

Liability and Compensation in Health Care*

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Findings

Trends in Civil Liability of Canadian Health Care Providers

Growth in Claims Filed Against Physicians

1. We find that in Canada between 1971 and 1987 the frequency of civil liability claims filed against physicians on a per capita basis increased almost threefold (and experienced an average compound annual growth rate of 9 percent).

Growth in Claims Paid by Physicians

2. We find that in Canada between 1971 and 1987 the frequency of civil liability claims paid (including settlements) by physicians on a per capita basis doubled (and experienced an average compound annual growth rate of 6.6 percent).

Growth in Size of Claims Paid by Physicians

3. We find that in Canada between 1971 and 1987 the size of the average civil liability claim paid (including settlements) by physicians increased fourfold in real terms.

Highest Risk Specialties Among Physicians

4. We find that orthopaedic surgeons, anaesthetists, obstetricians and gynecologists have experienced the highest frequency of claims, and family practitioners the lowest.

Changes in Relative Frequency of Claims Against Different Specialists

5. We find that the vast majority of differences and changes in the relative frequency of claims against different types of specialist physicians is explained by differences and changes in the relative frequency of major surgical interventions by these specialists.

* Findings from a report prepared in 1990 and presented to the Conference of Deputy Ministers of Health of the Federal/Provincial/Territorial Review on Liability and Compensation Issued in Health Care.

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Common Size of Claims Against Physicians

6. We find that the average size of claim paid does not vary substantially with the specialization of the defendant physician.

Regional Variation in Claims Experience of Physicians

7. We find that there are statistically significant but relatively modest regional variations in civil liability claims experience and that British Columbia and Ontario have the highest claims cost and Atlantic Canada the lowest.

Growth in Claims Against Other Professionals

8. We find that other professions including lawyers and dentists have experienced a substantial and comparable increase in claims frequency during the 1970s and early 1980s.

Growth of Claims Filed Against and Paid by Health Care Institutions

9. We find that in Canada both the frequency and the severity of civil liability claims filed against and paid by health care institutions have increased in the 1980s, but that the actual claims experience varies significantly from institution to institution and insurer to insurer.

Increased Claims Caused by Increased Utilization

10. We find that increased utilization of hospitals is directly and positively correlated with the number of civil liability claims against hospitals.

No Substantial Evidence to Support Some Explanations of Growth in Claims

11. We find no substantial evidence to support any of the following suggested explanations of the growth in civil liability claims paid by physicians:
 - the excessive availability of legal aid;
 - the use of contingent fees;
 - the number of practicing lawyers per capita;
 - significant changes in the legal doctrines governing the liability of physicians;
 - the doctrine of informed consent (although the doctrine may have contributed to the growth of claims filed);
 - the number of foreign-trained physicians;
 - the number of younger or older practicing physicians;

- recidivism by physicians found liable;
- levels of interprovincial migration and immigration;
- the availability of civil juries in some provinces; and
- unwarranted findings of negligence against physicians and health care institutions by courts.

Some Evidence to Support Some Other Explanations of Growth in Claims

12. We find some support for the following explanations of the growth in civil liability claims paid by physicians:
 - changes in the 1970s and 1980s in the law governing the calculation of personal injuries damages which have increased the level of damages awarded;
 - the increased level of damages having led to some increase in frequency of claims made;
 - the increasing and spreading expertise of plaintiffs' lawyers in pursuing civil liability claims against physicians;
 - the growing willingness to sue of persons suffering health care injuries; and,
 - the tendency of claims to arise in larger and more urban settings as a result of some migration to these centers by patients requiring complicated interventions.

Comparison with Growth of Claims in United Kingdom

13. We find that in the United Kingdom the rate of growth of civil liability claims against physicians appears to be comparable to Canada's and that the absolute frequency of claims in the United Kingdom appears to be somewhat higher than in Canada, but the data available for the United Kingdom is significantly less comprehensive than for Canada and the United States and as a result this finding is substantially impressionistic and tentative.

Comparison with Growth of Claims in the United States

14. We find that in the United States the rate of growth of civil liability claims against physicians is comparable to Canada's, that the average absolute frequency of claims in the United States is about five times higher than in Canada, and that the average absolute frequency in those states with the highest frequency of claims is at least ten times higher than the frequency of claims in British Columbia and Ontario.

Very Small Percentage of Injuries Compensated

15. We find that despite the substantial growth in the frequency of successful civil liability claims against physicians since 1971, the percentage of persons suffering health care injuries as a result of negligence who receive compensation remains modest and is certainly less than 10 percent of potential viable claims.

Very Substantial Potential for Growth in Frequency of Claims

16. We find that as a result of the present modest percentage of potential claims being made by persons suffering negligently caused health care injuries, there is very substantial potential for continued growth in the rate and frequency of civil liability claims against physicians and health care institutions in Canada. There is no reason to believe this growth will not occur unless some substantial changes are made. It is not possible to make reliable predictions with respect to the rate of future growth of claims. Our finding is simply that there will be growth over time even though over short periods the rate of claims may appear to be relatively stable or even decline slightly.

Trends in Liability Insurance for Canadian Health Care Providers*Increased Liability Insurance Costs for Physicians from 1976 to 1987*

17. We find that in Canada between 1976 and 1987 there was a 14 percent annual compound real rate of increase in average liability insurance costs for physicians.

Increased Liability Insurance Costs for Physicians from 1982 to 1987

18. We find that between 1982 and 1987 there was a 39 percent annual compound real rate of increase in average liability insurance costs for physicians.

CMPA Policy on Reserving

19. We find that a significant factor in causing average insurance costs to increase markedly faster than actual claims experience was the Canadian Medical Protective Association's prudent decision to begin reserving funds against future liabilities. Those reserves now amount to about \$220 million.

CMPA Policy on Risk Rating

20. We find that the rate of increase in liability insurance costs for high-risk specialties was much higher than for the average physician as a result of the Canadian Medical Protective Association decision in response to the threat of competitive entry by commercial insurers to risk rate different specialties for membership fee purposes.

Liability Insurance Costs for Physicians Compared to Other Professionals

21. We find that the average liability insurance costs for physicians as a percentage of average net professional income is not markedly different from other Canadian professionals, but that the average costs for some specialists is high relative to other physicians and other professionals.

Government Sharing of Increased Liability Insurance Costs

22. We find that the recent willingness of provincial governments to negotiate partial compensation for increases in physicians' liability insurance costs has substantially reduced the anxiety and sense of unfairness among physicians about the increased costs (but not the phenomenon of increased liability itself).

Increased Liability Insurance Costs for Health Care Institutions

23. We find that Canadian health care institutions experienced very significant (as high as tenfold) rates of increase in their liability insurance costs between 1983 and 1986.

Non-Commercial Insurers

24. We find that the reciprocals, cooperatives and other non-commercial insurers have been successful in stabilizing and in some cases lowering insurance costs for health care institutions.

Total Cost of Liability Insurance for Health Care System

25. We find that the total cost of liability insurance for Canadian physicians and health care institutions is in excess of \$200 million annually, and that if the liability insurance costs for vaccines, blood products and pharmaceuticals were included this total would increase significantly.

Effect of Civil Liability Claims on Canadian Health Care Providers*Net Positive Effect on Quality*

26. We find that, on balance, the potential for civil liability claims for negligently caused injuries has had a positive effect on the quality of Canadian health care.

Systematic Risk Reduction

27. We find that the most significant positive effects of civil liability claims have resulted from systematic and concerted attention by both physicians and health care institutions to reducing the risk of some recurring health care injuries.

Quality Assurance, Risk Management and Peer Review

28. We find that the increase in civil liability claims and liability insurance costs for health care institutions has contributed significant momentum to the introduction of quality assurance, risk management and peer review programs.

Some Negative Effects

29. We find that the most significant negative effects of civil liability claims on physicians have been in the development of symptoms of stress, anxiety and anger and the resulting diminution in their satisfaction from the practice of medicine.

Defensive Medicine

30. We find some support for the allegation that civil liability claims induce "defensive medicine" but that most of the allegations are exaggerated. In particular, we find civil liability claims have caused some physicians to take some undue precautions in some circumstances and in some cases to restrict unduly the scope of their practices but that factors other than civil liability also contribute substantially to these decisions.

Other Mechanisms Less Successful

31. We find that other mechanisms such as the complaints and formal disciplinary processes of the medical profession have not to date played a major role in monitoring or correcting physician conduct that gives rise to successful civil liability claims.

Costs of Civil Liability Claims Against Canadian Health Care Providers*High Costs of Processing Claims*

32. We find that the costs of processing civil liability claims are high, and that the total legal and related costs are likely approximately equal to the total compensation paid to persons suffering negligently caused health care injuries.

Prolonged Claims

33. We find that civil liability claims are frequently inherently factually and medically complex and, in the absence of vigorous case management, are often prolonged more than necessary and at additional considerable cost to all parties.

34. Effect of Short Limitation Period on Filing of Claims

We find that the short limitation periods applicable to civil liability claims against physicians and health care institutions in some provinces contribute in some cases to the premature filing of inadequately investigated claims which are subsequently abandoned at a later stage in the litigation process.

Availability of Medical Experts to Assess Claims

35. We find that the difficulty and costs some plaintiffs in some provinces face in obtaining expert medical assessments of potential claims contribute in some cases to pursuit of some claims that subsequently are found to lack merit.

Recommendations

Overview of Reforms

1. We recommend that all proposals for reform of liability and compensation issues in health care be judged against four principal normative benchmarks: reducing the frequency of avoidable medical injuries; enhancing social justice; promoting efficiency and long-term cost reduction; and ensuring fairness among patients, health care professionals and health care institutions.
2. We recommend that the basic strategy of reform contain three principal elements:
 - maintaining and reforming actions for negligence against physicians and health care institutions (Recommendations 3-18, 42-44 and 72);
 - increasing the responsibility of health care institutions for higher quality health care (Recommendations 29-40 and 67-68); and
 - developing a no-fault compensation system for persons suffering significant avoidable health care injuries (Recommendations 45-64 and 75).

Tort Reform

Maintaining Tort

3. We recommend that the basic negligence action against physicians, other health care professionals, and health care institutions be maintained both as a useful incentive for higher quality care and as a fundamental means of redress for injured patients. However, we recommend that various procedural and substantive reforms indicated below (see Recommendations 4-18 and 42-44) be introduced to improve the effectiveness of the tort action in achieving these goals.

Limitation Periods

4. With respect to limitation periods for tort actions, we recommend that the current patchwork of health care limitation periods across Canada including a variety of very short limitation periods be reformed and replaced with a uniform basic approach of a six-year limitation period from the date of discovery of the injury subject to a ten-year

maximum period from the date the services were rendered (and with a continuing exception in the case of deception, fraud or non-disclosure). This limitation period should apply to all health care professionals and health care institutions. With respect to children and to adults who lack legal capacity due to mental handicap, we recommend that the general principles providing relief in some circumstances from limitation periods be applicable to health care injuries also.

Eliminating the Need for Gross-Up

5. We recommend that the Ministers of Health across Canada urge in the strongest possible terms the Minister of Finance for Canada to amend the *Federal Income Tax Act* so as to eliminate the need for an allowance for gross-up in lump-sum personal injury awards.

Alternative: Calculation of Gross-Up

6. We recommend that in the absence of Federal legislation pursuant to Recommendation 5, an allowance for gross-up be made in lump-sum damage awards, but that the relevant provincial statutes and rules of practice be amended to standardize and simplify the calculation of the amount of gross-up in a manner analogous to the recommendations of the Ontario Law Reform Commission in 1988 on this subject.

Periodic Payments

7. We recommend that in awarding damages for future health care costs the court be given the power without the consent of the parties to make a periodic as opposed to a lump sum award in appropriate cases and thus eliminate the need for gross-up and reduce the significance of an inaccurate prediction about life expectancy. We also recommend that the court be given the power to include in its discretion in the award of periodic payments an opportunity to review the award at a future date in a specified manner in the event of significant changes in circumstances.

Collateral Benefits

8. We recommend that the current law concerning collateral benefits be changed to reduce the potential for double recovery.

Pre-Judgement Interest

9. We recommend that pre-judgement interest be awarded from the date at which the cause of action arises at rates calculated to ensure to the extent possible a neutral impact on the settlement incentives for both plaintiffs and defendants. In particular, we recommend that the rate of interest be set not less frequently than quarterly in order to avoid any extended disparity between the pre-judgement interest rate and market rates of interest.

Subrogation

10. We recommend that those jurisdictions which exercise the right of subrogation for future insured health care costs discontinue the practice for tort actions arising from health care injuries.

Third Party Claims

11. We recommend that care be taken not to expand the range of third party claims arising under family law legislation beyond spouses, dependent parents, dependent children and other dependent persons living with the plaintiff, and that in the case of Ontario, the recommendations made by the Ontario Law Reform Commission for restricting the class of potential claims be implemented.

Directions to Jury on Damages

12. In the case of trials with a jury, we recommend that the trial judge give guidance to the jury concerning the appropriate amount of damages for non-pecuniary losses.

Access to Justice*Greater Access to Justice*

13. We recommend that no further constraints be imposed on access to justice for victims of medical injury, and that the initiatives reflected in Recommendations 14-19 be implemented to enhance access to justice for victims of medical injury.

Contingent Fees

14. We recommend that in those provinces where contingency fees are permitted, they continue to be available to pursue medical malpractice actions, and that in Ontario, where contingency fees are not yet permitted, the provincial government introduce legislation to permit them as a means of increasing the possibility that a person suffering actionable medical malpractice will be able successfully to pursue an action. The enabling legislation should include the provisions necessary to ensure that possible abuses of contingent fees are precluded.

Cost Rules

15. We recommend no change in the existing rules with respect to recovery of costs in medical malpractice litigation, preferring the continuation of the Canadian rules as opposed to adoption of the American approach.

Legal Aid

16. We recommend no new restrictions be placed on the availability of civil legal aid to pursue medical malpractice cases and we recommend that those provinces that do not make available civil legal aid for such cases broaden the availability of legal aid in this respect.

Duty to Serve as Expert Witnesses

17. We recommend that in every province the College of Physicians and Surgeons (or the equivalent regulatory authority) urge its members to make themselves available as a matter of professional duty to serve as expert witnesses for both plaintiffs and defendants in medical malpractice cases.

Roster of Available Experts

18. We recommend that each College of Physicians and Surgeons (or the equivalent regulatory authority) undertake to develop and maintain rosters of experts available to lawyers for plaintiffs in each of the major specialty areas in order to ensure the wide availability of experts to assess potential cases and to appear in the event matters proceed to litigation. This recommendation is intended both to reduce the cost of access to justice for plaintiffs and to reduce the likelihood that ill-considered and unmeritorious claims will be advanced due to the unavailability of expert assessment. We also recommend that to the extent the availability of experts from the other health care professions is a problem, the appropriate regulatory bodies should develop a roster of available experts.

Patient Representation

19. We recommend that efforts be made to increase the availability of mechanisms of redress and accountability including complaints and discipline procedures, and to support patient advocates, ombudsmen, advocacy organizations and others to represent patients within the health care system across the full range of interests from individual incidents to the broad policy issues confronting the health care system as a whole.

Patient Rights and Responsibilities

20. We recommend that efforts be made to better educate patients about their rights and obligations in order to allow them to assume as much responsibility as possible for the health care they seek and receive.

Insurance Reform*Non-Commercial Supply*

21. We recommend that principal reliance for liability insurance in the health care system be placed on associations, reciprocals, cooperatives and other non-commercial forms of insurance rather than commercial insurance in order to ensure that premium and membership costs reflect Canadian law, claims experience and costs and to avoid to the extent possible blending Canadian with American experience for purposes of rating.

National Risk Pool for Physicians

22. With respect to physicians, we recommend that every effort be made to maintain the national risk pool for both general practitioners and specialists in order to gain the maximum possible spreading of risks and the maximum possible incentives for systematic attention to risk identification and reduction. While we believe that it would be inappropriate to create any artificial barrier to entry to the physician liability insurance market, and we recognize that the threat of competitive entry has had beneficial effects on the conduct of the Canadian Medical Protective Association, we recommend that no provincial government act in a manner which would be inconsistent with maintaining the substantial advantages of a national risk pool.

Provincial and Regional Variations in Claims Experience

23. We recommend that in those cases where the provincial and regional differences in claims experience are viewed as sufficiently substantial to warrant variation in provincial or regional insurance or membership charges for physicians, these be introduced by modifying charges within the national insurance scheme rather than by provinces or regions withdrawing from the national risk pool. The current membership charges of the Canadian Medical Protective Association could be modified to take account of provincial and regional differences if this is considered to be necessary.

Mandatory Insurance

24. We recommend that continuing membership in the Canadian Medical Protective Association or equivalent insurance be made mandatory for all physicians as a condition of practicing medicine.

Shared Increased Insurance Cost

25. We recommend that the provincial governments continue to be prepared to negotiate shared responsibility for the increased cost of insurance premiums or membership fees for physicians.

Non-Commercial Insurance for Health Care Institutions

26. We recommend that the various forms of reciprocals, cooperatives and other non-commercial insurance arrangements adopted by hospitals and other health care institutions across Canada in recent years be continued and strengthened, and we recommend that those provinces which have not yet permitted the primary replacement of commercial insurance in this area give urgent and serious attention to doing so in the interest of promoting high quality health care and reducing costs.

Scope of Non-Commercial Risk Pools

27. In order to ensure the greatest possible continued attention to reducing the frequency of health care injuries, we recommend that wherever possible the reciprocals, cooperatives and other non-commercial insurance schemes be limited to health care risks and that health care risks not be mixed or merged with other governmental liabilities such as schools, municipalities and road accidents.

National and Regional Non-Commercial Insurers for Health Care Institutions

28. We recommend that encouragement be given to developing regional and national reciprocals building on experiences such as the Hospital Insurance Reciprocal of Ontario and the Quebec Hospital Management of Civil and Professional Liability Programme in order to gain the full benefits nationally of risk pooling and the full benefits of risk management and the incentives for injury reduction that can best be introduced by these organizations.

Risk Reduction

29. We recommend that much greater attention be paid to risk and injury reduction through the hospital reciprocals, cooperatives and other non-commercial insurance arrangements, that an explicit commitment to this goal be included in the mandate of all the non-commercial insurers, and that a variety of financial incentives, education and research programmes, and direct regulations be utilized to pursue this goal.

Co-operation Between Insurers for Physicians and Health Care Institutions

30. We recommend that the Canadian Medical Protective Association and the principal non-commercial insurers of health care institutions pursue discussions to investigate possible cooperative insurance arrangements for physicians working in health care institutions that would avoid, to the extent possible, the need for double insurance and the incentives for disputes between physicians and their institutions while emphasizing the advantages of cooperative responsibility and accountability for purposes of risk reduction. Furthermore, we recommend that these discussions pursue the possibility of some pilot projects to test the potential of cooperative arrangements in this area.

Institutional Responsibility and Regulatory Accountability*Increased Institutional Responsibility*

31. We recommend increasing the responsibility of hospitals and other health care institutions for the quality of health care provided within them and for the reduction of medical injuries, while in no way diminishing the full individual responsibility of all health care professionals working in the institutions. (Specific proposals to pursue this objective are included in Recommendations 32-40 and 67-68).

Mandatory Quality Assurance, Risk Management and Peer Review

32. We recommend that effective quality assurance, risk management and peer review programmes be made mandatory by statute for all health care institutions.

Mandatory Participation by Physicians

33. We recommend that full participation in and cooperation with a health care institution's quality assurance, risk management and peer review programmes be a requirement for all physicians holding privileges in that institution, and that failure to participate fully should, by statute, be grounds for denying or withdrawing privileges.

Remove Financial Disincentives to Participation

34. We recommend that appropriate remuneration arrangements be developed to remove the current financial disincentives for many physicians' participation in quality assurance, risk management and peer review programmes, and that, in particular, those physicians assigned positions of leadership in these programmes be directly compensated for their work.

Criminal and Civil Penalties

35. We recommend that the statutory obligation to maintain quality assurance, risk management and peer review programmes be enforceable by both civil and criminal penalties against the health care institution, its chief executive officer and its senior medical officer or officers.

Reporting of Law Suits to College of Physicians and Surgeons

36. We recommend that all physicians and health care institutions be required to report to the College of Physicians and Surgeons (or the equivalent regulatory authority) all malpractice actions brought against them upon receipt of the document initiating the legal process and that the College be empowered to undertake any investigation it sees fit of either the physician's or the institution's conduct with respect to the alleged incident. We also recommend that all other health care professionals be under a similar obligation to report to their respective regulatory organizations.

Reporting of Law Suits to Health Care Institutions

37. We recommend that physicians be required to report to all health care institutions in which they hold privileges the receipt of any document initiating legal action for alleged malpractice arising in the institution and that the health care institution so informed be obliged, through the senior medical officer or officers, to review the allegations giving rise to the legal action.

Evidentiary Protection

38. In those provinces where it is absent, we recommend that a broad evidentiary protection be extended to safeguard health care institutions and health care professionals against

use of the results of their post-incident inquiries in personal injury claims in order to encourage the widest and most vigorous possible pursuit of these matters. This privilege in civil litigation should extend to the results of quality assurance, risk management, and peer review processes.

Vicarious Liability

39. We do not recommend at this time any legislative modification of the current law concerning vicarious liability and related legal doctrines regarding the responsibility of health care institutions for the torts of their non-employee physicians. Instead, we recommend that these doctrines be developed in appropriate cases by the judiciary, and that the principal efforts to increase institutional responsibility be those set out in Recommendations 32-38.

Imposition of Collective Liability

40. In the event steps similar to those set out in Recommendations 32-38 are not taken in one or more provinces, we recommend that the courts or legislature in that province proceed to impose a form of collective liability.

Alternative Dispute Resolution

41. We do not recommend at this time any substantial effort to divert malpractice litigation away from courts to arbitral or other administrative decision-making bodies, preferring to recommend that procedural innovation take place in the context of the compensation system proposed in Recommendations 45-64. At the same time we recommend that governments and health care providers monitor the numerous experiments taking place in the United States in this area to determine whether or not substantial opportunities for reform can be introduced in Canada along the same lines at a later date.

Improved Case Management

Improved Case Management

42. We recommend that a major effort be dedicated to improving the quality of case management for medical malpractice cases once the actions are initiated. The experience with case management is generally favourable with respect to most forms of civil litigation and the opportunities for expediting and simplifying litigation are very substantial in the medical malpractice area.

Case Assignment, Disclosure of Medical Opinions and Pretrials

43. We recommend that in each province a special effort be made to identify and manage medical malpractice cases with a view to resolving the cases more expeditiously and to

ensuring that counsel for both plaintiff and defendant are obliged to move as expeditiously as possible to obtain and share expert assessments of the case. While the particulars of the precise steps for better case management will vary from province to province in accordance with local practices, we recommend at a minimum that a single judge be assigned to each medical malpractice case at an early stage, that opinions with respect to liability be obtained and disclosed early in the litigation process, and that any party in a medical malpractice case have the opportunity to request a pre-trial hearing at any stage of the litigation with a view to obtaining earlier resolution of the case or narrowing of the issues or eliminating defendants who are not likely to be found liable.

Guidelines for Procedures

44. We recommend that consideration be given by the Chief Justice of the senior trial court in each province to inviting appropriate experienced legal representatives of plaintiffs and defendants to work with the court to develop guidelines for procedures for the proper processing of medical malpractice claims in that jurisdiction with the emphasis being placed on expedition, simplicity, disclosure, maximum opportunities for settlement and the avoidance of unmeritorious suits that continue longer than necessary.

Compensation Reform

No-Fault Compensation

45. We recommend the development of a no-fault compensation scheme for persons suffering significant avoidable health care injuries. This remedy should be available to injured patients as an alternative to pursuing a negligence action for medical malpractice. We recommend that the development of the compensation system be guided by the principles set out in Recommendations 46-64. In making these recommendations we have refrained from specifying more than these general principles in order to provide maximum flexibility to those charged with the next stage of development of the scheme.

Test of Avoidable Injury

46. We recommend that the general criterion for determining which significant medical injuries are compensable under the compensation scheme should be the test of avoidability. That is, we recommend that the principal inquiry to determine if an event is compensable should be whether, with the benefit of hindsight, the injury could have been avoided by an alternative diagnostic or therapeutic procedure or by performing the procedure differently. While this test would include all negligently caused injuries, it would encompass a wider range of avoidable injuries than the fault test would delineate.

Designated Compensable and Non-Compensable Events

47. We recommend that the general criterion of avoidability be supplemented with a number of designated compensable and non-compensable events classifying recurring injuries and accidents such that they could be included within or excluded from the scope of the

compensation scheme even if they do or do not, strictly speaking, meet the avoidability test.

Continuing Redefinition of Compensable and Non-Compensable Events

48. We recommend that the definition of the compensable and non-compensable events be done in a flexible and responsive manner that invites continuing redefinition as experience is gained with the compensation scheme. In this respect, following the Swedish example, we recommend that the definition not be embedded in legislation.

Scope of Compensation Scheme

49. We recommend that the scope of the compensation scheme be sufficiently broad that, if required, it could encompass vaccine injuries, blood product-related injuries and pharmaceutical injuries.

Alternative to Tort

50. We recommend that the compensation scheme provide an alternative to a tort action and that the injured patient be required at an appropriate point to elect between accepting the compensation benefits offered by the scheme or pursuing a tort action to its conclusion, successful or otherwise. We recommend that under no circumstances should an injured patient be permitted to pursue a tort action to its conclusion and, if unsuccessful, subsequently seek benefits under the no-fault compensation scheme. We recommend that the point at which an election is required be chosen in such a way as to on the one hand create a substantial incentive for the injured patient to opt for the compensation scheme benefits while on the other hand provide the injured patient with a reasonable opportunity (if necessary) to pursue the litigation option through the pre-trial stages to assess fully the possibility of a successful negligence action. We also recommend that in accepting compensation benefits from the scheme the injured patient be required to waive any tort action arising from the incident.

Focus on Rehabilitation, Lost Income and Future Health and Home Care Costs

51. We recommend that the benefits available from the compensation system be directed principally at rehabilitation, replacement of past and future lost income, and future health and home care costs not covered by provincial health insurance plans.

Periodic Payments

52. We recommend that the compensation benefits for future lost income and health and home care costs be paid through periodic payments.

Threshold Requirement of Significant Injury

53. We recommend that compensation for lost income and other benefits be limited to cases involving significant losses and that, at a minimum, the loss must involve either permanent partial disability or, in the case of employees, total loss of capacity to earn

income for at least eight weeks. In the case of non-earners (children, homemakers, elderly, unemployed, etc.) the test of significant loss should, at a minimum, involve either permanent partial disability or substantially complete impairment of functions for at least eight weeks.

Ceiling on Lost Income

54. We recommend that the compensation for lost income should reflect actual losses up to an adjustable ceiling, which should be two times the average industrial wage.

Future Health and Home Care Costs

55. With respect to future health care costs we recommend that provision be made for moderate home care expenses capped at the cost of institutional care for the equivalent injury, and that the injured person be permitted to choose between home and institutional care.

Collateral Benefits

56. We recommend that the compensation scheme benefits be available only as a source of compensation of last resort and that a strong collateral benefits rule attach to the scheme to ensure that all other sources of compensation, including first party disability insurance, are collected in advance of any entitlement to benefits from the compensation scheme.

Non-Economic Losses

57. We recommend that recovery for non-economic losses (pain and suffering) be strictly limited to nominal scheduled amounts analogous to those available through criminal injuries and workers compensation schemes, and that injured persons seeking more substantial non-economic losses pursue their claims in tort.

Administrative and Arbitral Decision Making

58. We recommend that the adjudicative decision-making processes of the compensation scheme not be assigned to courts but rather be assigned to a set of administrative and arbitral procedures culminating in a binding administrative appeal subject only to the possibility of judicial review on administrative law grounds. We recommend that procedures be developed to simplify the resolution of claims as quickly and inexpensively as possible.

Data Collection and Reducing Risks

59. We recommend that the compensation scheme be charged with responsibility for gathering data on health care injuries and using that data to encourage further risk reduction and improvement in the quality of health care. We recommend the enhanced data on medical injuries that would be made available through the compensation system be viewed as a major advantage of the proposed compensation scheme and that every

effort be made to link this data to enhancing the quality of health care and reducing the risk of injury.

National Principles and Provincial and Regional Administration

60. We recommend that every effort be made to implement this proposed compensation scheme across Canada, informed by uniform general principles, but we recognize that regional and provincial circumstances will dictate differences in the provincial application and administration of the scheme. We recommend that the administration of the scheme reflect the principally provincial constitutional jurisdiction in this area, but at the same time reflect our commitment to a national health care system and the reality of the national organization of physicians, other health care professionals and the blood supply system.

Cooperative Administration

61. We recommend that to the extent possible the administration of the proposed compensation scheme be cooperative, involving government and representatives of physicians and health care institutions. In particular, we recommend that the Canadian Medical Protective Association (and any other insurers of physicians) and the insurers of health care institutions be invited to participate directly in the design, implementation and administration of the proposed compensation scheme.

Financial Participation by Insurers of Physicians and Health Care Institutions

62. We recommend that substantial financial responsibility for the cost of the proposed compensation scheme be borne directly by government, but that the Canadian Medical Protective Association (and any other insurers of physicians) and the insurers of health care institutions also be involved financially in the compensation scheme in order to emphasize both the cooperative administration of the scheme and its role as an alternative to tort liability.

Federal Financial Support

63. We recommend that the federal government recognize and accept its historic financial role, particularly with respect to the less affluent provinces, in supporting the development of new social welfare policies by being willing to support initiatives by the provinces to implement the proposed health care injury compensation scheme. While not wishing to prejudge the particulars of the appropriate federal financial participation, we recommend that the federal government be prepared to support the proposed compensation scheme in a substantial way as an investment in improving the Canadian health care system and protecting it from the longer-term distortions and cost escalation that would otherwise be associated with unconstrained growth of civil malpractice actions against physicians and health care institutions.

Next Step in Development

64. We recommend that the next stage in the development of the proposed compensation scheme be for the Conference of Deputy Ministers to appoint an individual to consult with the affected governments and major affected interests in the health care system to establish the details of the actual scheme.

Other Reforms to Enhance the Quality of Health Care*Continuing Competence*

65. We recommend that the College of Physicians and Surgeons (or the equivalent regulatory authority) and the relevant regulatory organizations for each of the other health care professions in each province direct substantial attention to their efforts to ensure the continuing competence of health care professionals.

Education

66. We recommend that greater emphasis be placed in the education of health care professionals at both the undergraduate and graduate levels on developing an informed understanding of the legal context in which they must practice.

Accreditation

67. We recommend that the requirements for accreditation of health care institutions include meaningful standards for mandatory quality assurance, risk management and peer review programmes, and that provincial governments provide appropriate financial and budgetary incentives for health care institutions to obtain accreditation. In addition, we recommend that attention be given to broadening the range of health care institutions to which the accreditation process might apply.

Peer Review

68. We recommend that principal reliance for evaluating and ensuring the continuing competence of physicians be placed on peer review processes at all levels including the College of Physicians and Surgeons (or the equivalent regulatory authority), health care institutions, group practices and, in rural areas, regional groupings of physicians, and we recommend that steps be taken to ensure the regular and systematic operation of peer review processes in all of these settings.

Communication

69. We recommend that the education of all health care professionals include training in interpersonal communication as a clinical skill of critical importance to high quality health care.

Clinical Research

70. We recommend that substantially greater research be encouraged on the evaluation of the relative effectiveness of health care practices to reduce the uncertainty associated with the clinical judgements of physicians and to reduce the impact of non-medical considerations on this judgement to the extent possible.

Canadian Blood Supply System

Not a Distinctive Liability and Compensation Problem

71. While we recognize the distinctive history and nature of the Canadian blood supply system, we do not recommend that the liability and compensation issues arising from the Canadian blood supply system be treated prospectively as distinct and separate from the general liability and compensation issues in Canadian health care. However, in recommending that in future blood product injuries be treated as part of the general category of health care injuries, we have not addressed and are making no recommendations with respect to the question of liability and compensation for persons who may have suffered blood product injuries prior to the date of this Report.

Continue Tort Actions

72. We recommend that current tort law continue to be available to those suffering blood product-related injuries and that no grant of immunity from suit be granted to producers, suppliers, distributors and other participants in the Canadian blood supply system.

Insurance and Indemnity

73. While recommending the retention of tort liability for blood product related injuries, we recommend that the Canadian Blood Committee share responsibility for negotiating and arranging appropriate indemnity and insurance arrangements for producers, suppliers and distributors as required, but that these arrangements include adequate incentives and requirements for quality and risk management.

Non-Commercial Insurance

74. We recommend that to the extent possible, the insurance necessary for producers, suppliers and distributors of blood-related products be supplied by non-commercial sources. In particular, we recommend that the Canadian Blood Committee explore with the principal non-commercial insurers of Canadian health care institutions the possibility of their supplying the necessary insurance and attendant quality and risk management advice and services.

No Separate Compensation System

75. We recommend against the development of a separate compensation system for blood product-related injuries. Instead, we recommend that blood product-related injuries be brought within the scope of the proposed health care injury compensation system (see Recommendations 45-64) by identifying appropriate specific injuries caused by blood products as compensable events. As in the case of Recommendation 71, this Recommendation is prospective only.

Security of Supply

76. To the extent the Canadian blood supply system is seen to suffer from any absence of a secure and independent Canadian supply of blood products (an issue on which we make no finding as it falls outside the scope of the Review), we recommend that changing the applicable laws concerning liability and compensation not be viewed as a solution. We recommend that the Canadian Blood Committee focus its attention directly on the issue of a secure supply consistent with the broad parameters of Canadian policy in this area and that the Committee not look to relaxation of the current standards for liability and compensation as a way of enhancing supply.

Implementation*Continuing Interest and National Perspective*

77. We recommend that the Conference of Deputy Ministers of Health retain a strong continuing interest in the subject of liability and compensation for health care injuries. We also recommend that governments be cognizant of the many national features of the health care system and that they endeavour wherever possible to pursue uniform and integrated reforms in this area.

Act in Concert

78. We recommend that the Conference of Deputy Ministers of Health attempt to establish a consensus around the major recommendations of this Review and that all the governments represented continue to act in concert in implementing those initiatives which enjoy broad support.

Research

79. We recommend that the National Health Research and Development Programme continue to support research broadly in the field of liability and compensation issues in health care in order to enrich and broaden the available data in this area.