Government Tort Liability for Negligence in the Health Sector: A Critique of the Canadian Jurisprudence

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For half a century, provincial governments have had a near monopoly over most physician and hospital services. More recently, in response to growing concerns about cost and quality, they have begun to directly regulate hospital governance and patient care in some respects, and have made structural changes to the health system. This expanded role on the part of governments makes it more important to hold them accountable for their decisions—a goal which in the author's view will be furthered by a more receptive judicial attitude to tort claims against government. Unlike lawsuits based on constitutional or administrative law principles, tort claims can readily be based on shortcomings in quality of care, not just access to care. In reviewing government actions, courts have certain advantages, in terms of transparency, answerability to injured parties and remedial powers, over such bodies as commissions of inquiry, auditors general and ombudsmen. In the author's view, a multifaceted approach that couples reliance on such bodies with a broader scope for tort claims will bring greater accountability.

In health sector tort cases, however, courts have been reluctant to find that governments owe a duty of care to individual plaintiffs because of a tendency to assume that any such duty would conflict with statutory duties owed to the public as a whole. The author faults the courts for striking claims without due regard for the novelty, complexity and importance of the issues involved in each claim. The test for a duty of care should focus on the actual relationship of the parties, taking into account any expectations, representations or reliance. Later stages of the negligence analysis—in particular, whether the required standard of care has been met—can be relied on to filter out claims based on pure policy decisions by government. Allowing health sector tort claims to proceed to trial, for a full assessment of whether a duty exists and whether the duty has been breached, would more effectively balance the need for governmental accountability against concerns about undue interference in governmental policy-making.

Introduction

Historically, physicians bore sole responsibility for the quality of health care services, while hospitals merely furnished a location to practice medicine and provided nursing staff to assist. Until the middle of the twentieth century, the role of provincial governments[1] was restricted to providing limited funding for low-income individuals to obtain health services or insurance, and to providing specific health services (primarily public health and mental health services). Accordingly, these actors owed patients few legal obligations. Beginning with the implementation of Medicare, the government's role in the health sector underwent a dramatic expansion, motivated by escalating costs and concerns with the quality of medical services. This expanded role led to calls for accountability, as evidenced by an increasing number of legal claims against provincial ministries of health. In this paper, I explore the relationship between governmental tort liability and health sector accountability—a relationship which raises important legal, fiscal and policy issues. Yet, in contrast to other types of health sector claims, which are the subject of much commentary,[2] there is a paucity of literature examining the tort cases.

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1. Unless otherwise stated, I use the general term "government" to refer to Canadian provincial governments.

2. The constitutional health law cases in particular have attracted a great deal of scholarly attention. For example, commentary on *Chaoulli v Quebec (Attorney General)*, 2005 SCC 35, [2005] 1 SCR 791, occupied an entire journal issue ((2006) 44:2 Osgoode

In Part I, I describe the government's growing involvement in the health sector, particularly its control over other health system actors and its influence on the treatment received by patients. I turn to discuss the lack of commensurate accountability for this expanded role in Part II. In Part III, I compare tort law with other mechanisms for reviewing governmental decisions, concluding that the judiciary's reluctance to hear health sector tort claims leaves a gap in accountability. Nearly all of these claims have been struck on pre-trial applications (either motions to strike for lack of a cause of action or class certification motions). In Part IV, I briefly summarize the facts of the health sector tort claims. In Part V, I argue that courts are failing to give sufficient weight to considerations that indicate the health sector tort claims should proceed to trial, such as their complexity and the importance of the issues involved.

The health sector tort claims have all been resolved on the issue of whether the government owed a duty of care to the plaintiff. Courts have not considered other elements of negligence, such as breach of duty or causation. In Part VI, I discuss the Canadian test for the existence of a duty, using the health sector claims to illustrate my broader criticisms of the test. Specifically, I argue for a contextual approach that makes the parties' relationship central to the duty inquiry, and the use of judicial restraint in allowing policy considerations to negate a duty on a motion to strike. Because the judiciary's reluctance to review governmental health sector decisions seems to be largely attributable to a concern over the judicial reallocation of scarce health resources, I also address this issue. Although I do not advocate widespread governmental liability, I argue that the law could be applied in a manner that better facilitates accountability, by allowing more claims to proceed to trial and to be evaluated at the standard of care stage of the negligence inquiry, where the government would be called upon to justify its decisions.

Hall LJ), a book (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)), numerous articles and several conferences.

I. Government's Expanded Role in the Health Sector

Beginning in the late 1940s, a number of factors led Canadian provincial governments to assume the role of health system insurer: the increased efficacy of and resulting demand for medical services;[3] the post-war expansion of the welfare state;[4] the example of Saskatchewan, which successfully surmounted provider opposition to implement universal insurance for hospital services;[5] and the federal government's offer to share costs with participating provinces.[6] Although provincial health insurance plans required a significant financial commitment from governments, the state initially remained a passive payer, reimbursing the cost of services organized and delivered by hospitals and physicians.[7] The doctor-patient relationship and hospital organizational structure remained unchanged by Medicare, with provider self-regulatory bodies

3. Recognizing the importance of access to health services, several provinces already subsidized private insurance. Doctors who feared government insurance would erode their autonomy supported state-subsidized private insurance. For a discussion of the history of Medicare in Saskatchewan, see 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 Can Med Assoc J 1234; (1972) 107:(1-6) Can Med Assoc J 64, 159, 236, 337, 444 & 564.

4. The implementation of several other social assistance programs lent legitimacy to universal health insurance. For a general discussion of the development of the Canadian welfare state, see John Ralston Saul, *A Fair Country: Telling Truths About Canada* (Toronto: Viking Canada, 2008).

5. Saskatchewan's premier was deeply committed to public insurance. See Walter Stewart, *The Life and Political Times of Tommy Douglas* (Toronto: McArthur, 2003); MacTaggert, *supra* note 3.

6. *Hospital Insurance and Diagnostic Services Act*, SC 1957, c 28; *Medical Care Act*, SC 1966-67, c 64. These statutes were subsumed into the *Canada Health Act*, RSC 1985, c C-6.

7. Carolyn Hughes Tuohy, *Accidental Logics: The Dynamics of Change in the Health Care Arena in the United States, Britain, and Canada* (New York, NY: Oxford University Press, 1999) [Tuohy, *Accidental Logics*] (referring to the relationship of accommodation between providers and governments as the "fundamental bargain" upon which Medicare was founded at 258).

and the hospital medical staff system retaining jurisdiction over the quality of health services.[8]

By the late 1980s, provincial governments began to expand their health sector involvement, motivated by rapidly growing expenditures and concerns with the quality of medical services. Decades of expansion encouraged by federal cost-sharing resulted in excess hospital capacity,[9] the fee-for-service payment environment caused supplier-induced demand for medical services,[10] and costly advances in medical technology[11] led policy-makers to question the sustainability of the health system.[12] Fiscal pressures were exacerbated by concerns over high

8. These bodies regulate quality through entry requirements into the profession (licensure and hospital medical staff privileges) and discipline (revocation of licenses and suspension of hospital privileges). Additionally, hospital medical staff improve quality through morbidity and mortality reviews (retrospective reviews of the treatment given to injured patients).

9. Eugene Vayda & Raisa B Deber, "The Canadian Health Care System: An Overview" (1984) 18:3 Social Science & Medicine 191. See also David Reisman, *Health Care and Public Policy* (Cheltenham, UK: Edward Elgar, 2007) at 57 (although the demand for medical services may be less elastic than for other goods, health service supply correlates with use).

10. See generally Robert G Evans, "Supplier-Induced Demand: Some Empirical Evidence and Implications" in Mark Perlman, ed, *The Economics of Health and Medical Care: Proceedings of a Conference Held by the International Economic Association at Tokyo* (London: Macmillan, 1974) 162.

11. Medicare predated the proliferation of expensive medical treatments such as sophisticated diagnostic tests: Tal Geva, "Magnetic Resonance Imaging: Historical Perspective" (2006) 8:4 Journal of Cardiovascular Magnetic Resonance 573 at 576 (the research leading to MRIs was published in 1974); elaborate surgical procedures: Lawrence K Altman, "The Ultimate Gift: 50 Years of Organ Transplants", *The New York Times* (21 December 2004), online: New York Times <http://www.nytimes.com> (organ transplants began in the 1950s); and improvements in the viability of premature infants: I Seri & J Evans, "Limits of Viability: Definition of the Gray Zone" (2008) 28:(May 2008 Supplement) Journal of Perinatology S4 ("[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" at S4).

12. Total health expenditures were forecast to reach $200.5B in 2011. Canadian Institute for Health Information, *National Health Expenditure Trends, 1975 to 2011* (Ottawa: CIHI, 2011) at xv, online: <http://secure.cihi.ca/cihiweb/products/nhex_trends_report_ 2011_en.pdf>. In 2010, the Ontario government reported that 42% of total program spending was allocated to health care, and anticipated that it might soon rise to 50%. See Ontario Ministry of Finance, *Ontario's Long-Term Report on the Economy* (Toronto: Ontario Ministry of

volumes of unnecessary health care services, with numerous studies demonstrating considerable variation in health service utilization, with no clinical or demographic explanation.[13] For example, one study found that the use of high-volume services such as lab tests and x-rays could be reduced by 47 per cent without diminishing quality of care.[14] High rates of medical error were another catalyst for increased regulation. Using a conservative methodology, a 2004 study estimated that of the 2.5M annual hospital admissions in Canada, up to 232 250 were associated with adverse events, nearly 70 000 of which were preventable.[15]

Finance, 2010) at 44, online: <http://www.fin.gov.on.ca>. A recent report 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". See Don Drummond & Derek Burleton, *Charting a Path to Sustainable Health Care in Ontario: 10 Proposals to Restrain Cost Growth without Compromising Quality of Care* (Toronto: TD Financial Group, 2010) at foreword, online: <http://www.td.com/document/PDF/economics/special/td-economics-special-db0510-health-care.pdf>.

13. See e.g. Yunjie Song et al, "Regional Variations in Diagnostic Practices" (2010) 363:1 New Eng J Med 45; H Gilbert Welch et al, "Geographic Variation in Diagnosis Frequency and Risk of Death Among Medicare Beneficiaries" (2011) 305:11 JAMA 1113; John E Wennberg, "Practice Variations and Health Care Reform: Connecting the Dots" (2004) Health Affairs VAR-140, online: <http://www.healthaffairs.org>.

14. Marcia Angell, "Cost Containment and the Physician" (1985) 254:9 JAMA 1203 at 1204.

15. G Ross Baker et al, "The Canadian Adverse Events Study: The Incidence of Adverse Events Among Hospital Patients in Canada" (2004) 170:11 Can Med Assoc J 1678 at 1683–84. Various factors 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); excludes data from small hospitals (although one indicia of patient outcomes is volume: see 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); only relies on data from patient charts (failing to capture readmissions to other hospitals); and only includes incidents resulting in injury (one study, which monitored the rate and types of errors in acute care hospitals, found that 13% of reported errors were "near misses": Catherine E Milch et al, "Voluntary Electronic Reporting of Medical Errors and Adverse Events" (2006) 21:2 Journal of General Internal Medicine 165 at 167–68). Studies employing alternate 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;

Furthermore, the patient safety literature indicates that injuries once solely attributed to providers are frequently caused or contributed to by the systems within which providers work—systems organized, managed, coordinated and funded by actors such as hospitals and government.[16]

Motivated by the need to control costs and emerging concerns with quality of care, governments increasingly assert control over previously independent hospitals through organizational reforms and governance requirements and intervene in provider treatment decisions. Perhaps the most transformative example of governmental control over institutions was the implementation of regionalization.[17] Although policy-makers predicated this reform as a devolution of responsibility from the state to newly-created regions, it was also an assertion of governmental authority, as it involved a complete reconfiguration of the health system on the basis of little evidence.[18] Furthermore, regionalization generally involved replacing the boards of private corporations—which had

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L Lingard et al, "Communication Failures in the Operating Room: An Observational Classification of Recurrent Types and Effects" (2004) 13:5 Quality & Safety in Health Care 330).

16. See generally Committee on Quality of Health Care in America, *To Err is Human: Building a Safer Health System*, Linda T Kohn, Janet M Corrigan & Milla S Donaldson, eds (Washington, DC: National Academy Press, 2000). Conditions intrinsic to health care exacerbate the tendency to err. Health practitioners are busy, stressed and tired. They 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 (J Reason, "Safety in the Operating Theatre—Part 2: Human Error and Organisational Failure" (2005) 14:1 Quality & Safety in Health Care 56 at 58), 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 Brit Med J 771.

17. The goals of regionalization are to improve integration by eliminating duplication and cutting costs, and to enhance quality by facilitating continuity of care. There is interprovincial variation in its configuration, for example, in the size of regions and the scope of their responsibility for services delivered outside hospitals (such as public health or long-term care). See generally Jonathan Lomas, John Woods & Gerry Veenstra, "Devolving Authority for Health Care in Canada's Provinces: 1. An Introduction to the Issues" (1997) 156:3 Can Med Assoc J 371.

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

governed hospitals for many decades—with government-appointed regional health authorities.[19] These authorities are subject to extensive state oversight through reporting obligations,[20] approval requirements,[21] health service delivery specifications,[22] and accountability agreements detailing service volume and performance measure obligations.[23]

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19. Although some provinces initially experimented with elected board members, all subsequently shifted to government appointees. Steven J Lewis et al, "Devolution to Democratic Health Authorities in Saskatchewan: An Interim Report" (2001) 164:3 Can Med Assoc J 343; Tuohy, *Accidental Logics*, *supra* note 7 (describing the power to appoint boards as "a permanent expansion in the scope of formal state authority" at 180).

20. See e.g. *Regional Health Authorities Act*, CCSM c R-34. Authorities must submit a plan for approval. See *ibid*, s 24. The 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 as required by the Minister. Authorities must provide any reports, returns, statistical information and financial information the Minister requests. See *ibid*, ss 30, 40. In addition, authorities must submit an annual report describing their activities (including the services provided and their costs) and the health of the population, and must provide financial statements and other information required by the Minister. See *ibid*, s 38.

21. See e.g. *Local Health System Integration Act, 2006*, SO 2006, c 4. A Local Health Integration Network (LHIN) requires approval to transfer or encumber property, borrow, lend or invest money, create a subsidiary, indemnify any person from liability guaranteeing 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. See *ibid*, ss 6(3)–(5).

22. See e.g. *Regional Health Services Act*, SS 2002, c R-8.2, ss 52–53 (the Minister may determine the services that the authority is to provide with its yearly funding; ministerial approval is required to provide additional services).

23. See e.g. "Accountability Agreement April 1, 2007–March 31, 2010", online: Toronto Central LHIN <http://www.torontocentrallhin.on.ca/uploadedFiles/Public_Community/Board_of_Directors/Accountability_Agreement/Toronto%20Central%20Consolidated%20MLAA%202008_Aug1st.pdf>. 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. *Ibid* at 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. See *ibid* 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. See *ibid* at 14. The Ministry sets performance targets (on wait

In Ontario, where regionalization did not involve the replacement of hospital boards, the Ministry of Health and Long-Term Care nonetheless exerts significant control over hospitals through approval requirements[24] and an expanding array of governance requirements.[25] As in other provinces, the Ontario government has the authority to appoint individuals to inspect hospitals, investigate concerns within hospitals and, most intrusively, to assume the board's administrative responsibilities. On several occasions, the government has appointed an individual with "the exclusive right to exercise all of the powers of the board",[26] who implemented wide-ranging changes.[27]

In addition to influencing patient care indirectly by exerting control over hospitals and regional health authorities, governments are increasingly implementing reforms to influence or constrain the clinical decisions of providers. This is a significant change from the historic accommodation of provider autonomy, which was zealously guarded on the basis of maintaining the integrity of the doctor-patient relationship and on the basis of the specialized nature of medical knowledge.[28] Provincial ministries of health have sought to control spending by targeting both the supply of health services and the demand for them. For example, they have granted fewer billing

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times, re-admissions, alternate level of care days and avoidable emergency room visits) for which LHINs are held accountable. See *ibid* at 49–50.

24. *Public Hospitals Act*, RSO 1990, c P.40, s 4 (approval is required to incorporate, amalgamate, or operate a hospital, to add buildings or facilities to a hospital, or acquire or dispose of land or buildings for a hospital).

25. *Ibid*, s 12(3) (corporate and medical staff bylaws subject to approval); *Excellent Care for All Act, 2010*, SO 2010, c 14, s 9(1) (hospitals must tie executive compensation to hospital performance targets); *Hospital Management*, RRO 1990, Reg 965, s 2 (recent amendments govern the composition of hospital boards).

26. *Public Hospitals Act*, *supra* note 24, s 9(5). See also *Hospitals Act*, RSA 2000, c H-12, ss 8, 26–27, 29.

27. For example, during the ten months in which the Cambridge Memorial Hospital supervisor was in place, 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. Murray T Martin, "Final Report: Cambridge Memorial Hospital" (July 2010), online: Ontario Ministry of Health and Long-Term Care <http://www.health.gov.on.ca>.

28. See generally Eliot Freidson, *Professionalism Reborn: Theory, Prophecy, and Policy* (Cambridge, MA: Polity Press, 1994).

numbers to doctors,[29] capped physician incomes[30] and delisted services from the public plan.[31] Governments are now exploring the realignment of financial incentives with a view to saving money and encouraging appropriate care. For example, a growing proportion of physicians receive salaries, rather than fee-for-service reimbursement,[32] and governments are examining the benefits of pay-for-performance models.[33] In some circumstances, governments are also directly involved in determining what services patients will receive. Ministries of health increasingly scrutinize whether expensive new diagnostic services and pharmaceuticals should attract public funding. For example,

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29. Billing numbers are numbers issued to doctors enabling them to bill the government for providing insured health services.

30. David Coburn, Susan Rappolt & Ivy Bourgeault, "Decline vs. Retention of Medical Power Through Restratification: An Examination of the Ontario Case" (1997) 19:1 Sociology of Health & Illness 1 at 6.

31. In Ontario, the Ministry and the Medical Association collaborated on several initiatives to save costs by de-listing services from the public plan. 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.

32. Canadian Institute for Health Information, *Physicians in Canada: The Status of Alternative Payment Programs 2005-2006* (Ottawa: CIHI, 2008) at 5, online: CIHI <http://secure.cihi.ca/cihiweb/products/AltPay2005_2006_e.pdf> (in 2005/2006, 21.3% of payments to physicians for clinical services were not based on fee-for-service, up 12.6% from 2004/2005). Several studies indicate that alternative payment models positively affect clinical care. See e.g. Rose Anne Devlin & Sisira Sarma, "Do Physician Remuneration Schemes Matter? The Case of Canadian Family Physicians" (2008) 27:5 Journal of Health Economics 1168.

33. Laura A Petersen et al, "Does Pay-for-Performance Improve the Quality of Health Care?" (2006) 145:4 Annals of Internal Medicine 265 ("[f]ive of 6 studies of physician-level financial incentives and 7 of 9 studies of provider group-level financial incentives found partial or positive effects of financial incentives on measures of quality" at 269). Policy-makers are also seeking to modify incentives at the hospital level by shifting from global budgets (which use a fixed amount of money to pay for all hospital-based services over a certain period) to episode-based payment (whereby hospitals are paid for the costs of patient episodes of clinical care). Global budgets are traditionally determined through historical spending and hospital lobbying, rather than through the type and volume of services provided. Episode-based payment is believed to have the potential to encourage efficiency and appropriate service volumes. See generally Jason M Sutherland, *Hospital Payment Mechanisms: An Overview and Options for Canada* (Ottawa: Canadian Health Services Research Foundation, 2011).

PET scans, which cost up to $2 000 each, are only insured for certain medical conditions in Ontario.[34] The requirement that new health services must be cost-effective in order to receive public funding is a departure from the status quo, whereby new services were typically added to the schedule of insured services as a matter of course.

Concerns with quality and cost have also led governments to create bodies to disseminate clinical practice guidelines and other evidence-based practice tools.[35] The mandate of the Ontario Health Quality Council includes monitoring and reporting on health system outcomes, supporting continuous quality improvement and promoting the use of evidence in health care (through recommendations to health care organizations on standards of care and recommendations to the Minister concerning funding).[36] Ontario's hospitals have a corresponding duty to implement a quality committee to disseminate best practices information and to monitor its use.[37]

Governments also directly regulate patient care in some circumstances. For example, they dictate how hospital medical staff must address critical incidents,[38] what physicians must do before administering anesthesia or performing surgery,[39] what types of surgery require the presence of a second surgeon[40] and what types of tissue must be examined by a pathologist.[41]

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34. Ontario PET Steering Committee, *Pet Scan Primer: A Guide to the Implementation of Positron Emission Tomography Imaging in Ontario: Executive Summary* (Toronto: Ministry of Health and Long Term Care, 2008) at ii, online: Cancer Care Ontario <http://www.cancercare.on.ca>.

35. Evidence-based practice tools includes clinical practice guidelines, checklists, care pathways and logarithms.

36. *Excellent Care for All Act, 2010*, *supra* note 25, s 12(1).

37. *Ibid*, ss 2–4.

38. Saskatchewan *Regional Health Services Act*, *supra* note 22, s 58.

39. *Hospital Management*, *supra* note 25, ss 28–29.

40. *Operation of Approved Hospitals Regulation*, Alta Reg 247/90, s 20.

41. *Ibid*, s 23.

II. Gaps in Health Sector Accountability

There are several compelling arguments for improved governmental accountability.[42] The traditional means of holding government accountable through elections is becoming increasingly inadequate, given the growing complexity of the modern state and government's pervasive involvement in all aspects of the lives of citizens.[43] "The traditional mechanisms of accountability in representative democracy", Rhodes argues, "were never designed to cope with multi-organizational, fragmented policy systems".[44] In addition, an increasing portion of governmental decision-making occurs not in the legislature, through democratic processes such as parliamentary debates and legislative committee hearings, but behind closed doors in the executive branch.[45]

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42. Cathy Fooks & Lisa Maslove, *Rhetoric, Fallacy or Dream? Examining the Accountability of Canadian Health Care to Citizens* (Ottawa: Canadian Policy Research Networks, 2004) ("[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" at 1).

43. See e.g. Derek W Brinkerhoff, "Accountability and Health Systems: Toward Conceptual Clarity and Policy Relevance" (2004) 19 Health Policy Planning 371 (the size and scope of health care bureaucracies are two major contributors to accountability concerns).

44. RAW Rhodes, *Understanding Governance: Policy Networks, Governance, Reflexivity and Accountability* (Buckingham, UK: Open University Press, 1997) at 21. See also Colleen M Flood, Duncan Sinclair & Joanna Erdman, "Steering and Rowing in Health Care: The Devolution Option?" (2004) 30:1 Queen's LJ 156 (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" at 158).

45. See Alan C Cairns, "The Past and Future of the Canadian Administrative State" (1990) 40:3 UTLJ 319 (much of the state's behaviour "now lies outside the system of accountability supposedly sustained by the practice of responsible government" at 323); Edwin M Borchard, "Government Liability in Tort" (1924) 34:1 Yale LJ 1 (referring to the difficulty of successfully proving 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" at 1).

The growing proportion 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. Furthermore, there is considerable evidence of health system inefficiency and waste, suggesting that governments may be squandering these resources.[46]

The government's legal monopoly over hospital and physician services is another argument in support of improved accountability. All provinces limit access to private health care, either through direct limits, such as bans on duplicate private insurance for services covered by the public plan,[47] or through disincentives, such as prohibiting doctors from charging private patients more than the public fee schedule for a particular service.[48] There may be persuasive reasons for limiting the flourishing of a private tier, such as cream skimming by private providers or the drain of health human resources to the private system. However, such limitations often 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 wait times vary, but it is clear that some patients wait for care, particularly for elective surgeries and diagnostic testing.[49] Similarly, the government has sole control over the

46. 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> (suggesting strategies for improving health system efficiency). See also 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> (commenting on the sustainability of Ontario's health care system and suggesting strategies for improving health system efficiency).

47. In contrast, supplementary private insurance for services outside the public system (such as dental or optometric care) is permitted.

48. For a comprehensive summary of legislative restrictions on privatization, see Colleen M Flood & Tom Archibald, "The Illegality of Private Health Care in Canada" (2001) 164:6 Can Med Assoc J 825.

49. See Canadian Institute for Health Information, *Wait Times in Canada—A Comparison by Province, 2011* (Ottawa: CIHI, 2011), online: <http://www.cihi.ca> (in

provision of most public health services (such as the management of disease outbreaks) as it is the only actor with the financial and logistical capacity and necessary legal powers to respond to these concerns. Given the public's reliance and its vulnerability to public health threats, and the state's considerable power to constrain individual liberties to control the spread of disease,[50] mechanisms must be in place to hold governments accountable for their public health decisions.

III. Mechanisms to Improve Accountability

The availability of an independent body to review decisions of the executive branch of government is central to an accountable government. My focus in this paper is the role of the courts[51] but there are several other mechanisms that can be used to hold government accountable for its decisions, including ombudsmen, commissions of inquiry and auditors general.[52] In this section, I evaluate these

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2010–2011, 17% of cataract surgery patients, 16% of hip replacement patients, 21% of knee replacement patients and 22% of hip fracture repair patients did not receive surgery within "the amount of time that clinical evidence shows is appropriate" at 5–7).

50. 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.

51. *Ell v Alberta*, 2003 SCC 35, [2003] 1 SCR 857 (the preamble to the Constitution serves "as textual affirmation of an unwritten principle of judicial independence in Canada. . . . The preamble acknowledges judicial independence to be one of the pillars upon which our constitutional democracy rests" at para 19). My focus in this paper is on the independent review of governmental decisions by the courts. However, there are accountability mechanisms internal to government, including the provision of information to the public, accountability agreement obligations, and managerial accountability within the hierarchy of government (such as performance reviews of bureaucrats).

52. Protections of 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. See 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 controls. See e.g. Robert Centa & Patrick Macklem, "Securing Accountability Through Commissions of Inquiry: A Role for the

accountability mechanisms on the basis of three criteria: transparency, answerability to injured parties and the availability of sanctions or remedies.

Transparency is an essential component of accountability.[53] Courts, ombudsmen, commissions of inquiry, and auditors general 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 readily available to the public.[54] However, the ability of ombudsmen to improve health system transparency is limited by the fact that they release few individual case findings and report only aggregate complaint data;[55] and, unlike courts or commissioners, they interview complainants in private.[56]

Another component of government accountability is answerability to the affected individual.[57] Ombudsmen and courts may be in the best

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Law Commission of Canada" (2001) 39:1 Osgoode Hall LJ 117 at 120–21; 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.

53. See e.g. Brinkerhoff, *supra* note 43 at 372; Roy Romanow, *Building on Values: The Future of Health Care in Canada* (Ottawa: Commission on the Future of Health Care in Canada, 2002) ("[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" at 50).

54. See e.g. *Ombudsman Act*, RSO 1990, c O.6, ss 19(1)–(2); *Audit Act*, *supra* note 52, ss 10–11, 14.

55. See e.g. Ombudsman Ontario, *2010–2011 Annual Report* (Toronto: Office of the Ombudsman, 2011) at 57–69, online: <http://www.ombudsman.on.ca/Files/sitemedia/Documents/Resources/Reports/Annual/2011OmbudsmanAR_E.pdf> (summarizing the resolution of only twenty-five of the "thousands" of complaints received each year).

56. See e.g. *Ombudsman Act*, *supra* note 54 ("[e]very investigation . . . shall be conducted in private", s 18(2)).

57. See Julia Abelson & François-Pierre Gauvin, *Engaging Citizens: One Route to Health Care Accountability* (Ottawa: Canadian Policy Research Networks, 2004) ("linking [citizen] input back into the decision process [is] essential" at vi). See also Patricia Day & Rudolf Klein, *Accountabilities: Five Public Services* (London: Tavistock, 1987); Ezekiel J

position to facilitate this, 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 ombudsmen to refuse to hear complaints is not constrained by clear tests. For example, the Ontario ombudsman can decline to pursue a complaint if she is of the view that "having regard to all the circumstances of the case, any further investigation is unnecessary".[58] Despite this broad discretion, ombudsmen are more accessible than the courts in other respects. Unlike the legal system, ombudsmen are free to the complainant, employ flexible and user-friendly processes, and they typically resolve complaints expeditiously.[59]

In contrast, commissions of inquiry and auditor general investigations are not complaint-driven processes. The government frequently refuses to exercise its discretion to commence an inquiry, even when confronted with public or media pressure.[60] Complainants are even less likely to persuade an auditor general to review a health system matter. Over the past ten years, the Ontario auditor general has reported, on average, only eight health-related issues per year[61]—a

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Emanuel & Linda L Emanuel, "What is Accountability in Health Care?" (1996) 124:2 Annals of Internal Medicine 229.

58. *Ombudsman Act*, *supra* note 54, s 17.

59. The Nova Scotia Ombudsman reported that 73% of administrative reviews were resolved in under one week, 13% in one to four weeks, and 14% in more than four weeks. Systemic or policy reviews generally took several months to resolve. In contrast, litigation is often tied up in the courts for many years. See Nova Scotia Office of the Ombudsman, *Annual Accountability Report for the Fiscal Year 2009-2010* by Dwight Bishop (Office of the Ombudsman, 13 July 2010) at 13-14, online: Government of Nova Scotia <http://www.gov.ns.ca/ombu/ publications/Accountability-2009-2010.pdf>.

60. See e.g. Centa & Macklem, *supra* note 52 (commenting on the refusal to commence an inquiry into the police shooting of a protestor during a dispute over a provincial park on what was claimed to be aboriginal territory: "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" at 120).

61. See Office of the Auditor General of Ontario, "Reports by Topic: Health", online: <http://www.auditor.on.ca>.

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.[62] In contrast, auditors general rarely engage affected individuals or communities, but rather generally rely on interviews and government documents in making their recommendations.[63]

A third aspect of accountability is the ability to render sanctions or remedies.[64] 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. In contrast, ombudsmen, commissioners and auditors general elicit change through publicity and persuasion. Of course, compensation is not the only reason, and possibly not even the primary reason, that individuals commence claims.[65] Accordingly, extrajudicial accountability mechanisms 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 doctrines may alienate plaintiffs from their claims, user-friendly procedures (like those

62. 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).

63. See e.g. Office of the Auditor General of British Columbia, "Phase Three: Examination (Conducting)", online: <http://www.bcauditor.com>.

64. Carolyn Hughes Tuohy, "Agency, Contract, and Governance: Shifting Shapes of Accountability in the Health Care Arena" (2003) 28:2-3 J Health Pol 195 (accountability mechanisms must include "the availability of sanctions . . . the means to reward or punish accordingly" at 196) [Tuohy, "Agency, Contract and Governance"]; Brinkerhoff, *supra* note 43 ("[l]egal and regulatory sanctions are at the core of enforcing accountability" at 372).

65. Although there are no empirical studies on why individuals sue government, several studies explore 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) 343:8913 Lancet 1609.

used by ombudsmen) may be more effective at providing a sense of justice.

In sum, I do not argue that the courts are the best means of furthering governmental health sector accountability, but rather that they are a necessary means to that end. Because the various accountability mechanisms all have significant limitations,[66] a multi-pronged approach is likely necessary to achieve effective governmental accountability. Compared to the courts, ombudsmen are more accessible to complainants and are better able to mediate cost-effective and timely resolutions to complaints. Commissions of inquiry and auditors general are not constrained by legal doctrines, the parties to the litigation, their pleadings or the evidence they introduce. Accordingly, those bodies may more effectively explore the systemic causes of an adverse event and recommend ways to prevent similar problems in the future. However, without the courts, gaps would exist in accountability as other mechanisms that have wider discretion to refuse to hear complaints may not publicly report their findings, or permit complainant initiation or participation. Furthermore, the government may choose to disregard their recommendations.

Tort law is not the only way plaintiffs can advance claims before the courts. Accepting that the courts are essential to improving health sector accountability, plaintiffs can also advance their claims under administrative law or the *Canadian Charter of Rights and Freedoms*.[67] However, claims of both types have thus far been restricted to those involving *access* to health services. Administrative tribunals have only the authority delegated to them by statute. The existing tribunals with health sector jurisdiction lack the authority to deal with matters

66. This part of the paper highlights the gaps in the various mechanisms for independently reviewing governmental decisions. It is not intended to be a comprehensive discussion of the criticisms of tort law or its alternatives (such as no-fault compensation), which are well documented elsewhere. For a discussion of those criticisms, see e.g. Steven D Smith, "The Critics and the 'Crisis': A Reassessment of Current Conceptions of Tort Law" (1987) 72:4 Cornell L Rev 765, especially at n 2.

67. *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11.

involving the *quality* of health services.[68] To date, health sector administrative law cases have involved either applications for judicial review of refusals to reimburse patients for out-of-country health services[69] or claims of discrimination under human rights legislation based on the government's failure to fund particular services.[70]

The scope of the *Charter* is wider than that of administrative law. It applies to all government actions and prospective plaintiffs need not identify an administrative decision-maker. However, as with administrative claims, the *Charter* provisions applicable to health sector grievances have only been used to address access issues. To date, plaintiffs have either claimed that the government's failure to fund a particular service constituted discrimination on the basis of a disability under section 15,[71] or that legislation limiting access to health services violated the right to life, liberty or security of the person under section 7.[72]

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68. Colleen Flood, "Just Medicare: The Role of Canadian Courts in Determining Health Care Rights and Access" (2005) 33:4 JL Med & Ethics 669 at 678.

69. See e.g. *Stein v Québec (Régie de l'Assurance-maladie)*, [1999] RJQ 2416 (available on WL Can) (Sup Ct) (the Quebec Superior Court overturned the Tribunal Administratif's refusal to reimburse the plaintiff for cancer surgery performed in New York); *Flora v Ontario Health Insurance Plan (General Manager)* (2007), 83 OR (3d) 721, 278 DLR (4th) 45 (Div Ct) (the Ontario Divisional Court upheld a denial by the Health Services Appeal and Review Board of reimbursement for cancer treatment in England).

70. See e.g. *Hogan v Ontario (Minister of Health and Long-Term Care)*, 2006 HRTO 32, 58 CHRR D/317 (the plaintiff argued that the government's failure to fund sex reassignment surgery violated his right not to be discriminated against under human rights legislation); *Armstrong v British Columbia (Ministry of Health)*, 2010 BCCA 56, 2 BCLR (5th) 250 (the Court upheld a tribunal finding that the government's failure to fund prostate cancer testing while funding mammograms and pap tests for women did not violate the plaintiff's right not to be discriminated against on the basis of sex).

71. See e.g. *Auton (Guardian ad litem of) v British Columbia (Attorney General)*, 2004 SCC 8, [2004] 3 SCR 657 (parents unsuccessfully challenged the denial of funding for applied behavioural analysis therapy for their autistic children); *Cameron v Nova Scotia (Attorney General)* (1999), 204 NSR (2d) 1, 177 DLR (4th) 611 (CA) (a couple unsuccessfully challenged the government's refusal to fund fertility treatment); *Eldridge v British Columbia (Attorney General)*, [1997] 3 SCR 624 (the Court found that the government's failure to fund interpretation services for deaf patients was discriminatory).

72. See e.g. *Chaoulli, supra* note 2 (the Supreme Court split on the issue of whether long wait times coupled with a prohibition on private insurance violated the rights to life and security of the person); *R v Morgentaler*, [1988] 1 SCR 30 (the Court concluded that

In contrast to administrative law and *Charter* claims, many of the health sector tort claims have required the courts to review the quality of publicly-funded services, not only questions of access to those services. Examples include the claim that the Ontario Ministry of Health and Long-Term Care gave inadequate directions to nurses on the use of protective equipment during the SARS outbreak[73] and the allegation that the government failed to exercise oversight over chiropractic services. In addition, tort law has the potential to address access complaints beyond the scope of other areas of the law, for example, the claim of an infant who died after waiting for treatment. None of these cases involved an identifiable administrative decision-maker so there was no legal basis for a claim in administrative law. Nor did any of them involve discrimination against particular individuals or relate to a governmental deprivation of rights, so there was no legal basis to bring the claim under section 15 or 7 of the *Charter*. In addition, section 7 of the *Charter* has not been interpreted to guarantee positive rights[74]—governmental obligations to take positive action to ensure that individuals enjoy life, liberty or security of the person—while several health sector tort claims have alleged a failure to protect the claimants from a particular risk.

IV. The Health Sector Tort Cases

Tort law underwent a significant transformation in the latter half of the twentieth century, with the passage of legislation eroding Crown immunity and bringing the legal relationship between government and

delays associated with the therapeutic abortion committee approval process violated the security of the person).

73. SARS (Severe Acute Respiratory Syndrome) was a global epidemic that struck Ontario in Spring 2003. It killed 44 people and sickened 330 others in Ontario alone. See generally The SARS Commission, *Spring of Fear: Final Report* (Toronto: Ontario Ministry of Health and Long-Term Care, 2006).

74. See *Gosselin v Quebec (Attorney General)*, 2002 SCC 84, [2002] 4 SCR 429 (which leaves open the possibility that "[o]ne day s. 7 may be interpreted to include positive obligations" at paras 81–83).

its citizens closer to the relationship between private parties.[75] There were two main reasons for this change. The first was the need for the law to keep pace with social change, particularly the evolution of society's views on individual rights.[76] The second was the diversification of the activities of government, without corresponding answerability to citizens.[77] Although these changes did not open the litigation floodgates, courts imposed liability against governmental defendants in several cases, including ones involving a failure to maintain highways and other public facilities, negligent enforcement of building codes and police failure to investigate.[78] Judges have been much more reluctant to impose liability in the health sector, striking nearly all of the tort claims against provincial ministries of health on pre-trial motions.

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75. Crown immunity dates back to a maxim from the middle ages: "the king can do no wrong". See 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. This immunity devolved to the Westminster government when parliamentary democracy was implemented in Britain, and to colonial governments (including Canada) when they adopted Britain's laws. *Report on the Liability of the Crown* (Toronto: Ontario Law Reform Commission, 1989) at 8.

76. Woodfield, *supra* note 75 at 31–32.

77. Borchard, *supra* note 45 at 4.

78. See e.g. *McLoughlin (Guardian ad litem of) v Ray Luff Ltd*, 2003 NLCA 3, 32 MVR (4th) 78 (failure to maintain highways); *Wood v Hungerford (Township)* (2004), 3 MPLR (4th) 38 (available on QL) (Ont Sup Ct J) (negligent enforcement of building code); *Smith v Winnipeg (City)*, 2011 MBQB 52, [2011] 8 WWR 350 (failure to connect building to city sewer). In several cases, plaintiffs successfully proved duty, but failed on other elements of the test for negligence. See *BM v British Columbia (Attorney General)*, 2004 BCCA 402, [2004] 10 WWR 286 (failure to investigate a complaint of domestic violence); *Bowes v Edmonton (City)*, 2007 ABCA 347, 425 AR 123 (limited duty to disclose land report); *Burbank v RTB*, 2007 BCCA 215, 279 DLR (4th) 573 (police duty to enforce the law); *Condominium Corp No 9813678 v Statesman Corp*, 2009 ABQB 493, 472 AR 33 (negligent approval of building designs); *Cragg v Tone*, 2007 BCCA 441, 285 DLR (4th) 754 (police dispatcher duty to make reasonable judgment); *Dice v Ontario* (2004), 12 MVR (5th) 41 (available on WL Can) (Ont Sup Ct J) (duty when issuing or suspending licenses); *Heinicke v Cooper Rankin Ltd*, 2006 MBQB 273, [2007] 2 WWR 112 (duty with respect to inspections of residence); *Hill v Hamilton-Wentworth Regional Police Services Board*, 2007 SCC 41 at para 29, [2007] 3 SCR 129 (police officers' duty of care to suspects); *Wilson Fuel Co v Canada (Attorney General)*, 2009 NSSC 215, 280 NSR (2d) 298 (negligent investigation).

I define the health sector tort claims to refer to personal injury claims against provincial ministries of health. These cases have fallen into three broad categories: mismanagement of disease outbreaks, negligent oversight of the health system, and death or injury resulting from prolonged waits for care.[79] The first category includes claims by several plaintiffs who were infected with SARS. They alleged that the Ontario government failed to coordinate with other levels of government, neglected to maintain adequate public health equipment and facilities, issued inappropriate directives to hospitals, prematurely terminated preventive measures, failed to take actions to limit the spread of SARS and neglected to warn the public of the danger of SARS.[80] In other cases, health care workers who had been infected with the disease claimed that the government had failed to provide them with timely information and had issued inadequate directives to hospitals, exposing the plaintiffs to an unreasonable risk of harm.[81]

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79. I do not include claims solely alleging financial losses. See e.g. *1597203 Ontario Ltd v Ontario*, [2007] OJ no 2349 (QL) (Sup Ct J); *Apotex Inc v AstraZeneca Canada Inc*, 2009 FC 120 (available on QL). My searches captured the reported cases on CanLII and Westlaw, but motions to strike or class certification motions may be under-reported. I do not include two early health sector claims that were decided before the Supreme Court revised the test for duty in *Cooper v Hobart*, 2001 SCC 79, [2001] 3 SCR 537. Those claims had unique facts distinguishing them from subsequent claims. In one case, *Decock v Alberta*, the Court of Appeal refused to dismiss a claim against the Minister of Health and the Premier after a number of plaintiffs experienced delays in receiving care. 2000 ABCA 122, 255 AR 234. Unlike the other health sector cases, this decision focused on the proper naming of governmental defendants and on the legal status of the Minister of Health and the Premier. *Ibid.* In the other pre-*Cooper* case, *Marble (Litigation Guardian of) v Saskatchewan*, the plaintiff alleged that the government had failed to ensure that hospitals required doctors to carry malpractice insurance. 2001 SKQB 199, 208 Sask R 169. Although the initial motion to strike was dismissed, the Court later decided that a settlement between the plaintiff and the hospital defendant released the government from liability. *Ibid.*

80. *Williams v Canada (Attorney General)*, 2009 ONCA 378, 95 OR (3d) 401 [*Williams* CA]; *Jamal Estate v Scarborough Hospital—Grace Division*, 2009 ONCA 376, 95 OR (3d) 760.

81. *Abarquez v Ontario*, 2009 ONCA 374, 95 OR (3d) 414; *Laroza Estate v Ontario*, 2009 ONCA 373, 95 OR (3d) 764; *Henry Estate v Scarborough Hospital—Grace Division*, 2009 ONCA 375, 66 CCLT (3d) 184.

Similarly, following the 2002 West Nile virus outbreak, several individuals filed negligence claims alleging that the Ontario government failed to implement its plan to combat the disease, removed key scientists from the project, failed to take measures to reduce the mosquito population, neglected to coordinate with the Centers for Disease Control and Prevention and neighbouring jurisdictions, and provided inaccurate information to the public.[82] In all of the disease outbreak cases, judges granted the government's pre-trial motions to strike, finding that the government did not owe the plaintiffs a duty of care.

The second category of health sector tort cases include claims for negligent supervision of hospitals,[83] failure to ensure the safety of chiropractic services despite knowledge of the risks of cervical manipulation,[84] and failure to ensure adherence to the *Home Care and Community Services Act*'s[85] Client Bill of Rights.[86] Again, courts dismissed these claims, finding that the plaintiffs would be unable to prove that the government owed them a legal duty.[87]

The third category of cases involve individuals who sustained injury or died after failing to receive timely care. In *Mitchell v. Ontario*,[88] an infant

82. *Eliopoulos v Ontario (Minister of Health and Long-Term Care)* (2006), 82 OR (3d) 321, 276 DLR (4th) 411 (CA) [*Eliopoulos* CA]. The Centers for Disease Control and Prevention is a US agency under the auspices of the Department of Health and Human Services with considerable expertise in disease prevention and control.

83. *Blue v Ontario (Minister of Health and Long Term Care)*, [2009] OJ no 1653 (QL) (Sup Ct J).

84. *Nette v Stiles*, 2009 ABQB 422, 468 AR 54.

85. *Home Care and Community Services Act, 1994*, SO 1994, c 26.

86. *Ibid*, s 3; *Cerqueira v Ontario*, 2010 ONSC 3954 (available on WL Can) (which refers to the legislation by its previous title, the *Long-Term Care Act*).

87. For similar claims respecting the regulation of medical devices by Health Canada see e.g. *Drady v Canada (Minister of Health)*, 2008 ONCA 659, 300 DLR (4th) 443; *Taylor v Canada (Ministry of Health)*, 2010 ONSC 4799, 81 CCLT (3d) 106 (injuries from temporomandibular joint implants); *Attis v Canada (Minister of Health)*, 2008 ONCA 660, 93 OR (3d) 35 (injuries from breast implants); *Klein v American Medical Systems, Inc* (2006), 84 OR (3d) 217, 278 DLR (4th) 722 (Div Ct) (injuries from incontinence devices). Although my focus is on provincial ministries of health, I refer to the Health Canada cases where relevant, as the findings are similar in these cases.

88. *Mitchell (Litigation Administrator of) v Ontario* (2004), 71 OR (3d) 571 at para 3, 242 DLR (4th) 560 (Div Ct).

allegedly died due to emergency room overcrowding resulting from funding cuts and hospital restructuring decisions. In *Cilinger v. Quebec*,[89] a proposed class action against the Quebec provincial government and twelve hospitals claimed that women with breast cancer did not receive radiation therapy within the medically recommended time. The Court of Appeal refused to certify the action against the government, despite granting certification against the hospital defendants. In another case relating to cancer wait times, *Waap v. Alberta*,[90] the plaintiff sued the government for non-pecuniary damages and reimbursement for surgery he paid for out-of-pocket in Germany. The courts struck all three of these claims on the basis that the government did not owe a legal duty to the plaintiff. The sole exception is *Heaslip Estate v. Mansfield Ski Club*,[91] in which a boy died after government employees failed to follow an air ambulance policy respecting the prioritization of urgent cases. The Court of Appeal allowed this case to proceed to trial because of the government's direct involvement in the plaintiff's care as the health service provider.

In sum, of the thirteen claims I have identified against provincial ministries of health,[92] only one was permitted to proceed to trial. It is thus unclear whether anything short of the governmental provision of health care services and the resulting direct interaction between the parties will be sufficient to ground a duty of care. Interestingly, 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".[93]

89. *Cilinger v Québec (Procurer général)*, [2004] RJQ 2943, JE 2004-2175 (CA).

90. *Waap v Alberta*, 2008 ABQB 544, 95 Alta LR (4th) 167.

91. *Heaslip Estate v Mansfield Ski Club Inc*, 2009 ONCA 594, 96 OR (3d) 401.

92. This number only includes one of the 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 claims.

93. *Hill*, *supra* note 78.

V. A Criticism of the Courts' Application of the Test for Striking Claims

Historically, the primary purpose of the rules of civil procedure was to foster fairness in the litigation process through consistency and certainty. The rules reflected a commitment to the adversarial process, and thus favoured the collection of all relevant facts and the opportunity to make submissions before the court.[94] In 1911, the House of Lords stated that the power to dismiss was "one to be *very sparingly used*, and rarely, if ever, excepting in cases where the action is an abuse of legal procedure".[95] Citing that case with approval, the Supreme Court of Canada adopted a high burden to strike a claim—it must be "plain and obvious" that the plaintiff is bound to fail.[96] Judges have alternatively referred to this test as requiring that the claim is "unarguable",[97] is "incontestably bad",[98] "contains a radical defect",[99] is "certain to fail"[100] or is "hopeless".[101] This onerous standard is underscored by the adoption of wording that is more analogous to the criminal standard of proof than the civil one—it must be "beyond doubt" that a plaintiff cannot succeed.[102] The courts are to accept all facts asserted in the statement of

94. Julie Macfarlane, "The Future of the Civil Justice System: Three Narratives About Change" (2009) 35:3 Advocates' Q 284.

95. *Dyson v Attorney General*, [1911] 1 KB 410 at 418 (CA) (UK), cited in the seminal Canadian case on striking claims, *Hunt v Carey Canada Inc*, [1990] 2 SCR 959 at 972 (the Court in *Hunt* noted that 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" at 970).

96. *Ibid* at 975.

97. *Lonrho Plc v Fayed* (1991), [1992] 1 AC 448 at 469, [1991] 3 All ER 303 HL.

98. *Ibid.*

99. *Hunt*, *supra* note 95 at 975.

100. *Ibid.*

101. *Fullowka v Whitford*, 147 DLR (4th) 531 at 538, [1997] NWTR 1.

102. *Dumont v Canada (Attorney General)*, [1990] 1 SCR 279 at 280. See also *Minnes v Minnes* (1962), 34 DLR (2d) 479, 39 WWR 112 (BCCA) (claims should be struck "only where the case is absolutely beyond doubt" at 122). 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 interprovincial variation in class certification requirements, but by statute

claim as proven and should allow the plaintiff to proceed "so long as the pleadings disclose a cause of action".[103]

Courts now face pressure to interpret procedural rules in light of growing concerns respecting inadequate access to scarce judicial resources.[104] In other words, judges must balance fairness to the immediate parties to a case with fairness to the broader pool of prospective litigants.[105] While a full evidentiary record obtained at trial arguably improves accuracy, allowing clearly meritless claims to proceed to trial is an inefficient use of judicial resources and is unfair to defendants. General rules of interpretation set out in codes of civil procedure and the jurisprudence reflect a preference for allocating resources to specific types of claims.[106] In the context of motions to dismiss, courts emphasize 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. I now turn to assess these considerations in the context of health sector claims, concluding that the

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and at common law, a plaintiff must generally demonstrate that the pleadings disclose a cause of action. As the Ontario Superior Court had noted, 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"; however, while the onus is on a defendant to move to strike a plaintiff's claim, the burden is on a plaintiff to meet the requirements for certification. *Grant v Canada (Attorney General)* (2009), 81 CPC (6th) 68 at para 45 (available on WL Can).

103. *Lograsso v Kuchar* (2009), 80 RPR (4th) 272 at para 9 (available on WL Can) (Ont CA).

104. For a general critique of the state of access to justice, see e.g. The Right Honourable Beverley McLachlin, PC, Chief Justice of Canada, "The Challenges We Face" (2007) 40:2 UBC L Rev 819.

105. As Macfarlane, *supra* note 94 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 concern that shaving pieces off a system designed to uncover truth and promote certainty may in fact diminish, rather than enhance, access to justice" at 284. 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.

106. See e.g. *Rules of Civil Procedure*, RRO 1990, Reg 194 ("[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 involved, in the proceeding", r 1.04(1.1)).

courts should be more reluctant to strike these claims on pre-trial motions.

The preference for allowing novel claims to proceed to trial reflects a concern that "prematurely foreclosing arguments" will "hinder the growth of the common law".[107] With respect to the principles discussed above, judges are concerned that accuracy will be unduly compromised by striking claims that have not previously been assessed on a full evidentiary record. Many of the health sector dismissals have relied heavily on the Ontario Court of Appeal's brief motion to strike decision in *Eliopoulos* (a claim relating to the government's management of West Nile virus), with little consideration of novel factual matters applicable in the case before them. For example, during the SARS outbreak, nurses were at a particularly high risk of contracting the disease (relative to claimants from the general public), they were an identifiable group known to the government and the Ministry had issued directives and provided information directly to health care workers.[108] In striking the nurses' claims, the Court of Appeal relied primarily on its prior finding that a private duty of care would conflict with the government's duty to the public, summarily dismissing novel factual elements unique to the nurses' position. In addition, as I discuss below, judges adjudicating health sector claims have stated that plaintiffs are advancing novel legal duties without treating this novelty as relevant to the decision to strike.

Whether a claim involves an unsettled area of law is another relevant consideration in a motion to dismiss. The Nova Scotia Court of Appeal has stated that "[i]f the law in this area is not clear, the application to strike out the pleadings should fail".[109] As I discuss in Part VI, various

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107. *Mirage Consulting Ltd v Astra Credit Union Ltd*, 2008 MBCA 105 at para 9, 231 Man R (2d) 269. See also *Bow Valley Resource Services v Kansa General Insurance* (1991), 56 BCLR (2d) 337, 49 CCLI 253 (CA).

108. *Abarquez*, *supra* note 81.

109. *Sable Offshore Energy Inc v Ameron International Corp*, 2007 NSCA 70 at para 20, 255 NSR (2d) 164. See also *Sewell v Sewell*, 2007 NBCA 42, 314 NBR (2d) 330; *Reynolds v Kingston (City) Police Services Board*, 2007 ONCA 166, 84 OR (3d) 738 ("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" at para 13).

aspects of the test for duty in the context of governmental defendants are unclear or are still evolving, indicating that the courts should 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. . . . 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.[110]

Another factor relevant to a court's decision to strike is a case's complexity. According to the Supreme Court of Canada:

> [C]omplex 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".[111]

This reflects a concern that courts might reach incorrect conclusions in complex cases in the absence of a complete factual record. In health sector claims, that record may include, for example, testimony from expert witnesses explaining complex areas of science or public policy. In other words, the complexity of the health sector combined with the sparse facts available on a motion to strike may lead courts to overlook facts that suggest a legal duty exists. The health sector decision-making process, legislative landscape and policy context are fraught with complexity. Ministries of health employ a multitude of individuals working to coordinate, manage and deliver a plethora of programs and services.[112] Health sector decision-making involves ministry bureaucrats,

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110. Allen M Linden & Bruce Feldthusen, *Canadian Tort Law*, 8th ed (Markham, Ont: LexisNexis, 2006) at 710.

111. *Hunt*, *supra* note 95 at 972.

112. For example, in the program area of mental health alone, the Ontario Ministry of Health and Long Term Care is responsible for "facilitating and supporting systems 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".

advisory groups, provider self-regulatory organizations, interest groups, other ministries and levels of government, and health delivery organizations.[113] Those decision-makers are constrained by numerous governmental policies, funding agreements, accountability agreements and a multitude of statutes. They also face the contentious moral and ethical issues that underlie many areas of health policy.

Despite jurisprudence indicating that complex claims should proceed to trial, courts adjudicating health sector claims have instead treated complexity as a factor in favour of striking them. For example, in *Mitchell*, 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".[114] Similarly, in *Klein v. American Medical Systems*, an Ontario trial court concluded that "Health Canada is only one player in the complex regulatory and delivery scheme governing medical devices in Canada",[115] but did not discuss whether a full evidentiary record was needed to understand the role of the government or its relationship with other health system actors.

Finally, the importance of the issue is relevant to a court's decision to strike a claim. In *Hunt*, the Supreme Court 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".[116] Although the jurisprudence provides little guidance on factors indicative of an important issue, Canada's Federal Court cited the criteria of importance listed by Lord Justice Farwell in 1911. These criteria are equally

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See "Mental Health Programs and Services", online: Ontario Ministry of Health and Long-Term Care <http://www.health.gov.on.ca>.

113. For instance, under the heading "Tobacco: Ontario Tobacco Strategy" on the Ontario Ministry of Health and Long-Term Care website, which constitutes only a small part of the Ministry's programs and services, there are links to 27 interest groups, organizations, agencies and programs. Healthlinks, "Tobacco: Ontario Tobacco Strategy", online: Ontario Ministry of Health and Long Term Care <http://www.health.gov.on.ca/english/hlinks/ tobacco.html>.

114. *Supra* note 88 at para 33.

115. *Supra* note 87 at para 33.

116. *Supra* note 95 at 990.

applicable in the health sector cases—many individuals are affected by governmental health sector policies (particularly given its near monopoly over hospital and physician services), the interest at stake is serious (injury or death) and there are gaps in the availability of alternate remedies.[117] In permitting the SARS claim to proceed to trial, the lower court in *Williams v. Canada* found that the issues were "of some importance" because of the "questions of substantive law involved", including issues "relating to the application of the 'plain and obvious test'" and "fundamental questions about the manner in which—and the precision with which—claims against the Crown for the tort of negligence must be pleaded".[118] The Ontario Court of Appeal did not address these points when it overturned that decision.[119]

VI. A Criticism of the Courts' Application of the Test for Duty

A. The Test for Duty

Although there are four elements to a negligence claim—duty, breach of duty, damage and causation—courts have resolved all of the health sector claims on the first of these.[120] The function of duty is restrictive

117. Lord Justice Farwell said:

> 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 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.

See *Daniels v Canada (Minister of Indian Affairs and Northern Development)*, 2002 FCT 295 at para 10, [2002] 4 FC 550, citing *Dyson*, *supra* note 95 at 421.

118. *Williams v Canada (Attorney General)* (2005), 76 OR (3d) 763 at para 2, 257 DLR (4th) 704 (Sup Ct J), rev'd *Williams* CA, *supra* note 80 [*Williams* Sup Ct].

119 *Williams* CA, *supra* note 80.

120. Some authors separate cause-in-fact (the factual cause of the injury) and proximate cause (the legal cause of the injury).

or exclusionary: "it defines the scope and outer limits of the law of negligence".[121] I am critical of both how the test for duty has been applied to the health sector claims and of certain aspects of the test itself. I use the health sector cases to illustrate my broader critiques of the Canadian judiciary's approach to duty.

The modern test for duty originated in 1978 in the House of Lords,[122] with the Supreme Court of Canada adopting that test in 1984[123] and refining it in several subsequent cases, most notably the *Cooper* case in 2001.[124] The test has two stages: prima facie proof of a duty and policy considerations that limit or negate duty. The first stage of the test can be further divided into two requirements—there must be sufficient foreseeability of harm and proximity between the parties to warrant the imposition of a duty. I do not discuss foreseeability further, as the burden for meeting this requirement is low, it receives little attention from judges and it is frequently conceded by defendants. Furthermore, none of the health sector claims have been defeated on foreseeability alone.[125] Proximity requires that the plaintiff demonstrate a close and direct relationship between the parties. Courts first assess whether the facts conform to a category of duty established in a previous case and, if none of the categories apply, they consider expanding the law of negligence to encompass a new duty. The Supreme Court views this approach as one that "provides a large measure of certainty, through settled categories of liability-attracting relationships, while permitting expansion to meet new circumstances and evolving conceptions of justice".[126]

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121. David Owen, "Duty Rules" (2001) 54:3 Vand L Rev 767 at 777.

122. *Anns v Merton Borough Council*, [1978] AC 728, [1977] 2 All ER 492 HL.

123. *Kamloops (City) v Nielsen*, [1984] 2 SCR 2.

124. *Supra* note 79.

125. In the SARS claims, the defendant conceded foreseeability. See *Williams* CA, *supra* note 80 at para 21; *Abarquez*, *supra* note 81 at para 17. Several cases do not mention foreseeability. See e.g. *Blue*, *supra* note 83; *Cerqueira*, *supra* note 86. See also *Reference re Broome v Prince Edward Island*, 2010 SCC 11 at para 15, [2010] 1 SCR 360 (the Supreme Court suggesting that foreseeability may be difficult to assess on a motion to strike given its fact-specific nature).

126. *Hill*, *supra* note 78 at para 25.

Once a plaintiff establishes a prima facie duty, courts explore whether there are policy considerations that ought to limit or negate the duty. One consideration unique to governmental defendants is the policy/operational dichotomy, under which judges will not impose liability for policy decisions, while they will review how these decisions are operationalized (or implemented). In addition to the dichotomy, courts more broadly analyze "the effect of recognizing a duty of care on other legal obligations, the legal system and society more generally".[127]

B. Proximity

(i) Established Categories of Duty

Although the judiciary is open to recognizing new legal duties, the Supreme Court of Canada has stated that a judge should first assess whether the facts pleaded conform to a category of relationship deemed proximate in a previous case. However, the established categories typically do little to advance the analysis of whether a plaintiff satisfies proximity in a particular case. In the health sector claims, judges provide a cursory analysis of their applicability.[128] In *Heaslip*, the only health sector claim deemed to fall within an established category, the Ontario Court of Appeal nonetheless went on to explore whether the parties'

127. *Cooper*, *supra* note 79 at para 39.

128. In *Mitchell*, *supra* note 88 at paras 20–21, the Court summarily rejected the plaintiffs' argument that their case fell within the category of foreseeable physical harm. The Court contrasted their claim with the scenario in *Alcock*, which was cited by the Supreme Court in *Cooper*. In *Alcock*, state employees directly caused physical harm, whereas in *Mitchell*, the allegation was that the state *indirectly* caused physical harm—that funding cuts and restructuring caused delay, which in turn caused the death. However, the Supreme Court merely referred to *Alcock* as an example and did not state that directness was a required element for foreseeable physical harm. *Cooper*, *supra* note 79 at para 36; *Alcock v Chief Constable of South Yorkshire Police* (1991), [1992] 1 AC 310, [1991] 4 All ER 907 HL. In finding that none of the existing categories of duty apply (in other words, that the plaintiff is advancing a novel legal duty), the courts do not discuss the fact that under the test to strike a claim, novelty militates in favour of allowing the claim to proceed.

relationship was sufficiently close and direct.[129] Given the predominance of policy concerns in the health sector cases, it is not surprising that courts are reluctant to find that a case falls within an existing category, as this finding would require them to forego any analysis of policy concerns under the second stage of the duty test and to proceed to the breach of duty inquiry.[130] Indeed, even outside of the health sector, many courts have adopted a more contextual approach, analyzing the relevant legislation and the parties' relationship for indicia of proximity, rather than exploring whether that relationship conforms to an established category.[131]

There are several arguments that support this type of contextual approach. First, it is questionable whether the categories help to resolve the duty issue; defendants are unlikely to concede that a new fact situation falls within an existing category or that a new category should be created, and plaintiffs are likely to argue the opposite. Only when the facts are extremely similar to a previous case will there be no argument,

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129. *Supra* note 91 at para 20. The Court's analysis of the question of the appropriate category was minimal:

> [T]he alleged facts in this case support the existence of a duty of care: . . . "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." The duty of care alleged here belongs within the established category of a public authority's negligent failure 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. . . . [T]he motion judge erred by concluding that this case did not fall within an established category of negligence. *Ibid* at paras 21–22 [citations omitted].

130. *Cooper*, *supra* note 79 at paras 37–39.

131. 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 *Bellan v Curtis et al*, 2007 MBQB 221, 219 Man R (2d) 175; *Berg et al v Saskatchewan (Minister of Environment and Resource Management)*, 2003 SKQB 456, 243 Sask R 29; *Burgess (Litigation Guardian of) v Canadian National Railway Co*, 78 OR (3d) 209, 35 CCLT (3d) 288 (Sup Ct J), aff'd (2007), 85 OR (3d) 798, 41 CCLT (3d) 10 (CA); *Crystal Blue Farms v Newfoundland (Minister of Fisheries & Aquaculture)*, 2009 NLTD 17, 73 CPC (6th) 113 (SC (TD)); *Broome*, *supra* note 125.

and in those cases the categories of proximity do little to illuminate the parties' relationship, as the courts would consider factually similar precedents under the principle of *stare decisis* in any event.[132]

Other commentators question whether the Supreme Court intended the categories of proximate relationships to apply to all types of negligence cases.[133] In *Cooper*, the Court stated that an act that foreseeably causes physical harm is an established category of proximity,[134] a category that "is downplayed or ignored in most cases".[135] This dismissive approach was exemplified by the Ontario Court of Appeal in *Williams*, one of the SARS cases. The plaintiff argued that the claim fell into an existing category—negligence causing physical harm to person or property—but the Court of Appeal held that "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".[136] Although it is open to a lower court to conclude that a particular fact situation does not conform to an existing category, judges are bound by the categories set out by the Supreme Court.

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132. 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.

133. See e.g. Allen M Linden, *Canadian Tort Law Supplement*, 7th ed (Markham, Ont: LexisNexis Butterworths, 2004) at 10 (arguing that the Supreme Court meant to exempt cases of physical harm altogether from the *Cooper* analysis).

134. *Supra* note 79 at para 36.

135. Linden, *supra* note 133 at 10.

136. *Supra* note 80 at paras 18–19. See also *Waap*, *supra* note 90 ("[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" at para 150). Given the specificity of the Court's articulation of the appropriate category, it is questionable whether anything short of a factually identical case would satisfy an established category of duty. See also Russell Brown, "Still Crazy After All These Years: *Anns*, *Cooper v. Hobart* and Pure Economic Loss" (2003) 36:2 UBC L Rev 159 (arguing that two of the *Cooper* categories (government liability for building inspections and road maintenance) are not categories at all but "case-specific facts" that ought to be subsumed into a "liability of public authorities" category at 185).

(ii) Proximity Arising from the Parties' Relationship

If no established category of duty applies, courts will consider expanding the boundaries of negligence where the parties have a close and direct relationship. In *Cooper*, the Supreme Court of Canada provided a non-exhaustive list of considerations relevant to proximity: expectations, representations, reliance and the property or other interests involved.[137] Subsequent cases added to this list physical closeness[138] and whether the plaintiff is part of an identifiable group.[139] More generally, the Court stated that assessing proximity requires determining "whether it is just and fair having regard to [the particular] relationship to impose a duty of care".[140] Although that language suggests a broad contextual analysis of the parties' relationship, the Court went on to say that "the factors giving rise to proximity, if they exist, must arise from the statute. . . . That statute is the only source of duties, private or public".[141]

Statutes are ill-suited to defining the relationship between two parties. Brown and Brochu refer 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 where

137. *Supra* note 79 at para 36. The Court stated that policy considerations pertinent to the relationship between the parties could be addressed at the proximity stage, leaving residual policy considerations for the second stage of the test. *Ibid* at para 30. The Court acknowledged that this distinction might prove to be merely "academic" because, "[p]rovided the proper balancing of the factors relevant to duty of care are considered, it may not matter . . . at which 'stage' it occurs". *Ibid* at para 27. In practice, courts have not made any meaningful distinction between types of policy consideration, so I do not discuss this aspect of *Cooper* further.

138. See e.g. *Broome*, *supra* note 125 at para 16. *Contra Hill*, *supra* note 78 ("[t]his factor is not concerned with . . . physical proximity, so much as with whether the *actions* of the alleged wrongdoer have a close or direct effect on the victim" at para 29 [emphasis in original]).

139. See e.g. *Fullowka v Pinkerton's of Canada Ltd*, 2010 SCC 5 at para 31, [2010] 1 SCR 132.

140. *Cooper*, *supra* note 79 at para 34.

141. *Ibid* at para 43. *Cooper* involved duties of the Registrar of Mortgage Brokers.

legislators appear not to have ever actually turned their minds to questions of civil liability.[142]

The government's relationship with its citizens consists not only of legislation but also of the plethora of policies, agreements, reports, speeches, news releases and direct interactions that take place between citizens and governmental agents or employees.

Some subsequent jurisprudence departs from the narrow, statute-based approach to proximity introduced in *Cooper*. For example, in *Hill*, as well as looking to the *Charter* and to statutory duties owed by police to suspects under investigation, the Supreme Court considered the fact that "[t]he relationship between the police and a suspect identified for investigation is personal".[143] Although the Court noted that the police had made no representations to the plaintiff, they found that the parties had direct interactions and that the claim engaged serious interests (the plaintiff's freedom and reputation).

Despite the shift away from grounding proximity in legislation, the health sector decisions continue to focus primarily on whether proximity arises from the statutory context. For example, in *Mitchell*, the Court found:

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

142. Russell Brown & Shannon Brochu, "Once More Unto the Breach: *James v. British Columbia* and Problems with the Duty of Care in Canadian Tort Law" (2008) 45:4 Alta L Rev 1071 at 1083. See also Karen Horsman & Gareth Morley, *Government Liability: Law and Practice*, loose-leaf (consulted on 11 February 2012), (Toronto: Canada Law Book, 2011) ("[i]f the focus is on legislative intent to create civil liability, the test would only rarely be met given that few statutes in Canada are drafted with this purpose in mind" at 5-23); Lewis Klar, "The Tort Liability of the Crown: Back to Canada v. Saskatchewan Wheat Pool" (2007) 32 Advocates' Q 293 [Klar, "Tort Liability"] (arguing that grounding the duty analysis in statutory interpretation is contrary to the well-established principle that there is no civil action for breach of statutory duty).

143. *Supra* note 78 at para 33. For another example of a case that looked beyond statutory provisions and assessed the parties' relationship, including the defendant's knowledge of the plaintiff, representations and reliance, see *Design Services Ltd v Canada*, 2008 SCC 22 at paras 51-52, [2008] 1 SCR 737 (concluding that the government did not owe subcontractors of the tenderor a duty of care in the context of a tendering process for a construction contract).

the legislation make it clear that her duty is to the public as a whole, not to a particular individual. . . . [T]he 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.[144]

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".[145] Because health sector legislation typically sets out general duties to the public at large, a statute-centered proximity analysis encourages judges to conclude 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 addition, in contrast to the duty jurisprudence more broadly, judges adjudicating health sector claims devote little attention to the presence of proximity factors arising from the parties' relationship. For example, in *Eliopoulos*, the Ontario Superior Court referred to the fact that the government had identified particular West Nile virus hotspots as evidence that residents in those areas were in a close and direct relationship with the Ministry of Health.[146] Although the Court of Appeal described the government's legislative obligations to the public at length, it did not address that finding. The appeal judge "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".[147]

C. Policy Considerations to Limit Duty

Once a plaintiff establishes a prima facie duty, the court can limit or negate it on the basis of policy considerations. A specific consideration

144. The Court went on to devote seven paragraphs to a discussion of the statutory context. *Supra* note 88 at paras 28, 30.

145. *Ibid* at para 19.

146. *Eliopoulos v Ontario (Minister of Health & Long Term Care)*, [2004] OJ no 3035 (QL) at para 28 (Sup Ct J) [*Eliopoulos* Sup Ct].

147. Klar, "Tort Liability", *supra* note 142 at 305.

unique to governmental defendants is the policy/operational dichotomy, under which courts will not impose liability for governmental policies, but only for the operationalization of those decisions. In addition, judges may consider the impact of a duty on the legal system and on society more broadly.

(i) The Policy/Operational Dichotomy

In *Brown v. British Columbia*, the Supreme Court provided guidelines for classifying governmental decisions as either policy or operational:

> True policy decisions involve social, political and economic factors. . . . 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 direction, expert or professional opinion, technical standards or general standards of reasonableness.[148]

There is a substantial body of literature criticizing the underlying rationale of the dichotomy and the difficulties inherent in its application. The dichotomy initially appeared in American legislation exempting governmental liability arising from the performance of "a discretionary function or duty".[149] Despite the absence of an analogous provision in British law, the House of Lords—and then the Supreme Court of Canada—adopted this distinction, referring to discretionary duties as policy decisions.[150] However, Canadian crown liability legislation delineates no analogous sphere of protected governmental activity. For example, Ontario's *Proceedings Against the Crown Act* says:

> [T]he Crown is subject to all liabilities in tort to which, if it were a person of full age and capacity, it would be subject, in respect of a tort committed by any of its servants or agents . . . in respect of any breach of the duties attaching to the ownership, occupation,

148. *Brown v British Columbia (Minister of Transportation and Highways)*, [1994] 1 SCR 420 at 441.

149. See M Kevin Woodall, "Private Law Liability of Public Authorities for Negligent Inspection and Regulation" (1992) 37:1 McGill LJ 83 at 88, citing 28 USC §§ 2674, 2680(a).

150. *Kamloops*, *supra* note 123.

possession or control of property; and under any statute or under any regulation or by-law made or passed under the authority of any statute.[151]

Allowing the Canadian judiciary greater scope to hear tort claims against government accords with the fact that Canada and other Commonwealth countries traditionally place less emphasis than the US on the separation of powers between the different branches of government.[152]

Although there may be no statutory or political foundation for the policy/operational dichotomy in Canadian tort law, there are arguably compelling pragmatic concerns with judicial interference with the delicate balance of competing interests inherent in governmental decision-making.[153] I return to this issue below. However, as compelling as those concerns may be, they do not necessitate the retention of the dichotomy, as we can rely on other aspects of the negligence analysis to exclude the types of decisions typically categorized as policy decisions from review by the judiciary. For instance, if a plaintiff alleged that her wait for surgery was the result of budget cuts (a clear policy decision)

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151. RSO 1990, c P-27, s 5.

152. JA Smillie, "Liability of Public Authorities for Negligence" (1985) 23:2 UWO L Rev 213 at 218:

[t]he 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.

153. Aloke Chatterjee, Neil Craik & Carissima Mathen, "Public Wrongs and Private Duties: Rethinking Public Authority Liability in Canada" (2007) 57 UNBLJ 1 at 1–2:

[t]he 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.

without more specific allegations, she would be unlikely to prove proximity. That type of governmental decision would also be accorded considerable deference in formulating the standard of care, and the courts would be unlikely to find causation (given the presence of intervening actors such as hospitals and other health service providers).

Allowing the elements of a negligence claim other than duty to filter out policy decisions reduces the risk of inaccurately and unjustly excluding cases on the basis of a line that is difficult to draw. As Klar argues, "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".[154] Governmental decisions lie on a spectrum with clear policy decisions at one end and clear operational decisions at the other, and many (arguably most) decisions fall somewhere in the middle.[155]

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154. Lewis Klar, "Case Comment: Falling Boulders, Falling Trees and Icy Highways: The Policy/Operational Test Revisited" (1994) 33:1 Alta L Rev 167 at 167 [Klar, "Case Comment"]. For other criticisms of the test, see SH Bailey & MJ Bowman, "The Policy/Operational Dichotomy—A Cuckoo in the Nest" (1986) 45:3 Cambridge LJ 430; *R v Imperial Tobacco Canada Ltd*, 2011 SCC 42, [2011] 3 SCR 45 at para 78; Smillie, *supra* note 152 at 216–24:

> [t]he 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. . . . 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.

155. See Anne Deegan, "The Public/Private Law Dichotomy and Its Relationship With the Policy/Operational Factors Distinction in Tort Law" (2001) 1:2 Queensl U Tech L & Justice J 241 at 264–65 (characterizing the policy/operational dichotomy as part of a broader, increasingly obsolete distinction between public law and private law):

> [T]he 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 focussed on the relationship between the state and individual. . . . 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. *Ibid.*

Courts adjudicating health sector claims frequently categorize the impugned decisions as ones of policy. For example, in *Cilinger*, the Quebec Court of Appeal discussed the government's yearly health budget, the allocation of funds between hospitals and the use of funds, and exempted the government's decisions from review, because "[a]s a general rule, decisions concerning budgetary allotments for departments or government agencies will be classified as policy decisions".[156] However, the Court did not discuss whether the government negligently implemented a policy that was intended to reduce breast cancer.[157] In *Eliopoulos*, the Ontario Court of Appeal similarly characterized much of the government's involvement in managing the West Nile virus as matters of policy, deeming its plan to combat the virus as "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".[158] The Court concluded:

> The 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.[159]

The Court failed to consider whether, notwithstanding the government's limited role, it had control over local authorities and boards of health, or whether the government was negligent in its implementation of the plan.

As I discussed above, while the government's initial role in the health sector was that of passive payer, ministries of health now exercise considerable control over health system actors and make decisions affecting the care received by patients. By summarily labeling the government's health sector decisions as policy, it is unclear whether courts merely do not understand the nature of the state's modern health

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156. *Supra* note 89 at para 15 citing *Just v British Columbia*, [1989] 2 SCR 1228 at 1245.
157. *Supra* note 89 at paras 85–90.
158. *Supra* note 82 at para 23.
159. *Ibid.*

sector role or are purposefully applying the test for duty with a view to avoiding subjecting the actions of government to scrutiny.

(ii) Other Policy Considerations Limiting Duty

In addition to applying the policy/operational dichotomy, judges assess "the effect of recognizing a duty of care on other legal obligations, the legal system and society more generally".[160] The Supreme Court of Canada has provided a non-exhaustive list of considerations relevant to limiting a prima facie duty: 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".[161] Weinrib criticizes the policy analysis as being one-sided, as it "refers only to policy considerations that negative liability, not to those that might confirm liability".[162] This concern is particularly acute in the health sector, where there are compelling policy reasons in favour of allowing claims to proceed beyond the duty stage of the analysis.

The health sector cases briefly mention the presence of alternative remedies[163] and the potential for unlimited liability.[164] However, the

160. *Cooper*, *supra* note 79 at para 37.

161. *Ibid.*

162. Ernest J Weinrib, "The Disintegration of Duty" (2006) 31:2 Advocates' Q 212 ("[a]lthough the 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" at 235).

163. See e.g. *Williams* CA, *supra* note 80 at para 36 (remarking that the plaintiff could commence a claim against health care facilities or health care professionals for their application and enforcement of government directives); *Abarquez*, *supra* note 81 at para 41 (cursorily mentioning that nurses could also apply for workers' compensation benefits, and saying nothing about the differences between those benefits and tort damages). The Supreme Court jurisprudence is inconsistent with respect to whether the alternate remedy needs to be analogous to the remedy available in tort. See *Odhavji Estate v Woodhouse*, 2003 SCC 69 at para 60, [2003] 3 SCR 263 (the availability of a police complaints process was an insufficient remedy, as the plaintiffs were not seeking disciplinary sanctions, but compensation for psychological harm); *Syl Apps Secure Treatment Centre v BD*, 2007 SCC 38 at para 59, [2007] 3 SCR 83 (a parent's statutory right to apply for review of the status of a child under a wardship order is a sufficient alternate remedy, even though it does not result in compensation).

driving force behind the courts' reluctance to allow governmental health sector claims seems to be a concern about judicial interference in health policy. Throughout their analysis of duty, courts repeatedly express a reluctance to impose liability for governmental decisions made in the face of competing interests and limited budgets. For example, in examining the statutory context for indicia of proximity, the Ontario Court of Appeal in *Eliopoulos* adopted the words of the province's Divisional Court in *Mitchell*: "[T]he Minister . . . must balance a myriad of competing interests . . . her duty is to the public as a whole, not to a particular individual".[165] In applying the policy/operational dichotomy, the Court found that the plaintiff's claims related "to issues of public health policy, the establishment of governmental priorities, and the allocation of scarce health care resources".[166] With respect to additional policy considerations to limit or negate duty, the Court 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

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164. See e.g. *Nette*, *supra* note 84 (liability "would have the effect of making the Crown an insurer for chiropractic services" at para 65). This policy consideration is arguably somewhat redundant, as the purpose of the proximity analysis is to establish that the plaintiff or plaintiffs have a close and direct relationship—i.e. a relationship that differs from the government's relationship with the broader public.

165. *Supra* note 82 at para 17, quoting *Mitchell*, *supra* note 88. The Court in *Williams* highlighted the difficult policy decisions involved in dealing with the SARS outbreak:

> 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.

Supra note 80 at para 31.

166. *Supra* note 82 at para 29.

resources available to promote and protect the health of its citizens".[167] Finally, the Court concluded:

> [T]o 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.[168]

The concern with disrupting this balance is echoed by several commentators, who have argued that courts lack the institutional capacity to consider legal questions situated within the complex health system landscape.[169]

Government decisions are influenced by a complicated web of variables: resources (temporal, monetary and human), public and media pressure, provider and interest group advocacy, bureaucratic self-interest, and other political factors (for example, the timing of the next election). The health system adds yet more complexity: a mix of public and private financing; of market-based, professional and governmental regulation; of technical and sometimes contradictory scientific and policy evidence; and of provincial and federal jurisdiction.

However, immunizing government decisions from scrutiny merely because courts have less knowledge of the subject matter would be inimical to democracy. Empirical evidence demonstrating the judicial aptitude for comprehending complex matters suggests that concerns about institutional competence may be overstated.[170] Furthermore, while some critics see judicially-awarded damages as the substitution of

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167. *Ibid* at para 32.

168. *Ibid* at para 33.

169. See e.g. Christopher P Manfredi, "Déjà Vu All Over Again: *Chaoulli* and the Limits of Judicial Policymaking" in Flood, Roach & Sossin, *supra* note 2, 139 at 145; David Cohen & JC Smith, "Entitlement and the Body Politic: Rethinking Negligence in Public Law" (1986) 64:1 Can Bar Rev 1 ("[t]he 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" at 8).

170. See e.g. Neil Vidmar, "Juries and Medical Malpractice Claims: Empirical Facts Versus Myths" (2009) 467:2 Clinical Orthopaedics and Related Research 367.

the courts' policy choices for those of the legislators, compensation can also be viewed as causing the government to internalize the social costs of its decisions.[171]

The courts' concern about disrupting the government's allocation of resources suggests a judicial perception that damage awards will exacerbate health system cost pressures by diverting scarce resources from patient care. However, the concern that a dollar spent on compensation is a dollar not spent on patient care is an oversimplification of health system financing—a damage award does not necessarily come out of money allocated to patient care, given considerable waste and inefficiency. Additionally, the tort decisions fail 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.

Although I do not advocate widespread governmental liability, I argue that the law could be applied in a manner that more effectively balances reservations about judicial policy-making against the need for accountability. Allowing tort claims to proceed to an analysis of whether the government breached its duty would improve accountability, as ministries of health would be called upon to justify the reasonableness of their decisions. Subjecting governmental decisions to greater scrutiny would not render concerns with scarce resources or competing interests irrelevant, as the standard of care could incorporate considerable deference. In *Hill*, the Supreme Court emphasized that the standard of care is based on what a reasonable government actor would do in the circumstances, and "[t]he fact that funds are not unlimited is one of the circumstances that must be considered".[172] In other areas of the law, courts are increasingly reluctant to strike claims over

171. See Fleming James Jr, "Tort Liability of Governmental Units and Their Officers" (1955) 22:3 U Chicago L Rev 610 ("[t]he costs of government decisions are often passed on to injured individuals, rather than being spread among the taxpayers who benefit from the impugned policy. In this regard, James argues that because public purposes may have injury-producing effects, compensation should be viewed not as a diversion of resources, but rather as a "part of the activity's normal cost" at 614).

172. *Supra* note 78 at para 44. See also Smillie, *supra* note 152 ("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" at 248).

preliminary issues such as standing or jurisdiction,[173] but show deference in scrutinizing governmental decisions.[174] For example, in *Stein*, a case relating to reimbursement for out-of-country health services, the Quebec Superior Court employed the most deferential standard of review (patent unreasonableness), noting that courts "must exercise restraint".[175]

The health sector cases also reveal a judicial assumption that a governmental duty to individuals necessarily conflicts with the duty to act in the broader public interest. However, the Supreme Court suggested in *Odhavji* that a general statutory duty to the public (in this case, to monitor and oversee the adequacy and effectiveness of police services) did not foreclose the possibility of "a statutory obligation to address widespread or systemic misconduct of a particularly serious nature".[176] Following the SARS outbreak a commission of inquiry similarly found widespread systemic problems with Ontario's public health system.[177]

Furthermore, the Supreme Court indicated in *Hill* that a potential conflict with other duties is insufficient to negate a prima facie duty of care: such a duty "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".[178] That case considered whether the police owe a duty to suspects in a murder investigation. The Court held that despite duties to the general public, a duty to police suspects "may have positive policy ramifications", such as reducing the risk of wrongful convictions.[179] On

173. Manfredi, *supra* note 169 at 147–48.

174. See e.g. *Vriend v Alberta*, [1998] 1 SCR 493 ("[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 section 1 and again in determining the appropriate remedy for a *Charter* breach" at 530).

175. *Supra* note 69 at 2420. This case was decided well before the abolition of the patent unreasonableness standard of review at common law, in *Dunsmuir v New Brunswick*, 2008 SCC 9, [2008] 1 SCR 190.

176. *Supra* note 163 at para 71.

177. SARS Commission, *supra* note 73.

178. *Supra* note 78 at para 43.

179. *Ibid.*

this analysis, finding that the government owed a duty to nurses infected with SARS may have been congruent with the public interest, rather than in conflict with it, given the crucial role of nurses in controlling a disease outbreak, the risk that providers might refuse to work if the government does not adequately protect their health, and the broader difficulties in retaining health care workers.[180]

D. Conclusion on Duty

In the decade since the Supreme Court's decision in *Cooper*, Canadian courts have broadened the factors relevant to assessing duty. At the first stage of the analysis, many judges have shifted away from a rigid approach (determining whether a case conformed to existing categories and defining duty through legislation) to a more flexible, contextual approach (examining the totality of the parties' relationship as illuminated by legislation, precedents and the parties' interactions). Prior to *Cooper*, the policy/operational dichotomy was the touchstone of the duty analysis for government defendants.[181] Although judges continue to apply that dichotomy, they increasingly explore the impact a duty would have on the parties, the legal system and society.

Several corrective justice scholars support this increased focus on the parties' interactions in the duty inquiry, arguing that relationships give coherence to the law of negligence.[182] These authors are often critical of the prominence of policy considerations external to the parties' relationship. 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.[183]

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180. *Williams* CA, *supra* note 80.

181. Chatterjee et al, *supra* note 153 at 2.

182. Weinrib, *supra* note 162 (arguing that *Cooper* "contains a welcome emphasis on the relational nature of the considerations that govern the first stage" of the test for duty at 244); Owen, *supra* note 121 (referring to the parties' relationship as "the fundamental nexus that gives coherence to negligence claims" at 785).

183. Weinrib, *supra* note 162 at 235.

The health sector cases are particularly susceptible to a corrective justice critique, as the courts tend to narrowly interpret the relational aspect of duty (focusing on statutory duties and summarily discussing the parties' relationship) and treat policy considerations as paramount. 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 analysis.[184] I thus adopt the approach of Perry, who has argued that tort law is mainly founded on "principles of moral responsibility", and while policy considerations "do have a role to play[,] . . . it is inevitably a subsidiary one".[185]

Applying this approach, courts should be more cautious in negating a prima facie duty for policy reasons, particularly on a motion to strike. The lower court in *Eliopoulos* was cognizant of this concern: "To attempt to apply policy considerations in a vacuum, and without the benefit of a record, would be contrary to the principles on which our case law has long been understood to develop".[186] In a trial, a plaintiff

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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. *Ibid* at 246.

See also Daniel More, "The Boundaries of Negligence" (2003) 4:1 Theor Inq L 339 (criticizing a focus on policy factors as "judicial confiscation of what is rightly due the plaintiff in order to subsidize policy objectives unilaterally favorable to the defendant" at 344).

184. See e.g. *Cooper*, *supra* note 79 (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" at para 29).

185. Stephen R Perry, "Protected Interests and Undertakings in the Law of Negligence" (1992) 42:3 UTLJ 247 at 249.

186. *Eliopoulos* Sup Ct, *supra* note 146 at para 54, citing *Anger v Berkshire Investment Group Inc* (2001), 141 OAC 301 at para 15 (available on QL). See also *Williams* Sup Ct, *supra* note 118 (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" at para 96).

must establish the existence of a duty, but the onus is on the defendant to prove overriding policy concerns to limit the duty. On a motion to strike, a court must read a plaintiff's claim generously and accept all facts as proven; evidence to the contrary is irrelevant. Despite the Supreme Court's instruction that "the potential for the defendant to present a strong defence should [not] prevent the plaintiff from proceeding",[187] government arguments respecting policy concerns have been an influential factor, if not a determinative one, in the health sector decisions. Although those concerns may be legitimate,[188] I argued above that they may not be as compelling as the courts suggest and, at the very least, must be balanced against the accountability concerns discussed above.

Conclusion

In the face of cost and quality concerns, provincial governments—once passive payers in the health sector—now exert significant influence over other health system actors, thereby affecting patient care. This expanded role has led to growing calls for accountability, exemplified by legal claims naming ministry of health defendants. To date, judges have struck nearly all health sector tort claims on pre-trial motions, on the basis that governments did not owe a duty to the individual plaintiffs.

In the decade since *Cooper*, courts have broadened the factors relevant to duty. At the first stage of the duty analysis, many judges have shifted away from a narrow approach (examining categories of proximity and defining duty through legislation) to a contextual approach (examining the totality of the parties' relationship as illuminated by legislation, precedents and the parties' interactions). Before *Cooper*, the policy/operational dichotomy was the touchstone of the duty analysis for government defendants. Now, courts also explore

187. *Hunt*, *supra* note 95 at para 33.

188. Many commentators consider the Supreme Court's decision in *Chaoulli*, *supra* note 2, to exemplify the concerns about the judicial competence to evaluate matters of complex social policy. See generally, Flood, Roach & Sossin, *supra* note 2, especially Colleen Flood, Mark Stabile & Sasha Kontic, "Finding Health Policy 'Arbitrary': The Evidence on Waiting, Dying and Two-Tier Systems" at 296.

the impact a duty would have on the parties, on the legal system and on society. In contrast to these broad trends in the duty jurisprudence, and despite the centrality of the parties' relationship to a negligence claim, judges adjudicating health sector claims devote little attention to the parties' relationship. Instead, they focus on policy considerations, finding that a duty to individuals would conflict with the government's responsibility to make difficult allocation decisions in the broader public interest.

Courts should be particularly reluctant to allow policy concerns to decide the issue of duty on a motion to strike, given that the courts lack a full factual record and that the defendant's evidence is not entitled to the same preferential treatment as the plaintiff's. Courts emphasize the importance of allowing novel questions, claims relating to unsettled areas of the law, complex cases and cases raising important questions of law to proceed to trial. Although these factors suggest that the health sector claims ought to proceed to trial, judges fail to consider them.

Courts must balance policy concerns against the need for accountability. Allowing tort claims to proceed to an analysis of whether the government breached its duty would improve accountability, as ministry of health defendants would be called upon to justify the reasonableness of their decisions. Subjecting governmental decisions to greater scrutiny would not subvert concerns about scarce resources or competing interests, as the standard of care could be calibrated to incorporate considerable deference to government. It is crucial that citizens have an independent means of reviewing governmental decisions, given the state's growing 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 growing inadequacy of elections as a health sector accountability mechanism. Although there are other accountability mechanisms, these all have significant limitations, and thus a multi-pronged approach which includes tort law is necessary to achieve effective governmental accountability.