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Report April 2007

Liability Risks in Interdisciplinary Care
Thinking Outside the Box

HEALTH, HEALTH CARE AND WELLNESS

The Conference Board of Canada
Insights You Can Count On

Liability Risks in Interdisciplinary Care: Thinking Outside the Box
by *The Conference Board of Canada*

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ISSN 0827-1070 • ISBN 0-88763-752-3
Agreement No. 40063028
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Preface

This report analyzes liability concerns raised by health professionals in the context of interdisciplinary collaborative practices and provides recommendations to support broader adoption of these models of care.

An analysis of Canadian and selected United States court cases that addressed negligence in the provision of health services was undertaken, as well as a literature review, an examination of malpractice patient compensation systems in five OECD countries, and consultations with Canadian stakeholders in this area.

Production of this report has been made possible through a financial contribution from Health Canada. The views expressed here do not necessarily represent the views of Health Canada. The design, method of research and content of this report were determined solely by The Conference Board of Canada.

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EXECUTIVE SUMMARY

Liability Risks in Interdisciplinary Care

Thinking Outside the Box

At a Glance

- A close examination of the concerns expressed by health-care professionals suggests that liability is not the barrier they think it is.
- Although interdisciplinary collaboration might entail some legal risks, these can be overcome, or at least controlled, with easy-to-implement solutions.
- An examination of Canadian case law suggests that courts will likely continue to assess standard of care on an individual basis and it is improbable that they will apply a standard that exceeds the examined professional's scope of practice.

In health care recently, there has been a strong emphasis on promoting models for collaborative, interdisciplinary health-care delivery. Provincial and territorial health officials are advocating its benefits and providing incentives to health professionals to move toward it. Health professional groups have embraced principles for interdisciplinary collaboration and are advocating its benefits to their members. As well, the federal government has commissioned several studies aiming to support wide implementation of these practices.

Despite the many benefits that interdisciplinary collaborative practices might bring to health professionals, patients, and communities, some health professionals are hesitant to engage in these models of care. Among the concerns they have expressed are the possibility that these practices will lead to increased exposure to liability risks, and fears that they may be held accountable for the negligent acts of their colleagues.

Despite the possible benefits to patients, communities and themselves, some health professionals are hesitant to engage in interdisciplinary collaborative practices.

This report, funded by Health Canada, aims to identify and analyze these and other liability concerns of health professionals that arise in the context of interdisciplinary collaborative practices. To this end, The Conference Board of Canada has reviewed legal principles in tort law (as they relate to negligence) and conducted a systematic collection and analysis of court decisions in Canada that address negligence in the provision of health-care services. Given that very few Canadian court decisions have dealt specifically with liability in interdisciplinary collaborative care, relevant U.S. court cases were also reviewed. Complementing this research were a literature review, a review of malpractice patient compensation systems in five countries (Australia, New Zealand, Sweden, the United Kingdom

and the United States) and consultations (two reference meetings and eight interviews) with relevant stakeholders.

A close examination of the concerns expressed by health professionals suggests that liability is not the barrier that they think it is. Although interdisciplinary collaboration might entail some legal risks, these can be overcome, or at least controlled, with easy-to-implement solutions. Each collaborative team is different and must therefore assess the risks within its own context, but no circumstance is so dire as to discourage or prevent interdisciplinary practices.

A close examination of the concerns expressed by health professionals suggests that liability is not the barrier they think it is.

A study of court cases in Canada regarding malpractice shows that to win, a case must be very well founded. Courts examine the duty and standard of care that the health professional owes the patient. Health professionals are expected to show watchfulness, attention, caution and prudence when delivering health-care services to the patient/client; however, they are not expected to be perfect or to be able to foresee every possible circumstance that could go wrong.

As some health professionals expand their scopes of practice to perform activities historically restricted to other groups, concerns arise about the standard of care these professionals will be held against in the event of liability (e.g., nurse practitioners being held against the standard of care applicable to physicians). An examination of Canadian case law suggests that courts will likely continue to assess standard of care on an individual basis, and it is improbable that they will apply a standard that exceeds the examined professional's scope of practice. Canadian courts have "moved with the times" and recognize that overlapping scopes of practice exist and that a team approach is desirable and often used in patient care.

Notwithstanding the above, health-care professionals and their institutions need to be aware of certain risks inherent in team-based care, for example, the increased risk of joint and several liability and vicarious liability. They also need to be aware that lack of clarity regarding roles and responsibilities might lead to *inappropriate delegation of duties* or *abdication of responsibility*, which can result in negligent acts.

To mitigate these risks, members of interdisciplinary collaborative teams and their institutions also need to understand their individual responsibilities and role within the team, as well as the roles and responsibilities of other team members. Confusion about which professional is responsible for carrying out specific actions is likely to result in errors and omissions in care. Essential and simple mitigating strategies include instituting the following: policies clarifying roles and governing interdisciplinary interactions; strong communication processes and practices among all the health-care professionals *and* between the professionals and the patient/client and family; accurate and complete health records; and informed consent that covers the details of the interdisciplinary care proposed to the patient.

The most significant way for health professionals to ensure that they are not found liable for medical malpractice is to act competently and within their scopes of practice. It is vital to underscore that although there have been some legal cases involving several health professionals working as a team, liability has always been assessed against the individuals and not against the team. It is interesting to note that the *number* of legal actions (claims, settlements and court awards) brought against physicians and nurses in Canada has decreased over the past 10 years. That said, the *size* of awards or settlements has increased; however, this reflects an international phenomenon and cannot be attributed to collaborative health care.

Regarding availability of insurance/protection, collaborative practices have no bearing on obtaining the necessary liability protection/insurance as long as the insured/protected professionals are practising within their scope of practice. Neither does practising on a team with other professionals affect the cost of premiums/fees nor the coverage/protection available. Notwithstanding this, insurers and protective organizations have expressed some concerns, including the need to ensure effective and efficient communications within the team, to establish clear roles that are aligned with provincially legislated and regulated scopes of practice, and to ensure that all

team members have adequate liability protection to protect themselves, the institutions and the public.

Interdisciplinary health-care models are likely to increase within the next 10 years, especially given demographic and chronic disease trends that will require not only more comprehensive diagnostic and treatment options (which call for interdisciplinary practices), but also innovative solutions for the increasingly acute health human resources challenges. It is also very likely that these teams will continue to evolve; therefore, a single prescription for liability risk management is not prudent.

The following recommendations have resulted from this research. They are intended to encourage a wide embracement of interdisciplinary practices and to support their easy and risk-controlled adoption.

1ST RECOMMENDATION

Governments should work in partnership with professional associations to dispel the health professionals' fear of medico-legal liability as a significant barrier to interdisciplinary care.

It is necessary that health professionals clearly understand malpractice liability processes in Canada, including the basis of negligence and how courts establish standard of care. Health professionals also need to be familiar with the risks associated with interdisciplinary care and the mitigating strategies that can be put in place to effectively manage these risks. It is necessary to change some of the negative perceptions regarding interdisciplinary care and malpractice liability that some health professionals have. Wide dissemination of this report can contribute to achieving this goal.

2ND RECOMMENDATION

Health-care institutions need to be aware of and implement the following key practices:

- Health-care professionals must act according to the standards of practice of their professions and comply with their respective regulatory colleges.
- Policies are in place to guide interdisciplinary care, and all health professionals are aware of them. Specifically, these policies need to clarify roles and responsibilities and processes related to communication, decision-making and patient management within the team approach.
- The organization has malpractice liability insurance that covers the organization and its employees (e.g., direct liability, vicarious liability).
- All professionals have appropriate malpractice liability insurance/protection. Institutions should reinforce this during annual performance reviews or appraisals.

Once health-care institutions have implemented these practices, they should be no more vulnerable to liability than any health-care organization or system whose employees do not work collaboratively. Provincial governments can be instrumental in disseminating this information to the health-care organizations operating in their provinces and to carriers of insurance and protection programs.

3RD RECOMMENDATION

Health professionals need to understand their scope of practice and their limitations as set out in their provincial legislation. Equally, they need to understand the scopes of practice of the other health professionals in their team.

Professional associations can play a significant role in conveying this information to health professionals.

4TH RECOMMENDATION

Health professionals need to be aware of, and comply with, policies that govern their interdisciplinary interactions.

Policies can confirm and clarify scopes of practice and lay out appropriate roles for each practitioner. Of great importance are those policies that provide guidance on actions when there is role overlap. This recommendation also applies to those health professionals engaged in informal collaborations (those happening outside formal institutions, involving private providers of health services,

virtual networks, etc.). Given the liability and patient safety risks, it is fundamental for these health professionals to design their own policies to ensure an even understanding of the roles and responsibilities of all those participating in patient care. A simple collegial understanding among professionals is not enough to protect professionals and patients.

5TH RECOMMENDATION

Carriers of liability insurance and protection programs should consider creating a vehicle to exchange aggregate, non-identified data on malpractice liability cases.

This will allow the design of more comprehensive educational materials that will help their clients/members to be more aware of risks and risk-management strategies in interdisciplinary collaborative environments. Given that this information would be available to all professions, it could lead to a better appreciation for the roles of various types of health professionals within collaborative models. It could also lead to sharing best practices in risk management between professions and to safer and higher-quality health-care practices.

6TH RECOMMENDATION

Governments and (or) regulators should consider introducing legislation to make liability insurance/protection mandatory for all active (as defined by regulators) health professionals involved in interdisciplinary practices.

This action will give health professionals peace of mind and engender trust among team members; it will also ensure that patients and their families have access to a source of funds in the event of malpractice.

Mandatory liability protection for health professionals will likely result in greater demand for health professional insurance/protection. Therefore, an analysis to estimate the capacity of this market should be undertaken as a first step.

CONCLUDING REMARKS

This report brings home a strong message about liability and collaborative care. Liability is not the barrier to interdisciplinary care that many health professionals perceive it to be. Although interdisciplinary collaborative practice does carry some risks—for health-care institutions, health-care professionals, legal entities, insurers and liability protectors—these can be overcome with a few straightforward strategies, all of which contribute to patient safety and quality of care.

Although some experts advocate a no-fault patient compensation system, this report suggests that a radical reform in Canada might not be desirable or likely.

Our current litigation-based system seems to be responding well to the needs of interdisciplinary collaborative practices. While some experts have voiced concerns regarding this system, and have advocated a no-fault patient compensation system, this report suggests that a radical reform in Canada might not be desirable or likely. However, there *are* opportunities to strengthen our current litigation-based system. Patient safety and risk management initiatives deserve special consideration.

As *all* stakeholders think outside their individual boxes, their expertise will enrich the broader discussions. The ensuing solutions created by such a collaborative effort will go far to dispel uncertainty regarding liability and foster a climate of sound legal and health practices.

CHAPTER 1

Introduction

Chapter Summary

- Some health-care professionals and professional groups in Canada and elsewhere have consistently identified liability concerns as a potential barrier to implementing collaborative health care.
- Recently, there has been a strong emphasis on promoting collaborative models.
- This report, funded by Health Canada, aims to identify and analyze these and other liability concerns of health professionals that arise in the context of interdisciplinary collaborative practices.
- This report outlines the legal principles regarding handling of liability issues and discusses how the courts apply these principles. Also included are strategies to control liability risks and a set of recommendations that should lead not only to stronger collaborative practices but also to higher-quality and safer health-care services.

Interdisciplinary collaboration is a flexible and effective method of delivering health-care services. Collaborative practices have been defined as "the positive interaction of two or more health professionals who bring their unique skills and knowledge to assist patients/clients and families with their health decisions."[1]

Impressed with the benefits of interdisciplinary practice, provincial/territorial health officials are now incenting health professionals to embrace these models.

Recently, there has been a strong emphasis on promoting collaborative models. This is not entirely a new way of delivering health care. In fact, in some areas of the country, health professionals and patients have enjoyed the benefits of such models for decades. Provincial and territorial health officials are increasingly advocating the benefits of interdisciplinary models and providing incentives to health professionals to move toward them. Governments are finding that such models for health-care delivery help to achieve the following:

- Ensure the effective use of precious resources—both human and financial;
- Facilitate access to health services; and
- Provide more efficient and integrated health-care services to Canadians in their own communities.

1 Canadian Association of Occupational Therapists, *Pan-Canadian Awareness Initiative on Occupational Therapy and Interdisciplinary Collaboration in Primary Health Care* (Ottawa: COAT, 2005), p. 9.

Team-based interdisciplinary practices have been identified as one of the key elements of primary health-care reform. Supported mainly through the Primary Health Care Transition Fund, interdisciplinary primary health-care practices have rapidly expanded across provinces and territories. The approximately 150 family health teams approved in Ontario, the 18 primary care networks established in Alberta and the 9 family health centres in Prince Edward Island are just a few examples.

Some health-care professionals/groups—at home and abroad—have identified liability concerns as a potential barrier to implementing collaborative health care.

Governments are not alone in this journey. Health professionals have also committed to increasing their participation and strengthen collaborative practices. Recently, 10 leading national health professional associations agreed on and embraced principles and a framework to support and enhance interdisciplinary collaborative practices. Health Canada is supportive of this trend and has commissioned several studies to examine critical factors identified as barriers to implementing collaborative health care and to develop recommendations to boost collaboration. A precursor of this report, *Regulatory and Medico-Legal Barriers to Interprofessional Practices*,[2] raised questions and offered theoretical answers regarding general issues of liability in interdisciplinary practices. The current report, also commissioned by Health Canada, under the auspices of the Health Human Resources Strategies Division, identifies issues for all those involved in collaborative care—health professionals as individuals, health-care teams and the carriers of liability protection programs, including insurers and protective organizations. It also offers some practical guidance to support and encourage everyone's involvement in these models of care.

Some health-care professionals and professional groups in Canada and elsewhere have consistently identified liability concerns as a potential barrier to implementing collaborative health care. The key concerns are as follows:

- Collaborative practice may increase exposure to liability risks, both for individual professionals and for institutions.
- Individual professionals may be held accountable for the negligent acts of their colleagues, or they may be held to a higher standard of care than their own profession dictates.

One source of these concerns seems to be a twofold perception on the part of some health professionals: a) that collaborative care will involve increased use of less-skilled professionals, and b) that certain professionals will become responsible for care delivered by these less-skilled members of the team. For example, an Australian nursing paper notes that "[t]here are now concerns amongst registered nurses as to their liability when placed in the position of having to delegate care to less skilled workers with the possibility that such action may result in adverse patient outcomes and litigation."[3] A physician survey conducted by the British Columbia Medical Association in 2005 found that liability concerns rated second among reasons for not practising in a collaborative setting that includes non-physician providers. Likewise, a U.S. paper predicts that "[l]iberalizing the scope of practice of physician extenders[4] only adds another layer of complexity to our health care system. Added complexity means that there will be more hand-off and communication errors because the ultimate decision-maker, the physician, will be one step removed from the patient and the patient will be receiving medical care from less qualified individuals."[5]

Purpose of this report. This report aims to identify and analyze these and other liability concerns raised by health professionals in the context of interdisciplinary collaborative practices. It outlines the legal principles regarding handling of liability issues and discusses how

2 W. Lahey and R. Curry, "Regulatory and Medico-Legal Barriers to Interprofessional Practices," *Journal of Interprofessional Care* 19, Supplement 1 (May 2005), pp. 197–223.

3 K. Forrester and D. Griffiths, "So Where Will the Buck Stop? Liability and the Move for a More Diverse Health Care Workforce," *Journal of Law & Medicine* 2 (2001), p. 161.

4 A broad term that includes registered nurse anaesthetists, physician assistants, nurse practitioners and midwives.

5 Thomas R. McLean, "Crossing the Quality Chasm: Autonomous Physician Extenders Will Necessitate a Shift to Enterprise Liability Coverage for Health Care Delivery," *Health Matrix* 12 (2002), p. 295.

the courts apply these principles. Also included are strategies to control liability risks, and a set of recommendations that should lead not only to stronger collaborative practices but also to higher-quality and safer health-care services. It is important to note that because interdisciplinary practices vary greatly from each other (the types of professionals involved in the team, funding, governance structures, etc.), health professionals considering participation in an interdisciplinary model need to examine the issues and appropriate mitigating strategies that are relevant to their own context.

This report presents a set of recommendations that should lead to stronger collaborative practices and also to higher-quality and safer health-care services.

Areas of focus in this report. There is an increasingly widespread focus on collaborative care in Canada. This new focus is therefore only beginning to be represented in Canadian case law. To supplement such examples, we have reviewed case law from the United States, where not only has collaborative care been in practice longer, but there is also a higher volume of malpractice cases.

- **Analysis of legal principles in negligence.** By reviewing relevant court decisions in Canada, the report attempts to provide a comprehensive overview of the various legal issues. Nonetheless, it is worth keeping in mind the following caution: "Because so many of these developments are very recent there is little case-law to provide precedents, and even if there were they would be of questionable value since all situations will have to be analyzed separately on the basis of their own facts."[6] Although this statement was made nearly 10 years ago, it remains true that there is very little Canadian case law that addresses issues of liability in collaborative health-care practice.
- **Analysis of relevant U.S. court rulings.** Given the relatively few Canadian cases, this report also examines some legal rulings in the United States that have assessed interdisciplinary practices. The U.S. has a long history of collaborative health care. For example, as early as 1981, the American Nurses Association and the American Medical Association established a National Joint Practice Commission to examine collaborative practice in hospitals.[7] In reviewing examples of judicial decisions and literature from the U.S., it is important to note that jurisdictions outside Canada have legal doctrines and statutory frameworks that are not necessarily directly applicable to the Canadian context.
- **Focus on cases involving physicians and nurses.** Because a large proportion of the case law in Canada and the United States involves physicians and nurses, most of the cases presented in this report focus on these professions.

Court rulings are important, not only because they set legal precedents that impact current and future cases, but also because they have profound consequences in the medical indemnity insurance and not-for-profit liability protection markets. Table 1 presents some of the most significant landmarks that have impacted these markets in Canada over the last century.

Review of malpractice patient compensation systems in other countries. This report also examines the highlights of malpractice liability systems, patient compensation systems and insurance systems in selected Organisation for Economic Co-operation and Development (OECD) countries, including New Zealand, Australia, Sweden, the United Kingdom and the United Sates. While acknowledging that these countries' health-care systems may be organized and financed on models different from that used in Canada, nevertheless, their legal trends in liability may provide instructive lessons for Canada.

Organization of this report. This report discusses various aspects of negligence as they relate to health-care professionals, with a focus on collaborative care issues.

- Chapter 3 presents an overview of the malpractice liability system in Canada, focusing on negligence, and clarifies the conditions required to establish it.
- Chapter 4 discusses how courts in the U.S. and Canada are handling the new roles and responsibilities in collaborative health-care settings. It includes some inherent risks and appropriate mitigating strategies.

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

7 National Joint Practice Commission, *Guidelines for Establishing Joint or Collaborative Practice in Hospitals* (Chicago: Neely, 1981).

Table 1
Landmarks in the Canadian Indemnity Insurance Market and Not-For-Profit Liability Protection

Date	Activity
1901	Canadian Medical Protective Association (CMPA) was established.
1950s	"Professionalization" of medicine increased.
1970s	Yepremian case in Ontario ruled that hospitals are liable for the negligence of independent contractors. Although this ruling was overturned by the majority of the Courts of Appeal in 1980, this case sparked an upward curve in the number of malpractice cases.
1980s	ENCON Insurance began writing liability insurance for health professionals. High-profile cases led to an increase in medical malpractice suits across North America. A drop in insurance markets resulted in fewer providers of insurance services.
Late 1980s	Healthcare Insurance Reciprocal of Canada (HIROC) and the Canadian Nurses Protective Society (CNPS) were established. Liability limits started decreasing. "Tail coverage" began, offering optional protection in that claims could be reported after the policy had ended for alleged injuries that occurred while the policy was in force. (Tail coverage does not apply to physicians since CMPA protection is occurrence-based.)
Early 1990s	A trend began of enacting provincial laws that recognize a wider range of care providers as regulated health professionals.
Late 1990s	Royal Sun Alliance was created. The Maple Leaf Gardens sexual abuse case resulted in "abuse" issues coverage becoming complex and limited. St. Paul Fire & Marine, the largest commercial carrier, eliminated medical malpractice insurance, resulting in difficulties for some health professionals in obtaining insurance services. Significant increases in damage awards occurred across the globe.
2000	Higher awards for damages had a huge impact, especially in the United States, but reverberated around the world (e.g., the 2002 near collapse of UNITED Medical Protection in Australia).

- Chapter 5 focuses on various collaborative practice settings, including the risks for both the individual professionals *and* the organization.
- Chapter 6 presents Canadian trends in liability and assesses the effect of interdisciplinary collaboration on these trends.
- Chapter 7 examines liability protection/insurance available in Canada for various health professions and how collaboration affects premiums and fees.
- Chapter 8 assesses some of the concerns arising from tort-based systems and presents an overview of the main strategies to strengthen the effectiveness of these systems.
- Finally, the report presents conclusions and recommendations.

Other issues of interest. The scope of this report is restricted to legal liability issues that pertain to interdisciplinary collaborative health-care arrangements. It does not address other factors, such as professional culture or attitudinal barriers and funding issues that must be overcome before collaborative practice can become a reality. This paper also does not address legal questions related to legislated scopes of practice; however, clarification of this regulatory issue is a key factor in successful implementation of collaborative modes of care delivery. These issues are examined in the report *Achieving Public Protection Through Collaborative Self-Regulation: Reflections for a New Paradigm*, which is being released simultaneously with this report. However, because scope of practice issues cannot be neatly separated from liability issues, some reference to this matter will appear throughout this report.

CHAPTER 2

Methodology

Chapter Summary

- Methods for this report included a systematic collection and analysis of court decisions in Canada that address negligence in the provision of health-care services.
- Given that very few Canadian court decisions have dealt specifically with liability in interdisciplinary collaborative care, relevant U.S. court cases were also reviewed.
- Complementing this research were a literature review, a review of malpractice patient compensation systems in five countries (Australia, New Zealand, Sweden, the United Kingdom and the United States) and consultations (two reference meetings and eight interviews) with relevant stakeholders.

This policy report draws upon mostly qualitative data. Research methods for this report included the following:

- A systematic collection and analysis of court decisions in Canada that address negligence in the provision of health-care services;
- A search for relevant U.S. court cases to identify lessons that could be learned. This was necessary given the very few Canadian court decisions that have dealt specifically with liability in interdisciplinary collaborative practice;
- A review of articles in Canadian and international health-care and legal academic journals that examine liability issues in interdisciplinary collaborative practice;
- A review of Canadian and U.S. policy statements from health-care professional groups that recommend or mandate liability protection measures;
- An analysis of findings from a reference group meeting held on January 27, 2006. At this event, 27 individuals—representing health policy, malpractice insurers, professional protective associations and various health professions—discussed key liability issues for both the health-care professionals working collaboratively, and for their insurers/protectors. Appendix A lists the participants in this event;
- A review of malpractice liability insurance in five countries: Australia, New Zealand, Sweden, the United Kingdom and the United States; and
- An analysis of findings from a total of eight interviews with professional insurers, protective associations and brokers conducted between the fall of 2005 and early 2006. Appendix A presents a list of interviewees.

Search techniques involved an online review of academic research databases, e-journals, and the websites of various governmental and non-governmental organizations, including professional associations and insurance and protective organizations.

Resources used in this review included academic publications, peer-reviewed articles by scholars and commentators in the fields of health and law, commissioned papers on the topic (e.g., the Pew Commission in the United States), position papers, and proposed bills and other legislative documents.

The **key words** for this search included medical liability, medical indemnity, collaborative care, tort reform, negligence, malpractice, regulation of health professionals, liability protection and patient safety.

Participants of the first reference meeting were invited to a second reference meeting held in November 2006 to provide feedback on the preliminary findings of this research.

CHAPTER 3

Perceptions of Malpractice Liability—From Confusion to Confidence

Chapter Summary

- Courts will find a health professional liable for malpractice only if the plaintiff clearly establishes that the defendant owed them *a duty of care*; that the defendant breached the relevant *standard of care*; that the plaintiff suffered injury or loss; and that the defendant's conduct caused the injury or loss.
- The courts recognize that health care can be complex and demanding and that mistakes do happen.
- As part of obtaining informed consent, health professionals need to clearly explain the interdisciplinary model and the roles of each provider involved in the proposed care to the patient.

Health-care malpractice liability has traditionally been surrounded by uncertainty, with most health professionals being unfamiliar with the intricacies of our legal system. Professionals and their associations have often been unsure as to how courts will handle liability and how accountability for outcomes will be allocated. Now, with the increasing trend toward new models of collaborative, interdisciplinary practice, the unfamiliarity with the parameters of the new models has given rise to an associated uncertainty regarding liability issues in such models.

Professionals and their associations have often been unsure as to how courts will handle liability and how accountability for outcomes will be allocated.

In this chapter, we will present the principles on which courts assess the performance of health professionals when examining malpractice cases. In particular, we will focus on negligence, including duty of care and standard of care, and how these legal terms have been applied in Canadian malpractice liability cases. We also include a brief discussion of informed consent in the health-care context.

OVERVIEW OF THE MALPRACTICE LIABILITY SYSTEM IN CANADA

In Canada, the majority of lawsuits against health-care professionals and health-care organizations and their employees are based on the tort of negligence. Tort is a branch of civil law (as opposed to criminal law) that deals with civil wrongs. In this key area of litigation,

a victim (or plaintiff) generally seeks money from a person or some other legal entity (e.g., hospital) who harmed the victim.

There are three main objectives of tort law:[1]

- Compensate victims (or plaintiffs) for their losses;
- Ensure corrective justice by making people responsible for restoring the damage that the victims incurred (paying damages); and
- Deter people, including health professionals, from engaging in behaviours that can result in negligence or substandard care.

In tort-based systems, health professionals who are found negligent must compensate victims in full for losses. Therefore, liability for negligence cannot occur without a finding of fault. Victims, then, are given damage awards that could cover medical bills, lost income, future care, and pain and suffering.

UNDERSTANDING NEGLIGENCE

In health care, "negligence" refers to situations in which a health-care provider *accidentally fails* to provide an expected standard of care. To substantiate a claim of negligence, a plaintiff (victim) must establish four requirements:

- The defendant owed the plaintiff a *duty of care*.
- The defendant failed to meet the relevant *standard of care* (including a failure to obtain informed consent for the procedure).
- The plaintiff suffered injury or loss as a result.
- The defendant's conduct caused the injury or loss.

Understanding Duty of Care

"Duty of care" refers to the obligation of the health professional to provide care to the patient/client. In the majority of negligence cases, the patient argues this very point. Duty of care means that health professionals are expected to show watchfulness, attention, caution and prudence when delivering health-care services to the patient. They must always act in the best interest of their patients/clients and their care needs. In addition, they must not, by any act or omission, indirectly or directly cause harm to their patient/client.[2]

However, "a duty of care only exists in circumstances where the event giving rise to the duty is reasonably foreseeable."[3] For example, the Supreme Court of Canada ruled that a hospital could not be found liable when a patient, Mr. Lépine, unexpectedly jumped through a fourth-floor window of the facility.[4] In making his decision, the judge stated:

> . . . [T]he injuries sustained by Lépine were the result of an impulse on his part which could not reasonably have been foreseen. To hold otherwise would, in my judgment, make physicians and hospitals [responsible as] insurers against all such hazards which they are not.[5]

Understanding Standard of Care

"Standard of care" refers to the level of care expected from a health professional given his or her qualifications and experience.

The following passage from the decision in the 1956 case *Crits v. Sylvester* clearly identifies the expected standard of care for general physicians and specialists:

> 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.[6]

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1 Joan Gilmour, *Patient Safety, Medical Error and Tort Law: An International Comparison* [online]. (Toronto: York University, May 2006). http://osgoode.yorku.ca/osgmedia.nsf/0/094676DE3FAD06A5852572330059253C/$FILE/FinalReport_Full.pdf.

2 UNISON Health Care, "Duty of Care," *Nursing Times Live* [online]. (2005). http://unison.org.uk/acrobat/P1863.ppt#1.

3 J.J. Morris et al., *Canadian Nurses and the Law*, 2nd ed. (Toronto: Butterworths, 1999), p. 154.

4 *University Hospital Board v. Lépine*, [1966] S.C.R. 561.

5 Ibid.

6 [1956] O.R. 132 at 508, aff'd [1956] S.C.R. 991.

Overall, a health-care professional is expected to "possess the skill, knowledge and judgment of the generality or average of the special group … to which he/she belongs and will faithfully exercise them."[7]

In assessing the standard of care, courts recognize that professionals may make errors in judgment, but that such errors constitute potential negligence only if the professional's actions fell below an appropriate standard of care.[8] The decision in *Crits v. Sylvester* reinforces this. It adopted the following statements from British case law:

> . . . [W]e should be doing a disservice to the community at large if we were to impose liability on hospitals and physicians for everything that happens to go wrong. Physicians would be led to think more of their safety than of the good of their patients. Initiative would be stifled and confidence shaken. A proper sense of proportion requires us to have regard to the conditions in which hospitals and physicians have to work. We must insist on due care for the patient at every point, but we must not condemn as negligence that which is only a misadventure.[9]

If due care is not exercised, it could lead to situations of negligence wherein a health-care professional fails to meet the prevailing acceptable standard of care. By contrast, there are circumstances where harm has unwittingly been caused by a health professional, but involved errors in judgment that even a reasonably prudent professional, applying appropriate skills and training, could have made.

The Supreme Court of Canada has instructed that a court assessing a case of alleged negligence must put itself in the situation of the care provider.[10] More particularly, the court should endeavour to consider what the provider "should have reasonably anticipated as a natural and probable consequence of neglect, and not to give undue weight to the fact that a distressing accident has happened."[11]

Expert testimony. In negligence litigation, a court hears testimony from experts to determine what the standard of care is and whether it was met in a particular case. In most cases, the expert who gives evidence will be from the same profession (and specialty) as the defendant(s). However, in appropriate circumstances, a care provider from another profession may give evidence about the standard of care, as seen in the following two examples.

In negligence litigation, a court hears testimony from experts to determine what the standard of care is and whether it was met in a particular case.

An Ontario court ruled that physicians may testify as to the standard of care of nurses. "Despite their lack of nursing knowledge, physicians rather than nurses are permitted to give expert evidence regarding the standard of care expected by nurses."[12] Similarly, in a U.S. case, a nurse anaesthetist who had been involved in thousands of surgeries over 15 years of practice was permitted to give evidence about the manner in which a surgeon ought to have supervised a nurse anaesthetist. The court noted: "Given this experience, she was clearly as knowledgeable as anyone about what a nurse anesthetist can competently do without supervision and what he needs help with. This knowledge, of course, was germane to her own field of practice. However, having worked so frequently with surgeons, she was as knowledgeable as they about the way surgeons ordinarily supervise nurse anesthetists."[13]

INFORMED CONSENT

Health-care providers must generally obtain informed consent from a patient before initiating treatment. Depending on the circumstances, consent may be given

7 *Wilson v. Swanson*, [1956] S.C.R. 804 at 811.

8 Ibid. at 812, Rand J.

9 J.A. Schroeder in *Crits v. Sylvester*, supra note 6 at 509.

10 J. Hall, *University Hospital Board v. Lépine* (1966), 57 D.L.R. (2d) 701 (S.C.C.) at 718–719.

11 Quoting Lord Thankerton in *Glasgow Corp. v. Muir*, [1943] A.C. 448 at 454–455.

12 *Shumka v. Holloway*, [2002] O.J. No. 5017 (Sup. Ct.) at para. 40.

13 *Harris v. Miller*, 335 N.C. 379 (1994, Supreme Court of North Carolina).

verbally, nonverbally (e.g., the patient extends their arm to accept a needle) or in writing (a consent form may be used).

A new liability concern in collaborative care arises from the uncertainty of the need (or lack of) to disclose the health professional's profession as an aspect of the informed consent process. If, for instance, a nurse practitioner (NP) treats a patient, but the patient believes the NP is a physician, can that patient sue for a lack of informed consent if they are harmed by the NP?

There is uncertainty of the need (or lack of) for health professionals to disclose their profession as part of the informed consent process.

To date, Canadian courts have not yet addressed the specific situation of whether a care provider must inform the patient of their professional training or level of experience, and some commentators suggest that courts will hesitate to mandate disclosure of such information.[14] However, courts have found liability in some situations where a patient consented to one practitioner providing care, but another person with a different skill level carried out all or part of the treatment. In *Currie v. Blundell*,[15] a patient successfully sued a cardiovascular surgeon and his resident when the surgeon allowed the resident to carry out much of the surgery. The patient had not been adequately informed of all the risks of the surgery, nor of the fact that a resident would take over the procedure, albeit under supervision. It is important to note, however, that the large majority of informed consent lawsuits are unsuccessful,[16] a trend that is consistent with previous research on this topic.[17]

The complexity of modern health-care services requires a variety of practitioners to work in collaboration. This has occurred in acute care hospitals for many years. The authors of a Canadian health law textbook note that "[i]n practice a consent form is often used by hospitals to cover the many persons who will participate in the patient's care."[18] This solution may be adapted in the collaborative care context where, on an initial visit, patients are informed, and agree, that various practitioners will be involved in providing care to them.

CONCLUDING REMARKS

Courts will find a health professional liable for malpractice only if certain conditions are met. A plaintiff must clearly establish that the defendant owed them a *duty of care*, that the defendant breached the relevant *standard of care*, that they suffered injury or loss, and that the defendant's conduct caused the injury or loss. The courts recognize that health care can be complex and demanding and mistakes do happen. However, they must judge the care given to a patient against the expected professional standard, as established through expert testimony from health professionals. As part of obtaining informed consent, health professionals need to clearly explain the interdisciplinary model and the roles of each provider involved in the proposed care to the patient.

The next chapter will review more examples of how courts have assessed standard of care when a *team* of health professionals provided services. In addition, it will explore the challenges associated with expanded and overlapping scopes of practice, and how courts have responded to these new realities.

14 See for example Philip H. Osborne, "Informed Consent." In Sneiderman, Irvine and Osborne, *Canadian Medical Law: An Introduction for Physicians, Nurses and Other Health Care Professionals*, 3rd ed. (Toronto: Carswell, 2003), p. 70.

15 [1992], 10 C.C.L.T. (2d) 288 (Que. S.C.).

16 Gerald B. Robertson, "Informed Consent 20 Years Later," *Health Law Journal*, Special Edition 153 (2004).

17 Gerald Robertson, "Informed Consent Ten Years Later: The Impact of Reibl v. Hughes," *Canadian Bar Review* 70 (1991), p. 423.

18 Ellen I. Picard and Gerald B. Robertson, *Legal Liability of Doctors and Hospitals in Canada*, 3rd ed. (Toronto: Carswell, 1996), p. 83.

CHAPTER 4

Roles and Responsibilities Have Changed—And the Courts Have Noticed

Chapter Summary

- Courts are increasingly recognizing that health professionals have new roles and responsibilities and that those roles might overlap in collaborative settings.
- Courts are likely to continue to assess standard of care on an individual basis.
- Health professionals need to be aware that courts recognize the critical importance of a team approach. However, health professionals also need to be aware that there are some risks related to inappropriate delegation of duties and abdication of responsibility.
- To mitigate these risks, members of interdisciplinary collaborative teams need to understand their individual responsibilities and role within the team.

As some health professionals expand their scopes of practice to perform activities historically restricted to other groups (e.g., nurses performing tasks typically done by physicians), concerns arise about the standard of care these professionals will be held against in the event of liability. Do the courts recognize that health professionals are working in new ways, and are they aware of the various and sometimes overlapping roles and responsibilities of the various health professionals working on a team? Will health professionals with expanded roles be held to the standard of care applicable to other professional groups? As previously discussed, some health professionals have articulated these concerns, and their uncertainty regarding liability may hold some of them back from working in a collaborative way.

With health professionals expanding their scopes of practice, they are concerned about the standard of care they will be held against in the event of liability.

This chapter looks at how courts in Canada and the United States have addressed issues of liability in interdisciplinary, collaborative practice. While acknowledging that the intricacies of interdisciplinary care have yet to be fully addressed by Canadian courts, various cases *have* addressed relationships among health-care professionals who are involved in the provision of care to the same patient. These court decisions considered issues related to the obligations of health-care professionals to communicate and work with others involved in patient care. The following section summarizes relevant cases, from both Canada and the United States, and the key legal principles that are articulated. In addition, strategies are highlighted that can support health professionals in collaborative settings to effectively control liability risks.

DETERMINING STANDARD OF CARE

Canadian courts have had to address negligence claims in situations where a variety of professionals, all operating within separate spheres of expertise and knowledge, have participated in patient care and may have contributed to some degree in causing a patient's harm. As stated in the previous chapter, courts assess the standard of care expected from individual health professionals in accordance with the skills and knowledge of their professional peer group. Based on existing Canadian case law, it seems likely that courts will continue to assess standard of care on an individual basis, and it is improbable that courts will apply a standard that exceeds the examined professionals' scope of practice.

In cases of overlapping scopes of practice, courts will likely look to the professions for expert advice, so they must agree on new roles and responsibilities.

An Alberta case, *Misericordia Hospital v. Bustillo*,[1] clearly exemplifies this point. In this case, the court assessed liability among a surgeon, a nurse, a pharmacy and a hospital. The surgeon noticed foam at the top of a solution he was about to use during a cataract operation. He asked a nurse to hold up the bottle, which she did, but he failed to note that the bottle was for a product other than what he intended to use. The surgeon carried on administering the solution; the patient was harmed and then sued for compensation. In considering apportionment of liability, the court observed that "[t]he doctor was the only person in the operating theatre who knew the properties of Eye Stream (the solution that was wrongly applied to the patient). He knew that it was totally unsuited to the purpose for which he intended to use it. Neither the pharmacist nor the nurse had this knowledge."[2] This case indicates that courts are likely to establish the knowledge various professionals are expected to have and pass judgment based on this. They will be reluctant to impute knowledge or skills that are outside the standard of care expected from a particular professional.

In cases of overlapping scopes of practice, courts will likely look to the professions for expert advice. Therefore, it is critical for the different professions to agree on roles and responsibilities, including new and expanded ones. In *Atcheson v. College of Physicians and Surgeons*,[3] a family medicine clinic in Fort McMurray hired a nurse to perform functions typically associated with nurse practitioners (NPs). The nurse had advanced training in a nurse practitioner program and a Master of Health Science degree in health-care practice; however, at the time, the Province of Alberta did not recognize the title of "nurse practitioner." Nonetheless, both the nurse and the clinic advertised her services using that term. Concerned about liability issues, a physician at the clinic wrote to the College of Physicians to request approval of the physicians' working relationship with the nurse.

The Deputy Registrar of the College instructed the physicians to terminate this arrangement. Specifically, the NP "[was not to] see patients as a nurse practitioner [and] must not make independent diagnosis and management decisions with or without supervision." And "there must be no billings to the Alberta Health Care Insurance Plan for services which she has rendered." Instead of complying with this, the clinic terminated the nurse's employment. In turn, the nurse brought legal action against the College, alleging that it unlawfully induced the physicians to breach their contract with her. In this case, the court noted that "there are overlapping functions for physicians and nurses. Both professional organizations are aware of the tension at the interface and are studying the problem and looking for a resolution of it. *It is not appropriate or necessary for this court to attempt to do so*. The professions must work this out. Perhaps a change in the legislation will follow."[4] Interestingly, the Alberta government now has legislation in place that regulates nurse practitioners and protects their title. This case highlights the

1 [1983] A.J. No. 270 (C.A.).

2 Ibid., para. 9.

3 [1994] A.J. No. 151 (Q.B.) [emphasis added].

4 Ibid., para. 12 [emphasis added].

importance of engaging the health professions in a frank dialogue to determine agreed-upon roles their members play, particularly in new health-care delivery models.

ARE THERE CIRCUMSTANCES WHERE UNIFORM STANDARDS MIGHT BE APPLIED TO VARIOUS HEALTH PROFESSIONALS?

There *are* circumstances where uniform standards might be applied to various health professionals. A given act may be within the scope of duties of care of various professions, depending on the facts, accepted clinical practices and special conditions. Expert testimony is often used to determine the standard of conduct for the professionals involved. The following are examples of such situations.

Shared knowledge areas—when the harm or error results from actions that are within the knowledge area of various health professionals. The British Columbia case of *Reynard v. Carr*[5] illustrates this situation. In this case, the patient, Reynard, was diagnosed with ulcerative colitis by Dr. Carr, a specialist in gastroenterology. Reynard also received care from a general practitioner (GP), Dr. Wagner. Dr. Carr prescribed prednisone for Reynard, a steroidal drug that in time caused him to develop serious bone disintegration (avascular necrosis). He eventually underwent joint replacement surgery of both shoulders and hips.

There *are* circumstances where uniform standards might be applied to various health professionals.

Reynard alleged that his specialist and GP failed to communicate properly to him regarding his medication dosages and also failed to warn him because of their own ignorance of the drug's possible side effects. In its decision, the British Columbia Supreme Court considered the duty and standard of care that both physicians owed to Reynard. The court ruled that the higher standard of care expected of the specialist "does not particularly matter because as a GP, Dr. Wagner ought to have known prednisone attacks the bone structure."[6] In other words, the Court did not in fact apply a higher standard of care to the GP; rather, it ruled that knowledge of side effects of this drug falls within the standard of care one expects from a reasonably competent GP.

Overlapping scopes of practice—when regulation and (or) legislation permit overlapping scopes of practice for various health professionals. In the U.S. case of *Fein v. Permanente Medical Group*,[7] Lawrence Fein brought a negligence action against the Permanente Medical Group for alleged failure to diagnose a heart attack in a timely manner. Mr. Fein experienced intermittent chest pain over a period of several days and attended at the Permanente Medical Group for examination. A nurse practitioner examined him, left the room to consult with a physician, returned and advised the patient that she and the physician believed he had a muscle spasm. She gave him a prescription for Valium written by the physician. Less than 24 hours later, Mr. Fein returned to emergency where he had an electrocardiogram (EKG) that revealed he was experiencing acute myocardial infarction.

Among other negligence issues, the claim asserted that the nurse practitioner was negligent in not taking steps to procure an EKG when Mr. Fein first attended the clinic. At trial, the judge instructed the jury that a nurse's conduct in examining a patient or making a diagnosis must be judged against the standard of care of a physician. Specifically, the court instructed that "the standard of care required of a nurse practitioner is that of a physician and surgeon duly licensed to practice medicine in the state of California when the nurse practitioner is examining a patient or making a diagnosis." On appeal, the court ruled this instruction was incorrect as it "is inconsistent with recent legislation setting forth general guidelines for services that may properly be performed by registered nurses in this state."[8] However, the court cited a California statute that "recognize[s] the existence of overlapping functions between physicians

5 (1983), 50 B.C.L.R. 166.

6 Ibid., para. 103.

7 38 Cal. 3d 137, aff'd 474 U.S. 892 (1985).

8 Ibid,, para. 19.

and registered nurses and . . . permit[s] additional sharing of functions within organized health care systems which provide for collaboration between physicians and registered nurses."[9] Since California statute law permits nurses to examine patients, then examination and diagnosis "cannot in all circumstances be said—as a matter of law—to be a function reserved to physicians, rather than registered nurses or nurse practitioners."

Different factors—shared knowledge areas, overlapping scopes of practice, and shared clinical guidelines—impact health professionals' liability risks as part of a team.

Shared broad clinical guidelines—when widely accepted clinical guidelines that govern diagnostic and treatment protocols are the basis to establish standard of care. The case of *Kennedy v. United States*[10] exemplifies this situation. This case involved a negligence claim against a family practice clinic operated on a U.S. Air Force base. Mrs. Kennedy had detected a lump in her breast and attended the clinic to see her physician. The physician was unavailable so Mrs. Kennedy agreed to be examined by a primary care nurse practitioner, who confirmed the presence of a lump. The nurse practitioner called in two physicians who advised Mrs. Kennedy to have a mammogram to check for cancer, but suggested she need not worry. Mrs. Kennedy saw an independent radiologist for a mammogram and was advised that everything looked fine. She returned to the clinic four months later complaining that the lump had grown. A physician examined her and ordered a repeat mammogram, which was negative.

Fourteen months later, Mrs. Kennedy again visited the clinic because the lump continued to enlarge. A physician ordered a biopsy, which confirmed the presence of cancer. She underwent a mastectomy, but the cancer had metastasized. At the time of the court ruling, Mrs. Kennedy was 48 with a very poor prognosis for survival.

Ruling in Mrs. Kennedy's favour, the court stated: "Medical testimony unequivocally establishes that the standard of care relevant to the diagnosis and treatment of breast lumps is uniform. Thus, the standard of care is the same for family practitioners, internists, oncologists and surgeons." The court elaborates that the standard of care requires a biopsy of a suspicious lump and it is a "gross deviation from the relevant standard of care" to rely only on mammography. The court does not specifically state that the nurse practitioner must meet this "uniform" standard of care, but the court does refer globally to the failures of the clinic personnel and cites testimony from the nurse practitioner about the practices at the clinic in regard to relying on mammogram results.

WHAT ABOUT RELYING ON OTHERS TO PERFORM THEIR RESPONSIBILITIES PROPERLY?

Where more than one health professional is involved in providing care for a patient, they should all be able to rely on each other to appropriately carry out tasks within their scope of responsibility. And courts recognize this.

In *Granger (Litigation Guardian of) v. Ottawa General Hospital*,[11] the court examined an obstetrical negligence claim that involved numerous individuals, including staff physicians, interns, residents and obstetrical nurses. In its decision, the court emphasized the critical importance of a team approach to providing care for patients:

> [O]ne of the hallmarks of the Canadian health system in a tertiary care hospital such as the Ottawa General, with all of its attendant teaching responsibilities, is that those involved in obstetrics work as a team and that the interaction between members of that team is vitally important, particularly in terms of reliance on one another, for the provision of accurate information.[12]

9 Ibid., para. 19. The court referred to the *Business and Professions Code*, s. 2725.

10 *Kennedy v. U.S.* 750F. Supp 206 (1990).

11 [1996] O.J. No. 2129 (Gen. Div.).

12 Ibid., para. 32.

Although this statement emphasizes teamwork in often complex situations like obstetrics, the underlying point is applicable to any situation where health professionals work together to provide care for patients. Furthermore, the court went on to stress the need for care professionals to be able to rely on one another to carry out their own duties within an appropriate standard of care:

> . . . I have little doubt that our system of health care, with its obvious concerns for patient care as well as its defined budget considerations, could not function in any other way. We simply do not have the financial resources to enable every professional to double check the work of other professionals and because each professional within the obstetrical team has a defined role, it is essential that each person's role be carried out within a standard of care and training appropriate to the professional involved.[13]

WHAT HAPPENS IF THERE IS CONFUSION OR RESISTANCE REGARDING A RESPONSIBILITY?

Acknowledging personal limits. Health-care professionals must recognize when a patient's needs are beyond their competence and when consultation with, or referral to, another professional is necessary. Patients, other professionals and administrators cannot expect professionals to exceed their scope of expertise. Here is where having a team of colleagues to support the day-to-day work is key to providing adequate care, along with supporting a culture of continuous learning.

There are, however, some risks related to *inappropriate delegation of duties*. Other risks related to roles and responsibilities within a team are introduced by *abdication of responsibility*. These risks are more likely to occur in team-based health-care practices, but they can be easily controlled with appropriate policies.

13 Ibid., para. 32.

Inappropriate delegation of duties. This occurs when a health-care professional has primary responsibility for given tasks, but relies on another professional who does not have the necessary knowledge or skill to properly carry them out. For example, in *Semeniuk v. Cox*, a patient sued Dr. Cox, a gastroenterologist, for injury sustained during surgery to repair a tear in her stomach following a stapling procedure. In this case, the physician relied on a nurse to explain the potential risks and complications of gastroplasty.[14] The court found that Dr. Cox should have discussed risks and benefits of the revision surgery directly with Ms. Semeniuk and that had this happened, Ms. Semeniuk might have selected a different approach to her care.[15]

Health-care professionals must recognize when consultation with, or referral to, another professional is necessary.

Abdication of responsibility. This occurs when professionals may inadvertently (or even deliberately) abdicate their professional responsibilities toward a patient. This risk has been described as a type of "group think," that is, "collaborative decision-making may falsely reduce the sense of individual responsibility for decisions and patient care."[16] The following reasons, among others, have been described to explain why professionals might shift decision-making to other members of the team:

- The social benefits of team membership (enmeshment);
- Fear of losing the respect of fellow team members or even of losing one's job;
- A desire to avoid conflict; and
- A lack of power in the team hierarchy.

Despite the fact that various professionals might be involved in caring for the same patient, each person must fulfill their own professional obligations.

14 *Semeniuk v. Cox*, (2000) A.J. No. 51 (Q.B.) at para. 9.

15 Ibid. See paras. 13, 14.

16 Helen M. Sharp, "Ethical Decision-Making in Interdisciplinary Care," *Cleft Palate-Craniofacial Journal* 32, 6 (1995), p. 496.

Confusion about who is responsible. How health professionals perceive their role in a team is directly related to the risk of potential abdication of responsibility. One study examined how dietitians and physicians saw each of their responsibilities in caring for patients with renal disease.[17] It found "a serious discrepancy between the expectations of the dietitian role, as perceived by dietitians and physicians, and the prudent professional behaviour required under malpractice jurisprudence."[18] In examining roles of various health professionals, the author speculated that dietitians are uniquely qualified to be the nutrition authority who takes an active and key role in dietary management of patients; yet, the survey study discovered that "the majority (two-thirds) of dietitians believed they ought to follow the physician's dietary orders without question or adaptation."[19] The authors suggest that dietitians may be intimidated more by immediate reprisals of lost jobs for insubordination (i.e., challenging physicians' orders) than by fear of abstract legal penalties for either causing, or failing to avert, patient harm.

WHAT CAN A HEALTH PROFESSIONAL DO TO MITIGATE THESE RISKS?

Members of interdisciplinary collaborative teams need to understand their individual responsibilities and role within the team. Furthermore, team members need to establish clear processes for decision-making. This is fundamental for effective and safe interdisciplinary work.

The following strategies will significantly decrease the risk of liability in interdisciplinary groups. They will be discussed further below.

- The team follows *policies* that clearly articulate the shared understanding of the roles. All team members know, support and practise these policies.
- Team members have *strong communication practices* in dealing with each other and with patients/clients and their families.
- Team members consistently *inform patients/clients* as to the roles that all health professionals will have in their care.
- Team members ensure that patients/clients give *informed consent* to the proposed treatments.

Role of policies. In interdisciplinary health-care groups, policies can confirm and clarify scopes of practice and lay out appropriate roles for each professional. It has been said that "[t]he best initiatives for quality care and against liability [in collaborative practice] are written guidelines."[20] Policies can be used to demonstrate standards of conduct for health professionals and "may serve as a potent defense to claims of malpractice liability."[21] However, compliance with an organizational policy does not necessarily immunize a professional from liability as policies themselves can be inadequate.

In interdisciplinary health-care groups, policies can confirm and clarify scopes of practice and lay out appropriate roles for each professional.

Policies must be enforced and evaluated to be useful in managing liability risks in interdisciplinary settings. This may be accomplished through health professional meetings to discuss how policies are working in practice. Also, allowing opportunity for health professionals to openly ask questions and raise concerns related to the existing policies will not only increase the rate of compliance, but will also support consistency in patient care and strengthen the team.

17 Dorothy G. King, "Interdisciplinary Perceptions of the Dietitian's Legal Responsibility for Lethal Dietary Prescription Errors for Patients with End-Stage Renal Disease," *Journal of the American Dietetic Association* 93,11 (1993), p. 1269.

18 Ibid.

19 Ibid.

20 F. Trilla and A. Patterson, "Physicians and Nurse Practitioners in Collaborative Practices," *Harvard Risk Management Foundation Forum* (Winter 1998), p. 9.

21 Robert E. Ratner and Elizabeth Ritter El-Gamassy, "Legal Aspects of the Team Approach to Diabetes Treatment," *The Diabetes Educator* 16, 2 (1990), p. 116.

Strong communication practices. While communicating clearly with the patient/client is critical, equally important is diligent and efficient communication with other health-care professionals who are involved in the patient's care. Failure to do this may result in liability.[22] Ensuring appropriate communication is the only way to "make sure that no procedure or precaution has been overlooked because every physician [or other health professional] involved has assumed that 'someone else has done it.'"[23]

Maintaining a complete and accurate health-care record is essential for effective communication, particularly when various professionals are involved in patient care. Medical records have been described as "witnesses whose memories never die" and compulsive, legible, timely and accurate record-keeping is "the single best defensible mechanism for avoiding professional liability loss."[24]

Informing patients/clients and ensuring their consent. As mentioned before, health-care professionals should disclose their professional affiliation and their role in the patient's care as part of the informed consent process. A consent form could be used to cover the various health professionals who will participate in the patient's care. It should be signed on an initial visit, after explaining to the patient that various professionals will be involved in providing care, explaining the role of each professional, and disclosing the team's communication process (e.g., who will have access to the patient's information). It should be noted, however, that obtaining consent is a continuing process involving more than having the patient sign a form. Health professionals must meet ongoing obligations to disclose information to patients.

Obtaining consent is a continuing process involving more than having the patient sign a form.

CONCLUDING REMARKS

The existing case law suggests that courts do recognize that health professionals have new roles and responsibilities and that those roles might overlap in collaborative settings. As some health professionals expand their scopes of practice, concerns arise about the standard of care these professionals will be held against in the event of liability. This study concludes that courts are likely to continue to assess standard of care on an individual basis and would be unlikely to apply a standard of care to professionals that exceeds their scope of practice.

Health professionals need to be aware that courts recognize the critical importance of a team approach and the need for professionals to rely on each other for the provision of care to patients. However, health professionals also need to be aware that there are some risks related to inappropriate delegation of duties and abdication of responsibility. To mitigate these risks, members of interdisciplinary collaborative teams must understand their individual responsibilities and role within the team. Policies can confirm and clarify scopes of practice, lay out appropriate roles for each health professional, and establish strong communication processes within the team and between the team and the patients.

22 John C. Irvine, "Medical Negligence in Specific Contexts." In Barney Sneiderman, John C. Irvine and Philip H. Osborne (eds.), *Canadian Medical Law: An Introduction for Physicians, Nurses and Other Health Care Professionals*, 3rd ed. (Toronto: Carswell, 2003), p. 149.

23 Ibid.

24 Curtis L. Cetrulo and Lawrence G. Cetrulo, "The Legal Liability of the Medical Consultant in Pregnancy," *Medical Clinics of North America* 73, 3 (1989), pp. 562–563.

CHAPTER 5

Health-Care Organizations Face Some Risks, But Need Not Panic

Chapter Summary

- Institutional liability poses no significant barrier to interdisciplinary collaboration in any health-care institution.
- Institutions that employ or retain health professionals who work collaboratively can implement a set of policies to decrease their institutional liability risks.
- Assuming health-care institutions consistently implement these practices, they should be no more vulnerable to liability than any health-care institution whose employees or independent contractors do not work collaboratively.

Health-care professionals who work together in a collaborative way often do so in health-care institutions, such as hospitals, community health centres and family health groups. This chapter examines the liability risks of these health institutions.

Health-care institutions can face *direct* liability for their own negligent acts or *vicarious* liability for the acts of their employees (discussed in the next chapter). Institutions may also be liable for breach of contract since a contractual relationship between facility and patient may be implied and, in some cases, explicit. However, negligence claims are far more common than claims based on breach of contract, so this chapter addresses the former.[1]

In claims against an *institution*, *patients* must establish that the defendant owed them a *duty of care* and breached the *standard of care*, among other criteria.

A patient who brings a negligence claim against an *institution* must establish the same criteria discussed earlier for *individuals*. As well, there are other obligations specifically relevant to the institution. Picard and Robertson, authors of a leading Canadian text on the liability of physicians and hospitals, identify four key duties a health-care institution owes to its patients:

- To select competent staff and to monitor their continued competence;
- To provide proper instruction and supervision;
- To provide proper facilities and equipment; and
- To establish systems necessary for the safe operation of the hospital [or health-care organization].[2]

1 For further discussion of the contractual relationship between institution and patient, see Ellen I. Picard and Gerald B. Robertson, *Legal Liability of Doctors and Hospitals in Canada*, 3rd ed. (Toronto: Carswell, 1996), pp. 365–366.

2 Ibid., p. 367.

Furthermore, if an institution has teams of professionals working together to deliver health-care services, the institution has a legal obligation "to ensure that proper co-ordination occurs and that the treatment program operates as a unified and cohesive whole."[3] As well, health-care institutions have a *direct obligation* to patients to provide an environment for safe and appropriate care and may be held *indirectly* liable for the negligence of any employee.

Some have argued in favour of expanding the liability of health-care institutions to deter substandard practices and promote quality improvement. For example, the 1990 Prichard Report recommended "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 . . . ."[4] However, as Prichard emphasizes, augmenting institutional liability should not diminish "the full individual responsibility of all health care professionals working in the institutions."[5]

Breach of institutional policy. When health-care institutions develop policies to establish multidisciplinary approaches to delivering care, liability risks often centre on the implementation and enforcement of those policies. As stated above, institutions should take care to develop appropriate policies and, once they have done so, to ensure that performance complies with policies. Two examples will be presented to exemplify this statement.

The first example, a recent New Brunswick Court of Appeal decision, *Comeau v. Saint John Regional Hospital*,[6] highlights important institutional responsibilities. In this case, the Saint John Regional Hospital established a policy stipulating that all patients must be discharged from the emergency department (ED) by an ED physician, even if the patient had been referred to a specialist. Comeau, a patient who attended the ED, was examined first by an ED physician, then by internal medicine specialists. Against hospital policy, an internist discharged the patient without going through the ED physician. Comeau later died, and the hospital and physicians were sued for negligence in misdiagnosing his condition and failing to provide appropriate care.

Institutions should take care to develop appropriate policies and, once they have done so, to ensure that performance complies with policies.

Specifically in regard to institutional liability, the court ruled that the hospital had failed to see that the discharge policy was followed: ". . . the Hospital was negligent in not enforcing its own policies designed to ensure better patient care by failing to adopt adequate measures to ensure that the medical staff using its facilities operated as a cohesive whole towards achieving the targeted higher standard of care."[7] This statement clearly applies to situations where institutions adopt measures to promote collaborative team-based care.

In the second example, *Crandell v. Adams*,[8] a patient shaved his own abdomen before surgery, which was contrary to pre-surgery protocol that required nursing staff to shave hair and inspect a patient's skin before surgery. The patient scratched his skin repeatedly while shaving himself, which made him vulnerable to infection. After surgery, he developed a serious and uncontrollable infection that killed him. In a negligence claim against the nurses, surgeon and hospital involved in the patient's care, the court accepted that his death was directly related to improper pre-surgical skin preparation. The court dismissed the action against the surgeon, but found direct liability against the nurses and vicarious liability against the hospital.

In regard to the hospital's liability, the court stated: "A multi-tiered chain of responsibility expects compliance with the rules and regulations. Such a system also

3 *Lachambre v. Nair*, [1989] 2 W.W.R. 749 (Sask. Q.B.).

4 J.R.S. Prichard, *Liability and Compensation in Health Care: A Report to the Conference of Deputy Ministers of Health of the Federal/Provincial/Territorial Review on Liability and Compensation Issues in Health Care* (Toronto: University of Toronto Press, 1990), p. 26, Recommendation 31.

5 Ibid.

6 *Comeau v. Saint John Regional Hospital*, [2001] N.B.J. No. 450 (N.B.C.A.) (QL).

7 Ibid., at para. 4.

8 (1993) 110 Nfld. & P.E.I.R. 22 (Nfld. S.C.T.D.).

contemplates a certain amount of checking and positive reinforcement to ensure that the protocol is followed."[9]

This last statement emphasizes the importance of proper monitoring to ensure that health professionals working in a collaborative setting comply with any policies and protocols that are established to ensure appropriate patient care. Of course, the two previous examples involve hospitals, where professionals often deal with extremely acute health conditions and perform serious interventions. One would reasonably expect that these institutions would have a higher risk for liability than would primary health-care organizations, which do *not* deal with similarly high-risk and emergency situations.

Because they deal with high-risk and emergency situations, hospitals naturally have a higher risk for liability than primary healthcare organizations.

LEGAL RELATIONSHIPS—A REMINDER

Two Canadian health law experts have observed that the trend toward the multidisciplinary approach to treatment mandates analysis of the legal status of relationships among persons involved in collaborative practice.[10] Health-care professionals may operate in collaboration through various legal structures, including professional corporations and partnerships, and the nature of these legal relationships may have implications for professional liability.

A corporation is a legal entity just like a person. And just like people, corporations can be sued in civil courts and prosecuted for criminal or quasi-criminal conduct. Partnerships are formed by two or more legal entities. In these cases, if one partner commits an act of negligence and is sued, then all of the partners can be sued and found liable for that negligence.

9 Ibid., para. 72.

10 Picard and Robertson, *Legal Liability.*

While analysis of the array of laws and regulations that govern these various structures is beyond the scope of this report, several points are worth noting:

- **While health-care professionals may be permitted to practise through professional corporations, this will not limit their individual liability.** Legal rules may stipulate that care professionals remain liable for professional negligence, whether they practise in their personal capacity or through a corporation. For example, Ontario's *Business Corporations Act* states that "[t]he liability of a member [of a health profession] for a professional liability claim is not affected by the fact that the member is practicing through a professional corporation."[11]
- **Incorporation does not diminish individual obligations owed to patients.** For instance, Ontario's *Health Professions Procedural Code* states: "The professional, fiduciary and ethical obligations of a member to a [patient] are not diminished by the fact that the member is practicing through a health profession corporation."[12] If a team is incorporated, it will be subject to direct liability and vicarious liability risks.
- **Partnerships do not decrease individual responsibility and may even increase it.** Every partner in a partnership can be held jointly or severally liable for damages awarded against any one partner. Health professionals practising in partnerships are therefore liable for negligence of their partners.[13] Therefore, each partner can potentially be required to pay the full amount of a damage award even if they were not directly responsible for the negligence.

Limited partnerships, on the one hand, are a less risky alternative to general partnerships for health professionals. In the event that the partnership is sued, a limited partner is liable only for the amount that they initially contributed to the partnership. They would therefore stand to lose only this amount. On the other hand, there are disadvantages to being a limited partner. The limited partner has no control over the operation of the partnership and their

11 *Business Corporations Act*, R.S.O. 1990, c. B.16, s. 3.4(3).

12 *Health Professions Procedural Code*, s. 85.11.

13 See for example *Partnerships Act*, R.S.O. 1990, c. P.5; *Partnership Act*, R.S.B.C. 1996, c. 348.

name cannot appear in the name of the partnership. Also, a limited partnership cannot be exclusively composed of limited partners—there must be at least one general partner.

CONCLUDING REMARKS

Institutional liability poses no significant barrier to interdisciplinary collaboration in any health-care institution, including those in the primary health-care sector. Institutions that employ or retain health professionals who work collaboratively can implement a set of policies to decrease their institutional liability. These policies should aim to ensure the following practices:

- Health-care professionals must act according to the standards of practice of their professions and comply with their respective regulatory colleges.
- Policies are in place to guide interdisciplinary care and all health professionals are aware of them. Specifically, these policies need to clarify roles and responsibilities and processes related to communication, decision-making and patient management within the team approach.
- The organization has malpractice liability insurance that covers the organization and its employees (e.g., direct liability, vicarious liability).
- All professionals have appropriate malpractice liability insurance/protection. Institutions should reinforce this during annual performance reviews or appraisals.

Assuming health-care institutions consistently implement these practices, they should be no more vulnerable to liability than any health-care institution whose employees or independent contractors do not work collaboratively. Many organizations following these guidelines have successfully implemented interdisciplinary practices for decades and have had no problems with malpractice liability.[14]

14 Enhancing Interdisciplinary Collaboration in Primary Health Care Initiative, *Interdisciplinary Primary Health Care: Finding the Answers—A Case Study Report* [online]. (August 2006). www.eicp-acis.ca/en/toolkit/EICP-Case-Studies-Report-Final-Aug-14.pdf.

CHAPTER 6

Interdisciplinary Collaboration and Liability—A Double-Edged Duo

Chapter Summary

- The number of legal actions brought against physicians and nurses has decreased over the past 10 years in Canada.
- Awards settlements are higher, but this seems to be a worldwide phenomenon that can hardly be attributed to collaborative health care.
- Health professionals' vulnerability to liability depends less on whether they work in collaborative practices than on three other major factors: their own competency, system problems and other work factors (e.g., area of specialization, geographic location).
- Professionals who work in interdisciplinary practices face increased risk of joint and several liability. Also, they may face liability when they employ other health professionals (vicarious liability) or supervise others.
- These risks can be appropriately managed by knowing and complying with the legislation governing health professionals, ensuring that all members of the team and the institution have adequate professional liability protection, avoiding implementing policies that may unnecessarily increase liability risks, complying with policies that guide their practices, and ensuring adequate supervision of the staff.

Some commentators—both health-care professionals and lawyers—have expressed concern that collaborative care might lead to increased liability. This is already a hot topic in the United States, where the American Medical Association keeps a vigilant tab on the number of states "in crisis" regarding liability issues. In Canada, the Health Council of Canada reported a perception that the shift to more collaborative practice may leave individuals vulnerable to disciplinary or legal action on the basis of team decisions.[1]

This chapter argues that, although working in collaboration may increase risks (e.g., regarding joint and several liability), it is unlikely to result in a liability crisis.

RECENT TRENDS IN LIABILITY IN CANADA

In 1990, J. Robert Prichard tabled a report[2] that studied trends in liability in health care and liability among Canadian health-care providers from the 1970s to the late 1980s. Overall, this report found an increase in civil liability claims filed against physicians and health-care institutions. Explanations for this increase included increasing utilization of hospitals, a growing willingness

1 Health Council of Canada, *Modernizing the Management of Health Human Resources in Canada: Identifying Areas for Accelerated Change* [online]. (2005). www.healthcouncilcanada.ca/docs/papers/2005/HCC_HHRsummit_2005_eng.pdf.

2 Prichard, *Review on Liability.*

on the part of patients to sue, higher damage awards and more expertise of lawyers in representing patients. Interestingly, despite the growth in claims during this time period, the report found that fewer than 10 per cent of people with potentially viable claims had received compensation.

Much of the debate about extending NPs' scope of practice was that it would lead to more negligence claims being made. So far, this has not been the case.

However, the number of liability cases has been on the decline in Canada over the past 10 years. According to annual reports from the Canadian Medical Protective Association (CMPA), there was an increase in lawsuits in the early 1990s, which peaked in 1996 at 1,415. *Since 1996* there has been a gradual decrease in the number of medico-legal claims.[3] This includes a decrease in the number of settlements and court awards as well as a decrease in the number of claims made. *In 2004*, the CMPA reported 1,083 new legal actions against CMPA members, a 3 per cent decline from the previous year. Of the 104 actions that proceeded to trial, the plaintiff (patient) lost in the majority of cases (83 per cent). *In April 2006*, the CMPA issued a publication on malpractice trends noting that "[t]he number of new legal files opened annually on a national basis by the CMPA is on a discernible downward trend."[4] However, legal defence costs remain relatively constant, reflecting the complexity and time involved in medical malpractice litigation.

And what is the experience of other health professionals? The Canadian Nurses Protective Society (CNPS) reports similar trends since 1995. Nurses have been involved in fewer than 70 lawsuits since 2004. CNPS indicates that nurse practitioners "were involved in 1.6 per cent of the lawsuits and 2.1 per cent of all occurrences reported to CNPS between 1997 and 2001."[5] This low rate is corroborated by statistics from the United States, which "indicate that malpractice payments for nurses have been rare (1.8 per cent of all payments), of which nurse practitioners were responsible for only 6.7 per cent and advance nurse practitioners were responsible for 0.2 per cent of all nursing payments."[6]

Looking at the annual decrease in claims becomes particularly interesting after 2003, at which point the majority of provinces had introduced legislation regulating nurse practitioners. Much of the debate about the extension of the scope of practice for nurse practitioners was that it would lead to more negligence claims being made. So far, this has not been the case.

There is not enough data on liability cases involving pharmacists, occupational therapists, physiotherapists, dietitians, speech-language pathologists, audiologists and social workers to assess if they are also experiencing a downward curve. However, these professionals are involved in very few cases annually, and just a handful reaches the Canadian courts. In fact, as reported by the Canadian Psychological Association, legal claims against psychologists have remained constant over time despite an increase in the number of practitioners, which supports the conclusion that, *proportionally*, liability cases against these professionals are also experiencing a downward trend.

While the number of actions has decreased over the years, the size of the awards and settlements has increased. In 1995, the CMPA paid an average of $181,281 per claim, but by 2002 that number had increased by 50 per cent to $273,500.[7] In 2003, the highest award ever for medical malpractice in Canada was made in the case of *Crawford v. Penney*.[8] In that case, a young woman was awarded damages of $9.5 million because she sustained catastrophic injuries during her birth that resulted in her

3 The Canadian Medical Protective Association, "Supporting Health Care: 2005 CMPA Annual Report" [online]. [Cited October 4, 2006]. www.cmpa-acpm.ca/cmpapd02/cmpa_docs/english/resource_files/admin_docs/common/annual_reports/2005/pdf/com_annual_report-e.pdf.

4 Quoted in Matt Borsellino, "Ongoing Effort Needed to Balance and Maintain Malpractice Model," *Medical Post* 42, 16 [online]. (2006). www.medicalpost.com/mpcontent/article.jsp?content=20060501_175225_4304.

5 InfoLAW, *Nurse Practitioner* 12, 1 (February 2003).

6 National Practitioner Data Bank, *2003 Annual Report,* U.S. Department of Health and Social Services [online]. www.npdb-hipdb.hrsa.gov/pubs/stats/2003_NPDB_Annual_Report.pdf, p. 20.

7 CMPA, 1995–2002 Annual Reports [online]. [Cited October 4, 2006]. www.cmpa-acpm.ca.

8 2004 CanLII 22314 (ON C.A.).

being severely disabled. Two physicians were found to have been negligent in the case. In fact, it seems that the majority of the substantial awards have been given in cases where physicians were found solely liable. Therefore, it appears that interdisciplinary care is unlikely to have been the cause of this increase in the size of awards.

The phenomenon has been an international experience and has been most marked since the year 2000. In 2002, this dramatic increase in payouts caused the near collapse of UNITED Medical Protection, Australia's largest medical malpractice insurer. The insurer ultimately came out of insolvency, but physicians in Australia were left without insurance for a period of time.

KEY SOURCES OF LIABILITY RISKS

Health professionals' vulnerability to liability does not seem to depend primarily on whether they work in collaborative practices. Rather, it depends more on factors such as their own competency and systems problems that could result in adverse events (e.g., inadequate training of health-care staff, lack of patient engagement in care, poor adherence to standard operating procedures). Also relevant are other work-related factors such as the professional's area of work or specialization and geographic location. Given the relevance of the latter two, they are further explained below.

Their area of work or specialization. Risks related to the area of work are evident within the practice of medicine. General practitioners are more likely to be sued if they practise obstetrics and emergency work. In general, obstetrics, psychology/psychiatry and neurosurgery carry more risk of liability.

There are also some discrepancies related to specialization across health professions. Health professionals who make significant decisions in the care of patients bear the consequences of that responsibility in the way of complaints, claims and lawsuits when things go wrong. Consider the disparity between the number of claims and lawsuits brought against nurses and those brought against physicians. Based on CNPS statistics, over a two-year period (2004 to 2005), fewer than 70 lawsuits were initiated against nurses. By way of comparison, 900 lawsuits were brought against physicians in 2005 alone. This disparity is greater when one considers the fact that there are at least three times as many nurses in Canada as there are physicians.

Their geographic location of work. Certain jurisdictions within Canada have a higher frequency of complaints than others. For example, physicians in Ontario carry more risks than their colleagues in other provinces.

In cases of joint and several liability, co-defendants with "deep pockets" may seem more attractive to pursue, regardless of their assigned degree of fault.

Joint and several liability. In addition to direct liability, participation in interdisciplinary practices carries risks of joint and several liability. When a patient files a legal action claiming harm resulting from care and treatment, the patient will often name as defendants all the individuals and institutions involved in their care. Joint and several liability occurs when a court finds that more than one party was at fault in causing a patient's harm. In such cases, the patient may recover *all the damages from any of the defendants regardless* of their individual share of the liability. This is significant because co-defendants with "deep pockets" might be considered more attractive to pursue, regardless of their assigned degree of fault.

Health professionals interested in participating in interdisciplinary practices need to be aware of the risks present in all arrangements governing a legal relationship between professionals and plan accordingly. One way to protect everyone—health professionals, health-care institutions *and* the patients—is to ensure that all members of the health-care team and the institution have adequate liability protection.

Through eight interviews conducted for this research study, most of the health professional malpractice insurers and protective organizations reported that they knew of no claims or actions involving collaborative health care. One organization was a notable exception; it indicated that

almost every case in which it was involved entailed more than one discipline. However, it recognized that in the end, liability is assessed against individuals, not against the team. Another interviewee predicted that, given that patients tend to name everyone in law suits (risk of joint and several liability), a health professional's chances of being named as a defendant in a lawsuit might increase because of collaborative practice. However, he also predicted that claims are more likely to decrease because this model of care seems more efficient and safer and might lead to higher-quality patient care and increased patient satisfaction.

WILL I BE LEGALLY RESPONSIBLE FOR THE ACTS OF OTHERS?

Some jurisdictions, such as the United States, have applied a legal rule known as the "captain-of-the-ship" doctrine to hold physicians responsible for acts of all those working with a physician in a particular setting.[9] This doctrine, which originated in the late 1940s in Pennsylvania, was introduced in an era when many hospitals, because of their charitable status, were not involved in lawsuits. With the exception of physicians, health professionals carried little, if any, insurance coverage at the time. Consequently, attending physicians represented the only source from which negligently injured plaintiffs could be compensated.[10]

This type of doctrine no longer fits the current environment of health-care delivery; it is particularly inappropriate for an interdisciplinary team approach to health care where professionals work collaboratively and are recognized as having their own professional status. In addition, the majority of health professionals, if not all, now have professional liability insurance or protection. As the Prichard Report observed:

> [W]e must recognize that the provision of high quality health care is often a team responsibility, drawing upon multiple inputs of which physicians' services are but one. While at an earlier date the physician may have been properly understood as acting alone in the provision of medical services, there can be no doubt that modern medicine depends on both highly professional individuals and well-organized teams of properly equipped health care professionals.[11]

Nonetheless, there may be specific circumstances when one health professional is responsible for acts of another. These may be situations where *professionals employ others or are responsible for the supervision of others, or when institutional policies dictate hierarchies of accountability.* A discussion of these situations follows.

The "captain-of-the-ship" doctrine may no longer apply, but there are specific circumstances when one health professional is responsible for the acts of another.

Health-care professionals employing others. Health professionals may face liability when employing other health-care professionals. This is known as v*icarious liability*. This type of liability arises when an employer—whether an organization or an individual—is held legally responsible for the negligent acts of its employee, if the negligent act occurs within the scope of the employee's duties. If an employee exceeds the scope of their employment and harms a patient by negligence, the employer may also be found vicariously liable if it is established that the employer provided the opportunity to the employee to commit the wrong.

This doctrine has been criticized as it appears to hold parties responsible for harm simply because they have "deep pockets" or an ability to bear the loss even though they are not directly at fault.[12] However, the Supreme Court of Canada has said that vicarious liability "provides a just and practical remedy to people who suffer harm as a consequence of wrongs perpetrated by an

9 Kenneth De Ville, "Captain-of-the-Ship Is Dead," *North Carolina Medical Journal* 56, 4 (1995), p. 166.

10 Ibid., p. 169.

11 Prichard, *Review on Liability*, p. 6.

12 Ibid.

employee."[13] In addition, it encourages "deterrence of future harm as employers are often in a position to reduce accidents and intentional wrongs by efficient organization and supervision."[14]

Numerous Canadian court decisions have addressed claims of vicarious liability against hospitals and other health-care organizations. In *T.W. v. Seo*,[15] a private x-ray and ultrasound clinic in Toronto was found vicariously liable when one of its ultrasound technicians secretly videotaped a patient in the changing room and performed unauthorized examinations on her, including a pelvic exam. In this case, the clinic was vicariously liable as the employee's opportunity to commit wrongful sexual acts arose from his duties.

According to the Supreme Court of Canada, vicarious liability not only "provides a just and practical remedy" but also encourages "deterrence of future harm."

Health-care professionals responsible for the supervision of others. Health professionals may face liability when they are negligent in their supervision.[16] Sometimes, this supervisory role might be mandated by legislation. For example, in the Missouri case of *Callahan v. Cardinal Glennon Hospital and St. Louis University*, a physician was found liable for the negligence of an advanced practice nurse. At the time, state law stipulated that physicians were ultimately responsible for patient care. Following the Callahan decision, the law was amended to recognize the independence of advanced nursing practice in the state.

In some Canadian provinces (as well as in some boards of nursing and medicine in the United States), current legislation may specifically state that nurse practitioners must work "with medical direction and appropriate supervision."[17] It is important that health professionals be familiar with the legislation governing their practices in their provinces, to ensure that they comply with it. It is also important for health professionals to be aware of the scopes of practice of other members of the team, so that tasks can be assigned or delegated appropriately. Interdisciplinary collaboration can occur in all provinces, but the processes supporting these collaborative models must be aligned with the roles and expectations spelled out in provincial/territorial legislation and regulations, which differ between jurisdictions.

Institutional policies that dictate hierarchies of accountability. Institutional policies, when not designed appropriately, can result in pointless lines of accountability. Institutions and health professionals need to avoid implementing unnecessary policies that might increase their liability risks. The North Carolina case of *Harris v. Miller*[18] illustrates this point. In this case, the hospital anaesthesia manual specified that "anesthesia care shall be provided by a nurse anesthetist working under the responsibility and supervision of the Surgeon doing the case."[19] Interestingly, the court observed the following:

> . . . [Surgeons] are no longer the only experts in the operating room. The operating team now includes nurses, technicians, interns, residents, anesthetists, anesthesiologists and other specialized physicians . . . Some of them, like anesthesiologists and technicians, may have expertise not possessed by the surgeon. Thus, the surgeon will in some cases be ill-equipped, if not incapable, of controlling the manner in which assisting personnel perform their duties.[20]

Nonetheless, the existing policy was upheld by the court and the surgeon was deemed liable for the negligence of the nurse anaesthetist.

13 *671122 Ontario Limited v. Sagaz Industries Canada Inc.*, [2001] 2 S.C.R. 983.

14 Allen M. Linden et al., *Canadian Tort Law: Cases, Notes & Materials*, 12th ed. (Toronto: Butterworths, 2004), p. 548.

15 [2005] O.J. No. 2467 (Ont. C.A.).

16 For discussion in the U.S. context, see for example Leonard Berlin, "Malpractice Issues in Radiology: Liability of Attending Physicians When Supervising Residents," *American Journal of Roentgenology* 171, 2 (1998), p. 295.

17 F. Trilla and A. Patterson, "Physicians and Nurse Practitioners", p. 9.

18 335 N.C. 379 (1994, Supreme Court of North Carolina).

19 Ibid. [emphasis added].

20 Ibid. Internal citations omitted.

CONCLUDING REMARKS

The number of legal actions brought against physicians and nurses is on the decline in Canada, at least for now. While there has been a decrease in the number of claims, settlements and court awards over the past 10 years, the awards settlements are higher. Notwithstanding, this seems to be a worldwide phenomenon that can hardly be attributed to collaborative health care.

Health professionals can manage risks by knowing/complying with legislation governing their practices and by having adequate professional liability protection.

Health professionals' vulnerability to liability depends less on whether they work in collaborative practices than on three other major factors: their own competency, system problems and other work factors. These other work factors include area of specialization (obstetrics, psychology/psychiatry and neurosurgery carry more risks of liability) and geographic location (certain jurisdictions within Canada have a higher frequency of complaints than others, with Ontario being a prime example).

Health-care professionals need to be aware of certain risks inherent in collaborative arrangements. Professionals who work in interdisciplinary practices face increased risk of joint and several liability. Also, they may face liability when they employ other health professionals (vicarious liability) or when supervision of others falls within their responsibilities. Health professionals can appropriately manage these risks by knowing and complying with the legislation governing their practices in their province/territory and the legislation governing the practices of the other members of the team, ensuring that all members of the team and the institution have adequate professional liability protection, avoiding implementing policies that may unnecessarily increase liability risks, complying with policies that guide their practices and ensuring adequate supervision of the staff.

CHAPTER 7

Professional Liability Protection—Available to Support Interdisciplinary Collaboration

Chapter Summary

- Some perceive that collaborative health-care will be more expensive for our health-care system, will cause professional liability premiums/fees to increase and will make obtaining coverage/protection more difficult. This has not been the case in Canada.
- Collaborative practices do not appear to have any bearing on obtaining coverage/protection for the relevant premiums or fees, nor do they have a bearing on the premiums/fees.
- In an attempt to decrease liability risks, insurers and professional protective organizations are encouraging health professionals to take steps to reduce their risk of malpractice liability.

Several groups, including insurers and professional protective organizations, provide professional malpractice liability insurance or protection to health professionals and institutions in Canada. Among these are the Healthcare Insurance Reciprocal of Canada (HIROC), the Canadian Medical Protective Association (CMPA), the Canadian Nurses Protective Society (CNPS), Aon Reed Stenhouse and ENCON.

To assess the main concerns of the Canadian malpractice liability industry related to interdisciplinary collaboration in health care, a total of eight interviews were conducted with health professional malpractice insurers, an institutional insurer, and professional protective organizations. These interviews complemented the findings of two reference group meetings held with various stakeholders in professional liability, including representatives from professional associations, legal counselling groups, brokers, policy writers, professional protective organizations and insurers.

For professional liability insurance/protection to be considered adequate, it must provide sufficient protection to reflect damage awards and cost of legal defence.

This chapter presents an overview of the professional liability protection services in Canada and the industry's views of interdisciplinary collaboration.

WHAT LIABILITY PROTECTION IS AVAILABLE TO HEALTH PROFESSIONALS?

For professional liability insurance/protection to be considered adequate, it must provide sufficient protection to reflect damage awards, including the cost of legal defence, and to ensure protection is available for claims arising from

wrongful acts that occurred during a prior period (e.g., tail coverage or occurrence-based protection). Interviews with various malpractice carriers and professional protective organizations in Canada reveal that professional liability coverage/protection ranges from a low of $1 million per occurrence to unlimited but discretionary coverage. Insurers offer tail coverage for a defined period to ensure continued protection after a professional ceases practice or does not renew a policy.

HIROC, the biggest provider of health-care liability insurance in Canada, provides coverage to health professionals employed in more than 500 health-care organizations nationally, including hospitals, nursing homes, community health centres and home-care agencies. Professional liability insurance/protection is also offered by other insurers, protective organizations and unions, and varies somewhat across professions.

Even for the same professional group there might be variations in coverage/protection, given the variety of existing insurance/protection programs established in each province and territory. In some instances, national and provincial programs might compete. Table 2 indicates the liability protection/coverage available to practitioners in 11 health professions. It is important to highlight that these amounts are based on some national professional group-sponsored programs and not on individual policies. Coverage provided by HIROC is not presented in the table. The information presented for the nursing profession refers to the protection program available through CNPS.

Except in British Columbia and Quebec, nurses obtain automatic professional liability protection, provided by the Canadian Nurses Protective Society, through membership with their provincial/territorial associations or colleges. These organizations are members of CNPS and pay CNPS a membership fee each year for the benefit of their members.

Professional liability insurance for British Columbia and Quebec nurses varies depending on existing public and

Table 2
Liability Insurance/Protection and Premiums/Fees for Various Health Professions

	Coverage/Liability Protection		
Professional Group	**Per Occurrence**	**Aggregate, Per Annum**	**Annual Premiums/Fees**
Pharmacists	$1 million	$2 million	$65
Psychologists	$1 million $2 million	$3 million $6 million	$296–$344 $329–$368
Registered nurses	$1 million	$3 million	Variable[1]
Nurse practitioners	$5 million	$5 million	Variable[1]
Social workers	$2 million	$5 million	$100
Speech language pathologists and audiologists	$2 million	$5 million	$65
Dietitians	$5 million	$5 million	$80
Occupational therapists	$5 million	$5 million	$67
Physiotherapists	$5 million	$5 million	$200
Physicians	Discretionary[2]	Discretionary	Variable

1 Most nurses do not pay premiums. They obtain automatic professional liability protection through membership with their provincial/territorial associations and colleges.

2 Liability protection available to CMPA physician members is determined on a case-by-case basis, at the discretion of the CMPA.

Source: The Conference Board of Canada.

private insurance schemes. The College of Registered Nurses of British Columbia (CRNBC) provides professional liability protection to its members through the CRNBC Captive Insurance Corporation. In Quebec, the Ordre des infirmières et infirmiers du Québec provides professional liability insurance to its members through La Capitale.

In Ontario, the majority of nurses are hired as employees and have liability coverage through their employer's insurer (typically provided by HIROC). Nurses who are members of the Registered Nurses Association of Ontario (RNAO) are also eligible for CNPS protection. These include the majority of nurse practitioners and about one-quarter of all Ontario nurses. Other Ontario nurses may have additional professional liability insurance through their union (e.g., the Ontario Nurses' Association) or associations such as the Ontario Occupational Health Nurses Association, or may purchase it from a private source.

Some health professionals purchase additional or extended coverage for professional liability. Also, some professional liability programs cover professionals for all areas of risk in their practice, including libel and slander (defamation), professional discipline and legal actions.

HOW ARE THE MALPRACTICE INSURANCE PREMIUMS OR LIABILITY PROTECTION FEES STRUCTURED?

Insurers assess various elements when structuring programs and determining premiums. Mutual defence organizations also assess various factors when determining membership fees. These may include the following:

- The level of risk in the health professionals' practice (closely related with their *specialization* and *type of work*, with obstetrics, psychology/psychiatry and neurosurgery carrying more risk of liability);
- The frequency of claims or lawsuits and the amount of the award or paid-out claim;
- The geographic location; and
- Institutional experience and exposure.

The greater the probability of potential risk of harm in providing care to a patient, the higher the minimum professional liability coverage/protection, and so the higher the premium/fee.

Consider the range of premiums payable annually. For $1 million in coverage, the range is from $65 (pharmacists) to $344 (psychologists). For $5 million in coverage, the range is from $67 (occupational therapists) and $80 (dietitians) on the lower end to $200 (physiotherapists) on the higher end.

The greater the risk of harm involved in providing care to a patient, the higher the minimum professional liability coverage, and thus the higher the premium/fee.

However, there are circumstances when health professionals whose practice entails relatively lower levels of risk must have the same amount of professional liability coverage/protection as health professionals with higher-risk practices. Part of this can be explained by the fact that the carriers of insurance/protection programs are, for the most part, different from profession to profession. Where the carrier is the same, as with registered nurses and nurse practitioners protected by CNPS, the protection is typically adjusted for these differences. In this case, protection is higher for nurse practitioners, who have a much broader scope of practice and higher levels of risk than registered nurses. CNPS has responded to the increased risk created by this responsibility by providing nurse practitioners with extended protection.

Insurers and professional protective organizations also evaluate *the frequency of claims or lawsuits and the amount of the award or paid-out claim.* (See text box "Frequency of Claims Against Various Health Professionals.") The higher the frequency and the amounts paid out, the higher the premiums or fees. For example, compared to pharmacists, psychologists likely have more claims with higher awards. This difference contributes to the variation in premiums for similar coverage for the various professions noted above.

A notable exception to this cost principle would be insurance premiums for midwives, against whom only a small number of claims are initiated but for whom pay-outs can be high. For this reason, in 2001, there was a 382 per cent increase in midwives' insurance premiums in Alberta, going from $3,925 to $15,000.[1] The 21 midwives there could not afford to pay the premiums, so the Alberta government stepped in with a $200,000 grant to help them.

CMPA membership fees in Ontario are generally higher than fees payable by physicians who practise in Quebec or in the rest of Canada.

Information about out-of-court settlements is often protected from disclosure by confidentiality agreements. However, some secondary reports are available on average malpractice awards in Canada. In a 2005 analysis, *Health Affairs* reported the average Canadian malpractice payment at approximately $300,000.[2] Of course, there is a wide range in payments: catastrophic cases can reach into the millions of dollars[3] (in which cases, generally, the largest portion of the award goes to cover the cost of health care required as a result of the injury), while relatively minor cases are generally settled below $50,000.

The *geographic location* of health professionals is another factor affecting insurance premiums and fees. The CMPA assesses the risk of practising in a particular province or territory based on the number of claims and amount of the awards made there. Within the same type of work, CMPA membership fees in Ontario are generally higher than fees payable by physicians who practise in Quebec or in the rest of Canada. As an example, in 2006, an obstetrician practising *outside* Ontario and Quebec would have paid $24,768 annually while the same physician *in* Ontario would have paid $78,120. Similarly, a family physician practising *outside* Ontario and Quebec, and who does not do obstetrics, anaesthesia or emergency work, would pay $1,644 in fees, while the same physician *in* Ontario would pay $3,096. In many specialties in Ontario, physicians are paying three times what their colleagues are paying in the rest of Canada.

Frequency of Claims Against Various Health Professionals

- Physicians are likely to have the highest frequency. In 2005, approximately 900 lawsuits were begun. Of the cases concluded between 2000 and 2004, 33 per cent were resolved in favour of the plaintiff (just 1.8 per cent by trial and 30.9 per cent through settlement prior to trial).[1] Nurses, on the contrary, have always had a very low number of claims. Since 2004, there have been fewer than 70 lawsuits against nurses reported to CNPS.
- The average amount of awards or settlements paid since 2001 on behalf of physicians is somewhere between $300,000 and $375,000. Averages are much lower for nurses: the CNPS has never paid more than $300,000 on a nurse's behalf.
- Pharmacists, dietitians, speech-language pathologists, audiologists, physiotherapists, social workers and occupational therapists have very few claims per year. Most of these are settled out of court for under $10,000.

1 CMPA Annual Report for 2005 [online]. [Cited October 20, 2006]. www.cmpa-acpm.ca.

Source: The Conference Board of Canada

One of the elements institutional insurers consider when structuring premiums is the *experience of the institution in question and the exposure of the institution to risk.* The exposure is determined by the type of work done at the institution and by whom. An institution employing midwives would have higher premiums, for example.

To date, other than institutional insurance, there are no other insurance/protective services and programs tailored to protect collaborative teams. Insurance and protection programs exist for individuals and institutions, but given that teams are not recognized as a legal entity, no specific services/protection exists for them yet. Interestingly, the insurers and protectors interviewed for this research

1 Government of Alberta, *Increase in Insurance Premiums for Alberta Midwives Covered* [online]. News release. (April 26, 2001), [cited October 5, 2006]. Available from the Association for Safe Alternatives in Childbirth. www.asac.ab.ca.

2 Gerard F. Anderson et al., "Health Spending in the United States and the Rest of the Industrialized World," *Health Affairs* 24, 4 (2005), p. 903. Interestingly, despite media reports of multi-million dollar American malpractice payouts, the average U.S. payment is reported at around $265,000.

3 For example, the 2004 Ontario decision in *Crawford (Litigation guardian of) v. Penney* (2004) O.J. No. 3669 (C.A.).

demonstrated interest in the possibility of designing new products and services if there is an unmet need regarding coverage for interdisciplinary practices.

DOES COLLABORATIVE PRACTICE HAVE AN INFLUENCE ON LIABILITY INSURANCE PREMIUMS AND FEES?

Almost all of the interviewees for this study—all of them providers of professional liability insurance or protective services to health professionals—indicated that collaborative practices have no bearing on obtaining coverage/protection for the relevant premiums or fees, nor do they have a bearing on the premiums/fees. As long as insured/protected professionals are practising within their scope, the fact that they practise on a team with other professionals will not affect their ability to get coverage or protection.

Two interviewees indicated that the protection they provide has already adapted to the reality of collaborative practice. One interviewee, for example, has expanded its services to provide assistance to clinics or facilities that are wholly owned by physicians who are members of the mutual defence organization and who regularly do clinical professional work at the clinic or facility. If the clinic is owned by a corporation, majority ownership of the corporation must be held by members of the mutual defence organization.

Notwithstanding the fact that most of the participants said that there is no change in coverage/protection or premiums/fees for health professionals practising in interdisciplinary teams, all but three indicated that collaborative care creates issues for insurers/professional protective organizations. In particular, insurers and professional protective organizations are concerned about the need to ensure effective and efficient communications, and to establish clear roles that are aligned with provincially legislated and regulated scopes of practice. Interviewees stressed the importance for health professionals to be clear about who does what when their responsibilities overlap, so that patient management tasks won't "slip between the cracks." They also stressed the importance of communicating well with the other members of the team and with patients and their families. This includes maintaining appropriate documentation of care and obtaining signed consents from patients after explaining what being treated by a collaborative team entails.

CNPS and the CMPA consider the potential impact of collaborative practice on professional liability protection for nurse practitioners and physicians to be important enough to warrant the release of a joint statement about it.[4] Their primary concern is that nurse practitioners and physicians who work on teams with other health professionals may be held financially responsible for the negligence of other members of the team or the facility. This could happen, in their view, if a patient who is being treated by a team brings a legal action and names all the members of the team and facility.

CNPS and the CMPA released a joint statement about the potential impact of collaborative practice on professional liability protection for NPs and physicians.

As a means of risk management, CNPS and the CMPA warn nurse practitioners and physicians who work on teams to ensure that the following conditions are in place, both before starting work and on an ongoing basis:

- Nurse practitioners and physicians have adequate professional liability protection/insurance.
- All of the other professionals on the team have adequate professional liability protection/insurance.
- The facility or institution has adequate protection.

Some U.S. boards of medicine stipulate that physicians must not enter into collaborative practice arrangements with nurse practitioners unless the NP has a specified level

4 Canadian Medical Protective Association and Canadian Nurses Protective Society, "CMPA/CNPS Joint Statement on Liability Protection for Nurse Practitioners and Physicians in Collaborative Practice" [online]. (March 2005), [cited October 2006]. Available at www.cmpa-acpm.ca and www.cnps.ca.

of liability insurance.[5] Similarly, in Canada, the CMPA has expressed concern about physicians engaging in collaborative practice with NPs who carry no professional liability insurance or protection.

This same caution should be given to all members of a collaborative health-care team. In general, given that physicians and nurses are at a statistically higher risk for medical malpractice claims and actions than other health professionals, and given the principle of joint and several liability, it is important for *all* members of the collaborative care team, not just those who are exposed to a higher risk of a claim, to ensure that each health professional with whom they practise maintains adequate liability protection.

Also related to risk management, efforts to enlighten health professionals on how to avoid risky behaviours cannot be underestimated. Carriers of liability insurance and protection programs have a significant role in this regard given that, based on their case load data, they prepare and share educational materials with their clients/members. These materials represent a significant opportunity for health professionals not only to be aware of the main risk areas but also to learn practices to avoid or manage those risks and enhance the quality of patient care and safety. These efforts could be enhanced significantly if information exchange occurred between the insurance/protective organizations.

5 F. Trilla and A. Patterson, "Physicians and Nurse Practitioners", p. 9.

CONCLUDING REMARKS

While there may be a perception that collaborative health care will be more expensive for our health-care system, will cause professional liability premiums/fees to increase and will make obtaining coverage/protection more difficult, none of this has been the case in Canada so far.

Professional liability insurance/protection is offered by multiple stakeholders in Canada, including insurers, protective organizations and unions, and varies somewhat across professions. Collaborative practices do not appear to have any bearing on obtaining coverage/protection for the relevant premiums or fees, nor do they have a bearing on the premiums/fees.

In an attempt to decrease liability risks, insurers and professional protective organizations are encouraging health professionals to ensure effective and efficient communications, establish clear roles that are aligned with legislated and regulated scopes of practice, create and follow policies to guide their interdisciplinary interactions, and ensure every member of the team has adequate liability protection. Interestingly, there is significant alignment and consensus among all stakeholders (e.g., health-care organizations, health professionals, lawyers and judges, insurance companies, protective organizations) regarding what is required to manage liability risks in interdisciplinary practices.

CHAPTER 8

Tort Litigation System—Still Sound, With Some Weaknesses

Chapter Summary

- Some experts have pointed out the pitfalls of litigation-based systems.
- To avoid these potential pitfalls, Organisation for Economic Co-operation and Development countries have implemented a wide range of strategies.
- The success of these strategies depends on how well they align with other systems within the country (e.g., welfare, education, finance, insurance market) and with societal values and preferences.
- A radical reform in Canada might not be desirable or likely. However, several initiatives can be put in place to strengthen our current litigation-based system and enhance patient safety and risk management.

Rising medical liability costs and a stronger focus on patient safety have prompted some individuals and organizations within Canada to question the effectiveness and efficiency of our tort-based compensation system. In fact, this has been occurring across several OECD countries that are concerned about adequate liability protection, fair compensation for patients, and deterrence of behaviour and clinical practices that could lead to adverse events.

As a result, countries are introducing alternatives to address these pressing concerns. This chapter will present an overview of the main criticisms of litigation-based systems and some of the solutions that leading OECD countries have adopted.

WHAT ARE THE CONCERNS ASSOCIATED WITH TORT LITIGATION SYSTEMS?

A recent Canadian study that assessed the performance of the medical liability system in five countries concluded that tort law does not effectively achieve any of its central goals of compensation, deterrence of unsafe conduct, or corrective justice.[1] Some of the concerns related to litigation-based systems include the following.

Unsatisfactory system to compensate victims of clinical negligence. Many have argued that tort litigation systems are not very effective in compensating victims of malpractice. Litigation is typically lengthy and expensive, which may impose access barriers to those least well off in society. Along these lines, a recent Japanese study found that "lengthy litigation is shown to be correlated with outcome and implies that the Japanese medical dispute resolution mechanism favours those who can endure lengthy litigation, namely the defendants, who are physicians

1 Gilmour, *Patient Safety.*

or hospitals."[2] Typically, malpractice litigation involves very high overhead costs. A study in the United States found that for every dollar spent on compensation, $0.54 went to administrative expenses (including those involving lawyers, experts and courts).[3] (See text box "United States.")

In addition, only a small proportion of victims are awarded damages. One study suggested that, because of the costly and lengthy process involved with litigation, many victims with meritorious cases do not file claims.[4] The Harvard Medical Practice Study concluded that only 1 in 8 patients who had been injured as a result of negligence initiated legal action, and of those, only 1 in 16 received any compensation.[5] Similar results have been found in other countries, including Australia.

There is only limited evidence to demonstrate that tort litigation reduces the frequency of adverse outcomes and changes health professionals' practice behaviour toward a more appropriate standard of care. However, there is ample evidence that tort-based systems encourage secrecy and defensiveness,[6] which are two of the main roadblocks in the patient safety journey. Disclosure of harm done to patients, although a moral and legal obligation, too often does not occur; this non-disclosure can even be characterized as endemic.[7] It has been estimated that, in Canada in the year 2000, about 185,000 patients suffered an adverse event while in hospital, resulting in

2 Hagihara et al., "The Structure of Medical Malpractice Decision-Making in Japan," *Journal of Law and Medicine* 11, 2 (Nov. 2003), pp. 162–184.

3 Studdert et al., "Claims, Errors, and Compensation Payments in Medical Malpractice Litigation," *New England Journal of Medicine* 354, 19 (2006), pp. 2024–2033.

4 World Bank, Health, Nutrition and Population, *Medical Malpractice Systems Around the Globe: Examples From the US-Tort Liability System and the Sweden-No Fault System* [online]. http://siteresources.worldbank.org/INTRUSSIANFEDERATION/Resources/Malpractice_Systems_eng.pdf.

5 Localio et al., "Relation Between Malpractice Claims and Adverse Events Due to Negligence: Results of the Harvard Medical Practice Study III," *New England Journal of Medicine* 325 (1991), pp. 245–251.

6 Sir Liam Donaldson, Chief Medical Officer, *Making Amends. A Consultation Paper Setting Out Proposals for Reforming the Approach to Clinical Negligence in the NHS* [online]. (2003). www.dh.gov.uk/assetRoot/04/06/09/45/04060945.pdf.

7 Gilmour, *Patient Safety.*

United States

THE CRISIS

- Over the past decade at least, the United States' tort litigation system has been increasingly criticized for failing to encourage enhanced safety and quality, and failing to provide timely and fair compensation to injured patients.
- A 1996 Harvard Medical Practice Study found the tort system to be unpredictable, with "no correlation whatsoever between the presence or absence of medical negligence and outcome of malpractice litigation."
- Insurance costs for medical professionals have been rising; two major reasons are the growing size of claims, and the reduced supply of available coverage (several major insurers had left the medical practice business as it was too hard to make a profit).
- Fewer medical malpractice claims are filed, but the dollar amount per claim is steadily increasing: the median award increased from $0.5 million in 1997 to $1.2 million by 2003. The average non-economic award in a medical malpractice case was $318,666 in 1989; a year later it was $1,379,203.
- These costs are passed on to patients and significantly impact the health care system. Health professionals are more likely to relocate to states with lower premiums, retire or restrict their practices to patients with low risks. In 2003, almost half of all American hospitals lost physicians or reduced services because of liability concerns, resulting in a shortage of health professionals in some areas. Physicians in particular are more likely to practice "defensive medicine," ordering tests or writing prescriptions that are not really necessary in order to reduce the potential of a future lawsuit. This "drains some $60 to $100 billion out of the economy," says President Bush.

THE RESPONSE

- The American Medical Association tracks the number of states it considers to be in crisis. The generally agreed-upon solution, tort reform, has occurred at the state level but not yet at the national level, despite repeated efforts to pass legislation through the Senate and Congress, most recently in 2005. Nevertheless, tort reform at the state level is having a beneficial effect on the litigation environment.
- In 1975, California was the first state to introduce tort reform for medical liability. Its *Medical Injury Compensation Reform Act* (MICRA) is considered to be highly successful. It has reduced premium rates, improved access to care, and brought about faster and more equitable settlements.
- Among other things, MICRA has done the following: set a cap of $250,000 for non-economic damages (pain and suffering); limited attorney fees; encouraged periodic payments for future damages; and strengthened the physician discipline system.
- MICRA is often hailed as an example. Many states have emulated California's legislation, among them Colorado, Florida, Indiana, Montana, Texas and Virginia.

Source: The Conference Board of Canada.

injury or death, and that close to 70,000 (38 per cent) of these events were potentially preventable. Governments in Canada are looking at ways to enhance patient safety. More open disclosure of adverse events would likely provide lessons from which we could enhance our health-care system and decrease patient harm.

Some countries have implemented no-fault systems, in which patients receive compensation without suing and health-care professionals disclose mistakes without fear of legal action. New Zealand is a notable example, as it established a no-fault malpractice compensation scheme in 1974. Under this scheme, persons injured in the course of receiving health care may seek compensation from the Accident Compensation Commission in accordance with statutorily defined limits. Because the no-fault scheme replaces a patient's right to sue for damages, health-care professionals do not carry professional liability insurance, although some do purchase limited coverage for certain claims not covered under the no-fault scheme. (See text box "New Zealand.")

Similarly, Sweden has had a no-fault system of indemnification for medical malpractice since 1975. (See text box "Sweden.") This system has drastically improved an injured patient's ability to receive compensation. Complaints and discipline are handled through an organization called the Medical Responsibility Board (HSAN). This organization does not deal with financial compensation for a patient who has suffered an injury; a national, no-fault patient insurance scheme covers these claims. In this way, the process of holding staff responsible for their actions and deciding on sanctions is kept separate from determining the financial compensation for the patient. Finland and Denmark have similar no-fault systems.

New Zealand

- In the early 1970s, New Zealand abolished tort liability in favour of no-fault liability. The government funds the system through general taxation and an employer levy, and the Accident Compensation Corporation (ACC) operates it. ACC was created primarily to provide no-fault coverage against injury for all New Zealanders, who, in exchange, would give up their right to sue for personal injury damages. ACC provides coverage for all New Zealand citizens, residents and temporary visitors for accidents that occur in the home, in the workplace, on the road and elsewhere, no matter who is at fault.
- Claims can be made without attributing accountability to a health professional. Once they have been accepted, a range of services, treatments, and financial entitlements are available to claimants, including rehabilitative medical care, earnings-related compensation, moderate lump-sum compensation for permanent impairment, and death benefits.
- A frequent argument against no-fault systems of liability versus traditional tort-based systems is that eliminating the threat of litigation in a no-fault system creates a disincentive to good practice. This assumption is not supported by the New Zealand experience. In fact, research suggests that the risk of serious preventable in-hospital medical injury for patients in New Zealand is within the range reported in tort jurisdictions. On the other hand, there is no evidence that this system has dramatically improved patient safety compared to other countries. However, by creating systems that support health professionals while protecting patients, compared to other nations New Zealand has a "head start in moving away from a culture of blame, toward a culture of learning."
- Mechanisms for complaints resolution are mainly driven by the office of the Health and Disability Commissioner (HDC). This is the primary resource for resolving patient complaints about quality of care. The HDC forms an important complement to the ACC scheme. Despite an increase in the number of complaints since the Commissioner's office was founded, there has been "a dramatic decline in the number of medical practitioners facing disciplinary charges since 1996." For example, in 2000–01, of 111 cases where a doctor was found to have breached the code of consumers' rights, only 12 were referred for professional discipline.
- No-fault compensation for medical injuries is seen as being compatible with a systems approach to improving patient safety, with the Commissioner as a lead contributor to health-care systems improvement. The promotion and protection of patient and consumer rights is seen as being best fulfilled through resolution and learning, rather than blaming and retribution.

Source: The Conference Board of Canada.

Despite the benefits of no-fault compensation schemes, there are some shortcomings that can hinder their effectiveness. Some authors have pointed out that these regimes could result in a higher number of claims per capita, and thus, increased costs.[8] A report commissioned by the CMPA estimated that the annual cost of a no-fault system in Canada could range from $2.6 billion to $40 billion.[9] Interestingly, this allegation of a higher number of claims is not supported by the experience in New Zealand.[10]

Despite the benefits of no-fault compensation schemes, there are some shortcomings that can hinder their effectiveness.

In addition, there are concerns that the level of compensation might not be sufficient to appropriately compensate patients. In fact, countries that have implemented these schemes have introduced several reforms to fine-tune the compensation scheme, although not always successfully. Some countries, such as Sweden and Denmark, allow victims to opt out of the no-fault system and sue through civil law.

Yet, other authors have argued that the lack of personal accountability does not provide strong incentives for deterrence of risky practices and behaviours, which has also been pointed to as one of the weaknesses of the tort-based compensation systems.

Escalating costs of the awards generally increases professional liability insurance premiums or fees. Australia and the United States provide good examples of this. In the United States, insurance costs for medical professionals have risen dramatically in the last decade due to two major factors: the growing size of claims and the reduced supply

Sweden

- Sweden has had a no-fault system of indemnification for medical malpractice since 1975. The patients' insurance scheme is based on the "avoidable injury" principle. The claimant receives compensation if an injury is avoidable or results from treatment that is medically unjustifiable, and if it causes the person to spend at least 10 days in the hospital or miss at least 30 days of work.
- All health-care providers are required to obtain insurance and all insurers are required by law to compensate patients, even in the cases where the care provider is not insured. If this happens, insurers have a right to recover from the uninsured provider, who may also be fined for failing to carry insurance.
- One of the advantages to the Swedish system is that health professionals do not face any negative consequences from the claim. Thus, assisting the patient in making a claim is not necessarily against their interests. In most cases, health professionals are involved in the process: they tell patients about the problem and often help them in making the claims.
- Physicians have an ethical obligation to report their errors to patients and to assist with the claim. They, as well as other health professionals, reportedly do so in 60 to 80 per cent of cases. This also aids the resolution of the claim; half of all claims are resolved in six months compared to years in jurisdictions with fault-based liability.
- Patients can be compensated for loss of income, pain and suffering, disfigurement, permanent disability and (or) additional expenses. Economic losses are fully compensated and non-economic losses are paid according to a pre-determined schedule, capped at about US$220,000. In 2003, the amount paid by the scheme in compensation, including future payments to patients, was about US$53 million, which breaks down to an average per paid-out claim of just under $11,000. It is important to note that a large portion of the economic losses that a patient would suffer, such as lost income, is paid by the social system and does not form part of the compensation from the fund.
- It is possible for patients to opt out of the no-fault system and pursue their claim in tort. Only about 5–10 cases a year are brought to court, and compensation is awarded in only about one or two of those. Patients bringing legal actions are subject to the same damage schedule as patients using the Patient Insurance Scheme. In other words, bringing a legal action does not improve their chances for greater damages.

Source: The Conference Board of Canada.

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8 Organisation for Economic Co-operation and Development (OECD), *Medical Malpractice—Prevention, Insurance and Coverage Options* (Paris: OECD Publishing, 2006).

9 Canadian Medical Protective Association (CMPA), *Medical Liability Practices in Canada: Towards the Right Balance* (Ottawa: CMPA, 2005).

10 For discussion, see Peter Davis, "Compensation for Medical Injury in New Zealand: Does 'No-Fault' Increase the Level of Claims-Making and Reduce Social and Clinical Selectivity?" *Journal of Health Politics, Policy and Law* 27, 5 (2002), p. 833.

Australia

THE CRISIS

- Over the past six years, Australia's tort-based medical liability system has been on a roller coaster ride. Medical indemnity insurance had been provided through seven not-for-profit medical defence organizations called "mutuals," owned and operated by members. They provided insurance on a discretionary basis (i.e., unlimited indemnity protection when needed).
- In 2001, the largest public liability insurer collapsed, followed in 2002 by the largest organization, UNITED. A significant increase in medical indemnity insurance premiums resulted, as did a withdrawal of physician services. The insurance industry as a whole spiralled out of control with high premiums and increased litigation.
- In 2002, the government initiated various policy and tort reforms. It asked the Australian Competition and Consumer Commission (ACCC) to monitor the public liability and professional indemnity insurance market.
- Retrospective investigations identified the root cause of the collapse of the medical indemnity market as *high costs of negligence claims* and not unacceptable incidence of medical error. Two important reviews of medical liability led to substantial tort and policy reform.

THE RESPONSE

- In July 2003, the government legislated that medical indemnity insurance be provided in the form of an insurance contract between an authorized insurer and medical practitioner.
- The Australian government now regulates the industry through five authorized insurers that are organized primarily by geographic area. UNITED exists under a new name, Australasian Medical Insurance Limited (AMIL) and has maintained the largest market share (37 per cent).
- The Australian Securities and Investment Commission has set out a series of product standards and disclosure requirements for medical indemnity insurance policies. The most significant are the establishment of a minimum cover limit for medical practitioners of AUS$5 million and the necessity for a contract to provide retroactive and run-off cover, which provides insurance protection for physicians who have ceased medical practice.
- Tort law reforms have been aimed at addressing inconsistencies and unfairness in the medical indemnity system. Specifically, they have set caps on damages for economic and non-economic (pain and suffering) losses; established minimum thresholds of impairment to access damages for non-economic loss; shortened the limitation periods for personal injury claims; and increased discount rates that apply to claims payouts.
- In its third monitoring report, issued in 2005, ACCC showed that the average premium (in real terms) of medical indemnity had dropped by 13 per cent.
- The industry is now more regulated, resulting in an overall 17 per cent decrease in public liability and professional indemnity (including medical indemnity) premiums.

of available coverage. During this time, several major insurers decided to leave the medical practice business because it was hard for them to make a profit.[11]

In order to control the escalating costs of awards, substantial tort and policy reform occurred in Australia as well as some states in the United States.

Similarly, in 2001 Australia's largest public liability insurer, which had been a re-insurer of many of the medical defence organizations, collapsed, followed closely by the largest medical indemnity organization (UNITED) in 2002.[12] (See text box "Australia.") This crisis resulted in a significant increase in medical indemnity insurance premiums and a withdrawal of physician services; the insurance industry as a whole spiralled out of control, with high premiums and increased litigation. In order to control the escalating costs of awards, substantial tort and policy reform occurred in Australia as well as some states in the United States.

WHAT ARE THE ALTERNATIVES?

Clearly, no system is perfect. Those countries that have adopted tort systems have undergone reforms in an effort to improve the performance of the system, making it more predictable and rational. For example, some states in the United States have focused on, among other things, introducing caps on non-economic damages, shortening limitation periods for claims, introducing periodic payment of damages, and netting collateral sources available to the plaintiffs. Some of these have also been adopted in Australia. In Canada, caps on non-economic damages have been in place for decades, which seem to have had a moderating effect on the growth rate of litigation costs

11 Insurance Information Institute, *Medical Malpractice* [online]. [Cited July 5, 2006]. www.iii.org/media/hottopics/insurance/medicalmal/.

12 Minter Ellison Lawyers, *Special Report: The State of the Law in Australia* [online]. (July 2004), [cited July 31, 2006]. www.minterellison.com/public/resources/file/ebde28093023dbd/RG-MedicalNegligence_0407.pdf.

and awards.[13] Other reforms have focused on limiting excessive recourse to courts and (or) shortening settlement time (e.g., use of arbitration programs) and on modifying liability rules (e.g., limitations on joint and several liability).

A stronger focus on risk mitigation has brought about other initiatives aiming to support safer clinical practices. For example, the U.S. congress passed the *Patient Safety and Quality Improvement Act* in 2005 to facilitate the creation of network databases for reporting and analyzing medical errors. A key element of this legislation is that the information remains confidential and therefore cannot be used in medical malpractice claims.

The United Kingdom rejected the plan of a no-fault compensation scheme and introduced several reforms to improve the performance of its tort-based system.

Also related to risk mitigation, in addition to the accreditation programs that have been in place for several years, many OECD countries have established monitoring/supervisory bodies to assess clinical risks and to support the systematic reporting of adverse events. The United Kingdom is a good example of this. (See text box "United Kingdom.") After a careful examination, the United Kingdom rejected the plan of a no-fault compensation scheme and introduced several reforms to improve the performance of its tort-based compensation system. These reforms included significant administrative transformations that have allocated new funds to strengthen risk management. New organizations have been created and roles have expanded for existing ones. The new National Patient Safety Agency has introduced the National Reporting and Learning System, which collects incident reports monthly from across the country. Efforts are now underway to mobilize communities across the country and ensure effective actions resulting from the analysis of this valuable data. The civil society has also been very involved in patient safety efforts in the United Kingdom.

13 OECD, *Medical Malpractice*.

Action against Medical Accidents (AvMA) and The Health Foundation are just two examples of non-profit organizations that have joined efforts with public health-care organizations and government agencies to advance the patient safety agenda.

A no-fault medical compensation model is sometimes advocated in Canada. In 1990, the Prichard Report[14] recommended reforming the tort system to allow an alternative compensation system. More recently, the Health Council of Canada, in its 2006 annual report, recommended consideration of a no-fault scheme for victims of medical errors.[15] Canadian experience with no-fault systems has been limited to special circumstances (e.g., federal program to compensate people infected with HIV and hepatitis C from blood transfusions, Quebec's program to compensate people who suffer severe and permanent injuries from vaccines).

Opposition to no-fault schemes has pointed out some challenges, including the following: concerns about the feasibility of overhauling the existing liability-based system; difficulties in establishing compensation; and resistance from legal, insurance and health-care sectors. No-fault compensation systems have generally been implemented in response to crisis.[16] And yet, our malpractice liability system does not appear to be in crisis. As well, many interesting initiatives across OECD countries are experiencing positive results in attempting to overcome the challenges of a tort-based patient compensation system. Given these two factors, conventional wisdom seems to point to the assumption that a drastic reform might not be desirable, or likely, in Canada.

That said, there are opportunities to improve our malpractice liability system. For example, a recent CMPA report recommended introducing reforms to encourage full and protected reporting and analysis for patient safety

14 Prichard, *Review on Liability*.

15 Health Council of Canada, *Health Care Renewal in Canada: Clearing the Road to Quality* [online]. (February 2006). www.healthcouncilcanada.ca/en/index.php?option=com_content&task=view&id=70&Itemid=72.

16 Gilmour, *Patient Safety*.

United Kingdom

The United Kingdom has a tort-based system to compensate victims of health-care malpractice. Numerous reviews have pointed out the deficiencies of this system throughout the years. In 1996, Lord Woolf, in his report *Access to Justice*, reviewed the performance of the litigation process in handling claims for compensation for injury and clinical negligence. He observed that the British litigation system is disproportionately expensive in comparison with damages, has significant delays in resolving claims, has lower success rates than in other areas of personal injury litigation, and fosters suspicion and less cooperation between parties than in many other areas of litigation. Given these results and a movement toward stronger patient safety that has gained momentum in the last decade, some have encouraged the government to consider a no-fault compensation scheme.

Interestingly, the 2003 report *Making Amends* rejected no-fault compensation, recommended retaining tort in clinical negligence cases and introduced a series of compensation schemes including "NHS Redress" for low-value claims. This bill was assented to in November 2006 and is expected to be launched in 2008. The Redress scheme will allow low-value clinical negligence claims (up to a value of about £20,000) arising from hospital services to be settled outside of court. Primary care such as GP services will not be covered. Patients will be free to take civil legal action if they desire. In addition, the government has established a wide range of organizations and initiatives focusing on risk management, safety and quality. These include the following:

- Expanding the role of the National Health Service Litigation Authority (NHSLA), a special health authority within the NHS, which was established in 1995 to indemnify English NHS bodies against claims for clinical negligence. Since the early '90s, enterprise fault liability has been established, which makes NHS legally responsible for medical negligence claims made against its staff regardless of the discipline—thus widening the ownership of clinical risk beyond physicians. Risk management is therefore a major function of the NHSLA. Participation in its clinical risk management scheme is voluntary, but currently all NHS trusts and primary care trusts in England belong to it. All NHS organizations are monitored at least once every two years against risk management standards, and risk management advice is provided in order to minimize adverse incidents and ultimately claims.
- Creation of the National Patient Safety Agency (NPSA) to improve safety by promoting a culture of reporting and learning from patient safety incidents. NPSA has introduced the National Reporting and Learning System (NRLS), which receives about 60,000 incident reports monthly.
- Creation of The National Clinical Assessment Services, now under NPSA, to provide confidential advice and support to the NHS on how to manage doctors and dentists whose performance gives cause for concern.
- Creation and promotion of key reports that have guided government efforts on patient safety (e.g., *A Safer Place for Patients: Learning to Improve Patient Safety* [2005] and *Safety First—A Report for Patients, Clinicians, and Healthcare Managers* [2006]). This last report resulted in the creation of the National Patient Safety Forum, which comprises leading figures from health care and regulation, including Sir Liam Donaldson, Chief Medical Officer of the NHS and Sir Ian Kennedy, Chief Executive of the NHS.

Source: The Conference Board of Canada.

purposes.[17] Stronger focus on risk management and patient safety (e.g., a mandatory adverse event reporting system) would be worth considering. Also, there are some initiatives that have been in place in our health-care system for some time, but the benefits have not been maximized. For example, enforcing adherence to evidence-based clinical guidelines and ensuring electronic health records for all Canadians could go a long way in decreasing risks and delivering safer and higher-quality health-care services.

It is also possible to learn from international experience. The majority of OECD countries have adopted tort-based systems to compensate victims of malpractice, and many of them have introduced reforms to make the system better. However, more research in this area is needed to identify the types of reform and initiatives that align best with our priorities, values, preferences, principles and structures.

17 CMPA, *Medical Liability Practices*.

CONCLUDING REMARKS

Some experts have pointed out the pitfalls of litigation-based systems, which include apparent limited effectiveness to meet the following challenges:

- Adequately compensate victims of clinical negligence.
- Influence health professionals' practice behaviour to deter risky and unsafe practices.
- Reduce the frequency of adverse outcomes.
- Control escalating costs of the awards, which generally increases professional liability insurance premiums or fees.

In order to address these challenges, OECD countries have implemented a wide range of strategies, including tort reform; implementation of no-fault compensation systems or blended models of compensation; restructuring of the insurance and health-care systems to boost risk management; and introduction of new legislation to strengthen patient safety. No one single system is perfect. The success of these strategies depends on how well they align with other systems within the country (e.g., welfare, education, finance, insurance market) and with societal values and preferences.

A radical reform in Canada might not be desirable or likely. However, several initiatives can be put in place to strengthen our current litigation-based system. Patient safety and risk management initiatives deserve special consideration. More research in this area is needed to identify those initiatives that align best with our priorities, values, preferences, principles and structures.

CHAPTER 9

Conclusions and Recommendations

Chapter Summary

- Governments should work with professional associations to dispel health professionals' fear of liability in interdisciplinary care.
- Health-care institutions need to implement key practices to manage liability risks (e.g., adopt policies to guide interdisciplinary care; ensure malpractice liability insurance for the organization and its employees, and/or appropriate malpractice liability insurance/ protection for all professionals; ensure health professionals act according to their standards of practice).
- Health professionals need to understand their scope of practice, their limitations as set out in provincial legislation, and the scopes of practice of the other health professionals in their team.
- Health professionals need to comply with policies governing their interdisciplinary interactions.
- Carriers of liability insurance and protection programs should consider exchanging data on malpractice liability cases.
- Governments and (or) regulators should consider legislation to make liability insurance/ protection mandatory for all health professionals involved in interdisciplinary practices.

While many health professionals have indicated that they consider liability to be a barrier to interdisciplinary care, a close examination of their concerns suggests that liability is not the barrier that they think it is.

Many of these concerns are premised on the assumptions that patient care responsibilities may be delegated to workers who lack appropriate skills, and that certain professionals will retain ultimate control and responsibility in these new interdisciplinary models. Neither premise is necessarily accurate. Liability risks certainly skyrocket if patient care is entrusted to unskilled workers. However, the point of interdisciplinary collaboration is to ensure that patients have access to appropriate care from the most appropriate professional. Those who organize and oversee interdisciplinary care teams must take care to ensure that health professionals are not tasked with delivering care that is outside their competence or scope of practice.

The point of interdisciplinary collaboration is to ensure that patients have access to appropriate care from the most appropriate professional.

Health-care professionals who practise collaboratively in health-care settings can minimize potential legal liability through appropriate risk management strategies, which were identified throughout this report. As well, risk

may be transferred from individual health professionals to their insurers through professional liability insurance coverage.

Given the current variations in interdisciplinary collaboration across Canada (e.g., types of professionals involved in the team, funding, governance structures), health professionals considering participation in an interdisciplinary model need to reflect on the legal issues specific to their situation. No one solution will fit all teams, and although some situations might require more considerations than others, it is important to keep in mind that no circumstance is so dire as to discourage or prevent interdisciplinary practice.

CANADIAN COURTS AND COLLABORATIVE CARE

A study of court cases in Canada regarding malpractice shows that to win, a case must be very well founded. Courts examine the duty of care that the health professional owes the patient. Health professionals are expected to show watchfulness, attention, caution and prudence when delivering health-care services to the patient; however, they are not expected to be perfect or to be able to foresee every possible circumstance that could go wrong. Courts recognize that professionals can make errors in judgment, and an error will constitute potential negligence only if the professional fell below the appropriate standard of care.

An examination of Canadian case law suggests that courts will be unlikely to apply a standard that exceeds the examined health professional's scope of practice.

Courts also recognize that health professionals are working in new ways, and they are also aware of the sometimes overlapping roles and responsibilities of the various health professionals working on a team. In making decisions regarding negligence, courts tend to look at the duty of care owed to the patient and whether the health professionals involved in the negligence suit have met the standard of care expected of others in their profession. They also look at whether or not the team has communicated medical information effectively and whether it has followed its established policies and widely accepted clinical guidelines to ensure that the services it provided were safe and of high quality.

As some health professionals expand their scopes of practice to perform activities historically restricted to other groups (e.g., nurses performing tasks traditionally done by physicians), concerns arise about the standard of care these professionals will be held against in the event of liability. Some health professionals have voiced the concern that courts will hold these professionals with expanded roles (e.g., nurse practitioners) to the standard of care applicable to other professional groups (e.g., physicians). An examination of Canadian case law suggests, however, that courts will likely continue to assess standard of care on an individual basis, and it is improbable that courts will apply a standard that exceeds the examined health professional's scope of practice.

Courts rely heavily on peer review and judgment in making their decisions regarding liability. If a malpractice claim goes to court, judges look to the health professionals within the particular practice to identify the behaviours and roles that constitute an appropriate standard of care, in both traditional and collaborative care settings. The onus is on these professionals to do this in a way that reflects the interdisciplinary context. The courts also turn to professionals for information on how the health-care system is evolving and for guidance as to how the legal system can effectively respond to current social standards and new models of health-care delivery.

> . . . [T]he law is based on precedent and when some new approach to an old problem comes along, it may take the law a while to change. But the law is a reflection of our social standards and as the delivery of health care changes, so will the law.[1]

This involvement in providing key information represents an immense opportunity—and responsibility—for health professionals, who are truly in the driver's seat. To drive

1 Joseph L. Fink, "Interdisciplinary Health Care: Some Legal Aspects," *American Journal of Pharmacy* (March/April 1975), p. 54.

legal and regulatory reform, professionals must come together, hear each other's views and collectively articulate a shared vision of an interdisciplinary team that is well poised to meet the current and future health-care needs of Canadians.

Courts have "moved with the times" and recognize that overlapping scopes of practice exist and that a team approach is often taken to patient care. Nonetheless, as the CMPA stated: "Fear of increased medico-legal liability is often cited as a barrier to health professionals participating in collaborative care practices. To date, there appears to have been only limited action to overcome this perceived barrier."[2] Efforts need to be made to correct this.

1st Recommendation

Governments should work in partnership with professional associations to dispel the health professionals' fear of medico-legal liability as a significant barrier to interdisciplinary care.

It is necessary that health professionals clearly understand malpractice liability processes in Canada, including the basis of negligence and how courts establish standard of care. Health professionals also need to be familiar with the risks associated with interdisciplinary care and the strategies that can be put in place to effectively manage these risks. Governments across Canada are promoting interdisciplinary collaborative models as one of the key drivers of primary health-care renewal. In order to attract more health professionals to these types of models, it is necessary to change some of the negative perceptions regarding interdisciplinary care and malpractice liability. Wide dissemination of this report can contribute to achieving this goal. Health-care associations and insurance and protective organizations could be powerful partners for knowledge transfer and deployment of education strategies, both targeting health professionals in Canada.

2 Canadian Medical Protective Association, *Collaborative Care: A Medical Liability Perspective* [online]. (August 2006) www.cmpa-acpm.ca/cmpapd02/cmpa_docs/english/resource_files/admin_docs/common/pdf/06_collaborative_care-e.pdf.

RISKS IN COLLABORATIVE CARE

Collaborative care brings some challenges for health-care institutions, health-care professionals and carriers of health-care insurance/protection programs. The main findings and recommendations for each of these groups are presented below.

RISKS FOR HEALTH-CARE INSTITUTIONS

Health-care professionals who work together in a collaborative way often do so at health-care institutions such as hospitals, community health centres and family health groups. These institutions may be directly liable for their own acts or *vicariously* liable for the acts of their employees. Institutions may also be liable for breach of contract since a contractual relationship between the facility and patient may be implied and, in some cases, even explicit. A health-care institution owes four key duties to its patients:

- To select competent staff and monitor their continued competence;
- To provide proper instruction and supervision;
- To provide proper facilities and equipment; and
- To establish systems necessary for the safe operation of the health-care organization.

To meet the above obligations, institutions that employ or retain health professionals who work collaboratively would also do well to create policies that aim to ensure the following four key practices:

- Health-care professionals must act according to the standards of practice of their professions and comply with their respective regulatory colleges.
- Policies are in place to guide interdisciplinary care, and all health professionals are aware of them. Specifically, these policies need to clarify roles and responsibilities and processes related to communication, decision-making and patient management within the team approach.
- The organization has malpractice liability insurance that covers the organization and its employees (e.g., direct liability, vicarious liability).
- All professionals have appropriate malpractice liability insurance/protection. Institutions should reinforce this during annual performance reviews or appraisals.

2nd Recommendation

Health-care institutions need to be aware of the four key practices as outlined above and implement them.

Once health-care institutions have implemented these practices, they should be no more vulnerable to liability than any health-care system whose employees do not work collaboratively. Many organizations following these guidelines have successfully implemented interdisciplinary practices for decades and have had no problems with malpractice liability. Provincial governments can be instrumental in disseminating this information to the health-care organizations operating in their provinces and to carriers of insurance and protection programs.

RISKS FOR HEALTH-CARE PROFESSIONALS

The number of legal actions brought against physicians and nurses has been declining in Canada. This includes not only a decrease in the number of claims made but also a decrease in the number of settlements and court awards. That said, the size of awards or settlements has increased. But this cannot be attributed to collaborative health care because it seems that the majority of the substantial awards have been given in cases where physicians were found solely liable. Therefore, it appears that interdisciplinary care is unlikely to have been the cause of this increase in the size of awards. Health professionals' vulnerability to liability does not seem to depend primarily on whether they work in collaborative practices; rather it depends more on competency, system problems and other work factors, including their area of specialization and their geographic location.

Health professionals can ensure that they are not found liable for medical malpractice by acting competently and within their scopes of practice.

It is vital to underscore that, although there have been many legal cases involving several health professionals working as a team, liability has always been assessed against the individuals and not against the team. Therefore, the most significant way for health professionals to ensure that they are not found liable for medical malpractice is to act competently and within their scopes of practice. Changing scopes of practices, new legislation and regulations of health professionals can intensify or decrease liability challenges, but this is the topic of another research report.[3]

3rd Recommendation

Health professionals need to understand their scope of practice and their limitations as set out in provincial legislation. Equally, they need to understand the scopes of practice of the other health professionals in their team.

Professional associations can play a significant role in conveying this information to health professionals. Through the Enhancing Interdisciplinary Collaboration in Primary Health Care Initiative, 10 professional associations have committed to interdisciplinary practices. By leveraging the commitment, focus and communication vehicles created by this initiative—including newsletters, a website, several initiatives and several committees—these professional associations can further the dissemination of information to health professionals about issues arising from scopes of practice in interdisciplinary settings.

Health-care professionals need to be aware of certain risks inherent in team-based care, for example, the increased risk of joint and several liability. They also need to be aware that lack of clarity regarding roles and responsibilities might lead to one of two situations: *inappropriate delegation of duties*, which occurs when a health-care professional with a given responsibility relies on another who does not have the necessary knowledge or skill to properly carry out tasks related to that responsibility; and *abdication of responsibility*, which occurs when practitioners may inadvertently (or even deliberately) defer their professional responsibilities to a patient. Finally, health professionals may face a third form of liability, vicarious liability, when they employ other health professionals.

3 The Conference Board of Canada, *Achieving Public Protection Through Collaborative Self-Regulation: Reflections for a New Paradigm*. [To be released in April 2007].

To mitigate these risks, members of interdisciplinary collaborative teams need to understand their individual responsibilities and role within the team, as well as the roles and responsibilities of other team members. Confusion about which professional is responsible for carrying out specific actions is likely to result in errors and omissions in care.

4th Recommendation

Health professionals need to be aware of, and comply with, policies that govern their interdisciplinary interactions.

Policies can confirm and clarify scopes of practice and lay out appropriate roles for each practitioner. Of great importance are those policies that provide guidance on actions when there is role overlap. This recommendation also applies to those health professionals engaged in informal collaborations (those happening outside formal institutions, involving private providers of health services, virtual networks, etc.). Given the liability and patient safety risks, it is fundamental for these health professionals to design their own policies to ensure an even understanding of the roles and responsibilities of all those participating in patient care. A simple collegial understanding among professionals is not enough to protect professionals and patients.

Policies have been instrumental in helping health professionals participate appropriately in new models of care that call for expanded scopes and new roles. They are especially important when legislation supporting these new models is lagging. Health-care organizations have incorporated in their policies the use of Transfer of Function Agreements to delegate responsibilities to nurse practitioners and clinical pharmacists, while ensuring these professionals comply with the requirements of their regulating legislation.[4]

Strong communication is also critical among all the health-care professionals providing care to the patient *and* between the professional and the patient/client and family. Maintaining a complete and accurate health record is an essential communication element. Health-care professionals must also inform the patient/client of the roles that all health professionals will have in their care and ensure that patients/clients consent to the proposed treatments. Canadian courts have found liability in some situations where a patient consented to one practitioner giving care, but another person with a different skill level carried out all or part of the treatment. Maintaining good communication with the patient and obtaining an informed consent that explains a team approach to practice could prevent this situation from occurring.

RISKS FOR CARRIERS OF HEALTH-CARE PROFESSIONAL INSURANCE AND LIABILITY PROTECTION PROGRAMS

Almost all the interviewees for this study indicated that collaborative practices have no bearing on obtaining the necessary liability protection/insurance as long as the insured/protected professionals are practising within their scope of practice.

Interviewees' main concern is the need to establish clear roles that are aligned with provincially legislated and regulated scopes of practice.

Neither does practising on a team with other professionals affect the cost of premiums/fees nor the coverage/protection available. Notwithstanding this, all but three interviewees indicated that collaborative care does create issues for insurers and protective organizations. In particular, they are concerned about the need to ensure effective and efficient communications, and to establish clear roles that are aligned with provincially legislated and regulated scopes of practice. Interviewees stressed the importance of health professionals being clear about who does what when their responsibilities overlap so that patient/client management tasks will not slip between the cracks. They also stressed the importance of ensuring that all health professionals on the team, as well as the institutions and other legal entities, have adequate liability protection to protect themselves, the institutions and the public.

4 Enhancing Interdisciplinary Collaboration in Primary Health Care, *Finding the Answers.*

Carriers of liability insurance and protection programs typically analyze their case loads based on aggregate data and incorporate the lessons learned into educational materials that are shared with their clients/members. These materials represent a significant opportunity for health professionals to not only decrease risks in their practices but also enhance patient care safety and quality.

5th Recommendation

Carriers of liability insurance and protection programs should consider creating a vehicle to exchange aggregate, non-identified data on malpractice liability cases.

This will allow the creation of more comprehensive educational materials that will help their clients/members to be more aware of risks and risk management strategies in interdisciplinary collaborative environments. Given that this information would be available to all professions, it could lead to a better appreciation for the roles of various types of health professionals within collaborative models. It could also lead to sharing best practices in risk management between professions and to safer and higher-quality health-care practices.

WHAT DOES THE FUTURE HOLD FOR INTERDISCIPLINARY PRACTICE?

Interdisciplinary collaboration is a flexible, multi-faceted and effective method of delivering health care. There are many practices of this type across the country. Several of them have existed for decades. Recent government focus on interdisciplinary collaborative teams and their promotion as a key element in primary health-care renewal has resulted in a larger number of professionals engaged in these practices. Through the Primary Health Care Transition Fund, all provinces and territories in Canada have supported the development and strengthening of these teams over the past four years. The more than 150 family health teams approved in Ontario, the 18 primary care networks that have emerged in Alberta and the 9 family health centres in Prince Edward Island are just a few examples. Interdisciplinary health-care models are likely to increase within the next 10 years, especially given demographic and chronic disease trends that will require not only more comprehensive diagnostic and treatment options (which call for interdisciplinary practices) but also innovative solutions for the increasingly acute health human resources challenges. It is also very likely that these teams will continue to evolve; therefore, a single prescription for liability risk management is not prudent. Each team will have to assess the uniqueness of its situation and respond accordingly.

Until now, liability has been assessed in individual cases. This is the result of the lack of “team liability” (a type of enterprise liability) in our system, which supports assessment of liability against the entire team. Although there has been some uncertainty about the need to introduce enterprise liability in our malpractice liability system, this research seems to suggest that there is no need to follow this road. Canada does not appear to be experiencing a malpractice liability crisis and our system seems to be meeting the needs of health professionals and the judicial system, at least at this point in time. Furthermore, although some concerns have been voiced in Canada regarding the need to consider other systems to compensate patients and their families that could be more supportive of patient safety practices, radical reforms of our tort system are unlikely in the near future[5] and might not be desirable.

Canada does not appear to be experiencing a malpractice liability crisis and our system seems to be meeting the needs of health professionals and the judicial system, at least for now.

Notwithstanding the above, given that interdisciplinary practices might entail some risks, it will be fundamental for all health professionals to have liability protection. As more health professionals come together to formally or informally participate in collaborative practices outside institutions—which typically provide liability insurance to their employees—there is a need to ensure that all health professionals are insured/protected against liability risks. Physicians and nurses, through the CMPA and CNPS, have taken the lead in Canada by launching a

5 Joan Gilmour, *Patient Safety*.

Joint Statement in Liability Protection,[6] which advises their members to "have appropriate and adequate professional liability protection and/or insurance coverage." Given that there are inconsistencies across professions regarding policies addressing liability requirements, efforts should be made to address these inconsistencies.

6th Recommendation

Governments and (or) regulators should consider introducing legislation to make liability insurance/protection mandatory for all active (as defined by regulators) health professionals involved in interdisciplinary practices.

This action will give health professionals peace of mind and engender trust among team members; it will also ensure that patients and their families have access to a source of funds in the event of malpractice.

Mandatory liability protection for health professionals will likely result in greater demand for health professional insurance/protection. Therefore, an analysis to estimate the capacity of this market should be undertaken as a first step.

6 CMPA and CNPS, *Joint Statement on Liability*.

CONCLUDING REMARKS

This report brings home a strong message about liability and collaborative care. Liability is not the barrier to interdisciplinary care that many health professionals perceive it to be. Although interdisciplinary collaborative practice does carry some risks—for health-care institutions, health-care professionals, legal entities, insurers and liability protectors—these can be overcome with a few straightforward strategies, all of which contribute to patient safety and quality of care.

Our current litigation-based system seems to be responding well to the needs of interdisciplinary collaborative practices. While some experts have voiced concerns regarding this system, and have advocated a no-fault patient compensation system, this report suggests that a radical reform in Canada might not be desirable or likely. However, there *are* opportunities to strengthen our current litigation-based system. Patient safety and risk management initiatives deserve special consideration.

As *all* stakeholders think outside their individual boxes, their expertise will enrich the broader discussions. The ensuing solutions created by such a collaborative effort will go far to dispel uncertainty about liability and foster a climate of sound legal and health practices.

APPENDIX A

Contributors to This Report

ORGANIZATIONS THAT PARTICIPATED IN JANUARY AND NOVEMBER REFERENCE MEETINGS

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APPENDIX B

Suggested Reading

Enhancing Interdisciplinary Collaboration in Primary Health Care Initiative, *Interdisciplinary Primary Health Care: Finding the Answers—A Case Study Report*, 2006 [online]. www.eicp-acis.ca/en/toolkit/EICP-Case-Studies-Report-Final-Aug-14.pdf.

Enhancing Interdisciplinary Collaboration in Primary Health Care Initiative, *Barriers and Facilitators to Enhancing Interdisciplinary Collaboration in Primary Health Care, 2005* [online]. www.eicp-acis.ca/en/resources/pdfs/Barriers-and-Facilitators-to-Enhancing-Interdisciplinary-Collaboration-in-Primary-Health-Care.pdf.

Enhancing Interdisciplinary Collaboration in Primary Health Care Initiative, *The Principles and Framework for Interdisciplinary Collaboration in Primary Health Care*, 2006 [online]. www.eicp-acis.ca/en/principles/march/EICP-Principles-and-Framework-March.pdf.

Enhancing Interdisciplinary Collaboration in Primary Health Care Initiative, *Canadian Policy Context: Interdisciplinary Collaboration in Primary Health Care*, 2005 [online]. www.eicp-acis.ca/en/resources/pdfs/Canadian-Policy-Context-Interdisciplinary-Collaboration-in-Primary-Health-Care.pdf.

Enhancing Interdisciplinary Collaboration in Primary Health Care Initiative, *Individual Providers and Health Care Organizations in Canada*, 2005 [online]. www.eicp-acis.ca/en/resources/pdfs/Individual-Providers-and-Health-Care-Organizations-in-Canada.pdf.

Lahey, Wialliam, and Robert Curry. *Regulatory and Medico-Legal Barriers to Interprofessional Practices*, Journal of Interprofessional Care, Volume 19, Supplement 1, May 2005, pp. 197–223.

APPENDIX C

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This report explores the performance of provinces on a wide variety of health indicators.

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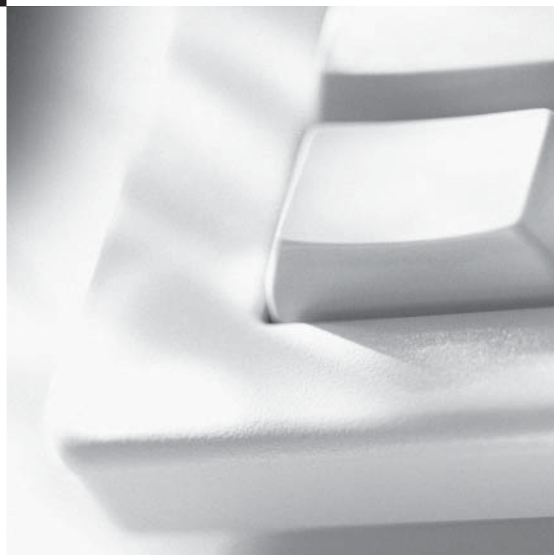

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Publication 091-07
E-copy: Complimentary • Printed copy: $40

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