

NOTES FOR AN ADDRESS BY

Bonnie Cham, MD, FRCPC
Chair, Committee on Ethics
Canadian Medical Association

Review of the Personal Information Protection and Electronic Documents Act (PIPEDA)

CMA's Presentation to the House of Commons
Standing Committee on Access to Information,
Privacy and Ethics

*Ottawa, Ontario
December 13, 2006*



*A healthy population...a vibrant medical profession
Une population en santé...une profession médicale
dynamique*

ASSOCIATION
MÉDICALE
CANADIENNE



CANADIAN
MEDICAL
ASSOCIATION

The Canadian Medical Association (CMA) is the national voice of Canadian physicians. Founded in 1867, CMA's mission is to serve and unite the physicians of Canada and be the national advocate, in partnership with the people of Canada, for the highest standards of health and health care.

On behalf of its more than 64,000 members and the Canadian public, CMA performs a wide variety of functions, such as advocating health promotion and disease/injury prevention policies and strategies, advocating for access to quality health care, facilitating change within the medical profession, and providing leadership and guidance to physicians to help them influence, manage and adapt to changes in health care delivery.

The CMA is a voluntary professional organization representing the majority of Canada's physicians and comprising 12 provincial and territorial divisions and 45 national medical organizations.



INTRODUCTION

The Canadian Medical Association (CMA) is pleased to be here today to participate in your review of the Personal Information Protection and Electronic Documents Act, or PIPEDA.

The CMA has had a long-standing interest in privacy-related matters, including enhancing measures to protect and promote the privacy of health information. We welcome the opportunity to share our policies and thoughts on these vital matters.

As a pediatric oncologist from Winnipeg and Chair of the CMA's Committee on Ethics, I come here today with one bottom line: Physicians have always—and continue to—take their patients' privacy very seriously. This is the cornerstone of the special bond between patients and their doctor and has been thus since the time of Hippocrates. In recognition of the importance of privacy, the CMA has produced such documents as the CMA Code of Ethics and the CMA Health Information Privacy Code to guide our more than 64,000 members across the country. These documents existed before the federal government introduced PIPEDA.

It is out of our concern for protecting and ensuring the privacy of medical information that we speak to you today.

There are three specific areas which we would like to raise:

- 1) Recognition in law of the unique nature of health care;
- 2) Physician information as “work product”; and
- 3) Emerging Privacy and Health information issues.

1. Recognition in law of the unique nature of health care

I would like to highlight the importance of recognizing in law the special circumstances of protecting health information. In fact, when PIPEDA was first being debated, CMA posed questions about the scope of the Act and was told that the legislation, originally designed for commerce and the private sector, would not capture health information. We were also told that even if it did, PIPEDA wouldn't change how we practiced medicine.

The passing of PIPEDA generated enough concern and uncertainty that government agreed to delay its application to health for 3 years. For example, PIPEDA failed to clarify the issue of implied consent for the sharing of patient information between health professionals providing care.

For example, when the family physician says to a patient “I’m going to send you to see an oncologist to run some tests” and the patient agrees and follows that course of action, then clearly there is “consent” to the sharing of their health information with others. As an oncologist I assume there is consent to send the test results to other specialists that I may need to consult in order to advance the patient’s care in a timely fashion. This, however, needed to be addressed before PIPEDA was applied to health care.

The delayed application allowed the federal government and health care community to work together and develop a set of guidelines for how PIPEDA would be applied. The resulting PIPEDA Awareness Raising Tools, known as PARTs, contain a series of questions and answers that make up guidelines for health care providers. They answered many of our concerns, provided necessary definitions and allowed for the implied consent model to continue to be used within the circle of care. The CMA applauds the government for this collaborative effort and the resulting guidelines have been used by health care providers ever since.

However, we remain concerned that the PARTs guidelines have no legal status. This limitation creates a degree of uncertainty that the CMA would like this legislative review to see addressed by ensuring the PARTs series of questions and answers are referenced in PIPEDA.

In addition to participating in the PARTS initiative, since PIPEDA’s implementation, the CMA has designed practical tools for physicians and patients:

- adopted the CMA policy *Principles Concerning Physician Information* to address the importance of protecting the privacy of physician information;
- produced *Privacy in Practice: a handbook for Canadian physicians* to help physicians maintain best practices in the protection of patient health information; and
- created the PRIVACYWIZARD™ designed to help physicians record their current privacy practices, communicate these to patients and identify possible areas for enhancement.

2. Physician Practice Information as “Work Product”

I referred earlier to CMA’s Policy document on physician information. The CMA strongly believes that physicians have legitimate privacy concerns about the use by third parties of information – such as prescribing and other practice data for commercial purposes. Currently deemed “work product” this information can be collected, used and disclosed without consent.

We feel PIPEDA inadequately protects this information. We recognize that it is information generated out of the patient-physician relationship. We disagreed with findings of the previous Privacy Commissioner that physician prescribing information is not subject to PIPEDA’s privacy protection provisions for “personal information”. The CMA has consistently advocated that physician prescribing data and other practice information is personal information and appeared as an intervener in a Federal Court review of this issue that was ultimately settled by the main parties.

Also, insufficient regard for the privacy of prescribing and other physician data could have a negative impact on the sanctity of the physician-patient relationship. Patients confide highly sensitive information to physicians with the expectation this information will be kept in the strictest confidence. This expectation exists because they know that physicians are under ethical and regulatory dictates to safeguard their information and that physicians take this responsibilities very seriously. The perceived and indeed actual loss of control by physicians over information created in the patient encounter, such as prescribing data, could undermine the confidence and faith of our patients that we are able to safeguard their health information. This concern is not hypothetical.

For physicians, so called “work product” information also encompasses practice patterns such as discharge rates, referral rates, billing patterns, hospital length of stays, complaints, peer review results, mortality and re-admittance rates. With the advent of electronic medical records and growth in pay-for-performance and outcome-based incentive programs for physicians, there is an enormous potential for the resulting physician “performance” data or “work product” to be “mined” by other parties and used to influence performance review (traditionally the purview of the medical licensing authorities) as well as decisions around treatment funding and system planning.

The lack of transparency in the sale and compilation of physicians’ prescribing and other performance data means that physicians might find themselves to be the unwitting subject and targets of marketing research. We believe practice decisions must be made in the best interest of patients and not the bottom-line interests of businesses and marketers.

CMA therefore recommends a legislative change to include physician information as personal information under PIPEDA. Legislation in Quebec provides an example that is consistent with CMA’s approach since it requires regulatory oversight and gives individuals the right to opt out of the collection, use and disclosure of “professional” information.

3. Emerging Privacy and Health information issues

With budgetary and demographic pressures, our health care system is under strain and physicians are striving to deliver timely, quality care to patients, often with competing and multiple demands. Physicians are therefore seeking assurances from law makers that any amendments to PIPEDA will take into account the potential impact on them and their patients. Therefore, we seek assurances that:

- health care is recognized as unique when it comes to the disclosure of personal information before the transfer of a business (one physician transferring his/her practice to another) because it is regulated at the provincial level through the appropriate licensing body. As a general rule, physicians must give notice to the public, whether via a newspaper ad or a notice in the office about the change in practice.
- the federal government will consider the impact of the trans-border flow of personal information on telehealth and Electronic Health Record activities. Communications between patients and physicians via electronic means are likely to increase and to move across geographic boundaries with increasing frequency; and

- the federal government will study the issue of international cross border data flows, particularly among Canadian researchers who receive funding from US drug companies. These arrangements should be governed by Canadian law (PIPEDA) not American (HIPAA or the US Patriot Act).

In closing, the privacy protection of personal health information is a responsibility that my colleagues and I do not take lightly. It is a key pillar of our relationship with Canadians, they not only expect it—they deserve it. I look forward to taking questions from Committee members.

Privacy legislation and its application to the health care sector

Confidentiality has been a fundamental principle of the medical profession since the time of Hippocrates and is a key tenet of the CMA *Code of Ethics*.

The medical profession takes patient confidentiality very seriously and it is an essential aspect of provincial–territorial regulation, breaches of which are subject to a finding of professional misconduct. Growing threats to the privacy of patient information, arising from increased demands and ability to manipulate and link data electronically, led to the adoption of the CMA *Health Information Privacy Code* in 1998.

The more than 64,000 CMA physician-members across Canada believe that patient privacy is fundamental to preserving and enhancing the patient–physician relationship. Accordingly, prior to the application of *Personal Information Protection and Electronic Documents Act* (PIPEDA) to health care, patient privacy and confidentiality were addressed under existing ethical codes, medical licensing authorities and provincial legislation.

In light of this framework, prior to the enactment of PIPEDA, the CMA questioned whether there was clear federal authority to impose a regulatory regime on professions regulated with respect to the same subject matter provincially. The CMA had also been concerned that the application of PIPEDA, a statute that had been designed to facilitate trade and commerce, to the health care sector could have created uncertainty and disruption within a health care system already under significant strain.

To that end, the CMA participated with other health care organizations and various federal government departments to develop a series of questions and answers (known as PIPEDA Awareness Raising Tools or PARTs) that interpreted the application of the act within the context of day-to-day activities in providing care and treatment to Canadians.

The CMA has also developed a number of tools to help physician members to enhance their privacy practices, including:

- “Principles concerning physician information” policy to address the importance of protecting the privacy of physician information.
- *Privacy in Practice: a handbook for Canadian physicians* to help physicians maintain best practices in the protection of patient health information.
- PrivacyWizard™ designed to help physicians record their current privacy practices, communicate these to patients and identify possible areas for enhancement.

In the course of providing care to patients, information is generated about physicians, such as prescribing information and practice patterns. Concern over increased demands for access to various types of physician data — particularly the sale of physician prescribing information without physician knowledge or consent for commercial purposes — is serious concern for the profession. The use of this information for activities such as target marketing of physicians by drug company representatives who come to physician offices with detailed profiles of their individual prescribing practices led the CMA to adopt policies regarding the “Sale of prescribing data” (1997) and “Principles concerning physician information” (2002) to protect the privacy of physician information.

In 2001, the CMA respectfully disagreed with the previous Privacy Commissioner’s ruling that physician information is not “personal” but rather “work product” information not protected under PIPEDA’s provisions. The CMA’s concerns encompass the wider significance and social repercussions of treating physician information as mere “work product.” In the CMA’s opinion, information gathered while treating patients is clearly “personal” information that must be protected given the importance of protecting the sanctity of the patient–physician

relationship, the health care system, funding for research and continuing medical education.

The CMA asks the committee to:

- Ensure the PARTs series of questions and answers are referenced in PIPEDA.
- Recognize that health care is unique when it comes to the disclosure of personal information before the transfer of a business (one physician transferring his–her practice to another) because it is regulated at the provincial level through the appropriate licensing body.
- Recommend a legislative change to include physician information (currently deemed a “work product”) as personal information under PIPEDA.
- Consider the impact of the trans-border flow of personal information on telehealth and electronic health record activities.
- Study the flow of international cross-border data, particularly among Canadian researchers who receive funding from US drug companies.