of adverse events among hospital patients in Canada” (2004) 170 CMAJ 1678 at 1678. Various factors suggest that these figures are a conservative estimate of the actual number of Canadian patients who experience adverse events. This study excluded obstetrical and psychiatric cases, the former of which is particularly rife with injuries (Atul A Gawande et al, “The incidence and nature of surgical adverse events in Colorado and Utah in 1992” (1999) 126:1 Surgery 66). The authors excluded data from small hospitals, despite the fact that one indicia of patient outcomes is volume (Ethan A Halm, Clara Lee & Mark R Chassin, “Is Volume Related to Outcome in Health Care? A Systematic Review and Methodologic Critique of the Literature” (2001) 137 Ann Intern Med 511). The researchers only collected data
studies drew considerable media attention and led the public to demand that governments take action to protect patients from adverse events.\textsuperscript{56} The importance of governmental involvement in patient safety efforts is underscored by growing evidence that injuries once attributed to health professionals are frequently caused or exacerbated by the systems within which those professionals work—systems that are organized, managed, coordinated and funded by a complex mix of self-regulation, hospital and health region policies, and governmental policies and laws.\textsuperscript{57}

As governments increase their role in the health system and their control over other health system actors, their influence over the various factors that affect patient outcomes also expands. As I discuss in Chapter One, numerous commissions of inquiry into patient injuries identify governmental decisions, particularly gaps in their oversight of the health system, as significant contributors to patient injuries.

Human beings are inherently fallible, and conditions intrinsic to the provision of health care services exacerbate their tendency to make mistakes. Health practitioners are often busy, from patient charts, thereby failing to capture readmissions to other hospitals. Finally, the authors only included incidents resulting in injury, thereby excluding near misses. One study found up to 95 near misses per 1,000 inpatient days, Catherine E Milch et al, “Voluntary Electronic Reporting of Medical Errors and Adverse Events” (2006) 21:2 J Gen Intern Med 165. Studies employing alternative methodologies, such as autopsies or observational studies, generally reveal higher error rates. See e.g. Kaveh G Shojaiania, Elizabeth C Burton, Kathryn M McDonald & Lee Goldman, “Changes in Rates of Autopsy-Detected Diagnostic Errors Over Time: A Systematic Review” (2003) 289:1 JAMA 2849, Lorelei Lingard et al, “Communication Failures in the Operating Room: An Observational Classification of Recurrent Types and Effects” (2004) 13:5 Qual Saf Health Care 330.

Leape and Berwick credit the Institute of Medicine report with three major changes: altering the view of error prevention (the way providers and managers think and talk about errors and a shift to a focus on systems), enlisting the support of stakeholders (for example, the federal government who budgeted $50 million annually for patient safety), and changing practices (for example, following the 2002 publication by the National Quality Forum of 30 evidence-based safety practices, the Joint Commission on Accreditation of Healthcare Organizations required hospitals to implement 11 of these practices). Lucian L Leape & Donald M Berwick, “Five Years After To Err is Human: What Have We Learned?” (2005) 293:19 JAMA 2384. In Britain, a significant driver of the patient safety movement was the Bristol Pediatric Cardiac Surgery Inquiry, which I discuss in Chapter One. Following Bristol, policymakers implemented clinical governance, which is defined as “a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding standardised care by creating an environment in which excellence in clinical care can flourish”. The government also established the Commission for Health Improvement to monitor compliance and the National Patient Safety Agency. There have also been regulatory changes aimed at improving communication, teamwork, risk management, and transparency, and enabling whistle-blowing. Donald Irvine, “Health Service Reforms in the United Kingdom After Bristol” (2004) 181:1 Med J Aust 27.

\textsuperscript{56} Leape and Berwick credit the Institute of Medicine report with three major changes: altering the view of error prevention (the way providers and managers think and talk about errors and a shift to a focus on systems), enlisting the support of stakeholders (for example, the federal government who budgeted $50 million annually for patient safety), and changing practices (for example, following the 2002 publication by the National Quality Forum of 30 evidence-based safety practices, the Joint Commission on Accreditation of Healthcare Organizations required hospitals to implement 11 of these practices). Lucian L Leape & Donald M Berwick, “Five Years After To Err is Human: What Have We Learned?” (2005) 293:19 JAMA 2384. In Britain, a significant driver of the patient safety movement was the Bristol Pediatric Cardiac Surgery Inquiry, which I discuss in Chapter One. Following Bristol, policymakers implemented clinical governance, which is defined as “a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding standardised care by creating an environment in which excellence in clinical care can flourish”. The government also established the Commission for Health Improvement to monitor compliance and the National Patient Safety Agency. There have also been regulatory changes aimed at improving communication, teamwork, risk management, and transparency, and enabling whistle-blowing. Donald Irvine, “Health Service Reforms in the United Kingdom After Bristol” (2004) 181:1 Med J Aust 27.

\textsuperscript{57} See generally To Err is Human, supra note 54.
stressed, and tired; must complete complex, simultaneous processes; and are required to make quick decisions based on limited information under the constraint of scientific uncertainty. If errors are the product of a chain of causes, human factors such as temporary inattention, misjudgment, and forgetfulness are the final, and least manageable, links in the chain. While the traditional approach to quality improvement focused on modifying the behavior of health professionals, the patient safety literature indicates that systems and processes designed to anticipate and prevent errors are a significantly more effective means of injury prevention. Actors such as governments, health regions, and hospitals have a greater logistical and financial capacity to implement error prevention systems than individual health practitioners. Governments in both Canada and abroad have responded to the emerging body of patient safety literature with a variety of regulatory requirements. For example, Ontario hospitals must report to the provincial government on a number of safety indicators (such as Clostridium difficile infection rates and hospital mortality ratios), which are then publicly reported at the hospital level on the Ontario Ministry of Health and Long-Term Care’s website.

Governments also directly regulate patient care in some circumstances, by prescribing, for example, how hospital medical staff must address critical incidents, the actions physicians must take before administering anesthesia or performing surgery, the types of surgeries

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58 The chain of causes view of medical error comes from Reason’s widely cited “Swiss Cheese” Model. He argues that when latent conditions that are conducive to error align with the mistakes of health professionals, a trajectory is created, where there is an opportunity for an adverse event. James Reason, “Human Error: Models and Management” (2000) 320 BMJ 768.


61 Regional Health Services Act, SS 2002, c R-8.2, s 58.

62 Hospital Management Regulations, supra note 38, s 28 and s 29.
requiring the presence of a second surgeon, and the types of tissues necessitating examination by a pathologist. This involvement in clinical decision-making extends far beyond the budgetary decisions that traditionally characterized the government’s health sector role. In addition, even if one accepts the argument that health providers still retain a great deal of autonomy and drive health decision-making, or the view that regionalization resulted in a devolution of state power to newly-created regional entities, I argue that the courts must still consider the nature of the government’s role in the health sector in determining whether to impose liability.

As noted above, governmental involvement in other areas of the health system, such as mental health and public health, took a somewhat different trajectory as compared to its expanding role in the management of health care services. I focus on public health, as it has been the subject of several health sector tort claims to date. Subject to some exceptions, the government always had three functions within the public health system—it paid for public health services, created public health policy, and managed the delivery of many public health services. In many cases, government employees (such as public health nurses) actually delivered public health services. Accordingly, public health is a particularly compelling example of governmental health sector control. Before modern sanitation efforts, many individuals succumbed to diseases such as typhoid fever and cholera, for which there were few effective treatments. Government involvement was crucial in the implementation of sanitation systems, such as the chlorination of drinking water, which dramatically reduced rates of waterborne

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64 *Ibid*, s 23.
65 For example, religious societies also assumed responsibility for the provision of some public health services. See generally Marguerite Van Die, *Religion and Public Life in Canada: Historical and Comparative Perspectives* (Toronto: University of Toronto Press, 2001).
infectious diseases.\textsuperscript{66} The 1900s saw the rise of other infectious disease, such as polio. Mass vaccination campaigns, which were largely responsible for eradicating several infectious diseases, similarly required governmental coordination, financing, and delivery (for example, through public health nurses).\textsuperscript{67}

As several recent reports indicate, public health is now an often-neglected part of the health sector in terms of resources and political support.\textsuperscript{68} Recent disease outbreaks have revealed significant weaknesses in provincial public health systems. For example, a commission tasked with examining Ontario’s 2003 SARS outbreak concluded that the province’s public health system was “broken.”\textsuperscript{69} As with the medical care sphere of the health sector, the report identified significant gaps in governmental accountability for its public health policies.\textsuperscript{70} In a public health emergency such as a disease outbreak, the government is the only actor with the financial and logistic capacity and the legal authority to respond to the threat, and thus the public has little alternative but to rely on government. I argue that the government’s expansive role in public health, coupled with the public’s reliance and their vulnerability to public health threats,

\textsuperscript{66} For a history of Canadian provincial governments’ efforts to improve sanitation see e.g. “Crisis in Housing and Sanitation” in John C Weaver, \textit{Shaping the Canadian City: Essays on Urban Politics and Policy, 1890-1920} (Toronto: The Institute of Public Administration of Canada, 1977).

\textsuperscript{67} For a general history of the development and implementation of vaccines see e.g. Stanley A Plotkin, ed, \textit{History of Vaccine Development} (New York: Springer, 2011).

\textsuperscript{68} Canadian Institutes for Health Research, \textit{The Future of Public Health in Canada: Developing a Public Health System for the 21st Century} (Ottawa: CIHR, 2003). This report noted concern with “[t]he impact of health system restructuring, chronic system underfunding and inattention” on the public health system (at v). Hemenway hypothesizes on the reasons for the lack of political and financial support for public health law: the benefits of public health investment do not vest until well into the future (possibly when other political parties are in power), the beneficiaries of public health efforts (such as cleaner water or air) are unidentifiable, the public’s lack of awareness of who public health professionals are or what they do, and the disinterest or opposition (often on the grounds of liberty) that public health efforts are met with. David Hemenway, “Why We Don’t Spend Enough on Public Health” (2010) 362:18 N Engl J Med 1657.

\textsuperscript{69} Archie Campbell, \textit{Spring of Fear: Final Report} (Toronto: Ontario Ministry of Health and Long-Term Care, 2003) at 17. Specifically, the report described the system as “unprepared, fragmented, poorly led, uncoordinated, inadequately resourced, professional impoverished, and generally incapable of discharging its mandate” (at 17).

\textsuperscript{70} The report commented that, “[a]ccountability was so blurred during SARS that it is difficult even now to figure out exactly who was in charge of what. Accountability means that when something goes wrong you know who to look for and you know where to find them. This kind of accountability was missing during SARS and remains blurred even today. What we need is a system with clear lines of authority and accountability to prepare us better for the next infectious outbreak.” \textit{Ibid} at 19.
ought to have been considered by the judges who struck tort claims alleging governmental negligence in the management of disease outbreaks.

B. Accountability and the Importance of the Courts

The government’s expanded role in the health sector contributed to growing calls for accountability by health policy scholars and members of the public alike. Citing the reports of several comprehensive inquiries into the health care system and the health policy literature more generally, Fooks and Maslove conclude that “[a]long with the system reviews, researchers, service providers and managers all agree that accountability in the health care system needs improvement and have proposed ways in which it could be strengthened.” There are several compelling arguments for improving governmental accountability, specifically growing health care bureaucracies and the resulting inadequacy of accountability through elections, the growing cost of the health care system, and the government’s monopoly over much of the health sector. I now turn to outline each of these arguments in more detail.

Two major contributors to accountability concerns are the size and scope of health care bureaucracies, both of which have increased with the expansion of the government’s role

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71 Several authors discuss heightened public expectations in the health sector. For instance, Decter notes that “[a]titudes and expectations are rapidly and markedly transforming as health consumers are becoming more educated and more demanding... health ministers are constantly questioned about the long waiting lists for certain procedures.” Supra note 44 at 28-29. See also Roy J Romanow, Commission on the Future of Healthcare in Canada, Building on Values: The Future of Healthcare in Canada (Ottawa: Commission on the Future of Healthcare in Canada, 2002) at xvi [Romanow Report].


beyond that of passive payer. For instance, the Ontario Ministry of Health and Long-Term Care administers or provides a plethora of services and programs, such as addiction services, children’s health services, a public drug program, a colorectal cancer screening program, emergency health services (air and land ambulance), dental services for low income children, an independent health facilities licensing program, mental health services, an emergency management unit, rabies awareness, and Telehealth, to list a few examples. In other words, the government administers a wide variety of programs that, when taken together, have the ability to significantly affect the health of its citizens. As I discuss below, the growing scope of bureaucratic activity was one factor prompting federal and provincial governments to pass legislation in the middle of the previous century abrogating their long-held common law immunity from tort liability.

The traditional means of holding government accountable through elections is increasingly inadequate, given the complexity of the modern state and government’s pervasive involvement in all aspects of the lives of citizens. In this regard, Rhodes argues that “[t]he traditional mechanisms of accountability in representative democracies were never designed to cope with multi-organizational, fragmented policy systems.” In addition, it is a major cause of concern that an increasing portion of governmental decision-making occurs not through the government as “an unjust burden which is becoming graver and more frequent as Government’s activities become more diversified and as we leave to administrative officers in even greater degree the determination of the legal relations of the individual citizen.” Edwin M Borchard, “Government Liability in Tort” (1924-1925) 34 Yale LJ 1 at 1.


75 RAW Rhodes, Understanding Governance: Policy Networks, Governance, Reflexivity, and Accountability (Buckingham: Open University Press, 1987) at 21. Although health is an important policy issue, as Flood et al argue, while a citizen may make a voting decision on broad health system platforms such as increased privatization, “the failure of a local hospital to streamline its information systems, the stalling of primary care reform in a remote community, or a gynecologist’s performance of more Caesarean sections than are medically necessary are issues unlikely to motivate a citizen to shift her vote.” Supra note 34 at 158.
passage of legislation, after democratic processes such as debate and committee hearings, but behind closed doors within the executive branch of government.\textsuperscript{76}

The growing portion of tax dollars allocated to the health system is another justification for improved accountability. With close to 50 percent of provincial budgets devoted to the health sector, there are legitimate concerns that health care is crowding out other social programs,\textsuperscript{77} such as education and other social services (which also have a significant impact on an individual’s health status).\textsuperscript{78} Furthermore, there is considerable evidence of health system inefficiency and waste, suggesting that governments are squandering some of these resources.\textsuperscript{79}

As Roy Romanow, the former Premier of Saskatchewan and head of a major federal commission on Medicare argues, Canadians “see increasing costs and, as taxpayers and owners of the health system, they expect efficiency and the best value for every dollar spent on health care…People are no longer prepared to simply sit on the sidelines and entrust the health system to governments and providers.”\textsuperscript{80}

Another justification for improved accountability is the fact that governments have used the law to carve out monopolies for themselves over most hospital and physician services. All provinces limit the availability of an alternative to the public system by curtailing the flourishing of a private tier. Although there is considerable interprovincial variation in these limits, regulations take the form of direct bans on privatization (for example, prohibitions on duplicate

\textsuperscript{76} Cairns argues that “so much of [the State’s] behaviour now lies outside the system of accountability supposedly sustained by the practice of responsible government.” Alan C Cairns, “The Past and Future of the Canadian Administrative State” (1990) 40 UTLJ 319 at 323.

\textsuperscript{77} Supra note 5

\textsuperscript{78} See generally Marc Lalonde, \textit{A New Perspective on the Health of Canadians} (Ottawa: Government of Canada, 1974).


\textsuperscript{80} Romanow Report, \textit{supra} note 71 at 49.
private insurance for services insured in the public system)\textsuperscript{81} and disincentives (for example, bans on doctors charging private patients more for a service than the rate paid by the public plan).\textsuperscript{82} There may be persuasive reasons for limiting the private system, such as cream-skimming by private providers (leaving the public system with the most difficult cases) or the drain of health human resources to the private system. However, these regulations frequently mean that patients have no alternative but to rely on the public system, regardless of the quality or accessibility of the care therein. Data on the number of patients waiting for care and the length of waiting times vary, but it is clear that some patients have to wait longer than medically recommended for health services, particularly for elective surgeries, such as knee and hip replacements, and diagnostic testing, such as MRIs.\textsuperscript{83} Given that the government has, in essence, conscripted citizens to the public system, it is essential that citizens have effective mechanisms to hold the government accountable in order to maintain public support for Medicare.

Similarly, the government has sole control over the provision of most public health services, as it is the only actor with the logistical and financial capacity and the necessary legal powers to respond to health concerns such as disease outbreaks. Given the public’s reliance on the government to respond to public health threats and the state’s considerable legal authority to

\textsuperscript{81} Duplicate private insurance covers the same services that the public plan covers, whereas supplementary private insurance, which is permitted across Canada, covers services outside of the public plan (such as optometry services, dental services, and pharmaceuticals).

\textsuperscript{82} For a comprehensive summary of legislative restrictions on privatization across Canada, see Colleen M Flood & Tom Archibald, “The Illegality of Private Health Care in Canada” (2001) 164:6 CMAJ 825.

\textsuperscript{83} According to one report, in 2010-2011, 17 percent of cataract surgery patients, 16 percent of hip replacement patients, 21 percent of knee replacement patients, and 22 percent of hip fracture repair patients did not receive surgery within “the amount of time that clinical evidence shows is appropriate to wait for a procedure.” Canadian Institutes for Health Research, \textit{Wait Times in Canada: A Comparison by Province, 2011} (Ottawa: Canadian Institutes for Health Research, 2011) at 5-7.
constrain individual rights in order to control the spread of disease, it is also important that effective mechanisms exist to hold the government accountable for its public health decisions.

There are several proposals to improve the accountability of the government for its health sector decisions. There are accountability mechanisms that are internal to government, for example, the increased flow of information regarding health system performance to the public, accountability agreement obligations, and managerial accountability within the hierarchy of government (for example, performance reviews of bureaucrats). However, my focus is on the availability of independent bodies, such as courts, to review governmental decisions.

As Longley argues, the law can be “a means of promoting and ensuring accountability and legitimacy in public decision-making,” and Brinkerhoff comments, “legal and regulatory sanctions are at the core of enforcing accountability.” The courts, and their independent review of government decisions, are an important component of a democratic system of government. However, as I discuss below, parliamentary supremacy certainly dictates some level of judicial deference to governmental policy choices and may even require that certain types of governmental decisions lie outside the scope of judicial scrutiny. Indeed, as I discuss in Chapter Four, Canadian courts have grappled with this balance in applying tort principles developed in the context of private parties to governmental defendants.

84 For example, provincial governments have such powers as quarantining infected individuals, closing premises, and commandeering necessary health care supplies. See e.g. Health Protection and Promotion Act, RSO 1990, c H.7, ss 22, 77.5.
85 For example, Romanow argues that, “[t]he decisions governments and providers make in operating our health care system should be clear and transparent. Canadians are entitled to regular reports on the status, quality and performance of our health care system.” Romanow Report, supra note 71 at 50.
86 Other proposals to improve accountability include calls to increase citizen participation (see e.g. J Church et al, “Citizen participation in health decision-making: past experience and future prospects” (2002) 23:1 J Public Health Policy 12) and proposals to increase transparency in the governmental decision-making process (see e.g. Joel Lexchin & Barbara Mintzes, “Transparency in drug regulation: mirage or oasis?” (2004) 171:11 CMAJ 1363).
87 Diane Longley, Public Law and Health Service Accountability (Buckingham: Open University Press, 1993) at 4.
88 Supra note 73 at 372-373. He goes on to call sanctions a “defining element of accountability” and argues that “[a]nswerability without sanctions is generally considered to be weak accountability.”
In addition to the courts, there are several other independent checks on state decision-making, including complaints to ombudspersons, commissions of inquiry, and auditors general.\(^89\) I argue that given their respective strengths and weaknesses, an optimal level of accountability requires that the courts and these other accountability mechanisms complement one another, rather than act as substitutes. For example, compared to the courts, ombudspersons are more accessible to complainants and are better able to mediate cost-effective and timely resolutions to complaints.\(^90\) Commissions of inquiry and auditors general are not constrained as judges are by pleadings, the parties to the litigation, legal doctrine, or the evidence introduced by the parties. Accordingly, they may be more effective at comprehensively exploring the systemic causes of an adverse event and making recommendations to avoid similar incidents in the future. However, without the courts, gaps would exist in accountability, as these other actors have wider discretion to refuse to hear grievances,\(^91\) may not publicly report their findings or conduct hearings in public,\(^92\) and the government may choose to disregard their recommendations.

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\(^{90}\) The Nova Scotia Ombudsman reported that 73 percent of administrative reviews were resolved in less than week, 13 percent were resolved between eight days and four weeks, and 14 percent took over four weeks to resolve. Systemic or policy reviews generally took several months to resolve. In contrast, litigation is often tied up in the courts for many years, particularly if the case proceeds through multiple levels of appeal. Nova Scotia Office of the Ombudsman, Annual Accountability Report for the Fiscal Year 2009-2010 (Halifax: Office of the Ombudsman, 2010) at 13-14, online: Government of Nova Scotia <http://www.gov.ns.ca/ombu/publications/Accountability-2009-2010.pdf>.

\(^{91}\) The Ontario Ombudsman can decline to pursue a complaint if “having regard to all of the circumstances of the case, any further investigation is unnecessary.” Ombudsman Act, RSO 1990, c O-6, s 17. The government frequently refuses to commence inquiries, even when confronted with public or media pressure. For example, commenting on the Ontario government’s refusal to appoint a commission to investigate the police shooting of a protestor taking part in a dispute over a provincial park on Aboriginal territory, Centa & Macklem argued that “the capacity of the commission of inquiry to secure governmental accountability is beginning to falter. Fearing adverse
Although I argue that courts are central to improving health sector accountability, plaintiffs can also advance their claims through administrative law or the Canadian Charter of Rights and Freedoms. I focus on tort law for a variety of reasons. First, it is only over the past decade that plaintiffs have filed tort claims against governmental health sector defendants and there is a resulting gap in the legal literature. Unlike the health sector Charter claims, which have been the subject of much academic commentary, tort claims against governmental defendants have received considerably less attention. These claims raise significant issues, such as the definition of governmental health sector responsibilities and the appropriate role of the courts in assessing public policy decisions, and plaintiffs are likely to continue to file these claims in the future.

Claims that are framed in administrative law and the Charter share many of the same characteristics as tort claims. They have the same advantages, including the availability of binding sanctions, judicial independence from government, and their ability to improve the transparency of the government’s decision-making process. These types of claims also share the same disadvantages, including access to justice barriers faced by prospective plaintiffs and concerns with judicial competence to consider complex social policy evidence. However, claims
commenced under administrative law and the Charter have thus far been restricted to complaints relating to access to health services, and these areas of the law provide limited means to review governmental decisions affecting the quality of health services. In contrast, many of the health sector tort claims to date challenge the quality of health services.

To date, health sector administrative law cases have either involved the judicial review of ministry of health refusals to reimburse patients for out-of-country health services or discrimination claims under human rights legislation based on the government’s failure to fund particular health services. Prospective plaintiffs are constrained by the fact that governments have only delegated a limited segment of health sector decision-making authority to the boards or tribunals whose decisions are amenable to challenge under administrative law. Furthermore, under administrative law, policy or legislative decisions do not attract judicial review by the courts.

The scope of the Charter is wider because it applies to all government actions. However, as with administrative claims, plaintiffs have only used the Charter provisions applicable to health sector grievances to address access to care issues. For example, plaintiffs have claimed that governmental failures to fund particular health services constitute discrimination contrary to

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95 For example, in Stein v Quebec (Regie de l’Assurance-maladie), (1999) RJQ 2416 [Stein v Quebec], the Quebec Superior Court overturned the Tribunal Administratif’s refusal to reimburse the plaintiff for cancer surgery he paid for out-of-pocket in New York. In contrast, in Flora v Ontario Health Insurance Plan, (2007) CanLII 339, the Ontario Divisional Court upheld the Health Services Appeal and Review Board’s decision not to interfere with the government’s refusal to reimburse the plaintiff for cancer treatment she paid for out-of-pocket in England.

96 For example, in Hogan v Ontario (Health and Long-Term Care), 2006 HRTO 32, the plaintiff argued that the government’s failure to fund sex reassignment surgery violated his right, under human rights legislation, not to be discriminated against on the basis of sexual orientation. In Armstrong v British Columbia (Ministry of Health), 2010 BCCA 56, the Court upheld the Human Rights Tribunal’s finding that the government’s failure to fund prostate cancer testing did not violate the plaintiff’s right not to be discriminated against on the basis of sex (despite the fact that the government funded cancer testing services for women).


section 15\footnote{99 See e.g. Auton (Guardian ad litem of) v British Columbia (Attorney General), 2004 SCC 8[Auton] in which the parents of autistic children unsuccessfully challenged the province’s denial of funding for applied behavioural analysis therapy for their children, on the basis that it discriminated on the basis of a mental disability; Cameron v Nova Scotia (Attorney General) (1999), 204 NSR (2d) 1 (CA), in which a couple unsuccessfully challenged the government’s refusal to fund fertility treatment on the basis that it discriminated on the basis of a physical disability (infertility); and Eldridge v British Columbia (Attorney General), [1997] 3 SCR 624, in which the British Columbia Court of Appeal found that the government’s failure to fund sign language interpretation services for deaf patients was discriminatory.} and that wait times in the public system coupled with bans on private insurance violate the right to life, liberty, and security of the person, as enshrined by section 7.\footnote{100 Chaoulli, supra note 8. See also R v Morgentaler, [1988] 1 SCR 30, 44 DLR (4th) 385, in which the Court concluded that delays associated with the therapeutic abortion committee approval process violated the right to security of the person.}

Additionally, courts have not interpreted section 7 of the Charter to guarantee positive rights—governmental obligations to ensure a plaintiff’s life, liberty, or security of the person—which acts as a bar to claims alleging failures to protect claimants from a particular risk.\footnote{101 However, see Gosselin v Quebec (Attorney General), 2002 SCC 84, which leaves open the possibility that “[o]ne day s. 7 may be interpreted to include positive obligations” (at paras 81–83).} In contrast, many health sector tort claims to date have alleged a governmental failure to take positive steps to protect the plaintiff (non-feasance), as opposed to negligence in carrying out its obligations (misfeasance).

\textbf{C. Governmental Health Sector Tort Liability Cases}

Crown immunity dates back to a maxim from the Middle Ages: “the king can do no wrong.”\footnote{102 Nicholas W Woodfield, “The Policy/Operational Dichotomy in Intra-State Tort Liability: An Example of the Ever-Continuing Transformation of the Common Law” (2000) 29 Denv J Int’l L Pol’y 27 at 33. However, an individual could apply for the Crown’s permission to proceed with a claim through a process called a petition of right. Ontario Law Reform Commission, \textit{Report on the Liability of the Crown} (Toronto: Ontario Law Reform Commission, 1989) at 8.} With the establishment of parliamentary democracy in Britain, this immunity was transferred to the government, and then to the governments of its colonies (including Canada) when they adopted Britain’s laws. Despite longstanding common law protection from tort liability, these governments passed legislation waiving their immunity from tort claims
beginning in the mid-twentieth century. The key rationales for this change were the need for the law to evolve in response to social changes, particularly the transformation of social values with respect to the rights of individuals and the diversification of governmental activities without accompanying redress for citizens. Although these changes did not open the litigation floodgates, courts did respond to these statutes by imposing liability against government in numerous cases, including claims for breaches of the duties to maintain highways and other public facilities, enforce building codes, and investigate criminal activity.

To date, health sector tort claims fall into three broad categories—negligent governmental management of disease outbreaks, failure to exercise adequate oversight of the health system, and claims by patients who died or sustained injuries waiting for care. In

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103 See e.g. Crown Liability and Proceedings Act, RSC 1985, c C-50, s 3.
104 Woodfield, supra note 102 at 31-32.
105 Borchard, supra note 73 at 4.
107 I define the health sector claims as personal injury cases naming provincial government defendants. Therefore, I do not include claims solely alleging financial losses (see e.g. 1597203 Ontario Limited v Ontario, 2007 CanLII 21966 (On Sup C) and Apotex Inc v AstraZeneca Canada Inc, 2009 FC 120). My searches captured the reported cases on CanLII and Westlaw, but motions to strike or class certification motions may be underreported (as compared to trial decisions). I also exclude two early health sector claims decided before the Supreme Court of Canada revised the test for establishing a duty of care in Cooper v Hobart, 2001 SCC 79 [Cooper], which is consistent with my treatment of cases from other sectors. In addition, these claims had unique facts that have not been applicable in subsequent cases. In Decock v Alberta, [2000] AJ No 419, the Court of Appeal refused to dismiss a claim against the Minister of Health and the Premier. The plaintiffs filed their claim after experiencing a variety of delays in receiving care. Unlike the other health sector cases, this decision focused on the proper naming of governmental defendants and the legal status of the defendants. The second pre-Cooper case was Marble (Litigation Guardian of) v Saskatchewan, 2001 SKQB 199, in which the plaintiff alleged that the government failed to ensure that hospitals required doctors to carry malpractice insurance. Although the initial motion to strike was dismissed, the Court of Queen’s Bench later decided that a settlement between the plaintiff and the hospital defendant released the government from liability, (2003), 236 Sask LR 14. Finally, I exclude claims against the federal government (see e.g. Attis v Canada, 2008 ONCA 660 and Drady v Canada (Health), 2008 ONCA 639).
contrast to most other sectors of government activity, the courts are reluctant to impose a duty of
care against provinces for their health sector decisions. Courts have dismissed almost all of these
claims prior to reaching trial, either on a motion to strike for lack of a cause of action or by
refusing to certify a class action. Although a negligence claim has four elements—duty of care,
breach of duty, causation, and damage—all of the unsuccessful health sector claimants failed to
establish that the government owed a duty of care. In the only health sector claim against a
provincial government that a court permitted to proceed to trial, the government was the health
service provider (in that case, an air ambulance operator). It is thus unclear whether anything
short of the governmental provision of health care services, and the resulting direct interaction
between ministry of health employees and the plaintiff, will justify the imposition of a duty of
care. This position persists in the health sector claims, despite the Supreme Court of Canada
holding that a personal relationship is not necessary to establish a duty of care: “[a] sufficiently
close and direct connection between the actions of the wrongdoer and the victim may
exist…where there is no personal relationship between the victim and wrongdoer.” Numerous
claims arising outside of the health sector have succeeded without any direct interaction between
government employees and plaintiffs.

In Chapters Three and Four, I critically analyze the Canadian judiciary’s application of
both the test for striking a claim and the test for establishing a duty of care in the context of
health sector tort claims. With respect to the former test, the Supreme Court of Canada has
adopted a high burden to strike a claim: it must be “plain and obvious” that the plaintiff is bound
to fail. This onerous standard is underscored by the adoption of wording that is more
analogous to the criminal burden of proof than the civil one: it must be “beyond reasonable

109 Hill v Hamilton, supra note 106 at para 29.
110 Hunt v Carey, supra note 9. This is the seminal Canadian case on the pre-trial dismissal of claims.
that a plaintiff cannot succeed. The application of this test and the rules of civil procedure more broadly call upon judges to balance fairness, accuracy, and efficiency. In light of scarce judicial resources, the courts are increasingly cognizant of the impact of their decisions not only on the immediate parties to a case, but also on the broader pool of prospective litigants. While a full evidentiary record obtained at trial arguably improves accuracy, it is an inefficient use of judicial resources and unfair to defendants to allow clearly meritless claims to proceed to trial. Canadian courts have attempted to balance fairness, accuracy, and efficiency by allocating judicial resources to particular types of claims. Specifically, there is an emphasis on the importance of allowing novel questions, claims relating to unsettled areas of law, complex cases, and cases raising important questions of law to proceed to trial.

Despite the fact that health sector tort claims generally satisfy these criteria, judges have dismissed these cases with no reference to these factors. In some of their decisions, courts actually treated health sector complexity as a justification for striking claims, rather than a factor suggestive of the importance of a trial to elicit all of the relevant evidence. The complexity of the health sector certainly requires that judges give considerable deference to the government at the standard of care stage of the negligence inquiry, but it does not justify striking these claims in

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111 Dumont v Canada (Attorney General), [1990] 1 SCR 279 at 280. See also Minnes v Minnes (1962), 39 WWR 112 at 122, in which the B.C. Court of Appeal stated that this rule “should be exercised only where the case is absolutely beyond doubt.” Although my focus is on the test for motions to strike, one of the health sector claims was an application for class certification. There is some inter-provincial variation in class certification requirements, however, under legislation and the common law test for certification, a plaintiff must generally demonstrate that the pleadings disclose a cause of action. As the Ontario Superior Court noted, “[i]t has been held in numerous cases that the test [for whether a class action discloses a cause of action] is essentially the same as that applicable for the purposes of a motion to strike.” Grant v Canada (Attorney General), 2009 CanLII 68179 (On Sup C) at para 45. However, while the onus is on a defendant to strike a plaintiff’s claim, the burden is on a plaintiff to meet the requirements for certification.

112 As MacFarlane argues, recent procedural amendments address “a tension between the simplification of the litigation process—with the avowed goals of achieving faster and less costly justice—and a concern that shaving pieces off a system designed to uncover truth and promote certainty may in fact diminish, rather than enhance, access to justice.” New rules facilitating the cost-effective resolution of simple claims include streamlined procedures for simple cases and increases in the monetary jurisdiction of small claims courts. J Macfarlane, “The Future of the Civil Justice System: Three Narratives About Changes” (2009) 35:3 Advoc Q 284.
the evidentiary vacuum of a pre-trial motion. In summarily dismissing the health sector tort claims, Ontario courts rely heavily on the first claim heard by the Ontario Court of Appeal in 2006, *Eliopoulos v Ontario (Ministry of Health)*,\(^{113}\) glossing over facts distinguishing the cases before them from *Eliopoulos*. Because the government’s health sector responsibilities are in a constant state of evolution, with the state continuously delving deeper into the management of the health delivery system and clinical decision-making, freezing its responsibilities in 2006 risks foreclosing plaintiffs’ legal remedies based on an outdated characterization of the role of government.

Unlike my discussion of the motion to strike jurisprudence in Chapter Three, which is confined to a critique of the Canadian judiciary’s application of the legal test to health sector claims, in Chapter Four, I take a broader approach to the duty of care jurisprudence and criticize both the application of the test to establish a duty of care in vis-à-vis health sector claims and certain aspects of the test itself. As I will explain, the test to establish a duty of care has two stages—a *prima facie* duty of care and policy considerations that limit or negate that duty of care.

Under the first stage of the test, courts determine whether there is sufficient foreseeability and proximity between the parties to warrant the imposition of a legal duty. In the decade since the Supreme Court’s adoption of the current interpretation of the duty test in *Cooper v Hobart*, Canadian courts have broadened the factors relevant to assessing the existence of a duty of care. The analysis has shifted away from a narrow and rigid approach, under which proximity depended upon whether a case conformed to an existing category of proximate relationship and focused on defining novel duties of care by reference to legislation. Judges now tend to employ a more flexible, contextual approach, whereby they examine the totality of the parties’

\(^{113}\)[2006] OJ No 4400.
relationship—as defined by legislation, precedents, and the parties’ interactions—for the presence of factors such as representations, reliance, legitimate expectations, and the nature of the interest engaged by the claim, all of which are relevant to proximity.

In contrast to these broader trends in the Canadian jurisprudence, judges adjudicating health sector tort claims tend to overlook the relational aspect of duty, summarily discussing the parties’ relationship and spending the bulk of their analysis on the policy concerns associated with governmental tort liability. To the extent that they do discuss the parties’ relationship, judges focus on the statutory context, and the broad duties that it creates to the public at large rather than individual citizens. Judges typically conclude that a duty to individuals would conflict with the government’s broad duties to the general public.

Once a plaintiff establishes a *prima facie* duty of care, the court moves to the second stage of the test and explores whether there are policy considerations that ought to limit or negate the duty. One specific policy consideration unique to governmental defendants is the policy/operational dichotomy, under which judges will not impose liability for policy decisions, while they will review the operationalization (also called implementation) of those decisions. Prior to *Cooper*, the policy/operational dichotomy was the touchstone of the duty analysis in the context of governmental defendants.\(^\text{114}\) Although judges continue to apply the dichotomy, they now more broadly explore “the effect of recognizing a duty of care on other legal obligations, the legal system, and society more generally.”\(^\text{115}\) Although I support the shift away from an emphasis on the policy/operational dichotomy, I go further and argue for its abolition. As judges themselves have acknowledged, the dichotomy is difficult to apply, with few governmental decisions clearly falling into one category or the other.

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\(^\text{115}\) *Cooper, supra* note 107 at para 37.
Because budgetary decisions generally fall onto the policy side of the dichotomy, judges adjudicating health sector tort claims have relied on the financial component inherent in most governmental decisions to exclude these claims from the judicial system. I also argue that the dichotomy is unnecessary because the first stage of the duty inquiry—in which the courts examine factors such as representations, reliance, expectations, and the nature of the interest affected—will filter out the types of decisions most clearly falling on the policy side of the dichotomy. Similarly, even if some of these clear policy decisions pass the duty stage of the negligence inquiry, many plaintiffs would fail to prove that the government breached its duty (as these decisions would attract considerable deference) or caused the injuries (as these plaintiffs would have difficulty proving that their injuries would not have occurred “but for” the government’s negligence).

At the second stage of the duty test, I adopt the critique of corrective justice scholars, who emphasize the importance of the parties’ relationship to the duty of care inquiry, and question the prominence of policy considerations external to the parties’ relationship in that analysis.116 I do not go so far as to argue that policy considerations should be irrelevant, because it is difficult to separate relationships from their broader context and policy issues are likely to affect judges’ decisions regardless of whether they explicitly form part of the duty analysis.117 However, I adopt the approach of Perry, who argues that while “principles of moral

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116 For example, Weinrib argues that policy factors “are uncontrolled by the relationship between the parties…A plaintiff can therefore be denied compensation on the basis of policy considerations that, while one-sidedly pertinent to the defendant…have no normative bearing on the position of the plaintiff as the sufferer of an injustice” (at 235). He argues that “policy involves articulating some independently desirable goal(s) and then dealing with a particular tort case in a way that forwards these goals or, if they are in tension, balances some against others to produce a result that is desirable overall. The goals are independent both in the sense that they rest on justifications that are independent of tort law, to which they are then applied, and that they are independent of one another, so that they may represent incompatible normative impulses that need to be balanced” (at 246). Ernest J Weinrib, “The Disintegration of Duty” (2006) 31 Advoc Q 212 at 235. More criticizes a focus on policy factors as “a judicial confiscation of what is rightly due to the plaintiff in order to subsidize policy objectives unilaterally favorable to the defendant.” Daniel More, “The Boundaries of Negligence” (2003) 4 Theoretical Inquiries in Law 339 at 344.

117 In Cooper, supra note 108 at para 29, the Supreme Court argued that the test for negligence, “no matter how it is phrased, conceals a balancing of interests. The quest for the right balance is in reality a quest for prudent policy.”
responsibility constitute the main theoretical foundations of tort law,” policy considerations “do
have a role to play in tort, but it is inevitably a subsidiary one.”

Applying this approach, I argue that courts should be more cautious in negating a *prima facie*
duty for policy reasons, particularly on a motion to strike. While a plaintiff must establish
the existence of a duty of care, the onus is on the defendant to prove that overriding policy
concerns should limit or negate that duty. Although a court must read a plaintiff’s claim
generously and accept all facts as proven on a motion to strike, the defendant’s evidence does not
receive the same benefit. Despite the Supreme Court’s instruction that “the potential for the
defendant to present a strong defense should not prevent the plaintiff from proceeding,”
governments’ arguments on policy concerns remain a disproportionately influential, if not
determinative, factor in health sector tort decisions. Although these policy considerations are
undoubtedly legitimate concerns, I argue that they are not as compelling as the courts suggest
and, at the very least, must be appropriately balanced against the countervailing accountability
concerns I discussed above.

A complicated web of variables influence governmental decisions, including resources
(time, monetary and human), public and media pressure, health professional and interest group
advocacy, bureaucratic self-interest, and political factors (for example, the timing of the next
election). In addition, the health system is a complex mix of public and private financing;
market, professional and governmental regulation; technical and sometimes contradictory
scientific and policy evidence; and provincial, federal, and local jurisdiction. The health sector
decisions suggest a judicial reluctance to disrupt this delicate balance, a concern that several

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119 Although the Supreme Court of Canada did not explicitly mandate shifting this burden onto the defendant in
*Cooper v Hobart*, the courts have generally assumed that the burden shifts and look to defendants to introduce
evidence of the applicable policy concerns raised by tort liability.
120 *Hunt v Carey*, supra note 9 at para 33.
commentators echo in arguing that the courts lack the institutional capacity to consider legal questions situated within the complexity of the health system landscape.\textsuperscript{121} However, immunizing government decisions from scrutiny merely because generalist courts may have less knowledge of the specific subject matter would be inimical to the notion that an independent judiciary is an important check on governmental decision-making. Although parliamentary supremacy dictates that there are some limits on the judicial review of governmental decision-making, the doctrine was never intended to exempt entire sectors of governmental activity from the review of the courts with no regard to the nature of the impugned decisions. Furthermore, while some critics view damages awards as the judiciary simply substituting their policy choices for those of legislators, compensation can also be conceptualized as the government being compelled to internalize the social costs of their decisions.\textsuperscript{122}

The health sector tort decisions suggest a judicial perception that damages awards exacerbate health system cost pressures by diverting scarce resources from patient care. However, this fails to account for the potential non-monetary benefits of increased judicial scrutiny of governmental health sector decisions, such as a more deliberate and transparent decision-making process. Furthermore, the concern that a dollar spent in compensation is a dollar diverted from patient care is an oversimplification of health system financing.

\textsuperscript{121} Christopher Manfredi, “Déjà Vu All Over Again : Chaoulli and the Limits of Judicial Policy-Making” in Flood et al, supra note 8 at 145. Similarly, Cohen and Smith argue that “the state is likely to be involved in polycentric disputes in which the determination of any particular factor or issue involves the simultaneous adjustment of numerous other factors and issues, and affects the interests of numerous individual and collective interests.” David Cohen & JC Smith, “Entitlement and the Body Politic: Rethinking Negligence in Public Law” (1986) 64 Can Bar Rev 1 at 8.

\textsuperscript{122} The cost of governmental decisions are often externalized onto injured individuals, rather than spread across the taxpayers who benefitted from the impugned policy. In this regard, James argues that because public purposes may have injury-producing effect, compensation should be viewed not as a diversion of resources, but rather part of the activity’s normal cost. Fleming James, “Tort Liability of Governmental Units and Their Officers” (1955) 22 U Chi L Rev 610 at 614.
An additional criticism of governmental tort liability relates to the cost and length of litigation. Although there are serious access-to-justice issues within the Canadian judicial system requiring the attention of policy-makers, these concerns are not sufficient to justify completely foreclosing tort remedies against governments. There is no evidence to suggest that health sector tort claims consume more judicial resources than other complex tort suits, and thus the courts’ singling out these cases is problematic. Courts must treat health sector claims just like any other, unless policy-makers are prepared to completely abandon the tort system, for example, in favor of a no-fault compensation scheme. Furthermore, one might argue that these cases are a somewhat effective use of judicial resources, given the fact that many involve multiple plaintiffs or are class actions. Alternative mechanisms of governmental health sector accountability, such as ombudspersons, may be more expeditious and cost-effective; however, these mechanisms involve other trade-offs. For example, as I noted above, ombudspersons are more limited than the courts in their ability to improve health system transparency, given that they do not report individual complaints or conduct public hearings. In addition, other accountability mechanisms, particularly commissions of inquiry, are often considerably more expensive than litigation.

123 For a general critique of access to justice in Canada, see e.g. Beverley McLachlin, “The Challenges We Face” (2007) 40 UBC L Rev 819 and Michael Trebilcock, Anthony Duggan & Lorne Sossin, eds, Middle Income Access to Justice (Toronto: University of Toronto Press, 2012). For a discussion of some of the procedural reforms aimed at the expeditious and cost-effective resolution of simple and low value claims, with a view to improving the overall efficiency of and access to the justice system, see e.g. Macfarlane, supra note 112.

124 These reforms are, of course, not without criticisms. For a general discussion see e.g. Michael Trebilcock, “Incentive Issues in the Design of No-Fault Compensation Systems” (1989) 23 UTLJ 19.

125 In the seminal Canadian case on class action litigation, Western Canadian Shopping Centres Inc v Dutton, 2001 SCC 46 at para 1, the Supreme Court of Canada stated that “[p]articularly in complicated cases implicating the interests of many people, the class action may provide the best means of fair and efficient resolution.”

126 Other accountability mechanisms may be even more costly than the courts. For example, in 1993, the Commission of Inquiry on the Blood System in Canada was appointed to investigate the circumstances surrounding the contamination of blood and blood products in Canada and the blood system more generally. The Commission was initially given a budget of $2.5 million and had approximately one year to submit its report. The deadline for the report was ultimately extended by two years and the budget increased to $16 million. Sonya Norris, Canada’s Blood Supply Ten Years After the Krever Commission (Ottawa: Parliamentary Information and Research Service, 2008) at 6.
Another major concern with governmental tort liability relates to the actual potential for damages awards to change the state’s behavior. In other words, there are questions respecting the efficacy of tort law to deter governmental actors given, for example, their ability to pass costs on to taxpayers.  Although there is little empirical evidence to refute or support these deterrence arguments, there is at least some anecdotal evidence of ministry of health responsiveness to judicial decisions. For example, health sector Charter cases, even those in which the plaintiff was ultimately unsuccessful, sometimes motivated policy changes. I argue that without clear evidence refuting the efficacy of governmental tort liability, accountability concerns justify a presumption in favor of close scrutiny of health sector decision-making, particularly on a pre-trial motion, where the defendant must meet a high evidentiary burden to have a plaintiff’s claim struck.

Although I do not advocate widespread governmental liability, courts could apply the law in a manner that more appropriately balances the concern with judicial policy-making against the need for government accountability. Allowing tort claims to proceed to an analysis of whether the government breached its duty of care has the potential to improve accountability, as defendants would have to justify the reasonableness of their decisions and explain the obscure health sector decision-making process in a public forum. Subjecting governmental decisions to greater scrutiny would not marginalize concerns with scarce resources or competing interests, as the standard of care could incorporate considerable deference to defendants. For example, in Hill v Hamilton, the Supreme Court of Canada specifically addressed the argument that a duty of care in the context of scarce resources would cause a conflict between a government’s obligations to an individual and to the public: “the standard of care is based on what a reasonable

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127 For a discussion of additional differences between governmental and private defendants and the different incentives governing each, see e.g. Cohen & Smith, supra note 121.

128 See e.g. Auton, supra note 99.
police officer would do in similar circumstances. The fact that funds are not unlimited is one of
the circumstances that must be considered.”
In other areas of the law, courts are increasingly
reluctant to strike claims over preliminary issues such as standing or jurisdiction, but show
deferece in scrutinizing governmental decisions.

Courts have traditionally been most reluctant to allow claims impugning governmental
policy decisions to proceed to trial, due to separation of power concerns and a judicial reluctance
to adjudicate matters of complex social policy. However, allowing these claims to proceed
beyond the duty of care stage of the negligence inquiry would not necessarily result in increased
tort liability, as plaintiffs would still have to satisfy other elements of the negligence test. Not
only would courts grant policy decisions considerable deference in formulating the standard of
care, but it would be difficult for plaintiffs to prove that the government’s negligence caused
their injuries.

In sum, I now turn to argue that accountability must be commensurate with the
government’s expanded role in the health sector. Specifically, I argue that tort law, along with
other independent checks on governmental health sector decisions, is essential to improving
accountability. Finally, I criticize the courts’ response to health sector claims to date, arguing
that judges should subject the parties’ relationship to greater scrutiny and that policy
considerations should not be dispositive of these claims, particularly on a motion to strike.

129 Supra note 106 at para 44. Smillie similarly argues that “special administrative or allocational problems faced by
a public authority can be given due weight when the court considers whether the authority was in breach of its duty
to take reasonable care.” JA Smillie, "Liability of Public Authorities for Negligence" (1985), 23 UWO L Rev 213 at
218 at 248.
130 Manfredi, supra note 121 at 147-148.
131 In Vriend v Alberta, [1998] 1 SCR 493 at para 53, the Court commented that “[t]he deference very properly due
to the choices made by the legislature will be taken into account in deciding whether a limit is justified under s. 1
and again in determining the appropriate remedy for a Charter breach.” In Stein v Quebec, supra note 95, a case
relating to reimbursement for out-of-country health services, the Court employed the most deferential standard of
review, patent unreasonableness, noting that courts “must exercise restraint.” This case was decided prior to the
collapse of the standards of review in Dunsmuir v New Brunswick, 2008 SCC 9.
Having set out my main themes, in the remainder of this introduction, I briefly outline the organization of each of the five chapters.

Part Two: Outline of Chapters

Chapter One: The Role of Systems in Patient Injuries

In Chapter One, I explore the patient safety literature, focusing on the systemic roots of adverse events. A substantial body of evidence suggests that while health professionals are often held liable for errors causing patient injuries, many errors are actually caused or contributed to by the systems in which those clinicians work—systems that are the cumulative product of decisions made by health practitioner groups, hospitals, regional entities, and ministries of health. As the government involves itself more in the management of the health sector, increasing its regulation of patient safety and exerting increasing control over other health system actors, it increases its ability to affect the quality of care received by patients.

The patient safety literature also suggests that the most effective means of preventing adverse events is to implement processes and systems that anticipate and guard against human errors. Human beings are inherently fallible, which is exacerbated by the fast-paced and stressful health care environment. While it is difficult for individual clinicians to avoid errors, actors at the institutional or governmental level have the logistical and financial capacity to implement systems that make it difficult or impossible for those errors to occur. Furthermore, error prevention systems implemented at the institutional or governmental level protect a much larger number of patients than the piecemeal adoption of these systems by individual practitioners or groups of practitioners (such as clinical departments within a hospital). Finally, I discuss several
specific cases of medical errors to illustrate the significant gaps that persist in the government’s oversight over patient safety.

The purpose of my discussion of the patient safety literature is fourfold. First, it provides the factual context for my argument in Chapter Two that safety concerns, and the government’s contribution to those concerns, is one of the justifications for enhanced accountability. Second, the patient safety literature is relevant to several of the factors indicating that judges ought to allow claims to proceed to trial, which I discuss in Chapter Three, such as complexity (as illustrated by the complex web of causal factors leading to patient injuries) and the importance of the issues raised by these cases (given the magnitude of the patient safety problem).

Third, the patient safety literature suggests that courts should adopt a more nuanced approach to the proximity analysis. Specifically, the courts should not focus on direct contact between the parties in order to establish a duty of care, as this is incongruent with the modern view of injury causation. Finally, the patient safety literature is relevant to the policy arguments for and against governmental tort liability for their health sector decisions. For example, without an understanding of the various causes of a patient injury, judges risk allocating liability to the party whose conduct is most obviously linked to the injury (generally the treating health professionals), rather than the actor that is most blameworthy or is most amenable to deterrence through liability.

Chapter Two: The Government’s Health Sector Role

In this chapter, I discuss the government’s evolving role in the health sector, with a view to facilitating my discussion of the legal implications of these changes in the third and fourth chapters. I begin Chapter Two with a discussion of the government’s expanding health sector
responsibilities—from insurer, to policy-maker, and finally, to manager. The government now exerts significant control, and in some circumstances directly manages, the decisions of other health system actors, such as hospitals, hospital boards, and regional entities. Provincial governments are also increasingly intruding upon the clinical decisions of health care practitioners. In other areas of the health sector, such as public health, the government is responsible for delivering health services.

As I discuss, the government’s expanding role in the health sector is relevant to both aspects of the test for establishing a duty of care—proximity and policy considerations. Although the government’s initial financial responsibilities in the health sector were remote from patient injuries, the state’s increasing control over hospitals and physicians, its management of health service delivery and, at times, its interference with clinical decision-making, result in a much closer nexus between patient injuries and government decisions than was historically the case. I argue that the courts must carefully consider these changes in determining whether governmental defendants owe plaintiffs a duty of care.

The state’s expanding health sector responsibilities are also relevant to the second stage of the duty analysis, which requires an assessment of policy considerations that ought to limit or negate a duty of care. In the context of governmental defendants, this includes a classification of the impugned decision as either a policy or an operational decision. I argue that the government’s evolving role in the health sector and its blurring of the traditional silos of health sector decision-making exacerbate the difficulties inherent in this classification. I conclude this chapter by discussing the accountability literature, arguing that the state’s broadened health sector role has not been accompanied by commensurate accountability.
Chapter Three: Premature Striking of Health Sector Tort Claims

The government’s expanded health sector responsibilities, coupled with concerns with the quality and accessibility of health services, have motivated an increasing number of aggrieved patients to turn to the courts for redress. To date, judges have dismissed nearly all of the health sector tort claims on pre-trial motions, either to strike a claim for lack of a cause of action or to certify a class action. In the first part of this chapter, I critically analyze the courts’ application of the legal tests in these pre-trial motions.

Despite the high burden required to strike a plaintiff’s claim at the pre-trial stage—that it is plain and obvious that the pleadings disclose no cause of action—courts adjudicating health sector cases routinely apply a higher threshold. Specifically, the courts fail to give appropriate weight to factors that favor claims proceeding to trial, such as their complexity, their novelty, the fact that they relate to unsettled areas of the law, and the importance of the questions involved. More broadly, I discuss the failure of judges adjudicating health sector tort claims to balance the broader goals of civil procedure—accuracy, fairness, and efficiency.

In the second half of Chapter Three, I contrast the number of pre-trial dismissals in health sector cases with the number of dismissals from other sectors of government activity, in order to demonstrate that the courts are more restrictive in their approach to health sector claims than they are in adjudicating other types of claims. I also consider a number of alternate explanations for the inter-sectoral variation in judicial receptiveness to tort claims, including the year in which the cases arose, the jurisdiction in which they arose, and the nature of the damages sought (whether for personal injuries or economic loss).
Chapter Four: Rethinking the Test for Establishing a Duty of Care

As with other types of negligence cases, in health sector tort claims, plaintiffs must prove a duty of care, breach of that duty, damage, and causation. To date, courts have resolved all of the health sector claims on the issue of whether the governmental defendant owed a duty of care. As I will explain, the first stage of the duty test requires judges to ask whether there is sufficient proximity and foreseeability between the parties to establish a *prima facie* duty of care, while the second stage of the test involves a consideration of policy factors that limit or negate this legal duty. Unique to the context of government defendants is the policy/operational dichotomy, under which the courts will not impose liability for policy decisions but will review their operationalization (also called implementation).

In the first part of Chapter Four, I describe the shifts in the Canadian judiciary’s approach to duty over the past decade, situating the health sector claims within these broader trends. I then proceed to analyze each element of the test for establishing a duty of care in further detail, criticizing both the courts’ application of the test to health sector claims and certain elements of the test itself. While I am critical of the courts’ restrictive approach to governmental health sector tort claims, I do not support widespread liability. Instead, I argue that the courts would improve accountability if they struck fewer claims and allowed plaintiffs to proceed beyond the duty stage of the negligence analysis. Allowing claims to proceed to trial would give courts the benefit of a full factual record, which is particularly important in the complex context of health sector decision-making. If claims proceed beyond the duty stage of the negligence test, the courts could subject governmental decisions to greater scrutiny, while still incorporating considerable deference into the standard of care.
Chapter Five: Justification for Governmental Health Sector Tort Liability

In the fifth chapter, I turn to address the criticisms of governmental tort liability. The health sector jurisprudence indicates a judicial reluctance to redirect scarce governmental health sector resources to compensation and to delve into matters of complex social policy. Although there are valid concerns, I argue that the courts should also consider the potential that tort liability has to improve accountability, and whether compensation is justifiable in certain circumstances.

In the second part of Chapter Five, I return to the issue of health sector accountability. Specifically, I compare tort law with other accountability mechanisms, including those that are internal to government (for example, accountability agreements or reporting on performance indicators), and those that are external to government (including ombudspersons, commissions of inquiry, auditors general, administrative law, and the Charter). Because the various accountability mechanisms have advantages and disadvantages and cover different scopes of governmental health sector activity, I argue that an optimal level of accountability requires a multi-prong approach that includes tort law.
CHAPTER ONE:
THE ROLE OF SYSTEMS IN ADVERSE EVENTS

“Experts on quality agree on one key point...it is the design of systems, and not the misdemeanours of individuals, that cause errors.”

-Kenneth Fyke, Chair of Saskatchewan’s Commission on Medicare

Introduction

In 1999, a landmark Institute of Medicine study reported that in the United States alone, up to 98,000 patients die each year due to adverse medical events. This study captured the attention of policy-makers, the public, and the media, catalyzing the patient safety movement and a systems-centric approach to injury prevention. Prior to this shift, when an adverse event occurred, the tendency was to scrutinize the actions of health professionals most closely involved in the patient’s care to ascertain what caused her injury and who to hold accountable. The law reflected this individual-centric approach—doctors historically bore almost sole legal

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1 Kenneth Fyke, Commission on Medicare, Caring for Medicare: Sustaining a Quality System (Regina: Government of Saskatchewan, 2001) at 45 [Fyke Report], citing patient safety expert Donald Berwick, former President and CEO of the Institute for Healthcare Improvement, former Administrator of the Centers for Medicare and Medicaid Services, and creator of the 100,000 lives campaign (a strategy to immediately take action and implement six highly feasible, efficacious patient safety interventions rather than merely continuing to study and talk about the patient safety problem). Donald M Berwick et al, “The 100,000 Lives Campaign: Setting a Goal and a Deadline for Improving Health Care Quality” (2006) 295:3 JAMA 324.

2 The Canadian Patient Safety Institute defines an adverse event as “[a]n 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.” Canadian Patient Safety Institute Disclosure Working Group, Canadian Disclosure Guidelines (Edmonton: Canadian Patient Safety Institute, 2008) at 8.

3 Committee on Quality of Health Care in America, To Err is Human: Building a Safer Health System (Washington, DC: Institute of Medicine, 1999) at 1 [To Err is Human]. Although there was some discussion of a systems approach to patient safety prior to the Institute of Medicine report (see e.g. Joseph B Davis & Barry S Bader, “The systems approach to patient safety” (1979) 5:2 Quality Review Bulletin 17), To Err is Human was the catalyst for the modern patient safety movement. In particular, it brought the magnitude of the patient safety problem to the attention of clinicians, policymakers, and the public. According to one estimate, within days of the release of the Institute of Medicine report, at least 100 million readers and viewers were exposed to information about patient safety. The report led the evening news on both NBC and ABC and was featured on the front page of numerous major newspapers, including the New York Times and the Washington Post. Susan Dentzer, “Media Mistakes in Coverage of the Institute of Medicine’s Error Report” (2000) 3:6 Effective Clinical Practice 305.
responsibility for patient injuries. Quality improvement efforts thus fell within the near exclusive jurisdiction of medical schools, health professional self-regulatory bodies, and the medical staff structure within hospitals.

A growing body of evidence suggests that many injuries once attributed to individual health professionals are frequently caused or contributed to by the systems within which those individuals work—systems that are organized and managed by a complex mix of professional self-regulation, hospital and regional policies, and governmental policies and regulations. The patient safety literature also indicates that the most effective injury recognition and prevention strategies are those implemented at the systems level. Human beings are inherently fallible, it is difficult to modify individual behaviors, and conditions intrinsic to the provision of health care exacerbate the tendency of humans to err. In contrast, actors such as hospitals, regional entities, and governments are well-situated, both logistically and financially, to implement processes and systems that anticipate and guard against human errors. Furthermore, error prevention systems protect more patients than strategies aimed at modifying the clinical decisions of individual health practitioners, as the latter may leave potentially dangerous conditions in place that may lead other practitioners to make the same errors in the future.

As I describe in the next chapter, the policies of Canadian provincial ministries of health increasingly embrace this systems approach to patient safety. For example, Ontario hospitals must report to the government on several safety indicators (such as clostridium difficile infection

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5 Regional entities include regional health authorities (RHAs) and, in Ontario, Local Health System Integration Networks (LHINs). I explain these entities in detail in Chapter Two. Briefly, most provinces implemented regional health authorities in the 1990s. Ontario implemented local health integration networks in the following decade. Unlike RHAs, LHINs did not replace hospital boards. Governments in all provinces purported to delegate some of their authority to these newly created regional entities.
rates and hospital mortality ratios\textsuperscript{6} and to the Ontario Health Quality Council on critical incidents within hospitals.\textsuperscript{7} The Ministry also sets performance targets for Local Health Integration Networks relating to patient safety in Ministry/LHIN accountability agreements.\textsuperscript{8} Recent legislation requires Ontario hospitals to link executive compensation to quality improvement targets, develop an annual quality improvement plan, and appoint a quality committee. Hospitals are required to report this quality improvement data to the Ontario Health Quality Council\textsuperscript{9}

Partly in response to the changing perception of medical errors, Canadian courts expanded the narrow legal duties hospitals historically owed to patients.\textsuperscript{10} For example, in several cases over the past two decades, judges imposed liability against hospital defendants for failing to implement patient safety systems,\textsuperscript{11} such as processes to track laboratory test results.\textsuperscript{12}

\textsuperscript{6}“Patient Safety Indicators”, online: Ontario Ministry of Health and Long-Term Care <http://www.health.gov.on.ca/patient_safety/public/ps_pub.html>. For a discussion of patient safety regulation in the U.S., which has focused mainly on the collection of information, see e.g. “A National Survey of Medical Error Reporting Laws” (2009) 9:1 Yale J Health Pol’y L & Ethics 201.

\textsuperscript{7}These data are reported at the hospital level on the Ontario Ministry of Health and Long-Term Care website.

\textsuperscript{8}For example, under the agreement between Ontario and the Toronto Central LHIN, the Ministry sets performance targets relating, for example, to avoidable readmissions and avoidable emergency room visits, for which LHINs are held accountable. “Ministry-LHIN Accountability Agreement” at 49–50, online: Toronto Central LHIN <http://www.torontocentrallhin.on.ca/uploadedFiles/Public_Community/Board_of_Directors/Accountability_Agreement/Toronto%20Central%20Consolidated%20MLAA%202008_Aug1st.pdf>.

\textsuperscript{9}Excellent Care for All Act, SO 2010, c 14, ss 3, 8, and 9.

\textsuperscript{10}Another factor that likely contributed to shifting hospital legal duties was the growing complexity and sub-specialization of medicine, which necessitated greater coordination and management by hospital administration. Historically, there were few effective medical procedures and physicians generally provided treatment in small doctors’ offices (often in their own homes) or in their patients’ homes. In Canada, the transition of care from patients’ homes to the modern hospital occurred between 1890 and 1920 (David Paul Gagan & Rosemary Ruth Gagan, \textit{For Patients of Moderate Means: A Social History of the Voluntary Public Hospital in Canada, 1890-1950} (Montreal: McGill-Queen’s University Press, 2002) at 3). The modern hospital was largely born out of the need for a structure to organize specialized professionals and its ability to raise the funds necessary for acquiring increasingly expensive medical technology. Prior to this, hospitals were largely viewed as places that poor patients went to die. According to Gagan and Gagan, “[t]he nineteenth-century general hospital was a medically marginal but socially essential agency of voluntary charity...Hospitals were associated with the most repugnant circumstances of disease and death. Respectable Canadians received medical treatment, and convalesced at home in the care of trusted family physicians, attentive female relatives, and domestic servants” (at 13). For a comprehensive discussion of the rise of the modern hospital, see Paul Starr, \textit{The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry} (New York: Basic Books, 1984).

\textsuperscript{11}Early direct hospital duties were limited to the maintenance of equipment and supervision of staff. Hospital duties were subsequently expanded to include a duty to establish safe systems, although Canadian courts only impose this...
There is wide support in the legal literature for expanded hospital liability, on the basis that it better aligns legal responsibility with the ability to prevent injuries.\textsuperscript{13} However, hospital liability in Canada is still relatively narrow compared to other jurisdictions, such as the United States and Britain, where hospitals owe a direct duty to patients to provide non-negligent medical care.\textsuperscript{14} In addition, while Canadian law continues to treat doctors as independent contractors rather than employees, British and American judges routinely impose vicarious liability for physician negligence within hospitals.\textsuperscript{15}

As I discuss in Chapter Four, Canadian courts are even more reluctant to consider liability against governmental defendants, despite the state’s dramatically expanded health sector responsibilities and the resulting growth in its ability to affect patient outcomes. In the health sector tort cases, Canadian courts have taken a narrow view of injury causation, frequently invoking the fact that other actors were more directly involved in providing treatment to the injured plaintiff as a reason to strike the claim. This approach is difficult to reconcile with the past decade of patient safety literature, which supports a systems-centric view of patient injuries that emphasizes the difficulty inherent in modifying the behavior of health providers and the problems associated with blaming individuals.

\textsuperscript{12} See e.g. \textit{Braun v Vaughan} (2000), 145 Man R (2d) 35 (CA). The Court stated that the hospital had an obligation “to provide a reasonable and practical ‘safe system’ including the coordination of services between physician, patient and the institution” (at para 49).
\textsuperscript{13} See e.g. Bruce Chapman, “Controlling the Cost of Medical Malpractice: An Argument for Strict Hospital Liability” (1990) 28 Osgoode Hall LJ 523 at 536. Pierce similarly argues that forcing those with more control over accidents to absorb their cost “provides an incentive to reduce the accident rate, the consequences of accidents, or both.” Richard J Pierce, Jr, “Encouraging Safety: The Limits of Tort Law and Government Regulation” 33 Vand L Rev 1281 at 1289.
\textsuperscript{14} See e.g. Picard & Robertson, \textit{supra} note 4 and Patrick C Osode, “Canadian Law and the Liability of the Modern Hospital for Negligence” (1993) 12 Med Law 593.
\textsuperscript{15} Both U.S. and British courts frequently hold hospitals vicariously liable for physician negligence. American courts also use the doctrine of agency to hold hospitals legally responsible for physician negligence. Picard & Robertson, \textit{supra} note 4 and Osode, \textit{ibid}. 
The purpose of my discussion of the patient safety literature is fourfold. First, in Chapter Two, I advance the significant concerns with the safety of the health care system and the gaps in governmental health sector oversight as justifications for improved accountability. Given the state’s monopoly over most physician and hospital services, I argue that there must be mechanisms in place to hold the government accountable when the health system fails patients. This chapter provides the factual context for this later discussion of the link between accountability and safety.

Second, as I describe in Chapter Three, Canadian courts have struck nearly all of the health sector tort claims against governmental defendants on pre-trial motions. According to Supreme Court of Canada jurisprudence, two of the factors that should be relevant to a judge’s decision to strike a claim are its complexity and the importance of the questions involved. My discussion of patient injuries in this chapter demonstrates that an adverse event is not merely a health professional’s error in clinical judgment, but rather the complex product of practitioner interactions with systems-level conditions that are conducive to errors. I argue that in some circumstances, judges may require a full evidentiary record to understand the complex process leading to injuries, rather than adjudicating these issues on the limited facts available on a pre-trial motion. The scope of the patient safety problem and the serious nature of the injuries often resulting from unsafe health services, both of which I discuss in this chapter, suggest that governmental tort liability claims raise important issues, which is another factor relevant to a court’s decision to dismiss a claim.

Third, as I discuss in Chapter Four, the test for establishing a duty of care requires courts to assess foreseeability, proximity, and any policy considerations that are relevant to whether the defendant owes the plaintiff a duty of care. In contrast to jurisprudence from other sectors,
courts adjudicating health sector claims frequently use the lack of a direct relationship between the parties as a justification for refusing to impose a duty of care on governmental defendants. More specifically, courts have considered the fact that government employees did not directly interact with plaintiffs, and the presence of other actors who had a closer relationship with the plaintiff (such as hospitals or health practitioners). This approach is incongruent with the patient safety literature, which demonstrates the profound effect that actors not directly involved in providing treatment have on patient outcomes. It is also incongruent with tort claims arising from other sectors of government activity, where judges have adopted a more nuanced approach to proximity.

The patient safety literature is also relevant to the second stage of the test for establishing a duty of care—an analysis of policy concerns relevant to the imposition of a legal duty. This requires a categorization of the impugned governmental decision as a policy or an operational decision, with no liability arising for the former. As I describe in Chapter Four, in applying this dichotomy, Canadian courts generally adopt an outdated view of the government’s health sector role by focusing on its financial responsibilities. My discussion in this chapter and the next illustrate that the state’s modern role in the health sector extends far beyond its traditional focus on budgetary allocations.

Finally, the patient safety literature is relevant to my analysis of the criticisms of governmental health sector liability in Chapter Five. Without an understanding of the various causes of a patient injury, judges risk allocating liability to the party whose conduct is most closely linked to the injury, which is generally the treating health professionals. As I discuss in this chapter, given the human tendency to make mistakes and the presence of flawed systems that are conducive to error, health professionals are not generally the most blameworthy actors

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involved in patient injuries, nor are they likely to be the actors who are most amenable to deterrence through tort liability.

As I discuss in Chapter Five, there is also some skepticism concerning the ability of tort law to act as an effective deterrent against governmental defendants. Because there are no judgements against the government in the health sector, or even broader empirical evidence respecting the effect of damage awards on governmental defendants, I use the commissions of inquiry discussed in this chapter as anecdotal illustrations of the catalyzing effect of judicial scrutiny on health sector policy-making. Another policy concern with imposing a duty of care on the government is the courts’ institutional competence to adjudicate issues of complex social policy. Again, I suggest that these inquiries provide at least some anecdotal evidence of the judicial capacity to understand and apply complex medical, epidemiological, and policy evidence.

This chapter proceeds in four parts. First, I set out empirical studies detailing the scope of the patient safety problem in Canada and abroad. In Parts Two and Three, I describe the systems approach to injury causation and adverse event prevention, respectively. Part Four contains a discussion of several comprehensive inquiries into patient injuries in Canada and abroad. Although these inquiry reports identified some criticisms of individual health professionals, the bulk of the recommendations focused on the actions of systemic actors such as hospitals, health professional self-regulatory organizations, health regions and, most relevant to my discussion, ministries of health. Specifically, these inquiries demonstrated that significant gaps exist in the government’s oversight of the health sector and that these gaps are contributing to significant numbers of patient injuries.
Part One: The Magnitude of Patient Safety Concerns

There are numerous reports of patients injured by the medical system they turned to while at their most vulnerable. In 2003, seventeen-year-old Jesica Santillan underwent a heart/lung transplant due to restrictive cardiomyopathy, a disorder where the heart chambers do not adequately fill with blood due to cardiac stiffness. Jesica’s story first gained publicity during the extensive fundraising campaign to pay for the surgery. Her parents raised the initial $5,000 required to smuggle their daughter across the Mexican border into the United States, and a charity founded by a wealthy local businessman, “Jesica’s Hope Chest,” raised an additional $500,000. The surgery occurred at Duke University, “one of the Meccas for transplant technology,” with Dr. James Jaggers, widely regarded as one of the country’s most talented pediatric heart surgeons, performing the procedure. However, Jesica received organs of the wrong blood type and died, despite the medical team’s effort to save her life with a second heart/lung transplant of the correct blood type (thereby wasting two potentially life-saving sets of organs).  

In another widely publicized case, fifty-one-year-old Willie King had one of his legs amputated at a Florida hospital due to complications from diabetes. However, doctors removed the wrong leg, leaving him a double amputee after they later removed the originally intended diseased limb. Recently, a Winnipeg man similarly underwent surgery on the incorrect Achilles tendon, resulting in reduced mobility and unnecessary pain. Other recent Canadian

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17 Wachter & Shojania, ibid at 267.

Patient safety scandals include two Ontario patients who underwent unnecessary mastectomies after a surgeon misread a pre-surgery pathology report, and 383 Newfoundland breast cancer patients who received false negative hormone receptor test results. One hundred and eight of these patients subsequently died, some of whom were deprived of potentially life-prolonging or life-saving treatment.

These tragic cases attracting media scrutiny are not isolated incidents. Numerous international and Canadian studies reveal alarming rates of adverse events. A landmark study by the Institute of Medicine Committee on Quality of Health Care in America reported up to 98,000 annual deaths in the United States due to medical error. This figure was higher than the number of yearly fatalities resulting from motor vehicle accidents, breast cancer, or AIDS. These mortality rates were equivalent to three jumbo jets crashing every two days—statistics that the public and the government would not tolerate from the aviation industry. Furthermore, this figure captures only part of the medical error problem, given that it does not include non-fatal injuries, unreported or undetected injuries, or the errors of health professionals that do not

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19 In one case, the patient underwent the removal of one breast and six lymph nodes on the recommendation of her surgeon. The post-surgical pathology report indicated that the excised tissue was benign. Further review revealed that the surgeon misread the pre-surgery pathology report, which indicated that the lump was malignant. Sonja Puzic & Laura Stone, “Woman launches $2.2 million lawsuit for ‘devastating’ mastectomy”, The Windsor Star (3 March 2010).


21 Supra note 2 at 1. At the time of this study, there were 43,458 annual deaths from motor vehicle accidents, 42,297 from breast cancer, and 16,516 from AIDS, thus the number of deaths from medical errors was nearly as high as all three of these other causes of fatalities combined. In the U.S., the total national costs (including losses in income, reductions in household production, disability costs, and health care costs) for preventable adverse events were estimated at between $17 billion and $29 billion, with health care costs representing half of this figure.

22 Jonathan Secker-Walker & Sally Taylor-Adams “Clinical incident reporting” in Charles Vincent, ed, Clinical Risk Management: Enhancing patient safety, 2nd ed (London: BMJ Books, 2001). The aviation industry is widely-regarded as one of the safest. That industry, along with the nuclear power sector, embraced the systems approach to safety long before the health sector began to consider this approach. The aviation industry has implemented numerous policies, such as near miss reporting and the use of checklists to guide pilot responses to unexpected situations or emergencies, that patient safety experts say are necessary to reduce medical error rates. See e.g. Atul Gawande, The Checklist Manifesto: How to Get Things Right (New York: Picador, 2010).
actually injure a patient despite the potential for harm (generally referred to as near misses).\textsuperscript{23} 

Nor does it include deaths from preventable adverse events in outpatient care, home care, or self-care,\textsuperscript{24} which are likely to be increasingly prevalent, given the trend towards health service deinstitutionalization. A major Australian patient safety study similarly revealed high rates of medical errors. Researchers found that 16.6 percent of hospital admissions were associated with adverse events, 51 percent of which were preventable, 13.7 percent of which resulted in permanent disability, and 4.9 percent of which resulted in death.\textsuperscript{25}

With regard to Canadian medical error rates, a 2004 study by Baker et al found an overall adverse event rate of 7.5 percent. In other words, of the approximately 2.5 million Canadian

\textsuperscript{23} An example of a near miss is a patient who is inadvertently given intravenous medication at a dosage ten times the concentration as that ordered by the physician, but the mistake is noticed and the IV is disconnected or the patient is given medication to counteract the overdose before he experiences any adverse effects.

\textsuperscript{24} Unfortunately, there is limited data relating to adverse events occurring outside of hospital settings. However, one study found that 22 percent of prescriptions filled in community pharmacies had a dispensing error (defined as one or more deviations from the physician’s written order). Elizabeth A Flynn et al, “Dispensing Errors and Counseling Quality in 100 Pharmacies” (2009) 49:2 J Am Pharm Assoc 171. In one of the only studies on adverse events in the home care setting, the author found that 13 percent of all home care patients suffered an adverse event. Elizabeth A Madigan, “A Description of Adverse Events in Home Healthcare” (2007) 25:3 Home Healthc Nurse 191. Error rates outside of hospitals may be of particular concern, given the fact that “home and community care, primary care and private care in Canada are unregulated or under-regulated in terms of patient safety.” Jocelyn Downie et al, \textit{Patient Safety Law: From Silos to Systems} (Halifax: Dalhousie University 2006) at 14 [Silos to Systems]. Furthermore, while there have been considerable efforts to develop strategies to improve patient safety within hospitals, these efforts have not occurred in other health care settings.

\textsuperscript{25} Ross M Wilson et al, “The Quality in Australian Health Care Study” (1995) 163:9 Med J Aust 458. In this study, researchers reviewed the medical records from over 14,000 medical admissions to 28 hospitals. Other studies examine particular types of adverse events or error rates in specific medical specialties. Two areas in which avoidable patient injuries are particularly prevalent are in the administration of medication and in the provision of anesthesia. For example, Spath’s research indicates that five to ten percent of hospitalized patients suffer serious medication errors, with less serious errors occurring ten times as often. Patrice L Spath, ed, \textit{Error Reduction in Health Care: A Systems Approach to Improving Patient Safety} (San Francisco: Jossey-Bass, 2000) at xxi. Another study found that between 70 and 82 percent of all anesthetic incidents in operating rooms were the result of human errors. These data indicate that up to 10,000 avoidable anesthesia-associated deaths occur each year in the United States alone. Balbir S Dhillon, \textit{Human Reliability and Error in Medical System} (Toh Tuck Link: World Scientific Publishing Co Pte Ltd, 2003) at 2. Anesthesia was one of the first medical specialties to devote significant attention to improving patient safety. Anesthetists worked with equipment manufacturers to standardize machines (for example, to ensure that turning the dial clockwise on a machine meant turning up the oxygen or anesthesia, regardless of the manufacturer of that machine). They also worked to implement systems to prevent human errors (for example, they worked with equipment manufacturers to ensure that the anesthesia and oxygen tubing had different connections, such that the oxygen tube could not be plugged into the anesthesia terminal on the machine and vice versa). Some of the lessons learned in anesthesiology were subsequently adopted by other specialties. See e.g. David Gaba, “Anaesthesiology as a model for patient safety in health care” (2000) 320 BMJ 785 and Jeffrey B Cooper & David Gaba, “No Myth: Anesthesia is a Model for Addressing Patient Safety” (2002) 97:6 Anesthesiology 1335.
hospital admissions per year, 232,250 were associated with an adverse event. More importantly, the study found that nearly 70,000 of these errors were preventable and 23,750 resulted in an avoidable fatality. A 1997 Ontario study with a smaller sample size found a similar, albeit slightly lower, error rate. The authors reported that for every 10,000 hospitalized patients, there were 30 avoidable misadventures, 500 preventable complications, and 162 avoidable adverse drug reactions.

Several factors indicate that the abovementioned studies underestimate the actual number of patients harmed by the health care system each year, likely by a considerable margin. For example, Baker’s study included errors resulting in a negative outcome for the patient—death, impairment, or disability—but excluded near misses. The study also excluded obstetrical and psychiatric cases, the former of which is particularly rife with adverse events. Baker et al relied exclusively on data from large hospitals, defined as having more than 1500 beds, operating

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27 The data from the Ontario study indicate that there were 692 errors per 10,000 patients, or a rate of 6.92 percent.
28 Duncan Hunter & Namrata Bains, “Rates of adverse events among hospital admissions and day surgeries in Ontario from 1992 to 1997” (1999) 160 CMAJ 1585 at 1586. One possible reason for the lower error rates in the Ontario study, published five years before Baker’s study, is the changing perception of what constitutes an adverse event, as opposed to an unavoidable complication of a particular procedure. Occurrences once viewed as routine complications—hospital acquired infections, pressure ulcers, ventilator induced pneumonia, and central line infections—are increasingly viewed as preventable adverse events. The Centers for Medicare and Medicaid developed a list of “never events”, which are previously routine complications that CMS has now deemed avoidable. They no longer reimburse hospitals for the cost associated with treating these conditions if they arise during a patient’s treatment at that hospital. Agency for Healthcare Research and Quality, “Never Events”, online: Department of Health and Human Services <http://psnet.ahrq.gov/primer.aspx?primerID=3>. As Atul Gawande reports, intensive care units put five million lines into patients each year, four percent of which become infected. Of the 80,000 annual infections in the United States, between five and 28 percent are fatal. “The Checklist” The New Yorker (10 Dec 2007) at 1.
29 There is little data on near misses and the reported figures are likely low, as the studies generally rely on voluntary reporting. One study found up to 95 near misses per 1,000 inpatient days. Catherine E Milch et al, “Voluntary Electronic Reporting of Medical Errors and Adverse Events” (2006) 21:2 J Gen Intern Med 165.
30 For example, in a study of adverse events relied on by the Institute of Medicine in To Err is Human, supra note 2, Gawande et al concluded that three types of surgeons—general surgeons, obstetrician-gynecologists and orthopedists—accounted for 66.9 percent of adverse events. They found that caesarean sections accounted for 3.1 percent of adverse events and hysterectomies accounted for 4.4 percent. Adverse events that occurred during caesarean sections and hysterectomies associated with obstetrics cases would be excluded from Baker’s figures. Atul A Gawande et al, “The incidence and nature of surgical adverse events in Colorado and Utah in 1992” (1999) 126:1 Surgery 66.
a 24-hour emergency department, and being located within 250 kilometers of a provincial research center. There is limited data on the relative error rates between hospitals based on size, but one indicia of patient outcome is the hospital’s surgical volume, which may be extremely low in a small community hospital, depending upon the surgical procedures performed in that facility.\textsuperscript{31} In addition, Baker’s data only included adverse events that occurred during the index admission or within the twelve months preceding the index admission. Certain patient injuries, such as lost laboratory test results showing a malignant tumor that is growing but is not immediately asymptomatic\textsuperscript{32} or retained surgical instruments or sponges, may take more than one year to manifest.\textsuperscript{33} Finally, because the researchers collected data from hospital charts rather than tracking patients through their health numbers, Baker’s error rates fail to capture adverse events that appeared post-discharge and resulted in readmission to another hospital or a visit to a doctor’s office.\textsuperscript{34}

Studies employing methodologies other than the retrospective review of patient medical records suggest even higher rates of medical errors. Patient charts likely fail to reveal all adverse events, as hastily recorded notes may be incomplete or illegible and health professionals may

\textsuperscript{31} For example, the authors of one literature review concluded that 71 percent of the reported studies found statistically significant associations between higher hospital volumes and patient outcomes. Ethan A Halm, Clara Lee & Mark R Chassin, “Is Volume Related to Outcome in Health Care? A Systematic Review and Methodologic Critique of the Literature” (2001) 137 Ann Intern Med 511.
\textsuperscript{32} For example, one can envision a situation where a laboratory report revealing irregular cell growth is lost. If the patient does not become symptomatic and return to the same hospital within the next year, this error would not be captured using Baker’s methodology.
\textsuperscript{33} A 2009 literature review of 147 cases of retained surgical sponges found that the average discovery time was 6.9 years. Common complications included adhesion (31 percent), abscess (24 percent) and fistula (20 percent). Wenshuai Wan, Thuan Le, Loren Riskin & Alex Macario, “Improving safety in the operating room: a systematic literature review of retained surgical sponges” (2009) 22:2 Anesthesiology 207. See also Zoran Rajkovic, Silvio Altarac & Dino Papes, “An Unusual Cause of Chronic Lumbar Back Pain: Retained Surgical Gauze Discovered After 40 Years” (2010) 11:12 Pain Med 1777.
\textsuperscript{34} A study of 26,045 patients in Toronto who were identified as being at risk for readmission found that one third of the patients were admitted to a different hospital than the original index admission. Fifty percent of these were admitted to a hospital outside of the study health region. Andrea Gruneir et al, “Unplanned readmissions after hospital discharge among patients identified as being at high risk for readmission using a validated predictive algorithm” (2011) 5:2 Open Medicine 104.
intentionally omit or conceal details divulging their mistakes. Studies analyzing data from autopsies or observations (where researchers observe and document interactions between patients and health professionals and meetings between professionals about patient care) suggest higher rates of adverse events than retrospective reviews of patient charts. For example, one systematic literature review found that of 53 autopsy studies, the median error rate was 23.5 percent for major errors.\(^{35}\)

Perhaps even more concerning than the high rate of medical errors initially brought to the public’s attention in 1999 is the modest progress over the past thirteen years. Evaluating five years of patient safety efforts, Longo et al concluded that, “[t]he current status of hospital patient safety systems is not close to meeting [Institute of Medicine] recommendations…patient safety system progress is slow and is a cause for great concern.”\(^{36}\) Six years later, Wachter noted only a “modest improvement” since 2004.\(^{37}\) In 2011, McCannon and Berwick concluded that despite

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\(^{36}\) Daniel R Longo, John E Hewett, Bin Ge & Shari Shubert, “The Long Road to Patient Safety: A Status Report on Patient Safety Systems” (2005) 294:22 JAMA 2858 at 2858. The authors’ data source was a survey of all acute care hospitals in Missouri and Utah following the Institute of Medicine Report, supra note 2, and a follow-up survey a few years later. The questionnaire asked hospitals to report on the uptake of several patient safety systems: computerized physician order entry systems, computerized test rests, assessments of adverse events, specific patient safety policies, use of data in patient safety programs, drug storage/administration/safety procedures, manner of handling adverse events/error reporting, prevention policies, and root cause analysis.

\(^{37}\) Robert M Wachter, “Patient Safety at Ten: Unmistakable Progress, Troubling Gaps” (2010 29:1 Health Aff 165 at 165. His qualitative study reviewed patient safety progress in several areas: efforts to create and enforce new safety standards through regulation and accreditation, weaknesses in how health system track and report errors, the disappointing uptake of promising information technology tools that promote patient safety, the lack of progress in reforming the medical malpractice landscape and fostering increased accountability, the paucity of provider
millions of dollars of investment in patient safety efforts since the release of *To Err is Human*, “the problem persists, and patients continue to sustain harm related to medical care.”

The reports of several comprehensive investigations into the Canadian health care system similarly reflect these ongoing concerns with patient safety and quality of care. For example, the report of the Commission on the Future of Health Care in Canada, chaired by Roy Romanow, stated that Canadians:

> [E]xpect high standards of quality to be met. They expect the treatments and services they receive to be based on the best available scientific evidence and the latest knowledge. And they expect the health care system to diagnose health problems, cure illnesses and treat injuries, and help improve not only their overall health but their quality of life as well. Too often, however, those expectations are not being met and, as a result, Canadians’ faith in the health care system is undermined.

Although these high-profile reports helped to bring the importance of systems to the attention of policy-makers and the public, leading to reforms such as the creation of the Canadian Patient Safety Institute and provincial health quality councils, high rates of adverse events continue to persist.

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41 Canadian Patient Safety Institute, online: Canadian Patient Safety Institute <http://www.patientsafetyinstitute.ca/English/Pages/default.aspx>.
42 For example, the Health Quality Council of Alberta is tasked with measuring, monitoring, and assessing patient safety and health service quality; identifying effective practices and making recommendations for the improvement of patient safety and health service quality; assisting in the implementation and evaluation of strategies designed to improve patient safety and health service quality; surveying Albertans on their experience and satisfaction with patient safety and health service quality; assessing, inquiring into or studying matters respecting patient safety and health service quality (on the Minister’s request); and assessing, inquiring into or studying matters respecting patient safety and health service quality (on the request of a regional health authority). *Health Quality Council of Alberta Regulation*, SA 2011, c H-7.2.
Part Two: Causes of Patient Injuries

Mechanisms for detecting the errors of health professionals—disciplinary self-regulatory bodies, the credentialing and privileging regimes within hospitals, and tort liability—are well established. Until recently, the legal responsibility for an adverse event rested with these individuals, who were most immediately involved in treating an injured patient. The actions of professionals are most closely connected to an injury, both temporally and spatially, while systemic contributors to an adverse event are further removed from the patient and are thus often not readily apparent. As Byers and White argue, although “[t]here are multiple factors involved in a single error...only the action of the practitioner is really visible.”

For example, when a surgical instrument or sponge inadvertently remains inside a patient post-operatively, the obvious causal factors are the physician who failed to adequately search the cavity before closing the patient or the nurses responsible for conducting and documenting the pre-surgical and post-surgical instrument counts. In contrast, the systemic contributors to the injury are typically less obvious: inadequate lighting, distracting levels of noise, operating room understaffing, the absence of a hospital policy governing surgical instrument counts, the lack of a policy instructing staff to routinely x-ray patients at high risk of surgical instrument retention.

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43 As I discuss below, there are certainly serious criticisms of the efficacy of these quality improvement regimes.
45 Retained metal surgical instruments (needles, knives, clamps, scalpels, or guidewires) can result in organ or vessel puncture. Surgical sponges or gauze, which are often undetectable by x-rays, can lead to infection. One study found that 12.5 percent of surgical cases involved intraoperative discrepancy in the instrument counts, which represented potential adverse events due to retained surgical instrument. Caprice C Greenberg et al, “The Frequency and Significance of Discrepancies in the Surgical Count” (2008) 248 Ann Surgery 337.
46 Vincent argues that high-intensity staffing in the intensive care unit (ICU) is associated with reduced mortality and reduced length of stay and could prevent up to 54,000 deaths per year. He also cites data indicating that daily rounds by ICU physicians are associated with a three-fold reduction in mortality and complications (supra note 22 at 378-382). High-intensity staffing is a situation where all ICU patients are managed or co-managed by intensivists (intensive care specialists). Byers and White similarly cite several studies that reveal an inverse relationship between staff levels and patient outcomes (supra note 44 at 30). They conclude that understaffing results in work overload, thereby creating conditions for slips, mistakes, and non-compliance with policy.
(such as emergency cases, where staff do not have time for a pre-surgical instrument count), the lack of standardized medical chart notations or forms for instrument counts, the failure to adopt instrument counting technologies such as barcoding, poor communication between surgeons and operating room nurses, the lack of a reporting system to track these types of errors, and the failure of leadership to emphasize the importance of patient safety.

A substantial body of empirical evidence suggests that the historic practice of focusing solely on the errors of individual health providers is an ineffective means of error prevention. In a review of 1452 patient charts revealing 889 medical errors, Mello and Studdert found that only 30 percent of the errors were attributable solely to individual health professionals, while 66 percent involved both individual and systemic factors. Several recent empirical studies link patient outcomes to the quality of care activities of hospital boards, for example, whether the

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47 Barcoding guards against the human errors inherent in instrument counts, as each item is scanned by nurses prior to surgery and again as it is removed from the surgical field. This system ensures a more accurate count because nurse may be interrupted or become distracted, thereby losing track of the instrument count. In addition, if an instrument is unaccounted for at the end of the surgical procedure, doctors know what type of instrument to look for as they search the cavity or x-ray the patient (as each surgical instrument has a unique bar code). For a discussion of risk factors for retained instruments see e.g. Atul Gawande et al, “Risk Factors for Retained Instruments and Sponges After Surgery” (2003) 348 New Eng J Med 299. Barcodes have potentially wide application in health care settings beyond instrument counts. For example, barcodes may be placed on pharmaceuticals and patient identification bracelets. Before providing a patient with a drug, a nurse can scan the identification bracelet to ensure that the correct drug and dose are administered at the correct time. One hospital reduced medication error rates by 70 percent through hand-held wireless computer technology and bar coding. Nilmini Wickramasinghe, Jatinder ND Gupta & Sushil K Sharma, Creating Knowledge-Based Healthcare Organizations (Hershey: Idea Group Publishing, 2005) at 264. See also John Banja, Medical Errors and Medical Narcissism (Boston: Jones and Bartlett Publishers, 2005) at 96-97.


board has a patient safety committee, devotes specific time at each meeting to patient safety issues, and whether board members receive training in patient safety.\textsuperscript{50} Other evidence indicates that the relationship between surgical volume and patient outcomes more closely correlates with the number of procedures performed in a particular hospital per year than the number of procedures performed by a particular doctor, despite the fact that surgery seems individualistic, with “the surgeon as the megastar with a large but unknown supporting cast.”\textsuperscript{51} Although there are no similar empirical studies exploring the association between governmental patient safety efforts and patient morbidity and mortality,\textsuperscript{52} as I describe in Chapter Two, Canadian provincial ministries of health are increasingly delving into the management of health service delivery and clinical decision-making. In other words, governments increasingly exert control over matters that previously fell within the purview of hospital boards, including matters of hospital governance that have been empirically linked to patient outcomes.

To focus solely on the role of individual health professionals in adverse events leaves dangerous conditions in place that may lead others to make similar errors in the future.\textsuperscript{53} In this

\textsuperscript{50} For example Jha and Epstein classified hospitals as either high-performing or low-performing (based on the hospitals falling in either the top or the bottom ten percent on quality indicators reported to the Hospital Quality Alliance). The results indicated that 49 percent of high-performing hospitals had board training in quality, compared with 21 percent of low performing hospitals. Eighty percent of high-performing hospital chairpersons were familiar with quality indicators, compared with 64 percent of low-performing hospital chairpersons. Ninety-one percent of high performing hospitals regularly reviewed quality indicators, compared with 62 percent of low-performing hospitals. Ashish Jha & Arnold Epstein, “Hospital Governance and Quality of Care” (2010) 29:1 Health Aff 182. For similar results see Joanna Jiang et al, “Board Engagement in Quality: Findings of a Survey of Hospital and System Leaders” (2008) 35:2 J Healthc Manag 121 and Joanna Jiang et al, “Board Oversight of Quality: Any Differences in Process of Care and Mortality?” (2009) 54:1 J Healthc Manag 15.

\textsuperscript{51} Wachter & Shojania, \textit{supra} note 16 at 143.

\textsuperscript{52} This would be difficult to measure, as there is significant variation in the government’s involvement in patient safety efforts between provinces and across programs, making it difficult to find a control group against which to measure increased efforts to improve safety. In addition, improvements in patient safety are linked to a host of factors and it would be difficult to isolate the portion of that improvement that is attributable to governmental efforts. At best, one might muster weak evidence of a correlation (rather than a causal relationship) between governmental patient safety efforts and improved patient outcomes.

\textsuperscript{53} Although there is certainly still a role for individual provider liability, there are systemic contributors to injuries that one could easily dismiss as the result of egregious or intentional deviations by individual health professionals. In other words, part of the role of actors at the health system level may be to detect and prevent the negligent, or even intentional, conduct of health providers that leads to patient injuries. Despite the clear criminal conduct of
regard, Byers and White argue that “[i]t is important to recognize that there are many unseen or invisible systems and processes that contribute to an error, and blaming a person does little to resolve the latent errors, which will persist until the next person makes the same error.”

Adverse events are not merely the mistake of a single health professional, but rather the product of a complex and multi-factorial series of circumstances. They occur when mistakes by practitioners align with systemic conditions that are conducive to the commission of errors. Reason’s widely-cited Swiss Cheese Model illustrates this phenomenon (Figure 1). The holes in his model represent active failures (the errors of health professionals) and latent failures (weaknesses in systems that are conducive to errors). The alignment of these active and latent failures creates “a trajectory of accident opportunity.”

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54 Supra note 44 at 30. Rosenthal & Sutcliffe argue that it is more serious to leave these systemic flaws in place because “higher-level errors are more likely to pick up and combine with smaller, lower-level errors that, by themselves, would not have produced anything untoward.” Supra note 49 at 185.


56 Ibid.
Several authors employ typologies to classify the various systemic contributors to patient injuries. At the broadest level, one can categorize these factors as organizational and institutional.\textsuperscript{57} There are six major categories of organizational error contributors:

1. Team factors,\textsuperscript{58} including communication barriers,\textsuperscript{59} the relationship between the various professionals involved in patient care, and unclear lines of authority.\textsuperscript{60}

2. Work environment and organizational design.\textsuperscript{61}


\textsuperscript{58} Rosenthal & Sutcliffe, \textit{supra} note 49 at 175.

\textsuperscript{59} This can be further broken down into inaccurate and incomplete information, questionable advice or interpretation, questionable consent process, questionable disclosure process, and questionable documentation. Andrew Chang et al, “The JCAHO Patient Safety Event Taxonomy: A Standardized Terminology and Classification Schema for Near Misses and Adverse Events” (2005) 17:2 Int J Qual Health Care 95 at 97.

\textsuperscript{60} Spath, \textit{supra} note 25 at xxii.

\textsuperscript{61} Rosenthal & Sutcliffe, \textit{supra} note 49 at 175. The evidence-based medicine movement has now led to discussions on evidence-based design (designing the hospital environment in a way that incorporates patient safety evidence and guards against adverse events). For example, certain construction materials improve acoustics (reducing health practitioner distraction), private patient rooms and the placement of sinks can improve hospital infection rates, improved ventilation systems can prevent hospital acquired infections, and an increased natural light can improve
3. Processes and practices, for example, patient management processes such as delegation, shift hand-off, tracking, follow-up, referral, or consultation.

4. Financial or other resource constraints, including policies, procedures, and decisions governing the allocation and management of resources, people, equipment, space, and time.

5. The support of organizational leadership and the organization’s culture with respect to patient safety.

6. Equipment and material design, malfunction, and availability.

Although institutional error contributors may seem far removed from an adverse event, the patient safety literature indicates that errors emanating from the top of an organization are the most serious. For example, according to Rosenthal and Sutcliffe, the higher in a hierarchy that an error occurs, “the more likely it is that the error will be magnified, the more likely it is that the error will be compounded with other errors, and the more likely it is that the error will be disastrous.” High-level errors are more far-reaching because they are “disseminated through the amplifying power of the organization.”

There are four major institutional contributors to adverse events:

1. The economic and regulatory context.

2. Societal and cultural factors.
3. National health standards.\textsuperscript{72}

4. The complexity of health care delivery, including the management of sophisticated technology and powerful drugs, the wide diversity of patients and their varying needs, and the simultaneous performance of multiple processes.\textsuperscript{73}

As I describe in detail in Chapter Two, over the past thirty years, Canadian provincial governments have increasingly blurred the traditional silos of health sector decision-making. With regard to the abovementioned categories, while the government historically acted at the institutional level of the health system, its growing involvement in health service delivery and patient care expanded state control over several of the organizational level factors that were formerly within the purview of hospitals and health professionals. In other words, while the government’s influence over patient outcomes has expanded over the past thirty years, the influence of other health system actors, such as health professionals and hospitals, has contracted. The law has failed to keep pace with these changes, as health professionals (and to a lesser extent hospitals) continue to bear legal responsibility for patient injuries, while the courts are reluctant to scrutinize governmental decision-making.

\textbf{Part Three: Preventing Patient Injuries}

Until relatively recently, the primary means of injury-prevention were to improve the clinical skills or change the behavior of health practitioners, and thus patient safety fell within the exclusive domain of self-regulated professionals. For example, physician regulatory bodies control quality through determining entry requirements to the profession, issuing licenses,\textsuperscript{71}

\textsuperscript{71} Vincent, \textit{supra} note 22 at 325.

\textsuperscript{72} Rosenthal \& Sutcliffe, \textit{supra} note 49 at 175.

\textsuperscript{73} Spath, \textit{supra} note 25 at xxii. Rosenthal \& Sutcliffe, \textit{supra} note 49 at 49-50 argue that “[i]t might seem that having more and better information would enhance the physician’s ability to make an informed decision about the best care for a patient. Indeed that is often the case. Just as often, however, too much information, especially complex information, produces mental overload and creates stresses on the human capacity to process information effectively.”
collaborating with medical schools on curriculum development, disciplining physicians whose competence is in question, and governing continuing medical education requirements. Within hospitals, the Medical Advisory Committee, department chiefs and the Chief of the Medical Staff exercise quality oversight through credentialing applicants to the medical staff and recommending privilege grants or revocations to the hospital board.\textsuperscript{74} Physicians on the medical staff also conduct morbidity and mortality rounds, which are retrospective reviews of adverse events.

There are significant limitations on the efficacy of these practitioner-focused methods of error prevention. Professional regulatory bodies and hospital medical staff structures have a conflict between their obligation to ensure patient safety on the one hand, and their loyalty to their peers and a desire to preserve physician autonomy on the other. Indeed, health professionals have received criticism for their lax approach to disciplining other providers.\textsuperscript{75} In addition, peer review fails to consider human factors and systems, narrowly focuses on individual performance (thereby excluding team and social issues), suffers from hindsight bias, tends to look for errors instead of the underlying causes, and lacks multidisciplinary integration.\textsuperscript{76}

\textsuperscript{74} Hospital boards are often criticized for merely rubber stamping these recommendations. See e.g. Jan Greene, “It’s a Privilege: The Board’s Role in Physician Credentialing and Privileging” (2008) 61:3 Trustee 8. However, there is some movement towards greater board oversight of privileging decisions (see e.g. Lauren Vogel, “Ontario Hospital Association Proposes to Scuttle Privileges Model for Doctors” (2010) 182:10 CMAJ 441) and of physicians more generally (see e.g. John P Marren, G Landon Feazell & Michael W Paddock, “The Hospital Board at Risk and the Need to Restructure the Relationship with the Medical Staff: Bylaws, Peer Review and Related Solutions” (2003) 12 Ann Health Law 179 and John D Blum, “Feng Shui and the Restructuring of the Hospital Corporation: A Call for Change in the Face of the Medical Error Epidemic” (2004) 14:3 Health Matrix 5).

\textsuperscript{75} A study of a nationwide American database that looked at a data collection period of eight years found significant rates of recidivism among doctors who had been the subject of disciplinary action. The authors argued that their results suggested a greater need for monitoring disciplined physicians or less reliance on rehabilitative sanctions. Darren Grant & Kelly C Alfred, “Sanctions and Recidivism: An Evaluation of Physician Discipline by State Medical Boards” (2007) 32:5 J Health Pol Pol’y Law 867.

With regard to morbidity and mortality rounds specifically, the American College of Physicians advocates that “routine case-by-case reviews be abandoned and replaced by profiling patterns of care,” in order to ascertain whether a physician committed an individual error, or whether isolated incidents are part of a broader pattern of potentially dangerous care. In addition, there are few mechanisms to integrate the information learned in morbidity and mortality reviews into institutional policies or to transfer this information to other practitioners or institutions (such as hospitals or medical schools). Comprehensive and systematic dissemination of this information would require coordination by actors such as regional health authorities, professional self-regulatory bodies or, for the most widespread dissemination of this information, the government.

The patient safety literature indicates that system level solutions are generally more effective at preventing errors than attempts to alter the clinical decisions of health professionals. Due to the difficulty inherent in modifying individual behavior and the inevitability of human fallibility, it is the contributor to an adverse event that is often least amenable to change. Well-known human weaknesses include difficulty attending to several tasks simultaneously, problems recalling detailed information expeditiously, and poor computational ability, all of which are necessary skills in the health care context. These human limitations are compounded by stress, sleep-deprivation, and conditions inherent in the work environment that are

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78 See e.g. Spath, *supra* note 25 at 7.
79 Spath, *supra* note 25 at 188.
80 Citing several studies relating to clinician performance, Dhillon concludes that, “stress beyond a moderate level will lead to deterioration in human performance.” *Supra* note 25 at 120. He argues that there are four types of stress: work-related stress (work overload or underload), occupational frustration stress (goals are inhibited by workplace conditions such as a lack of communication, ambiguity of one’s role, poor career development guidance, and bureaucratic difficulties), occupation change-related stress (forces that disrupt an individual’s behavioral, cognitive and psychological patterns of functioning, such as promotion, relocation, scientific development, and organizational restructuring) and miscellaneous stresses (such as too little or too much noise, inadequate lighting, or
detrimental to complex decision-making (for example, distracting noise or poor lighting). If errors are the product of a chain of causes, as Reason’ Swiss Cheese Model indicates, human factors such as temporary inattention, misjudgment, and forgetfulness are the final, and least manageable, links in the chain.\(^8\)

Instead of focusing on individual behavior, the patient safety literature indicates that the best strategy to avoid adverse events is to design systems that anticipate and guard against human errors.\(^8\) In this regard, Sutcliffe argues that “[g]iven an organization of fallible human beings, the issue is not why does an error occur, but rather, why wasn’t the error corrected.”\(^8\) Similarly, Nolan concludes that “although we cannot change the aspects of human cognition that cause us to err we can design systems that reduce error and make them safer for patients.”\(^8\)

Systems level safeguards not only make it difficult for individual health professionals to err, but can help to avoid numerous patient injuries by preventing multiple individuals from committing the same errors. Its logistical and financial capacity to make wide-ranging health system

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81 Wachter and Shojania cite evidence that “twenty-four hours of sustained wakefulness results in performance equivalent to a blood alcohol level of 0.1 percent—legally drunk in every state.” Supra note 16 at 198. The authors also note that most call schedules keep residents at the hospital every third or fourth night, resulting in an 80 to 100 hour work week (at 96). Similarly, Vincent, comments that “[s]leep loss is likely to contribute to, or combine with, on-shift work fatigue effects and decreases in alertness and performance capabilities at certain times of day to compromise take performance and safety.” Supra note 22 at 325. Unlike some U.S. states and the European Union, Canadian provincial governments do not regulate the work hours of medical practitioners, leaving these issues to self-governing bodies. For example, the New York State Department of Health Code, s 405 states that medical residents cannot work more than 80 hours per week. This law was passed after eighteen-year-old Libby Zion died after doctors ordered a drug that negatively interacted with the antidepressants and cocaine in her system. Zion received treatment from overworked residents and interns (who routinely worked 36 hour shifts and did not spend significant time evaluating the patient). For a comparative discussion of regulatory approaches to physician work hours see Fiona McDonald, “Working to Death: The Regulation of Working Hours in Health Care” (2008) 30:1 Law & Policy 108. In other sectors, such as transportation, Canadian governments limit the number of hours pilots and commercial drivers can work, Silos to Systems, supra note 24 at 17 and Jocelyn Downie et al, Patient Safety Laws: From Silos to Systems, Appendix 3: Sector Reports, Transportation (Halifax: Dalhousie University, 2006).

82 Spath, supra note 25 at 7.

83 Although it is arguable that there are practitioners who may be careless or who do not actively make an effort to prevent errors, this is likely not the case with the majority of those working in health care, and is thus not the focus of this section.

84 Rosenthal & Sutcliffe, supra note 49 at 188.

changes means that the government is well-suited to implement error prevention systems. Indeed, as I describe in the next part, numerous commissions of inquiry have linked failures in governmental health sector oversight to patient safety scandals.

**Part Four: Specific Cases of Patient Injuries**

In this part, I discuss several specific examples of patient injuries. Because Canadian courts have struck nearly all of the tort claims against governmental defendants, I use examples from commissions of inquiry. Although these inquiries revealed error contributors that were attributable to various actors in the health system—health professionals, self-regulatory organizations, hospitals, regional health authorities, and government—I focus on their criticisms of the government. The inquiries I discuss in this part arose in varied contexts: the individuals sustained different injuries and received various treatments from a spectrum of health professionals and the incidents occurred in different jurisdictions at various times during the past two decades. Despite these contextual differences, the inquiry reports identified similar contributors to patient injuries and made many of the same recommendations for reforms. These reports universally concluded that gaps in governmental health sector oversight contributed to a significant number of avoidable patient injuries.

The Manitoba Pediatric Cardiac Surgery Inquiry was an investigation into twelve pediatric deaths that occurred in 1994 at the Winnipeg Health Science Centre. The provincial government appointed the Associated Chief Justice of Manitoba, Murray Sinclair, to head the inquiry. Despite the fact that the same surgeon, Dr. Odim, performed all twelve surgeries, Justice Sinclair’s report concluded that the actions of the hospital and the government were

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The Bristol Royal Infirmary Inquiry similarly investigated the treatment of pediatric cardiac surgery patients. However, in this case, the Secretary of State for Health gave its chair, law professor Ian Kennedy, a broader mandate to examine the treatment received by hundreds of patients over an eleven-year period (1984-1995). Professor Kennedy’s report similarly focused on the role of systemic actors in the injuries, concluding that, “to a very great extent, the flaws and failures of Bristol were within the hospital, its organization and culture, and within the wider NHS as it was at the time.”

The majority of the patient safety literature focuses on the hospital context and the web of relationships between patients, health professionals, and hospitals. However, several of the health sector tort claims arose in the public health context, for example, claims relating to the government’s management of the SARS and West Nile Virus outbreaks and its regulation of chiropractic services. Therefore, I also discuss several inquiries into injuries arising outside of the hospital context. For example, in 1997, the federal Minister of Health appointed Justice Horace Krever of the Federal Court of Canada as the chair the Commission of Inquiry on the Blood System in Canada. Justice Krever’s task was to investigate the safety of the blood system after hundreds of recipients of tainted blood and blood products developed HIV/AIDS or hepatitis. In 2003, Justice Archie Campbell of the Ontario Superior Court of Justice explored the SARS outbreak in Toronto and the health system’s capacity to respond to public health emergencies more broadly. Justice Campbell adopted a systems approach to the injuries, rather than attributing blame to front-line health professionals or individual public health officials. He found that Ontario’s public health system was “unprepared, fragmented, poorly led, uncoordinated, and underfunded.”

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88 Ibid at 9.
uncoordinated, inadequately resourced, professionally impoverished, and generally incapable of discharging its mandate,"\(^{90}\) and concluded that “[t]he problems that arose during SARS were systemic problems, not people problems.”\(^{91}\)

Finally, I address the 2007 Commission of Inquiry on Hormone Receptor Testing, which the Newfoundland government tasked with investigating the provision of inaccurate hormone receptor test results to 383 women,\(^{92}\) thereby depriving these patients of potentially life-saving or life-prolonging treatment. The government appointed Justice Margaret Cameron of Newfoundland’s Court of Appeal to act as the commissioner. Instead of focusing on the skills of the pathologists tasked with reviewing these biological samples, Justice Cameron made numerous recommendations directed to the Department of Health and Community Services and the Eastern Regional Integrated Health Authority. Rather than cataloguing the hundreds of recommendations emerging from the abovementioned inquiry reports, in this this section, I highlight some of the contributions that governments made to patient injuries.

The commissioners of these inquiries criticized the inadequate training and recruitment of health professionals. The reports attributed this problem to decisions at the governmental level, the health region level and, in the pediatric cardiac inquests, the hospital level. For example, after concluding that staff recruitment difficulties threatened patient safety,\(^{93}\) Justice Cameron recommended that the Newfoundland Department of Health and Community Services develop a contingency plan for the provision of pathology services in the event that regional or hospital


\(^{91}\) *Ibid* at 60.

\(^{92}\) After a surgeon removes a tumor, a pathologist examines the specimen and gives her opinion on whether the tumor is a carcinoma, the type of cancer involved, and the estrogen receptor and progesterone receptor status of the cells. These hormone receptor results guide the treating physician in determining whether to provide anti-hormonal therapy. *Supra* note 20 at 15.

\(^{93}\) *Supra* note 20 at 156.
recruitment efforts failed to yield an adequate number of pathologists. She also concluded that the Department must address rural recruitment and retention by exploring alternative means of providing pathology services and assistance to rural pathologists (who often have no colleagues). Specifically, she recommended the provision of adequate resources for telemedicine technology to support rural health professionals. Similarly, Justice Campbell, chair of the inquiry into SARS, was concerned with staff recruitment: “Over the years, as many senior experienced professionals left the Ontario public health system, the government failed to recruit comparable replacements,” replacing them instead with “junior, inexperienced scientists.”

The report from the Manitoba Pediatric Cardiac Surgery Inquiry also criticized the government’s human resource decisions, which constrained the decisions available to hospitals, and contributed to dangerous conditions within the Winnipeg Health Sciences Center. Specifically, when the government and the provincial medical association negotiated the fee schedule for the provision of health services, pediatric cardiac surgery was a limited field and, as a result, fees paid to surgeons for pediatric procedures were lower than the fees paid for adult procedures. Furthermore, the number of pediatric cases was considerably lower than the number of cases that a surgeon operating on adults could perform, resulting in a much lower annual income for those treating children. Returning to the typology of adverse event causes set out in

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94 Supra note 20 at 467.
95 See also Krever Commission Report, supra note 89 at 989 and 1000: “If the bureau had been given adequate resources, it would have been able to carry out regular inspections of both the Red Cross’s plasmapheresis centres and the premises of the manufacturers of blood products…The operator of the blood supply system must be financially self-reliant. Subject to regulation, the operator of the blood supply system must be free to contract in a manner it believes will best serve the needs of the system.” This critique arose because the provincial ministers of health forced the Red Cross to cancel a fractionation contract it had made with a U.S. manufacturer and required it to allocate the future supply of domestic plasma among three Canadian manufacturers—only one of which was an active fractioner. Krever concluded that these decisions “were influenced more by provincial industrial policy than by the needs of the national blood supply system.” Similar criticisms arose in the context of the Ontario government’s response to SARS, with critics alleging that policy-makers were more concerned with maintaining economic stability by lifting the state of emergency than they were with protecting the health of the population or health care practitioners.
96 Supra note 89 at 96.
Section Two, Justice Sinclair found that institutional factors, such as the economic and regulatory environment, exacerbated concerns with practices and processes at the organizational level. Specifically, the low fees paid to pediatric cardiac surgeons caused difficulties with staff recruitment and retention, which led to safety concerns. He concluded that, “the loss of and failure to replace professional medical staff...represented a serious erosion in the ability of the Pediatric Cardiac Surgery Program to continue to provide the level of service that it had previously provided.”

Another criticism common to the inquiry reports was the institutional and governmental failure to adequately monitor and oversee the quality of health services. For example, the report of the Commission of Inquiry on Hormone Receptor Testing recommended enhanced governmental monitoring through laboratory licensing and mandatory participation in a recognized accreditation program. The report was critical of the fact that “there was sufficient information provided by Eastern Health to the Department of Health and Community Services that, had due diligence been exercised, [Department of Health] officials would have realized that

97 Supra note 86 at 111. Low remuneration was one of the reasons given for the departure of the predecessor of Dr. Odim, who operated on the twelve injured children.
98 Supra note 86 at 467. Specific deficiencies within the hospital that exacerbated the failures at the governmental level included the fact that those responsible for staff replacements were slow to begin recruitment, took too long to find replacements, relied on inadequate staff recruitment processes, and failed to take appropriate steps to address issues such as caseload when positions were vacant for long periods of time. The report was also critical of post-recruitment staffing issues, as there was only one pediatric cardiologist, the director of the program was a junior cardiologist who held the position in an acting capacity, the surgeon was at the start of his career and was new to the hospital, and there were no other pediatric cardiac surgeons to mentor or monitor the new doctor (at 128). Justice Sinclair recommended that an experienced physician should have been present to provide guidance and to monitor the new surgeon through his first year. Furthermore, he found that patient selection ought to have been restricted to the more simple cases, commensurate with Dr. Odim’s skill and experience (at 473).
99 The report clearly stated that the Minister “had an obligation to act in an oversight role” (supra note 20 at 457). The Winnipeg Inquiry identified oversight lapses at all levels of the health care system. Dr. Odim, the doctor who performed the surgeries on the infants who died, had the responsibility to ensure he did not undertake procedures beyond the scope of his ability and to monitor his surgical results (supra note 85 at 472). The referring cardiologist had a responsibility to monitor the surgical outcomes of the cases he referred to Dr. Odim (at 472). At the hospital level, “[t]he heads of the Department of Surgery and the Department of Pediatrics had overall responsibility for ensuring that the program was providing an appropriate level of service” (at 471). There was confusion over who had responsibility over the program, as it was multidisciplinary (run by cardiology and pediatrics). Finally, the report found that the government had a role in encouraging monitoring and reporting, for example, by passing legislation to protect whistleblowers and to address critical incident reporting.
there was a difference in their understanding of what was to be publicly communicated and what was in fact communicated.”

The Krever Commission similarly identified failures in oversight by both the Red Cross and the Bureau of Biologics, part of the Health Protection Branch of the Department of Health and Welfare. In January 1985, Connaught Laboratories identified batches of blood that contained plasma from persons who had developed AIDS and notified both the Red Cross and the Bureau, but neither took steps to withdraw or recall the contaminated products. Justice Krever also criticized the failure of the Bureau to use its regulatory authority to require the Red Cross to introduce measures to reduce the risk of disease, and its failure to compel manufacturers to restrict the plasma supply to plasma and blood centers employing disease-prevention measures. The Commission concluded that the Health Protection Branch must set standards for the blood supply.

The SARS Commission similarly identified governmental monitoring and oversight issues. Specifically, the report criticized the failure of the Public Health Branch to monitor local compliance, adopting the comments of the Provincial Auditor following the Walkerton Inquiry: “The Ministry had conducted virtually no regular assessments of local health units in the last five years to determine whether the health units were complying with the guidelines for

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100 Justice Cameron went on to link these failures to accountability: “The whole of the health system, to varying degrees can be said to have failed…patients. There was a failure of both accountability and oversight at all levels.” Supra note 20 at 438.
101 Supra note 89 at 995.
102 Supra note 89 at 999.
103 Supra note 89 at 996.
104 This 2000 Inquiry occurred after the water supply in Walkerton, Ontario was contaminated with *E. coli* bacteria. The source of contamination was farm runoff into a well that officials knew was vulnerable to contamination. The Walkerton Public Utilities Commission insisted that the water supply was safe, even after many residents showed symptoms and despite laboratory test results showing evidence of contamination. At least seven individuals died, and 2,500 fell ill. Walkerton Commission of Inquiry, *Part One: The Events of May 2000 and Related Issues* (Toronto: Ministry of the Attorney General, 2002).
mandatory programs and services.” As I discuss in Chapter Three, despite the clear deficiencies in the province’s management of the SARS outbreak and, more broadly, its failure to maintain an adequate public health system, the Ontario Court of Appeal was not receptive to tort claims against the government by members of the public or health care workers who contracted SARS. Instead, they summarily dismissed these claims on a pre-trial motion, with little discussion of the parties’ relationship or the government’s role in the management or delivery of public health services.

The Bristol Inquiry report also cited a lack of monitoring at both the governmental and the institutional levels as a contributor to patient injuries. At the institutional level, the Bristol Inquiry report referred to a comment of Dr. Roylance, Chief Executive of the Trust responsible for the Bristol Royal Infirmary, which was inconsistent with the systems approach to patient safety: “Only clinicians could identify defects in clinical performance, and management was merely to provide the facilities to allow the exercise of clinical freedom.” The Department of Health was criticized because “[i]t had not yet created systems to detect or act on problems of clinical care, other than by referring them back to the district or hospital concerned.” Finally, the report recommended that the government implement a system of validation and periodic reevaluation of trusts.

In sum, several commissions of inquiry into patient injuries have identified widespread, systemic deficiencies in the government’s regulation of patient safety. The reports concluded

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105 Ibid at 39. The SARS Commission report was also critical of the government’s failure to identify clusters of illness among hospital staff and to notify infection control officials at the affected hospital, leaving surveillance to individual institutions and front line practitioners.

106 Supra note 87 at 68. There was also a failure to monitor quality at the regional level. The report concluded that the District “sought to use the tool available to it, the service agreement, to get some grip on monitoring and security the quality of clinical care…the District’s efforts were frustrated” (at 191).

107 Supra note 87 at 187.

108 Validation was distinguished from licensure, as validation is an ongoing process, rather than a one off event. Supra note 87 at 453.
that federal and provincial governments were generally aware of these safety concerns (or ought to have been aware), yet they allowed dangerous conditions to persist. As I discuss in Chapter Three, several health sector tort claims alleged that the government failed to exercise adequate oversight of the health sector, for example, by failing to address repeated complaints respecting the safety of cervical spine adjustments by chiropractors\(^\text{109}\) or failing to provide adequate safety protections and directives to nurses treating patients infected with SARS.\(^\text{110}\) To date, Canadian courts have not been willing to scrutinize the reasonableness of the government’s oversight of the health sector or the potential for tort liability to incentivize safety improvements. Instead, judges have struck all but one of the tort claims against provincial governments.

**Conclusion**

Patient safety traditionally fell within the exclusive domain of self-regulated health professionals, while the government and hospitals concerned themselves with financing and the organization of health care delivery. However, beginning with a 1999 U.S. Institute of Medicine report, countless studies called into question the traditional practitioner-centric view of patient safety. This literature indicates that injuries are frequently caused or contributed to by the environment within which health professionals work—an environment that is designed, managed, coordinated, and controlled by a complex mix of provider self-regulation, governmental policies and regulations, and institutional policies. Several recent commissions of inquiry tasked with exploring patient injuries confirmed that flawed systems and processes, such as gaps in governmental oversight, are significant contributors to adverse events. Furthermore, because human behavior is difficult to modify, empirical evidence also suggests that the most

\(^{109}\) *Nette v Stiles*, 2009 ABQB 422.

\(^{110}\) *Abarquez v Ontario*, 2009 ONCA 374.
Effective error prevention strategies are generally those that target the systemic causes of injuries and make it difficult for health professionals to err.

In response to the changing perception of the causes of medical errors, Canadian courts expanded the narrow legal duties historically owed by hospitals. For example, in a handful of cases, judges imposed liability against hospital defendants for failing to implement patient safety systems, such as those tracking lab test results. Many legal scholars have invoked the patient safety literature in support of expanded hospital liability, on the basis that this approach better aligns legal responsibility with the ability to prevent injuries. Similar arguments apply in the context of governmental defendants.

As I discuss in detail in Chapter Four, despite the changing perception of the causes of patient injuries, Canadian courts are reluctant to consider liability against the government, despite the state’s dramatically expanded health sector role and its resulting increased ability to affect the care received by patients. In the health sector tort claims, Canadian courts have taken a narrow view of injury causation, frequently invoking the fact that other actors were more

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111 Another factor that likely contributed to shifting hospital legal duties was the growing complexity and sub-specialization of medicine, which necessitated greater coordination and management by hospital administration. The modern hospital was largely born out of the need for a structure to organize specialized professionals and its ability to raise the funds necessary for acquiring increasingly expensive medical technology. Supra note 10.

112 Early direct hospital duties were limited to the maintenance of equipment and supervision of staff, the latter of which did not include physicians. These legal duties were subsequently expanded to include a duty to establish safe systems, although Canadian courts have only imposed this duty in a handful of cases. See e.g. Braun v Vaughan, supra note 12. In that case, the Court stated that the hospital had an obligation “to provide a reasonable and practical ‘safe system’ including the coordination of services between physician, patient and the institution” (at para 49). Similarly, while physicians were once vicariously liable for nurses and medical residents under their direct supervision (under the “captain of the ship” or “borrowed servant” doctrines), courts subsequently shifted this vicarious liability to hospitals. However, hospitals are still not generally vicariously liable for the negligence of physicians. Picard & Robertson, supra note 4.

113 See e.g. Chapman, supra note 13 and Pierce, supra note 13. The latter author argues that forcing those with more control over accidents to absorb their cost “provides an incentive to reduce the accident rate, the consequences of accidents, or both” (at 1289). The argument that hospitals are in a better logistical and financial position than individual providers to implement systems and procedures designed to improve patient safety can be extended to governmental defendants, particularly as they expand their control over hospitals and health providers. The errors of health professionals are difficult to deter, particularly when they are the product of snap decisions made in response to an emergency situation. In contrast, as I discuss in Chapter Five, the government may be more amenable to deterrence through tort liability, as it generally has the opportunity to carefully weigh the various policy alternatives in making its decisions.
directly involved in providing treatment to the injured plaintiff as a reason to strike the claim. This view is difficult to reconcile with the past decade of patient safety literature, which generally employs a systems-centric view of patient injuries that emphasizes the difficulty inherent in modifying the behavior of health providers and the problems associated with blaming individuals. As I discuss in Chapter Four, the courts also use the existence of alternative remedies—claims plaintiffs could make against other defendants that were more directly involved in providing the impugned health services—as a policy reason to strike health sector tort claims, regardless of which actor is the most blameworthy, responds most effectively to deterrence through tort liability, or has the best capacity to prevent future injuries.
CHAPTER TWO
THE ROLE OF PROVINCIAL GOVERNMENTS IN THE HEALTH SECTOR

Introduction

Prior to the implementation of universal insurance for physician and hospital services, physicians dominated health care decision-making and there was no effort by other actors to regulate the quality or the cost of these services. Hospitals acted merely as “doctors’ workshops”\(^1\) by providing equipment and personnel to assist in the practice of medicine. Their boards were largely concerned with raising sufficient capital to build and maintain hospital facilities. Provincial governments also played a relatively minor role in the health sector, delivering limited public health and mental health programs, funding some care for the destitute, and providing some subsidies for the purchase of private insurance by low-income individuals.

Medicare was born out of an accommodation of professional interests, with the state making significant concessions to preserve physician autonomy in exchange for doctors’ participation in the public health insurance plan.\(^2\) In this Chapter, I argue that since the implementation of Medicare during the 1950s and 1960s, the responsibilities of Canadian provincial governments have significantly expanded, culminating in three major roles in the health sector—insurer, policy-maker, and manager.\(^3\) Although self-regulated professionals still


\(^2\) For a discussion of this accommodation of professional interests, see e.g. Carolyn Hughes Tuohy, *Accidental Logics: The Dynamics of Change in the Health Care Arena in the United States, Britain, and Canada* (New York: Oxford University Press, 1999) at 258.

\(^3\) I define these terms in Part Two, below.
have considerable autonomy in treating patients, their decisions are increasingly constrained by
the government, through its power over resource allocation and the basket of publicly insured
services, and its increasing regulation of the quality of medical care and clinical decision-
making.

I explore the evolving responsibilities of provincial ministries of health with a view to
facilitating my discussion of the legal implications of these changes in the following two
chapters. Under Canadian negligence law, whether one party owes another a legal duty of care is
dependent upon the closeness and directness (or proximity) of their relationship and the policy
implications associated with the imposition of a legal duty. The government’s expanding role in
the health sector is relevant to both stages of the test for establishing a duty of care. Its early role
as the insurer of health care services was remote and disconnected from patient injuries,
particularly given the intervening actions of actors such as hospitals and physicians and the
autonomy of those actors from the government. However, the state’s growing control over
physicians, hospitals, and newly-created regional entities, its management of health service
delivery and, at times, its interference with clinical decision-making, result in an increasingly
close nexus between patient injuries and government decisions.

Even if one accepts the opposite view—that autonomous health providers are most
responsible for the quality of care received by patients, or that provincial governments have
devolved their responsibilities to regional entities and thus have little impact on patient
outcomes—I argue that the courts must still carefully consider the nature of the government’s
role in the health sector in assessing whether it has a proximate relationship with claimants. In
addition, in other areas of the health sector, such as public health, the government’s relationship
with or control over other health system actors is much less relevant, as it is actually responsible for organizing and delivering many public health programs.

The government’s expanding health sector responsibilities are also relevant to the second stage of the duty analysis—policy considerations that limit or negate a *prima facie* duty of care. This analysis requires a categorization of the impugned governmental decision as either a policy or an operational decision, with the courts refusing to impose liability for the former. I argue that the state’s changing health sector responsibilities and its blurring of the traditional silos of health sector decision-making make this categorizations increasingly difficult. For example, when a patient fails to receive timely care in an emergency room, it is difficult to separate which decisions leading to that delay were attributable government, which were those of the hospital or regional entity, and which were caused by treating health professionals, particularly given the government’s growing control over these other actors. The difficulty inherent in categorizing government decisions is especially acute in the context of pre-trial motions (the stage at which all of the health sector tort claims to date have been resolved), when courts have limited evidence relating to the complex mix of factors that contributed to a patient’s injury.

With respect to the analysis of broader policy concerns that impact a court’s decision of whether to impose a duty of care, I argue that the government’s increasing health sector responsibilities and the resulting need for improved accountability present a compelling policy argument against negating a duty of care, even if there may be good policy reasons to ultimately defer to the government’s policy choices in setting the standard of care.

In the first part of this chapter, I contrast the government’s historic role in the health system with its modern tripartite role. I also discuss the motivating forces leading to these changes, namely, rapidly increasing health care costs (and resulting concerns with the
sustainability of the health system) and, as I described in the previous chapter, a growing body of evidence calling into question the safety and quality of health services. In addition to my discussion of the government’s expanding involvement in the management and delivery of health care services, I also discuss its direct responsibility for delivering other services, such as public health and mental health programs. In particular, I focus the state’s role in the provision of public health services, which is particularly important to my later discussion of tort liability, as numerous plaintiffs filed tort claims alleging that the Ontario government was negligent in managing the SARS and West Nile Virus outbreaks.

In Part Two of this chapter, I explore the effect of regionalization on the state’s expanding role in the health sector and the implications of this reform for the government’s legal duties. Beginning in the mid-1990s, Canadian provincial governments devolved some of their health sector functions to regional health authorities (RHAs) in most provinces, or Local Health Integration Networks (LHINs) in Ontario. Collectively, I refer to these bodies as regional entities. As I describe below, outside of Ontario, regionalization also generally entailed replacing hospital boards—private companies that had governed hospitals for many decades—with government-appointed RHAs.

If regionalization resulted in a significant transfer of power from the government to regional entities, then it would undermine my argument respecting the link between tort liability and growing state control in the health sector. However, in Part Two, I argue that despite the rhetoric of power transfer that accompanied regionalization, a health system reorganization of this magnitude also represented an assertion of state authority. Furthermore, provincial governments retained important health sector responsibilities post-regionalization, such as fee schedule negotiations with physicians and decisions respecting the contents of provincial
formularies, which list the pharmaceuticals available in programs for publicly funded drugs. Governments also exert a significant level of control over regional entities through funding arrangements, reporting obligations, approval processes, and governance requirements. Most intrusively, provincial ministries of health have the authority to directly manage the delivery of health care services, for example, by appointing a supervisor to assume control of a hospital, ordering the amendment of hospital bylaws, or issuing mandatory directions to regional health authorities. I argue that the government’s expanding health sector role, and these managerial responsibilities in particular, demand careful consideration by the courts in assessing the government’s legal responsibilities.

In the third part of this chapter, I turn from a discussion of the state’s control over hospitals and regional entities to explore the ways in which the government regulates the treatment decisions of health professionals. Although providers are the actors that are most closely involved in providing patient care, the government increasingly constrains their treatment choices, incentivizes particular types of treatment and, in some circumstances, directly manages clinical decision-making. By exerting control over these decisions, the government has increased its influence over patient outcomes, which should be relevant to the judiciary’s assessment of whether the parties have a close and direct relationship in a tort claim. In the fourth part of this chapter, I employ two specific examples (one relating to health care services and the other to public health) to illustrate my discussion of the relationship between health system changes and tort liability and the types of governmental decisions that may ground a legal duty of care.

In the final part of this chapter, I explore the relationship between the government’s changing responsibilities in the health sector and accountability. Citing several reports on the
Canadian health care system and health policy literature more generally, Fooks and Maslove conclude that “[a]long with the system reviews, researchers, service providers and managers all agree that accountability in the health care system needs improvement...”⁴ I argue that governmental accountability is not commensurate with the state’s modern role in the health system. Although political accountability, or elections, may be an adequate mechanism to hold the government responsible for its budgetary decisions, such as broad funding allocations between policy portfolios and competing programs within the health sector, they are ill-suited to address the managerial decisions that characterize the government’s modern health sector responsibilities.

Although I broadly explore the government’s health sector responsibilities in this chapter, I do not argue that all of the state’s decisions ought to give rise to legal duties. For reasons that I discuss in further detail in Chapter Four, certain types of governmental decisions will fail to ground legal duties or, at the very least, will receive considerable deference from judges when they are assessing whether the government met the requisite standard of care. It is necessary to provide a more detailed description of the government’s health sector responsibilities, rather than merely focusing on decisions that are most vulnerable to tort liability, to provide the context for several of my later arguments. For example, in Chapter Three, one of my major criticisms of the judiciary’s willingness to strike claims in the evidentiary vacuum of a pre-trial motion is the complexity of the health sector, which I illustrate in this chapter through a discussion of the government’s widely varied health sector responsibilities.

A broad discussion of the government’s health sector responsibilities is also relevant to my discussion of the policy/operational dichotomy, under which the courts will not review the government’s policy decisions, while they will impose negligence for their operationalization. In Chapter Four, I argue for the abolition of this dichotomy on the basis that few government decisions clearly satisfy one category or the other, but rather most fall into a grey area in the middle, having both policy and operational characteristics. My discussion in this chapter illustrates the broad range of governmental health sector decisions. While the courts tend to focus on the state’s policy-making responsibilities in health sector tort claims, particularly its budgetary decisions, the examples in this chapter demonstrate that the government’s modern health sector responsibilities extend far beyond financing.

A broad discussion of the state’s health sector responsibilities is also necessary because plaintiffs’ legal claims do not typically focus on a single governmental decision, but rather require the courts to comprehensively explore the state’s responsibilities in a particular area of the health sector. Furthermore, many of the health sector tort claims are not framed in misfeasance (governmental negligence in carrying out its responsibilities) but rather relate to nonfeasance (a failure to act to protect the plaintiff from a health risk). In the latter type of case, there may be no specific managerial decisions for a claimant to point to, but rather the plaintiff may invoke the government’s extensive involvement in a particular area of the health sector in support of her claim that the government ought to have assumed managerial responsibilities in order to assure that the public was protected from a particular health risk.

Throughout this chapter, I focus primarily on the health systems of Ontario and Alberta, also drawing examples from other provinces where relevant. I selected these provinces because they approached devolution in significantly different manners. Alberta created regional health
authorities (RHAs) whereas Ontario implemented Local Health Integration Networks (LHINs).

Alberta’s initial experience with regionalization was more representative of the Canadian norm, with the government implementing RHAs in the 1990s. As was the case with other provinces, regionalization involved both decentralization of authority from Alberta Health and Wellness to RHAs and centralization of authority from hospital boards to RHAs. In contrast, Ontario implemented regionalization in 2004 and left individual hospital boards in place. Although provincial governments have experimented with the size and responsibilities of regional entities, Alberta is the only province that subsequently collapsed all of its regional health authorities into a single health authority. As I discuss below, regardless of the particular way in which a province configured regionalization, the reform involved a blurring of traditional health sector responsibilities and an assertion of governmental control, which has implications for the government’s legal duties.

Part One: The Government’s Evolving Role in the Health Sector

Charles and Demaio distinguish between three domains of health care decision-making—treatment, service delivery, and systems.5 Physicians were historically responsible for treatment decisions, which the authors define as decisions relating to treatments or services provided to individual patients. Doctors used the specialized nature of medical knowledge and the unique characteristics of the doctor-patient relationship to give legitimacy to their exclusive jurisdiction over treatment decisions.6 Physicians regulated the quality of health care services through

6 In his seminal work on the sociology of professions, Freidson discusses the special character of knowledge that distinguishes professions from other occupations. Eliot Freidson, Professionalism Reborn: Theory, Prophecy, and Policy (Chicago: University of Chicago Press, 1994).
licensure and hospital credentialing and privileging regimes. Conversely, other actors, such as the government and hospitals, exercised little oversight over clinical decision-making or the quality of the treatments that patients received. Similarly, prior to Medicare, there was no regulation of the cost of medical services, but rather medical professionals determined their own fees and patients paid for care out-of-pocket or through insurance plans, which were generally administered by physicians.

Hospitals and physician organizations (including medical associations and self-regulatory bodies) were traditionally responsible for service delivery decisions, which include what health services are available, how and where services are delivered, and by whom they are delivered. Physician self-regulation and oversight over medical education enabled the profession to exert control over the types of services that were available to patients and how they were delivered. For example, doctors determined what services had to be provided by specialists rather than general practitioners and what procedures had to be performed in hospitals rather than doctor’s offices. They also taught particular approaches to patient care and surgical techniques in medical schools and during post-graduate training. Physicians used their power as an interest group to

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7 Self-regulatory bodies control entry to the profession though licensure requirements and the medical advisory committees of hospitals control entry to their medical staffs through credentialing and privileging. The former involves reviewing the qualifications of and checking the references of prospective applicants to the medical staff. Privileging involves determining what authority doctors will have within the hospital (for example, to admit or discharge patients or do order treatment). These bodies also regulate quality through discipline—revocation of licenses by self-regulatory bodies or recommendations to hospital boards for the revocation of hospital privileges by medical advisory committees. Finally, the medical staff structure within hospitals improves quality through morbidity and mortality reviews of patient injuries (retrospective reviews of health professional treatment decisions that are designed to prevent similar adverse events in future cases).

8 Ken MacTaggart, “The First Decade: The story of the birth of Canadian Medicare in Saskatchewan and its Development During the Following Ten Years” (1972) 106:11 CMAJ 1234. Particularly during the Great Depression, many doctors provided pro bono medical services, provided medical services in exchange for goods or services, and many patients went without medical care.

9 Medical associations are advocacy bodies that are primarily concerned with protecting the political and economic interests of physicians, for example, by negotiating physician fees with provincial governments. In contrast, self-regulatory bodies, or colleges of physicians and surgeons, have a public interest component, as they are tasked with responding to complaints about practitioners and rendering disciplinary sanctions. They also have some responsibility for the education of practitioners and professional competence, for example, by disseminating clinical practice guidelines, running continuing legal education programs, and licensing physicians.
assert jurisdiction over services formerly provided by other health professionals, such as childbirth (which was formerly the domain of midwives), thereby medicalizing these services and bringing them out of the home and into the hospital.¹⁰ Hospital decisions respecting the acquisition of equipment and their control over allied health professionals (such as nurses or hospital-based physiotherapists or pharmacists) enabled them to influence what health services were available and how they were delivered.

Until the late 1980s, provincial governments were only responsible for system-level decisions, which Charles and DeMaio define as public policy, the allocation of resources between health and other sectors of government activity, and the allocation of resources between programs within the health sector. However, as I explore in the remainder of this part, provincial governments are increasingly blurring these traditional silos of health sector decision-making and expanding their involvement in areas that were previously within the jurisdiction of hospitals and physicians.

In this chapter, I use the labels insurer, policy-maker, and manager to describe the primary roles of Canadian provincial governments in the health sector. The purpose of this part is to define these three terms and to briefly sketch out the historical evolution of the government’s tripartite role in the health sector, before moving on to a more detailed discussion of the state’s control over hospitals and regional entities and its management of clinical decision-

¹⁰ The rising prominence of science, the biomedical model as the basis of health practice and health policy, the development of technology exclusive to physicians (such as forceps), and the lack of professional organization of non-physician providers allowed doctors to garner government support for the marginalization of midwives. According to Plummer, it was nearly impossible to practice midwifery until 1991, when Ontario included midwifery as a regulated health profession and integrated midwifery services into the schedule of insured services. Kate Plummer, “From nursing outposts to contemporary midwifery in 20th century Canada” (2000) 45:2 J Midwifery & Womens Health 169. See also Rachael McKendry & Tom Langford, “Legalized, regulated, but unfunded: midwifery’s laborious professionalization in Alberta, Canada, 1975-99” (2001) 53 Soc Sci Med 531. For a discussion of the similar path taken by chiropractors, see David Coburn & C Lesley Biggs, “Limits to medical dominance: the case of chiropractic” (1986) 22:10 Soc Sci Med 1035. Provincial governments have been slow to evolve the legal structure that perpetuates physician dominance, by protecting their scope of practice.
making (in Parts Three and Four, respectively). Despite the government’s blurring of traditional silos of health sector decision-making, as I discuss in detail in Chapter Four, Canadian judges generally continue to focus on the state’s budgetary role in defining its legal duties. In other words, the judiciary’s approach to health sector tort claims fails to reflect the government’s modern role in the health sector.

A. The Government’s Insurer Role

As I mentioned above, prior to the implementation of universal insurance for physician and hospital services, the government’s involvement in the health sector was restricted to funding some health services for the poor, subsidizing the purchase of private health insurance by some low-income individuals, and providing limited public health and mental health programs. Beginning in Saskatchewan in the late 1940s, several factors created a window of opportunity for Canadian provincial governments to assume the role of health system insurer: the increased efficacy of and resulting demand for medical services, post-World War II prosperity and the expansion of the welfare state, and the example of Saskatchewan, a province that had

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11 Recognizing the importance of access to health services, a number of provincial governments had already started to subsidize the purchase of private insurance prior to the implementation of Medicare. Medical practitioners, who feared that government insurance would impede their autonomy, supported these state subsidies. For a comprehensive discussion of the events leading up to the implementation of Medicare in Saskatchewan, with a focus on the dynamic between physicians and the government, see the seven-volume series of articles in the Canadian Medical Association Journal by Ken MacTaggert, “The First Decade: The Story of the Birth of Canadian Medicare in Saskatchewan and its Development During the Following Ten Years” (1972) 106:11 CMAJ 1234, (1972) 107:1 CMAJ 64, (1972) 102:2 CMAJ 159, (1972) 107:3 CMAJ 236, (1972) 107:4 CMAJ 337, (1972) 107:5 CMAJ 444 and (1972) 107:6 CMAJ 564.

12 The rise of the welfare state in Canada and abroad also lent legitimacy to the creation of this type of program. For example, in the late 1940s Britain passed its National Insurance Act (1946), Ministry of National Insurance Act (1945), Disabled Persons Act (1945), Family Allowances Act (1945) and National Health Service Act (1946), WA Robson, “The National Insurance Act, 1946” (1947) 10:2 Modern Law Review 171 at 171. In the United States, Congress passed the Hill-Burton Act in 1946, which allocated significant federal funding to the expansion of hospitals (J Mantone, “The Big Bang: The Hill-Burton Act Put Hospitals in Thousands of Communities and Launched Today’s Continuing Healthcare Building Boom” (2005) 35:33 Mod Healthc 6). During this period, the Canadian federal government also implemented public housing, federal assistance programs for blind and disabled persons, old-age pensions, means-tested social security, and a permanent social assistance program, John Ralston Saul, A Fair Country: Telling Truths About Canada (Toronto: Viking Canada, 2008).
successfully surmounted physician opposition to implement universal health insurance for hospital services. Motivated by the federal government’s offer to share costs with participating provinces, every Canadian provincial government implemented insurance for hospital services beginning in the 1950s. Universal insurance for physician services followed a similar path in the 1960s. The goal of this policy was primarily redistributive, with the underlying premise of Medicare being the allocation of health services on the basis of an individual’s need rather than their ability to pay. Prior to universal health insurance, many patients either went without health care services or relied upon the charity of physicians.

Although the government’s role as insurer required a significant financial commitment, the state remained a passive payer, merely reimbursing the cost of services organized and delivered by hospitals and physicians. Physician autonomy, the doctor-patient relationship, self-regulation of quality of care, and the hospital organizational structure remained largely unchanged by the initial implementation of Medicare. Tuohy refers to the relationship of

13 Saskatchewan had a premier, Tommy Douglas, who was deeply committed to public insurance. He would have lost his leg due to a childhood affliction of osteomyelitis, as his parents could not pay for surgery. However, a doctor provided the care for free as he believed that Douglas was a good teaching case for his medical students. Furthermore, Douglas’s political party, the Co-operative Commonwealth Federation (predecessor to the New Democratic Party), had an overwhelming number of seats in the legislature. There was also high public support for the government’s involvement in health care, as the province had been particularly impoverished during the Great Depression. However, Saskatchewan did endure a physician’s strike and resulting public opposition after the introduction of universal hospital insurance. Walter Stewart, Tommy Douglas (Toronto: McArthur & Company, 2004). For an extensive discussion of the historical events leading to medical insurance in Saskatchewan, see MacTaggart, supra note 11.

14 Hospital Insurance and Diagnostic Services Act, SC 1957, c 28.
15 Medical Care Act, 1966, SC 1966-67, c 64. These two statutes were later subsumed into the Canada Health Act, SC 1984, c C-6. This federal-provincial cost-sharing arrangement led to federalism debates, as the federal government’s financial contribution decreased over time, leaving the provinces with an extremely expensive program that was politically infeasible to abandon. For a discussion of federalism issues in Canadian health care see e.g. Steven Lewis, “The Bog, the Fog and the Future: Five Strategies for Renewing Federalism in Health Care” (2002) 166:11 CMAJ 1421 and Carolyn Hughes Tuohy, “The Costs of Constraint and Prospects for Health Care Reform in Canada” (2002) 21:3 Health Aff 32. The Canada Health Act sets out five main conditions that the provinces must meet in order to qualify for federal funding, including portability, universality, comprehensiveness, public administration, and accessibility. In addition, the Act prohibits user fees and extra billing for medically necessary services. For a discussion of the federal government’s lax enforcement of these conditions see e.g. Sujit Choudhry, “Bill 11, the Canada Health Act and the Social Union: The Need for Institutions” (2000) 38 Osgoode Hall LJ 39.
16 MacTaggart, supra note 11.
accommodation between physicians and the government as the “fundamental bargain” upon which Medicare depended.\textsuperscript{17}

In their modern capacity as health system insurer, provincial governments are responsible for allocating funds between health and other policy portfolios and between programs or services within the health sector (for example, determining how much funding to devote to long term care services versus public health services or the relative budgets of different regional health authorities). I also include budgetary oversight in the state’s insurance responsibilities. Regional entities, hospitals, and other publicly-funded health organizations are subject to extensive financial reporting requirements. For instance, in Alberta, RHAs are required to submit a financial report, audited financial statements, financial performance information specified by the Minister, forecasted revenue and expenditures, and information regarding the remuneration and benefits of employees.\textsuperscript{18}

B. The Government’s Policy-Making Role

By the late 1980s, serious concerns had emerged over the sustainability of Medicare. Decades of expansion encouraged by federal cost-sharing resulted in excess hospital capacity,\textsuperscript{19} fee-for-service physician reimbursement caused supplier-induced demand for medical services,\textsuperscript{20} and costly advances in health technology led to rapidly escalating costs. Although I focus on the health sector responsibilities of provincial governments, as the terms of the federal/provincial cost-sharing arrangement gave the federal government no means of controlling its share of health

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\textsuperscript{17} Tuohy, \textit{supra} note 15. \\
\textsuperscript{18} \textit{Regional Health Authorities (Ministerial) Regulation}, Alta Reg 17/95, ss 1-3. \\
\textsuperscript{19} Although the demand for medical services may be less elastic than other goods, there is a correlation between health service supply and utilization. David Reisman, \textit{Health Care and Public Policy} (Cheltenham: Edward Elgar Publishing Limited, 2007) at 57. \\
\textsuperscript{20} See generally Robert G Evans, “Supplier-induced Demand: Some Empirical Evidence and Implications” in Mark Perlman, ed, \textit{The Economics of Health and Medical Care} (London: Macmillan, 1974).
\end{flushleft}
care expenditures, it similarly sought to curb spending by abolishing the existing cost-sharing arrangement and shifting to a combination of transfer payments and tax points assigned to the provinces.21

Provincial governments responded to sustainability concerns by expanding their health sector involvement through the implementation of cost-containment policies. One of the primary vehicles for provincial efforts to control escalating costs was their negotiations with physicians over the list of insured services and the reimbursement rates for those services. Specifically, provinces attempted to control the supply of health services (for example, by restricting the number of billing numbers granted to doctors,22 capping physician incomes,23 and reducing medical school spaces24) and the demand for health services (for example, by delisting certain services from the public insurance plan).25 However, for a variety of reasons, including physician opposition to restrictions on billing numbers and budget caps,26 public outcry against service de-listings,27 and the ongoing technological sophistication (and thus cost) of medical

21 For a discussion of the federal government’s shifting financial commitment to Medicare, see Steven Lewis et al, “The Future of Health Care in Canada” (2001) 323 BMJ 926. The authors note that by 1995, through some negotiated and some unilateral changes, the federal government’s 50 percent contribution was reduced to 16 percent (according to the provinces) or 32 percent including tax points (according to the federal government). The transfer payment portion of the federal contribution was grouped together with other social programs (post-secondary education and welfare) in the Canadian Health and Social Transfer, but these programs have since been disaggregated into the Canada Health Transfer and the Canada Social Transfer.


23 Ibid.


25 In Ontario, the Ministry of Health and Long-Term Care and the Ontario Medical Association collaborated on several initiatives to save costs through de-listing services from the public plan. For a discussion of these initiatives, see Colleen M Flood & Joanna N Erdman, “The Boundaries of Medicare: Tensions in the Dual Role of Ontario’s Physician Services Review Committee” (2004) 12 Health LJ 1.

26 Although unsuccessful, several physicians challenged these billing number restrictions on the basis that they violated the right to security of the person, which they argued included financial security resulting from employment). For example, see Waldman v British Columbia (Medical Services Commission) 1999 BCCA 508.

27 For a discussion on the process by which services were de-listed and the subsequent court challenges by the public and by members of professions whose services had been de-listed see Colleen M Flood & Joanna Erdman, The Boundaries of Medicare: The Role of Ontario’s Physician Services Review Committee, IRPP Working Paper Series no. 2004-02 (Montreal: Institute for Research on Public Policy, 2004).
services, governmental policies were only moderately successful at containing escalating health care expenditures.\textsuperscript{28}

These budgetary decisions certainly affect patient care, albeit indirectly.\textsuperscript{29} For example, resource constraints imposed by government affect waiting times for treatment and the availability of services at rural hospitals. However, for reasons that I explore in Chapter Four, these types of decisions are highly unlikely give rise to legal duties. Courts are likely to classify cost-containment reforms as policy decisions, which, in contrast to operational decisions, are immune from the review of judges. Although I argue for abolition of this difficult-to-apply classification scheme in Chapter Four, plaintiffs would face several other barriers in advancing a claim based, for example, on government limits on billing numbers or medical school class spaces. These decisions are likely to be too remote from patient injuries to give rise to the close and direct relationship that is a necessary pre-requisite to a duty of care. In addition, a plaintiff would be unlikely to prove that her injury would not have occurred but for these decisions (in other words, that the government caused the injury).

C. The Government’s Managerial Role

The ongoing fiscal pressures of the 1990s, coupled with emerging concerns with the appropriateness and safety of health care services, motivated the government to further expand its health sector responsibilities to include an active role in the management of the delivery


\textsuperscript{29} Morreim argues that parties other than physicians “now control the crucial elements in health care,” such as which technologies are developed and will be available, the level of funding that is available, which health services are available, the incentives that will limit and direct physicians’ choices, and the medical specialties that are attractive to physicians. E Haavi Morreim, \textit{Balancing Act: The New Medical Ethics of Medicine’s New Economics} (Washington: Georgetown University Press, 1995) at 139. Morreim advances these changes in the level of control exercised by physicians as a rationale for greater tort liability of payers in the American context.
system and clinical decision-making. There is a considerable body of evidence suggesting that patients frequently receive health services that are either unnecessary or inappropriate. For example, one study found that the use of high-volume services such as lab tests and x-rays could be reduced by 47 percent without diminishing quality of care.\(^{30}\) Although these services are relatively inexpensive items, the potential aggregate cost savings are large, given the high utilization of these services. Other studies show significant variation in the utilization of health services, including intrusive surgical procedures such as Caesarean sections, with no clinical or demographic factors to explain the clinical practice variation. In many studies, low utilization groups did not experience worse health outcomes (as measured by morbidity or mortality) than the high utilization groups.\(^{31}\)

High rates of medical errors acted as another catalyst for the increased governmental regulation of medical decision-making and health service delivery. As I discussed in the previous chapter, using a conservative methodology, a 2004 study estimated that of the 2.5 million annual hospital admissions in Canada, up to 232,250 were associated with adverse events, nearly 70,000 of which were preventable.\(^{32}\) The government’s expanded regulation of


\(^{32}\) G Ross Baker et al, “The Canadian Adverse Events Study: The Incidence of Adverse Events Among Hospital Patients in Canada” (2004) 170:11 CMAJ 1678 at 1683-84. Various factors, which I discussed in detail in Chapter One, suggest that these figures are conservative. The study excludes obstetric and psychiatric cases, the former of which are rife with injuries (see Atul A Gawande et al, “The Incidence and Nature of Surgical Adverse Events in Colorado and Utah in 1992” (1999) 126:1 Surgery 66 at 70). The figures exclude data from small hospitals, despite the fact that one indicia of patient outcomes is volume (Ethan A Halm, Clara Lee & Mark R Chassin, “Is Volume Related to Outcome in Health Care? A Systematic Review and Methodologic Critique of the Literature” (2002) 137:6 Annals of Internal Medicine 511). The authors rely on data from patient charts, thus failing to capture readmissions to other hospitals. Finally, the authors only include incidents resulting in injury (one study, which monitored the rate and types of errors in acute care hospitals, found that 13 percent of reported errors were “near misses”: Catherine E Milch et al, “Voluntary Electronic Reporting of Medical Errors and Adverse Events” (2006) 21:2 J Gen Intern Med 165 at 167–68). Studies employing alternative methodologies (autopsies or observational studies) generally reveal higher rates of errors (see e.g. Kaveh G Shojania et al, “Changes in Rates of Autopsy-Detected Diagnostic Errors Over Time: A Systematic Review” (2003) 289:21 JAMA 2849; Lorelei Lingard et al,
patient safety was also legitimized by a growing body of literature indicating that injuries once solely attributed to health professionals are often caused or contributed to by the systems within which those practitioners worked—systems organized, managed, coordinated, and funded by a complex mix of health professional self-regulation, hospital and RHA/LHIN policies, and governmental policies and regulations. This evidence of unsafe and inappropriate care was a matter of concern both from a clinical perspective, due to preventable patient injuries and unnecessary medical risks, and a financial perspective, due to the costs associated with unnecessary services and the treatment of avoidable medical complications.

As I discuss in greater detail below, provincial governments sought to address emerging concerns with health service quality and ongoing sustainability concerns by exerting control over the decisions of other actors (including hospitals, RHAs, and LHINs) and, increasingly, by intervening directly in the treatment decisions of health practitioners. Mounting evidence impugning the quality and safety of medical care called into question the objectivity of medical decision-making, which undermined arguments for the preservation of physician autonomy and created an opportunity for greater governmental intrusion into clinical decision-making. I explore the government’s managerial responsibilities in the health sector below, after discussing its role in the provision of public health services.


33 See generally Committee on Quality of Health Care in America, To Err is Human: Building a Safer Health System (Washington, DC: National Academy Press, 2000). Conditions intrinsic to health care exacerbate the tendency to err. Health practitioners are busy, stressed and tired, must complete complex processes, and are required to make quick decisions based on limited information in the presence of scientific uncertainty. While factors such as inattention, distraction and forgetfulness are difficult to manage (James Reason, “Safety in the Operating Theatre—Part 2: Human Error and Organisational Failure” (2005) 14:1 Quality & Safety in Health Care 56 at 58), the government has the logistical and financial capacity to implement systems to prevent human error. See e.g. Thomas W Nolan, “System Changes to Improve Patient Safety” (2000) 320:7237 BMJ 771.
D. The Government’s Role in Public Health Services

In contrast to their role in the organization and delivery of health care services, where provincial governments have expanded their involvement over the past half century, the state has always had some financial, policy-making, and managerial responsibilities within the public health system. In some cases, the government actually delivers public health programs. For example, government employed medical officers of health and their delegates may make decisions respecting the quarantining of infected individuals or closing of premises, and public health nurses may be responsible for administering vaccines in a province-wide inoculation program. Although the nature of the government’s involvement in public health has not undergone a significant transformation, the scope of the public health services provided by the state has expanded to encompass a broader range of programs and services. Specifically, there has been a shift from focusing solely on preventing the spread of infectious diseases to include efforts to prevent chronic diseases (for example, preventing cancer and lung disease through tobacco cessation programs).

Before modern sanitation efforts, many individuals succumbed to diseases such as typhoid fever and cholera, for which there were few effective treatments. Government financing and policies were crucial in the implementation of sanitation systems, such as the chlorination of drinking water, which dramatically reduced rates of waterborne infectious diseases. The 1900s saw the rise of other infectious disease, such as polio. Mass vaccination campaigns, which were largely responsible for eradicating several infectious diseases, similarly required governmental

34 Other entities, such as religious societies and other levels of government (i.e. municipalities) were also responsible for providing some public health services. For a discussion of the role of religious societies in the provision of public health services see generally Marguerite Van Die, Religion and Public Life in Canada: Historical and Comparative Perspectives (Toronto: University of Toronto Press, 2001).

35 For a history of Canadian provincial governments’ efforts to improve sanitation see e.g. “Crisis in Housing and Sanitation” in John C Weaver, Shaping the Canadian City: Essays on Urban Politics and Policy, 1890-1920 (Toronto: The Institute of Public Administration of Canada, 1977).
coordination and financing, and service delivery by government-employed public health
nurses. Although there have been some efforts to improve the integration of public health
services into the delivery of health care services, for example, by encouraging doctors to engage
in more preventive care and patient education, the government has retained its responsibility for
the management and delivery of many public health services.

Ontario’s Public Health Standards and Protocols exemplify the government’s managerial
involvement in public health services. These documents set out the minimum requirements for
public health programs delivered by the province’s 36 boards of health. These Standards and
Protocols set out very specific and detailed instructions respecting the management of health
threats and the treatment of specific clinical conditions, such as the monitoring and treatment of
rabies, the handling and storage of vaccines, the monitoring and management of water conditions
(including drinking water and beaches), and the inspection of daycare centres. In other words,
there is very little room for clinical discretion, but rather the government instructs health
professionals on how to treat these illnesses or address these health threats.

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36 For a general history of the development and implementation of vaccines see e.g. Stanley A Plotkin, ed, History of Vaccine Development (New York: Springer, 2011). Although beyond the scope of my discussion in this Chapter, governmental efforts are not only integral to controlling the spread of infectious diseases, but are also necessary to limiting mortality and morbidity from chronic diseases, which now represent the majority of the disease burden (the World Health Organization lists the causes of death for Canadians: cardiovascular disease (34 percent), cancer (29 percent), chronic respiratory disease (6 percent), diabetes (3 percent), other chronic diseases (17 percent), and communicable diseases (5 percent). World Health Organization, “Projected Deaths by Cause, All Ages, Canada, 2005,” online: WHO <http://www.who.int/chp/chronic_disease_report/media/CANADA.pdf>. These diseases necessitate complex, expensive medical interventions, such as dialysis, organ transplantation, and chemotherapy, and, due to the long-term nature of these illnesses, coordination between health professionals, hospitals and other services such as home care and long-term care. Although provincial governments have delegated some responsibility for home care and long-term care services to regional entities, government is often the only actor with the ability to coordinate services across this broader continuum of care. Furthermore, chronic diseases are caused by a complex matrix of factors—genetic, environmental, and behavioral factors, as well as the broader socio-economic context—some of which can only be addressed by government. Chronic disease prevention requires not only the provision of individual health care services, but cross-sectoral policies requiring government involvement (for example, urban planning and agriculture policies affect dietary choices and trade policies affect tobacco consumption).

I discuss the implications of regionalization for health care services below; however, it is important to note that most provincial governments devolved little authority over public health services to regional entities, preferring to continue to centrally manage these services. Because of the government’s monopoly over the delivery of many public health services (as the only actor with the logistical capacity and legal authority to respond to many public health crises), and the vulnerability of citizens to health threats such as disease outbreaks or natural disasters, public health represents a particularly compelling example of a close relationship between patient injuries and governmental decisions. However, as I discuss in Chapter Three, Canadian courts have not been receptive to tort claims arising from the government’s management of disease outbreaks, striking all of these cases on the basis that the defendants did not owe the plaintiffs a duty of care. I return to discuss the types of governmental public health decisions that may ground a duty of care in part four of this chapter.

**Part Two: Regionalization and Government Control Over Health Care Institutions**

Beginning in the 1990s, Canadian provincial governments transformed their health care systems through regionalization. The goal of this reform was to foster integration in order to cut costs (by eliminating health service and administrative duplication) and to enhance quality (by improving continuity of care).\(^{38}\) There is inter-provincial variation in the configuration of regional structures, for example, the size of health regions and the scope of their responsibility for services delivered outside of hospitals.\(^{39}\) However, governments generally predicated

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\(^{38}\) For example, see “Regional health authorities: Mandate”, online: Alberta Health and Wellness <http://www.health.gov.ab.ca/regions/RHA.html#mandate>.

regionalization on decentralization of authority from government⁴⁰ to regional entities and centralization of authority from hospital boards to regional health authorities (RHAs).⁴¹ The exception to this general trend was Ontario, in which the Ministry of Health and Long-Term Care delegated some of its functions to Local Health Integration Networks (LHINs), but left hospital boards intact. In addition, Ontario did not implement this reform until about a decade later than most other jurisdictions.⁴²

If regionalization resulted in a significant devolution of authority, as provincial governments suggested, this may undermine my argument that the state has increased its control over the health sector, from which greater judicial receptiveness to tort liability should flow. Although Tuohy suggests that the roles of the various health system actors have remained relatively stable over time, she acknowledges that regionalization required a “greater degree of state activism”⁴³ than previous reforms. In comparison, Hurley et al characterize regionalization as the most extensive round of health sector reform since the implementation of Medicare itself.⁴⁴ Despite rhetoric of power transfer, regionalization also represented an assertion of

⁴⁰ Provincial governments purported to delegate some of their responsibilities for local policy-making and planning to regional entities and tasked these newly-created entities with finding opportunities for integration. For example, under Ontario’s Local Health System Integration Act, SO 2006, c 4, s 5, the responsibilities of LHINs are to “plan, fund and integrate the local health system.” Specifically, this includes promoting integration; planning for local needs; engaging the community; ensuring there are processes to respond to patient concerns; evaluating, monitoring and reporting and being accountable for their performance; participating in developing the provincial strategic plan; cooperating with health service providers; participating in joint strategies with other LHINs; disseminating information on best practices; bringing economic efficiencies to health service delivery; allocating funding to providers; entering performance agreements with providers; and ensuring the effective and efficient management of resources. Under Alberta’s Regional Health Authorities Act, RSA 2000, c R-10, s 5, RHAs are responsible for promoting and protecting health and preventing disease and injury, assessing regional health needs, determining priorities and allocating resources accordingly, ensuring reasonable access to quality services, and promoting integration.

⁴¹ Although the terminology across Canada varies, for all provinces other than Ontario, I use the term regional health authorities (RHAs). I collectively refer to RHAs and Ontario’s LHINs as regional entities.

⁴² However, Ontario had previously experimented with some forms of regionalization, such as regional offices of the Ministry of Health and Long-Term Care.


⁴⁴ Jeremiah Hurley, Jonathan Lomas & Vandna Bhatia, “When Tinkering is Not Enough: Provincial Reform to Manage Health Care Resources” (1994) 37 Can J Pub Admin 490 at 491. Regionalization was arguably even more
governmental authority, as it involved a complete reconfiguration of the health care system, with very little evidence as to its anticipated benefits.\textsuperscript{45} A reform of this magnitude required the government to believe the reorganization of private hospital corporations and independent medical practitioners was a legitimate domain for the exercise of its power. I argue that instead of reducing the government’s power, regionalization actually facilitated the state’s ability to manage other health system actors. Prior to the implementation of this reform, provincial ministries of health had to spread finite oversight capacity across hundreds of hospitals and health care facilities, while it is now logistically feasible to closely monitor and manage the activities of a handful of RHAs. This is particularly true in the case of Alberta, which now has a single health authority that works very closely with Alberta Health and Wellness.

The extent to which integrative reforms actually involved the devolution of authority is also called into question by the significant powers that provincial governments retained post-regionalization and the control they exert over RHAs and, in Ontario, LHINs and hospital boards. In this regard, in the 2001 Alberta Premier’s Advisory Council on Health Report, Donald Mazankowski, former Deputy Prime Minister, observed:

> The [health care] system is organized by government, paid for by government, insured by government, and evaluated by government. Regional health authorities have an important role to play in delivering health services but their budgets are almost completely determined by government, the expectations are set by government, and they are accountable to government. They have too little real authority…\textsuperscript{46}

\textsuperscript{45} In this regard, Leatt et al note that “[t]o date, there has been little evaluation of the outcomes of the move to regional health authorities.” Peggy Leatt, George H Pink, & Michael Guerriere, “Towards a Canadian Model of Integrated Healthcare” (2000) 1:2 Healthcare Papers 13 at 18.
In the remainder of this part, I discuss some specific examples of the ways in which provincial governments are engaged in managing the affairs of RHAs, LHINs, and hospitals, and the effect of this managerial role on the relationship between the government and patients.

a. Approval Powers

RHAs and LHINs must set out detailed plans describing how they intend to carry out their responsibilities, which health services they will provide and their cost, and how they will measure their own performance. These plans are subject to government approval. As I noted above, these entities are also subject to a variety of financial reporting requirements and their budgets require governmental approval. Approval is also required for LHINs and RHAs to exercise a variety of powers such as the acquisition or disposition of property and major equipment purchases.

Despite the fact that hospitals are private corporations that managed their own affairs for many decades, Ontario legislation subjects the decisions of hospital boards to numerous approval requirements, this oversight function not having been devolved to LHINs. For example,

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47 In Alberta, RHAs must submit a health plan detailing how they intend to carry out their responsibilities, how they intend to measure their performance, the health services they will provide, the anticipated costs of those services, and any other information the Minister of Health requires. RHAs are also required to prepare annual reports and other reports and returns requested by the Minister. Regional Health Authorities Act, supra note 40, ss 9, 14. Similarly, LHINs must develop integrated health service plans, which the Minister of Health and Long-Term Care has the discretion to approve, amend, or refer back to the LHIN with directions. LHINs must also submit annual reports (s 13) and annual audited reports (s 12). In addition to the annual audit, the Minister may “at any time, review or audit any aspect of the operations” of a LHIN, and the Auditor General may “at any time, audit any aspect of the operations” of a LHIN (s 12). A LHIN must also provide the Ontario Health Quality Council “with the information about the local health system that the Council requests” (s 13(6)). Local Health System Integration Act, supra note 40.

Supra note 18.

48 For example, under Ontario’s Local Health System Integration Act, supra note 40, s 6, the Lieutenant Governor in Council must provide approval for a LHIN to acquire, dispose of, or encumber real property; borrow or lend money; invest money; encumber personal property; create a subsidiary; indemnify any person from liability or act as a guarantor; or provide health services (except through its directors, officers, employees or agents). Ministerial approval is required to make charitable donations, apply as a registered charity, enter into an agreement for the provision of health services outside of Ontario, or enter into an agreement with a government or government agency outside of Ontario. Finally, LHINs shall not, without the approval of the Ministers of Health and Long-Term Care and Finance, receive money from a person other than the Crown.
Ministerial approval is required to incorporate a hospital, amalgamate hospitals, operate a hospital, add buildings or facilities to a hospital, or to acquire, dispose of, or encumber hospital land or buildings.\textsuperscript{50} The corporate and medical staff bylaws of hospitals also require governmental approval.\textsuperscript{51} For example, in Ontario, hospital bylaws are of no force and effect until the Lieutenant Governor in Council approves them, upon receiving the recommendation of the Minister of Health.\textsuperscript{52} The legislation of some provinces authorizes the government to create model bylaws and to mandate their adoption by hospitals.\textsuperscript{53} This intrusion into matters of internal hospital governance and the organization of hospital medical staffs extends far beyond the financial relationship that provincial governments historically had with hospital boards.

There is little available information on the way in which provincial governments exercise these approval powers—whether they routinely subject hospital and regional board decisions to a rigorous review or whether they tend to merely rubber stamp board decisions. However, the power to refuse to approve board decisions or to mandate the adoption of particular governance practices via hospital bylaws is certainly an available lever by which the state can manage the health service delivery system. As I discuss in Chapter Four, based on their current approach to health sector tort claims, Canadian courts are unlikely to consider the government’s control over

\textsuperscript{50} Public Hospitals Act, RSO 1990, c P40, s 4.
\textsuperscript{51} Corporate bylaws govern a hospital’s management and administration, addressing such matters as the responsibilities of the officers of the board, board committees and their functions, board meeting procedures, procedures for appointing administrators and auditors, and the responsibilities of hospital administrators. Medical staff bylaws address such matters as the criteria for appointment to the medical staff, medical staff departments, election of officers of the medical staff, procedures for appointing the chief of staff and department chiefs and their duties, committees of the medical staff and their duties, and the appointment of the Medical Advisory Committee and its duties.
\textsuperscript{52} Public Hospitals Act, supra note 50, s 11(3).
\textsuperscript{53} For example, in Nova Scotia, medical staff bylaws are set out in regulations passed by government, rather than being left to hospital discretion. District Health Authorities Medical Staff (Disciplinary) Bylaws, NS Reg 289/2007. See also British Columbia’s Hospitals Act, RSBC 1996, c 200, s 2(2), which states that the “bylaws of rules of a hospital, including medical staff bylaws, are not effective until approved by the Minister.” Furthermore, under section 42, the “Minister may require that the bylaws or rules of a hospital…be revised in a manner satisfactory to the minister in order to meet changing conditions and policies, and to provide for greater uniformity and efficiency in all matters concerning the administration and operation of hospitals.”
hospitals in determining whether a patient injured in a hospital and the government had a proximate relationship. However, if provincial governments routinely engage in the management of hospital decisions, particularly those relating to quality of care (for example, mandating particular medical staff bylaws governing the response to critical incidents or to removing physicians whose competence is in question), this should be relevant in determining whether injured patients and governmental defendants have a close and direct relationship.

b. Appointment Powers

Provincial governments also seek to influence RHA and LHIN decisions by controlling the composition of their boards. Although some provinces initially experimented with elected board members, governments now appoint individuals to these boards. Tuohy describes the power to appoint boards as “a permanent expansion in the scope of formal state authority.” Citing data from a survey of board members, Lomas argues that “board members may be influenced towards meeting government expectations as a result of the fact that one third of the members had been appointed to another board, commission or agency by the federal or provincial government.” Provincial governments also have the authority to dismiss board members and have used this power in the past. For example, both the British Columbia and Alberta governments have dismissed board members due to their conflicts with other board members.

55 See e.g. Regional Health Authority Membership Regulation, Alta Reg 164/2004.
56 Supra note 44 at 180.
57 Jonathan Lomas, Gerry Veenstra & John Woods, “Devolving authority for health care in Canada’s provinces: 2. Backgrounds, resources and activities of board members” (1997) 156 CMAJ 513 at 519. Another respondent to the study noted that that “I am disappointed that much of what we do is directed by the Department of Health…Through [government’s] funding allocations they are making us move in the direction they want.”
members or with staff or physicians, arguing that these conflicts compromised their ability to effectively serve on the board.\textsuperscript{58}

As I mentioned above, unlike other jurisdictions, hospital boards remained intact post-regionalization in Ontario. However, the Ontario government has been expanding its management of board composition and other board governance matters, despite the fact that hospitals are still private corporations. For example, recent amendments to the \textit{Hospital Management Regulations} mandate that if members of the medical staff or hospital employees sit on the board, they cannot be voting members.\textsuperscript{59} In addition, the 2010 \textit{Excellent Care for All Act} requires hospitals to tie CEO compensation to performance\textsuperscript{60} and to appoint a quality committee to advise the board.\textsuperscript{61} Regulations promulgated under this \textit{Act} govern the composition of hospital quality committees.\textsuperscript{62}

Without something more, requirements such as mandatory hospital quality committees or performance-based CEO compensation are unlikely to ground tort claims. However, the changes discussed in this section signify an increasing degree of governmental intrusion into the management of the health care delivery system and a trajectory towards policies that could certainly ground tort claims. In Chapter Three, I argue that given the government’s constantly evolving role in the health sector, courts should be cautious about relying on their definition of

\textsuperscript{58} James Frankish et al, “Social and political factors influencing the functioning of regional health boards in British Columbia” (2002) 61 Health Policy 125.

\textsuperscript{59} \textit{Hospital Management Regulations}, RRO 1990, Reg 965, s 2.

\textsuperscript{60} \textit{Excellent Care for All Act}, SO 2010, c 14, s 9(1).

\textsuperscript{61} Future governance regulations may require that hospitals implement skills-based boards, where board members must have knowledge in specific areas to qualify for appointment, as recommended by the Ontario Medical Association and several scholars.

\textsuperscript{62} \textit{General Regulation}, O Reg 445/10, s 1. The quality committee shall be composed of at least the number of voting members of the hospital’s board that are required to ensure that one third of the members of the quality committee are voting members of the hospital’s board, one member of the hospital’s medical advisory committee, the hospital’s chief nursing executive, one person who works in the hospital and who is not a member of the College of Physicians and Surgeons of Ontario or the College of Nurses of Ontario, the hospital’s administrator, and such other persons as are appointed by the hospital’s board.
the government’s responsibilities in their previous decisions. In addition, because the duty analysis involves an examination of the totality of the parties’ relationship, numerous examples of government powers that would not lead to tort liability by themselves (such as those discussed in this section) may be sufficient, when viewed together, to establish a close and direct relationship between the government and a plaintiff. However, the courts would have to look more deeply at the government’s responsibilities to determine the precise nature and degree of its control over the health sector.

c. Direct Control Mechanisms

Health sector legislation gives provincial governments the authority to directly control the decisions of RHAs, LHINs, and hospitals. Specifically, governments have the power to appoint an individual to inspect a hospital, investigate concerns within a hospital or, most intrusively, to assume a board’s administrative responsibilities. In Ontario, the government retained these responsibilities post-devolution, rather than devolving them to LHINs.

With respect to inspections, the Alberta Minister of Health and Wellness may “make all necessary inquiries” into the management of a hospital, visit and inspect a hospital, and examine all hospital records to verify the accuracy of reports provided to the Ministry. In Ontario, the Lieutenant Governor in Council may appoint a person to “investigate and report on the quality of the management and administration of a hospital, the quality of the care and treatment of patients in a hospital or any other matter relating to a hospital” if it is in the public interest.

More intrusively, as with other provinces, in Alberta, the Minister may dismiss all members of a regional health authority and appoint an administrator, if the Minister believes that

63 Hospitals Act, RSA 2000, c H-12, ss 8, 26–27.
64 Public Hospitals Act, supra note 50, s 9(5).
the board “is not properly exercising its powers or carrying out its duties in the public interest.”

The administrator assumes all of the powers of the RHA, including the authority to exercise the board’s responsibilities. Similarly, in Ontario, the Lieutenant Governor in Council may, upon the Minister of Health’s recommendation, appoint a supervisor who “has the exclusive right to exercise all of the power of the [hospital] board.” The government has exercised this power on numerous occasions in recent years, appointing at least four hospital supervisors in 2007, one supervisor in 2009, and two supervisors in 2010. Supervisors frequently remain in place for long periods of time and make significant changes within hospitals. For example, the supervisor of Cambridge Memorial Hospital served for ten months, during which time he developed and implemented a new financial plan, appointed a new board chair, recruited new board members, amended the corporate and medical staff bylaws, and interviewed and recommended a new candidate for Chief of the Medical Staff.

Provincial governments also have the power to issue directions to LHINs or regional health authorities. For example, in Alberta, the Minister of Health may “give directions...for the purpose of providing priorities and guidelines for [the RHA] to follow in the exercise of its

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65 *Hospitals Act, supra* note 63, s 29.
66 *Public Hospitals Act, supra* note 50, s 9(5).
67 There are no reports comprehensively setting out the government’s exercise of the power to appoint hospital supervisors. However, a search of the Ontario Ministry of Health and Long-Term Care website produced the reports of several inspectors. Online: Ontario Ministry of Health and Long-Term Care <http://www.health.gov.on.ca/english/media/news_releases/archives/nr_07/jul/nr_20070730_2.html>, and <http://www.health.gov.on.ca/english/media/news_releases/archives/nr_07/jun/nr_20070611.html>. See also Peter Criscione, “Brampton Civic Hospital supervisor meets with surgeons to discuss problems” *Brampton Guardian* (25 July 2008), online: Brampton Guardian <http://www.bramptonguardian.com/bramptonguardian/article/518978>.
powers, and co-ordinating the work of the regional health authority with the programs, policies and work of the Government and public and private institutions.” In Ontario, the Minister of Health and Long-Term Care may order a health service provider to cease operating or dissolve its operations, amalgamate with another service provider, or transfer its operations to another person or entity.

In contrast to the broad funding allocation decisions that historically characterized the government’s role in the health sector, its direct management of health service delivery is much more amenable to liability in tort. As I describe in Chapter Four, parties to a tort claim must have a close and direct, or proximate, relationship in order for the defendant to owe the plaintiff a duty of care. Governmental control over the health service delivery system brings the state into a much closer relationship with plaintiffs than its traditional budgetary decisions. When the state is involved in managing health service delivery, for example, by assuming administrative control over a hospital, there are fewer intermediary actors between the patient’s injuries and the government’s decisions.

Indeed, in a health sector claim based on an infant’s death in an emergency room, the Ontario Divisional Court remarked that the “extraordinary step” of appointing a supervisor constituted “take[ing] over the day to day operations of a hospital”, which they treated as relevant to whether the government had adequately supervised the hospital. A Canadian court has never heard a claim where a plaintiff was injured while a hospital was under the control of a government-appointed supervisor. However, one could also envision a claim where the government knew, or ought to have known, about persistent problems within a hospital and

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71 Regional Health Authorities Act, supra note 40, s 8.
72 Local Health System Integration Act, supra note 40, s 7.
73 Mitchell Estate v Ontario, 2004 CanLII 4044 at para 33 (Sup Ct). The Court noted that plaintiff in that case had not alleged that a supervisor had been appointed. The Court did not consider whether the failure to appoint a supervisor could also ground a duty of care.
failed to take steps to protect patients, which may include exercising its power to appoint a supervisor.

In the next part, I turn from a discussion of the government’s control of other health delivery institutions (namely hospitals, RHAs and LHINs), to an analysis of its direct regulation of clinical decision-making.

Part Three: Governmental Management of Clinical Decision-Making

Prior to the advent of universal health insurance, the services a patient received depended entirely upon her doctor’s recommendations and her ability to pay for those services. As noted above, with the implementation of Medicare, the doctor-patient relationship remained unchanged, and governments passively paid for the hospital and physician services that doctors deemed medically necessary. The list of services initially included in provincial insurance plans largely mirrored those covered under the existing physician-sponsored insurance plans, at a similar rate paid by those plans.74 At that time, governments had little financial need to limit the services patients were entitled to, given the prosperous post-war economy and the fact that Medicare pre-dated the proliferation of expensive medical treatments such as sophisticated

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74 MacTaggert, supra note 11 and Coburn et al, supra note 22. In Ontario, this rate was set at 85 percent of the Ontario Medical Association fee schedule.
diagnostic tests,\textsuperscript{75} elaborate surgical procedures,\textsuperscript{76} and significant improvements in both the viability of premature infants and the ability to prolong the end of life.\textsuperscript{77}

A variety of pressures now challenge physician dominance over medical decision-making, including evidence of widespread clinical practice variation, concerns with the safety of health care services, growth in the power of other health professionals, increasing patient autonomy and the perception of patients as consumers, and rapidly growing health care costs exacerbated by fee-for-service physician reimbursement. In response to these pressures, provincial governments have exerted increasing control over clinical-decision making. In the remainder of this Part, I discuss specific examples of the government’s control over the treatment decisions of health professionals.

Prior to the 1990s, governmental efforts to contain health care costs consisted primarily of limiting the number of billing numbers granted to doctors (particularly in over-served urban areas), limiting medical school spaces, capping physician incomes, and limiting overall percentage increases in physician fees (leaving provincial medical associations to allocate these increases among individual items in the fee schedule).\textsuperscript{78} The negotiations between provincial medical associations and the government did not generally address the content of the schedule of insured services or the relative value of insured services, which “changed little since a broad base


\textsuperscript{76} Organ transplants began in the 1950s with the first successful kidney transplant between identical twins, which was followed by the first successful human heart transplant in the 1960s. Lawrence K Altman, “The Ultimate Gift: 50 Years of Organ Transplants” \textit{The New York Times} (21 December 2004).

\textsuperscript{77} Citing a number of studies, Seri and Evans conclude that “[t]he gestational age at which at least half of the infants survive has decreased from 30 to 31 weeks in the 1960s to 23 to 24 weeks during this decade” Istvan Seri & Jacquelyn Evans, “Limits of Viability: Definition of the Gray Zone” (2008) 28 J Perinatology 4.

\textsuperscript{78} Coburn et al, \textit{supra} note 22 at 6.
of coverage was established in each province upon the establishment of Medicare.”\textsuperscript{79} New hospital and physician services were typically added to the list of insured services as a matter of course.

In the 1990s, this dynamic evolved to include some government involvement in what services ought to be deemed “medically necessary,” and thus attract public funding. In Ontario, the Physician Services Review Committee, comprised of members from the Ministry of Health and Long-Term Care and the Ontario Medical Association (OMA), was appointed to determine which services comprised the Schedule of Benefits and the fees for these services.\textsuperscript{80} Throughout the 1990s, this list of services was a target for governmental cost-containment efforts, with the province and the OMA negotiating some service de-listings and overall cost cuts.\textsuperscript{81} Although some very modest savings were achieved, medical costs continued to grow during this period.\textsuperscript{82}

Governments are now increasingly scrutinizing whether expensive new diagnostic services and pharmaceuticals are sufficiently cost-effective to warrant inclusion in provincial health insurance plans, independent of their negotiations with provincial medical associations. For example, governments are attempting to contain the costs of expensive new pharmaceuticals, which can be a significant driver of health system costs, by refusing to insure drugs that are not sufficiently cost-effective to warrant public funding.\textsuperscript{83} In Ontario, whether a particular


\textsuperscript{81} Pursuant to a series of agreements, a joint Ontario Medical Association and Ontario Ministry of Health and Long-Term Care committee was tasked with reducing costs through removing services from the Schedule of Benefits. Under a 1991 agreement, the government realized $20 million in annual cost savings through the elimination of 19 services from the Schedule of Benefits. Under a 1995 agreement, the Ministry and the OMA agreed to eliminate an additional $50 million in annual costs. By 1998, the Ministry reached this target through 39 changes to the Schedule of Benefits. Under a 2000 Agreement, the parties again agreed to achieve another $50 million in annual savings. Flood & Erdman, \textit{ibid}.

\textsuperscript{82} Flood & Erdman, \textit{ibid}.

\textsuperscript{83} Medicare does not include universal insurance for pharmaceuticals, aside from those received by hospital in-patients. However, provincial governments have a variety of programs covering drugs for certain residents,
pharmaceutical is included in the Ontario Drug Benefit Program, and is thus entitled to public
funding, is not part of a bargaining process with physicians, but rather is the decision of a
government-appointed Executive Director with the benefit of the advice of the Committee to
Evaluate Drugs (CED).84 Although the CED, which makes recommendations on cost-
effectiveness, includes physicians, it also includes scientists, patients, pharmacists, and health
economists.85

In a significant departure from the status quo, whereby physicians could provide insured
services at their discretion, the Ontario government now dictates the eligibility of patients for
positron emission tomography (PET) scans. PET scans, which cost up to $2000 per scan, only
attract public funding under certain circumstances.86 Patients must generally have one of eight
cancers or cardiac conditions to be eligible for an insured scan. This list is based on the results
of clinical trials designed to assess the technology’s efficacy in aiding the diagnosis of these
conditions.87 The government’s management of the definition of medical necessity and its
willingness to allow cost containment goals to trump physician autonomy represents a significant
assertion of government authority.88

primarily the elderly and those with low incomes, and those with certain health conditions such as HIV, cancer, and
organ transplant recipients. Governments control which drugs are included in provincial formularies. This, in turn,
affects which drugs patients will receive in hospital, as hospital formularies generally reflect provincial formularies.
84 “How Drugs Are Approved: Review Process”, online: Ontario Ministry of Health and Long-Term Care
85 “Committee to Evaluate Drugs”, online: Ontario Ministry of Health and Long-Term Care
86 “Pet Scan Primer: A Guide to the Implementation of Positron Emission Tomography Imaging in Ontario,” online:
87 Ibid. Scans may also attract discretionary public funding if a physician applies on behalf of a patient, providing a
justification for why that particular patient’s condition necessitates a PET scan. In addition, PET scans may receive
funding as part of a clinical trial to test their efficacy for additional medical conditions. These limits have been
subject to some physician criticism. For example, Dr. Jean-Luc Urban, Chair of Nuclear Medicine at St. Joseph’s
Health Center has stated that, “I’m not proud to be in the diagnostic imaging field [in Canada]...I’m ashamed ... not
to be able to provide ... the diagnostic imaging tool — the service — that [patients] not only deserve, but also pay for
when they pay their taxes.” “Radiologists, physicians push for PET scans”, online: Canadian Medical Association
Journal <http://ecmaj.ca/cgi/content/full/172/13/1670>.
88 Patient pressure, aided by the power of the media to garner public sympathy, has sometimes thwarted efforts to
limit the basket of insured services, for example, in the case of expensive cancer drugs. However, in other cases, the
In response to high rates of inappropriate and unsafe health services, provincial governments created bodies to disseminate clinical practice guidelines and other evidence-based practice tools. One such body is the Ontario Health Quality Council, whose mandate includes monitoring and reporting on health system outcomes, supporting continuous quality improvement, and promoting evidence-based health care. The latter is achieved through making recommendations concerning standards of care to health care organizations and recommendations to the Minister of Health and Long-Term Care concerning the funding of health services.\textsuperscript{89}

Recent legislation goes further than the mere dissemination of evidence-based practice tools, and modifies hospital governance structures in order to encourage the uptake of this evidence. Under the recently enacted \textit{Excellent Care for All Act}, Ontario hospitals must link executive compensation to quality improvement targets, develop annual quality improvement plans, and appoint a quality committee.\textsuperscript{90} This committee is responsible for monitoring and reporting to hospital boards on quality of care (“with reference to appropriate data”), making recommendations regarding quality improvement, ensuring that best practices information is distributed within the hospital, and overseeing the preparation of annual quality improvement plans.\textsuperscript{91} If the government begins to participate in the creation of evidence-based practice tools (as opposed to merely disseminating those developed by professional organizations), injuries 

\textsuperscript{89} \textit{Excellent Care for All Act, supra} note 60, s 12.
\textsuperscript{90} \textit{Supra} note 60, s 9, s 8, and s 3.
\textsuperscript{91} \textit{Supra} note 60, s 4.
arising from the application of those tools may be amenable to a claim in tort where, for example, the government fails to update guidelines to reflect changes in medical science.\(^92\)

In some circumstances, provincial governments have created legislative requirements mandating the specific care that patients are to receive. For example, there are provisions prescribing how hospital medical staff must address critical incidents,\(^93\) the actions physicians must take before administering anesthesia or performing surgery,\(^94\) the types of surgeries requiring the presence of a second surgeon,\(^95\) and the types of tissues necessitating examination by a pathologist.\(^96\)

In sum, since provincial governments implemented Medicare, they have dramatically expanded their health sector responsibilities. Beginning with the implementation of regionalization in the 1990s, governments assumed an integral role in the management of the health delivery system, for example by replacing hospital boards with their own appointees, and appointing supervisors tasked with assuming the administration of hospitals. Governments are also increasingly intruding in medical decision-making by determining what services patients are entitled to receive and regulating the provision of health services. In the next part, I turn to

\(^92\) Although the evidence-based medicine movement largely focuses on the dissemination of best practice guidelines created by professional bodies, governments are increasingly developing its own protocols to guide the treatment decisions of practitioners. For example, Alberta Health and Wellness has developed a lengthy document comprehensively setting out the care to be provided to HIV-positive pregnant women and their infants. Although this document cites a significant body of medical research, the government-appointed committee would have consolidated this existing evidence and presumably had to make decisions such as what to recommend in the face of conflicting evidence or whether the methodology/strength of the results from a particular study was sufficient to rely on. This document provides very specific treatment recommendations, including the provision of anti-retroviral medications “as early as 14 weeks” into their pregnancy and recommending that intravenous zidovudine “should be administered to the pregnant woman from onset of labour to delivery or three hours prior to Caesarean section until delivery.” “Prenatal HIV: Public Health Guidelines for the Management and Follow-up of HIV Positive Pregnant Women and their Infants” at 8-9, online: Alberta Health and Wellness <http://www.health.alberta.ca/documents/Prenatal-HIV-PH-Guidelines.pdf>.

\(^93\) Regional Health Services Act, SS 2002, c R-8.2, s 58.

\(^94\) Hospital Management Regulation, supra note 61, ss 28-29.

\(^95\) Operation of Approved Hospitals Regulation, Alta Reg 247/1990, s 20.

\(^96\) Ibid., s 23.
discuss two specific examples of patient injuries and the legal implications of the different decisions of the government that contributed to those injuries.

**Part 4: The Duties of Government Arising From Specific Examples of Injuries**

In this part, I discuss the relationship between specific examples of injuries and the health sector responsibilities of the government. The first example I provide is a patient who dies while waiting for care in a crowded hospital emergency room. The second example is an individual who dies of SARS, after contracted the disease from his wife, who is a nurse working in a hospital that treats patient during a SARS outbreak. I selected these two examples because, as I mentioned above, the government’s role in public health services differs from its role in health care services, with the government having greater responsibility for organizing and delivering the former. As the table below illustrates, a variety of decisions could contribute to these injuries, including decisions made by the government in the discharge of all of its roles in the health sector—insurer, policy-maker, and manager.

The government makes a variety of financial decisions that certainly affect the quality of care received by individual citizens. For example, the government allocates budgets between public health programs, thereby affecting whether disease surveillance information technology can be adopted and the number of public health officials that are available to respond to physician or hospital reports of infectious diseases (for example, by closing premises or quarantining infected individuals). Although these financial decisions affect patients, they are unlikely to result in a legal duty of care. As I discuss in greater detail in Chapter Four, the test for establishing a duty of care requires a close and direct relationship between the parties. Governments determine which hospital funding methodology to adopt (i.e. global budgets or care-based funding) and the resulting allocation of budgets between hospitals. This may affect
the ability of hospitals to adequately staff and equip their emergency rooms. However, the precise relationship between these governmental decisions and patient injuries is unclear, as the intervening decisions of numerous other actors may also contribute to the patient’s long wait in the emergency room, for example, nurses’ triage decisions and hospital staff scheduling decisions. It would thus be difficult for a plaintiff to demonstrate a close and direct nexus between governmental insurance decisions and patient injuries.

<table>
<thead>
<tr>
<th>Role of the government</th>
<th>Specific government decisions</th>
<th>Specific government decisions</th>
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<tr>
<td><strong>Example 1:</strong> A patient dies while waiting for care in a crowded hospital emergency room</td>
<td>Decision to publicly fund hospital services</td>
<td>Decision to publicly fund public health services</td>
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<td></td>
<td>Allocation of budgets between hospitals</td>
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<td></td>
<td>Funding methodology for determining hospitals budgets (global budgets, case-based funding, etc.)</td>
<td>Allocation of budgets between public health programs (i.e. tobacco control versus Medical Officer of Health’s Office versus programs for pre-natal care)</td>
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<td></td>
<td>Approval of hospital’s budget (including resources allocated to staffing the emergency room)</td>
<td>Allocation of funds within the unit tasked with infectious disease surveillance and control</td>
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<td><strong>Insurer</strong></td>
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<tr>
<td><strong>Example 2:</strong> An individual dies of SARS, after contracting the disease from his wife, a nurse working in a hospital affected by a SARS outbreak</td>
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<td></td>
<td>Approval of hospital bylaws (including those relating to hiring staff and responding to safety concerns in hospital)</td>
<td>Decision to restrict travel or close borders in order to prevent the spread of diseases into Canada</td>
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<td>Regulations requiring hospitals to create quality committees</td>
<td>Legislation respecting the mandatory reporting of diseases, the diseases on that list, and the power to quarantine infected individuals</td>
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<td>Creation of Quality Council to disseminate evidence (including evidence on managing emergency room patients)</td>
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<td>Role in decisions over medical class size and the availability of residency positions (including doctors specializing in emergency care)</td>
<td>The decision to purchase/implement information technology systems allowing public health officials to track the spread of disease/monitor the pattern of the outbreak</td>
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<td><strong>Policy-maker</strong></td>
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<tr>
<td><strong>Manager</strong></td>
<td>Appointment of a hospital supervisor to the hospital where injury occurred (to address quality of care problems within the hospital, including wait times)</td>
<td>Mandatory directives issued to nurses respecting safety precautions they are to take within hospitals</td>
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<td></td>
<td>Failure to act on information provided to the government respecting a problem with wait times in the hospital where the injury occurred</td>
<td>Decisions by public health officials respecting the quarantine of potentially infected health care workers</td>
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Policy decisions, such as the governmental dissemination of evidence respecting the effective management of patients in the emergency room, may similarly impact the wait times of patients. As with legal claims impugning the government’s financial decisions, claimants challenging these policy decisions would similarly be unlikely to establish a close and direct relationship with the government. For example, an individual patient’s wait time would not only be affected by the evidence disseminated by the government, but also by the incorporation of that evidence into hospital policies and the manner in which health professionals employ that evidence in treating patients.

In contrast to insurance and policy decisions, the government’s managerial decisions are more likely to create the close and direct relationship that is necessary to ground a duty of care, under the approach to duty of care that I advocate in Chapter Four.97 The individual who contracted SARS from his wife, who is a nurse, could argue that the government issued inadequate directives to health care workers respecting the adoption of safety equipment such as face masks. More specifically, the individual could argue that the government had received updated information on how the disease is spread from the U.S. Centers for Disease Control, but failed to update directives in a timely fashion and effectively disseminate that updated information to health professionals. The prospective claimant could similarly argue that public health officials were negligent in their decision not to quarantine health care workers that were exposed to the risk of SARS. In these examples, there is close nexus between the decisions of public health officials and the injury.

97 Under the Canadian judiciary’s current approach to governmental tort liability in the health sector, even these managerial decisions are unlikely to ground a duty of care. I discuss these decisions in greater detail in the following two chapters.
Part Five: Governmental Health Sector Accountability

There is a substantial body of literature criticizing the lack of accountability at all levels of the Canadian health care system. For example, the final report of the Commission on the Future of Health Care in Canada, chaired by the former Premier of Saskatchewan Roy Romanow, concluded that accountability must be improved because Canadians “are often left out in the cold, expected to blindly accept assertion as fact and told to simply trust governments and providers to do the job.” Citing this document, several other reports, and health policy literature more generally, Fooks and Maslove concluded that, “[a]long with the system reviews, researchers, service providers and managers all agree that accountability in the health care system needs improvement.” There are several compelling arguments for improving the accountability of provincial governments, including the growth in health care bureaucracies and the resulting inadequacy of elections as an accountability mechanism, the increasing cost of the health care system, numerous concerns with the quality of health services and access to these services, and the government’s monopoly over much of the health sector. I now turn to discuss each of these arguments in turn.

Two major contributors to accountability concerns are the size and scope of health care bureaucracies, both of which have increased with the expansion of the government’s role beyond that of passive payer. In its report on the health care system, the Standing Senate

99 Supra note 4.
100 Derick W Brinkerhoff, “Accountability and health systems: toward conceptual clarity and policy relevance” (2004) 19:6 Health Policy Plan 371. Borchard refers to the difficulty of successfully proving legal claims against government as “an unjust burden which is becoming graver and more frequent as Government’s activities become more diversified and as we leave to administrative officers in even greater degree the determination of the legal relations of the individual citizen.” Edwin M Borchard, “Government Liability in Tort” (1924-1925) 34 Yale LJ 1 at 1.
Committee on Social Affairs, Science and Technology specifically identified the blurring of traditional health sector functions as an accountability concern: “[t]he Committee is convinced that the separation of the three functions of financing (or insuring), delivering and evaluating health care is an essential step” that will “introduce a much greater degree of transparency and accountability by government.”101 In other words, the Committee, which was chaired by Senator Michael Kirby, concluded that the entity financing and delivering care should not be responsible for evaluating its own performance.

The increasing portion of tax dollars allocated to the health system is another justification for improved accountability. With close to half of provincial budgets now devoted to health care, there are legitimate concerns that Medicare is crowding out other social programs, such as education and other social services (which also have a significant impact on an individual’s health status). Furthermore, there is evidence of health system inefficiency and waste and concerns with the appropriateness and safety of health services, suggesting that governments may be squandering some of these scarce resources.102 As Roy Romanow argues, Canadians “see increasing costs and, as taxpayers and owners of the health system, they expect efficiency and the best value for every dollar spent on health care...People are no longer prepared to simply sit on the sidelines and entrust the health system to governments and providers.”103

102 See generally Ontario Association of Community Care Access Centres, Ontario Hospital Association & Ontario Federation of Community Mental Health and Addiction Programs, Ideas and Opportunities for Bending the Health Care Cost Curve: Advice for the Government of Ontario (Toronto: Ontario Hospital Association, 2010), online: <http://www.oha.com/News/MediaCentre/Documents/Bending%20the%20Health%20Care%20Cost%20Curve%20(Final%20Report%20-%20April%202013%202010).pdf>. In this publication, the institutional authors discuss several strategies for improving health system efficiency. See also Don Drummond, Commission on the Reform of Ontario’s Public Services, Public Services for Ontarians: A Path to Sustainability and Excellence (Toronto: Queen’s Printer for Ontario, 2012), online: Ontario Ministry of Finance <http://www.fin.gov.on.ca/en/reformcommission/chapters/report.pdf>. This report addresses the sustainability of Ontario’s health care system and suggests strategies for improving health system efficiency.
103 Supra note 98 at 49.
The fact that provincial governments have passed legislation creating monopolies for themselves over hospital and physician services is another justification for improved accountability. All provinces limit the availability of alternatives to the public health care system by curtailing the flourishing of a private tier. Although there is interprovincial variation in the specific limits on privatization, regulations typically take the form of direct bans on privatization (for example, bans on duplicate private insurance for publicly insured health services)\textsuperscript{104} and disincentives (for example, prohibitions on doctors charging private patients more for an insured health service than the rate paid under the public plan).\textsuperscript{105} There are arguably persuasive reasons for limiting the growth of a private tier, such as cream-skimming by private providers (leaving the public system with the most difficult cases) or the drain of scarce health human resources to the private system. However, these regulations frequently mean that patients have no alternative but to wait for care within the public system. Data on the number of patients waiting for care and the length of waiting times vary, but it is clear that some patients have to wait longer than medically recommended for care, particularly for elective surgeries, such as knee and hip replacements, and diagnostic testing, such as MRIs.\textsuperscript{106} Given that provincial governments have, in essence, conscripted citizens to the public health system, it is essential that citizens have effective mechanisms to hold governments accountable in order to maintain public support for Medicare.

\textsuperscript{104} Duplicate private insurance covers services that the public plan also covers, while supplementary private insurance, which is permitted across Canada, covers services outside of the public plan (such as optometry services, dental services, and pharmaceuticals).

\textsuperscript{105} For a comprehensive summary of legislative restrictions on privatization across Canada, see Colleen M Flood & Tom Archibald, “The Illegality of Private Health Care in Canada” (2001) 164:6 CMAJ 825.

\textsuperscript{106} According to one report, in 2010-2011, 17 percent of cataract surgery patients, 16 percent of hip replacement patients, 21 percent of knee replacement patients, and 22 percent of hip fracture repair patients did not receive surgery within “the amount of time that clinical evidence shows is appropriate to wait for a procedure.” Canadian Institute for Health Information, \textit{Wait Times in Canada: A Comparison by Province, 2011} (Ottawa: Canadian Institute for Health Information, 2011) at 5-7.
Similarly, the government has sole control over the provision of many public health services, as it is the only actor with the financial and logistical capacity and necessary legal powers to respond to public health threats such as disease outbreaks or natural disasters. Given the public’s reliance on government, its vulnerability to public health threats, and the state’s considerable power to constrain individual liberties to control the spread of disease, mechanisms must also be in place to hold governments accountable for their public health decisions.

Despite an abundance of literature advocating improvements to the accountability of provincial governments, there is considerably less consensus on what accountability means or what is required to achieve accountability. Brown et al refer to accountability as “the suitcase word,” as policy-makers, managers, researchers, and health professionals “pack accountability with meaning, carry it around with us and open it up to explain everything from the quality of our relationships with and expectations of one another, to our requirements for more transparency in the use of resources, to our diagnosis of problems and remedies for improving our healthcare system.”

Several authors adopt typologies to aid in more clearly defining accountability. These typologies are generally quite similar, and I adopt that of Hinton and Wilson:

1. Political accountability, where those with authority are answerable to citizens through elections;
2. Legal accountability, which focuses on the role of courts;
3. Professional accountability, which focuses on the ethical obligations of self-regulating professionals;

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107 For example, provincial governments have such powers as quarantining infected individuals, closing premises, and commandeering necessary health care supplies. See e.g. Health Protection and Promotion Act, RSO 1990, c H.7, ss 22, 77.5.

4. Consumer accountability, which focuses on ombudsmen procedures;

5. Managerial accountability, which is comprised of stewardship, audit and performance assessment;\(^{109}\) and

6. Personal accountability, which relates to the integrity and morality of public service officials.\(^{110}\)

To varying degrees, each of these accountability mechanisms is employed in the Canadian health sector. For example, patients hold health professionals accountable through a mix of legal accountability and professional accountability. Provincial governments subject regional entities to managerial accountability, for example, by creating extensive reporting requirements and accountability agreement obligations. As I discuss in detail in Chapter Five, ombudspersons (consumer accountability) are now an integral component of health sector accountability in Canada. In addition, some individuals working in health delivery organizations or ministries of health would certainly have a sense of personal accountability to the recipients of health services, which would be likely to affect their decisions. However, the primary mechanism by which citizens hold the government accountable for its health sector decisions is by voting in elections. Indeed as Day and Klein argue, democracy demands a system whereby the elected are accountable to the citizenry.\(^{111}\)

Relying on the electoral system as the primary mechanism of governmental accountability may have been sufficient when the state’s sole health system function was that of insurer and its primary decisions were budgetary allocations between health and other sectors or different programs and organizations within the health sector. However, political accountability

\(^{109}\) Day and Klein further divide managerial accountability into 3 subcategories: fiscal (ensuring that money is spent as was agreed upon and in accordance with the appropriate rules), process (ensuring that a given course of action has been carried out and that value for money has been achieved in the use of resources) and program (ensuring that a given course of action or investment of resources achieved its intended result). Patricia Day & Rudolph Klein, *Accountabilities: Five Public Services* (London: Tavistock Publications, 1987) at 27.


\(^{111}\) *Supra* note 109 at 1.
does not adequately address the government’s modern, expanded responsibilities in the health sector. As Rhodes argues, “the traditional mechanisms of accountability in a representative democracy were never designed to cope with multi-organizational, fragmented policy systems.”  Similarly, Day and Klein argue that accountability “flowing from the fact of election, springs from traditional democratic theory uncontaminated by considerations about the complexities of large modern organizations or about the problems of large, uninterested electorates.” These concerns with the adequacy of elections as an accountability mechanism is compounded by the fact that a substantial portion of governmental decision-making occurs not in the legislature, through democratic processes such as parliamentary debate and legislative committee hearings, but behind closed doors in the executive branch of government.

Elections are also inadequate to address the types of managerial decisions that are now an integral component of the government’s modern role in the health sector. As Flood et al argue, a citizen’s voting decision may be influenced broad policy changes, such as a government’s increased support of health system privatization. However, “the failure of a local hospital to streamline its information systems, the stalling of primary care reform in a remote community, or a gynecologist’s performance of more Caesarean sections than are medically necessary are issues unlikely to motivate a citizen to shift her vote.”

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113 Supra note 109 at 51.
114 See Alan C Cairns, “The Past and Future of the Canadian Administrative State” (1990) 40:3 UTLJ 319 at 323. He argues that much of the state’s behaviour “now lies outside the system of accountability supposedly sustained by the practice of responsible government.”
Several scholars argue that accountability demands a remedial component, which is most closely associated with legal accountability.\textsuperscript{116} For example, Brinkerhoff argues that “[a]nswerability without sanctions is generally considered to be weak accountability…legal and regulatory sanctions are at the core of enforcing accountability”\textsuperscript{117} Fraser also links accountability and liability, arguing that “if you want to be truly accountable you should expect and appreciate the fact of liability…accountability without any fear or coercion for consequences is not accountability at all.”\textsuperscript{118}

Other authors advocate enhanced legal accountability on the basis that the courts are a necessary check on legislative decision-making in a democratic system of government. In this regard, Longley argues that the law is “a means of promoting and ensuring accountability and legitimacy in public decision-making, principles which are fundamental to our ideas of democracy and citizenship.”\textsuperscript{119} In the next two chapters, I turn to focus on the role of the courts in improving health sector accountability. I return to the accountability literature in Chapter \textsuperscript{119}Diane Longley, \textit{Public law and health service accountability} (Buckingham: Open University Press, 1993) at 4. See also de Seife, who goes so far as to argue that “[t]he cancer of [governmental] immunity [from liability] erodes the body of democracy and it eventually kills the spirit of democracy by creating a bureaucratic aristocracy which can oppose the people without accountability.” Rodolphe JA de Seife, “The King is Dead, Long Live the King: The Court-Created American Concept of Immunity, the Negation of Equality and Accountability Under Law” (1995-1996) 24 Hofstra L Rev 981 at 989.
Five, when I discuss the relative advantages and disadvantages of the courts and several other accountability mechanisms.

Conclusion

Since the inception of Medicare, provincial governments have significantly expanded their involvement in the health sector, in order to control escalating health care costs and to respond to high rates of unsafe and inappropriate health services. Governments are no longer merely passive payers of services overseen, organized, and delivered by other actors, but rather now have an active role in the management and regulation of clinical decision-making and the delivery of health services.

Beginning in the 1990s, provincial governments implemented regionalization, which was arguably the most transformative health system reform since the inception of Medicare itself. Although one of the stated goals of regionalization was the devolution of state authority to RHAs, the power of these newly-created entities was constrained by the governmental retention of important health sector responsibilities. Furthermore, provincial governments exert significant control over regional entities and hospitals, for example, by requiring ministerial approval of their bylaws and other exercises of their powers, mandating the adoption of particular governance practices and, most intrusively, by appointing administrators with the temporary power to assume the responsibilities of hospital or regional health authority boards. These activities all go well beyond the government’s traditional role of merely fixing health care budgets. Despite these changes, as I discuss in the following chapters, the courts continue to focus on the government’s financial responsibilities in determining whether the parties have a sufficiently close and direct relationship to support a legal duty of care. Even if one accepts the
counter-argument that health providers still exercise primary control over the quality of services received by patients or the view that regionalization resulted in a devolution of state authority, I argue that the courts must still consider the nature of the government’s role in the health sector in determining whether to impose liability.

In addition to the management of previously independent hospitals, governments in Canada and abroad are turning to reforms aimed at influencing or controlling physician decision-making. For example, governments typically added new health services to the schedule of insured services as a matter of course, and physicians could then provide these services at their discretion. However, provincial governments are now increasingly scrutinizing whether new technologies and pharmaceuticals are sufficiently cost-effective to attract public funding and, in some circumstances, what types of patients should receive those services. I argue that the government’s growing regulation of clinical decision-making and the delivery of health services create an increasingly close nexus between patient injuries and government decisions. This is relevant to the legal test for establishing a duty of care, which, as I discuss in Chapter Four, requires a close and direct relationship between the parties. I also discussed areas of the health sector, such as public health, in which the government’s direct organization and delivery of services provide a particularly compelling argument for a close nexus between plaintiffs and governmental defendants.

The government’s expanding involvement in the health sector, along with concerns with rising costs, accessibility of services, and quality of services, have led health policy scholars and members of the public to demand increased governmental accountability. Elections may have been an effective accountability mechanism for the exercise of the government’s traditional budgetary responsibilities. However, in and of itself, political accountability is not equipped to
address the government’s growing managerial responsibilities in the health sector. In the following three chapters, I explore the need for legal accountability, and tort law in particular, to evolve to respond to the government’s modern health sector responsibilities.

I return to this discussion of accountability in Chapter Five, by comparing the advantages and disadvantages of legal accountability with other mechanisms, including complaints to ombudspersons, auditors general, and commissions of inquiry, concluding that the courts are an essential component of improved health sector accountability. While plaintiffs may also be able to advance claims through the Charter and administrative law, these capture different types of claims than tort law. In other words, by taking a restrictive approach to health sector tort cases, Canadian courts are exacerbating the gaps in accountability. Before turning to this comparative analysis of accountability mechanisms, I now explore the judiciary’s treatment of the health sector tort claims in greater detail.
CHAPTER THREE

THE PREMATURE STRIKING OF HEALTH SECTOR TORT CLAIMS

It is as much the duty of Government to render prompt justice against itself in favor of its citizens as to administer the same between private individuals.

- President Abraham Lincoln

Introduction

Tort law underwent a significant transformation in the latter half of the twentieth century, with the passage of legislation bringing the legal relationship between government and citizens closer to the relationship between private parties. This stood in sharp contrast to the historic Crown immunity from tort liability, which was premised upon the courts’ lack of jurisdiction over the sovereign. Although the statutory erosion of immunity did not open the litigation floodgates, over the past few decades, Canadian courts have imposed liability against the government in numerous cases, including claims for breaches of its duties to maintain highways and other public facilities, enforce building codes, and investigate criminal activity. As I discuss in this chapter, this increased judicial receptiveness to governmental tort liability has not occurred in the health sector.

2 There is a complete list of governmental tort liability claims from the past decade in Appendix One. However, see e.g. Cole v McLoughlin, 2003 NLCA 3, Wood v Hugerford (Township), 2004 Carswell Ont 4432 (S.C.), Smith v The City of Winnipeg, 2011 MBQB 52, and BM v British Columbia (Attorney General), 2004 BCCA 402. In many other cases, plaintiffs successfully proved duty, but ultimately failed on other elements of the test for negligence. See e.g. 495862 BC Ltd v Y (CD), 2003 BCSC 1160, Bowes v Edmonton (City), 2007 ABCA 347, Burbank v RTB, 2007 BCCA 215, C(L) v British Columbia, 2005 BCSC 1668, Condominium Corporation No, 9813678 v Statesman Corporation, 2009 ABQB 493, Cragg v Tone et al, 2007 BCCA 441, Dice v Ontario, 2004 Carswell Ont 5147 (Sup C), Foster v Dahiwal, 2006 BCSC 1331, Heinicke v Cooper Rankin Ltd, 2006 MBQB 273, Hill v Hamilton-Wentworth Regional Police Services Board, 2007 SCC 41 [Hill v Hamilton], and Wilson Fuel Co Limited v. Canada (Attorney General), 2009 NSSC 215. Although Brown and Brochu argue that there has been a retreat from widespread governmental liability, these authors also cite several cases that were allowed to proceed to trial. Russell Brown & Shannon Brochu, “Once More Unto the Breach: James v. British Columbia and Problems with the Duty of Care in Canadian Tort Law” (2007-2008) 45 Alta L Rev 1071 at 1071-1072, especially note 10.
I begin this chapter by briefly outlining the facts and the legal findings in the reported governmental health sector tort claims to date. All of these decisions related to pre-trial motions, either by plaintiffs to certify a class action or by governmental defendants to strike the pleadings for failure to state a cause of action. This is reflective of the governmental tort liability jurisprudence more broadly, where defendants tend to challenge claims prior to trial. In Part Two, I explore the primary goals of the rules of civil procedure: accuracy, fairness, and efficiency. I analyze the extent to which the pre-trial dismissals of health sector tort claims further or frustrate these goals, concluding that the judicial reluctance to permit health sector claims to proceed to trial is not justifiable on the basis of these goals.

Having broadly discussed the goals of civil procedure, I then turn to explore the specific procedural rules applicable in the reported health sector tort claims to date—the tests for dismissing claims and certifying class actions. A defendant must meet an onerous burden for a judge to strike a plaintiff’s claim. The seminal decision on pre-trial dismissals is *Hunt v Carey Canada Inc*, in which the Supreme Court of Court stated:

The requirement that it be ‘plain and obvious’ that some or all of the statement of claim disclose no reasonable cause of action before it can be struck out, as well as the proposition that it is singularly inappropriate to use the rule’s summary procedure to prevent a party from proceeding to trial on the grounds that the action raises difficult questions, has been affirmed repeatedly in the last century.³

The Supreme Court and provincial appellate courts have developed a list of factors to inform the decision of whether to permit a case to proceed to trial. Specifically, it is preferable to resolve novel claims, complex claims, claims relating to unsettled areas of the law, and questions of general importance at trial. I argue that courts adjudicating health sector tort claims have failed

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to give appropriate weight to the presence of these factors, which indicated that many of these cases ought to have proceeded to trial. Indeed, in several of the health sector tort claims, judges treated complexity as a justification for striking the claim, rather than a factor in favor of allowing the case to proceed to trial.

In the final part of this chapter, I demonstrate that Canadian courts are more restrictive in their approach to health sector claims than most other types of cases, by empirically contrasting the number of pre-trial dismissals in various sectors of governmental activity. I also consider alternative explanations for the judicial reluctance to impose legal duties in the health sector, including the nature of the injuries typically sustained in those cases (personal or economic injuries), the year of the decisions, the jurisdiction in which the case arose, and the fact that the same court (frequently the same judge) was responsible for deciding most health sector tort cases.

**Part One: A Description of Health Sector Tort Claims**

As the government’s role in the health sector expanded, the public’s expectations rose commensurately, as evidenced by increased calls for governmental accountability. Injured patients historically focused their health sector tort claims on individual health practitioners and, to a lesser extent, hospitals. However, several lawsuits commenced over the past decade name

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4 Several authors discuss heightened public expectations in the health sector. For instance, Decter notes that “[a]ttitudes and expectations are rapidly and markedly transforming as health consumers are becoming more educated and more demanding…health ministers are constantly questioned about the long waiting lists for certain procedures.” Michael B Decter, *Four Strong Winds: Understanding the Growing Challenges to Health Care* (Toronto: Stoddart Publishing Co Limited, 2000) at 28-29. Similarly, in his report on the future of the health care system, Roy Romanow, former Premier of Saskatchewan, makes a number of comments relating to public expectations: “Canadians want and expect both quality of care and timely access to care to be essential hallmarks of the health system…People see increasing costs and, as taxpayers and owners of the health system, they expect efficiency and the best value for every dollar spent on health care…People are no longer prepared to simply sit on the sidelines and entrust the health system to governments and providers. They want to be involved, engaged and acknowledged, and well informed as owners, funders, and essential participants in the health care system” Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada* (Ottawa: Commission on the Future of Health Care in Canada, 2002) at 49.
governmental defendants, either as the sole defendant or in addition to other defendants (primarily hospitals). To date, all of the decisions in the health sector tort cases relate to motions by governmental defendants to strike statements of claim for lack of a cause of action or class certification motions, rather than trials. The purpose of this part is to set out the facts of these cases, in order to facilitate the analysis thereof that occurs in the remainder of this chapter and in the following chapter.

In this part, I only discuss claim arising from personal injuries, thereby excluding governmental decisions resulting solely in economic losses. Examples of the latter type of case include a claim by physiotherapy clinic owners who sought economic damages following a reduction in governmental funding for physiotherapy services, a claim for economic damages resulting from the government’s requirements for a generic drug manufacturer, and a claim by an osteopath who argued that government caused economic damages by failing to appoint a Board of Directors of Osteopathy. The reason for excluding these claims is that different legal rules and policy considerations apply to claims of pure economic loss, as compared to claims for non-pecuniary damages.

In addition, I exclude two health sector cases decided prior to the Supreme Court of Canada’s substantial revision of the test for establishing a duty of care in 2001, which I discuss in further detail in Chapter Four. The exclusion of cases decided prior to 2001 is consistent with

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5 1597203 Ontario Limited v Ontario, 2007 CanLII 21966 (Sup Ct).
6 Apotex Inc. v Astrazeneca Canada Inc., 2009 FC 120.
7 Fenn v Ontario (Health and Long-Term Care), 2005 CanLII 56208 (On CA). Other health sector claims seeking economic damages include a claim that the Canadian Food Inspection Agency’s recall of carrots caused the plaintiff salad company economic losses (The Los Angeles Salad Company Inc v Canadian Food Inspection Agency, 2011 BCSC 779), and a claim that a public health official’s comments to a newspaper respecting the food safety of a restaurant constituted defamation and negligence (PG Restaurant Ltd v Northern Interior Regional Health Board et al, 2004 BCSC 294).
8 For a history of the Supreme Court’s development of the doctrine for pure economic loss see Bruce Feldthusen, “The Recovery of Pure Economic Loss in Canada: Proximity, Justice, Rationality, and Chaos” (1996-1997) 24 Man LJ 1. Pure economic loss refers to financial losses that occur independent of personal injury to the plaintiff or injury to his property.
my treatment of cases from other sectors in Part Three and the Appendices. Furthermore, these health sector claims had unique factual elements that have not been applicable in subsequent claims.9

To date, health sector tort cases against governmental defendants fall into three broad categories: mismanagement of disease outbreaks, negligent oversight of the health sector, and patients who have died or sustained injuries waiting for medical care.10 With respect to the first of these categories, several individuals infected with either severe acute respiratory syndrome (SARS) or West Nile Virus commenced claims alleging that the Ontario government was negligent in responding to these disease outbreaks. The plaintiffs in the SARS cases were

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9 In 2000, in Decock v Alberta, [2000] AJ No 419, the Court of Appeal refused to dismiss a claim against the Minister of Health and the Premier that was commenced by several plaintiffs who experienced delays in receiving care. After the first plaintiff suffered an eye injury, personnel at a small community hospital referred him to a hospital in Calgary for treatment. He alleged that his injury was exacerbated by the lack of treatment at the first hospital and inadequate treatment at the second hospital in Calgary. The estate of the second plaintiff, who died after suffering a series of seizures, alleged that hospital personnel failed to provide treatment. The third plaintiff, who was pregnant, went to a hospital after suffering from severe abdominal pain and bleeding. She alleged that medical personnel examined her but turned her away without treatment on two separate occasions. When she returned for a third visit, hospital personnel notified her that the fetus was dead and prescribed analgesics. She returned to the hospital on a fourth occasion with abdominal pain and waited for approximately one and a half hours without being examined. The fourth plaintiff underwent neurosurgery in Toronto and returned to Calgary via air ambulance. He alleged that he suffered injury by being placed in a sitting position, rather than the prone position ordered by his physician. The final plaintiff attended at a hospital with tingling in her arms and legs, facial numbness, and chest pain. After spending two hours in the waiting room, she suffered a massive stroke that led to her death. These plaintiffs pointed to a number of deficiencies in the defendants’ oversight of the health system, including failure to supervise the operation of hospitals, failure to provide reasonable and proper health care services, and failure to ensure that hospitals had adequate staffing and equipment. Unlike the other health sector decisions, this motion focused on the proper naming of governmental defendants, vicarious liability, and the legal status of the Minister of Health and the Premier. Although the Supreme Court of Canada had granted leave to hear this case, the Crown discontinued its appeal, perhaps after settling the claim. “Docket 27980”, online: Supreme Court of Canada <http://cases-dossiers.scc-csc.gc.ca/information/cms/docket_e.asp?27980>. The second pre-Cooper case was Marble (Litigation Guardian of) v Saskatchewan, 2001 SKQB 199. In that case, the plaintiff obtained a judgment against the negligent treating physician, which was unenforceable when he emigrated to South Africa. She then commenced an action against the hospital and the College of Physicians and Surgeons, alleging that they were negligent for failing to ensure the physician had insurance. After settling this action with the hospital defendant, the plaintiff executed a release, in which she agreed not to make any further claims against the hospital or any other party who might claim contributory indemnity from the released defendants. The plaintiff then brought an action against the government, alleging that it was negligent in failing to ensure that hospitals required doctors to carry malpractice insurance, and the government sought indemnity from the hospital. The Court dismissed the claim, accepting the province’s argument that because it was entitled to indemnity from the hospital, it was entitled to rely on the release, (2003), 236 Sask R 14.

10 My searches captured the available cases on CanLII and Westlaw, but motions to strike or class certification motions may be underreported, particularly as compared to trial decisions.
individuals who contracted the disease, their family members, and nurses. Despite some variance in the language of the pleadings, Williams v Ontario, is illustrative of the claims by members of the public who contracted SARS. In that case, the plaintiffs set out numerous specific allegations against the government, including:

- failing to co-ordinate with other levels of government;
- failing to maintain and upgrade equipment and facilities;
- issuing inappropriate directives to hospitals;
- prematurely terminating preventative measures;
- failing to take measures the government ought to have known would limit the spread of SARS; and
- failing to protect the health of citizens and warning them of the danger of SARS.

Abarquez v Ontario is illustrative of the allegations made by health care workers against the government in response to its management of SARS. In that case, the plaintiffs claimed that the government failed to provide nurses with timely information about SARS and issued inadequate directives to hospitals that exposed the plaintiffs to the risk of infection. In the various SARS claims, trial judges struck several overly broad and vague allegations from the pleadings and the Ontario Court of Appeal struck the remaining claims in their entirety, on the basis that the government did not owe the plaintiffs a duty of care.

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11 2009 ONCA 378 [Williams], Jamal Estate v The Scarborough Hospital, 2009 ONCA 376 [Jamal].
12 2009 ONCA 374[Abarquez], Laroza Estate v Ontario, 2009 ONCA 373 and Henry Estate v The Scarborough Hospital, 2009 ONCA 375.
13 Supra note 11 at paras 9-12.
14 Supra note 12. There were also allegations under occupational health legislation that the Ministry of Health and Long-Term Care was an employer/supervisor and failed to ensure the nurses’ health and safety. The plaintiffs also alleged that the Ministry of Labour failed to enforce directives and occupational health and safety standards. Finally, the plaintiffs claimed that the government breached the nurses’ section 7 Charter rights by exercising discretion in bad faith and for improper motives (i.e. the government was more concerned with lost tourism revenue than worker safety in prematurely lifting the state of emergency).
In 2006, the Ontario Court of Appeal heard *Eliopoulos v Ontario (Minister of Health and Long Term Care)*.\(^{15}\) This action was one of approximately forty claims in which the plaintiffs alleged that the government owed a duty to take reasonable steps to prevent the spread of West Nile Virus.\(^{16}\) Specifically, the pleadings alleged that the government:

- failed to implement a plan that it developed to combat the disease;
- removed key scientists from the project;
- failed to take effective measures to reduce the mosquito population;
- failed to coordinate its efforts with the Centers for Disease Control and neighboring jurisdictions; and
- failed to provide accurate information to the public regarding the threat of West Nile Virus.

In all of the SARS and West Nile Virus disease outbreak cases, the Ontario Court of Appeal granted governmental pre-trial motions to strike, finding that the plaintiffs’ allegations could not support a negligence claim against the province. These motions were resolved solely on the issue of whether the defendant owed the plaintiff a duty of care, and judges did not consider other aspects of the negligence inquiry (namely, breach of duty, causation, or damage).

The next category of claims are allegations of gaps in governmental health sector oversight. In 2009, in *Nette v Stiles*,\(^{17}\) the Alberta Court of Queen’s Bench struck a prospective class action that claimed that the province failed to discharge its responsibility to safeguard the quality of chiropractic services. The plaintiff, who was injured after a cervical manipulation, claimed that the defendant had received numerous complaints respecting the safety of this specific service and had a corresponding duty to respond to those safety concerns. Also decided

\(^{15}\) [2006] OJ No 4400 [*Eliopoulos*].
\(^{16}\) The parties agreed to proceed with one claim in order to avoid repeated adjudication of the same legal and factual issues.
\(^{17}\) 2009 ABQB 422.
in 2009, in *Blue v Ontario*, the Ontario Superior Court struck a claim in which a self-represented litigant made vague allegations that the Minister of Health and Long-Term Care ought to have overseen her elderly father’s care in a hospital. Although the court stated that they were willing to read the claim broadly and overlook the considerable drafting deficiencies, the plaintiff failed to explicitly plead a duty of care or any cause of action. Finally, in *Cerqueira v Ontario*, the plaintiff alleged that the government failed to ensure adherence with the Ontario *Long Term Care Act*’s client Bill of Rights and failed to exercise oversight over an approved agency providing services under the *Act*. As with the disease outbreak claims, the courts dismissed all three of these negligent oversight claims on the basis that the plaintiffs would be unable to prove that the government owed them a duty of care.

Plaintiffs have made similar allegations of negligent health system oversight at the federal level regarding Health Canada’s regulation of medical devices, including temporomandibular joint implants, breast implants, and incontinence devices. These claims allege that Health Canada knew of the dangers associated with these products and negligently approved these devices, failed to regulate their use, or permitted their continued use in the face of reported injuries. Similar to the claims against provincial governments, courts struck all but one of the claims against Health Canada on pre-trial motions. Although I focus on the evolving

\[\text{18} \quad 2009 \text{CanLII 18671.} \\
\text{19} \quad 2010 \text{ONSC 3954.} \\
\text{20} \quad \text{*Drady v Canada (Health)*, 2008 ONCA 639 and *Taylor v Canada (Health)*, 2010 ONSC 4799. The pleadings alleged that the defendant knew of the dangers of the implants (in particular, of prolonged implantation), and failed to regulate their approval or warn consumers of their risks. The plaintiffs also claimed that they relied on the safety of implants by virtue of their status as an approved device. The only significant difference between these two actions was the fact that in *Taylor*, the plaintiff was unable to sue the manufacturer, as the device was unlabeled. The Ontario Court of Appeal struck the claim in *Drady*, but permitted class certification in *Taylor*.} \\
\text{21} \quad \text{*Attis v Canada*, 2008 ONCA 660. The proposed class of plaintiffs argued that they had relied on Health Canada to ensure the safety of medical devices. They further claimed that as the federal government had established a comprehensive system of regulation, it was obliged to operate that system non-negligently. Finally, the plaintiffs argued that the government had knowledge of the unsuitability of the implants, including their predilection to deteriorate and link. The Ontario Court of Appeal denied the plaintiff’s class certification motion.} \\
\text{22} \quad \text{*Klein v American Medical Systems, Inc.*, 2006 CanLII 42799 (On Sup C)[Klein].} \]
responsibilities and resulting legal duties of provincial governments, where relevant, I use these Health Canada claims as examples, as the legal findings and policy issues are substantively similar to the cases against the provinces.

The third category of health sector tort claim involves individuals who sustained injury or died after failing to receive timely care. In *Mitchell Estate v Ontario*, an infant allegedly died due to emergency room overcrowding resulting from reductions in funding and hospital restructuring decisions. The estate commenced a claim against the province, the Premier, and the Minister of Health, alleging that the defendants had a duty to provide reasonable and proper medical care and treatment, particularly when the patient was vulnerable and required life-saving, medically necessary care. The estate commenced a separate action against the doctors and the hospital. The Ontario Superior Court struck the claim against the government, finding that the plaintiff could not prove that the defendants owed them a duty of care.

In 2004, a group of plaintiffs applied to certify a class action against the Quebec government and twelve hospitals. In this case, *Cilinger v Centre Hospitalier de Chicoutimi*, the plaintiffs argued that they did not receive radiation therapy for breast cancer within the medically recommended time. Although the Quebec Court of Appeal certified the class action against the hospital defendants, they nevertheless refused to allow the claim to proceed against the provincial government. In another case relating to oncology treatment waiting times, *Waan v Alberta*, the plaintiff sued the government for non-pecuniary damages and reimbursement for surgery he paid for out-of-pocket in Germany. The Court of Queen’s Bench found that the plaintiff’s claim could not satisfy the test to establish a duty of care.

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23 2004 CanLII 4044 (Sup C)[Mitchell].
24 [2004] RJQ 3083 [Cilinger].
25 2008 ABQB 544.
Finally, in *Heaslip Estate v Ontario*, a boy died after employees of the Ontario government failed to follow an air ambulance policy addressing the prioritization of urgent cases.\(^{26}\) In this case, the child suffered a collapsed lung, a lung laceration, numerous rib fractures, vascular congestion, and edema\(^{27}\) after hitting a tree in a tobogganing accident. Physicians at a nearby community hospital sent him in a land ambulance to Toronto after the Medical Air Transport Centre informed them that a helicopter would not be available for two hours. The patient died at another hospital mid-transfer. The pleadings claimed that the province’s only air ambulance in operation that day\(^{28}\) was nearby the scene of the accident and was carrying a non-urgent patient. The Court of Appeal allowed this case to proceed to trial because, as the health service provider, the government (through its employees) had direct involvement with the deceased. Unlike other health sector tort claims, there were no other defendants more closely involved in providing health care services to the child. A trial decision has not been issued in *Heaslip* to date, and given that three years have lapsed since the motion to strike, it is possible that the Ontario government elected to settle this case and that the settlement agreement was confidential.

In sum, of the thirteen health sector claims\(^{29}\) against provincial governments, judges permitted only one to proceed to trial. At this time, it is unclear whether anything short of the governmental provision of health care services, and the resulting direct interaction between the defendant’s employees and the plaintiff, will suffice to ground a governmental duty of care.

\(^{26}\) 2009 ONCA 594 [*Heaslip*].

\(^{27}\) Vascular congestion is the engorgement of blood vessels. Edema is an accumulation of fluid under the skin or in a body cavity (the chest cavity in this case).

\(^{28}\) There were two other on-duty air ambulances. One was grounded because the pilot had reached his maximum number of permissible flying hours for that day. The other air ambulance was grounded for repairs.

\(^{29}\) As noted above, I only include post-*Cooper*, personal injury claims against provincial governments in this figure. In addition, I only counted one of the approximately forty West Nile Virus claims. The Court selected one case to proceed and issued one decision with the intention that its conclusions would apply in the other, similar-worded, claims.
Interestingly, outside of the health context, the Supreme Court of Canada has indicated that a personal relationship between the parties is not a prerequisite to a duty of care: “A sufficiently close and direct connection between the actions of the wrongdoer and the victim may exist where there is a personal relationship between alleged wrongdoer and victim. However, it may also exist where there is no personal relationship between the victim and wrongdoer.”

Although I discuss the test for establishing a duty of care in detail in the following chapter, briefly, the plaintiff must prove that her injury was foreseeable and that the parties had a close and direct (or ‘proximate’) relationship. The defendant may then demonstrate that the courts should limit or negate a duty of care due to policy considerations. The burden for meeting the foreseeability test is low, and all of the health sector claims discussed in this part have met that requirement. However, nearly all of the plaintiffs failed to satisfy the test for proximity, generally because the government owed a duty to the public as a whole, which would conflict with a duty to a specific individual. In addition, several policy considerations have militated against a finding of duty, including potentially indeterminate liability, the imposition of an unreasonable burden on government, and the desire to permit government to make difficult resource allocation decisions in the general public interest rather than out of fear of liability. In addition, the courts have generally focused on the government’s financial role, which precludes the imposition of a legal duty, as the courts will not review governmental policy decisions, a category that typically captures budgetary decisions. Having set out the facts of the reported health sector tort claims to date and the legal test they required the courts to apply, I now turn to criticize the judiciary’s resolution of these claims on pre-trial motions.

30 Hill v Hamilton, supra note 2 at para 29.
Part Two: An Analysis of the Pre-Trial Dismissal of Health Sector Tort Claims

The Canadian judiciary has set a high burden to strike a claim on a pre-trial motion, with courts preferring to allow plaintiffs to have their day in court, even in claims against governmental defendants. While I explore the legal test in detail below, briefly, a defendant must prove that it is “plain and obvious” that the plaintiff is bound to fail at trial in order for a judge to dismiss a claim for lack of a cause of action.\(^{31}\) With respect to class certification motions, the courts similarly inquire whether the pleadings disclose a cause of action, in addition to several other requirements.\(^{32}\) However, unlike a motion to dismiss, the plaintiff bears the burden of proof in a class certification motion. I begin this section with a general discussion of the goals of civil procedure and the extent to which the pre-trial dismissal of health sector tort claims advanced these goals. I then turn to a specific discussion of the legal tests for striking claims and certifying class actions and the application of this jurisprudence in health sector tort claims.

A. The Goals of Procedural Rules and the Health Sector Claims

Historically, the primary purpose of the rules of civil procedure was to promote fairness in litigation through consistency and certainty. The judiciary’s view of fairness was relatively narrow, with courts focusing on the impact of their decisions on the immediate parties to the litigation, rather than a broader notion of fairness to the entire community of potential litigants. The rules reflected a commitment to the adversarial process, and favored the collection of all

\(^{31}\) Hunt v Carey, supra note 3. As noted above, this is the seminal Canadian case on striking claims.

\(^{32}\) As I discuss below, the specific wording of the requirements for class certification vary depending on the jurisdiction. Generally, in addition to the requirement that the pleadings disclose a cause of action, the plaintiff must prove that she is a suitable class representative, that the various members of the class have common legal and/or factual issues, and that a class action is the preferable procedural vehicle to advance the claim.
relevant facts and the opportunity to make submissions before a judge. However, the courts balanced these rights of plaintiffs against protection for defendants from meritless or vexatious suits. In *Metropolitan Bank, Ltd v Pooley*, the Lord Chancellor explained that even prior to the codification of the rules of civil procedure in 1873, courts could use their inherent jurisdiction to stay a “manifestly vexatious suit which was plainly an abuse of the authority of the court.” In other words, judges could ensure that litigants did not use the courts as a forum to harass other parties with claims that were clearly without merit.

The modern rule governing the pre-trial dismissal of claims developed from this judicial concern with abuse of process. Due to the narrow range of behavior that this discretion was designed to prevent and the importance attributed to the right to be heard, judges developed a restrictive test for striking claims. In 1911, the House of Lords stated that this rule was “to be very sparingly used, and rarely, if ever, excepting in cases where the action is an abuse of legal procedure…” Citing this case with approval, the Supreme Court of Canada similarly set a high burden to strike a claim: it must be “plain and obvious” that the plaintiff is bound to fail. The Court went on to state that “it is evident that our judicial system would never permit a plaintiff to be ‘driven from the judgment seat’ in this way without any Court having considered his right to

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33 J Macfarlane, “The Future of the Civil Justice System: Three Narratives About Changes” (2009) 35:3 Advoc Q 284. This also includes, for example, the right to cross-examine witnesses, disclosure of documents, and pre-trial discovery of witnesses.

34 [1881] All ER 949 at 951 (HL), referring to the *Supreme Court of Judicature Act*.

35 According to the Supreme Court of Canada, the modern rule permitting pre-trial dismissals “was derived from the courts' power to ensure both that they remained a forum in which genuine legal issues were addressed and that they did not become a vehicle for ‘vexatious’ actions without legal merit designed solely to harass another party.” *Hunt v Carey*, supra note 3 at 970. The Court also noted that the provisions for striking a claim for lack of a cause of action often appear in the same section of procedural rules as the rule permitting a judge to strike a claim as an abuse of process, and the power to dismiss “take[s] some color” from this context.

36 *Dyson v Attorney General*, [1911] 1 KB 410 at 418 (CA) [Dyson], cited in *Hunt v Carey*, supra note 3 at 972 and by the Ontario Superior Court decision in the West Nile Virus claim, *Eliopoulos v Ontario (Minister of Health and Long Term Care)*, 2004 CanLII 4030 at para 8 (later overturned by the Court of Appeal, *supra* note 15).

37 *Hunt v Carey*, supra note 3 at 975.
be heard, excepting in cases where the cause of action was obviously and almost incontestably bad.”³⁸

Judges have alternatively referred to this test as requiring that the claim is “unarguable,”³⁹ “contains a radical defect,”⁴⁰ is “certain to fail,”⁴¹ or is “hopeless.”⁴² Courts must accept all facts asserted in the plaintiff’s statement of claim as proven, and must allow the case to proceed to trial “so long as the pleadings disclose a cause of action.”⁴³ This onerous standard is underscored by the Supreme Court’s adoption of wording that is more analogous to the criminal burden of proof than the civil standard: it must be “beyond reasonable doubt” that a plaintiff cannot succeed.⁴⁴

The courts now face pressure to interpret procedural rules in light of growing concerns with inadequate access to scarce judicial resources.⁴⁵ Judges are now not only concerned with whether their interpretation of the rules is fair to the litigants before them, but may also consider the impact of their decisions on the ability of other individuals to access the courts. In other words, judges must balance fairness, accuracy, and efficiency, not only to the immediate parties to the litigation, but across the broader pool of prospective litigants. Although the judiciary’s articulation of the test for striking claims has not explicitly changed in light of mounting access to justice concerns, these considerations are likely to affect the disposition of procedural motions. In governmental tort liability cases, including health sector claims, judges have

³⁸ Hunt v Carey, supra note 3, citing Dyson, supra note 36 at 419 [emphasis added].
⁴⁰ Hunt v Carey, supra note 3 at 975.
⁴¹ Hunt v Carey, supra note 3 at 975.
⁴³ Lograsso v Kichar, 2009 CanLII 7093 at para 9 (On CA).
⁴⁴ Dumont v Canada (Attorney General), [1990] 1 SCR 279 at 280. See also Minnes v Minnes (1962), 39 WWR 112 at 122 in which the British Columbia Court of Appeal stated that this rule “should be exercised only where the case is absolutely beyond doubt.”
⁴⁵ For a general critique of access to justice in Canada, see e.g. Beverley McLachlin, “The Challenges We Face” (2007) 40 UBC L Rev 819 and Michael Trebilcock, Anthony Duggan & Lorne Sossin, eds, Middle Income Access to Justice (Toronto: University of Toronto Press, 2012).
expressed a concern with opening the litigation floodgates, which has implications for the use of scarce judicial resources. In addition, due to the complexity of the health sector, which I discuss below, trying these tort claims is likely to consume more of the courts’ time than many other types of claims.

With regard to the balance between fairness and efficiency, judges strive to fairly allocate resources across all cases, minimizing the resources expended on cases that are clearly without merit. In describing the desirable attributes of an effective civil justice system, Zuckerman highlights the importance of this balance: “A service is efficient if its resources are used to maximise benefit output and are not unnecessarily wasted on unproductive activities…A service is fair if the resources available to it are justly distributed between those entitled to the service, whether their needs are present or merely contingent…”46 Zuckerman does not define the criteria that determine whether resources are “justly distributed.” However, as I discuss below, the Canadian judiciary’s interpretation of the test for striking claims reflects a preference for allocating scarce resources to particular categories of cases, such as important questions of law. Cases raising important issues are seen to be an efficient use of resources due to, for example, the broad applicability of their findings beyond the parties or their potential impact on governmental policy-making more broadly.

The judicial preference for devoting resources to specific types of claims finds support in the rules of interpretation in codes of civil procedure. For example, Ontario’s Code of Civil Procedure states that “[i]n applying these rules, the court shall make orders and give directions that are proportionate to the importance and complexity of the issues, and to the amount

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Recent amendments to procedural rules facilitate the cost-effective resolution of claims that fail to meet criteria such as complexity or high monetary value, for example, streamlined procedures for simple cases and increased limits on the monetary jurisdiction of small claims courts.\(^{48}\)

The tension between efficiency and accuracy also guides the application of procedural rules. Our legal system is adversarial, whereby the truth is presumed to emerge through the exhaustive investigation of evidence, the cross-examination of witnesses to assess credibility, and the production of all relevant documents, all before an impartial arbiter.\(^{49}\) However, various rules of civil procedure, such as summary judgment or the pre-trial dismissal of actions, abrogate this historical commitment to the adversarial system. Parallel process to the judicial system, such as mediation and arbitration, further shift us away from the traditional mode of dispute resolution. These procedures, which expedite the resolution of claims, may restrict the ability of the litigants and the courts to uncover all relevant facts, thereby increasing the likelihood of erroneous decisions.\(^{50}\) As MacFarlane argues, these recent procedural amendments raise “a tension between the simplification of the litigation process—with the avowed goals of achieving

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\(^{47}\) *Ontario Code of Civil Procedure*, Rule 1.04 (1.1). Several commentators also advocate proportionality in the application of procedural rules. For example, Clarke argues that the goal of civil procedure should be “to guide court and litigant behaviour so as to enable disputes to be resolved justly through the use of proportionate time and at proportionate expense.” Sir Anthony Clarke, “Civil justice: the importance of the rule of law” (2009) 43 International Lawyer 39. Similarly, the British Columbia Civil Rules Working Group concluded that “the court must allow each case only a share of the court’s resources that is proportionate to the significance of the case, while taking into account the need to allot resources to other cases,” British Columbia Justice Review Task Force, *Effective and Affordable Civil Justice* (Vancouver: British Columbia Ministry of Justice, 2006) at 20, online: B.C. Justice Review Task Force <http://www.bcjusticereview.org/working_groups/civil_justice/cjrgw_report_11_06.pdf>. See also Ontario’s Osborne report, which noted that in assigning time and resources to cases, the courts should consider “the amount at stake and the issues in dispute.” Coulter A Osborne, *Civil Justice Reform Project: Summary of Findings and Recommendations* (Toronto: Ontario Ministry of the Attorney General, 2007) at ii, online: Ontario Ministry of the Attorney General <http://www.attorneygeneral.jus.gov.on.ca/english/about/pubs/cjrp/CJRP-Report_EN.pdf>.

\(^{48}\) It is important to note that efficiency is not the only concern underlying these rule changes. Rules of simplified procedure also reflect a desire to make the judicial system more accessible to self-represented litigants.

\(^{49}\) Macfarlane, *supra* note 33.

\(^{50}\) There is a great deal of subjectivity in applying legal rules, and thus it is difficult to decisively say whether a particular decision was right or wrong. However, the definition of error that I employ here is whether a judge would have decided a claim differently if he or she had all of the available evidence.
faster and less costly justice—and a concern that shaving pieces off a system designed to uncover truth and promote certainty may in fact diminish, rather than enhance, access to justice.”

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The rules of civil procedure also legitimize the relevance of cost concerns in the resolution of disputes. For example, a general principle of interpretation in Ontario’s Code of Civil Procedure is that “rules shall be liberally construed to secure the just, most expeditious and least expensive determination of every civil suit on its merits.”

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While a full evidentiary record obtained at trial arguably improves the accuracy of a judge’s decision, it is an inefficient use of judicial resources to allow clearly meritless claims to proceed to trial. As I discuss in detail below, the modern interpretation of the test for striking claims accounts for the need to balance accuracy and efficiency, with judges preferring to allow novel claims to proceed to trial, and acknowledging that complex legal determinations may require the fact-finding process of a trial. In other words, the risk of inaccuracy in these types of cases is sufficient to merit the use of judicial resources.

Having set out the tensions between fairness, accuracy, and efficiency that judges face in applying the rules of civil procedure, in the remainder of this part, I argue that the pre-trial dismissal of nearly all of the health sector tort claims fails to appropriately balance these broader goals. Specifically, I argue that although the dismissal of these claims conserves scarce judicial resources, these monetary gains do not justify the negative implications of these decisions for the goals of fairness and accuracy.

51 Supra note 33.
52 Supra note 47, Rule 1.04(1).
i. Fairness

With respect to fairness, as I argued in Chapter Two, governmental health sector accountability is crucial, given the substantial share of provincial expenditures devoted to the health system, growing concerns with the quality of and access to health services, expanding governmental health sector control and influence, and the state’s monopoly over much of the health sector. It is thus essential for policy-makers to employ a fair and deliberate decision-making process, and for citizens to have a forum where an independent arbiter can review the government’s decisions. Exempting the state’s decisions from scrutiny not only denies the individual plaintiffs an opportunity to be heard, but deprives citizens more generally of the transparency that would flow from the judicial scrutiny of the reasonableness of the government’s health sector decisions.

Although health sector tort pleadings are broad and sometimes vague, this is arguably due to the complexity of the health sector and the lack of transparency in the government’s decision-making process, rather than reflective of the merits of the plaintiffs’ claims. Because the government has exclusive knowledge of the particulars of its decision-making process, it is unfair to plaintiffs when courts strike claims solely on these grounds. Furthermore, the motion to strike jurisprudence permits courts to read the plaintiffs claim generously, which includes overlooking considerable drafting deficiencies. For example, the New Brunswick Court of Appeal has stated that: “judges of this Province have, without fail, applied the test articulated in Hunt to...‘accommodate drafting deficiencies by a generous reading of the contested

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53 See e.g. Williams, supra note 11, in which the courts were critical of very general allegations with respect to “systemic negligence.”
text’…where a generous reading of [the provisions of the Statement of Claim] fails to breathe life into a pleading, all suitable amendments should be allowed.”

With respect to fairness to governmental defendants, there is nothing in health sector jurisprudence to suggest that the plaintiffs are attempting to abuse the court’s process or advance meritless claims. Indeed, a commission of inquiry into the SARS outbreak was highly critical of the government’s management of the disease, suggesting that these plaintiffs had legitimate grievances, even if their claims were ultimately not actionable in negligence. Specifically, the report described the public health system as “unprepared, fragmented, poorly led, uncoordinated, inadequately resourced, professional impoverished, and generally incapable of discharging its mandate.” Given the considerable advantages that governmental defendants have in the litigation process (in terms of resources and favorable legal doctrine and procedural rules), it is difficult to argue that a less restrictive approach to liability would be unfair to the government. In addition, the judiciary’s discretion over cost awards acts as a deterrent to prospective claimants seeking to advance frivolous or meritless claims.

**ii. Accuracy**

The resolution of complex health sector claims on pre-trial motions, without a detailed factual foundation, jeopardizes the accuracy of the courts’ determinations. As I discuss in the next chapter, health sector tort claims do not merely call upon the courts to apply well-defined legal tests to clear sets of facts. Instead, the law of governmental tort liability has evolved a great deal in the past twenty years and there are several unresolved and contentious issues in this body

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56 For example, the fact that policy decisions are exempt from the review of the courts, a generous interpretation of reasonableness in the standard of care, and procedural advantages relating to notice and limitation periods.
of jurisprudence that require a more exacting approach. As I described in Chapter Two, since the inception of Medicare, the government’s role in the health sector has also been continually evolving. Furthermore, as I discuss in the next section, the government’s health sector responsibilities, its web of relationships with other health system actors, and its policy-making process are fraught with complexity. Given this complexity, there is a considerable risk that judges would have reached different conclusions on the merits of health sector tort claims had they been permitted to proceed to trial and the court had a full factual record to inform its decision.

**iii. Efficiency**

With respect to efficiency, excluding complex health sector claims from the judicial system certainly conserves resources, as these claims would likely have resulted in high litigation costs had they proceeded to trial. However, because plaintiffs are commencing health sector tort claims with increased frequency, and the majority of these cases are reaching provincial appellate courts, it may be more efficient to allow some of these claims to proceed to trial. This would allow a judge to provide a more comprehensive analysis of the government’s health sector responsibilities and to send an important signal to those trusted with running our health care system to engage in a more transparent and deliberate decision-making process and to achieve a minimum level of competence in carrying out its responsibilities, which may help to avoid future claims.

Many health sector tort claims are class actions, claims with multiple plaintiffs, or representative claims. The fact that a single case is determinative of the rights of multiple

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57 For example, *Cilinger, supra* note 24; *Williams, supra* note 11.
58 For example in *Abarquez, supra* note 12, the plaintiffs were 28 nurses who contracted SARS.
plaintiffs improves the efficiency of the use of judicial resources. In this regard, in the seminal case on class action litigation, *Western Canadian Shopping Centres Inc v Dutton*, the Supreme Court of Canada stated, “[p]articularly in complicated cases implicating the interests of many people, the class action may provide the best means of fair and efficient resolution.”

**iv. Balancing These Goals in Health Sector Tort Claims**

Instead of reflecting a concern with balancing fairness, accuracy, and efficiency, the health sector decisions reveal different judicial policy concerns. In these cases, the courts repeatedly stress the importance of allowing the government to make decisions in the broader public interest, rather than in response to the threat of litigation. Judges also emphasize their concerns about indeterminate liability and the unjust burden on government that tort liability could create. As I discuss in Chapter Four, while these concerns properly form part of the second stage of the duty analysis—policy considerations that may limit or negate duty—judges must balance these concerns against countervailing considerations such as fairness, accuracy, and efficiency. Furthermore, vaguely articulated policy considerations such as ‘indeterminate liability,’ for which there is no empirical evidence before the court, are arguably impossible to

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59 In *Eliopoulos, supra* note 15, the parties agreed to proceed with one of approximately forty individual claims, on the understanding that those findings would apply to the other claims.
60 2001 SCC 46 at para 1. The test for class actions from this case was influential in the subsequent codification of the requirements for class action certification by a number of provinces.
61 For example, in *Williams, supra* note 11, the Ontario Court of Appeal stressed the fact that the powers to protect the public from disease “are to be exercised…in the general public interest” and they “are not aimed at or geared to the protection of the private interests of specific individuals” (para 25). The Court went on to state that acting in the public interest requires balancing “a myriad of competing interests,” which is inconsistent with a duty in tort (para 25). Later in the decision, the Court again emphasized that “Ontario was required to address the interests of the public at large rather than focus on the particular interests of the plaintiff” (para 31). The Court also stated that public officials “must weigh and balance the advantages and disadvantages and strive to act in a manner that best meets the overall interests of the public at large” (para 31).
62 In *Williams, supra* note 11, the Court of Appeal found that “to impose a private law duty of care…would create an unreasonable and undesirable burden on Ontario that would interfere with sound decision-making in the realm of public health. Public health priorities should be based on the general public interest. Public health authorities should be left to decide where to focus their attention and resources without the fear or threat of lawsuits” (para 31).
adjudicate in the absence of a factual record on a pre-trial motion. For example, what is the actual potential scope of governmental liability in the face of a disease outbreak or for the deaths of patients who die in the emergency room? What evidence is there that fear of liability will actually adversely affect sound government decision-making? These are complex issues that likely require expert testimony and economic and policy evidence.\(^{63}\) If a court uses policy considerations to foreclose a plaintiff’s legal remedies and, more broadly, declines to act as an independent check on government decisions, it should only do so on the basis of clear evidence.

Although a plaintiff must establish a *prima facie* duty of care, the burden is on the defendant to prove the policy considerations that it seeks to invoke to limit or negate that duty.\(^{64}\) The courts are to read a plaintiff’s claim generously and accept all facts as proven.\(^{65}\) The defendant’s evidence does not receive the same benefit. The Supreme Court of Canada has instructed that “the potential for the defendant to present a strong defense” should not prevent the plaintiff from proceeding to trial.\(^{66}\) Therefore, although there may be persuasive reasons for limiting governmental liability in certain circumstances,\(^{67}\) vague government allegations of overriding policy concerns such as ‘indeterminate liability’ should not have the significant, if not determinative, effect they have in health sector claims.

\(^{63}\) In an Ontario Court of Appeal case, *Spasic Estate v Imperial Tobacco Ltd*, 2000 CanLII 17170, the Court discussed the importance of having a full factual record to assess the policy effects of its legal determinations: “A motion such as this is not the place to set out a detailed treatise on the tort of spoliation for many reasons, chief among them being that as with virtually all legal analysis, a factual nexus is needed to properly assess the consequences of the various conclusions.”

\(^{64}\) In *Cooper v Hobart*, 2001 SCC 79, the Court did not explicitly articulate this burden shift. However, almost all subsequent cases have looked to the defendant to introduce policy considerations to limit or negate duty.

\(^{65}\) *Lograsso v Kichar*, supra note 43.

\(^{66}\) The Court went on to state that “Only if the action is certain to fail because it contains a radical defect…should the relevant portions of a plaintiff’s statement of claim be struck out.” *Hunt v Carey*, supra note 3 at para 33. The Court adopted the following quotation from Lord Pearson of the House of Lords: “It is not permissable to anticipate the defence or defences—possibly some very strong ones—which the defendants may plead and be able to prove at the trial, nor anything which the plaintiff may plead in reply and seek to rely on at the trial.”

\(^{67}\) I address the criticisms of governmental liability in detail in Chapter Five.
Having discussed the general principles underlying the pre-trial adjudication of claims—fairness, accuracy, and efficiency—I now turn to analyze the courts’ application of the specific legal tests to health sector claims. Although there is a great deal of flexibility inherent in legal tests as broad as “plain and obvious,” I argue that judges adjudicating health sector tort claims have disregarded various specific considerations deemed relevant to the application of this rule by the Supreme Court of Canada and provincial appellate courts. Instead, judges are seemingly using the considerable discretion built into the broad language of the pre-trial dismissal test to advance the abovementioned policy objectives—the protection of government from perceived indeterminate liability, and a belief that legal duties will hinder the state from acting in the interest of the population at large.

B. The Application of the Legal Tests to Health Sector Tort Claims

The seminal Canadian case setting out the test for striking claims is the Supreme Court of Canada’s decision in *Hunt v Carey*, in which the Court stated that a pre-trial dismissal requires that it is “plain and obvious” that the plaintiff will fail at trial. The decision involved the Court’s interpretation of the British Columbia Rules of Civil Procedure, judges have applied the principles from this case in hundreds of cases across the country, as all provinces have substantively similar legal rules respecting pre-trial dismissals, derived from the

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68 Supra note 3.
69 The British Columbia *Supreme Court Civil Rules*, BC Reg 168/09 state that “[a]t any stage of a proceeding, the court may order to be struck out or amended the whole or any part of a pleading, petition or other document on the ground that it discloses no reasonable claim or defence, as the case may be, it is unnecessary scandalous, frivolous, or vexatious, it may prejudice, embarrass or delay the fair trial or hearing of the proceeding, or it is otherwise an abuse of the process of the court” (Rule 9(5)). Alberta’s similarly-worded *Rules of Court*, Alta Reg 124/10 grant the power to order “that all or any part of a claim or defence be struck out; that a commencement document or pleading be amended or set aside; that a judgment or an order be entered; [or] that an action, an application or a proceeding be stayed” if “the Court has no jurisdiction; a commencement document or pleading discloses no reasonable claim or defence to a claim; a commencement document or pleading is frivolous, irrelevant or improper; a commencement
abovementioned historical concern with abuse of process. Judges adjudicating health sector claims have specifically affirmed the test from *Hunt v Carey* and the high burden it places upon the defendant.\(^70\)

It is also necessary to set out the requirements to certify a class action, due to my discussion of *Cilinger*,\(^71\) a health sector class action. Other health sector tort claims were proposed class actions, such as *Williams* (one of the SARS claims), but in that case, the government proceeded with its motion to strike prior to a court hearing the plaintiff’s certification motion.\(^72\) Under Quebec law, which applied in *Cilinger*, there are five requirements to certify a class action:

1. The plaintiffs’ claims raise identical, similar or related questions of law or fact;
2. The facts alleged seem to justify the conclusions sought;
3. The composition of the group makes other procedures such as joinder difficult or impracticable; and
4. The representative plaintiff is in a position to adequately represent the class members.\(^73\)

Most relevant to the discussion below is the second requirement—that “the facts seem to justify the conclusions sought.” The Supreme Court of Canada has elaborated on this provision, stating, “there must be in the judge’s view a good colour of right in order for him to authorize the [class] document or pleading constitutes an abuse of process; [or] an irregularity in a commencement document or pleading is so prejudicial to the claim that it is sufficient to defeat the claim” (Rule 3.68).

\(^70\) See e.g. *Eliopoulos*, *supra* note 15 at para 8 and *Williams*, *supra* note 11 at para 2.

\(^71\) *Cilinger* note 24.

\(^72\) *Cilinger* note 11. Accordingly, the Court did not consider the test for certifying a class action.

\(^73\) *Code of Civil Procedure*, RSQ 2000, c C-25, s 1002. Similarly, in Ontario, under the *Class Proceedings Act*, SO 1992, c 6, s 5, the requirements for a class action are as follows: “the pleadings or the notice of application discloses a cause of action,” there is an identifiable class of two or more persons that would be represented by the representative plaintiff, the claims raise common issues, a class proceeding would be the preferable procedure for the resolution of the common issues, and there is a representative plaintiff (who would fairly and adequately represent the interests of the class, who has produced a plan for the proceeding that sets out a workable method of advancing the proceeding on behalf of the class and of notifying class members of the proceeding, and who does not have a conflict of interest with other class members).
action, though he is not thereby required to make any determination as to the merits in law.”\textsuperscript{74} In other words, the pleadings must reveal a \textit{prima facie} cause of action.\textsuperscript{75}

This requirement is similar to the test to strike a claim, as both require the judge to accept the facts pleaded by the plaintiff as true, require that the pleadings merely disclose a cause of action, and prohibit the judge from exploring the merits of the claim. Indeed, the courts have acknowledged that the two tests are substantively similar. For example, the Ontario Superior Court stated that “[i]t has been held in numerous cases that the test [for whether a class action discloses a cause of action] is essentially the same as that applicable for the purposes of a motion to strike.”\textsuperscript{76} The main difference between these tests is that while a defendant must meet the “plain and obvious” requirement to dismiss a claim, the burden of proof is upon the plaintiff to satisfy the test for class action certification. Due to the similarity between these two tests, I focus my discussion on the motion to dismiss jurisprudence. However, my conclusions are generally equally applicable to class action claims.

In the remainder of this section, I discuss specific factors deemed relevant by the Supreme Court of Canada and provincial appellate courts to determining whether to strike a claim, namely, the claim’s complexity, whether the plaintiff advances a novel claim, the importance of the issues raised, and whether the claim relates to an unsettled area of the law. I argue that because health sector claims clearly met these requirements, Canadian courts should have been more reluctant to strike these cases prior to trial. Instead, judges summarily dismissed health sector claims, with no consideration of the factors suggesting that a claim should proceed to trial.

\textsuperscript{75} \textit{Marcotte v Longueuil (City)}, 2009 SCC 43 at para 90.
\textsuperscript{76} \textit{Grant v Canada (Attorney General)}, 2009 CanLII 68179 (On Sup Ct) at para 45 citing, for example, \textit{Cloud v Canada}, [2004] OJ No 2924 (CA) at para 41.
i. Complexity

The Supreme Court of Canada has stated that “complex matters that [disclose] substantive questions of law [are] most appropriately addressed at trial where evidence concerning the facts [can] be led and where arguments about the merits of the plaintiff’s case [can] be made.” Decisions following this statement of principle have treated both complex legal determinations and complex factual circumstances as relevant to the decision to strike a claim. For example, with respect to legal complexity, the Alberta Court of Appeal concluded that not only are these issues most appropriately addressed at trial, but also rather they must be resolved at trial: “a motion to strike out a statement of claim is not to be used to decide complex legal issues.” In rejecting the defendant’s motion to dismiss in Minnes v Minnes, the British Columbia Court of Appeal was similarly influenced by the fact that “[t]he arguments as to law and fact are intricate and complex and should be dealt with at trial after all the evidence is adduced.” The judicial preference for allowing complex claims to proceed to trial reflects a concern that in cases obscured by complexity, the courts may foreclose a plaintiff’s legal rights as a result of inaccurate conclusions in the absence of a complete factual record. The evidence obtained at trial may include, for example, the testimony of expert witnesses improving the courts’ understanding of complicated scientific matters or conflicting public policy evidence.

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77 Hunt v Carey, supra note 3 at 972.
78 Arcand v Imperial Oil Limited, 2006 ABCA 13 at para 7.
79 Supra note 44 at 122. In Bow Valley Resource Services v Kansas General Insurance Co, (1991) 56 BCLR (2d) 337 (CA), the Court considered a legally complex issue—the terms of a complicated settlement agreement—as a factor favoring allowing the plaintiff to proceed to trial. With respect to factual complexity, in Spasic (Estate) v Imperial Tobacco Ltd, supra note 63 at para 21, the Ontario Court of Appeal noted that “[t]he plaintiff may have to make complex submissions about whether the evidence establishes that the defendants conspired either with a view to causing him harm or in circumstances where they should have known that their actions would cause him harm” in deciding not to exercise the discretion to strike a claim.
The health sector decision-making processes, legislative landscape, and policy context are fraught with factual complexity. Comparing the health system with other sectors of governmental activity, such transportation, which has been the subject of several tort claims, highlights this complexity. Ministries of health employ a multitude of individuals working to coordinate, manage, and deliver a wide range of services. For example, staff in Ontario’s Ministry of Health and Long-Term Care manage diverse programs areas such as addictions, assistive devices, children’s health, drug programs, emergency health services, emergency management unit, French language health services, regulation of health care professionals, HIV and AIDS, Hepatitis C, immunization, independent health facilities, influenza immunization program, mental health, midwifery, nursing and the health care team, organ and tissue donation, public health, rabies, seniors care, SARS, telehealth, and West Nile Virus. Within a single program area, mental health, the Ontario Ministry of Health and Long-Term Care is responsible for:

…facilitating and supporting system change required for the implementation of mental health reform, as well as funding, policy development and operational monitoring of mental health services, including the 4 provincial psychiatric hospitals, 5 specialty hospitals, 53 general hospital psychiatric units, approximately 359 community mental health programs and 148 homes for special care.

80 See e.g. Just v British Columbia, [1989] 2 SCR 1228; Cameron v GNWT et al, 2005 NWTSC 2; Cole v McLoughlin, supra note 2; Frost v Whistler (Resort Municipality), 2003 BCSC 22; Hiscock v Newfoundland 2002 Carswell Nfld 275 (SCTD); McIlvenna (litigation guardian of) v Insurance Corporation of British Columbia, 2008 BCCA 289; Saskatchewan v Campbell, 2008 SKQB 437; Octa Evergreens Ltd v New Brunswick (Province of), 2002 NBQB 195.
82 “Mental Health Programs and Services,” online: Ontario Ministry of Health and Long Term Care <http://www.health.gov.on.ca/english/public/program/mentalhealth/mental_services/services_mn.html>.
In contrast, the Ontario Ministry of Transportation operates only five main programs, including driver and vehicle licensing, highways, road safety, and shared responsibility with municipalities for public transportation.83

Health sector policy-making involves coordination and cooperation between ministry bureaucrats, advisory groups, health professional self-regulatory organizations and unions, medical research organizations, interest groups, other ministries, other levels of government and a host of organizations responsible for delivering health services.84 Decision-makers are constrained by numerous governmental policies, funding agreements, accountability agreements, a multitude of statutes,85 and the contentious moral and ethical issues underlying many areas of health policy. Furthermore, the health sector involves a complex division of responsibility between the federal government, provincial governments, regional entities and, in the case of public health, municipalities and local departments of health.

Governmental tort liability jurisprudence speaks to the complexity inherent in the health sector. In Eliopoulos, the Ontario Court of Appeal described the numerous organizations involved in the preparation of the West Nile Virus Plan that was the subject of the plaintiffs’ claim. The Plan’s development and implementation required the consultation and cooperation of numerous agencies, including the Ontario Ministry of Health and Long-Term Care, local health authorities, local boards of health, hospitals, the Canadian Cooperative Wildlife Health Centre,

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84 For instance, under a single heading, “tobacco”, on the Ontario Ministry of Health and Long-Term Care website, an area that constitutes one small aspect of the Ministry’s programs and services, there are links to 29 interest groups, organizations, agencies and programs. “Healthlinks: Tobacco”, online: Ontario Ministry of Health and Long Term Care <http://www.health.gov.on.ca/english/hlinks/tobacco.html>.
85 For example, in Alberta, the Ministry of Health is responsible for 156 statutes, whereas the Ministry of Infrastructure and Transportation is only responsible for 69. “Laws Online”, online: Alberta Queen’s Printer <http://www.qp.gov.ab.ca>.
neighboring provinces, the National Steering Committee for West Nile Virus, and the U.S. Centers for Disease Control.86

This complex web of health sector’s stakeholder relationships stands in contrast to the Ministry of Transportation’s highway maintenance decision-making process, as described by the Supreme Court of Canada in Just v British Columbia.87 In that case, after a boulder fell from a cliff onto the plaintiff’s car, the Court refused to dismiss the claim against the provincial government. As outlined in the decision, at the apex of the organization responsible for highway inspection and remedial work was the regional geotechnical material engineer who, with another engineer, was responsible for inspecting slopes and making recommendations regarding their stability.88 The Department also contained a rock-work section, with an engineer responsible for rock stabilization, and a crew that performed the remedial work on the slopes.89 When the rock-work engineer inspected the slopes, the findings and recommendations were reported to the regional highways manager, who would submit requests for the services of the crew through the geotechnical material engineer.90

The clear hierarchical arrangements for making and implementing decisions within the Ministry of Transportation stand in stark contrast to the numerous stakeholders that participate in health sector policy-making. Although this complexity may ultimately justify considerable deference to the government’s policy choices at the standard of care stage of the negligence inquiry, it does not justify the judicial abrogation of their role as an independent check on the decisions of other branches of government. I return to this issue of judicial competence to adjudicate matters of complex social policy in Chapter Five.

86 Supra note 15 at paras 23-24.
87 Supra note 80.
88 Supra note 80 at para 4.
89 Supra note 80 at para 5.
90 Supra note 80 at para 6.
Despite Supreme Court of jurisprudence indicating a preference for permitting complex claims to proceed to trial, courts adjudicating health sector claims have treated complexity as a factor in favor of striking claims. For example, in *Mitchell*, a case in which an infant died after she failed to receive timely care in an emergency room, the Ontario Divisional Court suggested that complexity contributed to its decision to dismiss the claim: “in matters concerning health care funding and hospital restructuring, the Minister and the government must make complex and difficult policy decisions based on a variety of considerations.”  

Similarly, in *Klein*, a case alleging that the federal government failed to adequately regulate medical devices, the Ontario Superior Court concluded that: “Health Canada is only one player in the complex regulatory and delivery scheme governing medical devices in Canada.”  

The Court did not comment upon whether the presence of a full evidentiary record at trial would have been useful in understanding the role of Health Canada or its relationship with other actors.

The complexity of the health sector is also relevant to the legal determinations courts must make to resolve these claims. As I discuss in the next chapter, both academics and judges have commented extensively on the difficulties inherent in the distinction between policy and operational decisions. While some governmental decisions clearly fall into one category or the other, most lie in the grey area in the middle, with characteristics of both policy and operational decisions. The Supreme Court of Canada itself has referred to the dividing line between these two types of decisions as “difficult to fix” and “one of degree.”  

In *Jamal*, one of the health

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91 *Supra* note 23 at para 33.

92 *Supra* note 22 at para 33.

93 *Just v British Columbia, supra* note 80 at para 17. Similarly, Klar comments that “[d]eciding the issue of the tort liability of public authorities by applying the policy/operational dichotomy to their activities has long seemed to be an exercise in frustration. Reflection reveals that governmental activities do not neatly divide into policy decision making, on the one hand, and policy implementation, on the other, because inherent in each are elements of the other.” Lewis A Klar, “Falling Boulders, Falling Trees and Icy Highways: The Policy/Operational Test Revisited” (1994) 33 Alta L Rev 167 at 167.

94 *Kamloops (City) v Neilsen*, [1984] 2 SCR 2 at 9.
sector claims arising from the government’s management of the SARS outbreak, the Ontario Superior Court was concerned with its ability to accurately resolve the dichotomy on a pre-trial motion:

Some, or all, of the remaining negligence may fall on the policy side of the line but, in my judgment, this is not sufficiently obvious and the question…should only be decided after a full consideration of the evidence of decisions made by the Crown’s representatives and officials in light of the various governing statutes. Accordingly, the characterization of the decisions reflected in such allegations must be left to trial.\(^95\)

In overturning this decision, the Ontario Court of Appeal did not comment upon the lower court’s concern with applying the policy/operational dichotomy in a factual vacuum.

**ii. Novelty**

Judges frequently express a preference for refusing to strike novel claims. For example, the British Columbia Court of Appeal observed a general Canadian trend of requiring novel causes of action to be resolved at trial in *Bow Valley Resource Services v Kansa General Insurance Co.*\(^96\) This reflects a concern that “prematurely foreclosing arguments in novel cases” will “hinder the growth of the common law.”\(^97\) With respect to the goals of civil procedure discussed above, judges are concerned that accuracy will be unduly compromised by striking claims raising issues that courts have not previously explored on a full evidentiary record and that it is unfair to litigants if legal duties are not permitted to evolve to reflect modern society. In several health sector tort claims, courts found that plaintiffs were advancing novel legal duties, a

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\(^95\) *Supra* note 11 at para 14.


\(^97\) *Mirage Consulting Ltd et al v Astra Credit Union Ltd*, 2008 MBCA 105 at para 9.
consideration relevant to the proximity stage of the duty test (as I discuss in Chapter Four). However, none of these decisions treated this novelty as relevant to their decision to strike.98

Many of the pretrial dismissals in health sector tort cases rely heavily on the reasoning of the Ontario Court of Appeal in its relatively brief motion to strike decision in Eliopoulos (a claim relating to the government’s management of West Nile Virus).99 The judges in these cases engage in little analysis of novel factual elements in the cases before them. For example, unlike the disease outbreak claims by members of the general population (such as Eliopoulos), the nurse plaintiffs in Abarquez were at a particularly high risk of contracting the disease, they were an identifiable group known to the government, and the Ontario Ministry of Health and Long-Term Care had issued mandatory directives and provided information directly to health care workers.100 In striking the nurses’ claims, the Ontario Court of Appeal relied primarily on its finding in Eliopoulos that a duty of care to individual plaintiffs would conflict with the government’s duty to the public, summarily dismissing the unique position of health care workers in a disease outbreak.

Because the government’s role in the health sector is in a constant state of evolution, with the state intruding increasingly deeper into the management of the health delivery system and clinical decision-making, the courts risk inaccurately characterizing the province’s legal responsibilities by constantly relying on the Ontario Court of Appeal’s decision in Eliopoulos.

98 In Mitchell, supra note 23 at paras 20-21, in which an infant died after experiencing delays in treatment in an emergency room, the Court summarily rejected the plaintiffs’ argument that their case fell within an existing category of proximate relationship, foreseeable physical harm: “In Alcock, supra, the case cited by the Supreme Court in Cooper, a local police force providing crowd control at a football game negligently allowed an excessive number of spectators to enter a section of the stadium, causing a crush that resulted in many deaths and injuries. It is not alleged here that the Defendant, the Premier, the Minister or government employees directly caused physical harm to [the Plaintiff], as in Alcock. Rather, the Plaintiffs allege that the funding cuts and restructuring caused delay, which in turn was a cause of her death.” Although Alcock involved a direct relationship, the Supreme Court merely provided this case as an example and did not refer to the direct relationship in that case or state that this was a required element for foreseeable physical harm. Numerous cases from other sectors have succeeded without a direct relationship between the parties.
99 Supra note 15.
100 Supra note 12.
In other words, the government’s legal duties remain frozen in 2006, despite significant ongoing changes in its health sector responsibilities.

iii. Unsettled Areas of the Law

Another consideration relevant to a court’s disposition of a motion to dismiss is whether the claim engages an unsettled area of law. Citing numerous authorities, the Nova Scotia Court of Appeal stated, “[i]f the law in this area is not clear, the application to strike out the pleadings should fail.”101 This reflects a concern that in the face of uncertainty, a full factual record is central to the accuracy of a court’s legal findings. For example, in Reynolds v Kingston (Police Services Board), the Ontario Court of Appeal concluded, “at the interlocutory stage of proceedings the court should not dispose of matters of law that are not fully settled in the jurisprudence. Such issues should be decided at trial on the basis of a full evidentiary record.”102

As I discuss in the next chapter, various aspects of the test for establishing a duty of care in the context of governmental defendants are unclear or are evolving, and the courts should thus proceed cautiously in striking these claims. Linden and Feldthusen describe the uncertain state of the law in this area:

Since the middle of the last century, the ambit of negligence liability for statutory public authorities has ebbed and flowed. At times, the legislatures and courts have adopted new principles and rules to expand or contract the ambit of liability. At other times, the principles have remained the same, but their interpretation has varied dramatically from one period to another, and even from case-to-case. The interpretation of the scope of immunity for policy decisions is a case in point.

Underlying this lack of certainty is a fundamental disagreement amongst judges and scholars about what ought to be the appropriate scope of liability.\textsuperscript{103} The trial court in \textit{Williams}, one of the SARS claims, expressed a concern with the pre-trial dismissal of claims engaging unsettled areas of the law: “it has been held in a number of cases that the decision to strike should not be made if it would require a resolution of difficult legal questions in an area where the law is unsettled.”\textsuperscript{104} The Court of Appeal granted the government’s appeal from this decision, with no mention of this finding by the lower court.

A handful of decisions treat the lack of judicial or academic commentary as a factor relevant to the unsettled nature of the law. For example, in declining to strike the plaintiff’s claim in \textit{Freeman-Maloy v Marsden}, the Ontario Court of Appeal commented that while there was a great deal of general commentary on the tort of misfeasance in a public office, there was limited discussion of which individuals satisfy the criteria for a “public officer”, which was a requirement of the tort.\textsuperscript{105} Although there is some academic commentary on governmental liability in Canada,\textsuperscript{106} there is a gap in the literature addressing tort liability in the health sector. Furthermore, given the cursory analysis courts typically give to health sector tort claims, and the fact that no such claim has benefitted from the more complete analysis of a trial decision, there is also limited judicial analysis of the government’s legal duties in the health sector.

\textsuperscript{103} Allen M Linden & Bruce Feldthussen, \textit{Canadian Tort Law}, 8th ed (Markham: LexisNexis, 2006) at 710.
\textsuperscript{104} \textit{Williams v Canada (Attorney General)}, 2005 CanLII 29502 at para 15. This decision was overturned by the Court of Appeal, \textit{supra} note 11.
\textsuperscript{105} (2006), 79 OR (3d) 401 at para 19.
\textsuperscript{106} Although there were several post-\textit{Cooper} case commentaries, there has also been a lack of academic discussion of several subsequent Supreme Court of Canada cases addressing governmental tort liability or analyses of the lower courts’ treatment of \textit{Cooper}. I discuss this literature in greater detail in Chapter Four.
iv. Importance of the Question

In *Hunt v Carey*, the Supreme Court of Canada stated that “where a statement of claim reveals a difficult and important point of law, it may well be critical that the action be allowed to proceed. Only in this way can we be sure that the common law in general, and the law of torts in particular, will continue to evolve to meet the legal challenges that arise in our modern industrial society.” With respect to the goals of civil procedure discussed above, the preference for allowing important questions to proceed to trial reflects judicial concerns with accuracy and efficiency—courts should allocate scarce resources to important cases, as their potentially wide ramifications demand accuracy. In this regard, the Nova Scotia Court of Appeal discussed the importance of devoting sufficient fact-finding efforts to questions of general importance:

If the question of law is of general importance and the key to its resolution lies in the correct construction of ambiguous and complex legislative or contractual provisions, the court should carefully consider the possibility of putting off any determination, particularly where it would be helpful if the parties deepened their understanding of the pertinent legislative or contractual scheme, the arguments for and against the proposed interpretations and the repercussions of each. The court may also favor deferral to foster an enhanced contextualization of the problem through the production of evidence shedding light on the provision’s true object and its drafters’ intention.

The motion to strike jurisprudence provides little guidance on what factors are indicative of an important question. In *Dyson v Attorney General*, a taxpayer challenged a notice received by all British taxpayers. In a passage cited by Canada’s Federal Court, Lord Justice Farwell stated that:

It is obviously a question of the greatest importance; more than eight million of Form IV have been sent out in England, and the questions asked entail much

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107 *Hunt v Carey*, supra note 3 at 990.
108 *LeBlanc v Boisvert*, 2005 NBCA 115. See also *Sierra Club v Canada*, [1999] 2 FC 211 (TD); “At this stage of the proceeding, the court may not have all the relevant facts before it, or the benefit of full legal argument on the statutory framework within which the administrative action in question was taken. To the extent that the length of the applicant’s case, and other factors, are relevant to the ground of discretionary standing.”
109 *Daniels v Canada (Minister of Indian Affairs and Northern Development)*, 2002 FCT 295.
trouble and in many cases considerable expense in answering; it would be a blot on our system of law and procedure if there is no way by which a decision on the true limit of the power of inquisition vested in the Commissioners can be obtained by any member of the public aggrieved.\textsuperscript{110}

The British Columbia Court of Appeal similarly viewed the number of affected individuals and the seriousness of the interest involved as indicative of a claim’s importance:

The labour movement in this province has collectively resolved to boycott the Industrial Relations Council created by the Act. The sooner that gesture of civil disobedience is either justified or condemned by a decision of this court, the better it will be for all concerned…The attack which is made on the Act involves both serious questions of law and questions of general importance to the labour movement…\textsuperscript{111}

The indicia of importance in \textit{Dyson} and \textit{BBF v British Columbia} are equally applicable to health sector claims. Governments’ health sector policies affect many individuals, particularly given the state’s near monopoly over hospital and physician services; the interest at stake is serious, often injury or death;\textsuperscript{112} and, as discussed below, there are gaps in the availability of alternative remedies. In permitting the SARS claim to proceed to trial, the lower court in \textit{Williams} found that the issues were:

…of some importance not only because of the questions of substantive law involved, and those relating to the application of the ‘plain and obvious test’…but also, because the motions of the Provincial Crown and the Federal Crown raised fundamental questions about the manner in which—and the precision with which—claims against the Crown for the tort of negligence must be pleaded.\textsuperscript{113}

\begin{footnotesize}
\begin{enumerate}
\item[\textsuperscript{110}]\textit{Dyson}, supra note 36 at 421.
\item[\textsuperscript{111}] \textit{BBF, Lodge 359, D277, D385, D468, D503 v British Columbia}, 1989 CarswellBC 1085 at para 6 \textit{[BFF v British Columbia]}. This case was an action brought by ten unions and individual members with respect to amendments made to labor legislation. In \textit{Fullowka v Whitford}, the Court was similarly cognizant of the interest at stake in assessing a motion to dismiss: “[t]he expense and inconvenience of defending a complicated suit is not a sound ground to strike out a pleading, particularly if the plaintiff was seriously harmed.” (1997), 147 DLR (4th) 532 (NWT CA)[emphasis added].
\item[\textsuperscript{112}] These interests are particularly serious when compared with the inconvenience and expense interests engaged in \textit{Dyson}.
\item[\textsuperscript{113}] \textit{Williams v Canada (Attorney General)}, supra note 104 at para 2. This decision was overturned by the Court of Appeal, supra note 11. The indicia of importance in this case differ somewhat from those introduced in \textit{Dyson}, supra note 36. This case was concerned with the importance of the legal issues raised, for example, the pleading of claims against governmental defendants. In contrast, in \textit{Dyson}, the Court was concerned with the importance of the factual context, for example the number of individuals affected by the impugned government policy and the nature of the interest involved. Other cases treating legal importance as relevant to a decision to strike a claim include
\end{enumerate}
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The Ontario Court of Appeal did not address this concern in overturning the lower court’s decision.

v. Conclusion on the Application of the Test to Strike a Claim

As I have argued in this section, judges have struck health sector tort claims despite the presence of factors that normally indicate a claim ought to proceed to trial, namely:

- complexity of the health sector and the law of governmental tort liability;
- the novelty of the legal duties advanced in the claims and elements of factual novelty;
- the importance of the issues they raise; and
- the unsettled nature of the law of governmental tort liability.

It is important to note that the mere presence of any one of these factors does not necessarily mean that a claim must proceed to trial, but rather that they are considerations that judges must balance in reaching their decision. For example, a court may legitimately strike a claim raising an important legal issue where the pleadings disclose no cause of action. However, the fact that health sector tort claims generally satisfy all of the factors above suggests that judges should be more cautious in striking these claims.

Instead of dismissing a claim on a pre-trial motion, there are alternative procedural remedies available to judges to avoid a full trial. For example, summary judgments may strike a better balance between efficiency, fairness, and accuracy. This remedy conserves judicial

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*Public Service Alliance of Canada v Canada*, [2002] 1 FC 342 at para 40 (TD), in which the Federal Court found that an action raising a “substantive Charter claim” was important, and *Midwest Management (1987) Ltd v BC Gas Utility Ltd* (1997), 34 BLR (2d) 28, in which the British Columbia Supreme Court deemed the question of whether there is a legal basis for a free-standing duty of fairness arising from the tendering process a question of general importance.
resources relative to a trial, whilst providing a judge with a more comprehensive factual record\textsuperscript{114} and giving a plaintiff the right to pursue his claim further. Motions to dismiss and summary judgements are somewhat similar remedies, with judges expressing a concern that pre-trial dismissal motions may “morph” into summary judgments if courts erode the high burden required to strike a claim,\textsuperscript{115} as they seem to have done in the health sector claims.

In addition to a summary judgement, courts may also conserve judicial resources by striking the portions of the statement of claim that are clearly outside the realm of governmental duties, while allowing the other allegations to proceed to trial. The Superior Court judge in Williams took this approach, striking broadly worded claims of “systemic negligence”, while allowing allegations relating to the specific directives issued by the Ministry of Health to proceed to trial.\textsuperscript{116} On appeal, the Court of Appeal struck this claim in its entirety.

Although my discussion thus far has demonstrated that the courts are reluctant to impose legal duties against provincial governments for their health sector decisions, it is unclear whether this reluctance is peculiar to the health sector, or is the result of a broader non-interventionist approach to governmental tort liability. In the next section, I explore this question by situating the health sector claims within an analysis of the broader trends in the governmental tort liability jurisprudence.

\textsuperscript{114} There is little information available to a court on a motion to dismiss, generally only that contained in the pleadings. In contrast, a summary judgment motion comes at a later stage of the proceedings, when the court has a more detailed evidentiary record. The facts surrounding health sector tort claims have been largely unknown to the plaintiffs at the pleadings stage, making the resolution of cases on pleadings alone particularly problematic. Plaintiffs may have difficulty detailing the particulars of the health sector decision-making process and the government’s role in the health sector, given the complex division of responsibilities between the various levels of government, the ministry of health, health delivery organizations, and providers. Furthermore, as I discuss below, provincial governments have been criticized for the lack of transparency in health sector decision-making.

\textsuperscript{115} Sewell v ING Insurance Company of Canada, supra note 54 at para 26.

\textsuperscript{116} Supra note 104.
Part Three: An Empirical Comparison of Sectors of Government Activity

A. Methodology

In the Appendices, I list all of the reported tort cases against governmental defendants from nine Canadian provinces, all three territories, and the federal courts since the Supreme Court of Canada’s 2001 restatement of the test for establishing a duty of care in *Cooper v Hobart*.117 I exclude cases from Quebec, due to the differences in the law and because many of these cases were not translated into English.118 In Appendix One, I summarize the legal findings in the claims arising outside of the health sector. In Appendix Two, I sort these claims by sector of government activity. Finally, I summarize the courts’ findings in health sector claims in Appendix Three. Although the focus in my discussion thus far has been health sector claims for personal injuries against provincial governments, in the Appendices, I also include claims against the federal government and claims seeking compensation for economic losses.

I include all government tort liability cases in the Appendices, aside from those decided entirely on issues unrelated to the merits of the tort claimed (for example, questions of jurisdiction or statute of limitations issues). Although the vast majority of the cases in the Appendices alleged governmental negligence, I also include claims pleading other torts such as misfeasance in a public office or defamation. Many of these torts have elements or general policy considerations that overlap with the requirements of a negligence claim. Furthermore, although some of these claims may have been decided on these other torts, the plaintiffs often also alleged that the government had been negligent.

117 *Supra* note 64.
118 I did not include the cases that were translated into English because I would not be able to arrive at generalizable conclusions from that sample of cases. Presumably, the reported decisions would not be a representative sample of cases heard in Quebec over the past decade, but rather certain types of cases (such as issues of broad significance or important matters of social policy) would be overrepresented in the sample. This is because legal reporting services are presumably more likely to incur the expense to have those types of claims translated.
In determining which actors are sufficiently governmental for the purpose of inclusion in the Appendices, I include government itself (the federal government, a province, or a municipality), personally named government officials or employees (for example, a premier, minister, or police chief), governmental ministries and departments, agents of government, and Crown corporations. I define government broadly because similar policy considerations apply to all of these actors and they are frequently named as co-defendants in the same actions. Furthermore, particular aspects of the test for establishing a duty of care that are unique to governmental defendants, such as the policy/operational dichotomy, apply to all of these actors. However, I exclude claims with governmental actors as both the plaintiff and the defendant, such as claims by former government employees for wrongful dismissal.

In the tables in the Appendices, I summarize the courts’ findings at each stage of the duty analysis, setting out the elements of the test the plaintiffs successfully proved and those that they

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119 My search did not capture any decisions with RHA or LHIN defendants. To date, the only cases involving RHA defendants involve the duties they inherited from hospitals, such as vicarious liability for nurses (for example, see Gemoto v Calgary Regional Health Authority, 2006 ABQB 740). No court has considered liability for the obligations that governments devolved to RHAs (i.e. allegations relating to their role as the agents of government). However, a number of factors suggest that claimants may have more success pursuing claims alleging systems-level negligence against RHAs than government (for example, a claim that a patient died as a result of emergency room understaffing). One of the main barriers to claims against government has been the lack of a close and direct relationship between the parties. Unlike government, an RHA has a more direct relationship with the plaintiff, as the plaintiff receives treatment in the region’s facilities, often delivered by the region’s employees. Another obstacle in health sector tort claims against government is the court’s perception that government is not engaged in the health system at the operational level, but rather its decisions are immune from review under the policy/operational dichotomy. Despite questions over the extent to which government in fact devolved policy-making authority to RHAs, these entities are certainly operationalizing governmental policies. A final factor that differentiates the legal position of regional health authorities and the government is the latter’s general obligations to the public at large. Although RHAs—indeed most actors working in the health sector (including practitioners)—must balance competing demands, the government must allocate scarce resources not only between health programs but between health care and other sectors. Contrastingly, Alberta’s legislation gives regional health authorities the more narrow duties to “ensure that reasonable access to quality health services is provided” and to “promote the provision of health services in a manner that is responsive to the needs of individuals and communities” (Regional Health Authorities Act, RSA 2000, c R-10, s 5). One potential barrier to lawsuits against RHAs are statutory immunity provisions. Although there is variation across Canada, some provinces include immunity clauses in their legislation. For example, Ontario’s Local Health System Integration Act, SO 2006, c 4, s 35 precludes actions for damages against “a local health integration network…with respect to any act done or omitted to be done or any decision or order under this Act that is done in good faith in the execution or intended execution of a power or duty under this Act.” I also do not include claims against hospitals as they have never been held to be the agents of government, and thus the unique requirements of governmental tort claims, such as the policy/operational dichotomy, do not apply to these defendants.
did not (in other words, the elements that prevented the claim from proceeding to trial or succeeding at trial). For example, it was common for a plaintiff to successfully prove foreseeability but then fail to satisfy the requirements for proximity. The “stage of the proceeding” categorizations in the Appendices are not mutually exclusive. For example, although I may categorize a particular case as a trial, there may have been a previous motion to strike decision issued in the same case. I list each case only once, categorizing them according to the most recently reported decision. In addition, I only list the most recent citation for each case, even if the claim proceeded through multiple levels of appeal. Generally, the findings I report are from the highest court to issue a decision in the case, unless the appellate court merely adopted the trial judge’s findings without explanation, in which case I cite the highest court decision, but also summarize the lower court’s findings.

There are several limits on the conclusions I draw from the cases in the Appendices. First, masters or prothonotaries may have jurisdiction to hear pre-trial dismissal motions. Their decisions are sometimes oral and are often unreported. Therefore, the number of cases in the Appendices likely underreports of the number of claims actually filed against the government during the past decade. Furthermore, because decisions on a pre-trial motion are less likely to be reported than trials, the ratio of motions to trials in this sample is likely not reflective of the ratio actually heard by the courts during the ten-year period. Nearly 40 percent of the cases in the Appendices are trial decisions. Similarly, appellate court decisions are likely reported with

120. These categorizations are sometimes inexact, as there can be blurring in judges’ discussions of the requirements at the various stages of the duty analysis. For example, a judge may make a general statement that a defendant ought to have contemplated a plaintiff when making a particular decision, a finding that is applicable to both proximity and foreseeability.

121. The names for these individuals vary, depending upon the jurisdiction. However, they have limited jurisdiction to preside over specific, often procedural, pre-trial matters (such as motions to dismiss, applications to obtain the production of documents, or ex parte orders for substitutional service or service ex juris).
greater frequency than lower court decisions, particularly cases heard in small claims court. Over 40 percent of the reported decisions in the Appendices are from an appellate court.\textsuperscript{122}

The tables of cases in the Appendices exclude settlements and cases discontinued for other reasons, as these dispositions are not reported. Given its considerable litigation advantage (in terms of financial and human resources and favorable doctrinal and procedural rules), it is reasonable to assume that government infrequently settles tort claims, except in clear cases of liability, for example, when a government employee causes a car accident. However, if a plaintiff is successful in defending a motion to strike, the government may be motivated to settle the case, particularly if it is a low-value claim, in order to avoid an unfavorable reported precedent for future plaintiffs to rely upon. If these assumptions are true, one might expect that the pre-trial motion figures set out below are a more accurate reflection of the number of tort claims actually filed by plaintiffs than the percentage of cases in which plaintiffs ultimately succeeded at trial (because both the clear cases of liability and the low-value cases would have been selected out of my sample of trial decisions).

Certain provinces are potentially overrepresented or underrepresented in my sample, relative to the number of claims actually filed in that jurisdiction. This depends upon several factors, such as the criteria by which online case reporting databases select claims. For example, database editors may attribute superior precedential value to certain provincial appellate courts and report those decisions with greater frequency. Moreover, because appellate decisions are more likely to be reported than lower court decisions (particularly those of small claims courts), differences in the types of cases that different provincial appellate courts select to hear, the resources each province devotes to its legal system (which may affect the number of appeals that

\textsuperscript{122} Fifty-nine percent of the reported decisions did not proceed beyond the trial court. Of the remaining 41 percent, 35 percent were heard by provincial appellate courts or the Federal Court of Appeal, and 5 percent were Supreme Court of Canada decisions (the numbers do not add up to 100 percent due to rounding).
may be heard), and the monetary jurisdiction of their small claims courts will contribute to this overrepresentation or underrepresentation. This variation is significant because, as I discuss below, the judges of certain jurisdictions appear to be more receptive to tort liability against government than those who frequently strike these claims. Therefore, if provinces whose judges are more receptive to tort claims are overrepresented in my sample, the overall judicial receptiveness to liability across all claims will be skewed upwards.

A final limit on the conclusions I draw in the following section is the fact that certain sectors are potentially overrepresented in the reported decisions. This may be attributable to the significance of the policy issues that cases from particular sectors tend to raise. For example, one might expect that a health sector class action claim for a high-profile issue that attracted a great deal of media attention, such as waiting times at hospitals, is much more likely to be reported than the trial of a single plaintiff claiming that her property damage was caused by a municipality’s failure to enforce a construction bylaw. The potential underreporting of cases from some sectors of government activity is problematic because the small sample of cases from some sectors makes it difficult to draw generalizable conclusions about the judiciary’s approach to those types of claims. With these limits in mind, in what follows, I contrast the courts’ approach to the health sector claims with their treatment of claims arising in other areas of governmental activity.

123 Indeed, the number of cases from each province does not reflect that jurisdiction’s population. For example, 34.1 percent of the reported cases were from British Columbia (despite the fact that British Columbia only has 17.3 percent of the country’s population. “Population by year, by province and territory”, online: Statistics Canada <http://www40.statcan.gc.ca/l01/cst01/demo02a-eng.htm>. Although I discuss one health sector case from Quebec (Cilinger, supra note 24), I do not include that case in my calculations because I exclude other Quebec cases from the Appendices (due to the different legal tests that apply and the fact that few of the relevant cases were translated into English). The respective percent of reported cases/percent of population figures for the remainder of the provinces are Alberta 10.0 percent/14.2 percent, Manitoba 2.9 percent/4.7 percent, New Brunswick 4.1 percent/2.9 percent, Newfoundland 4.1 percent/1.9 percent, Northwest Territories 1.2 percent/0.2 percent, Nova Scotia 7.1 percent/3.6 percent, Nunavut 0 percent/0.1 percent, Ontario 27.6 percent/50.4 percent, Prince Edward Island 0.6 percent/0.5 percent, Saskatchewan 7.6 percent/4.0 percent, Yukon 0.6 percent/0.1 percent.
B. Findings

I divided the sample of cases in the Appendices into three categories—class certification motions, motions to dismiss/summary judgments, and trials. Although there is some inter-provincial variation in the requirements to certify a class action, provincial legislation (and the common law, where applicable) typically requires that class members have common issues, the plaintiff is an appropriate representative of the class, a class action is the preferable procedure, and the claim discloses a cause of action. The plaintiff succeeded in 38 percent of the reported class certification motions from the past decade. Although the government prevailed in the remaining 62 percent, the plaintiff proved that the defendant owed a duty of care in 30 percent of those claims. In those cases, the court refused to certify the claims on other requirements, for example, the fact that the class members did not have common interests or that a class action was not the preferable procedural vehicle. In other words, the court was willing to find that government owed a legal duty in 56 percent of the total sample of class certification motions. To date, there have been two health sector class actions—one against the Quebec government and another against Health Canada—and the courts denied both on the basis that the defendant did not owe the plaintiff a legal duty.\(^\text{124}\)

The second category of claim includes motions to dismiss and summary judgment motions. Although there is some inter-provincial variation in the requirements for these tests, motions to dismiss call upon judges to determine whether it is “plain and obvious” that the plaintiff’s claim discloses no cause of action.\(^\text{125}\) In contrast, summary judgment motions typically arise at a later phase of the proceeding. The test in these cases is generally whether

\(^{124}\) Although there were other proposed health sector class actions, the government proceeded by way of a motion to strike the claim before the plaintiff commenced the class certification application. See e.g. Williams, supra note 14.

\(^{125}\) See Hunt v Carey, supra note 3 and the countless cases applying this decision.
there is “no genuine case for trial.”

Canadian courts permitted the plaintiff to proceed to trial in 37 percent of these pre-trial motions overall, while the defendant was successful 63 percent of the time. In contrast, plaintiffs succeeded in defending only 17 percent of the motions to strike in health sector claims. If one only includes claims for personal injuries against provincial governments—the subject of my analysis—the plaintiff only succeeded in 8 percent of the health sector pre-trial motions.

Trial decisions represent the third category of case in the Appendices. The plaintiff succeeded in 36 percent of these cases, while the defendant succeeded in 64 percent. However, the plaintiff established the existence of a governmental duty of care in nearly half (48 percent) of these cases, but failed on other requirements. Judges frequently preferred to resolve these claims at the standard of care stage of the negligence inquiry, an approach that I advocate in the next chapter. In other words, of the cases that went to trial, the plaintiff proved that the government owed a duty of care in two thirds of those cases. There are no reported health sector trials with provincial government defendants, and the plaintiff failed in the only trial with Health Canada as a defendant.

Although these figures indicate that courts are more likely to strike health sector tort claims than cases arising in all other sectors of governmental activity combined, it is important to consider whether the health sector is unique in this regard, or whether there are other areas in which judges are reluctant to impose legal duties on government. In Appendix Two, I separate the governmental liability cases by sector. These are rough categorizations, as there are many inter-provincial discrepancies in the division of policy portfolios between ministries. These

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126 See e.g. *Crystalline Investments Ltd v Domgroup Ltd*, 2004 SCC 3.

127 In 15 percent of the cases in which the defendant successfully had the negligence claim struck, the courts permitted the plaintiff to proceed with other claims (for example, *Charter* claims). Furthermore, in many cases, successful dismissals did not foreclose the plaintiff’s tort remedies, as the claim proceeded against non-governmental defendants.
categorizations are particularly inexact in the case of municipal defendants, due to the even wider inter-municipal variation in the division of responsibilities. Because municipalities may not divide responsibilities by subject matter, but rather by function (for example, bylaw officers who are responsible for enforcing a wide array of rules arising in different sectors), in some situations, I adopt functional rather than subject matter divisions. The table below shows the percentage of cases in which the plaintiffs successfully proved duty in each sector of governmental activity. The sample size from a few of the sectors was too small for the conclusions to be generalizable. I note when there are less than five cases in a group with an asterisk.

<table>
<thead>
<tr>
<th>Sector of Government Activity</th>
<th>% Cases Plaintiff Proved Duty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agriculture</td>
<td>63%</td>
</tr>
<tr>
<td>Building Inspections</td>
<td>55%</td>
</tr>
<tr>
<td>Bylaw Enforcement</td>
<td>11%</td>
</tr>
<tr>
<td>Community Service</td>
<td>50%</td>
</tr>
<tr>
<td>Defense</td>
<td>100%*</td>
</tr>
<tr>
<td>Education</td>
<td>17%</td>
</tr>
<tr>
<td>Environment/Natural Resources</td>
<td>79%</td>
</tr>
<tr>
<td>Government Contracts</td>
<td>0%*</td>
</tr>
<tr>
<td>Health</td>
<td>17%</td>
</tr>
<tr>
<td>Immigration</td>
<td>22%</td>
</tr>
<tr>
<td>Justice</td>
<td>33%</td>
</tr>
<tr>
<td>Labor</td>
<td>0%*</td>
</tr>
<tr>
<td>Land Development</td>
<td>50%</td>
</tr>
<tr>
<td>Liquor/Gaming</td>
<td>40%</td>
</tr>
<tr>
<td>Municipal Property</td>
<td>60%</td>
</tr>
<tr>
<td>Police</td>
<td>64%</td>
</tr>
<tr>
<td>Tax and Finance</td>
<td>25%*</td>
</tr>
<tr>
<td>Transport/Highways</td>
<td>83%</td>
</tr>
<tr>
<td>Utilities</td>
<td>54%</td>
</tr>
</tbody>
</table>

With the exception of the sectors with fewer than five reported decisions, the percentage of cases in which plaintiffs successfully proved that the government owed a duty ranges from 11
percent to 83 percent. The only area in which plaintiffs were unsuccessful more frequently than the health sector was bylaw enforcement (the court imposed a legal duty in 11 percent of those cases). Because the bylaw enforcement actions bear very little similarity to the health sector claims, it is not likely that there are common explanations for the judicial reluctance to impose a legal duty in these two sectors. Bylaw enforcement cases generally involve a clear legislative standard passed by a municipality that the defendant allegedly failed to enforce. In contrast, the health sector claims tend to involve broad, general legislative duties, often arising from multiple statutes. In addition, the plaintiffs’ claims do not generally revolve around the legislative scheme, but rather the government’s failure to protect the plaintiff against health risks. The municipal departments responsible for enforcing bylaws do not have the same level of complexity (in terms of organizational structure or policy-making process) that characterizes the health sector.

The plaintiffs’ lack of success in the bylaw enforcement claims is likely attributable to three factors, none of which are present in the health sector claims. First, until recently, the courts have not accorded municipal decisions the same level of deference as decisions from other levels of government. Another barrier to the bylaw enforcement claims is that the Supreme Court of Canada has clearly stated that breach of statutory duty, without something more, is insufficient to ground a duty of care. Finally, while all of the health sector claims (aside from one claim against Health Canada) were motions to strike, 44 percent of the bylaw enforcement claims were trials. These final determinations of the merits of the claim require the plaintiff to

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128 Although his focus is on the administrative law review of local government decisions, Craig argues that “Historically, Canadian courts have viewed municipalities with an attitude of ‘suspicion and distrust’…predicated on the paternalistic belief that ‘judicial supervision is required to prevent local governments from acting irresponsibly…Municipalities are not a ‘sovereign’ government, at least in explicit constitutional terms.” Jared Craig, “Defending City Hall After Dunsmuir” (2008) 46 Alta L Rev 275 at 277.
satisfy the court, on a balance of probabilities, that the defendant owes a legal duty to the plaintiff. In contrast, on a motion to dismiss, the defendant must prove that it is plain and obvious that the plaintiff has no claim. In other words, plaintiffs are much less likely to succeed at trial. In sum, there seem to be few factors common to the bylaw claims and the health sector claims that would explain their similar treatment by judges.

Another factor that may explain the wide inter-sectorial variation in the judiciary’s willingness to impose a legal duty is the nature of the plaintiffs’ injuries. Different sectors of governmental activity are often conducive to different types of injuries. For example, the claims arising from the agricultural sector generally involve a claim that governmental negligence impeded the plaintiff’s ability to earn money. Until relatively recently, Canadian courts were reluctant to impose damages for pure economic loss.130 Accordingly, I also grouped the cases in the appendices into two categories—plaintiffs with personal injuries (either to themselves or to their property) and those seeking compensation for pure economic loss.131 As expected, the courts generally prefer to impose a legal duty in cases involving personal injuries. In 66 percent of the personal injury claims from all sectors, claimants were successful, compared to 39 percent of claims alleging pure economic loss. This is in stark contrast to health sector claims involving personal injuries, where only 17 percent of the plaintiffs were successful. If one isolates the health sector claims alleging economic losses, the results more closely conform to the broader trends in the Canadian jurisprudence, with 29 percent of those plaintiffs succeeding against governmental defendants.

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130 For a history of the Supreme Court’s development of the doctrine for pure economic loss see Feldthuens, supra note 8. Pure economic loss refers to financial losses that occur independent of personal injury to the plaintiff or injury to his property.
131 In some cases, the plaintiff claimed both types of damages, but I categorized the cases according to the main allegation.
Another potentially relevant explanation for the wide variation in the percentage of cases in which defendants owed a legal duty is the year of the decision. As noted above, my search captured cases arising after the Supreme Court of Canada’s 2001 revision of the test for establishing a duty of care in *Cooper*. Changes in the law may be slow to trickle down to the lower courts, with judges gradually phasing in a more restrictive approach to duty over time. This may be particularly true of the type of change that occurred in *Cooper*. Although the Supreme Court of Canada introduced significant changes to the test for establishing a duty of care, in the decision the Court purported to merely “clarify” the existing test for establishing a duty of care.\(^\text{132}\) In contrast, a change of *Cooper*’s magnitude may garner an immediate reaction, with lower courts strictly applying the changes, and subsequently relaxing the requirements over time. If the former approach—a gradual trend towards a stricter approach duty—occurred, this could explain the restrictive attitude towards health sector tort claims, as the majority of those decisions were reported in the past three years. However, as the table below indicates, I observed no trend towards a stricter approach to duty in the decade following *Cooper*.

<table>
<thead>
<tr>
<th>Year</th>
<th>% Plaintiff Succeeded Overall</th>
<th>% Plaintiff Succeeded on Duty</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>50%</td>
<td>58%</td>
</tr>
<tr>
<td>2003</td>
<td>33%</td>
<td>53%</td>
</tr>
<tr>
<td>2004</td>
<td>63%</td>
<td>79%</td>
</tr>
<tr>
<td>2005</td>
<td>40%</td>
<td>50%</td>
</tr>
<tr>
<td>2006</td>
<td>24%</td>
<td>41%</td>
</tr>
<tr>
<td>2007</td>
<td>40%</td>
<td>60%</td>
</tr>
<tr>
<td>2008</td>
<td>50%</td>
<td>55%</td>
</tr>
<tr>
<td>2009</td>
<td>47%</td>
<td>53%</td>
</tr>
<tr>
<td>2010</td>
<td>27%</td>
<td>45%</td>
</tr>
</tbody>
</table>

A final potential explanation for the judiciary’s apparent reluctance to permit health sector tort claims to proceed to trial is the jurisdiction in which the cases arose. The Ontario

\(^{132}\) *Cooper, supra* note 64 at para 29.
Court of Appeal issued 47 percent of all the health sector decisions alleging personal injuries (and 32 percent of the health sector decisions overall). Furthermore, of the cases heard by the Ontario Court of Appeal, Sharpe J. wrote the Court’s opinion in 71 percent of the health sector cases. If the Ontario Court of Appeal employs a more restrictive approach to governmental liability than other courts, rather than a particular bias against health sector claims, it may explain the apparent discrepancy in the treatment of health sector claims across jurisdictions.

In Table Three, below, I compare the percentage of cases in which provincial or federal appellate courts imposed a legal duty on government. I exclude the courts that issued fewer than five decisions in the past ten years. As the figures indicate, the Ontario Court of Appeal imposes governmental liability less frequently than other provincial appellate courts, particularly the British Columbia Court of Appeal. The Ontario Court of Appeal is also less likely to impose a legal duty but to dismiss the claim on other elements of the negligence inquiry, especially compared to the British Columbia Court of Appeal and the Supreme Court of Canada. Judges from these courts frequently find that the defendant owed a legal duty, but go on to find that it did not breach the standard of care (an approach that I advocate in Chapter Four). However, this inter-provincial variation does not completely explain the reluctance to hear health sector tort claims. Defendants were deemed to owe legal duties in 25 percent of the cases from all sectors before the Ontario Court of Appeal. In contrast, the Court only found that the government owed a legal duty in 13 percent of the health sector claims.133

133 The defendant succeeded in Abarquez, supra note 12; Attis v Canada, supra note 20; Drady v Canada (Health), supra note 20; Eliopoulos, supra note 15; Fenn v Ontario (Health and Long-Term Care), 2005 CanLII 56208; Laroza Estate v Ontario, supra note 12; and Williams, supra note 11. The plaintiff succeeded in Heaslip, supra note 26.
End of the table.

**Conclusion**

Beginning in the second half of the twentieth century, Canadian federal and provincial governments passed legislation eroding their long-standing immunity from tort claims. Following these statutory changes, Canadian judges imposed liability in numerous cases, including claims for negligent highway maintenance and building inspections. However, courts have not been similarly receptive to governmental health sector liability, allowing only 17 percent of these claims to proceed to trial. This number is only 8 percent if one only includes claims for personal injuries against provincial governments, which are the subject of my discussion. In contrast, courts have been willing to find a legal duty in 55 percent of the tort claims against governmental defendants across all other sectors.

I explored other explanations for the judiciary’s seeming reluctance to impose a legal duty in the health sector, including the nature of the injuries generally sustained in those cases, the date of the decisions, and the courts that rendered the decisions. The Ontario Court of Appeal, who heard a considerable majority of the health sector decisions, seems to be less receptive to governmental tort liability than other courts. The Court of Appeal imposed a legal duty in only 25 percent of its decisions across all sectors. However, even taking this inter-provincial variation into account, that Ontario Court of Appeal is still more reluctant to hear

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134 In the provinces with fewer than five cases, the percentages in which the plaintiff succeeded were as follows: Manitoba 100 percent (however, there was only one case), New Brunswick 33 percent, Newfoundland 50 percent, Saskatchewan 66 percent, and the Federal Court of Appeal 25 percent.
health sector claims than claims arising from most other sectors, finding that the government owed a legal duty in only 13 percent of the health sector claims.

Health sector tort cases against provincial governments fall into three broad categories—mismanagement of disease outbreaks, negligent oversight of the health sector, and claims by patients who have died or sustained injuries waiting for medical care. To date, all but one of these cases have been struck on a pre-trial motion, despite the high burden the Supreme Court of Canada has set for striking a claim. Under this test, it must be plain and obvious that the pleadings disclose no reasonable cause of action. In applying the rules of civil procedure, including the power to dismiss a claim before trial, judges must strike a balance between fairness, accuracy, and efficiency. While there is a strong presumption in favor of allowing a plaintiff to engage in an exhaustive fact-finding process and to have her claim heard by an impartial arbiter, the courts cannot squander scarce judicial resources adjudicating clearly meritless claims. Similarly, while a full evidentiary record at trial arguably improves the accuracy of a judge’s findings, it is an inefficient use of resources to allow claims doomed to fail to proceed to trial.

In an effort to strike a balance between fairness, accuracy, and efficiency, courts have determined that judicial resources should be devoted to certain types of claims, specifically, complex cases, novel claims, cases raising important issues, and claims relating to unsettled areas of the law. Yet courts have struck the majority of the health sector cases despite the presence of those factors—the complexity of the health sector, the novelty of the legal duties advanced in the claims and elements of factual novelty, the importance of the issues they raise, and the unsettled nature of the law of governmental tort liability. Although several lower courts
mentioned the presence of these factors in refusing to strike the health sector claims, appellate courts generally disregarded these findings.

In this chapter, I focused on the restrictive approach that Canadian courts take in determining whether to strike health sector claims prior to trial, relative to claims arising in other sectors. As I discuss in the next chapter, this reluctance to hear health sector claims is also apparent when one compares the courts’ application of the test for establishing a duty of care in health sector claims to the broader trends in the Canadian jurisprudence. Specifically, courts adjudicating other types of claims tend to apply a broad, contextual approach, whereby they examine the parties’ relationship, the statutory context, previous cases, the statutory context, and policy considerations. In contrast, courts adjudicating health sector tort claims seem almost singularly concerned with the policy consequences of their decisions.
CHAPTER FOUR

RETHINKING THE TEST FOR ESTABLISHING A DUTY OF CARE

Although duty’s strength in most negligence cases lies embedded and untapped, it contains a robust power that, like a sleeping giant, often must be called upon at the margin of the law of torts to determine the proper scope of this area of the law.¹

-David Owen

Introduction

The starting point for any discussion of the law of negligence is the frequently quoted statement of Lord Atkin in Donoghue v Stevenson:

The rule that you are to love your neighbour becomes in law you must not injure your neighbour... You must take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbour. Who, then, in law, is your neighbour? The answer seems to be—persons who are so closely and directly affected by my act that I ought reasonably to have them in contemplation as being so affected when I am directing my mind to the acts or omissions that are called into question.²

This case—and this passage in particular—is credited with establishing the tort of negligence. Prior to this decision, without privity of contract between the parties, a plaintiff would have no claim in negligence unless her relationship with the defendant fell into one of the narrow categories of previously recognized tort liability.³ Struggling to reach just results in the cases before them, judges had allowed many exceptions to the privity of contract requirement,⁴ which

² [1932] AC 562 at 580 [Donoghue].
³ Vivienne Harpwood, Principles of Tort Law (London: Cavendish Publishing, 2000) at 23. The well-known facts of Donoghue involved a plaintiff consuming a ginger beer that contained a snail. There was no privity of contract between the manufacturer and the plaintiff because the plaintiff had purchased the beverage from a restaurant, rather than purchasing it directly from the manufacturer (the privity of contract was thus between the manufacturer and the restaurant owner). Furthermore, the plaintiff’s claim did not fall into any of the narrow categories of tort liability developed as exceptions to the privity of contract requirement, such as a manufacturer fraudulently misrepresenting a product, or a manufacturer producing a product that is inherently dangerous.
led Lord Atkin to set out a general neighborhood principle of liability applicable in all cases. Following the decision of the House of Lords in *Donoghue*, an expansionary period in negligence ensued (both in Britain and in other common law jurisdictions like Canada), reflecting Lord Macmillan’s statement that “the categories of negligence are never closed.”

In developing the general principle of liability set out in *Donoghue*, judges created four requirements for negligence claims—the existence of a duty of care, breach of that duty, damage, and causation. First, the defendant must owe a duty of care, which requires that the plaintiff prove that she has a close and direct (or proximate) relationship with the defendant. If a plaintiff establishes a *prima facie* duty, a defendant can argue that policy considerations ought to limit or negate this duty. The role of duty of care is to act as a gatekeeper to the law of negligence, determining whether a claim may proceed or whether the courts should exclude it from the judicial system. Thus, the duty of care requirement is restrictive or exclusionary, as “it defines the scope and outer limits of the law of negligence.”

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5 *Supra* note 2 at 619. The principle that a defendant could be liable in negligence without the facts conforming to a previous category of case was confirmed in two subsequent seminal House of Lords decisions, *Hedley Byrne & Co v Heller & Partners Ltd*, [1964] AC 465 and *Home Office v Dorset Yacht Co*, [1970] AC 1004.

6 Although most torts scholars treat negligence as having four requirements, some distinguish between cause-in-fact and proximate cause (or remoteness). The former refers to the requirement that the defendant’s negligence was the factual cause of the plaintiff’s loss. The latter is not a factual determination but a legal test. When a plaintiff suffers unusual injuries or the defendant starts a chain of events causing an unexpected injury, liability will be limited to foreseeable injuries. While cause-in-fact is a significant part of the Canadian courts’ negligence analysis, the latter is seldom discussed as part of the causation inquiry, as foreseeability comprises part of the duty analysis (as I discuss below). Other torts scholars view negligence as having three requirements, conflating the damage and causation elements (in other words, the defendant must owe a duty, have breached that duty, and caused the plaintiff to suffer a compensable injury).

7 Owen, *supra* note 1. Although most legal scholars accept the importance of duty as an element of the negligence inquiry, it is important to mention the body of literature written by what are referred to as “duty skeptics.” These scholars view duty as a mere label that is applied to the judicial exercise of discretion. Goldberg and Zipursky describe duty skepticism as follows: “a description of an actor being under a legal duty to do X is always dressed up as a confusing way of saying the actor runs the risk of sanction if he does not do X. Duty does not convey the notion of an obligation but only that of a threat.” A resurgence in duty skepticism was prompted by a proposed redraft of the American Restatement of Torts, which did not include duty as an element of negligence. Goldberg and Zipursky disagree with this line of reasoning, arguing that duty does not entail complete judicial discretion, but rather where there are difficult cases on the border of negligence that have more than one reasonable solution, the court is the final arbiter. John Goldberg & Benjamin Zipursky, “Seeing Tort Law from the Internal Point of View: Holmes and Hart on Legal Duties,” (2006) 75 Fordham LR 1563. Given the prominence of duty in the Canadian
Under the second element of a negligence claim, a defendant breaches his duty if he fails to take reasonable care to avoid acts or omissions that result in foreseeable harm to the plaintiff. At this stage of the inquiry, courts measure the defendant’s conduct against what a reasonable person in the defendant’s position would have done in the same circumstances.\(^8\) The third requirement is that the plaintiff must have suffered a compensable injury or damage. Finally, the defendant’s conduct must have caused the plaintiff’s loss. Courts typically apply the “but for” test for the causation requirement, inquiring whether the defendant’s negligence is sufficiently connected to the plaintiff’s injury such that the injury would not have occurred but for the negligent conduct.\(^9\)

Because many of the tort claims against the government, including all health sector claims, have been resolved on the question of whether the defendant owed a duty of care to the plaintiff,\(^10\) I focus my discussion on this aspect of the negligence inquiry. Unlike my analysis of the test for striking claims in the previous chapter, which I confined to a critique of the courts’ negligence jurisprudence, particularly in the case of governmental defendants (which are typically resolved solely on whether the defendant owed a duty of care) and the lack of duty skepticism literature in Canada, this radical departure in Canadian law is unlikely. Accordingly, I do not discuss duty skepticism in further detail in this chapter. However, the fact that some legal scholars question whether duty is anything other than a \textit{post facto} label placed on relationships from which liability flowed could perhaps be advanced as an argument in favor of allowing more claims to be resolved at the standard of care stage of the negligence inquiry and for greater clarity to be given to the various proximity and policy factors comprising the duty test, both of which I advocate below.

\(^8\) The judicial interpretation of the reasonableness requirement has been subject to a great deal of criticism. For comprehensive description of this literature, see e.g. Mayo Moran, “The Reasonable Person: A Conceptual Biography in Comparative Perspective” (2010) 14 Lewis & Clark L Rev 1233.

\(^9\) Although Canadian courts generally employ the ‘but for’ test for causation, at times, they have employed other approaches. For example, in \textit{Athey v Leonati}, [1996] 3 SCR 458, the Supreme Court of Canada stated that in cases where the ‘but for’ test is unworkable, judges may explore whether the defendant’s negligent conduct materially contributed to the plaintiff’s loss. In other words, the plaintiff need not establish that the defendant’s conduct was the sole cause of the injury, but rather it is sufficient that the defendant’s negligence was a substantial contributor to the harm the plaintiff suffered. For a general discussion of the Supreme Court of Canada’s recent causation jurisprudence, see e.g. Russell Brown, “The Possibility of ‘Inference Causation’: Inferring Cause-in-Fact and the Nature of Legal Certainty” (2010) 55 McGill LJ 1 and Erik S Knutsen, “Clarifying Causation in Tort” (2010) 33 Dalhousie LJ 153.

\(^10\) As indicated by the case sample in the Appendices, a majority of the reported governmental tort liability decisions are motions to strike rather than trials. It is unclear what happens to the numerous unsuccessful motions to strike that do not proceed to trial. It is possible that the government settles many cases after they are found to owe a legal duty, seeking to avoid reported decisions that could serve as precedents for future plaintiffs suing the government to rely on.
application of the relevant jurisprudence, in this chapter, I critique both the judiciary’s application of the duty test to the health sector claims and certain aspects of the test itself. I use the health sector cases to illustrate these broader criticisms of the Canadian approach to duty of care.

In Part One of this chapter, I briefly outline the historical evolution of governmental tort liability in Canada. Beginning in the mid-twentieth century, the federal and provincial governments passed legislation eroding their longstanding immunity from tort liability. Following the passage of these statutes, courts had the difficult task of determining how to apply legal concepts developed in the context of private parties to governmental defendants.

In Part Two, I set out the tensions that courts must balance in defining the boundaries of negligence law in the context of governmental defendants—flexibility versus certainty, the relevance of policy considerations, and the separation between public and private law. I return to the judicial balance between these tensions throughout the chapter in describing the changes that have occurred over the past ten years in the Canadian duty of care jurisprudence.

In the third part of this chapter, I turn to the test for establishing a duty of care. I begin by outlining the two broad approaches courts may take in determining whether two parties have a sufficiently close relationship to attract a legal duty. Under the first approach, favored by corrective justice scholars, judges focus on the parties’ relationship to define the boundaries of negligence law. The second approach emphasizes policy considerations—the effect that a legal obligation has on the parties to the litigation, the legal system, and society more generally. These approaches are not mutually exclusive. Indeed, each comprises part of the Canadian test for establishing a duty of care, with the courts considering foreseeability and the proximity between the parties at the first stage of the analysis and overriding policy considerations at the
second stage of the test. However, at various times in the history of governmental tort liability, Canadian jurisprudence has reflected a preference for either one approach or the other. Specifically, beginning in 2001, Canadian courts moved away from an approach under which governmental legal duties were almost entirely dependent upon policy considerations (what I refer to as a policy approach) to an approach under which the parties’ relationship had a greater impact on the assessment (what I refer to as a relational approach).

In Part Three, I also draw a distinction between an incremental and a contextual approach to the duty of care analysis. Under the former approach, courts are reluctant to expand the law of negligence to encompass new duties of care. Judges employing this approach are primarily concerned with whether the case at hand conforms to a category of relationship deemed proximate in a previous case. Under the latter approach, courts comprehensively address any relevant considerations arising from the parties’ relationship, the relevant statutory scheme, previous cases, and the policy context in determining whether the defendant ought to owe the plaintiff a duty of care.

In Parts Four and Five of this chapter, I critically analyze the two stages of the Canadian test for establishing a duty of care—proof of a *prima facie* duty and policy considerations that limit or negate a finding of duty. I support the judiciary’s increased emphasis on the first stage of the test, and thus the increased relevance of the parties’ relationship in assessing legal duties. However, this increased emphasis on the parties’ relationship has not occurred in health sector jurisprudence. Instead, the courts focus almost exclusively on policy considerations in assessing whether they should impose a duty, for example, concerns with indeterminate liability and a perceived conflict between a duty to a specific plaintiff and a duty to allocate health system resources in the greater public interest. I discuss these concerns in detail in Chapter Five. In
addition to my specific critiques with the health sector cases, I argue that in the duty jurisprudence more broadly, Canadian courts must make an effort to more clearly define concepts that the Supreme Court has deemed relevant to proximity, such as representations and reliance, in order to add greater certainty to the test for establishing a duty of care.

At the second stage of the test for establishing a duty of care, one of the policy considerations unique to governmental defendants is the policy/operational dichotomy, with courts refusing to impose liability for policy decisions. Prior to Cooper, the policy/operational dichotomy was the touchstone of the second stage of the duty analysis in the context of governmental defendants. I argue that the Supreme Court ought to explicitly abandon the policy/operational dichotomy, as its application risks the foreclosure of a plaintiff’s legal rights on the basis of a line that is arbitrary and difficult to draw. Indeed, the judiciary’s application of the dichotomy in health sector cases reveals an outdated perception of the government’s health sector responsibilities, with the courts focusing on the government’s financial role and using any hint of a budgetary decision to exempt health sector decisions from judicial scrutiny.

In addition to applying the policy/operational dichotomy at the second stage of the duty analysis, courts now more broadly explore the impact a duty would have on the parties, the legal system, and society more generally. In the health sector tort claims, judges devote little attention to the parties’ relationship, preferring to focus on the policy implications of a legal duty. Although there are undoubtedly legitimate policy concerns with imposing tort liability on the government, I argue that courts should be particularly reluctant to allow these concerns to determine whether a defendant owes a duty on a motion to strike, where judges lack a full factual record and the defendant’s evidence is not entitled to the same preferential treatment as the plaintiff’s. Furthermore, instead of restricting their analysis to policy factors that are unilaterally
favorable to the defendant, I argue that courts must balance these concerns against factors in favor of greater judicial scrutiny of governmental decision-making, such as improved accountability.

Although I do not advocate the widespread imposition of governmental tort liability, I conclude this chapter by arguing that courts should more readily permit cases to proceed to the standard of care stage of the negligence inquiry. This would facilitate accountability, as it would call upon the courts to scrutinize the reasonableness of the government’s decisions. It would also improve transparency, an integral component of accountability, as the government would have to explain its decision-making process and the trade-offs it made in adopting a particular policy. However, given concerns with judicial competence to examine matters of complex social policy and democratic concerns relating to the appropriate separation of powers between elected officials and the courts, judges should also incorporate considerable deference to government in determining the applicable standard of care.

Part One: The Evolution of Governmental Tort Liability

Historically, judges refused to hear tort claims against Crown defendants on the basis that “the King can do no wrong.”11 As Blackstone explains, this immunity arose from the courts’ lack of jurisdiction over the sovereign:

That special preeminence which the King hath over and above all other persons, and out of the course of the common law, in the right of his royal dignity…He is sovereign and independent within his own dominions and owes no kind of subjection to any potentate on earth. Hence it is that no suit or action can be

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11 Nicholas W Woodfield, “The Policy/Operational Dichotomy in Intra-State Tort Liability: An Example of the Ever-Continuing Transformation of the Common Law” (2000) 29 Denver J Int’l L Pol’y 27 at 33. Interestingly, some authors argue that the meaning of the original maxim, “the King was not privileged to do wrong” was subsequently distorted. They argue that the original language suggested that the King was not above the law, but rather was under an unenforceable duty to give the same redress to a subject he had wronged as private individuals owed one another.
brought against the King, even in civil matters, because no court can have jurisdiction over him, for all the jurisdiction implies superiority of power.\textsuperscript{12}

Despite this immunity, litigants could apply to the Crown through a process called a ‘petition of right’ for permission to proceed with claims against Crown defendants. However, these petitions were initially only available for suits in debt and contract, not tort claims.\textsuperscript{13}

Upon the advent of parliamentary supremacy, the monarch’s immunity from tort liability passed to the British government.\textsuperscript{14} By the nineteenth century, while most European countries permitted tort suits against governmental defendants, Britain and its colonial offspring (including Canada) continued to rely on the petition of right as the procedure for suing government.\textsuperscript{15} This persisted in Canada upon Confederation, as the Canadian government was entitled to the same privileges and immunities as the British Crown, including immunity from tort liability.\textsuperscript{16}

The primary rationales for legislation removing the government’s tort immunity\textsuperscript{17} were the need for the law to respond to social changes, particularly the transformation of values with respect to individual rights,\textsuperscript{18} and the post-World War II expansion and diversification of governmental activities.\textsuperscript{19} As Cory J. explained in \textit{Just v British Columbia}, a case relating to the government’s highway maintenance:

The functions of government and government agencies have multiplied enormously in this century…The increasing complexities of life involve agencies of government in almost every aspect of daily living. Over the passage of time the increased

\textsuperscript{12} \textit{Ibid} at 32-33.
\textsuperscript{13} Mark Aronson & Harry Whitmore, \textit{Public Torts and Contracts} (Sydney: Law Book Co, 1982) at 1.
\textsuperscript{15} Woodfield, \textit{supra} note 11 at 34. He goes on to state that “...the strained law of Crown liability, along with the rest of the English common law legal system, had been installed in the various colonies as part of their own embryonic legal systems.”
\textsuperscript{16} Ontario Law Reform Commission, \textit{supra} note 14 at 8-9.
\textsuperscript{17} Woodfield, \textit{supra} note 11 at 10. Other former British colonies, including the United States, Australia, and New Zealand, passed similar legislation.
\textsuperscript{18} Woodfield, \textit{supra} note 11 at 31-32.
\textsuperscript{19} Edwin M Borchard, “Governmental Liability in Tort” (1924) 34 Yale LJ 4 at 4.
government activities gave rise to incidents that would have led to tortious liability if they had occurred between private citizens.\textsuperscript{20}

The Diceyan conception of the rule of law, which suggests that public authorities “should be liable through the application of the same common law as would a private individual,”\textsuperscript{21} also provided a theoretical basis for the shift towards increased governmental exposure to liability.

In Canada, the repeal of governmental immunity began in 1952, with the federal government’s passage of the \textit{Crown Liability Act}. According to this legislation:

3. The Crown is liable for the damages for which, if it were a person, it would be liable….in respect of

   (i) a tort committed by a servant of the Crown, or

   (ii) a breach of duty attaching to the ownership, occupation, possession or control of property.\textsuperscript{22}

Around the same time, Canadian provincial governments also passed legislation limiting their immunity from tort liability. For example, under Ontario’s \textit{Proceedings Against the Crown Act}:

5…the Crown is subject to all liabilities in tort to which, if it were a person of full age and capacity, it would be subject,

   (a) in respect of a tort committed by any of its servants or agents;

   (b) in respect of a breach of the duties that one owes to one’s servants or agents by reason of being their employer;

   (c) in respect of any breach of the duties attaching to the ownership, occupation, possession or control of property; and

\textsuperscript{20} \textit{Just v British Columbia}, [1989] 2 SCR 1228 \textit{[Just v BC]}.

\textsuperscript{21} David S Cohen, "Regulating Regulators: The Legal Environment of the State," (1990) 40 UTLJ 213 at 222.

\textsuperscript{22} This legislation was most recently consolidated in \textit{Crown Liability and Proceedings Act}, RSC 1985, c C-50, s 3. This provision applies to all provinces other than Quebec, where the Crown can be liable for “the damage caused by the fault of a servant of the Crown, or the damage resulting from the act of a thing in the custody of or owned by the Crown or by the fault of the Crown as custodian or owner.” Although the government waived its broad immunity from tort liability, there are numerous specific procedural requirements that are advantageous to governmental defendants (such as special notice requirements and shorter limitation periods). Furthermore, as I discuss in greater detail below, the courts have developed legal principles to insulate particular types of governmental decisions from the review of judges.
(d) under any statute or under any regulation or by-law made or passed under the authority of any statute.\textsuperscript{23}

As with the federal statute, the language of Ontario’s legislation suggests that although the government can be vicariously liable for the actions of its employees, direct liability is limited to circumstances where property is involved or when there is a statutory basis for liability.\textsuperscript{24}

The federal and Ontario statutes stand in contrast to some other jurisdictions, whose legislation indicates that the government will be subject to the same potential tort liability for vicarious or direct negligence. For example, British Columbia’s Crown Proceeding Act states, “the government is subject to all the liabilities to which it would be liable if it were a person.”\textsuperscript{25}

Despite this interprovincial variation in the potential limits on direct liability, courts have not required proof of negligence on the part of a particular Crown employee. Instead, they have been willing to impose direct liability on the basis that an unidentified government employee must have been negligent, as the government can only act through its employees. This interpretation finds support in the Supreme Court of Canada’s decision in Swinamer v Nova Scotia, a case relating to the government’s negligence in the maintenance of its highways.\textsuperscript{26}

\textsuperscript{23} Proceedings Against the Crown Act, RSO 1990, c P-27, s 5.
\textsuperscript{24} The language of s 5(d) of Ontario’s legislation, \textit{ibid}, could be interpreted to suggest that the government may be liable for breaching its legislation. However, the Supreme Court of Canada has clearly stated that the government’s breach of legislation is not, in and of itself, actionable. \textit{Canada v Saskatchewan Wheat Pool}, [1983] 1 SCR 205. For a discussion of this issue, see Lewis Klar, “The Tort Liability of the Crown: Back to \textit{Canada v. Saskatchewan Wheat Pool}” (2007) 32 Advoc Q 293.
\textsuperscript{25} Crown Proceeding Act, RSBC 1996, c 89, s 2.
\textsuperscript{26} Swinamer v Nova Scotia, [1994] 1 SCR 445. In that case, Cory J. provided the following example: “Let us assume…that the actions complained of by the appellant were indeed negligent. That is to say the failure of the Crown to rely on trained personnel to inspect the trees and the failure of those persons or this personnel to identify the tree in question as a hazard constituted negligence. Yet those very actions or failure to act were those of the Crown’s servants undertaken in the course of the performance of their work. If those were indeed acts of negligence than the Crown would be liable.”
A failure to plead the negligence of a specific governmental employee has also not acted as a barrier in health sector tort claims. For example, in Williams v Ontario, the plaintiffs claimed that the government failed to take reasonable measures to limit the spread of SARS, that it failed to maintain an adequate public health system, and that it prematurely lifted its declaration of a state of emergency. In the absence of an express mention of vicarious liability in the pleadings and despite no attempt to identify particular employees, the Ontario Superior Court of Justice concluded, “[o]n the present state of the authorities, it does not appear to be necessary to be more precise or specific.” Having set out the statutory context for governmental tort liability, I now turn to discuss some of the tensions that underlie the judiciary’s interpretation of these provisions.

**Part Two: Tensions Underlying the Test for Establishing a Duty of Care**

In adjudicating tort claims against the government, Canadian courts strive to balance several competing tensions. In the following discussion, I briefly outline these tensions, and return to them throughout this chapter in order to highlight my criticisms of the judiciary’s approach to the test for establishing a duty of care. The first set of values courts must reconcile are certainty and flexibility, both of which are essential to the effective functioning of the legal system. McLachlin J., as she then was, reflected on the trade-off between these values in Canadian National Railway Co v Norsk Pacific Steamship Co., adopting a preference for flexibility: “uncertainty…is inherent in the common law generally. It is the price the common

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27 This is in contrast to administrative law, where the inability to identify a specific decision-maker can act as a barrier to a plaintiff’s claim.


29 Ibid. Although the Ontario Court of Appeal did not comment upon this aspect of the lower court's decision, it arguably implicitly affirmed this finding by not overturning it, despite overturning many of the Superior Court’s findings.
law pays for flexibility, for the ability to adapt to a changing world. If past experience serves, it is a price we should willingly pay, provided the limits of uncertainty are kept within reasonable bounds.”  

Certainty in legal doctrine is central to democratic governance and the fulfillment of the rule of law. In order for citizens to respect and obey government and its laws, it is essential that they are able to ascertain what the law is and how judges will apply it. Certainty depends upon the application of clear legal principles and precedents to claims and the gradual evolution of the common law. In contrast, a more flexible approach to the common law values the ability of legal doctrine to keep pace with societal changes. The law of negligence, as formulated in *Donoghue v Stevenson*, was founded on a preference for flexibility, as the House of Lords sought to distance themselves from the earlier rigid requirement of privity of contract as a precondition to a negligence claim. The need for flexible legal instruments is particularly important in the health sector where, as I described in Chapter Two, the government’s responsibilities and its relationship with other health system actors has been in a constant and rapid state of evolution over the past three decades.

The slow and incremental expansion of legal duties through the articulation of clear legal tests and categories, while less flexible, promotes certainty in the law. In contrast, when judges conduct a contextual analysis, examining any considerations they deem relevant to the question of whether a defendant owes a duty, certainty is often sacrificed to achieve greater flexibility in

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30 [1992] 1 SCR 1021 [*CNR v Norsk*].
31 See e.g. *R v Ferguson*, [2008] 1 SCR 96 and *Reference re Secession of Quebec*, [1998] 2 SCR 217. Some jurists question the level of certainty the law can attain. For instance, in *South Pacific Manufacturing Co Ltd. v NZ Security Consultants & Investigations Ltd* Cooke J. stated that “whatever formula be used, the outcome in a grey area case has to be determined by judicial judgment. Formulae can help to organise thinking but they cannot provide answers.” [1992] 2 NZLR 282 at 294.
32 Lord Bingham, “The Rule of Law” (2007) 66 Cambridge LJ 67 at 69 stated that “the law must be accessible and so far as possible intelligible, clear and predictable.”
the common law. As I describe in the following part, due to widespread inconsistency in the lower court jurisprudence and extensive academic criticism, the Supreme Court of Canada revised the test for establishing a duty of care in 2001, with a view to improving certainty in the law. Following that decision, courts applied a more rigid approach to duty, focusing on fitting cases into categories of relationships and defining legal duties by reference to statute. Canadian courts have since retreated from that initial rigidity in favor of a more flexible, contextual approach.

The second tension underlying the test for establishing a duty of care is the extent to which courts consider policy factors in conducting their analysis, as opposed to defining legal duties solely by reference to the parties’ relationship. A focus on policy factors typically has a correlation with a more flexible approach. For example, the Supreme Court of Canada drew the connection between policy considerations and flexibility in *Hall v Hebert:* “…the remedy provided by the law of tort is a flexible one…It must remain flexible and be permitted to grow with a changing society. Similarly [public policy principles] should be flexible and evolve with our ever changing society.”

Some commentators argue that there is an inextricable link between policy considerations and relationships, such that judges cannot separate them. They argue that policy considerations give relationships legal significance, and relationships provide the context for considering policy issues. In this regard, Randall comments that “[r]ights are perhaps more fully apprehended as relational which means they must be understood not only in terms of the bipolar relationship of

33 Henderson argues that the lack of a unifying principle for tort law will jeopardize the rule of law: “We are rapidly approaching the day when liability will be determined routinely on a case by case, ‘under all the circumstances’ basis, with decision makers…guided only by the broadest of general principles. When that day arrives, the retreat from the rule of law will be complete, principled decisions will have been replaced with decision by whim, and the common law of negligence will have degenerated into an unjustifiably inefficient, thinly disguised lottery.” James A Henderson, “Expanding the Negligence Law Concept: Retreat from the Rule of Law,” (1975-1976) 51 Ind LJ 467 at 468.
34 [1993] 2 SCR 159.
litigants but also more broadly in terms of the social context in which they arise and are given form and substance.”

If policy considerations always influence a judge’s assessment of duty, regardless of whether they are explicitly articulated or whether they have been legitimized as part of the negligence analysis, a duty of care analysis that excludes these considerations risks obscuring the actual reasons for a court’s decision.

There are also compelling arguments against the inclusion of policy considerations in the duty of care analysis. There are questions regarding judicial competence to evaluate complex policy issues, as exemplified by criticisms of the Supreme Court of Canada’s decision in Chaoulli v Quebec (Attorney General), a health sector claim under the Charter that turned on the interpretation of comparative health policy evidence. A related concern is that if policy considerations dominate the duty analysis, courts may use the legal claim before them as a means to substitute their own policy choices for those of government. As Weinrib argues, policy considerations “fragment the relationship between the parties and transform the law’s concern from the wrong done and suffered to the choice of social goals.”

As I describe below, Canadian courts have moved away from an approach that defines legal duties primarily by reference to policy considerations external to the parties’ relationship.


36 Manfredi argues that “Chaouilli is a good illustration of the dynamic of judicial policymaking: identifying a problem (waiting lists), assert jurisdiction over the problem through a broad interpretation of particular rights, and then specify a solution to the problem (access to private health insurance).” Christopher Manfredi, “Déjà Vu All Over Again: Chaouilli and the Limits of Judicial Policy-Making” in Colleen M Flood, Kent Roach & Lorne Sossin, eds, Access to Care, Access to Justice: The Legal Debate Over Private Health Insurance in Canada (Toronto: University of Toronto Press, 2005) at 145. Cohen argues that “the state is likely to be involved in polycentric disputes in which the determination of any particular factor or issue involves the simultaneous adjustment of numerous other factors and issues, and affects the interests of numerous individual and collective interests.” David Cohen & JC Smith, “Entitlement and the Body Politic: Rethinking Negligence in Public Law” (1986) 64 Can Bar Rev 1 at 8.

However, one of my primary criticisms of health sector jurisprudence is a failure to follow this trend. In those cases, the determination of whether provincial governments owed a legal duty turned mainly on the judicial concern with policy factors, namely the reallocation of scarce health system resources in an area of complex social policy.

The law of negligence developed over many decades in the context of private parties, and its application to governmental defendants highlights a third tension underlying the test for establishing a duty of care—the extent to which judges should attempt to maintain a distinction between private and public law. There is an abundance of literature questioning the ongoing relevance of this distinction, given the increasing blurring of these two areas of the law. For example, Deegan criticizes judicial efforts to maintain a strict separation: “[t]he public/private law dichotomy is a formalistic distinction which belies the fact that there are overlaps in private and public law and that all law is in fact guided by considerations of public policy.”38 This overlap is increasingly apparent in tort law, as the government expands its involvement in areas previously restricted to private parties. In *Just v British Columbia*, Cory J. acknowledged that:

> The functions of government and government agencies have multiplied enormously in this century...The increasing complexities of life involve agencies of government in almost every aspect of daily living. Over the passage of time the increased government activities gave rise to incidents that would have led to tortious liability if they had occurred between private citizens.39

As I discussed in Chapter Two, the government’s role in the health sector has grown exponentially since the middle of the previous century, with provinces assuming an increasing number of managerial and delivery system responsibilities. These changes result in a much closer nexus between governmental decisions and injured patients than the state’s traditional

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39 *Supra* note 20 at 1239.
financial responsibilities. Historically, these managerial and delivery functions were carried out by hospitals and physicians, who were subject to little government control and who owed legal duties to patients.

Even if private and public responsibilities are increasingly blurred, there remain significant differences between governmental defendants and private parties. Cohen sets out six of these differences:

- government responds to the risk of liability differently than private parties;
- governmental liability entails spreading risk to taxpayers;
- bureaucrats deliver services and benefits that have no private analogies;
- governmental decisions may represent the expression of democracy to which courts should defer;
- governmental responsibilities are defined through complex regulatory enactments that private parties do not experience; and
- governments have a monopoly over certain services, imposing risks to which the public has no alternative.\(^{40}\)

The courts have to grapple with deciding which of these considerations are relevant to the government’s legal obligations. Specifically, they have to determine whether these factors are sufficient to limit or negate the government’s legal duties to its citizens, or whether the law of negligence is flexible enough to incorporate these considerations (for example, whether a unique test is required for governmental defendants or whether existing common law principles are can accommodate these considerations).

In the context of governmental defendants, Canadian courts apply the policy/operational dichotomy, whereby judges will not review decisions they define as policy decisions, while they

\(^{40}\) Cohen, supra note 21 at 222.
will review operational (also called implementation) decisions. This dichotomy is essentially a way of maintaining a distinction between public and private law, as governmental activities falling into the operational category are more analogous to the activities traditionally undertaken by private parties. Over the past decade, Canadian courts have softened their approach to the policy/operational dichotomy, by placing less reliance on this test. Furthermore, judges have further blurred the line between public law and private law by importing considerations developed in the context of private parties (such as representations and reliance) into the duty analysis.

In the following discussion, I explore how Canadian judges have grappled with the tensions I discussed in this Part—flexibility versus certainty, a consideration of policy considerations versus relationships, and the boundary between public and private law—in articulating and applying the test for establishing a duty of care.

**Part Three: Judicial Approaches to Duty**

In Table One, below, I distinguish between two broad approaches courts can adopt in defining the boundaries of negligence—what I refer to as a relational approach and a policy approach. Under the former, courts treat the parties’ relationship as paramount in the duty of care analysis. The relational approach can be further subdivided into what I label as incrementalism and contextualism.\(^{41}\) Judges applying incrementalism assess whether the facts at

\(^{41}\) Vines presents an alternate typology to categorize the judicial approaches to duty of care arising in the Australian context. Under her approach, there are four different categories. The first approach is proximity-as-principle, in which the courts emphasize the importance of relationships and consider the applicable category of case as a secondary consideration. Second is a rules-based approach to proximity, under which a determination of the applicable category of case is the most important factor in establishing a duty of care. In my typology, I do not adopt this distinction, as I believe it is drawing a distinction of kind when it is really a distinction of degree. Her third category of proximity is incrementalism, under which the courts consider categories first and extend them, if at all, by analogy. As Vines acknowledges, there is overlap between incrementalism and the rules-based category. The fourth approach to duty in Vines’ categorization scheme is policy-based decisions, under which policy
hand conform to an established category of legal duty. They will only recognize novel duties through the gradual and cautious expansion of the established categories to encompass analogous relationships. At the other end of the spectrum is contextualism, under which courts examine the totality of the parties’ relationship (including their interactions, relevant precedents, the statutory context, and relevant governmental policies) for the presence of factors indicative of a close and direct relationship. While an incremental approach is characterized by greater certainty, a contextual approach is more flexible, as it allows judges to incorporate any changing circumstances they deem relevant.

The alternative to the relational approach is the policy approach, under which considerations external to the parties’ relationship govern the types of cases that will attract a legal duty. As with the relational approach, courts can employ incrementalism, using clearly defined legal tests or rules to delineate the applicable policy considerations. Alternatively, courts can employ contextualism, whereby they can invoke any policy considerations they deem relevant to the effect that a legal duty would have on the parties, the legal system, or society more generally. The relational and policy approaches to duty are not mutually exclusive, and courts may incorporate both into their duty analyses. Indeed, together, these two broad approaches comprise the two-stage Canadian test for establishing a duty of care.

The Canadian test for establishing a duty of care originated in the House of Lords in *Ann v Merton Borough Council*.\(^{42}\) The Supreme Court first adopted this test into Canadian law in *Kamloops (City) v Neilson*,\(^{43}\) refining it in several subsequent cases, most notably *Cooper v Hobart* in 2001.\(^{44}\) The first stage of the test requires a plaintiff to establish that her injury was foreseeable and that she has a proximate relationship with the defendant.\(^{45}\) Under the second stage of the duty test, judges assess whether there are policy considerations that ought to negate, reduce, or limit the *prima facie* duty established at the first stage of the test. At different times since the statutory erosion of governmental immunity from tort liability, Canadian courts have emphasized one stage of the test or the other, thus favoring either a relational or a policy approach to duty.

\(^{42}\) [1978] AC 728.

\(^{43}\) [1984] 2 SCR 2 [Kamloops].

\(^{44}\) *Cooper v Hobart*, 2001 SCC 79 [Cooper].

\(^{45}\) Moran explains the distinction between these two requirements. Foreseeability requires that the plaintiff establish that he or she is “within the ambit of risk…he or she is among those on whom the defendant’s negligence imposed a foreseeable risk of harm.” In contrast, proximity requires “that the injury suffered was within the ambit of the risk in the sense that it was a materialization of the reasonably foreseeable risk of harm that gave rise to the duty of care.” Mayo Moran, “Rethinking Winnipeg Condominium: Restitution, Economic Loss, and Anticipatory Repairs” (1997) 47 UTLJ 115 at 131.
As illustrated in Table Two, Canadian courts relied primarily on a policy/incremental approach from the Supreme Court’s 1984 adoption of the *Anns* test until its restatement of the test *Cooper*, seventeen years later. For example, the following passage from *Ryan v Victoria (City)*, a 1999 Supreme Court of Canada decision, encompassed the Court’s entire analysis of the foreseeability and proximity elements of the test for establishing a duty of care: “The Store Street tracks ran down the centre of an urban street, in direct proximity to the public. It was plainly foreseeable that carelessness by the Railways with respect to those tracks could cause injury to users of the street. Accordingly, a *prima facie* duty of care arose…”\(^{46}\) The Court itself acknowledged that the first stage of the *Anns* test posed a “relatively low threshold.”\(^{47}\) In other words, the courts engaged in little analysis of the parties’ relationship in determining whether the government owed a legal duty, preferring to rely solely on policy considerations to define the boundaries of negligence. In particular, judges relied on a single policy consideration—the policy/operational dichotomy—in determining whether a governmental defendant owed a plaintiff a duty of care.

In 2001, the Supreme Court of Canada overhauled the test for establishing a duty of care. As Table Two illustrates, in *Cooper*, the Supreme Court adopted an incremental approach at the first, relational, stage of the test. Judges were to define proximity through an analysis of whether the facts at hand conformed to a category of relationship deemed proximate in a previous case. If none applied, judges could expand the categories of duty, cautiously, through an analysis of the relevant legislation. Since 2001, there has been a shift towards contextualism, with judges

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\(^{46}\) *Ryan v Victoria (City)*, [1999] 1 SCR 201 at para 41.

\(^{47}\) *Ibid* at para 23. As Klar argued, prior to the Supreme Court of Canada’s decision in *Cooper*, “[w]hether a duty of care should exist in any particular case inevitably comes down to whether or not there are any policy considerations which ought to negate or limit a presumed duty. This is because the foreseeability of the plaintiff as a potential victim of harm from negligent conduct is easily established. There have been no Supreme Court of Canada cases, or in fact any reported recent cases from any court, where a plaintiff has failed on the foreseeability test.” *Supra* note 4 at 221.
now looking not only at categories of proximate relationships and the statutory context, but also at the parties’ relationship more broadly.

With respect to the second (policy) stage of the duty test, Canadian courts employed incrementalism prior to Cooper, focusing on a single legal test in the context of governmental defendants. The touchstone of the duty analysis was a categorization of the impugned governmental decision as either a policy decision (for which judges would not impose liability) or an operational decision. Beginning with Cooper, Canadian courts shifted towards incrementalism, by broadly considering the effect of a legal duty on the parties’ relationship, the legal system, or society more generally at the second stage of the test for establishing a duty of care.

<table>
<thead>
<tr>
<th>Table Two: CANADIAN JUDICIAL APPROACHES TO THE DUTY TEST</th>
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<tbody>
<tr>
<td>Incrementalism</td>
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<tr>
<td>Relational Approach to Duty</td>
</tr>
<tr>
<td>Beginning in 2001, the first stage of the duty test required applying the categories of proximate relationships.</td>
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<tr>
<td>Policy Approach to Duty</td>
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<tr>
<td>From the 1980s to 2001, duty turned on one policy consideration (the policy/operational dichotomy). There was little analysis of the parties’ relationship.</td>
</tr>
<tr>
<td>Contextualism</td>
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<tr>
<td>Relational Approach to Duty</td>
</tr>
<tr>
<td>Since 2001, the first stage of the duty test has become an increasingly broad analysis of the parties’ relationship.</td>
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<tr>
<td>Policy Approach to Duty</td>
</tr>
<tr>
<td>Since 2001, the second stage of the duty test has become a broad examination of the impact of a duty on the parties, the legal system, and society.</td>
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</tbody>
</table>

Drawing from the cases in the Appendices, Table Three empirically illustrates the post-Cooper shift towards greater contextualism at both stages of the test for establishing a duty of care. In 2002, 73 percent of the governmental tort liability decisions included an analysis of whether the parties’ relationship conformed to an existing category of proximate relationship.

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48 This table illustrates the broad shifts in the Canadian duty jurisprudence. However, it is important to note that these are generalizations and there are certainly outlying cases.
By 2010, although courts continued to mention the categories of proximity (sometimes only in passing in their recitation of the legal test), only 35 percent reached a conclusion on whether the case at bar fit within a category of proximate relationship. Similarly, while in 2002, only 9 percent of the governmental tort liability decisions went beyond the statutory context to broadly explore the parties’ relationship for the presence of proximity factors (such as representations and reliance), in 2010, 80 percent of the decisions explored these factors in determining whether to impose a legal duty.

Table Three also illustrates the shift towards contextualism at the second stage of the test for establishing a duty of care. In this regard, a gradually decreasing portion of governmental liability decisions reached a conclusion on the policy/operational dichotomy (73 percent in 2002 versus 35 percent in 2010). Instead of negating a legal duty through the application of a single legal rule, judges increasingly prefer to resolve the second stage of the duty test through a broad examination of such policy factors as the risk of indeterminate liability, the availability of alternative legal remedies, the presence of conflicting duties, and the chilling effect of liability on governmental decision-making. While only 18 percent of the governmental tort liability decisions explored these factors in 2002, this figure had risen to 70 percent by 2010.
Table 3: % OF CASES IN WHICH COURTS ANALYZED EACH ASPECT OF THE DUTY TEST BY YEAR OF DECISION

<table>
<thead>
<tr>
<th>Year</th>
<th>Foreseeability</th>
<th>First State of the Duty Test</th>
<th>Second Stage of the Duty Test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Proximity</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Categories of Proximity</td>
<td>Proximity Arising from Statute</td>
</tr>
<tr>
<td>2002</td>
<td>92%</td>
<td>73%</td>
<td>73%</td>
</tr>
<tr>
<td>2003</td>
<td>86%</td>
<td>64%</td>
<td>57%</td>
</tr>
<tr>
<td>2004</td>
<td>84%</td>
<td>68%</td>
<td>84%</td>
</tr>
<tr>
<td>2005</td>
<td>89%</td>
<td>57%</td>
<td>68%</td>
</tr>
<tr>
<td>2006</td>
<td>94%</td>
<td>59%</td>
<td>82%</td>
</tr>
<tr>
<td>2007</td>
<td>79%</td>
<td>47%</td>
<td>68%</td>
</tr>
<tr>
<td>2008</td>
<td>75%</td>
<td>55%</td>
<td>65%</td>
</tr>
<tr>
<td>2009</td>
<td>69%</td>
<td>50%</td>
<td>75%</td>
</tr>
<tr>
<td>2010</td>
<td>65%</td>
<td>35%</td>
<td>78%</td>
</tr>
<tr>
<td>2011</td>
<td></td>
<td>80%</td>
<td>40%</td>
</tr>
</tbody>
</table>

In addition to the limits on the case sample in the Appendices that I discussed in the previous chapter, there is another limit on the trends that I describe in Table Three. After a judge finds that a plaintiff failed to discharge his burden at a particular stage of the duty analysis, the judge often goes on to conclude, often summarily, that the plaintiff would have failed to meet other requirements of the test. For example, courts that conclude that the plaintiff failed to prove proximity often briefly list a variety of policy concerns that would also have negated a legal duty. Due to their cursory discussion of these factors, it is unclear whether judges would have reached these conclusions independent of their finding on proximity, or whether they are using the vague category of ‘other policy considerations’ to bolster their initial conclusion respecting proximity. In other cases, however, courts do not discuss the policy stage of the duty test after the plaintiff fails to prove proximity, stating that it is not necessary.

Having described the broad shifts in the Canadian judiciary’s approach to duty, I now turn to a more detailed analysis of each stage of the test and its application in the health sector.

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49 These numbers are drawn from the cases in the Appendices.
50 My sample from 2011 is small, as it only includes the cases reported before the end of June.
tort cases. Although I support the trend towards a greater role for the parties’ relationship and the adoption of a contextual approach at both stages of the test, I argue that this shift has not occurred in the health sector jurisprudence. More broadly, I argue that the courts must now seek to more clearly define and consistently apply the various contextual factors applicable to whether a defendant owes a duty of care.

Part Four: A Critical Analysis of the First Stage of Duty Test

As I mentioned above, the first stage of the test for establishing a duty of care has two requirements—the plaintiff must prove that there is both sufficient foreseeability and proximity between the parties to warrant the imposition of a legal duty. I do not discuss foreseeability further, because:

- the burden for meeting this requirement is low, with the plaintiff proving foreseeability in approximately 90 percent of the cases in the Appendices;
- this element of the duty test receives little attention by commentators;
- judges seldom devote more than a sentence or two to their foreseeability analysis;
- governmental defendants frequently concede foreseeability;

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51 Ryan v Victoria (City), supra note 46.
52 As Klar argued, prior to the Supreme Court of Canada’s decision in Cooper, “Whether a duty of care should exist in any particular case inevitably comes down to whether or not there are any policy considerations which ought to negate or limit a presumed duty. This is because the foreseeability of the plaintiff as a potential victim of harm from negligent conduct is easily established. There have been no Supreme Court of Canada cases, or in fact any reported recent cases from any court, where a plaintiff has failed on the foreseeability test.” Supra note 4 at 221.
53 For example, in 783783 Alberta Ltd v Canada (Attorney General), 2010 ABCA 226 at para 44, the Court of Appeal summarily stated that “[i]t is likely that the Canada Revenue Agency assessors could foresee that if they improperly allowed the deduction of advertising expenses in SEE Magazine, revenues could be diverted away from its competitors.” In James v British Columbia, 2005 BCCA 136 at para 46, the following passage encompassed the Court of Appeal’s entire foreseeability analysis: “[t]he plaintiff’s case is that Clause 7 was imposed on the licensee at the urging of the employees and their union to prevent harm to them from a mill closure. That being so, there is a reasonable basis upon which it could be found that it was foreseeable that negligently allowing the clause to disappear would cause harm to the employees.”
• this requirement has not acted as a barrier to any health sector tort claims;\textsuperscript{55} and

• several governmental tort liability decisions, including some from the health sector, do not even mention foreseeability.\textsuperscript{56}

Despite the low bar plaintiffs have faced in proving foreseeability, a recent Supreme Court of Canada decision suggests that in the future, the Court may be willing to attach greater significance and rigor to the foreseeability analysis at the trial stage of a case (as opposed to a motion to strike). This is because “the limited facts before the Court make it difficult to come to a decision about the issue of foreseeability. For example, we have no facts about what the Province knew or might reasonably be taken to have known at the time the alleged harm occurred.”\textsuperscript{57}

The proximity stage of the test for establishing a duty of care requires the plaintiff to prove that she has a close and direct relationship with the defendant. Following Donoghue v Stevenson, a judicial preference for flexibility and the dominance of public policy concerns in the duty analysis significantly expanded the types of relationships attracting tort liability. Referring to its post-Donoghue duty activism, Klar referred to the Supreme Court of Canada as “the most bold, imaginative and adventuresome high court in the Common Law world.”\textsuperscript{58} However, in its 2001 decision in Cooper, the Supreme Court sought to temper this expansion by emphasizing the importance of categories of legal duties and an incremental approach to duty.

Canada was not the only common law jurisdiction in which the courts moved towards incrementalism. This cautious approach to duty originated in the High Court of Australia in

\textsuperscript{54} See e.g. Design Services Ltd v Canada, 2008 SCC 22 at para 49 and Holtslag v Alberta, 2006 ABCA 51 at para 13.

\textsuperscript{55} For example, the defendant conceded foreseeability in the SARS claims. See e.g. Williams, supra note 28 at para 21 and Abarquez v Ontario, 2009 ONCA 374 at para 17[Abarquez].

\textsuperscript{56} See e.g. Blue v Ontario, 2009 CanLII 18671 and Cerqueira v Ontario, 2010 ONSC 3954.

\textsuperscript{57} Reference Re Broome v Prince Edward Island, 2010 SCC 11 at para 15 [Broome].

\textsuperscript{58} Supra note 4 at 216.
Sutherland Shire Council v Heyman. In that case, Brennan J. espoused the principle that the law should develop “incrementally and by analogy with established categories.” Following its decision in Anns v Merton Borough Council, the House of Lords also retreated to an incremental approach to duty. The comments of Lord Bridge in Caparo v Dickman describe this shift: “I think that the law has now moved in the direction of attaching greater significance to the more traditional categorization of distinct and recognizable situations as guides to the existence, the scope and the limits of the varied duties of care which the law imposes.”

As noted above, according to the Supreme Court’s decision in Cooper, proximity requires a judge to first assess whether the case at bar falls within a category of relationship deemed sufficiently proximate in a previous case. If none of the recognized categories of proximity apply, courts may expand the law of negligence incrementally to encompass a new duty. Specifically, Cooper instructs judges to examine the statutory context for the presence of proximity factors indicative of a close and direct relationship, namely, representations, reliance, expectations, and the nature of the interest involved. The Court views this approach as one that “provides a large measure of certainty, through well settled categories of liability-attracting relationships, while permitting expansion to meet new circumstances and evolving conceptions of justice.”

59 (1985) 157 CLR 424 at 481.
60 [1990] 2 AC 605 at 618.
61 Hill v Hamilton-Wentworth Regional Police Services Board, 2007 SCC 41 at para 32 [Hill v Hamilton]. Although there were sporadic references to categories of proximity in a few of its decisions leading up to Cooper, the Supreme Court of Canada had not previously explicitly articulated the categories as a necessary first step in the proximity analysis. See e.g. CNR v Norsk: “The case did not fall within any of the categories where proximity and liability had previously been found to exist.” Supra note 30. Prior to Cooper, the general approach was to merely treat similar cases as factually analogous precedents. See e.g. Swinamer v Nova Scotia, supra note 26 and Ryan v Victoria (City), supra note 46. The exception to this general approach was the categorical approach the Court developed to analyze claims of pure economic loss. In Martel Building Ltd v Canada, [2000] 2 SCR 860, the Court set out five categories of compensable economic losses: independent liability of statutory public authorities, negligent misrepresentation, negligent performance of a service, negligent supply of shoddy goods or structures, and relational economic loss.
In the remainder of this part, I explore my criticisms of the proximity stage of the duty analysis. Although I support the renewed focus on relationships introduced by the Supreme Court in Cooper (for reasons I detail in Part Six), I criticize the Court’s use of categories and its reliance upon the statutory context to define proximity. As noted in the previous part, there is some recent movement away from this rigid application of Cooper, towards greater contextualism. However, Canadian judges have not universally adopted these changes, as exemplified by health sector tort claims. Courts adjudicating the health sector claims have instead pursued a cursory, statute-focused analysis of proximity, apparently to bolster their policy conclusions at the second stage of the duty test, which are the dominant factors in striking these claims.

A. The Categories of Proximate Relationships

In Cooper, the Supreme Court of Canada provided the following non-exhaustive list of categories of proximate relationships that had given rise to a duty of care in previous cases:

1. A defendant’s act foreseeably causes physical harm to the plaintiff or the plaintiff’s property,
2. A defendant’s act foreseeably causes nervous shock to the plaintiff,
3. Negligent misstatement,
4. Misfeasance in public office,
5. Duty to warn of the risk of danger,
6. Municipal duty to real estate purchasers to inspect housing developments non-negligently,
7. Governmental duty to execute road maintenance non-negligently, and
8. Relational economic loss (in some situations).\(^{62}\)

\(^{62}\) Supra note 44 at para 36.
In what follows, I argue that a judicial attempt to conform the facts before them to these established categories does little to advance the duty analysis and that the categories fail to achieve the Supreme Court’s stated goal of improving certainty in the proximity analysis.

Even with the establishment of categories of proximate relationships, it is unlikely that courts can avoid considering each case on its individual facts. As Barker argues, a defendant is unlikely to accept that a case involving a new fact situation falls within an existing category of proximate relationship, while a plaintiff is likely to either argue that the fact situation does conform to an existing category or, in the alternative, that a new category should be recognized.63

The only situation where there will be no argument over the applicability of the categories is when the facts at hand are nearly identical to a previous case in which a court held that the defendant owed a legal duty. In this type of situation, the existence of the categories adds little to the duty analysis, as the parties would already introduce factually similar precedents.64

The categories of relationships set out in Cooper vary greatly in their specificity. At one end of the spectrum is the general duty of care that arises when a defendant’s act causes foreseeable physical harm to a plaintiff or her property.65 At the other end of the spectrum are precisely defined relationships such as a municipal authority’s duty of care to real estate purchasers when inspecting housing developments and the governmental duty of care with

63 Andrew Barker, “The Duty of Care and the Search for Certainty: Sullivan v. Moody, Cooper v. Hobart, and Problems in the South Pacific” (2003) NZLJ 44. In moving away from the use of categories and creating a general tort of negligence, Lord Atkin stated in Donoghue v Stevenson, supra note 2 at 579-580 that “…the courts have been engaged upon an elaborate classification of duties as they exist in respect of property, whether real or personal, with further divisions as to ownership, occupation or control, and distinctions based on the particular relations of the one side or the other, whether manufacturer, salesman or landlord, customer, tenant stranger, and so on. In this way, it can be ascertained at any time whether the law recognises a duty, but only where the case can be referred to some particular species which has been examined and classified.”

64 Barker, ibid.

65 Supra note 44 at para 36.
respect to road maintenance. Brown criticizes the Supreme Court’s application of the label “categories” to these latter relationships. He argues that relationships of this level of specificity are not actually categories, but rather “case-specific facts” that courts should subsume into a broader category he refers to as “the liability of public authorities.”

In *Eliopoulos v Ontario*, the West Nile Virus claim, there was disagreement between the Ontario Superior Court of Justice and the Court of Appeal regarding the necessary specificity of the applicable proximity category. The lower court accepted that the plaintiff’s case of West Nile Virus was a foreseeable result of the government’s alleged mismanagement of the disease, and therefore met the requirements for the foreseeable physical harm category of proximity. In contrast, the Court of Appeal felt that the appropriate category description should instead be a governmental “private law duty to protect all persons within its boundaries from contracting a disease.” This level of specificity illustrates Barker’s and Brown’s arguments. Even without the existence of this category, future plaintiffs injured by negligent disease outbreak management would nevertheless use this case as a precedent due to its factual similarity. Given the specificity of the Court of Appeal’s articulation of the legal duty being advanced in the plaintiff’s claim, it is questionable whether any case short of a factually identical case would satisfy the requirements to fit within this category of duty.

Instead of fulfilling the Supreme Court’s goal of bringing certainty to the law of negligence, the foreseeable harm category has been the subject of academic speculation and jurisprudential inconsistency. Linden argues that “[t]he established category of physical harm…is downplayed or ignored in most of the cases in spite of the fact that the Supreme Court...”

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66 *Supra* note 44 at para 36.
69 [2006] OJ No 4400 at para 12 [*Eliopoulos*].
meant to exempt physical harm….cases altogether from the *Cooper* analysis.”^{70} Similarly, Crosbie argues that the Supreme Court intended the new test set out in *Cooper* “to apply only to cases of pure economic loss outside the established categories of recovery for pure economic loss.”^{71} In other words, both commentators argue that cases resulting in foreseeable personal injury (either physical injury or injury to the plaintiff’s property) should proceed directly to the standard of care stage of the negligence inquiry.

The approach of the Ontario Court of Appeal in *Williams*, one of the SARS claims, exemplifies the dismissive approach of most Canadian courts to the foreseeable physical harm category. In that case, the Court commented that:

The plaintiff submits that the case as pleaded falls into the existing category of ‘negligence causing physical harm to person or property’….In my view, the category advanced by the plaintiff is cast at such a level of generality that it fails to provide sufficient analytic content capable of obviating the need for a full…analysis… the proximity analysis cannot be short-circuited by focusing simply on the fact that the plaintiff has alleged that the defendant’s negligence has resulted in foreseeable harm to [the] plaintiff’s person.^{72}

Similarly, in *Mitchell Estate v Ontario*, in which an infant died after experiencing delays in receiving treatment in an emergency room, the Court summarily rejected the argument that the plaintiff’s claim fell within the foreseeable physical harm category:

In *Alcock*, *supra*, the case cited by the Supreme Court in *Cooper*, a local police force providing crowd control at a football game negligently allowed an excessive number of spectators to enter a section of the stadium, causing a crush that resulted in many deaths and injuries. It is not alleged here that the Defendant, the Premier, the Minister or government employees directly caused physical harm to

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^{72} *Supra* note 28 at paras 18-19. In *Waap v Alberta*, 2008 ABQB 544 at para 150, after rejecting the plaintiff’s contention that the case fell into the foreseeable physical harm category, the Court stated that “[n]one of these categories recognize a private law duty of care owed by the Crown to protect all of its citizens from receiving a misdiagnosis, less than perfect medical service, or from undue waits for surgery.”
[the Plaintiff], as in *Alcock*. Rather, the Plaintiffs allege that the funding cuts and restructuring caused delay, which in turn was a cause of her death.\(^{73}\)

Although *Alcock* involved a direct relationship between the parties, the Supreme Court merely provided this case as an example of a case involving foreseeable physical harm. It did not discuss the fact that there was a direct relationship in that case or state that directness was a required element for the foreseeable physical harm category.

While it is certainly open to a lower court to conclude that the facts at hand do not bring a case within the requirements of an existing category, it is not open to it to question the categories themselves or to add additional requirements to the categories set out by the Supreme Court of Canada. However, the Supreme Court itself has nevertheless subjected most subsequent cases alleging foreseeable physical injuries or property damage to a full proximity analysis.\(^{74}\) To date, the Court has not yet explicitly overruled this aspect of its decision in *Cooper* or clarified the types of cases to which the foreseeable physical harm category applies.

Although some judges continue to rely on existing categories of duties, and the Supreme Court has not overruled their applicability, Canadian judges increasingly focus on the relevant legislation and the parties’ relationship for indicia of proximity. While these judges still discuss factually similar cases as precedents to inform their analysis, but they do not treat these cases as

\(^{73}\) 2004 CanLII 4044 at paras 20-21(Sup Ct)[Mitchell].

\(^{74}\) For example, in *Hill v Hamilton*, *supra* note 61, a wrongfully charged plaintiff sued the police. The Court considered factually similar cases, proximity factors (expectations, the serious interest at stake, and the parties’ personal relationship), and policy considerations (the lack of alternative remedies). In *Fullowka v Pinkerton’s of Canada Ltd*, 2010 SCC 5, miners who were injured in an explosion sued the government. The Court discussed similar cases, the government’s statutory duty to inspect mines and order cessation of unsafe work, proximity factors (the government’s knowledge of the problem, the serious risks, the fact that the plaintiffs were an identifiable group), and policy considerations (indeterminate liability, the overdeterrence or underdeterrence of governmental regulation, and conflicting duties). See also *Syl Apps Secure Treatment Center v BD*, 2007 SCC 38 and *Odhavji Estate v Woodhouse*, 2003 SCC 69. However, see *Housen v Nikolaisen*, 2002 SCC 33, in which the plaintiff claimed that a posted speed limit was unsafe. After concluding that the injury was foreseeable, the Court engaged in a very limited proximity analysis (summarily concluding that there was a statutory duty and affirming that the impugned decision was operational) before concluding that the municipality breached its duty.
categories within which they must attempt to fit the facts before them. Nor do they treat conformity with a category of proximity as dispositive of the duty of care analysis. Table Three, above, illustrates the broad shift away from a reliance on the categories of proximate relationships. While 73 percent of the governmental tort liability decisions reached a conclusion regarding the applicability of the categories of proximate relationships in 2002, by 2011, this number had reduced to 40 percent.

Of the total cases in which the courts reached a conclusion on this element of the test for establishing a duty of care, judges found that the claim at hand fit within an established category of proximate relationship in only 12 percent of the cases in the Appendices. However, this conclusion was not generally determinative of whether the defendant owed a duty of care, as the courts continued to consider the remaining elements of the test in nearly all of these cases. In finding that none of the existing categories of duty applied (in other words, that the plaintiff was advancing a novel legal duty), no court made the connection between this finding and the relevance of novelty to their decision to strike. As I described in the previous chapter, the Supreme Court of Canada has stated that novelty is a factor in favor of permitting a claim to proceed to trial.

In Heaslip (Estate) v Ontario, the only health sector claim deemed to fall within an established category of duty, the Ontario Court of Appeal still went on to explore whether the parties’ relationship supported a finding of proximity. In that case, the Court deemed the

75 In these cases, the courts either briefly mention established categories but spend the bulk of the decision examining the parties’ relationship or do not refer to the categories at all. See e.g. Bellan v Curtis et al, 2008 MBQB 221; Berg v Saskatchewan, 2003 SKQB 456; Burgess v Canadian National Railway Company, 2005 CanLII 39687 (On Sup Ct), aff’d 2006 CanLII 30215 (CA); Crystal Blue Farms v Newfoundland (Fisheries & Aquaculture), 2009 NLTD 17, and Broome, supra note 57.
76 2009 ONCA 594 at para 21[Heaslip]. The Court’s analysis of the appropriate category was minimal: “I agree with the appellants that the alleged facts in this case support the existence of a duty of care akin to the one identified in Attis: ‘once the government has direct communication or interaction with the individual in the operation or implementation of a policy, a duty of care may arise, particularly where the safety of the individual is at risk.’
appropriate category to be that of a public authority’s duty to act in accordance with an established policy, where it is reasonably foreseeable that failure to do so will cause physical harm to the plaintiff. Given the predominance of policy concerns in health sector cases, which I discuss below, it is not surprising that the Court refused to find that an established legal duty applied, as this finding would require the Court to forgo an analysis of the relevant policy factors. According to Cooper, if a plaintiff’s claim falls within an existing category of proximate relationship, duty is established and the analysis bypasses policy concerns and proceeds to the question of whether the defendant met the applicable standard of care. This approach is not unique to the health sector cases. As I mentioned above, judges routinely and increasingly prefer to base their finding on whether to impose a duty of care on a comprehensive analysis of the parties’ relationship, relevant precedents, the statutory context, and policy considerations, rather than a simple application of the categories of legal duties.

B. Duty as Defined by Statute

If no established category of duty is applicable, courts may consider expanding the boundaries of negligence if the parties have a sufficiently close and direct relationship. In Cooper, the Supreme Court of Canada adopted the comments of McLachlin J, as she then was, from Canadian National Railway Co v Norsk Pacific Steamship Co: “Proximity may be usefully
viewed, not so much as a test in itself, but as a broad concept which is capable of subsuming different categories of cases involving different factors.” In Cooper, the Supreme Court provided a non-exhaustive list of the factors relevant to proximity: expectations, representations, reliance, and the property or other interests involved.

These factors were not new considerations. For example, in Just v British Columbia, a highway maintenance case decided eleven years before Cooper, the Supreme Court of Canada considered the defendant’s representations to the general public: “[i]t would be hard to imagine a more open and welcoming invitation to use [the skiing facilities] than that extended by the provincial highway leading to them.” The decision also referred to the plaintiff’s resulting expectations: “it would be eminently reasonable for the appellant as a user of the highway to expect that it would be reasonably maintained.” Finally, the Court considered the interest at stake, namely “injury from falling rock.” Although the Supreme Court grounded the proximity factors in Cooper in precedent, it had not previously explicitly articulated a list of factors as universally applicable to proximity.

Subsequent cases added additional proximity factors to the Supreme Court’s original list from Cooper, such as physical closeness and whether the plaintiff is part of an identifiable group. Through an analysis of these and any other pertinent factors, the Supreme Court has stated that judges are to “evaluate the closeness of the relationship between the plaintiff and the defendant” and determine “whether it is just and fair having regard to that relationship to impose

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79 Supra note 30 at 1151.
80 Supra note 44 at para 34.
81 Supra note 20.
82 The only prior attempt at articulating factors relevant to proximity was McLachlin’s dissent in CNR v Norsk, supra note 30, parts of which the Supreme Court adopted in Cooper.
83 See e.g. Broome, supra note 57 at para 16 and Hill v Hamilton, supra note 61 at paras 23-24 and 29. The former involved abuse in an orphanage. The latter related to an individual who was investigated and wrongfully charged by the police.
84 See e.g. Fullowka v Pinkerton’s of Canada Ltd, supra note 74 at para 55, in which the plaintiffs were injured in an intentional mine explosion that resulted from a protracted labor dispute.
a duty of care.” Although this quotation suggests a broad, open-ended examination of the parties’ relationship, the Court went on to state that “the factors giving rise to proximity, if they exist, must arise from the statute… That statute is the only source of the [defendant Registrar of Mortgage Broker’s] duties, public or private.”

Statutes are an ill-suited method for defining the relationship between two parties. It is difficult to envision how one could find the presence of factors such as reliance and representations in the broad wording typically employed in legislation. Brown refers to this as “Cooper’s requirement that courts discern the abstract notion of ‘proximity’… through a process as ill-defined and riddled with subjectivity as divining legislative intent…” He goes on to question whether legislators “turned their minds to questions of civil liability” in drafting statutes. Similarly, Horsam argues that if the focus of defining proximity is on “the legislative intent to create civil liability, the test would only rarely be met given that few statues in Canada are drafted with this purpose in mind.” Klar is also critical of a statute-based approach to proximity, concluding that it is contrary to the well-established legal principle that there is no action for breach of statutory duty. The pervasive and expanding nature of the state’s role in the lives of its citizens means that the government’s relationship with individuals is no longer captured solely by the statutory context. Instead, judges must also consider the plethora of policies, agreements, reports, speeches, news releases, and direct interactions between government agents or employees and citizens.

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85 Supra note 44 at para 34.
86 Supra note 44 at para 43.
89 Supra note 24.
Despite the narrow basis for proximity introduced in Cooper, the Court did not clarify whether proximity must be grounded in statute in all cases, or whether the defendant in that case, the Registrar of Mortgage Brokers, was unique in that regard. It is possible that the Court intended this type of analysis to be particular to certain types of defendants, as the Registrar was a creature of statute, he had a limited set of responsibilities defined entirely by legislation, and his decision-making power and discretion were narrowly constrained by the governing statute. Indeed, the Supreme Court of Canada has departed from this statute-focused approach to proximity in several subsequent cases. While these decisions still discussed the statutory context, the Court also examined the parties’ relationship more broadly for indicia of closeness and directness.

For example, in Hill v Hamilton, the Supreme Court of Canada considered whether the police were negligent in their investigation of a man wrongfully convicted of a criminal offense. In addition to the plaintiff’s Charter rights and the statutory duties of police, the Court considered the fact that “the relationship between the police and a suspect identified for investigation is personal.” Although the police made no representations to the plaintiff, the parties had direct interactions, and this claim engaged a serious interest:

90 Supra note 61 at para 33. See also Design Services Ltd v Canada, supra note 54 at paras 51-52. In that case, Public Works launched a tendering process for the construction of a building. Tenders could be submitted either by a company alone or with other entities as a joint venture. Public Works awarded the contract to a non-compliant bidder, and the subcontractors associated with the contractor that ought to have received the contract sued Public Works. In assessing whether the government owed a duty of care to the subcontractor, the Court examined such factors as the nature of the interest involved (the subcontractor had expended considerable time and energy preparing their bids), the defendant had knowledge of the subcontractor (the government had information about all subcontractors), and reliance (the subcontractor relied on government documentation and representations implying a fair methodology in selecting a bid). Most recently, the Supreme Court stated that a duty can arise in two situations—explicitly or by implication from a statutory scheme, or “from interactions between the claimant and statute.” The Court did not explain what it means to interact with a statute. The Court acknowledged the difficulty in proving the first of these scenarios: “Some statutes may impose duties on state actors with respect to particular claimants. However, more often, statutes are aimed at public goods…In such cases, it may be difficult to infer that the legislature intended to create private law tort duties to claimants. This may be even more difficult if the recognition of a private law duty would conflict with the public authority’s duty to the public.” R v Imperial Tobacco Canada Ltd, 2011 SCC 42 at paras 43-44.
We are not concerned with the universe of all potential suspects... In this case personal representations and consequent reliance are absent. However, the targeted suspect has a critical personal interest in the conduct of the investigation. At stake are his freedom, his reputation and how he may spend a good portion of his life.91

Although the Supreme Court has looked beyond the statute in a handful of post-*Cooper* cases, the Court has still not explicitly overruled its statement that judges must tie the proximity analysis to the legislative context in cases where the plaintiff advances a novel legal duty. It is thus unclear whether proximity must arise from the statute in some cases and, if so, what types of cases these are.

Turning to the broader trends in the Canadian jurisprudence, courts did not reach a conclusion on the statutory context or discuss the statutory context at all in 30 percent of the cases in the Appendices. Judges did not examine the legislation for a variety of reasons, for example, because they focused mainly on the standard of care rather than the duty stage of the negligence analysis, they accepted the lower court’s findings on the statute (and those findings were unreported) or, most commonly, because previous similar cases had explored the applicable legislative scheme. In the remaining 70 percent of the cases in the Appendices, judges found that statutes were indicative of proximity in 32 percent of the cases, while they concluded that there was no legislative intent to impose a duty of care in 38 percent of the cases. In 69 percent of the cases in which judges found the statute did not support a duty of care, they typically made this finding on the basis that a private right of action would be inconsistent with a statutory duty to the public at large. This reasoning similarly acted as barrier to a duty of care in 73 percent of health sector tort claims.

As noted above, courts found that the plaintiff’s claim fell within an established category of proximity in only one health sector claim, *Heaslip*. In all of the remaining decisions, the

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91 *Supra* note 61 at para 33-34. *Odhavji Estate v Woodhouse*, *supra* note 74.
courts focused primarily on the statutory context (as opposed to the categories of negligence or the parties’ relationship more broadly) in determining whether to recognize a duty of care. For example, in *Mitchell*, the Ontario Divisional Court concluded:

The legislative framework gives the Minister the power to act in the public interest, and in exercising her powers, she must balance a myriad of competing interests. The terms of the legislation make it clear that her duty is to the public as a whole, not to a particular individual.” Furthermore, “the overall scheme of the relevant Acts confers a mandate on the Minister of Health to act in the broader public interest and does not create a duty of care to a particular patient.  

The Court dismissed the argument that proximity arose from the parties’ relationship with the brief statement that “[i]t is not alleged that the [defendants] knew the Plaintiffs personally, knew of their circumstances, made any representations to them or participated in [the decedent’s] actual treatment.” Because health sector legislation typically sets out general duties to the public at large, a statute-centered proximity analysis bolsters judges’ conclusion at the policy stage of the analysis that a duty to individual plaintiffs would conflict with the government’s broader obligation to act in the public interest. In contrast to this cursory discussion of the parties’ relationship, in *Mitchell* the judge spent seven paragraphs discussing the statutory context.

The health sector tort cases reveal a judicial assumption that a governmental duty to individuals necessarily conflicts with the duty to act in the broader public interest. This assumption stands in contrast to the Supreme Court of Canada jurisprudence, which takes a more nuanced approach when rejecting a legal duty because of conflicting obligations. For example, in *Odhavji Estate v Woodhouse*, the Court found that a broad statutory duty to the general public to monitor and oversee the adequacy and effectiveness of police services did not foreclose the

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92 *Supra* note 73 at paras 27-29.
93 *Supra* note 73 at para 19.
94 Which, as I argue below, is the most significant, if not determinative, factor in health sector tort claims.
possibility of an “obligation to address widespread or systemic misconduct of a particularly serious nature.” Following the SARS outbreak, a commission of inquiry similarly found widespread systemic problems with Ontario’s public health system and a general lack of accountability for public health.

In *Hill v Hamilton*, the Supreme Court of Canada found that a potential conflict between the government’s duty to the general public and a specific plaintiff was insufficient to negate a *prima facie* duty of care: “a duty of care will be negated only when the conflict, considered together with other relevant policy considerations, gives rise to a real potential for negative policy consequences. This reflects the view that a duty of care in tort law should not be denied on speculative grounds.” The Court went on to state that despite governmental duties to the general public, a duty to suspects under police investigation “may have positive policy ramifications,” such as reducing the risk of wrongful convictions. In other words, the Court was willing to recognize that the countervailing policy concerns in favor of tort liability were sufficient to allow the claim to proceed to trial.

Applying this rationale to health sector cases, the imposition of a legal duty on government may cohere with the public interest, rather than conflict with it. For example, in *Abarquez*, a claim by nurses infected by SARS, the Ontario Court of Appeal might have considered the crucial role nurses play in controlling a disease outbreak, the risk of health professionals refusing to work if the government fails to adequately protect their health, and the difficulties in health care worker recruitment and retention more broadly as policy factors relevant to a governmental duty to protect nurses from SARS.

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95 Supra note 73 at para 71.  
97 Supra note 61 at para 43.  
98 Supra note 61 at para 43.  
99 Supra note 55.
C. Proximity Factors

As described in the previous part, one of the most significant changes in the duty jurisprudence over the past ten years has been an increasingly broad approach to the indicia of proximity. While the requirements from Cooper are still good law, Canadian courts are increasingly declining to reach a definitive conclusion on the applicable categories of proximity or whether the statute creates a legal duty, preferring instead to broadly analyze the relevant precedents, legislative context, and the parties’ relationship for indicia of proximity. Due to the criticisms with tying proximity to the legislative context and relying on the categories of proximity discussed above, and for additional reasons I discuss in Part Six, I argue in favor of this contextual approach. However, courts adjudicating tort claims have not consistently applied this contextual approach.

As indicated by the sample of cases in the Appendices, while only 9 percent of the cases from 2002 employed the broader, contextual approach to proximity, by 2011, 80 percent of the decisions examined the parties’ relationship for the presence of the Cooper factors (representations, reliance, expectations, the interest involved, etc.) arising from outside of the statutory context. While courts seldom engage in a comprehensive, systematic analysis of each of the Cooper factors, 16 percent of the cases in the Appendices mentioned reliance and 11 percent of the cases considered whether the parties had a direct relationship. Other factors considered in less than 10 percent of the cases included representations by government, the plaintiff’s legitimate expectations, the plaintiff’s vulnerability, the nature of the plaintiff’s interest, the presence of a direct causal link between the harm and the government’s conduct, and the level of governmental control.
In contrast to these broader trends in the jurisprudence, in health sector tort claims, courts generally engage in little analysis of these proximity factors. For example, in *Eliopoulos*, a West Nile Virus claim, the Ontario Court of Appeal described the government’s legislative obligations to the public at length. However, the decision did not address evidence cited by the Superior Court that the government had identified particular West Nile Virus hotspots, thereby placing particular residents in a close and direct relationship with the Ministry of Health.100 In this regard, Klar commented that, “Sharpe J.A. did not look to the expectations, representations, reliance or other factors to evaluate the closeness of the relationship between the parties. He looked to the statutory provisions.”101

In *Williams*, the plaintiff argued that SARS was distinguishable from West Nile Virus, as the Ontario Court of Appeal had already struck claims based on the government’s management of the latter. Specifically, the plaintiffs argued that unlike West Nile Virus, SARS was communicable only by close person-to-person contact, limiting the risk of transmission to certain high-risk hospitals. In other words, the plaintiffs were not exposed to a general risk to the public at large, but rather “a very specific risk particular to her and a limited class of persons—namely hospital patients, employees, visitors and persons in close contact with the first three groups.”102 Despite the fact that judges are to accept all facts pleaded by the plaintiff as true on a motion to strike,103 and without expert testimony introducing epidemiological or medical evidence, the Ontario Court of Appeal nevertheless concluded that “[t]he risk of contracting an infectious disease from attending a hospital…was a random risk facing the public at large.”104

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100 *Supra* note 69.
101 *Supra* note 24 at 305.
102 *Supra* note 28.
103 *Hunt v Carey Canada Inc.* [1990] 2 SCR 959 at 975 [*Hunt v Carey*].
104 *Supra* note 28.
In the one health sector claim to survive a motion to strike, *Heaslip*, the Ontario Ministry of Health and Long-Term Care was the air ambulance provider and thus its employees had direct contact with the plaintiff. The Court of Appeal repeatedly stressed this direct relationship between the parties. However, the Supreme Court of Canada has clearly stated that a personal relationship is not necessary for a legal duty: “A sufficiently close and direct connection between the actions of the wrongdoer and the victim may exist...where there is no personal relationship between the victim and wrongdoer.”

**Part Five: A Critical Analysis of the Second Stage of the Duty Test**

Once a plaintiff has established a *prima facie* duty of care, a defendant can introduce policy considerations to limit or negate that duty at the second stage of the *Cooper* test. When dealing with governmental defendants, courts will distinguish between policy and operational decisions, only imposing liability for the latter. This dichotomy was initially the touchstone of the duty analysis, with the question of whether the government owed a duty of care turning primarily on a classification of the impugned governmental decision. In other words, prior to *Cooper*, the courts engaged in very little analysis of the parties’ relationship or policy considerations, other than the policy/operational dichotomy.

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105 *Supra* note 76.
106 *Hill v Hamilton*, *supra* note 61 at para 29.
107 In *Cooper, supra* note 44, the Supreme Court of Canada stated that courts could engage in an analysis of policy considerations at both stages of the duty analysis. According to the Court, policy concerns could bar a relationship from being deemed sufficiently proximate to warrant the imposition of a duty of care at the first stage of the test. Specifically, judges could inquire whether notwithstanding proximity, “there are any reasons...that tort liability should not be recognized.” The second stage of the test would then be used for “residual policy concerns outside the relationship of the parties that may negate the imposition of a duty of care.” The Court acknowledged that this distinction may be merely “academic” because “provided the proper balancing of the factors relevant to duty of care are considered, it may not matter, so far as a particular case is concerned, at which ‘stage’ it occurs.” I do not discuss this aspect of *Cooper* further, as the distinction has indeed proved to be merely academic, with the courts not making any meaningful distinctions between first and second stage policy considerations in subsequent cases.
In this part, I begin by critically analyzing the policy/operational dichotomy, ultimately arguing for its abolition on the basis that it is difficult to apply and is unnecessary. I then turn to discuss the post-Cooper changes to the second stage of the duty test. Specifically, although the Supreme Court affirmed the relevance of the dichotomy in Cooper, they also instructed judges to broadly consider how a duty of care would affect other legal obligations, the legal system, and society more generally. These broader policy considerations are the focal point of judges adjudicating health sector tort claims.

A. The Policy/Operational Dichotomy

In Brown v British Columbia, a case in which the plaintiffs alleged that the province was negligent in its maintenance of a highway, the Supreme Court of Canada provided the following guidelines for classifying governmental decisions as either policy or operational:

True policy decisions involve social, political and economic factors. In such decisions, the authority attempts to strike a balance between efficiency and thrift, in the context of planning and predetermining the boundaries of its undertakings and of their actual performance...The operational area is concerned with the practical implementation of the formulated policies; it mainly covers the performance or carrying out of a policy. Operational decisions will usually be made on the basis of administrative discretion, expert or professional opinion, technical standards or general standards of reasonableness.

Applying these guidelines has proven difficult, with many commentators and judges criticizing the dichotomy on this basis. This prompted a substantial body of literature calling into question the legal and theoretical justifications for the retention of the dichotomy in Canada law.

The policy/operational dichotomy initially appeared as a requirement under American legislation exempting a particular sphere of federal governmental activity from tort liability. Under the Federal Tort Claims Act, the United States federal government is liable “in the same

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109 Cooper, supra note 44 at para 37.
110 Brown v British Columbia (Minister of Transportation and Highways), [1994] 1 SCR 420 at 441.
manner and to the same extent as a private individual under like circumstances,” but not for “any act or omission…based upon the exercise or performance or the failure to exercise or perform a discretionary function or duty.” Despite the absence of an analogous provision in British law, in *Anns v Merton Borough Council*, the House of Lords cited the American jurisprudence with approval, referring to discretionary duties or functions as policy decisions. Similarly, with no statutory basis, the Supreme Court of Canada adopted this distinction in *Kamloops*. On the contrary, Canada’s legislation contains no such sphere of protected governmental discretionary activity. For example, the federal *Crown Liability and Proceedings Act* provides that,

4. The Crown is liable for the damages for which, if it were a person, it would be liable….in respect of

(i) a tort committed by a servant of the Crown, or

(ii) a breach of duty attaching to the ownership, occupation, possession or control of property.

This provision clearly indicates that the legislature intended for governmental defendants to owe similar legal duties as private defendants.

Smillie not only questions the legal foundation for the policy/operational dichotomy, but goes further and argues that in contrast to the United States, the structure of the Canadian political system does not demand such a distinction:

111 MK Woodall, "Private Law Liability of Public Authorities for Negligent Inspection and Regulation" (1992) 37 McGill LJ 83 at 88 [emphasis added].
112 Supra note 43.
113 *Crown Liability and Proceedings Act*, RSC 1985, c C-50, s 3. This provision applies to all provinces other than Quebec, where the Crown is liable for “the damage caused by the fault of a servant of the Crown, or the damage resulting from the act of a thing in the custody of or owned by the Crown or by the fault of the Crown as custodian or owner.” Each of the provincial governments have enacted similar legislation, which does not distinguish between policy and operational decisions. See e.g. Ontario’s *Proceedings Against the Crown Act*, RSO 11990, c P-27, s 5 and British Columbia’s *Crown Proceeding Act*, RSBC 1996, c 89, s 2. A similar distinction exists in Canadian administrative law between two spheres of governmental decision-making. Specifically, a duty of fairness is dependent upon the classification of a decision as administrative or quasi-judicial. In contrast, decisions of a “legislative or general nature” that are based on broad policy issues are unlikely to attract a duty of fairness. *Knight v Indian Head School Division No 19*, [1990] 1 SCR 653.
The philosophical objection to judicial interference with the functions of other branches of government based on the notion of a strict separation of powers between legislature, executive and judiciary carries much less weight in commonwealth countries. The constitutions of parliamentary democracies based on the Westminster model contain no such notion of a strict separation of powers. Instead the fundamental principle dictates the complete supremacy of the law as formulated by parliament and interpreted by the ordinary courts.\textsuperscript{114}

More broadly, Deegan characterizes the policy/operational dichotomy as part of a broader, increasingly obsolete, distinction between public law and private law.\textsuperscript{115}

Another criticism of the policy/operational dichotomy is the difficulty inherent in placing governmental decisions into one of these categories. In this regard, Klar comments:

Deciding the issue of the tort liability of public authorities by applying the policy/operational dichotomy to their activities has long seemed to be an exercise in frustration. Reflection reveals that governmental activities do not neatly divide into policy decision making, on the one hand, and policy implementation, on the other, because inherent in each are elements of the other.\textsuperscript{116}

Smillie similarly argues that “A rule of complete immunity for ‘non-justiciable policy decisions’ is too blunt an instrument to be applied consistently and sensibly across the whole spectrum of governmental functions: it is at once too subjective and uncertain in its application, and too rigid in its effect.”\textsuperscript{117}

Courts themselves have acknowledged the struggle to distinguish between policy and operational decisions, with the Supreme Court of Canada calling the dividing line between the

\textsuperscript{114} JA Smillie, "Liability of Public Authorities for Negligence" (1985) 23 UWO L Rev 213 at 218.
\textsuperscript{115} In this regard, Deegan argues that “The public/private law dichotomy is a formalistic distinction which belies the fact that there are overlaps in private and public law and that all law is in fact guided by considerations of public policy...the law will develop properly if the policy/operational factors distinction and the public/private law dichotomy are allowed to dissolve, as they should, and that the emphasis in considering the liability of statutory authorities in negligence should be focused on the relationship between the state and the individual.” Supra note 38 at 264.
\textsuperscript{117} Supra note 114 at 218.
two types of decisions “difficult to fix,”\textsuperscript{118} referring to the distinction between policy and operational decisions as “one of degree.” \textsuperscript{119} The problem with the dichotomy is that governmental decisions are not categorical, but lie on a spectrum with clear policy decisions at one end, clear operational decisions at the other, and many (if not most) decisions falling somewhere in the middle. Furthermore, in many areas, the government does not make a single isolated decision leading to a plaintiff’s injury, which the courts can then categorize, but rather a variety of governmental policy decisions and their subsequent application are relevant to the injury. Acknowledging these difficulties, the Supreme Court of Canada may have set the stage for a retreat from the dichotomy in its most recent governmental tort liability decision:

The main difficulty with the policy/operational approach is that courts have found it notoriously difficult to decide whether a particular government decision falls on the policy or operational side of the line…Is the decision of a social worker when to visit a troubled home, or the decision of a snow-plow operator when to sand an icy road, a policy decision or an operational decision? Depending on the circumstances, it may be argued to be either or both. The policy/operational distinction, while capturing an important element of why some government conduct should generally be shielded from liability, does not work very well as a legal test.\textsuperscript{120}

As this quotation suggests, despite the difficulties inherent in the application of the dichotomy and its lack of a statutory or political foundation, there are several compelling pragmatic and theoretical rationales for protecting certain types of governmental decisions from judicial scrutiny. One justification for isolating policy decisions from review is judicial competence, or the fact that government is in a better position than a court to engage in a delicate balancing of competing interests and an allocation of finite budgetary resources in an area of complex social policy. The dichotomy is thought to protect governmental policies requiring

\begin{footnotesize}
\textsuperscript{118} Just, supra note 20 at para 17.
\textsuperscript{119} Kamloops, supra note 43 at 9.
\textsuperscript{120} R v Imperial Tobacco Canada Ltd, supra note 90 at para 78. Despite this very critical description discrediting the policy/operational dichotomy, the Court went on to apply the test.
\end{footnotesize}
these balancing exercises from the review of courts, while still permitting judges to assess whether the government was negligent in the implementation of these policies.

Another explanation for the exclusion of certain governmental decisions from the courts is the fact that unlike judges, citizens democratically elect the legislature, and thus its decisions reflect the will of the people. In this regard, Klar states, “it is felt that those who engage in political decision-making ought to have the quality of their decisions judged by the electorate, and not ‘second-guessed’ by the judiciary.” 121 Similarly, Bailey and Bowman comment that “[i]t is not difficult to accept the inappropriateness of allowing the courts to be used as an appeal tribunal against the results of a General Election…” 122

I discuss the merits of the rationales for a protected realm of governmental decision-making in further detail in the next chapter. However, the mere existence of persuasive reasons for excluding certain types of decisions from the review of the judiciary does not necessitate the retention of the policy/operational dichotomy. The alternative—allowing the other required elements of the test for negligence to filter out clear policy decisions—reduces the risk of inaccurately and unjustly excluding cases based on a line that is arbitrary and difficult to draw. A plaintiff would generally have difficulty satisfying the other requirements of a negligence claim if the impugned decision is a clear policy decision.

As I discussed in the previous section, a plaintiff must demonstrate that she has a close and direct (or proximate) relationship with the defendant, which involves an analysis of such factors as representations, expectations, and whether there were interactions between the parties.

122 Bailey & Bowman, supra note 116. Chatterjee et al similarly argue that “…the courts must balance the idea of equality before the law, which militates against governmental immunity from tortious liability, with parliamentary supremacy and judicial deference for the policy choices of statutory decision-makers. The policy/operational distinction provides a basis for delineating those decisions that ought not be subject to judicial oversight…To disturb those decisions through a finding of negligence is to allow the court to substitute its decision for that of the legislature’s chosen delegate.” Supra note 108 at 1.
It is difficult to envision how a plaintiff would successfully prove that she had a legitimate expectation of receiving a particular health service within a particular time if the only government decision at issue was its allocation of funds—a clear policy decision under the dichotomy.\(^{123}\)

Similarly, claims based on clear governmental policy decisions would generally fail to satisfy the causation requirement—the connection between the defendant’s negligence and the plaintiff’s loss.\(^{124}\) For instance, if a plaintiff waited for treatment for longer than was medically recommended, she might claim this was the result of governmental cuts to the health care budget, which is a clear policy decision under the dichotomy. However, it would be very

\(^{123}\) In *Just, supra* note 20, the Supreme Court of Canada stated that “[a]s a general rule, decisions concerning budgetary allotments for departments or government agencies will be classified as policy decisions.”

\(^{124}\) In Chapter One, I discussed the approach to injury causation in the health policy scholarship, which seeks to undertake an exhaustive exploration of all the contributors to an injury. In some cases, the most effective means of error prevention are those furthest removed from the patient, as these causes do not depend upon human behavior modification. The systems approach to error causation in the health policy literature stands in contrast to the legal approach to causation. Plaintiffs typically name the individuals most directly involved in their injuries as defendants—usually health care professionals and less frequently hospitals. Due to Canadian rules permitting joint and several liability, whereby any defendant is responsible for paying the entire damage award, plaintiffs have little incentive to name defendants whose conduct may be more remote from the injury, thereby perpetuating the courts’ focus on the negligence of providers. Advocates of tort reforms such as no-fault compensation schemes point to the disconnect between the patient safety literature’s focus on systems and the courts’ narrow focus on individual liability. Until recently, the legal test for causation reflected the fact that negligence claims generally involved two individuals who had a temporally and spatially close relationship, with courts asking whether the plaintiff’s injury would have occurred “but for” the defendant’s negligence. In the medico-legal context, causation often poses a barrier to a plaintiff’s recovery. First, because a patient seeking medical treatment is often already very ill and may have sustained injury or died regardless of the treatment he received, it may be difficult to establish that his injuries were the result of negligence rather than the natural progression of his condition. Second, due to the inherent risks that accompany medical procedures, expert witnesses may disagree on whether an injury was the result of negligence or an accepted risk of the medical treatment. Finally, with respect to hospital or governmental defendants, it may be difficult to establish causation due to the numerous intervening acts of health providers or other actors. Because of these intervening actors and the temporal and spatial gap between government decisions and patient injuries, it would be difficult for a plaintiff to prove that her injuries would not have occurred “but for” the government’s negligence. Recognizing the difficulties inherent in the “but for” test, in 1990, the Supreme Court of Canada adopted a more flexible approach that may assist plaintiffs in pursuing claims against systemic actors in the health sector. Under this approach, the court asks whether the defendant’s negligence materially contributed to the risk of injury. For a discussion of the lack of clarity surrounding this test, see e.g. Knutsen, *supra* note 9 and Brown, *supra* note 9. In the governmental tort liability context, courts increasingly recognize claims for “systemic negligence”, whereby the state may owe legal duties in conjunction with its failure to have appropriate oversight mechanisms. For example, in *Rumley v British Columbia*, 2001 SCC 69 at para 30, the Supreme Court of Canada certified a class action in which residential school students alleged, among other things, that the government’s actions constituted “systemic negligence—the failure to have in place management and operations procedures that would reasonably have prevented the abuse.” See also *Mr K v EK*, 2004 ABQB 159 at para 3.
difficult for her to prove causation, given the remoteness of the government’s actions relative to
the plaintiff. Furthermore, a court would also consider the intervening actions of actors more
closely connected to the plaintiff’s injury, such as the hospital’s distribution of their global
budget between departments, the departmental allocation of funds within the hospital, and
doctors’ decisions relating to the seriousness of the plaintiff’s condition and her resulting priority
on the waitlist.

Courts can also account for the rationales underlying the dichotomy when determining
the appropriate standard of care. For example, judges could accord considerable deference to a
government’s strategy to combat a disease outbreak, a decision that clearly calls for a difficult
balance between competing interests and stakeholders and the analysis of complex, and
sometimes conflicting, scientific and policy evidence.\textsuperscript{125} In contrast, the courts could give less
deerence to the failure of government-employed public health nurses to follow a policy
respecting the re-use of medical supplies, as this type of decision has private analogues and
involves measuring the defendant’s conduct against a clearly defined standard. Smillie argues
that the standard of care is sufficiently malleable to account for the characteristics unique to
government: “Any special administrative or allocational problems faced by a public authority
can be given due weight when the court considers whether the authority was in breach of its duty
to take reasonably care in all the circumstances of the case.”\textsuperscript{126}

The health sector jurisprudence exemplifies the difficulties resulting from the courts’
application of the policy/operational dichotomy. As I discussed in Chapter Two, the

\textsuperscript{125} For example, in the context of \textit{Charter} reviews of governmental policy decisions, in some cases involving
complex matters of social policy, the courts have accorded the state some flexibility in the standard of evidence
required under s. 1 of the \textit{Charter} to justify a rights infringement. In these cases, judges ask whether the
government had a “reasonable basis” for its policies. In other words, instead of demanding the government
produces definitive, scientific proof, a factual basis for its decision is sufficient. Sujit Choudhry, “So What is the
Real Legacy of \textit{Oakes}? Two Decades of Proportionality Analysis Under the Canadian \textit{Charter’s Section 1}” (2006)
34 SCLR (2d) 501.

\textsuperscript{126} \textit{Supra} note 114 at 248.
government’s role in the health sector has expanded dramatically since the middle of the twentieth century to include an active role in the management of health service delivery and clinical decision-making. In applying the test for establishing a duty of care to provincial governments, courts tend to focus on the defendant’s traditional financial role, which exempts the impugned decisions from review, as budgetary decisions typically fall on the policy side of the dichotomy.\textsuperscript{127} By summarily labeling the government’s role in the health sector as financial, it is unclear whether courts merely do not understand the nature of government’s modern role in the health sector or are interpreting the test for establishing a duty of care with a view to avoiding subjecting the actions of government to scrutiny (the latter of which I discuss in the next section).

In \textit{Cilinger v Quebec (Procureur General)}, the plaintiff attributed delays in receiving radiation for breast cancer to budgetary controls, control of personnel and professionals, and other regulatory controls.\textsuperscript{128} The Court focused on the government’s financial decisions, specifically the yearly budget for health care, the allocation of this amount between hospitals, and the use of these funds. However, the Court did not discuss whether the government was negligent in the implementation of a policy describing the government’s intention to reduce breast cancer mortality, a publication detailing the Quebec program to fight cancer, information bulletins published by a committee regarding waiting times for treatment, and announcements respecting a series of measures to reduce wait lists.\textsuperscript{129}

\textsuperscript{127} The Supreme Court of Canada stated in \textit{Just, supra} note 20 that “[a]s a general rule, decisions concerning budgetary allotments for departments or government agencies will be classified as policy decisions.” However, because the vast majority of government decisions are affected by scarce resources, the Court distinguished between budgetary decisions and decisions merely impacted by budgetary considerations. For example, in that case, although budgetary decisions would affect the frequency and manner of inspections for rocks, decisions relating to the frequency and manner of inspection were not policy decisions.
\textsuperscript{128} \textit{Cilinger v Quebec (Procureur General)}, [2004] RJQ 2943 at para 81 [Cilinger].
\textsuperscript{129} \textit{Ibid}, paras 85-90.
In *Eliopoulos*, the Court similarly characterized much of the government’s involvement in managing the West Nile Virus outbreak as policy, deeming the government’s plan to combat the virus “an attempt by the Ministry to encourage and coordinate appropriate measures to reduce the risk of WNV by providing information to local authorities and the public.” 130 The Court went on to conclude that, “[t]he Ministry undertook to do very little, if anything at all, beyond providing information and encouraging coordination. The implementation of specific measures was essentially left to the discretion of members of the public, local authorities, and local boards of health.” 131 The Court failed to consider whether the government was negligent in its implementation of the plan or its provision of information to the public, whether it failed to exercise adequate oversight over local authorities and boards or health, or whether its control over these other actors was so extensive that they were not acting independently of government.

Despite the government’s pervasive involvement in all areas of the health sector, the cases in the Appendices suggest that the courts are less likely to classify health sector decisions as operational than those arising from other sectors of governmental activity. Judges found that 44 percent of the non-health sector claims contained allegations relating to operational decisions, while they classified 18 percent of the claims as solely involving policy decisions. Of the remaining 39 percent of the decisions, judges did not reach a conclusion on the policy/operational dichotomy, frequently because they had already found that there was no proximity under the first stage of the *Cooper* analysis. However, in a few of these cases (4 percent), the courts stated that they required further factual evidence to determine whether the

130 Supra note 69 at para 23.
131 Supra note 69 at para 23. In *Mitchell*, supra note 73 at para 33, the Court found that aside from the limited power to appoint a hospital supervisor, governmental defendants “do not have the power to engage in day to day supervision of hospitals,” that “Ontario has no direct supervisory relationship over the hospital in question,” and that “Ontario does not make decisions with respect to the operations of hospitals.” The Court did not discuss whether the government was negligent in the exercise of those powers.
government had made operational decisions. Of the health sector decisions that contained a conclusion on the policy/operational dichotomy, 78 percent of the courts classified the impugned government decisions as falling on the policy side of the dichotomy.

B. Other Policy Considerations

Prior to Cooper, Supreme Court of Canada jurisprudence provided little guidance on the factors relevant to a judge’s decision to negate or limit a legal duty, aside from the policy/operational dichotomy. However, in Cooper, the Court instructed that judges should assess “the effect of recognizing a duty of care on other legal obligations, the legal system and society more generally.” 132 In addition, the Court provided a non-exhaustive list of pertinent considerations to limit a prima facie duty of care, including the existence of another legal remedy, the potential for unlimited liability to an unlimited class, or “other reasons of broad policy that suggest that the duty of care should not be recognized.” 133

Similar to the Canadian judiciary’s broadening of the first stage of the duty test, in assessing policy considerations, courts are now increasingly less likely to rely on the application of a single test (the policy/operational dichotomy) to determine whether to negate a prima facie duty of care. While in 2002, 73 percent of the governmental tort liability decisions in the Appendicies reached a conclusion on the dichotomy, this number had decreased to 50 percent by 2011. Conversely, while only 18 percent of the decisions from 2002 discussed the broader policy consequences of a legal duty (such as unlimited liability or alternative remedies), by 2011, 70 percent of the cases addressed these factors. When courts discussed whether policy considerations ought to negate a duty, they most commonly cited the potential for unlimited

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132 Supra note 44 at para 37.
133 Supra note 44 at para 37.
liability (22 percent of the cases), the existence of an alternative remedy (11 percent of the cases), and the presence of conflicting duties (8 percent of the cases). Less frequently, judges considered the chilling effect of liability, or a general concern with judicial intrusion into governmental decision-making.

These policy considerations seem to be the driving force in the decisions to strike health sector claims. Throughout their decisions, and at all stages of the duty analysis, judges repeatedly express a reluctance to impose liability, due to policy concerns. For example, in examining the statutory context for indicia of proximity, the Court of Appeal in Eliopoulos concluded: “The legislative framework gives the Minister the power to act in the public interest, and in exercising her powers, she must balance a myriad of competing interests. The terms of the legislation make it clear that her duty is to the public as a whole, not to a particular individual.” In addition, the Court found that “This case is concerned with a general risk faced by all members of the public and a public authority mandated to promote and protect the health of everyone located in its jurisdiction.”

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134 The policy concern relating to conflicting duties often overlap with the court’s discussion of proximity arising from the statute, since these conflicting duties are often grounded in legislation. I discussed conflicting duties in health sector above.
135 Supra note 69 at para. 17 (quoting Mitchell). The Court continued: “The overall scheme of the relevant Acts confer a mandate on the Minister of Health to act in the broader interest and does not create a duty of care to a particular patient.” Furthermore, legislative powers “are to be exercised, if the Minister chooses to exercise them, in the general public interest. They are not aimed at or geared to the protection of the private interests of specific individuals…a general public law duty of that nature does not give rise to a private law duty sufficient to ground an action in negligence. I fail to see how it could be possible to convert any of the Minister’s public law discretionary powers, to be exercised in the general public interest, into private law duties owed to specific individuals.”
136 Supra note 69 at para. 20. Similarly, in Williams, supra note 28 at para 31, the Court stated that “When assessing how best to deal with the SARS outbreak, Ontario was required to address the interests of the public at large rather than focus on the particular interests of the plaintiff or other individuals in her situation. Decisions relating to the imposition, lifting, or re-introduction of measures to combat SARS are clear examples of decisions that must be made on the basis of the general public interest rather than on the basis of the interests of a narrow class of individuals. Restrictions limiting access to hospitals or parts of hospitals may help combat the spread of disease, but such restrictions will also have an impact upon the interests of those who require access to the hospital for other health care needs or those of relatives and friends. Similarly, a decision to lift restrictions may increase the risk of the disease spreading but may offer other advantages to the public at large including enhanced access to health care facilities. The public officials charged with the responsibility for imposing and lifting such measures must weigh
Court in *Eliopoulos* characterized the plaintiff’s allegations as relating to “issues of public health policy, the establishment of governmental priorities, and the allocation of scarce health care resources.”\(^{137}\) Furthermore, the Court commented that government “must weigh and balance the advantages and disadvantages and strive to act in a manner that best meets the overall interests of the public at large.”\(^{138}\)

With respect to additional policy considerations that could limit or negate a duty of care, the Court of Appeal stated that “[i]n deciding how to protect its citizens from risks of this kind...Ontario must weigh and balance the many competing claims for the scarce resources available to promote and protect the health of its citizens.”\(^{139}\) Finally, the Court concluded that:

> ...to impose a private law duty of care on the facts that have been pleaded here would create an unreasonable and undesirable burden on Ontario that would interfere with sound decision-making in the realm of public health. Public health priorities should be based on the general public interest. Public health authorities should be left to decide where to focus their attention and resources without the fear or threat of lawsuits.\(^ {140}\)

In sum, courts adjudicating health sector claims are concerned with the conflict between a legal duty to individual plaintiffs and the government’s broad duty to make decisions in the general public interest, the unreasonable burden that liability would place on the state, and disrupting the delicate balance the government seeks to achieve between competing health sector programs and interests. To a lesser extent, the courts also express concerns with the potential for

\(^{137}\) *Supra* note 69 at para 29.

\(^{138}\) *Supra* note 69 at para 31.

\(^{139}\) *Supra* note 69 at para 32.

\(^{140}\) *Supra* note 69 at para 33. Given that this was the first health sector decision from the Ontario Court of Appeal, all of its subsequent decisions invoke these arguments, and this passage in particular.
unlimited liability,\textsuperscript{141} the fact that plaintiffs have other legal remedies,\textsuperscript{142} and the potential chilling effect of tort liability on governmental decision-making.

Although I address the substance of these concerns in the following chapter, in the next part, I question whether courts have sufficient evidence to effectively grapple with these complex policy considerations at the pre-trial stage the proceedings. Furthermore, I argue that these concerns must be balanced against countervailing concerns favoring the judicial scrutiny of health sector decisions, such as improved accountability and limits on the other available remedies (which I also discuss in detail in Chapter Five).

**Part Six: Proposed Approach to Duty**

As I discussed in Parts Four and Five, in the decade since the Supreme Court’s decision in *Cooper*, Canadian courts have adopted what I characterize as a contextual approach by broadening the factors relevant to whether a defendant owes a legal duty. At the first stage of the analysis, most judges now examine the totality of the parties’ relationship as illuminated by legislation, precedents, and the parties’ interactions.\textsuperscript{143} Prior to *Cooper*, the policy/operational dichotomy was the touchstone of the second stage of the duty analysis in the context of

\textsuperscript{141} For example, in *Nette v Stiles*, 2009 ABQB 422, the Court stated that liability “would have the effect of making the Crown an insurer for chiropractic services.”

\textsuperscript{142} For example, in *Williams, supra* note 28 at para 36, the Court remarked that the plaintiff could commence a claim against health care facilities or health care professionals for their application and enforcement of government directives. In *Nette v Stiles, ibid*, the Court mentioned that in addition to suing the government for the negligent regulation of chiropractors, the plaintiff had commenced claims against individual practitioners and the College of Chiropractors. In *Abarquez, supra* note 55, the Court cursorily mentioned that nurses could also apply for Workers’ Compensation benefits.

\textsuperscript{143} The type of contextual, multi-factorial analysis that increasingly characterizes the approach to the duty of care analysis is well-established in other areas of the law. For example, in *Law v Canada (Minister of Employment and Immigration)*, the Supreme Court of Canada advocated such an approach in Charter claims: “[The] equality analysis under the Charter must be purposive and contextual. The guidelines set out here are…points of reference which are designed to assist a court in identifying the relevant contextual factors in a particular discrimination claim, and in evaluating the effect of those factors in light of the purpose of s. 15.” [1999] 1 SCR 497. See also the Supreme Court’s application of a multi-factorial, contextual approach to determining the duty of fairness in administrative law in *Baker v Canada*, [1999] 2 SCR 817. See also the Supreme Court’s approach to court orders limiting freedom of expression, *Dagenais v Canadian Broadcasting Corporation*, [1994] 3 SCR 835.
governmental defendants. However, judges now also explore the impact of a legal duty on the parties, the legal system, and society more generally. Although the judiciary’s approach to health sector claims differed from these broader trends in the governmental tort liability jurisprudence, my criticisms in this part apply to claims against governmental defendants more generally.

I argued in favor the trend towards a contextual approach, due to the limits of the policy/operatorial dichotomy and the categories of proximate relationships. In addition, I argued that a reliance on the statutory context to define the state’s legal responsibilities fails to capture the government’s modern, expansive role in the lives of its citizens. However, a flexible, contextual approach to duty is often achieved at the expense of certainty. Some authors suggest that this trade-off is justified. For example, Spiller argues that “[t]he criticism often made of a contextual approach is that this undermines legal certainty and predictability…But the hope of legal certainty in the sense of predictable outcomes in every case is an illusory one and carries the potential for injustice.” Indeed, the Supreme Court of Canada itself has acknowledged that “[t]he task of doctrine is to identify the factors which unite the different applications with a view to formulating emergent principles…absolute legal formulations may not in all cases be possible or practical.”

144 See e.g. Just v BC, supra note 20. Because the proximity analysis was limited prior to Cooper, the policy/operatorial dichotomy was generally determinative of governmental tort liability. In this regard, Chatterjee et al, supra note 108 at 2 state that “Canadian courts have moved away from using the policy/operatorial distinction as the predominant basis for determining whether a public authority will owe a duty of care, adopting instead a more searching analysis of proximity in the first stage of the Anns test.”

145 He goes on to quote Lord Wilberforce in Owners of mv Eleftherotria v Owners of mv Despina R, [1979] AC 685 at 698-699: “To say that this [approach] produces a measure of uncertainty may be true, but this is an uncertainty which arises in the nature of things from the variety of human experience…To attempt to confine this within a rigid formula would be likely to produce injustices…” Peter Spiller, “Judging in Context: Lord Wilberforce’s Legacy to New Zealand Law” (2004) Waikato Law Review 5.

146 CNR v Norsk, supra note 30.
In this part, I argue that although uncertainty is inherent in a contextual approach, Canadian courts should now focus on mitigating this uncertainty by developing more clear definitions for the various applicable contextual factors and consistently applying them across all governmental tort liability claims. As currently applied, proximity and policy factors such as reliance, expectations, and alternative remedies are mere labels that lack analytical content in the context of the test for establishing a duty of care. For example, in assessing reliance in the proximity analysis, courts have not discussed whether detrimental reliance is necessary and if not, whether it provides a stronger claim for proximity. Similarly, in analyzing the plaintiff’s expectations, judges have not discussed whether they should evaluate these expectations against an objective or a subjective standard or whether the former is more indicative of a close and direct relationship. In assessing alternative remedies under the second stage of the duty analysis, the courts have not clarified whether any sort of remedy is sufficient (for example, an internal complaints or appeals process that does not result in compensation) or whether the only relevant alternative remedies are those that are compensatory.

My other proposal at the second stage of the duty analysis is a change in the role of policy considerations. As I discuss below, corrective justice scholars advance persuasive arguments in support of the increased focus on the parties’ interactions in the duty inquiry, arguing that relationships are essential to give the law of negligence coherence. Many of these scholars argue for the exclusion of policy considerations from the duty of care analysis altogether. I argue that policy issues are likely to affect judges’ decisions regardless of whether they explicitly form part of the test for establishing a duty of care, and their exclusion from the analysis risks obscuring the actual reasons for a decision. Accordingly, while I do not support the exclusion of policy considerations from the duty analysis altogether, I argue that they should
play a subsidiary role to the analysis of the parties’ relationship. This is particularly true on a motion to strike, where the Supreme Court of Canada has instructed that “the potential for the defendant to present a strong defense should not prevent the plaintiff from proceeding”\textsuperscript{147} to trial.

A. The First Stage of the Duty Test: Proximity

As I outlined in Part Two, in applying the test for establishing a duty of care, the courts must strive to strike a balance between certainty and flexibility. The shift away from incrementalism towards contextualism has altered the balance between these values, with the latter often associated with greater flexibility and uncertainty. Although some uncertainty is inherent in the contextual approach, Canadian courts can mitigate this uncertainty by more clearly defining the various contextual factors so that they can be applied with greater consistency. Although the proximity factors set out by the Supreme Court of Canada in Cooper currently lack definition or analytic content in the context of the duty of care analysis, concepts such as representations and reliance are well-defined in other areas of law and in duty of care jurisprudence from other jurisdictions. In this section, I discuss how Canadian courts might borrow from these other cases in order to begin to define the proximity factors, thereby adding clarity and consistency to the test for establishing a duty of care. My discussion in this Part is not intended to be an exhaustive examination the ways in which courts might interpret the various contextual factors that are relevant to proximity, but rather I provide examples of how judges might define these factors.

\textsuperscript{147} The Court further stated that “[i]t is not permissible to anticipate the defence or defences—possibly some very strong ones—which the defendants may plead and be able to prove at the trial.” \textit{Hunt v Carey, supra} note 103 at para 33.
i. **Representations and Reliance**

I discuss these factors under a single heading, as the two concepts are interrelated—reliance arises from representations. In this regard, Brown and Brochu argue that courts cannot consider representations independently of reliance, because it is from one party’s reliance that a representation acquires legal significance. Reliance transforms an unfulfilled undertaking to do something into an actionable wrong by transforming a mere statement into an interference with the plaintiff’s legal rights.  

Several commentators and the jurisprudence from Canada and abroad suggest that representations and reliance are the most significant factors in establishing whether two parties have a proximate relationship. Indeed, as I noted above, more of the cases in the Appendices mentioned reliance than any other proximity factor (albeit with no effort to define the term or conduct a detailed analysis of whether reliance existed in that particular case). In *Sutherland Shire Council v Heyman*, Mason J. of Australia’s High Court discussed the importance of reliance:

> Reliance has always been an important element in establishing the existence of a duty of care. It has been suggested that liability in negligence is largely, if not exclusively, based on the plaintiff’s reliance on the defendant’s taking care in circumstances where the defendant is aware or ought to be aware of that reliance.  

Mason J. went on to state that “the concept of proximity...involves in most cases a degree of reliance.” American courts similarly treat reliance as a precondition to a legal duty in the

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149 See e.g. Woodall, *supra* note 111 and Brown & Brochu, *supra* note 87.
150 *Supra* note 59 at 461.
151 *Supra* note 59 at 461.
context of public authority liability.\textsuperscript{152} The relevance of representations and reliance to the definition of legal relationships also finds support in other areas of the law, including negligent misrepresentation, social host liability,\textsuperscript{153} employee negligence, fiduciary law, and principles of constitutional and administrative law.\textsuperscript{154} In addition to the legal basis for the relevance of reliance, legal theorists advance moral rationales for holding actors legally accountable for their representations. For example, Black conceptualizes reliance as a broad moral concept governing human interactions: “In our ordinary moral thinking, the fact that one person (A) has relied on another person (B) to do something is often taken to be a relevant factor in judging that B is obliged to do that thing.”\textsuperscript{155}

If representations and reliance are relevant to proximity, the question that then arises is under what circumstances will plaintiffs invoking these factors have a stronger argument for a close and direct relationship vis-à-vis the government? One pertinent distinction that emerges from other areas of the law, such as contracts, and jurisprudence from other jurisdictions is the difference between a representation of which the plaintiff is unaware (sometimes referred to as general reliance) and detrimental reliance (where the claimant acts to his detriment in response to a representation). Applying this distinction to the health sector, one might envision a situation where a provincial ministry of health represented in a press release that they would provide an influenza vaccine to particular high-risk groups in the event of an outbreak. A plaintiff in this

\textsuperscript{152} In \textit{Sutherland Shire Council v Heyman}, supra note 59 at 463, the Court summarized the American jurisprudence as follows: “The American experience therefore furnishes support for the view that a public authority is liable for negligent failure to perform a function when it foresees or ought to foresee that: (a) the plaintiff reasonably relies on the defendant performing the function and taking care in doing so, and (b) the plaintiff will suffer damage if the defendant does not take care.”

\textsuperscript{153} For example, in the seminal Canadian case on social host liability, \textit{Childs v Desormeaux}, 2006 SCC 18, the Supreme Court of Canada searched for themes or unifying concepts among cases where defendants have a positive duty to act. The Court identified reliance as one of these themes. Many of the tort claims against government, both in the health sector and more broadly, are based on nonfeasance (a failure to act), rather than misfeasance.

\textsuperscript{154} Oliver Black, “Reliance and Obligation” (2004) 17 Ratio Juris 269.

\textsuperscript{155} \textit{Ibid} at 269. See also C Robert Morris, “Some Notes on Reliance” (1991) 75 Minn L Rev 815.
high-risk group who was unaware of the press release arguably has a weaker argument for proximity than a plaintiff who consulted her doctor about privately purchasing the vaccine or taking other precautionary measures, but then chose not to do so because the government had represented that it would be available to her demographic group in the event of an outbreak.

Although a plaintiff who relied to her detriment has a stronger argument for proximity, it is important to note that none of the proximity factors are, by themselves, necessary preconditions to establishing duty, but rather are to be weighed against other considerations. In this regard, Mason J. made the following remarks in *Sutherland Shire Council v Heyman*: “That the plaintiff has acted to his detriment may strengthen the case for imposing a duty of care, especially if the defendant is aware that the plaintiff has so acted, but there is no underlying reason why it should be regarded as a necessary condition.”156

Courts might also treat the specificity of an impugned representation as a consideration relevant to proximity. Although this distinction has not been adopted in governmental tort liability jurisprudence in Canada, it is integral to American cases against public authorities. For example, Woodall contrasts a general governmental commitment to improve highway safety with the more specific representation to light a specific lighthouse at a specific place, as occurred in a seminal American public authority liability case, *Indiana Towing v United States*.157 The latter of these two situations grounded a stronger claim for a proximate relationship.

Alberta’s *Pandemic Influenza Plan* contains a variety of statements that illustrate the variation in the specificity of governmental representations. For example, the *Plan* states that “[Alberta Health and Wellness] will allocate pandemic influenza vaccine in lots to each [Regional Health Authority] on a per capita basis by priority group…RHAs will be responsible

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156 Supra note 59.
157 Woodall, supra note 111 at 139, citing 350 US 61 (1955).
for delivery of this vaccine based on the criteria established for each of the nationally determined
driority groups.”158 This relatively specific representation stands in contrast to the more general
statement that “[Alberta Health and Wellness], in partnership with the [Regional Health
Authorities], will lead the health response and is the health subject matter expert. [Government
of Alberta] ministries will provide support for the health response…”159 The former statement
provides a much stronger argument for a close and direct relationship, whereas the second does
not clearly indicate what actions the government is going to undertake in order to prevent or
control the spread of influenza. It would be difficult for a plaintiff to claim that she acted to her
detriment on the basis of such a broad and vague representation.

Canadian jurisprudence provides two additional factors, the presence of which may give
a plaintiff a stronger justification for holding the government to its representations—the public’s
vulnerability and the state’s control (especially in the case of a governmental monopoly). The
Supreme Court of Canada discussed the first in Lewis (Guardian ad litem of) v British Columbia,
a case relating to negligent highway maintenance:

The vast majority of highway travelers are in no position to assess the extent or
nature of the construction and maintenance work which should be done, the
competence of those undertaking the work or the financial responsibility of an
independent contractor performing the work. Their lack of knowledge and very
natural tendency to rely upon the Ministry in these matters indicate the potential
vulnerability of highway travelers when maintenance work is done negligently.160

A similar information asymmetry exists in the health system, where patients have a limited
ability to rationally assess the safety or quality of health services, given the complexity of the

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158 Alberta Health and Wellness, Alberta Pandemic Influenza Plan for the Health System (Edmonton: Alberta Health
and Wellness, 2008) at 40.
159 Ibid at 1.
Australia’s High Court similarly argued that a plaintiff could have a viable argument for a proximate relationship in
the absence of detrimental reliance in circumstances where members of the public would generally rely upon a
public authority. Specifically, proximity could be established if the plaintiff is particularly vulnerable and the
authority is empowered to protect them from the very loss that occurred.
health sector and the fact that health services are often required on an urgent basis. Furthermore, given the limits on the availability of private hospital and physician services in Canada, patients often have little alternative but to rely on the public system.

In his dissenting opinion in Lewis, McIntyre J. addressed the significance of a governmental monopoly to the parties’ proximity: “road maintenance is entirely within the power of the Ministry,” which “renders the public, who often have no choice but to use the highway, totally vulnerable as to how, and by whom, road maintenance is performed.”

Similarly, in Pyrenees Shire Council v Day, Mason J., of the Australian High Court, found an argument for reliance particularly compelling in situations “of such magnitude or complexity that individuals cannot, or may not, take adequate steps for their own protection,” such as firefighting or air traffic control. Furthermore, he stated that the interest is more serious where the public sector “has supplanted private responsibility.”

In the Canadian health sector, the various statutory limits on private delivery and duplicate private insurance, and the government’s exclusive role in the provision of many public health services, often similarly compel individuals to use the public health care system. Although not determinative of the government’s liability, or even whether it owes a plaintiff a duty of care, the degree of governmental health sector control and the public’s vulnerability should certainly give the courts pause in striking health sector tort claims on a pre-trial motion.

ii. Expectations

As with reliance and representations, the Canadian tort jurisprudence provides little guidance on how to assess a plaintiff’s expectations in the context of the duty of care analysis.

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161 Ibid at para 53.
162 Ibid at 156.
The term expectations has legal significance in both contract law and administrative law, but the Supreme Court of Canada may have also intended to use the word in its plain language sense. With regard to contract law, there are two different types of losses for which judges can award damages—the reliance interest or the expectation interest. According to Fuller and Perdue, the reliance interest is a loss incurred from relying on the contract, whereas the expectation interest is a loss incurred because of the expectation to profit from the contract. Many of the tort claims naming governmental defendants, particularly those arising in sectors such as agriculture and mining, related to financial expectations and lost anticipated profits (indeed, these plaintiffs often framed their claims in contract law as well as negligence). However, it is unlikely that the Supreme Court intended the contract law definition of the term expectations to be universally applicable to the question of proximity, given that many of the tort claims against the state relate to personal injuries or property damage and not economic loss.

The question that then arises is whether the Supreme Court of Canada intended to import the administrative law concept of legitimate expectations into the private law context. Under the doctrine of legitimate expectations, an individual whose expectations were induced by the government is not entitled to a particular substantive outcome, but a court can “require that procedural protection be provided before an expectation of a particular outcome can be dashed.” Some governmental tort liability decisions imply a procedural dimension that would

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164 Grant Huscroft, “The Duty of Fairness: From Nicholson to Baker and Beyond” in Colleen M Flood & Lorne Sossin, eds, *Administrative Law in Context* (Toronto: Edmond Montgomery Publications Limited, 2008) at 120. Forsyth offers the following rationale for the protection of expectations in the administrative law context: “if the executive undertakes, expressly or by past practice, to behave in a particular way the subject expects that undertaking to be complied with. That is surely fundamental to good government and it would be monstrous if the executive could freely renege on its undertakings. Public trust in the government should not be left unprotected.” Christopher Forsyth, “the Provenance and Protection of Legitimate Expectations” (1988) 47 Cambridge LJ 238 at 239. Courts in some other jurisdictions have interpreted legitimate expectations to include a substantive component. For example, in reference to the British interpretation of legitimate expectations, Roberts commented that “if a public body represents that it will behave in a particular way, then the individual expects that representation to be
be somewhat analogous to the administrative law concept of legitimate expectations. For example, in Design Services Ltd. v Canada, in considering whether the government property owner had a duty to a subcontractor during the tendering process, the Supreme Court of Canada stated that, “given that the tendering process required significant effort and that only the team selected would be rewarded, the appellants expected the selection process to be fair.”

However, most of the governmental tort liability cases that consider expectations appear to use the word in its plain language sense. For example, in Odhavji v Woodhouse, the Supreme Court stated that the proximity between the crime suspect plaintiff and the Chief of Police defendant was strengthened by “the fact that members of the public reasonably expect a chief of police to be mindful of the injuries that might arise as a consequence of police misconduct.”

There is a sizable body of literature outlining the public’s high expectations of government in the health sector. For example, a report on the Ontario government’s management of the SARS outbreak commented on public expectations: the “public health system lacked the critical mass of professional expertise one would expect in a crucial branch of government in a province the size of Ontario,” and “the public is entitled to expect that the government’s worker safety arm

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165 Supra note 54 at para 52.
166 Supra note 74 at para 57.
167 For instance, Decter notes that “expectations are rapidly and markedly transforming as health consumers are becoming more educated and more demanding.” Michael B. Decter, Four Strong Winds: Understanding the Growing Challenges to Health Care (Toronto: Stoddart Publishing Co Limited, 2000) at 28-29. Similarly, Romanow comments that “Canadians want and expect both quality of care and timely access to care to be essential hallmarks of the health system…People see increasing costs and, as taxpayers and owners of the health system, they expect efficiency and the best value for every dollar spent on health care…People are no longer prepared to simply sit on the sidelines and entrust the health system to governments and providers. They want to be involved, engaged and acknowledged, and well informed as owners, funders, and essential participants in the health care system.” Roy Romanow, Commission on the Future of Healthcare in Canada, Building on Values: The Future of Healthcare in Canada (Ottawa: Health Canada, 2002) at xvi.
will be more aggressive next time in its protection of workers.”\textsuperscript{169} However, the plain language usage of the word expectations adds little analytic content to the concept of proximity, as it is unclear what types of expectations are more indicative of a close and direct relationship than others. Furthermore, it is unclear how expectations may differ from reliance, as both relate to an individual’s belief that the government will act in a certain manner.

Amirthalingam offers a distinction between reliance and expectations that could be relevant to the judiciary’s interpretation of the proximity factors. He criticizes reliance, arguing that it is a fictitious inquiry requiring a plaintiff to establish that he had relied on something after the fact. He contrasts this with a judicial inquiry into whether a plaintiff could have a reasonable expectation that the government was going to behave in a certain way in a particular factual context.\textsuperscript{170} Tate also draws this distinction, noting that unlike reliance, courts considering the concept of expectations do not explore the state of mind of a particular plaintiff, but rather ask whether a reasonable person in the position of the plaintiff would have formed the relevant expectation.\textsuperscript{171} Applying this distinction to the proximity analysis, Canadian courts may examine both the plaintiff’s state of mind and actions taken to her detriment (reliance), and the expectations of a reasonable person (expectations). In other words, a plaintiff would have a stronger claim to a duty of care where his subjective expectations of government were those that a reasonable person would have in similar circumstances.\textsuperscript{172}

\textsuperscript{169} Ibid at 845.
\textsuperscript{170} He also argues that “The tort, which has always been viewed through the prism of reliance, should instead be viewed through the prism of expectations.” Kumaralingam Amirthalingam, “The Shifting Sands of Negligence: Reasonable Reliance to Legitimate Expectation?” (2003) 3 Oxford U Commonwealth LJ 81 at 89.
\textsuperscript{171} She argues that this test is objective in two senses. First, it must be objectively justified by virtue of being based on reasonable and grounds, and second it has to be seen as the objective status of the applicant as opposed to being identified with her hopes or anticipation, both of which are subjective. Pamela Tate, “The Coherence of ‘Legitimate Expectations’ and the Foundations of Natural Justice” (1988) 14 Monash U L Rev 15 at 49.
\textsuperscript{172} This type of modified objective test is not foreign to tort law. For example, in determining whether a plaintiff has satisfied the causation requirement in an informed consent case, courts ask whether a reasonable person in the
iii. The Interest at Stake

The final proximity factor that the Supreme Court of Canada set out in Cooper is the nature of the interest at stake. As discussed in the previous chapter, Canadian courts also regard this factor as relevant to the disposition of a motion to strike, with judges being more reluctant to strike a claim engaging a serious interest (such as life or a serious threat to health). Even outside of the negligence context, there is a jurisprudential basis for considering a plaintiff’s affected interest when defining a governmental defendant’s obligations. In both Charter jurisprudence and administrative law, courts are concerned with the nature of the interest at stake. For example, in Baker v Canada, the Supreme Court of Canada articulated five factors that are relevant to establishing the content of an administrative decision-maker’s duty of fairness: the nature of the decision, the statutory scheme, legitimate expectations, the procedural choices, and the nature of the interest at stake. 173 Similarly, in conducting a section 15 discrimination analysis under the Charter, judges consider “the nature and scope of the interest affected by the impugned law.” 174

In the tort liability context, the courts have made no effort to define what constitutes a serious interest at stake suggestive of a finding of proximity. However, there is considerable variation in the types of interests that may be engaged in a particular case. Many health sector claims involve a very serious interest. For example, government decisions relating to oncology waiting times management or disease outbreak control could cause or contribute to serious injury or death. However, one can envision cases engaging less serious interests, such as a plaintiff's position would have consented to the procedure, had he been informed of the relevant risks. Reibl v Hughes, [1980] 2 SCR 880.

174 Law v Canada (Minister of Employment and Immigration), [1999] 1 SCR 497.
who must use crutches and experience minor pain for a few additional weeks while awaiting knee surgery. In the former category of case, the courts should arguably be more cautious about refusing to scrutinize the government’s decisions.

**B. The Second Stage of the Duty Test: Policy Considerations**

Similar to my criticisms respecting the proximity factors, the courts have not clearly defined the policy considerations applicable at the second stage of the duty analysis. The courts also fail to apply these factors in a consistent manner. My second criticism of the second stage of the duty analysis, which I discuss in Section Two of this Part, is the extent to which courts sometimes permit policy considerations to dominate their duty analysis, as opposes to balancing those concerns against an analysis of the parties’ relationship. This criticism is exemplified by the health sector tort claims.

**i. Defining the Policy Considerations**

Although the Supreme Court of Canada broadly stated in *Cooper* that judges should consider the impact of a duty of care on the parties, the legal system, and society more generally, the Court also provided a non-exhaustive list of more specific considerations relevant to this inquiry: the risk of indeterminate liability, the availability of alternative legal remedies, the presence of conflicting duties, and the chilling effect of liability on governmental decision-making. As with the proximity factors discussed above, courts have not made any effort to clarify or define these considerations. The Canadian judiciary’s application of the “alternative legal remedies” factor exemplifies the resulting inconsistency in the governmental tort liability jurisprudence.
Judges considered this factor in striking several of the health sector tort claims. For example, in *Williams*, in discussing the policy reasons to limit or negate a duty of care to individuals infected with SARS, the Ontario Court of Appeal remarked that the plaintiff could also commence a tort claim against health care facilities or health care professionals for their application and enforcement of directives from the Ministry of Health and Long-Term Care.\(^{175}\) Similarly, in *Nette v Stiles*,\(^{176}\) the Alberta Court of Queen’s Bench stated that in addition to suing the government for the negligent regulation of chiropractors, the plaintiff also had potential legal remedies against individual practitioners and the College of Chiropractors. In *Abarquez*,\(^{177}\) a claim by nurses who had contracted SARS, the Ontario Court of Appeal mentioned that the plaintiffs could also apply for Workers’ Compensation benefits. However, the Court failed to discuss the differences between damages in tort and workers’ compensation benefits (for example, possible differences in the scope of available benefits versus damages awards and the lack of vindication associated with the latter).

The Supreme Court of Canada jurisprudence is inconsistent with respect to the requisite specificity of an alternative remedy—whether some broad alternative form of redress is sufficient or whether the specific tort remedy being sought is necessary to negate a legal duty for policy reasons. This uncertainty in the law makes it impossible for a prospective plaintiff to ascertain whether her claim is likely to be struck on this basis. For example, in *Odhavji Estate v Woodhouse*,\(^{178}\) the Supreme Court found that the availability of a police complaints process was an insufficient alternative remedy, as the plaintiffs were not seeking disciplinary sanctions, but compensation for psychological harm (after a family member was killed by police). In *Hill v*  

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\(^{175}\) *Supra* note 28 at para 36.  
\(^{176}\) *Supra* note 141 at para 78.  
\(^{177}\) *Supra* note 55.  
\(^{178}\) *Supra* note 74 at para 60.
other remedies in tort (such as false arrest, false imprisonment, and malicious prosecution) and government compensation schemes for wrongfully convicted individuals were also held to be insufficient alternative remedies, due to limited eligibility and ceilings on compensation. These cases suggest that very few alternative remedies will be sufficient to negate a *prima facie* duty of care.

In contrast, in *Syl Apps Secure Treatment Centre v BD*, the Court found that a parent’s right to appeal a child welfare order and the statutory procedure to apply for review of a child wardship order were sufficient alternative remedies to a tort suit, despite the fact that they did not result in any compensation. The Court did not make any attempt to distinguish this case or explain the inconsistency with its previous cases. As with the proximity factors, the Supreme Court of Canada should clarify the requirements of the various policy considerations in order for lower courts to more consistently apply the law and for plaintiffs to be able to determine whether they have viable claims.

**ii. The Role of Policy Considerations**

While I discuss the substantive merits of the policy concerns applicable to tort claims against governmental defendants in the next chapter, in this section, I address the appropriate role for the inclusion of such considerations in the duty of care analysis. Corrective justice scholars advance persuasive arguments in support of the increased focus on the parties’ interactions in the duty inquiry, arguing that relationships are what give the law of negligence coherence. For example, as Weinrib argues, “*Cooper v. Hobart* contains a welcome emphasis on the relational nature of the considerations that govern the first stage [of the test for establishing a

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179 *Supra* note 61 at para 35.
180 *Supra* note 74 at para 59.
Similarly, Owen refers to the parties’ relationship as “the fundamental nexus that gives coherence to negligence claims.” These scholars are generally critical of the prominence given to policy considerations external to the parties’ relationship in the duty analysis. For example, Weinrib argues that policy factors “are uncontrolled by the relationship between the parties…A plaintiff can therefore be denied compensation on the basis of policy considerations that, while one-sidedly pertinent to the defendant…have no normative bearing on the position of the plaintiff as the sufferer of an injustice.” He goes on to criticize the two-stage test for establishing a duty of care, arguing that it:

…requires judges to balance categorically different considerations, in order to determine whether in a given case the policy considerations are more important than the justice considerations they can displace…In effect, the two-stage test puts into circulation two different normative currencies between which no rate of exchange exists.

Health sector cases are particularly susceptible to this corrective justice critique, as the courts tend to narrowly analyze the relational aspect of duty (focusing on statutorily defined duties to the general public and summarily dismissing other aspects of the parties’ relationship), while treating policy considerations as paramount in determining the government’s legal obligations. Because it is difficult to separate relationships from their broader context, policy issues are likely to affect judges’ decisions regardless of whether they explicitly form part of the duty of care analysis. Indeed, in Cooper, the Supreme Court argued that the test for negligence, “no matter how it is phrased, conceals a balancing of interests. The quest for the right balance is

182 Supra note 1 at 785. See also Brown, supra note 67.
183 Supra note 181 at 235. He went on to argue that “policy involves articulating some independently desirable goal(s) and then dealing with a particular tort case in a way that forwards these goals or, if they are in tension, balances some against others to produce a result that is desirable overall. The goals are independent both in the sense that they rest on justifications that are independent of tort law, to which they are then applied, and that they are independent of one another, so that they may represent incompatible normative impulses that need to be balanced” (at 246).
184 Supra note 37 at 567.
in reality a quest for prudent policy.”\textsuperscript{185} Therefore, I do not advocate the abolition of policy factors from the test for establishing a duty of care, as this would risk obscuring the actual reasons for a judge’s decision. Instead, I argue that policy considerations should play a subsidiary role compared to the analysis of the parties’ relationship. In other words, I adopt the approach of Perry, who argues that while “principles of moral responsibility constitute the main theoretical foundations of tort law,” policy considerations “do have a role to play…but it is inevitably a subsidiary one.”\textsuperscript{186}

In applying this approach, courts should exercise caution in negating a \textit{prima facie} duty for policy reasons, particularly on a motion to strike. In contrast to the Ontario Court of Appeal, the lower court in \textit{Eliopoulos}, a West Nile Virus claim, was cognizant of the danger of allowing policy factors to determine a motion to strike: “To attempt to apply policy considerations in a vacuum, and without the benefit of a [evidentiary] record, would be contrary to the principles on which our case law has long been understood to develop.”\textsuperscript{187} Similarly, the lower court in \textit{Williams}, a SARS claim, noted that while policy considerations “are relevant and powerful,” the “complexity, importance and novelty of the task of weighing the suggested overriding policy considerations in the context of this emergency situation requires that all the relevant evidence that bears on such allegations should be before the court.”\textsuperscript{188}

While the plaintiff must establish the existence of a legal duty, the onus is on the defendant to prove that overriding policy concerns should limit that duty.\textsuperscript{189} Although the jurisprudence clearly states that a court must read a plaintiff’s claim generously and accept all

\begin{footnotes}
\item[185] Supra note 44 at para 29.
\item[186] Stephen R Perry, “Protected Interests and Undertakings in the Law of Negligence” (1992) 42 UTLJ 247 at 249.
\item[187] Supra note 68 at para 54.
\item[188] 2005 CanLII 29502 at para 96 (Sup Ct).
\item[189] Although the Supreme Court of Canada did not explicitly articulate this shift in the burden of proof in \textit{Cooper}, governmental defendants are the ones who typically introduce these policy considerations in their pleadings and courts thus look to defendants to prove the presence of these considerations.
\end{footnotes}
facts as proven on a motion to strike, the defendant’s evidence does not receive the same benefit. Despite the Supreme Court’s instruction that “the potential for the defendant to present a strong defense should not prevent the plaintiff from proceeding” to trial, governmental arguments respecting policy concerns remain an influential, if not determinative, factor in health sector decisions. Although these may be legitimate concerns, in the next chapter I argue that they may not be as compelling as the courts suggest and, at the very least, should be balanced against the accountability concerns I identified in Chapter Two.

Canadian courts generally only consider policy considerations that limit or negate a duty of care, neglecting to consider competing policy factors suggesting that the defendant’s conduct should be subject to judicial scrutiny. In this regard, Weinrib criticizes the policy analysis as one-sided, as it “refers only to policy considerations that negate liability, not to those that might confirm liability.” More similarly describes the policy stage of the duty analysis as “a judicial confiscation of what is rightly due to the plaintiff in order to subsidize policy objectives unilaterally favorable to the defendant.” A more balanced assessment of the policy context surrounding a tort claim necessitates the incorporation of all relevant factors, including those that favour the plaintiff’s claim proceeding to trial.

The more restrictive approach to striking tort claims that I have argued for would not necessarily result in widespread government liability. As I noted at the outset of this chapter, judges will also consider whether the defendant failed to meet the standard of care, whether the plaintiff suffered a compensable injury, and whether the defendant’s conduct caused that injury.

190 Hunt v Carey, supra note 103.
191 The Court further stated that “[i]t is not permissible to anticipate the defence or defences—possibly some very strong ones—which the defendants may plead and be able to prove at the trial.” Hunt v Carey, supra note 103 at para 33.
192 Although he acknowledged that a court “occasionally gestures in the direction of a policy adverse to the defendant, it rarely engages either in an extended examination of that policy or in a rigorous comparison of the competing policy considerations.” Supra note 181 at 235.
I now turn to argue why resolving more governmental tort liability cases at the standard of care stage of the negligence analysis would be a positive development in Canadian law.

**C. Resolving Cases on the Standard of Care**

Although I do not support widespread governmental liability (largely because of the policy objections to tort liability that I discuss in the following chapter), judges could apply the law in a manner that more effectively balances the concern with judicial policy-making against the need for accountability. As I explained above, negligence claims have four elements—duty of care, breach of duty, causation, and damage or injury. Allowing tort claims to proceed to the standard of care stage of the negligence inquiry has the potential to improve accountability, as governmental defendants would be called upon to justify the reasonableness of their decisions. Transparency, which is an integral component of accountability, would also be improved by the courts calling upon the government to explain the factors that it balanced and the trade-offs that it made in making its decisions.

Subjecting governmental decisions to greater scrutiny would not render concerns about scarce resources or competing interests irrelevant, as the standard of care could incorporate considerable deference to government’s decisions. In *Hill v Hamilton*, the Supreme Court of Canada addressed an argument that a duty of care in the context of scarce resources would cause a conflict between a government’s obligations to an individual plaintiff and to the broader public: “the standard of care is based on what a reasonable police officer would do in similar
circumstances. The fact that funds are not unlimited is one of the circumstances that must be considered.”

In other areas of law, courts are increasingly reluctant to strike claims over preliminary issues such as standing or jurisdiction, but instead show deference in scrutinizing governmental decisions at the later stages of the case. For example, in Stein v Quebec, an administrative law case relating to reimbursement for out-of-country health services, the Court employed the most deferential standard of review, patent unreasonableness, noting that courts “must exercise restraint.” Similarly, in the context of Charter cases involving complex matters of social policy, judges have accorded the state flexibility in the standard of evidence required under s. 1 of the Charter to justify a rights infringement. In these cases, courts ask whether the government had a “reasonable basis” for its policies. In other words, instead of requiring that the state produce definitive, scientific proof to support its decisions, it is sufficient that the government had a reasonable factual basis for its policy choices.

Conclusion

Duty acts as the gatekeeper to the law of negligence—a defendant must owe a plaintiff a legal duty in order for her conduct to be actionable. Canadian judges apply a two-stage test for establishing a duty of care. First, they analyze the parties’ relationships to determine if it is

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194 Supra note 61 at para 44. Smillie, supra note 114 at 248 similarly argues that: “special administrative or allocational problems faced by a public authority can be given due weight when the court considers whether the authority was in breach of its duty to take reasonable care.”

195 Manfredi, supra note 36 at 147-148.

196 For example, in Vriend v Alberta, [1998] 1 SCR 493 at para 53, the Court commented that “[t]he deference very properly due to the choices made by the legislature will be taken into account in deciding whether a limit is justified under s. 1 and again in determining the appropriate remedy for a Charter breach.”

197 Stein v Quebec (Regie de l’Assurance-maladie), (1999) RJQ 2416 (Sup Ct). This case was decided prior to the collapse of the standards of review in Dunsmuir v New Brunswick, 2008 SCC 9.

198 Choudhry, supra note 125.
sufficiently close and direct to warrant the imposition of a legal duty. Second, courts inquire whether there are policy considerations that ought to limit or negate a prima facie duty.

Under the first stage of the duty test, I criticized the courts’ reliance on previous categories of proximate relationships on the basis that these categories add little to the analysis and the categories themselves are unclear and unworkable. In cases where the plaintiff alleges a novel legal duty, I criticized the Supreme Court’s instruction to judges to ground proximity in legislation. I used the health sector tort cases to illustrate these critiques. Specifically, the judges in these cases have disagreed over the applicability of the ‘foreseeable physical harm’ category of proximate relationship. They have also focused on the government’s statutory duties to the public at large, without considering its legal relationship with the specific plaintiff. Although it is certainly relevant to the proximity analysis, legislation fails to fully capture the state’s modern managerial role in the health sector.

Outside of the health context, over the past ten years, some Canadian judges have moved towards a contextual approach, whereby the courts examine the totality of the parties’ relationship through an analysis of the applicable legislation, factually similar precedents, and the parties’ interactions. Although I argued in favor of this trend, given its adaptability to the government’s ever-expanding role in the lives of citizens, courts must now strive to give greater analytic content to the proximity factors. I set out a number of examples, derived from other jurisdictions and other areas of law, for example, the principle that more specific representations ground a stronger argument for proximity, and the argument that detrimental reliance is more suggestive of a close and direct relationship between the parties than general reliance.

Under the second stage of the test for establishing a duty of care, I argued that the Supreme Court of Canada ought to explicitly abandon the policy/operational dichotomy, as its
application risks the foreclosure of a plaintiff’s legal rights on the basis of a line that is arbitrary and difficult to draw. Prior to Cooper, the policy/operational dichotomy was the touchstone of the second stage of the duty analysis in the context of governmental defendants; however, courts now also explore the impact a duty would have on the parties, the legal system, and society more generally.

In the health sector claims, judges devote little attention to the parties’ relationship at the first stage of the Cooper test, preferring to focus on the policy implications of their decisions. Specifically, courts focus on the risk of unlimited liability, the burden that liability would impose on government, and a perceived conflict between a private law duty of care and the government’s obligations to the general public. Although I examine the legitimacy of these considerations in further detail in the next chapter, I argue that courts should be particularly reluctant to allow policy concerns to determine duty on a motion to strike, where judges lack a full factual record and the defendant’s evidence is not entitled to the same preferential treatment as the plaintiff’s.

Instead of restricting their analysis to policy factors that are unilaterally favorable to the defendant, I argued that courts must balance concerns with liability against factors in favor of greater judicial scrutiny of governmental decision-making, such as the state’s expanding role in the health sector, its legal monopoly over most physician and hospital services, growing health system costs, high rates of inappropriate services and patient injuries, and the inadequacy of elections as a health sector accountability mechanism. In the next chapter, I explore these countervailing policy concerns in further detail. Although I do not advocate widespread governmental liability, allowing claims to proceed to the standard of care analysis, but still giving considerable deference to government, would strike a better balance between the policy
considerations favouring judicial restraint and those favoring judicial scrutiny of the state’s decisions.
CHAPTER FIVE:

THE ADVANTAGES OF DISADVANTAGES OF GOVERNMENTAL HEALTH SECTOR TORT LIABILITY

Introduction

Since the inception of Medicare, the state’s involvement in the health sector has dramatically expanded from a purely financial role to include policy-making and managerial responsibilities. The government’s increased regulation of health care delivery and clinical discretion, coupled with concerns regarding the accessibility and quality of health services, have prompted calls for accountability, as evidenced by the increasing number of tort claims against provincial governments. The Canadian judiciary has not been receptive to these claims, refusing to allow almost all of them to proceed to trial. Having criticized both the judiciary’s unwillingness to scrutinize governmental health sector decisions and its application of the test for establishing a duty of care, I now turn to explain why this judicial restraint is problematic.

It is important to reiterate that the Canadian judiciary’s reluctance to review health sector tort claims does reflect legitimate policy concerns with imposing tort liability on governmental defendants, such as the diversion of strained health system resources to compensate injured patients, the courts’ institutional competence to consider complex matters of social policy, and the ability of tort liability to deter the government. However, in what follows, I argue that, on balance, countervailing policy arguments are sufficient to overcome these concerns, particularly when a court is first assessing whether to allow a claim to proceed to trial on a motion to strike. The criticisms of governmental tort liability may ultimately provide a justification for courts to refuse to impose tort liability or, at the very least, to accord considerable deference to governmental policy choices in defining the standard of care. However, I argue that they do not
justify refusing to permit nearly all of the health sector tort claims from proceeding beyond a motion to strike or beyond the duty of care stage of the negligence inquiry.

Furthermore, an assessment of these policy concerns may require the benefit of a full evidentiary record obtained at trial. This is not to say that every single case that comes before a court must proceed to a trial and to the standard of care stage of the negligence analysis, but rather that the courts should not unduly refuse to adjudicate these kinds of claims merely because they engage difficult policy issues. Assessing these complex policy concerns would not present a significant drain on scarce judicial resources, because if the courts analyze the applicable policy concerns on a full factual record in one case, they can apply these conclusions in other similar cases. For example, if the Ontario Court of Appeal had permitted the West Nile Virus case to proceed to trial, many of their conclusions on the strength of the government’s policy concerns would have been equally applicable in the subsequent claims by members of the public infected with SARS.

In the second part of this chapter, I return to the discussion of accountability that I introduced in Chapter Two, by comparing the various independent checks on governmental decision-making. Given their respective strengths and weaknesses, I argue that an optimal level of accountability requires that the courts and other accountability mechanisms complement one another, rather than act as substitutes. Members of the public can easily, expeditiously, and at little or no cost, have their complaints resolved by an ombudsperson. Commissions of inquiry and auditors general are better suited to comprehensively exploring safety concerns at the broader systems level. Unlike the courts, these other actors have wider discretion to refuse to hear complaints, their findings or deliberations may lack transparency (i.e. they take place in private), and the government can disregard their recommendations. In addition to filing tort
claims, plaintiffs can also seek legal accountability through administrative law or the Charter. But unlike tort claims, these areas of the law provide limited means to review governmental decisions affecting the quality of health services (as opposed to the accessibility of those services) or claims framed in nonfeasance.

**Part One: Policy Concerns with Governmental Tort Liability**

In this part, I address the three major policy objections to governmental tort liability; that the courts lack the institutional competence to adjudicate matters of complex social policy; the concern that diverting resources to compensate injured patients will strain an already over-taxed health system; and the inefficacy of tort liability as a deterrent to governmental behavior.

**A. Judicial Competence to Adjudicate Complex Social Policy**

A complicated web of variables influence governmental decision making—resources (monetary and human), public and media pressure, health professional and interest group advocacy, bureaucratic self-interest, political variables (for example, the timing of the next election), policy and clinical evidence, and competing priorities. To this list, Schuck adds “[f]ormal procedures, informal politics, legal interpretation, the force of inertia, and pure happenstance.”¹ The health care system itself is a complex mix of public and private financing; market, professional and governmental regulation; highly technical and sometimes contradictory scientific and policy evidence; and provincial and federal jurisdiction. Scholars such as Cohn and Kremnitzer question the institutional capacity of courts to consider legal questions situated within this complex landscape, given the judiciary’s traditional focus on rights-based claims arising

between two parties.\(^2\) Cohen and Smith argue that, “the state is likely to be involved in polycentric disputes in which the determination of any particular factor or issue involves the simultaneous adjustment of numerous other factors and issues, and affects the interests of numerous individual and collective interests.”\(^3\)

The fact that government has more experience and expertise than judges in health sector decision-making does not mean that courts cannot or should not review these matters, but rather that they must show the proper deference to the state in scrutinizing its decisions. Immunizing ministry of health decisions from review merely because generalist courts have less knowledge of the subject matter would be inimical to the rule of law, a central tenet of which is the availability of an independent body to review governmental decisions. As the Supreme Court of Canada argued in *RJR MacDonald Inc v Canada (Attorney General)*, “to carry judicial deference to the point of accepting Parliament’s view simply on the basis that the problem is serious and the solution difficult would be to diminish the role of the courts.”\(^4\)

Although judges will clearly be unable to amass the health sector expertise of government over the course of a trial, their decisions will be informed by written submissions and expert testimony. Reports from commissions of inquiry, such as those I discussed in Chapter One, provide anecdotal examples of the ability of judges to understand and reflect upon complex health policy problems. Commissions of inquiry chaired by judges have tackled such issues as the response of a provincial government to a disease outbreak, the regulation of blood products, and the role of hospital organization and governmental decisions in the injuries of

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\(^4\) [1995] 3 SCR 199. Although the courts do not have the same obligations respecting tort claims as they do in the *Charter* context (where they are seen as the guardians of the constitution), the concern that deference can be taken too far is equally applicable in tort claims.
pediatric patients. Several empirical studies also confirm the aptitude of courts and laypersons to understand complex information outside their scope of expertise. Studies in which physicians analyzed the medical evidence from malpractice trials found that clinicians overwhelmingly agreed with the verdicts of judges and juries.\(^5\)

Allowing tort claims to proceed beyond the duty of care stage of the negligence test would also align the courts’ approach to tort liability with their approach to administrative and Charter claims. All three types of legal claims have built in mechanisms for judicial deference to governmental decisions, and in the latter two types of cases, the courts have not been willing to strike the claims over preliminary matters. As I discuss in greater detail below, in claims alleging that the government was negligent, the courts can accord the state considerable deference in assessing whether it met the standard of care.

In contrast to claims framed in tort law, courts have been reluctant to strike Charter and administrative law cases over preliminary issues such as standing or jurisdiction,\(^6\) preferring to evaluate these claims on their merits and to scrutinize the government’s policy choices. However, in doing so, judges have repeatedly affirmed the importance of deference to governmental decisions. For example, in applying section 1 of the Charter in Vriend v Alberta, the Supreme Court of Canada commented that “[t]he deference very properly due to the choices made by the legislature will be taken into account in deciding whether a limit is justified under s. 1 and again in determining the appropriate remedy for a Charter breach.”\(^7\) Similarly, courts adjudicating administrative law claims have acknowledged the importance of deference. For


\(^7\) [1998] 1 SCR 493.
example, in Stein v Quebec (Regie de l’Assurance-maladie), a health sector claim in which an individual sought reimbursement for health services that were privately purchased outside of Canada, the Quebec Superior Court employed the most deferential standard of review, patent unreasonableness, noting that courts “must exercise restraint.”\(^8\) It is important to note, however, that judges still struggle with the balance between governmental accountability and judicial restraint in cases framed in administrative law or those invoking the Charter, as exemplified by Chaoulli v Quebec (Attorney General). In that case, the Supreme Court of Canada delved into comparative health policy evidence and the majority attracted a great deal of criticism for deeming the government’s policy choices arbitrary (and thus contrary to the principles of fundamental justice as required by section 7 of the Charter).\(^9\)

B. Judicial Interference with Resource Allocation

Despite significant changes in the responsibilities of provincial ministries of health over the past fifty years, Canadian courts typically focus on the government’s financial role when applying the test for establishing a duty of care. Given the judiciary’s preoccupation with the state’s budgetary responsibilities, it is not surprising that one of its main policy concerns is the potential cost implications of imposing tort liability on the government. The comments of the Ontario Court of Appeal in Williams v Ontario (Attorney General), which were cited with approval in several subsequent health sector decisions, exemplify the judicial concern with interfering with health care budgets:

\(^8\) (1999) RJQ 2416 (Sup C). This case was decided prior to the Supreme Court of Canada’s decision to collapse the three standards of review in Dunsmuir v New Brunswick, 2008 SCC 9.

\(^9\) For an extensive discussion of various issues arising from this case, see Flood, Roach & Sossin, supra note 6. In Chaoulli, three of the judges found that the legal limits on duplicate private insurance constituted a breach of both the Canadian Charter of Rights and Freedoms and the Quebec Charter of Human Rights and Freedoms, three of the judges found that the limits did not violate the either statute, and the seventh judge found that the government had breached the Quebec Charter (and declined to consider whether it also breached the Canadian Charter).
To impose a private law duty of care...would create an unreasonable and undesirable burden on Ontario that would interfere with sound decision-making in the realm of public health...Public health authorities should be left to decide where to focus their attention and resources without the fear or threat of lawsuits.\textsuperscript{10}

The ever-increasing share of provincial budgets consumed by the health sector has led policy-makers to question the sustainability of the health care system as it is currently configured. Judges adjudicating health sector tort claims seem reluctant to exacerbate these cost pressures by imposing liability, which they seem to suggest would divert strained resources from patient care to pay damage awards. However, the concern that a dollar spent on compensation is a dollar that is not spent on patient care is an oversimplification of health system financing. There is considerable waste that may be eliminated or other cost shifting that can occur before any resources are diverted from patient care.\textsuperscript{11} Furthermore, a considerable body of evidence shows that more resource-intensive care does not necessarily result in better patient outcomes. For example, one study found that the use of high-volume services such as lab tests and x-rays could be reduced by 47 percent without diminishing quality of care.\textsuperscript{12} In other words, diverting funding from the provision of services may not actually have an adverse effect on patient outcomes.

Even if a judicial decision to impose governmental liability did cause some resources to shift from patient care, this is not, in and of itself, a sufficient justification to foreclose the judicial scrutiny of government decisions. The question that courts must address is whether a plaintiff ought to be compensated, given the circumstances of the case and her relationship with

\begin{footnotesize}
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\item \textsuperscript{10} 2009 ONCA 378 at para 33.
\item \textsuperscript{12} Marcia Angell, “Cost Containment and the Physician” (1985) 254 JAMA 1203 at 1204.
\end{enumerate}
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the defendant, or whether compensation may advance another pressing goal, such as improving accountability. The judicial preoccupation with disrupting governmental health care budgets fails to account for the potential non-monetary benefits flowing from the increased judicial scrutiny of governmental health sector decisions. Greater receptiveness to health sector tort claims would send an important signal to governments trusted with running our health care systems to engage in a more transparent and deliberate decision-making process and to achieve a minimum level of competence in carrying out their responsibilities. The courts have also failed to explore the argument that compensation may be justified in certain circumstances. For example, it is arguable that nurses infected with SARS in the course of providing life-saving, emergency treatment to the public were entitled to compensation, given that they were sacrificing their own well-being for the public good, and due to the inadequacies in the government’s efforts to contain the spread of disease and the deficiencies in its protection of health care workers.\textsuperscript{13} In this regard, James characterizes damages not as a diversion of resources, but rather as the incidental costs of an injury-producing activity.\textsuperscript{14}

\textbf{C. Deterrence and Governmental Defendants}

There is a significant body of scholarship addressing the efficacy of tort law at deterring physician negligence,\textsuperscript{15} and some literature addressing deterrence in the context of hospital

\textsuperscript{13} For criticisms of the Ontario government’s management of the SARS outbreak, see Archie Campbell, \textit{Spring of Fear: Final Report} (Toronto: Ontario Ministry of Health and Long-Term Care, 2003).

\textsuperscript{14} Fleming James, “Tort Liability of Governmental Units and Their Officers” (1954-1955) 22 U Chi L Rev 610 at 614.

\textsuperscript{15} See e.g. Thomas J Benedetti, Laura-Mae Baldwin & Susan M Skillman, “Professional liability issues and practice patterns of obstetric providers in Washington State” (2006) 107:6 Obstetrics & Gynecology 1238 and Robert G Brooks et al, “Availability of Physician Services in Florida Revisited: The Effect of the Professional Liability Insurance Market On Access to Health Care” (2005) 165:18 Arch Intern Med 2136. However, the majority of the literature on deterrence is from the United States and there are important differences between the two jurisdictions that limit the transferability of American evidence into the Canadian context. For example, unlike the United States, unsuccessful litigants in Canada are responsible for the other parties’ costs, and the Canadian Medical Protective
defendants. However, there is considerably less literature addressing the ability of tort liability to deter the government, with a particularly notable gap in empirical studies.

The health policy literature distinguishes between two types of deterrence, over-deterrence and under-deterrence, which I now address in turn. In the health context, the quintessential example of over-deterrence is defensive medicine, a phenomenon where doctors provide services not because they are clinically indicated, but for fear of liability (for example, the provision of unnecessary diagnostic tests to confirm a diagnosis). Other examples of over-deterrence include physicians who move to jurisdictions with legal rules that are more favorable to defendants (such as shorter limitation periods), those who refuse to treat patients they perceive to be potentially litigious, and those who discontinue the casual and infrequent practice of services such as obstetrics or anesthesia because the increased revenue is insufficient to

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16 Some statistics suggest that defensive medicine is extremely prevalent and that the resulting costs are astronomical. For example, the U.S. Congress Office of Technology Assessment estimated that defensive medicine accounts for 5-8 percent of all diagnostic tests. In 1993, Rubin and Mendelson estimated the cost of defensive medicine at $10 billion per year (Robert Rubin & Daniel Mendelson, “Measuring Defensive Medicine” (1996) 21:2 J Health Pol Pol’y Law 185). According to Studdert et al, 93 percent of doctors surveyed reported sometimes or often practicing defensive medicine (David Studdert et al, “Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment” (2005) 293 JAMA 2609). Although the primary focus of the defensive medicine literature is unnecessary costs, there may be significant avoidable medical risks associated with these unnecessary services. For instance, a common example of defensive medicine is a doctor delivering a baby by caesarean section not because she believes her patient’s condition requires it, but because she feels it involves less legal risk. See e.g. A Dale Tussing & Martha A Wojtowycz, “Malpractice, Defensive Medicine and Obstetric Behavior” (1997) 35:2 Med Care 172 and E von Levante et al, “The impact of malpractice fears of caesarean section rates” (1999) 18:4 J Health Econ 491. Although caesarean sections carry substantial medical risks, including scarring, pain, infection, and increased recovery time, the potential damage award for a baby born with a disability resulting from oxygen deprivation during the delivery is extremely high, as it can include not only damages for pain and suffering but also future care costs and lost income.

17 The major Canadian study on negative defensive medicine was a survey of doctors conducted in 1988 as part of the Prichard report, which was a comprehensive examination of Canada’s medical liability system commissioned by Canada’s deputy health ministers. Over a period of five years, 56.3 percent of physicians reported changing the scope of their practice. Specifically, 32.2 percent of the respondents reported decreasing or excluding at least one aspect of obstetric care from their practices (either performing deliveries or providing prenatal care). Although 26.5 percent attributed this to liability concerns, 47.5 percent reported that this was due to a change in their lifestyle, 23.1 percent reported an insufficient number of cases per year, and 21.4 percent cited inadequate compensation. Similarly, 13.2 percent of respondents reported reducing or eliminating one or more anesthesia practice areas, which
compensate for the higher insurance premiums associated with these high-risk specialties.\textsuperscript{18}

Although it is beyond the scope of my discussion, there are serious questions regarding the methodological soundness of empirical studies suggesting that tort liability over-deters physicians.\textsuperscript{19}

Applied to governmental defendants, over-deterrence could result in an investment of more time, effort, or monetary resources into the decision-making processes than is socially optimal. Fear of tort liability could, in theory, spur governments to unduly reduce their involvement in patient safety initiatives or to divest themselves of this responsibility altogether. However, this theoretical possibility seems unlikely in practice, given the pervasiveness of governmental involvement in the financing and management of the health system and the importance of health policy as an election issue. Indeed, Canadians often turn to the government

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  \item included administering local anesthetic, administering spinal and epidural anesthetic, or administering general anesthetic. The majority of the respondents attributed this change to litigation (41.8 percent), followed by an insufficient number of cases (41.5 percent), rapidly changing technology (22.4 percent) and lifestyle factors (21.4 percent). Christel A Woodward & Walter Rosser, “Effect of medicolegal liability on patterns of general and family practice in Canada” (1989) 141 CMAJ 291. Other factors affecting physician scope of practice decisions include family choices, patient preferences, and a lack of back-up coverage. In some circumstances, a reduction in physician scope of practice does not represent a decline in access, but rather a trade-off between access and quality. A number of factors may negatively affect service quality, including an inability to amass a sufficient number of annual cases, a lack of back-up coverage, and insufficient facilities and/or equipment to deliver increasingly advanced services. Citing a survey in which 45 percent of family physicians who had once provided obstetric services in rural Ontario had ceased to provide these services, Dickens commented that “[w]hile patients’ convenient access to services was…reduced, there was…evidence indeed that average standards were actually enhanced. Withdrawn and withheld services tended to be those of practitioners who believed that their proficiency was apt to be below standard.” Bernard Dickens, “The Effects of Legal Liability on Physicians’ Services” (1991) 41 UTLJ 168 at 205.

\textsuperscript{18} Although the medical malpractice insurance premiums paid by physicians may certainly increased over time, Kysar et al question whether this is due to a malpractice crisis or the “boom-and-bust pattern…known as the ‘underwriting cycle’.” For example, when malpractice claim payments remain unchanged over time, insurers can still incur losses if their premium prices were based on overly optimistic projections. Furthermore, companies may engage in “short-sighted pricing practices” by offering low premium rates in an effort to capture an increased market share. Douglas A Kysar, Thomas O McGarity & Karen O Sokol, “Medical Malpractice Myths and Realities: Why an Insurance Crisis Is Not a Lawsuit Crisis” (2006) 39 Loyola LA L Rev 785 at 798.

\textsuperscript{19} First, it is difficult to isolate fear of liability as the cause of a provider’s decision to cease the provision of certain services. Second, self-reporting typically forms the basis of empirical studies of defensive medicine, which has a number of methodological limits. For example, it is difficult to isolate one’s own motivations for behaving in a certain way (see e.g. Daniel L Schacter, “The seven sins of memory: insights from psychology and cognitive neuroscience” (1999) 54 American Psychology 182, citing several limits on human memory). In addition, data derived from self-reports may be biased towards a response aimed at achieving particular social goals, such as the implementation of limits on physician liability.
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and demand that it take action to protect the public in the face of a patient safety scandal or a health threat affecting the general public (such as a disease outbreak).

If governments reduced their involvement in patient safety and doctors and hospitals bore sole liability for injuries, this would do little to reduce government expenditures, as these other actors are likely to externalize a significant portion of the cost of damage awards onto the state. For example, doctors would seek to negotiate higher reimbursement rates from the government in the face of growing premiums, rather than reducing their incomes. Similarly, hospitals would be likely to ask the government for additional resources if they were required to pay large damage awards, rather than reducing the level of services they provide. Furthermore, these actors already externalize some of the cost of treating patient injuries onto the government. For example, the government bears the cost of antibiotics for a patient who contracts a hospital-acquired infection or the extra patient days associated with an avoidable case of ventilator-induced pneumonia. If governments will indirectly bear the cost of patient injuries in any event, it is unlikely that they will become less involved in the regulation of patient safety. If the history of Canadian Medicare is any indication, provincial governments are no longer content to passively pay for health services, while other actors control the quality and safety of those services.

Previous cases that resulted in tort liability did not prompt governments to either significantly reduce their involvement in those sectors or to enact immunity clauses to protect themselves from future claims. For example, after the Supreme Court of Canada established the duty to reasonably maintain highways in Just v British Columbia, and courts imposed liability on provincial ministries of transportation in several subsequent cases, provincial governments

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did not amend their highways legislation to include immunity clauses\textsuperscript{21} or otherwise limit their legal duties (for example, by restricting liability to situations of gross negligence). Similarly, in the face of potential tort liability and a sizeable settlement resulting from the tainted blood scandal, the federal government increased its involvement in the regulation of the blood system, rather than reducing it.\textsuperscript{22}

As I mentioned above, in addition to concerns with over-deterrence, tort liability may also under-deter defendants. For example, in the context of governmental defendants, there are questions regarding the ability of tort law to motivate behavioral changes given the state’s ability to pass costs on to taxpayers. One of the few scholars to have published on deterrence and governmental tort liability in the Canadian context is David Cohen, who advances several theoretical arguments to support his skepticism of the deterrent effects of tort liability.\textsuperscript{23} He uses the significant differences between the incentives that govern the behavior of governmental defendants and private defendants to question whether damage awards will influence the behavior of the state. For example, Cohen argues that the government does not experience financial penalties in the same way as corporations, because it can raise taxes to pay damage awards and because damages are not paid from the budget of the negligent government department.\textsuperscript{24} Although it is true that financial deterrents may affect governmental defendants differently than private defendants, Cohen neglects to account for the political costs that can flow from tax increases. The media attention, interest group lobbying, and public criticism resulting

\textsuperscript{21} When British Columbia replaced the \textit{Highway Act} (the statute at issue in \textit{Just}) with the \textit{Transportation Act}, SBC 2004, c 44, it did not include general immunity provisions.

\textsuperscript{22} Horace Krever, \textit{Commission of Inquiry on the Blood System in Canada} (Ottawa: Health Canada, 1997), Chapter 38.

\textsuperscript{23} See e.g. David S Cohen, “‘Regulating Regulators: The Legal Environment of the State’” (1990) 40 UTLJ 213.

\textsuperscript{24} Cohen categorizes this as the “substantial transaction costs” that occur when “wealth is shifted from one group of (tort) victims to a second group of (tort law) victims.” \textit{Ibid} at 259.
from a court’s imposition of liability against government, particularly in a high profile area such as health care, may also yield considerable political costs.

Cohen also distinguishes between the ability of private firms and governmental defendants to externalize the costs of their decisions. He notes that the rationale for holding private defendants liable is that they would otherwise externalize costs onto individuals.\textsuperscript{25} In contrast, he argues that a well-functioning bureaucracy will account for the welfare of those who may be harmed in making its policy decisions. Although the government may consider the welfare of potential victims in a utilitarian fashion—for example, in deciding that the benefits of vaccinating the whole population outweigh the harm that will occur to a few individuals—without having to compensate those individuals, the government is not internalizing all of the costs of its decisions. Instead, a few injured individuals may be compelled to bear the cost of a governmental decision that sacrifices their health for the health of the public at large (for example, in the case of nurse infected by SARS).

Finally, Cohen argues that bureaucratic decisions may not be a deliberate calculation of the costs and benefits of a particular policy, but rather may be motivated by the self-interest of bureaucrats who are seeking to enhance personal wealth, professional stature, or prestige, to increase department size, power, or budget, or increase managerial discretion.\textsuperscript{26} Acknowledging these limits, Cohen suggests that, “we ought to engage in a review process that investigates whether a particular bureaucratic decision….accurately identifies a socially optimal choice and then implements the choice in an efficient manner.”\textsuperscript{27} I am in agreement with Cohen and this argument could be invoked to suggest that tort claims should proceed to the standard of care.

\begin{itemize}
\item \textsuperscript{25} Ibid at 231-232.
\item \textsuperscript{26} Ibid at 235.
\item \textsuperscript{27} Ibid at 232.
\end{itemize}
stage of the negligence analysis, in order for courts to properly assess the government’s motivations for enacting a particular policy and the efficacy of their implementation strategy.

In his analysis of sovereign immunity, Spitzer constructs a variety of models of government behavior, which range from wealth maximizing to welfare maximizing. He concludes that all but one of his models indicate that government should be subject to tort liability, either for economic efficiency rationales (to force them to account for the social costs of their decisions) or, where the efficiency of liability is unclear, for reasons of fairness and comparative utility. I have addressed the former in this part and the latter point is similar to an argument that I introduced in Chapter Three—that without clear evidence supporting the government’s policy arguments against the imposition of a duty of care, fairness demands that a plaintiff’s claim be allowed to proceed to trial. According to Spitzer, the only model that supports governmental immunity is a situation where the state could demonstrate that it decided, after weighing all social costs and the potential for tort loss, to take the risk of incurring the loss. This type of calculus could arguably only occur at the standard of care stage of the negligence inquiry.

Even if there is skepticism regarding the ability of tort liability to deter the government, assuming that tort law is going to be part of the response to injuries resulting from the health system (which I advocate in Part Two, below), it is important that liability aligns with the actor who is most likely to respond to liability and who is the most blameworthy. The patient safety literature suggests that on both criteria, actors other than health professionals (namely, hospitals, LHINs/RHAs, and governments) ought to bear liability for most injuries. Although this body of scholarship, especially the empirical literature, is most developed in the context of hospital defendants, many of these arguments are equally applicable to the government.

Numerous scholars have invoked the patient safety literature to argue against tort law’s focus on the liability of individual health professionals. As I outlined in Chapter One, there is an increasing recognition that most adverse events are caused or contributed to by the systems within which health professionals operate. According to Mello and Studdert:

Holding individuals liable for a disproportionate share of the damages associated with medical injuries is problematic because it disrupts possibilities for efficient deterrence. Deterrence requires that a tortfeasor’s liability be restricted to the injuries that he causes…Liability above this level will lead the defendant to take excessive (socially inefficient) precautions, which may result in higher economic costs…

Cohen similarly argues that “imposing liability at the lowest level of the organization may not be an effective means of modifying institutional behavior.”

As I discussed in Chapter One, the patient safety literature increasingly suggests that the most effective means of error prevention is not modifying the behaviour of individual health professionals, but rather the implementation of systems designed to anticipate and prevent patient injuries. Human beings are inherently fallible, particularly when there are sleep deprived and stressed, have multiple tasks requiring their attention, are required to make quick decisions based on little information and conflicting scientific evidence, and when their environment is chaotic and noisy, all of which are characteristics of health care environments. Unlike health practitioners, actors such as hospitals, RHAs/LHINs, and governments have more time to make deliberate and evidenced-based policy choices. Furthermore, these actors have the financial and logistical capacity to implement systems and processes to guard against human errors.

30 Supra note at 23 at 220. Morreim similarly argues that external pressures from other patients, hospitals and governments are superseding the doctor-patient relationship and that these changes make it no longer justifiable that doctors are held to the same legal standards that they were subject to prior to changes in the health system. E Haavi Morreim, Holding Health Care Accountable: Law and the New Medical Marketplace (New York: Oxford University Press, 2001).
In arguing for the expanded liability of hospitals, several authors invoke arguments about the superior capacity of health care institutions to prevent injuries as compared to health professionals. As Peters argues, “[e]nterprise liability has the potential to be far more effective because it will shift responsibility onto actors with greater organizational and financial ability to reduce medical errors and generally improve safety and a more tangible reason to use that capacity.”

Although the bulk of this literature addresses the liability of hospital defendants, governments share the ability of hospitals to implement systems to prevent patient injuries and, as I argued in Chapter Two, exert increasing control over hospitals and providers (including control over the governance of patient safety). Provincial governments have blurred traditional health sector responsibilities and have assumed some of the managerial functions of hospitals, thereby increasing their ability to affect patient care.

With respect to blameworthiness, Mello and Brennan argue that most health professionals do not engage in deliberate, intentional conduct that is later deemed negligent, but rather make mistakes while tired, stressed, and under pressure to make quick decisions. In other words, there is little that they could have done to prevent patient injuries. In contrast, many of the tort claims against provincial governments alleged a failure to address safety concerns that were repeatedly brought to the government’s attention. For example, a plaintiff injured by a chiropractic treatment brought a claim against the Alberta government alleged that the defendant knew of the dangers of cervical manipulation and had failed to respond to these concerns.


33 Nette v Stiles, 2009 ABQB 422.
Similarly, plaintiffs infected with West Nile Virus based their claim, in part, on a plan that the government had developed in consultation with several other agencies, including local health authorities, local boards of health, hospitals, the Canadian Cooperative Wildlife Health Centre, neighboring provinces, the National Steering Committee for West Nile Virus, and the U.S. Centers for Disease Control.  

Although some authors advance theories to predict the expected response of governmental defendants to tort liability, there is a lack of empirical evidence to substantiate these theories. The few attempts to gather this data explored liability for police negligence in the United States. These studies did not yield clear conclusions on the efficacy of governmental liability as a motivator for policy change. The authors found that municipalities had implemented few of the courts’ criticisms and concluded that liability did little to motivate broader policy changes. However, they did note that police legal departments did not have the resources to implement most of the judicial criticisms that emerged from the lawsuits, even if they had wanted to. In addition, the authors cited some isolated examples of improvements driven by liability, including detailed regulations defining proper police conduct, enhanced requirements for police reports, and a prohibition on retaliatory arrests of citizens who filed complaints against police.

Although there is little empirical evidence to refute or support the argument that governmental actors are not effectively deterred by tort liability, there are some anecdotal examples of ministry of health responsiveness to judicial decisions. For example, in the wake of Canada’s tainted blood scandal, individuals infected with AIDS, HIV and Hepatitis filed class actions against the government. These class actions, along with the commission of inquiry into

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34 Eliopoulos v Ontario (Ministry of Health and Long Term Care), [2006] OJ No 4400.
the safety of the blood system (which I discussed in Chapter One), helped to motivate a significant settlement offer and sweeping changes to Canada's blood system.\textsuperscript{36} It is difficult to draw any definitive conclusions from the implementation of these recommendations though, as it is impossible to isolate the relative contributions of tort liability, public and media pressure and, in some cases, the recommendations of an inquiry, in motivating governmental policy changes.

\textbf{D. Conclusion on the Criticisms of Tort Liability}

While there are several legitimate concerns with imposing tort liability on governmental defendants, these concerns are not be as persuasive as judges assume. Furthermore, vaguely articulated policy considerations such as “indeterminate liability” or “a chilling effect” on governmental decision-making, for which there is no empirical evidence before the court, are arguably impossible to adjudicate in on a pre-trial motion. For example, what is the actual potential scope of governmental liability in the face of a disease outbreak or for the deaths of patients who die in the emergency room? What evidence is there that fear of liability will adversely affect sound government decision-making? These are complex issues that arguably require expert testimony and economic and policy evidence.\textsuperscript{37} As I mentioned above, the burden is on the defendant to prove the policy considerations that it seeks to invoke to limit or negate a \textit{prima facie} duty of care. In health sector tort claims, judges have failed to demand this evidence from government. In addition, courts have not attempted to balance the criticisms of liability against countervailing concerns that favor greater scrutiny of governmental decisions. In the

\textsuperscript{37} In an Ontario Court of Appeal case, \textit{Spasic Estate v Imperial Tobacco Ltd}, 2000 CanLII 17170, the Court discussed the importance of having a full factual record to assess the policy effects of its legal determinations: “A motion such as this is not the place to set out a detailed treatise on the tort of spoliation for many reasons, chief among them being that as with virtually all legal analysis, a factual nexus is needed to properly assess the consequences of the various conclusions.”}
next part, I turn to address one of these countervailing concerns—the importance of tort law as a mechanism of governmental accountability.

Part Two: Advantages and Disadvantages of Tort Liability and its Alternatives

A. Independent Review of Governmental Decision-Making

As I discussed in Chapter Two, the state’s expanding involvement in the health sector prompted calls for improved accountability by both members of the public and health policy scholars. Indeed, numerous comprehensive reports on the health care system released in the late 1990s and early 2000s identified the lack of accountability as a significant problem within the Canadian health care system. In the decade since the proliferation of these reports, provincial ministries of health implemented numerous reforms to improve health sector accountability. However, provinces generally focused on making other health system actors (particularly regional entities) more accountable to the government, rather than enhancing its own accountability obligations. For example, provinces use legislation and accountability agreements to require hospitals, LHINs and RHAs to report on a variety of financial, quality, and patient safety indicators. Ontario, legislation mandates that hospitals report hospital-acquired infection and mortality rate data to both the Ministry of Health and Long-Term Care and to the public. Many provinces have implemented wait list registries, which provide the public with information

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39 Hospital Management, RRO 1990, Reg 965, s 22.2.
regarding the wait times for various medical procedures.\footnote{See e.g. “Alberta Wait Times”, online: Government of Alberta <http://waittimes.alberta.ca/>.
} Provincial governments have also sought to improve transparency and accountability through the increased inclusion of patients and the general public in the health decision-making process. For example, in Ontario, LHIN meetings must be open to the public,\footnote{Local Health System Integration Act, SO 2006, c 4, s 9(4).} any person is entitled to make written submissions when a LHIN is contemplating a decision to integrate services,\footnote{Ibid, s 26.} and LHINS are required to “engage the community of diverse persons and entities involved with the local health system.”\footnote{Ibid, s 16(1). The legislation specifically contemplates community engagement through community meetings, focus groups, and advisory committees.} The recently passed \textit{Excellent Care for All Act}\footnote{SO 2010, c 14.} requires Ontario hospitals to engage patients through yearly patient and caregiver satisfaction surveys, declarations of patient values, and mandatory patient relations processes.\footnote{Ibid, s 16(1).}

Provincial governments have made some progress in improving the accountability of hospitals or regional entities to patients (for example, mandatory patient relations processes) or the accountability of these actors to government (for example, accountability agreements), but little has been done to enhance the accountability of government to its citizens. Although political accountability was perhaps an effective mechanism for citizens to hold governments accountable for their budgetary responsibilities, as I discussed above, it is inadequate to address the state’s modern, managerial responsibilities. I have focused on legal accountability thus far, but there are several other independent checks on government decision-making, including complaints to ombudspersons, commissions of inquiry, and auditors general.\footnote{Protections on the independence of ombudsmen include conflict of interest provisions, legislative rather than executive appointment, remuneration similar to judges’, limited executive authority to remove an ombudsman, confidentiality of proceedings, and control over the manner of investigations. Mary A Marshall & Linda C Reif, “The Ombudsman: Maladministration and Alternative Dispute Resolution” (1995) 34:1 Alta L Rev 215 at 219. Critics of the independence of commissioners cite the abrupt termination of inquiries and governmental budgetary restrictiveness.} In this section, I
evaluate the various accountability mechanisms on the basis of three criteria—transparency, answerability to injured parties, and the availability of sanctions or remedies—all of which have been identified as necessary components of accountability.

i. Transparency

One of the most widely-accepted components of accountability is transparency. For example, according to a report on accountability from Manitoba Health, “[i]n a democratic government, all citizens have the right to know how their elected representatives are performing.” Similarly, the report from the Commission on the Future of Health Care in Canada stated that, “[t]he decisions governments and providers make in operating our health care system should be clear and transparent. Canadians are entitled to regular reports on the status, quality and performance of our health care system.” Indeed, several of accountability mechanisms implemented by governments, such as wait list registries, hospital infection rate reporting, and extensive LHIN and RHA reporting requirements are concerned with providing the public with information on the performance of the health system.

Courts, commissions of inquiry, auditors general, and ombudspersons can all improve health system transparency. The attention given to their reports and decisions by the media, interest groups, and opposition political parties brings information about health system deficiencies to the public’s attention. Their powers to summon and examine witnesses under oath and to inspect government documents give them access to information beyond what is controls. See e.g. Robert Centa & Patrick Macklem, “Securing Accountability Through Commissions of Inquiry: A Role for the Law Commission of Canada” (2001) 39:1 Osgoode Hall LJ 117 at 120–21 and Peter Desbarats, “The Independence of Public Inquiries: Dixon v Canada” (1997) 36:1 Alta L Rev 252. Similar provisions protect the independence of auditors general. See e.g. Audit Act, RSO 1990, c A.35, ss 3–5.

47 Roy Romanow, Building on Values: The Future of Health Care in Canada (Ottawa: Commission on the Future of Health Care in Canada, 2002) at 50.
readily available to the general public.\textsuperscript{48} However, the ability of ombudspersons to improve health system transparency is limited by the fact that they release few individual case findings, but rather primarily report aggregate complaint data.\textsuperscript{49} Furthermore, unlike courts or commissioners of inquiry, whose proceedings are generally open to the public, ombudspersons interview individual complainants in private.\textsuperscript{50}

\textit{ii. Answerability to Injured Parties}

Another component of accountability is answerability to the affected individual.\textsuperscript{51} Courts and ombudspersons may be in the best position to facilitate answerability, as any aggrieved individual is entitled to pursue a complaint in these forums. Judges can decline to hear claims on a limited number of established grounds, including failure to plead a cause of action, lack of jurisdiction, frivolousness or vexatiousness, and lack of standing. In contrast, the power of ombudspersons to refuse to hear complaints is not constrained by clear tests. For example, the Ontario ombudsperson can decline to pursue a complaint if he is of the view that “having regard to all the circumstances of the case, any further investigation is unnecessary.”\textsuperscript{52} Despite this broad discretion to refuse to hear complaints, ombudspersons are more accessible than the courts in other respects. Unlike the legal system, ombudspersons are free to the complainant, employ flexible and user-friendly processes, and they typically resolve complaints relatively

\textsuperscript{48} See e.g. Ombudsman Act, RSO 1990, c O.6, ss 19(1)–(2) and Audit Act, supra note 45, ss 10–11, 14.
\textsuperscript{50} See e.g. Ombudsman Act, supra note 48, s 18(2): “[e]very investigation … shall be conducted in private”.
\textsuperscript{52} Ombudsman Act, supra note 48, s 17.
expeditiously. For example, while litigation is often tied up in the courts for years, the Nova Scotia Ombudsperson reported that 73 percent of its administrative reviews were resolved in under one week, 13 percent in one to four weeks, and 14 percent in more than four weeks.\(^{53}\)

In contrast, commissions of inquiry and auditor general investigations are not complainant-driven processes. Governments may refuse to exercise their discretion to commence inquiries, even when confronted with public or media pressure. For example, Centa and Macklem criticized the Ontario government’s refusal to commence an inquiry into the police shooting of a protestors during a dispute over a provincial park on what protestors claimed was aboriginal land. The authors argued that, “the capacity of the commission of inquiry to secure governmental accountability is beginning to falter. Fearing adverse political consequences, governments increasingly appear reluctant to establish commissions of inquiry into public crises that merit independent investigation.”\(^{54}\)

Aggrieved individuals are even less likely to persuade an auditor general to review a health system grievance. Over the past ten years, the Ontario Auditor General has reported on an average of only eight health-related issues per year,\(^{55}\) a strikingly small number, given the proportion of government budgets devoted to health and its importance as a policy issue. With respect to complainant participation, commissioners have wide discretion to allow affected individuals to participate.\(^{56}\) In contrast, auditors general rarely engage affected individuals or


\(^{54}\) Supra note 45 at 120.


\(^{56}\) Under Ontario’s Public Inquiries Act, 2009, in determining who can participate in an inquiry, the manner and scope of participation, the rights and responsibilities of participants, and the limits or conditions on participation, a commissioner shall consider whether a person has a substantial and direct interest in the subject matter, is likely to be notified of a possible finding of misconduct, would further the conduct of the inquiry, or would contribute to openness and fairness. SO 2009, c 33, Schedule 6, ss 15(1)–(2).
communities, but rather generally rely on government documents and reports in making their recommendations.\(^57\)

### iii. Availability of Sanctions or Remedies

A third aspect of accountability is the ability to render sanctions or remedies. For example, Tuohy argues that accountability mechanisms must include “the availability of sanctions…the means to reward or punish accordingly”\(^58\) and Brinkerhoff argues that, “[l]egal and regulatory sanctions are at the core of enforcing accountability.”\(^59\) The ability to sanction is most closely associated with the courts, as judges can order a wide range of remedies, including monetary damages, injunctions, or declarations of unconstitutionality. Of course, compensation is not the only reason, and possibly not even the primary reason, that individuals commence claims.\(^60\) Accordingly, extrajudicial accountability mechanisms (particularly ombudspersons and commissions of inquiry, which engage complainants in their processes) may be just as effective at providing what may be referred to as emotional compensation—the sense that one’s grievances have been vindicated and that other people will not suffer similar harm in the future. Furthermore, while complex legal processes and the lag time between an injury and a judge’s decision may alienate plaintiffs from their grievances, user-friendly procedures that engage the complainant (like those used by ombudspersons) may be more effective at providing a sense of justice or vindication.


\(^{60}\) Although there are no empirical studies exploring the reasons why individuals sue government, several studies examine why patients sue doctors and hospitals. See e.g. Charles Vincent, Magi Young & Angela Phillips, “Why Do People Sue Doctors? A Study of Patients and Relatives Taking Legal Action” (1994) 343 Lancet 1609.
In contrast to the courts, ombudspersons, commissioners, and auditors general elicit change through publicity and persuasion. Even without the ability to sanction government, these mechanisms may be as effective as the courts at improving accountability if the government routinely follows their recommendations. However, there is mixed evidence regarding the efficacy of the various accountability mechanisms at motivating governmental policy change. For example, in a report assessing the provincial government’s implementation of its previous recommendations, the Manitoba Auditor General found that of its 555 recommendations, 117 were implemented, 22 were no longer required (due to changes in circumstance), 7 were not going to be implemented, 318 had been addressed in previous reports (and were thus no longer being monitored), and the remaining 91 had not yet been implemented.\textsuperscript{61}

These statistics likely overstate the actual implementation of the Auditor General’s recommendations, as they are based on self-reporting by the affected government entity. For example, Manitoba Health reported that they had implemented a recommendation to “ensure the best health outcomes for Manitobans and the containment of costs for the Pharmacare Program” through “coordinating, with the professional bodies, any communication of guidance to physicians on the most appropriate and economical prescribing of drugs.”\textsuperscript{62} Given the broad scope of this recommendation and its ongoing nature, its more appropriate classification would arguably have been “work in progress.”

Ombudspersons report similarly promising rates of governmental compliance. For example, Nova Scotia’s ombudsperson reported that of the 1164 complaints it received in 2008-2009, 1035 had “positive outcomes”, which includes “assistance rendered to complainant” (729

\textsuperscript{61} Office of the Auditor General of Manitoba, \textit{Follow-up of Previously Issued Recommendations} (Winnipeg: Auditor General of Manitoba, 2010) at 10.

\textsuperscript{62} \textit{Ibid} at 45.
complaints), “resolved for the complainant” (231 complaints), “resolved for the public body/properly implemented” (61 complaints), and “settled between the parties” (14 complaints). Of the remaining complaints, 31 were carried over into the following year, and 98 were discontinued or withdrawn.

Despite these promising statistics, it is difficult to attribute a governmental policy change to any one of the accountability mechanisms, as an unknown mix of public and interest group advocacy, industry and health provider lobbying, and media and political opposition party pressure also motivate governmental policy changes. Furthermore, it is difficult to compare the efficacy of the different accountability mechanisms due to the lack of empirical data respecting the implementation of commission of inquiry recommendations and policy changes resulting from judicial decisions. Furthermore, even where data is available, it is not arrived at using a consistent methodology, making comparisons across the different accountability mechanisms difficult.

In sum, I do not argue that the courts are the best means of improving governmental health sector accountability, but rather that they are necessary. Because the various accountability mechanisms all have advantages as well as significant limitations, a multi-prong approach is crucial to achieving improved governmental accountability. For example, compared to the courts, ombudspersons are more accessible to complainants and are better able to mediate cost-effective and timely resolutions to grievances. In addition, unlike judges, commissions of inquiry and auditors general are not constrained by legal doctrines, or by the parties to the

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63 The report does not define this term, which could merely mean the complaint was referred somewhere else and the grievance was ultimately left unresolved.
65 For example, the Manitoba Auditor General uses the term “implemented” while the Nova Scotia Ombudsman uses the phrase “positive outcome”.

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litigation, their pleadings, or the evidence they introduce. Accordingly, those bodies may be better suited to effectively exploring the systemic causes of an adverse event and recommending ways to prevent similar problems in the future. However, without the courts, gaps would exist in accountability, as other mechanisms have wider discretion to refuse to hear grievances, may not publicly report their findings or permit complainant initiation or participation, and the government may choose to disregard their recommendations.

**B. Other Mechanisms of Legal Accountability**

Although the courts are essential to improving health sector accountability, plaintiffs can also advance their claims through administrative law or the *Charter*. 66 These mechanisms of accountability share many of the same advantages as tort law, namely the availability of sanctions, judicial independence from government, and the ability to improve the transparency of governmental decision-making. These mechanisms also have many of the same disadvantages as tort law, such as the access barriers faced by prospective plaintiffs and concerns with institutional competence to engage with complex policy evidence. However, in this section, I argue that without tort law, there would be a significant gap in the accountability of the government for its health sector decisions.

As I discuss in this section, claims framed in administrative law or by way of the *Charter* have thus far related to access to health services, and these legal mechanisms provide limited means to review governmental decisions affecting the quality of health services. In contrast, health sector tort claims have challenged both the quality of health services and access to those services. Plaintiffs seeking to advance claims in administrative law are also limited by the types

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of decisions that attract judicial review. In addition, while there are limits on the use of the Charter to challenge governmental failures to take positive actions, claims framed in nonfeasance are common in the context of tort claims against governmental defendants.

In administrative law, policy or legislative decisions do not attract judicial review by the courts. In addition, administrative tribunals are limited in the types of claims they can adjudicate by the authority that is delegated to them by statute. Plaintiffs are constrained by the fact that governments have only delegated limited health sector decision-making authority to boards or tribunals whose decisions are amenable to challenge under administrative law. The existing bodies with health sector jurisdiction generally lack the authority to deal with matters involving the quality of health services.

To date, health sector cases framed in administrative law have involved either applications for judicial review of refusals to reimburse patients for out-of-country health services or claims of discrimination under human rights legislation based on the government’s failure to fund particular health services. For example, in Stein v Quebec (Régie de l’Assurance-maladie), the claimant succeeded in overturning a refusal by the Tribunal Administratif for reimbursement for cancer surgery he paid for in New York. In contrast, in Flora v Ontario Health Insurance Plan (General Manager), the Ontario Divisional Court upheld a decision of the Health Services Appeal and Review Board denying the plaintiff’s claim for reimbursement for cancer treatment she paid for in England. An example of an administrative law claim invoking

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69 [1999] RJQ 2416 (Sup Ct).
70 (2007) 83 OR (3d) 721. See also CCW v Ontario Health Insurance Plan (2009), 95 OR (3d) 48, in which the Ontario Divisional Court heard three appeals from decisions of the Health Services Appeal and Review Board denying reimbursement for out-of-country services. The Court dismissed the appeal of one plaintiff, who had obtained residential mental health and addiction treatment in Utah. The Court remanded the appeals of the other two
human rights legislation is *Hogan v Ontario (Minister of Health and Long-Term Care)*, in which the plaintiff successfully claimed that the Ontario government’s failure to fund sex reassignment surgery violated his rights not to be discriminated on the basis of sexual orientation.\(^{71}\) In *Armstrong v British Columbia (Ministry of Health)*, the plaintiff unsuccessfully claimed that the government’s failure to fund testing for prostate cancer violated his right not to be discriminated against on the basis of sex, in light of the fact that the province funded testing for cancers afflicting the reproductive systems of women.\(^{72}\)

As with administrative claims, plaintiffs have only invoked the *Charter* provisions applicable to health sector grievances to address access to care issues, rather than complaints respecting the quality of health services. To date, plaintiffs advancing *Charter* claims have either alleged that the government’s failure to fund a particular health service constituted discrimination on the basis of a disability in contravention of section 15, or that legislation limiting access to health services violated their right to life, liberty and security of the person, as enshrined by section 7. For example, in *Eldridge v British Columbia (Attorney General)*,\(^{73}\) hearing impaired individuals successfully claimed that the British Columbia government’s failure to fund sign language interpreters constituted discrimination on the basis of a disability. Similarly, in *Auton (Guardian ad litem of) v British Columbia (Attorney General)*,\(^{74}\) a group of

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\(^{71}\) 2006 HRTO 32. This victory was narrowly confined to the facts at hand. This particular plaintiff succeeded on the basis that he had already commenced the extensive pre-surgical counselling and care program. The government’s refusal to fund sex reassignment surgery for future individuals was deemed not to violate human rights legislation.

\(^{72}\) 2010 BCCA 56.

\(^{73}\) [1997] 3 SCR 624.

\(^{74}\) 2004 SCC 8. See also *Cameron v Nova Scotia (Attorney General)* (1999), 204 NSR 2d 1 (CA), in which a couple unsuccessfully challenged the government’s refusal to fund fertility treatment. They alleged that the refusal was discriminatory on the basis of a disability (infertility) in light of the fact that pre-natal services were provided to fertile couples.
parents challenged the government’s refusal to fund applied behavioral analysis therapy for their autistic children.

An example of a section 7 claim is *R v Morgantaler*, in which the defendant successfully claimed that the requirement that a woman obtain the approval of a therapeutic abortion committee before obtaining an abortion violated her right to security of the person.75 Another example is *Chaoulli v Quebec (Attorney General)*, in which the Supreme Court of Canada split on the issue of whether unreasonably long wait times for health care services in the public system, when coupled with a prohibition on private insurance, violated the claimants’ rights to life and security of the person.76 An additional limit on Charter claims is the fact that Canadian courts have not generally interpreted section 7 to guarantee positive rights—governmental obligations to ensure a plaintiff’s life, liberty, or security of the person—which is a barrier to claims alleging a failure to protect claimants from a particular risk.77

In contrast to the administrative and Charter claims, many health sector tort claims have called upon the courts to review the quality of publicly funded services, in addition to the accessibility of those services. Examples include a claim that the Ontario government failed to take steps to protect members of the public from a SARS outbreak and the allegation that the Alberta government failed to exercise adequate oversight over chiropractic services. These claims did not involve discrimination against particular individuals or relate to a governmental deprivation of rights, so there would be no legal basis to bring them under section 15 or 7 of the Charter. In addition, these claims were framed in nonfeasance rather than misfeasance, with the plaintiffs alleging that the government had failed to take steps to protect them from a particular risk.

76 2005 SCC 35.
77 However, see *Gosselin v Quebec (Attorney General)*, 2002 SCC 84 at paras 81-83, which leaves open the possibility that “[o]ne day s. 7 may be interpreted to include positive obligations.”
risk. Without tort law, these plaintiffs would not have legal recourse against the government, as the Charter has not generally been found to guarantee positive rights.

Conclusion

In this Chapter, I explored the tension between governmental accountability and the importance of judicial restraint in reviewing health sector decisions. I acknowledged that there are several legitimate concerns with imposing tort liability on governmental defendants, specifically, the potential diversion of strained health system resources to compensate injured patients, the courts’ institutional competence to consider complex matters of social policy, and the ability of tort liability to effectively deter the government. However, I argued that the criticisms of liability are not as persuasive as courts presume, and judges can mitigate these concerns by giving the government considerable deference when setting the standard of care. Furthermore, vaguely articulated policy considerations such as “indeterminate liability”, for which there is no empirical evidence before the court, are arguably impossible to adjudicate in on a pre-trial motion. Judges adjudicating health sector claims fail to demand this evidence before striking a claim.

I also criticized health sector tort claims on the basis of the judiciary’s complete failure to consider policy concerns that demand greater scrutiny of governmental decision-making. Specifically, because the various independent checks on governmental decision-making all have strengths and weaknesses, an optimal level of accountability requires a multi-prong approach that includes tort liability. For example, compared to the courts, ombudspersons and auditors general have wider discretion to refuse to hear grievances, and their findings and deliberations lack transparency (as they report aggregate complaint data and conduct their hearings in private).
While any aggrieved individual can file a claim with the courts, the government may refuse to appoint a commission of inquiry to investigate a particular health system concern and auditors general review few health system matters. In addition, unlike judicial remedies, the government can disregard the recommendations of ombudspersons, auditors general, and commissioners of inquiry. With regard to other types of legal claims, unlike tort law, administrative law and the Charter provide limited means to review governmental decisions affecting the quality of health services (as opposed to their accessibility). Plaintiffs framing their claims administrative law are also limited by the types of decisions that attract judicial review. In addition, while tort claims routinely challenge a government’s failure to take particular actions (nonfeasance), Canadian courts do not typically interpret the Charter as a mechanism to protect positive rights.
CONCLUSION

In this thesis, I explored the potential for tort liability to improve governmental decision-making in the health sector. I argue that Canadian courts have largely ignored the government’s vastly expanded health sector responsibilities and have failed to explore the impact of these changes on the legal duties the state owes its citizens. This judicial non-interventionism stands in sharp contrast to their treatment of claims arising from other sectors of governmental activity. I conclude with two recommendations for courts adjudicating health sector tort claims in the future. First, I argue that judges should more frequently permit health sector tort claims to proceed beyond the duty of care stage of the negligence analysis to an assessment of whether the government satisfied the standard of care. This approach would allow judges to scrutinize the reasonableness of the government’s decisions, potentially motivating an improved decision-making process, but would not necessarily lead to widespread liability. Second, I argue that judges should permit more of these claims to proceed to trial, so they can engage with the considerations for and against liability with the benefit of a full evidentiary record.

Until the middle of the previous century, Canadian provincial governments had a very limited role in the health care system and thus had little impact on either access to health services or the quality of those services. Even with the implementation of Medicare during the 1950s and 1960s, governments merely underwrote the existing delivery system, thereby preserving physician autonomy over clinical decision-making and hospital governance of health service delivery. By the 1980s, rapidly growing spending led provinces to expand their role in the health sector through policies designed to limit the supply of and demand for health services. In the 1990s, ongoing cost pressures and emerging concerns with both the safety and appropriateness of health care services prompted provinces to begin to implement integrative reforms. Although governments framed these changes as the devolution of some of their authority to newly-created
regional entities, this transformative reorganization of the health system also represented an assertion of state authority. Governmental control of clinical decision-making and health service delivery has continued to grow since the implementation of regionalization. Provincial governments also solidified their control of the health sector by implementing legal restrictions on private health services. This gave the state a monopoly over most hospital and physician services and compelled the public to rely on the public system, regardless of the accessibility or quality of the services therein.

Health professionals and, to a lesser extent, hospitals typically bear legal responsibility for patient injuries. Historically, these actors were more temporally and spatially connected to adverse events than the government, whose role was solely financial. However, the responsibilities of and the relationships between health professionals, hospitals, government and patients have undergone significant changes over the past fifty years. A dramatic shift has also occurred in the patient safety literature, whereby patient injuries once attributed to errors in clinical judgment are now seen as the product of flawed systems. Canadian tort law has failed to keep pace with these changes in the health policy and medical literature. To date, Canadian courts have struck all but one health sector tort claim on a pre-trial motion, with little substantive analysis of the government’s modern role in the health sector. Judges have failed to consider whether the state’s increasing control over clinical decision-making and hospital governance has resulted in a closer nexus between patient injuries and governmental decisions. The closeness of the parties’ relationship is relevant to tort liability, as a claimant must demonstrate that the parties have a proximate (or close and direct) relationship in order for the defendant to owe the plaintiff a duty of care.
In order to determine whether the judiciary’s non-interventionist approach to governmental liability is unique to the health sector, I compiled a dataset of all tort claims against governmental defendants from the past decade. My analysis indicated that the judiciary’s restrictive approach to health sector tort claims is difficult to reconcile with its treatment of claims arising in other sectors of government activity. For example, according to my dataset, Canadian courts have been willing to find that a governmental defendant owed a duty of care in 55 percent of the tort claims across all sectors, yet this figure was only 17 percent in the health sector tort claims. Even when I controlled for other explanatory variables, such as the dates of the decisions, the type of injury sustained (i.e. personal injuries or claims for pure economic loss), or the courts hearing the cases, there was an inexplicable judicial reluctance to scrutinize governmental health sector decisions.

In determining whether to dismiss a claim prior to trial, judges strive to strike a balance between the goals of fairness, accuracy, and efficiency. There is a strong presumption in favor of allowing a plaintiff to engage in an exhaustive fact-finding process before an impartial arbiter. In addition, a full evidentiary record arguably improves the accuracy of a judge’s findings. However, judges will not allow plaintiffs to harass defendants with vexatious claims or squander scarce judicial resources adjudicating clearly meritless claims. In an effort to strike a balance between the goals of fairness, accuracy, and efficiency, Canadian courts have determined that judicial resources should be allocated to certain types of cases, including those raising complex issues, novel duties of care, important issues, or unsettled areas of the law. Yet judges have struck nearly all health sector tort claims despite the presence of factors suggesting they should proceed to trial, including the complexity of the health sector, the novelty of the legal duties
advanced by the plaintiffs, elements of factual novelty, the importance of the issues these claims raise, and the unsettled nature of the law of governmental tort liability.

Although negligence claims have four elements—duty of care, breach of duty, damage and causation—health sector tort claims (indeed, many tort claims against government) have been resolved on the first of these elements. In order to compare the Canadian judiciary’s approach to health sector claims with its broader treatment of governmental tort liability claims, I developed a framework to classify the different approaches judges have taken to the test for establishing a duty of care. In a growing proportion of tort claims over the past decade, judges conducted a comprehensive analysis of the parties’ relationship and the policy concerns with imposing liability in determining whether to impose a duty of care on a defendant.

In contrast to this general approach to governmental liability, judges adjudicating health sector claims have been almost singularly focused on the policy implications of their decisions, specifically their perception that damage awards will divert resources from the provision of health care services and their reluctance to interfere with governmental decisions in an area of complex social policy. One specific policy consideration unique to governmental defendants is the policy/operational dichotomy, under which judges will not impose liability for policy decisions, while they will review the operationalization of those decisions. In applying this dichotomy, Canadian courts have, I argue, unduly fixated on any hint of resource allocation and, as a consequence, categorized most health sector decision-making as policy without fully exploring the level and nature of control exerted by government.

There are undoubtedly legitimate policy concerns with governmental tort liability, such as the judiciary’s institutional competence to adjudicate complex matters of social policy and questions over the deterrent effects of governmental liability. However, it is of great concern
that the courts use the label of “policy” to thwart tort claims against governmental defendants without any substantive consideration of the legitimacy or magnitude of these policy concerns. Judges ought to be particularly cautious in striking claims due to policy considerations on pre-trial motions, given the limited evidence available to the court at that stage of the proceedings and the preferential treatment they must give the plaintiff’s claim. In this regard, the Supreme Court of Canada has stated that it must be plain and obvious that a plaintiff will fail in order for a judge to dismiss her claim prior to trial. I am also critical of the fact that courts adjudicating health sector claims have failed to consider countervailing policy concerns suggestive of the importance of judicial scrutiny of governmental decisions, particularly the crucial role that tort law plays in improving health sector accountability.

In addition to my analysis of tort law, I discussed several other mechanisms by which injured citizens can seek to hold the government accountable for its health sector decisions. Specifically, I addressed complaints made to ombudspersons, auditor general reports, commissions of inquiry, and legal claims framed in administrative or constitutional law. I concluded that the respective strengths and weaknesses of these various accountability mechanisms and the different types of governmental decisions covered by each necessitate a multi-prong approach, whereby the various accountability mechanisms complement rather than substitute for one another. For example, compared to the courts, ombudspersons are more accessible to complainants and better able to mediate cost-effective and timely resolutions to complaints. Commissions of inquiry and auditors general are not constrained as judges are by pleadings, the parties to the litigation, legal doctrine, or the evidence introduced by the parties. Accordingly, they may be more effective at comprehensively exploring the systemic causes of an adverse event and making recommendations to avoid similar incidents in the future. However,
without the courts, gaps would exist in accountability, as these other actors have wider discretion to refuse to hear grievances, may not publicly report their findings or conduct hearings in public, and the government may choose to disregard their recommendations.

Apart from actions in tort, claims in administrative law or by way of the Charter may also be a means of enhancing governmental accountability. However, most administrative and Charter claims have focused on access to health care services rather than the quality of those services, as has been the case with many claims framed in tort law. Furthermore, while many of the tort claims to date have alleged nonfeasance—governmental failures to undertake particular actions—the Charter has not generally been interpreted to impose positive obligations on government. The judiciary’s reluctance to hear health sector tort claims thus leaves a serious gap in the independent review of governmental decision-making that is not filled by other accountability mechanisms.

I conclude by arguing that the courts could apply the law in a manner that more appropriately balances the concerns with judicial policy-making and the reallocation of scarce resources against the need for improved government accountability. Specifically, judges should more frequently permit health sector tort claims to proceed beyond the duty of care stage of the negligence analysis to an assessment of whether the government met the standard of care. This approach would allow judges to explore the reasonableness of the government’s decisions, potentially motivating the state to make changes in its decision-making process, but would not necessarily lead to widespread governmental liability. Subjecting governmental decisions to greater scrutiny would not marginalize concerns with scarce resources or competing interests, as the standard of care could incorporate considerable deference to these defendants. Indeed, the judicial willingness to find that the government owed a duty of care in sectors other than health
care has not resulted in widespread liability, with courts frequently concluding that the government met the requisite standard of care.

Further, judges should more frequently permit the health sector tort claims to proceed to trial, where they would have the benefit of a full evidentiary record to inform their analysis of the policy implications of governmental tort liability. Courts should also shift away from an approach that is unilaterally favorable to governmental defendants, to one in which they attempt to balance the genuine policy concerns that exist with the imposition of tort liability against the potential benefits of liability, such as improved accountability and a more deliberate and transparent decision-making process.
Appendix One: A Summary of the Governmental Tort Claims From All Sectors

In the Appendices, I list all of the reported tort cases against governmental defendants from nine Canadian provinces, all three territories, and the federal courts since the Supreme Court of Canada’s 2001 restatement of the test for establishing a duty of care in *Cooper v Hobart*. I exclude cases from Quebec, due to the differences in the law and because many of these cases were not translated into English. The focus of my discussion is health sector tort claims resulting in personal injuries. I summarize those cases in Appendix Three. In this Appendix, I summarize the legal findings from all other tort claims against governmental defendants, subject to the exceptions discussed below.

I include all government tort liability cases, aside from those decided entirely on issues unrelated to the merits of the tort claimed (for example, questions of jurisdiction or statute of limitations issues). Although the vast majority of the cases alleged governmental negligence, I also include claims pleading other torts such as misfeasance in a public office or defamation. Many of these torts have elements or general policy considerations that overlap with the requirements of a negligence claim. Furthermore, although some of these claims may have been decided on these other torts, the plaintiffs often also alleged that the government had been negligent.

In determining which actors are sufficiently governmental for the purpose of inclusion, I include government itself (the federal government, a province, or a municipality), personally named government officials or employees (for example, a premier, minister, or police chief), governmental ministries and departments, agents of government, and Crown corporations. I define government broadly because similar policy considerations apply to the liability of these actors and they are frequently named as co-defendants in the same
actions. Furthermore, particular aspects of the test for establishing a duty of care that are unique to governmental defendants, such as the policy/operational dichotomy, apply to these actors. However, I exclude claims with governmental actors as both the plaintiff and the defendant, such as claims by former government employees for wrongful dismissal.

In the tables below, I summarize the courts’ findings at each stage of the duty analysis, setting out the elements of the test the plaintiffs proved and those that they did not (in other words, the elements that prevented the claim from proceeding to trial or succeeding at trial). For example, it was common for a plaintiff to successfully prove foreseeability but then fail to satisfy the requirements for proximity. The ‘stage of the proceeding’ categorizations are not mutually exclusive. For example, although I may categorize a particular case as a trial, there may have been a previous motion to strike decision issued in the same case. I list each case only once, categorizing them according to the most recently reported decision. In addition, I only list the most recent citation for each case, even if the claim proceeded through multiple levels of appeal. Generally, the findings I report are from the highest court to issue a decision in the case, unless the appellate court merely adopted the trial judge’s findings without explanation, in which case I cite the highest court decision, but also summarize the lower court’s findings.

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<tr>
<th>Case</th>
<th>Sector</th>
<th>Stage of the Proceedings</th>
<th>Courts’ Findings</th>
<th>Facts</th>
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<tbody>
<tr>
<td>495862 BC Ltd v Y (CD), 2003 BCSC 1160</td>
<td>Community services</td>
<td>Trial, plaintiff succeeded on duty</td>
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<td>Case</td>
<td>Area of Law</td>
<td>Motion to Dismiss</td>
<td>Plaintiff Succeeded</td>
<td>Defendant’s Response &amp; Reasoning</td>
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<tr>
<td>783783 Alberta Ltd v Canada (Attorney General), 2010 ABCA 226</td>
<td>Tax and finance</td>
<td>Motion to dismiss, government succeeded</td>
<td>Yes</td>
<td>Did not discuss</td>
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<tr>
<td>1597203 Ontario Limited v Ontario, 2007 CanLII 21966 (Sup Ct)</td>
<td>Health (economic loss)</td>
<td>Motion to dismiss, plaintiff succeeded</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>AL v Ontario (Ministry of Community and Social Services) (2006), 83 OR (3d) 512 (CA)</td>
<td>Community services</td>
<td>Class certification motion, government succeeded</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Adams v Borrel, 2008 NBCA 62</td>
<td>Agriculture</td>
<td>Trial, plaintiff succeeded</td>
<td>Yes</td>
<td>Did not discuss</td>
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Plaintiff’s competitor received a more favorable tax assessment with respect to business expenses. Plaintiff alleged negligent enforcement of Tax Act.

Plaintiffs purchased two physiotherapy clinics. Had historical dealings with the government in providing insured services. Government reduced scope of insured physiotherapy services. Prior to change, plaintiff had discussions with Ministry employees indicating funding changes temporary.

Plaintiffs were disabled minors. Children’s Aid/Minister empowered to enter Special Needs Agreements to provide services so parents did not lose children (because they couldn’t fulfill needs of children). Ministry decided that no new Agreements would be entered.

Plaintiffs farm and market seed potatoes. Claimed economic loss for government’s handling of a potato virus.
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<td>Aksidan v. Henley, 2008 BCCA 43</td>
<td>Education</td>
<td>Trial, government succeeded</td>
<td>No</td>
<td>Did not discuss</td>
<td>Statutory duties to appoint truant officers indicative of proximity.</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Limited discussion of duty, focused on the fact that school had control, not government.</td>
<td>Plaintiffs were students at a public elementary school on reserve. Alleged that their teacher sexually assaulted them. Defendant admitted the teacher committed the assaults but denied the Crown owed a duty of care at the time of the assaults.</td>
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<tr>
<td>Alberta v. Elder Advocates of Alberta Society, 2011 SCC 24</td>
<td>Health (economic loss)</td>
<td>Motion to dismiss, government succeeded on negligence</td>
<td>No</td>
<td>Did not discuss</td>
<td>Statute shows no duty to audit, supervise or administer the funds relating to accommodation charges. Only permissive monitoring powers.</td>
<td>Merely supplying a service without anything more is insufficient.</td>
<td>Policy</td>
<td>Unlimited liability, chilling effect.</td>
<td>Allowed to proceed on unjust enrichment and Charter.</td>
<td>Alleged government artificially inflated the accommodation charge portion of nursing home fees to subsidize the cost of medical expenses (which are covered by Medicare).</td>
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<td>Amankwah v. Canada, 2005 FC 900</td>
<td>Immigration</td>
<td>Summary judgment, government succeeded</td>
<td>Did not discuss</td>
<td>Did not discuss. Plaintiff failed to plead duty (merely asserted misdiagnosis)</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>No breach of standard of care.</td>
<td>Plaintiff HIV carrier. Denied entry to Canada. Later tested negative and visa issued.</td>
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<tr>
<td>Apotex Inc v</td>
<td>Health</td>
<td>Motion to</td>
<td>Yes</td>
<td>No</td>
<td>Yes. The</td>
<td>Yes. Minister</td>
<td>Did not</td>
<td>Remedy in</td>
<td>Did not discuss</td>
<td>Minister allowed Apotex</td>
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<td>Case</td>
<td>Court/Location</td>
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<td><em>Astrazenca Canada Inc.</em> v Government of Canada, 2009 FC 120</td>
<td>Justice</td>
<td>Motion to dismiss, plaintiff succeeded</td>
<td>Did not discuss</td>
<td>Purpose of the Act is to protect rights of generics and innovators.</td>
<td>Had relationship with patent holder and had duty to be mindful of its legitimate interests.</td>
<td>Did not discuss</td>
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<td>Discuss, but implied operational.</td>
<td>Judicial review, but not sufficient to negate a duty. Potential for conflicting duties not evident on face of Act.</td>
<td>Did not discuss</td>
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<td>to proceed as a New Drug Submission. Patent holder commenced prohibition action, which was denied. Apotex sued patent holder who counterclaimed against Ministry.</td>
<td>Did not discuss</td>
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<td><em>Aubichon v Saskatchewan</em>, 2010 SKQB 49</td>
<td>Justice</td>
<td>Motion to dismiss, government succeeded</td>
<td>Did not discuss</td>
<td>Statutory immunity clause indicated no duty.</td>
<td>Importance of not interfering with prosecutorial discretion (independence of attorney general, etc.).</td>
<td>Did not discuss</td>
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<td>Adjusters bound by statute, could not have pursued plaintiff's claim. Conduct not causally related to plaintiff’s losses.</td>
<td>Did not discuss</td>
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<td>Plaintiff in car accident, alleged negligent prosecution of negligent driver. Government adjuster failed to act in plaintiff’s interest and to investigate plaintiff’s claim.</td>
<td>Did not discuss</td>
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<td><em>BM v British Columbia (Attorney General)</em>, 2004 BCCA 402</td>
<td>Police</td>
<td>Trial, plaintiff succeeded</td>
<td>Yes</td>
<td>Discussed some similar cases</td>
<td>Did not discuss but stated that it is just and fair to impose a duty and no policy reason to negate duty.</td>
<td>Did not discuss</td>
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<td>RCMP did not investigate domestic violence and subject of complaint shot and killed the plaintiff, her friend and her daughter, another plaintiff and a child escaped physical injury but were traumatized.</td>
<td>Did not discuss</td>
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<td><em>Bagnell v Vancouver Police Board</em>, 2008 BCCA 171</td>
<td>Police</td>
<td>Motion to dismiss, plaintiff succeeded</td>
<td>Yes</td>
<td>Discussed some similar cases</td>
<td>Yes. She was identified to police rather than being a general member of the public. Policy documents limit discretion in this area.</td>
<td>Did not discuss</td>
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<td>Did not discuss but stated that it is just and fair to impose a duty and no policy reason to negate duty.</td>
<td>Did not discuss</td>
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<td>The plaintiff died while in police custody due to the officers’ use of a taser. His family sued the police</td>
<td>Did not discuss</td>
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<td><em>Basque v Saint John (City)</em>, 2002</td>
<td>Municipal</td>
<td>Trial, plaintiff succeeded</td>
<td>Yes</td>
<td>Discussed similar cases</td>
<td>Statute indicated duties owed. Did not explicitly discuss, but Implied operational</td>
<td>Did not discuss</td>
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<td>police</td>
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<td>Breached duty, caused damages. The plaintiff slipped and fell while climbing stairs to a building owned by</td>
<td>Did not discuss</td>
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<td><em>Bellan v Curtis et al, 2007 MBQB 221</em></td>
<td>Tax and Finance</td>
<td>Motion to dismiss, plaintiff succeeded</td>
<td>Plaintiff succeeded</td>
<td>Did not discuss, but presumed. Unlike Cooper, specific statute governing this fund, province extensively involved (provided capital, sat on board, etc.). Did not discuss. Need full factual record to determine. Did not discuss. Did not discuss. Labor-sponsored venture capital corporation went into receivership. Class action by shareholders.</td>
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<td><em>Benaissa v Canada (Attorney General), 2005 FC 1220</em></td>
<td>Immigration</td>
<td>Motion to dismiss, government succeeded</td>
<td>Plaintiff succeeded</td>
<td>Did not discuss. No duty to render decision in specific time, nothing in the statute suggesting duty. Did not discuss. Did not discuss. Administrative remedies available. Indeterminate liability concerns. Failed to plead sufficient facts. Delays in finalizing immigration applications. Plaintiff alleged the delay was intentional.</td>
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<td><em>Berg v Saskatchewan, 2003 SKQB 456</em></td>
<td>Agriculture</td>
<td>Motion to dismiss, government succeeded</td>
<td>Plaintiff succeeded</td>
<td>Did not discuss. No private law duty of care arising from Act. Act had immunity clause. No relationship between the parties. Policy. Did not discuss. Did not discuss. Affirmed on appeal (with very limited discussion of negligence issue). Plaintiff’s ship detained for repairs.</td>
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<td><em>Berhad v Canada, 2004 FC 501</em></td>
<td>Maritime/Fisheries</td>
<td>Trial, plaintiff succeeded</td>
<td>Yes</td>
<td>Did not discuss. No, nothing in Act to suggest duty. Yes, direct causal link between the defendant’s conduct and the harm. Plaintiff had expectation that no detention. Operational. No policy reasons to negate duty. Also satisfied other negligence requirements. Plaintiff’s ship detained for repairs.</td>
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<td>Bingo City Games Inc et al v BC Lottery Corp et al, 2005 BCSC 25</td>
<td>Liquor/Gaming</td>
<td>Trial, government succeeded</td>
<td>No</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Various policy factors (keeping land values in check, the need to negotiate in private with other levels of government etc.)</td>
<td>Defendant also did not breach standard of care.</td>
<td>Plaintiff lost money in bingo hall venture. Alleged that government breached duty to warn that they were planning changes to gaming industry that would eliminate the plaintiff’s license.</td>
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<td>Border Enterprises Ltd v Beazer East Inc, 2002 BCCA 449</td>
<td>Environment</td>
<td>Motion to dismiss, government succeeded</td>
<td>No</td>
<td>Did not discuss</td>
<td>No. Could not have foreseen that legislation would later be passed.</td>
<td>Did not discuss</td>
<td>Concern with indeterminate liability.</td>
<td>Did not discuss</td>
<td>Crown ordered remediation on land and controlled, supervised and directed the investigation of the property and the execution of the clean-up. The government ordered ongoing remediation, which the plaintiff (who bought the land) was not aware of.</td>
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<td>Bowes v Edmonton (City), 2007 ABCA 347</td>
<td>Building inspections</td>
<td>Trial, plaintiff succeeded on duty</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Operational</td>
<td>Did not discuss</td>
<td>Would also have lost on limitation issue.</td>
<td>The plaintiffs purchased a property and the City granted building permits. The City was in possession of geotechnical investigations undertaken by the former owner. The home was destroyed when the earth collapsed beneath it</td>
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<td>Bracken v Vancouver (City) 2006 BCSC 136</td>
<td>Municipal property</td>
<td>Trial, government succeeded (implied that plaintiff succeeded on duty)</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Operational</td>
<td>Did not discuss</td>
<td>No breach of the standard of care. The City had inspected the sidewalk in accordance with its policy. There was no negligence</td>
<td>The plaintiff injured her knee when she tripped on sidewalk stones pushed up by tree roots. She sued the City</td>
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<td><em>British Columbia v Canadian Forest Products Ltd.</em> 2002 BCCA 217</td>
<td>Forestry Trial, plaintiff succeeded</td>
<td>Did not discuss (trial decision unreported) Did not discuss Did not discuss Did not discuss Did not discuss Liability apportioned 70% to defendant and 30% to plaintiff. The defendant’s failure to monitor the burning process was a serious omission. Burning undertaken by the Crown caused a fire. The fire damaged the plaintiff’s property.</td>
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<td><em>Brodie v Richmond Hill (Town)</em> 2008 CanLII 67889 (On Sup Ct)</td>
<td>Building inspections Motion to dismiss, government succeeded</td>
<td>No Did not discuss No Did not discuss Did not discuss, but implied operational. Did not discuss but said there were policy considerations that limited duty (government had not turned its mind to this issue). Implied that the defendant also did not breach the standard of care. Municipal building inspection regarding safety of fence around pool. Municipality approved. It later emerged that the fence was over the property line.</td>
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<td><em>Brooks v North Okanagan (Regional District)</em> 2005 BCPC 606</td>
<td>Utilities Trial, plaintiff succeeded</td>
<td>Yes Did not discuss (focused on standard of care) Did not discuss Did not discuss Policy decision to renovate landfill. Government negligent in implementation. Breached standard of care. Also liable in nuisance. The plaintiffs operated a chinchilla farm near landfill. Municipality built a new entry into the landfill without the consulting plaintiffs. The plaintiffs had notified the Municipality before and during construction that noise and fumes could kill the chinchillas.</td>
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<td><em>Bryson v Canada (Attorney General)</em> 2009 NBQB 204</td>
<td>Defense Class certification motion, plaintiff succeeded</td>
<td>Did not discuss but implied yes Yes Did not discuss Did not discuss Needed full evidentiary record. Did not discuss Court of Appeal denied motion for appeal. Department of Defense applied herbicides at military base. Plaintiffs said they were injured by herbicides.</td>
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<td><em>Burbank v RTB</em> 2007 BCCA 215</td>
<td>Police Trial, plaintiff succeeded</td>
<td>Yes Yes Did not discuss Did not discuss Operational Did not discuss Did not breach duty. Police officer suspected a driver was impaired and chased the car through a</td>
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The car collided with the plaintiffs. Regulations required that the seriousness of the offence and need for immediate apprehension outweigh the risks.

**Burgess v Canadian National Railway Company, 2006 CanLII 30215 (On CA)**
- **Transport**
- **Motion to dismiss, government succeeded**
- **Yes, Did not discuss**
- **Duty to the public. No duty to issue emergency directives.**
- **Policy**
- **Did not discuss.**
- **Supreme Court of Canada denied leave to appeal.**
- **Yes**
- **Pedestrian killed by train. Alleged that railway inspectors were negligent and left a dangerous situation in place.**

**Burns et al v British Columbia (Workers Compensation Board), 2003 BCSC 1826**
- **Labor**
- **Motion to dismiss, government succeeded**
- **Did not discuss**
- **Did not discuss**
- **Policy**
- **Did not discuss.**
- **Plaintiffs allege that employees of Workers Comp failed in their duties and workers suffered physical and emotional distress due to the mishandling of claims.**

**Burrell v Metropolitan Entertainment Group, 2010 NSSC 467**
- **Liquor/Gaming**
- **Motion to dismiss, government succeeded**
- **Did not discuss**
- **No, and not in other jurisdiction that have considered this issue.**
- **Policy**
- **Did not discuss.**
- **Plaintiff was addicted to gambling. Alleged that the defendant had a duty to ensure appropriate steps taken to prevent his gambling.**

**CHS v Alberta (Director of Child Welfare), 2010 ABCA 15**
- **Community services**
- **Motion to dismiss, plaintiff succeeded**
- **Yes**
- **Yes**
- **Duty to parents could conflict with duty to children, but duty to children would not.**
- **Allowed the children’s claim to proceed. Struck the mom’s claim in tort but allowed to proceed on Charter claim.**
- **No, and not in other jurisdiction that have considered this issue.**
- **Plaintiffs are parents and children that are the subject of temporary guardianship order. This required the defendant to file a service plan within 30 days or the order is void. The defendant failed to do so.**
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<tr>
<th>Case Details</th>
<th>Parties</th>
<th>Type</th>
<th>Court</th>
<th>Jurisdiction</th>
<th>Summary</th>
<th>Result</th>
<th>Key Findings</th>
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<tr>
<td><strong>C(L) v British Columbia, 2005 BCSC 1668</strong></td>
<td>Community services</td>
<td>Trial, plaintiff succeeded on duty</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Did not explicitly discuss, but some hint of expectations.</td>
<td>Operational</td>
<td>Did not discuss</td>
<td>Did not breach duty</td>
<td>When the plaintiff took her injured baby to the hospital, doctors believed the injuries were not accidental. The Crown removed the children from her home. The plaintiff claimed the social workers did not conduct a proper investigation.</td>
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<td><strong>Cameron v GNWT et al, 2005 NWTSC 2</strong></td>
<td>Transport</td>
<td>Motion for summary judgment, plaintiff succeeded</td>
<td>Yes</td>
<td>Did not discuss</td>
<td>Yes</td>
<td>Did not explicitly discuss but implied reliance and representations.</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>No</td>
<td>Plaintiff injured on a road. The road was a section of gravel road on airport land (owned by NWT government) with an unusual curve between two stretches of municipal road. No sign warning of curve.</td>
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<td><strong>Canus v Canada Customs, 2005 NSSC 283</strong></td>
<td>Tax and Finance</td>
<td>Trial, government succeeded</td>
<td>Yes</td>
<td>No</td>
<td>Duty to taxpayers and public in conflict.</td>
<td>Did not discuss</td>
<td>Did not discuss but clear operational</td>
<td>Duty would affect ability to raise revenue. Other remedies.</td>
<td>No breach of standard of care. Not all losses claimed caused by CCRA.</td>
<td>Plaintiff assessed by auditor and reassessed for substantial additional taxes. The reassessment subsequently vacated.</td>
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<td><strong>Ceapro Inc v Saskatchewan, 2008 SKQB 76</strong></td>
<td>Tax and Finance</td>
<td>Summary judgment, government succeeded on negligence</td>
<td>No</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Government responsible for reviewing and evaluating finances but not overseeing individual business relationships.</td>
<td>Did not discuss</td>
<td>Unlimited liability to unlimited class of persons.</td>
<td>Allowed to proceed against Crown corporation and crown investment fund defendants on breach of contract.</td>
<td>Plaintiff entered joint venture funded by government. Plaintiff defaulted on obligation to pay government and government assumed control of plaintiff. Company went into receivership and plaintiff lost investment.</td>
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<td><strong>Chadwick v Canada (Attorney General), 2010 BCSC 1744</strong></td>
<td>Transport</td>
<td>Motion to amend pleadings, plaintiff succeeded</td>
<td>Yes</td>
<td>Discussed similar cases</td>
<td>No statutory immunity negating proximity.</td>
<td>Negligence alleged is with respect to something government had direct</td>
<td>Operational</td>
<td>No concern with indeterminate liability. Mere existence</td>
<td>Did not discuss.</td>
<td>Plaintiffs in helicopter crash. Repairs to helicopter were done by mechanic that should not have been approved. Mechanic installed faulty.</td>
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<td>Case Title</td>
<td>Issue</td>
<td>Plaintiff Succeeded</td>
<td>Crown Succeeded</td>
<td>Did not discuss</td>
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<td><em>Cheltenham Estates Ltd v Ontario</em> 2004 Carswell Ont 2619 (Sup Ct)</td>
<td>Control over. of wide mandate not enough to show conflict with duty to plaintiff.</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No, did not explicitly discuss but implied legitimate expectation.</td>
<td>Operational</td>
<td>No</td>
<td>No</td>
<td>Plaintiff purchased car that was stolen. Crown motor vehicle report indicated previously registered in Quebec, based on fraudulent forms. Crown had general knowledge of fraudulent forms from Quebec and did not take action.</td>
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<td><em>Cherubini Metal Works Ltd v Nova Scotia (Attorney General)</em>, 2011 NSCA 43</td>
<td>Operational Liability apportioned 60% to driver and 40% to government.</td>
<td>No</td>
<td>No</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Also failed on standard of care and causation.</td>
<td>Plaintiff owed company established to create a steel fabrication plant. Alleged that government made labor decisions and worked in concert with its union to make plaintiff go out of business.</td>
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<td><em>City Sand &amp; Gravel Ltd v Newfoundland</em> 2007 NLCA 51</td>
<td>Policy</td>
<td>No</td>
<td>No</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Also lost on limitation issue.</td>
<td>Concerns over rocks blasted from quarry into residential areas led the municipality to impose restrictions on quarry operations. The quarry owner brought an action for damages incurred.</td>
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<td><em>Cole v McLoughlin</em> 2003 NLCA 3</td>
<td>Operational Liability apportioned 60% to driver and 40% to government.</td>
<td>Yes</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Tractor trailer collided with an oncoming car, which slid into the wrong lane after a snow storm. The plaintiff sued government for highway maintenance.</td>
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<td><em>Collins v Bylaw</em></td>
<td>Did not discuss. Focus on standard of care.</td>
<td>No</td>
<td>Nothing in</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Plaintiff sought damages</td>
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<td>Case</td>
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<td>Corman Park (Rural Municipality), 2004 SKQB 74</td>
<td>enforcement government succeeded discuss Act to suggest a duty discuss discuss discuss</td>
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<td>due to odors emanating from two livestock operations situated near where he resides. He alleged city wrongfully permitted the continuation of these operations in contravention of the municipality’s development plan.</td>
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<td>Condominium Corporation No, 9813678 v Statesman Corporation, 2009 ABQB 493</td>
<td>Building inspection Trial, plaintiff succeeded on duty Did not discuss, but implied yes Yes Statute didn’t exempt duty. Did not discuss Did not discuss No policy considerations to negate.</td>
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<td>Fire in neighboring construction site damaged plaintiff’s building. Alleged city negligently approved deficient design.</td>
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<td>Costello v Hornby Island Local Trust Committee, 2009 BCSC 1334</td>
<td>Bylaw enforcement Trial, government succeeded Yes No No, nothing in Act to indicate duty. No Did not discuss Did not discuss Conflict between duties to individuals and public as a whole.</td>
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<td>Plaintiff purchased building and barged it to her property. Applied for permit. Once building arrived, clear it violated height restrictions. Defendant advised plaintiff on how to bring it into compliance, which eventually occurred.</td>
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<td>Cowichan Tribes v Canada (Attorney General), 2007 BCSC 1115</td>
<td>Justice Motion to dismiss third party notice, government succeeded on negligence Did not discuss Did not discuss Did not discuss Government owed fiduciary duty to the plaintiff, unlike a regular commercial transaction. Defendant had its own solicitor. Reliance on government not reasonable. Did not discuss Did not discuss Conflicting duties. Potential to breach solicitor client privilege. Government did not contest other claim (breach of covenant). Negligent acts improperly pled.</td>
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<td>Lease transaction involving reserve land. Defendant alleged government’s solicitor gave negligent legal opinions respecting lease validity.</td>
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<td>Plaintiff's Advocacy</td>
<td>Defendant's Advocacy</td>
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<td>Cragg v Tone et al, 2007 BCCA 441</td>
<td>Police</td>
<td>Yes</td>
<td>Discuss some similar cases.</td>
<td>Statutory duty to investigate and attempt to prevent crime. Ordinary citizens required to leave law enforcement to police.</td>
<td>Did not discuss, not indeterminable liability. No issues of resource allocation or staffing limitations. Other defendant liable as well. Trial court found breach of standard of care but appeal overturned that finding. Did not overturn finding of duty. Plaintiff attacked by girlfriend's ex-husband. Had called the police about vehicle damage and dispatcher did not prioritize the call in light of earlier threats, etc.</td>
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<td>Cragton v North Vancouver (District), 2006 BCPC 212</td>
<td>Utilities</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Did not discuss, Policy Did not discuss The decision to deal with roots by rodding was a policy decision. The defendant was not negligent in implementing this policy decision. District repaired a storm sewer by clearing a tree root blockage with a rod. The plaintiffs' house later flooded because of another blockage. The plaintiffs allege that the District should have replaced the sewer instead of repairing it because the roots would continue to cause problems.</td>
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<td>Crystal Blue Farms v Newfoundland, 2009 NLTD 17</td>
<td>Marine / Fisheries</td>
<td>Motion to dismiss, plaintiff succeeded</td>
<td>Yes</td>
<td>Did not discuss</td>
<td>Yes</td>
<td>Considered reliance and legitimate expectations. Declined to decide on a motion to strike. Declined to consider policy on a motion to strike. Did not discuss Government led them to destroy their fishery when shorefastened moorings outlawed. Plaintiff had a license, complied with various licensing requirements, and worked closely with government for a long time.</td>
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<td>Cummings v DeSouza, 2005 CanLII 469 (On Sup Ct)</td>
<td>Municipal property</td>
<td>Motion to amend pleadings, plaintiff succeeded</td>
<td>Yes</td>
<td>No, but similar to Just</td>
<td>Yes</td>
<td>Did not explicitly discuss, but quoted passages from other cases relating to reliance. Did not discuss, but implied operational Indeterminate liability was not a concern. Did not discuss Plaintiff lost control of car, swerved off the road and hit a large mailbox which was not properly attached to the curb.</td>
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<tr>
<td>Cummings v MacKay, 2003 NSSC</td>
<td>Justice</td>
<td>Motion to dismiss, plaintiff</td>
<td>Did not explicitly find yes,</td>
<td>Yes</td>
<td>Did not discuss, Did not explicitly discuss, but Rejected unlimited liability Did not discuss Plaintiffs sued for trespass. Defendants added government as third party.</td>
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<tr>
<td>196</td>
<td>succeeded</td>
<td>but cited some similar cases.</td>
<td>implied operational concerns.</td>
<td>party. Alleged government assessor negligent in carrying out duties and that defendants owed the land.</td>
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<tr>
<td>DH (Guardian ad litem of) v British Columbia, 2008 BCCA 222</td>
<td>Justice</td>
<td>Trial, plaintiff succeeded</td>
<td>Did not discuss</td>
<td>Also breached standard of care.</td>
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<tr>
<td>Dennis v OLG, 2010 ONSC 1332</td>
<td>Liquor/Gaming</td>
<td>Class certification motion, plaintiff succeeded on cause of action</td>
<td>Did not discuss</td>
<td>No concern with indeterminate liability.</td>
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<tr>
<td>Design Services Ltd v Canada, 2008 SCC 22</td>
<td>Government contracts</td>
<td>Trial, government succeeded</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
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<tr>
<td>Desjardins (Litigation Guardian of) Muni- cipal proper-</td>
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</table>

Did not discuss | Did not discuss | Decision not to clear sidewalk was reasonable. | A car hit the plaintiff and her son. The streets had not been cleared due to a party. Alleged government assessor negligent in carrying out duties and that defendants owed the land.
<table>
<thead>
<tr>
<th>Case</th>
<th>Description</th>
<th>Parties</th>
<th>Court</th>
<th>Result</th>
<th>Did not discuss</th>
<th>Did not discuss</th>
<th>Did not discuss</th>
<th>Did not discuss</th>
<th>Did not discuss</th>
<th>Did not discuss</th>
<th>Municipal employee strike. They sued City for failing to maintain streets and sidewalks.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dical Investments Ltd v Aurora (Town of), 2003 CanLII 440116 (On CA)</td>
<td>Land development</td>
<td>Trial, government succeeded</td>
<td>No</td>
<td>Did not discuss</td>
<td>No reliance</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Implied also would not have breached standard of care.</td>
<td>Defendants gave false information to would-be purchasers of plaintiff’s lots respecting development charges, causing the purchasers to change their minds.</td>
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<tr>
<td>Dice v Ontario, 2004 Carswell Ont 5147 (Sup C)</td>
<td>Transport</td>
<td>Trial, plaintiff succeeded on duty</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Did not discuss</td>
<td>Operational</td>
<td>Did not discuss</td>
<td>Crown was not negligent. The standard of care did not require the Minister to conduct investigation or to require the driver to supply medical test results before suspending a license.</td>
<td>Plaintiff’s drivers’ license reassessed when his doctor advised the Crown that the plaintiff suffered a seizure. Second doctor advised that medical tests were normal but driver advised not to drive until further investigations conducted. License suspended. Doctor later found driver was free of seizures and license was reinstated. Driver sued the Crown for suspending his license without proper investigation.</td>
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</tr>
<tr>
<td>Elkow v Sana, 2006 ABQB 851</td>
<td>Education</td>
<td>Motion to dismiss counter-claim, government succeeded</td>
<td>Yes</td>
<td>No. Other cases found no duty of care to parents in similar situation.</td>
<td>No unlimited right to be on school property. Legislation authorized the ban.</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Would undermine the ability of school officials to manage schools. Balance between public and private interests.</td>
<td>Pleadings deficient in terms of facts pled. Also would not have found breach of the standard of care or damage.</td>
<td>Plaintiff was school principal. Alleged defendant made defamatory statements after she banned defendant parent from school property. Defendant cross claimed against plaintiff and school board alleging defamation and that the ban was unjustified.</td>
<td></td>
</tr>
<tr>
<td>Elliott v Insurance Crime Prevention</td>
<td>Utilities</td>
<td>Trial, government succeeded</td>
<td>Yes</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Conflicting duties. Remedy against</td>
<td>Collected from insurer. Claims for inconvenience and mental</td>
<td>Plaintiff’s home destroyed by fire. Insurer denied claim based on investigations and reports.</td>
<td></td>
</tr>
<tr>
<td>Bureau, 2005 NSCA 115</td>
<td>Motion to dismiss, government succeeded</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Distress denied. by the defendants (private fire investigator and fire marshal).</td>
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<tr>
<td>Ellwood v Yukon (Government of), 2009 YKSC 41</td>
<td>Government contracts</td>
<td>Yes</td>
<td>No</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Other remedy (complaint process in the Act), public purse is not an insurance scheme for contractors. Suggested government may also not have breached standard of care.</td>
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<tr>
<td>Farzam v Canada (Minister of Citizenship and Immigration), 2005 FC 165</td>
<td>Immigration</td>
<td>Yes</td>
<td>No</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Other remedies (judicial review).</td>
<td>Indeterminate liability. Also would have failed on causation. Suggested he may have failed on standard of care. Delays in processing immigrant’s wife’s application. She remarried in Iran and did not come to Canada. Plaintiff alleged this caused his depression.</td>
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<tr>
<td>Fen v Ontario (Health and Long-Term Care), 2005 CanLII 56208 (On CA)</td>
<td>Health (economic loss)</td>
<td>Motion to dismiss, government succeeded</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>No duty to appoint a board.</td>
<td>Did not discuss</td>
<td>Policy</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Plaintiff wished to be registered as an osteopath but government hadn’t yet appointed a Board of Directors for osteopathy.</td>
<td></td>
</tr>
<tr>
<td>Flynn v Halifax (Regional Municipality) 2005 NSCA 81</td>
<td>Building inspection</td>
<td>Yes</td>
<td>Limited discussion of similar cases</td>
<td>Yes</td>
<td>Did not discuss</td>
<td>Operational</td>
<td>Did not discuss</td>
<td>Contractor and municipality liable for negligence. The inspector should have identified the defects. Inspector carried out 4 inspections prior to the final occupancy inspection of plaintiff’s house. The occupancy permit noted extreme cracking in the slab and the slab deteriorated. Sued the Municipality for negligent failure to detect defects before or during construction.</td>
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<tr>
<td>Foley v Shamess,</td>
<td>Bylaw enforce</td>
<td>Trial, plaintiff</td>
<td>Yes</td>
<td>Limited discussion</td>
<td>Yes</td>
<td>Did not discuss</td>
<td>Operational</td>
<td>Did not discuss</td>
<td>Other defendants liable to plaintiff. Plaintiff owned a unit attached to other units that</td>
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<tr>
<td>Case Name</td>
<td>Date</td>
<td>Court</td>
<td>Motion/Decision</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Plaintiff should have exhausted remedies under the Act.</td>
<td>Proceeded on breach of contract and unjust enrichment.</td>
<td>Province reappraised stumpage rate unreasonably high.</td>
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<tr>
<td>Forest Glen Wood Products Ltd v British Columbia (Minister of Forests), 2007 BCSC 273</td>
<td>2007</td>
<td>BCSC</td>
<td>Motion to dismiss, government succeeded on negligence</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>breaching standard of care.</td>
<td>Breaching standard of care, but no causation. Having made the policy decision to have signs, the government breached their duty in not maintaining them. However, the lack of signs did not cause or contribute to the collision.</td>
<td>Plaintiff in collision. Defendant brought third party action against the Crown due to digital traffic warning signs not working. He claimed the Crown had a duty to maintain them.</td>
<td></td>
</tr>
<tr>
<td>Foster v Dhaliwal, 2006 BCSC 1331</td>
<td>2006</td>
<td>BCSC</td>
<td>Trial, plaintiff succeeded on duty</td>
<td>Yes</td>
<td>Did not discuss</td>
<td>Yes</td>
<td>Did not discuss</td>
<td>Operational. Decision to install policy, but negligence in maintaining them operational.</td>
<td></td>
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</tr>
<tr>
<td>Fox v Vancouver (City) 2003 BCSC 1492</td>
<td>2003</td>
<td>BCSC</td>
<td>Trial, government succeeded</td>
<td>Yes</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>City had a detailed system of street inspection, which was a policy decision. The City followed the requirements</td>
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</table>

The plaintiff broke her foot after slipping on the worn down edge of a sidewalk.
<table>
<thead>
<tr>
<th>Case</th>
<th>Field</th>
<th>Type</th>
<th>Result</th>
<th>Discussion Other Similar Cases</th>
<th>Relevant Facts</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frost v Whistler (Resort Municipality), 2003 BCSC 22</td>
<td>Transport</td>
<td>Trial,</td>
<td>Yes</td>
<td>Did not discuss</td>
<td>The policy was implemented non-negligently (the road was inspected 3 weeks before the accident). Did not discuss</td>
<td>Did not breach standard of care.</td>
</tr>
<tr>
<td>Fallowka v Pinkerton’s of Canada Ltd, 2010 SCC 5</td>
<td>Natural</td>
<td>Trial,</td>
<td>Yes</td>
<td>Did not discuss</td>
<td>Governemental miners had a statutory duty to inspect mine and order cessation of work if unsafe. Did not discuss</td>
<td>Did not breach standard of care.</td>
</tr>
<tr>
<td>Grace v Fort Erie (Town), 2003 Carswell Ont 3355 (Sup Ct)</td>
<td>Utilities</td>
<td>Summary</td>
<td>Yes</td>
<td>Did not discuss</td>
<td>No indeterminate liability. Concern for over or under regulation and conflicting duties not compelling. Did not discuss</td>
<td>Did not breach standard of care.</td>
</tr>
<tr>
<td>Granite Power Corp v Ontario, 2004 CarswellOnt 3204 (CA)</td>
<td>Utilities</td>
<td>Motion to</td>
<td>Yes</td>
<td>No</td>
<td>Class certification motion also denied but not for lack of a cause of action. Did not discuss</td>
<td>Did not discuss</td>
</tr>
<tr>
<td>Case</td>
<td>Field</td>
<td>Type</td>
<td>Description</td>
<td>Result</td>
<td>Developed</td>
<td>Discussed</td>
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<tr>
<td>Grant v Canada (Attorney General), 2009 CanLII 68179 (On Sup Ct)</td>
<td>Land development</td>
<td>Class certification motion</td>
<td>plaintiff succeeded</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Gobin (Guardian ad litem of) v British Columbia, 2002 BCCA 373</td>
<td>Transport</td>
<td>Trial, government succeeded but implied duty owed</td>
<td>Yes</td>
<td>Discussed some similar cases</td>
<td>Did not discuss</td>
<td>Conflict in duty to plaintiffs and public.</td>
</tr>
<tr>
<td>Haj Khalil v Canada, 2009 FCA 66</td>
<td>Immigration</td>
<td>Trial, government succeeded</td>
<td>Did not discuss</td>
<td>No</td>
<td>Conflict in duty to plaintiffs and public.</td>
<td>Did not discuss</td>
</tr>
<tr>
<td>Hartmann v Amourgis, 2009 ONCA 33</td>
<td>Justice</td>
<td>Motion to dismiss, government succeeded</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
</tr>
<tr>
<td>Heinicke v Cooper Rankin Ltd, 2006 MBQB 273</td>
<td>Building inspections</td>
<td>Trial, plaintiff succeeded</td>
<td>Yes</td>
<td>Discussed some similar cases</td>
<td>Yes</td>
<td>Did not discuss, but some hint of reliance.</td>
</tr>
<tr>
<td>Case</td>
<td>Nature</td>
<td>Motion to Dismiss</td>
<td>Success</td>
<td>Discussed Similar Cases</td>
<td>Sufficient to Proceed to Trial</td>
<td>Eluded to Reliance</td>
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<tr>
<td>Henkelman v Guy, 2008 ABQB 66</td>
<td>Transport</td>
<td>Motion to Dismiss</td>
<td>Yes</td>
<td>Discussed similar cases</td>
<td>Sufficient to proceed to trial</td>
<td>Eluded to reliance</td>
</tr>
<tr>
<td>Hewson v Whistler (Resort Municipality) 2006 BCPC 359</td>
<td>Municipal Property</td>
<td>Trial, plaintiff succeeded</td>
<td>Yes</td>
<td>Yes</td>
<td>Did not discuss</td>
<td>Operational</td>
</tr>
<tr>
<td>Heyes v City of Vancouver, 2011 BCCA 77</td>
<td>Transport</td>
<td>Trial, plaintiff succeeded on duty</td>
<td>Yes</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Yes, based largely on physical proximity and the fact that the plaintiffs known to the defendant.</td>
</tr>
<tr>
<td>Hill v Hamilton-Wentworth Regional Police Services Board, 2007 SCC 41</td>
<td>Police</td>
<td>Trial, plaintiff succeeded on duty</td>
<td>Did not discuss, but implied yes</td>
<td>Discussed similar cases</td>
<td>Did not discuss</td>
<td>Expectations of party being investigated, serious interest at stake, personal relationship, reliance.</td>
</tr>
<tr>
<td>Hiscock v Newfoundland 2002 Carswell Nfld 275</td>
<td>Transport</td>
<td>Trial, plaintiff succeeded</td>
<td>Yes</td>
<td>Yes</td>
<td>Did not discuss</td>
<td>Operational</td>
</tr>
<tr>
<td>Case</td>
<td>Court</td>
<td>Case Details</td>
<td>Result</td>
<td>Discussion</td>
<td>Implications</td>
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<tr>
<td>Holland v Saskatchewan, 2008 SCC 42</td>
<td>Agriculture</td>
<td>Motion to dismiss, plaintiff succeeded</td>
<td>Yes</td>
<td>Did not explicitly discuss the statutory scheme; the facts suggested expectation.</td>
<td>Farmers refused to enter federal program to prevent cervid disease (objected to indemnification). Their herds downgraded, reducing their price. Judicial review invalidated these clauses. Government did not reinstate certification or compensate lost revenue. This was class action.</td>
<td></td>
</tr>
<tr>
<td>Holtslag v Alberta, 2004 ABQB 268</td>
<td>Building inspection</td>
<td>Summary judgment, government succeeded</td>
<td>Yes</td>
<td>Did not explicitly discuss, but implicitly found no reliance.</td>
<td>Plaintiffs’ homes roofed in untreated pine. Extensive decay. Materials had been approved by government.</td>
<td></td>
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<tr>
<td>Homburg Canada Inc v Halifax (Regional Municipality), 2003 NSCA 61</td>
<td>Bylaw enforcement</td>
<td>Motion to dismiss, government succeeded on negligence</td>
<td>Yes</td>
<td>Did not conclude, but said it might have been policy.</td>
<td>Did not discuss. Claim proceeded on issue of contract law.</td>
<td></td>
</tr>
<tr>
<td>Housen v Nikolaisen, 2002 SCC 33</td>
<td>Transport</td>
<td>Trial, plaintiff succeeded</td>
<td>Yes</td>
<td>Did not discuss, but hinted at reliance.</td>
<td>Municipality breached duty keep the road in reasonable state of affair.</td>
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</tr>
<tr>
<td>Hussain v Edmonton (City), 2004 ABQB 204</td>
<td>Municipal property</td>
<td>Trial, plaintiff succeeded</td>
<td>Yes</td>
<td>Did not explicitly discuss, but hinted at reliance.</td>
<td>City had an obligation to ensure equipment was adequate for its purpose, and to ensure the safety. The plaintiff was a customer at a weight room owned and operated by the City. A Cable on the weight room equipment snapped and hit him in the</td>
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<tr>
<td>Case</td>
<td>Jurisdiction</td>
<td>Department</td>
<td>Motion to</td>
<td>Government</td>
<td>Plaintiff</td>
<td>Plaintiff</td>
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<tr>
<td>JLP v CRP, 2008 CanLII 1835 (On Sup C)</td>
<td>Education</td>
<td>Motion to add government defendant, plaintiff succeeded</td>
<td>Did not discuss but implied yes</td>
<td>No</td>
<td>Did not discuss</td>
<td>Evidence could establish that the defendant had obligation to be mindful of plaintiff’s interests</td>
</tr>
<tr>
<td>James v British Columbia, 2005 BCCA 136</td>
<td>Forestry</td>
<td>Class certification motion, plaintiffs succeeded</td>
<td>Yes</td>
<td>No</td>
<td>Yes, comprehensive statutory scheme included specific obligations in granting licenses.</td>
<td>Yes, considered reliance</td>
</tr>
<tr>
<td>Jedlynak v Wheatland (County), 2006 ABQB 500</td>
<td>Utilities</td>
<td>Motion to dismiss, plaintiff succeeded</td>
<td>Yes</td>
<td>Discussed some similar cases</td>
<td>Yes</td>
<td>Did not discuss</td>
</tr>
<tr>
<td>Jones v Donaghey, 2010 BCSC 1498</td>
<td>Community Service</td>
<td>Motion to dismiss, government succeeded</td>
<td>Preferred to decide on proximity</td>
<td>Did not discuss</td>
<td>Duty to the public at large not specific plaintiff</td>
<td>Did not discuss</td>
</tr>
<tr>
<td>Jones v Masonry Ltd v Defense</td>
<td>Government</td>
<td>Motion to dismiss, government</td>
<td>Did not discuss</td>
<td>Discussed similar cases</td>
<td>Would be a radical expansion of No relationship between the</td>
<td>Did not discuss</td>
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<tr>
<td>Josephson v Merritt (City), 2003 BCSC 1505</td>
<td>Municipal property</td>
<td>Summary judgment motion, government succeeded</td>
<td>Yes</td>
<td>Did not discuss</td>
<td>Yes</td>
<td>Policy</td>
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<tr>
<td>K v K(E), 2004 ABQB 159</td>
<td>Community Service</td>
<td>Motion to dismiss, plaintiff succeeded</td>
<td>Yes</td>
<td>Some discussion of similar cases.</td>
<td>Yes</td>
<td>Operational</td>
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<tr>
<td>KF Evans Ltd v Canada (Attorney General), 2002 BCSC 1709</td>
<td>Forestry</td>
<td>Trial, government succeeded</td>
<td>Yes</td>
<td>Discussed some similar cases</td>
<td>No, statute gave discretionary powers.</td>
<td>Did not discuss</td>
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<tr>
<td>Kimpton v Canada (AG) and British Columbia, 2004 BCCA 72</td>
<td>Building inspection</td>
<td>Class certification motion, government succeeded</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>No</td>
<td>Did not discuss</td>
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<tr>
<td>R v Imperial Tobacco Canada Limited, 2009 BCCA 541</td>
<td>Health (economic loss)</td>
<td>Motion to strike, government succeeded</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>General duties to the public. No interactions, so relationship must arise</td>
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<tr>
<td>Case</td>
<td>Court/Property</td>
<td>Motion to Dismiss</td>
<td>Government Succeeded</td>
<td>Discussion of Similar Cases</td>
<td>Policy and No Negligence in Its Implementation?</td>
<td>Implied No Breach of Standard of Care?</td>
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<tr>
<td><em>Knodel v New Westminster (City)</em>, 2005 BCSC 1316</td>
<td>Municipal Property</td>
<td>Motion to dismiss, government succeeded</td>
<td>Yes</td>
<td>Discussed some similar cases</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td><em>LC v Alberta</em>, 2010 ABCA 14</td>
<td>Community Service</td>
<td>Motion to dismiss, government succeeded</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
</tr>
<tr>
<td><em>LC &amp; LS v HMTQ et al</em>, 2005 BCSC 1668</td>
<td>Community Service</td>
<td>Trial, plaintiff succeeded on duty</td>
<td>Yes</td>
<td>Discussed similar cases, but did not conclude on that basis.</td>
<td>Duty to parents as they were under supervision of government.</td>
<td>No determinate liability. Would not give the government conflicting duties between children and parents.</td>
</tr>
<tr>
<td><em>LeDrew v Corner Brook (City)</em>, 2004 Carswell Nfld 100 (Sup Ct)</td>
<td>Municipal Property</td>
<td>Trial, plaintiff succeeded on duty</td>
<td>Yes</td>
<td>Did not explicitly decide, but discussed some similar cases</td>
<td>Yes</td>
<td>Did not discuss</td>
</tr>
<tr>
<td><em>MacQueen v Ispat Sidbec Inc</em>, 2007 NSCA 33</td>
<td>Natural Resources</td>
<td>Motion to dismiss, plaintiff succeeded</td>
<td>Yes</td>
<td>Did not discuss</td>
<td>Some portions struck relating to “regulatory negligence”.</td>
<td>Unclear if policy or operational at the motion to dismiss stage.</td>
</tr>
<tr>
<td>Case Title</td>
<td>Type</td>
<td>Issue</td>
<td>Result</td>
<td>Allocation</td>
<td>Lead Allocation</td>
<td>Decision</td>
</tr>
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<tr>
<td>Manufacturers Life Ins Co v Pitblado &amp; Hoskin et al, 2009 MBCA 83</td>
<td>Land development</td>
<td>Trial, plaintiff succeeded</td>
<td>Yes</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>City made representation on which the plaintiff relied. Direct connection between negligence and loss.</td>
</tr>
<tr>
<td>Marlor Farm Inc v The Ontario Flue-Cured Tobacco, 2010 ONSC 1573</td>
<td>Agriculture</td>
<td>Motion to dismiss, plaintiff succeeded</td>
<td>Yes</td>
<td>No</td>
<td>Struck claims arising from statute</td>
<td>Allowed claims based on reliance and representations. Needed more facts to assess.</td>
</tr>
<tr>
<td>McIlvenna (litigation guardian of) v Insurance Corporation of British Columbia, 2008 BCCA 289</td>
<td>Transport</td>
<td>Motion to dismiss, plaintiff succeeded</td>
<td>Yes</td>
<td>Sufficiently analogous to another case to proceed</td>
<td>Did not discuss</td>
<td>Some indication of reliance.</td>
</tr>
<tr>
<td>McMillan v Canada Mortgage and Housing Corporation, 2008 BCCA 543</td>
<td>Building inspection</td>
<td>Class certification motion, government succeeded</td>
<td>Did not discuss</td>
<td>No</td>
<td>No. CMHC has no regulator authority over residential premises.</td>
<td>Did not discuss</td>
</tr>
<tr>
<td>McMurray v Marshall et al, 2005 BCSC 961</td>
<td>Transport</td>
<td>Motion to dismiss, plaintiff succeeded</td>
<td>Yes</td>
<td>Yes, damages arising from personal injury</td>
<td>Duties to establish procedures to general public. Did not discuss in context of failure to act on specific</td>
<td>Did not discuss</td>
</tr>
<tr>
<td>Case</td>
<td>Defendant</td>
<td>Plaintiff</td>
<td>Decision</td>
<td>Example</td>
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<tr>
<td>Mooney v British Columbia (Attorney General) 2004 BCCA 402</td>
<td>Police</td>
<td>Trial, plaintiff succeeded</td>
<td>Yes</td>
<td>Did not explicitly fall into previous categories but discussed similar cases. Did not explicitly discuss, but hinted at reliance. Operational</td>
<td>Did not discuss Breached duty, but no causation. The husband’s behavior was unpredictable and erratic and he embarked on violence despite legal restraints. Plaintiff’s husband had a history of violence. She reported incident to the RCMP who concluded there was insufficient grounds to recommend a Criminal Code complaint. He later came to her house and shot her friend and child. She alleged inadequate investigation by the RCMP.</td>
<td></td>
</tr>
<tr>
<td>Mr D v Phillips, 2004 ABQB 380</td>
<td>Community services</td>
<td>Motion to dismiss, plaintiff succeeded</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Suggested statute would probably not ground proximity. Proximity established by state usurping role of parent. Did not discuss, but implied that this may present an issue at trial.</td>
<td>Did not discuss</td>
</tr>
<tr>
<td>N(D) v Oak Bay (District) 2005 BCSC 1412</td>
<td>Justice</td>
<td>Trial, plaintiff succeeded</td>
<td>Yes</td>
<td>Discussed similar cases Limited discussion of legislation.</td>
<td>Yes, focused on relationship between foreseeability and proximity. Operational</td>
<td>Did not discuss</td>
</tr>
<tr>
<td>Nelson v Saskatchewan, 2003 SKQB 265</td>
<td>Agriculture</td>
<td>Trial, plaintiff succeeded</td>
<td>Yes</td>
<td>Did not discuss</td>
<td>Did not explicitly discuss but some indicia of reliance. Operational</td>
<td>Did not discuss</td>
</tr>
</tbody>
</table>
**Neuman v Parkland (County), 2004 ABPC 58**

Utilities Trial, plaintiff succeeded Yes Discussed some similar cases Limited discussion of legislation Did not explicitly discuss, but did note that plaintiff known to defendant. Operational Did not discuss The defendant failed to exercise a reasonable standard of care in capping the culverts completely and without further expert consultation, ignoring the design recommended by its expert, and failing to provide an alternative mechanism to ensure the flow of the creek.  

**Northern Goose Processors Ltd v Canadian Food Inspection Agency 2006 MBQB 198**

Agriculture Trial, plaintiff succeeded Yes Did not discuss Limited discussion Discussed reliance at length. Operational Did not discuss Defendant was negligent in carrying out its obligations to the plaintiff. The defendant gave plaintiff incorrect, misleading or inaccurate information knowing the plaintiff would rely on the information to its detriment.  

**Octa Evergreens Ltd v New Brunswick (Province of), 2002**

Transport Trial, government succeeded No Stated that they were deciding on foreseeability Did not discuss Stated that they were deciding on foreseeability alone but commented Did not discuss Did not discuss Did not discuss Plaintiff opened nursery. Ministries of Agriculture/Environment gave permission to use river/knew they used river.
<table>
<thead>
<tr>
<th>Case</th>
<th>Party 1</th>
<th>Party 2</th>
<th>Party 3</th>
<th>Party 4</th>
<th>Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Odhavji Estate v Woodhouse, 2003 SCC 69</td>
<td>Police</td>
<td>Motion to dismiss, plaintiff succeeded (against some government defendants)</td>
<td>Chief: yes. Board/Government: questionable but decided on proximity</td>
<td>Did not discuss</td>
<td>Chief: did not accept argument that it would compromise the independence of investigations.</td>
</tr>
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<td>Allowed to proceed against Police Chief and officers, struck against Board and Province</td>
</tr>
<tr>
<td>Ogden v Gulf Log Salvage Co-Operative Association, 2004 BCSC 53; 2005 BCSC 56</td>
<td>Forestry</td>
<td>Motion to add Crown defendant, plaintiff succeeded; Motion for class certification, plaintiff succeeded</td>
<td>Yes</td>
<td>No</td>
<td>No, did not explicitly discuss but did mention reliance.</td>
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<td>Operational</td>
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<td></td>
<td>Did not discuss</td>
</tr>
<tr>
<td>Ouellette v Hearst (Town), 2004 Carswell Ont 1064 (On CA)</td>
<td>Municipal property</td>
<td>Trial, plaintiff succeeded</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<td>Did not discuss</td>
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<td>Did not discuss</td>
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<td>Did not discuss</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td>Breached duty.</td>
</tr>
<tr>
<td>PG Restaurant Ltd v Northern Interior</td>
<td>Health (economic loss)</td>
<td>Trial, government succeeded</td>
<td>Implied yes</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
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<td>Did not discuss</td>
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<td></td>
<td>Did not discuss</td>
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<td></td>
<td>Preferred to resolve these questions under the Plaintiff succeeded against newspaper defendant. Claim would have failed</td>
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<td>Customer vomited at buffet and questionable clean-up ensued. Newspaper published defamatory comments</td>
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<td>Transportation flushed causeway, flooding plaintiff’s land with salt water.</td>
</tr>
<tr>
<td>Case Title</td>
<td>Discussed Cases</td>
<td>Statutory Immunity</td>
<td>Law of Defamation</td>
<td>Breach of Standard of Care</td>
<td>Order to Garnish Plaintiff’s Wages for Child Support</td>
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<tr>
<td>Parsons v Finch, 2006 BCCA 513</td>
<td>No</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
</tr>
<tr>
<td>Paszkowski v Canada (Attorney General) 2006 FC 198</td>
<td>No</td>
<td>Discussed similar cases</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
</tr>
<tr>
<td>Pfeiffer v Ontario, 2006 CanLII 32922 (On Sup Ct)</td>
<td>No</td>
<td>Did not discuss but implied no</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Indeterminate liability</td>
</tr>
<tr>
<td>Regional Health Board et al, 2004 BCSC 294</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
</tr>
<tr>
<td>Case Title</td>
<td>Issue</td>
<td>Judgment</td>
<td>Successful</td>
<td>Discussions</td>
<td>Reasoning</td>
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<tr>
<td>Premakumaran v Canada, 2006 FCA 213</td>
<td>Refunded some of garnished wages.</td>
<td>Yes</td>
<td>No</td>
<td>Did not discuss</td>
<td>This case related more to the plaintiff's failure to establish the requirements for negligent misrepresentation than the duty test. Many overlapping requirements though. Supreme Court of Canada denied leave to appeal.</td>
</tr>
<tr>
<td>Project 360 Investments Limited (Sound Emporium Nightclub) v Toronto Police Services Board, 2009 CanLII 36380 (On Sup C)</td>
<td>Plaintiff could not find employment. Claimed he was enticed to Canada thinking accountants were in demand.</td>
<td>Yes</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
</tr>
<tr>
<td>R v Brooks, 2010 SKCA 55</td>
<td>Defendant sprayed herbicides at military base. Plaintiff said he had health problems due to this exposure (he was not a member of the military but a user of a local park).</td>
<td>Yes</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Unlimited liability.</td>
</tr>
<tr>
<td>R v Churchill Spurr, 2009 SKQB 478; 2010 SKCA 99</td>
<td>Plaintiff alleged he suffered injuries as a result of exposure to chemicals in experiments by the military.</td>
<td>Need full evidentiary record</td>
<td>Did not discuss</td>
<td>Need full evidentiary record</td>
<td>No identifiable class.</td>
</tr>
<tr>
<td>Reference</td>
<td>case</td>
<td>action</td>
<td>Duty admitted</td>
<td>Duty admitted</td>
<td>Duty admitted</td>
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<tr>
<td>Radke v S(M)(Litigation Guardian of), 2007 BCCA 216</td>
<td>Police</td>
<td>Trial, plaintiff succeeded</td>
<td>Duty admitted</td>
<td>Duty admitted</td>
<td>Duty admitted</td>
</tr>
<tr>
<td>Reference re Broome v Prince Edward Island, 2010 SCC 11</td>
<td>Community service</td>
<td>Reference question</td>
<td>Insufficient evidence</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
</tr>
<tr>
<td>Ribeiro v Vancouver (City), 2005 BCSC 395</td>
<td>Police</td>
<td>Motion to dismiss and motion to add another government defendant (Police Board), government succeeded, but proceeded against another</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Case Study/Case Name</td>
<td>Court/Ref.</td>
<td>Summary</td>
<td>Details</td>
<td>Result/Outcome</td>
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<tr>
<td><strong>Ring v The Queen, 2007 NLTD 146</strong></td>
<td>Defense</td>
<td>Class certification motion, plaintiff succeeded</td>
<td>Need evidence at trial on indemnity liability.</td>
<td>Did not discuss. Court of Appeal denied leave to appeal.</td>
<td></td>
</tr>
<tr>
<td><strong>River Valley Poultry Farm Ltd v Canada (Attorney General), 2009 ONCA 326</strong></td>
<td>Agri.</td>
<td>Motion to dismiss, defendant succeeded but proceeded against another government defendant</td>
<td>No, statute indicated no proximity.</td>
<td>Did not discuss. Did not discuss. Did not discuss. Did not discuss. Did not discuss.</td>
<td></td>
</tr>
<tr>
<td><strong>Rivet v British Columbia, 2007 BCSC 731</strong></td>
<td>Com.</td>
<td>Motion to dismiss, plaintiff succeeded</td>
<td>Child protection legislation may indicate proximity.</td>
<td>Did not discuss. Would not decide without evidence at trial. Struck duty to protect but allowed other claims to proceed.</td>
<td></td>
</tr>
<tr>
<td><strong>Robinson v Saskatoon (City), 2010 SKQB 98</strong></td>
<td>Bylaw</td>
<td>Class certification motion, government succeeded</td>
<td>No duty arising from breach of statute.</td>
<td>Did not discuss. Did not discuss. Did not discuss. Did not discuss. City granting taxicab licenses in a manner contrary to the bylaw.</td>
<td></td>
</tr>
<tr>
<td><strong>Ruby Lake Country Developments Ltd v Kennedy, 2010 BCSC</strong></td>
<td>Justice</td>
<td>Motion to dismiss, government succeeded</td>
<td>No. Duties to the public in general not specific plaintiffs.</td>
<td>Did not discuss. Did not discuss. Did not discuss. Unclear really what they were alleging against Crown except some general duty to supervise.</td>
<td></td>
</tr>
</tbody>
</table>

Plaintiff alleged injured by military spraying of herbicides. Plaintiff sued Health Canada and Canadian Food Inspection Agency for negligently investigating whether its flock was infected with a disease. Alleged testing took too long and it was obliged to destroy its entire flock while awaiting test results indicating only part of flock infected. Plaintiff sued for negligence in relation to a failure to protect the plaintiff of risk, which led to car accident, failures to detect the plaintiff’s brain injury and provide care, and failure to investigate and collect evidence in relation to accident so plaintiff could later sue. Plaintiffs involved in foreclosure actions. Their lawyer was negligent. They sued the law society and the Crown.
<table>
<thead>
<tr>
<th>Case</th>
<th>Issue</th>
<th>Type</th>
<th>Did not discuss</th>
<th>Did not discuss</th>
<th>Did not discuss</th>
<th>Did not discuss</th>
<th>Did not discuss</th>
<th>Did not discuss</th>
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</thead>
<tbody>
<tr>
<td>Sagharian v Ontario (Education), 2007 CanLII 6933 (CA)</td>
<td>Education</td>
<td>Class certification motion, government succeeded</td>
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<td></td>
<td>Failure to provide a service is a policy decision.</td>
<td></td>
<td>Allowed to proceed on Charter issues. Did not discuss proximity as those facts were not pled. Supreme Court of Canada denied leave to appeal.</td>
</tr>
<tr>
<td>St Elizabeth Home Society v Hamilton (City), 2005 CanLII 46411 (Ont CA)</td>
<td>Bylaw enforcement</td>
<td>Trial, government succeeded</td>
<td>No</td>
<td>No</td>
<td>Duty to public not private individuals.</td>
<td>Did not discuss</td>
<td>Policy</td>
<td>Conflict of duties. Other remedies.</td>
</tr>
<tr>
<td>Samimifar v Canada (Minister of Citizenship), 2007 FCA 248</td>
<td>Immigration</td>
<td>Motion for summary judgment, plaintiff succeeded</td>
<td>Discussed some similar cases</td>
<td>Did not discuss</td>
<td>Relationship with specific officer responsible for processing application created reliance.</td>
<td>Did not discuss, but implied operational decision.</td>
<td>Policy</td>
<td>There are policy reasons that would apply in some circumstances (ex. indeterminable liability) but didn’t apply here, when officer completely ignored the file.</td>
</tr>
<tr>
<td>Saskatchewan v Campbell, 2008 SKQB 437</td>
<td>Transport</td>
<td>Motion to dismiss, plaintiff succeeded</td>
<td>Yes</td>
<td>Did not discuss</td>
<td>Statute indicative of proximity.</td>
<td>Did not discuss</td>
<td>Operational</td>
<td>No concern with indeterminate liability or conflict between public and private</td>
</tr>
<tr>
<td>Saskatchewan Power Corporation v Swift Current (City), 2007 SKCA 27</td>
<td>Utilities</td>
<td>Motion to dismiss, government succeeded</td>
<td>Yes</td>
<td>Did not discuss</td>
<td>No. Duties to the public in general not specific plaintiffs.</td>
<td>Did not discuss</td>
<td>Rate review a policy decision. Categorized allegation that once it decided review rates it had to do so nonnegligently as policy (this questions the adequacy of the process which is a policy decision).</td>
<td>Did not discuss</td>
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<tr>
<td>Sauer v Canada (Attorney General) 2007 ONCA 454; 2008 CanLII 43774</td>
<td>Agriculture</td>
<td>Motion to dismiss, plaintiff succeeded. Class certification motion, plaintiff succeeded.</td>
<td>Yes</td>
<td>Did not discuss</td>
<td>Yes</td>
<td>Did not discuss</td>
<td>Operational</td>
<td>Insufficient evidence of policy concerns at this stage.</td>
</tr>
<tr>
<td>Schweitzer v City of Fredericton, 2008 NBQB 192</td>
<td>Municipal property</td>
<td>Trial, government succeeded</td>
<td>No, no area for swimming, large area to put signs up, didn’t have previous prob-</td>
<td>No</td>
<td>Did not discuss</td>
<td>Plaintiff not known to government.</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
</tr>
<tr>
<td>Case</td>
<td>Court</td>
<td>Decision</td>
<td>Did not discuss</td>
<td>Policy and operational decisions</td>
<td>Did not discuss</td>
<td>The systems, manner and frequency of maintenance were reasonable. The City was not negligent in the implementation of its policy.</td>
<td>Plaintiff tripped on the uneven edge of a sidewalk and sued the City.</td>
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</tr>
<tr>
<td>Shanks v Calgary (City), 2003 ABQB 56</td>
<td>Municipal property</td>
<td>Trial, plaintiff succeeded on duty</td>
<td>Yes</td>
<td>Discussed similar cases</td>
<td>Yes</td>
<td>Did not discuss</td>
<td>Policy and operational decisions</td>
<td>Did not discuss</td>
</tr>
<tr>
<td>Sivertson (Guardian ad litem of) v Dutrisac, 2011 BCSC 558</td>
<td>Community services</td>
<td>Motion to dismiss, government succeeded</td>
<td>Did not discuss</td>
<td>Discussed similar cases</td>
<td>Duty to the public as a whole. Myriad of concerns to balance.</td>
<td>Had complaints about the daycare, but not sufficient to establish relationship with plaintiff. No direct regulatory control.</td>
<td>Policy</td>
<td>Conflicting duties. Would create insurance scheme for all children attending daycare.</td>
</tr>
<tr>
<td>Smith v The City of Winnipeg, 2011 MBQB 52</td>
<td>Utilities</td>
<td>Trial, plaintiff succeeded</td>
<td>Yes</td>
<td>Did not discuss</td>
<td>Yes, reliance.</td>
<td>Operational</td>
<td>Did not discuss</td>
<td>City breached duty and city’s negligence caused her loss.</td>
</tr>
<tr>
<td>South Yukon Forest Corporation v Canada, 2010 FC 495</td>
<td>Forestry</td>
<td>Trial, plaintiff succeeded</td>
<td>Yes</td>
<td>Did not discuss</td>
<td>Close relationship fostered over many years. Intertwined relationship. Specific representation.</td>
<td>Operational</td>
<td>Rejected indeterminate liability.</td>
<td>Breached standard of care</td>
</tr>
<tr>
<td>Spencer v Canada (Attorney General),</td>
<td>Police</td>
<td>Summary judgment, government succeeded</td>
<td>No, he had been violent</td>
<td>No. Statutory duties to the public as a</td>
<td>Did not discuss</td>
<td>Did not discuss, but implied operational.</td>
<td>Duties to private would conflict</td>
<td>Also did not breach the standard of care.</td>
</tr>
<tr>
<td>Case</td>
<td>Defendant</td>
<td>Plaintiff</td>
<td>Motion to dismiss</td>
<td>Plaintiff succeeded</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
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<tr>
<td>2010 NSSC 446</td>
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<tr>
<td>Spika v Port Alberni (City), 2002 BCSC 700</td>
<td>Utilities</td>
<td>Utilities</td>
<td>Motion to dismiss, plaintiff succeeded</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Did not discuss</td>
<td>Operation- al. No duty to inspect but could be negligence after complaint lodged.</td>
</tr>
<tr>
<td>Stachniak v Thorhold No 7 (County), 2006 ABPC 182</td>
<td>Utilities</td>
<td>Utilities</td>
<td>Trial, plaintiff succeeded on duty</td>
<td>Yes</td>
<td>No</td>
<td>Some discussion of legislation</td>
<td>Did not discuss, focused on standard of care.</td>
<td>Policy and operational</td>
</tr>
<tr>
<td>Strata Plan VR 2275 v Davidson, 2008 BCSC 77</td>
<td>Building inspections</td>
<td>Building inspections</td>
<td>Motion to dismiss, plaintiff succeeded</td>
<td>Did not discuss</td>
<td>No</td>
<td>Nothing in statute to suggest proximity with architects.</td>
<td>Agreement with plaintiffs created proximity with them.</td>
<td>Did not discuss</td>
</tr>
<tr>
<td>Street v Ontario Racing Commission, 2008 ONCA 10</td>
<td>Liquor/ Gaming</td>
<td>Liquor/ Gaming</td>
<td>Motion to dismiss, government succeeded</td>
<td>Yes</td>
<td>No</td>
<td>No. Placed the obligation of compliance on trainers (a policy decision). A duty would thus override the Commission’s discretion.</td>
<td>No</td>
<td>Policy</td>
</tr>
<tr>
<td>Stoneman v Land</td>
<td>Land</td>
<td>Motion to</td>
<td>Did not</td>
<td>Public</td>
<td>Did not</td>
<td>Did not</td>
<td>Did not</td>
<td>Did not</td>
</tr>
<tr>
<td>Denman Island Local Trust Committee, 2010 BCSC 636</td>
<td>development</td>
<td>dismiss, government succeeded at having current statement of claim dismissed but did not dismiss action in its entirety (gave leave to amend).</td>
<td>discuss</td>
<td>authority liability recognized in many cases.</td>
<td>discuss</td>
<td>discuss</td>
<td>discuss</td>
<td>discuss</td>
</tr>
<tr>
<td>Sumere v Transport Canada, 2009 CanLII 55324 (On Sup Ct)</td>
<td>Transport</td>
<td>Motion to dismiss, plaintiff succeeded</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Did not reach conclusion on whether Act grounded duty.</td>
<td>Did not discuss</td>
<td>Operational aspects to their pleadings that should go to trial.</td>
<td>Did not discuss</td>
</tr>
<tr>
<td>Syl Apps Secure Treatment Center v BD, 2007 SCC 38</td>
<td>Community services</td>
<td>Motion to dismiss, government succeeded</td>
<td>Yes</td>
<td>No</td>
<td>No, duty to parents would conflict with duties in statute (best interest of child). Legislation immunized child protection workers.</td>
<td>Did not discuss</td>
<td>Did not explicitly consider but implied operational</td>
<td>Yes, there is another remedy in the Act (appeal protection order). Recognizing this duty could result in parallel proceedings.</td>
</tr>
<tr>
<td>Szebenyi v Canada, 2007 FCA 118</td>
<td>Immigration</td>
<td>Motion to dismiss, government succeeded</td>
<td>Did not discuss</td>
<td>Discussed similar cases</td>
<td>Nothing in statute to establish proximity.</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Alternative remedy (judicial review).</td>
</tr>
<tr>
<td>Talarico v Trial,</td>
<td>Did not</td>
<td>Discussed</td>
<td>Did not</td>
<td>Did not</td>
<td>Policy</td>
<td>Did not</td>
<td>Also would not</td>
<td>Plaintiff slipped and fell</td>
</tr>
<tr>
<td>Case Title</td>
<td>Outcome</td>
<td>Motion to Dismiss</td>
<td>Proximity to Breach</td>
<td>Immunity Clause</td>
<td>Limitation Issue</td>
<td>Plaintiff's Allegation</td>
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<tr>
<td><strong>Town of Fort Nelson, 2008 BCSC 861</strong></td>
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<tr>
<td>CIPAL property - principal proper -ty government succeeded</td>
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<tr>
<td><strong>Talbot v Hornby Island Local Trust Committee, 2010 BCSC 54</strong></td>
<td></td>
<td>Motion to dismiss</td>
<td>Proximity could arise from statute. Immunity clause may ultimately bar liability.</td>
<td></td>
<td></td>
<td>Plaintiff’s neighbor operated unauthorized dump. Alleged defendant negligent in remediying this.</td>
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<tr>
<td>Bylaw enforcement - enforcement of road bylaw</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td></td>
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<tr>
<td><strong>Tayview Properties Inc v The Corporation of the Town of Perth, 2010 ONSC 5234</strong></td>
<td>Yes No</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Plaintiff developer bought land. Had been used as landfill. Town didn’t warn but they didn’t know that it had been landfill.</td>
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<td>Land development - enforcement of bylaw</td>
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<tr>
<td><strong>The Los Angeles Salad Company Inc v Canadian Food Inspection Agency, 2011 BCSC 779</strong></td>
<td>Yes No</td>
<td>Duties to public at large. Commercial interests are not the interests regulators are to have in their contemplation.</td>
<td>General public statements are not representations.</td>
<td>Did not discuss</td>
<td>Indeterminate liability.</td>
<td>Canadian Food Inspection Agency investigated the plaintiff’s carrots. Incurred economic harm from their recall.</td>
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<td>Health (economic loss) - enforcement of health bylaw</td>
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<tr>
<td><strong>Thompson v Webber, 2010 BCCA 308</strong></td>
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<td>Plaintiff alleged failure to investigate domestic dispute, leading to children being taken away, which had psychological consequences.</td>
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<tr>
<td>Police - enforcement of road bylaw</td>
<td>No No</td>
<td>Did not discuss</td>
<td>No. No connection, plaintiff removed from any negligence.</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
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<tr>
<td>Traversy v Smith, 2007 CanLII 49879 (On Sup Ct)</td>
<td>Police</td>
<td>Motion to dismiss, plaintiff succeeded</td>
<td>Yes</td>
<td>Yes. Duties of police in conducting investigations.</td>
<td>Yes, some statutory responsibilities pled.</td>
<td>Did not discuss, although some hint of reliance.</td>
<td>Did not discuss, but clearly operational.</td>
<td>Relevant policy factors but more appropriate for trial.</td>
</tr>
<tr>
<td>Tsoutsoulas v Canada (Attorney General), 2006 CanLII 7839 (On Sup Ct)</td>
<td>Justice</td>
<td>Motion to dismiss, government succeeded</td>
<td>No</td>
<td>Did not discuss</td>
<td>Obligations to general public not individual plaintiffs.</td>
<td>Did not discuss</td>
<td>Operational</td>
<td>Did not discuss</td>
</tr>
<tr>
<td>Tubal Cain Properties Ltd v Halifax (Regional Municipality), 2002 NSSC 277</td>
<td>Bylaw enforcement</td>
<td>Motion to dismiss, government succeeded</td>
<td>Yes</td>
<td>No. Statutory duties owed to the general public not individual plaintiffs.</td>
<td>Did not discuss</td>
<td>Policy</td>
<td>Yes. Indeterminate liability, burden for taxpayers.</td>
<td>Did not discuss</td>
</tr>
<tr>
<td>Turner v Halifax (Regional Municipality), 2009 NSCA 106</td>
<td>Justice</td>
<td>Summary judgment, government succeeded</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Nothing in statute to suggest proximity.</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
</tr>
<tr>
<td>Wareham v Ontario (Community and Social Services), 2008 ONCA 771</td>
<td>Community services</td>
<td>Motion to dismiss, government succeeded on negligence</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Owe duties to all potential beneficiaries, no relationship with specific beneficiaries.</td>
<td>Expectations or reliance are not based on Ministry representations.</td>
<td>Policy</td>
<td>Did not discuss</td>
</tr>
<tr>
<td>Case</td>
<td>Party</td>
<td>Decision</td>
<td>Discussion of Statute</td>
<td>Operation</td>
<td>Remedies</td>
<td>Result</td>
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<tr>
<td>Wegren v Prince Albert (City), 2004 SKPC 52</td>
<td>Municipal property</td>
<td>Trial, plaintiff succeeded on duty</td>
<td>Yes</td>
<td>Limited discussion of statute</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>The City’s response once they found out about the loose cover was reasonable and the employees followed proper inspection procedures.</td>
<td></td>
</tr>
<tr>
<td>Wellington v Her Majesty the Queen, 2011 ONCA 274</td>
<td>Police</td>
<td>Motion to dismiss, government succeeded</td>
<td>Yes</td>
<td>Discussed similar cases</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Family of person killed by police claimed unit responsible for investigating misconduct in the killing was negligent.</td>
</tr>
<tr>
<td>Western Forest Products Ltd v British Columbia, 2003 BCSC 1951</td>
<td>Forestry</td>
<td>Motion to dismiss, plaintiff succeeded</td>
<td>Yes</td>
<td>No</td>
<td>Did not explicitly discuss, but plaintiffs had a relationship with defendants.</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
</tr>
<tr>
<td>White v Canada (Attorney General), 2004 BCSC 99</td>
<td>Defense</td>
<td>Class certification motion, plaintiff succeeded</td>
<td>Yes</td>
<td>Yes</td>
<td>Did not explicitly discuss, but some hint of reliance.</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
</tr>
<tr>
<td>Whiteman v Iamkhong</td>
<td>Immigration</td>
<td>Motion to dismiss</td>
<td>Yes</td>
<td>Discussed similar Health defendants</td>
<td>Some indication of Health defendants</td>
<td>Not conflicted</td>
<td>Claim struck against Toronto</td>
<td>Plaintiff sponsored immigrant who turned out</td>
</tr>
<tr>
<td>Year</td>
<td>Citation</td>
<td>Plaintiff</td>
<td>Cases</td>
<td>Owed Duty to Public</td>
<td>Reliance</td>
<td>Policy</td>
<td>With Duties to All Potential Immigrants</td>
<td>And Ontario and Allowed to Proceed Against Canada</td>
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<tr>
<td>2010 ONSC 1456</td>
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<td>Plaintiff succeeded</td>
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<tr>
<td>2009 BCSC 121</td>
<td>Wiggins v British Columbia, 2009</td>
<td>No</td>
<td></td>
<td>No</td>
<td>Nothing</td>
<td>Did not</td>
<td>Policy</td>
<td>Indeterminate liability.</td>
</tr>
<tr>
<td>2011 ONSC 2832</td>
<td>Williams v Corporation of the City of Toronto, 2011</td>
<td>Yes</td>
<td></td>
<td>Did not discuss</td>
<td>Nothing</td>
<td>Did not</td>
<td>Impracticable for city to give notice. Liability should lie with landlord.</td>
<td>Would have failed other elements of class action.</td>
</tr>
<tr>
<td>2009 NSSC 215</td>
<td>Wilson Fuel Co Limited v Canada (Attorney General), 2009</td>
<td>Yes</td>
<td></td>
<td>Yes, negligent investigation (Hill)</td>
<td>Act creates relationship between government and owners who are required to comply.</td>
<td>Did not discuss</td>
<td>No floodgates or chilling effect.</td>
<td>Did not breach standard of care.</td>
</tr>
<tr>
<td>Case</td>
<td>Issue</td>
<td>Result</td>
<td>Statutory Duties</td>
<td>Discussion</td>
<td>Government Responsibility</td>
<td>Remedies Considered</td>
<td>Outcome</td>
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<tr>
<td>Wilson v Saskatchewan, 2007 SKQB 141</td>
<td>Education Motion to dismiss, government succeeded</td>
<td>Yes</td>
<td>No</td>
<td>No. Statutory duties owed to general public not specific plaintiffs.</td>
<td>Did not discuss</td>
<td>Yes. Legislation had other remedies. This would be imposing insurance scheme on government.</td>
<td>Did not discuss</td>
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<td>Crown failed to audit/ regulate private post-secondary schools and plaintiffs lost money by taking courses, for example, by instructors not licensed by Microsoft.</td>
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<tr>
<td>Wood v Hungerford (Township), 2004 Carswell Ont 4432 (Sup Ct)</td>
<td>Building inspection Trial, plaintiff succeeded</td>
<td>Yes</td>
<td>Yes</td>
<td>Did not explicitly discuss, but some hint of reliance.</td>
<td>Operational</td>
<td>Experts agreed that construction was faulty and there were multiple contraventions of the Building Code, which should have been identified by the building inspector. The Municipality was negligent in its inspection.</td>
<td>The plaintiff purchased a home and later discovered the foundation was cracked. The house was declared uninhabitable and the plaintiff sued the Municipality.</td>
<td></td>
</tr>
<tr>
<td>Wynberg v Ontario 2006 Carswell Ont 4096 (CA)</td>
<td>Community services Trial, government succeeded</td>
<td>Yes</td>
<td>No</td>
<td>No, duties owed to public generally.</td>
<td>Did not discuss</td>
<td>Policy. Not negligent in the implementation of that policy.</td>
<td>Did not discuss</td>
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<td></td>
<td>Would not have found negligence on operational aspects of policy either. The Supreme Court of Canada denied leave to appeal.</td>
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<td></td>
<td>Minister of Community and Social Services announced funded Intensive Behavioral Intervention for children aged 2-5 with autism. The Plaintiffs were caregivers of children outside this age range.</td>
<td></td>
</tr>
<tr>
<td>Yelle v Children’s Aid Society of Ottawa-Carleton 2002 Carswell Ont 2848 (Sup Ct)</td>
<td>Community services Trial, plaintiff succeeded</td>
<td>Yes</td>
<td>Some discussion of similar cases</td>
<td>Did not discuss</td>
<td>Operational</td>
<td>Did not discuss</td>
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<td>The Society breached its duty by failing to provide the child with necessary counseling and treatment.</td>
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<td>A child in the care of the Society set fire to the plaintiff’s home.</td>
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</tbody>
</table>
Appendix Two: Governmental Tort Claims Sorted by Sector

In this Appendix, I separate the governmental liability cases from Appendix One by sector. These are rough categorizations, as there are many inter-provincial discrepancies in the division of policy portfolios between ministries. These categorizations are particularly rough in the case of municipal defendants, due to the even wider inter-municipal variation in the division of responsibilities. Because municipalities may not divide responsibilities by subject matter, but rather by function (for example, in the case of bylaw officers who may be responsible for enforcing a wide array of rules arising in different sectors), in some cases, I adopt functional rather than subject matter divisions.

<table>
<thead>
<tr>
<th>SECTOR AND SUMMARY</th>
<th>CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agriculture</td>
<td>Adams v Borrel, 2008 NBCA 62</td>
</tr>
<tr>
<td></td>
<td>Berg v Saskatchewan, 2003 SKQB 456</td>
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<td></td>
<td>Holland v Saskatchewan, 2008 SCC 42</td>
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<td></td>
<td>Marlor Farm Inc v The Ontario Flue-Cured Tobacco, 2010 ONSC 1573</td>
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<td>Nelson v Saskatchewan, 2003 SKQB 265</td>
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<td></td>
<td>Northern Goose Processors Ltd v Canadian Food Inspection Agency 2006 MBQB 198</td>
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<td>River Valley Poultry Farm Ltd v Canada (Attorney General), 2009 ONCA 326</td>
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<td>Sauer v Canada (Attorney General) 2007 ONCA 454; 2008 CanLII 43774</td>
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<tr>
<td>Building Inspections</td>
<td>Bowes v Edmonton (City), 2007 ABCA 347</td>
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<td></td>
<td>Brodie v Richmond Hill (Town), 2008 CanLII 67889 (On Sup Ct)</td>
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<td></td>
<td>Condominium Corporation No, 9813678 v Statesman Corporation, 2009 ABQB 493</td>
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<td>Flynn v Halifax (Regional Municipality) 2005 NSCA 81</td>
</tr>
<tr>
<td>3 motions to dismiss/summary judgment motions (plaintiff succeeded in 1, government succeeded in 2)</td>
<td>Heinicke v Cooper Rankin Ltd, 2006 MBQB 273</td>
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<td>Holtslag v Alberta, 2004 ABQB 268</td>
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<tr>
<td>Kimpton v Canada (AG) and British Columbia, 2004 BCCA 72</td>
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<tr>
<td>McMillan v Canada Mortgage and Housing Corporation, 2008 BCCA 543</td>
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<td>Parsons v Finch, 2006 BCCA 513</td>
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<tr>
<td>Strata Plan VR 2275 v Davidson, 2008 BCSC 77</td>
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<tr>
<td>Wood v Hungerford (Township), 2004 Carswell Ont 4432 (Sup Ct)</td>
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<tr>
<td>6 trials (plaintiff succeeded in 3, government succeeded in 3 but plaintiffs proved duty in 2 of those)</td>
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<tr>
<td>Bylaw Enforcement</td>
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<tr>
<td>2 class certification motions (government succeeded in both)</td>
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<tr>
<td>Collins v Corman Park (Rural Municipality), 2004 SKQB 74</td>
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<tr>
<td>Costello v Hornby Island Local Trust Committee, 2009 BCSC 1334</td>
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<tr>
<td>Foley v Shames, 2008 ONCA 588</td>
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<tr>
<td>Homburg Canada Inc v Halifax (Regional Municipality), 2003 NSCA 61</td>
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<tr>
<td>Robinson v Saskatoon (City), 2010 SKQB 98</td>
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<tr>
<td>St Elizabeth Home Society v Hamilton (City), 2005 CanLII 46411 (On CA)</td>
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<tr>
<td>Talbot v Hornby Island Local Trust Committee, 2010 BCSC 54</td>
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<tr>
<td>Tubal Cain Properties Ltd v Halifax (Regional Municipality), 2002 NSSC 277</td>
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<tr>
<td>Williams v Corporation of the City of Toronto, 2011 ONSC 2832</td>
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<tr>
<td>3 motions to dismiss (government succeeded in all 3 but plaintiff proceeded with other causes of action in 1 of those)</td>
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<tr>
<td>4 trials (government succeeded in all 4 but plaintiff proved duty in 1 of those)</td>
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<tr>
<td>Community service</td>
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<td>1 reference question</td>
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<tr>
<td>1 class certification motion (government succeeded)</td>
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<tr>
<td>10 motions to dismiss (plaintiff succeeded in 4, government succeeded in 6 but plaintiff proceeded with other causes of action in 1 of those)</td>
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<tr>
<td>5 trials (plaintiff succeeded in 1, government succeeded in 4 but plaintiff proved duty in 3 of those)</td>
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<tr>
<td>495862 BC Ltd v Y (CD), 2003 BCSC 1160</td>
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<tr>
<td>AL v Ontario (Ministry of Community and Social Services)(2006), 83 OR (3d) 512 (CA)</td>
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<tr>
<td>CHS v Alberta (Director of Child Welfare), 2010 ABCA 15</td>
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<tr>
<td>C(L) v British Columbia, 2005 BCSC 1668</td>
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<tr>
<td>Jones v Donahghey, 2010 BCSC 1498</td>
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<tr>
<td>K v K(E), 2004 ABQB 159</td>
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<tr>
<td>LC v Alberta, 2010 ABCA 14</td>
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<tr>
<td>LC &amp; LS v HMTQ et al, 2005 BCSC 1668</td>
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<tr>
<td>Mr D v Phillips, 2004 ABQB 380</td>
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<tr>
<td>Pfeiffer v Ontario, 2006 CanLII 32922 (Sup Ct)</td>
<td></td>
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<tr>
<td>Reference re Broome v Prince Edward Island, 2010 SCC 11</td>
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<tr>
<td>Rivet v British Columbia, 2007 BCSC 731</td>
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</tr>
<tr>
<td>Reference re Broome v Prince Edward Island, 2010 SCC 11</td>
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<tr>
<td>Defense</td>
<td>5 class certification motions (plaintiff succeeded in 3, government succeeded in 2 but plaintiff proved the existence of a cause of action in both)</td>
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<td></td>
<td><strong>Bryson v Canada (Attorney General), 2009 NBQB 204</strong></td>
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<td></td>
<td><strong>R v Brooks, 2010 SKCA 55</strong></td>
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<td></td>
<td><strong>R v Churchill Spurr, 2009 SKQB 478; 2010 SKCA 99</strong></td>
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<td></td>
<td><strong>Ring v The Queen, 2007 NLTD 146</strong></td>
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<tr>
<td></td>
<td><strong>White v Canada (Attorney General), 2004 BCSC 99</strong></td>
</tr>
<tr>
<td>Education</td>
<td>2 class certification motions (government succeeded in both)</td>
</tr>
<tr>
<td></td>
<td><strong>Aksidan v Henley, 2008 BCCA 43</strong></td>
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<td></td>
<td><strong>Elkow v Sana, 2006 ABQB 851</strong></td>
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<td><strong>JLP v CRP, 2008 CanLII 1835 (On Sup Ct)</strong></td>
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<td><strong>Sagharian v Ontario (Education), 2007 CanLII 6933 (CA)</strong></td>
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<td><strong>Wiggins v British Columbia, 2009 BCSC 121</strong></td>
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<td></td>
<td><strong>Wilson v Saskatchewan, 2007 SKQB 141</strong></td>
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<tr>
<td></td>
<td>3 motions to dismiss/motions to add defendant (plaintiffs succeeded in 1, government succeeded in 2)</td>
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<tr>
<td></td>
<td>1 trial (government succeeded)</td>
</tr>
<tr>
<td>Environment/Natural resources</td>
<td>2 class certification motions (plaintiffs succeeded in both)</td>
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<tr>
<td></td>
<td><strong>Berhad v Canada, 2004 FC 501</strong></td>
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<td></td>
<td><strong>Border Enterprises Ltd v Beazer East Inc, 2002 BCCA 449</strong></td>
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<td></td>
<td><strong>British Columbia v Canadian Forest Products Ltd, 2002 BCCA 217</strong></td>
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<td><strong>Crystal Blue Farms v Newfound-land, 2009 NLTD 17</strong></td>
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<td></td>
<td><strong>Forest Glen Wood Products Ltd v British Columbia (Minister of Forests), 2007 BCSC 273</strong></td>
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<td></td>
<td><strong>Fullowka v Pinkerton’s of Canada Ltd, 2010 SCC 5</strong></td>
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<td></td>
<td><strong>James v British Columbia, 2005 BCCA 136</strong></td>
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<td></td>
<td><strong>KF Evans Ltd v Canada (Attorney General), 2002 BCSC 1709</strong></td>
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<td>Category</td>
<td>Description</td>
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<tr>
<td></td>
<td>6 trials (plaintiffs succeeded in 3, government succeeded in 3 but plaintiffs proved duty in 2)</td>
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<td></td>
<td>Government contracts (i.e., with Public Works Canada)</td>
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<td></td>
<td>2 motions to dismiss (government succeeded in both)</td>
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<td></td>
<td>1 trial (government succeeded)</td>
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<tr>
<td>Health (economic claims)</td>
<td>6 motions to dismiss/summary judgment motions</td>
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<tr>
<td></td>
<td>(plaintiff succeeded in 2, government succeeded in 4 but plaintiff proceeded on other causes of action in 1 of those)</td>
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<td></td>
<td>1 trial (government succeeded)</td>
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<tr>
<td>Immigration</td>
<td>7 motions to dismiss/summary judgment motions</td>
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<tr>
<td></td>
<td>(plaintiff succeeded in 2, government succeeded in 5)</td>
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<tr>
<td></td>
<td>2 trials (government succeeded in both)</td>
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<tr>
<td><strong>Justice</strong></td>
<td><strong>Labor</strong></td>
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<tr>
<td>7 motions to dismiss/summary judgment motions (plaintiffs succeeded in 1, government succeeded in 6 but plaintiff allowed to proceed on other causes of action in 1)</td>
<td><strong>Labor</strong></td>
</tr>
<tr>
<td>2 trials (plaintiffs succeeded in both)</td>
<td><strong>Aubichon v Saskatchewan</strong>, 2010 SKQB 49</td>
</tr>
<tr>
<td><strong>Cummins v MacKay</strong>, 2003 NSSC 196</td>
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<tr>
<td><strong>DH (Guardian ad litem of) v British Columbia</strong>, 2008 BCCA 222</td>
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<tr>
<td><strong>Hartmann v Amourgis</strong>, 2009 ONCA 33</td>
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</tbody>
</table>
but plaintiff proved cause of action)  

2 motions to dismiss (government succeeded in both)  

2 trials (government succeeded in both but plaintiff proved duty in 1)  

<table>
<thead>
<tr>
<th>Municipal Property</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 motions to dismiss/summary judgment motions/motions to add governmental defendant (plaintiffs succeeded in 1, government succeeded in 2)</td>
</tr>
<tr>
<td>12 trials (plaintiffs succeeded in 4, government succeeded in 8 but plaintiffs proved duty in 4 of those cases)</td>
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</table>

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<thead>
<tr>
<th>Police</th>
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</thead>
<tbody>
<tr>
<td>8 motions to dismiss/summary judgment motions (plaintiffs succeeded in 3, government succeeded in 5 but plaintiff proceeded against another governmental defendant not party to the motion to dismiss in 1 of those)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cases</th>
</tr>
</thead>
</table>
| PSD Enterprises Ltd v New Westminster (City), 2011 BCSC 436  
Street v Ontario Racing Commission, 2008 ONCA 10 |  
| Basque v Saint John (City), 2002 NBQB 131  
Bracken v Vancouver (City) 2006 BCSC 136  
Cumming v DeSouza, 2005 CanLII 469 (On Sup Ct)  
Desjardins (Litigation Guardian of) v Moncton (City) 2002 NBQB 352  
Fox v Vancouver (City) 2003 BCSC 1492  
Hewson v Whistler (Resort Municipality) 2006 BCPC 359  
Hussain v Edmonton (City), 2004 ABQB 204  
Josephson v Merritt (City), 2003 BCSC 1505  
Knodell v New Westminster (City), 2005 BCSC 1316  
LeDrew v Corner Brook (City), 2004 Carswell Nfld 100 (Sup Ct)  
Ouellette v Hearst (Town), 2004 Carswell Ont 1064 (On CA)  
Schweizer v City of Fredericton, 2008 NBQB 192  
Shanks v Calgary (City), 2003 ABQB 56  
Talarico v Town of Fort Nelson, 2008 BCSC 861  
Wegren v Prince Albert (City), 2004 SKPC 52 |  
| BM v British Columbia (Attorney General), 2004 BCCA 402  
Bagnell v Vancouver Police Board, 2008 BCCA 171  
Burbank v RTB, 2007 BCCA 215  
Cragg v Tone et al, 2007 BCCA 441  
Hill v Hamilton-Wentworth Regional Police Services Board, 2007 SCC 41  
Mooney v British Columbia (Attorney General) 2004 BCCA 402  
Odhavji Estate v Woodhouse, 2003 SCC 69  
Project 360 Investments Limited (Sound Emporium Nightclub) v Toronto |
<table>
<thead>
<tr>
<th>Tax and Finance</th>
<th>Transport/Highways</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 trials (plaintiffs succeeded in 3, government succeeded in 3 but plaintiffs proved duty in all 3)</td>
<td>9 motions to strike/summary judgment motions/motions to add defendant to pleadings (plaintiff succeeded in 8, government succeeded in 1)</td>
</tr>
<tr>
<td>3 motions to dismiss/summary judgment motions motions (plaintiff succeeded in 1, government succeeded in 2 but plaintiff allowed to proceed on other causes of action in 1 of those)</td>
<td>9 trials (plaintiff succeeded in 3, defendant succeeded in 6 but plaintiff proved duty in 4 of those)</td>
</tr>
<tr>
<td>Police Services Board, 2009 CanLII 36380 (On Sup Ct)</td>
<td>Burgess v Canadian National Railway Company, 2006 CanLII 3021 (On CA)</td>
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<tr>
<td>Radke v S(M)(Litigation Guardian of), 2007 BCCA 216</td>
<td>Cameron v GNWT et al, 2005 NWTSC 2</td>
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<tr>
<td>Ribeiro v Vancouver (City), 2005 BCSC 395</td>
<td>Chadwick v Canada (Attorney General), 2010 BCSC 1744</td>
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<tr>
<td>Spencer v Canada (Attorney General), 2010 NSSC 446</td>
<td>Cheltenham Estates Ltd v Ontario 2004 Carswell Ont 2619 (Sup Ct)</td>
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<tr>
<td>Thompson v Webber, 2010 BCCA 308</td>
<td>Cole v McLoughlin, 2003 NLCA 3</td>
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<tr>
<td>Traversy v Smith, 2007 CanLII 49879 (On Sup Ct)</td>
<td>Dice v Ontario, 2004 Carswell Ont 5147 (Sup Ct)</td>
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<tr>
<td>Wellington v Her Majesty the Queen, 2011 ONCA 274</td>
<td>Foster v Dhaliwal, 2006 BCSC 1331</td>
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<tr>
<td>783783 Alberta Ltd v Canada (Attorney General), 2010 ABCA 226</td>
<td>Frost v Whistler (Resort Municipality), 2003 BCSC 22</td>
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<tr>
<td>Bellan v Curtis et al, 2007 MBQB 221</td>
<td>Gobin (Guardian ad litem of) v British Columbia, 2002 BCCA 373</td>
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<tr>
<td>Canus v Canada Customs, 2005 NSSC 283</td>
<td>Henkelman v Guy, 2008 ABQB 66</td>
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<tr>
<td>Ceapro Inc v Saskatchewan, 2008 SKQB 76</td>
<td>Heyes v City of Vancouver, 2011 BCCA 77</td>
</tr>
<tr>
<td>783783 Alberta Ltd v Canada (Attorney General), 2010 ABCA 226</td>
<td>Hiscock v Newfoundland 2002 Carswell Nfld 275 (SCTD)</td>
</tr>
<tr>
<td>Bellan v Curtis et al, 2007 MBQB 221</td>
<td>Housen v Nikolaisen, 2002 SCC 33</td>
</tr>
<tr>
<td>783783 Alberta Ltd v Canada (Attorney General), 2010 ABCA 226</td>
<td>McIlvenna (litigation guardian of) v Insurance Corporation of British Columbia, 2008 BCCA 289</td>
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<tr>
<td>Utilities</td>
<td>McMurray v Marshall et al, 2005 BCSC 961</td>
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<td>Octa Evergreens Ltd v New Brunswick (Province of), 2002 NBQB 195</td>
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<td></td>
<td>Saskatchewan v Campbell, 2008 SKQB 437</td>
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<tr>
<td></td>
<td>Sumere v Transport Canada, 2009 CanLII 55324 (On Sup Ct)</td>
</tr>
<tr>
<td>5 motions to dismiss/summary judgment motions (plaintiff succeeded in 2, government succeeded in 3)</td>
<td></td>
</tr>
<tr>
<td>6 trials (plaintiff succeeded in 3, government succeeded in 3 but plaintiff proved duty in 1 of those)</td>
<td></td>
</tr>
</tbody>
</table>

**Utilities**

- Brooks v North Okanagan (Regional District), 2005 BCPC 606
- Craxton v North Vancouver (District), 2006 BCPC 212
- Elliott v Insurance Crime Prevention Bureau, 2005 NSCA 115
- Grace v Fort Erie (Town), 2003 CarswellOnt 3355 (Sup Ct)
- Granite Power Corp v Ontario, 2004 CarswellOnt 3204 (CA)
- Jedynak v Wheatland (County), 2006 ABQB 500
- Neuman v Parkland (County), 2004 ABPC 58
- Saskatchewan Power Corporation v Swift Current (City), 2007 SKCA 27
- Smith v The City of Winnipeg, 2011 MBQB 52
- Spika v Port Alberni (City), 2002 BCSC 700
- Stachniak v Thorhild No 7 (County), 2006 ABPC 182
Appendix Three: A Summary of the Governmental Health Sector Tort Claims

In this appendix, I summarize the courts’ findings in health sector tort claims (aside from the cases relating to economic loss, which I discuss in Appendix One) decided since the Supreme Court of Canada’s 2001 revision of the test for establishing a duty of care.

<table>
<thead>
<tr>
<th>Case</th>
<th>Stage of the proceedings</th>
<th>Foreseeability</th>
<th>Proximity Test</th>
<th>Courts’ Findings</th>
<th>Duty Negated</th>
<th>Facts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abarquez v Ontario, 2009 ONCA 374</td>
<td>Motion to dismiss, defendant succeeded</td>
<td>Yes</td>
<td>No</td>
<td>Did not examine legislation in context of negligence action (did look at it in reference to occupational health claim)</td>
<td>Policy</td>
<td>Potential conflict with duty to the public at large. Other remedies under Workplace Safety and Insurance Act. Hospital nurses, alleged government failed to provide information and issued inadequate directives.</td>
</tr>
<tr>
<td>Attis v Canada, 2008 ONCA 660</td>
<td>Class certification motion, defendant succeeded</td>
<td>Yes</td>
<td>Discussed many cases, but found this one did not come within those categories.</td>
<td>Duty owed to the public, not to specific consumers.</td>
<td>Policy</td>
<td>Indeterminate liability, chilling effect on government decision-making in public interest.</td>
</tr>
<tr>
<td>Blue v Ontario</td>
<td>Motion to dismiss, did not discuss</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Unfair/unworkable to require Crown to</td>
<td>Plaintiff’s father died in hospital. Her (self-</td>
</tr>
</tbody>
</table>

Public Hospitals Act
<table>
<thead>
<tr>
<th>Case Title</th>
<th>Defendant Succeeded</th>
<th>Motion to Dismiss</th>
<th>Duties Under Act</th>
<th>Did Not Discuss</th>
<th>Did Not Discuss</th>
<th>Did Not Discuss</th>
<th>Did Not Discuss</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cerqueira v Ontario, 2010 ONSC 3954</td>
<td>Motion to dismiss, defendant succeeded</td>
<td>Did not discuss</td>
<td>Duties under Long Term Care Act</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Plaintiff had a stroke and was hospitalized. Received personal care services from CCAC defendant. Vague allegations that defendants failed to provide adequate services. Extremely limited discussion of duty. Focused more on other defendants.</td>
</tr>
<tr>
<td>Cilinger v Quebec (Procureur general), [2004] RJQ 2943 (CA)</td>
<td>Class certification motion, defendant succeeded</td>
<td>Did not discuss</td>
<td>Some discussion of statutory context</td>
<td>Did not discuss</td>
<td>Policy</td>
<td>Did not discuss</td>
<td>Plaintiff waited longer than medically recommended for breast cancer radiation. Alleged that government decisions relating to budgets and staffing contributed to these losses.</td>
</tr>
<tr>
<td>Drady v Canada (Health), 2008 ONCA 639</td>
<td>Motion to dismiss, defendant succeeded</td>
<td>Yes</td>
<td>No, legislation aimed at regulating devices with the cooperation of the industry</td>
<td>No direct contact with Health Canada. Alleged various representations (ex. Notice of Compliance)</td>
<td>Did not discuss (discussed in companion case)</td>
<td>Did not discuss (discussed in companion case)</td>
<td>Health Canada comprehensively regulated medical devices. Plaintiff alleges knew about danger from TMJ implants and</td>
</tr>
</tbody>
</table>

1 Note that I did not include this case in my calculations, as I exempted cases from Quebec from my broader analysis of governmental tort liability from all sectors. However, because I refer to this case in my discussion, I summarize the findings here.
<table>
<thead>
<tr>
<th>Case Study</th>
<th>Motion to dismiss, defendant succeeded</th>
<th>Did not discuss in detail, but existence of plan was insufficient.</th>
<th>Did not discuss</th>
<th>Policy. Plan not operational because generally to be carried out by other actors.</th>
<th>Competing claims for scarce resources, must allocate in public interest. Unreasonable burden. Shouldn’t have to make decisions with fear of liability</th>
<th>Plaintiff contracted West Nile Virus and made various allegations against government.</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Eliopoulos Estate v Ontario</em>, 2006 CanLII 37121 (CA)</td>
<td>Yes</td>
<td>Statute created a duty to public at large.</td>
<td>No</td>
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<tr>
<td><em>Heaslip Estate v Ontario</em>, 2009 ONCA 594</td>
<td>Motion to dismiss, plaintiff succeeded</td>
<td>Did not discuss</td>
<td>Suggested it was, but little analysis.</td>
<td>Government knew of the plaintiff. Government had adopted a clear policy.</td>
<td>Operational. Failed to implement its own policy</td>
<td>No concern with indeterminate liability.</td>
</tr>
<tr>
<td><em>Klein v American Medical Systems, Inc</em>, 2006 CanLII</td>
<td>Motion to dismiss, defendant succeeded</td>
<td>Yes</td>
<td>Statute created general duties to the public. Duty is limited to a review of</td>
<td>Did not discuss</td>
<td>Did not discuss</td>
<td>Unlimited liability. Would create insurance scheme. Chilling effect on regulation of medical devices.</td>
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<td>Plaintiff claimed Health Canada negligent in its regulation of a medical device.</td>
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<tr>
<td>Case</td>
<td>Decision</td>
<td>Did Not Examine Legislation</td>
<td>Did Not Discuss Explicitly</td>
<td>Indeterminate Liability Concerns</td>
<td>Did Not Discuss General Duties</td>
<td>Duty Would Have a Chilling Effect</td>
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<tr>
<td>Laroza Estate v Ontario, 2009 ONCA 373</td>
<td>Motion to dismiss, defendant succeeded</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Statute created a duty to public at large not a specific plaintiff.</td>
<td>Indeterminate liability concerns.</td>
</tr>
<tr>
<td>Mitchell Estate v Ontario, 2004 CanLII 4044 (Sup Ct)</td>
<td>Motion to dismiss, defendant succeeded</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Did not discuss explicitly, but noted that government had no power to engage in day to day supervision of hospitals.</td>
<td>Indeterminate liability concerns.</td>
</tr>
<tr>
<td>Nette v Stiles, 2009 ABQB 422</td>
<td>Motion to dismiss, defendant succeeded</td>
<td>Did not discuss</td>
<td>No</td>
<td>No</td>
<td>Statute created general duties to the public not specific plaintiff.</td>
<td>Duty would have a chilling effect on Minister’s ability to carry out function of his office.</td>
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</tbody>
</table>

Minister's information brought to Minister’s attention. No direct relationship with patient. Directives were not representations. Were required to comply with them but no representations about consequences if they were not followed. Nurses had no greater claim than general public. Policy.

Potential conflict with duty to the public at large. Other remedies under Workplace Safety and Insurance Act.

Hospital nurses alleged government failed to provide information and issued inadequate directives.
| **Taylor v Canada (Health), 2010 ONSC 4799** | Motion to decertify class action, plaintiff succeeded | Yes | Distinguished contrary cases | More general obligations to the public, but government conduct created proximity. | May be able to prove representations and reliance at trial. Knowledge of non-compliance. | Operational | Did not wish to consider floodgates, indeterminate liability, etc. on a motion to strike. | Plaintiff suffered injuries relating to temporomandibular joint implants regulated by Health Canada. |
| **Waap v Alberta, 2008 ABQB 544** | Summary judgment, government succeeded | Did not discuss | No | Nothing in the Act to create a private right of action. Regionalization legislation is merely funding legislation. | No direct relationship between the parties. No specific representations. | Policy decision. | Chilling effect on government. | Plaintiff diagnosed with cancer. He thought his treatment would be delayed in Alberta, so he went to Germany for surgery. Sued the Crown for failure to reimburse him. |
| **Williams v Ontario, 2009 ONCA 378** | Motion to dismiss, defendant succeeded | Yes | No | Statute created a duty to the public generally not a specific plaintiff. | Did not discuss factors in detail, but rejected the notion that patients and visitors to hospital could have sufficiently proximate relationship. | Policy | Indeterminate liability. Unreasonable burden on government. | Made numerous allegations about the government’s management of SARS including failure to have adequate systems in place, negligently issued directives and prematurely lifting the state of emergency. |
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Adams v Borrel, 2008 NBCA 62.


Aksidan v Henley, 2008 BCCA 43.


Amankwah v Canada, 2005 FC 900.


Apotex Inc v Astrazenca Canada Inc, 2009 FC 120.

Apotex Inc v Hässle, 2007 FC 683.

Arcand v Imperial Oil Limited, 2006 ABCA 13.

Armstrong v British Columbia (Ministry of Health), 2010 BCCA 56.


Attis v Canada, 2008 ONCA 660.

Aubichon v Saskatchewan, 2010 SKQB 49.

Auton (Guardian ad litem of) v British Columbia (Attorney General), 2004 SCC 8.

BBF, Lodge 359, D277, D385, D468, D503 v British Columbia, 1989 CarswellBC 1085 (CA).
BM v British Columbia (Attorney General), 2004 BCCA 402.

Bagnell v Vancouver Police Board, 2008 BCCA 171.


Basque v Saint John (City), 2002 NBQB 131.

Bellan v Curtis et al, 2007 MBQB 221.

Benaissa v Canada (Attorney General), 2005 FC 1220.


Berhad v Canada, 2004 FC 501.

Bingo City Games Inc et al v BC Lottery Corp et al, 2005 BCSC 25.

Blue v Ontario (Health and Long Term Care), 2009 CanLII 18671 (Sup Ct).

Border Enterprises Ltd v Beazer East Inc, 2002 BCCA 449.

Bowes v Edmonton (City), 2007 ABCA 347.


Bracken v Vancouver (City) 2006 BCSC 136.

Braun v Vaughan (2000), 145 Man R (2d) 35 (CA).

Brooks v North Okanagan (Regional District), 2005 BCPC 606.


Brodie v Richmond Hill (Town), 2008 CanLII 67889 (On Sup Ct).

Brown v British Columbia (Minister of Transportation and Highways), [1994] 1 SCR 420.

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