THE HEALTHCARE LAW REVIEW

Sixth Edition

Editor
Ulrich Grau

THE LAWREVIEWS

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PREFACE

The sixth edition of *The Healthcare Law Review* covers six new jurisdictions and a total of 17 jurisdictions from Europe, North and South America and Asia. All chapters have been provided by leading experts in the field of healthcare law in their countries. The reviews have been prepared by the authors as a practical, business-focused analysis of recent changes and developments, their effects, and a look forward at expected trends. The reviews are intended to provide an overview of legal issues that are of interest for healthcare providers and related businesses.

The past two years have been dominated by the covid-19 pandemic. The pandemic not only affected all healthcare providers and staff working in health and social care but also scientists, public health officials and politicians throughout the world. Each country was hit hard by the pandemic, some countries were even overwhelmed, and major sources of the healthcare systems had to focus on maintaining the functioning of the health systems even in this exceptional situation. Therefore, all countries took additional exceptional measures to fight the pandemic. According to the reviews from the individual countries, these exceptional measures have now largely been scaled back or totally withdrawn, even though the pandemic is not yet over.

As a major result of the pandemic, many countries have geared their healthcare systems to ensure safe access to healthcare for citizens, even in extraordinary situations, through greater digitisation and use of telemedicine. This is not only about supplementing or replacing face-to-face doctor visits with communication options via telephone or video consultation. Many countries have also introduced electronic patient files, regulations for the exchange of health data and other digital communication channels. The next few years will show whether these innovations can also be successfully implemented in a healthcare reality that is no longer solely determined by a pandemic. A particular challenge in the future will also be to utilise the new digital tools not only within a national healthcare system in a single country, but also across borders. The European Union is already well on the way with the implementation of a European Health Data Space.

Even if individual countries solve their problems differently, we all can only benefit from knowing the different approaches to solving the problems and how successful the respective countries have been with their solutions in each case. I truly hope that the publication of *The Healthcare Law Review* will be particularly helpful in that respect.

I am more than happy to take over the editorship from Sarah Ellson from Fieldfisher LLP, London. I would like to sincerely thank her for her commitment over the past years. It is an extraordinary pleasure to work with this group of exceptional authors of *The Healthcare Law Review* in this edition and in the years to come to provide a practical overview of the

healthcare systems of the countries covered. We will continue our efforts to include more countries to this publication to be able to give a comprehensive worldwide approach to healthcare issues by each country.

Ulrich Grau
D+B Rechtsanwälte Partnerschaft mbB
Berlin
August 2022

Chapter 3

CANADA

Zohar Levy, Laurie Turner, Victoria Mitrova and Heather Whiteside[1]

I OVERVIEW

Canada is a federated country comprising 10 provinces and three territories,[2] populated by over 38 million people.[3] Under a 'separation of powers' concept, Canada's Constitution allocates responsibility for various matters between the federal government of Canada and the provincial governments. Canada has a publicly funded universal healthcare system, accessible by all Canadians, as described in more detail below; there is also a significant market for private healthcare services outside of the medically necessary services provided by the universal system.

While the federal government is responsible for the delivery of healthcare to a subset of Canada's population,[4] generally, the regulation of healthcare is within the provincial jurisdiction and is a significant function of the provincial governments. The delivery of healthcare is, year in and year out, among the issues of greatest import to Canada's populace. Provincial legislatures pass laws relating to issues including: healthcare delivery; health protection and promotion; the governance and operation of facilities in which healthcare is delivered; the regulation of healthcare professionals; healthcare privacy, procurement, accountability and transparency; and the means by which physicians may be compensated for the provision of their services. Individual health professions are self-regulated and each health profession has its own provincial regulatory college, which can add a further layer of complexity to the regulation of healthcare services in Canada.

1 Zohar Levy and Laurie Turner are partners and Victoria Mitrova and Heather Whiteside are associates at Fasken Martineau DuMoulin LLP.

2 As the distinction between a province and a territory is not important for the purposes of this chapter, all will be referred to herein as 'provinces'.

3 Statistic provided by Statistics Canada.

4 The government of Canada provides direct healthcare services to First Nations people living on reserves, Inuit populations, serving members of the Canadian Forces, eligible veterans, inmates in federal penitentiaries and some groups of refugee claimants.

II THE HEALTHCARE ECONOMY

i General

The Canada Health Act, a federal statute, helps define how healthcare is delivered in Canada. Its goal is to ensure that all eligible Canadian residents have reasonable access to a publicly funded universal healthcare system for medically necessary services.[5] Although the federal government does not have the constitutional authority to regulate healthcare, the Canada Health Act shapes the provision of healthcare because the federal government provides significant funding for healthcare. The statute sets out criteria and conditions that provinces must meet in order to receive funding.[6]

ii The role of health insurance

To receive federal funding under the Canada Health Act, each province must have a health insurance plan in effect which satisfies the following five programme criteria:

a Public administration: the plan must be administered and operated on a non-profit basis by a public authority which is accountable to the provincial government.

b Comprehensiveness: the plan must cover all insured health services provided by hospitals, physicians or dentists.

c Universality: the plan must cover all insured persons of the province on uniform terms and conditions.

d Portability: the plan must not impose minimum waiting periods or residency requirements of more than three months before residents are eligible for coverage and must cover insured persons when they are temporarily absent from their home province.

e Accessibility: the plan must provide all insured persons with reasonable access to insured services, which is not to be impeded or precluded by financial or other means (e.g., discrimination on the basis of health status).

The healthcare services that a province funds are determined by each provincial government on the basis of 'medical necessity', which is not clearly defined in the Canada Health Act or in provincial health insurance statutes.

The result of the Canada Health Act is that each province has its own government-operated health insurance plan that pays for medically necessary healthcare services provided to eligible residents. In fact, all persons other than the provincial health insurance plans – including hospitals and healthcare providers – are prohibited by law in most provinces from charging Canadians for medically necessary healthcare. Canada is one of the few countries in the world where the sale of supplemental or private healthcare insurance for medically necessary healthcare services is generally prohibited (although this prohibition varies by province).

5 Only residency, not citizenship, is required for coverage. For example, in order to be an eligible resident in Ontario, subject to certain exceptions, an individual must, among other things, be present in Ontario for 153 days in any 12-month period.

6 According to the federal budget, in 2022–2023, the provinces will receive, in the aggregate, approximately C$45.2 billion from the federal government as part of the Canada Health Transfer under the Canada Health Act.

iii Funding and payment for specific services

Although most provinces prohibit private insurance companies from selling insurance for medically necessary healthcare services delivered to Canadians, a private insurance market exists for healthcare services that are not covered by provincial plans, including the following:

a most dental services;
b most prescription drugs; and
c non-medically necessary services (e.g., most physiotherapy, chiropractic services and home care).

These services and the healthcare providers are largely regulated provincially, but the pricing of these private services is not typically publicly determined.

III PRIMARY/FAMILY MEDICINE, HOSPITALS AND SOCIAL CARE

Healthcare is delivered in various settings including hospitals, physicians' offices, private clinics, surgical clinics, and community health centres. Because not all healthcare services are medically necessary and thus, not insured services under provincial health insurance plans, certain services in the above settings may be paid for privately, including by the patients receiving such services and their private insurers.

Typically, patients access medically necessary healthcare through a general practitioner or family physician, if one is available, and otherwise through clinics or emergency departments. Nearly all other practising physicians in Canada are specialists and are accessed via referral from a family physician. While there is no specific legal framework requiring a referral, most specialists do not accept direct patient contact.

To reduce the number of patients seeking care at clinics or emergency departments, a growing number of hospital-sponsored urgent care centres and telemedicine solutions have emerged to meet patient demands stemming from, among other things, the inaccessibility of their family physician.

The scope of healthcare services that may be provided in these settings is often restricted by legislation. In some provinces, legislated licensing regimes regulate the settings in which services can be performed. The provinces of Ontario and Saskatchewan, for example, require facilities in which specified diagnostic or laboratory services are performed to possess licences. Most provinces also empower the provincial body responsible for regulating physicians in that province to establish and institute criteria for facilities where specified healthcare services are provided, such as surgical clinics.

To respond to increased demands placed on healthcare systems, provinces have begun to adopt patient-centred approaches to the delivery of healthcare. Ontario, for example, has made a number of changes to its healthcare structures in an effort to improve patient care coordination. One of these changes has been the introduction of Ontario Health Teams, through which patients within a specified geography receive integrated care, including, for example, primary care, hospital services, mental health and addictions services, long-term care and community care from healthcare providers who are part of the same Ontario Health Team. Another change has been to centralise a number of pre-existing healthcare agencies into one entity, Ontario Health. The new Ontario Health agency has a mandate to connect and coordinate the province's healthcare system under one centralised system with an aim of reducing prior inefficiencies while overseeing healthcare delivery across the province.

Canada does not yet have a national electronic health record (EHR) system, although most healthcare practitioners use electronic records in their own practices.

Services to support seniors

As Canada's population continues to age, services and programmes to support the health needs and social well-being of seniors continue to be necessary components along the continuum of care. The majority of provincial governments offer or provide services and programmes to benefit the health and social needs of seniors. For example, home care services and community support services are generally funded, at least in part, by the provinces and aim to keep seniors living within their residences for as long as possible, thereby reducing unnecessary hospital admissions and lengthy hospital stays. Many of the services offered by provincial governments are provided for or coordinated in partnership with community agencies.

IV THE LICENSING OF HEALTHCARE PROVIDERS AND PROFESSIONALS

i Regulators

Healthcare professions are regulated by profession-specific 'colleges', each of which is a not-for-profit corporation established by profession-specific statutes. In Ontario, for example, there are more than 25 colleges, including the College of Physicians and Surgeons of Ontario, which is the college governing the profession of medicine in the province.

Each college has a council that manages and administers the college's affairs and functions as the college's board of directors. Generally, colleges are funded by the healthcare professionals that comprise their membership, but some receive partial operating funding from the government.

The provincial legislation that is applicable to healthcare professions sets out to protect the public by establishing the scope of the practice of the profession and restrictions on who can practise the profession. Colleges are required by such legislation to, among other things, ensure that the public has access to qualified, skilled and competent healthcare professionals. Colleges seek to uphold such obligation by, for example, developing, establishing and maintaining standards of practice, quality assurance programmes, and standards of professional ethics. The profession-specific legislation also generally provides colleges with authority to investigate complaints regarding their members' conduct and to impose disciplinary measures on their members in prescribed circumstances.

ii Institutional healthcare providers

Professionals within institutional healthcare providers

Employers in Canada have vicarious liability for certain employees. Thus, healthcare providers are diligent in ensuring that the healthcare professionals they employ are qualified and licensed to practise. Where healthcare providers deliver healthcare services in a hospital, long-term care home or other healthcare institution on a non-employed basis (e.g., physicians and dentists as independent contractors to hospitals), the institution applies the same rigour but with a different lens, knowing that in most cases it is these non-employed professionals who will be overseeing and directing the care provided by other professionals.

Institutional healthcare providers themselves

With a limited number of exceptions, hospitals in Canada are charitable organisations that are not privately owned. They are not licensed per se, but are classified by the government as to type (e.g., acute, chronic, tertiary, community) and receive funding from their provincial government (or a government intermediary). The funding is based on a number of criteria, including population base, patient composition and fixed-service fees. In some provinces, hospitals are overseen by volunteer boards; in other provinces, they are overseen by a regional authority. Hospitals are not legally limited in the services that they offer, but given that nearly all of their operating revenue comes from the provincial government (or a government intermediary), generally they cannot expand into new service offerings without government support.

Long-term care homes and independent health facilities (Ontario) (which provide insured services) are operated under licence. A large percentage of the long-term care homes and independent health facilities are privately owned, and a market exists for the purchase and sale of such licences. It is noted, however, that long-term care home licences and independent health facility licences cannot be transferred without the consents required by the applicable statute.

Subject to the comments above regarding long-term care homes and independent health facilities, generally, in most provinces, licences are not required to operate private clinics unless they offer surgical procedures. However, in several provinces, such as British Columbia, Saskatchewan, Manitoba, Alberta, Ontario and Quebec, private clinics providing surgical procedures are subject to accreditation or licensure by the college governing the medical profession.

Healthcare professionals

As noted above, the requirements for registration or licensure[7] as a member of a healthcare profession are set out in the various provincial health profession acts described in Section IV.i, above. In general terms, the registration requirements for healthcare professionals include: (1) having a degree in their area of practice from an accredited school, or a degree that is determined to be equivalent by the relevant college; (2) successfully completing certain postgraduate training or education; and (3) passing certain qualifying examinations or assessments. It is also a general registration requirement that an applicant's past and present conduct afford reasonable grounds for the belief that the applicant will practise the profession competently and with integrity.

The health profession acts provide that a member's contravention of a term, condition or limitation imposed on their certificate of registration constitutes an act of professional misconduct. Typically, those health profession acts also permit regulators to prosecute any entity engaged in the unlicensed provision of healthcare services in the provincial courts.

7 Many provinces in Canada are moving away from a licensing model to a registration model with a focus on harm prevention. For the purposes of this chapter, the term 'registration' will be used to refer to both licensing and registration models.

V OWNERSHIP OF HEALTHCARE BUSINESSES

While healthcare in Canada is generally paid for publicly, it is delivered in large part by those in private business, including physicians and operators of private clinics, long-term care homes, and, in Ontario, independent health facilities.

Although some physicians are hospital employees (e.g., radiologists, those working in labs and research areas, and a limited number of hospitalists), most physicians are self-employed or work in partnership with other physicians. Physicians may incorporate medical professional corporations to enter into leases and other non-clinical agreements. In most provinces, physicians must hold all of the voting shares of medical professional corporations, but their spouses or family members, or in some provinces other persons, may own non-voting shares of such businesses (provided that the physicians themselves remain liable for the professional services they provide). The same is true for certain other healthcare providers. A market exists for the purchase and sale of businesses operated by professional corporations, subject to applicable provincial law and the policies of each regulatory college, but control of these professional corporations is limited to other healthcare professionals of the same designation.

Non-professionals may provide services to professional corporations and so may indirectly participate in the business arrangements of such professionals. Private corporations that provide space and other administrative services to healthcare professionals are common. Opportunities exist for purchase and investment in these service corporations. Notwithstanding their private nature, these corporations and the professionals practising within them are required to comply with the provincial laws prohibiting private payment for insured services. Private payment for insured services is at the centre of a high-profile case that originated in British Columbia, *Cambie Surgeries Corp v. British Columbia (Attorney General)*.

Like other provinces, British Columbia prohibits the use of private insurance for insured services and does not allow services provided in private surgical clinics to be billed outside of the public insurance plan. The constitutionality of these restrictions is being challenged at this time by Cambie Surgeries Corp, an owner and operator of private healthcare facilities in British Columbia. Cambie alleges that prohibitions on extra billing and private insurance violate the Canadian Charter of Rights and Freedoms by limiting timely access to medical services for residents. While British Columbia's public insurance legislation, the Medicare Protection Act, does not preclude private clinics or private billing, it prohibits a public-private model such as Cambie's, in which a private clinic engages in extra billing (billing a patient directly for an insured service) in addition to receiving funding for insured services.

In September 2020, the Supreme Court of British Columbia ruled against Cambie. The Court found that Cambie had not established that the Canadian Charter of Rights and Freedoms had been breached because: (1) while Cambie had established that certain provisions of British Columbia's Medicare Protection Act cause a deprivation of security of the person for some individuals, such deprivation was in accordance with the principles of fundamental justice; and (2) Cambie did not satisfy the threshold considerations to establish a claim that the impugned provisions of the Medicare Protection Act violated the right to equal protection and equal benefit of the law to all. The Supreme Court of British Columbia's decision was appealed to the British Columbia Court of Appeal, which heard the appeal in mid-2021. At the time of writing, we continue to await the decision of the British Columbia Court of Appeal in the *Cambie* case.

VI MARKETING AND PROMOTION OF SERVICES

Communication with the public about healthcare services is regulated to ensure accuracy and maintain professionalism, although the degree of regulation varies between practice areas and provinces. In general, healthcare professionals may advertise for the purpose of providing information relevant to informed decision-making. Provincial legislation and college policies prescribe how professionals can market their services and describe their qualifications and education. Non-compliance may be considered professional misconduct.

Generally, legislation and policies prohibit:

a advertising that is false, misleading or unprofessional;
b information that cannot be verified;
c claims of superiority, comparisons or guarantees;
d endorsements or testimonials; and
e reference to a specialisation unless certified by an official body.

It is generally acceptable to advertise fees for services that are not publicly funded; however, some policies restrict the use of promotional deals. Many professions have conflict of interest rules that preclude fee-sharing or other forms of 'kickback', and require healthcare providers to pay fair market value for advertising.

The prevalence of social media has raised new issues, including in respect of privacy and copyright infringement. Existing regulations apply to all means of communication, including print, oral or electronic. For example, prohibitions on inducements, such as coupons, continue to apply when using platforms such as mobile applications. Larger regulatory bodies have developed specific social media use policies.

Advertisement by email and similar electronic means (e.g., SMS text) is also subject to privacy laws as well as Canada's anti-spam law, which requires a person sending such an electronic marketing message to have prior consent or other authority to send that message. Canada's anti-spam law also requires the message to identify the sender, the sender's mailing address and other contact information, and to include an easy-to-use unsubscribe mechanism through which a person can request to no longer be sent electronic marketing messages.

VII PROCUREMENT OF SERVICES AND GOODS

Some Canadian healthcare providers (e.g., hospitals and health authorities) are subject to public procurement rules. These rules arise out of international trade agreements; national and regional domestic trade agreements; provincial statutes and procurement directives; and the specific policies of each public sector purchaser. Procurement rules are intended to ensure fairness, transparency and accountability in decisions about the use of public funds. They apply to contracts for the purchase of goods or services that meet or exceed certain value thresholds. Generally, procurement rules require those contracts to be awarded through an open competitive process – that is, a process that is open to any person to submit a bid. They also require public sector purchasers to share material information with prospective bidders at the outset, and through particular communications channels; evaluate bids consistently and only against stated criteria; and publish information about successful bids. Also, new public procurement requirements require provincial governments to designate an impartial administrative or judicial authority to review challenges from bidders or prospective bidders (either in the first instance, or as an appeal body). Potential providers of healthcare goods and services should look to various online procurement portals for notices about pending and

open competitive procurement processes. It is now common for publicly funded healthcare providers (hospitals, health authorities, etc.) to be members of organisations that provide centralised procurement services (these organisations are often referred to as 'shared service organisations').

VIII REIMBURSEMENT OF SERVICES AND GOODS

i Reimbursement of insured services and goods

Insured (medically necessary) healthcare services are eligible for reimbursement by provincial health insurance plans. As described above, provincial governments determine which services are eligible and – by way of legislation – set the criteria to be met for reimbursement. These criteria may include, among others, that a prescribed healthcare professional or entity perform the service, and that it be listed as an insured service in the applicable schedule of benefits. For example, there are certain services that are reimbursed if performed by physicians but not by nurse practitioners, as required under provincial legislation.

Individual healthcare professionals who perform eligible insured services seek reimbursement directly from provincial health insurance plans. Entities such as hospitals receive global funding from provincial governments which is meant to cover the costs of insured services provided by those entities.

Provincial health insurance plans may also reimburse the costs of insured goods. Certain medications and medical devices may be fully or partially reimbursable for patients who meet certain age and/or health criteria.

ii Recent developments

Owing to the limited supply of funding available from provincial health insurance plans, patients may encounter difficulties obtaining funding for innovative healthcare treatments. To alleviate such issues, provincial governments allocate some funds to programmes administered by agencies that assess proposed medical treatments. These programmes provide funding to patients for innovative treatments, such as cancer drugs, that would not otherwise be covered under provincial health insurance plans.

IX DIGITAL HEALTH DEVELOPMENTS

The coronavirus pandemic imposed new pressures on the Canadian healthcare system that accelerated the adoption of new technologies to deliver healthcare services. Virtual care and broader uses of health data are playing an increasing role in healthcare delivery in Canada.

Virtual care – generally understood as the use of communication technologies to facilitate interactions between patients and their healthcare providers – continues to expand with support from both the public and private sectors. The federal and provincial governments have been encouraging the use of virtual care solutions to improve patient outcomes, increase access to services, and lower the costs of healthcare administration.[8] However, virtual care has not traditionally been covered under provincial health insurance plans. During the coronavirus pandemic, all Canadian provinces revised the fee schedules to

8 In 2020, the federal government invested C$200 million to help provinces and territories accelerate their use of virtual tools and digital approaches to meet healthcare needs.

their health insurance plans to facilitate virtual care; to date, some provinces have committed to making this change permanent.[9] Private companies have rapidly moved into the virtual care space and now offer broader telehealth services to Canadians, either by charging patients directly or integrating with public or private insurance plans and employer benefits packages.

Increasing access to digitised and centralised health data has provided new opportunities for data analytics and the use of artificial intelligence in healthcare delivery. Canadian healthcare providers are applying artificial intelligence to support diagnostic and other clinical decisions, automate treatment planning, and manage chronic disease. Private companies play a key role in developing new applications for artificial intelligence, often in collaboration with public health stakeholders and academic institutions. Still, data sharing among various government agencies, healthcare providers and private sector organisations is constrained by health privacy legislation and the service-centric and siloed nature of Canada's health data framework.

X CORONAVIRUS

While healthcare has historically attracted significant investment from the federal (and provincial) governments, the federal government's healthcare spending rose significantly in response to the coronavirus pandemic. For example, in 2020, the federal government's total health expenditure rose by 12.8 per cent (versus an average annual growth in the pre-pandemic period of 4 per cent) on account of funding dedicated to the effects of coronavirus.[10]

As described above, one of the biggest changes flowing from the coronavirus pandemic in Canada is increased use of virtual care for both insured and uninsured healthcare services. Provinces have passed various coronavirus-specific legislation, including temporary measures intended to promote public health and temporary but stringent lockdowns. As described in more detail in Section XI below, both federal and provincial governments have taken steps to try to pre-empt or respond to issues highlighted by the coronavirus pandemic.

XI FUTURE OUTLOOK AND NEW OPPORTUNITIES

The increasing prevalence of e-health and virtual care represents a significant change in how Canadians access healthcare. Given Canada's ageing population and relatively low population density throughout much of the country, e-health is likely to continue to grow over the next few years despite legal and structural barriers (e.g., there is no national framework for telemedicine).

Medical aid in dying (MAiD) has been legal in Canada since 2016; in 2021, the legislation permitting MAiD was amended to broaden the eligibility criteria, and the government is in the process of a further parliamentary review. It is likely that Canadians will have increased access to MAiD in the years to come. Canada has also recently banned conversion therapy, providing criminal sanctions for any person engaging in practices intended to alter a person's sexuality to heterosexual, or gender identity to cisgender.

9 See Canadian Medical Association, The College of Family Physicians of Canada and Royal College of Physicians and Surgeons of Canada, 'Virtual Care in Canada: Progress and Potential' (February 2022).

10 Canadian Institute for Health Information's National Health Expenditure Trends, 2021. See: https://www.cihi.ca/en/national-health-expenditure-trends.

While not unique to Canada, the coronavirus pandemic also highlighted the need for improvement in certain areas of Canada's healthcare system. For example, at a federal level, in 2022, the government of Canada announced that in response to the coronavirus, it was making 'major' investments in equipment and supplies (including personal protective equipment, for example) for health and other essential service sectors.[11] At a provincial level, the government of Ontario created the Long-Term Care Covid-19 Commission to investigate the spread of the coronavirus within long-term care homes, the impact of the coronavirus on residents (and their families) and staff of long-term care homes, and the sufficiency of the measures taken by the province to prevent, isolate and contain the virus, and also to provide recommendations in respect of any future outbreaks.[12]

XII CONCLUSIONS

As Canada and the rest of the world emerge from the pandemic, we expect that the shift to virtual services will remain a significant driving force in the provision of healthcare services in Canada. The taxpayer-funded model of universal healthcare remains in place and has largely not been altered over the past two years since the commencement of the pandemic; however, the definition of medically necessary services has been broadened to respond to the effects of the pandemic, including in respect of the availability of and access to in-person care.

11 See: Government of Canada. 'Supplying Canada's response to COVID-19' (22 April 2022) https://www.tpsgc-pwgsc.gc.ca/comm/aic-scr/provisions-supplies-eng.html.

12 See government of Ontario's 'Long-Term Care COVID-19 Commission: final report and progress on interim recommendations' (30 April 2021) https://www.ontario.ca/page/long-term-care-covid-19-commission-progress-interim-recommendations.

Appendix 1

ABOUT THE AUTHORS

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Zohar Levy is a partner in the litigation department of Fasken Martineau DuMoulin LLP. She works out of the Toronto office. Zohar has advised clients on the implications of Canadian healthcare legislation for companies interested in entering the Canadian markets. She was a member of a panel of litigators at Fasken who act as counsel to the Discipline and Fitness to Practise Committees of the College of Physicians and Surgeons of Ontario. She has represented numerous healthcare professionals both in civil and regulatory proceedings and has also represented clients who operate in the healthcare space in litigation matters.

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Previously, Laurie was a full-time executive research assistant to the Canada Research Chair in Breast Cancer at Sunnybrook & Women's College Health Sciences Centre and a research assistant for Professor Jurgen Rehm at the Centre for Addiction and Mental Health. During her legal career, Laurie has participated in numerous secondments in the health sector, including at two large teaching hospitals and a shared service organisation.

Together with other members of Fasken, she co-authored the Ontario Hospital Association's Toolkit on the Freedom of Information and Protection of Privacy Act.

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