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Health Law: Introduction

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I. Introduction

Healthcare providers, including institutions, are subject to a myriad of professional obligations, including ethical, civil, regulatory, and sometimes even criminal obligations. These obligations derive from statute, jurisprudence, codes of ethics, hospital policies and by-laws, and regulatory authority standards of practice or guidelines. Patients have a variety of rights when receiving health services from providers and healthcare institutions. These corresponding rights and duties make up the vast area of law commonly called “health law.”

Health law includes practitioners in a wide variety of disciplines that fall under its umbrella. Health law practitioners may find themselves arguing medical liability cases in civil or criminal courts; defending a healthcare provider in proceedings before their regulatory authority or hospital; assisting their client in billing reviews, privacy complaints, or mental health or capacity reviews; or supporting a client at a coroner’s inquest or fatality inquiry.

This book will focus on civil liability claims, especially but not limited to those made as a claim in negligence. We will often use the term medical liability to cover the broad spectrum of claims that can be brought by claimants. The book will provide an overview of the law applicable to such claims and practical insight into how such claims are assessed, brought, defended, and litigated. This chapter will outline the various sources of liability or other forms of accountability that a healthcare provider or healthcare institution may face.

Subsequent chapters will explore the nature of the healthcare provider–patient relationship and the various aspects of a civil liability claim, focusing on negligence claims that may be brought against a healthcare provider. Elements of a negligence claim, damages that a patient may seek when bringing such a claim, the various types of negligence commonly seen in health litigation, and defences that are typically advanced in response to such claims will be explored. In the context of this discussion, the book will briefly touch on intentional torts that are often associated with, but are legally distinct from, those that arise in the area of negligence and mental health law, such as battery and false imprisonment.

This book will also address the practice of health law and what it means to litigate a medical liability case. Finally, the book will cover a number of current topics relevant to healthcare, including mental health issues.

II. Sources of Liability and Other Forms of Accountability

A. Civil Actions

When a patient suffers harm as a result of the acts or omissions of a healthcare provider, the patient may seek accountability for that harm by commencing a civil action.

Canada’s legal system benefits from the legacy of both common law and civil-law legal traditions. In practice, precedent from one legal tradition tends not to be cited by the other in civil liability cases. Civil liability in provinces and territories other than Quebec is determined by the common law. In Quebec, the civil law is the

prevailing legal system, and civil responsibility (as civil liability is called in Quebec) is determined by the principles in the *Civil Code of Quebec*,¹ which finds its roots in the French Napoleonic Code.² However, when it comes to civil medical liability, the legal norms in each tradition are not fundamentally at odds with each other. On the contrary, legal norms are shared and mostly consistent with each other, and the most important differences are those related to terminology, nuance, and procedure.

This book will focus on the common law system relating to healthcare providers and will only touch on issues arising in Quebec's distinct medico-legal environment.

1. Negligence

Tort law is a branch of the common law that concerns the relationship between private individuals or entities in which an act of commission or omission by one party gives rise to injury or harm to another. Tort law compensates successful plaintiffs for their injury or harm through an award of damages.³

*Negligence*⁴ is a type of tort. A claim in negligence asserts a failure of the defendant to exercise the level of care and attention that an ordinary and reasonably prudent person would exercise in similar circumstances. Negligence claims are brought by plaintiffs who have suffered harm and wish to pursue compensation for damages, including future care costs, rehabilitation expenses, lost earnings, and pain and suffering.

In the context of an injured patient, a claim can be brought for *medical negligence*. This is a subset of negligence claims specific to healthcare providers and institutions and is the main cause of action seen in civil lawsuits brought against them. In medical negligence cases, healthcare providers may be held civilly liable if they are found to have breached the expected standard of care, resulting in harm to a patient.

BOX 1.1

PRACTICE TIP

As in all negligence cases, the plaintiff in a medical negligence case must establish all of the following elements:

- the defendant healthcare provider owed a duty of care to the plaintiff;
- the defendant breached that duty by failing to observe the applicable standard of care;
- the plaintiff sustained injury; and
- that injury was caused by the defendant's breach.

1 CQLR c CCQ-1991.

2 Department of Justice Canada, *Bijuralism in Supreme Court of Canada Judgments Since the Enactment of the Civil Code of Quebec* (Ottawa: Government of Canada, 2025), s 2.2, online: <<https://www.justice.gc.ca/eng/rp-pr/csj-sjc/harmonization/hfl-hlf/b3-f3/bf3f.html>>.

3 Damages are discussed in more detail in Chapters 3 and 4.

4 Negligence is discussed in more detail in Chapter 3.

The issues of duty of care, standard of care, damages, and causation will be addressed in more detail in Chapters 2–4.

Less common in medical negligence cases are claims in *vicarious liability* against a healthcare provider. Vicarious liability arises when the healthcare provider is deemed to be liable to the patient for the tortious acts of another person, typically their employee. The employee may also be named in the action for their direct liability in the case.

Hospitals, health authorities, and medical clinics are generally vicariously liable for the negligent acts of their employees acting within the scope of their employment. Individuals who are healthcare providers are not normally held vicariously liable for the acts of other healthcare professionals acting within their scope of practice.⁵ A physician, for example, is not generally responsible for the negligence of a resident who used their own independent judgment in the treatment of a patient.⁶ They are also not vicariously liable for the negligent acts of nurses with whom they work at a hospital.⁷ This distinction is important given that the healthcare system increasingly relies on collaborative care teams to provide services to patients.

Where a healthcare professional fails to adequately supervise the work of another healthcare provider who is not their employee and to whom the healthcare professional has delegated tasks, or where the task delegated is beyond the competence and training of the other healthcare provider, the delegating healthcare professional could be liable directly in negligence for those failures, but not vicariously liable.⁸

2. Intentional Torts

Intentional tort claims differ from a typical negligence claim because intent is a necessary element.

Battery and false imprisonment are the two most common intentional torts in the health law context. Less frequent are claims for defamation brought by a patient against a healthcare provider and claims for intrusion upon seclusion, discussed later in this chapter.

a. Battery

Battery is an intentional infliction of unlawful force or contact on another person. Once the plaintiff establishes the battery, the onus is on the defendant to show consent or other lawful excuse. Sexual battery involves intentional touching of a sexual nature.

*Reibl v Hughes*⁹ remains the leading decision on battery in the healthcare context. This decision distinguished battery from the concept of informed consent, which will

5 *Scharnagl v Stimpson*, 2009 SKQB 474 at para 51.

6 *Kielley v General Hospital Corp*, 1997 CanLII 14701 at para 35 (NLCA).

7 *Granger (Litigation Guardian of) v Ottawa General Hospital*, [1996] OJ No 2129 (QL), 7 OTC 81 (CJ).

8 *Kielley v General Hospital Corp*, 1997 CanLII 14701 at para 36 (NLCA).

9 1980 CanLII 23 (SCC).

be discussed later in this book. In *Reibl*, the Supreme Court of Canada clarified that battery occurs where treatment is done without consent or extends beyond the scope of the consent that was given:

In my opinion, actions of battery in respect of surgical or other medical treatment *should be confined to cases where surgery or treatment has been performed or given to which there has been no consent at all or where, emergency situations aside, surgery or treatment has been performed or given beyond that to which there was consent.*¹⁰

Claims of battery in medical negligence claims are usually made where:

1. there has been no consent at all, or
2. the treatment is different than what was consented to, or
3. the consent was obtained by fraud or misrepresentation.¹¹

Battery may be alleged if the wrong operation or procedure was conducted,¹² or if a non-urgent medical procedure is conducted on an incapable patient without obtaining the consent of their substitute decision-maker.¹³

In claims of medical battery, the plaintiff does not need to obtain costly experts if they establish the elements of the tort, and the onus is on the defendant to prove that consent was obtained. Damages may be awarded for mental distress even if no physical injury occurred and the treatment was beneficial to the plaintiff's health.¹⁴

b. False Imprisonment

The intentional tort of false imprisonment involves an act of detaining or restraining another person without lawful purpose.

In the healthcare context, such claims can arise when a patient is confined or restrained against their will without legal justification, including situations where committal under a mental health statute is alleged to be unjustified.¹⁵ Most claims for false imprisonment are brought by patients against psychiatrists and psychiatric institutions.¹⁶ See Chapter 8 for a more fulsome discussion of false imprisonment claims.

¹⁰ *Ibid* at 890-91 (emphasis added).

¹¹ *Suserski v Nurse*, 2006 CanLII 40677 at para 29 (ONSC), aff'd 2008 ONCA 416, leave to appeal to SCC dismissed, 2008 CanLII 55976 (SCC).

¹² *Bollman v Soenen*, 2014 ONCA 36 at para 18; *Denman v Radovanovic*, 2024 ONCA 276 at para 43.

¹³ Ayanna Ferdinand, *Halsbury's Laws of Canada: Medicine and Health* (Toronto: LexisNexis, 2007) at HMH-275.

¹⁴ *Malette v Shulman*, 1990 CanLII 6868 (ONCA).

¹⁵ *Kozak v Beatty*, 1957 CanLII 161 (SKCA); *Cochlin v Alberta*, 1983 CanLII 1148 (ABQB).

¹⁶ Canadian Medical Protective Association, *Medico-Legal Handbook for Physicians in Canada* (Ottawa: CMPA, 2021), online: <<https://www.cmpa-acpm.ca/en/advice-publications/handbooks/medical-legal-handbook-for-physicians-in-canada>>.

c. Defamation

While rare in the healthcare setting, defamation is another intentional tort that may give rise to civil liability. There have been very few actions in defamation initiated by patients against healthcare providers, but such claims could increase in the future since healthcare providers are increasingly using social media, websites, and blogs. Patients are becoming more accustomed to accessing their medical records online or by making formal access requests, and they may take issue with information contained in their records. However, there remain defences available to healthcare providers that may prove helpful in keeping the number of successful claims low.

Defamation actions against healthcare providers require proof that a healthcare provider has made a false written or oral statement that has diminished the patient's reputation in the community.¹⁷ For example, a patient may allege that statements made in a physician's medical report provided to a third party, such as an insurer, are defamatory.¹⁸

Truth is an absolute defence in a defamation action. The defence of "qualified privilege" can also often be raised in the healthcare context.¹⁹ This defence protects a person, whether or not the words are in fact true, provided the person had a duty to make the comments and acted fairly in so doing. The duty does not necessarily need to be a legal one; a moral duty suffices. In order to be seen to have acted fairly, the individual must have made the statement honestly, in good faith, and without malice.

B. Regulatory Authorities

Most healthcare providers are subject to regulation as a condition of their professional licence. Approximately 30 health professions are regulated under Canadian provincial and territorial legislation.²⁰ Jurisdictions differ as to which professions are regulated and how a regulation is implemented.

Provincial and territorial health regulatory authorities typically adopt by-laws, policies, standards of practice, and guidelines that outline the expected conduct and professional behaviour of the members they license. Regulatory authorities have the

17 For an example of an action in defamation successfully brought by a physician against a patient blogger, see *Peterson v Deck*, 2021 BCSC 1670.

18 See e.g. *Rubens v Sansome*, 2017 NLCA 32.

19 *McLoughlin v Kutasy*, 1979 CanLII 39 (SCC); *Halls v Mitchell*, 1928 CanLII 1 (SCC); *Hynes v Hayes*, 1999 CanLII 1818 (NSSC).

20 See e.g. Government of Alberta, "Regulated Health Professions and Regulatory Colleges" (last visited 28 May 2026), online: <<https://www.alberta.ca/regulated-health-professions>>; Health Profession Regulators of Ontario, "Quick Facts About HPRO Members" (last visited 28 May 2026), online: <<https://www.regulatedhealthprofessions.on.ca>>; BC Health Regulators, "Regulated Health Professionals" (last visited 28 May 2026), online: <<https://bchealthregulators.ca/health-regulation-in-bc/regulated-health-professions>>; Government of Manitoba, "Regulated Occupations" (last visited 28 May 2026), online: <<https://immigratemanitoba.com/life/regulated-occupations>>.

power to discipline their members for contravening these standards of practice. They do not have the power to award damages to patients, but they can impose a variety of sanctions on their members, including cautions, requiring participation in mandatory education and remediation programs, mandating practice supervision, imposing conditions on a member's health practice, ordering licence suspension or revocation, or imposing fines.

By way of example, it is not unexpected for a physician to become involved in matters before their medical regulatory authority at some point in their career,²¹ including complaints of professional misconduct, college-initiated investigations, discipline or fitness proceedings, and practice reviews.²²

Complaints can be initiated by patients, a colleague, or an institution at which the healthcare provider practices. The latter may occur because of a statutory obligation imposed on healthcare providers or healthcare facilities to report a healthcare provider to their regulatory authority in certain circumstances, such as where they have reasonable grounds to believe the healthcare provider has committed sexual misconduct,²³ is impaired, is incompetent, or is engaging in professional misconduct.²⁴

21 A five-year review included in the Canadian Medical Protective Association's (CMPA) 2023 Annual Report shows that regulatory cases are by far the most common type of medical-legal case handled by the CMPA each year: CMPA, "2023 Annual Report" (last visited 28 May 2026), online: <<https://www.cmpa-acpm.ca/en/about/annual-report/2023-cmpa-annual-report>>. See also CMPA, "Understanding How Colleges Handle Complaints or Allegations of Professional Misconduct" (March 2023), online: <<https://www.cmpa-acpm.ca/en/advice-publications/browse-articles/2012/understanding-how-colleges-handle-complaints-or-allegations-of-professional-misconduct>>.

22 See e.g. *Regulated Health Professions Act, 1991*, SO 1991, c 18, Schedule II, *Health Professions Procedural Code*.

23 See e.g. BC's *Health Professions Act*, RSBC 1996, c 183, s 32.4; Manitoba's *The Regulated Health Professions Act*, CCSM c R117, s 138(1); Alberta's *Health Professions Act*, RSA 2000, c H-7, s 127.2; and Ontario's *Regulated Health Professions Act, 1991*, SO 1991, c 18, Schedule II, *Health Professions Procedural Code*, ss 85.1-85.3.

24 See e.g. New Brunswick's *Medical Act*, SNB 1981, c 87, s 52.3; PEI's *Regulated Health Professions Act*, RSPEI 1988, c R-10.1, s 62(1); Newfoundland and Labrador's *Medical Act, 2011*, SNL 2011, c M-4.02, ss 39(c), 41(1); Quebec's *Code of Ethics of Physicians*, CQLR c M-9, r 17, s 119; and College of Physicians and Surgeons of Alberta, "Standards of Practice: Duty to Report Colleague" (last modified 1 October 2020), online: <<https://cpsa.ca/physicians/standards-of-practice/duty-to-report-a-colleague>>.

BOX 1.2**PRACTICE TIP**

Health regulatory authorities are generally granted broad powers to investigate complaints made against their members. In many instances, minor or low-risk complaints can be resolved informally or at an early stage, including through an alternative dispute resolution process or by the registrar.

It is not uncommon for allegations in a complaint to a health regulatory authority to be raised by the patient in a related civil action. Many statutes governing regulated health professions provide that documents or evidence gathered or decisions rendered in the context of a regulatory proceeding cannot be used in any other proceeding.²⁵ As an example, section 53 of British Columbia’s *Health Professions Act*²⁶ contains a provision intended to protect the confidentiality of regulatory proceedings. The purpose of the provision is “to protect persons who allege misconduct and the process through which alleged misconduct is judged from civil litigation that is brought outside of the disciplinary process that is designed to ensure quality of care.”²⁷

C. Institutions That Provide Healthcare

Institutions that provide healthcare, such as a hospital or a health authority, have separate duties toward patients that are imposed by law. A hospital has an obligation to meet the standards reasonably expected by the community it serves in the provision of competent personnel and adequate facilities and equipment. The Ontario Court of Appeal in *Yepremian v Scarborough General Hospital*²⁸ confirmed that a hospital has a responsibility to provide a “safe system” for patients. A hospital must ensure that systems are in place to coordinate personnel, facilities, equipment, and records so that patients receive adequate care.

As such, it is the hospital’s responsibility to ensure that the healthcare providers it grants privileges to and the healthcare providers it employs have the necessary qualifications, skills, and training to perform the duties they are requested to undertake. It is also up to the hospital to develop appropriate policies and protocols with respect to healthcare delivered within the institution.

25 See e.g. Ontario’s *Regulated Health Professions Act, 1991*, SO 1991, c 18, Schedule II, *Health Professions Procedural Code*, s 36(3); Nova Scotia’s *Medical Act*, SNS 2011, c 38, s 67, and Alberta’s *Health Professions Act*, RSA 2000, c H-7, s 125(1).

26 RSBC 1996, c 183.

27 *Stelmaschuk v The College of Dental Surgeons of British Columbia*, 2018 BCSC 2421 at para 13. See also *Beale v Nagra*, 1998 CanLII 5078 at para 26 (BCCA).

28 1980 CanLII 1906 (ONCA).

Many healthcare providers, such as nurses, are employees of their institutions. Other healthcare providers, such as physicians, may be independent contractors who have contracted with the institution or been granted privileges to admit and treat patients and access its resources. While the traditional privileges model is subject to procedural fairness requirements set out in by-laws and applicable statutes or case law, contractual arrangements may not provide the same protection to the healthcare provider when defending a hospital complaint against them.²⁹ In addition, although a physician's privileges might remain intact following the termination of the contract, the physician will likely be unable to exercise (or be significantly restricted from exercising) their privileges without a contract. One of the necessary components of an effective healthcare system is a well-designed, functional medical liability system that assures both healthcare providers and their patients that their interests and access to due process will be protected.

The relevant legislation in most jurisdictions requires hospitals or health authorities to advise the healthcare provider's regulatory authority when the provider is suspended or their authority to admit, attend to, or treat patients has been cancelled or significantly altered because of incompetence, negligence, or misconduct.³⁰ The legislation also typically requires that the regulator be notified when a healthcare provider resigns during an investigation into their competence, negligence, or conduct. These hospital or health authority reports can therefore lead to related disciplinary proceedings before the healthcare provider's regulatory authority.

D. Criminal Proceedings

Healthcare providers rarely incur criminal liability in connection with their professional practice. However, charges have been laid, and convictions entered, against healthcare providers for intentional criminal acts, such as theft of narcotics and billing fraud.³¹

Of greater concern to healthcare providers is their exposure to criminal liability related to the treatment they provide to their patients. The discussion below focuses on two areas of criminal liability: criminal negligence and failing to provide the necessities of life. Chapter 7 will discuss the exposure to criminal liability that a physician or nurse practitioner may face arising from the *Criminal Code*³² provisions related to medical assistance in dying.

29 *Ready v Saskatoon Regional Health Authority*, 2017 SKCA 20.

30 See e.g. *Regulated Health Professions Act, 1991*, SO 1991, c 18, Schedule II, *Health Professions Procedural Code*, s 85.2.

31 The nurse in *Demme v Healthcare Insurance Reciprocal of Canada*, 2022 ONCA 503, who stole narcotics from an automatic dispensing machine over a ten-year period, was charged with several crimes and pleaded guilty to breach of trust and theft over \$5,000. The physician accused in *R v Bogart*, 2002 CanLII 41073 (ONCA) pleaded guilty to defrauding OHIP (Ontario Health Insurance Plan) of almost \$1 million over a period of seven years.

32 RSC 1985, c C-46.

1. Criminal Negligence

Absent egregious or exceptional circumstances, it is rare for charges of criminal negligence to succeed against a healthcare provider acting in their professional capacity in the treatment of a patient. Criminal negligence differs significantly from negligence in common law. To prove criminal negligence, there must be evidence beyond a reasonable doubt that the healthcare provider showed “wanton or reckless disregard for the lives or safety of other persons.”³³ Pursuant to the *Criminal Code*, everyone who, through criminal negligence, causes death or bodily harm to another person is guilty of an indictable offence and could be liable for imprisonment for life (in the case of criminal negligence causing death) or imprisonment for up to ten years (in the case of criminal negligence causing bodily harm).³⁴

The conviction of a UK physician for gross negligence manslaughter³⁵ raised concerns in Canada that a similar charge could be laid in this country. In the UK case, the physician was treating a child in hospital who later died of septic shock. The criminal conviction was very troubling to the medical profession since it suggested that there was a likelihood that an honest mistake could carry criminal consequences. Given the severity of the outcome, the case attracted extensive media attention and scrutiny from physicians and trainees within Canada and internationally.³⁶

Historically there have been very few Canadian cases involving healthcare providers charged with criminal negligence, and even fewer that resulted in a conviction.³⁷ There is no indication of a change occurring in this trend.

In *R v Javanmardi*,³⁸ a Quebec naturopath was charged with criminal negligence causing death and manslaughter after a patient died of endotoxic shock following the naturopath intravenously administering nutrients to the patient, who had heart disease. The trial judge acquitted the naturopath of both charges, but the Court of Appeal set aside both acquittals. The Supreme Court of Canada restored the acquittals.

The Supreme Court articulated the legal standard to determine whether the fault element—*mens rea*—of each offence has been proven. The Court set out a

33 *Criminal Code*, s 219.

34 *Criminal Code*, ss 220-21.

35 *R v Bawa-Garba*, [2016] EWCA Crim 1841.

36 Wendy Glauser, “Should Medical Errors Ever Be Considered Criminal Offences?” (2018) 190:16 CMAJ E518.

37 See e.g. *R v Swanney*, 2006 BCSC 1766 for an example of an acquittal for a charge of criminal negligence causing death; *R v Manjanatha*, 1995 CanLII 3980 (SKCA), where an anesthetist was charged with criminal negligence and pleaded guilty after he left the operating room to place a call, during which time there was an equipment failure and the patient died; *R v Armour Pharmaceutical Company*, 2007 CanLII 40864 (ONSC), where the criminal negligence and common nuisance charges relating to the distribution of contaminated blood products in Canada against the former director of the Canadian Red Cross were “disproved.”

38 2019 SCC 54.

high standard for criminal negligence causing death: a “marked and substantial departure”³⁹ from the reasonable person standard. This is substantially higher than the civil negligence standard. For manslaughter, there must be proof beyond a reasonable doubt of a “marked departure” from the standard expected of a reasonable person in the circumstances. For both offences, an accused’s training, experience, and qualifications are relevant to the analysis. The Court called this an activity-sensitive approach to the modified objective standard.⁴⁰

2. Failing to Provide the Necessaries of Life

Perhaps even less common are charges for failing to provide the necessities of life.⁴¹ However, in a significant decision of the Ontario Court of Appeal,⁴² the Court upheld convictions against two paramedics for not following protocols in the case of a 19-year-old patient suffering from a penetrating wound to the abdomen. The paramedics were held to have made an erroneous assumption that the patient’s behaviour was rooted in a psychiatric condition or intoxication. The patient died while being transported to a psychiatric facility.

The Court confirmed that the criminal offence under section 215 of the *Criminal Code* requires the Crown to prove that, in failing to provide the necessities of life, the paramedics’ conduct represented a marked departure from that of a reasonably prudent paramedic in similar circumstances (the *mens rea* or fault element) where it was objectively foreseeable that the failure to provide the necessities of life would lead to a risk of danger to the patient’s life (the *actus reus* or prohibited act). The Court cited *Javanmardi* in finding that trial judges are obliged to consider an accused’s prior training, experience, and qualifications in a particular specialized field or activity before determining the standard of care in that field and whether the accused’s conduct markedly departed from that standard. The Court of Appeal agreed with the trial judge’s conclusion that the paramedics’ actions amounted to a marked departure from the standard of care expected from reasonably trained primary care paramedics.

A reasonably held honest mistake of fact constitutes a complete defence to a charge of failing to provide the necessities of life. In *R v Marchant*, the Court agreed with the trial judge that the accused paramedics were not engaged in inadvertence, thoughtlessness, or simple error in judgment, but instead made a conscious decision to ignore the obvious evidence before them, their training, and the standards with which they were familiar. The Court upheld the 18-month conditional sentences imposed by the trial judge.

39 *Ibid* at para 21.

40 *Ibid* at para 38.

41 *Criminal Code*, s 215.

42 *R v Marchant*, 2024 ONCA 537.

3. Sexual Misconduct

Health professionals can also face criminal liability for allegations of sexual misconduct. These allegations can occur in the context of the delivery of patient care, most often lack of informed consent for a medical procedure.⁴³ Alternatively, there may be allegations that a practitioner engaged in sexual misconduct unrelated to the medical procedure itself.⁴⁴

4. Duty to Report Criminal Charges and Convictions

When charged and convicted of an offence under the *Criminal Code* or *Controlled Drugs and Substances Act*,⁴⁵ most healthcare providers have a duty to report the charge and conviction to their regulatory authority. For example, in Ontario, section 85.6.1 of the *Regulated Health Professions Act, 1991*⁴⁶ requires members of regulated health professions to “file a report in writing with the Registrar if the member has been found guilty of an offence.” In Alberta, section 127.1 of the *Health Professions Act*⁴⁷ requires regulated members to report in writing to the registrar of their college, as soon as reasonably possible, if the regulated member has been charged with or convicted of an offence under the *Criminal Code*.

A report made to a regulatory authority could expose the healthcare provider to proceedings before their regulatory authority to determine if there are grounds to find professional misconduct based on the same set of facts. A finding of professional misconduct could lead to disciplinary sanctions up to and including the revocation of their licence.⁴⁸

E. Privacy and Confidentiality Proceedings

1. Breach of Confidence

Healthcare providers have both an ethical and legal duty to protect patient confidentiality. The duty of confidentiality is essential to the healthcare provider–patient relationship so that patients can be assured that the private health information they share with their healthcare provider is protected from disclosure to others. There are very specific exceptions to this duty, which are discussed further in Chapter 2.

Regulatory authorities often rely on a profession’s code of ethics to create their policies and standards. Failure to comply with the code of ethics is often considered to constitute unbecoming or unprofessional conduct. Accordingly, a health professional’s

⁴³ See e.g. *R v Connelly*, 2024 ABCJ 28.

⁴⁴ *R v Doodnaught*, 2017 ONCA 781.

⁴⁵ SC 1996, c 19.

⁴⁶ SO 1991, c 18, Schedule II, *Health Professions Procedural Code*.

⁴⁷ RSA 2000, c H-7.

⁴⁸ *College of Nurses of Ontario v Wettlaufer*, 2017 CanLII 77173 (ONCNO).

non-compliance with the code can lead not only to complaints, but to discipline before the regulatory authority. For physicians, the Canadian Medical Association's *Code of Ethics and Professionalism*⁴⁹ confirms the expansive nature of the ethical duty of confidentiality and its limited exceptions. The ethical practice of nurses is based on the Canadian Nurses Association's *Code of Ethics for Nurses*.⁵⁰ Psychologists are subject to the *Canadian Code of Ethics for Psychologists*.⁵¹

The Supreme Court has recognized the civil duty of confidentiality owed by physicians to their patients as resulting from the fiduciary relationship between physician and patient.⁵² A patient may sue a healthcare provider for breach of confidence in civil court to seek damages for the resulting harm caused by the breach. In practice, there have been few such cases. It has generally been more common for patients to complain to regulatory authorities or privacy commissioners about such breaches.

2. Tort of Intrusion upon Seclusion

Intrusion upon seclusion is another common law remedy that may be pursued by a patient against a healthcare provider who has breached confidentiality. In *Jones v Tsige*,⁵³ the Ontario Court of Appeal confirmed that the intentional tort of intrusion upon seclusion exists in Ontario.⁵⁴

49 Canadian Medical Association, *Code of Ethics and Professionalism* (Ottawa: Canadian Medical Association, 2018) at paras 18-21, online (pdf): <<https://policybase.cma.ca/viewer?file=%2Fmedia%2FPolicyPDF%2FPD19-03.pdf#page=1>>.

50 Canadian Nurses Association, *Code of Ethics for Nurses* (Ottawa: Canadian Nurses Association, 2025) at Guiding Principle 7.3, online: <<https://www.cna-aic.ca/en/nursing/regulated-nursing-in-canada/nursing-ethics>>.

51 Canadian Psychological Association, *Canadian Code of Ethics for Psychologists*, 4th ed (Ottawa: Canadian Psychological Association, 2017), s. 1.43, online (pdf): <https://cpa.ca/docs/File/Ethics/CPA_Code_2017_4thEd.pdf>.

52 *McInerney v MacDonald*, 1992 CanLII 57 (SCC). Fiduciary duties are discussed further in Chapter 2.

53 2012 ONCA 32.

54 This tort has yet to be widely adopted in other Canadian jurisdictions; see e.g. *Forgeron v Garner*, 2024 NSSC 80 at para 221; *Racki v Racki*, 2021 NSSC 46; *Unipco Ltd, a body corporate, Unipco Purchasing Program, a partnership v Scott Mullin*, 2023 NBKB 200 at paras 77-89. It also remains an undecided question whether common law provinces and territories with a statutory privacy tort (such as BC's *Privacy Act*, RSBC 1996, c 373, s 1 and Manitoba's *The Privacy Act*, CCSM c P125) will allow pleadings for the common law tort of intrusion upon seclusion. See e.g. *Moon v International Alliance of Theatrical Stage Employees (Local 891)*, 2024 BCSC 1560; *Insurance Corporation of British Columbia v Ari*, 2023 BCCA 331; *Grant v Winnipeg Regional Health Authority*, 2015 MBCA 44 at para 126; *Welshman v Central Regional Health Authority*, 2024 NLSC 35 at para 37.

BOX 1.3**PRACTICE TIP**

The Ontario Court of Appeal held that the tort of intrusion upon seclusion requires proof of three elements:

1. the defendant engaged in intentional or reckless conduct;
2. the conduct involved an intrusion, without lawful justification, into the plaintiff's private affairs or concerns; and
3. a reasonable person would regard the invasion as highly offensive causing distress, humiliation, or anguish.

If these three elements are established, the behaviour is actionable without proof of damages.

A healthcare provider may be liable for intrusion upon seclusion if, for example, they accessed a patient's medical records for non-clinical purposes without the patient's consent ("snooping"). Damages for such claims are typically modest where the plaintiff has suffered no pecuniary loss. However, the Court of Appeal in *Jones* stated that damages should be "sufficient to mark the wrong that has been done."⁵⁵

The tort of intrusion upon seclusion was pleaded in claims commenced by several patients against a nurse who improperly accessed over 11,000 patient records to obtain narcotics for her own use.⁵⁶ Despite the volume of patient records accessed, the Ontario Divisional Court overturned the decision to certify the intrusion upon seclusion claim on the basis that the improper access was not "highly offensive" because the access was fleeting and not for the purpose of snooping.⁵⁷ Following the Divisional Court's decision, eight individual actions were commenced. No reasons for decision have been published in those cases.

The Ontario Superior Court of Justice allowed the claim for intrusion upon seclusion in *JC v Jugenburg*,⁵⁸ arising from allegations that a medical clinic used cameras to record patients without their consent. The Court made a finding of intrusion upon seclusion and awarded aggregate and punitive damages for the intrusion claim; however, because negligence and breach of fiduciary duty require proof of actual harm, causation and damages for those claims were left to be addressed through a subsequent individual claims process.⁵⁹

⁵⁵ *Jones v Tsige*, 2012 ONCA 32 at para 87.

⁵⁶ *Demme v Healthcare Insurance Reciprocal of Canada*, 2022 ONCA 503.

⁵⁷ *Stewart v Demme*, 2022 ONSC 1790 at para 27.

⁵⁸ 2026 ONSC 3061.

⁵⁹ *Ibid* at paras 274, 289, 311.

Not all cases of unauthorized access to personal information will result in a successful claim for intrusion upon seclusion. In *Broutzas v Rouge Valley Health System*,⁶⁰ employees of two hospitals accessed records of patients who had recently given birth and used or sold their contact information for the purposes of soliciting sales of registered education savings plans. The patients were notified of the breach by the hospital and commenced a class action. They relied on the tort of intrusion upon seclusion in bringing their claim.

The Ontario Superior Court of Justice dismissed the claim in *Broutzas* on the grounds that there was no significant invasion of personal privacy, and a reasonable person would not find the disclosure of contact information without the disclosure of medical, financial, or other sensitive information offensive or a cause of distress, humiliation, or anguish. The Court emphasized that although some of the defendants were found liable for professional misconduct or other civil, criminal, or statutory wrongs associated with personal privacy, the separate and narrow parameters of the tort of intrusion upon seclusion were not established in this case.

3. Breach of Privacy

Healthcare providers also have a statutory duty to protect the privacy of their patients' personal health information. Most Canadian provinces and territories have enacted health-specific privacy legislation that sets out the duties of a custodian of personal health information.⁶¹ A custodian has custody and control of a patient's personal health information. Custodian duties are imposed, for example, on a physician who has their own medical practice, on a physiotherapy clinic, and on hospitals. In addition, in a healthcare institution, it is not uncommon for healthcare providers to be considered "agents" of the hospital custodian, and that agent role carries its own duties under privacy legislation.

A patient who believes their personal health information has been subject to unauthorized collection, use, or disclosure by a healthcare provider may complain to their provincial or territorial privacy commissioner. They may also complain to the provider's regulatory authority. Most privacy statutes in Canada also require reporting a privacy breach to affected individuals, the privacy commissioner, the regulatory authority, or possibly all three.

60 2018 ONSC 6315, upheld on this point by the Divisional Court, 2023 ONSC 540.

61 *Health Information Act*, RSA 2000, c H-5; *The Health Information Protection Act*, SS 1999, c H-0.021; *The Personal Health Information Act*, CCSM c P33.5; *Personal Health Information Protection Act*, 2004, SO 2004, c 3, Schedule A; *Act respecting health and social services information*, CQLR c R-22.1; *Personal Health Information Privacy and Access Act*, SNB 2009, c P-7.05; *Personal Health Information Act*, SNS 2010, c 41; *Health Information Act*, RSPEI 1988, c H-1.41; *Personal Health Information Act*, SNL 2008, c P-7.01; *Health Information Act*, SNWT 2014, c 2; *Health Information Privacy and Management Act*, SY 2013, c 16.

Privacy commissioners can impose penalties and make various compliance orders, but they cannot award damages. It is therefore significant that the Ontario Court of Appeal held in *Hopkins v Kay*⁶² that a patient can commence civil proceedings in the Superior Court to seek damages related to an invasion of privacy, and that the *Personal Health Information Protection Act, 2004*⁶³ does not create an exhaustive code that overrides the jurisdiction of the Superior Court to entertain a common law claim for intrusion upon seclusion. Plaintiffs pursuing a common law remedy of intrusion upon seclusion will find it is generally more difficult to prove the elements of the cause of action than it is to establish a breach of privacy legislation.

F. Other Sources of Accountability

In addition to the sources of legal accountability discussed above, the acts or omissions of healthcare providers may also be reviewed or subject to a complaint in other settings, such as a human rights complaint or a fatality inquiry or coroner's inquest.

1. Human Rights Complaints

Patients have the legal right to equality and to receive healthcare services without discrimination. Section 1 of the Canadian Medical Association's *Code of Ethics and Professionalism*⁶⁴ and section 23 of Quebec's *Code of Ethics of Physicians*⁶⁵ prohibit physicians from discriminating against their patients. Human rights legislation across Canada also affirms a patient's right to receive health services without discrimination.⁶⁶

A patient may initiate a complaint to their provincial or territorial human rights commission where they believe they have faced discrimination in the care they have received from their healthcare provider. This can arise, for example, where a healthcare provider refuses to accept an individual as a patient or provide certain treatment on one of the protected grounds of discrimination.⁶⁷

62 2015 ONCA 112.

63 SO 2004, c 3, Schedule A.

64 (Ottawa: Canadian Medical Association, 2018), online (pdf): <<https://policybase.cma.ca/viewer?file=%2Fmedia%2FPolicyPDF%2FPD19-03.pdf#page=1>>.

65 CQLR c M-9, r 17.

66 See *Human Rights Code*, RSBC 1996, c 210; *Alberta Human Rights Act*, RSA 2000, c A-25.5; *The Saskatchewan Human Rights Code, 2018*, SS 2018, c S-24.2; *The Human Rights Code*, CCSM c H175; *Human Rights Code*, RSO 1990, c H.19; *Charter of Human Rights and Freedoms*, CQLR c C-12; *Human Rights Act*, RSNS 1989, c 214; *Human Rights Act*, RSNB 2011, c 171; *Human Rights Act*, RSPEI 1988, c H-12; *Human Rights Act, 2010*, SNL 2010, c H-13.1; *Human Rights Act*, RSY 2002, c 116; *Human Rights Act*, CSNu, c H-70; *Human Rights Act*, SNWT 2002, c 18.

67 See e.g. *Cantwell v Toronto East General Hospital*, 2017 HRT0 872; *Potter v Korn*, 1995 CanLII 18185 (BCHRT), appeal dismissed, 1996 CanLII 1818 (BCSC); *Morrison-George v Norman Krupa Medicine Professional Corporation*, 2015 HRT0 729.

2. Fatality Inquiry or Coroner's Inquest

A coroner's inquest or fatality inquiry is a public hearing examining the circumstances of an individual's death when that death occurs in statutorily specified circumstances. Such circumstances may include violence; misadventure; negligence; misconduct; malpractice; unfair means; during, following, or related to pregnancy; sudden and unexpected death, disease, or sickness not treated by a physician; any cause other than disease; or suspicious circumstances.⁶⁸ The inquiry or inquest may be held to explore the circumstances of the death and make recommendations aimed at preventing further deaths in similar circumstances.⁶⁹

The inquiry or inquest may include consideration of the healthcare provided to the individual at or around the time of death. However, a coroner's inquest or fatality inquiry cannot make findings of legal responsibility or fault.⁷⁰

All provinces and territories impose a mandatory duty to report on individuals who have knowledge of or reason to believe that a death occurred unexpectedly, suddenly, or because of violence, an accident, or negligence, or any of the other reportable circumstances set out in the statutes. A healthcare provider's failure to report such a death is considered an offence under many of the healthcare statutes in Canada and is subject to penalty.

III. Conclusion

As this chapter has demonstrated, healthcare providers operate within a complex web of accountability mechanisms. From civil liability in negligence to regulatory oversight, from criminal proceedings to privacy obligations, healthcare professionals must navigate multiple overlapping legal frameworks in their daily practice. Patients, in turn, have a variety of avenues through which they may seek redress when they believe they have been harmed or their rights have been violated.

Understanding these sources of liability and accountability is essential for healthcare providers, their legal counsel, and the institutions in which they practice. The various accountability mechanisms serve different purposes, including compensating injured patients, maintaining professional standards, protecting public safety, and safeguarding privacy. A single incident may give rise to civil litigation, regulatory proceedings, and privacy complaints simultaneously.

The chapters that follow will examine these issues in greater depth. Chapter 2 will explore the nature of the healthcare provider–patient relationship and the duties that flow from it. Subsequent chapters will address the elements of a negligence claim, damages, specific types of medical negligence, and available defences. The book will

68 *Coroners Act*, RSO 1990, c C.37, s 10; *Coroners Act*, SBC 2007, c 15, s 18; *Fatality Inquiries Act*, RSA 2000, c F-9, s 34.

69 *Faber v The Queen*, 1975 CanLII 12 (SCC). See e.g. *Coroners Act*, RSO 1990, c C.37, s 31.

70 See e.g. *The Fatality Inquiries Act*, CCSM c F52, s 33; *Coroners Act*, RSO 1990, c C.37, s 31(2).

also discuss the practical aspects of litigating medical liability cases and address current topics in healthcare, including mental health law. Together, these chapters provide a comprehensive foundation for understanding and navigating the medical-legal landscape in Canada.