6. Privacy and Disclosure

To fight infectious disease, public health authorities require timely access to personal health information. The first step to correct the access problems encountered during SARS is to strengthen the reporting and information-sharing provisions of the *Health Protection and Promotion Act* as recommended above.

This, however, is far from enough. The second step is to amend the privacy legislation to make it crystal clear that it was never intended to impede the flow of vital health information mandated by the *Health Protection and Promotion Act.*

Since SARS, a new set of privacy laws have come into force. These complex laws are poorly understood and they create, as a practical matter, serious barriers to the sharing of patient information urgently required by public health authorities.

Even if the *Health Protection and Promotion Act* is amended to expand and clarify reporting obligations and information-sharing powers, those who have the information and the public health officials who need it, will have to navigate a complicated series of privacy laws to see if they are able to disclose information. Consequently, medical officers of health may now expect resistance on two fronts: firstly that the disclosure is not required under the *Health Protection and Promotion Act,* then if they pass that hurdle, that the disclosure is not permissible because it would violate existing privacy legislation.

This is not to criticize the policy behind the new privacy regime. It is not fair to blame privacy policies for failures to report infectious disease as required by law. The problem is that the privacy laws are so complex they are not easily understood even by lawyers. This lack of understanding, coupled with a privacy culture that conditions people to say no to disclosure automatically, must be overcome in relation to the reporting of disease to public health officials.

It is not enough to dismantle the first hurdle of reporting powers and sharing information without addressing also the second hurdle of confusing privacy requirements.

Ontario's Privacy Legislation

In Ontario, Bill 31, *The Personal Health Information Protection Act, 2004* received royal assent on May 20, 2004.[192]

The main provision of *The Personal Health Information Protection Act* authorizing the disclosure of information to public health officials under the *Health Protection and Promotion Act* is s. 39(2)(a) which provides:

> 39(2) A health information custodian may disclose personal health information about an individual,
>
> (a) to the Chief Medical Officer of Health or a medical officer of health within the meaning of the Health Protection and Promotion Act if the disclosure is made for a purpose of that Act …

This provision gives health information custodians discretion to disclose information for the purpose of the *Health Protection and Promotion Act*. The broad purposes of the *Health Protection and Promotion Act* include the prevention of the spread of disease.[193]

Although the provision deals with a broad range of disclosure that health information custodians are under no legal obligation to disclose under the *Health Protection and Promotion Act*, it confusingly ignores disclosure that is legally required under specific provisions of the Act.

This provision, by ignoring the legally required disclosure that is at the heart of the *Health Protection and Promotion Act*, does nothing but confuse. It may be understood by lawyers steeped in the intricacies of the *Personal Health Information Protection Act*, to whom the distinction is clear between disclosure "made for a purpose" of the *Health*

192. The schedules to the Act did not come into full force until November 1, 2004.
193. Section 2 of the *Health Protection and Promotion Act* provides:

> The purpose of this Act is to provide for the organization and delivery of public health programs and services, the prevention of the spread of disease and the promotion and protection of the health of the people of Ontario.

Protection and Promotion Act and disclosure required by the Act.[194] But it cannot be clear to anyone else.

The provision misleads because it fails to distinguish between the "discretion" to disclose information "for the purpose of" the *Health Protection and Promotion Act* and the duty to disclose information required by the Act. To anyone but a privacy lawyer, it misleadingly suggests that disclosure under the *Health Protection and Promotion Act* is discretionary, not mandatory.

Whatever the internal legal logic that produced this provision,[195] its dangerous lack of clarity cannot be allowed to stand. It must be made clear to health information custodians that they must disclose all information required by the *Health Protection and Promotion Act* and that they have no discretion to refuse.

The Commission therefore recommends that s. 39 of the *Personal Health Information Protection Act* be amended by the following addition to make it clear that disclosure required by the *Health Protection and Promotion Act* is mandatory, not discretionary:

> A health information custodian shall disclose personal health information about an individual,
>
> > to the Chief Medical Officer of Health or a medical officer of health if the disclosure is required under the *Health Protection and Promotion Act*.

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194. They would doubtless point to s. 6(3) of the *Personal Health Information Protection Act* which provides:

    Permissive disclosure

    (3) A provision of this Act that permits a health information custodian to disclose personal health information about an individual without the consent of the individual,

    (a) does not require the custodian to disclose it unless required to do so by law;

    (b) does not relieve the custodian from a legal requirement to disclose the information; and

    (c) does not prevent the custodian from obtaining the individual's consent for the disclosure.

195. See previous footnote. The only way to do this is to give the mandatory reporting duty in respect of reports required under the *Health Protection and Promotion Act* a more prominent position in relation to s. 39(2) of the *Personal Health Information Protection Act*.

Disclosures that are not authorized by the *Health Protection and Promotion Act* or "for the purpose of the Act" must be authorized by another section in the *Personal Health Information Protection Act*. Authorization for such a disclosure would appear to lie in ss. 43(1)(g) or (h) of the Act, which provides:

> 43(1) A health information custodian may disclose personal health information about an individual . . .
>
> > (g) subject to the requirements and restrictions, if any, that are prescribed, to a person carrying out an inspection, investigation or similar procedure that is authorized by a warrant or by or under this Act or any other Act of Ontario or an Act of Canada for the purpose of complying with the warrant or for the purpose of facilitating the inspection, investigation or similar procedure;
> >
> > (h) subject to the requirements and restrictions, if any, that are prescribed, if permitted or required by law or by a treaty, agreement or arrangement made under an Act or an Act of Canada.

Subsection 43(2), the interpretation provision, provides:

> (2) For the purposes of clause (1) (h) and subject to the regulations made under this Act, if an Act, an Act of Canada or a regulation made under any of those Acts specifically provides that information is exempt, under stated circumstances, from a confidentiality or secrecy requirement, that provision shall be deemed to permit the disclosure of the information in the stated circumstances.

This latter demonstrates the lack of clarity that creates problems in the *Personal Health Information Protection Act*. Although a legal privacy expert may understand it, anyone else would find it hard to grasp. The question is not whether those lawyers intimately familiar with the statute understand what they think it means, but whether the statute is clear to those who have to work with it, and those lawyers who have to advise those who work with it.

In addition to these disclosure provisions, there is a general disclosure power contained in ss. 40(1) of the *Personal Health Information Protection Act:*

> 40(1) A health information custodian may disclose personal health information about an individual if the custodian believes on reasonable grounds

> that the disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons.

A disclosure in this case is discretionary and will depend on the custodian's belief that reasonable grounds exist to make the disclosure, adding a subjective decision making layer. It is up to the individual deciding whether to disclose to determine what evidence is sufficient to meet the standard of "reasonable grounds to believe" and what constitutes a "risk of serious bodily harm to a person or group of persons."

The sections permitting disclosure to public health officials are intended to enable where necessary the free flow of information for the protection of the public. But they are far from clear and the decision to disclose will, in many cases, require the health information custodians to use their discretion. The problem is that health information custodians with any doubt about their ability to disclose will naturally err on the side of nondisclosure, having regard to the presumption of nondisclosure created by the privacy culture and the severe penalties against violating the privacy laws.

Subsection 72(1) of the *Personal Health Information Protection Act* provides that anyone who "wilfully collects, uses or discloses personal health information in contravention of this Act or its regulations" is guilty of an offence. Section 65 provides that damages may be sought where there has been a violation of the Act, either as a consequence of an order by the Commissioner to remedy a violation or as a result of conviction under s. 72(1).[196] A breach of s. 72 carries the potential for significant monetary

196. Section 65 provides:

> Damages for breach of privacy
>
> (1) If the Commissioner has made an order under this Act that has become final as the result of there being no further right of appeal, a person affected by the order may commence a proceeding in the Superior Court of Justice for damages for actual harm that the person has suffered as a result of a contravention of this Act or its regulations. 2004, c. 3, Sched. A, s. 65 (1).
>
> Same
>
> (2) If a person has been convicted of an offence under this Act and the conviction has become final as a result of there being no further right of appeal, a person affected by the conduct that gave rise to the offence may commence a proceeding in the Superior Court of Justice for damages for actual harm that the person has suffered as a result of the conduct. 2004, c. 3, Sched. A, s. 65 (2).
>
> Damages for mental anguish
>
> (3) If, in a proceeding described in subsection (1) or (2), the Superior Court of Justice determines that the harm suffered by the plaintiff was caused by a contravention or offence, as the case may be, that the defendants engaged in willfully or recklessly, the court may include in its award of damages an award, not exceeding $10,000, for mental anguish.

penalities,[197] including a fine of up to $50,000 for an individual like a nurse and up to $250,000 for a corporation like a hospital. Officers, members, employees or other agents of a corporation may also be personally subject to prosection under s. 72(3) if they authorized the offence or had the authority to prevent it, and knowingly refrained from doing so.

It is essential to clarify the privacy legislation by way of a simple amendment lest it be blamed for nondisclosure of vital information about infectious diseases.

Consider the tragic case in British Columbia of the young university student who committed suicide in February, 2004. University staff and health professionals, out of a mistaken belief that privacy legislation prevented disclosure, did not advise her mother of a previous suicide attempt, preventing her from taking action that might stop another attempt.[198] British Columbia's privacy legislation contained provisions that could have arguably authorized the disclosure.[199] As one newpaper editorial described the problem with the legislation:

> That these parts of the law [the sections that could have authorized the disclosure] can be interpreted in different ways presents a problem for hospital staff in that they're unlikely to act on their own interpretations for fear of running afoul of the law.[200]

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197. Subsection 72(2) provides:

> Penalty
>
> A person who is guilty of an offence under subsection (1) is liable, on conviction,
>
> (a) if the person is a natural person, to a fine of not more than $50,000; and
>
> (b) if the person is not a natural person, to a fine of not more than $250,000. 2004, c. 3, Sched. A, s. 72 (2).

198. Vancouver Sun, Editorial, July 13, 2004.

199. Consider, for example, the following sections of the *Personal Information Protection Act* (British Columbia).

> 18(1) An organization may only disclose personal information about an individual without the consent of the individual, if
>
> (k) there are reasonable grounds to believe that compelling circumstances exist that affect the health or safety of any individual and if notice of disclosure is mailed to the last known address of the individual to whom the personal information relates.
>
> (l) the disclosure is for the purpose of contacting next of kin or a friend of an injured, ill or deceased individual.

200. Vancouver Sun, Editorial, July 13, 2004.

The sentiment heard by the Commission in respect of Ontario's privacy legislation is that people are confused and intimidated by its complexity. The prevailing attitude seems to be, when in doubt, do not disclose. When the health of the public is at risk, this nondisclosure born of doubt and confusion cannot be permitted to continue.

Recommendation

The Commission therefore recommends that:

- **Section 39 of the *Personal Health Information Protection Act* be amended to include:**

- **A health information custodian shall disclose personal health information about an individual, to the Chief Medical Officer of Health or a medical officer of health if the disclosure is required under the *Health Protection and Promotion Act*.**

Disclosures by a Medical Officer of Health or the Chief Medical Officer of Health

The recommended amendments, set out above and below, will clarify the power of a health care custodian to disclose information to a medical officer of health or the Chief Medical Officer of Health. The problem remains of the ability of a medical officer of health or the Chief Medical Officer of Health to disclose information in respect of a person against whom an application, order, certificate or report is made in respect of a communicable disease. This is a power that is integral to their ability to protect the public.

Consider an example of a person infected with a virulent disease, such as SARS, against whom the medical officer of health issues an order under s. 22, requiring that they isolate themselves to avoid spreading the disease to others in the community. If that person ignores the order and continues to move about in the community, it is unclear if the medical officer of health can share with any person any information about that person, that will or is likely to identify them.

Consider the example of the woman with TB who managed to evade public health authorities, avoid apprehension under a s. 35 order, and leave Canada to travel to another country. If the medical officer of health in the jurisdiction which obtained the

order was unable to share personal identifying information with federal public health officials, border officials and quarantine officials in the federal government, they could not apprehend her as she attempted to re-enter Canada.

Although both disclosures might be permitted under the *Personal Health Information Protection Act,*[201] s. 39(1) of the *Health Protection and Promotion Act* contains a prohibition on disclosure of the name or identifying information of a person against whom an application, order, certificate or report under the communicable disease provisions of the Act have been made. Subsection 39(1) provides:

> No person shall disclose to any other person the name of or any other information that will or is likely to identify a person in respect of whom an application, order, certificate or report is made in respect of a communicable disease, a reportable disease, a virulent disease or a reportable event following the administration of an immunizing agent.

Subsection 2 sets out exceptions to the prohibition of disclosure in s. 39(1). It provides:

> Subsection (1) does not apply,
>
> (a) in respect of an application by a medical officer of health to the Ontario Court of Justice that is heard in public at the request of the person who is the subject of the application;
>
> (b) where the disclosure is made with the consent of the person in respect of whom the application, order, certificate or report is made;
>
> (c) where the disclosure is made for the purposes of public health administration;

201. For example, s. 40(1) of the *Personal Health Information Protection Act*, discussed in greater detail below, permits disclosure if "the custodian believes on reasonable grounds that the disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons." Subsection 39(2)(b) of the *Personal Health Information Protection Act* permits disclosure of personal health information by a health information custodian to a public authority that is similar to the Chief Medical Officer of Health or a medical officer of health, that is established under the laws of Canada, some other province or territory, if the disclosure is made for a purpose that is substantially similar to a purpose of the *Health Protection and Promotion Act*. Section 2 of the *Health Protection and Promotion Act* includes the prevention of the spread of disease and the promotion and protection of the health of the people of Ontario. A medical officer of health is defined as a health information custodian under s. 3 of the *Personal Health Information and Protection Act*.

> (d) in connection with the administration of or a proceeding under this Act, the Regulated Health Professions Act, 1991, a health profession Act as defined in subsection 1 (1) of that Act, the Public Hospitals Act, the Health Insurance Act, the Canada Health Act or the Criminal Code (Canada), or regulations made thereunder; or
>
> (e) prevent the reporting of information under section 72 of the Child and Family Services Act in respect of a child who is or may be in need of protection.

For a medical officer of health or the Chief Medical Officer of Health to disclose identifying or potentially identifying information in respect of a person against whom an order, application, certificate or report has been made under Part IV (communicable diseases) of the Act, they must fit within one of these exceptions. Paragraph (c) appears to be the only provision that might authoritze disclosure in the circumstances described above.

This means that unless the medical officer of health can be confident that such a disclosure is for the purposes of "public health administration," they would be disclosing that information on the hope and a prayer that they are correct in their interpretation of the phrase. One public health lawyer descibed its lack of clarity to the Commission:

> There is a need to clarify what is meant by public health administration. Many might say that public health administration is meant to be interpreted to mean that you can tell your staff, for example those who are helping you draft orders, as opposed to meaning the medical officer of health can do what he or she needs to do to protect the public. It is not really very clear.

It is far from clear that this vague terminology allows the medical officer of health or the Chief Medical Officer of Health to do what is necessary to protect the public.

The Canadian Oxford Dictionary defines "administration" as "a management of a business" or "management of public affairs". It is far from clear that this would permit the disclosure of identifying or potentially identifying information to anyone outside of the local health unit of the Ministry of Health.

As one public health lawyer said:

> There are a lot of circular arguments. The bottom line is that would probably be fine to disclose and people might not get wound up about it but it would be nice to be clear.

The Chief Medical Officer of Health and medical officers of health must be able to share identifying information, where necessary to protect the public. The fact that the person has been the subject of an application, order, certificate or report should not prohibit disclosure, provided it is in compliance with the privacy legislation. This is particularly vital in respect of disclosures to public health officials in other provinces or in the federal government.

As Dr. Basrur told the Justice Policy Committee:

> It is not quite clear as yet how the chief medical officer of health in this case can and should report that information more broadly to, say, Health Canada or other authorities, and whether that can be nominal, or named, information with personal information in it or whether it must be anonymized information. So when you're looking at things that should be clearer in the future – again, I can expect you'll hear this from Justice Campbell in his interim report – that is one of those areas that would benefit from greater clarity.[202]

Recommendations

The Commission therefore recommends that:

- **Subsection 39(2) of the *Health Protection and Promotion Act* be amended to allow an exception to s. 39(1) to permit the disclosure of the name of or any information that will or is likely to identify a person in respect of whom an application, order, certificate or report is made in respect of a communicable disease, by the Chief Medical Officer of Health or a medical officer of health to any person where it is necessary to investigate or prevent the spread of a communicable disease.**

- **Subsection 39(2) of the *Health Protection and Promotion Act* be amended to allow an exception to s. 39(1) to permit the disclosure of the name of or any**

202. Justice Policy Committee, Public Hearings, August 18, 2004, p. 139.

> **information that will or is likely to identify a person in respect of whom an application, order, certificate or report is made in respect of a communicable disease, by the Chief Medical Officer of Health or a medical officer of health to a public health authority as described in s. 39(2)(b) of the *Personal Health Information Protection Act*.**

The Need for Clarity

Lawyers who advise health professionals and hospitals whether they should disclose will likely bear in mind the severe penalties in the privacy legislation and lean towards nondisclosure if there is any lack of clarity about the legal duty to disclose. Another risk is that the complexity of the law may enable individuals or institutions who do not want to disclose information, for whatever reason, to use the legislation as a shield and delay or breach their disclosure obligations.

The Ministry of Health and Long-Term Care, in a submission to the Commission, stated:

> It is our view that the new Personal Health Information Protection Act, 2004, (PHIPA) resolves any concerns relating to "legal obstacles" and "lack of clarity" as outlined in your attachment entitled "Possible Issues Re: Legislation." The passage of PHIPA received unanimous support in the Legislature. During the Committee hearings on the bill, there was no criticism that the proposed Act failed to address the concerns raised during the SARS outbreak.

While the legislation may appear clear to those who wrote it, the Commission has heard from many groups and individuals who find it unclear and confusing. As for the Committee hearings, one close observer of the proceedings told the Commission that the impact of the legislation on a new SARS-like outbreak was not discussed.

Consider the case of the hospital that took the position that there was not only an absence of legal authority to report cases of febrile respiratory illness to public health officials, but that to do so constitutes an illegal contravention of privacy legislation. Their interpretation of the legislation prohibited disclosure. Although no infection resulted from this position, it demonstrates that some will resist any disclosure to public health, however reasonable, unless an explicit legal duty can be demonstrated conclusively.

One professional organization described the need for clarity:

> … the patient's right to confidentiality does NOT override the public good. In providing care to any patient with a potentially infectious or contagious disease, all health care professionals (physicians, nurses, paramedics) and institutions MUST share such information in order to safeguard staff and to prevent further spread of the disease in question. The professionals involved are obligated to treat such information as confidential. Processes should be in place to address those individuals and/or institutions that fail to address this or who fail, in a timely manner, to provide appropriate confidentiality for the patient information that has been shared with them.

Expanded reporting duties and expanded information gathering and sharing powers under the *Health Protection and Promotion Act* are only part of the solution. Information necessary to enable public health officials to protect the public must not be blocked by the misunderstandings created by the complexities of privacy legislation. This is not to suggest that the provisions in the Act are not helpful, or thoughtfully drafted. But the duty to disclose information to public health officials, free from penalty under the privacy legislation, must be clear. It must be clear that if there is a duty to report a matter to public health, that duty prevails over any other consideration. As one health care provider told the Commission:

> … specific legislation that clearly defines which act supercedes another in given situations will be important.

The Ministry, in a letter to the Commission,[203] although reluctant to agree that changes are needed in the *Personal Health Information Protection Act*, acknowledged that the legislation is complex to the point that it would encourage health care providers to seek legal advice instead of acting immediately to comply with a valid demand for information under the *Health Protection and Promotion Act*:

> If Ontario had had a PHIPA in place during the SARS outbreak, all of these provisions that have been highlighted would have provided greater clarity around information sharing. PHIPA, therefore, addresses the perceived "lack of clarity" or "legal obstacles" facing various health infor-

203. Letter from Mr. Phil Hassen, Deputy Minister of Health and Long-Term Care, to the Mr. Justice Archie Campbell, SARS Commission, August 4, 2004. See Appendix H to this report.

> mation custodians during the SARS outbreak. The legislation, however, is complex as the rules cover a broad range of custodians and recipients. We cannot say, therefore, that this new Act is so clear that it would preclude health care providers from "seeking legal advice and direction instead of acting immediately." Even if legislation were to be written in mandatory language, this may not alleviate concerns of those who need to rely on it for authority to do something or refrain from doing something. PHIPA does clearly set out that custodians, such as hospitals, nursing homes, nurses and doctors, can disclose personal health information to the Chief Medical Officer of Health or a medical officer of health or a person with similar authority in another province and ultimately does provide protection from liability to those providers who exercise their discretion reasonably in the circumstances.

The point is not that there is anything wrong with legal advice. In the early stages of the life of a statute a measure of education is necessary. The problems reviewed here, however, require clarifying amendments as well as education. The point is that the law should be so clear that lawyers do not have to argue with each other in the middle of an infectious disease outbreak about the obligation to disclose information to public health. Notwithstanding the logic of those who are intimately familiar with the exquisite legal intricacies of the privacy legislation, it must be remembered that the life of the law is not logic, but experience. Experience tells us that if the privacy law does not clearly authorize disclosure where legally required for public health purposes, such disclosure will be impeded.

As Dr. Henry told the Justice Policy Committee:

> The one other caveat I wanted to bring up is the whole protection of privacy of health information. As you know, Bill 31 is going through the legislative process right now and it will in some ways severely curtail our ability to actually track and monitor certain diseases. I think we need to build our IT systems around protection of personal health information, but also somehow strike the balance between being able to use that information for the broader good and the prevention of transmission of disease. Right now that balance is a little unclear.[204]

204. Justice Policy Committee, Public Hearings, August 18, 2004, p. 151.

What is required is a simple statutory override to make clear that the duty to disclose to public health officials prevails over the privacy legislation. Even those who resist amendment agree that the duty to disclose to public health officials prevails over the privacy legislation. Why not say it clearly in the legislation?

Override provisions are not unheard of in statutes and indeed the *Health Protection and Promotion Act* itself contains one. The *Health Protection and Promotion Act* has been amended to set out the duties of disclosure and nondisclosure of a medical officer of health in respect of reports received about environmental or occupational health hazards, and the statute now provides an explicit override of the privacy legislation. Subsection 11(3) provides:

> The obligation imposed on the medical officer of health under subsection (2) prevails despite anything to the contrary in the *Personal Health Information Protection Act, 2004*. 2004.[205]

Both the *Personal Health Information Protection Act* and the *Health Protection and Promotion Act* must make it clear that the reporting obligations and information sharing powers set out in the *Health Protection and Promotion Act* prevail.

The Commission therefore recommends that the *Personal Health Information Protection Act* be amended to provide that nothing in the Act prevents a health information custodian from disclosing personal health information to the Chief Medical Officer of Health or a medical officer of health, pursuant to the *Health Protection and Promotion Act*.

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205. The complete provision reads as follows:

> 11(1) Where a complaint is made to a board of health or a medical officer of health that a health hazard related to occupational or environmental health exists in the health unit served by the board of health or the medical officer of health, the medical officer of health shall notify the ministry of the Government of Ontario that has primary responsibility in the matter and, in consultation with the ministry, the medical officer of health shall investigate the complaint to determine whether the health hazard exists or does not exist.
>
> (2) The medical officer of health shall report the results of the investigation to the complainant, but shall not include in the report personal health information within the meaning of the *Personal Health Information Protection Act, 2004* in respect of a person other than the complainant, unless consent to the disclosure is obtained in accordance with that Act.
>
> (3) The obligation imposed on the medical officer of health under subsection (2) prevails despite anything to the contrary in the *Personal Health Information Protection Act, 2004*.

The Commission recommends that both the *Health Protection and Promotion Act* and the *Personal Health Information Protection Act* be amended to provide that in the event of any conflict between the two statutes, the disclosure duties in the *Health Protection and Promotion Act* prevail.

The *Personal Health Information Protection Act* provides protection from punishment in those cases where a health information custodian makes a reasonable disclosure, in good faith reliance on the *Personal Health Information Protection Act*, that later turns out should not have been made. Section 71(1) provides:

> 71(1). No action or other proceeding for damages may be instituted against a health information custodian or any other person for,
>
> (a) anything done, reported or said, both in good faith and reasonably in the circumstances, in the exercise or intended exercise of any of their powers or duties under this Act; or
>
> (a) any alleged neglect or default that was reasonable in the circumstances in the exercise in good faith of any of their powers or duties under this Act.

While this provides a measure of protection, similar protection should be extended to those who disclose in reliance on the *Health Protection and Promotion Act*.[206]

The Commission recommends that the *Personal Health Information Protection Act* be amended to provide that where a good faith disclosure is made to the Chief Medical Officer of Health or a medical officer of health, in reliance on the *Health Protection and Promotion Act*, the health information custodian will be exempt from liability.

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206. The *Health Protection and Promotion Act* does exempt from liability a person who makes, in good faith, a report of a communicable disease under the Act. Subsection 95(4) provides:

> No action or other proceeding shall be instituted against a person for making a report in good faith in respect of a communicable disease or a reportable disease in accordance with Part IV.

This protection does not clearly protect them from liability under privacy legislation. Morevoer, if the reporting powers are broadened as recommended in Chapters 5 and 6 of this report, the protection afforded in s. 95(4) will have to be similarly broadened to protect any report authorized under the *Health Protection and Promotion Act*.

Recommendations

The Commission therefore recommends that:

- **The *Personal Health Information Protection Act* be amended to provide that nothing in the Act prevents a health information custodian from disclosing personal health information to the Chief Medical Officer of Health or a medical officer of health, pursuant to the *Health Protection and Promotion Act*.**

- **The *Health Protection and Promotion Act* and the *Personal Health Information Protection Act* be amended to provide that in the event of any conflict between the two statutes, the disclosure duties in the *Health Protection and Promotion Act* prevail.**

- **The *Personal Health Information Protection Act* be amended to provide that where a good faith disclosure is made to the Chief Medical Officer of Health or a medical officer of health, in reliance on the *Health Protection and Promotion Act*, the health information custodian is exempt from liability.**

Disclosure for Research

A number of groups and individuals expressed concern to the Commission about the process by which scientists, during a health emergency, would have access to personal health information urgently required for the purpose of research to fight the emergency. During SARS, it was critical for scientists to have access to data to learn more about the cause of SARS and research possible treatment.

Section 44 of the *Personal Health Information Protection Act* sets out the rules in respect of disclosure of personal health information for the purposes of research.[207]

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207. Section 44 provides:

> Disclosure for Research
>
> 44(1) A health information custodian may disclose personal health information about an individual to a researcher if the researcher,
>
> (a) submits to the custodian,

While long-term research is important, SARS revealed the importance of immediate short-term research. Rules and guidelines that permit the fast tracking of approval for disclosure of personal health information where research is urgently required are

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(i) an application in writing,

(ii) a research plan that meets the requirements of subsection (2), and

(iii) a copy of the decision of a research ethics board that approves the research plan; and

(b) enters into the agreement required by subsection (5).

Research Plan

(2) A research plan must be in writing and must set out,

(a) the affiliation of each person involved in the research;

(b) the nature and objectives of the research and the public or scientific benefit of the research that the researcher anticipates; and

(c) all other prescribed matters related to the research.

Consideration by Board

(3) When deciding whether to approve a research plan that a researcher submits to it, a research ethics board shall consider the matters that it considers relevant, including,

(a) whether the objectives of the research can reasonably be accomplished without using the personal health information that is to be disclosed;

(b) whether, at the time the research is conducted, adequate safeguards will be in place to protect the privacy of the individuals whose personal health information is being disclosed and to preserve the confidentiality of the information;

(c) the public interest in conducting the research and the public interest in protecting the privacy of the individuals whose personal health information is being disclosed; and

(d) whether obtaining the consent of the individuals whose personal health information is being disclosed would be impractical.

Decision of Board

(4) After reviewing a research plan that a researcher has submitted to it, the research ethics board shall provide to the researcher a decision in writing, with reasons, setting out whether the board approves the plan, and whether the approval is subject to any conditions, which must be specified in the decision.

needed for the protection of the public's health. As one health organization submitted to the Commission:

> … the *Personal Health Information Protection Act* needs to address the collection and use of confidential health information for research purposes during an infectious disease outbreak. During a health emergency, pressure may be brought to bear on hospital Research Ethics Boards for expedited approval of research and investigations designed to gain a better understanding of a new infectious disease. While such expediency is understandable, clear guidelines for the fast track approval of such studies is required, and the emergency sharing of health information on which the study depends. This is extremely critical when dealing with new agents of illness, where research findings will enable control of the outbreak.

Recommendation

The Commission therefore recommends that:

- **The Ministry of Health and Long-Term Care, in consultation with the appropriate community, establish fast-tracking approval procedures for access to personal health information for the purposes of urgently required research, to enable health care custodians to provide access to data in a timely manner, without fear of violating privacy legislation.**

Privacy Safeguards

Safeguards are required to ensure that personal health information does not get disclosed beyond public health professionals who have public health duties.[208] During SARS, one medical officer of health reported that functionaries in the Minister's office, who had no public health duties, were at times privy to personal health information. They questioned why this was the case and maintained that under no circumstances would this be necessary:

208. The *Health Protection and Promotion Act* provides some safeguards to protect personal health information in the hands of public health officials. For example, s. 39 of the Act, discussed in the previous chapter.

> We sat in the SARS Committee meetings and I recall [an individual] from the Minister's office while we were discussing nominal information but very detailed clinical information – we were going through our line list of individuals – I thought it was completely outrageous … Non-health professionals, i.e. … Ministers and political staff, except those in the public health division who fall under confidentiality provisions of *HPPA,* should have no access to personal health information in times of crisis.

One professional organization described this problem to the Commission:

> During SARS multiple reports of the improper sharing of confidential health information, being requested by political staff who had no clear need for the information, and open teleconference discussions of nominal information on patients where the teleconference participants were unclear, were had. This is unacceptable, placing the individual and their care provider in a difficult position, should the information be inappropriately disseminated further.

The power to obtain personal health information brings with it strong obligations to safeguard its privacy. Medical officers of health, as health information custodians, are required under the *Personal Health Information Protection Act* to have in place practices that comply with the requirements of the Act and regulations:

> 10(1). A health information custodian that has custody or control of personal health information shall have in place information practices that comply with the requirements of this Act and its regulations. 2004, c. 3, Sched. A, s. 10(1).

These practices should be uniform across the province and should ensure that only those public health officials who require access to personal health information to perform their duties under the *Health Protection and Promotion Act* have access to such information.

Recommendation

The Commission therefore recommends that:

- **The Chief Medical Officer of Health review and, if necessary, strengthen the internal protocols and procedures now in place to ensure effective**

privacy safeguards for personal health information received by public health authorities.

Conclusion

Health professionals and public health professionals should not have to negotiate through lawyers to enable the disclosure of information required by law. There should be no avenue for delay. In an infectious disease outbreak, time is of the essence. Public health physicians and staff require access to personal health information to enable them to identify cases of disease and to investigate and manage an outbreak. Medical officers of health must be able to obtain the information they need to do their job, the disclosure of which is required by law. Confusion around complex privacy laws must not impede the vital flow of this legally required information. Simple amendments, which in no way affect the integrity of privacy legislation, are required to fix this problem.

Recommendations

The Commission therefore recommends that:

- **Section 39 of the *Personal Health Information Protection Act* be amended to include:**
    - **A health information custodian shall disclose personal health information about an individual, to the Chief Medical Officer of Health or a medical officer of health if the disclosure is required under the *Health Protection and Promotion Act*.**

- **Subsection 39(2) of the *Health Protection and Promotion Act* be amended to allow an exception to s. 39(1) to permit the disclosure of the name of or any information that will or is likely to identify a person in respect of whom an application, order, certificate or report is made in respect of a communicable disease, by the Chief Medical Officer of Health or a medical officer of health to any person where it is necessary to investigate or prevent the spread of a communicable disease.**

- **Subsection 39(2) of the *Health Protection and Promotion Act* be amended to allow an exception to s. 39(1) to permit the disclosure of the name of or any information that will or is likely to identify a person in respect of whom an**

application, order, certificate or report is made in respect of a communicable disease, by the Chief Medical Officer of Health or a medical officer of health to a public health authority as described in s. 39(2)(b) of the *Personal Health Information Protection Act*.

- **The *Personal Health Information Protection Act* be amended to provide that nothing in the Act prevents a health information custodian from providing personal health information to the Chief Medical Officer of Health or a medical officer of health, pursuant to the *Health Protection and Promotion Act*.**

- **The *Health Protection and Promotion Act* and the *Personal Health Information Protection Act* be amended to state that in the event of any conflict between the two statutes, the duties in the *Health Protection and Promotion Act* prevail.**

- **The *Personal Health Information Protection Act* be amended to provide that where a good faith disclosure is made to the Chief Medical Officer of Health or a medical officer of health, in reliance on the *Health Protection and Promotion Act*, the health information custodian will be exempt from liability.**

- **The Ministry of Health and Long-Term Care, in consultation with the appropriate community, establish procedures for the fast-tracking of approval of access to personal health information for the purposes of urgently required research, to enable health care custodians to provide access to data in a timely manner, without fear of violating privacy legislation.**

- **The Chief Medical Officer of Health review, and if necessary strengthen, the internal protocols and procedures now in place to ensure effective privacy safeguards for personal health information received by public health authorities.**