

Health Matters

HEALTH LAW SECTION / SECTION DU DROIT DE LA SANTÉ

Mandatory Revocation of Physician Licence Upheld in Sexual Abuse Case

Mary Jane Dykeman*

Background

On May 20, 2003, Ontario's Superior Court of Justice released its much-anticipated decision in the case of Dr. Anil Mussani.¹ In September 2000, a panel of the Discipline Committee of the College of Physicians and Surgeons of Ontario (CPSO) found Dr. Mussani guilty of professional misconduct for the sexual abuse of his patient, A.K. Dr. Mussani did not challenge the finding of professional misconduct, but contested the penalty imposed: the mandatory revocation of his certificate of registration (in effect, his licence to practice medicine).

The *Health Professions Procedural Code* (Code), Schedule 2 to the *Regulated Health Professions Act, 1991 (RHPA)*² requires a reprimand and revocation of a member's certificate of registration if the sexual abuse consisted of, or included, one of five specific sexual activities, including intercourse.³ Subsection 72(3)(a) of the Code precludes a member who has been found to have sexually abused a patient from applying to the Registrar to have a new certificate issued until five years have passed.

Dr. Mussani acted as primary physician to his patient, A.K., over a ten-year period between 1985 and 1994, during which time he saw her on approximately 170 occasions. A.K. was herself a physiotherapist, governed by the *RHPA*. She was also Dr. Mussani's employee, and he was referred to her clinic for physiotherapy and became her patient. Their sexual relationship started in 1992, at which point each was married and their families socialized and traveled together. When A.K. became pregnant, Dr. Mussani referred her to an obstetrician/gynecologist for an abortion. Shortly thereafter, A.K. terminated her sexual relationship with Dr. Mussani. Dr. Mussani was also convicted of sexually abusing another female patient, arising out of an incident in June of 1994, at the same time he was engaged in a sexual relationship with A.K.

The panel of the Discipline Committee ultimately concluded that:

- Dr. Mussani breached the fiduciary relationship with his patient A.K. by entering into a sexual relationship with her;
- A power imbalance existed between the two; and
- A breach of trust occurred.

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The Attorney General of Ontario and the Ontario Medical Association (OMA) sought and were granted intervenor status in the case.

Superior Court of Justice

As a preliminary matter, the Attorney General argued that the constitutional challenge of certain provisions of the *RHPA* should not proceed, on the basis that the Discipline Committee would have revoked Dr. Mussani's certificate regardless of the mandatory revocation provisions. The Court deemed the argument irrelevant, stating:

The Discipline Committee was required to apply these provisions. Therefore, this court must resolve the issues of whether the Mandatory Revocation Provisions violate the appellant's *Charter* rights.⁴

As a second matter, the Attorney General also argued that the OMA should be precluded from expanding the scope of the inquiry to include consideration of the constitutionality of additional provisions of the Code, specifically s. 1(3) and 1.1 of the Code. The Court permitted these additions, in part on the basis that subsection 1(3) defines "sexual abuse", and section 1.1 sets out the purpose of the sexual abuse provisions:

1.1 The purpose of the provisions of this *Code* with respect to sexual abuse of patients by members is to encourage the reporting of such abuse, to provide funding for therapy and counselling for patients who have been sexually abused by members and, ultimately, to eradicate the sexual abuse of patients by members.

The Court also reviewed the legislative history of the sexual abuse provisions, relying on the work of Marilou McPhedran, Chair of the Final Report of the Task Force on the Sexual Abuse of Patients, commissioned by the CPSO and released in November 1991.

Canadian Charter of Rights and Freedoms

Section 7

Much of the argument in the Mussani case centred around s. 7 of the *Charter*:

Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

Then J., writing for the Court, held that the s. 7 liberty interest could apply outside a criminal context. However, he distinguished the Mussani case from others (including a Prince Edward Island case where mandatory revocation provisions were challenged by a physician who had entered into a sexual relationship with a former patient).⁵ Then J.'s comments focus primarily on the issue of consent:

[I]t is difficult to discern a valid "liberty" interest in sexual relations between physician and patient, even if consensual, given the concern over the power imbalance, the "inherently suspect" nature of any "consent", the exploitive nature of the relationship, and in circumstances where the cultural values of our society have held for centuries the belief that sexual contact between physician and patient is fundamentally improper.⁶

He also rejected the notion that s. 7 protects a physician's constitutional right to practise his or her profession, a position that was supported by the OMA. The OMA also argued that the mandatory revocation provisions constitute ". . . a profound interference by the state with an individual interest of fundamental importance, resulting in harm to the psychological integrity of the physician sufficient to trigger the protection of s. 7 of the *Charter*." Then J. dismissed the argument that ". . . the combination of stigmatization, loss of privacy and disruption to the physician's personal and emotional life restricts the security of the person contrary to s. 7". He held that, if in fact the liberty or security interests were found to be impugned, this was done in accordance with the principles of fundamental justice.

Some of the more compelling parts of the Mussani decision hinged on the physician's choice in continuing to pursue a relationship with a patient:

The prohibition on having intimate relations extends only to those who are currently patients. In this respect, should a doctor wish to have such a relationship, all that is required is for a doctor to stop treating the patient. [para. 118]

...

Moreover, mandatory revocation of a certificate of registration would only affect those doctors who failed to exercise their judgment by discontinuing the treatment of patients with whom they were contemplating having an intimate relationship. Ultimately, the removal of an offending doctor from the practice of medicine will serve to protect the public. Such strong action should also send a message that a doctor-patient relationship is not allowed and will be sanctioned severely. [para. 12]

Section 12

Two additional *Charter* arguments were made, on the basis of section 12 and subsection 2(d). Section 12 states that "[E]veryone has the right not to be subject to any cruel and unusual treatment or punishment." Then J. found that the appellant had not discharged the burden of satisfying the Court that the mandatory revocation provisions breached a constitutionally protected right:

A licence is not a right, but a privilege, and in my view *Charter* rights are not engaged in the regulatory disciplinary process by which a health professional seeks to retain the privilege of a certificate of registration in order to practice a particular profession. [para. 142]

He went on to say that, even if section 12 did apply, it would not constitute cruel or unusual treatment and punishment.

Subsection 2(d)

With respect to subsection 2(d) of the *Charter*, which guarantees as a fundamental freedom the freedom of association, the Court also rejected this, stating that "... there is no Canadian jurisprudence which has held that the guarantee of freedom of association extends to the right to have intimate personal relationships".⁷ In fact, the mandatory

revocation provisions did not prohibit Dr. Mussani from having a relationship with A.K.:

[Dr. Mussani] simply was required to decide which relationship he wished to have with her, sexual or professional. This was not a difficult choice. Instead, he knowingly undertook the risk of having both relationships.

At the time of writing, a decision on the appellant's leave to appeal to the Ontario Court of Appeal had not been reported.

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¹ Court File 629/00 (Sup. Ct. Jus.). Available on-line from the Canadian Legal Information Institute (last accessed September 3, 2003): <http://www.canlii.org/on/cas/onscdc/2003/2003/onscdc10645.html>. Also reported at: [2003] O.J.No. 1956; (2003) D.L.R. (4th) 511; (2003) O.A.C. 1.

² S.O. 1991, c. 18 (*RHPA*).

³ Code, s. 51(5).

⁴ *Supra*, note 1 at para. 40.

⁵ Then J. noted at para. 53 that "... in *A.B. v. College of Physicians and Surgeons of Prince Edward Island*, [2001] P.E.I.J. No. 89 (QL), the Trial Division of the Supreme Court of Prince Edward Island found that section 38.1 of the *Medical Act*, S.P.E.I. 1988, c. M-5 violated a doctor's s.7 liberty guarantees. In this respect, the Mandatory Revocation Provisions (ss. 38.1 - 38.4) of the *Medical Act*, which were triggered by findings of sexual abuse of a patient, were held to be an interference with an inherently personal decision of A.B. to enter into a personal relationship with a former patient". (my emphasis)

⁶ *Supra*, note 1 at para. 63.

⁷ *Ibid.*, at para. 168.

Use of Restrictive Covenants in Association Agreements

Lonny J. Rosen*

The following is a summary of the presentation given by Lonny Rosen at the June 2, 2003 Health Law Section Program "A Health Law Potpourri".

The use of restrictive covenants in association agreements has become standard for health professionals wishing to bring colleagues into their practices while ensuring that their patient base remains their own. The ability to develop and sell one's health practice is predicated on the corresponding ability to protect the practice's most important assets, its patients. The two most common forms of protection are non-competition clauses and non-solicitation clauses. Typically, the proper inclusion of these clauses in agreements at the outset of the relationship governs whether, and the extent to which, the former colleagues can compete for patients of the practice after the termination of their association.

A non-competition clause can be used to prevent a departing associate from competing against his or her former principals or associates by restricting the departing associate's right to compete in a certain geographical or practice area. Such restrictions are most often found in the form of limiting competition for new patients to a specified geographical area, business area, product field or client base and for a specific period of time. Generally, the limitations included in association agreements are dependent on the practice involved (i.e. general practices are typically less restricted than specialist or referral-based practices) and the relationship between the former associates.

A non-solicitation clause is much narrower in scope than a non-competition clause. It is designed to prevent departing associates from soliciting their former practice's client base. In this context, solicitation is restricted to the active and focussed attempt to seek out and offer professional services to patients of the former associate or principal. Such a clause in no manner restricts the departing associate from advertising or utilizing goodwill to compete with his former colleague or from accepting as patients individuals who were patients of his former principal or colleague.

As in any area of the law where personal freedoms are constricted, there are important public policy considerations at play in the development of the law respecting use of restrictive covenants. The Ontario Court of Appeal, in *Lyons v. Multan*,¹ recognized such considerations and folded them into the existing law by developing three factors for use when evaluating restrictive covenants.

The first factor is whether the party enforcing the covenant has a proprietary interest that is entitled to protection. The most common protected interests are client lists (but not potential clients) and referring professionals (those who make regular referrals). If something of value (a proprietary interest) is found to exist, the court will then proceed to evaluate how it was protected during the term of the association, and how it could reasonably be protected following termination of the association.

The second factor is whether the restrictive covenant's temporal and spatial features are appropriate. There are no specific standards or scales to measure the appropriateness of these features, but there are some general guidelines, for example:

- a monopoly will not be enforced;
- a specialist will have fewer restrictions than a general practitioner;
- the restricted area must not surpass the geographical area that the practice draws from; and
- the scope of the restrictions must be proportionate to the size of the community.

If the temporal and spatial components are reasonable, the court will then look to the form of the restrictive covenant.

The third factor is whether the covenant is against competition generally or is limited to the solicitation of former clients. In an associate agreement, a

non-competition clause will generally not be enforced if a non-solicitation clause would have adequately protected the recognized interests. This principle is a direct reflection of the court's desire to balance one's freedom to pursue a livelihood and the societal benefit of competition, with the recognized right of individuals to contract freely with each other. This attempt at balancing has created the need for "exceptional circumstances" to be present in order for a non-competition clause to be upheld.

Whether "exceptional circumstances" exist can be determined by assessing such factors as:

- whether there was equality in bargaining power;
- whether there was confidential information in need of protection;
- whether the parties concerned appreciated the nature of the restrictive covenant; and
- whether the departing associate exhibited considerable influence over his or her former clients.

Once again, there is no defined list of circumstances that will compel the court to uphold a non-competition clause. Simply put, in the context of health professionals' association agreements, the circumstances must be sufficiently substantial to override the public's right to accessible health services and the societal benefit from competition.

Lyons v. Multari involved the classic case of a senior health professional bringing a junior colleague into the practice to service the principal's patients while gaining experience himself. The Court assessed whether one oral surgeon was precluded from competing with his former principal not only for new patients but for referrals from general dentists in the Windsor area, when he had signed an association agreement covenanting not to do so. The non-compete agreement was determined to be overly broad, since the Court held that a non-solicitation clause would have adequately protected the practice and patient base of the principal. Interestingly, the Court did not "read down" the clause to one that would be upheld, but simply allowed the departing associate to continue seeking referrals from dentists in the community.

While the Court of Appeal refused to uphold the non-compete clause at issue in *Lyons v. Multari*, a couple of recent decisions by Ontario courts articulate the subjective nature of the courts' evaluation of restrictive covenants. In *Button v. Jones*,² a dentist sold his practice to another dentist and became an associate of the practice. The Ontario Superior Court found that a non-competition clause in the association agreement was valid because there was equality in the bargaining power and the relationship was one of a mutual association, rather than of a hierarchical employment.

Similarly, in *Roy v. Moss*,³ a case that involved a physiotherapist who sold her practice to her associate, the non-competition clause contained in the association agreement was upheld. The Ontario Superior Court recognized the equality in the association relationship and determined that the purchase price of the practice was mostly for goodwill. When a departing associate is compensated explicitly for the goodwill built up in their former practice, it would be extremely unfair to allow the former associate to devalue that asset by competing with the purchaser.

These cases demonstrate that, even though the court will not generally uphold a non-competition clause where a non-solicitation clause would suffice, there are a variety of exceptional circumstances that make restrictions on competition appropriate. Lawyers must be extremely careful when drafting these clauses. A court will not read down a restrictive covenant that attempts to overreach what is necessary and fair. The terms of these covenants will either be accepted or rejected on the basis of their plain language.

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¹ *Lyons v. Multari* (2000), 50 O.R. (3d) 526 (C.A.).

² *Button v. Jones* (2001), 11 C.C.E.L. (3d) 312 (Ont. S.C.J.).

³ *Roy v. Moss* (2002), 30 B.L.R. (3d) 76, [2002] O.T.C. 466 (Ont. S.C.J.).

Ontario Follows Lead of British Columbia Decision on Autism

*Julia E. Schatz & Jessica Rufrano**

The Superior Court of Justice has taken an important first step to follow the British Columbia Court of Appeal decision in *Auton v. British Columbia*¹ (“*Auton*”). The *Auton* case held that the failure by the Crown to fund behavioural therapies for autistic children constituted an unjustifiable infringement of the equality rights of the children.

On April 11, 2003, Mr. Justice Gans in *Lowrey (Litigation Guardian of) v. Ontario*² (“*Lowrey*”) issued an order granting a mandatory interlocutory injunction requiring the Ministry of Community, Family and Children’s Services to continue funding the Intensive Behavioural Intervention treatment for the complainant’s son. Andrew Lowrey was diagnosed with autism at the age of four and, as a result, was enrolled in the Intensive Behavioural Intervention treatment. When Andrew turned six, the Ministry stopped funding this program. The Lowreys challenged the age eligibility as a violation of their son’s sections 7 and 15 *Charter* rights.

The Lowreys argued that Andrew had made progress and was now entering a critical phase of the program. This phase is aimed at integrating Andrew into a “regular” school curriculum, without which he would undoubtedly regress and lose any chance of maintaining the skill sets he had learned and mastered over the last year and a half.

The Attorney General argued, on behalf of the Ministry, that the age requirements established for the program were not arbitrarily set and were based on scientific and clinical research. Further, the Attorney General argued that the public would suffer harm if the injunction were granted since it would tax an already beleaguered program and result in an increase in the waiting list.

Mr. Justice Gans ordered the Ministry to continue providing the funding to Andrew until the issues

are dealt with in a 15-week trial involving an anticipated 35 plaintiffs. Mr. Justice Gans found that cutting off the funding at this time would close the “window of opportunity” for Andrew to develop and learn.

On May 15, 2003, the British Columbia Crown was granted leave to appeal the *Auton* decision to the Supreme Court of Canada. This decision will be closely monitored and will impact autistic children across Canada.

Along with the court actions that have been commenced as a result of the age eligibility requirement imposed by the Ministry, there have been a number of human rights complaints filed with the Ontario Human Rights Commission. These complaints are currently in the investigation stage.

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¹ [2002] B.C.C.A. 538.

² (2003), 64 O.R. (3d) 222.

NEW: Natural Health Products Regulations – What You Should Know

Megan Evans*

On June 18, 2003 the federal government released the final version of the *Natural Health Products Regulations* (the “*Regulations*”) that will come into effect on January 1, 2004.¹ When these *Regulations* come into force, natural health products in Canada will be subject to a separate regulatory scheme under the *Food and Drugs Act*, as a subset of drugs.

The *Regulations* will apply to all natural health products, including, for example, vitamins, minerals, herbal remedies and homeopathic preparations.

The *Regulations* address the following:

1. A product licensing system

Under the *Regulations*, a licence will be required for all natural health products. Licensed products will be issued a product identification number (NPN or, in the case of homeopathic medicines, a DIN-HM) once the product has been approved for sale in Canada by the Natural Health Products Directorate (NHPD). In order to obtain approval for sale, one must produce either a natural health product monograph published by the NHPD or other evidence of the safety of the product and the veracity of the health claims made about the product. The *Regulations* also establish a process for refusing, suspending or cancelling a natural health product licence.

2. A site licensing system

The *Regulations* will require that all manufacturers, packagers, labellers and importers of natural health products be licensed. Manufacturing, packaging, labelling and importing sites will be required to have approved procedures in place for the handling, storage and delivery of natural health products and will also be required to maintain good manufacturing practices (GMPs), as described below. As with the product licensing system, the site licensing system under the *Regulations* sets

out a process for refusing, suspending or cancelling a site licence.

3. Good manufacturing practices requirements

The *Regulations* will require that those involved in the manufacture, storage, handling and distribution of natural health products in Canada adhere to established standards and practices in respect of the products. The GMPs address issues such as product specification, premises, equipment, personnel, sanitation, operations, quality assurance, stability, records, sterile products, lot or batch samples and recall reporting.

4. Clinical trials regulation

Under the *Regulations*, human clinical trials of natural health products will be regulated to ensure a transparent process that protects the safety of trial participants. The *Regulations* will assist investigators in providing a mechanism by which they may test new products with little or no history of traditional use, including those that have not yet been licensed for market use.

5. Labelling requirements

The *Regulations* impose standard labelling requirements to ensure that consumers can make informed choices about natural health products. It will be a requirement under the *Regulations* that the labels contain such things as: the product name, the quantity of the product in the bottle and the recommended conditions for use which includes recommended use or purpose and dose, warnings, cautionary statements, contra-indications, and possible adverse reactions.

6. Adverse reaction reporting system

The *Regulations* will impose an adverse reaction reporting system for natural health products that is similar to the one currently in place for pharmaceuticals. Such a system will assist Health Canada in monitoring the safety of natural health products and in issuing advisories to the public, where appropriate. The *Regulations* will require all product licence holders to monitor adverse reactions allegedly related to their natural health products. Serious adverse events must be reported to Health Canada.

7. Transitional Provisions

The *Regulations* contain transitional provisions that provide for a staged implementation, so

that there is sufficient time for stakeholders to implement the necessary training, education and systems in order to achieve compliance. The transition period for implementing GMPs and obtaining site licences is two years (by December 31, 2005). The transition period for obtaining product licences for those products that have a DIN is six years (by December 31, 2009).

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¹ The *Regulations* come into effect on January 1, 2004 with the exception of section 6, which comes into effect on July 1, 2004. Section 6 (“sixty-day disposition”) sets out the timeframes in which licence applications must be disposed of by the Government.

Mandatory Blood Samples under the *Health Protection and Promotion Act*

*Kathy O'Brien**

As of September 1, 2003, Medical Officers of Health across Ontario acquired significant new powers, with the coming into force of Regulation 166/03 under the *Health Protection and Promotion Act* (“HPPA”).

Ever since December 2001, an amendment to the *Health Protection and Promotion Act* (the “HPPA”) has been in effect that gives the Medical Officers of Health in Ontario the ability to order certain individuals to submit to the taking of a sample of their blood to determine whether those individuals have a virus that causes a prescribed communicable disease. That amendment (Section 22.1) has been essentially toothless over the past 20 months since its enactment because regulations were needed to prescribe the communicable diseases that could be tested for and the process for making the order and taking the blood.

The process begins when a person who has been exposed to another person’s bodily fluids makes an application to the Medical Officer of Health requesting a mandatory blood sample from the person to whom they have been exposed (the “respondent”). The only persons eligible to make such an application are individuals who have been exposed:

- as a result of being a victim of a crime;
- while providing emergency health care services or emergency first aid to the respondent, if the respondent is ill, injured or unconscious as a result of an accident or other emergency; or
- while performing a function prescribed by the regulations in relation to the respondent. (No such functions have been prescribed by the new regulations.)

The application may only be made by the exposed person within 7 days of exposure, and no later. The respondent can only be tested for specific communicable diseases prescribed by the regulations, being HIV/AIDS, Hepatitis B and Hepatitis C.

There is a detailed process set out in Regulation 166/03 that allows the Medical Officer of Health to determine, in his or her discretion, whether to require the respondent to submit to the taking of a blood sample. (If the respondent agrees to submit voluntarily, there is no need for the exposed person to have resort to the *HPPA*.) The process may, but does not necessarily, involve a hearing at which the applicant and respondent make written submissions for consideration by the Medical Officer of Health. Undoubtedly Medical Officers of Health will be seeking legal advice the first time they receive an application for an order for a mandatory blood sample. All orders must include written reasons for the Medical Officer of Health's decision.

Section 22.1 and the accompanying regulations will impact directly on health care professionals, because any order issued by the Medical Officer of Health must name a person to take the blood sample. That person must be a physician or another person or class of persons named in the order. The physician named in the order must take the sample of blood (or cause it to be taken) and deal with it as Regulation 166/03 requires.

The regulations impose a clear obligation on the person taking the sample to verify the identify of the respondent through inspection of photo identification. The person taking the sample must not only check the respondent's photo ID but also be satisfied that the ID in fact verifies the respondent's identity. If the person taking the sample has doubts that the person presenting for the blood sample is in fact the respondent identified on the order, the blood sample cannot be taken.

Physicians may also encounter Regulation 166/03 when an exposed person requests the physician complete a "Physician Report" required by Section 22.1 of the *HPPA*. The Physician Report must accompany the exposed person's application to the Medical Officer of Health for the blood sample order. The Regulation sets out in detail what must be contained in the Physician Report, including an assessment of the applicant's risk of exposure and

whether the applicant (exposed person) has agreed to base line testing, post-exposure prophylaxis, treatment and counselling for the prescribed communicable diseases. If the Physician Report discloses that the applicant refuses to consent to base line testing, post-exposure prophylaxis, treatment or counselling, the application is considered invalid.

Of note, the Ministry of Health and Long-Term Care backgrounder on the new regulations stresses that:

"Although there is remuneration for completing the Physician Report, no physician is required to complete a Physician Report."¹

Completion of the Physician Report was added to the Schedule of Benefits, effective as of September 1, 2003.

Under Regulation 166/03, the respondent who is the subject of an order requiring the taking of a blood sample has seven days to submit to the blood sampling after receiving the order. The respondent may, however, apply to the Health Services Appeal and Review Board ("HSARB") for a stay of the order pending a hearing on the issue before the HSARB.

The results of the blood testing are provided to the Medical Officer of Health, the applicant's physician, and the respondent's physician (if named on the lab request). The blood samples cannot be used for any purpose other than for analysis and reporting under Section 22.1 of the *HPPA*, nor can the test results. The test results are expressly not admissible in a criminal proceeding, pursuant to Section 22.1(13).

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¹ "Health Protection and Promotion Act: Bill 105 — Information for Physicians", from the Ministry of Health and Long-Term Care Web site (as of September 4, 2003).

New Professional Regulations for Medical Radiation Technologists and Physicians

Naomi Margo*

Over the last year we have seen the initiation and implementation of the Ontario Ministry of Health and Long-Term Care's new direction to license independent health facilities to provide magnetic resonance imaging (MRI) services. In February 2003, the government announced a number of facilities that had been selected to provide these services. More recently, in a market in which the demand for medical radiation (MR) technologists exceeds supply, we have seen media coverage regarding the alleged "poaching" of hospital MR technology staff to independent health facilities to support their MRI activities.

As the market provision of these services changes, it is obviously not surprising to see new regulations introduced to address some of these changes. On May 29, 2003, the government brought into force new professional regulations under the *Medical Radiation Technology Act, 1991* that result in the regulation of MR technologists by the College of Medical Radiation Technologists of Ontario (CMRTO). Regulation 226/03 provides that the scope of practice of MR technologists includes the use of electromagnetism to produce diagnostic images and tests. The registration requirements for the specialty of magnetic resonance for MR technologists are outlined in O. Reg. 227/03. Those MR technologists who have received on-the-job training may be registered by the CMRTO provided they apply for registration on or before June 18, 2004 and meet the requirements outlined in the regulation. Only those members of the CMRTO registered in the sub-specialty of magnetic resonance can represent themselves as qualified to practice the specialty of magnetic resonance in Ontario.

Similarly, on May 29, 2003, the government also passed a new regulation under the *Regulated Health Professions Act, 1991 (RHPA)* (O. Reg. 228/03) that, among other things, addresses the authorization of MR technologist services in independent health facilities. The Regulation also amends the "controlled acts" regulations under the *RHPA* by authorizing an MR technologist to apply electromagnetism if the application is ordered by a member of the College

of Physicians and Surgeons (CPSO) and is applied in the circumstances outlined in the regulation. What is interesting about this regulation is that it not only outlines the circumstances in which MR technologists can provide MRI services in independent health facilities, but also addresses the circumstances for authorized services in public hospitals — something one may have expected to be done under the regulations to the *Public Hospitals Act*.

The criteria for authorized electromagnetism services by MR technologists in the regulation covers such conditions as ensuring the MR technologist only provides such services when, in the case of public hospitals, the MRI equipment is "operated by [a] public hospital" mentioned in the regulation, or in the case of independent health facilities, ensuring that the MRI service is not being used "...to support, assist and be a necessary adjunct, or any of them, to an insured service within the meaning of the *Health Insurance Act...*", and that the operator of the independent health facility is "...a party to a valid and subsisting agreement with the Minister concerning the provision of magnetic resonance imaging".

Interestingly, the same provisions in O. Reg. 228/03 outlining the conditions for applying electromagnetism in public hospitals and independent health facilities for MR technologists equally apply to physician members of the CPSO (see section 2). However, the sections of the regulation applying to CPSO members came into force on the filing of the regulation (May 29, 2003), whereas the sections of the regulation applying to MR technologists only come into force in June 2004, presumably to provide sufficient time for MR technologists to register with the CMRTO and to ensure they are in compliance with the regulation, depending on whether they practice in a public hospital or an independent health facility.

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Correction

In the last issue of *Health Matters* (Volume 12, No. 3, May 2003), the article entitled "Health Care in Canada: What Does The Future Hold?" mistakenly identified Lonny Rosen of Tremayne-Lloyd Partners LLP as the author. The author of the article was, in fact, Simmie Palter, Counsel with the Ministry of Health and Long-Term Care, Legal Services Branch. Our apologies for this error.

The articles, which appear in this publication, represent the opinions of the authors. They do not represent or embody any official position of, or statement by the OBA except where this may be specifically indicated; nor do they attempt to set forth definitive practice standards or to provide legal advice. Precedents and other material contained herein are intended to be used thoughtfully, as nothing in the work relieves readers of their responsibility to consider it in the light of their own professional skill and judgment.

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