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MAKING MORE COVID-19 DATA AVAILABLE - PRIVACY AND THE SHARING OF PATIENT DATA IN COVID-19 HEALTHCARE

— Noel Courage and Amanda Branch,
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Canadian institutions and companies are subject to federal and provincial laws relating to the collection, use and disclosure of personal information. Personal information is broadly defined as information about an identifiable individual and could potentially include de-identified information if it could be readily rendered identifiable. These laws are particularly strict for highly sensitive personal health information. It is easy to understand why data is generally kept confidential and privacy is paramount in a health-care context.[1] There are compelling reasons why more data needs to urgently be made publicly available in a pandemic, while respecting individual patient privacy.

Getting More Information Out To The Public

Tracking and predicting the spread of COVID-19 and individuals' responses to it is of crucial importance, and governments and health organizations need all the help they can get. There can understandably be limited resources in compiling and analyzing information when healthcare resources are being overwhelmed by patients in need. The extra effort taken now to collect and analyze information is critical to develop a playbook to counter COVID-19 in the future.

Hospitals should continue to comprehensively record and, as permitted, share data with public health agencies. Without proper collection and sharing of comprehensive basic health information, health care providers can feel like they are operating with only a partial picture of the virus and how to treat it. It is also helpful for public health agencies to share aggregated or anonymized information with the public so they have a fuller understanding about the extent of community spread of disease. The public release of data is more than simply an exercise in transparency. It provides important public outreach and it is educational. Data is also a basis for local government policy decisions, for example, whether to close businesses or restrict travel. Public compliance with government policy on protective measures and travel restrictions depends in part on their awareness and acceptance of the public health data.

Collection of Data

The data must be captured as fully as possible once necessary consents are in place (patient consent may be express, implied or obviated in some cases). It is critical that the

[1] See https://www.bereskinparr.com/doc/handling-patient-data-in-artificial-intelligence for our earlier article.

backlog of diagnostic testing be resolved to collect as much useful input data as possible. In jurisdictions where there are limited test kits available, and unsuspected mild cases do not qualify for testing (self-isolate instead), the "curve" has been slower to flatten. Here in Ontario, there have been as many as 10,000 pending test results at times, and reports of over a week wait for results in some areas. Testing capacity and through put need to increase to get better input data.

The Benefits of Collaboratively Analyzing Collected Data

There is no substitute for human analysis. However, everyone recognizes that all tools at our disposal need to be utilized. Technology, such as artificial intelligence ("AI") can step in, particularly in analyzing large amounts of patient data after it has been collected by hospitals. This is an area where healthcare providers may have their own in-house solutions, but often they collaborate with outside companies to access expertise. The shared data in a COVID-19 context could include data about initial patient assessments, comorbidities (underlying health issues), drug treatments, physical treatments (e.g., ventilators), timelines, demographics, geography and patient outcome. For companies developing healthcare AI solutions, large volumes of quality input data are essential to allow the AI to learn quickly and provide useful output. Read our article about digital health companies and the power of AI in healthcare.[2]

Any Disclosure of Collected Data Must Comply With Privacy Legislation - Privacy Commission Views

Using large volumes of data can be at odds with privacy legislation, however, it need not be an impediment to getting effective data into healthcare software solutions.

Many federal and provincial privacy commissioners have published guidance noting the importance of complete and accurate information flow during a crisis and how this can be permitted through applicable privacy legislation.

For example, in its statement[3] the Office of the Information and Privacy Commissioner of Newfoundland and Labrador urges "do not let privacy considerations put anyone's health at risk." It released a document entitled "Don't Blame Privacy – What To Do and How To Communicate in an Emergency"[4] which, among other things, notes that both the *Access to Information and Protection of Privacy Act*, *2015* and the *Personal Health Information Act* include provisions that allow for disclosure in emergencies or when the public interest trumps the protection of privacy.

Similarly, the Office of the Privacy Commissioner of Canada has released guidance, "Privacy and the COVID-19 outbreak"[5], which discusses when personal information may be disclosed by a private or public sector entity without consent.

The Office of the Information and Privacy Commissioner of Alberta released a statement, "Privacy in a Pandemic",[6] which also stresses the import of ensuring that public bodies, health custodians and private sector organizations know how personal or health information may be shared during a pandemic or emergency situation. Its statement also confirms that all three of its privacy laws include provisions which allow for the sharing of personal or health information in the event of an emergency.

How To Prepare Health Data For Sharing - Aggregated or De-Identified Data

Every type of disclosure must comply with privacy laws. For example, a health authority may disclose information to an arm's length research partner or make it publicly available. Organizations may be hesitant to disclose personal or health information because they are unclear about whether the disclosure is permitted under applicable legislation.

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[2] https://www.bereskinparr.com/doc/canada-needs-to-urgently-feed-more-data-into-healthcare-ai-solutions.

[3] https://www.oipc.nl.ca/guidance/documents/emergencies/.

[4] https://www.oipc.nl.ca/pdfs/EmergenciesPrivacy.pdf.

[5] https://www.priv.gc.ca/en/privacy-topics/health-genetic-and-other-body-information/health-emergencies/gd_covid_202003/.

[6] https://www.oipc.ab.ca/resources/privacy-in-a-pandemic-advisory.aspx.

A key tool for sharing information is to use de-identified or aggregated data. Data that is truly de-identified, anonymized or aggregated is not within the definition of "personal information" (how to "truly" render data de-identified or anonymous is beyond the scope of this article). Using aggregated and anonymized data can be very useful in identifying trends.

It is important to be mindful of potential re-identification risks and whether the "anonymous" data release could actually lead to identification of an individual. As a hypothetical example, if it is disclosed COVID-19 Patient 500 is female, is in their 30s, lives in Milton, Ontario, traveled to Italy in March, and has diabetes as an underlying condition, then that narrows pool of individuals that could fit that criteria, and privacy issues must be carefully measured.

Sharing Collected Data with Research Partners Using Data Sharing Agreements

Health care institutions also typically control use and retention of anonymized data through agreements with companies. Data sharing agreements can be used to facilitate the transfer of data between organizations or institutions. These types of agreements identify the parameters which govern, for example, how each party may collect, use, analyze, safeguard, transmit, store, retain and destroy data. Data sharing agreements can also ensure that both parties have considered and are abiding by any obligations that may exist under provincial privacy statutes or various research and ethical guidelines.

These information sharing initiatives can facilitate health care delivery and research projects and can provide valuable data needed for AI systems.

Sharing Collected Data with The Public

Anonymizing data can also facilitate public sharing of data. We have seen governments share daily reports[7] on anonymized patients. Public sharing of anonymized or aggregated information is important for public education, research, and to round out the information that healthcare workers receive from their own institutions.

The importance of properly assessing privacy issues and making data quickly available is apparent. For example, the extent of community transmission can appear to be greatly understated in the absence of up to date health data. Younger demographics seeing only mortality demographics may believe that they are overall low risk if hospitalization and ICU data by age group is not released (death is rare in youth, but hospitalizations or ICU admissions are more common). Powerful AI software tools may be able to plug some of the gaps in data collection and analysis, but AI does this best when we feed as much information into it as possible. As the scope of data release by health authorities evolves, data releases must be clearly qualified as to the restrictions on the quality of the data released (e.g., number of tests backlogged).

Conclusion

Privacy law balances patient protection with allowing public health authorities to generate and share their best data in aggregate or anonymized form. The collection of the best data and transparent release to research partners and the public are critical for managing the COVID-19 situation.

We appreciate the challenging and important work being done by public health authorities, and this article is provided as a constructive comment to explain how data is shared in compliance with privacy laws.

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[7] https://www.ontario.ca/page/2019-novel-coronavirus.

NEW DEVELOPMENTS IN ONTARIO HEALTH CARE DUE TO COVID-19

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Province of Ontario Suspends Collective Agreement Provisions in Hospital and Long-Term Care Sector

As a result of the state of emergency that was declared on March 17, 2020, the Provincial Government issued an Order under the *Emergency Management and Civil Protection Act* on March 21, 2020 which applied to hospitals and psychiatric facilities ("Health Service Providers") and which effectively allows Health Service Provider to suspend certain provisions in collective agreements with trade unions.

Pursuant to the Order, Health Service Providers are authorized to deploy staff as they deem necessary in order to respond to, prevent and alleviate the outbreak of COVID-19 for patients.

This includes the right to:

(i) identify staffing priorities, and the right to redeploy staff within different locations in or between facilities;

(ii) the right to change work assignments including the right to assign work to non-unionized staff and/or to contractors;

(iii) the right to change work schedules/assignments;

(iv) the right to defer/cancel vacations, leaves of absence regardless of whether such vacations or leaves are established by statute, agreement or otherwise;

(v) the right to employ extra part-time or temporary employees or contractors to perform bargaining unit work; and

(vi) the right to use volunteers to perform work which may include bargaining unit work.

The Order expressly provides that a Health Care Provider may implement redeployment plans without having to comply with collective agreement provisions, including lay-off, seniority/service and or bumping provisions.

What was particularly noteworthy to employers in this sector, was that the Health Service Provider can "suspend for the duration of this Order, any grievance process, with respect to any matter that is referred to in this Order".

Pursuant to a Regulation dated March 23, 2020, an additional Order was enacted by the Province with respect to licensees within the meaning of the *Long-Term Care Homes Act, 2007* and, to a municipality or board of management that maintains a long-term care home.

The most recent Order effectively extends the right of employers who operate long- term care facilities to suspend certain collective agreement obligations in the same manner that the Province did so in the earlier Order that applied to Hospitals. The most recent Order is the same as the Hospitals' Order save and except for the following two differences: Long-Term Care employers do not have the right to redeploy staff to work in COVID-19 assessment centres (screening centres do not exist in Long-Term Care Facilities) and, Long-Term Care employers do not have the right to cancel or postpone services not related to responding to, preventing or alleviating the outbreak of the virus.

While no regulations/Orders have been enacted for facilities that operate retirement homes, nor for social and community service employers at this time, it is evident that the Province is prepared to respond quickly with new regulations and/or Orders as the progression of this health crises continues to unfold.

Limitations on Employees To work In One Long-Term Care Facility/Hospital

In a COVID-19 Directive that has been sent to Long-Term Care Homes under the *Long Term Care Homes Act, 2007* (issued under the *Health Protection and Promotion Act*), the Province has indicated that *Employers should work with employees to limit the number of different work locations that employees are working at so as to minimize the risk to patients of exposure to COVID-19*.

Both Hospitals and Long-Term Care Homes (and in some cases Retirement Homes) have been requiring their part-time employees to disclose any other positions of employment that they occupy in other health care facilities and to effectively choose to work at only one facility. There may well be resistance to this initiative from certain employees and from the Unions that represent them. We would recommend that the Unions (in a unionized environment) be advised of the implementation of a policy like this prior to eliminating any part-time employee's right to work pursuant to any collective agreement.

While the initiative makes a great deal of sense in the context of containing the rate and spread of the virus, many employers in this sector (who have already been challenged to recruit and retain qualified PSW's), will be presented with challenges to replace workers who opt to work elsewhere and not for the Employer that has put them to an election.

Childcare for Frontline Staff

In order to support health care and frontline workers during the COVID-19 outbreak, the Province has indicated that it will exempt certain child care centres from the Order[1] to close all licensed child care centres pursuant to the state of emergency that was declared by the Premier previously. In allowing select child care centers to resume operations, frontline workers will be able to focus their efforts in protecting the general public so that they are not concerned about family members not being looked after.

The initiative is intended to provide certain health care and other frontline workers (including doctors, nurses, paramedics, firefighters, police, and correctional officers) with access to emergency child care. These child care centres will be required to follow prescribed health and safety requirements and have a plan in place should any staff, children or parents be exposed to the virus.

If you have any questions about COVID-19 and your workplace, or any other human resource law issue, please contact a member of the Torkin Manes LLP team (https://www.torkinmanes.com/expertise/service/employment-labour). For more information about dealing with COVID-19, please visit their COVID-19 Resource Center (https://www.torkinmanes.com/our-resources/covid-19-resource-centre).

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RECENT DEVELOPMENTS

COVID-19 Update

In response to the COVID-19 pandemic, governments across Canada have declared states of emergency and issued orders affecting health care providers and organizations.

Note: the COVID-19 situation is continually evolving and the information below is current as of April 27, 2020.

Alberta

On March 17, 2020, Alberta declared a state of public health emergency under the *Public Health Act*, in effect for 90 days. See: http://www.qp.alberta.ca/documents/Orders/Orders_in_Council/2020/2020_080.pdf.

The Alberta Chief Medical Officer of Health has issued orders under the *Public Health Act* affecting the health sector. See: https://open.alberta.ca/dataset?sort=title_string+desc&q=&audience=Health+Care+Professionals&tags=CMOH+orders.

British Columbia

On March 18, 2020, British Columbia issued an order declaring a state of emergency under the *Emergency Program Act*. See: http://www.bclaws.ca/civix/document/id/oic/oic_cur/m073_2020.

[1] https://news.ontario.ca/opo/en/2020/03/ontario-enacts-declaration-of-emergency-to-protect-the-public.html.

On April 14, 2020, the declaration of a state of emergency was extended for a third period, ending April 28, 2020. See: http://www.bclaws.ca/civix/document/id/oic/oic_cur/0173_2020.

The Provincial Health Officer has issued orders under the *Public Health Act* affecting the health sector. See: https://www2.gov.bc.ca/gov/content/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/current-health-topics/covid-19-novel-coronavirus.

Manitoba

On March 20, 2020, Manitoba declared a state emergency under *The Emergency Measures Act*. See: https://www.gov.mb.ca/asset_library/en/proactive/2019_2020/declaration-soe.pdf.

The Chief Provincial Public Health Officer has issued orders under *The Public Health Act* affecting the health sector. See: https://www.gov.mb.ca/covid19/soe.html.

New Brunswick

On March 19, 2020, New Brunswick declared a state of emergency pursuant to the *Emergency Measures Act*. See: https://www2.gnb.ca/content/gnb/en/news/news_release.2020.03.0139.html.

On April 16, 2020, the state of emergency was extended for a third period, ending April 30, 2020. See: https://www2.gnb.ca/content/gnb/en/news/news_release.2020.04.0209.html.

The Chief Medical Officer of Health has issued guidance memos and guidance documents affecting the health sector. See: https://www2.gnb.ca/content/gnb/en/departments/ocmoh/cdc/content/respiratory_diseases/coronavirus/HealthandAlliedHealthProfessionals.html.

New Brunswick Pandemic Task Force Created

New Brunswick has established a pandemic task force to help combat COVID-19.

The task force is vested with decision-making authority about the pandemic response for all aspects of the health-care system, including the regional health authorities, Extra-Mural and Ambulance New Brunswick, primary care, and the long-term care system.

A clinical group of experts with relevant practice experience will be called upon as appropriate to provide advice that will inform or validate the decisions of the task force.

See https://www2.gnb.ca/content/gnb/en/news/news_release.2020.04.0184.html to read the Department of Health news release.

Newfoundland and Labrador

On March 18, 2020, Newfoundland and Labrador declared a public health emergency pursuant to the *Public Health Protection and Promotion Act*. See: https://www.gov.nl.ca/snl/files/NLG20200318_EXTRA.pdf.

On April 17, 2020, the Minister of Health and Community Services ordered the extension of the public health emergency for a third period of 14 days, effective April 17, 2020. See: https://www.gov.nl.ca/covid-19/files/Public-Health-Emergency-Extension-Declaration-April-16-2020.pdf.

The Chief Medical Officer of Health has issued orders affecting the health sector. See: https://www.gov.nl.ca/covid-19/public-health-orders/.

Northwest Territories

On March 24, 2020, the Northwest Territories declared a state of emergency pursuant to the *Emergency Management Act*, in effect until April 7, 2020. See: https://www.gov.nt.ca/en/newsroom/news-release-state-emergency-declared-northwest-territories.

On March 18, 2020, the Minister of Health and Social Services declared a public health emergency under the *Public Health Act*, in effect until April 1, 2020. See: https://www.gov.nt.ca/en/newsroom/news-release-public-health-emergency-declared-northwest-territories.

The public health emergency, which was first extended on April 1, 2020 (https://www.gov.nt.ca/en/newsroom/territorial-public-health-emergency-and-state-emergency-have-been-extended.

As of April 27, 2020, the Northwest Territories has not issued other orders specifically affecting the health sector.

Nova Scotia

On March 22, 2020, Nova Scotia declared a provincial state of emergency pursuant to the *Emergency Management Act*. See: https://novascotia.ca/coronavirus/docs/Declaration-of-Provincial-State-of-Emergency-by-Minister-Porter-Signed-March-22-2020.pdf.

On April 19, 2020, the state of emergency was extended for a third period, ending May 3, 2020. See: https://novascotia.ca/coronavirus/docs/2020-04-19-SOE-Renewal.pdf.

The Medical Officer of Health has issued orders under the *Health Protection Act* affecting the health sector. See: https://novascotia.ca/coronavirus/alerts-notices/.

Nunavut

On March 20, 2020, Nunavut declared a state of emergency pursuant to the *Public Health Act*. See: https://www.gov.nu.ca/sites/default/files/pha_order_state_of_ph_emergency_200320.pdf.

On March 18, 2020, the Minister of Health declared a public health emergency under the *Public Health Act*. See: https://www.gov.nu.ca/health/news/minister-health-declares-public-health-emergency.

On April 16, 2020, the Minister of Health issued an order extending the state of public health emergency for a third period, ending April 30, 2020. See https://gov.nu.ca/sites/default/files/order_extending_public_health_emergency_to_april_30_2020.pdf.

As of April 27, 2020, Nunavut had not issued other orders specifically affecting the health sector.

Ontario

On March 17, 2020, Ontario declared an emergency under the *Emergency Management and Civil Protection Act*. See: https://www.ontario.ca/orders-in-council/oc-5182020.

On April 14, 2020, an order was issued extending the state of emergency for a third period of 28 days. See: https://news.ontario.ca/opo/en/2020/04/ontario-extends-declaration-of-emergency-to-continue-the-fight-against-covid-19.html.

Ontario has issued orders affecting the health sector. See: https://www.ontario.ca/page/emergency-information.

Ontario Develops New Health Data Platform to Help Defeat COVID-19

In consultation with the Ontario Privacy Commissioner, the province is developing a new health data platform called the Pandemic Threat Response ("PANTHR").

PANTHR will hold secure health data that will allow researchers to better support health system planning and responsiveness, including the immediate need to analyze the current COVID-19 outbreak.

The information gathered in PANTHR will allow researchers to help with:

- increasing detection of COVID-19;
- discovering risk factors for vulnerable populations;
- predicting when and where outbreaks may happen;
- evaluating how preventative and treatment measures are working; and
- identifying where to allocate equipment and other resources.

When launched, PANTHR will provide access to de-identified, integrated data on publicly funded administrative health services records, including:

- physician claims submitted to the Ontario Health Insurance Plan;
- medical drug claims submitted to the Ontario Drug Benefit Program;
- discharge summaries of hospital stays and emergency department visits; and
- claims for home care and long-term care.

PANTHR will also contain clinical data from special registry collections, such as the Critical Care Information System, which reports on critical care capacity in the province, and clinical data extracted from public health, hospital, laboratory and diagnostic imaging information systems. Other supporting data may also be added based on needs of researchers in achieving COVID-19 objectives.

See https://news.ontario.ca/mohltc/en/2020/04/province-developing-new-health-data-platform-to-help-defeat-covid-19.html to read the Ministry of Health news release.

Ontario Removes Three Month OHIP Waiting Period

Effective March 19, 2020, the three-month waiting period for Ontario Health Insurance Plan ("OHIP") coverage has been temporarily removed from the *General Regulation*, RRO 1990, Reg. 552 under the *Health Insurance Act*, RSO 1990, c. H.6 due to the COVID-19 situation.

Individuals who are currently in their three-month waiting period are eligible for OHIP coverage as of March 19, 2020. Individuals enrolled for OHIP after March 19, 2020, will have immediate coverage.

See http://www.health.gov.on.ca/en/pro/programs/ohip/bulletins/4000/bul4749.aspx for more information.

Prince Edward Island

On March 16, 2020, Prince Edward Island declared a state of public health emergency under the *Public Health Act*. See: https://www.princeedwardisland.ca/sites/default/files/publications/20200316truwww_2.pdf.

On April 16, 2020, the state of public health emergency was extended for an additional 30 days. The province also declared a state of emergency under the *Emergency Measures Act* effective until April 30, 2020. See: https://www.princeedwardisland.ca/en/news/prince-edward-island-declares-a-state-of-emergency.

On March 31, 2020, the Chief Public Health Officer issued an order affecting the health care sector. See: https://www.princeedwardisland.ca/sites/default/files/publications/20200401130341726.pdf.

Quebec

On March 13, 2020, Quebec declared a public health emergency under *the Civil Protection Act* for 10 days (in French only) (https://cdn-contenu.quebec.ca/cdn-contenu/adm/min/sante-services-sociaux/publications-adm/lois-reglements/decret-177-2020.pdf).

On April 15, 2020, an order was issued extending the declaration of a public health emergency for a third period, ending on April 24, 2020. See: https://cdn-contenu.quebec.ca/cdn-contenu/adm/min/sante-services-sociaux/publications-adm/lois-reglements/decret-460-2020-anglais.pdf.

On April 22, 2020, the state of emergency was extended for an additional eight days. See: https://cdn-contenu.quebec.ca/cdn-contenu/adm/min/sante-services-sociaux/publications-adm/lois-reglements/decret-478-2020-anglais.pdf.

The Minister of Health and Social Services has issued orders affecting the health sector. See: https://www.quebec.ca/en/health/health-issues/a-z/2019-coronavirus/situation-coronavirus-in-quebec/#c47907.

Saskatchewan

On March 18, 2020, Saskatchewan issued a declaration of emergency under *The Emergency Planning Act*. See: https://www.saskatchewan.ca/government/news-and-media/2020/march/18/covid-19-state-of-emergency.

The Chief Medical Health Officer has issued orders affecting the health sector. See: https://www.saskatchewan.ca/government/health-care-administration-and-provider-resources/treatment-procedures-and-guidelines/emerging-public-health-issues/2019-novel-coronavirus/public-health-measures/public-health-orders.

Yukon

On March 27, 2020, Yukon declared a state of emergency pursuant to the *Civil Emergency Measures Act*. See: https://yukon.ca/en/news/yukon-declares-state-emergency-response-covid-19.

On March 27, 2020, the Chief Medical Officer ordered dental practices to suspend all non-urgent treatment until further notice. See: https://yukon.ca/en/news/march-27-2020-yukons-chief-medical-officer-health-provides-update-covid-19.

On April 17, 2020, the Minister of Community Services issued an order restricting entry into Yukon. See: http://www.gov.yk.ca/legislation/regs/mo2020_019.pdf.

LEGISLATION UPDATE

Federal

Regulations Amending the Schedule to the Quarantine Act (COVID-19 Coronavirus Disease)

Regulations Amending the Schedule to the Quarantine Act (COVID-19 Coronavirus Disease), SOR/2020-53, came into effect on March 17, 2020.

The Regulations amend the *Quarantine Act*, SC 2005, c. 20 ("Act") to add COVID-19 to the Schedule of reportable illnesses under the Act.

The amendment requires travellers to notify Canadian authorities of their suspected or confirmed presence or exposure to COVID-19 prior to entering Canada. The amendment also requires conveyance operators to notify Canadian authorities before they arrive at their destination in Canada that a person on board their conveyance might be capable of spreading COVID-19.

Previously, travellers and conveyance operators were not required to notify authorities, in the absence of being asked.

The Regulations were published in the *Canada Gazette* on April 1, 2020.

Alberta

Bill 10 - Public Health (Emergency Powers) Amendment Act, 2020

The *Public Health (Emergency Powers) Amendment Act, 2020*, SA 2020 c. 5 (the "Act", formerly Bill 10) received Royal Assent on April 2, 2020. The Act, except sections 2, 5 to 8 and 11, came into effect on March 17, 2020. Section 11 took effect on March 27, 2020.

The Act amended the *Public Health Act*, RSA 2000, c. P-37 to, among other things, increase the maximum penalty for violating public health orders from $2,000 to $100,000 for a first offence and from $5,000 to $500,000 for a subsequent offence.

Ontario

Ontario Regulation 72/20

On March 20, 2020, O. Reg 72/20 amended the *General Regulation*, O. Reg. 79/10 under the *Long-Term Care Homes Act, 2007*, SO 2007, c. 8 to provide long-term care homes with flexibility to address staffing requirements during a pandemic.

The general rule is that at least one registered nurse ("RN") who is employed by the home and part of the home's regular nursing staff must be on duty at all times. The amendments provide that if a pandemic prevents an RN from attending work in the home and the home's back-up plan cannot be met, the home may use:

- an RN who works at the home pursuant to a contract with the home or who works at the home pursuant to a contract between the home and an employment agency;
- a registered practical nurse who is an employee of the home or who works at the home pursuant to a contract with the home and an employment agency, if the Director of Nursing and Personal Care or an RN is available for consultation; or
- a member of a regulated health profession who is a staff member of the home and who has a set of skills that, in the reasonable opinion of the home, would allow them to provide care to a resident, if the Director of Nursing and Personal Care or an RN is available for consultation.

The amendments provide that the prescribed minimum hours that the Director of Nursing and Personal Care of a long-term care home must provide at the home do not apply during a pandemic.

The amendments also modify the training and criminal reference check requirements for homes hiring new staff members and volunteers during a pandemic.

O. Reg 72/20 was published in *The Ontario Gazette* on April 11, 2020.

Ontario Regulation 83/20

On March 24, 2020, O. Reg 83/20, amended the *General Regulation*, O. Reg. 79/10 under the *Long-Term Care Homes Act, 2007*, SO 2007, c. 8 to provide that if a long-stay or short-stay resident of a long-term care home or the resident's substitute decision-requests in writing to be discharged due to a pandemic, the home must discharge the resident and communicate the resident's medical care requirements.

If a resident who was discharged seeks re-admission to the home from which they were discharged within three months from the date of discharge, they will have fewer requirements to meet for being admitted back into the home.

The amendments also expediate admission for persons occupying beds in public hospital as well as for persons from the community, to a long-term care home during a pandemic.

O. Reg 83/20 was published in *The Ontario Gazette* on April 11, 2020.

Limiting Work to a Single Long-Term Care Home Regulation

On April 14, 2020, the Ontario government issued an emergency order, *Limiting Work to a Single Long-Term Care Home Regulation*, O. Reg. 146/20, under the *Emergency Management and Civil Protection Act*, RSO 1990, c. E.9.

The order directs long-term care employers to ensure their employees, including registered nurses, registered practical nurses, personal support workers, kitchen and cleaning staff only work in one long-term care home, effective 12:01 a.m. on Wednesday, April 22, 2020. The order must be posted by employers in the long-term care home.

Ontario Regulation 159/20

On April 16, 2020, O. Reg 159/20 amended the *General Regulation*, O. Reg. 257/00 under the *Ambulance Act*, RSO 1990, c. A.19, to allow operators of land ambulance services to employ or engage, or continue to employ or engage, persons who do not meet the prescribed requirements, but who have successfully completed certain prescribed programs, to provide patient care as emergency medical attendants during a declared state of emergency.

RECENT CASES

Court of Appeal Allowed Physician's Appeal of Directive Suspending Licence to Practice Medicine

Alberta Court of Appeal, November 28, 2019

Dr. Collett, a 74-year old family medicine physician, appealed a decision of the Council of the College of Physician and Surgeons of Alberta (the "College"). The Council dismissed his appeal against a 2018 directive that suspended his licence

to practice medicine. The College's complaints director issued the directive following a peer review report that suggested Dr. Collett suffered from a cognitive impairment. The complaint's director had a concern that the suggestion of cognitive impairment meant Dr. Collett's patients were potentially impacted in the way Dr. Collett was caring for them. There was no evidence that Dr. Collett's health impaired his ability to practice family medicine safely and competently. None of Dr. Collett's treating physicians or colleagues indicated any concerns that his health prevented him from practicing medicine in a safe and competent manner. The complaints director gave Dr. Collett two business days to decide whether he would voluntarily cease practicing medicine until he was able to provide the complaints director with a qualified assessor's statement that his health did not prevent him from practicing medicine safely and competently. In 2019, the College terminated Dr. Collett's suspension and reinstated Dr. Collett as an active member of the College. Dr. Collett challenged the 2018 suspension directive on three grounds: firstly, there was no evidence that he was incapacitated; secondly, the College did not grant him procedural fairness; and thirdly, a reasonable person would conclude that the College was biased against him. The College argued that the appeal was moot because Dr. Collett's suspension had been lifted in 2019.

The appeal was allowed. The appeal was not moot. The complaints director had no authority under subsections 118(1) and (4) of the *Health Professions Act* ("Act") to direct Dr. Collett to undergo a medical examination and to suspend his licence on the ground of incapacity. Subsection 118(1) of the Act authorizes the complaints director, if he or she has grounds to "believe" that a regulated member is incapacitated, to order a regulated member to submit to a medical examination and to authorize the examiner to disclose the results to the complaints director. Subsection 118(4) allows the complaints director, who has lawfully exercised the authority under subsection 118(1), to direct the regulated member to cease practicing medicine until the complaints director receives the results of the examinations ordered under subsection 118(1). In the instant case, the complaints officer had no lawful basis to exercise the authority vested in him under subsections 118(1) and (4) of the Act. The Appeal Committee erred in coming to the contrary conclusion. Firstly, the complaints director did not state in writing that he "believed" Dr. Collett was incapacitated. The fact that he had a "concern" was not good enough. Secondly, the grounds which the complaints director identified for his "concern" would not cause a person acting rationally to conclude that Dr. Collett suffered from a physical, mental, or emotional condition or disorder that impaired his ability to provide professional services in a safe and competent manner. The complaints director had to explain how Dr. Collett's mild cognitive impairment or executive function deficit would impair Dr. Collett's ability to practice family medicine safely. He did not do this. The complaints director's decision to allow Dr. Collett only two business days to respond to the complaints director's demand to temporarily withdraw from the practice of medicine was inadequate and procedurally unfair. The short window for a response did not give Dr. Collett an appropriate amount of time to assess the merits of the complaints director's request and to organize a compelling response in opposition to it if he decided not to accede to his request. A one-month deadline would have been fair. Concurring reasons were provided.

College of Physicians & Surgeons of Alberta v. Collett, 2020 CHFL ¶ 15,878

Surgeon Did Not Breach Standard of Care in Not Performing Carpal Tunnel Release

Manitoba Court of Queen's Bench, December 16, 2019

In August 2013, Baier fell from a tractor at work. He fractured his right wrist. Baier was taken to hospital where X-rays were taken. The emergency doctor noted Baier had sensation and movement in all fingers and blood circulation was satisfactory. In consultation with the Dr. Tung, an orthopaedic surgeon, the fracture was aligned and a partial cast was applied. The next day, Dr. Tung performed surgery to secure Baier's fracture with a plate and screws. Following the surgery, Baier complained of increased pain and swelling in his fingers and a decrease in sensation. Dr. Tung ordered that Baier's arm be iced and elevated. The next day, Dr. Tung performed surgery to secure Baier's fracture with wires and pins. Following surgery, Dr. Tung applied a partial cast. Baier experienced less pain, an increased ability to gently move fingers, and numbness throughout his hand due to swelling. Baier used a small percentage of the permitted pain medication. Baier was discharged from hospital and his pain was controlled by Tylenol #3. In September 2013, Baier saw Dr. Tung and complained of increased pain in his hand and wrist, numbness in his index finger, and some stiffness. Dr. Tung removed Baier's cast and observed some reduced sensation in the median nerve distribution, but the injury was healing well. The cast was re-applied. Baier attended a follow-up appointment with Dr. Tung in October 2013 where Baier's cast was removed as the pain was under better control. When Baier's wrist, fingers, and thumb were moved gently, he did not

experience pain. Sensation in the median nerve distribution was reduced slightly. Range of motion in Baier's wrist, fingers, and circulation were normal, and the incisions were healing well. The pins were removed although X-rays showed the fracture was not fully healed. Baier was asked to return in four weeks. In November 2013, Baier sought a second opinion from Dr. Mazek, an orthopaedic surgeon. Dr. Mazek noted purple colouration of Baier's hand and that there were no nerve or circulatory abnormalities. Dr. Mazek diagnosed Baier with complex regional pain syndrome ("CRPS"). In December 2013, Dr. Clark, an experienced hand and upper limb orthopaedic surgeon, confirmed the CRPS diagnosis. Baier was treated for CRPS by Dr. Tung. Since the summer of 2014, Baier had seen no doctors other than his family physician. His last visit to his family physician was in June 2017. Baier had pursued no therapies or counselling, including occupational therapy, since 2014. Baier claimed that he continued to experience symptoms and disability in his right hand that he attributed to negligent medical treatment by Dr. Tung. Baier's medical expert concluded that Dr. Tung failed to meet the expected standard of care by not performing carpal tunnel release. Dr. Tung's medical expert concluded that Dr. Tung was not negligent by not performing carpal tunnel release. At issue was whether Dr. Tung met the standard of care required of him and whether anything done, or not done, by Dr. Tung caused Baier's disabilities.

The action was dismissed. Dr. Tung was not negligent. Dr. Tung did not breach the standard of care expected of him by not performing carpal tunnel release. That conclusion was supported by the totality of evidence, which included: the diffuse nature of Baier's symptoms (i.e., they were not focused in the median nerve distribution); the absence of escalating pain; and the absence of an opinion from Baier's treating physicians that carpal tunnel release ought to have been performed or that Baier's CRPS was related to nerve damage. The statements in the medical records were consistent with there being no nerve damage. Alternatively, not performing carpal tunnel release was an honest and intelligent exercise of Dr. Tung's judgment. Carpal tunnel release was not standard practice where there was a distal radius fracture absent clear evidence of median nerve dysfunction. Dr. Tung treated Baier in a sufficiently aggressive, attentive and appropriate manner. Dr. Tung's standard practice when examining Baier and others suffering from a similar injury was consistent with his training and practices in other emergency wards and clinics. Dr. Tung did not breach the standard of care by failing to take sufficient measures (other than carpal tunnel release) to mitigate anticipatable problems. Baier failed to establish that anything done, or not done, by Dr. Tung caused his CRPS or the symptoms he continued to experience.

Baier v. Tung, 2020 CHFL ¶ 15,879

Discipline Committee Erred in Rejecting Physician's Evidence Without Considering Whether It Was Credible and Reliable

Ontario Superior Court of Justice, Divisional Court, July 23, 2019

On March 21, 2017, the Discipline Committee ("Committee") of the College of Physicians and Surgeons of Ontario ("College") found that Dr. Kunynetz had committed sexual abuse and disgraceful, dishonourable or unprofessional conduct involving four patients.

With respect to three patients (Patients A, B, and D), it was alleged that Dr. Kunynetz failed to leave the room while the patient was undressing; failed to use drapes; and removed clothing without warning.

With respect to two patients (Patients C and D), it was alleged that Dr. Kunynetz pressed his genitals against their legs in the course of an examination. With respect to Patient B, it was alleged that he touched her breasts in a manner not consistent with the clinical examination. The Committee found that Dr. Kunynetz had committed acts of professional misconduct with respect of all four patients.

With respect to Patients C and D, the Committee found that he had engaged in conduct that would reasonably be regarded as disgraceful, dishonourable or unprofessional conduct by allowing his abdominal fat pad to contact their bodies without warning, apology or excuse.

With respect to Patient B, the Committee found that Dr. Kunynetz had committed sexual abuse. The Committee held that amendments to the Regulated Health Professions Act, 1991 ("RHPA"), which came into force on May 30, 2017, had retrospective effect with respect to the finding of sexual abuse of Patient B. The amendments, which were effected by the Protecting Patients Act, 2017 ("PPA"), added breast touching for a non-clinical reason to the list of sexual acts that would result in mandatory revocation of a member's certificate of registration. The Committee also found that even if the amendments did not have retrospective effect, revocation was appropriate. Dr. Kunynetz was order to pay costs in the amount of $145,460. Dr. Kunynetz appealed the Committee's decision.

The appeal was allowed in part. The Committee's finding that Dr. Kunynetz had engaged in professional misconduct by removing clothing of Patients A and D without warning or explanation was reasonable and was sustained. After Patient B had made a complaint in 2008, the College investigator had provided Dr. Kunynetz with reading material that emphasized the importance of explaining to a patient ahead of time the nature and reason for any portion of a physical examination. This was not done before the shifting of clothing performed by Dr. Kunynetz. The Committee's finding that Dr. Kunynetz had engaged in sexual abuse of Patient B, by touching her breasts in the manner not consistent with the clinical examination, was unreasonable and was quashed. The Committee rejected all of Dr. Kunynetz's evidence because he said he had no individual memory of the events at issue. The Committee did not consider whether the evidence he gave about what he would have done or what his usual practice would have been was credible and reliable. The Committee erred in rejecting his evidence without considering whether it was credible and reliable. The Committee was selective in its consideration of discrepancies and inconsistencies and did not explain why it accepted and relied on some evidence of Dr. Kunynetz's evidence and rejected other parts of it. The Committee concluded that, at the hearing, Dr. Kunynetz had changed his evidence with respect to whether he put his hands inside her bra. The Committee isolated that single subject and failed to consider the entirety of Dr. Kunynetz's evidence. By isolating Dr. Kunynetz's evidence on that single subject, the Committee failed to consider his evidence in an even-handed manner. The Committee compounded that unfairness by emphasizing Patient B's demeanour as supportive of her credibility. The Committee failed to assess any of the evidence relating to the allegation that Dr. Kunynetz had touched Patient B's breasts on the standard of clear, convincing, and cogent evidence. The Committee found that there was no clinical justification for the touching of Patient B's breasts. In coming to that conclusion, the Committee reversed the burden of proof, which was an error of law and unreasonable. The Committee's finding that Dr. Kunynetz had engaged in professional misconduct by allowing his abdominal fat pad to contact the bodies of Patients C and D without warning, apology or excuse was unreasonable and was quashed. In the Notice of Hearing, the College alleged that he was engaged in sexual abuse by pressing his genitals against the leg of Patients C and D. The allegation of allowing contact between his abdominal fat pad and Patients C and D was never raised in the particulars of the allegations, in cross-examination or in closing submissions. It surfaced for the first time in the Committee's reasons for decision. Dr. Kunynetz met the case as it was alleged. He had no opportunity to meet a significantly different allegation. The Committee's decision ordering revocation was unreasonable.

Given that the Divisional Court quashed the Committee's finding that Dr. Kunynetz had engaged in sexual abuse by touching Patient B's breasts, it was not necessary for the Court to address the issue of retrospectivity. However, the Court chose to do so. In the normal course, legislation operates from the day it comes into force. There is a general presumption that legislation should not be applied in a retrospective manner. The presumption can be rebutted if the primary purpose of the legislation is public protection. In the instant case, while it was clear that the purpose of the PPA was to protect the public, there was no indication in the statute that the Legislature had turned its mind to whether the amendments to the RHPA were intended to operate retrospectively. There was no other basis to find that the presumption against retrospectivity had been displaced. The Committee erred in its analysis and in its decision that the amendments brought by the PPA had retrospective effect. Given the Court had quashed the Committee's findings of sexual abuse and professional misconduct by touching, the penalty of revocation had to be quashed. The remaining findings were removal of clothing without warning or consent and two breaches of an interim order. Dr. Kunynetz had been under suspension for 28 months and had been subject to the revocation order for 17 months for a total of 45 months. It was unlikely that a penalty greater than that period of time would be imposed with respect to the remaining findings. The penalty imposed for those findings was a suspension up to the date of the release of the decision. Given that Dr. Kunynetz had been successful in his defence of the allegations that attracted the most severe penalty, but was found to have committed an act of professional misconduct and to have contravened a term of his certificate of registration, there would be no costs of the hearing before the College. On consent, there would be no costs of the appeal.

College of Physicians and Surgeons of Ontario v. Kunynetz, 2020 CHFL ¶ 15,880

Court Allowed Motion for Summary Judgment by Physician to Dismiss Negligence Action Against Him

Ontario Superior Court of Justice, December 17, 2019

In 2016, Noddle commenced an action against Dr. Levy, a family medicine physician, and the Ontario Ministry of Health (the "Ministry"). Noddle alleged that Dr. Levy negligently prescribed medication which caused him cognitive impairment and vision loss. Noddle also alleged that the Ministry was liable because it negligently approved the medication and failed

to warn of its side effects. Dr. Levy had treated Noddle from 1999 to 2013. In 2010, Dr. Levy diagnosed that Noddle had genital warts and prescribed Aldara, a topical cream for genital warts. A month later, Noddle saw Dr. Levy and complained of a mild adverse reaction to Aldara. Dr. Levy recommended that Noddle immediately discontinue the use of Aldara and referred Noddle to a dermatologist. The dermatologist confirmed the diagnosis of genital warts and cauterized the warts. In 2017, Dr. Levy brought a motion for summary dismissal of the claims against him on two grounds. First, there was no genuine issue requiring a trial regarding Dr. Levy's discharge of his duty of care. Second, the action was barred through expiry of the applicable two-year limitation period. The Ministry brought a motion to strike the Statement of Claim as a nullity at law. The Ministry maintained that the action was a nullity on two grounds: first, Noddle did not provide the appropriate statutory notice of the claim; and second, the Ministry did not have the capacity to be sued and was not a proper party to the action. The Ministry also sought an order striking Noodle's statement of claim against it without leave to amend on the basis that Noodle's claim did not disclose a reasonable cause of action and was an abuse of process.

The motions were allowed. Dr. Levy's motion for summary judgment was granted and the action against him was dismissed. The Ministry's motion to strike the Statement of Claim as a nullity at law was granted and the action against it was struck. In naming the Ministry as a defendant, Noodle had improperly sued an entity that was incapable of being sued. The Ministry is a department of the Crown, not its own legal entity. There was no basis for the commencement of an action against a ministry of the Crown. The action against the Ministry was also a nullity because Noodle did not provide the 60-day statutory notice to the Crown. Proper notice is a necessary pre-condition to a claim in damages against the Crown, which cannot be waived or abridged. Given the action against the Crown contravened the 60-day statutory notice period for the institution of Noddle's claim against the Crown, it was a nullity. Noddle did not establish on a balance of probabilities that Dr. Levy breached his duty of care. The Court accepted Dr. Levy's medical expert opinion that Dr. Levy's clinical decisions, investigations, referral, and treatment were all within the standard of care. Accordingly, there was no genuine issue for trial as to Dr. Levy's discharge of his duty of care. Additionally, the action against Dr. Levy was statute barred. By 2013, upon receipt of his complete medical records from Dr. Levy, Noddle knew and had all the evidence on which he reasonably ought to have known. The limitation period expired in 2015. Noddle therefore initiated the action against Dr. Levy beyond the two-year limitation period.

Noddle v. Ontario (Ministry of Health), 2020 CHFL ¶ 15,881

No Basis for Extending Limitation Period to Add Physician as Defendant in Negligence Action

Ontario Court of Appeal, September 24, 2019

In July 2007, Rumsam attended the Huronia Urgent Care Clinic ("Huronia") for treatment of a wrist injury. Dr. Pakes assessed her wrist and ordered an x-ray. Dr. Pakes reviewed the x-ray results which indicated a possible hairline fracture. He then discharged her with advice that she immobilize, rest, ice, and compress the wrist. A few days later, Huronia received a copy of the x-ray report prepared by a radiologist. The report confirmed a "suspected displaced scaphoid fracture" and recommended a follow up x-ray. A physician at Huronia reviewed the report but Rumsam was not advised that further follow up was required. After the pain in her wrist worsened, Rumsam visited her family doctor who referred her to an orthopaedic surgeon. She had surgery in April 2008 and in August 2008. Rumsam reached the age of majority in June 2010. In May 2012, Rumsam commenced an action in negligence against Dr. Pakes and Huronia. She claimed that Dr. Pakes and Huronia failed to advise her that follow up medical consultation was required and failed to notify her of the x-ray which indicated that a follow up x-ray should be done, resulting in the need for further surgeries for which she sought damages. Huronia and Dr. Pakes maintained that the radiologist's report confirming the fracture was reviewed by a second clinic physician, who had attempted to contact Rumsam at the telephone number provided by Rumsam in order to advise her of the findings. In a factum filed in August 2013, Rumsam stated that on the day following her attendance at Huronia, a second clinic physician had called her to tell her about the x-ray findings and the radiologist's recommendation for a follow up x-ray. In February 2016, Dr. Pakes and Huronia, in response to an undertaking given at an examination for discovery in August 2014, confirmed that Dr. Kargel had made a handwritten note on the x-ray report indicating that he had called Rumsam but the call was not answered. In November 2016, Dr. Pakes and Huronia advised Rumsam that, contrary to the earlier statement, there was no evidence that anyone had ever attempted to call Rumsam. In January 2017, Rumsam sought to add Dr. Kargel as a defendant in the action on the basis that Dr. Kargel had reviewed the x-ray report which indicated a potential fracture, but failed to advise and treat her. Dr. Pakes and

Huronia opposed the motion to add Dr. Kargel as a defendant, maintaining that the claim against Dr. Kargel was statute-barred. The motion judge concluded that the claim against Dr. Kargel was not statute-barred. The motion judge held that it was reasonable to conclude that Rumsam was unable to identify Dr. Kargel as the physician who wrote the handwritten note. Therefore, Rumsam arguably failed to communicate with her until November 2016 when Pakes and Huronia complied with the undertaking, advising that no one from the clinic had called Rumsam. He therefore held that the claim against Dr. Kargel was not statute-barred. Dr. Pakes and Huronia appealed, maintaining that the motion judge had failed to apply the correct test for discoverability under subsection 5(1) of the Limitation Act, 2002 ("Act"). The Act provides that a claim is discoverable when the plaintiff has or ought to have knowledge of the material facts of the claim, not when the plaintiff discovers potential liability. The appellants argued that the motion judge erred in his application of the principle that a plaintiff must exercise reasonable diligence to discover a claim after being advised of a triggering event. The Act sets out a basic limitation period of two years. As such, a claim must be brought within two years of a claim being discovered.

The appeal was allowed. The motion judge erred in his application of paragraph 5(1)(b) of the Act. The injury was sustained in July 2007, and therefore the limitation period ordinarily would have expired on July 2009. Given that Rumsam did not turn 18 until June 2010, the presumptive limitation period did not begin to run until that date. The limitation period would have expired in June 2012 but for the discoverability principle. By August 2013, Rumsam knew all of the material facts except the name of the second clinic physician. By August 2013, she was required to exercise reasonable diligence to get the name of the second clinic physician within the two-year period as she knew she likely had a claim against that person for her injuries. August 2013 was "the day on which a reasonable person with the abilities and in the circumstances of the person with the claim first ought to have known of the matters referred to" as set out in paragraph 5(1)(b) of the Act. The onus to prove reasonable diligence was on Rumsam. She failed to exercise reasonable diligence as she did not make any inquires to determine the author of the note or her involvement in Rumsam's care from August 2013 until Dr. Pakes' examination for discovery in August 2014. As such, there was no basis to extend the limitation period for more than two years as Rumsam knew of the likely claims and was in a position to ascertain the name by reasonable diligence. There was a palpable and overriding error in the motion judge's finding because he did not address Rumsam's knowledge of the material facts of the claim apart from the name of the second clinic physician. He erred in his application of paragraph 5(1)(b) of the Act as he did not address Rumsam's obligation and failure to exercise reasonable diligence to obtain the name as of August 2013.

Rumsam v. Pakes, 2020 CHFL ¶ 15,882

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