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RESOURCE ALLOCATION AND THE STANDARD OF CARE OF PHYSICIANS

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Often referred to as the 'gate keepers' of the health care system, physicians, as the primary providers of medical care, are increasingly required to implement the resource allocation decisions made at the various levels of government and health care administration. To date, courts have been unwilling to alter the standard of care imposed on physicians to reflect systemic realities or to recognize the defense of economic justification in medical liability claims. Instead, they have responded by extending the standard of care and, in some cases, requiring that physicians assume heightened obligations to act as advocates for their patients.

If, as it appears, the prevailing principles of professional and civil liability are not sufficiently flexible to adapt to the consequences of cost-containment measures, alternative mechanisms must be available for physicians to protect themselves from professional liability. In Quebec, the provisions of the Act Respecting Health Care Services and Social Services may serve that purpose. First, the Act recognizes the resource limitations inherent in the health care system and expressly provides health institutions with the latitude to make decisions about how to allocate the resources available. Second, it circumscribes the physician's disclosure obligations to the patient with respect to service limitations and institutionalizes the physician's role in the administration of the hospital. Finally, the most recent amendments to the Act, which provide for the

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creation of risk management and quality control committees, provide physicians with a formal procedure to signal deficiencies, report 'near misses' and highlight any weaknesses or risk factors within the system.

Considérés comme la porte d'accès au système des soins de santé, les médecins, en tant que principaux fournisseurs de soins médicaux, sont de plus en plus contraints de donner suite aux décisions prises à différents paliers de gouvernement et de l'administration des soins de santé en ce qui a trait à la répartition des ressources. Jusqu'à présent, les tribunaux ont été réticents à modifier la norme de soins imposée aux médecins dans les réclamations relatives à la responsabilité médicale pour refléter les contraintes du système de santé ou à accueillir une défense fondée sur des motifs d'ordre économique. Les tribunaux ont plutôt eu tendance à accroître les obligations des médecins en exigeant dans certains cas qu'ils défendent les intérêts de leurs patients à l'encontre du système.

Si les principes de la responsabilité médicale ne sont pas suffisamment souples pour tenir compte des conséquences des mesures de compression des coûts, d'autres mécanismes doivent être envisagés pour que les médecins n'en soient pas tenus responsables. Au Québec, les dispositions de la Loi sur les services de santé et les services sociaux peuvent être évoquées à cette fin. Premièrement, la loi reconnaît les limites des ressources inhérentes au système de soins de santé et donne expressément aux établissements de santé la latitude de prendre des décisions sur la manière de répartir les ressources disponibles. Deuxièmement, elle délimite l'obligation de renseignement du médecin en ce qui a trait aux limites des services de santé offerts par un établissement de santé et elle institutionnalise le rôle du médecin dans l'administration hospitalière. Enfin, les modifications apportées récemment à la loi, prévoyant la création de comités de gestion des risques et de contrôle de la qualité, font en sorte que les médecins disposent d'une procédure formelle pour signaler les faiblesses ou défaillances du système de santé lorsque survient un accident ou lorsqu'un préjudice est évité de justesse.

I. *Introduction*

Traditionally, the law has dealt with the limitations of medicine by holding physicians to an obligation of means rather than an obligation of result. As a general principle, physicians are expected to follow reasonable standards of practice in their treatment and use the means that a competent physician in similar circumstances would use. They are not expected to guarantee a cure to all their patients' ailments.

In the past, the limitations of medicine arose primarily from a lack of knowledge to treat certain ailments and the absence of proper technology

to intervene. Today, the exponential evolution of medical science has led to the development of specialized and, in many cases, increasingly costly treatment options. This, coupled with the expectation in Canada of universal access to healthcare, has put an unprecedented strain on the public coffers. In an effort to cap the rising costs of healthcare, government agencies as well as individual institutions have been forced to implement cost-containment measures. Thus, we have seen the debate shift as economic considerations are factored into our expectations of how much medicine can achieve.

This has led to difficult questions about the role, if any, that considerations of economic efficiency should have in medical treatment decisions. What is the legal basis to limit access to hospital services, specific treatments or medication? Who has the obligation to inform the patient of these limitations? Are physicians and hospitals in a potential conflict of interest with patients? To what extent is it justifiable to continue providing care when it may be futile?[1]

In this era of budgetary restraint, physicians are placed in a difficult position. Often referred to as the 'gatekeepers' of the healthcare system, physicians, as the primary providers of medical care, are required to implement the choices made at the various levels of healthcare administration.

To date, the courts have fiercely protected the decision-making autonomy of public bodies in the allocation and distribution of healthcare resources. In contrast, they seem all too willing to place the blame on physicians who, when the system fails, do not become crusaders for patient rights, defending their patients' interests against those of the administration. It seems that we now require physicians to become advocates for each of their patients and we challenge them to overcome administrative obstacles so that patients may receive the quality of care that the system itself, through its inherent limitations, renders elusive. Instead of altering the

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[1] Several cases have dealt with this issue, such as the case of *Nancy B. v. L'Hôtel-dieu de Québec et al.*, [1992] R.J.Q. 361 (C.A.). While the cessation of end-of-life treatment is not the focus of this discussion, it is relevant to the extent that all of these questions raise not only medical, but ethical, legal and administrative issues that can only be unravelled by developing guiding principles to be applied on a case-by-case basis. Where, as in the United States, health care is privately funded, the reasonableness of cost-control policies may be discerned by evaluating one HMO's funding policies against those of other HMOs. However, this comparative approach cannot be applied in our Canadian publicly-funded health care system and we have yet to develop universal benchmarks to guide and, where necessary, evaluate the appropriateness of resource allocation decisions. For a discussion of the need for governments and health care authorities to identify 'economies of scale' for the purposes of making rational resource allocation decisions, see Peter W. Kryworuk, Brian T. Butler & Allyson L. Otten "Liability in the Allocation of Scarce Health Care Resources" (1996) 16 Health Law in Canada 65.

standard of care expected of physicians to reflect systemic realities, courts appear to have imposed additional duties on physicians to compensate for the consequences of cost-containment measures.

Balancing competing interests is a fundamental aspect of legal analysis. Thus, judges have no difficulty, in the abstract, weighing the interests of a single patient, on one hand, against those of the general population, on the other, to determine where the balance should fall. However, when the application of this cost-benefit analysis would require the court to deny compensation for the victim of a medical decision based on cost considerations, the benefit of which is difficult to quantify, the analysis becomes much more difficult. In reality, it is virtually impossible for a healthcare provider to justify a decision by showing how many other patients benefited as a result, or, alternatively, how many other patients would have suffered if the plaintiff and all other patients in his or her position had been given optimal treatment. As a result, the courts have been relatively ineffective in dealing with the inevitable consequences of cost-containment mechanisms and, in many cases, physicians have borne the brunt of the resulting liability.[2]

As an alternative, the *Act respecting health services and social services*[3] (the "HSSS") in Quebec may provide a legislative avenue for physicians to overcome the problems associated with cost-containment.

The 1992 amendments to the HSSS recognize the resource limitations inherent in the healthcare system and the need for hospitals to make decisions about how to allocate the resources available. In addition, they allow physicians to inform their patients of any limitations in the scope of care available in their particular hospital and to perform an advisory function, through the Council of Physicians, Dentists and Pharmacists ("CPDP"), in the administration of the hospital. However, even then, the only avenue open to physicians when problems arose as a result of resource allocation decisions was to ensure that the situation was properly documented and to invoke their disclosure duties under the HSSS to ensure that their patients were apprised of any deficiencies in the nature and

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[2] Timothy Caulfield has written extensively on the limitations of traditional legal principles for dealing with the consequences of health care reform : see Timothy A. Caulfield, "Malpractice in the Age of Health Care Reform" in *Health Care Reform and the Law in Canada : Meeting the Challenge,* Timothy A. Caulfield and Barbara von Tigerstrom, eds. (Alberta: University of Alberta Press, 2002) 1; Timothy A. Caulfield, Submission to the Commission on the Future of Health Care in Canada (discussion paper #24), "How do Current Common Law Principles Impede or Facilitate Change?" (September 2002) online: Health Canada http://www.hc-sc.gc.ca/english/care/romanow/hcc8437.html; Timothy A. Caulfield, "Health Care Reform: Can Tort Law Meet the Challenge?" (1994) 32 Alberta Law Review 685.

[3] R.S.Q., c. S-4.2, as am by S.Q. 1991, c.42 [1992 14 SSS].

quality of services offered by the hospital. While these tools allowed physicians to have some input on the quality of care and financial decision-making, there was no way for them to bring specific incidents or recurring problems to the hospital's attention.

More recent changes to the HSSS, which provide for the creation of a risk management and quality control committee in each institution, will give physicians a formal voice within the hospital administration through which they can signal deficiencies and report, in confidential circumstances, any "near misses" that may occur.[4] The creation of these committees may also provide physicians with the opportunity to highlight any weaknesses or risk factors within the system that could have had an impact on the quality of patient care, had it not been for the fastidious care and diligence of the medical and nursing staff.

II. *The Physician and the Healthcare System: Contextualizing the Physician's Duty of Care*

A. *Distinguishing the Physician's Duty to the Patient from the Duty of Healthcare Authorities*

Once the doctor-patient relationship is formed, physicians owe a personal duty of care to their patients, independent of any duty owed by the hospital or regional or provincial health authorities.

In medical liability claims, the courts treat physicians and the hospitals in which they practise as separate legal actors, each having independent, though sometimes overlapping, duties to the patients they serve. Thus, absent exceptional circumstances, physicians are characterized as independent contractors and the hospital is not vicariously liable for their negligent acts or decisions simply because they are given hospital privileges.[5] Conversely, provided that they satisfied their own duty of care to their patients, physicians will not be liable for the hospital's negligence

[4] *An Act to amend the Act respecting health services and social services as regards the safe provision of health services and social services*, S.Q. 2002, c.71 [Bill 113]. As a result of these amendments, all hospital employees and medical professionals now have the obligation to report any accident that occurs during the provision of care as soon as possible after the occurrence. An 'accident' is defined as the manifestation of any risk event which has or could have had actual or potential consequences for the health and welfare of a user, an employee, a professional or any other person. On the basis of these accident reports, the hospital's risk and quality management committee is then responsible for identifying the causes of these accidents and making recommendations to the board of directors of the institution to prevent recurrences.

[5] *Yepremian v. Scarborough General Hospital* (1980), 110 D.L.R. (3d) 513 (Ont. C.A.); *Kungl v. Fallis*, [1989] O.J. No. 15 (Supreme Court of Ontario B High Court of Justice) (Q.L.); *Bateman v. Doiron* (1991), 118 N.B.R. (2d) 20 (Q.B.), aff'd (1993), 141N.B.R. (2d) 321 (C.A.); *Camden-Bourgault c. Brochu*, [2001] R.J.Q. 832 (C.A).

in the provision of services.

Thus, the courts will judge the actions of the physician and the hospital or any other healthcare authority independently, based on the applicable standard of care. The most significant consequence for the purposes of this paper, as we will see below, is that physicians will not be able to escape their own liability to the patient by simply deferring to the cost-containment policies and decisions of the hospital or another healthcare authority.

B. *Distinguishing the Physicians' Duty to their Patients from their Duty to Healthcare Authorities*

The Supreme Court has recognized the fiduciary nature of the doctor-patient relationship.[6] According to Picard, "[this means that doctors have an obligation to their patients to act with utmost good faith and loyalty, and must never allow their personal interests to conflict with their professional duty".[7] Thus, in the event that physicians' fiduciary duty to their patients conflicts with their obligation to follow the directives of the hospital or the healthcare system, their duty to the patient must prevail.[8]

A number of U.S. cases have reinforced the point that a physician's duty of care does not change simply because of the implementation of cost-containment measures, or the fact that the physician reports to a healthcare insurer.[9] As a matter of principle, it has been held that a patient who suffers damage is entitled to recover from all parties responsible for the damage, including physicians, hospitals and, where appropriate, health insurers or third-party payors. Moreover, physicians who comply without protest with the directives of a third party, contrary to their medical judgement, cannot avoid ultimate responsibility for the patient's care.

The courts' perseverance in upholding the physician's primary

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6 *McIerney V. MacDonald*, [1992] 2 S.C.R. 138; *Norberg v. Wynrib*, [1992] 2 S.C.R. 226.

7 Ellen I. Picard and Gerald B. Robertson, *Legal Liability of Doctors and Hospitals in Canada*, 3rd ed. (Toronto: Carswell, 1996) [Picard] at 4.

8 *Law Estate v. Simice* (1984), 21 C.C.L.T. (2d) 228 (B.C.S.C.), aff'd (1995), 17 B.C.L.R. (3d) 1 (C.A.) is commonly cited as the leading Canadian case on whether a physician may use a cost containment initiative as an "economic defence" to a negligence action. The action was brought by a widow against several physicians following the death of her husband due to a ruptured aneurism. One of the primary allegations was that the physician breached the standard of care by failing to order a CT Scan in a timely manner. In defence, one of the issues raised was the existence of budgetary constraints imposed by the provincial insurance scheme on the use of such diagnostic tools. The Court categorically refused to accept this "economic defence". See 46 below and accompanying text.

9 *Wickline v. State of California*, 228 Cal. Rptr. 661 (1986).

responsibility to the patient suggests that the courts will not accept the cost-containment objectives of third parties as an 'economic defence' for withholding medically necessary treatment.

C. *The Potential Liability of Other Healthcare Actors*

In addition to physicians, hospitals, regional or provincial public authorities, public or private insurers as well as other healthcare professionals are all potential targets for medical liability claims where the injury results from the implementation of a cost-containment measure.

1. Hospitals

Hospitals owe a duty of care to the patients who use their facilities and may be liable where injury results from a failure to maintain the required standard of care.

Yepremian v. Scarborough General Hospital set out the standard of care required of a hospital and the duties that arise as a result. Thus, a hospital has the "obligation to meet standards reasonably expected by the community it serves in the provision of competent personnel and adequate facilities and equipment and also with respect to the competence of the physicians to whom it grants privileges to provide medical treatment".[10] In addition, a hospital is responsible for "establishing such systems as are required for the co-ordination of personnel, facilities, equipment, and records so that the patient receives reasonable care."[11] Thus, a hospital could be liable if the consequence

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[10] See *Bateman v. Doiron*, *supra* note 5 at 290 where this notion of the hospital's standard of care was cited and upheld. Mr. Bateman died of cardiac arrest following his admission to the defendant Moncton Hospital. His wife and son brought an action in medical negligence against both the treating physician who was on staff in the emergency department and the hospital. The claim was dismissed. The principal argument against the hospital was that, by staffing its emergency department with general practitioners, often with limited experience, the hospital had failed to ensure that its emergency department staff was competent to provide the level of care expected. The Court found that the defendant hospital had met the standard of care reasonably expected in the community it served: "to suggest that the defendant Moncton Hospital might be reasonably expected by the community to staff its emergency department with physicians qualified as experts in the management of critically ill patients does not meet the test of reality nor is it a reasonably expected community standard. The non-availability of trained and experienced personnel to say nothing of the problems of collateral resource allocation, simply makes this standard unrealistic albeit desirable." The Court also dismissed the claim against the physician, finding that his treatment of the patient met the standard of care and skill which might reasonably be expected of a normal, prudent practitioner of the same experience and standing. See also *Yepremian v. Scarborough General Hospital, supra* note 6.

[11] Picard, *supra* note 7 at 369-70.

of cost constraints or resource limitations is inadequate equipment or drugs or insufficient or inadequate staff.[12]

That being said, the law does not expect that all hospitals be specialized in every medical treatment or offer the full spectrum of medical care. They are simply required to ensure adequate staffing and the level of equipment necessary to maintain a reasonable standard of care.[13] Hospitals must establish their orientation, their priorities, the parameters within which they will treat patients, the type of patients they wish to target and the kinds of medical services they wish to offer. They must then manage their resources effectively and efficiently in accordance with those orientations. Moreover, decisions regarding the allocation of resources within the hospital must be made rationally, in light of all the relevant circumstances and in accordance with the requirements set out in any applicable legislation. Provided that the decision-making process is lawful and properly documented, a hospital will not be liable simply because it has chosen not to offer a particular service or to use a treatment or equipment that, though still generally satisfactory, is not the most up to date.

Finally, a hospital's standard of care is evaluated in light of the expectations of the community in which it operates. Thus, a hospital may have the obligation to notify the public of any specific limitation or deficiency in the services it offers or any change in the availability or quality of those services.[14]

2. Health Authorities and Health Insurers

Actions brought against health authorities and insurers for failure or refusal to allocate resources to particular services have yielded mixed results from the courts.

In the U.S., some decisions have recognized the potential liability of third-party insurers in the event that a medically inappropriate decision is made as a result of the application of cost containment measures.[15]

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[12] See discussion of *Landry v. Hôpital St-François d'Assise*, [1996] R.R.A. 218, J.E. 96-370 (S.C.), below.

[13] See *Bateman v. Doiron*, *supra* note 5. This issue will be discussed at greater length in the context of the *Quebec Act respecting health services and social services*.

[14] See *Baynham v. Robinson* (1993), 18 C.C.L.T. (2d) 15 (Ont. Gen. Div.); see also *Bateman v. Doiron*, *ibid.*

[15] Picard, *supra* note 7 at 209; *Wickline v. State of California*, *supra* note 9. Alternatively, the liability of third-party insurers may arise in the context of class actions by doctors claiming reimbursement for medically necessary services that were performed despite the fact that the insurer, in an attempt to restrict access to certain treatments, refused to pay for them. The following article from "Aetna settles with doctors" *Globe & Mail* (23 May 2002) B8 illustrates this proposition:

However, British and Canadian courts have, to date, been reluctant to impose liability for their decisions on how to allocate limited resources.[16] According to Picard, public authorities would likely be immune from tort liability on the grounds that decisions on how to allocate resources are 'policy decisions'. Moreover, even if a particular decision was characterized as 'operational', thus giving rise to a duty of care, it would be extremely difficult for a patient who suffered damage to discharge the burden of proving that the decision was unreasonable in the circumstances.[17]

"Aetna Inc. has agreed to pay $170-million (U.S.) to settle a class-action lawsuit brought by doctors who claimed insurers short-changed them and interfered with their recommended treatment for patients. Under the settlement announced yesterday, Aetna said it will revamp its bill payment systems and estimated that would save physicians an additional $300-million over several years. It is also creating a panel of doctors to advise it on issues important to physicans and establishing a foundation to improve the quality of health care. Aetna is the first insurer to settle a number of doctors' lawsuits, some dating back four years ago, that have been consolidated in U.S. District Court in Miami. The proposed settlement requires approval of the federal court. In trading on the New York Stock Exchange yesterday, Aetna shares fell 34 cents to $56.90. Aetna, Cigna Corp., United-Health Group Inc., Wellpoint Health Networks Inc., Anthem Inc., Humana Inc., PacifiCare Health Systems Inc. and other managed care companies are accused of improperly denying and delaying payments to physicians. The suits allege that insurers used their coercive economic power to force doctors into unfavourable contracts and used pay schemes — including tests and referrals to specialists — to reduce care. The proposed settlement calls for Aetna to pay $100-million to doctors and $20-million to allow doctors to establish a foundation aimed at reducing medical errors, childhood obesity and racial disparities in treatment. Aetna also would pay up to $50-million in plaintiffs' legal fees."

[16] However, at least one Canadian case has raised the possibility that such liability could arise. In *Decock v. Alberta* (2000), 75 A.R. 234 (C.A.), the appellants, in four separate pleadings, sought damages for injuries suffered as the result of receiving allegedly negligent medical care, attention and treatment. The pleadings named, *inter alia*, The Honourable Ralph Klein (the Premier of Alberta) and The Honourable Shirley McClellan (Alberta Minister of Health). The appellants alleged a breach of the duty to ensure the provision of reasonable and proper medical care, attention and treatment in the province. The Court of Appeal, without commenting on whether the public officials had such a duty of care, held that both the Minister of Health and the Premier could be named as defendants in a medical malpractice suit for their personal negligence. It could not be said at that stage of the proceedings that the claims against the public officials revealed no reasonable cause of action, nor could it be said that they were scandalous, frivolous, vexatious, embarrassing or constituted an abuse of process. [Note: Leave for Appeal to the Supreme Court granted [2000] S.C.C.A. No. 301; Notice of Discontinuance filed 10/9/2001.]

[17] Picard, *supra* note 7 at 209-210.

3. Other Health Professionals

In 2002, the *Québec Professional Code* was amended to allow greater latitude for other healthcare professionals to perform medical acts which, previously, were within the exclusive competence of physicians. Prior to these amendments, the *Regulation respecting the acts contemplated in section 31 of the Medical Act which may be done by classes of persons other than physicians*[18] set out an exhaustive list of all the medical acts that could be performed by non-physicians, for example, by nurses or inhalation therapists. However, this rigid regulatory approach could not accommodate the realities of the hospital environment and medical professionals, in practice, had difficulty respecting the restrictions. As such, in the amendments to the *Professional Code*, the legislator sought to define the scope of practice of the various health professions, eleven in all, leaving it up to the professionals to determine whether, in each case, a particular act falls within their field of practice and whether they have the skill and training required to perform it.

The result of these amendments is that the boundaries of the medical profession, in relation to other health professions, will not be as sharply defined, allowing for greater flexibility in the administration of care. This conscious widening of the scope of practice of non-physicians was based on rational objectives; for example, allowing cardiac surgical nurses to have a greater autonomy in their practice eliminates the need for constant medical intervention and the expenditures that go with it.

A correlative consequence is that the range of medical acts that may be performed by non-physicians will be decided at the level of the individual healthcare facility. This is indicative of a general trend towards decreased regulation and, inevitably, greater disparities between facilities. From a legal perspective, it will become far more difficult to distinguish the legal responsibility of physicians from that of the other health professionals assisting in the patient's treatment.

To the extent that physicians will have a direct hand in determining which medical acts may be shared, they are likely, once again, to be found personally liable if the other health professional did not in fact have the skill or training required to perform the said act.

III. *The Standard of Care Applied to Physicians*

A. *The Modified Objective Standard*

The standard of care required of a physician is that of a reasonable medical practitioner in the same circumstances.

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[18] R.R.Q. 1981, c. M-9, r. 1.1.

Crits v. Sylvester, which continues to be the leading case on this point, establishes the appropriate standard as follows:

> Every medical practitioner must bring to his task a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. He is bound to exercise that degree of care and skill which could reasonably be expected of a normal, prudent practitioner of the same experience and standing, and if he holds himself out as a specialist, a higher degree of skill is required of him than of one who does not profess to be so qualified by special training and ability.[19]

To determine whether a physician met the standard of care in a particular case, the courts rely on the evidence of medical experts to establish the approved practice and evaluate the level of acceptance of any changes or advances in treatment or technology. That being said, a medical practitioner who acted in accordance with the standard practice may still be found negligent if it is determined that the standard practice is itself negligent — that is, 'fraught with obvious risks such that anyone is capable of finding it negligent' without the need for expert opinion.[20]

While the test is fundamentally objective, the Court will take certain individual factors into consideration in establishing the appropriate standard. For instance, the Court will likely enquire into the physician's training and experience, the nature of the treatment or procedure performed, the locality and the nature of the medical facility in which the physician practises, and the resources available to the physician at the time of the alleged negligent act.

It is important to note that even where a court finds that a physician did not meet the required standard of care, liability will not be imposed unless, on the balance of probabilities, the breach of duty was the legal cause of the patient's injuries. By way of example, physicians will not be liable where they withheld treatment which, in the circumstances, would have been futile.[21]

B. *The Locality Principle Revisited*

The locality principle is a particular application of the modified objective standard that recognizes the potential differences in the quality and type of equipment and other resources available as well as the variation in experience of physicians practising in different locations. The rule is usually invoked to alter the standard of care to compensate for the

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[19] [1956] O.R. 132 (C.A.) at 143, aff'd [1956] S.C.R. 991.

[20] *ter Neuzen v. Korn*, [1995] 3 S.C.R. 674 at para. 41.

[21] For a discussion of causation in the context of resource allocation, see J.C. Irvine, "The Physician's Duty in the Age of Cost-Containment" (1994) 22 M.L.J. 345.

challenges faced by rural practitioners in relation to those practising in large urban centres. Thus, the applicable standard of care will be that of a practitioner in a 'similar locality' and with similar resources at his disposal.

The principle found favour with common law courts and a number of recent decisions have referred to the locality rule in establishing the appropriate standard of care.[22] In contrast, the principle has never found its way into the civil law and Quebec courts have given it little, if any, consideration.

However, even where it is accepted, the application of the rule may have little actual impact on the outcome of cases and the relevance of the rule in a modern context has been seriously questioned. Critics suggest that this antiquated principle is no longer necessary in a modern society where improved communications and uniform medical education and examinations allow all Canadian practitioners, regardless of their geographic location, to have access to the latest advances in medical research and treatment.[23] The courts have also criticized the continued existence of the rule, with some going so far as to advocate abandoning it altogether, at least in cases where large urban facilities are reasonably accessible, on the grounds that it creates an unjustified differentiation in the standard of medical care from one area to another within a province.[24]

Moreover, the courts have increasingly applied the individual factors

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[22] See Picard, *supra* note 7 at 204-206.

[23] *Ibid.*; see also A.M. Linden, *Canadian Tort Law*, 5th ed. (Ont. S.C.J.) (Toronto: Butterworths, 1993) at 147-49.

[24] See, for example, the recent decision of the Ontario Superior Court of Justice in *Crawford v. Penney* (2003), 14 C.C.L.T. (3d) 60. This case deals with the issue of limited resources in general rather than cost containment *per se.* However, it raises several points of interest about the appropriate standard of care in medical malpractice cases. As a result of a series of complications during her birth, the plaintiff suffered a permanent and disabling brain injury. The Court determined that the ultimate cause of the injury was the failure of the treating physicians to diagnose and treat diabetes during the pregnancy. The claim against the physicians was upheld. One of the major issues raised in the case was the standard of care for a family physician delivering babies in a rural area. On this point, the Court made several interesting findings. First, the Court held that the locality rule should be abandoned and that doctors should be held to the same standards of practice regardless of the locality of that practice. Moreover, physicians practising in rural areas or with limited resources have a duty to recognize their own limitations and use all resources at their disposal, including the possibility of referring patients to larger centres. Second, when a physician is in a situation with limited resources, he must have a carefully considered plan of action in place in the event of a medical emergency. It is not enough for the physician to say that, faced with an emergency, he performed at his best under the circumstances. The principles upheld in this case are useful as a general indication of the judicial trend to impose additional duties on physicians when they know that they may not have access to all the necessary resources required to provide optimal patient care.

in the modified objective test to tailor the standard of care to the specific practice of the physician in question. For instance, the Alberta Court of Queen's Bench found that a family practitioner who devoted 50% of her practice to obstetrics should be held to the standard of a reasonable "family practitioner engaging in a significant practice in obstetrics".[25] Similarly, in a recent decision, the Ontario Superior Court of Justice held two general practitioners from Smiths Falls to the standard of care attributable to "the normal, prudent general practitioner practicing obstetrics in 1983 in a fairly small community but which has a quick and easy access to major medical centres and experts".[26] By using this approach, courts are able to take the unique circumstances of the physician into consideration without creating broad exceptions to the general standard of care.

C. *The Impact of Cost-Containment Measures on the Applicable Standard of Care*

Because the consideration of available resources is inherent in the locality principle, it was suggested that it could be applied, by analogy, to cases involving resource constraints resulting from cost-containment measures. However, the reaction of the courts to date makes it unlikely that the locality principle will be extended to lower the applicable standard of care where resource allocation decisions result in a reduction in the quality of facilities, equipment or treatment.

A distinction is commonly made between situations in which resources are simply not available because of the size, location or particular circumstances of the medical facility, and situations in which a physician makes a decision not to use resources that are available but subject to budgetary considerations.

In the first case, courts are willing to acknowledge that physicians in rural centres may not have access to the same human and technical resources as large urban centres and cannot be expected to maintain the same level of service. To determine whether the standard of care was met in a particular case, the services provided will be measured against the reasonable expectation of the community in which the facility operates. For instance, in *Bateman v. Doiron*,[27] the court held that it was not unreasonable for a hospital in a smaller centre to staff its emergency room with general practitioners instead of emergency room specialists and that, in doing so, it could not be judged by the same standards as a large teaching hospital. Similarly, the standard of care may be lower for

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[25] *Fleury v. Woolgar*, [1996] 5 W.W.R. 721 (Ab. Q.B.).

[26] *Crawford v. Penney*, *supra* note 24 at para. 260.

[27] *Supra* note 5.

physicians practising alone[28] and those providing emergency treatment in less than ideal conditions.[29]

However, even where courts recognize that a physician's particular circumstances justify lowering the standard of care, they impose correlative duties on such physicians to use all resources at their disposal to ensure that their patients have access to the best care possible. Thus, courts have held physicians in rural locations liable for failing to inform a patient of the risk of insufficient resources,[30] failing to access all available resources within a reasonable distance[31] or failing to foresee potential complications by putting in place a plan of action.[32]

Conversely, where the resources required for necessary treatment are available to physicians but they make the choice, based on cost considerations, not to use them, they will not be able to raise the 'economic defence' to avoid liability. In these situations, the reasonableness of the physicians' decisions will be scrutinized to determine whether they met the appropriate standard of care in light of the prevailing public or community expectations. While this issue has never been the subject of direct judicial consideration, the courts have shown their willingness to find a physician liable where medically necessary treatment is withheld due to budgetary constraints.[33] As well, physicians may be penalized for accepting to work in substandard conditions or accepting to use obsolete treatments or equipment.[34]

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[28] *Lacroix c. Léonard*, [1992] R.R.A. 799 (S.C.).

[29] *Zanchettin c. Dr. René De Montigny*, [1995] R.R.A. 87 (S.C.).

[30] *St. Jules v. Chen*, [1990] B.C.J. No. 23 (Q.L.).

[31] *Crawford v. Penney*, *supra* note 24.

[32] *Ibid*.

[33] *Law Estate v. Simice*, *supra* note 8.

[34] *Landry v. Hôpital St.-François d'Assise and Dr. Dubé*, *supra* note 12. See also *Houde c. Côté*, [1987] R.J.Q. 723 , where the Superior Court confirmed the principle that the lack of proper resources cannot justify an unacceptable decrease in the quality of care. The plaintiff, a man in his forties, became paraplegic after the administration of an epidural anaesthesia during knee surgery. At the time, the anaesthetist was covering three operating rooms and he was not present at the patient's bedside when the epidural was given to monitor his blood pressure. The Court concluded that the resulting hypotension caused the thrombosis of an artery irrigating the spinal cord which, in turn, caused the paraplegia. The hospital was held liable for imposing an excessive workload on the anaesthetist. The physician was held jointly liable for accepting such a heavy workload. The Court of Appeal took the view that a physician could legally accept a heavy workload but nonetheless held the physician liable for his failure to provide adequate care of the patient.

See also *Rémillard c. Centre hospitalier de Chandler*, [1992] R.J.Q. 2227 (S.C.), where the plaintiff physician sought to have declared null and illegal a scheduling regulation approved by the board of directors on the grounds that it imposed an excessive workload, restricted his professional liberty to refuse to take on such a workload, and endangered the health of

In this context, the question of whether the physician breached the required standard of care in making the treatment decision is one that can be determined by an ordinary trier of fact. As a result, it is open to the court to find physicians negligent even though they acted in accordance with the standard practice, on the ground that the practice itself is unreasonable.[35]

IV. *Liability Issues when Cost-Containment Measures Conflict with the Physician's Duty to the Patient*

With the compound effects of repeated cuts to public spending on healthcare, resource allocation decisions often entail difficult decisions about how to distribute insufficient funds. As a result, physicians may find themselves 'stuck between a rock and a hard place' when budgetary constraints conflict with their personal duties to their patients.[36] To further complicate the problem, there is a strong argument that the prevailing principles of professional and civil liability are not sufficiently flexible to adapt to the realities within the healthcare system.

A. *General Principles*

As we have seen, the courts, to date, have shown little sympathy for

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both his patients and himself. The Court granted the Declaratory Judgment. The physician had no legal obligation to act in accordance with regional funding plans. Moreover, given that his own personal responsibility was at stake, the physician had a right, and perhaps even a duty, to refuse to follow a regulation that exceeded his capabilities. Essentially, the Court upheld the physician's right to refuse to work under unreasonable conditions.

[35] *ter Neuzen v. Korn*, *supra* 20.

[36] The modifications to the Quebec *Code of Ethics of Physicians*, R.R.Q. 1981, c. M-9, r. 4-1, which came into force in November 2002, reinforce, on one hand, the role of physicians in the effort to control costs and, on the other hand, the expectation that physicians conduct their practice in accordance with the "highest possible current medical standards". The following provisions are of particular :

12. A physician must be judicious in his use of the resources dedicated to health care.
41. A physician must collaborate with his colleagues in maintaining and improving the availability and quality of the medical services to which a clientele or population must have access.
42. A physician must, in the practice of his profession, take into account his capacities, limitations and the means at his disposal. He must, if the interest of his patient requires it, consult a colleague, another professional or any competent person, or direct him to one of these persons.
44. A physician must practise his profession in accordance with the highest possible current medical standards; to this end, he must, in particular, develop, perfect and keep his knowledge and skills up to date.
46. A physician must take his diagnosis with the greatest care, using the most appropriate scientific methods and, if necessary, consulting knowledgeable sources.

physicians who are forced to make treatment decisions in a context of strict budgetary controls. Specifically, cost-containment measures may have a significant impact on the nature of the physician's duty to treat the patient, as well as the duty to inform. In addition, where a physician does not have access to medically necessary resources as a result of budgetary constraints, special obligations may arise to avoid potential injury to a patient.

1. The Duty to Treat

The physician's duty to provide the patient with optimal medical care will be invoked in any case where medically necessary treatment is available but access to that treatment is restricted due to cost constraints. As well, it may arise where a physician chooses to use an outdated, less costly drug or procedure when a newer, safer alternative is available.

As a general principle, physicians will be held liable if they withhold medically necessary treatment due to cost considerations and patients suffers injury as a result.[37] However, where alternative treatments are available and physicians choose to use the less costly one, they will not be liable unless it is established that the treatment used is so outdated or obsolete that it is no longer an accepted medical practice. In all cases, the physician's decision to follow a cost-containment policy will be scrutinized to determine whether it was reasonable in the circumstances.

2. The Duty to Inform

Canadian physicians are bound to disclose any reasonably material information regarding a patient's care which could affect the patient's ability to make an informed treatment decision. As diagnostic procedures and treatments are subjected to increasing controls, this legal concept of 'informed consent' may have serious implications for physicians.

In the context of limited medical resources, the physician's duty to inform may give rise to the following particular obligations:

> The obligation to inform the patient of any special risks due to the lack of necessary equipment or resources;
> The obligation to inform the patient of risks due to long waiting lists for treatment;
> The obligation to notify the patient of resources or treatments offered in other facilities.

The law requires physicians to inform patients of all matters that a reasonable person in the patient's position would consider important or

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[37] *Law Estate v. Simice*, *supra* note 8.

necessary in making healthcare decisions. This has led some authorities to suggest that physicians have a duty to notify patients of any concerns related to the waiting times for treatment, especially with respect to patients with potentially life-threatening conditions that may be exacerbated by the delay.[38]

In a recent case, the Ontario Superior Court of Justice recognized that physicians, especially those practising in rural settings, may not all possess the same abilities or have access to the same resources. Rather than supporting the application of a lower standard of care, the court held that physicians with limited resources must be particularly vigilant. They have the obligation to recognize their own limitations, to keep up with medical developments and, where possible, to refer patients to experts and larger medical facilities.[39] This statement is consistent with earlier cases establishing the principle that physicians, regardless of their location, have the obligation to use all available resources to procure effective treatment for their patients. In the context of cost-containment, it has been argued that this obligation may be extended by analogy to cases where a treatment is not available in a particular facility due to cost constraints, but is offered in another facility or in a different region, province or country.[40] However, given the need to show causation, even if such a duty were recognized, it would only arise where the alternative treatment held a potential benefit to the patient.

If a physician is aware of alternative interventions which, as a matter of course will not be made available to the patient but could be made available in a different facility, a different country or at personal cost, the physician must consider the patient's position. If the physician knew or ought to have reasonably known that the patient would seek or has customarily sought healthcare outside of the patient's jurisdiction or at a personal cost, disclosure of alternative treatments would be mandatory, because such information would clearly influence the decision of a reasonable person in the patient's position.[41]

3. The Duty to Advocate?

It seems unreasonable to require that physicians embark on a personal crusade against the system when conditions beyond their control have a

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[38] J. Thomas Curry, "Are Cuts to Health Care Funding Changing the Legal Standard of Care?" (2000) 22 Advoc. Q. 337; Ryan Collier, 'The Obligation to Inform Individual Patients about a Lack of Resources" (2002) 4 Risk Management in Canadian Health Care 33.

[39] *Crawford v. Penney*, *supra* note 24.

[40] Picard, *supra* note 7 at 132.

[41] D.J. Roy, B.M. Dickens & M. McGregor, "The Choice of Contrast Media: Medical, Ethical and Legal Considerations" (1992) 147 C.M.A.J. 1321 at 1323.

detrimental effect on their patients.

However, it has been argued that, in light of recent British and U.S. case law imposing liability where a physician complied without protest with limitations imposed by third parties, physicians may be subject to an added duty to act as a "patient advocate" in the event of unreasonable limitations on resources.[42] According to Curry,

> [t]his duty would place an obligation on a doctor to do all that is possible to obtain access to scarce and/or rationed resources for a patient. If a physician fails to do so, or fails to do so adequately, a physician could be held liable for any treatment that falls below the judicially accepted standard of care."[43] As we will see, this duty has also been recognized by the Quebec courts.[44]

B. *The Judicial Approach to Cost-Containment: A Discussion of the Landry Case*

As we have seen, the courts have been unwilling to recognize the impact of resource constraints in their treatment of physicians. This oft-cited statement from *Law Estate* v. *Simice* is referred to as evidence of the court's categorical refusal to recognize the defence of economic justification:

> [I]f it comes to a choice between a physician's responsibility to his or her individual patient and his or her responsibility to the medicare system overall, the former must take precedence in a case such as this. The severity of the harm that may occur to the patient was permitted to go undiagnosed is far greater than the financial harm that would occur to the medicare system if one more CT Scan procedure only shows that the patient is not suffering from a serious medical condition.[45]

The subsequent decision of the Quebec Superior Court in *Landry v. Hôpital Saint-François d'Assise and Dubé,*[46] rendered December 14, 1995, further illustrates the severity with which physicians are judged when the system fails.

In *Landry*, the Court was called upon to determine a hospital's responsibility with respect to defective or outdated equipment, in this case, haemodyalisis equipment that did not contain a water purifier. Prior to the incident which gave rise to the action, the treating nephrologist had written

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[42] See Picard, *supra* note 7 at p. 208-209; see also Curry, *supra* note 37 at 358-59.

[43] *Ibid* at 359.

[44] See the discussion of *Landry v. Hôpital St-François d'Assise* in Section 4.(b), below.

[45] *Supra* note 8 at para. 28.

[46] *Supra* note 12.

four letters, between 1976 and 1985, asking the hospital to purchase a water purifier for the haemodialysis department. In effect, the plaintiff's injury was caused by the presence of aluminium in the tap water used in haemodialysis, an injury that would have been avoided if the hospital had purchased the water purifier as requested. The hospital ultimately purchased the equipment, *after* the institution of the plaintiff's action, at a cost of less than $10,000.

The judge recognized that the physician was trapped in a difficult situation: only one other hospital in the Québec City region offered dialysis and it would have been impossible to transfer all of the patients to that facility. As a result, if the physician made the decision to close the haemodialysis unit a significant number of kidney patients would be at risk of imminent death. Therefore, knowing that performing haemodialysis without a water purifier would not be dangerous for a certain period of time because the increase of the level of aluminium in the body would be progressive, he chose the lesser of two evils.

In this case, it was clear that the principal cause of the injury was the inadequate equipment and thus, the only logical conclusion should have been to hold the hospital solely responsible for the damages resulting from its unreasonable refusal to purchase a water purifier. Having chosen to provide dialysis facilities, the hospital had a duty to ensure that its equipment was safe and adequate. Certainly, the hospital was not required to offer all types of medical treatment. But once it chose to provide haemodialysis, it had the obligation do so competently. Conversely, the claim against the physician should have been dismissed on the basis that he met his standard of care by making written demands to the hospital to rectify the situation.

Instead, the court went to great lengths to impose joint liability on the physician on the grounds that, by failing to take steps to compensate for the hospital's shortcomings, the physician had committed a collateral fault. The court found that the physician should have been more diligent in monitoring the level of aluminium in the patient's blood to compensate for the deficiencies in the equipment, allowing him to detect any aluminium poisoning as soon as possible and react quickly to mitigate the damage to the patient. In addition, the court held that he should have informed his patient of the complications inherent in undergoing haemodialysis with tap water to give him the opportunity to seek treatment in the other Québec hospital offering the treatment.[47] Finally, and perhaps most importantly, the hospital's lawyers successfully argued that the physician should have

[47] With respect to the physician's duty to inform and monitor the patient following treatment, see the following trilogy of cases from the Quebec Court of Appeal: *Parenteau c. Drolet*, [1994] R.J.Q. 689 (C.A.), *Paterson c. Rubinovich*, [2000] R.R.A. 26 (C.A.) and *Brochu v. Campden-Bourgault*, *supra* note 5. These cases generally establish that to

been more insistent in his appeals to the hospital. In effect, the physician had made his request in writing and in unequivocal terms:

> It is now accepted by all dialysis centers that we must have purified water because experience has shown that after several months of dialysis patients show signs of particular symptoms, resulting among other things from the presence of heavy metals in tap water.

More than anything else, this analysis illustrates the extent to which courts resist placing the blame for deficient equipment on a hospital and, correlatively, their willingness to shift the responsibility to the physician in the event of an accident. It also indicates how aggressively hospitals may force the blame on the treating physician rather than accept responsibility for their own administrative decisions.

In addition to providing a glaring example of the potential liability to which physicians may be exposed when they tolerate cost-containment policies, this decision sets a number of troubling precedents and demonstrates the extent to which courts are removed from the economic realities that physicians face on a daily basis.

First, it seems to endorse the hospital's expert's unreasonable suggestion that the physician should have ceased treating his patients if he was not provided with the necessary equipment. It is common knowledge that, in our state-run healthcare system, specialists cannot practise, and thus make a living, unless they have hospital privileges. Surely, threats to cease treating patients would have serious consequences for the physician's reputation within the hospital. Moreover, the new provisions of the *Québec Code of Ethics of Physicians*, which came into force at the end of 2002, prohibit physicians from applying such pressure tactics.[48]

Second, the court's suggestion that the physician should have sent his patients to another facility illustrates how, when the courts address systemic problems in healthcare retrospectively, taking the injury as the point of departure, they arrive at conclusions which are logical, but hardly realistic. In this case, only two hospitals in the Québec city region performed dialysis at that time, St-François d'Assise Hospital where the equipment was outdated, and Hôtel-Dieu Hospital where the equipment was adequate. In these circumstances, it would clearly have been impracticable for the defendant physician to transfer all of his patients to

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discharge his duty to inform in the post-operative phase, a physician must disclose all the possible complications, side-effects and their attendant risks, such that the patient is able to react to his or her symptoms appropriately and seek further hospital care if need be.

[48] *Supra* note 36, s. 13: "A physician must refrain from taking part in a concerted action of a nature that would endanger the health or safety of a clientele or population."

the only other facility in the area where they could conceivably be treated.

This approach does little to encourage efficiency in the healthcare system. With the benefit of hindsight it is obvious that, in the case of *Law Estate v. Simice* for instance, it would have been better to order the CT-Scan and avoid serious injury to the patient. But in truth, the effect of the court's decision is not simply that "one more CTScan" should have been performed. The unfortunate consequence of this decision is that physicians, to avoid liability, will react by lowering the bar on the criteria required to order a CT-Scan in any case, artificially altering the standards of medical practice.

Third, by subjecting physicians to such a rigorous standard of care that they ultimately bear the greatest burden of responsibility, the courts may inadvertently be encouraging passivity in the hospital system. In effect, by ascribing to physicians the responsibility to intervene to ensure that hospital inefficiencies do not deteriorate to the point of causing prejudice to patients, judges may be giving the message that hospitals are not expected to follow standards of practice and that such standards will not be enforced.

Finally, the *Landry* case raises the issue of disparities in the resources allocated to and, correlatively, the quality of treatment available at different centres within the province and, in all likelihood, across Canada. Though we would like for physicians and hospitals to be judged against accepted standards of practice, these standards are theoretical at best. Even if we are able to discern a standard of medical care that is "acceptable to all", that does not mean that it will be practically feasible for all physicians in all hospitals to apply that standard.

For instance, when Dr. Dubé made his initial demand in 1976, water purifiers had been in use at the Royal Victoria hospital since 1971. In contrast, his hospital acquired the equipment in 1985, and then only after a claim was brought by a patient suffering from aluminium poisoning. Moreover, the evidence at trial revealed that, of the 78 haemodialysis centers in Canada in 1985, 68 had water purification equipment. This means that they were not used in ten other centers, even though they were relatively inexpensive, readily available and approved by provincial health authorities.

The sometimes astounding realities of resource allocation abound, especially when we are dealing with smaller, older or more remote centres. Yet when we see judges refusing, without a second thought, to acknowledge the defence of economic justification, we realize that it is not worthwhile, and may even be "politically incorrect" to argue that physicians must operate within the parameters imposed on them by the healthcare system. The courts have repeatedly shown that they are not

prepared to acknowledge this reality by allowing victims to go uncompensated on the basis of the need to ration public health resources.[49]

In the idyllic eyes of the justice system, it is the physician who treats the patient, who has the most intimate contact with the patient and who is still, accordingly, responsible for ensuring that the patient receives the quality of care that he or she deserves. In practice, the courts do not want to make the victims of the healthcare system suffer the consequences of limitations in the quality of care which, though imposed on the basis of budgetary considerations, are necessary to ensure that quality health services are provided in an equitable fashion.

V. *The Legislative Response: Cost Controls Embedded in the Quebec Health Services and Social Services Act*

The current situation, in which physicians are often forced to bear the professional and legal consequences of systemic budgetary controls, is unfair. Resource allocation is a reality of our public healthcare system and it is here to stay. There simply are not sufficient funds to provide the maximum and highest quality treatment to every patient, without distinction. It is absolutely critical to the long-term viability of the system that we have criteria in place to determine when specific procedures, treatments or drugs will be warranted and the physician cannot be responsible every time the application of those criteria produces unexpected and unfortunate results.

If, as we have ascertained, the courts are unable or unwilling to adopt a more pragmatic approach to medical malpractice claims resulting from the implementation of cost-containment policies, then we must find an alternative way to give relief to physicians. In Quebec, the 1992 *Act respecting health services and social services*[50] and its subsequent amendments may provide a way for physicians to discharge their obligation of means towards their patients without undue hardship and without compromising the efficiency of the healthcare system.

The 1992 HSSS implicitly recognizes the limitations inherent in the system and clearly provides that it is the function and responsibility of individual hospitals to manage their resources effectively and efficiently to ensure continuous and accessible quality care.[51] As well, it sets out the relative responsibilities of the various actors in the administration of the hospital and provides an active voice for physicians to give input into the

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[49] Similarly, we remember that it was with reticence that the courts finally accepted that doctors should not bear responsibility for complications arising from vaccinations.

[50] *Supra* note 3.

[51] *Ibid.*, s. 100

decision-making process. In addition, it reinforces the obligation that hospitals and healthcare authorities have to inform patients of the nature and quality of health services available to them.

A. *The Objectives of the HSSS*

The HSSS, first adopted on June 1, 1972 is the basis of the Quebec Health Insurance System together with the *Hospital Insurance Act*[52] and the *Health Insurance Act.*[53]

Originally, Section 3 of the 1972 HSSS (S.Q. 1971, c.48) provided that the purpose of the Law was to:

a) Improve the health of the population;
b) Give access to any person, on a continuous basis and for all his life, to the complete spectrum of all health services;
c) Promote the participation of the population in the administration of hospitals;
d) Better adapt health services to the needs of the population and the proper allocation of human and financial resources in a fair and reasonable manner.

These goals reflected the findings of the Castonguay report which recommended that the health system should have as its objectives:

a) Universal accessibility;
b) Popular acceptance;
c) The provision of quality care on a scientific, human and social levels;
d) The well-organized, modern distribution of health services.

When the HSSS was amended on October 1, 1992, the objective of the legislation was redefined. Accordingly, the current aim of the 1992 HSSS is to provide medical care to persons so that they can maintain and improve their physical, psychological and social capacity to act in their community and fulfil their roles in life in an acceptable manner for themselves and for the groups to which they belong.[54] Most importantly, it acknowledges that, while respecting the rights of patients, the Health system must be organized with goals of efficiency in mind.[55]

This represents a radical change in approach from the 1972 HSSS, where the goal of the health system was to provide every person with the full spectrum of health services. Thus, the revised objective of the HSSS is essentially to attain a level of medical care which is acceptable for users

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[52] R.S.Q. 1977, c. A-28.
[53] R.S.Q. 1977, c. A-29, s. 2
[54] 1992 HSSS, *supra* note 3, s. 1.
[55] *Ibid.*, s. 2.

and the community to which they belong. The law does not purport to guarantee the "best" medical care; rather, it gives patients the right to receive care that is scientifically, humanly and socially appropriate in the circumstances.[56]

Moreover, the 1992 HSSS establishes the following principles to guide the internal administration of the system:

- The goal of the health system is to ensure the functionality of people;
- Each hospital will have to make choices as to its orientations;
- Such choices will be taken with the participation of patients as well as medical and nursing staff;
- These choices will be governed by concepts of public health and efficacy.

In short, the 1992 HSSS defines the notion of "quality care" in relation to the effective and efficient management of resources and a realistic understanding of what it is possible to achieve within the current healthcare system.

B. *The Responsibilities of the Hospital Administration*

In addition to acknowledging the inherent resource limitations in medical centres, the HSSS clearly sets out the procedure that hospitals must follow in making their resource-allocation decisions.

First, each hospital must determine its scope of health services, taking into consideration its mission and the community in which it operates. Whereas the 1972 HSSS simply provided that the board of directors was responsible for the management of the hospital, the 1992 HSSS gives the board the responsibility to establish the priorities and orientations of the hospital and to manage the hospital by taking into account the efficacy of health services and the judicious use of resources.[57]

These priorities must be predicated on the healthcare needs of the community, the type of clients, and the services to be offered. More specifically, they must take into account the geographic, linguistic, socio-cultural and socio-economic conditions of the users, and the human, material and financial resources of the hospital. These priorities must also be consistent with the medical staffing plan, i.e. the number and the type of specialists allowed to practice in the hospital.

The board of directors must organize a yearly public meeting at which it will be called upon to justify its choice of priorities as well as its new orientations and answer questions relating to the services it provides. The

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[56] *Ibid.*, ss. 5, 6 & 13.

[57] *Ibid.*, ss. 171 & 172.

board of directors may hold several such meetings if it considers that the nature of the services rendered to patients justifies it.

Finally, the priorities set by the board must meet with the approval of the Regional Board.[58]

C. *Formalizing Physician Input: The Role of the CPDP and the Creation of Risk and Quality Management Committees*

The HSSS also formalizes the role of medical professionals in the administration of healthcare by guaranteeing them an active role in setting the orientations and managing the resources of individual health institutions.[59]

The active role of physicians in the decisional process is established primarily through the Council of Physicians, Dentists and Pharmacists, whose responsibilities include controlling the quality and the relevance of medical acts.[60] To this end, the CPDP may retain the services of an external expert. The CPDP may also give its advice on the technical and scientific organization of the hospital. Finally, it may make recommendations on professional aspects of the appropriate distribution of medical care and on the medical organization of the hospital. In this capacity, physicians are accorded an advisory role in the choice of orientations of hospitals and the establishment of their priorities, though the ultimate decisions are left up to the board of directors.

Even more important is the input that physicians may have through the mandatory creation of risk and quality management committees. As of December 2002, each institution must have in place a committee with a balanced representation of employees, users and practitioners, the primary functions of which are to identify and analyze risks, provide support to victims of accidents, and prevent future accidents through appropriate monitoring and control measures as well as recommendations to the board of directors.[61] In addition, the new provisions create an obligation for physicians as well as other hospital staff to report the occurrence of any incident or accident to the

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[58] These priorities should also be reflected in the hospital's organization plan, but there is no provision in the 1992 HSSS to that effect.

[59] 1992 HSSS, *supra* note 3, s. 2. This section also recognizes the importance of patient input and provides a mechanism for individuals and groups of users to participate in the choices and orientation of health services and the organisation of human, material and financial resources through the establishment of users' committees. As well, these committees are responsible for electing two of the members of the board of directors, ensuring that their interests are represented at the decision-making level (s. 129 (3)).

[60] *Ibid.*, s. 214.

[61] Bill 113, *supra* note 4, s. 9; 1992 HSSS, *supra* note 3, ss. 183.1 ff.

executive director of the institution.[62]

D. *The Codification of the Hospital's Duty to Inform*

Another interesting feature of the 1992 HSSS is that it legislates the duty to inform incumbent on the hospital.

Reinforcing the patient's role in the system, Section 3 (5) sets out the general principle that the patient must be fully informed in order to be able to use the services available in the most judicious manner. More specifically, it codifies the hospital's obligation to inform each and every patient of the nature and limitations of the health services it offers.[63] In the same vein, Section 8 of the *Act* provides that patients should be fully informed of their state of health, in particular, to understand the various options which are open to them and the risks and consequences of each option.[64]

This section may have a pronounced effect when we consider how the courts have extended the physician's duty to inform when faced with the implications of cost-containment measures. Certainly, this will not relieve physicians of their independent duty to their patients, but it serves to reinforce the notion that hospitals are also responsible to the individual users of the system who are affected by their internal administrative and budgetary decisions.

Under the HSSS, hospitals are responsible for communicating directly with patients to inform them, for instance, that a certain treatment option is not offered by the hospital but is available in a specialized hospital within the Province or outside the Province. Hospitals are therefore forced to account, at all levels, for the implications of their choices.[65]

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[62] Bill 113, *supra* note 4, s. 10; 1992 HSSS, *supra* note 3, s. 233.1.

[63] Section 4 of the 1992 HSSS provides:

"Information and access.

Every person is entitled to be informed of the existence of the health and social services and resources available in his community and of the conditions governing access to such services and resources."

The right of information set out in the legislation would imply being informed of health services available not only in the hospital where the patient is being treated but also in other hospitals within the health system and, inasmuch as they are paid for by the Regie de l'assurance-maladie du Québec, of services offered outside the Province which would be covered by the Régie. It is important to restate that the obligation under section 4 is incumbent on the hospital.

[64] 1992 HSSS, *supra* note 3, s. 8.

[65] In this context, it is also noteworthy that s. 113 of the HSSS stipulates that a hospital cannot offer a new service which requires ultra-specialized medical services or equipment without first obtaining the written authorization of the Minister. There is a similar provision

The most recent amendments to the HSSS extended the duty to inform to include the obligation to notify a patient of the occurrence of any 'risk event' in the treatment. It therefore creates the right for users to

> be informed, as soon as possible, of any accident having occurred during the provision of services that has actual or potential consequences for the user's state of health or welfare and of the measures taken to correct the consequences suffered, if any, or to prevent such an accident from recurring.[66]

E. *Conclusions on the Significance of Legislative Enactments in Quebec*

The 1992 HSSS leaves it up to individual hospitals to establish their orientation, their priorities, the parameters within which they will treat patients, the type of clients they want to serve and the type of medical services they wish to offer. This begs the question: what are the implications of this responsibility?

Must a hospital justify a decision to use tests or medical equipment which, although still generally satisfactory, are not up to date? Does every hospital have the obligation to provide the best possible medical care in whatever type of services it decides to offer?

A negative response appears to be justified under the 1992 HSSS, which clearly states that the objectives of our public health system is "functional" medicine at a level of quality that is acceptable both individually and socially. It also recognizes the need for a hospital to take its financial resources into account when making choices as to the evolution of medicine. In other words, money matters and hospitals are amply justified by the law as it has stood since 1992 to take into account the cost-efficiency ratio in the orientation of the hospital to better serve the population within the constraints of its financial resources.

That being said, the legislation also provides mechanisms for both hospitals and individual physicians to ensure that they satisfy their duty of care to patients despite the inevitable consequences of funding decisions on the quality of certain treatment. First, it concretizes the duty to inform patients of the nature and quality of services available in the institution as well as services that may be offered by other institutions and that are accessible to the patient. This duty would include the obligation to warn a patient of any risks arising from resource limitations, institutional policies, equipment deficiencies, etc. Second, given the likelihood that courts will persist in imposing on physicians a duty to advocate, they now have institutional forums through which they can discharge that duty. Provided that physicians use the tools now available to them through the CPDP and

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for donations of equipment which might entail additional costs.

[66] Bill 113, *supra* note 4, s. 4; see also 1992 HSSS, *supra* note 3, s. 8.

risk and quality management committees to voice any concerns they may have about problems in the administration of medical care, they should be able to satisfy their obligation of means towards their patients and protect themselves from liability.

VI. *Other Factors that may Influence the Physician's Standard of Care*

A. *The Expanding Definition of what is "Medically Necessary"*

As we have seen, the HSSS clearly provides that each hospital centre has the power and the right to define the scope of treatment it will offer to the community it serves. Thus, the level of medical treatment that a patient can expect to receive may vary from one locality to another, or even one institution to another, depending on the circumstances. Consequently, a 'medically necessary' procedure that is provided as a matter of course in one hospital may, justifiably, not be available or may be subjected to more onerous conditions in another hospital.

That being said, this principle is tempered by the terms of the Health Insurance *Act,*[67] which provides, as a general premise, that every Quebec citizen shall receive medical insurance coverage for any medically necessary treatment. In the event that such a treatment cannot be obtained in Quebec, the patient may make a request for authorisation to have the treatment performed in an out-of-province facility. The *Health Insurance Act* specifically entitles patients who are required to obtain necessary medical services outside Quebec to be reimbursed the cost of such services that, were it not for the fact that they were not available within the province, would be covered under the Quebec health insurance system.[68]

The only legislative exception to this rule is with respect to pharmaceutical services and medications specifically referred to in the *Act*. However, in the recent case of *Stein v. Régie de l'Assurance-maladie du Québec,*[69] the Régie sought to place a further limitation on this right on the ground that "experimental" procedures do not comply with the definition of treatment which is "medically required".

The facts of the case are as follows. In December of 1995, Mr. Stein, a 41-year-old father of three children was diagnosed as having colon carcinoma with one liver metastasis. The metastasis could not be removed at the time of the original surgery due to its placement. Further investigations detected three other liver lesions. Stein's physician strongly

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[67] *Supra* note 54.

[68] *Ibid.*, s. 10.

[69] *Stein v. Régie de l'Assurance-maladie du Québec*, Administrative Tribunal of Quebec, SS 130, decision rendered on 11 September 1998 rev'd; (1999), R.J.Q. 2416 (S.C.).

recommended that the liver metastases be removed as soon as possible after his recovery from the colon surgery.

The surgery was scheduled several times in a Montreal hospital and was cancelled each time due to various intervening occurrences. In the meantime, the physician determined that the preferred course of treatment was conventional surgery, followed, if need be, by cryosurgery and the insertion of an intra-arterial pump for localised chemotherapy. The intra-arterial chemotherapy was offered only in the United States. According to Mr. Stein's physician, this procedure, though highly specialized, could not be qualified as experimental because there was reliable clinical evidence of its potential benefits to patients in his position. As a result of the undue delays for surgery and the unavailability of the secondary treatment, the physician supported Mr. Stein's request for authorization from the Régie to have the entire procedure performed in New York.

The Régie refused to authorize the treatment on the ground that the effectiveness of intra-arterial chemotherapy had not been proven, that it was not standard practice in Quebec, and that regular cryosurgery could be performed in either Ontario or Alberta. Mr. Stein contested the Régie's decision before the Administrative Tribunal of Quebec.

The New York surgeon who was to perform the procedure testified before the Administrative Tribunal of Quebec that it was standard practice in New York Hospitals (referring to the Cornell Medical Center and the Memorial Sloan-Kettering Cancer Centre) to use a continuous hepatic arterial infusion pump for the treatment of colorectal carcinoma and for the prevention of further metastases.

Conversely, the Régie's expert oncologist testified that the treatment was experimental, although occasionally performed in Canada and in Quebec, and thus could not be said to be a standard practice in Quebec. Moreover, he filed statistics showing the small number of Quebec patients who underwent the treatment as justification for the Régie's conclusion that the treatment was still experimental.

The Administrative Tribunal of Quebec decided that although the intra-arterial chemotherapy was used on a routine basis in some large American cancer centres, its effectiveness was not recognized by the entire medical community. It also accepted the argument that the small number of patients involved in the studies reported in the medical literature indicated that the procedure was not a standard treatment and should therefore be characterized as an experimental treatment.

Mr. Stein filed a Motion for Judicial Review before the Superior Court. The Superior Court quashed the Tribunal's decision on the basis that the mere fact that a procedure is not performed in Canada does not necessarily mean that it is experimental. Moreover, the court held that it

was inappropriate to base funding decisions on the standard of medical practice in Canada for procedures which are not performed here. Most importantly, the Superior Court refused the restrictive interpretation of 'medically necessary' offered by the Régie which would qualify as experimental all treatments which are not performed on a regular basis in Canada. The Court considered that treatments offered at a specialized centre in the United-States may be 'medically necessary' even if some Canadian experts consider that it is not financially efficient because it does not significantly improve the survival rate.

If it is maintained, this extension of the definition of 'medically necessary' treatment may have a number of consequences that are relevant to our discussion. First, it may raise the bar on hospitals and physicians' duty to inform patients of alternative treatment options both within the province and in other jurisdictions, without distinction based on the patient's personal circumstances. In addition, it could conceivably have an impact on the analysis of the appropriate standard of care required of physicians and the physicians' duty to keep abreast of medical advances made in other countries so that they may properly advise their patients as to the best course of treatment. In this sense, the responsibilities bearing on physicians in a cost-containment environment could become even more onerous.

The potential effect of this decision on the duty of care owed by hospitals and other healthcare authorities is more difficult to gauge. Under one interpretation, it may serve to reduce the pressure for individual hospitals, or even Quebec hospitals as a whole, to provide a broad range of medical services or to implement newer, more costly procedures. If the definition of the medically necessary procedures to which all Quebec citizens have a right include those services which are offered outside of the province within reasonable reach of Quebec residents, then hospitals may be satisfied to refer the few patients who require highly specialized treatments to other centres, rather than offer the treatment in their own hospital. Conversely, if the standard of practice is extended such that courts are entitled to consider the prevailing practices in neighbouring jurisdictions in order to establish the appropriate standard of care, there may be a heavier burden on hospitals to meet that higher standard of care, at least for the services that they have chosen to offer. Where adherence to that standard is not economically feasible, the duty to inform the patient of the deficiencies of the hospital's facilities would once again arise.

B. *The Role of Practice Guidelines*

Clinical practice guidelines describe a range of generally accepted approaches to diagnosis, management and prevention and are not inclusive

of all methods of care, nor exclusive of other potentially appropriate methods of care. Such guidelines are designed to provide information and assist decision-making, but are not intended to define a standard of care.

Indeed, it is often because of observed disparities in methodology or treatment that medical associations deem it necessary to address a particular issue and guide physicians towards a scientifically sound and accepted common practice. But it is not necessarily the only acceptable practice.

Moreover, one major concern is that the organizations preparing these guidelines are not in a position to provide to physicians and hospitals the material means to implement their recommendations. In other words, guidelines do not always take into consideration the limitations in resource allocation, and it is not realistic to expect that they will be universally put in practice within a short time following their publication.

VII. *Conclusion*

Physicians owe a personal duty of care to their patients independent of any duty owed by healthcare institutions or public authorities. Thus, where the physician's obligations to the patient conflict with existing institutional policies or cost-containment measures, the duty to the patient must prevail and courts are unlikely to accept the adherence to internal policies as a defence to medical liability. Though the standard of care applicable to physicians has always accounted for differences in circumstances, the case law to date suggests that courts will not lower the standard to reflect the economic constraints resulting from resource allocation decisions. Quite the opposite in fact, courts have used the existence of budgetary constraints to extend the standard of care in some cases by requiring that physicians assume heightened disclosure obligations and act as advocates for their patients within the healthcare system.

As a result, if necessary medical treatment is withheld, and the patient suffers injury as a result, treating physicians may be found negligent notwithstanding the fact that they acted in accordance with an imposed cost-containment measure. In each case, the reasonableness of the physician's decision to follow the policy will be evaluated in light of all the relevant circumstances.

Physicians are therefore exposed to liability in any case where they are faced with the competing pressures of institutional policies and the patient's medical treatment needs. In this environment, it is imperative that physicians be provided with mechanisms through which they may satisfy their primary obligation to the patient without being in a constant battle with the healthcare system. In Quebec, the provisions of the *Act respecting health services and social services* may serve that purpose. By

institutionalizing a role for physicians in the administration of health services and providing them with a procedure to submit complaints and document 'near-misses', the legislation may facilitate the physician's disclosure and advocacy obligations. In the event of litigation, physicians would then be in a position to demonstrate that they made every effort that could reasonably be expected to ensure that their patients received appropriate care.