



**POSITION PAPER**  
**Class Actions**

**SUMMARY OF ISSUE**

Class actions against hospitals are on the rise. Claims brought by a single person on behalf of hundreds or even thousands of people who would otherwise refrain from litigation represent a significant threat to healthcare facilities. The costs are enormous, both in terms of the resources required to defend such claims, and the potential for payment through settlement or judgment. These costs are compounded by the high fees routinely awarded to plaintiff's counsel to compensate them for the risk of unsuccessful litigation and the extremely limited ability of class action defendants to recover a meaningful legal costs award from a representative plaintiff in the event of success. Class action certification is being granted in many cases despite significant individual issues which creates further pressure to settle claims in order to avoid significant, ongoing legal cost.

Nosocomial or hospital acquired infections are a recent target of legal action. Such infections can be difficult to control, even with good care, in the face of limited resources, ageing infrastructure, medically complex patient populations and increasing virulence & resistance of new organisms. Hospitals risk being found liable for factors beyond their control. Since Joseph Brant Memorial Hospital reported its *c. difficile* outbreak (now the subject of a class action), a number of hospitals have identified *c. difficile* outbreaks, and nosocomial infection rates are now made public. A recent study found that 250,000 patients per year experience surgical wound infection or contract antibiotic-resistant organisms in hospital. Healthcare facilities potentially face multiple and recurring class actions resulting from infection claims.

Further, a number of class actions have been brought against hospitals in the absence of physical harm to patients, alleging mental distress caused by the disclosure of potential risk. These claims typically involve the situation where a patient is told, after treatment, of a low infection risk and advised to rule it out with routine testing. The patient is subsequently given a clean bill of health but seeks compensation for the stress of waiting for test results which may be provided in weeks or even days. For example, in *Farkas v. Sunnybrook*, the hospital advised 900 men they may have been exposed to an extremely low risk of bloodborne infection resulting from the disinfection of medical equipment. Important policy considerations in terms of improving hospital processes and ensuring public health & safety motivated this widespread notification. In this instance no active disease was identified by the testing, thus confirming the extremely low risk of transmission, the precautionary nature of the screening and the fact no harm resulted from the potential exposure.

### *HIROC's Role and Initiatives*

HIROC is the largest healthcare liability insurer in Canada. While insurance is our business, our vision is a safer healthcare system. HIROC is structured as a reciprocal which means that risk is shared amongst members/subscribers and claims payments are made with healthcare dollars.

The cost of class actions threatens to overwhelm the healthcare system as limited hospital budgets cannot afford the increased premiums and potential payments associated with thousands of additional claims. Additionally, compensating uninfected patients penalizes hospitals and public health agencies for prudently notifying patients of a potential health risk, and discourages the priority given by HIROC and its members/subscribers to ensuring patient safety.

### *Position Statement & Call to Action*

HIROC supports the imposition of limits on class actions brought against hospitals for nosocomial infections and for disclosure of a remote health risk. The legal system currently has too few checks and balances in place to prevent the abuse of class actions and the waste of public money. The fee premiums awarded to plaintiff's counsel can be millions of dollars taken away from healthcare funds. Reform is needed in this area to ensure that hospitals can continue to prioritize patient safety by disclosing remote health risks without fear of costly litigation. Infection is a known risk of hospitalization that occurs despite good care. Further funds are required for research into nosocomial infections and education, training and implementation of infection control practices as well as changes to infrastructure to reduce infection risk.