

CMA's Submission to the Senate Standing
Committee on Transport and Communications

Bill S-4: An Act to amend the Personal
Information Protection and Electronic
Documents Act and to make a consequential
amendment to another Act

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Submitted by: Canadian Medical Association



A healthy population and a vibrant medical profession • Une population en santé et une profession médicale dynamique

Founded in 1867, the Canadian Medical Association (CMA) is the national voice of Canadian physicians. CMA's mission is helping physicians care for patients. Our vision is that CMA will be the leader in engaging and serving physicians, and be the national voice for the highest standards for health and health care.

On behalf of its more than 80,000 members and the Canadian public, CMA performs a wide variety of functions. Key functions include advocating for 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 51 national medical organizations.



Introduction

The Canadian Medical Association (CMA) is pleased to make submissions on Bill S-4. CMA has followed the history of PIPEDA and participated in the studies of various Standing Committees, most notably and recently in 2007 to the House of Commons Standing Committee on Access to Information, Privacy and Ethics. CMA is pleased that amendments to PIPEDA are once again being considered.

The Canadian Medical Association represents over 80,000 physicians in Canada. Privacy is an important value to physicians and the patients to whom they serve. This is reflected in our *Code of Ethics* and policies, in particular, *Principles for the Protection of Patients' Personal Health Information* and *Statement of Principles: The Sale and Use of Data on Individual Physicians' Prescribing*. Physicians are also required to abide by privacy and confidentiality standards of practice. Thus, the CMA has a strong interest and valuable insights into the topic of personal information and privacy with respect to health information.

We thank the Standing Committee for the opportunity to comment on the proposed amendments to PIPEDA. Our key comments are outlined below:

Issue 1:

CMA supports the existing legislative framework on the collection, use and disclosure of personal information produced by an individual in the course of their employment, business or profession ("work product") and suggests further amendments focus on strengthening it further.

CMA supports the current standing of work products, that work products are considered to be personal information. That is, we support the framework defining personal information as information about an identifiable individual and that there is no carved out definition or exemption for "work product".

CMA supports the position of the Office of Privacy Commissioner's following its 2007 investigation on work products, that they should not be exempted for two main reasons:

The exemption is not needed, and it would be inconsistent with the balanced approach in the current definition of personal information. The current definition of personal information and the approach to deciding issues based on that definition have worked well. They have promoted a level of privacy protection that balances the right of privacy in personal information with the needs of organizations for the reasonable and appropriate collection, use and disclosure of personal information. ...Because the concept of "work product" is ambiguous, excluding it from the definition of personal information could have unpredictable consequences that would diminish privacy unnecessarily.

http://www.priv.gc.ca/parl/2007/sub_070222_03_e.asp

It is the CMA's position that work products should be considered personal information and given the section 7 amendments, work products should only be collected, used or disclosed without consent only if it is consistent with the purposes for which the information was produced.

In the case of physicians, a prime example of a physician's work product is prescribing information. Prescribing information is a synthesis of assessing patients - by probing into their health, familial, social and sometimes financial background - infused with medical knowledge, skill and competencies resulting in a diagnosis and treatment plan, which often includes prescribing a medication or test. Not

only is the physician's prescribing information a product of physicians' work but would not exist but for a trusting physician-patient relationship wherein the patient's private and personal information are shared under circumstances of vulnerability and trust. The outcome is that this is personal information. Prescribing information is about an individual: it includes the name of the patient, the name of the prescribing physician, and the drug name, dosage, amount and frequency; giving major clues as to what the patient's health issue(s) are.

For further clarity, however, CMA recommends that physician information, and physician work products, should be specifically recognized within the legislation as personal information. To this end, we would propose that the following addition be made to the definition section under personal health information:

Section 2.(1) "personal health information", with respect to an individual, whether living or deceased, means(d) information that is collected or is the outcome of collecting information in the course of providing health services to the individual;

CMA supports the amendments to subsections 7(1)-(3) of the Act that any subsequent collection, use and disclosure of work products without consent must be related to the original purpose (of collection, use and disclosure). This relationship reflects the government's understanding and faithfulness to privacy principles. This is particularly critical when dealing with health information, and is even more critical in today's world given the ease of linking information through advancements in technology. In the absence of a causal relationship, personal information should not be used for system performance, commercial enterprise, data brokering, research, assessment or other purposes.

CMA recommends that the legislation should go further and allow persons who believe that protection cannot be afforded under the legislation that they have the authority to refuse to communicate the information. This is the conceptual approach taken in Quebec's *Act Respecting the Protection of Personal Information in the Private Sector* wherein persons have an opportunity to refuse that professional information (as defined therein) be used for commercial purposes. Physicians are constantly writing prescriptions and such information should only be used for other purposes in the interests of patients and the health care system, and not to serve commercial interests or marketing strategies. If physicians do not feel that such protection is afforded patients, then they should be permitted to refuse that such information be collected, used or disclosed. Patient privacy should be primary.

And finally, addressing work products in legislation clears up past differences of interpretation by Privacy Commissioners thus, providing certainty and clarity to the public.

Recommendation 1:

That Section 2. (1) "personal health information", be amended to read as follows: "personal health information", with respect to an individual, whether living or deceased, means(d) information that is collected or is the outcome of collecting information in the course of providing health services to the individual;

Issue 2:

CMA is pleased to see a section on breaches of security safeguards and recommends greater specificity.

As noted above, physicians have responsibilities as data stewards and custodians of health information. As such, CMA supports breach notification measures that would enhance and protect patient privacy. In principle, we support the proposed amendments of breach disclosures to the Privacy Commissioner, to individuals and to organizations.

However, CMA is concerned that meeting the requirements may be confusing. For example, in the health care context, it is easy to surmise that all health information is “sensitive”. A far more difficult matter is determining whether the risk reaches the threshold of “significant harm” and the “probability” that the information “will be misused”. The result being that incidental disclosures will be reported causing unnecessary concern and confusion in the patient population. Further specificity is recommended and we suggest something akin to Ontario’s *Personal Health Information Protection Act, 2004* (PHIPA).

The PHIPA is an act specifically dealing with personal health information. One of its purposes is “to establish rules for the collection, use and disclosure of personal health information about individuals that protect the confidentiality of that information and the privacy of individuals with respect to that information, while facilitating the effective provision of health care” (section 1a). The PHIPA notification provision states that the individual shall be notified “...at the first reasonable opportunity if the information is stolen, lost or accessed by unauthorized persons”, [section 12(2)]. CMA is unaware of any concerns with this approach.

The language of PIPEDA is one of reasonable belief of real risk of significant harm to an individual. The issue is the test for required notification of patients for incidental inadvertent breaches and decreasing “notification fatigue”. To illustrate the issue, if physicians were told today that patient data could be retrieved from the drums of discarded photocopiers and printers, it would be inappropriate for legislation to suggest that the entire patient population during the life of the photocopier or printer be notified. To this end, we recommend that there be acknowledgement that in some circumstances notification may not be required. The probability of misuse under PIPEDA is more ambiguous than the PHIPA test. Under PHIPA, the approach is more objective in that the data must be stolen, lost or accessed by unauthorized persons. To our knowledge, the Ontario model has been in place for almost a decade with no significant issues and thus we submit is one that works.

In other jurisdictions (eg., Newfoundland and Labrador, Nova Scotia, New Brunswick) with health privacy legislation, there is acknowledgement of trying to balance notification and those breaches unlikely to result in harm by directly indicating when notification is not required.

Recommendation 2:

CMA recommends that the statute move towards a more objective test and acknowledge that there are situations when notice is not required.

Issue 3:

CMA supports disclosure without consent under limited circumstances, but finds the current list of disclosures overly inclusive.

Health information is considered highly sensitive information and is initially collected for the purpose of individual patient health care. It should only be disclosed with consent and in only some exceptions without consent. The PIPEDA amendments for disclosure without consent have been broadened.

Privacy, confidentiality and trust are the foundations of the patient-physician relationship. Without these fundamental values in play, open and honest communications cannot occur and patients would not receive the care they require. Both the patient and the physician have significant investment in the relationship. CMA respects the requirements to disclose information without consent under certain premises, such as required by court order or statute. However, any kind of activity requiring physicians to disclose patient's information without consent for the purposes of advancing a government or institution's goal could jeopardize the relationship.

Both the patient's consent and the physician's consent should be required if there is potential to disturb this relationship. The physician is fiduciary of the relationship and is appropriately situated to assess and determine whether disclosure will disturb the relationship.

While CMA acknowledges that certain situations may require that disclosure occur without consent (eg. purposes of investigating fraud, national security, abuse or as legally required), disclosure for less malicious activities (e.g., breaches of an agreement, insurance claims) ought to require a court order or warrant. For example, under the proposed section 7(3)(d.1) if a physician were in default of a contract with a technology company supplying electronic medical record software or app to his/her clinic, the company could disclose health information without consent for the "purposes of investigating a breach of an agreement". While we appreciate that there is a caveat that disclosure without advising the patient can only occur if there is a reasonable expectation that the disclosure would compromise the investigation, we submit that leaving the determination of what is "reasonable" to an interested party to the breach is unfair to all. Another example, if a physician is a witness to a dispute between an employer and union representing an employee for denial of long term disability by an insurance company, and has filed a witness statement which includes a medical report he/she wrote to the employer's insurance company, under the proposed section 7(3)(e.1) disclosure of health information without consent is permitted in order to assess, process or settle an insurance claim.

CMA is concerned that the disclosure amendments are overly broad and do not differentiate sufficiently between highly time sensitive or grossly malicious situations, and those where it is merely expedient or an administrative encumbrance to seek consent.

In addition, the disclosure requirements are framed in permissive (ie., may) and not mandatory language (ie., shall). This is very problematic when the "organization" is a physicians' clinic unless the physician's own consent is made as a pre-condition. CMA believes this suggestion is a progressive one in keeping with the broadened disclosure amendments. Physicians are in a relationship of trust and take seriously the protection of patient privacy and confidentiality, for which they are trained and are ethically and legally required to protect.

To place physicians in a position which might entail breaching this trust may impact the confidence of the physician and the patient in the patient-physician relationship which is required to properly formulate appropriate treatment plans; thus, negatively impacting the health of Canadians.

Recommendation 3:

That disclosures of health information without consent require a warrant or subpoena or court order. Furthermore, disclosures of health information require the physician's consent that in his/her opinion the disclosure does not harm the patient-physician relationship. And, finally any broadened disclosure situations be restricted to criminal activity or that impacting national security.

Conclusion

Once again, CMA appreciates the opportunity to provide comment as part of the committee's study of Bill S-4. CMA is prepared to work with Parliament, governments, health professionals and the public in ensuring legislative frameworks for the collection, usage and disclosure of personal information for legitimate and reasonable purposes.