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Statutory Good-Faith Immunity for Government Physicians: Cogent Policy or a Denial of Justice?

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STATUTORY GOOD-FAITH IMMUNITY FOR GOVERNMENT PHYSICIANS: COGENT POLICY OR A DENIAL OF JUSTICE?

*Andrew Flavelle Martin**

Recent events such as the SARS outbreak and the controversy over pediatric forensic pathology in Ontario have increased awareness and scrutiny of physicians employed by the government, including medical officers of health, coroners, and pathologists. At common law, physicians are held to a standard of care that can be summarized as reasonable professional competence. Statutory provisions effectively neutralize this standard of care for government physicians by providing civil immunity so long as they act in “good faith”. The appropriateness of this protection from civil liability is assessed in this paper.

The author argues that statutory good-faith immunity is inconsistent with the requirements that these positions be held by licensed doctors; indeed, it is a common provision of legislation for government employees that is not appropriate to the special case of government physicians. The Ontario statutory and case law is canvassed in relation to the powers and duties of coroners, forensic pathologists, and medical officers of health. It is then demonstrated that this statutory good-faith immunity is applied to the vast majority of public actors in Ontario. Within this context, the historic and current policy rationales for the immunity are assessed with reference to the recent judgments of the Supreme Court of Canada and the Ontario Court of Appeal establishing a tort of negligent investigation by police. The author then assesses how the common law of tort would apply to government physicians if these provisions were repealed.

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“To deny a remedy in tort is, quite literally, to deny justice.”

- The Right Honourable Beverley McLachlin, Chief Justice of Canada¹

INTRODUCTION

Events of recent years have increased both public awareness and political scrutiny of the work of physicians performing public functions. In 2003, the outbreak of Severe Acute Respiratory Syndrome (“SARS”) illustrated the importance of public health as a medical discipline.² In response to the SARS experience, the federal government commissioned an advisory committee led by Dr. David Naylor, and the Ontario government appointed a commission under Justice Archie Campbell, to examine the handling of SARS and make recommendations to strengthen public health programs and policy.³ Not long after SARS, death investigation—the discipline of coroners and forensic pathologists—attracted attention. In April 2007, the Office of the Chief Coroner for Ontario publicly confirmed serious problems with the work of once-renowned pediatric forensic pathologist Dr. Charles Smith.⁴ The government chose Justice Stephen Goudge of the Ontario Court of Appeal to lead a public inquiry that would “conduct a systemic review ... in order to make recommendations to restore and enhance public confidence in pediatric forensic pathology in Ontario and its future use in investigations and criminal proceedings.”⁵ A span of a few years had brought public examinations of three different kinds of government physicians: medical officers of health, coroners, and forensic pathologists.

Despite the merits of these examinations, a major issue remains unaddressed. The three reports were fundamentally concerned with the quality of public health and death investigation, two areas in which physicians play crucial roles. As a generalization, “[c]ivil liability is widely used in Canada as a mechanism to ensure quality of health services.”⁶ However, none of the

¹ *Hill v. Hamilton-Wentworth Regional Police Services Board*, 2007 SCC 41, [2007] 3 S.C.R. 129 at para. 35, 285 D.L.R. (4th) 620, affg (2005), 76 O.R. (3d) 481, 259 D.L.R. (4th) 676 (C.A.) [*Hill* (S.C.C.) cited to S.C.R.; *Hill* (C.A.) cited to O.R.].

² See e.g. Nola M. Ries, “Quarantine and the Law: The 2003 SARS Experience in Canada: A New Disease Calls on Old Public Health Tools” (2005) 43 Alta. L. Rev. 529; Roxana Salehi & S. Harris Ali, “The Social and Political Context of Disease Outbreaks: The Case of SARS in Toronto” (2006) 32 Canadian Pub. Pol’y 373.

³ National Advisory Committee on SARS and Public Health, *Learning from SARS: The Renewal of Public Health in Canada* (Ottawa: Health Canada, 2003) (Chair: Dr. David Naylor), online: Public Health Agency of Canada <<http://www.phac-aspc.gc.ca/publicat/sars-sras/pdf/sars-e.pdf>> [*Naylor Report*]; Commission to Investigate the Introduction and Spread of SARS in Ontario, *Final Report* (Toronto: Queen’s Printer for Ontario, 2006) (Commissioner: Justice Archie Campbell), online: Ontario Ministry of Health and Long-Term Care <http://www.health.gov.on.ca/english/public/pub/ministry_reports/campbell06/online_rep/index.html> [*Campbell Report*].

⁴ Office of the Chief Coroner, Background: Public Announcement of Review of Criminally Suspicious and Homicide Cases Where Dr. Charles Smith Conducted Autopsies or Provided Opinions (Toronto: Ministry of Community Safety and Correctional Services, 2007), online: Legislative Library, Legislative Assembly of Ontario <<http://www.ontla.on.ca/library/repository/mon/17000/272655.pdf>> [Coroner, “Background”].

⁵ Inquiry into Pediatric Forensic Pathology in Ontario, online: Ontario Ministry of the Attorney General, <<http://www.attorneygeneral.jus.gov.on.ca/inquiries/goudge/>>; *Inquiry into Pediatric Forensic Pathology in Ontario Report* (Toronto: Ontario Ministry of the Attorney General, 2008) (Commissioner: the Honourable Stephen T. Goudge), online: Ontario Ministry of the Attorney General <<http://www.attorneygeneral.jus.gov.on.ca/inquiries/goudge/report/index.html>> [Goudge Report]; O.C. 826/2007 at 2-3 (Order in Council establishing the Goudge Inquiry), in Goudge Report, vol. 4 at 678-79, online: Ontario Ministry of the Attorney General <<http://www.attorneygeneral.jus.gov.on.ca/english/news/2007/20070425-pi-oc-en.pdf>>.

⁶ Tracey Epps, “Regulation of Health Care Professionals” in Jocelyn Downie, Timothy Caulfield & Colleen Flood, eds., *Canadian Health Law and Policy*, 3d ed. (Markham: LexisNexis Canada, 2007) 69 at 75, citing M.J. Trebilcock, D. Dewees & D. Duff, *Exploring the Domain of Accident Law: Taking the Facts Seriously* (New York: Oxford University Press, 1996) at 96.

three reports questioned in any detail the dramatic extent to which government physicians, specifically medical officers of health, coroners, and forensic pathologists, are protected from civil liability.⁷ At common law, the standard of care that applies to doctors is “that degree of care and skill which could reasonably be expected of a normal, prudent practitioner of the same experience and standing.”⁸ Legislation effectively lowers this standard by providing civil immunity to government physicians so long as they act in “good faith”. Thus, doctors with duties and powers arguably much greater than a typical practitioner are subject to a much lower standard of care.

This reduced liability of government physicians is a critical public policy issue. Ultimately at stake are the responsibility of government physicians to the public and the responsibility of the governments that employ them. These go to the fundamental core of public law, the relationship between the individual and the state. Ideally the state and its servants will not harm the individual. Indeed, the Naylor Report, the SARS Commission, and the Goudge Inquiry focused on how to prevent or at least reduce that harm. Nonetheless, the question remains: when such harm does occur, who should bear the cost?

In this paper, I argue that statutory good-faith immunity for government physicians is fundamentally inconsistent with the expectation of professional competence by licensed doctors. Instead, it is a relatively standard legislative provision that is not appropriate in the particular contexts of death investigation and public health. While this issue is not unique to Ontario, that province will be the primary focus because the SARS and Charles Smith affairs were centred there.

This argument will proceed in four parts. First, the relevant statutory and case law in Ontario will be canvassed. I will consider the powers, duties, and good-faith immunity provisions, first of coroners and forensic pathologists, and then of medical officers of health. I will also survey the immunities granted to physicians at large corresponding to general duties imposed by statute. The second part argues that the Ontario immunity provisions for government physicians are more likely to be an application of standard practice than the result of conscious consideration of the special context of government physicians. I begin by demonstrating the ubiquity of similar provisions among Ontario statutes. I then consider the legislative history of the acts governing coroners, forensic pathologists, and medical officers of health. The third part evaluates the historical and current policy rationales for good-faith immunity provisions. I explain how parallel jurisprudence from the Ontario Court of Appeal and the Supreme Court of Canada, recognizing the tort of negligent investigation by police, can be harnessed to reject these rationales. The fourth part considers how the common law of tort liability would apply to government physicians in the absence of statutory immunity.

⁷ The *Naylor Report*, *supra* note 3 does not consider this issue. The second interim report of the SARS Commission considers it very briefly and concludes that the protection should be extended to additional actors in the public health system: *Campbell Report*, *supra* note 3, vol. 5, at 19, 65-66, 69. The issue was also addressed briefly in a research paper prepared by Professor Lorne Sossin for the Goudge Inquiry, *Accountability and Oversight for Death Investigations in Ontario* (Toronto: Goudge Inquiry, 2008) at 33-34, online: Ontario Ministry of the Attorney General <http://www.attorneygeneral.jus.gov.on.ca/inquiries/goudge/policy_research/pdf/Sossin_Accountability-and-Oversight.pdf>. Professor Sossin’s analysis will be discussed below. While Commissioner Goudge recommended several legislative amendments, he did not address the provision that provides immunity from civil liability: Goudge Report, *supra* note 5, vol. 3 at 288, 309-12, 338-39 (Recommendations 1, 12-14, 17, 38). The issue of good-faith immunity in the context of coroners has recently been raised by at least one journalist: Natalie Alcoba, “Picking up the Pieces: Those Whose Lives Were Shattered by Charles Smith Have Little Recourse” *National Post* (12 December 2009) A14.

⁸ *Crits and Crits v. Sylvester et al.*, [1956] O.R. 132 at 143, 1 D.L.R. (2d) 502 (C.A.) [*Crits* (C.A.) cited to O.R.], *aff’d* [1956] S.C.R. 991, 5 D.L.R. (2d) 601, quoted in Ellen I. Picard & Gerald B. Robertson, *Legal Liability of Doctors and Hospitals in Canada*, 4th ed. (Toronto: Thomson, 2007) at 225 (as “[t]he classic statement”).

I

STATUTORY GOOD-FAITH IMMUNITY FOR PHYSICIANS

I begin by canvassing the law on statutory immunity for physicians, primarily in Ontario. I will first consider coroners and forensic pathologists and then medical officers of health. In each case, I will survey the extensive powers and duties involved as well as the immunity provisions. I then provide some broader context by examining the major duties imposed by statute on physicians at large and the extent to which corresponding immunity is given.

A. Coroners and Forensic Pathologists

Coroners in Ontario are physicians with substantial duties and powers. A coroner must be a “legally qualified medical practitione[r],” both upon appointment and in order to keep the position.⁹ Indeed, the *Coroners Act* imposes a duty on the College of Physicians and Surgeons of Ontario to inform the Chief Coroner if any coroner ceases to hold a valid medical licence.¹⁰ Coroners investigate virtually all unnatural deaths, and deaths in various institutions, in order to establish “how ... when ... where ... and by what means the deceased came by his or her death.”¹¹ In order to do so, coroners have broad powers of entry, search, and seizure.¹² Obstruction of a coroner is an offence punishable by fine and/or imprisonment.¹³ As part of an investigation, a coroner can commission an autopsy or other tests.¹⁴ These tests and investigations can be critical evidence in criminal prosecutions. Coroners can order inquests “in the public interest,” at which any evidence or person can be summoned.¹⁵

The forensic pathologist performs a discrete complementary role to that of the coroner. Under the *Coroners Act*, pathologists are required to be physicians with specializations in pathology.¹⁶ Parallel to the provision concerning coroners, the Act imposes a duty on the College of Physicians and Surgeons of Ontario to notify the Chief Forensic Pathologist if a pathologist is no longer in good standing.¹⁷ The pathologist has a duty to perform an autopsy where one is ordered by a coroner.¹⁸ This obligation comes with a broad power of entry, not only of places where the body is, but also of places from which the pathologist believes (on reasonable and probable grounds) the body has been removed.¹⁹ Moreover, this power can be exercised not only where a warrant for the autopsy has been issued by the coroner, but also in the absence of a warrant where the pathologist reasonably believes such a warrant will be issued.²⁰

⁹ *Coroners Act*, R.S.O. 1990, c. C.37, s. 3 (The *Coroners Amendment Act, 2009*, S.O. 2009, c. 15, received royal assent on 5 June 2009. And all sections but s. 4 came into force on 27 July, 2009 and s. 4 came into force on 16 December 2010.). The *Legislation Act, 2006*, S.O. 2006, c. 21, Sched. F, s. 87 provides that in Ontario legislation, “legally qualified medical practitioner” and similar terms “mean a member of the College of Physicians and Surgeons of Ontario”.

¹⁰ *Coroners Act*, *ibid.*, s. 3(3).

¹¹ *Ibid.*, ss. 10, 15, 31(1).

¹² *Ibid.*, s. 16.

¹³ *Ibid.*, ss. 16(6), 55.

¹⁴ *Ibid.*, s. 28.

¹⁵ *Ibid.*, ss. 20, 40. See also ss. 22.1, 26, 27, 30-52. As will be discussed further below, the role of a coroner at a coroner’s inquest is a quasi-judicial function that would not attract liability in negligence at common law.

¹⁶ *Ibid.*, s. 1(1) (This definition of pathologist, like every mention of the term “pathologist” in the Act, was absent prior to the *Coroners Amendment Act, 2009*, *supra* note 9).

¹⁷ *Ibid.*, s. 7.1(2).

¹⁸ *Ibid.*, s. 28(1), (3).

¹⁹ *Ibid.*, s. 28(4).

²⁰ *Ibid.*

While these powers of coroners and forensic pathologists are extensive, the corresponding liability is minimal. Section 53 of the *Coroners Act* provides as follows:

No action or other proceeding shall be instituted against *any person exercising a power or performing a duty under this Act* for any act done *in good faith* in the execution or intended execution of any such power or duty or for any alleged neglect or default in the execution *in good faith* of any such power or duty.²¹

It is critically important to note that section 53 does more than provide good-faith immunity to the coroner or forensic pathologist. It also ensures that the Crown is immune from vicarious liability for the acts of that person on its behalf, again so long as good faith cannot be disproved. This result occurs because of the interaction of section 53 of the *Coroners Act* with the *Proceedings Against the Crown Act*.²² Section 5 of *PACA* makes the Crown vicariously liable in tort for its agents and servants; however, it also precludes Crown liability where those servants and agents are not personally liable.²³ Thus, section 53 precludes recovery not only from the coroner or forensic pathologist, but also from the Crown. This immunity has two key features: it requires only good faith, and it applies to a power or duty under the Act.²⁴

The *Coroners Act* illustrates the potential uncertainty over the scope of good-faith immunity. “Good faith” has been recognized as a term that must be interpreted in its specific context.²⁵ In general, “[i]f there is one word that delineates or characterizes the expression ‘good faith’, it is ‘honesty’.”²⁶ In granting summary judgment against a claim asserting bad faith of a pathologist acting under the *Coroners Act*, Justice MacKinnon adopted the following definition of good faith from *Black’s Law Dictionary*:

a state of mind consisting in (1) honesty in belief or purpose, (2) faithfulness to one’s duty or obligation, (3) observance of reasonable commercial standards of fair dealing in a given trade or business, or (4) absence of intent to defraud or to seek unconscionable advantage.²⁷

Good faith thus involves honesty or absence of malicious intent. However, a unanimous 2004 decision of the Supreme Court broadened the circumstances in which an absence of good faith can be inferred:

[T]he concept of bad faith can and must be given a broader meaning that encompasses *serious carelessness or recklessness*. Bad faith certainly includes intentional fault ... Such conduct is an abuse of power for which the State, or sometimes a public servant, may be held liable. However, *recklessness implies a fundamental breakdown of the orderly exer-*

²¹ *Ibid.* [emphasis added] (Prior to the *Coroners Amendment Act, 2009*, *supra* note 9, s. 53 read as follows: “No action or other proceeding for damages lies or shall be instituted against *a coroner or any person acting under the coroner’s authority* for an act done by him or her *in good faith* in the performance or intended performance of *any power or duty under this Act or the regulations*, or for any neglect or default in the performance in good faith of any such power or duty” [emphasis added].).

²² R.S.O. 1990, c. P.27 [PACA].

²³ *Ibid.* This is a codification of common law: see Peter W. Hogg & Patrick Monahan, *Liability of the Crown*, 3d ed. (Toronto: Carswell, 2000) at 120 (citing cases from the U.K. and Australia: “Unless such a clause expressly preserves the vicarious liability of the Crown, the clause will also immunize the Crown from liability”); see also Karen Horsman & Gareth Morley, eds., *Government Liability Law and Practice*, looseleaf (Aurora: Canada Law Book, 2009) at 5.50.10.

²⁴ Sossin, *supra* note 7 at 33; see also Horsman & Morley, *ibid.* at 5.50.

²⁵ *McAlpine v. H.(T.)* (1991), 57 B.C.L.R. (2d) 1 at para. 35, 82 D.L.R. (4th) 609, 7 C.C.L.T. (2d) 113 (C.A.); *R. v. Devereaux* (1996), 147 Nfld. & P.E.I.R. 108, 112 C.C.C. (3d) 243 at 254 (Nfld. C.A.) [*Devereaux* cited to C.C.C.].

²⁶ *Devereaux*, *ibid.* at 255.

²⁷ *Burns v. Johnston*, [2003] O.T.C. 290, [2003] O.J. No. 1452 at para. 26 (Sup. Ct. J.) (QL) [*Burns I*] quoting Bryan A. Garner, ed., *Black’s Law Dictionary*, 7th ed. (Minnesota: West, 1990) at 701, action via amended statement of claim dismissed, [2003] O.T.C. 549 (Sup. Ct. J.) [*Burns II*].

cise of authority to the point that absence of good faith can be deduced and bad faith presumed. The act, in terms of how it is performed, is then inexplicable and incomprehensible to the point that it can be regarded as an actual abuse of power, having regard to the purposes for which it is meant to be exercised.²⁸

The Ontario Court of Appeal has recently addressed the relationship between the wrongness of a decision and bad faith: “[w]hile a wrong decision, even a very wrong decision cannot be equated to a decision made in bad faith, a decision may be so clearly wrong on the merits as to provide some evidentiary support for a finding of bad faith.”²⁹ Thus good faith is also negated by “recklessness” or “serious carelessness”, even in the absence of demonstrable malice, and can be questioned where a decision is “clearly wrong”.

However, a second element must also be met to obtain good-faith immunity: that the conduct at issue was in the exercise of a power or duty under the Act. This element of section 53 has arisen in the context of forensic pathologists. In *Burns v. Johnston*, at issue was whether a pathologist was liable in negligence for providing an oral opinion of cause of death to the police before receiving toxicology results.³⁰ The plaintiff was charged with murder based on that opinion, and the charge was withdrawn when the pathologist later changed the cause of death to drug overdose.³¹ At that time, section 28(2) of the *Coroners Act* required the autopsy report to be made “in writing only to the coroner who issued the warrant, the Crown Attorney, the regional coroner and the Chief Coroner.”³² Nonetheless, Justice Manton found that such communication between coroners and police was common practice, reasonable, and “necessary if feasible”, and thus covered by section 53.³³ The Ontario Court of Appeal came to the opposite conclusion in *Reynolds v. Kingston (City) Police Services Board*.³⁴ A murder charge based on a pathologist’s oral report to police was withdrawn after a second autopsy.³⁵ Without mentioning the decision in *Burns*, the Court of Appeal characterized the provision of an oral opinion to police as “[c]ontrary to s. 28(2) of the [Coroners] Act.”³⁶

²⁸ *Finney v. Barreau du Québec*, 2004 SCC 36, [2004] 2 S.C.R. 17 at para. 39, 240 D.L.R. (4th) 410 [citations omitted; emphasis added]. An extended version of this passage is quoted in Horsman & Morley, *supra* note 23 at 5.50.20.

²⁹ *Rosenhek v. Windsor Regional Hospital*, 2010 ONCA 13, 257 O.A.C. 283 [Rosenhek], leave to appeal refused, [2010] S.C.C.A. No. 89, aff’d [2007] O.J. No. 4486 (Sup. Ct. J.) (QL).

³⁰ *Supra* note 27. Note that this case occurred before the class of persons covered by s. 53 was extended by the *Coroners Amendment Act*, *supra* note 9. However, the change in language does not go to the issues in the case. See the previous version of s. 53, *supra* note 21. For a discussion of s. 53 in the context of the relationship between the coroner and the police, see Andrew Flavelle Martin, “Beyond the Goudge Inquiry: Is the Coroner Part of ‘The Crown’ for *Stinchcombe* Disclosure Obligations?” (2009) 67 U.T. Fac. L. Rev 9 at 31-32.

³¹ *Burns II*, *ibid.* at paras. 4, 27.

³² *Coroners Act*, *supra* note 9, quoted in *Burns II*, *ibid.* at para. 29. Note that this part of s. 28 is no longer in force after the *Coroners Amendment Act*, *supra* note 9. The current s. 29(1) governing the reporting of results by the pathologist omits the word “only”: “The pathologist who performed the *post mortem* examination of a body under section 28 shall forthwith report in writing his or her findings from the *post mortem* examination and from any other examinations or analyses that he or she conducted to the coroner who issued the warrant, the regional coroner and, if the pathologist who performed the *post mortem* examination is not the Chief Forensic Pathologist, the Chief Forensic Pathologist.” It is unclear how this non-exclusive list of persons to whom the report is to be made will affect the recurrence of a challenge parallel to that in *Burns*. The phrase “in writing” may still be interpreted to preclude oral reporting.

³³ *Burns II*, *ibid.* at paras. 30-35.

³⁴ 2007 ONCA 166, 84 O.R. (3d) 738, 280 D.L.R. (4th) 311 [*Reynolds* cited to O.R.].

³⁵ *Ibid.* at paras. 1-6.

³⁶ *Ibid.* at para. 1, referring to the *Coroners Act*, *supra* note 9. Note that the pathologist sought to strike the statement of claim by asserting the common-law doctrine of witness immunity. The Court found that witness immunity did not necessarily apply to the pathologist’s death-investigation functions before his testimony, and the issue would need to be resolved at trial. However, witness immunity is not statutory and so is outside the focus of this paper.

The matter is further complicated by the research program and policy roundtables of the Goudge Inquiry. In his report, Professor Sossin stated that “[t]he third stage of the death investigation consists of the pathologist communicating the results of the autopsy to the coroner (and, where appropriate, to the police).”³⁷ He did not elaborate on the meaning of “where appropriate”. Mark Sandler, Special Counsel, Criminal Law, framed a panel discussion of the issue as though the oral reporting of the tentative findings to the police was accepted as appropriate, and only its content and documentation were in issue:

[A]t the end of the autopsy, the forensic pathologist completes his or her examination and then speaks to the police officers. And the question arises: What should the forensic pathologist be saying to the police at that stage and whether what they’re saying to the police should be captured in writing.³⁸

While there was consensus around the importance of making a record of these communications to allow their disclosure to the defense, the oral reporting itself had wide support from the police and Crown Attorney panelists.³⁹ Indeed, Commissioner Goudge wrote that the provision of a preliminary opinion was not “necessarily wrong” and could be useful, although a written record of the opinion should be kept.⁴⁰

This disagreement over the precise breadth of section 53 of the *Coroners Act*, specifically whether an oral report by the pathologist is allowed, or expected, or mandated, demonstrates a critical aspect of statutory immunity for government physicians.⁴¹ It also reveals a larger underlying issue. Even if the particular action taken by a government physician is in the performance of a power or duty under the relevant legislation, should he or she escape civil liability for taking that action negligently? Ultimately, it is preferable for that determination to result not from an exercise in statutory interpretation as in *Burns*, but instead from a normative policy choice.

Some, but not all, of the regimes governing death investigation in other Canadian jurisdictions have provisions parallel to section 53. In the four provinces with medical examiner systems,⁴² where medical examiners must be physicians and the chief medical examiner must be a pathologist, there are no good-faith immunity provisions.⁴³ Other than Ontario, P.E.I. is the only jurisdiction in which coroners must be physicians,⁴⁴ and those coroners also enjoy good-faith immunity.⁴⁵ Of the remaining coroner jurisdictions, New Brunswick and the Yukon provide no immunity,⁴⁶ Saskatchewan, B.C. and Quebec provide good-faith immunity,⁴⁷ and in the

³⁷ Sossin, *supra* note 7 at 14.

³⁸ Goudge Inquiry, *Transcripts: Roundtables* (12 Feb. 2008) at 192, online: IIS7 <http://mail.tscript.com/trans/pfp/feb_12_08/index.htm>.

³⁹ *Ibid.* at 205-06, 262-64.

⁴⁰ Goudge Report, *supra* note 5, vol. 2 at 174-75.

⁴¹ Sossin, *supra* note 7 at 34 (uncertainty around the scope of s. 53 contributes to corresponding uncertainty in “the extent to which civil suits may provide an effective forum for accountability and oversight”).

⁴² Under the traditional coroner system, developed in England and imported to Upper Canada prior to confederation, coroners were not doctors. In contrast, a defining feature of the medical examiner system of death investigation—which originated in the U.S. in the 20th century—was the requirement that medical examiners be doctors, usually pathologists. See Randy Hanzlick, *Options for Modernizing the Ontario Coroner’s System* (Toronto: Goudge Inquiry, 2008) at 5, 16-17, 37-38, online: Ontario Ministry of the Attorney General <http://www.attorneygeneral.jus.gov.on.ca/inquiries/goudge/policy_research/pdf/Hanzlick_Options-for-Modernizing.pdf>.

⁴³ *Fatality Investigations Act*, S.N.S. 2001, c. 31, ss. 3-4; *Fatality Inquiries Act*, C.C.S.M. c. F52, ss. 1- 2; *Fatality Inquiries Act*, R.S.A. 2000, c. F-9, ss. 5, 7; *Fatalities Investigations Act*, S.N.L. 1995, c. F-6.1, ss. 2-4. To be precise, Manitoba provides statutory immunity to the Chief Medical Examiner with regard to the disposal of inquest exhibits, and the provision does not require good faith: *Fatality Inquiries Act*, C.C.S.M. c. F52, s. 33.

⁴⁴ *Coroners Act*, R.S.P.E.I. 1988, c. C-25.1, ss. 3-4.

⁴⁵ *Ibid.*, s. 53.

⁴⁶ *Coroners Act*, R.S.N.B. 1973, c. C-23; *Coroners Act*, R.S.Y. 2002, c. 44.

Northwest Territories, and Nunavut, the immunity applies unless the coroner “acted in bad faith or without reasonable and probable cause.”⁴⁸

B. Medical Officers of Health

A medical officer of health (“MOH”) or an associate medical officer of health must be a physician, where physician is defined as “a legally qualified medical practitioner,” with a community medicine fellowship or other academic training in public health.⁴⁹ Furthermore, the Chief Medical Officer of Health (“CMOH”) and Associate Chief Medical Officer of Health are each required to have been a physician for at least five years.⁵⁰ In addition to these qualifications, every MOH has a duty to “keep himself or herself informed in respect of matters related to occupational and environmental health.”⁵¹ Thus, the qualifications required of an MOH are more extensive than those of a coroner.

The significant powers and duties of MOHs reflect these qualifications. MOHs have a duty to inspect or order inspection of their territory, including places used for food storage or service or as boarding houses, and have broad powers of entry to do so.⁵² Obstruction of such an investigation is an offence.⁵³ Where there is a health hazard, the MOH can require remedial measures.⁵⁴ The MOH has the power to seize and destroy “any substance, thing, plant or animal other than man” constituting a hazard.⁵⁵ The MOH also has extensive powers to quarantine individuals or classes of individuals, as well as the power to compel their examination or treatment without consent.⁵⁶ If such an order for quarantine, examination, or treatment is not followed, a judge can order that person detained for that purpose with the assistance of the police.⁵⁷ The CMOH has significant additional powers to those of the MOHs. If the CMOH certifies “an immediate risk”, the Minister can declare any premises a quarantine facility and order any medical supplies seized.⁵⁸ Similarly, the CMOH can require the release of any health records necessary if there is “an immediate and serious risk.”⁵⁹ In case of “an immediate risk”, the CMOH can issue a mandatory directive “respecting precautions and procedures” to any health professional or facility.⁶⁰

Subsection 95(1) of the *Health Protection and Promotion Act* (“HPPA”) provides, similarly to section 53 of the *Coroners Act*, as follows:

No action or other proceeding for damages or otherwise shall be instituted against the Chief Medical Officer of Health or the Associate Chief Medical Officer of Health, a member of a board of health, a medical officer of health, an associate medical officer of health of a board of health, an acting medical officer of health of a board of health or a public health inspector or an employee of a board of health who is working under the direction of a medical officer of health for any act done *in good faith* in the execution or the intended

⁴⁷ Coroners Act, 1999, S.S. 1999, c. C-38.01, s. 59; An Act respecting the determination of the causes and circumstances of death, R.S.Q. 1983 c. R-0.2, s. 16; Coroners Act, S.B.C. 2007, c. 15, s. 62(2).

⁴⁸ Coroners Act, R.S.N.W.T. 1988, c. C-20, s. 60.

⁴⁹ *Health Protection and Promotion Act*, R.S.O. 1990, c. H.7, as am. by S.O. 2007, c. 10, ss. 1, 64 [HPPA]; *Qualifications of Boards of Health Staff*, R.R.O. 1990, Reg. 566, s. 1.

⁵⁰ HPPA, *ibid.*, ss. 81(2), 81.1(3).

⁵¹ *Ibid.*, ss. 12(1), 81(3).

⁵² *Ibid.*, ss. 10, 41, 43.

⁵³ *Ibid.*, ss. 42, 100-101.

⁵⁴ *Ibid.*, s. 13.

⁵⁵ *Ibid.*, s. 19.

⁵⁶ *Ibid.*, s. 22.

⁵⁷ *Ibid.*, ss. 35, 36.

⁵⁸ *Ibid.*, ss. 77.4, 77.5.

⁵⁹ *Ibid.*, s. 77.6.

⁶⁰ *Ibid.*, s. 77.7.

execution of *any duty or power under this Act* or for any alleged neglect or default in the execution in good faith of any such duty or power.⁶¹

However, unlike the *Coroners Act*, the section proceeds to preserve the liability of the Crown notwithstanding *PACA*.⁶² Similarly, boards of health remain liable.⁶³ Section 95(1) has been applied to protect MOHs from liability regarding an alleged failure to address pollution from a metal refinery⁶⁴ and inspections of a lodging house for the elderly.⁶⁵ However, these applications of the immunity are very straightforward and provide little material for analysis. In particular, none of the SARS cases have involved section 95 immunity.⁶⁶

Statutory good-faith immunity in the public health context applies in most Canadian jurisdictions. The crown and individuals are explicitly immune in Alberta, Quebec, and Saskatchewan;⁶⁷ individuals are immune, and thus the Crown immune, in Manitoba, Nova Scotia, and

⁶¹ *Ibid.*, s. 95(1) [emphasis added]. Note that prior to the 2007 amendment, which followed a recommendation by the Campbell Commission to extend the coverage of this immunity to all public health actors (*Campbell Report*, *supra* note 3), s. 95 only covered “a member of a board of health, a medical officer of health, an associate medical officer of health of a board of health, an acting medical officer of health of a board of health or a public health inspector”.

⁶² *Ibid.*, s. 95(1.1); *PACA*, *supra* note 22.

⁶³ *Ibid.*, s. 95(3). Note that prior to the 2007 amendments, the individuals protected by s. 95(1) were most often employees of boards of health and not the provincial government, so Crown liability was not at issue—s. 95(3) preserved vicarious liability. The addition of subsection 95(1.1) was necessary to extend the preservation of vicarious liability for the new Crown agents, such as the CMOH, added to s. 95(1). Note also that protection for MOHs equivalent to s. 95(1) and (3) under the *HPPA* is found in s. 9(1) and (3) of the *Mandatory Blood Testing Act, 2006*, S.O. 2006, c. 26. However, the MOH has no decision-making role in the process other than determining that the application for testing “meets the requirements of the regulations” (s. 3). Due to the lack of a substantive role for the MOH under the Act, and the absence of case law, these provisions will not be discussed further.

⁶⁴ *Pearson v. Inco Ltd.*, [2002] O.T.C. 515, 33 C.P.C. (5th) 264 at paras. 88-92 (Sup. Ct. J.), *aff'd* (2004), 183 O.A.C. 168, 44 C.P.C. (5th) 276 (Div. Ct.), *rev'd* on other grounds (2006), 78 O.R. (3d) 641, 261 D.L.R. (4th) 629 (C.A.) (this case was a proposed class action involving the health effects of pollution emitted by the refinery, and the MOH was alleged to have failed in her duties to inspect, investigate, and eliminate the relevant health hazards).

⁶⁵ *St. Elizabeth Home Society v. Hamilton (City)*, [2005] O.T.C. 1074, [2005] O.J. No. 5369 at para. 95 (Sup. Ct. J.) (QL) (this was a complex case in which the Society claimed, among other things, that the MOH and the city’s public health department were negligent in their investigations of complaints about the level of care at the home and in their enforcement of the relevant by-laws).

⁶⁶ The SARS cases generally do not involve claims against MOHs, so s. 95 immunity is not at issue: *Jamal Estate v. Scarborough Hospital - Grace Division* (2005), 34 C.C.L.T. (3d) 271, [2005] O.J. No. 3506 (Sup. Ct. J.) (QL), *rev'd* 2009 ONCA 376, 95 O.R. (3d) 760, 66 C.C.L.T. (3d) 188, leave to appeal refused, [2009] S.C.C.A. No. 30 [*Jamal Estate*]; *Henry Estate (Trustee of) v. Scarborough Hospital* (2005), 34 C.C.L.T. (3d) 278, [2005] O.J. No. 3505 (S.C.J.) (QL), *rev'd* 2009 ONCA 375, 66 C.C.L.T. (3d) 184, leave to appeal refused, [2009] S.C.C.A. No. 306 [Henry Estate]; *Laroza Estate v. Ontario* (2005), 257 D.L.R. (4th) 761, 34 C.C.L.T. (3d) 264 (Ont. Sup. Ct. J.), *rev'd* 2009 ONCA 373, 95 O.R. (3d) 764, 251 O.A.C. 119 [*Laroza Estate*]; *Abarquez v. Ontario* (2005), 257 D.L.R. (4th) 745, 34 C.C.L.T. (3d) 249 (Ont. Sup. Ct. J.), *rev'd* 2009 ONCA 374, 95 O.R. (3d) 414, 252 O.A.C. 267, leave to appeal refused, [2009] S.C.C.A. No. 297 [*Abarquez*]; see also *Williams v. Canada (Attorney General)* (2005), 76 O.R. (3d) 763 at para. 102 (Sup. Ct. J.), *rev'd* on other grounds, 2009 ONCA 378, 95 O.R. (3d) 401, 249 O.A.C. 150, leave to appeal refused, [2009] S.C.C.A. No. 298 (at trial Cullity J. noted that “no duties of care or acts of negligence are pleaded against the City’s Medical Officer of Health”) [*Williams*]. For a discussion of the private law duties of care owed by public health authorities and government, see Bernard M. Dickens, “Legal and Ethical Obligations of Public Health Authorities and Government” in Commission of Inquiry on Hormone Receptor Testing, “*Looking Forward...*” *Policy Papers*, vol. 2 (St. John’s: Newfoundland and Labrador, 2009) at 11-19, online: CIHRT <<http://www.cihrt.nl.ca/Final%20Report/index.pdf>> [Dickens, “Legal and Ethical Obligations”].

⁶⁷ *Public Health Act*, R.S.A. 2000, c. P-37, s. 66.1 as am. by S.A. 2002, c. 32, s. 12(12); *Public Health Act*, R.S.Q. c. S-2.2, s. 123; *The Public Health Act, 1994*, S.S. 1994, c. P-37.1, s. 68(1).

P.E.I.;⁶⁸ individuals are immune but the Crown is not immune in B.C. and New Brunswick.⁶⁹ The relevant statute is silent on immunity only in Newfoundland and two of the three territories; the recent *Public Health Act, 2007* of the Northwest Territories provides individual immunity, but is silent on Crown liability.⁷⁰ Other than the respective provisions regarding the Crown, the only variations of any import are that the P.E.I. provision and one of the two B.C. provisions refer to bad faith instead of good faith, and the Quebec provision applies only during a “public health emergency.”⁷¹

C. Other Physicians Exercising Statutory Powers & Duties

It should be noted that similar statutory provisions protect physicians at large in their exercise of duties mandated by statute. For example, the *HPPA* creates a duty on doctors (and various other health professionals) to report to the MOH if any person they treat “has or may have a reportable disease.”⁷² Section 95(4) provides corresponding good-faith immunity for the reporting professional.⁷³ The effective scope of that section is limited, however, as described in the recent case of *Healey v. Lakeridge Health Corp.*:

I do not find in these provisions, or in the scheme of *HPPA* as a whole, any implication of a legislative intention to relieve physicians and hospitals of liability for negligence in the event that, through a want of reasonable care, they fail to diagnose and report a case of TB in a timely manner.⁷⁴

The *Mandatory Gunshot Wounds Reporting Act* creates a similar duty to report to the police any patient that is treated for a gunshot wound, and provides corresponding good-faith immunity.⁷⁵ Statutory good-faith immunity is also extended to the College of Physicians and Surgeons (and other Colleges), its Council and committees and panels, and the individuals acting under their authority, by the *Regulated Health Professions Act, 1991*.⁷⁶ Thus, doctors involved in registration, complaints, discipline, incapacity, and reinstatements are protected.⁷⁷

⁶⁸ *The Public Health Act*, C.C.S.M. c. P210, s. 106(1); *Proceedings Against the Crown Act*, C.C.S.M. c. P140, s. 4; *Health Protection Act*, S.N.S. 2004, c. 4, s. 12; *Proceedings Against the Crown Act*, R.S.N.S. 1989, c. 360, s. 5; *Public Health Act*, R.S.P.E.I. 1988, c. P-30, s. 22.3 as am. by S.P.E.I. 2006, c. 17, s. 3; *Crown Proceedings Act*, R.S.P.E.I. 1988, c. C-32, s. 4.

⁶⁹ *Public Health Act*, S.B.C. 2008, ss. 28, 92; *Public Health Act*, S.N.B. 1998, c. P-22.4, s. 64.

⁷⁰ *Health and Community Services Act*, S.N. 1995, c. P-37.1; *Public Health and Safety Act*, R.S.Y. 2002, c. 176; *Public Health Act*, R.S.N.W.T. 1988, c. P-12 (Nu); *Public Health Act*, S.N.W.T. 2007, c. 17, s. 41.

⁷¹ R.S.P.E.I. 1988, c. P-30, s. 22.3; *Health Act*, R.S.B.C. 1996, c. 179, s. 34.1; *Public Health Act*, R.S.Q. c. S-2.2, s. 123.

⁷² *Supra* note 49, ss. 25, 26.

⁷³ *HPPA*, *ibid.*

⁷⁴ (2006), 38 C.P.C. (6th) 145 at paras. 62-63, [2006] O.J. No. 4277 (Sup. Ct. J.) (QL), Cullity J. [*Lakeridge Health*]. Note that Perell J. has recently granted in the same proceedings a partial motion for summary judgment against those persons who were informed of exposure to TB but were not infected: *Healey v. Lakeridge Health Corp.*, 2010 ONSC 725 at para. 13, 72 C.C.L.T. (3d) 261 (Sup. Ct. J.) (Perell J. held that the hospital had no duty of care to those persons, that there is no compensation available in law for psychological injury short of recognizable psychiatric illness, and that such damages would fail for remoteness).

⁷⁵ S.O. 2005, c. 9, ss. 2, 4.

⁷⁶ S.O. 1991, c.18, s. 38.

⁷⁷ *Health Professions Procedural Code*, being Sched. 2 of the *Regulated Health Professions Act, 1991*, *ibid.* (and by virtue of s. 4 of that Act, deemed part of the *Medicine Act, 1991*, S.O. 1991, c. 30); see e.g. *Deep v. Massel*, [2007] O.J. No. 2811 at paras. 17-23 (Sup. Ct. J.) (QL), *aff'd* 2008 ONCA 4, [2008] O.J. No. 18 (QL). Immunity for other administrative and quasi-administrative functions that may be performed by doctors or others, beyond the scope of this paper, are found in the *Trillium Gift of Life Network Act*, R.S.O. 1990, c. H.20, s. 9, the *Independent Health Facilities Act*, R.S.O. 1990, c. I.3, s. 38, and the *Public Hospitals Act*, R.S.O. 1990, c. P.40, s. 13. For a discussion of bad faith in the context of a hospital board under the *Public Hospitals Act*, see *Rosenhek*, *supra* note 29 at paras. 26-35.

Two subtle variations on these schemes of statutory good-faith immunity are “reasonable grounds” and “gross negligence”. The *Health Care Consent Act* provides civil immunity to physicians for treatment in the absence of consent, where there is not only a good-faith belief in consent but also reasonable grounds for that belief.⁷⁸ A similar requirement for immunity is found in the *Child and Family Services Act*, which imposes on physicians, among others, a duty to report child abuse or neglect.⁷⁹ It provides good-faith immunity unless the reporting physician “acts ... without reasonable grounds for the suspicion.”⁸⁰ The “gross negligence” variation of good-faith immunity is demonstrated by the *Good Samaritan Act, 2001* and the *Chase McEachern Act (Heart Defibrillator Civil Liability), 2007*.⁸¹ These acts provide civil immunity to health professionals giving “emergency health care services or first aid” or using an automated defibrillator outside a hospital or equivalent facility in good faith, but only in the absence of “gross negligence”.⁸² These “reasonable grounds” and “gross negligence” variations demonstrate that the government is willing to require more than good faith for immunity when it imposes obligations on physicians at large.

II

GOOD-FAITH IMMUNITY AS A STANDARD LEGISLATIVE PROVISION

Far from being a unique feature of the health care field or the medical profession, good-faith immunity is a standard provision across many legislative regimes in Ontario. As between coroners and MOHs, some regimes cover the actor and the Crown while others protect only against personal liability; however, the latter scheme is much more common. For example, the vast majority of Ontario government ministries have personal, but not Crown, immunity.⁸³ Equivalent statutory schemes cover many other actors exercising important public functions, including: the Building Code and Building Materials Evaluation Commissions, building code officials and inspectors;⁸⁴ firefighters, the Fire Marshal, and the Fire Safety Commission;⁸⁵ the diagnostic and

⁷⁸ *Health Care Consent Act, 1996*, S.O. 1996, c. 2, s. 29(1).

⁷⁹ R.S.O. 1990, c. C.11, s. 72(1)-(3), (5)(a) [CFSA].

⁸⁰ *Ibid.*, s. 72(7) (The requirement of good faith is expressed as an absence of malice.).

⁸¹ *Good Samaritan Act, 2001*, S.O. 2001, c. 2 [Good Samaritan Act]; *Chase McEachern Act (Heart Defibrillator Civil Liability), 2007*, S.O. 2007, c. 10, Sch. N [Chase McEachern Act].

⁸² *Good Samaritan Act, 2001*, ss. 1-2; *Chase McEachern Act, 2007*, s. 2. Section 2 of both Acts also requires the action to be “voluntarily and without reasonable expectation of compensation or reward”.

⁸³ *Ministry of Agriculture, Food and Rural Affairs Act*, R.S.O. 1990, c. M.16, s. 6; *Ministry of Citizenship and Culture Act*, R.S.O. 1990, c. M.18, s. 8; *Ministry of Community and Social Services Act*, R.S.O. 1990, c. M.20, s. 4; *Ministry of Consumer and Business Services Act*, R.S.O. 1990, c. M.21, s. 8; *Ministry of Correctional Services Act*, R.S.O. 1990, c. M.22, s. 12 (liability is also precluded “for any act of an inmate, parolee, probationer or young person while under his or her custody and supervision”); *Ministry of Economic Development and Trade Act*, R.S.O. 1990, c. M.27, s. 10; *Ministry of Energy Act*, R.S.O. 1990, c. M.23, s. 5; *Ministry of Government Services Act*, R.S.O. 1990, c. M.25, s. 15 (also covers the Queen’s Printer for Ontario); *Ministry of Intergovernmental Affairs Act*, R.S.O. 1990, c. M.28, s. 7; *Ministry of Labour Act*, R.S.O. 1990, c. M.29, s. 4.1, as am. by S.O. 2006, c. 19, Sched. M, s. 4; *Ministry of Municipal Affairs and Housing Act*, R.S.O. 1990, c. M.30, s. 7; *Ministry of Natural Resources Act*, R.S.O. 1990, c. M.31, s. 5; *Ministry of Northern Development and Mines Act*, R.S.O. 1990, c. M.32, s. 5; *Ministry of Revenue Act*, R.S.O. 1990, c. M.33, s. 8; *Ministry of Tourism and Recreation Act*, R.S.O. 1990, c. M.35, s. 9; *Ministry of Transportation Act*, R.S.O. 1990, c. M.36, s. 9, as am. by S.O. 2006, c. 19, Sched. T, s. 9; *Ministry of Treasury and Economics Act*, R.S.O. 1990, c. M.37, s. 7. Notable examples of Ministry acts that do not provide good-faith immunity include the *Ministry of Health and Long-Term Care Act*, R.S.O. 1990, c. M.26; *Ministry of the Solicitor General Act*, R.S.O. 1990, c. M.34; *Ministry of the Attorney General Act*, R.S.O. 1990, c. M.17 (the *Crown Attorneys Act*, R.S.O. 1990, c. C.49, s. 14.3(3) provides personal immunity in matters of property relating to criminal offences); see also Hogg & Monahan, *supra* note 23 at 120, n. 56 (the numerical results of a similar survey of Ontario ministries conducted as of 2000).

⁸⁴ *Building Code Act, 1992*, S.O. 1992, c. 23, s. 31.

⁸⁵ *Fire Protection and Prevention Act, 1997*, S.O. 1997, c. 4, s. 74.

therapeutic X-ray safety Director and inspectors;⁸⁶ and the Director of the Family Responsibility Office.⁸⁷ Examples of actors immunized under regimes that do not provide for Crown liability are the Ontario Health Quality Council⁸⁸ and Directors appointed under the *Accessibility for Ontarians with Disabilities Act, 2005*.⁸⁹ Furthermore, the immunity provided to the College of Physicians and Surgeons under the *Regulated Health Professions Act, 1991* is equivalent to that granted to the Law Society of Upper Canada.⁹⁰ The ubiquity of these provisions suggests that they may be accepted as standard legislative features.

The legislative origins of the immunity provisions in the *Coroners Act* and the *HPPA* demonstrate that they were not the subject of public debate, which suggests an absence of conscious policy consideration by legislators. The current section 53 of the *Coroners Act* was originally introduced in 1978 in *The Coroners Amendment Act, 1978 (No. 1)*.⁹¹ There is no mention of this provision in the legislative record.⁹² On first reading, the Solicitor General described *The Coroners Amendment Act* as “basically housekeeping amendments required to update the act. There’s no change in the principle of the bill but the amendments will help to clarify some provisions in the Coroners Act and assist the operation of the coroners office in certain areas.”⁹³ More recently, the *Coroners Amendment Act, 2009* amended section 53 to provide good-faith immunity to all persons acting under the *Act*, not only coroners and their designates.⁹⁴ However, the legislative history contains no discussion, much less mention, of extending that protection, nor of whether good-faith immunity is appropriate for physicians.⁹⁵ Interestingly, this is despite the emphasis on accountability expressed by the Minister of Community Safety and Correctional Services on second reading: “The proposed legislation ... would ... establish the framework needed to hold pathologists *fully accountable* for their work.”⁹⁶ Also missing in the legislative history is any consideration of adding a clause that would maintain Crown liability notwithstanding *PACA*. The legislative history of section 95 of the *HPPA* is similar. That provision was originally introduced in the *Health Protection and Promotion Act, 1983*,⁹⁷ but it was not mentioned in any of the corresponding legislative debates.⁹⁸ Insofar as parliamentary debates dem-

⁸⁶ Healing Arts Radiation Protection Act, R.S.O. 1990, c. H.2, s. 26.

⁸⁷ Family Responsibility and Support Arrears Enforcement Act, S.O. 1996, c. 31, s. 59.

⁸⁸ Commitment to the Future of Medicare Act, 2004, S.O. 2004, c. 5, s. 3.

⁸⁹ S.O. 2005, c. 11, s. 30.

⁹⁰ S.O. 1991, c. 18, s. 38. Cf. *Law Society Act*, R.S.O. 1990, c. L.8, s. 9.

⁹¹ S.O. 1978, c. 38, s. 17 [*The Coroners Amendment Act*], adding s. 44a to *The Coroners Act*, S.O. 1972 c. 98.

⁹² First reading: Ontario, Legislative Assembly, *Official Report of Debates (Hansard)*, No. 59 (11 May 1978) at 2394. Second reading: No. 67 (23 May 1978) at 2729-33; No. 68 (23 May 1978) at 2739-55. Committee of the Whole: No. 79 (6 June 1978) at 3176-93; No. 90 (19 June 1978) at 3620-25. Third reading: No. 90 (19 June 1978) at 3638.

⁹³ Ontario, Legislative Assembly, *Official Report of Debates (Hansard)*, No. 59 (11 May 1978) at 2394 (Hon. George Albert Kerr).

⁹⁴ *Coroners Amendment Act, 2009*, *supra* note 9, s. 27, amending s. 53 of the *Coroners Act*, *supra* note 9.

⁹⁵ Ministerial statement & first reading: Ontario, Legislative Assembly, *Official Report of Debates (Hansard)*, No. 79 (23 October 2008) at 3537-38, 3539-40. Second reading: No. 97 (2 December 2008) at 4369-78; No. 98 (3 December 2008) at 4407-14; No. 101 (9 December 2008) at 4569-71. Standing Committee on Justice Policy: JP-12 (12 March 2009) at JP-261 - JP-281; JP-13 (26 March 2009) at JP-283 - JP-294; JP-14 (2 April 2009) at JP-295 - JP-320; JP-15 (9 April 2009) at JP-321 - JP-338. Bill reported as amended: No. 136 (20 April 2009) at 6085-86. Third reading: No. 155 (28 May 2009) at 7017-26.

⁹⁶ Ontario, Legislative Assembly, *Official Report of Debates (Hansard)*, No. 97 (2 December 2008) at 4370 (Hon. Rick Bartolucci) [emphasis added].

⁹⁷ S.O. 1983, c. 10, s. 94.

⁹⁸ Ministerial statement & first reading: Ontario, Legislative Assembly, *Official Report of Debates (Hansard)*, No. 68 (8 June 1982) at 2435-36, 2452. Second reading: No. 93 (29 June 1982) at 3329-45, 3349-50. Committee of the whole: No. 211 (13 February 1983) at 7599-607. Third reading: No. 211 (13 February 1983) at 7607-09.

onstrate legislative purpose and intention, it is noteworthy that the addition of these provisions for government physicians was not mentioned once in the legislature.

In combination, the ubiquity of good-faith immunity provisions in Ontario legislation and the absence of any consideration of the appropriateness of such provisions in the relevant legislative record of both the *Coroners Act* and the *HPPA* suggest that the relevant sections of those Acts may be the result of a standard drafting approach, and not of a consideration of the particular context of government physicians.

III

ARGUMENTS FOR AND AGAINST GOOD-FAITH IMMUNITY

In this part, I evaluate the role of statutory good-faith immunity. I begin by assessing the historic and current basis for its use. I then turn to the arguments against such use, drawing on analyses by the Ontario Court of Appeal and the Supreme Court of Canada in *Hill*.

A. Historic and Current Policy Rationales for Good-Faith Immunity

While Ontario is a useful case study of statutory good-faith immunity, it is not unique or even unusual. As Professors Hogg and Monahan have observed, “[m]any statutes contain immunity clauses that relieve Crown servants for liability in tort for acts done in good faith in the intended execution of their duties.”⁹⁹ Here I canvass the rationales for this policy.

Personal liability was historically considered necessary because the Crown was immune, and so otherwise the victim would not be able to collect damages.¹⁰⁰ Thus, modern Crown liability makes personal liability unnecessary.¹⁰¹ The specific rationale for Crown liability is “loss shifting or spreading ... among those who benefit from its services: the taxpayers.”¹⁰² However, due to *PACA* the default effect of providing the public actor with immunity is to provide that same immunity to the Crown. Professors Hogg and Monahan describe this as “indefensible as a matter of policy, because it leaves the innocent victim without redress.”¹⁰³ Indeed, they suggest that even where the scope of the immunity is framed as one of statutory interpretation, judges may engage normative policy considerations by “giv[ing] the immunity clause an artificially narrow interpretation.”¹⁰⁴ As noted above, the *HPPA* immunity regime for MOHs is different from that of the *Coroners Act*, as under the former the government remains liable for the acts of the immune physician. On this basis, the statutory immunity provided by the *Coroners Act* is problematic from an equity perspective—the person harmed by the negligence of an MOH has recourse against the government, but the one harmed by a coroner or forensic pathologist does not.

The more enduring reasoning behind immunity for public actors is that liability may have a net negative effect on the performance of their duties:

[A]n effective public administration is best achieved when public officials who are given discretionary functions to perform, are free from intimidation of litigation and damages for the exercise of that function.... [I]t is better to risk misperformance, albeit in good faith, due

⁹⁹ Hogg & Monahan, *supra* note 23 at 120; see also Horsman & Morley, *supra* note 23 at 5.50 (who refer to “a myriad of provincial statutes”).

¹⁰⁰ Kurt J.W. Sandstrom, “Personal and Vicarious Liability for the Wrongful Acts of Government Officials: An Approach for Liability Under the Charter of Rights and Freedoms” (1990) 24 U.B.C. L. Rev. 229 at 262; see also Hogg & Monahan, *supra* note 23 at 117.

¹⁰¹ *Ibid.*

¹⁰² Sandstrom, *ibid.* at 261-62.

¹⁰³ Hogg & Monahan, *supra* note 23 at 120.

¹⁰⁴ *Ibid.*, citing e.g. *Beatty v. Kozak*, [1958] S.C.R. 177. Any such covert normative analysis is not apparent in *Burns*, *supra* note 27, or *Reynolds*, *supra* note 34.

to no threat of civil responsibility for the misperformance, than to take no action at all based on a fear of such responsibility.¹⁰⁵

Note that this concern is also reflected in the common law. For example, in its recent decision on malicious prosecution, the Supreme Court emphasized the importance of deference to prosecutorial discretion:

[P]rosecutors are vested with extensive discretion and decision-making authority to carry out their functions. Given the importance of this role to the administration of justice, courts should be very slow indeed to second-guess a prosecutor's judgment calls when assessing Crown liability for prosecutorial misconduct. *Nelles* affirmed unequivocally the public interest in setting the threshold for such liability very high, so as to deter all but the most serious claims against the prosecuting authorities, and to ensure that Crown liability is engaged in only the most exceptional circumstances.¹⁰⁶

This inaction due to the fear of litigation is often termed a “chilling effect”.¹⁰⁷ Recall that the protection under section 95 of the *HPPA* was extended to a broader class of public servants in 2007, following the recommendation of the SARS Commission.¹⁰⁸ It was once called “naïve” to consider civil liability necessary to prevent “malicious or negligent acts”; instead, “deterrence should be deferred to the particular institution.”¹⁰⁹ Indeed, Professors Hogg and Monahan identify the idea “that the government's internal disciplinary procedures would be effectively employed against incompetent or over-zealous public servants” as an assumption inherent to the assertion that civil liability of the individual “is an unpredictable and usually disproportionately severe penalty.”¹¹⁰

The adverse impact of tort liability on job performance, including the chilling effect, is often cited as a concern for physicians at large as well as medical professionals more generally. The potential for liability may influence a physician to do things he would not otherwise do, such as run unnecessary tests—“positive defensive medicine”—or not to do things he would normally do, such as perform a procedure that commonly attracts malpractice litigation—“negative defensive medicine”.¹¹¹ The latter is a specific application of the chilling effect. The most extreme manifestation of defensive medicine, just as any other chilling effect, is to discontinue a job or not to take it in the first place. This would include a practicing physician changing specialities or retiring from the profession, or a new physician choosing against certain specialties.¹¹² In his report, *Liability and Compensation in Health Care*, Dean Prichard made the following finding regarding defensive medicine:

We find some support for the allegation that civil liability claims induce “defensive medicine” but that most of the allegations are exaggerated ... [C]ivil liability claims have caused some physicians to take some undue precautions in some circumstances and in some cases

¹⁰⁵ Sandstrom, *supra* note 100 at 259. See also 263-64.

¹⁰⁶ *Miazga v. Kwelllo Estate*, 2009 SCC 51, [2009] 3 S.C.R. 339 at para. 50 [*Miazga*], quoting from *Proulx v. Quebec (Attorney General)*, 2001 SCC 66, [2001] 3 S.C.R. 9 at para. 4 [*Proulx* emphasis in *Miazga*], referring to *Nelles v. Ontario*, [1989] 2 S.C.R. 170 [*Nelles*].

¹⁰⁷ See e.g. *Hill* (S.C.C.), *supra* note 1 at para. 56.

¹⁰⁸ *Health Systems Improvement Act, 2007*, S.O. 2007, c. 10, Sched. F, s. 18; *Campbell Report*, *supra* note 3, vol. 5 at 19, 65-68.

¹⁰⁹ Sandstrom, *supra* note 100 at 265. With the benefit of experience unavailable to Sandstrom in 1990, it is instead his view that would now seem naïve. See, for example, the recent revelations of years of serious incompetence by pediatric forensic pathologist Dr. Charles Smith: Coroner, “Background”, *supra* note 4.

¹¹⁰ Hogg & Monahan, *supra* note 23 at 191, including n. 27.

¹¹¹ Bernard Dickens, “The Effects of Legal Liability on Health Care Providers” in *Liability and Compensation in Health Care: A Report to the Conference of Deputy Ministers of Health* (Toronto: University of Toronto Press, 1990) app. B, vol. 2, c. 5 at 8 [Dickens, “Prichard Report”].

¹¹² *Ibid.* at 12-13.

to restrict unduly the scope of their practices but ... factors other than civil liability also contribute substantially to those decisions.¹¹³

Commissioner Goudge specifically discussed the difficulty in attracting physicians to practice forensic pathology.¹¹⁴ In addition to “heavy workloads” and “poor remuneration”, he cited “severe public scrutiny.”¹¹⁵ He recommended better funding for training and fellowships, opportunities for career advancement, reduced workloads to allow for research and teaching, more consistent compensation, more full-time positions, and “state of the art” facilities and equipment.¹¹⁶ Notably, he never suggested that scrutiny was unwarranted or standards should be lowered; instead, the solution was to address the other factors making the profession unattractive. This is a good example to follow for government physicians in general—if indeed the removal of good-faith liability promotes a chilling effect, it can be offset by other means.

It should be noted that the Ontario Law Reform Commission questioned the long tradition of personal immunity for Crown servants in its *Report on the Liability of the Crown*.¹¹⁷ One basic criticism was that the clauses were common but exhibited inconsistency: “there is no rhyme or reason to the existing pattern of statutory immunity clauses that are currently scattered through a large number of statutes. There are occasional departures from the more standard form of the clause and the clause is inexplicably missing altogether from some statutes.”¹¹⁸ The Report also criticized statutory immunity from a public law perspective:

[T]he present law governing liability of the Crown ... is opposed to popular and widely-held conceptions of government ... [T]he government and its officials ought to be subject to the same legal rules as private individuals ... This is a notion that lies at the heart of the “rule of Law” and of “constitutionalism” ... [T]he Crown requires some unique powers and immunities in order to govern effectively ... a long and powerful tradition requires that the scope of such powers and immunities should be carefully defined, and should be no broader than is necessary ...¹¹⁹

The Report recommended that all statutory immunity provisions be replaced with an indemnity scheme—whether in statute or in contract—which is the mechanism open to most employers and employees where there is concern of a chilling effect.¹²⁰

B. The Rejection of Parallel Policy Rationales by the Ontario Court of Appeal and the Supreme Court of Canada

While the policy rationale for legislation is typically not the province of the courts, both the Ontario Court of Appeal and the Supreme Court of Canada recently recognized a tort of negligent investigation by police.¹²¹ The key policy arguments opposing a duty of care owed by police to suspects parallel those opposing liability for government physicians acting in good faith. More-

¹¹³ *Ibid.*, vol. 1 at 19.

¹¹⁴ Goudge Report, *supra* note 5, vol. 3 at 302-07.

¹¹⁵ *Ibid.*, vol. 3 at 302.

¹¹⁶ *Ibid.*, vol. 3 at 303-07.

¹¹⁷ Ontario Law Reform Commission, *Report on the Liability of the Crown* (Toronto: Queen’s Printer for Ontario, 1989) [OLRC Report] (Not only was Professor Hogg the research director, but three commissioners are particularly noteworthy: Rosalie S. Abella, now Justice Abella of the S.C.C.; J. Robert S. Prichard, then Dean of the University of Toronto Faculty of Law, and a respected tort scholar; and Earl A. Cherniak, one of the province’s leading litigators.).

¹¹⁸ *Ibid.* at 28 [citations omitted].

¹¹⁹ *Ibid.* at 2-3.

¹²⁰ *Ibid.* at 27-29, 33.

¹²¹ *Hill* (S.C.C.) and *Hill* (C.A.), *supra* note 1. Note that while the S.C.C. split 6:3 on the existence of such a tort, the panel of the C.A. was unanimous on its existence and split 3:2 on whether it had been committed in the case at bar.

over, the roles of government physicians largely parallel those of police. Thus, the Courts' rejection of the arguments against a tort of negligent investigation by police provides an excellent basis for the rejection of arguments for good-faith immunity for government physicians.

In most of their duties and functions, coroners, forensic pathologists, and MOHs are similar to police. The core duties of the police include investigating possible offences and "laying charges and participating in prosecutions," as well as "preventing crimes and other offences" and "assisting victims of crime."¹²² Outside those functions related to coroners' inquests, the coronial system functions as investigative agency, comparable to a police force.¹²³ Recall from above that coroners investigate unnatural deaths in order to establish "how ... when ... where ... and by what means the deceased came by his or her death."¹²⁴ In doing so, coroners employ entry, search, and seizure powers.¹²⁵ The forensic pathologist, in performing any autopsy or other analysis ordered by a coroner, is an integral part of this investigative apparatus.¹²⁶ Recall that pathologists often provide oral reports to the police.¹²⁷ If the investigation reveals that the death was not due to natural causes, there is a statutory requirement that the Crown Attorney be informed.¹²⁸ Crown Attorneys are explicitly required to consider the information provided by coroners if that information may relate to criminal (or provincial) offences.¹²⁹

In a similar manner, MOHs essentially function as the public health police with investigative and remedial powers. Recall from above that MOHs have a duty to inspect their territory, including places used for food storage or service or as boarding houses, and to investigate complaints about health hazards.¹³⁰ They have powers of entry, search, and seizure.¹³¹ They exercise broad remedial powers to rectify health hazards that include ordering a property cleaned, closed, or vacated, or any thing destroyed.¹³² Several of the matters that may be discovered in the course of an investigation constitute offences.¹³³ Where communicable diseases are at issue, MOHs similarly have broad remedial powers that include ordering any property closed or any person to submit to medical examination or treatment.¹³⁴

Government physicians, as do the police, investigate offences and promote public safety—like police, often using extensive coercive powers over persons and property to do so. On this basis, the decisions in *Hill*—recognizing a tort of negligent investigation by police—can be instructively applied to government physicians. I turn now to those decisions.

At the Court of Appeal, the major argument against the duty of care was a "chilling effect" on police.¹³⁵ The core of this argument is that civil liability will discourage police from asserting their powers for fear of litigation. In his rejection of this assertion as "speculative and counterintuitive", Justice MacPherson explicitly invoked the example of medical professionals:

¹²² *Police Services Act*, R.S.O. 1990, c. P. 15, s. 42(1)(b)-(c), (e).

¹²³ I have made this argument in more detail and for a different purpose elsewhere. See Martin, *supra* note 32 at 31-33.

¹²⁴ *Coroners Act*, *supra* note 9, ss. 10, 15, 31(1).

¹²⁵ *Ibid.*, s. 16.

¹²⁶ *Ibid.*, ss. 28-29.

¹²⁷ *Rosenhek*, *supra* note 29.

¹²⁸ *Coroners Act*, *supra* note 9, s. 18.1

¹²⁹ *Crown Attorneys Act*, *supra* note 83, s. 11.

¹³⁰ *HPPA*, *supra* note 49, ss. 10, 11.

¹³¹ *Ibid.*, ss. 19, 41.

¹³² *Ibid.*, ss. 13, 14.

¹³³ *Ibid.*, s. 100 (e.g. failure to maintain and operate a food premise in accordance with the regulations, sale of diseased food or unpasteurized milk, or failure of the owner of a residential building to provide potable water and/or sanitary facilities: ss. 16-18, 20).

¹³⁴ *Ibid.*, s. 22.

¹³⁵ *Hill* (C.A.), *supra* note 1 at para. 53.

[T]here are legal standards that already govern those investigations - for example, the reasonable and probable grounds standard for making an arrest.... Surgeons do not turn off the light over the operating room table because they owe a duty of care to their patients. They perform the operation, with care.¹³⁶

As police are held to “legal standards” in the absence of tort liability, so too are physicians held to professional standards enforceable via disciplinary sanctions by the College of Physicians and Surgeons.¹³⁷ Thus, it is equivalently speculative that the same civil liability for negligence that other physicians routinely endure would influence the behaviour of government physicians in a way that professional liability does not. Related to the “chilling effect,” and similarly rejected by the Court, was the “floodgates” assertion that litigation would unduly occupy the police.¹³⁸ While physicians may resent the time and effort spent defending their actions in court, near-total immunity given the low threshold of good faith is a facile and overbroad response.

In rejecting these arguments against a duty of care, the Court also recognized the positive dual role of such a duty, a role that would also apply to liability for government physicians: the need to balance police powers against the rights of those affected by the police, and the absence of an “alternative remedy”.¹³⁹ The proposition that resort to the College of Physicians and Surgeons is an adequate response to erroneous harmful acts by government physicians is weakened by the characterization by Justice MacPherson: “the existence of a public complaints process that might result in the imposition of disciplinary sanctions is ‘no alternative to liability in negligence.’”¹⁴⁰ Just as the reprimand or suspension of a police officer is no more than moral vindication for a complainant, so too is regulatory action against a government physician.¹⁴¹

The Court of Appeal held that instead of no liability, the correct response to policy concerns was “a carefully tailored standard of care”;¹⁴² thus, the Court also rejected the additional argument of the adequacy of malicious prosecution as a cause of action.¹⁴³ A standard of care incorporating “normal professional negligence” would be “not overly onerous” for police.¹⁴⁴ As it is the same standard of care typically applicable to physicians, it would seem similarly appropriate to government physicians. The normative argument made by Justice MacPherson was straightforward and eloquent:

[a requirement of malice] would set the bar too high ... [T]here is another category of police misconduct that has the potential to cause serious harm to members of the public ... [T]he misconduct is anchored in very poor performance of important police duties. It is important to give some flesh and blood to this non-malicious category of police misconduct ... Should Canadian law not provide a cause of action in negligence to people [harmed by neg-

¹³⁶ *Ibid.* at para. 63.

¹³⁷ It has been clearly established by the Health Professions Appeal and Review Board that coroners and pathologists as medical doctors are subject to regulation, including disciplinary action, by the College of Physicians and Surgeons of Ontario: Sossin, *Accountability and Oversight*, *supra* note 7 at 28, quoting *Between: DM (Complainant) and Charles Randal Smith, M.D. (Member Complained Against)* [2000] File #5421.

¹³⁸ *Hill* (C.A.), *supra* note 1 at para. 64.

¹³⁹ *Ibid.* at paras. 68-69.

¹⁴⁰ *Ibid.* at para. 68, quoting *Odhawji Estate v. Woodhouse*, 2003 SCC 69, [2003] 3 S.C.R. 263 at para. 60, 233 D.L.R. (4th) 193.

¹⁴¹ See also Tracey Epps, “Regulation of Health Care Professionals” in Downie, Caulfield & Flood, eds., *Canadian Health Law and Policy*, *supra* note 6 at 75-76, contrasting discipline and civil liability with regard to compensation.

¹⁴² *Hill* (C.A.), *supra* note 1 at para. 70.

¹⁴³ *Ibid.* at paras. 53, 72-81. Note that the elements of malicious prosecution established in *Nelles*, *supra* note 106, were recently re-visited in *Miazga*, *supra* note 106.

¹⁴⁴ *Ibid.* at paras. 70-71.

ligent police conduct]? Honest reflection about what happened to them suggests only one answer.¹⁴⁵

In affirming this reasoning, Chief Justice McLachlin was more concise: “To deny a remedy in tort is, quite literally, to deny justice.”¹⁴⁶ Justice MacPherson’s reasoning on malice is similarly applicable to government physicians. Statutory good-faith immunity leaves the tort of negligence available only where there is bad faith, be it by malice or serious carelessness or recklessness.¹⁴⁷ There is a whole other “non-malicious category” of misconduct by government physicians that is not actionable.¹⁴⁸ It “has the potential to cause serious harm to members of the public” just as police negligence does.¹⁴⁹

The Court of Appeal recognized key factors that would preclude liability in negligence, but held that such factors did not apply to police. The Court cited the propositions of the Supreme Court that a duty of care was less appropriate for policy reasons where the action was “in the nature of governmental or legislative policy-making” (as opposed to “operational”) or “in the performance of a quasi-judicial function.”¹⁵⁰ Note that these factors do apply to some of the functions of government physicians. For example, a major and publicly visible role of coroners is to hold inquests.¹⁵¹ The role of a coroner at an inquest is quasi-judicial, as she essentially sits in place of a judge.¹⁵² Similarly, a widespread quarantine of a whole class of persons could be a policy decision, and the CMOH’s annual report “on the state of public health in Ontario” is partly of a policy nature.¹⁵³ How tort law would apply to these policy or quasi-judicial functions of government physicians will be considered further below.

¹⁴⁵ *Ibid.* at paras. 75, 77-78, 81.

¹⁴⁶ *Hill* (S.C.C.), *supra* note 1 at para. 35. The extent to which tort law is an *efficient* mechanism for justice is beyond the scope of this paper. In his 1990 Report on Liability and Compensation in Health Care, Dean Prichard noted that tort was “a fundamental means of redress for injured patients” (Prichard Report, *supra* note 111, vol. 1 at 21). However, he also found that “only a modest percentage” of those injured by medical negligence, estimated at under ten percent, received such redress (*ibid.* vol. 1 at 5).

¹⁴⁷ Note that the tort of misfeasance in public office could also be available where there is bad faith. The elements of this tort were recently re-stated by the Ontario C.A. in *Foschia v. Conseil des Écoles Catholique de Langue Française du Centre-Est*, 2009 ONCA 499 at para. 22, 266 O.A.C. 17, [2009] O.J. No. 2536 (QL). This tort requires three particular elements—“a public official who was exercising public functions”, an unlawful act by that official, and an awareness by that official that the “conduct is unlawful and... is likely to injure the plaintiff.” The four kinds of unlawful acts are “a breach of relevant statutory provisions, acting in excess of the powers granted to the public official, omitting to act in circumstances in which the public officer is under a legal duty to act, or acting for an improper purpose.” The required awareness that he or she is doing one of these things would constitute bad faith, whether by malice, recklessness, or serious carelessness. For a recent finding of misfeasance in public office due to bad faith, see *Rosenhek*, *supra* note 29 at paras. 26-35.

¹⁴⁸ *Hill* (C.A.), *supra* note 1 at para. 78.

¹⁴⁹ *Ibid.* at para. 77.

¹⁵⁰ *Hill* (C.A.), *ibid.* at paras. 67-68, citing *Cooper v. Hobart*, 2001 SCC 79, [2001] 3 S.C.R. 537 at paras. 37-38, 206 D.L.R. (4th) 193 [*Cooper*]. On the policy-operational distinction in the health care context, see also Dickens, “Legal and Ethical Obligations”, *supra* note 66 at 9-11.

¹⁵¹ Inquests are governed by the *Coroners Act*, *supra* note 9, ss. 10, 15, 18-20, 22.1, 26-27, 30-52.

¹⁵² Among other things, the coroner determines standing (s. 41), makes any orders to maintain order (s. 47), administers oaths and affirmations (s. 49), makes orders to prevent abuse of process, limits inappropriate cross-examination, and excludes representatives the coroner finds to be incapable (s. 50). The determination of whether an inquest is necessary requires a consideration of the public interest as well as the objective issue of whether the circumstances of the death are known, and as such may also be regarded as quasi-judicial (ss. 20, 31(1)). This is reflected in the sections of the Act that came into force in December 2010, governing complaints about coroners, which specify that the decision whether to hold an inquest and how to schedule it, as well as a coroner’s conduct and decisions at an inquest, cannot be the subject matter of a complaint (s. 8.4(3)).

¹⁵³ *HPPA*, *supra* note 49, s. 81(4), as am. by S.O. 2004, c. 30, s. 1(2). A decision to order an individual examined, treated, and/or isolated is certainly an “operational” one, but the scale at which quarantine becomes a policy matter is an issue beyond the scope of this paper.

While Chief Justice McLachlin for the majority in the Supreme Court largely affirmed the reasoning of the Court of Appeal, she also addressed Justice Charron's dissenting argument that the proposed duty to suspects was irreconcilable with the established duty to the public.¹⁵⁴ The tension asserted by Justice Charron between these two duties has an equivalent for government physicians. Just as "it is always in the *interest* of individual members of society to be left alone rather than to be investigated by the police,"¹⁵⁵ so too is it in that interest not to be considered in the causation of a suspicious death by a coroner or pathologist, or not to be inspected or quarantined by an MOH. Thus, as Justice Charron held that "the suspect's interest is *always* at odds with the public interest,"¹⁵⁶ so too is it for those who are the target of the coercive powers of the coroner, pathologist, or MOH. Nonetheless, the "authority to make decisions in the public interest that are adverse to certain citizens" would not be seriously threatened if those physicians lacked good-faith statutory immunity, any more than if the police were subject to a tort of negligent investigation—only the ability to do so negligently without repercussion would be removed.¹⁵⁷ In this regard, Chief Justice McLachlin explained that the conflict between the interest in being left alone and the duty to the public arose because the wrong pair of elements was being weighed. The duty to the public "does not conflict with the presumed duty to take reasonable care toward the suspect ... the suspect is a member of the public."¹⁵⁸ What was at issue was not "a duty to leave the citizen alone, but only a duty to investigate reasonably."¹⁵⁹ These comments are prescient to the liability of government physicians, as their duties to the public as a whole are consistent with, not opposed to, their duties to act without negligence toward particular members of the public.

IV

AFTER GOOD-FAITH IMMUNITY FOR GOVERNMENT PHYSICIANS: A RETURN TO THE COMMON LAW OF TORT

I have discussed above how statutory good-faith immunity is inconsistent with the requirement that coroners, forensic pathologists, and MOHs be licensed physicians. It is inequitable that government physicians are held to a legislated standard of care that is lower than that required of all other physicians by the common law. However, the abolition of this statutory good-faith immunity would not mean that all harm done by government physicians would lead to liability in negligence. The equality that would result is the equal application of the common law of tort, not an equality of outcome. Potentially tortious conduct by government physicians and other physicians would both be judged according to the evolving common-law principles of tort. For example, as discussed above the role of a coroner in relations to inquests is a quasi-judicial function that would not incur liability in negligence.¹⁶⁰ In this section, I discuss how the law of negligence would apply to government physicians if statutory good-faith immunity were removed.

In the absence of statutory good-faith immunity, there will nonetheless be no liability where there is insufficient proximity to the harmed individual. The Ontario Court of Appeal has held that the high-level prevention of disease and promotion of health is a duty to the public at large and not to any particular member of the population. However, this does not preclude all tort liability in the public health sphere.

¹⁵⁴ *Hill*, *supra* note 1.

¹⁵⁵ *Ibid.* at para. 140 [emphasis in original].

¹⁵⁶ *Ibid.* at para. 131 [emphasis in original]. In the long term, forced examination and treatment may well be in the individual's interest; however, it certainly conflicts with autonomy.

¹⁵⁷ *Ibid.* at para. 140.

¹⁵⁸ *Ibid.* at para. 41 [emphasis added].

¹⁵⁹ *Ibid.* at para. 42.

¹⁶⁰ See *supra* notes 151, 152.

Justice Sharpe applied this private duty versus public duty distinction in the West Nile Virus case of *Eliopoulos v. Ontario (Minister of Health & Long Term Care)*¹⁶¹ and in the SARS cases. In *Eliopoulos*, a negligence claim against the Ontario government for contracting the virus from a mosquito bite was struck as disclosing no cause of action.¹⁶² Justice Sharpe held that the plaintiffs failed at the first stage of the *Anns/Cooper* test for a government's private duty of care, that of foreseeability and proximity—even if foreseeability was assumed, there was no proximity.¹⁶³ The statute created a public law duty but not a private duty:

[T]hese important and extensive statutory provisions create discretionary powers that are not capable of creating a private law duty ... They are not aimed at or geared to the protection of the private interests of specific individuals. From the statement of purpose in s. 2 and by implication from the overall scheme of the *HPPA*, no doubt there is a general public law duty that requires the Minister to endeavour to promote, safeguard, and protect the health of Ontario residents and prevent the spread of infectious diseases. However, a general public law duty of that nature does not give rise to a private law duty sufficient to ground an action in negligence.¹⁶⁴

Justice Sharpe also observed that the plaintiffs would have failed at the second stage of the *Anns/Cooper* test, i.e. that residual policy considerations made a private duty problematic.¹⁶⁵ He emphasized the importance of policy discretion at the macro level and implicitly invoked chilling-effect concerns:

[T]o impose a private law duty of care ... would create an unreasonable and undesirable burden on Ontario that would interfere with sound decision-making in the realm of public health. Public health priorities should be based on the general public interest. Public health authorities should be left to decide where to focus their attention and resources without the fear or threat of lawsuits.¹⁶⁶

Justice Sharpe similarly rejected the claims in the SARS cases.¹⁶⁷ In *Abarquez* he stated: “[W]hile Ontario is obliged to protect the public at large from the spread of communicable diseases such as West Nile Virus and SARS, Ontario does not owe ... individual residents of the province who contract such diseases a private law duty of care giving rise [to] claims for damages.”¹⁶⁸ From these cases, it is clear there is no private duty of care owed by the government to formulate its policies or determine its priorities so as to prevent the infection of specific members of the public.

¹⁶¹ (2006), 82 O.R. (3d) 321 at paras. 1-3, 276 D.L.R. (4th) 411 (C.A.) [*Eliopoulos*], leave to appeal refused, [2006] S.C.C.A. No. 514. Given that there was “no allegation of bad faith, misfeasance, or irrationality” (para. 5), it is not surprising that the action did not name the CMOH as a defendant.

¹⁶² *Ibid.* at paras. 1-3.

¹⁶³ *Ibid.* at para. 9; *Cooper*, *supra* note 150, adopting *Anns v. Merton London Borough Council*, [1978] A.C. 728 (H.L.).

¹⁶⁴ *Eliopoulos*, *ibid.* at para. 17, referring to *HPPA*, *supra* note 49.

¹⁶⁵ *Ibid.* at paras. 31-33.

¹⁶⁶ *Ibid.* at para. 33.

¹⁶⁷ *Williams*, *supra* note 66 at paras. 28-31; *Larozza Estate*, *supra* note 66 at para. 6; *Henry Estate*, *supra* note 66 at para. 7; *Jamal Estate*, *supra* note 66 at para. 11; *Abarquez*, *supra* note 66 at para. 20.

¹⁶⁸ *Abarquez*, *supra* note 66 at para. 20.

However, this does not preclude liability where government physicians are negligent in their interactions with specific members of the public. In *Williams*, Justice Sharpe referred to potential negligence on the part of practicing physicians:

[T]his result does not leave the plaintiff without a remedy if she can show that she suffered harm as a result of negligence at the operational level on the part of those responsible for the application and enforcement of the Directives; namely, health care facilities and health care professionals.¹⁶⁹

In a similar manner, the improper exercise of powers of treatment or quarantine, or the failure to exercise those powers, could constitute negligence by an MOH.¹⁷⁰ Similarly, a coroner that negligently investigates a particular death such that the wrong person is charged or even convicted—or a pathologist that negligently conducts an autopsy to the same effect—could be liable to that person.¹⁷¹

Indeed, Justice Sharpe's subsequent decision in *Heaslip Estate v. Mansfield Ski Club Inc.* confirms that the calculus of negligence changes once a particular individual comes to the attention of the arms of the state.¹⁷² *Heaslip Estate* involved the unavailability of an air ambulance to transfer a patient, and the allegation that the province failed to follow its policy for air ambulance allocation.¹⁷³ The motion judge struck out the claim against the province, applying *Eliopolous* in finding only a public duty and not a private duty; likewise, policy considerations, including a potential "chilling effect", would have gone against finding a duty.¹⁷⁴ Justice Sharpe, in overturning that decision, cited *Attis v. Canada (Minister of Health)* for the proposition that "once the government has direct communication or interaction with the individual in the operation or implementation of a policy, a duty of care may arise, particularly where the safety of the individual is at risk".¹⁷⁵ Thus, an MOH that becomes aware of a specific individual that could require quarantine, examination, or treatment, and negligently determines which steps are necessary or negligently enforces those steps, is in an analogous position.

These cases are consistent with the recognition of the Court of Appeal in *Hill* that policy-making and quasi-judicial functions are generally protected from liability in negligence.¹⁷⁶ High-level governmental decisions made regarding the general protection of the public against communicable diseases would likely not create a private duty of care.¹⁷⁷ However, that still leaves negligence applicable to a substantial range of operational performance regarding the exercise of statutory powers in the case of specific individuals.

¹⁶⁹ *Williams*, *supra* note 66 at para. 36.

¹⁷⁰ Perell J.'s decision in *Lakeridge*, *supra* note 74, suggests there would be no liability to persons merely exposed, but not infected, by that negligence.

¹⁷¹ The Ontario C.A. has held that whether common-law witness immunity covers only the testimony of a pathologist, as opposed to the autopsy and the provision of an oral opinion to the police, must be considered on the specific facts (*Reynolds*, *supra* note 34 at para. 24). Thus, the effect of witness immunity on a negligence claim in the absence of statutory immunity remains to be seen.

¹⁷² 2009 ONCA 594, 96 O.R. (3d) 401, 252 O.A.C. 1 [*Heaslip Estate*].

¹⁷³ *Ibid.* at para. 17.

¹⁷⁴ *Ibid.* at paras. 13-14.

¹⁷⁵ *Ibid.* at para. 21, citing *Attis v. Canada (Minister of Health)*, 2008 ONCA 660, 93 O.R. (3d) 35, 300 D.L.R. (4th) 415 at para. 66, leave to appeal refused, [2008] S.C.C.A. No. 491.

¹⁷⁶ *Hill* (C.A.), *supra* note 1.

¹⁷⁷ See *Just v. British Columbia*, [1989] 2 S.C.R. 1228, 64 D.L.R. (4th) 689 [*Just*]. Justice Sharpe cited *Just* in *Heaslip Estate*, *supra* note 172 at para. 21 for the following: "The duty of care alleged here belongs within the established category of a public authority's negligent failure to act in accordance with an established policy where it is reasonably foreseeable that failure to do so will cause physical harm to the plaintiff".

CONCLUSION: AN INEQUITABLE DENIAL OF JUSTICE

Statutory good-faith immunity for coroners, pathologists, and MOHs is ultimately an inequitable denial of justice. The justice provided by tort law should be available to those harmed by any negligent physician.¹⁷⁸ Government physicians are required by statute to hold valid medical licences. The same statutes grant them extensive investigative and coercive powers and so create the potential for extensive harm. Nonetheless, they negate the common law competence standard of care for physicians with a good-faith requirement for civil immunity. This statutory good-faith immunity is common for government employees, and there is no evidence that its appropriateness in the special context of government physicians was actively considered during the legislative process. The reasoning of the Ontario Court of Appeal and the Supreme Court of Canada in recognizing a tort of negligent investigation by police suggests that liability in negligence is appropriate where a government employee exerts investigative and coercive powers over the individual. In particular, a disciplinary process is no substitute for civil liability, and speculation regarding a chilling effect should be given little weight. Moreover, there is no conflict of duties in the exercise of powers over the individual in the interests of the general public—the public is made up of such individuals.

There are two levels of changes that would address this inequity. At a minimum, governments should remove the distinction between those harmed by MOHs and those harmed by coroners or forensic pathologists. This would involve amending the immunity provision in the *Coroners Act* so that the government remains liable despite the physicians' personal immunity. The next level of action would be to remove good-faith immunity provisions from statutes governing government physicians. If the government remains concerned about the potential chilling effect, it could offset it by other means such as those suggested by Commissioner Goudge—better training, compensation, facilities, or equipment. It could also adopt an employer-employee indemnity provision as suggested by the *OLRC Report*—whether in statute or contract.¹⁷⁹

The revocation of statutory good-faith immunity would restore the application of the common law of tort.¹⁸⁰ There would be no liability where there is only a duty to the public at large (such as in outbreaks of contagious diseases), or in policy or quasi-judicial matters (such as a coroners' inquest). However, the duties and functions directed toward specific individuals—particularly decisions concerning coercive quarantine, examination or treatment, or involvement in suspicious deaths—could give rise to liability.

The Naylor Report, the SARS Commission, and the Goudge Report each made valuable recommendations to reduce or prevent future harm in death investigation and public health. In their wake, it would be valuable to recognize the state's responsibility when such harm nonetheless occurs, by restoring Crown liability for the tortious conduct of coroners and pathologists. Doing so could indeed improve the quality of death investigation and public health services. Ending the Crown's *PACA*-created immunity under the *Coroners Act* would tend to improve the quality of death investigation, as it would no longer be in the state's financial interest to dedicate insufficient resources to the hiring, training, and supervision of the physicians involved. If the

¹⁷⁸ See *supra* note 146.

¹⁷⁹ Indeed, McLachlin C.J.C. in *Hill*, *supra* note 1 at para. 59 recognized that such indemnity was common in the police context and would reduce the impact of any chilling effect: “[M]any police officers (like other professionals) are indemnified from personal civil liability in the course of exercising their professional duties, reducing the prospect that their fear of civil liability will chill crime prevention.” See e.g. *Police Services Act*, *supra* note 122, s. 50. Also see *OLRC Report*, *supra* note 117.

¹⁸⁰ To keep statutory immunity but add a further element of “reasonable grounds” or “gross negligence” would be a weak reform. Such standards may be appropriate when the government is imposing requirements on all physicians regardless of their expertise, but not where the government is hiring and empowering its own physicians on the basis of such expertise.

government went further and abolished good-faith immunity for government physicians, tort liability might play the same quality-enhancing role it does in health care.

In closing, it must be noted that there is nothing forcing the government to act. Statutory good-faith immunity provisions are certainly not unlawful. The majority of the Supreme Court held in 1994 that the legislative choice to limit Crown liability was to be addressed, if at all, at the ballot box: “If the Crown wishes to exempt itself from tortious liability ... it is a simple matter to legislate to that effect, and to leave the propriety of that legislative action for the voters’ consideration.”¹⁸¹ The core arguments for change are based on justice and equity. I adopt the observation of the *OLRC Report*—“the answer to the question why the government should relinquish many of the advantages that it now enjoys is very simple, yet compelling. It is the right and fair thing for good government to do.”¹⁸²

¹⁸¹ *Swinamer v. Nova Scotia (Attorney General)*, [1994] 1 S.C.R. 445 at 461, 112 D.L.R. (4th) 18, Cory J. (Note that McLachlin J. [as she then was] did not sign on to the majority judgment, but instead wrote a short concurring opinion at 449-50. It is difficult to infer from her reasons whether she agreed with the quoted statement of Cory J. at that time.). An extended version of this passage is quoted in Horsman & Morley, *supra* note 23 at 5.50.10.

¹⁸² *Supra* note 117 at 6.