

# Memorandum on Potential Liability in Negligence for Use of Technologies

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# MEMORANDUM ON POTENTIAL LIABILITY IN NEGLIGENCE FOR USE OF TECHNOLOGIES

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This memorandum is structured around some of the questions that may arise within themes 1 and 2 in the course of this project. It should be noted that this memorandum deals with legal issues at the level of legal principles and, as in many other fields, it is impossible to predict with any degree of certainty how principles will be applied in any particular situation. Many of the issues discussed below have not yet been litigated in Canada. **Nothing contained herein is intended to constitute legal advice and anyone who has specific questions should consult with a lawyer.**

This memorandum begins with a discussion of the general principles of negligence.<sup>1</sup> Next, we examine potential liability within the context of a patient/physician interaction where technology has played some part in the interaction. We also briefly touch on liability for those who post information on the internet, and on hospital liability for equipment.

## Negligence Generally

Medical malpractice is a form of negligence, and many of the issues discussed below require a familiarity with its elements. In order to find that negligence has occurred, the law examines the following issues:<sup>2</sup>

1. *Duty of Care*: Does the health care provider owe a duty to the patient? Generally this is established by showing that a relationship exists between the parties such that, in the reasonable contemplation of one party, lack of care on his or her part could cause damage to another. It is clear in law that where the health care provider is providing treatment or services to his or her patient, a duty of care is owed.
2. *Standard of Care*: In order to meet the requisite standard of care, a health care provider has to show that he or she provided the level of care that a reasonable and prudent practitioner would provide in similar circumstances. If a health care provider cannot show that he or she acted as a responsible health care provider would have acted in the circumstances, a breach in the standard of care will be found.

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<sup>1</sup> Negligence is part of common law (as opposed to statute law or constitutional law). In particular, negligence is a species of tort law which seeks to address disputes between parties (in contrast with statute law which is essentially regulation by the state through the use of codified rules).

<sup>2</sup> See A.M. Linden & L.N. Klar, *Canadian Tort Law: Cases, Notes & Materials*, 11<sup>th</sup> ed. (Toronto: Butterworths, 1999) at 155.

3. *Causation*: The injured party must show a connection between the injury and the health care provider's failure to meet the expected standard of care. That is, the injured party must show that a breach of the standard of care caused the injury.
4. *Remoteness*: The injured party must show that the kind of injuries suffered should have been within the reasonable contemplation of the health care provider. In other words, the injuries must be not so out-of-the-ordinary that the health care provider should have been able to foresee this kind of injury as a possible consequence of his or her actions.
5. *Harm*: The injured party must show that the injuries have caused losses for which they ought to be compensated.

The law puts the burden of establishing that these conditions have been met squarely upon the person complaining of the injury. If the injured party is successful in establishing a *prima facie* case of negligence, the person who has been accused of causing the injury can offer defences to either avoid liability entirely or reduce liability. Here we shall only deal with the partial defence of contributory negligence, as this would be most likely at issue in the situations envisaged for the purposes of this memorandum.

*Contributory negligence*: Has the injured party acted in a way that has contributed to their injury so as to lessen the liability imposed on the health care provider. Note, however, that contributory negligence will be assigned only after the health care provider has been found negligent. If the injured party was wholly responsible for their injury, then the health care provider will not be found contributory negligent.

## **LIABILITY**

### **ISSUES:**

1. In a telemedicine context, if the doctor in the patient's jurisdiction obtained consent, would the doctor being consulted via telemedicine also have to obtain consent?
2. Liability where patients relied on on-line health information and were injured as a result of it.
3. Liability for not updating health information on the internet.
4. Liability on practitioners for relying on information they receive from other physicians with whom they consult via electronic means, without considering how that medical advice may or may not be appropriate for their individual patient.
  - 4.1 What duty of care is owed by a physician to a patient when the physician is consulted via electronic means?
5. Liability for engaging in the unlawful practice of medicine by non-physicians who provide medical advice over the internet
6. Hospital liability for inadequate equipment.
7. Duty to follow up where a patient is given medical advice over the telephone and is told to go to the hospital.
8. The "locality rule" and liability.

9. If the physician who was treating the patient was a general practitioner and he or she consulted a specialist, what standard of care would be applied?
10. Given that institutions frequently make decisions regarding equipment based on economic factors, can cost considerations be used as a defence to avoid or reduce liability?
11. Changing standards as to what constitutes reasonableness for purposes of meeting the standard of care.

## ANALYSIS

### **1. In a telemedicine context, if the doctor in the patient's jurisdiction obtained consent, would the doctor being consulted via telemedicine also have to obtain consent?**

Touching or in any way acting upon a patient in the absence of an emergency requires the health care provider to obtain the consent of the patient (or the consent of the surrogate if the patient is incompetent). Absent consent, the health care provider is committing a battery under the law.<sup>3</sup> As well, an action in negligence could be launched if a misadventure occurs in the course of treating without consent.

A valid consent requires that four elements be satisfied:

1. the consent must be given voluntarily;
2. the consent must be given by a patient who has capacity (that is, the patient is competent to give consent)
3. the consent must be specific to the treatment and the provider (e.g., if the patient consents to Dr. Smith doing a particular procedure and Dr. Smith does an additional or different procedure, then there would not be consent for the second or different procedure.<sup>4</sup>); and
4. the consent must be informed.

With respect to the question at issue, the discussion would primarily revolve around the fourth element. In order for this element to be met, the health care provider must convey to the patient all of the information that a reasonable person in the patient's position would want to know before making decisions regarding treatment.<sup>5</sup> The amount and kind of information required by the patient varies with the nature of the treatment. Generally, the material risks involved and the likelihood of misadventure taking place must be

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<sup>3</sup> *Malette v. Shulman* (1990), 67 D.L.R. (4<sup>th</sup>) 321 at 327 where the Ontario Court of Appeal stated:  
No special exceptions are made for medical care, other than in emergency situations, and the general rules governing actions for battery are applicable to the doctor-patient relationship. Thus, as a matter of common law, a medical intervention in which a doctor touches the body of a patient would constitute battery if the patient did not consent to the intervention.

<sup>4</sup> See *Marshall v. Curry*, [1933] 3 D.L.R. 260.

<sup>5</sup> P. Washington, "Consent to Treatment" in M.J. Dykeman, ed., *Canadian Health Law Practice Manual*, looseleaf (Markham: LexisNexis Butterworths, 2005) at para. 2.28.

relayed. Note that a common albeit minor risk would have to be conveyed, as would a serious risk with a low probability of occurrence.

There are a number of circumstances where, with respect to the consultant, the conditions for a valid consent may not be met. For example, if the patient's primary physician sends x-rays or an MRI scan to a physician in another locality, the participation of the consultant may be unknown to the patient. The first physician may have received consent for the scan but may not have received consent for the participation of the other physician. This scenario is rather commonplace in health care settings and courts, and some legislation<sup>6</sup> permits the application of a type of implied consent in health care situations. That is, while generally the patient consents to a particular surgeon doing a procedure, the patient does not have to provide explicit consent to the participation of a particular anaesthetist or nurse.<sup>7</sup> As well, when a patient has blood drawn or an x-ray, they impliedly consent to the blood being sent to a laboratory or for a radiologist to examine the x-rays. It is unclear how broadly the implied consent can run. While patients are basically familiar with the workings of a hospital – they realize their physician is not going to analyze their blood or act as their nurse – it is not so apparent that patients would understand that health care providers in other localities may be involved in their care.

In many circumstances, the distant telehealth provider is not “touching” the patient in a manner that could lead to a charge of battery, but an action against the consultant would be part of a suit in negligence. An important issue that would have to be addressed is determining whether a doctor-patient relationship exists between the consultant and the patient. This would have to be clarified to determine whether *prima facie* the consultant owed a duty of care to the patient. If the consultant did not stand in a relationship with the patient, then the consultant could not be found to be liable. In many cases of consultation – two doctors chatting about a case over the telephone – there is not enough knowledge of the case or participation in treatment decisions to ground a physician-patient relationship. However, the more knowledge the consultant has regarding the case and the more input the consultant has in treatment decisions, the more likely it is that a relationship will be inferred.

One possible way in which a distant health care provider may “touch” the patient in a manner that could lead to liability is through the use of robotically assisted examinations

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<sup>6</sup> For example, the *Personal Information Protection and Electronic Documents Act S.C. 2000, c. 5* permits disclosure of personal information within the “circle of care.” See J. Stoddard, “Privacy Laws and Health Information: Making it Work” at [http://www.privcom.gc.ca/speech/2004/sp-d\\_041027\\_e.asp](http://www.privcom.gc.ca/speech/2004/sp-d_041027_e.asp).

<sup>7</sup> See *Marcoux v. Bouchard*, [2001] S.C.R. 726 at para. 31:

That fact is expressed in the traditional vocabulary of the law, which says that an agreement for medical care must be made *intuitu personae*, with a specific person in mind. A patient will often wish to see a particular physician or to be handled by a particular, clearly identified surgeon. In the case of surgery, the patient is entitled to know who the main actors in the operation will be. However, that obligation would not extend to the usual secondary players who are present during surgery, including anaesthetists, nurses, and physicians in training, such as residents and interns.

or surgeries. While this has never been litigated in Canada,<sup>8</sup> it is clear that a health care professional would be found to be in a suitably close relationship that they would be responsible for the welfare of the patient. The consent of the patient both to the procedure and the practitioner would be absolutely necessary except in case of an emergency.

## **2. Liability where patients relied on on-line health information and were injured as a result of it.**

We can find no Canadian or American cases where a suit was initiated alleging negligent harm as a result of following on-line health information; generally, litigation thus far has been based on on-line defamation.

Generally, those who post information on websites are responsible for the content.<sup>9</sup> Industry Canada commissioned a study entitled “The Cyberspace is not a “No Law Land”.”<sup>10</sup> The report is concerned primarily with the commercial context; presumably, many of the sites that post health information are non-commercial sites. Generally, greater liability would attach to commercial than non-commercial sites. The report notes that in both the common law and in the Quebec Civil Code, there is a duty to be prudent and diligent in the provision of information and that “[t]he communication of erroneous information in the framework of a professional activity can be a quasi-offence, even if the information was provided free of charge.”<sup>11</sup> Similarly, Barry Sookman writes:

In the case of negligent provision of information, it is now established that if, in the ordinary course of business or professional affairs, a person seeks information from another, who is not under a contractual or fiduciary obligation to give the information, in circumstances in which a reasonable man so asked would know he was being trusted, or that his skill or judgment was being relied on and the person asked chooses to give the information without so clearly qualifying his answer to show that he does not accept responsibility, then the person replying accepts a legal duty to exercise such care as the circumstances require in making his reply.<sup>12</sup>

As mentioned in the above quotes, negligent misstatement requires that the negligent party be a professional engaged in a profession that requires the exercise of specialized

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<sup>8</sup> A suit was launched in December 2003 in Florida when a robotically assisted operation went wrong and the patient died. The surgeon was at a computer station approximately 10 feet from the patient. The suit alleged that the surgeon was too inexperienced with the machine to do the job safely. The present status of this suit is unknown. See article at <http://www.yerridlaw.com/verdict60.cfm>.

<sup>9</sup> The issue of internet service provider liability is outside the scope of this memorandum.

<sup>10</sup> M. Racicot et al., *The Cyberspace is not a “No Law Land”* (Ottawa: Industry Canada, 1997) Available at [http://strategis.ic.gc.ca/epic/internet/insmt-gst.nsf/vwapj/1603118e.pdf/\\$FILE/1603118e.pdf](http://strategis.ic.gc.ca/epic/internet/insmt-gst.nsf/vwapj/1603118e.pdf/$FILE/1603118e.pdf).

<sup>11</sup> M. Racicot et al., *The Cyberspace is not a “No Law Land”* (Ottawa: Industry Canada, 1997) citing L. Sabater-Bono, *Banques de données: la responsabilité de informations* (1987) Expertise No. 98/99, 309 at 314.

<sup>12</sup> B. Sookman, *The Liability of Information Providers in Negligence* 1989 5 *Computer Law and Practice*, 141; qtd. M. Racicot et al., *The Cyberspace is not a “No Law Land”* (Ottawa: Industry Canada, 1997) at 156.

skill or knowledge. Thus, if a doctor posted information that was careless and incorrect and someone relied on the advice (given that it was coming from a medical professional) negligent misstatement could be argued.

Even if the information was not supplied by a professional, negligence may be present. If a site posted erroneous health information, and someone followed that information to their detriment, the issue would most likely be framed as negligence on the part of the poster of such information. In particular, someone acting on behalf of the injured party would have to show that the on-line poster owed the injured party a duty of care to ensure that the information was accurate, that the standard of care that would be expected of a reasonable person posting on-line health information was not met, that the advice was the cause of the injury, and that the injury was not too remote.

A particular hurdle would be to show that it was reasonable for the injured party to rely on on-line advice. In the case of a site run by a doctor or other health care professional this hurdle would not be as high as it would be if the information was supplied by a lay person. Another issue that would incline towards or away from a finding of reasonable reliance would be how specific and tailored to facts provided by the information seeker the information was. That is, any evidence of interaction between the parties would result in a greater likelihood that the poster would be found negligent.<sup>13</sup> As has been argued, “normally a general publication...does not give rise to liability because the author does not owe a duty of care to the general public at large.”<sup>14</sup>

Another consideration would be the existence or lack of a disclaimer. For example, the Healthy Ontario website operated by the provincial government provides information on a number of medical topics. When the user clicks on a topic, a disclaimer must be read and accepted before the requested information will be displayed.<sup>15</sup> Courts are often

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<sup>13</sup> For example, a site has a board where you can ask Dr. Bob about a condition and the injured party supplies a good deal of medical information to Dr. Bob who then answers the specific question. Indeed, in circumstances like these, a physician-patient relationship may exist between the parties.

<sup>14</sup> J.E. Pelly et. al., “Clinical Practice Guidelines Before the Law: Sword or Shield?” (1998) 169 Med. J. Aust. 330 at 332.

<sup>15</sup> The disclaimer reads:

The MediResource Drug and Disease Databases are for informational purposes only. Please read the conditions of use below, and indicate your consent to these conditions by clicking the 'AGREE' button.

#### CONDITIONS OF USE:

The information within this website is for Canadian audiences only. The information in the MediResource Drug and Disease Databases is for informational purposes only. The information is not intended to cover all possible uses, directions, precautions, drug interactions or adverse effects. It should not be construed to indicate that the use of a particular drug is safe, appropriate or effective for you. It should not be relied upon or interpreted as a recommendation for any specific treatment plan, product or course of action. The information on the site is not intended as a substitute of any kind for professional medical advice, diagnosis or treatment. Speak to your healthcare professional before taking any product, changing your lifestyle, or beginning or discontinuing any course of treatment. If you suspect that you are ill or may have a medical emergency, contact a physician, a health professional or call 911 immediately.

persuaded that a disclaimer should allow the injuring party to escape liability, as the injured party is knowingly using information subject to a caution.<sup>16</sup>

Note that a finding of negligence in situations like the one under examination is unlikely and would depend on a number of factors, including: the nature of the information; whether it would be reasonable to rely on information posted on a website; the relationship between the injuring and injured parties; and whether the provision of information was a commercial transaction.

### **3. Liability for not updating health information on the internet.**

Where a failure to update health information results in injury to a person relying on such information, liability may follow. In the context of clinical practice guidelines, it has been argued that if they were marketed as cutting-edge medical knowledge, there could be potential liability for a contractual undertaking or warranty.<sup>17</sup> Again, a disclaimer can act to limit the liability imposed on the website owner, and “current as to date” should be added to pages containing health information.

### **4. Liability on practitioners for relying on information they receive from other physicians with whom they consult via electronic means, without considering how that medical advice may or may not be appropriate for their individual patient.**

The phrasing of this question is somewhat unfortunate. It would be fairly clear that a physician *who did not consider whether the advice of a consultant was appropriate for his or her patient* has not met the standard of care. This would especially be the case in technologically mediated consultations, as the physician who sought consultation should realize the limitations on the advice provided by the distant consultant. Moreover, as the physician would be administering the treatment recommended by the consultant, he or she would be wise to assess whether the advice was reasonable. It is true that doctors are

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I acknowledge that I have read the conditions of use and confirm my consent to the conditions of use.

Available at [http://www.healthyonario.com/english/condition\\_detail.asp?diseaseid=221](http://www.healthyonario.com/english/condition_detail.asp?diseaseid=221).

<sup>16</sup> There are limits to how effective disclaimer clauses or waivers can be. Generally speaking, courts often read such clauses very narrowly so the injuring party may yet be held liable. Well-formed disclaimers often are very clear about what risks are explicitly being waived, they are written in clear and easily understandable language, and the party seeking to rely on them must take all reasonable steps to ensure that the injured party understands the risks. See *Crocker v. Sundance Northwest Resources Ltd.*, [1988] 1 SCR 1186 for a situation in which the injuring party was not allowed to rely on a signed waiver to escape liability. Those seeking to rely on disclaimer clauses should seek legal advice on how to frame the waiver.

<sup>17</sup> A.J. Rosoff, “The Role of Clinical Practice Guidelines in Health Care Reform” (1995) 5 Health Matrix 369 at 392. See also Elaine Gibson, “Clinical Practice Guidelines: Their Influence on the Standard of Care in Malpractice” (2004) 4:1 Journal of Evidence-Based Dental Practice 96.

entitled to rely on the skills of another health professional,<sup>18</sup> but they would also have to ensure that the consultant had all the information required in order to properly assess the patient's condition. Picard and Robertson note that referring doctors have a duty to take reasonable steps to ensure that all significant information in their possession, including their own findings, opinion and diagnosis, is brought to the attention of the other doctor or facility.<sup>19</sup>

A more apt question might be as follows:

#### **4.1 What duty of care is owed by a physician to a patient when the physician is consulted via electronic means?**

Physicians and their patients are generally considered to have entered into a therapeutic relationship where the physician has agreed to use their skill and training to the best of their ability to attend to the patient's needs. Whether a duty of care exists between parties is determined as a matter of law by looking at whether there is sufficient proximity between the parties, and whether it is foreseeable that a failure to meet the requisite standard of care on the part of the doctor will have adverse consequences for the patient. For the most part, establishing whether a duty of care exists between a physician and a patient is fairly easy: has the physician agreed to accept the person as their patient, and has the physician examined the patient and rendered a diagnosis?

Scenario 1: A patient goes to their GP with a medical difficulty. The GP is stumped and seeks a consultation with a reputable specialist located in the same city. The health records are forwarded to the specialist, who reviews the records and examines the patient. The specialist misses an obvious sign of a potentially fatal condition. Harmful consequences result to the patient. What liability issues arise?

In this case, it is clear that both the GP and the specialist owe the patient a duty of care, as they have both entered into a therapeutic relationship with the patient; both have examined the patient, reviewed their records, and intend on treating the patient.

There have been no telemedicine malpractice cases in either the US or in Canada. Commentators speculating about how the situation would be analyzed by a court have relied on an analogy from telephone consultation cases.

Scenario 2: A patient goes to a GP with a medical difficulty. The GP seeks a consultation with a reputable specialist located in another city. The GP phones up the consultant and relates the issues regarding the patient. The consultant asks questions and offers suggestions to the GP. The GP does a bit more research following along from what the consultant has said. A misfortune occurs and the patient is injured.

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<sup>18</sup> See Picard and Robertson at 175 where, in discussing the idea of delegating duties, the authors state that in certain circumstances, the doctor can "rely on the duty owed by other professionals." For example, they cite *MacKinnon v. Ignacio*, (1978), 29 N.S.R. (2d) 656, wherein the Court held that a surgeon could rely on an anaesthetist to perform his or her task properly.

<sup>19</sup> *Ibid.* at 249, citing *Kersey v. Wellesley Hospital* (1988), 46 C.C.L.T. 271.

The courts in the United States have been reluctant to impose liability on consultants in such circumstances. In *Lopez v. Aziz*,<sup>20</sup> a consulting obstetrician had a telephone conversation with a patient's physician but never reviewed the chart or examined the patient. The court refused to attach any liability to the consultant.

In the US, various factors arising out of telephone consultations have been identified to determine whether a duty of care is owed. These factors would be relevant in the Canadian context as well:

1. Whether the consulting physician and patient ever saw each other;
2. Whether the consultant ever examined the patient;
3. Whether the consultant viewed the patient's records;
4. Whether the consultant knew the patient's name; and
5. Whether the consultation was gratuitous or for a fee.<sup>21</sup>

Another factor that has been identified that may impose a duty on the consultant is the degree of 'control' exercised over the patient. If the consultant is merely providing advice to the GP who makes the final decision regarding proposed treatment, it may be argued that the consultant has not assumed responsibility for the patient and has not overseen treatment. If the consultant, however, exercises a greater degree of control, by ongoing contact with the GP for example, then a doctor-patient relationship may be found and liability may follow.

A recent Canadian case, however, demonstrates a greater willingness to impose a duty of care for the advice provided, even by telephone.<sup>22</sup> The defendant physician, Dr. Penney, allegedly had a conversation with a Dr. Gillieson regarding treatment of a pregnant woman with diabetes. Dr. Penney did not consider the discussion with Gillieson to be a consultation but, rather, something more akin to a hallway conversation. While the court found as a fact that the conversation did not take place, the court commented on the duty of those who provide advice even in less formal circumstances:

It is the position of the Defendants that the alleged contact between Drs. Penney and Gillieson was what is known as a "hallway conversation" or "corridor consult" and that such a conversation, even if an opinion is expressed and relied on, does not give rise to a duty of care for the person or persons whose care is being discussed. Notwithstanding that I am not required to rule on this question, in the circumstances of this case, had I concluded that a conversation did, in fact, take place and had I concluded that the advice given by Dr. Gillieson was negligent, in the absence of a clear disclaimer, I would have had no difficulty in

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<sup>20</sup> *Lopez v. Aziz*, 852 S.W. 2d 303 (Tex. App. 1993).

<sup>21</sup> *Clarke v. Hoek*, 219 Cal. Rpt. 845, 851-52 (Ct. App. 1985).

<sup>22</sup> *Crawford (Litigation Guardian of) v. Penney*, [2003] O.J. No. 89.

concluding that a physician owes a duty to provide advice that meets the relevant standard of care and that a duty of care does, indeed, exist. In other words, I have serious doubts that there is, as the Defendants argue, a class of consultation known as a "hallway conversation" or a "corridor consult" attached to which there is no duty of care in favour of the patient for whom the advice or opinion is sought.<sup>23</sup>

In this case, the mere giving of advice would have been sufficient for the court to impose the duty.

I agree that a finding of negligence cannot exist absent a duty of care; however, a duty of care can arise in circumstances beyond the strict physician/patient relationship. If Dr. Gillieson was consulted by Dr. Penney for an opinion, he, Dr. Gillieson, was aware that Dr. Penney would consider and probably rely on that opinion. Therefore, had he been consulted, Dr. Gillieson would have known that any advice he gave would have an impact on the treatment that would be provided to the patient. Therefore, he would have been aware that there was a proximate relationship between him and the patient.<sup>24</sup>

Whether this view will prevail in Canada is not assured. This seems an overly broad application of a duty of care and whether this broad an application of the duty of care could stand further judicial scrutiny is unknown. Obviously, practitioners should not give advice recklessly but there may be policy reasons not to extend the application of the duty. In the American case of *Lopez*, the court remarked that "To expose physicians...to liability for simply conferring with a colleague would be detrimental in the long run to those seeking competent medical attention and is contrary to the public policy of this state" (at 307).

What is clear is that the facts of the case will determine whether a duty of care exists between a patient and a consultant.

Scenario 3: A patient goes to their GP with a medical difficulty. The GP seeks a consultation with a reputable specialist located in another city. The doctor, using the clinic's computer system and programs, electronically transmits the patient's relevant health information to the specialist. The specialist downloads and analyses the information on another computer program purchased by the hospital from which she operates. The specialist never examines the patient herself but makes recommendations. The GP reviews the specialist's recommendations and follows the specialist-recommended course of treatment. Harmful consequences for the patient result.

In this case, it is possible that a duty of care will attach to the consultant. They now have established a greater proximity to the patient, and the foreseeability criterion has been strengthened by the consultant's direct knowledge of the patient's medical history.

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<sup>23</sup> *Ibid.*, at 89 at para. 5.

<sup>24</sup> *Ibid.* at para. 255.

Nonetheless, the question of control over the patient's course of treatment will still be an important question in establishing liability.

Scenario 4: As above, except that the consultant is connected via video teleconferencing technology to the patient. She asks the patient questions and conducts an examination to the extent that the technology permits.

In this case, it is likely that a duty of care will attach to the consultant. Indeed, the technology has closed the distance gap so that in many respects, this kind of doctor-patient interaction more closely resembles a traditional visit to a specialist. The significant difference is, of course, the inability of the consultant to physically examine the patient. The debatable issue then would not be whether or not a physician-patient relationship will be found to exist, but rather, whether or not the consultant has met the requisite standard of care in conducting only a partial examination of the patient.

## **5. Liability for engaging in the unlawful practice of medicine by non-physicians who provide medical advice over the internet**

Professionals are considered to have special training and skill in certain areas, and it is this special training that makes them fit to practice their profession. Often professions are marked by regulations regarding who can practice, what the practice constitutes, who can call themselves by what designated title, etc. As well, professions also are marked by specialized training with a specific curriculum, standards that practitioners are expected to meet, adherence to a code of ethics, and the possibility of disciplinary proceedings for any infractions. Only those with the requisite training and skills are allowed to practice the discipline, and those who do not belong to the profession are not allowed to practice these skills.

Certain professional activities are restricted by legislation to either specific disciplines, such as physicians or nurses, or to regulated professions generally.<sup>25</sup> One such restricted activity is giving medical advice. Therefore, if medical advice is provided over the internet by persons who are not licensed to provide it, they could be in violation of the legislation. Similarly, if a professional gives advice that is beyond the scope of what they are permitted to do (eg., nurses engaging in practices that are solely under the purview of physicians), liability and disciplinary action could ensue.

In Canada, most of the regulations applying to health professionals follow two kinds of models. The first type is profession-specific, and defines the scope of practice for each profession separately. The second legislative model addresses all regulated professionals

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<sup>25</sup> See for example, the *Medicine Act*, S.O. 1991, c. 30, s. 4 which describes which acts are permitted for physicians. Available at [http://www.e-laws.gov.on.ca/DBLaws/Statutes/English/91m30\\_e.htm](http://www.e-laws.gov.on.ca/DBLaws/Statutes/English/91m30_e.htm).

in one piece of legislation, and tends to discuss restricted activities, which are those that must be performed by a regulated professional.

An illustration of the first type of legislation is Nova Scotia's *Medical Act*, which governs the activities of physicians.<sup>26</sup> Section 40(1) of this *Act* states that:

Except as provided in this Act and the regulations, no person, other than a medical practitioner who holds a license shall

- a. publicly or privately, for hire, gain or hope of reward, practice or offer to practice medicine,
- b. hold himself or herself out in any way to be entitled to practice medicine, or
- c. assume any title or description implying or designed to lead the public to believe that the person is entitled to practice medicine.

“Practice of medicine” is defined as including:

- i. advertising, holding out to the public or representing in any manner that one is authorized to practice medicine in the jurisdiction;
- ii. offering or undertaking to prescribe, order, give or administer any drug or medication for the use of any other person;
- iii. offering or undertaking to prevent or to diagnose, correct or treat in any manner or by any means, methods, devices or instrumentalities, any disease, illness, pain, wound, fracture, infirmity, defect or abnormal physical or mental condition of any person; or
- iv. offering or undertaking to perform any obstetrical procedure or surgical operation upon any person.<sup>27</sup>

Thus, any person who does not meet the requirements outlined in the *Act* but who represented that they could, for instance, diagnose illnesses over the internet or prescribe courses of treatment could be found to have violated the provisions of the *Medical Act*. If so, they would be subject to the penalties prescribed. Likewise, the *Registered Nurses Act* defines the scope of practice for a nurse.<sup>28</sup> Nurse practitioners have greater scope under the legislation to undertake diagnosing and treating than those who are qualified only as registered nurses.<sup>29</sup> If a registered nurse takes on some of the duties of a nurse practitioner, or if a nurse practitioner acts beyond the scope of her duties, each can be found to have violated the Act and could potentially be subject to discipline.

An example of the second legislative model is Alberta's *Health Professions Act*.<sup>30</sup> This model seems to give nurses a wider scope of practice, so arguably they may be able to engage in more activities without incurring liability or professional discipline. For

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<sup>26</sup> S.N.S. 1995, c. 10.

<sup>27</sup> *Ibid.*, at ss. 2(w).

<sup>28</sup> Registered Nurses Act, S.N.S. 2001, c. 10, ss. 2(y).

<sup>29</sup> *Ibid.*, at ss. 2(y)(z).

<sup>30</sup> R.S.A. 2000, c. H-7.

example, physicians are able to do assessments of the condition of patients to diagnose, assist individuals in making medical decisions, treat conditions, promote wellness, engage in research and education, and provide restricted activities authorized by the regulations.<sup>31</sup> In comparison, “based on an ethic of caring and the goals and circumstances of those receiving nursing services, registered nurses apply nursing knowledge, skill and judgment to” assist individuals in achieving optimal health; “assess, diagnose and provide treatment and interventions and make referrals”; “prevent or treat injury and illness”; teach and counsel to enhance health; coordinate and monitor the provision of services; teach nursing; manage and allocate resources related to health services; engage in research; and provide restricted activities authorized by the regulations.<sup>32</sup> Although there are no regulations pertaining to the restricted activities that may be performed, the wide scope of practice given to nurses could arguably enable them to engage in a greater role in treating and advising patients of health related matters using technology.

What is clear, however, is that the medical advice should only be provided by a health professional acting within the scope of their practice. Thus, for example, in Nova Scotia nurse practitioners are entitled to make diagnoses, as are physicians. Anyone else who undertakes to give a diagnosis is engaging in a practice which could result in liability, discipline, or a summary offence conviction.<sup>33</sup> Clearly, someone who is not a health professional should not be dispensing medical advice over the internet.

## **6. Hospital liability for inadequate equipment.**

Hospitals owe a duty to patients to ensure that the equipment used is properly maintained, that it is adequate to the task, and that hospital personnel are competent users of the equipment.<sup>34</sup> For example, in *Murphy v. St. Catherines General Hospital*<sup>35</sup> a length of polythene tubing was severed and remained in the patient’s vein during an intravenous injection by an intern. The patient sued both the manufacturer of the intravenous equipment and the hospital. Both the hospital and manufacturer settled with the patient, and proceeded to court for the apportioning of liability between the two.<sup>36</sup> The court found that the hospital was fully liable, as there were no defects in the design or manufacture of the device, and that the injury to the patient was caused by improper supervision of staff by the hospital. As Crolla notes, however, hospitals often require that

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<sup>31</sup> *Ibid.* s. 3, Schedule 21.

<sup>32</sup> *Ibid.* s. 3, Schedule 24.

<sup>33</sup> *Registered Nurses Act*, S.N.S. 2001, c. 10, s. 29.

<sup>34</sup> Picard and Robertson at 379.

<sup>35</sup> (1963), 41 D.L.R. (2d) 697 (Ont. H.C.J.); discussed in D. Crolla, “Health Care Without Walls: Responding to Telehealth’s Emerging Legal Issues” in M.J. Dykeman, ed. *Canadian Health Law Practice Manual* looseleaf (Markham: LexisNexis Butterworths, 2005) at APP.30. Note, too, in the Florida robotic surgery case, the plaintiff alleges that the doctor was not adequately skilled to be using the equipment.

<sup>36</sup> Apportioning liability suggests that the parties would in the first instance have to pay the percentage of the settlement that reflected their degree of liability. That is, if the injured party receives \$10,000 and A’s liability is 70% and B’s is 30%, then A has to pay \$7,000 and B has to pay \$3000.

the supplier provide technicians to operate the equipment. This may reduce the duty imposed on the hospital.<sup>37</sup>

A related question is whether hospitals or clinics are required to have the most up-to-date equipment. A clinic, for example, may have monitors that can display MRI images, but the resolution might not be as sharp as that offered by the most recent technology. In this kind of situation, a patient's care may be adversely affected by what is not shown on the older model. Whether an institution will be found liable will depend on whether the institution has fallen below the accepted standard of care. If the technology used is inadequate to the task and patient care is compromised, then an institution may be found liable for any misadventure that results from using out-of-date equipment. Picard and Robertson note, however, that being required to have up-to-date equipment does not mean that institutions are required to have the latest and most innovative technology.<sup>38</sup> Picard and Robertson cite an Ontario case in which the Court of Appeal stated:

I think a reckless disregard of a new discovery, and an adhesion to a once approved but exploded or abandoned practice resulting in injury to a patient would give a cause of action. But on the other hand, no medical man can be bound to resort to any practice or remedy that has not had the test of experience to recommend it...<sup>39</sup>

Indeed, Picard and Robertson note that a few cases have found that “a doctor who chooses to treat with the latest equipment or the newest techniques must meet a higher standard of care.”<sup>40</sup>

## **7. Duty to follow up where a patient is given medical advice over the telephone and is told to go to the hospital.**

When a patient calls or uses the internet to obtain health advice, and the patient is advised by the professional to go to the hospital, if the patient does not follow this advice, the professional may be relieved of responsibility. For example, an early Saskatchewan case found that a physician was not negligent when a patient was injured because he was entitled to rely on the patient's statement that she would go to the hospital for further treatment.<sup>41</sup>

## **8. The “locality rule” and liability.**

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<sup>37</sup> Crolla at APP.31. Full analysis of this question would require an investigation into the employment status of the technician and delegated duties and a host of other issues beyond the scope of this memorandum.

<sup>38</sup> Picard and Robertson at 200-204.

<sup>39</sup> *McQuay v. Eastwood* (1886), 12 O.R. 402 at 408.

<sup>40</sup> Picard and Robertson at 203, citing *Zimmer v. Ringrose* (1978), 89 D.L.R. (3d) 646 (Alta. T.D.), *Murphy v. St. Catharines General Hospital* (1964), 41 D.L.R. (2d) 697 (Ont. H.C.).

<sup>41</sup> *Hampton v. Macadam* (1912) 22 W.L.R. 31 (Dist. Ct.).

The locality rule holds that the standard of care could differ depending on whether one was in a rural or urban area. An expression of the rule can be found in *Zirkler v. Robertson* where the Court remarked that “[i]t surely cannot be said that the skill of a physician, attending a patient in a private home with few conveniences, and no assistants, is to be measured by the same standard as the city surgeon, provided with an operating room, assistance, nurses and all the aids of a modern hospital.”<sup>42</sup>

It is unlikely that this is still good law in Canada. In *Crawford v. Penney*<sup>43</sup> a baby in Smith Falls, Ontario suffered an injury at birth. The defendant doctors argued that they were rural doctors who could not be expected to provide the same level of care as they could provide in a high risk obstetric unit in Ottawa. The Court was persuaded by the following extract from Linden:

It was once clear that doctors were protected from tort liability if they merely lived up to the standard of the profession in their own community or similar localities. Someone in ‘country practice’ did not have to be as proficient as an urban physician. This idea still has devotees. In the recent case of *McCormick v. Marcotte*, [1972] S.C.R. 18, a doctor was held liable when he performed an obsolete type of operation on a patient because he was unable to do the one recommended by a specialist. Mr. Justice Abbott imposed liability and stated that a doctor is required to possess and use, ‘that reasonable degree of learning and skill ordinarily possessed by practitioners in similar communities in similar cases’. He quoted, however, from the trial judge to the effect that this was a ‘hospital in a well-settled part of the Province [Quebec] within easy reach of the largest centres of population’...

The locality rule should be abandoned. This would reflect the improvements in modern communications, medical education and the uniformity of examinations for doctors in Canada. In the case of *Town v. Archer*, [1902] O.J. No. 163, Chief Justice Falconbridge criticized the ‘locality rule’ on the ground that ‘all the men practising in a given locality might be equally ignorant and behind the times, and regard must be had to the present advanced state of the profession and to the easy means of communication with, and access to the large centres of education and science ...’. In *Town v. Archer* the community in question was Port Perry, which at that time was only two hours travel from Toronto, then a city of a quarter of a million people, with three medical colleges and numerous hospitals. Communications and access to information have improved greatly since then so that there is even less reason to differentiate between localities. Moreover, a principle that permits an inferior brand of medicine for rural Canadians cannot be countenanced. A single standard may promote an upgrading of medical practice across the country. It would also enable Plaintiffs to secure medical evidence from a larger pool of experts, a distance advantage.<sup>44</sup>

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<sup>42</sup> (1897), 30 N.S.R. 61 at 70 (C.A.).

<sup>43</sup> (2003) 14 C.C.L.T. (3d) 60, (Ont. S.C.J.), aff’d (2004) 26 C.C.L.T. (3d) 246 (Ont.C.A.).

<sup>44</sup> Allen M. Linden, *Canadian Tort Law*, 6th ed. (Toronto: Butterworths, 1997) at 157-160; qtd. at *ibid.* at para. 251.

The Court concluded that "...a rural physician practicing his/her profession is under the same obligation as is a physician with a similar practice in an urban setting to keep up with developments in areas of medicine pertinent to their practices."<sup>45</sup> Finally, the judge indicated that once information had been disseminated to family practitioners in Ontario, those physicians had a duty to keep up with developments. Moreover, if physicians cannot treat a patient to a standard that could be offered at another location, they have a duty to refer the patient to someone who can give the patient the treatment they require.

With respect to the subject matter of this memorandum, we suggest that the locality rule is not wholly dead; it would be unfair to rural health care providers to meet the same standard of care that doctors in urban centers can meet because they will often lack the resources that are available to their city counterparts. But we must distinguish what knowledge a physician is required to possess to meet the standard of care and the capabilities of the facility where the physician is providing service. Clearly, a rural hospital will not have the same ability to manage some kinds of injuries and illnesses as a large hospital in an urban centre. As noted by a New Brunswick court, the capacity of the facility will be a factor in determining whether the standard of care has been met but the onus is still on the physician to act in a reasonable and prudent manner:<sup>46</sup>

The standard of care Dr. Wecker owed to the Plaintiff is exactly the same as that expected of an urban doctor. This does not mean that he had available to him the same facility, equipment, or staff as available in a large critical-care centre, and this is only one factor to consider in determining the skill and care required in this situation. Essentially doctors must conform to the accepted standards of the day, and if the conduct complies with the customary practices of the profession then he is virtually assured of being exonerated when something goes awry, although this defence is not conclusive. The doctor is liable for malpractice when failing to act like a reasonably prudent doctor.

**9. If the physician who was treating the patient was a general practitioner, and he or she consulted a specialist, what standard of care would be applied?**

The standard of care expected of health care professionals is not perfection; mistakes are allowed to happen so long as the mistakes are reasonable. Whether a mistake is reasonable in the circumstances is a question of fact which courts decide based on expert evidence. The courts rely on experts to inform them of the expected standard of care in like circumstances and to describe what would be considered appropriate treatment.

The accepted legal principle for the appropriate standard of care to be exercised by a physician comes from *Crits v. Sylvester*:

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<sup>45</sup> *Crawford v. Penney* at para. 253.

<sup>46</sup> *Sunnucks (Litigation guardian of) v. Tobique Valley Hospital*, [1999] N.B.J. No. 344 at para. 180.

The legal principles involved are plain enough but it is not always easy to apply them to the particular circumstances. 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 than of one who does not profess to be so qualified by special training and ability.<sup>47</sup>

Thus, a higher standard of care is required of a specialist than of a general practitioner.

It is also established that the greater the degree of risk of a procedure, the higher the standard of care. As Picard and Robertson state:

The standard of care is influenced by the foreseeable risk. As the degree of risk involved in a certain treatment or procedure increases, so rises the standard of care expected of the doctor. The principle was expressed succinctly in one case as follows: the "degree of care required by the law is care commensurate with the potential danger."<sup>48</sup>

The standard of care imposes certain duties on a practitioner. While not an exhaustive list, these duties include the following<sup>49</sup>:

1. The duty to be competent (which includes the duty to keep up one's knowledge and skills);
2. The duty to diagnose. Picard and Robertson explain this duty:  
The duty to diagnose requires doctors to take a full history, use appropriate tests and consult or refer if necessary. They must take reasonable care to detect signs and symptoms and formulate a diagnosis using good judgment. They cannot act only on what they are told, nor ignore what they are told. Sophisticated tests and continuing knowledge of disease must be employed when appropriate (at 245);
3. The duty to refer when the doctor is unable to properly treat the patient; and
4. The duty to inform the patient of all material risks.

It is unclear exactly how technological applications will affect the standard of care analysis but it seems clear that technology affects the duties just enumerated. It may be that soon the duty to be competent will require practitioners to become proficient in telehealth technologies. How will the ability of practitioners to "examine" a patient at a distance alter the requirements for the duty to diagnose? Will there be an increased expectation that practitioners will refer now that referrals can be made more

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<sup>47</sup> *Crits v. Sylvester*, [1956] O.R. 132 at 143 (C.A.).

<sup>48</sup> Picard and Robertson at 193.

<sup>49</sup> Picard and Robertson at ch. 5.

expeditiously? What aspects of the technology will have to be explained to the patient in order for health care providers to meet the duty to inform the patient?

At this point a consensus has not yet developed to establish clear standards in this situation. Some professional organizations are developing standards and guidelines for their members. In Manitoba, for example, the College of Physicians and Surgeons have issued guidelines for the provision of telemedicine services: “The College of Physicians and Surgeons Manitoba expects a physician who provides telemedicine services to have the same standards of practice as a physician who sees patients directly.”<sup>50</sup> The guideline attempts to set out a standard of care for doctors in Manitoba by imposing duties on them. Two, in particular, are interesting. The first appears to impose a new duty on Manitoba doctors:

**Awareness of the Telemedicine Treatment Option:** Physicians treating remote or mobility-limited patients must be aware of the telemedicine treatment option and its potential application to their patients.<sup>51</sup>

Arguably, the wording of this provision is broad and suggests that the duty to consider telemedicine falls on all physicians, including those who do not currently practice in that manner. The second duty is:

**Adequate Equipment:** Any physician delivering treatment or gathering information through electronic means should take reasonable steps:

- to ensure the hardware and software being relied upon is functioning properly, including ensuring that:
- any support staff involved in operating the equipment are adequately trained and competent to use the equipment, and
- equipment is up to date and reliable.
- in the case of computer equipment, to ensure that the possibility of computer viruses and malfunctions is kept to a minimum.
- in the case of an urgent medical or surgical procedure being conducted by a telemedicine process, to ensure a backup system is in place to protect the patient in the event of an equipment malfunction.
- where the patient controls some component of the equipment used in the telemedicine intervention, such as a computer or monitoring device, to ensure that:
- the patient understands the importance of that equipment to the process, and
- the patient is competent to handle it properly and to advise the appropriate person or facility in the event of a malfunction or an inability to operate it.
- Where a physician participates in a telemedicine process as part of a team or for a specific health care facility, it is the physician's responsibility to

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<sup>50</sup> College of Physicians and Surgeons of Manitoba, Statement No. 166 - Telemedicine, 2002, online: [www.cpsm.mb.ca/about/bylaws\\_guidelines/statements/Ethics/Statement166](http://www.cpsm.mb.ca/about/bylaws_guidelines/statements/Ethics/Statement166).

<sup>51</sup> *Ibid.*

determine who will be responsible for the technical aspects of the telemedicine intervention.<sup>52</sup>

When technology is used, it is reasonable to assume that often it would be for the purposes of getting the opinion of a specialist. As discussed earlier, specialists are held to a higher standard of care than general practitioners. A doctor in an emergency room may send an X-ray to a radiologist's home or office computer. When these kinds of activities take place, a question could arise as to whether the standard expected of the general practitioner would be applied, or the higher standard of the specialist.

### **10. Given that institutions frequently make decisions regarding equipment based on economic factors, can cost considerations be used as a defence to avoid or reduce liability?**

There has been a veritable explosion of technologies created for the health care field. It is impossible to expect that all facilities can afford the newest and best technologies. Governments and institutions are put in the position of deciding which technologies present the best value for the money. Thus, while it is not possible for all hospitals to have Zeus or di Vinci robotically assisted surgery systems, it would be rare to find a facility without an x-ray machine. Similar to health care providers, the standard of care required for health facilities is to have the equipment and staff that a similarly situated facility would possess. As Morris and Gleason state:

As with standard treatment, health facilities will be expected as a matter of law, to provide up-to-date supplies and equipment consistent with the supplies and equipment being employed by health facilities in similar circumstances. While fiscal restraints may make it difficult for a health facility to purchase and maintain state-of-the-art supplies and equipment, legal liability will not be avoided if the supplies and equipment being used in the facility are substandard, poorly maintained or operated by inadequately trained personnel.<sup>53</sup>

Although there have been very few cases addressing the issue of economic arguments in the health care context, claims in this area are beginning to arise. For example, in *Law Estate v. Simice*, the British Columbia Supreme Court addressed the idea of a defence based on the economics of the health care system. In this case, the estate of the deceased argued that a failure to diagnose occurred because the defendant doctors did not order a timely CT scan. The defendants argued that they felt constrained by the British Columbia Medical Insurance Plan and the B.C. Medical Association standards related to using CT scans as a diagnostic tool. With respect to the cost constraint issue, the Court stated:

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<sup>52</sup> *Ibid.*

<sup>53</sup> J. Morris and M.L. Gleason, "Malpractice and Institutional Liability" in M.J. Dykeman, ed. *Canadian Health Law Practice Manual* looseleaf (Markham: LexisNexis Butterworths, 2005) at para 6.70.

I understand that there are budgetary problems confronting the health care system...I respectfully say it is something to be carefully considered by those who are responsible for the provision of medical care and those who are responsible for financing it. I also say that if it comes to a choice between a physician's responsibility to his or her individual patient and his or her responsibility to the medicare system overall, the former must take precedent in a cause such as this. The severity of the harm that may occur to the patient who is permitted to go undiagnosed is far greater than the financial harm that will occur to the medicare system if one more CT scan procedure only shows the patient is not suffering from a serious medical condition.<sup>54</sup>

A distinction must be made, however, between technologies that are well established and available (like a CT scan) and novel or scarce technologies. Cost containment arguments may not win the day when the technology is available but they may be more persuasive if an injured party argues that the absence of a novel or scarce technology would have avoided the harm. There is the potential for patients to litigate on the grounds that the facility had not put enough resources into technology so as to avoid the kind of harm that is alleged (e.g., if the rural hospital had put more money into technology to enable computer consultations, the surgery would have gone differently.) In determining whether this argument would be successful, the court would look to the situation in similarly situated facilities. If the technology is considered a part of the expected standard of care, the facility may be held responsible.

With rising health care costs and the public's fierce interest in maintaining and expanding our health care system, the question of cost containment will be one that is likely to remain. There has been a lack of consistency in Canadian courts' willingness to intervene regarding government attempts at fiscal restraint. As noted above, in *Law Estate v. Simice*, the court was not persuaded by cost containment as a factor in how the health care was allocated. In *Auton v. British Columbia*,<sup>55</sup> the plaintiffs argued that the failure of the B.C. government to cover the costs of an autism treatment violated the petitioners' equality rights under the *Charter*. One of the arguments put forward by the province was that it was not financially able to support the treatment given its other obligations. The Supreme Court found for the province and held that the treatment for autism did not have to be publicly funded. The recent decision of *Chaoulli v. Quebec*<sup>56</sup> held, on the other hand, that the province violated the petitioner's right to life, liberty and security of the person when it failed to provide him with a hip operation in a timely fashion, and refused to allow him to purchase insurance so that he might pay for it outside of the publicly funded system. The province argued that the prohibition on private insurance was partly to maintain the financial viability of the public system. Controversially, a majority of the Supreme Court of Canada found that there was no evidence to support that a parallel private system would jeopardize our publicly funded system. Provincial governments are now scrambling to respond to the *Chaoulli* decision

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<sup>54</sup> (1994) 21 C.C.L.T. (2d) 228.

<sup>55</sup> [2004] 3 S.C.R. 657.

<sup>56</sup> [2005] S.C.J. No. 33.

for, in effect, the decision is forcing them to either spend more scarce resources on healthcare costs to reduce waiting times or to amend legislation prohibiting private insurance.

### **11. Changing standards as to what constitutes ‘reasonableness’ for purposes of meeting the standard of care.**

As has been mentioned above, the standard of care expected from a physician is that “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 reasonable be expected of a normal, prudent practitioner...”<sup>57</sup> Better technologies have often resulted in raising the standard of care, as what is novel or scarce becomes accepted and available. The College of Physicians and Surgeons of Manitoba Guidelines contain the following:

**Awareness of the Telemedicine Treatment Option:** Physicians treating remote or mobility-limited patients [in Manitoba] must be aware of the telemedicine treatment option and its potential application to their patients.<sup>58</sup>

Arguably, this imposes a higher standard of care on rural practitioners in Manitoba. Presumably, a practitioner who fails to avail him or herself of this option in appropriate circumstances is not meeting the standard of care.

However, the use of technology to enable consultation with practitioners located elsewhere may affect what is reasonable in another way. Picard and Robertson note that a “thorough history, proper examination, appropriate tests” are “clearly basic to a proper diagnosis.”<sup>59</sup> However, consultations at a distance do not allow, for example, a ‘proper examination’, and yet the consultant may be called upon to make a diagnosis. In this case, courts may have to adjust the standard as to what will be deemed reasonable, and to be flexible in the face of new technologies.

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<sup>57</sup> *Crits v. Sylvester* (1956) 1 D.L.R. (2d) 502 at 508.

<sup>58</sup> College of Physicians and Surgeons of Manitoba, Statement No. 166 - Telemedicine, 2002, online: [www.cpsm.mb.ca/about/bylaws\\_guidelines/statements/Ethics/Statement166](http://www.cpsm.mb.ca/about/bylaws_guidelines/statements/Ethics/Statement166).

<sup>59</sup> Picard and Robertson at 240-241.