Lawyered – Episode 87
Public Health Law ft. Jess Szabo

[00:03] HUSEIN: This is Episode 87 of Lawyered. I'm Husein Panju. And on this week's episode, we're chatting about public health and legal issues featuring health and healthcare lawyer, Jess Szabo. First, we'll chat about the controversy involving Medical Assistance in Dying, always known as MAID. The federal government has recently postponed the expansion of MAID to cover individuals who are suffering solely from mental illness. And this has prompted new legal and ethical questions about who can choose to die.

[00:33] We'll also speak about a new Ontario law that would allow hospitals to transfer elderly patients to nursing homes without their consent. And later, we'll also cover the latest trend of private actors in the healthcare space. Ontario, for example, recently introduced that they will be creating new health care centres that are privately run but publicly funded. And this is prompting important questions about the role of our healthcare system.

[00:58] And in our Ask-Me-Anything segment, we'll relay the questions submitted by our listeners about topics related to the opioid crisis, patient health data, the future of healthcare, to name a few. All of that and a lot more coming up in just a bit. This is Lawyered.

[Music Break]

[01:23] Hey, everybody. Thanks for joining us on this show again for another installment and happy to have you here. Not too much to share by way of housekeeping updates, except to say that fortunately we have filled our roster for the balance of the season.

[01:38] So thanks to everyone who reached out to put their names forward and/or to put other names forward. I'm very happy to say that we've hit our cap for the season, but you know, still have space for next year as well. So, if you are someone who's looking to be on the show or know of someone who might be a good fit for the show, please reach out. We do start quite early for the bookings for the coming year. So, love to get a great diversity of guests on the upcoming season. I'm very pleased with how the season worked out as well. So, I appreciate everyone's support in that respect.

[02:13] On our previous episode, we had a very interesting conversation about foreign investment law with Dany Assaf. Dany as you may know, is a very prominent lawyer and heads for investment and relevant practice at Torys LLP. We spoke about a bunch of issues in this area. We spoke about there's a new act that's going to be coming out soon called Bill C-34.

[02:**38]** It involves the National Security Review of Investments Modernization. There are significant changes happening to this area, which are going to impact the way that governments regulate foreign investment to strike this balance between welcome investment on one hand and safeguard national interest on the other.

[02:**57]** We also did a case study deep dive on the area of critical minerals and spoke about how there's going to be a new approach for countries and companies who are looking to invest in a specific area. And we also spoke about a new tweak to the legislation that's going to allow foreign investors to voluntarily notify the government of investments whenever they acquire ownership of a new Canadian business.

[03:**22]** Very fascinating area of law, especially if you're someone like me who had very little exposure to this prior. And as you might expect, a nice blend of law and politics. I mean, necessarily we got into this in the AMA to a large extent. You need to know a lot about what's going on in different countries, especially because the dynamics between Canadian and international countries is necessary to whether or not these investment bills get approved or not.

[03:**52]** And as I spoke about these dynamic changes on a regular basis, so we need to learn about both the substantive area of law and also the day-to-day as well. And it was also an engaging episode for the other reason that Dany is also a repeatedly published author. So he spoke about his new book that relates to Canada's prosperity through the 21st Century. So a great lesson, highly recommended. You can find that on our archive, which is episode number 86.

[04:**24]** Today's episode, very important episode, very timely episode, we're going to go out the area of public health. And obviously public health has been in the news as of late, especially since COVID. For a while, it seems like it was the only thing that was in the news for those couple of years. This episode, believe it or not, does not have too much COVID content.

[04:**45]** But we speak about a bunch of other current topics, some new bills that are either in progress or recently passed and a lot of live legal issues that come into play as well. So regardless of who you are, you are impacted by the way that our public health system operates. And I'm sure that people you know and care about are also equally impacted as well.

And as always, we have found a guest who is very well-suited to speak about this particular area. She's both enthusiastic and well-versed in this particular area of health

law. And I'm really excited to hear what she has to say. And so without further ado, here is our public health law episode with our guest, Jess Szabo.

[05:21] Jess is a health law lawyer practicing at McIntyre-Szabo, which is a boutique firm that she founded with a former colleague. Prior to this, Jess worked as a legal counsel at Ontario Health, advising on a wide variety of corporate policy and risk matters, including digital research, privacy, mental health and clinical issues.

[05:51] She's also worked in private practice at Bourdon-Lander-Gervais, also known as BLG, and in-house at the Centre for Addiction and Mental Health, also known as ChemH. In law school, Jess specialized in human rights law, international criminal law, and after graduating law school, Jess worked at the International Criminal Court as a legal consultant on the successful appeal of Mr. Jean-Pierre Bemba's convictions.

[06:11] And prior to law school, Jess worked with female offenders detained in a secure forensic hospital in England, while completing her master's in forensic mental health. Jess then worked with hospitals in England to improve outcomes and promote better integrated care for people with mental health needs. So Jess, thanks for doing something on the show today.

[06:31] JESS: Yeah, thank you. I'm so excited to be here.

[06:34] HUSEIN: Yeah, of course. It feels the same way. Before we get into the question itself, I want to try a bit more about your origin story, because I know you're a health law lawyer right now. And as I mentioned, you did a bunch of health-related work before going to law school. So tell us a bit about that work and the transition to how this kind of led to you becoming a health law lawyer.

[06:52] JESS: Yeah, well, I should note, I come from a family of people that also work in healthcare. So, kind of, I grew up in the healthcare space and studied behavioral neuroscience. When I was in my undergrad, I was really interested in kind of psychology and brain and behavior. And then I worked in community care as a summer student and was exposed to that kind of Ontario's community care system. It was the community care access centres at the time.

[07:27] And so I did that. And instead of just working in the office, I also got to go into the hospital. And so I was exposed to healthcare kind of in that way. And then I decided to do my master's in forensic mental health, really enjoyed the kind of cross section of law, criminal behavior, mental health needs and then decided to go to law school. I

realized that it was actually the legal piece of that intersection that was the most interesting for me.

[07:54] HUSEIN: Tell us what was so interesting to you about that.

[07:56] JESS: Yeah, so I realized that in the intersection of the criminal and the mental health side, the mental health is kind of the enduring part of it, and that's a factor of it. But what really shapes, I guess, people's outcomes—or at least as I saw it, their outcomes and the way that they can exist in society and the way that they can contribute, it's really the legal framework around that.

[08:22] And so the mental health side was a little bit more nebulous, I found, and it didn't have the same resource contributed to it and things like that. But the legal side of it, I thought was kind of a sturdier framework. And I really wanted—to be quite honest, I really wanted a way to help. And change things and change the system and promote better results and outcomes for people with mental health needs. So I realized with my background on the healthcare side of things, that then if I had the legal piece of it too, I could really marry the two and hopefully contribute more.

[09:02] HUSEIN: Great. And now looking back as like a fully-fledged lawyer, like, is this kind of what you imagined you'd be doing back when you were applying to law school?

[09:12] JESS: Yeah, I think so actually. I think it's a really good mix. And there's a whole bunch of things actually that I would say that I'm doing that I never really even thought about. So, it's what I expected, but even more. Like, there's an even greater need for some of this work. And I still get to do a lot of the clinical side of things too, which is really interesting for me.

[09:35] HUSEIN: Really a good match.

[09:37] JESS: Mm-hmm.

[09:38] HUSEIN: Great. So, we've got a bunch of interesting topics to speak about in this area of health law, which I think deal with intersection you were just speaking about. I mean, the first topic we're going to speak about involves the topic of Medical Assistance in Dying. The concept of Medical Assistance in Dying, also known as MAID for short, has a legal history in Canada ever since it was first introduced back in the year 2016. And after a series of legal challenges and new bills, the most recent controversy involved expansion of MAID to cover individuals who are suffering "solely" from mental illness.

[10:**09]** And the federal government recently postponed this expansion for a year through a bill called Bill C-39. And this has prompted new legal and ethical questions about who can choose to die. So, Jess as I mentioned in the intro, this concept of Medical Assistance in Dying has had an eventful history in the courts and in legislature in the last couple of years. So I'm going to advise for that a short summary about what's been going on.

[10:**34] JESS:** Historically, we've been dealing with this since the early 90s, there have been court cases, but the really big ones that we need to know for, I think, for today and for where we're at moving forward. In 2015, there was a case brought to the Supreme Court. It's the Carter case. And that prompted a change. So former Bill C-14, which changed the criminal code. So this allowed for Medical Assistance in Dying to be brought about. Now, there was at that point a requirement that death be reasonably foreseeable.

[11:**13]** Now, in 2019, we see a couple people in Quebec bring about a challenge saying that it's unconstitutional for that criteria of reasonably foreseeable death. So they said, "Listen, I'm not about to die, but I don't want to live anymore. And it's unconstitutional for you to make me live like this, or that I don't have access in the same way other people would."

[11:**33]** So the government went, "Yep, got it, okay." So in 2021, we see Bill C-7. And then it says that, okay, maybe there should be two streams. And we should have the reasonably foreseeable death stream. And then there should be a stream where death is not reasonably foreseeable. In Bill C-**7**, that's when they say, but wait, wait, we're not ready to look at grievous and irremediable medical conditions solely that are mental illness. So medical condition is going to exclude mental illness.

[12:**10]** And so now we look at Bill C-39. And that's saying, "Okay, C-**7** said we have a two-year exclusion period." And then the government still wasn't ready and said, "Okay, wait, we need one more year." And so that's kind of where we're at right now.

[12:**26] HUSEIN:** You mentioned that we have this year postponement for this category of persons. And so this bill is going to attack on a year for this class of people who are suffering from mental illness and want to access MAID. So what is going to happen this year? What do you think is going to happen?

[12:**43] JESS:** Yeah, so there have been some expert committees that have been founded. The expert committee that was required under Bill C-**7,** gave in their final

report. There were 19 recommendations. My view or my sense of all this is that there's not a lot of agreement. We've got two sides to this on whether this should go ahead or not. The government's very clear it's going to go ahead, but I think they really needed this last year. When I read about it, it said, we want to make sure everybody's ready.

[13:**18]** And they said, we need to make sure the provinces and the territories are ready and we need to make sure clinicians are ready. So I think we're looking at standardized guidelines or standardized assessments, clearer standards of practice around this, clearer definitions, and really just making sure that this is a big deal and I think they want to make sure that they do this in the right way. So I think there's a lot more consulting and developing around those guidelines happening.

[13:**49] HUSEIN:** Absolutely. One of the most important terms here is mental illness, which can mean different things to different people. So how is this term defined for the purpose of this law and like how do you think the criteria might be established to assess this?

[14:**02] JESS:** In true law fashion, mental illness is not defined. And so, and the government has acknowledged, okay, we know it's not defined, but it's in the domain of psychiatry, they've said. They've said that it does not include neurocognitive or neurodevelopmental issues. So it won't include dementia, it won't include autism or things like that. It's not a mental—they specifically don't use the term mental disorder. Mental disorder is defined in the DSM and gives all sorts of different definitions.

[14:**40]** So it's not that. So, I think what we're looking at as opposed to what it is, we know what it isn't. So, we know it's a subset of mental disorders, it's in the realm of psychiatry. People have talked about treatment refractory illnesses. So treatment resistant illnesses, we've talked about them being enduring. A lot of things that are being mentioned are your kind of treatment resistant schizophrenia's, personality disorders or depression or things like that.

[15:**13] HUSEIN:** Got it. And I know you're not the ultimate decision maker here, but do you think that we'll get some clarity about this in a year's time before this goes live?

[15:**23] JESS:** I don't think so, to be honest. I think there will be criteria again on what it's not. And I think sometimes that exclusionary criteria is easier. I also think with this, it's been clear on the non-reasonably foreseeable death stream of things, to be eligible, you need to have a specialist in the field of the underlying medical condition weigh-in. So I

think once MAID is granted for people who solely have a mental illness, I think psychiatrists' roles are going to be very important in this.

[16:03] HUSEIN: For sure. And you mentioned that there's like two sides or maybe there's at least two sides in this and it's been talking a lot of discussions between health experts and legal experts. So can you dispel to us what the two sides look like?

[16:17] JESS: So I think at a really high level, with MAID, and I guess actually with a lot of healthcare decisions and controversies, a lot of times you're really looking at autonomy versus the protection of vulnerable people. So I have the right to live my life how I want to live it, as long as I'm able to make that decision and as long as I'm not being pressured into it and as long as I'm not so vulnerable that I can't make that decision.

[16:45] So I think what we're seeing now is that with mental illness being the—if it's the sole condition, I think what a lot of people are saying is, there shouldn't be a difference between mental health and physical health. And that's kind of what underpins this, is it's not fair to exclude a whole group of people just because they don't have the same physical ailments. But then when you look at it, the other side saying, yes, but while it should all be treated as health issues, they are fundamentally different.

[17:21] So the people that don't necessarily want this to go through are saying, suicidality, for example, is a symptom of mental illness. How do you tease apart, whether somebody's suicidal or whether they've really considered having MAID? And other people are also saying, and are we just kind of overreaching or are we providing this to backfill for some government shortcomings? So are we doing this because really, people don't have adequate support?

[17:57] People with mental health issues don't have adequate treatment, they don't have adequate social supports, they don't have adequate housing. So are we really just providing this as an answer to some of those issues?

[18:08] HUSEIN: And I know that this bill is still not passed ultimately. But do you foresee that these issues might develop into a charter issue down the road in terms of like the right to life, the right to not live?

[18:21] JESS: Well, I think they will. And interestingly, Quebec has now filed a bill. I think it's Bill 11 in Quebec. And they've said mental health, the sole condition being mental health will never be a reason for MAID. I'm paraphrasing. Obviously, that's not the legal way it's framed. But they've already said this, and they're saying we're not even going to

touch it. So, I think if provinces start doing that, there's opportunity for a lot of challenges in that.

[18:55] HUSEIN: Yeah, and I know that there's some advocates who say that psychedelic assisted therapy should or could be available to deter those who might otherwise be seeking MAID. So what do you think about that?

[19:05] JESS: As you say it, my first gut reaction is, I think that's a little bit of an oversimplification, or I think that's a bit of a parallel discussion. But then the other side of me says, we should just be helping everybody we can with whatever means we know to help reduce suffering and harm. So on those two sides of things, so psychedelic assisted therapy isn't approved. I think you can still apply for special approval for it. I think getting that approval is a lot less likely than it was in the past.

[19:40] Recently, the Minister of Health and Addictions, Mental Health and Addictions has said, they recognize that the people in Canada are interested in this and that Health Canada is aware of that. So, I think if there's any way that we can reduce people's suffering, of course we should try that. Now, is that going to help everybody who would also be seeking MAID, or who would have sought MAID instead of doing that? I don't know, I don't know enough about it. So I think all of these things need to be advancing so that we're providing people with appropriate options. I think that's what we want to do, right, is we want to be ending suffering.

[Music Break]

[20:33] HUSEIN: Last summer, the Ontario government introduced a controversial bill known as Bill **7** that would allow hospital to transfer elderly patients to nursing homes without their consent. And while this bill was intended to preserve hospital capacity, it also triggers new issues regarding patient autonomy and quality of care for vulnerable individuals. And this spring, in 2023, a coalition of advocacy groups filed a charter application arguing that this new law violates Section **7** of the charter and unfairly discriminates against elderly persons on the basis of age and disability.

[21:04] So I know there's a lot to go into here, but if we're going into the details of the bill, it might help to explain before Bill **7**, what would happen to a patient in a hospital if they refused to be transferred to a long-term care home.

[21:16] JESS: So, if an elderly person goes into the hospital and let's say their admission was because they had a heart attack or because they had a stroke, the doctors will treat the patient for that acute care episode. So, for that acute need, that heart attack, that

stroke, that broken hip, that broken wrist, whatever it is, that kind of brought them in the doors of the hospital. But then what might end up happening is that they're not able to then go home. So they're designated as an alternate level of care because they don't still require acute care services in a hospital, but they also need to go somewhere else and they can't just be discharged home.

[21:**57]** We're looking at patients who are in hospital, who are occupying a hospital bed under the Public Hospitals Act, but who no longer require that intensity of services. So this is usually the precursor to admission, either to a complex care facility or to long-term care. Under the Act, what would typically happen is the patient or their substitute decision maker would request of a placement coordinator or would consent to a placement coordinator, doing an assessment of them to say, are they even eligible for long-term care?

[22:**29]** So there's eligibility criteria, but the patient or the RSTM would consent to that and then the placement coordinator would undertake that. If they're eligible, then they would apply to up to five long-term care homes.
And again, they would do this, they would consent to this, they would talk to their placement coordinator about this and figure it all out. And then what would happen is the long-term care homes would either approve them or reject them.

[22:**52]** There was only specific times that they couldn't be approved, like it would be if they had really special needs that the home couldn't accommodate, so then they would be approved and then they would go on a waitlist typically. There's never usually a bed just waiting for the person. So, they'd be on a waitlist, a bed would come up, it would be a bed offer, and then they could, they would consent, so they would consent either approve it and say, yeah, okay, I'm willing to move, or they would reject it. And they were able to do either.

[23:**21]** Now, if they rejected it, they would still remain on the waitlist for the other places. And then the hospital could, it was a little bit more discretionary, the hospital could decide whether they were going to charge them a rate to stay in hospital every day.

[23:**38] HUSEIN:** So, tell us about the highlights that are getting a lot of attention.

[23:**41] JESS:** The biggest thing is it doesn't repeal the former legislation or the former process, but it adds in a specific section, and it's a section called ALC patients or Alternate Level Care patients. And then it says certain circumstances or certain actions

can be done without consent. So now a doctor can go to a placement coordinator and say, can you assess this person for eligibility to long-term care? I think they might be eligible. Neither the patient nor their SDM need to consent to that.

[24:**17]** So a doctor or a physician can initiate that. The placement coordinator can also initiate it, and then they're able to assess them. If the person doesn't consent to being assessed, they can still undertake this assessment just based on like a health records review. They're allowed to apply to long-term care homes for them. They're allowed to pick the long-term care homes for them. And one of the other big things is they're allowed to now share personal health information. So they're allowed to share the assessments with the long-term care homes without any consent.

[24:**52] HUSEIN:** So as a practical matter, it means that the doctors can essentially like move them to a long-term care home without their consent. Is that right?

[25:**00] JESS:** Well, it's interesting. It doesn't quite get us there. So, they're allowed to do all of these things up until that actual last phase of physically moving them. So, it's very clear that they are not allowed to physically move anyone absent consent. And I think this gets lost a little bit. They can assess eligibility, apply to the long-term care home, do their selections. But once the long-term care home says, yes, we have a bed for that, they've been approved and now we have a bed for them, if the person says, no, I don't want to go, they don't have to go.

[25:**37]** What ends up happening is they remain on the wait list for the other homes that the placement coordinator suggested or applied for. They remain on that. But then there is a mandatory $400 per diem charge. So once you've technically been discharged, the hospital has to charge that. So the practical outcome, they're still not able to be moved without their consent. But all of these other things leading up to it seem like they're really pushing you in that direction.

[26:**10] HUSEIN:** Yeah, like a $400 fine is significant for most people. So I imagine that can be a way of gently and not too gently nudging them out of the hospital, right?

[26:**18] JESS:** Yeah, well, $400 a day, just because you don't want to go to that long-term care home, that is a lot.

[26:**26] HUSEIN:** So, you're talking about consent. I want to learn more about that. Because I know that part of the law is that if there's a placement coordinator, it needs to make reasonable efforts to obtain consent from patients. So what do you think about that language?

[26:39] JESS: Yeah, well, as in most law, of course, the most important parts of those phrases in legislation are not defined. So reasonable efforts isn't defined in the legislation. Commentators have said that the legislation implies that you need to engage in discussion with the patient, with their SDM or their Substitute Decision Maker, with the clinician, with the hospital, with the discharge team, with the placement coordinator.

[27:09] So it's saying, this is what's supposed to happen. You're supposed to be engaging with them. Those are kind of reasonable efforts. You're supposed to strive to understand their preferences. You're supposed to promote choice. Ontario Health has come out with a guidance document, a field kind of guidance document on this, and has said reasonable efforts to obtain consent mean you really should be doing this at all stages of this process.

[27:39] HUSEIN: What do you think personally, as somebody who's working in this area, I know consent kind of spans through all of health care. But what do you think about this flowchart approach or attempts to get consent?

[27:50] JESS: I mean, I'm of two minds. I think that's the right thing to do. I you should be getting consent for all health care decisions. And I think this is where the controversy in this lies, right? Is that people should be able to make their own health care decisions. That's the fundamental principles behind all the legislation that I kind of deal with is that personal autonomy, decision making and protecting vulnerable people is the right thing to do. That's what we're supposed to be promoting.

[28:21] So, you know, trying to obtain consent at every stage, you know, and working with people and how Ontario Health says, you know, strive to understand preferences and promote choice and seek consent at every available opportunity. I think that's the right thing to do. But then I also think there's this part of it where if my family member was in hospital and I was their Substitute Decision Maker, if people were coming to me at every stage saying, "Okay, now we need to talk about this again and I'm trying to seek your consent and I want you to consent," it does feel like you're getting backed into a bit of a corner, I would think.

[28:58] I would think that this is like, well, obviously, they want me to consent. And if I do consent, then I'm under the old regime, right? And if I do consent, then I don't have to pay $400 a day if I don't go to this long-term care home. So, I think consent is the right way to go. But pushing people at every single stage, I can see how that would feel. That would be a little bit hard to bear.

[29:28] HUSEIN: Fair point. So speaking of which, relatedly, I know that the Ontario Health Coalition and the Advocates Centre for the Elderly have recently filed a charter application regarding this bill. So maybe tell us a bit about their position.

[29:41] JESS: Yeah, so the coalition and ACE, so the Advocates Centre for the Elderly have filed a charter challenge saying that Bill **7** violates Section 7 and 715 of the charter. They're saying that this bill is discriminatory based on age and disability and that these people are deprived of their right to make informed decisions. So, they're deprived of their right to informed consent and they're deprived of their right to privacy because as we know Bill **7** also allows these institutions or organizations to share personal health information without consent.

[30:18] HUSEIN: What do you think about the merits of an application like this?

[30:22] JESS: It's an interesting application. They've filed affidavits and affidavit evidence on behalf of very reputable people in the field, very interesting arguments being put forward, saying that it only takes into account hospital resources. You're not actually looking at the long-term care home side of things, that it's improperly or unfairly painting elderly people as bed blockers and things like that. I mean, I'm not surprised that a charter application has been brought on behalf of these organizations.

[30:59] I wonder about the success of it given that really, like as we talked about at the end of the day, even though you're deprived of your consent the whole way along, you really don't actually have to move. They don't physically move you. So I wonder if that's going to be a little bit of a stumbling block in this.

[Music Break]

[31:24] HUSEIN: In 2023, there have been several high-profile cases related to the role of private actors in the healthcare space. Particularly, the Ontario government recently introduced Bill 60, which will create new healthcare centres that are privately run but publicly funded. This new law is always been introduced against the backdrop of a new British Columbia appeal case about whether patients should be allowed to access private medical treatment when the public healthcare system cannot adequately provide timely care.

[31:50] So, Jess, we'll start by talking about Bill 60, the Ontario Bill. I know there's been a lot of discussion about this. It's obviously known as the Your Health Act. So, someone can tell us more about what this new legislation means for the healthcare system in Ontario.

[32:05] JESS: So, interestingly, I kind of see it as a little bit same, same, but different. So, the bill, it repeals an older act. So, it repeals the Independent Health Facilities Act. And so then it provides for the Integrated Community Health Services Centres Act, which is a bit of a mouthful. So I'll just say the new act going forward. And so I think what a lot of people don't know is that independent health facilities have been around for quite some time, even in Ontario. And so typically they've done things like diagnostic imaging. So we've had this system for a while.

[32:46] HUSEIN: For those things, those independent health facilities, were those public or private or both?

[32:53] JESS: So they were similar to what the government has now proposed. So they are providing insured services or public services, but they're privately run. Now, with the new legislation, I think the biggest thing it does, to be honest, is it really signals where the government's moving. I think it signals the government's desire to move into this private realm. And part of the reason I say that is, it's very similar to the Independent Health Facilities Act, but instead of adding to it or relying on that act, they've repealed that act and they've brought this whole new act in.

[33:31] And they've added certain things to it that again signal this shift. So they've added that these independent facilities or these, let's say, we'll called in private clinics, these private clinics can also now do surgeries. So that's very specific in this act. And again, so I think that shows the government's desire, or it's kind of showing where the puck's going. It's showing like, hey, we're signaling, this is where we want to go, we have the ability to do this.

[33:59] It also provides for specific structure and oversight. It's clearer on what's required for the applications for these private clinics. So, it lays out some of that, it lays out more of the oversight. We're seeing a little bit of an expansion on that. And the other thing it does, is it does as-of-right licensing. So if somebody were to come here from a different province, they're able to work here for a temporary amount of time without having to go through all the rigmarole of getting certified here. So they can work while they're doing that.

[34:37] HUSEIN: So what do you think about how this bill is drafted with respect to the structure oversight over these Integrated Community Health Service Centres?

[34:45] JESS: It's good to lay out some of these pieces. So the act lays out what I kind of distilled down to the application phase and then the actual operation phase. And the act

says, in applying, these are the things you need to tell us about for us to approve you. And there needs to be quality assurance and quality improvement initiatives. They have to talk about staffing models and the sustainability of their staffing models, how the facilities are going to integrate care, who they're working with, who their partners are.

[35:**19]** The operations have to be a mechanism for patient complaints. You can't refuse a patient care just because they want an insured service. So just based on cost. It's good on paper. And then you start digging a bit and it says, okay, you can't refuse a person—and I'll use cataracts as an example—you can't refuse a person because they want the OHIP-covered cataract surgery and they don't want the Cadillac of cataracts that they have to pay for it. So you can't refuse them, but it doesn't say that they have to be at the top of your wait list either.

[35:**56]** So is it open for private clinics to say, well, obviously we're going to put the people that pay at the top? I don't know, that's more my cynical side saying that. So I think there's some of those issues that played.

[36:**11]** for sure. I know that there was this recent case called Cambie Surgeries Corp. and B.C. This edition there was in 2022. B.C.C.A. 245. Some court recently denied... Can you give us a quick summary of what happened there.

[36:**23] JESS:** So, Cambie Surgery was a private entity, private health clinic. And so the medical director of the clinic brought a charter challenge and said that the Medicare Protection Act violated sections **7** and 15. This is the theme of our podcast, I think, is these challenges against section **7** and 15. But it's saying that to not allow private providers to charge patients for services that they need, medically necessary services, to be able to get them to get them faster, that these patients were suffering.

[37:**01]** So, kind of suffering on waitlists, prolonged waiting for the actual insured service, they were deteriorating, they were missing their surgical milestones. And they said, "You know what, that's not right. That has to be a charter violation." And they ultimately said, "No, even if it violated the right to security of a person, it's in line with the principles of fundamental justice." And the Court of Appeal then also upheld that decision. And really looking at it, they were saying, you know, we have to preserve the integrity of the public health care system. And that's what this is doing.

[37:**38] HUSEIN:** I know this bill is getting a lot of attention from legal commentators and policy analysts as well. What leadership do you foresee our course grappling with in the future regarding this tension between public versus private healthcare services?

[37:52] JESS: Yeah, I think there's going to be some issues around the insured and uninsured services. I think we're already starting to see that where people say, okay, if we're operating in this space, how can we…If we're in a private clinic and yes, we're providing OHIP services, but we're also allowed to provide private service, provided that they're not under our OHIP regime, are people going to start being creative on how they make insured services uninsured?

[38:22] I think that's something that might come up. I think another issue is that the "director" in this legislation who's going to be making these decisions, interestingly, they're not a public servant. So they're not required to follow the same conflict of interest policies, the same financial disclosure policies, all that kind of stuff. Are we going to start to see some of that shine through? And then I just think there's a lot of gray area in this, right? So I think that always leads to legal challenges. I think you're going to find people saying, well, I just want private care. It's more timely and I have the right to that.

[Music Break]

[39:14] HUSEIN: And finally, we'll do our Ask-Me-Anything segment with Jess to chat about some of the healthcare questions that were submitted by our listeners. As our regular listeners will know, one of the bonus words we have for members of our Patreon crowdfunding community is the opportunity to submit questions they want to hear answered on the show.

[39:30] These can be questions about anything within the guest's area of expertise, so long as they're not asking for legal advice. If you want to find out how you can become a patreon and submit your own questions to our coming guests and get other rewards as well, you can check out our crowdfunding website which is www.lawyeredpodcast.com/patron.

[39:47] So I've got a lot of questions for this segment. Most of them are anonymous. I will say that most of the questions were submitted by people who work in or adjacent to the healthcare space, so I think they will get some insightful questions in that respect.

[40:03] The first question we have relates to the opioid crisis. So the question is, what are your thoughts on how the government provides care services for those who are impacted by the opioid crisis? Some commentators argued that a lack of a person-centred approach undermines the individual's ability to meaningfully access the care required.

[40:22] JESS: Yeah, it's a great question. I'll start by saying that first and foremost, I think all care should be patient centred. So, you know, of course…

[40:32] HUSEIN: And what do you mean by patient-centred?

[40:35] JESS: Yeah, so you're really…the whole idea is that you're supposed to put the patient in the middle of everything you're doing. There's a phrase, you know, "nothing about me without me." And that's kind of in the patient's world.

[40:49] So, if I'm coming to you and I have an issue, I should be at the centre of that issue. And you should be coming to me to ask me what I need and telling me what services are available or helping me to find the information that I need or the treatment I need or the services I need.

[41:09] So I think the interesting thing about mental health and addictions is it's very personal. And I think health care generally is very personal. But in terms of things like cancer, we have certain treatments that we know work.
I think potentially what this person might be asking about—I'm hoping I'm interpreting the question right—is that, should there be more safe injection sites? Should there be more supervised safe consumption?

[41:43] Should there be more treatment with, like, let's say your methadone type treatment when people are ready for treatment? Do we need housing? Do we need educational supports? Do we need social supports? So I think the thing about the opioid crisis or those suffering from addiction is everybody's at a different stage of their journey. It's not the same as saying this person has stage 4 cancer and this is what we're going to do because it's evidence-based treatment and we know it works.

[42:10] So I would say that the care services that are provided by the provincial government, I think, have a long way to come. And I'm guessing that's probably what the listener is hinting at. I think we do need to look more at that. And I will say in preparation for the podcast, I looked at the Government of Canada's website and I for addiction services and I looked specifically under Ontario and I only found that there were six numbers that you could call.

[42:43] There was a link for safe supplies, so like clean syringes or things like that, and a link for getting naloxone kits. To me, that doesn't sound like a lot. It's not providing people with like, hey, here's safe consumption sites. Hey, here's where you can go to do this and things like that. So I think there's a long way to come, but I would agree,

patient-centred is the way to go and you need to find out where people are on their journey and tailor their treatment to them.

[43:15] HUSEIN: And this is a very complex issue, but like what are some things that governments could be doing to make services more person-centred?

[43:24] JESS: Mm-hmm. Well, really, I think we need to stop telling people how they need to be treated and how they need to be living, and we need to be listening to them. So, in developing any service, I think it's imperative that you have somebody with lived experience or who's going, you know, either going through a currently or has been through it to say, no, no, this is what we need. Like, I'm the user of the healthcare system. This is what I need to get better. So I think you really need those, those personal aspects to be able to build care around that. you

[43:59] HUSEIN: Yeah, that's a great answer. The next question on a very different note is, what sorts of protections are currently in place to protect patients' health care data?

[44:08] JESS: We do have protection through statute. So, we have PHIPA. So that's the Personal Health Information Protection Act. And so this is the legislation that allows for the consent use and disclosure of personal health information.

[44:27] HUSEIN: And I know that there's analogous bill legislation in other provinces as well, right?

[44:31] JESS: There are. Yeah. And so this is consent based legislation. So essentially, it's saying my personal health information is protected unless I consent to you collecting, using, or disclosing it. But with all law, there's always exceptions. And I think there are a lot of exceptions to this consent-based approach.

[44:55] There's also the other side. And that's more, I would say, I call it the physical side as opposed to the legal side, like it's the on the ground stuff. So you're looking at cybersecurity. You're looking at, like I kind of say, you know, your personal health information from that perspective is really only as safe as the entity or the organization that's holding it. So what are their cybersecurity protections? What are the structural things that they have in place? And then what's their training for their staff?

[45:34] So we know there's been cases on snooping, we call them the snooping cases, where they found out that staff in different medical organizations were snooping in people's charts, not for any specific purpose. But that's against PHIPA. So, there's the legal side, we have PHIPA, it protects your personal health information subject to

exceptions. And you can rely on that. But then really, it's only so protected as the people that have it.

[45:51] HUSEIN: So, what are the mechanisms? Like if there is an allocation of a breach or something, what recourse is available?

[45:58] JESS: Right, so there's the organization, the IPC. So that's the Information and Privacy Commission, and they get involved in privacy breaches and they can review these things. Now actually, organizations have a requirement to report breaches to the IPC, but then also the general public can make complaints to the IPC and they can investigate.

[46:22] HUSEIN: Now, the next question we have is, I mean, we're talking a lot about public versus private health care. The question here is, health care is publicly funded in Ontario, but privately delivered. So, what is the legal basis for nurse practitioners providing access to primary care services in private medical clinics?

[46:39] JESS: So one thing I will say is healthcare is publicly funded and can be privately delivered. It's not always the case. It's not always privately delivered, but that certainly can happen. And asking about nurse practitioners providing primary care services. So what we're seeing is nurse practitioners have extended powers—powers probably isn't the right word, but extended abilities to do assessment, diagnosis, treatment and things like that. And so what we're seeing is that some nurse practitioners are seeing that a lot of people don't have family doctors and they're saying, well, I can do a lot of what they do.

[47:25] I can refer them to a specialist, I can assess them. And so why don't I open up a clinic and it can almost be like their primary care physician or like their GP. Now, the interesting thing about this is that, and to this person's question or the answer, how are they even allowed to charge for this? You know, what's legal basis? Nurse practitioners can't bill through OHIP. So physicians can bill through OHIP. I believe recently there's been one exception and now nurse practitioners, if they're referring to consultants, there might be a separate OHIP code for that, but doctors bill OHIP, nurse practitioners don't.

[48:09] And doctors are not allowed…if there isn't, we call it an insured service. So if doctors are providing an insured service under OHIP, they can't privately charge for that because the person's entitled to it under OHIP.
Given that nurse practitioners don't bill OHIP and can't bill OHIP, they can charge for

these services. So it's no federal or provincial law stops this. The other thing is it also depends on the type of clinic that the nurse practitioner is working in.

[48:**43]** So sometimes in family health teams, there's certain provincial funding that is given to the family health team and the doctors there to say, okay, run this clinic and make sure you have a multidisciplinary clinic and we're going to give you money and that will pay for these nurse practitioners services. So, your patients don't have to pay for it. Whereas if a doctor is doing fee-for-service, then they're not getting that provincial funding for the nurse practitioner or the multidisciplinary team. And so then they can charge for it. So, part of it is also due to how funding flows.

[49:**20] HUSEIN:** Okay. Interesting. The last question we have here is what changes or trends do you anticipate we will see or maybe are currently seeing that we're in the future of public health in Canada.

[49:**31] JESS:** Increasingly, we're seeing much like education, healthcare is becoming a political issue. So, I can see it, it's political. I think we've seen it's very divisive. I think COVID really shone a light on that, is that people are not all on the same page when it comes to healthcare and on kind of the right thing to do and the right way to move healthcare forward.

[49:**54]** So I think that answer is going to depend a lot on the government of the day and then what their mandate is and how they push that forward. I think we're just seeing the tip of the iceberg on the privatization side. We see in the bill that they're going to be opening private clinics, it's for insured services. I think that's a slippery slope. Like, I think that's where we're moving. I lived in the UK previously and they have a dual system.

[50:**30]** So they have the NHS and then they also have private healthcare. And I think increasingly, we're moving towards that more dual system. And then the other part or one of the ways this intersects with the law is that I think judicial resources right now, certainly in Ontario are strapped.

[50:**50]** And so I think when people are bringing some of these claims forward or some of these applications forward, they're not being dealt with in a super timely way. So, some of the citizens ability to dictate this and the laws ability to dictate this and the trends, we might end up being a little bit behind. And then the other thing I would say, I do a lot of mental health work. I think there's going to be a real need for more and

better mental health services because based on a lot of data, a lot of those issues are increasing.

[51:30] HUSEIN: I just want to pick up on the first thing you mentioned about how health care is becoming more of a political issue. What do you think about that? Because I can see, you know, there's a lot of controversy in the media about people saying all sorts of things, but I can also see an argument about it's good it's becoming a political issue. It's getting more attention and, you know, more diversity of thought to get better solutions. I'm curious to see what you think as some who practice this in this area.

[51:54] JESS: Yeah. Well, I think, like you said, I think there's pros and cons to it, right? I think the good thing about it is, if it's a political issue, given that we live in a democratic society, you're putting that in people's hands if they so choose, right? So I think this is what really should push people to know who they're voting for, to vote, to really look at some of these agendas to talk to their MPs and to really move some of these issues forward.

[52:25] So I think in that sense, it's good. You're giving people the opportunity to help move it forward. So, in that sense, it's good. In another sense, it's difficult when politicians are making decisions either based on reelection or campaign funding or things like that, that aren't actually better for healthcare or better for patients.

[52:53] HUSEIN: I fully agree this is an important issue. Are you optimistic that we'll see a greater level of mental health care in the future given what you've seen in your line of work?

[53:05] JESS: I think it's on a lot of people's radar. I know a lot of our partners and a lot of people who work in healthcare know that this is an issue. I think more funding is being devoted to it, but I do think it's the tip of the iceberg. So, I think also given COVID and the effect that that might have on people's mental health, we're going to start seeing that in the next few years. And I think we're in for a surprise. Like, I really think that there is a great need for more mental health services.

[53:47] HUSEIN: Jess, I want to thank you for walking us through these exciting and complex issues. We were talking off mic before we hit record and we were talking about how this is being as like human-centred as law gets in terms of the impact that this really has. So I think you did a great job explaining what these issues are and how it impact individual people and will impact people down the road. I think that your

commentary about the patient-centred model really resonated with me. I think we'll see a lot of important developments in this are in the future. So I want to thank you for your time and we look forward to staying in touch in the future.

[54:18] JESS: Yeah, thank you so much for having me. I really enjoyed it.

[Music Break]

[54:27] HUSEIN: And that's going to be a wrap for this week's episode of Lawyered. Thanks for listening. On today's episode, our guest was Jess Szabo. You can learn more about her and her practice at her firm's website, which is www.mcintyre-szabo.com. And for more about today's show and for links to all the cases that we spoke about on today's episode, including all the bills and statutes, you can find those on our website, which is www.lawyeredpodcast.com.

[54:54] On our next episode, we're going to be speaking about the area of cryptocurrency. And we've got a bunch of fascinating topics to speak about. We're going to chat about injunctions as a tool to freeze crypto assets. There's going to be some new requirements for crypto trading platforms, as well as a potential new defense called Code is Law. And you'll learn more on the episode. We're going to be talking about this theory, which essentially says that a program code constitutes the law and that exploited vulnerabilities in the code is considered lawful. A lot of movement in this space, there's going to be a very common discussion—all the segments are. And I hope you'll check it out.

[55:33] This podcast is largely supported by community contributions. So if you want to help to improve this show and get some neat and affordable legal awards, including the opportunity to submit questions on our show and our reactions to upcoming episodes, the very best thing that you could do would be to become a Patreon of our show.

[55:52] You can learn more about how to do that on our crowdfunding website, which is www.lawyeredpodcast.com/patron. I want to give a thank you to a number of our patrons, including Rebecca Finley- Schidlowsky, Riyaz and Batul, Saad Baig and Sajjad & Farhana Kassamali. Thanks so much for supporting the show and keeping the movement going.

[56:15] And if you haven't done so already, you can subscribe to our podcast for free on iTunes or anywhere else can get podcasts. You can also follow the show on LinkedIn or Twitter or Facebook. And the handle is Lawyered Podcast.

[56:**24]** Solomon Krause-Imlach helps with our sound editing work, Ben Swirsky provided our theme music, and Steve DeMelo helps to maintain our website. And finally, please be advised about the show, it's going to be helpful and informative that it is not legal advice. However, if you do want legal advice, please reach out to a lawyer directly to help you with your particular situation. And with that, we'll see you here in two weeks. Until then, keep it legal.