Sources of Law for Health Care Providers

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- 3 main sources of law / legal rules to consider:
  - **Regulatory,** relating to the legislative framework governing your license/registration to practice medicine, nursing, social work
  - **Civil law,** relating to the compensation of individuals for harms suffered as a result of civil wrongs established through judge-made ("common") law
  - **Criminal law,** relating to the imposition of punishment by the state for wrongdoing that violates the public order and is so blameworthy it deserves penal sanction

- **Regulatory**
  - **Medicine Act, 1991;** Professional Misconduct, O. Reg. 856/93, section 1(1) paras 2, 10, 27
  - **Nursing Act, 1991;** Professional Misconduct, O. Reg. 799/93, section 1(1) paras 1, 10, 19
  - **Social Work and Social Services Work Act, 1998;** Professional Misconduct, O. Reg. 384/00, section 2 paras 2, 11, 28, 29

- Essentially common requirements:
  - Practitioners must maintain the standards of practice of their respective professions; content of standards informed by:
    - laws relevant to practice: e.g., HPPA and PHIPA
    - professional guidelines: e.g., College & other sources (PHAC)
    - Codes of Ethics: e.g., CMA, CNA, CASW
    - Expert opinion from peers
  - Practitioners must not disclose information without patient consent unless required [or permitted*] by law
  - Practitioners must not contravene the professional misconduct regulation

*For nurses & social workers, but not physicians

- **Civil law**

  - Negligence: the duty to take reasonable care to avoid foreseeable harms
    - Duty of care owed to one's patient;
    - Duty of care to owed third parties: is this relationship so close that one may reasonably be said to owe that party a duty to take care not to injure him or her?
    - What is "reasonable care"; informed by:
      - Standard of care, as above
      - Court's limited ability to "second-guess" the professional standard where the matter is one of "common sense"

  - Breach of confidence: a person (including a health care provider) who has received information in confidence must not take unfair advantage of it, e.g., disclosure without consent
    - Defences include public interest

- **Criminal law**
  - *Cuerrier*, SCC 1998:
    - Established that a failure to disclose HIV status may vitiate consent to sexual activity
    - Because HIV poses a risk of serious bodily harm, the operative offence is aggravated sexual assault; life imprisonment the maximum punishment
    - Obligation to disclose triggered by a “significant risk of serious bodily harm”

- *Mabior*, SCC 2012:
  - Affirmed *Cuerrier* obligation to disclose
  - Interpreted "significant risk of serious bodily harm" to require disclosure "if there is a realistic possibility of transmission of HIV" (para 91)
  - Concluded that a low viral load plus condom use precludes significant risk and does not trigger obligation to disclose for purposes of the criminal law (para 95)
    - A general proposition that does not prevent the common law from adapting to future advances in treatment and circumstances beyond those considered in this case

- Age is a relevant factor to consent
  - Under 16, a complainant has limited capacity to consent
  - Re aggravated sexual assault (s.273, *Criminal Code*), it is no defence that the complainant consented to the activity that forms the subject-matter of the charge

- **“Take away” points:**

  - Develop clinic materials to explain your information practices to all patients, in advance of any problem (PHIPA, s.16)
    - Include information regarding the limits to confidentiality, e.g., public health reporting, the potential for summons in legal proceedings

- Be clear and consistent in your clinic practices re pre- and post-test counselling and disclosure obligations (including approaches to partner notification)
  - Ensure your practices are consistent with generally accepted standards, as reflected by relevant professional guidelines; include in your consideration resources reflecting community-based perspectives
  - Familiarize yourselves with:
    - public health practices and resources in your health unit
    - local community-based resources

- In circumstances of concern, consider these factors (PHIPA, s.40):
  - Is there a significant risk (PHIPA, s. 40(1)/risk of serious bodily harm or death (*Smith v. Jones*)*?* Why?
    - The civil standard re disclosure may differ from the criminal standard
  - Does the risk relate to an identifiable person or group of persons?
  - Is disclosure without consent necessary?
    - Always better to work with your patient to obtain consent

- A duty to take reasonable care to protect third parties, if imposed, might be fully discharged by engaging public health
  - Course of action recommended by PHAC guidelines; justified by specialized expertise, resources, legislative authorities
  - HPPA, s.34(1), s.25, s.95(4); preferable to reference a mandatory reporting obligation
    - The potential for public health reporting pursuant to these provisions should be addressed in your written description of information practices for patients (above)
  - Minimally intrusive; public health may succeed in obtaining voluntary cooperation/compliance
  - Ontario courts have taken stringent approach to statutory reporting obligations
  - Take reasonable steps to advise your patient that the usual requirements for confidentiality will be breached (CMA Code of Ethics, s.35)

- Maintain appropriate records: complete, accurate, factual/neutral
- Seek legal advice
  - CMPA, institutional, union
  - Cases are fact-specific, and there is a lot at stake (from every perspective)
  - It may be useful to develop related clinic policies/practices in advance, with the benefit of legal advice
    - Identify all available resources, to be prepared