Medical Malpractice Claims Guide

2026 Edition

The plaintiffs comprehensive guide to navigating claims related to Medical Malpractice or Negligence in

Atlantic Canada

Table of Contents

What Is Medical Malpractice?

Medical malpractice is one of the most complex and consequential areas of civil law. It touches on the most vulnerable moments in a person's life, moments of illness, injury, and trust in the professionals responsible for their care. When that trust is broken through negligence, patients and families deserve to understand their rights.

This guide is designed to walk you through the entire process of a medical malpractice claim in Atlantic Canada: what it is, how it works, what it costs, and what you can realistically expect. Whether you are at the very beginning of trying to understand what happened to you, or already speaking with a lawyer, this guide is meant to be a clear and honest reference.

The Legal Definition

Medical malpractice is a form of professional negligence. It occurs when a healthcare provider, a physician, surgeon, nurse, specialist, or any other regulated health professional, fails to provide care that meets the accepted standard of their profession, and that failure causes harm to a patient.

The law does not expect healthcare providers to be perfect. Medicine involves uncertainty, judgment, and genuine risk. What the law requires is that a provider bring reasonable skill and knowledge to their work, and exercise reasonable care in doing so. The defining statement in Canadian law comes from the Ontario Court of Appeal in Sylvester v Crits et al, affirmed by the Supreme Court of Canada:

> **"Every medical practitioner must bring to his task a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. He is bound to exercise that degree of care and skill which could reasonably be expected of a normal, prudent practitioner of the same experience and standing, and if he holds himself out as a specialist, a higher degree of skill is required of him."**

This principle, reasonable skill and care measured against what a competent peer in the same specialty would do, is the foundation of every medical malpractice claim in Canada.

Medical Error vs. Medical Negligence: An Important Distinction

Not every medical error is medical negligence. This is one of the most important distinctions in malpractice law and one that surprises many people. A **medical error** is any unintended outcome or mistake in the delivery of healthcare. Errors happen in medicine, as they do in every other human endeavour. The question the law asks is not whether an error occurred, but whether a reasonably competent provider in the same circumstances would have made the same decision or taken the same action.

An error in judgment, a clinical decision that turns out to be wrong, made by a practitioner who exercised reasonable care in reaching it, is not negligence. The Supreme Court of Canada confirmed this in Wilson v Swanson [1956] SCR 804: a practitioner who exercises reasonable care in carrying out treatment is not liable simply because the treatment was unsuccessful or a different practitioner might have taken a different approach. **Negligence** requires more: a departure from what a reasonably competent practitioner would have done, causing harm that would not otherwise have occurred.

This distinction is practically important. Many patients who feel harmed by medical care do not have a legal claim, because the treatment they received, even if it did not produce the hoped-for result, was within the acceptable range of competent medical practice. A good malpractice lawyer will tell you this honestly after reviewing the facts, rather than encourage you to pursue a claim that is unlikely to succeed.

Who Can Be Held Responsible

Medical malpractice claims can be brought against a wide range of healthcare providers and institutions, not only the most obvious defendants:

- Physicians, surgeons, and specialists
- Residents, interns, and medical students under supervision (the supervising physician may also bear responsibility)
- Nurses and nurse practitioners
- Hospitals and regional health authorities (for systemic failures, inadequate staffing, or negligent credentialing)
- Anaesthesiologists, radiologists, and pathologists who misread imaging or specimens
- Pharmacists who dispense incorrectly or fail to identify dangerous interactions
- Dentists, chiropractors, physiotherapists, and other regulated health professionals

Identifying all potentially responsible parties is an important task in the early stages of a claim. The duty of care can extend beyond the most obvious defendant, to a specialist who was consulted in the hallway, to the administrative assistant who failed to relay a critical test result, or to a hospital that delayed a necessary procedure. An experienced malpractice lawyer will investigate the full chain of events to ensure all responsible parties are identified.

The Four Elements Every Medical Malpractice Claim Must Establish

To succeed in a medical malpractice claim in Canada, a plaintiff must prove four distinct elements on the balance of probabilities, meaning more likely than not. These elements must all be established. A failure on any one of them will defeat the claim, regardless of how strong the others appear.

Element 1: Duty of Care

The first question is whether the healthcare provider owed a legal duty of care to the patient. In medicine, this duty arises from the healthcare relationship: when a practitioner undertakes to assess or treat a patient, they accept a corresponding obligation to do so with reasonable skill and care. This relationship is usually obvious, but it is not always clear-cut, and this is where an experienced lawyer can identify defendants a patient might never think to name:

- A specialist who provides a telephone consultation without seeing the patient directly may owe a duty if they should have known their advice would be acted upon
- A physician who supervises a resident may share responsibility for the resident's decisions
- A hospital owes duties not only for what its employed staff do, but for the systems it operates, including systems for following up on abnormal test results and for credentialing practitioners
- Covering physicians who take over care during a handover inherit certain duties in relation to ongoing investigations and treatment plans

The foundational principle that a duty of care arises whenever one person ought reasonably to foresee that their conduct could cause harm to another comes from the landmark decision of Donoghue v Stevenson [1932] AC 562, which forms the bedrock of negligence law across Canadian common law provinces.

Element 2: Breach of the Standard of Care

Once a duty of care is established, the question becomes whether it was breached. The standard of care is not a fixed rule that applies uniformly to all situations. It is a context-specific assessment of what a reasonable, competent practitioner in the same specialty, with the same training and in the same circumstances, would have done. Several principles shape how courts apply the standard:

The standard is not perfection. A practitioner may make a decision that turns out to be wrong and still have met the standard of care, if the decision reflected what a competent peer would reasonably have done with the same information.

Specialists are held to a higher standard. A general practitioner is measured against the standard of a general practitioner. An obstetrician is measured against the standard of a competent obstetrician.

The standard requires expert testimony. Because courts cannot be expected to know what competent medical practice looks like in a given specialty, the standard of care must almost always be established through expert evidence from a qualified practitioner in the same or a comparable discipline.

The standard reflects best practices, not just common practice. A practitioner who follows common practice in their area cannot always rely on that fact as a defence. Where common practice falls below what the evidence supports as appropriate care, following it does not automatically satisfy the standard.

Element 3: Harm

A claim requires proof that the patient suffered actual harm, physical injury, psychological injury, or financial loss. A breach of the standard of care that causes no harm is not actionable in negligence. Harm can take many forms:

- Physical injury, including worsening of a pre-existing condition
- A condition that would have been treatable if diagnosed earlier, progressing to a more serious stage
- Permanent disability caused by an error that would not have occurred with appropriate care
- Emotional and psychological suffering
- Financial losses including lost wages, treatment costs, and care expenses

The harm does not need to be catastrophic, but it must be real and measurable. The law also requires that the harm be something more than the bad outcome the patient already risked by virtue of their underlying condition, distinguishing between harm caused by the illness itself and harm caused by the negligence.

Element 4: Causation

Causation is frequently the most difficult element to establish and the most contested issue in medical malpractice litigation. It is not enough to show that the standard of care was breached and that harm occurred. The patient must also prove that the breach caused the harm. The standard test is the **"but for"** test: but for the negligence of the defendant, would the harm have occurred? The Supreme Court of Canada affirmed this as the primary causation test in Clements v Clements, 2012 SCC 32.

In medicine, this question is often deeply complex. A delayed cancer diagnosis: if the cancer had been detected three months earlier, would the patient's outcome probably have been different? A missed infection: if antibiotics had been started one hour sooner, would the patient probably have survived? A surgical error: was the complication caused by the error itself, or an unavoidable consequence of the surgery that would have occurred regardless?

The Supreme Court of Canada confirmed in Snell v Farrell, 1990 CanLII 70 (SCC) that causation is essentially a practical question of fact approached with common sense, and does not require scientific precision. An inference of causation may be drawn from the evidence, provided it has a reliable factual foundation. The medical expert must not only explain what went wrong, but also explain, on the evidence, what would probably have happened if it had been done correctly.

Why All Four Elements Must Be Present

A case that can establish three of the four elements but not all four will not succeed. The most common reasons claims fail:

- Breach is established, but the harm was caused by the underlying disease or condition, not by the negligence
- Harm is serious and clear, but expert review concludes the care met the standard
- The standard of care was arguably breached, but the patient cannot show the outcome would probably have been different with better care
- The claim was not filed within the applicable limitation period

An honest assessment of all four elements before committing to litigation is one of the most important things a malpractice lawyer can do for you. Establishing harm and even a breach is not enough; the causal link must hold, and the claim must be brought in time.

Common Types of Medical Malpractice Claims

Medical malpractice can arise in almost any healthcare setting. The following are the categories of claims that arise most frequently in Canadian courts. Each has its own failure patterns, evidentiary challenges, and assessment considerations.

Diagnostic Errors: Missed, Delayed, and Wrong Diagnoses

Diagnostic errors are among the most common and most consequential forms of medical malpractice. A missed or delayed diagnosis of a serious condition, cancer, stroke, heart attack, infection, pulmonary embolism, can allow the condition to progress to a stage where effective treatment is no longer possible. The key legal question is not simply whether the diagnosis was wrong, but whether a reasonably competent physician, applying the standard of care, would have reached the correct diagnosis given the information available at the time. (See the Cancer Diagnosis, Stroke, and Heart Attack Claims Guides in this series for detailed discussion.)

Surgical and Procedural Errors

Surgical malpractice claims arise from errors in the operating room, in the consent process before surgery, and in post-operative care. Common grounds include:

- Operating on the wrong site, performing the wrong procedure, or (rarely) operating

on the wrong patient
- Technical errors causing avoidable damage to adjacent structures
- Retained surgical instruments or sponges
- Anaesthesia errors
- Failure to obtain adequate informed consent before a procedure

See the Surgical Error Claims Guide in this series for detailed discussion of the standard of care in surgical settings and how negligence is established.

Medication Errors

Medication errors can occur at multiple points: prescribing (wrong drug, wrong dose, wrong patient, failure to identify a contraindication), dispensing (pharmacy error), and administration (incorrect dosing or route by nursing staff). Each can give rise to a claim against the responsible party. Some medications carry particularly significant risks when misused, anticoagulants that cause internal bleeding when incorrectly dosed, chemotherapy agents with narrow therapeutic windows, cardiac medications that are dangerous if given to the wrong patient type.

Birth Injuries

Birth injury cases are among the most significant in Canadian medical malpractice law, both because of the severity of the harm, conditions such as cerebral palsy, hypoxic ischemic encephalopathy, and brachial plexus injuries, and because their effects are lifelong. They are also among the most complex to litigate, requiring experts in obstetrics, neonatology, and paediatric neurology. (See the Birth Injury Claims Guide in this series.)

Failure to Monitor

Healthcare providers have an ongoing duty to monitor patients in their care and to respond appropriately to changes in condition. Failures in monitoring are a distinct category of malpractice and include:

- Failure to perform serial ECGs or troponin measurements in a patient with chest pain, allowing a heart attack to go undiagnosed
- Failure to recognize deterioration in a post-operative patient
- Inadequate monitoring of vital signs in an intensive care setting
- Failure to follow up on abnormal laboratory or imaging results

The monitoring duty extends to the systems that support monitoring. A failure of the clinic's recall system that means an abnormal test result sits in a file without being reviewed is a failure of care at the institutional level as well as the individual level.

Negligent Post-Operative and Aftercare

Poor outcomes are sometimes not the result of anything that happened in the operating room, but of failures in the care that followed. Premature discharge of a patient who was not medically stable, failure to recognize early signs of a surgical complication, or failure to provide adequate discharge instructions can all form the basis of a malpractice claim independent of any intraoperative error.

Failure to Refer

A physician or other healthcare provider who recognizes, or should recognize, that a patient's condition requires specialist assessment has a duty to arrange that referral. Delays or failures in referral that allow a treatable condition to progress are a recurring source of malpractice claims, particularly in the context of cancer diagnosis, cardiac conditions, and neurological emergencies.

Informed Consent: When the Problem Is What You Were Not Told

Informed consent is both a cornerstone of medical ethics and an independent ground for a legal claim. It is based on a patient's fundamental right to decide what is done

with their own body, but that right can only be exercised if the patient has the information they need to make a real decision.

What Informed Consent Means in Canadian Law

As Chief Justice Laskin stated in Hopp v Lepp (1980 CanLII 14 SCC):

> **"The term 'informed consent' reflects the fact that although there is, generally, prior consent by a patient to proposed surgery or therapy, this does not immunize a surgeon or physician from liability for battery or for negligence if he has failed in a duty to disclose risks of the surgery or treatment, known or which should be known to him, and which are unknown to the patient."**

The companion case, Reibl v Hughes (1980 CanLII 23 SCC), established the standard that governs consent claims in Canada to this day: a practitioner must disclose what a reasonable patient in the patient's specific circumstances would want to know before deciding whether to proceed with treatment.

The Elements of Valid Consent

Consent in healthcare must be:

- **Voluntary:** Free from coercion, pressure, or manipulation. A patient who agrees because they were led to believe there was no other option has not given voluntary consent.
- **Given by a patient with capacity:** The patient must have the mental and emotional capacity to understand and process what is proposed. Where a patient lacks capacity, consent must come from an authorized decision-maker.
- **Specific:** Consent for one procedure does not authorize a different procedure, even if performed at the same time.
- **Adequately informed:** The patient must have received information sufficient to make a real decision. Signing a form is not the same as being adequately informed;

the obligation is on the clinician to ensure understanding.

What Must Be Disclosed

Not every conceivable risk must be disclosed. The duty of disclosure is calibrated according to the significance of the information. Canadian courts have distinguished:

- **Material risks:** Those with a significant chance of causing serious consequences, regardless of how commonly they occur. A risk that is rare but catastrophic, such as stroke from certain chiropractic adjustments, must be disclosed because its severity makes it material.
- **Special or unusual risks:** Those with a particular quality that makes them important to a specific patient, such as a risk to a professional musician's hands.
- **Personal risks:** Those that arise from the patient's own particular circumstances, their religious beliefs, occupation, or family situation.
- **Reasonable alternatives:** A patient cannot make an informed choice without knowing the alternatives, including the option of not proceeding at all.
- **Immaterial risks:** Those with a very low probability and mild consequences do not require disclosure in most circumstances.

When a Consent Form Is Not Enough

The existence of a signed consent form does not automatically mean informed consent was obtained. Courts have consistently held that the form is evidence of consent, not conclusive proof of it. A form that lists a risk by name without explaining what it means does not constitute adequate disclosure. A patient who signs a form without being told what a “stroke” is, or what “nerve damage” means for daily life, has not been adequately informed. A form handed to a patient moments before a procedure, with no time for questions or reflection, does not provide the meaningful opportunity for decision-making that the law requires.

The Reasonable Patient Standard

The test for causation in a consent claim is also important: even if a practitioner failed to disclose a material risk, a claim succeeds only if a reasonable patient, properly informed, would probably have declined or deferred the procedure. This is the modified objective test from Reibl v Hughes. It is not enough that the individual plaintiff says they would never have agreed. The court asks whether a reasonable person in that patient's specific circumstances would probably have made a different decision with full information. In elective procedures, the bar is somewhat lower because there is more scope for a reasonable patient to have declined.

Before You File: What to Do First

If you believe you or a family member was harmed by medical negligence, there are practical steps to take before any legal proceedings are commenced that will significantly improve your position.

Obtaining Your Medical Records

Your complete medical records are the foundation of any malpractice claim. You have a right to access them, and you should request them as soon as possible after deciding to investigate what happened. Request records in writing from every facility and provider involved, including:

- Hospital records: admission notes, discharge summaries, nursing notes, operative notes, anaesthesia records, medication administration records, laboratory results, and imaging reports
- Family physician or clinic records: all office notes, test results, referral letters, and correspondence
- Specialist records: consultation notes and letters
- Any imaging studies: request the actual images on disc, not just the reports

Records should be requested across the full timeline of events, not only the episode

you believe was negligent, but the history leading up to it. Earlier records often contain information critical to establishing what the treating team knew and when.

Patients (and estates of deceased patients) have a legal right to access their complete medical records in all Atlantic provinces. Facilities must provide these records upon written request, though they may charge a reasonable fee for copying. If a facility refuses or significantly delays producing records without adequate explanation, this should be documented and discussed with a lawyer.

Writing Down What Happened

Memory fades. As soon as possible, write a detailed, chronological account of everything you can recall: the timeline of your care and all contacts with providers; what you were told at each appointment; what risks were or were not explained before you consented; what symptoms you reported, when, and to whom; the names of all providers; and the names of anyone who witnessed important conversations. This account does not need to be a legal document. Its purpose is to preserve your recollection while it is freshest.

Getting a Second Medical Opinion

If you are unsure whether what happened represented a departure from appropriate care, obtaining an independent clinical assessment from another provider in the relevant specialty can be an important first step. This is not the same as the formal expert opinion required for litigation, but it can help you understand whether your concerns have a clinical foundation and whether further investigation is warranted.

Filing a Regulatory Complaint

If you believe a physician, nurse, or other regulated health professional acted improperly, you may file a complaint with the relevant provincial regulatory college. This is entirely separate from a civil claim and does not affect your legal rights:

- **Nova Scotia:** College of Physicians and Surgeons of Nova Scotia
- **New Brunswick:** College of Physicians and Surgeons of New Brunswick
- **Prince Edward Island:** College of Physicians and Surgeons of PEI
- **Newfoundland and Labrador:** College of Physicians and Surgeons of NL

A finding by a regulatory body that a practitioner breached professional standards is not binding on a court, but it can be significant supporting evidence in a civil proceeding. Regulatory investigations can also produce documents and findings that may not be otherwise available.

Understanding Your Timeline

The single most time-sensitive concern at this stage is the limitation period, the legal deadline by which a civil claim must be commenced. In all Atlantic provinces, this period is two years from the date the claim was discoverable. Missing this deadline almost always means losing the right to sue, no matter how strong the underlying case. The limitation periods for each province are set out in detail in Section 12. If you have any concern about whether a claim may be time-limited, consult a lawyer immediately.

Do You Need a Lawyer?

Self-Represented Litigants in Medical Malpractice

Legally, nothing prevents a person from representing themselves in a medical malpractice claim. In practice, self-represented litigation in this area is extremely difficult and rarely successful. Medical malpractice cases require:

- Expert medical evidence to establish both the standard of care and causation, experts an experienced lawyer already has relationships with
- Detailed knowledge of civil procedure including discovery, productions, pre-trial motions, and trial practice
- The ability to review, analyze, and argue on the basis of complex medical records over a multi-year period
- Negotiation experience with defence counsel from the CMPA or private insurers who have defended these cases many times

A self-represented litigant will lose significant time advancing a file, time that could otherwise be spent on work, family, and recovery from the harm itself. This does not mean that legal representation is inaccessible. The contingency fee model means that access to qualified malpractice counsel does not require upfront payment.

What a Medical Malpractice Lawyer Does

A medical malpractice lawyer's role extends well beyond courtroom advocacy. From the first consultation through to resolution, they:

- Conduct a preliminary review of the facts to assess whether the case has potential before any resources are committed
- Obtain and organize the complete medical record, and identify all potentially responsible defendants
- Retain qualified medical experts to provide opinions on the standard of care and causation
- Manage the formal litigation process including pleadings, productions, discoveries, and pre-trial steps
- Negotiate with defence counsel and insurance adjusters, and advise on whether to accept settlement offers or proceed to trial
- Represent you at trial if the case is not resolved

The lawyer is also your advocate in the human sense: guiding you through a process that revisits painful events, explaining what is happening at each stage, and ensuring that your voice and your experience are accurately reflected in how the case is advanced.

What to Look for in a Lawyer

Medical malpractice is a highly specialized area of law. Not every personal injury lawyer has the medical knowledge, expert relationships, and litigation experience these cases demand. Look for:

- Experience specifically in medical malpractice, not just personal injury
- Familiarity with the medical subject matter relevant to your claim
- Access to qualified expert witnesses in the relevant specialty
- Experience with the unique challenges of the jurisdiction where your claim will be litigated
- A track record of cases pursued through to resolution, including trials
- Clear and honest communication about the strengths, weaknesses, and costs of your specific case

One distinguishing feature to look for is the depth of medical knowledge available to evaluate your case. Firms with in-house medical expertise can conduct a faster and more cost-effective preliminary review, which benefits both the client and the overall economics of the case.

The First Consultation

Most malpractice lawyers offer a free initial consultation. Use it to assess whether the lawyer understands the medical issues in your case; whether they are giving you a realistic assessment, or only telling you what you want to hear; whether the fee structure and disbursement arrangement is clearly explained; and whether you feel heard and respected in the conversation. You are not obligated to retain anyone you consult with, and speaking with more than one firm before deciding is entirely reasonable.

How a Medical Malpractice Case Is Built

Understanding how a case is constructed from the ground up helps you understand why these claims take as long as they do and cost as much as they do. There are no shortcuts in building a malpractice case, and the ones that fail most often do so because this foundation was laid hastily or incompletely.

The Investigation Phase

Before any legal proceedings are commenced, a thorough investigation is conducted. This involves reviewing the client's account of events; obtaining all relevant medical records; identifying the complete cast of providers involved and their roles; and conducting an initial medical review to assess whether the clinical picture raises genuine concerns about the standard of care. Some firms have the advantage of in-house clinical expertise at this stage, which allows a faster preliminary review and filters cases more precisely before significant expert resources are committed.

Medical Record Analysis

The medical record is the primary evidence in any malpractice claim. Its review requires both legal and clinical literacy. Key documents that are analyzed include:

- Admission and discharge summaries; operative and procedure notes
- Nursing notes and medication administration records
- Laboratory results and imaging reports (including the actual images)
- Fetal heart monitoring strips in obstetric cases
- Consent forms, pre-procedure assessments, and referral correspondence
- Any internal incident reports or quality reviews

Records are often voluminous, internally inconsistent, and written in clinical shorthand that requires medical expertise to interpret correctly. Discrepancies between different providers' documentation, the surgeon's operative note versus the nursing record, for example, are often the most revealing evidence in a case.

The Role of Expert Witnesses

Expert witnesses are not optional in medical malpractice cases. They are required by Canadian courts to establish both the standard of care and causation. Expert witnesses in a malpractice case typically include:

- A clinical expert in the same specialty as the defendant, who reviews the records and opines on whether the standard of care was met
- A causation expert who addresses what would probably have happened with appropriate care
- A life care planner or rehabilitation specialist in serious injury cases, to assess and quantify future care needs
- A forensic economist or actuary to calculate future lost income and the present value of future care costs

Expert reports are expensive. Each specialist report can cost between $10,000 and $30,000 or more depending on the scope of review required. The quality of expert evidence is frequently the most important factor in the outcome of a malpractice case. A compelling, well-qualified expert who can explain complex clinical decisions clearly to a court is an enormous asset; a weak or poorly qualified expert is a serious vulnerability.

Assessing Whether to Proceed

Not every case with a concerning clinical picture meets the legal threshold for a viable malpractice claim. Before committing to litigation, a competent lawyer will conduct an honest assessment of whether expert review supports a breach of the standard of care; whether the causal link can be established on the balance of probabilities; whether the damages are sufficient to justify the cost of litigation (typically $50,000 to $100,000 in disbursements and expert fees); and whether the defendants are appropriately insured to pay any judgment.

The Stages of a Medical Malpractice Case

Medical malpractice cases follow the same general stages as other civil litigation, but each stage is amplified in complexity and duration by the nature of the evidence. Understanding this process helps set realistic expectations from the outset.

Stage 1: Issuing the Claim

Once the investigation is complete and expert evidence supports a viable claim, a Statement of Claim is issued and served on the defendants. This formally initiates court proceedings, sets out the factual allegations, identifies the defendants, and describes the damages being sought. Service triggers the involvement of the defence, typically the Canadian Medical Protective Association (CMPA) for physician defendants, the Healthcare Insurance Reciprocal of Canada (HIROC) for hospital defendants, or private insurers for other providers. The CMPA is one of the most well-resourced medical defence organizations in the world, which is a reason to ensure your counsel has deep experience in this specific area.

Stage 2: Exchange of Written Evidence

After the claim is filed and the defendants have delivered their Statement of Defence, the parties exchange the written evidence that will form the documentary record: the full medical record; all documents relating to the patient's condition and treatment; and documents relevant to damages such as employment records, tax returns, medical receipts, and future care plans. This stage is called production and discovery of documents. Assembling this record is time-consuming and the documentary record continues to grow throughout the proceeding.

Stage 3: Examinations for Discovery

Once the written record has been exchanged, the parties conduct examinations for discovery, a process in which the key parties are questioned under oath about their knowledge of the events at issue. This is one of the most important and revealing phases of malpractice litigation. The questioning lawyer is assessing not only the content of the answers but the credibility and presentation of the witness. How a physician explains their decision-making, and how a plaintiff describes their harm and its impact, matter enormously in how a case is valued. Discoveries in complex cases can take multiple days.

Stage 4: Settlement Negotiations and Mediation

Most medical malpractice cases that survive the investigation phase and proceed through discoveries are resolved by settlement rather than trial. Settlement discussions are most productive after discoveries are complete, when both sides have the full evidentiary picture. Formal mediation is increasingly common and is required before trial in some Atlantic provinces. Settlements allow both parties some control over the outcome; a court judgment, by contrast, is an all-or-nothing result that neither party can fully predict. Any settlement on behalf of a minor or a person under a legal disability requires court approval.

Stage 5: Trial

When settlement cannot be reached, the case proceeds to trial. Trials in complex medical malpractice cases are lengthy, expensive, and emotionally demanding, typically lasting from two to six weeks or more. Both sides call their expert witnesses to testify on the standard of care and causation, and the credibility of that testimony is often the deciding factor. The plaintiff typically testifies about their experience and the impact of the harm. A judge (and in some provinces, a jury) then weighs the evidence and delivers a judgment, and the losing party may be ordered to pay a portion of the winner's costs.

Stage 6: Appeals

Either party may appeal the trial judgment on questions of law, on questions of mixed fact and law, or in some circumstances on questions of fact. Appeals add additional time and cost to the resolution of a case. The possibility of an appeal is part of the realistic landscape that both parties consider when evaluating whether to settle rather than proceed to or through trial.

How Much Is a Medical Malpractice Claim Worth?

The purpose of damages in civil litigation is to restore the plaintiff, as much as money can, to the position they would have been in had the negligence not occurred, sometimes called being “made whole.” No amount of compensation can truly achieve this in the most serious cases, but the law provides for several categories of damages that address both the financial and the human dimensions of the harm.

Pecuniary Damages: Your Financial Losses

Pecuniary damages are the financial, quantifiable losses caused by the negligence. They fall into several sub-categories:

Medical and healthcare expenses
Costs of treatment required because of the negligent care, corrective procedures, additional hospitalizations, specialist visits, medications, devices, and home modifications, including both past costs and projected future costs.

Lost income and earning capacity
Where the harm affects the patient's ability to work, past lost wages and future impaired earning capacity are recoverable. These calculations are prepared by forensic economists or actuaries and take into account the patient's age, occupation, income history, likely career trajectory, and the permanence of the disability.

Future care costs

In serious injury cases, a life care planner prepares a detailed projection of the patient's anticipated care needs over their lifetime. In catastrophic cases, a young person left with permanent neurological injury, these future care costs are often the largest single component of the award and can run into the millions of dollars.

Loss of housekeeping and home management capacity

Where the injury limits the patient's ability to perform household tasks, the reasonable cost of replacement services is recoverable.

Non-Pecuniary Damages: Pain, Suffering, and Loss of Enjoyment

Non-pecuniary damages compensate for the intangible harm that cannot be measured in lost wages or treatment receipts: physical pain, emotional suffering, loss of enjoyment of daily life, loss of relationships and activities, and the psychological burden of living with a serious or permanent disability. These damages are inherently difficult to quantify. They are assessed based on the specific circumstances of the plaintiff's life and loss, and calibrated against precedent cases involving comparable injuries.

The Cap on Non-Pecuniary Damages

Canada's Supreme Court, in the 1978 trilogy of cases (Andrews v Grand & Toy Alberta Ltd; Arnold v Teno; and Thornton v Board of School Trustees), established a cap on non-pecuniary damages for pain and suffering. Adjusted for inflation, this cap sits at approximately $430,000 to $450,000 in the mid-2020s. This cap applies only to non-pecuniary damages. Pecuniary losses, future care costs, lost income, and out-of-pocket expenses, are not capped. In serious and catastrophic injury cases, total awards can far exceed the non-pecuniary cap because of the size of the pecuniary components.

Punitive and Aggravated Damages

Punitive damages are available in rare cases involving conduct so egregious that ordinary compensatory damages are insufficient to reflect the wrongfulness of the defendant's actions. In medical malpractice they are genuinely uncommon but not impossible, and courts have awarded them in cases involving deliberate concealment of harm. Aggravated damages may be available where the circumstances of the negligence, or the defendant's conduct after the fact, significantly increased the plaintiff's suffering.

The Honest Assessment: Not Every Claim Is Financially Viable

The costs of pursuing a medical malpractice case, expert fees, court costs, discovery transcripts, actuarial reports, are typically estimated at $50,000 to $100,000 or more. On a contingency arrangement these costs are advanced by the law firm and recovered from the settlement or judgment, which means a case must justify those costs. A claim where the total damages would not meaningfully exceed the litigation costs is not in the client's best interest to pursue, regardless of how clearly the standard of care was breached. An honest lawyer will tell you this plainly.

How Much Does a Medical Malpractice Case Cost?

The Contingency Fee Model

Medical malpractice cases in Canada are almost always handled on a contingency fee basis. The lawyer is paid a percentage of the amount recovered, typically 25% to 33% of the final settlement or judgment. If the case is unsuccessful, no legal fee is charged. This model exists because of the access to justice principle: cases that could establish clear negligence should not go unpursued simply because the plaintiff cannot afford to pay a lawyer by the hour for three to five years of complex litigation. It also aligns the lawyer's interests with the client's. All contingency fee arrangements must be set out in a written retainer agreement before you sign.

Disbursements: The Hidden Costs

Separate from the lawyer's fee are disbursements, the actual out-of-pocket costs of running the litigation. These are advanced by the law firm and repaid from the settlement or judgment. In a complex case, disbursements commonly include:

- Medical expert reports: $10,000 to $30,000 or more per report
- Life care planning reports: $5,000 to $15,000
- Actuarial and forensic economic reports: $5,000 to $15,000
- Medical record retrieval costs, court filing fees, and service costs
- Discovery transcript costs and travel expenses for experts and counsel

Total disbursements in a complex case regularly exceed $50,000 and in some cases approach or exceed $100,000. Before retaining any lawyer, clarify in writing how disbursements are handled, what happens to outstanding disbursements if the case is unsuccessful, and whether there is any cap on disbursement exposure.

What Happens If You Lose?

Canadian civil litigation generally follows the “loser pays” principle for a portion of legal costs. If a case goes to trial and is unsuccessful, the plaintiff may be ordered to pay a contribution toward the defendant's legal costs. This adverse costs award is a meaningful financial risk that shapes every decision about whether to proceed to trial or accept a settlement. A good lawyer will address this risk honestly at every key

decision point.

Why Cases Need a Realistic Damages Assessment Before Proceeding

The intersection of costs and potential recovery is the key test of a case's viability. A case where liability is clear but damages are modest may not be worth pursuing if the likely recovery will not meaningfully exceed the cost of litigation. A patient who suffered real harm but limited financial or physical consequences may have more to gain from a regulatory complaint than from civil litigation. Conversely, cases involving serious and permanent harm, catastrophic injuries, significant lost earning capacity, high future care needs, or deaths in people with dependants, often have strong economic foundations that justify the costs of pursuing them.

How Long Will It Take?

Medical malpractice cases are among the longest-running matters in the civil justice system. Families should realistically plan for a process measured in years, not months. A typical timeline from initial consultation to resolution:

- **Investigation and case evaluation:** 3 to 12 months (obtaining records, preliminary expert review, and assessment of viability)
- **Filing and serving the claim:** 1 to 3 months after investigation
- **Document productions and written evidence exchange:** 6 to 18 months
- **Examinations for discovery:** 6 to 18 months after productions
- **Pre-trial negotiations and mediation:** ongoing throughout, most productive after discoveries
- **Trial scheduling:** 1 to 3 years after discoveries; trial duration 2 to 6 weeks
- **Appeals (if any):** an additional 1 to 3 years

Total from initial consultation to resolution: four to eight years in complex cases; sometimes shorter in straightforward cases that settle early. Cases that are well-prepared from the beginning, with strong expert evidence and a clear damages

picture, settle more efficiently. The best approach is to pursue the case thoroughly and methodically, remain informed at each stage, and make decisions based on the evidence rather than impatience or emotion.

Limitation Periods in Atlantic Canada: Don't Miss Your Window

A limitation period is the legal deadline by which a lawsuit must be started in court. Missing this deadline almost always ends the right to sue permanently, regardless of how strong the underlying case may be. This is one of the most critical pieces of information for anyone considering a malpractice claim.

If you have any concern that your claim may be approaching or past its limitation period, seek legal advice immediately. Do not delay while you gather information, wait for a regulatory complaint to conclude, or try to resolve things informally. The clock runs regardless of those other processes.

Nova Scotia

The Limitation of Actions Act (SNS 2014, c 35) sets a basic limitation period of 2 years from the date the claim was discovered, with an ultimate limitation period of 15 years from the date of the negligent act. The period does not run while the claimant is a minor (under 19) or is incapable of bringing a claim, and a court has a narrow discretion to allow a late claim within defined limits.

New Brunswick

The Limitation of Actions Act (SNB 2009, c L-8.5) sets a 2-year basic limitation period from discovery, with an ultimate period of 15 years. The period does not run while the claimant is a minor or is incapable of bringing a claim, and judicial discretion to extend is narrow.

Prince Edward Island

The Statute of Limitations (RSPEI 1988, c S-7) provides a 2-year limitation period from the date the harm was discovered or occurred. The period does not run while the claimant (including a minor) is unable to advance a claim.

Newfoundland and Labrador

The Limitations Act (SNL 1995, c L-16.1) provides a 2-year limitation period, which begins when the claimant reasonably ought to have known they had a cause of action. The period does not run while a person, including a minor, is unable to advance a claim.

The Discoverability Principle

In all Atlantic provinces, the limitation period does not necessarily begin on the date of the medical event. It begins when the claimant knew, or reasonably ought to have known, that an injury occurred, that it may have been caused by the act or omission of a healthcare provider, and that a legal claim was potentially available. This is particularly significant where the harm was not immediately apparent, the patient was told the poor outcome was a normal risk, the diagnosis was not made until months or years later, or the patient only learned of the potential malpractice when they obtained an independent expert opinion.

Special Exceptions: Minors and Incapacity

In all Atlantic provinces, the limitation period is suspended for individuals who lack legal capacity to bring a claim, including minors and people unable to manage their own affairs due to a physical, mental, or psychological condition. For minors, the period begins to run when they reach the age of majority. This protection is particularly important in birth injury cases, where the injured party is the child rather than the parent: the child's limitation clock does not start until they are old enough to assert their own rights.

Frequently Asked Questions

Q: Do I need to have a bad outcome to have a malpractice claim?

A: You need to have suffered actual harm, not simply a bad outcome. A treatment that produces a poor result but was delivered with appropriate care is not malpractice. And malpractice that does not cause harm is not actionable in negligence. Both elements are required.

Q: My doctor apologized. Does that mean they admit negligence?

A: Not legally. Federal and provincial apology legislation protects expressions of sympathy and apology from being used as admissions of liability in civil proceedings. An apology or expression of regret is not the same as an acknowledgment of legal fault.

Q: What is the CMPA and why does it matter?

A: The Canadian Medical Protective Association is a physician-funded organization that provides legal defence to physicians and surgeons across Canada, one of the most well-resourced medical defence organizations in the world. When you file a claim against a physician, you are in most cases effectively litigating against the CMPA. This is a reason to ensure you are represented by a lawyer with specific experience in this area.

Q: Can I sue a hospital as well as a doctor?

A: Yes. Hospitals can be liable for their own institutional negligence, failing to maintain adequate staffing, failing to ensure proper communication of test results, failing to maintain safe facilities, as well as vicariously liable for the negligence of their employed staff. In complex cases, both the individual provider and the hospital may be named as defendants.

Q: My loved one died. Can I still make a claim?

A: Yes, in two ways. The estate may bring a claim for the harm suffered before death under the Survival of Actions Act in each province. Family members and dependants may also bring claims for their own losses under the applicable Fatal Injuries or Fatal Accidents Act. These two types of claims are often pursued together. (See the Fatal Accident Claims Guide in this series.)

Q: The event happened more than two years ago. Have I lost my rights?

A: Not necessarily. The limitation period runs from when you discovered (or reasonably ought to have discovered) that you had a claim. If you only recently learned that the care you received may have been negligent, the clock may not have started running yet. The ultimate limitation period in most provinces is 15 years from the negligent act, subject to specific exceptions. Consult a lawyer immediately.

Q: Will I have to testify?

A: Almost certainly at the discovery stage, you will be examined under oath by defence counsel. Whether you testify at trial depends on whether the case reaches trial and what role your own evidence plays. Your lawyer will prepare you thoroughly for both stages.

Q: What if I can't afford the disbursements if we lose?

A: This is an important question to address in your retainer agreement before you begin. Most firms advance disbursements on the client's behalf and recover them from the settlement or judgment. You should clarify in writing what happens to advanced disbursements if the case is unsuccessful.

References and Resources

Key Case Law

All of the following cases are accessible on CanLII

Sylvester v Crits et al, 1956 CanLII 34 (ON CA)
Defining statement on the standard of care; affirmed by the SCC.
https://www.canlii.org/en/on/onca/doc/1956/1956canlii34/1956canlii34.html

Hopp v Lepp, 1980 CanLII 14 (SCC)
Informed consent; duty of disclosure.
https://www.canlii.org/en/ca/scc/doc/1980/1980canlii14/1980canlii14.html

Reibl v Hughes, 1980 CanLII 23 (SCC)
Informed consent standard; modified objective test.
https://www.canlii.org/en/ca/scc/doc/1980/1980canlii23/1980canlii23.html

Snell v Farrell, 1990 CanLII 70 (SCC)
Causation; the "but for" test; practical common-sense approach.
https://www.canlii.org/en/ca/scc/doc/1990/1990canlii70/1990canlii70.html

Clements v Clements, 2012 SCC 32 (CanLII)
Causation; clarification of "but for" and material contribution to risk.
https://www.canlii.org/en/ca/scc/doc/2012/2012scc32/2012scc32.html

Andrews v Grand & Toy Alberta Ltd [1978] 2 SCR 229
Non-pecuniary damages cap; the 1978 damages trilogy.
https://www.canlii.org/en/ca/scc/doc/1978/1978canlii1/1978canlii1.html

Robertson & Picard, Legal Liability of Doctors and Hospitals in Canada (5th ed.)
The leading Canadian text on medical malpractice law.
https://store.thomsonreuters.ca/en-ca/products/
legal-liability-of-doctors-and-hospitals-in-canada-5th-edition-30835555

Provincial Legislation (Limitation of Actions)

Nova Scotia Limitation of Actions Act (SNS 2014, c 35)
https://nslegislature.ca/sites/default/files/legc/statutes/
limitation%20of%20actions.pdf

New Brunswick Limitation of Actions Act (SNB 2009, c L-8.5)
https://laws.gnb.ca/en/BrowseTitle

PEI Statute of Limitations (RSPEI 1988, c S-7)
https://www.princeedwardisland.ca/en/legislation/statute-limitations

Newfoundland and Labrador Limitations Act (SNL 1995, c L-16.1)
https://www.assembly.nl.ca/legislation/sr/statutes/l16-1.htm

Regulatory Bodies and Support Organizations

Regulatory Colleges and Institutions

College of Physicians and Surgeons of Nova Scotia
https://cpsns.ns.ca/

College of Physicians and Surgeons of New Brunswick
https://cpsnb.org/en/

College of Physicians and Surgeons of PEI
https://cpspei.ca/

College of Physicians and Surgeons of NL
https://cpsnl.ca/

Canadian Medical Protective Association (CMPA)
https://www.cmpa-acpm.ca/

Safety, Research, and Referral

Canadian Patient Safety Institute
https://www.healthcareexcellence.ca/

CanLII, Free access to Canadian case law
https://www.canlii.org/

Law Society of Nova Scotia
Lawyer Referral Service
https://www.nsbs.org/

Law Society of New Brunswick
https://www.lawsociety-barreau.nb.ca/en/

Law Society of Prince Edward Island
https://lawsocietypei.ca/

Law Society of Newfoundland and Labrador
https://lsnl.ca/