

GENERAL PRINCIPLES OF MEDICAL MALPRACTICE LITIGATION

Introduction

Law and medicine are two of the most sophisticated professions in Canada. Medical malpractice litigation is an exciting combination of both, which brings with it a unique set of challenges. Unsurprisingly, medical malpractice has become a highly specialized area of law. The intent of this paper is to discuss some of the general legal principles applicable to medical malpractice litigation, namely, the doctrine of informed consent, the standard of care applicable to a defendant physician, causation, a physician's fiduciary duties to the patient and changes to limitation periods imposed by Ontario's *Limitations Act, 2002*.

A. Principles of Informed Consent

Medical malpractice usually occurs when a physician acts in a negligent manner when treating a patient. Malpractice can occur from a course of conduct undertaken by the physician, or by the physician's failure to take appropriate action to treat the patient's condition. Examples of such medical negligence would be a physician's failure to carry out appropriate investigations in order to diagnose a medical condition in a timely manner, or the provision of medically inappropriate treatment. However, a physician may also be liable if a patient does not provide informed consent to a medical procedure that results in harm to the patient, even if the procedure is performed properly.

A physician has duties of disclosure to a patient. The duties of disclosure arise from both the common law and legislation¹. One such duty is to disclose risks associated with treatment. The

¹ Section 11 of the *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sch. A [Hereinafter *Health Care Consent Act*], indicates a person is considered to have provided informed consent when they have received information about the nature of the treatment, expected benefits, material risks, material side effects, alternative courses of action, and likely consequences of not receiving treatment concerning the proposed treatment that the reasonable person would require to make decision. The person must have also received responses to further questions that the person may have had about those matters.

duty to disclose is limited to the disclosure of “material, special or unusual risks”². The likelihood of the risk materializing and the gravity of the risk are key factors considered by the Court in determining whether the risk should have been disclosed to a patient. A likely possibility must be disclosed³. A mere possibility is generally not required to be disclosed, unless the possible outcome is very serious such as in the case of paralysis or death. If the outcome could be very detrimental to the patient, the risk must be disclosed to the patient regardless of its likelihood of occurring⁴.

A physician must also disclose risks which may be unique to the particular patient. It is the importance of the risk to the patient which determines whether it requires disclosure. As explained by Laskin C. J. of the Supreme Court of Canada in *Reibl v. Hughes*:

...The patient may have expressed certain concerns to the doctor and the latter is obliged to meet them in a reasonable way. What the doctor knows or should know that the particular patient deems relevant to a decision whether to undergo prescribed treatment goes equally to his duty of disclosure as do the material risks recognized as a matter of required medical knowledge.⁵

In order to determine what risks the patient would reasonably consider to be important to them, there must be sufficient communications between the physician and the patient⁶. The Court, when determining whether a physician knew or ought to have known of the importance of the risk to the patient, will consider whether the patient asked questions that would provide sufficient notice to the physician of the patient’s specific concerns⁷. A physician should answer any

2 *Hopp v. Lepp*, [1980] 2 S.C.R. 192 at 210.

3 Although dangers inherent in any operation ie. dangers of anaesthetic or risks of infection, do not need to be disclosed: *Videto v. Kennedy* (1981), 33 O.R. (2d) 497 (C.A.)

4 *Hopp v. Lepp*, *supra* note 2 at 209.

5 [1980] 2 S.C.R. 880 at 894.

6 *Videto v. Kennedy*, *supra* note 3.

7 *Augustine v. Lopes*, [1994] O.J. No. 2646 (QL) (Gen. Div.).

questions posed by the patient regarding the procedure and the risks involved⁸ and fully engage in such discussions.

In appropriate cases, a physician may exercise some discretion when disclosing risks of treatment. In *Reibl v. Hughes*, Laskin C. J. indicated:

... It is, of course, possible that a particular patient may waive aside any question of risks and be quite prepared to submit to the surgery or treatment, whatever they be. Such a situation presents no difficulty. Again, it may be the case that a particular patient may, because of emotional factors, be unable to cope with facts relevant to recommended surgery or treatment and the doctor may, in such case, be justified in withholding or generalizing information as to which he would otherwise be required to be more specific.⁹

In *Videto v. Kennedy*, the Ontario Court of Appeal also specifically noted that the emotional condition of the patient and the patient's apprehension and reluctance to undergo the operation may *in certain cases* justify a surgeon in withholding or generalizing information as to which he or she would otherwise be required to be more specific¹⁰. However, obviously a physician who does withhold information, should exercise the utmost caution in ensuring that such conduct is appropriate as otherwise they are exposing themselves to a negligence claim based on insufficient disclosure of risk.

The duty to properly inform the patient of risk may become confusing in cases where the patient is treated by multiple physicians. For example, the referring physician usually depends upon the specialist performing the procedure to thoroughly explain the risks. Although generally this practice has been accepted by the courts, there have been cases where the referring doctor was also held to have a duty to disclose material risks to their patient. In *Ferguson v. Hamilton Civic Hospitals*¹¹, a patient suffered a stroke following a diagnostic angiography performed by a

⁸ *Hopp v. Lepp*, *supra* note 2 at 209-210.

⁹ *Supra* note 5 at 895.

¹⁰ *Supra* note 3.

¹¹ (1983), 144 D.L.R. (3d) 214 (Ont. H.C.), *aff'd* (1985), 33 C.C.L.T. 56 (C.A.).

resident. The possibility of a stroke was not mentioned to the patient by anyone. The trial judge found the referring doctor had a duty to disclose this risk to his patient. It should be noted however that in this case the referring physician knew the resident was not qualified to properly inform the patient as to risk.

The ability to identify who holds the responsibility to explain risks to a patient can become difficult in cases where a physician belongs to a team of health care professionals who provided a plan or course of treatment to a patient. As long as the patient was provided sufficient information to make an informed decision, the individual physician will not be held liable for failing to personally obtain informed consent¹². To avoid liability, there should be a clear procedure within the hospital or health care institution to ensure that informed consent has been obtained from the patient. In cases where the patient has not provided informed consent, the physician directly carrying out the procedure or providing the treatment is generally the one who bears the onus of disclosing the material risks and ensuring the patient is well informed¹³.

Another duty of disclosure of the physician, is the duty to advise of treatment alternatives, such as no treatment or conservative management. Authors Ellen Picard and Gerald Robertson state in *Legal Liability of Doctors and Hospitals in Canada*:

...The doctor must inform the patient of those risks which a reasonable person in the patient's position would want to know. However, it is now well established that the duty of disclosure is not confined to risks, but extends to other material information which a reasonable patient would want to have. In particular, the patient must be informed of any available alternatives to the treatment being proposed, as well as the material risks associated with those alternatives. The duty to disclose available alternatives is especially important where these are more conservative, and involve fewer risks, than the treatment which is being proposed.¹⁴

12 *Davidson v. Connaught Laboratories* (1980), 14 C.C.L.T. 251 (Ont. H.C.). See also *Scott v. Chapnik*, [1998] O.J. No. 1305 (QL) (Gen. Div.), aff'd [2000] O.J. No. 412 (QL) (C.A.).

13 *Van Mol (Guardian ad litem of) v. Ashmore*, [1995] B.C.J. No. 2623 (QL) (S.C.).

14 E.I. Picard & G.B. Robertson, *Legal Liability of Doctors and Hospitals in Canada*, 3d ed. (Scarborough: Carswell, 1996) at 129-130.

Some Judges have held that a physician must disclose alternative means of treatment and risks even if they would not recommend those options as the patient is entitled to be advised, so that they may make an informed decision to undertake a risk¹⁵. However, some Judges in Ontario have limited this obligation to inform patients only of alternative treatment options that the physician believes would offer some advantage and are reasonably likely to achieve a beneficial result¹⁶.

The circumstances surrounding the patient's need for the procedure affect the standard of disclosure for informed consent. There is a high standard of disclosure for elective procedures given that it is more unlikely that a patient would have consented to an elective procedure if advised of the material risks¹⁷. For similar reasons, a very high standard of disclosure exists for patients who participate in research studies¹⁸.

Generally, the appropriate legal claim for an informed consent case is an action in negligence. Although in some cases, the tort of battery may be applicable. In *Reibl v. Hughes*, Laskin C. J. explained the evidentiary considerations and noted that the tort of battery would require intent on the part of the defendant physician. In this regard, His Honour stated:

...The tort [of battery] is an intentional one, consisting of an unprivileged and unconsented to invasion of one's bodily security. True enough it has some advantages for a plaintiff over an action of negligence since it does not require proof of causation and it casts upon the defendant the burden of proving consent to what was done. Again, it does not require the adducing of medical evidence, although it seems to me that if battery is to be available for certain kinds of failure to meet the duty of disclosure there would necessarily have to be some such evidence brought before the Court as an element in determining whether there has been such a failure.

¹⁵ *Haughian v. Paine*, [1987] S.J. No. 240 (QL) (Sask C.A.). See also *Ferguson v. Hamilton Civic Hospitals*, *supra* note 11.

¹⁶ *Bonnell v. Moddel*, [1987] O.J. No. 97 (Q.L.) (H.C.J.). See also *Bucknam v. Kostjuk* (1983), 44 O.R. (2d) 102 (H.C.) and *Ferron v. Yadav*, [1990] O.J. No. 473 (QL) (H.C.). But see *Ross v. Welsh*, [2003] O.J. No. 3141 (QL) (S.C.J.) where the Court distinguished those cases on the basis of the expert evidence which suggested the surgical procedure undertaken should have been the last resort.

¹⁷ *Nichols v. Keyzer*, [2000] O.J. No. 4356 (QL) (S.C.J.). See also *Ross v. Welsh*, *supra* note 16, *White v. Turner* (1981), 120 D.L.R. (3d) 269 (Ont. H.C.J.), and *Brain v. Mador*, [1985] O.J. No. 119 (QL) (C.A.).

¹⁸ Picard, *supra* note 14 at 149.

...

...In my opinion, actions of battery in respect of surgical or other medical treatment should be confined to cases where surgery or treatment has been performed or given to which there has been no consent at all or where, emergency situations aside, surgery or treatment has been performed or given beyond that to which there was consent.¹⁹

Laskin C. J. also indicated that misrepresentation or fraud on the part of the defendant physician will be a determinative factor for cases where battery is alleged²⁰.

A trier of fact must determine whether a risk to treatment is “material, special or unusual” and whether there has been a breach of the duty of disclosure. The professional standards are a relevant factor to be considered by the trier of fact when determining a breach of the duty of disclosure²¹. This evidence is generally obtained by expert opinion and other medical evidence. However, the standards of the medical professions are not determinative²². The duty of disclosure is defined by the particular case, and therefore other evidence from the patient or family members of the patient as to importance of the risk to the patient is also helpful to a trier of fact when establishing a risk which is “material, special or unusual” to the patient and whether there has been a breach of a duty to disclose that risk²³.

The case law is helpful in identifying risks that were previously considered to be material by a court. However, one should keep in mind that the materiality of the risk is specific to the patient, and therefore the factual circumstances should be thoroughly examined.

Once a breach of the duty to disclose has been established, the Court must address the issue of causation. In *Reibl v. Hughes*²⁴, the Court recognized that there may be no causation if the patient would have undertaken the procedure notwithstanding the proper disclosure of its risks.

¹⁹ *Supra* note 5 at 890.

²⁰ *Ibid* at 891.

²¹ *Videto et al. v. Kennedy, supra*, note 3 at 133-134.

²² *Leung v. Campbell*, [1995] O.J. No. 10 (QL) (Gen. Div.). See also *Reibl v. Hughes, supra* note 5 at 894 and *Videto v. Kennedy, supra* note 3 at 133-134.

²³ *Reibl v. Hughes, ibid.* at 894-895.

²⁴ *Ibid.*

In determining whether the patient would have undergone the procedure, a modified objective standard has been imposed. The test is whether a reasonable patient, in this patient's particular position, would have agreed to have undergone the procedure after having been informed about alternative treatment as well as probable benefit. The rationale for the adoption of the modified objective standard was explained by Laskin C. J. in *Riebl v. Hughes* as follows:

The adoption of an objective standard does not mean that the issue of causation is completely in the hands of the surgeon. Merely because medical evidence establishes the reasonableness of a recommended operation does not mean that a reasonable person in the patient's position would necessarily agree to it, if proper disclosure had been made of the risks attendant upon it, balanced by those against it. The patient's particular situation and the degree to which the risks of surgery or no surgery are balanced would reduce the force, on an objective appraisal, of the surgeon's recommendation. Admittedly, if the risk of foregoing the surgery would be considerably graver to a patient than the risks attendant upon it, the objective standard would favour exoneration of the surgeon who has not made the required disclosure. Since liability rest only in negligence, in a failure to disclose material risks, the issue of causation would be in the patient's hands in the subjective test, and would, if his evidence was accepted, result inevitably in liability unless, of course, there was a finding that there was no breach of the duty of disclosure. In my view, therefore, the objective standard is the preferable one on the issue of causation.²⁵

In *Arndt v. Smith*²⁶, the Supreme Court of Canada revisited and affirmed the modified objective standard when determining causation. The Court addressed the subjective component of the causation test and noted that the particular attributes of the plaintiff which do not specifically relate to the procedure itself and are unknown to the physician, will not be considered. Cory J. explained the test of "a reasonable person" in the plaintiff's particular circumstances as follows:

In other words, fears which are idiosyncratic, which do not relate directly to the material risks of a proposed treatment and which would often be unknown to a physician, cannot be considered. This is what ensures that the objective standard truly is based on the actions of a "reasonable person". It means that a doctor will not be held responsible for damages attributable to a plaintiff's idiosyncrasies. It ensures that a plaintiff would not be able to successfully prove causation simply by demonstrating an irrational fear which, had the physician exposed all the risks, would have convinced the patient to forego medical treatment... The modified objective test serves to eliminate some consideration

²⁵ *Ibid.* at 899.

²⁶ [1997] 2 S.C.R. 539.

the honesty held but idiosyncratic and unreasonable or irrational beliefs of patients.²⁷

Clearly, the application of the test of causation for non-disclosure cases involves a fine assessment of the evidence. The Court will consider evidence of the plaintiff's circumstances, and the reasons why the plaintiff says he or she would not have undergone the procedure when determining whether a reasonable person in the plaintiff's circumstances would not have undergone the procedure had he or she been informed of the risks.

i. Informed Refusal

A patient has the right to refuse unwanted medical treatment. The right to refuse treatment is an inherent component of the supremacy of the patient's right to his own body. This right is fundamental to a person's dignity and autonomy, and well respected by the law²⁸.

Robins J. A. of the Ontario Court of Appeal described the right to refuse treatment as being the premise for the doctrine of informed consent when stating:

The doctrine of informed consent has developed in the law as the primary means of protecting a patient's right to control his or her medical treatment. Under the doctrine, no medical procedure may be undertaken without the patient's consent, obtained after the patient has been provided with sufficient information to evaluate the risks and benefits of the proposed treatment and other available options . . .

. . .

The right of self-determination, which underlies the doctrine of informed consent, also obviously encompasses the right to refuse medical treatment. A competent adult is generally entitled to reject a specific treatment or all treatment, or to select an alternative form of treatment, even if the decision may entail risks as serious as death and may appear mistaken in the eyes of the medical profession or of the community. . . The doctrine of informed consent is plainly intended to ensure the freedom of individuals to make choices concerning their medical care. For this freedom to be meaningful, people must have the right to make choices

²⁷ *Ibid.* at 552.

²⁸ Section 26 of the *Health Care Consent Act* provides that a physician is not permitted by law to administer treatment if a capable person who after attaining the age of 16 years, has refused consent.

that accord with their own values, regardless of how unwise or foolish those choices may appear to others.²⁹

Surprisingly there is very little case law directly dealing with the principle of informed refusal.

In *Malette v. Shulman*³⁰, an unconscious patient was in a life threatening situation. She had a card which indicated that she was a Jehovah's witness and that under no circumstances was she to be given blood or blood products. Notwithstanding the card, the doctor transfused the patient. She sued for battery, given that the doctor was aware of the card yet intentionally undertook such treatment. The doctor argued that the doctrine of informed consent should be extended to informed refusal. They argued that since there is an obligation on the doctor recommending treatment to advise as to the risks, it must logically follow that there is a higher duty where the patient proposes a course of action that the doctor believes to be prejudicial. In this case, there was no evidence that when the plaintiff made the decision and signed the card, she was informed of risks of refusal of treatment and therefore, the plaintiff did not make an informed decision to refuse treatment. The trial judge rejected the defendant's arguments on the basis that an individual has a right to freedom of religion. The Court determined that if the objection to treatment is on a religious basis, this does not permit the scrutiny of "reasonableness" by the Court. As such, the Court did not extend the doctrine of informed consent to informed refusal, and the defendant physician was found to have committed a battery when he failed to follow the patient's written direction in the card.

The Court of Appeal dismissed the defendant's appeal. The Court felt it was unnecessary to determine whether there was a doctrine of informed refusal which was distinct from the doctrine of informed consent because the physician could not inform the patient in any event as she was unconscious. The Court found that the patient was entitled to reject a procedure inimical to her religious values, in advance of the emergency situation. The card set forth unqualified

²⁹ *Malette v. Shulman*, (1990) 72 O.R. (2d) 417 (C.A.) at 423-424 aff'g (1987), 63 O.R. (2d) 243 (H.C.J.) [hereinafter *Malette*].

³⁰ *Ibid.*

instructions applicable to the circumstances presented by the emergency. It was not for the physician to second guess the reasonableness of the decision. This case could therefore arguably be interpreted to suggest refusal of treatment does not have to be informed, in order to be valid.

In *Wijngaarden v. Tzialis*³¹, a patient was seriously injured in a car accident. The patient was taken to hospital and underwent extensive surgery during which 7 units of blood were administered. Similar to the circumstances in *Malette*, the patient had a card indicating she was a Jehovah's Witness and directing no blood transfusions be given to her "even though physicians deem such vital to [her] health or [her] life". The card was subsequently discovered in the patient's purse. The patient was in need of further treatment so the treating physician and hospital immediately brought an application for a declaration that the card was not binding on them and that such physicians were at liberty to administer blood should it be required in their opinion to preserve the patient's life or health. A Public Trustee was appointed as litigation guardian for the patient and the Order was granted. The trial judge felt there was evidence which casted doubt on whether the directive card was a true expression of the patient's wishes at the time. This evidence was not disclosed in the decision. Ironically, the trial judge relied on *Malette v. Shulman* for his conclusion that the doctors were entitled to proceed as they would in the usual emergency case. The decision was appealed. After the Order was obtained but before the hearing of the appeal, a second operation was performed on the patient. The physicians were making every effort to avoid giving the patient blood unless it was absolutely necessary. This case can likely be distinguished as it was determined that the Public Trustee apprised the trial judge that what was known of the patient's wishes led the Trustee to take the position that the patient's interest was to receive whatever treatment was necessary to preserve her life, including blood transfusions. The appellate Court noted that the patient's right to refuse

31 [1992] O.J. No. 2234 (QL) (C.A.).

treatment, even when faced with life threatening consequences, should not be taken lightly. The Court was cognizant of the potential harm that would be inflicted if the patient was administered a blood transfusion against her wishes and in contravention of her religious beliefs. However, the Court was not prepared to substitute its conclusion for the trial judge's decision as to whether there was sufficient evidence casting doubt on the directive card.

The above cases are factually distinct and it is questionable whether they provide any helpful authority on the issue of informed refusal. However, it appears that the Courts afford equal, if not more protection of a patient's right to refuse treatment. Certainly, a patient in anticipation of circumstances wherein he or she may be unconscious or otherwise incapacitated and thus unable to contemporaneously express his or her wishes about a particular form of medical treatment, may specify in advance his or her refusal to consent to treatment, and such refusal does not have to be informed. In these circumstances, a physician is not free to disregard such advance instructions, even in an emergency.

Authors Ellen Picard and Gerald Robertson in *Legal Liability of Doctors and Hospitals in Canada*³² indicate that comments made in various decisions suggest a physician has a duty to inform the patient of the risks of declining treatment. They refer to the comments made by Laskin C. J. of the Supreme Court of Canada in *Reibl v. Hughes*³³, when discussing the patient's right to know what risks are involved in undergoing or forgoing certain surgery or other treatment. They also refer to comments made by the Supreme Court of Canada in *Hollis v. Dow Coring Corp.*³⁴ to the effect that the doctrine of informed consent "dictates that every individual has a right to know what risks are involved in undergoing or forgoing medical treatment and a concomitant right to make meaningful decisions based on a full understanding

³² *Supra* note 14 at 156.

³³ *Supra* note 5.

³⁴ (1995), 129 D.L.R. (4th) 609 (S.C.C.).

of those risks”. It appears however that the application of a “doctrine” of informed refusal has yet to be squarely addressed by the Courts of Ontario.

B. Legislation as to Capacity

The doctrine of informed consent presupposes the patient’s capacity to make a subjective treatment decision. There are three Ontario statutes relevant to the issues of consent, capacity and substitute decision making. These are the *Health Care Consent Act, 1996*³⁵, the *Substitute Decisions Act, 1992*³⁶ and the *Mental Health Act*³⁷. It is strongly recommended that any lawyer dealing with the issue of informed consent and capacity to consent, review the legislation to ensure the parameters concerning valid consent and capacity have been met. Below is a brief summary of some of the relevant provisions of the *Health Care Consent Act, 1996*.

Section 4 of the *Health Care Consent Act*³⁸ provides that a person is capable with respect to treatment if he or she is able to understand the information that is relevant to making a decision about the treatment and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision. It also specifies that a person is presumed to be capable for treatment.

A person’s capacity to undergo treatment may be specific to the treatment. Section 15 of the *Health Care Consent Act*³⁹ indicates that a person may be incapable with respect to some treatments and capable with respect to others. A person may also be incapable with respect to a treatment at one time yet capable at another time.

³⁵ *Health Care Consent Act, supra* note 1.

³⁶ S.O. 1992, c. 30 [hereinafter *Substitute Decisions Act*].

³⁷ R.S.O. 1990, c. M.7.

³⁸ *Supra* note 1.

³⁹ *Ibid.*

Section 45 of the *Substitute Decisions Act*⁴⁰ also defines capacity with respect to personal and health care. It provides that a person is incapable of personal care if they are unable to understand information that is relevant to making a decision concerning his or her own health care, nutrition, shelter, clothing, hygiene or safety, or is not able to appreciate the reasonably foreseeable consequences of a decision or lack of a decision.

A health practitioner who proposes treatment for a person is not permitted to administer the treatment unless the health practitioner is of the opinion that the person is capable with respect to the treatment and has given consent. If the health practitioner is of the opinion that the person is incapable with respect to treatment, he or she must consider whether there is a substitute decision maker who may consent on the person's behalf in accordance with the legislation.⁴¹

Section 20(1) of the *Health Care Consent Act*⁴² indicates consent may be given on behalf of a person by any of the individuals listed therein. However, the health care provider must ensure that the ranking order indicated in section 20 is followed and there is no person described in an earlier paragraph who may provide the necessary consent.

Treatment must not begin if the health practitioner proposes a treatment for a person and finds that the person is incapable of consenting to the treatment but learns that the patient or their representative intends to apply to the Capacity and Consent Board for a review of the finding⁴³. In those circumstances, treatment shall not begin until specified criteria met⁴⁴.

A different set of rules apply in the case of an emergency. Section 25(1) of the *Health Care Consent Act* indicates there is an emergency if the person for whom the treatment is proposed

40 *Supra* note 36.

41 *Ibid.* s. 10.

42 *Supra* note 36.

43 *Ibid.* s. 18.

44 *Ibid.* s. 18.

is apparently experiencing severe suffering or is at risk, if the treatment is not administered promptly, of sustaining serious bodily harm. In the case of “emergency” treatment, treatment may be administered without consent to a person who is incapable with respect to the treatment if in the opinion of the health practitioner proposing the treatment that an emergency exists and the delay to obtain the consent or refusal on the persons behalf will prolong suffering or will put the person at risk of sustaining serious bodily harm⁴⁵. If the person is capable and there is an emergency, treatment may be administered without consent to a person if:

- (1) the communication required in order for the person to give or refuse consent to the treatment cannot take place because of a language barrier or because the person has a disability that prevents the communication from taking place
- (2) steps that are reasonable in the circumstances have been taken to find a practical means of enabling the communication to take place, but no such means has been found,
- (3) the delay required to find a practical means of enabling the communication to take place will prolong the suffering that the person is apparently experiencing or will put the person at risk of sustaining bodily harm; and
- (4) there is no reason to believe that the person does not want the treatment⁴⁶.

C. Principles Relating to Standard of Care

A physician is not held to a standard of perfection⁴⁷. The test for standard of care is a test of reasonableness. In determining whether the defendant physician acted reasonably, one must

⁴⁵ *Ibid.* s. 25.

⁴⁶ *Ibid.* It should be noted that examinations or diagnostic procedures that are reasonably necessary to determine whether there is an emergency may be conducted by the health practitioner without consent, if the criteria listed in section 25(4) are met.

take into account the physician's specialty. As indicated by Schroeder J. A. of the Ontario Court of Appeal in *Crits v. Sylvester*:

Every medical practitioner must bring to his task a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. He is bound to exercise that degree of care and skill which could reasonably be expected of a normal, prudent practitioner of the same experience and standing, and if he holds himself out as a specialist, a higher degree of skill is required of him than of one who does not profess to be so qualified by special training and ability.⁴⁸

The standard of care will always be determined by the circumstances of the particular case. Factors such as the presenting symptoms of the patient and the disclosure by the patient to the physician as to their symptoms, are some considerations for determining the standard of care.

Another factor considered when determining the standard of care is the timing of the alleged negligence. The law is sensitive to the fact that the practice of medicine is always improving. As a result, courts are careful to assess doctors according to the standard of care at the time of the alleged negligent act, and not at the time of trial⁴⁹.

Generally, the determination of the standard of care requires input from an expert who has similar qualifications as that of the defendant physician. This is because courts do not have the expertise to determine whether medical professionals have provided treatment in accordance with the medically accepted standard. The standard in and of itself may however be found negligent if "fraught with obvious risks", and in such circumstances, the professional's conduct will amount to negligence regardless of his or her conformity with the standard practice⁵⁰.

The standard of care issue can be determined without expert input in appropriate cases. Where as a matter of common sense, a layperson can readily see that the standard of care exercised

47 Courts should also not judge doctors based on the "perfect vision afforded by hindsight": *Lapointe v. Hôpital Le Gardeur*, [1992] 1 S.C.R. 351 at 362-363.

48 (1956), 1 D.L.R. (2d) 502 at 508 (Ont. C.A.), aff'd (1956), 5 D.L.R. (2d) 601 (S.C.C.) (the test was not commented on by the S.C.C.).

49 *Picard*, supra note 14 at 186.

50 *Lapointe v. Hôpital Le Gardeur*, supra note 47. See also *Ter Neuzen v. Korn*, *ibid.* at 695 to 701.

was negligent, a trier of fact may find a breach of the standard of care without the benefit of expert testimony⁵¹.

Although this has been the subject of criticism⁵², locality and resource constraints are also considerations for determining the standard of care. In *Wilson v. Swanson*, Abbott J. of the Supreme Court of Canada introduced the concept when His Honour stated:

As has been said in the United States, the medical man must possess and use, that reasonable degree of learning and skill ordinarily possessed by practitioners in similar communities in similar cases...⁵³

The rationale for what has been described as the “locality rule”, are the practicalities facing rural or small town practitioners when providing healthcare. Such physicians may have limited access to equipment and facilities, and this may directly affect the care provided to the patient by the physician⁵⁴.

Although the locality rule has not been overruled, the judiciary has expressed concerns over the notion that a lesser standard of care applies to some communities as opposed to others⁵⁵. Some courts have reconciled this concern by applying the locality rule in the context of considering whether the physician has recognized his or her limitations and has exercised his or her ability to refer patients to larger medical facilities for proper care⁵⁶. However, even the ability to refer may be limited by the geographic location of the physician⁵⁷.

In keeping with the principle that physicians are not held to a standard of perfection, a distinction has been made between errors in judgment and negligent conduct. Sometimes clinical

⁵¹ *Ter Neuzen v. Korn* at 705.

⁵² See *Crawford v. Penney*, [2003] O.J. No. 89 (S.C.J.), aff'd [2004] O.J. No. 3669 (C.A.).

⁵³ (1956), 5 D.L.R. (2d) 113 at 124 (S.C.C.).

⁵⁴ *Crawford v. Penney*, *supra* note 52.

⁵⁵ *Ibid.* at para. 254. See also *Law Estate v. Simice*, [1994] B.C.J. No. 979 (QL) (S.C.) aff'd [1995] B.C.J. No. 2596 (QL) (C.A.) and *De Vos v. Robertson*, [2000] O.J. No. 51 (QL) (S.C.J.).

⁵⁶ *Crawford v. Penney*, *supra*, note 52.

⁵⁷ *Mirembe v. Tarshisi*, [2002] O.J. No. 2704 (QL) (S.C.J.).

judgment will be wrong but it will not amount to a breach of standard of care. In *Wilson v. Swanson*, Rand J. of the Supreme Court of Canada explained:

An error in judgment has long been distinguished from an act of unskillfulness or carelessness or due to lack of knowledge. Although universally accepted procedures must be observed, they furnish little or no assistance in resolving such a predicament as faced the surgeon here. In such a situation a decision must be made without delay based on limited known and unknown factors; and the honest and intelligent exercise of judgment has long been recognized as satisfying the professional obligation.⁵⁸

As long as the physician exercised reasonable care when making the error of judgment, there will be no negligence⁵⁹. The exercise of reasonable care in this context, requires sound and thorough investigation of the patient's condition. As stated by Power J. of the Superior Court of Justice in *Crawford v. Penney*:

The proper exercise of judgment by a physician is one that is made after his/her weighing, assessing and evaluating such information as may be available. What "may" be available includes the results of tests or consultations that should have been carried out. In other words, the information upon which a judgment or decision is reached must be as complete as is reasonably available and possible in the circumstances...⁶⁰

D. Principles of Causation

Once a breach of standard of care has been established, the Court must examine whether the breach caused the plaintiff to suffer injury. Causation is a question of fact which is determined by the Court. Given the significant legal expenses associated in retaining experts for medical negligence actions, it is important for counsel to assess causation early in the litigation process. Regardless of whether the plaintiff has successfully proven a breach of the standard care, the principles of causation can result in a significantly reduced damage award or in some cases, no damage award.

⁵⁸ 5 D.L.R. (2d) 113 at 120 (S.C.C.).

⁵⁹ *Wilson Estate v. Byrne*, [2004] O.J. No. 2360 (QL) (S.C.J.).

⁶⁰ *Supra* note 52 cited to S.C.J. at para. 229.

The traditional test for causation is the “but for” test which poses the following question: But for the defendant’s wrongful conduct, would the injury have occurred? If the answer to this test is that the injury would have occurred in any event, then the defendant’s conduct will not be found to be the cause of the injury⁶¹.

Given the inherent difficulties in determining causation for some medical situations, the common law has been modified so that a defendant cannot escape liability simply because the plaintiff cannot prove the defendant specifically caused the plaintiff’s injury. In *Athey v. Leonati*, the Supreme Court of Canada adopted a more flexible approach in this regard and indicated causation need not be determined with scientific precision when it stated:

Causation is established where the plaintiff proves to the civil standard on a balance of probabilities that the defendant caused or contributed to the injury ...

The general, but not conclusive, test for causation is the “but for” test which requires the plaintiff to show that the injury would not have occurred but for the negligence of the defendant...

The “but for” test is unworkable in some circumstances, so the courts have recognized that causation is established where the defendant’s negligence “materially contributed” to the occurrence of the injury ... A contributing factor is material if it falls outside the *de minimis* range...⁶²

Further, where the facts of a case lie particularly within the knowledge of a defendant, then “very little affirmative evidence” can justify an “inference of causation” in the absence of evidence to the contrary⁶³. This has been described as taking a “robust and pragmatic approach” to the facts⁶⁴.

The above principles have been applied in medical negligence cases⁶⁵. The Ontario Court of Appeal discussed these causation issues in the context of a medical negligence action in

⁶¹ *Snell v. Farrell*, [1990] 2 S.C.R. 311 at 310-320.

⁶² (1997), 140 D.L.R. (4th) 235 (S.C.C.) at 238-239.

⁶³ *Snell v. Farrell*, supra note 61.

⁶⁴ *Ibid.* at 330.

⁶⁵ See *Kollaras v. Olympic Airways S.A.*, [1999] O.J. No. 1447 (QL) (S.C.J.).

*Cottrelle v. Gerrard*⁶⁶. In that case, the plaintiff sued the physician on the basis that the defendant negligently treated a sore that developed on the plaintiff's foot. The plaintiff alleged that his leg was amputated as a result of inadequate treatment. A breach of the standard of care was established. The trial judge awarded damages on the basis that the breach caused the plaintiff to lose a "window of opportunity" in avoiding a bad infection. The Court of Appeal allowed the appeal and dismissed the plaintiff's action. The decision was based on the fact that all of the experts agreed that the plaintiff would have lost her leg regardless of the defendant's breach of the standard. Sharpe J. held that the law of causation requires the plaintiff to prove that the defendant caused or contributed to the injury. It was determined that in such cases of delayed medical diagnosis and treatment, the plaintiff must prove that the defendant's negligence caused or contributed to the unfavourable outcome. The "loss of chance" to avoid the unfavourable outcome is not compensable.

Although the plaintiff bears the onus of demonstrating, on the balance of probabilities, that the defendant's negligence caused the injury⁶⁷, it is arguable that the modified rules for causation have effectively displaced the onus of proof to the defendant physician. In *Aristorenas v. Comcare Health Services*⁶⁸, the defendant physician and health care agency negligently treated an incision from a caesarian section. The defendants' negligent conduct caused the plaintiff's necrotizing fasciitis. The Court specifically adopted a relaxed approach to the "but for" test for the reason that necrotizing fasciitis is not known well to the medical profession and there was no evidence to establish what caused the plaintiff's necrotizing fasciitis. The plaintiff did prove that one possible and foreseeable cause of necrotizing fasciitis was the complication of leaving an infected wound untreated. However, this was indicated to be a rare occurrence. The Court

66 (2003), 233 D.L.R. (4th) 45 (Ont. C.A.) rev'g [2001] O.J. No. 5472 (QL) (S.C.J.), leave to appeal to SCC dismissed [2003] S.C.C.A. No. 549 (QL).

67 *Snell v. Farell*, *supra* note 61. Also see *Cottrelle v. Gerrard*, *supra* note 66.

68 [2004] O.J. No. 3647 (S.C.J.).

nonetheless found that the plaintiff met her onus of proof in these circumstances and showed that the defendants' conduct materially contributed to her injury.

The *Aristorenas* decision was subsequently appealed and in October of 2006, the Court of Appeal reversed the decision. The appellants contended that the causal link for the onset of necrotizing fasciitis and the negligent treatment was not proven. The Court thoroughly reviewed the present state of the law of causation as outlined in various Supreme Court of Canada's decisions and discussed the following:

1. The "but for" test is used as the standard for establishing causation in most negligence cases. In an action for delayed medical diagnosis and treatment, a plaintiff is obliged to provide on a balance of probabilities that the delay caused or contributed to the unfavourable outcome. In other words, the plaintiff must prove that the unfavourable outcome would have been avoided with a prompt diagnosis and treatment. It is not sufficient to prove that a timely and adequate diagnosis would have afforded a chance of avoiding the unfavourable outcome unless the chance surpasses the threshold of "more likely than not".
2. The "material contribution" test can apply in cases where the "but for" test is unworkable and particularly, to cases that involve multiple inputs that all have harmed the plaintiff. It is invoked because of logical or structural difficulties in establishing that the negligent act was part of the causal chain. The negligent act will be determined to be the cause-in-fact of the plaintiff's injuries if the plaintiff can prove that the defendant materially contributed to the injury of the plaintiff. The contributing factor will be considered material if it falls outside of the *de minimis* range.
3. The "robust and pragmatic" approach is not a test but an approach to the analysis of the evidence to demonstrate the necessary causal connection between the conduct and the

injury. The Court warned that the “robust and pragmatic” approach did not relieve a plaintiff of his or her burden of proof and this approach was not a substitute for evidence to show that the defendant’s negligent conduct caused the injury. The plaintiff still needs to meet the civil standard of proof (being on a balance of probabilities) and establish a series of facts and circumstances in the evidence that would allow a trial judge to draw an inference even though medical and scientific expertise could not arrive at a definitive conclusion.

In *Aristorenas*, the Court of Appeal took no issue with the trial judge’s decision to adopt the “material contribution” test for causation and to take the “robust and pragmatic” approach to the fact finding component of the causation analysis given that scientific proof of causation was not attainable. In this case, the trial judge’s causation analysis was noted to have simply hinged on his view that it was a matter of common sense that the negligence or delay on the part of the defendants allowed the wound to reach a complicated state and lead to rapid unpredictable consequences. The Court found that there was insufficient evidence in the record to provide the necessary evidentiary foundation that would support an inferential finding that the necrotizing fasciitis was caused by the negligence of the defendants. The evidence about the impact of the defendants’ delayed treatment on wound care and infections was considered to be limited and vague, and of little assistance. There was no evidence that the delay in treatment caused the plaintiff to contract necrotizing fasciitis. In fact, there was a wide variety of possible causes of necrotizing fasciitis and the Court could not determine from the evidence which one was correct or the most probable. As such, the appeal was allowed and the finding that the necrotizing fasciitis suffered by the plaintiff was caused by the defendants’ negligence was set aside.

A third decision wherein the law of causation was recently reviewed is that of local Justice Rady in *Fisher v. Attack*⁶⁹. In this matter, the Court expressed the following as its understanding of the current state of causation law in Ontario and applied same to a baby compromise case. Causation is to be established on a balance of probabilities and the burden of proof always lies with the plaintiffs. The plaintiffs will generally need to show that the injury would not have occurred “but for” the negligence of the defendant. The “but for” test however was not to be applied too rigidly as causation often cannot be demonstrated with scientific precision. In some cases, such as where the information regarding the injury is almost completely in the hands of the defendant, a “robust and pragmatic” approach may be taken and an inference of causation may be drawn from the evidence without having the benefit of positive scientific proof. A defendant will not be relieved from liability where there are concurrent non-tortious causes of the injury. Full liability may attach if it can be shown that the defendant’s negligence was *one* of the sources that contributed to the harm. Finally, loss of a chance of a more favourable outcome will not be compensated. In order to succeed, the plaintiff must show that a more timely diagnosis and/or treatment would “more likely than not” have avoided the harm.

In *Fisher v. Attack*, critical to the Court’s analysis of causation was the timing of the minor plaintiff’s brain injury and the precision with which it could be measured. A number of experts testified. Three scenarios were advanced to explain the plaintiff’s brain injury: 1) solely acute total or near total asphyxial exposure, 2) mixed form of asphyxial exposure and 3) prolonged partial exposure. The Court determined that the timing of the injury with minute accuracy could not be determined, but the Court accepted one expert’s evidence that there was likely both partial prolonged asphyxia and an acute near total event that occurred in a specified range of hours before birth. These events were determined to have occurred before the defendant physician assumed responsibility for the delivery of the child and therefore there was no causal

69 [2007] O.J. No. 507 (Q.L.) (S.C.J.).

connection between his alleged breach (which was not proven) and the damages sustained by the plaintiff. However, causation was made out for the nurses who, based on expert evidence, were found to have breached the applicable standard of care, when they failed to auscultate the fetal heart during the specified range of hours before birth. The Court indicated that there was support for this conclusion as it was established in the evidence that there were no decelerations of bradycardia at other times when the fetal heart was being auscultated properly. There also was evidence from a defendant nurse that she observed the fetal heart to be barely fluttering some time after the specified range of hours before birth and this signified a very slowly beating heart. The Court felt it was reasonable to also infer that if the nurses auscultated the fetal heart during that time period, they would have detected decelerations or perhaps a bradycardia of the fetal heart, which would have raised concern that some form of an asphyxial event was occurring. The Court also felt it was reasonable to conclude that the nurses would have likely conducted the appropriate nursing interventions and summoned assistance from a physician. Steps would have been taken to expedite the delivery and the plaintiff would have been spared the magnitude of her injuries. Based on this “pragmatic and robust” approach to the evidence, the nurses’ breach of care in not auscultating the fetal heart during the specified range of hours before birth, was found to have caused or materially contributed to the plaintiff’s injuries on a balance of probabilities.

E. Principles of Fiduciary Law in the Physician-Patient Relationship

Breach of a fiduciary duty is another legal doctrine upon which a Court may award damages.

The Supreme Court of Canada has explored the nature and scope of a fiduciary relationship in

a series of significant decisions⁷⁰. The test for determining whether a fiduciary duty exists can be stated as follows:

1. The fiduciary has scope for the exercise of some discretion of power.
2. The fiduciary can unilaterally exercise a power or discretion so as to affect the beneficiary's legal or practical interests.
3. The beneficiary is peculiarly vulnerable to or at the mercy of the fiduciary holding the discretion of power.⁷¹

It is clear that the physician-patient relationship is a fiduciary relationship. However, not all duties owed by the fiduciary to the beneficiary will be "fiduciary" duties. Mere negligence does not by virtue of the fiduciary relationship amount to a breach of fiduciary duty and the Courts are extremely cognizant of this principle when dealing with such allegations against a physician.

The Supreme Court of Canada discussed the concept of a fiduciary relationship in the context of a physician-patient relationship in two key decisions: *Norberg v. Wynrib*⁷² and *McInerney v. MacDonald*⁷³.

In *Norberg v. Wynrib*⁷⁴, a male doctor who was aware of a female's drug addiction prescribed her painkillers in exchange for sexual favours. In addition to violating her sexually, Dr. Wynrib's action prolonged Norberg's drug addiction. The Supreme Court of Canada found the physician committed battery. The Court however was divided as to the applicable legal doctrine. McLachlin and L'Heureux Dube JJ. dissented from the approach taken by the majority and found Dr. Wynrib breached his fiduciary duty to Norberg by taking advantage of her drug-

70 *Guerin v. The Queen*, [1984] 2 S.C.R. 335. Also see *Frame v. Smith*, [1987] 2 S.C.R. 99, *Lac Minerals Ltd. v. International Corona Resources Ltd.*, [1989] 2 S.C.R. 574 [hereinafter *Lac Minerals Ltd.*], *Norberg v. Wynrib* (1992), 92 D.L.R. (4th) 449 (S.C.C.) additional reasons at [1992] 2 S.C.R. 318 (S.C.C.), *McInerney v. MacDonald*, [1992] 2 S.C.R. 138; *M.(K) v. M. (H.)*, [1992] 3 S.C.R. 6 and *Hodgkinson v. Simms*, [1994] 3 S.C.R. 377.

71 *Lac Minerals Ltd.*, *supra* note 69 at 599.

72 *Supra* note 69.

73 *Supra* note 69.

74 *Supra* note 69.

induced vulnerability for his own sexual gratification. When analyzing the physician-patient relationship, McLachlin J. stated:

...I think it is readily apparent that the doctor-patient relationship shares the peculiar hallmark of the fiduciary relationship – trust, the trust of a person with inferior power that another person who has assumed superior power and responsibility will exercise that power for his or her good and only for his or her good and in his or her best interests. Recognizing the fiduciary nature of the doctor-patient relationship provides the law with an analytic model by which physicians can be held to the high standards of dealing with their patients which the trust accorded them requires...⁷⁵

Sopinka J., who also dissented from the approach taken by the majority, found there was a breach of the professional duty owed by a physician to his or her patient which would have resulted in damages in tort. He did not find a breach of a fiduciary relationship in the circumstances of this case. He warned that the facts of the case must warrant both the finding of a fiduciary relationship and the determination that the obligation at issue is fiduciary in nature.

In *McInerney v. MacDonald*⁷⁶, the Court dealt with a dispute over medical records. La Forest J. held that the physician, institution, or clinic responsible for compiling a medical record owns the patient's physical record. However, the special relationship of trust and confidence between the doctor and patient lead to a fiduciary duty on the part of the physician, which requires the physician to allow the patient to have access to his or her own medical record. With respect to the fiduciary duty of confidentiality, La Forest J. specifically stated:

In characterizing the physician-patient relationship as "fiduciary", I would not wish it to be thought that a fixed set of rules and principles apply in all circumstances or to all obligations arising out of the doctor-patient relationship. As I noted in *Canson Enterprises Ltd. v. Boughton & Co.*, [1991] 3 S.C.R. 534, not all fiduciary relationships and not all fiduciary obligations are the same; these are shaped by the demands of the situation. A relationship may properly be described as "fiduciary" for some purposes, but not for others. That being said, certain duties do arise from the special relationship of trust and confidence between doctor and patient. Among these are the duty of the doctor to act with utmost good faith and loyalty, and to hold information received from or about a patient in confidence.

⁷⁵ *Norberg v. Wynrib*, *supra* note 69 at 486.

⁷⁶ *Supra* note 69.

(*Picard, supra*, at pp. 3 and 8; *Ellis, supra*, at pp. 10-1 and 10-12, and *Hopper, supra*, at pp. 73-74). When a patient releases personal information in the context of the doctor-patient relationship, he or she does so with the legitimate expectation that these duties will be respected.⁷⁷

Negligent conduct rarely, if ever, amounts to a breach of fiduciary duty. In *Arndt v. Smith*⁷⁸, a physician made a deliberate choice not to disclose to a pregnant mother the significant risks to the fetus caused by the mother's chicken pox. The parents sued for "wrongful birth". McLachlin J. explicitly rejected the proposition that the mother's claim should be approached as a claim for breach of fiduciary duty and stated:

...I would reject the alternative approach of fiduciary obligation proposed by the respondent... the effect would be to replace the factual analysis of standard of care and causation appropriate to negligence actions with a choice-based analysis that make recovery virtually automatic upon proof of failure to provide relevant information. I see no reason to depart from the approach which considers the failure of a physician to advise of medical risks under the law of negligence relating to duty of care, absent special circumstances like fraudulent misrepresentation or abuse of power for an unprofessional end... Such conduct is neither alleged nor proven in the case at bar.⁷⁹

In order to prove a breach of fiduciary duty by the defendant physician, Courts have held that there must be an element of exploitation or predation on the patient by the physician. Such was the case in *Welch v. Dore*⁸⁰, where the Court noted that the obligation of a fiduciary is not attracted by the fact that the one party relinquished his or her power to another. It was rather when the fiduciary with power abuses it, that the fiduciary obligation will be breached and the Court will intervene to restrict its inappropriate or damaging use. In this case, the physician's conduct in continuing to prescribe drugs to his patient after realizing she was addicted, was found to amount to negligence as opposed to an abuse of power. The Court based this finding on the fact that there was nothing to suggest the physician exploited or preyed on his patient's vulnerability.

⁷⁷ *McInerney v. MacDonald, supra* note 69 at 149.

⁷⁸ [1997] 2 S.C.R. 539.

⁷⁹ *Ibid.* at 562.

⁸⁰ [2000] O.J. No. 737 (S.C.J.).

A similar approach was taken in *T.C. v. Scott*⁸¹, wherein the Court dealt with a case in which a patient alleged improper psychiatric treatment and sexual abuse by a psychiatrist. The psychiatrist was found to have breached his fiduciary duty for the specific reason that he took advantage of his influence over the patient. The psychiatrist knew of the patient's highly vulnerable state and because of the inequality of power that existed in the relationship between them, he exploited it.

If the physician's conduct is clearly motivated by self-interest, such conduct will likely amount to a breach of fiduciary duty. In *Gerula v. Flores*⁸², the Ontario Court of Appeal found a physician's failure to disclose to a patient that he operated on the wrong level of the patient's back amounted to a misrepresentation by omission. The misrepresentation was deliberate and amounted to a battery. The physician's conduct in then proceeding to operate a second time (on the correct area of the back) without disclosing the true purpose of the second operation also constituted a battery as well as a breach of fiduciary duty. The Court found that the physician, by withholding important information from the patient, acted in his own self-interest and he abused his position and his patient's trust that he would not act out of self-interest.

Whether the patient is a child, is another factor considered by the Courts when determining the existence of a breach of fiduciary duty. In *R.(J.) v. W. (E.S.)*⁸³, the Court dealt with a dental patient who was sexually assaulted by her dentist when she was 13 years old. The court found no material distinction between the fact that the defendant was a dentist as opposed to a physician when holding that a medical professional generally stands in a fiduciary relationship with their patients as they hold the power to advise and treat the patient, and can frequently do so in a unilateral way. When finding the defendant had breached his fiduciary duty, the Court emphasized the fact that the plaintiff patient was 13 years old at the time, and she was dealing

81 [1997] O.J. No. 2389 (QL) (Gen. Div.).

82 [1995] O.J. No. 2300 (QL) (C.A.).

83 [2001] O.J. No. 133 (QL) (S.C.J.).

with an adult who was a medical professional. She was therefore clearly vulnerable to the power which she would perceive the defendant professional to have over her and be particularly susceptible to its misuse. As such, the defendant's act in sexually assaulting the plaintiff constituted a breach of the fiduciary duties owed to the plaintiff.

A fiduciary duty may also arise in the context of a referral by a physician. In *Williams v. Wai-Ping*⁸⁴, the Court dismissed a motion to strike allegations in a Statement of Claim containing allegations of breaches of fiduciary duties. Several patients were suing a surgeon who appeared to be well known for his incompetence. The patients were also suing their own treating physicians who were responsible for their referrals to this surgeon. In refusing to strike the breach of fiduciary duty claim, the Court noted that the types of situations which may give rise to a fiduciary duty breach are not finite. The duty may include obligations to disclose errors, not to act in one's self-interest, and to disclose information which a reasonable patient would want to know, which arguably included information as to the incompetence of the physician to whom they were referring their patients. The court commented that the physician and patient relationship at its core is one of a fiduciary. It reasoned that a patient with inferior power trusts that another person with superior medical power, knowledge and responsibility will exercise the duty for the patient's good and only for her good and only in her interest.

The motive for a plaintiff to prove a fiduciary breach generally lies in the damage award. When dealing with damages arising from such a breach, the plaintiff does not need to address legal principles that often affect causation or the quantum of relief for tort or contract damage awards⁸⁵. There are several forms of relief for a breach of fiduciary duty including equitable compensation, equitable accounting, declaration, constructive trust, equitable lien, equitable tracing, injunctive relief, and rescission. The circumstances of the relationship and the breach

84 [2005] O.J. No. 1940 (QL) (S.C.J.).

85 L. I. Rotman, *Fiduciary Law*, (Toronto: Carswell 2005) at 688, 693 and 709.

determine the relief awarded. In fiduciary breach cases involving physician-patient relationships, the plaintiff is often awarded equitable compensation⁸⁶. Such compensation is designed to address the wrong of the physician's conduct. The compensation is considered to be exemplary in nature and its rationale is to deter fiduciaries from engaging in misconduct. Such a damage award provides monetary compensation for actual or potential harm or loss caused by a breach of fiduciary duty. The damage award in such cases is therefore generally higher than what one would expect to receive in tort or contract law for this reason as well. It should also be noted that fiduciaries liable for fiduciary misconduct may also have solicitor client costs awarded against them⁸⁷.

In sum, the physician-patient relationship is unique and the Courts are reluctant to automatically find a fiduciary breach by the physician absent special circumstances. Therefore the circumstances of the relationship and the alleged misconduct must be thoroughly investigated in order to address the appropriateness of advancing a breach of fiduciary duty claim. Factors to consider include the imbalance of the physician-patient relationship, the age of the patient, the motive of the physician's conduct, and whether the patient was exploited or "preyed upon" by the physician at the time of the wrong doing.

F. Changes to Ontario's Law of Limitations

The limitation period for actions against physicians was previously provided in the *Health Professions Procedural Code*⁸⁸. Section 89(1) of the *Code* stated:

No person who is or was a member is liable to any action arising out of negligence or malpractice in respect of professional services requested of or rendered by the person unless the action is commenced within one year after the date when the person commencing the action knew or ought to have known the fact or facts upon which the negligence or malpractice is alleged.

⁸⁶ *Ibid.* at 709.

⁸⁷ *Ibid.* at 706.

⁸⁸ Being schedule 2 to the *Regulated Health Professions Act*, S.O. 1991 c. 18 [hereinafter *Code*], deemed by section 4 of the *Regulated Health Professions Act* to be part of every health profession's act

The above provision was repealed with the enactment of the long awaited *Limitations Act, 2002*⁸⁹. The new legislation has altered the limitation period for actions against physicians where the cause of action arose after January 1, 2004 and in some cases, before January 1, 2004 as well.

The new Limitations Act provides a basic limitation period of two years for all proceedings from the date the claim is discovered. The incorporation of the discoverability principle into the legislation reflects the common law principle that has developed in our courts. By introducing the discoverability principle into the legislation, there will be more uncertainty as to when a limitation period for a claim has expired. Pursuant to the legislation, a claim is not discovered until the day on which the person with the claim first knew or ought to have known:

- (i) that the injury, loss of damage had occurred,
- (ii) that the injury, loss or damages was caused by or contributed to by an act or omission
- (iii) that the act or omission was that of the person against whom the claim is made, and
- (iv) that having regard to the nature of the injury, loss or damage, a proceeding would be an appropriate means to seek to remedy it⁹⁰.

The Act also however imposes a rebuttable presumption that a claim is discovered on the day the act or omission took place⁹¹. The onus is on the plaintiff to prove otherwise.

⁸⁹ S.O. 2002, c. 24, Sch. B.

⁹⁰ *Ibid.*, s. 5(1).

⁹¹ *Ibid.*, s. 5(2).

The two year limitation period does not run during any time which the person with the claim, is a minor and is not represented by a litigation guardian in relation to the claim⁹². Time also does not run when the person with the claim is incapable of commencing a proceeding because of his or her physical, mental or psychological condition and is not represented by a litigation guardian in relation to the claim⁹³. Again, there is a presumption that a person is capable of commencing a proceeding at all times unless the contrary is proved⁹⁴.

If a person is represented by a litigation guardian in relation to the claim, the discoverability rules apply as if “the person with the claim” is the litigation guardian⁹⁵. The new legislation is helpful to potential defendants who seek resolution to a claim in a timely fashion. A potential defendant may appoint a litigation guardian for a potential plaintiff on application or motion, if the running of a limitation period is postponed or suspended because the person is a “minor” or “incapable”. The appointment of the litigation guardian ends the postponement or suspension of the running of the limitation period if the following criteria are met:

1. the appointment is made by a Judge on the application or motion of a potential defendant, and
2. the Judge is satisfied that the litigation guardian,
 - (i) has been served with the motion,
 - (ii) has consented to the appointment in writing or in person before the Judge,

⁹² *Ibid.*, s. 6.

⁹³ *Ibid.*, s. 7.

⁹⁴ *Ibid.*, s. 7(2).

⁹⁵ *Ibid.*, s. 8.

- (iii) in connection with the claim, knows of the matters referred to in section 5(a) which defines the period of discoverability,
- (iv) does not have an interest adverse to that of the potential plaintiff, and
- (v) agrees to attend to the potential plaintiff's interests diligently and to take all necessary steps for their protection, including the commencement of a claim if appropriate⁹⁶.

Aside from the transition rules discussed below, there are exceptions to the basic two year limitation period. For an individual statute to maintain a limitation period different from that of the Act, the statute must be specified in Schedule A to the *Limitations Act, 2002*. For example, the *Trustee Act*⁹⁷, which has been included in Schedule A to the new Limitations Act, contains a limitation period of two years from the date of the death of the deceased in respect of certain types of claims.

Claims for assault and sexual assault are specifically protected by the new Limitations Act. The two year period does not run during any time in which the person with the claim is incapable of commencing the proceeding because of his or her physical, mental or psychological condition⁹⁸. Such plaintiffs reap the benefit of rebuttable presumptions in that they are presumed to have been incapable of commencing the proceeding earlier than it was commenced⁹⁹. The presumption for the person with the claim based on an assault however applies only if at the

⁹⁶ *Ibid.*, s. 9.

⁹⁷ R.S.O. 1990, c. T.23, s. 38(3).

⁹⁸ *Supra* note 87, s. 10(1).

⁹⁹ *Ibid.*, s. 10(3).

time of the assault, one of the parties to the assault had an intimate relationship with the person or was someone on whom the person was dependent, whether financially or otherwise¹⁰⁰.

Further, there is no limitation period for a proceeding arising from a sexual assault if at the time of the assault, one of the parties to it had charge of the person assaulted, was in a position of trust or authority in relation to the person or was someone on whom he or she was dependent, whether financially or otherwise.

The *Limitations Act, 2002* also provides for an “ultimate limitation period” in that no proceeding shall be commenced in respect of any claim more than 15 years after the day on which the act or omission on which the claim is based took place¹⁰¹. Accordingly, claims commenced after the 15th anniversary of the occurrence that gave rise to the claim will be statute barred, even if a claim has not been discovered within the 15 years of the occurrence which gave rise to the claim. This feature mitigates some of the uncertainty resulting from the now legislated discovery principle. There are specific provisions governing when the 15 year period begins for claims where there is a continuous act or omission or a series of acts or omissions¹⁰². Further, the ultimate limitation period does not run at any time during which a potential plaintiff is incapable of commencing an action on account of physical or psychological incapacity, or is a minor without a litigation guardian¹⁰³. Time also does not run for the purposes of the ultimate limitation period when the person against whom the claim is made willfully conceals the fact that there was a loss, or that the loss was caused by their act or omission¹⁰⁴.

100 *Ibid.*, s. 10(2).

101 *Ibid.*, s. 15.

102 *Ibid.*, s. 15(6).

103 *Ibid.*, s. 15(4).

104 *Ibid.*

Agreements to vary or suspend limitation periods are null and void if the new Limitations Act provides for a limitation period for the claim, unless the agreement was made before January 1, 2004¹⁰⁵.

i. Transition Provisions

For causes of action which arose before January 1, 2004 there are transition provisions where no proceeding has been commenced before January 1, 2004¹⁰⁶.

For causes of action which arose prior to January 1, 2004, if the former limitation period expired before January 1, 2004, the new Limitations Act will not revive the claim except in certain cases involving assault or sexual assault.

For causes of action which arose prior to January 1, 2004, if the former limitation period had not yet expired by January 1, 2004 but the cause of action would have been subject to a limitation period under the new Act had the events giving rise to the action occurred after January 1, 2004, then the applicable limitation period is determined by the date the claim was discovered:

- (a) Where the claim was not discovered before January 1, 2004, the new Act applies as if the act or omission had taken place on January 1, 2004.
- (b) However, where the claim was discovered before January 1, 2004, the former limitation period applies.

For causes of action which arose before January 1, 2004 and where the former limitation period had not yet expired by January 1, 2004, if there is no limitation period under the new Act for such a claim had the cause of action arose after January 1, 2004, then no limitation period would apply.

¹⁰⁵ *Ibid.*, s. 22.

¹⁰⁶ *Ibid.*, s. 24.

In cases where no limitation period applied under the former legislation, but where under the new Act a limitation period would apply when based on an act or omission that took place after January 1, 2004, then again the applicable limitation period is determined by the date the claim was discovered:

- (a) If the claim was not discovered before January 1, 2004, the new Act applies as if the act or omission had taken place on January 1, 2004.
- (b) If the claim was discovered before January 1, 2004 then there is no limitation period.

Although the purpose of the new Limitations Act is to simplify and clarify the law of limitations, most feel the Act is far from simple. At present, its application is uncertain and the law of limitations for Ontario will undoubtedly undergo significant analysis in the Courts. This may well result in further changes to Ontario's law of limitations, and affect limitations pertaining to medical malpractice actions. Counsel should therefore ensure they keep apprised of the impending developments in this area.

G. Conclusion

In conclusion, when assessing a medical malpractice case, counsel should thoroughly examine the factual circumstances in order to ensure the appropriate legal claims or defences are applied. There are several legal duties imposed upon a physician throughout the course of the physician's treatment of the patient. Physicians are not held to a standard of perfection but rather a standard that may be established by their peers. A prudent plaintiff's counsel will secure a financial retainer from the client for the purpose of obtaining an expert medical opinion advising as to the merits of the case, before commencing costly litigation. Counsel should also determine the applicable limitation period as soon as possible, given the recent significant changes to Ontario's law of limitations.