Risk Management in Canadian Health Care

Editors-in-Chief: Mary Jane Dykeman and Kate Dewhirst

VOLUME 12, NUMBER 6 | Cited as 12 R.M.C.H.C. | DECEMBER 2010

• MEDICAL MALPRACTICE — THE BASICS THAT EVERY HEALTHCARE PRACTITIONER SHOULD UNDERSTAND •

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I had never before experienced a more captive audience than when I spoke to a group of emergency room physicians and nurses about medical malpractice at a drug company sponsored dinner a few years ago.

As the waiters cleared away the plates, I quickly settled into my presentation. However, before I could get through the first three minutes of a case study, I was bombarded with questions by the audience which both surprised and saddened me at the same time.

I was surprised by the fact that these doctors and nurses had little concept of what the legal requirements are to prove medical malpractice in court and somewhat saddened by my impression from their questions of the high level of fear they had of being sued and consequently their tendency to practice defensive medicine.

It occurred to me that if practitioners had a better idea of what was truly involved in legally proving medical malpractice, their concerns and this defensive tendency would lessen which, I imagine, is clearly better for medical practitioners, patients and the medical system as a whole.

Medical malpractice lawsuits are amongst the most complicated, strongly defended injury-related lawsuits. In order to be successful in medical malpractice claim a patient/plaintiff must prove the following three core elements: a) a breach of the standard of care by a medical practitioner; b) that the breach was the cause of injury or damage to the patient; and c) the value of the injuries or damages sustained.

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BREACH OF THE STANDARD OF CARE

Many doctors and nurses and other health care practitioners are under the false impression that in a medical malpractice lawsuit their actions and decisions

RISK MANAGEMENT IN CANADIAN HEALTH CARE

Risk Management in Canadian Health Care is published bi-monthly by LexisNexis Canada Inc., 123 Commerce Valley Drive East, Suite 700, Markham, Ontario L3T 7W8

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ISBN: 0 433-41589-4 **ISSN: 1488-0555**
ISBN: 0-433-44398-7 (Print & PDF)
ISBN: 0-433-44707-9 (PDF)

Subscription rates: $200 plus GST per year (Print or PDF)
$300 plus GST per year (Print & PDF)

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are scrutinized by a judge or six lay people on a jury who have no idea what the demands and pressures of their daily responsibilities are like. While it is true that the ultimate decision of whether a health care practitioner is negligent or not rests with a judge or jury, they are first informed and guided by the testimony of an expert or experts who advise the judge or jury on what the standard of care is under the circumstances and whether, in his or her opinion, the health care practitioner(s) in question breached that standard in the treatment of the patient/plaintiff.

In order to qualify as an expert, the health care practitioner testifying must not only have the same training, education and qualifications as the practitioner on trial but, most importantly, must have a comparable practice and face the same daily pressures and demands. (*i.e.* an orthopaedic surgeon who doesn't do arthroscopic procedures cannot testify against an orthopaedic surgeon in a trial about a nerve injury taking place during an arthroscopic procedure) In other words, if a court finds a practitioner to have committed malpractice it is because as least one peer has testified, under oath, that in his or her opinion, malpractice had indeed occurred.

WHAT STANDARD ARE YOU MEASURED AGAINST?

Although I'm sure all practitioners strive to provide their patients with the gold standard of treatment, doctors, nurses and other health care practitioners are not held to a "gold" standard of care. Rather, the legal test is whether they provide treatment that was within the standard of a reasonably competent practitioner facing the same circumstances. In other words, the patient/plaintiff must prove that the practitioner treated him or her in a manner below that expected of even your average practitioner.

20/20 HINDSIGHT IS AVOIDED AT ALL COSTS

Often injuries suffered during surgery or as a result of other events in hospital can be catastrophic and there is a great deal of sympathy for the patient/plaintiff as their lives are forever changed. It is human nature to look back after an untoward event and piece together what happened, what went wrong, what was missed and what could have been done differently.

However, the legal system strives to take hindsight out of the equation and requires experts to put themselves in the time and place of the events in

question and analyze the actions of the practitioner from that perspective.

CAUSATION

Proving a health care practitioner's treatment fell below the standard of care is only half the battle. A patient/plaintiff must draw a clear link, usually by way of more expert evidence, between the negligence and the injury sustained. While in many cases, causation may be clear, it is still the plaintiff's burden to prove that the practitioner's negligence was, more likely than not, the cause of the injury.

From recent cases I have handled, I can point out the following examples where causation as opposed to negligence was the main issue in dispute.

1) Were the plaintiff's neurological complaints of loss of bladder and sexual function a result of an injury during a spinal anaesthetic or due to his long-standing and progressive diabetes?

2) Were the plaintiff's symptoms of incontinence following a hysterectomy due to the fact that both of her ureters were transected by the surgeon or due to menopause and known complications post surgery?

3) Would the plaintiff's compartment syndrome in her fractured leg have had a significantly better outcome if diagnosed 24 hours earlier, or was the damage done by then?

4) How long would the plaintiff's transplanted kidney have lasted if she weren't mistakenly taken off her anti-rejection medication by her doctor for four months?

DAMAGES

While assessing the value of injuries and damages is really the end point in a medical malpractice case, in reality, it is the starting point. Doctors, nurses, other health care practitioners and hospitals are so vigorously defended (and rightly so) and the costs associated with prosecuting these cases are so high that no scrupulous lawyer would take on a case where the damages sustained are not significant. My rule of thumb is that outside of cases involving clear-cut negligence, I only take on medical malpractice cases when the injured patient is either no longer able to work and/or requires a significant level of day-to-day care.

CONCLUSION

It is true that any patient can file a lawsuit against a doctor, nurse or other practitioner and that alone triggers a series on unpleasant events for the practitioner involved. However, only a relative few cases can overcome the challenges of proving a breach of the standard of care and causation and have significant enough damages to justify the time, expense and mental energy that are required by the lawyer, the patient and his or her family.

There is nothing a doctor, nurse or other health care practitioner can do to avoid a lawsuit when there are serious life altering injuries sustained and there are legitimate questions as to the care provided. However, when procedures don't go as planned or other untoward events take place in hospital, I believe that open and honest communication with a patient and his or her family goes a long way to maintain confidence and trust in the medical system and dissuade unhappy patients from pursuing the matter further. When communication breaks down and a patient feels ignored and/or neglected, I do believe they are more motivated to pursue the matter legally.

The pressures facing health care practitioners are unlike those facing any other professional. They have the power of health, illness, life and death in their hands on a daily basis and confidence is key in carrying out their responsibilities. Practitioners should know that the legal system acknowledges these pressures and it is understood that just because an untoward event takes place does not mean there is anyone to blame. That is why such a small percentage of medical malpractice lawsuits are actually successful. If a practitioner is careful and conscientious and is reasonable in exercising their clinical judgment, there is no need to practice defensively.

[*Editors' Note*: Howard Blitstein is a partner at Howie, Sacks & Henry LLP. Howard was admitted to the Law Society of Upper Canada in 2002. He graduated from the University of Western Ontario with his Honours B.A. in 1998 and from the University of Western Ontario's Faculty of Law with his LL.B in 2001. He is a member of the Ontario Bar Association, Toronto Lawyers Association and the Ontario Trial Lawyers Association. Approximately one-third of Howard's practice is devoted to medical and hospital negligence lawsuits.]

• ONTARIO HEALTH PRIVACY UPDATE: IPC/O ORDERS 8 AND 9 •

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The Information and Privacy Commissioner of Ontario ("IPC/O") has issued nine orders under the *Personal Health Information Protection Act, 2004*, S.O. 2004, c. 3, Schedule A [*PHIPA*]. This article reviews the two most recent orders — orders 8 and 9 — from June 2010 and October 2010, respectively. The former involves issues of information security, while the latter involves the fees organizations charge to access personal health information.

ORDER 8: HOSPITAL BREACHES *PHIPA* OBLIGATIONS REGARDING SECURITY (JUNE 2010)[1]

THE FACTS

In May 2010 a nurse employed at a large Toronto hospital took her work-issued laptop home for the weekend. When she completed her work, she put the laptop on the front seat of her car. On Monday morning she noticed that the laptop was missing. She reported the theft to her hospital's security and information management ("IM") departments, her clinical director and the risk management/privacy office. The hospital was able to confirm two key things: (1) the laptop was not encrypted; and (2) the information contained on the laptop consisted of about 20,000 patient records.

IPC/O'S FINDINGS

The IPC/O reviewed a number of the hospital's policies and found that it did not have adequate practices in place. For example, it did not have a policy or practice requiring the IM Department to monitor or respond to error messages related to faulty encryption. Even though there was an encryption process for new laptops, it was not followed through to ensure all laptops were successfully encrypted. As well, the IPC/O found that the nurse and persons in the IM Department did not comply with the practices that were in place.

The IPC/O found that the hospital failed in its obligations under *PHIPA* to ensure that records of personal health information ("PHI") were retained and transferred in a secure manner. Similarly, the IPC/O determined that the hospital did not take reasonable steps to ensure that PHI was secured against theft, loss and unauthorized use or disclosure. However, the hospital did comply with its obligation to notify patients at the first reasonable opportunity about the breach.

Finally, while the hospital had taken many steps to ensure that all of its agents were appropriately informed of their duties under *PHIPA*, the IPC/O found those steps to be inadequate in the face of the breach.

RISK MANAGEMENT LESSONS FROM ORDER 8

No mobile device (laptop, USB stick, portable disk, etc.) should be issued by a health information custodian unless it is encrypted, and if an error occurs, it should be immediately investigated and corrected. Every hospital's IM Department (or similar body) should be required, via policy, to monitor and respond to error messages related to faulty encryption. If encryption is not possible, information *must* be de-identified before it is taken off site.

Hospitals should introduce policies or processes to review records on old devices and delete unnecessary records. When information is transferred onto a new device, care should be taken that "only information required for performance of their duties is retained and placed on the new device."[2] The IPC/O requires IM departments to provide guidelines about privacy and the importance of deleting old information to staff when a new mobile device is distributed.

Hospitals have an obligation under *PHIPA* to ensure that their agents are appropriately informed of their duties.[3] Agents must securely store mobile devices containing PHI and ensure that such devices are in their custody and control at all times. They should not unnecessarily remove records of PHI from hospital premises. The IPC/O recommends that hospitals provide job-specific privacy and security training that is comprehensive and ongoing.

All of these practices can be included in one comprehensive mobile device policy. In fact, the IPC/O specifically recommends health information custodians ("HICs") to create a "stand-alone" corporate policy to address the expectations and requirements of all staff with respect to privacy and mobile devices.

ORDER 9: PHYSICIAN BREACHES *PHIPA* OBLIGATIONS REGARDING FEES FOR ACCESS (OCTOBER 2010)[4]

THE FACTS

A patient requested 34 pages of psychological therapy notes from her physician, who determined that a fee of $125.00 was an appropriate charge for providing access to the records. HICs are allowed to charge a fee for access, but the fee "shall not exceed the prescribed amount or the amount of reasonable cost recovery, if no amount is prescribed."[5] There is no prescribed amount in *PHIPA* or elsewhere, and therefore the physician was entitled to use his discretion in deciding upon a reasonable charge.

The physician based his calculation on Ontario Medical Association's ("OMA") *Physician's Guide to Third Party and Other Uninsured Services* ("the Guide") and the fact that the charge is consistent with the "Medical Records" policy of the College of Physicians and Surgeons of Ontario ("CPSO").

The Complainant pointed to the Ministry of Health and Long-Term Care's proposed fee regulations[6] and stated she ought to be charged only $30.00. She also requested a fee waiver on the basis of financial hardship, citing the discretionary provision allowing a HIC to waive the fee if it is equitable and fair to do so.[7]

The physician replied that he had spent approximately 50 hours dealing with the request and that the fee of $125.00 takes into account the requester's financial hardship.

IPC/O'S FINDINGS

In the analysis of what constitutes "reasonable cost recovery," the IPC/O took into account not only the representations of the parties, but also comments from the Ontario Hospital Association and the OMA, statutory interpretation, case law, previous orders under *Freedom of Information and Protection of Privacy Act*, R.S.O. 1990, c. F.31 [*FIPPA*], and *Municipal Freedom of Information and Protection of Privacy Act*, R.S.O. 1990, c. M.56 [*MFIPPA*], the proposed regulations, and extra-provincial privacy legislation.

The IPC/O agreed with the Complainant that the proposed regulation is the preferred interpretation of "reasonable cost recovery." The IPC/O concluded that the fee charged by the physician was not in compliance with *PHIPA* and ordered that a fee of $33.50 qualified as "reasonable cost recovery." However, the IPC/O agreed with the physician that the complainant was not entitled to a waiver of the fee.

RISK MANAGEMENT LESSONS FROM ORDER 9

HICs that want to charge a fee for access to records should consider the proposed fee regulations in determining what constitutes "reasonable cost recovery."[8] Although these amounts may be lower than what the HIC deems reasonable, in the long-run it may actually be more cost-effective to charge less for access to records and avoid a complaint.

HICs should be aware that their ability to determine a charge for access to records may soon come to an end. On September 16, 2010, MPP David Caplan moved the first reading of Bill 104, *An Act to amend the Personal Health Information Protection Act, 2004*, respecting access to personal health information, security of personal health information and informed consent.[9] Section 35 of the Bill proposes that HICs should not charge for the use, collection or disclosure of personal health information.

Finally, HICs will want to ensure that their staff continue to take great care in reviewing records and severing information where required (*e.g.* severing information subject to legal privilege). There may be decreased motivation to spend adequate time reviewing records if the fees HICs can charge are significantly reduced or removed altogether, but obligations under *PHIPA* must be fulfilled regardless of the fees.

[*Editors' Note*: Lisa Feldstein is an Articling Student with Dykeman Dewhirst O'Brien LLP, a boutique health law firm in Toronto. Lisa's interests include intellectual property, mental health and addiction issues and privacy law.]

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1 Information and Privacy Commission, *PHIPA Order HO-008* (Toronto, 2010), online: IPC/O <http://www.ipc.on.ca/images/Findings/ho-008_1.pdf>.

2 *Ibid.* at p. 16. The IPC recommends using the issuing of a new device as an opportunity to delete unnecessary records.

3 *PHIPA, 2004,* s. 15(3)(b).

4 Information and Privacy Commission, *PHIPA Order HO-009* (Toronto, 2010), online: IPC/O <http://www.ipc.on.ca/images/Findings/ho-009_1.pdf>.

5 *Supra* note 3 at s. 54(11). No amount is prescribed as of October 22, 2010.

[6] Several years ago the Minister of Health and Long-term Care published in the Ontario Gazette a notice of proposed regulation suggesting a maximum charge of $30.00, followed by a table of some costs that would be permitted for other activities related to providing access to documents (*e.g.* making and providing a copy of an audio cassette). As of October 15, 2010, neither these nor any other regulations have been added to *PHIPA*.

[7] *Supra* note 3 at s. 54(12).

[8] "*Proposed Regulation under the Personal Health Information Protection Act, 2004*", O. Gaz. 2006. 378, online: Government of Ontario <http://www.ontario.ca/ontprodconsume/groups/content/@onca/@so/@gazette/documents/infobundlecontent/stel02_039412.pdf>.

[9] Bill 104, *An Act to Amend the Personal Health Information Protection Act, 2004 respecting access to personal health information, security of personal health information and informed consent,* 2nd Sess., 39th Leg., Ontario, 2010 (first reading 16 September 2010), online: Legislative Assembly of Ontario <http://www.ontla.on.ca/web/bills/bills_detail.do?locale=en&BillID=2399&detailPage=bills_detail_the_bill&Intranet=>.

• EMPLOYMENT AND HUMAN RESOURCES IN SMALL HEALTH CARE SETTINGS •

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INTRODUCTION

Dental, ophthalmology, and fertility clinics are just a few of the numerous health care clinics that encounter difficult human resources and employment issues on a daily basis. These are some of the same problems faced by larger health sector organizations, including public hospitals. However, smaller health care clinics often don't have the resources or expertise to deal with these complex matters. Office managers, with little to no human resources or legal training, end up spending inordinate amounts of time trying to find answers to questions that need to be addressed immediately.

One of the most important steps a health care clinic (or any organization) can take to keep disputes with its employees out of court, thereby avoiding signification legal costs, is to have in place a well-drafted employment contract that sets out the terms and conditions of employment. Especially important are the provisions that will apply upon termination of employment.

This article provides these clinics (and all health care providers, large or small) with a succinct list of the top ten tips to help protect your organization's interests when drafting employment contracts:

TOP 10 TIPS:

1. **Importance of Sufficient Consideration:** Do not enter into an employment contract (especially one with a termination clause) with an employee who does not currently have one, unless you provide sufficient consideration, such as a one-time payment, salary increase, longer vacation time or other benefit, in exchange. The promotion of an employee, who does not have a written employment contract, could be an opportunity to enter into one. The promotion, itself, if meaningful and significant, may be sufficient consideration to make the contract enforceable.

2. **Policies and Procedures:** Include a provision which incorporates your organization's policies and procedures in to the employment contract and ensure that the employee receives copies or reviews them before signing the contract. If you have an interest in restricting an ex-employee's efforts to compete or to solicit your customers or employees post termination, your contract should contain non-competition and non-solicitation clauses. These clauses are often difficult to enforce, but a properly drafted and reasonably restrictive clause may provide your organization with the opportunity to reduce or restrict competition and solicitation post termination.

3. **Termination of Fixed-Term Contracts:** Make sure you clarify the notice required to terminate a fixed-term contract (contract for a specific period, such as one year). Failure to specify the required notice could result in your organization's liability for all payments under the original term of the contract.

4. **Termination of Indefinite Term Contracts:** Specify the amount of notice (or pay in lieu of notice, often referred to as termination pay) your organization will be required to provide to an employee when terminating an indefinite term contract (a contract that does not provide for an end date). A properly drafted employment contract can provide for less than common law notice (which is the amount of termination notice determined by a judge in a wrongful dismissal lawsuit based on a number of factors, such as age and length of service). However, it cannot provide for less than the minimum termination notice set out in the applicable provincial employment standards legislation ("Employment Standards Minimum Notice"). A properly drafted termination clause can save an organization tens of thousands of dollars in termination pay and legal costs.

5. **Importance of Limiting Benefits:** If you provide for more than the Employment Standards Minimum Notice, make sure you create a caveat for benefits and limit them to the Employment Standards Minimum Notice. Legally, "notice" requires that all terms and conditions of the employee's compensation plan, including health-care benefits, continue during the specified notice period. Many organizations unwittingly expose themselves to a potentially huge liability by providing notice well in excess of the Employment Standards Minimum Notice, only to discover their insurance companies won't extend the benefits beyond the Employment Standards Minimum Notice. If a terminated employee were to become disabled during the contractually extended notice period and the insurance company refused to cover the long-term disability benefits, your organization could find itself liable for those benefits. Such liability could extend to monthly payments until the now disabled, former employee turns 65.

6. **Alignment with Your Insurer:** Make sure your insurer will continue all benefits, including long-term disability benefits, during the Employment Standards Minimum Notice. All benefits should continue even when the employee stops work immediately and receives pay in lieu of notice. Take the necessary steps to ensure your insurance companies will do this. Employers are legally obligated to continue all benefits during the Employment Standards Minimum Notice, and insurance companies should work with their clients to be statutorily compliant.

7. **Advantage of Payment in Lieu of Extra Notice:** If your employment contract provides an employee with more than the Employment Standards Minimum Notice, consider giving the excess as base salary instead of extra notice. As stated above, "notice" usually implies a continuation of all elements of the compensation plan, including benefits and bonus.

8. **Implications of Changes to Constructive Dismissal:** Recent changes to the law of constructive dismissal have resulted in employers no longer being able to unilaterally alter terms and conditions of employment after providing an employee with appropriate notice. A possible method of overriding these changes is to include a clause that allows the employer to alter the terms and conditions of employment after providing the employee with at least Employment Standards Minimum Notice.

9. **Create Enforceable Contracts:** Maximize the enforceability of a contract throughout the term of employment by including a stipulation that it will apply regardless of any changes to the terms and conditions of employment (such as a promotion), unless it is modified in writing. For added measure, clarify in writing prior to a specific substantial change in employment, such as a promotion, that the employment contract continues to apply subject to the specific written employment changes resulting from the promotion (such as salary, reporting relationship, etc.).

10. **Proper Execution of Contracts:** Provide prospective employees with sufficient time to review the employment contract before being required to return a signed copy. We recommend at least five (5) business days if possible. In addition, always require your new employees to provide you with a signed copy of the employment contract at least one day prior to their first day of work. Avoid having new employees sign the contract during their first work day; this could negatively affect the enforceability of the contract.

PRESCRIPTIONS FOR EMPLOYERS

1. No matter how many employees your organization has, you should have a standard employment contract which all new employees are required to sign and which provides for the amount of notice an employee is entitled to upon termination of employment.
2. Review your standard employment contract to ensure it contains all the relevant provisions to protect your organization's interests.
3. Ensure that all personnel involved in the process of hiring employees are trained to do the following:
   - Provide new employees with sufficient time to review the employment contract prior to execution.
   - Require a signed copy of the contract prior to the first day of work.
4. Contact your insurance provider to ensure that it will continue all benefits during the Employment Standards Minimum Notice regardless of whether the employee works during the notice period.
5. Make a list of employees without an employment contract and look for opportunities to introduce one (such as when there is a significant change to the terms and conditions of employment).

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Is your organization involved in a risk management strategy you would like to share with our readers?

Do you have any suggestions for topics you would like to see featured in future issues of *Risk Management in Canadian Health Care*?

If so, please contact

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