THE BALANCE BETWEEN PRIVACY AND DISCLOSURE OF HEALTH INFORMATION:

An Examination of Legal Access to Hospital Records

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INTRODUCTION

It is common knowledge that communication between a lawyer and a client is both privileged and confidential. The lawyer is under a legal duty not to disclose the communications to third parties and, except in limited circumstances, the client may refuse to disclose the communications to anyone. The privilege and confidentiality are imposed because of the solicitor/client relationship. This relationship is based on trust and the requirement for full and frank disclosure to enable the solicitor to provide the client with the most effective legal representation. The relationship between a physician and a patient is also based on trust and requires full and frank disclosure if the physician is to provide the patient with the most effective treatment. Yet, our legal system does not "protect" physician/patient communications to the same extent as it does solicitor/client communications. Frequently, the patient's wishes for confidentiality and privacy may be overridden by the reasons of furtherance of truth, achievement of a full defence for an accused and the maintenance of justice.

Legislation, codes of ethics, and decided cases reveal a struggle and balancing act between patients' rights of privacy, the integrity of the health system and the legal need for certain information. This struggle and balancing act becomes more complex when the patients involved are children or are adults requiring psychiatric treatment, as vulnerable groups are often not capable of protecting their own rights. This paper tries to record the struggle and balancing act by reviewing law on disclosure of health records, particularly as it relates to minors' health records and mental health records. The paper will discuss:

i) a person's right to privacy;

ii) a health professional's obligation to maintain confidentiality;

iii) access issues; and

iv) proposed changes in our legal system.

RIGHT TO PRIVACY

II. RIGHT TO PRIVACY[1]:

It is generally recognized that individuals have a limited right to privacy. As against the government, the right to privacy has been held to be protected by both sections 7 and 8 of the *Canadian Charter of Rights and Freedoms*.[2] Section 7 provides that every person has the right to life, liberty and security of person, and the right not to be deprived thereof except in accordance with the principles of fundamental justice.[3] Courts have held that "liberty", and "security of person" relate to privacy as they each are connected to human dignity. In order to enjoy the rights guaranteed in section 7, a person must be entitled to maintain control over his or her autonomy.[4] This autonomy includes having control over one's physical and psychological integrity.[5] The courts recognize that "when a private document or record is revealed and the reasonable expectation of privacy is therein displaced, the invasion is not with respect to the particular documents or record in question. Rather it is an invasion of the dignity and self-worth of the individual, who enjoys the right to privacy as an essential aspect of his or her

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[1]Privacy includes all spheres: spatial, physical and informational. *R.* v. *Dyment*, [1988] 2 S.C.R. 417 at p. 419 (hereinafter *Dyment*).

[2] Part I of the *Constitution Act*, 1982, being Schedule B to the *Canada Act* 1982 (U.K.), 1982, c. 11 (hereinafter *Charter*). The following cases have discussed the notion that s. 7 includes the right to privacy: *R.* v. *Beare*, [1988] 2 S.C.R. 385 at 412; *B. (R.)* v. *Children's Aid Society of Metropolitan Toronto*, [1995] 1 S.C.R. 315 at 369. The following cases have discussed that s. 8 includes the right to privacy: *Hunter* v. *Southam Inc.*, [1984] 2 S.C.R. 145; *R.* v. *Pohoretsky*, [1987] 1 S.C.R. 945; *Dyment*, *supra* at note 1.

[3] It must be noted that these rights are only guaranteed against the state because the *Charter* does not apply to disputes between individuals.

[4] Reasons of Mme Justice Wilson in *R.* v. *Morgentaler*, [1988] 1 S.C.R. 30 at 171.

[5]As Madame Justice Wilson states, in the *Morgentaler* case that struck down the criminal code provision prohibiting abortion, "the right to security of person protects both the physical and psychological integrity of the individual." *Ibid.* at 173.

liberty in a free and democratic society."[6] This is why section 7 requires a system of "pre-authorisation" which justifies court intrusions into the records of witnesses in legal actions.[7] This system which will be explained below, will help maintain the integrity and hence the privacy of the individual.

Section 8 guarantees an individual's right to freedom from unreasonable search and seizure. The principal right protected by section 8 is individual privacy.[8] The rationale for this is because section 8 applies only where there is a reasonable expectation of privacy[9]. Again, lack of consent to obtain information about a patient invades an area of privacy essential to the maintenance of human dignity.

Thus, as a result of the connection between sections 7 and 8, and human dignity, the protection of a patient's privacy has been an area of growing concern for the courts. This fact is further enhanced given the vulnerability of certain individuals who seek treatment.[10] There is little doubt that the curtailment of access to records is justified where there is a need to protect the integrity and privacy of individuals. However, privacy can never be absolute, as it must be balanced with societal needs such as solving a crime or resolving a dispute.

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[6] Mme. Justice L'Heureux-Dube noted in *R.* v. *O'Connor*, [1995] 4 S.C.R. 411 at 487 (hereinafter *O'Connor*).
[7] *Ibid.* at 487.
[8] *R.* v. *Colarusso*, [1994] 1 S.C.R. 20.
[9] Reasonable expectation of privacy can be defined as the point where it can reasonably be seen the individual ceased to have a privacy interest in the subject-matter. (*Dyment*, *supra* note 1 at 418.)
[10] *Colarusso*, *supra* note 8 at para. 70.

OBLIGATIONS TO MAINTAIN CONFIDENTIALITY

III. OBLIGATIONS TO MAINTAIN CONFIDENTIALITY:

a) Ethical Obligations

The ethical obligation to maintain confidentiality of patient records and information is set out in both the *Canadian Psychological Association's* ("CPA") *Code of Ethics* and the *Canadian Medical Association's* ("CMA") *Code of Ethics*. The CPA's *Code of Ethics* mandates that information is not to be disclosed that is gathered about "colleagues, clients, students and members of organizations gained in the process of their activities, as psychologists, and which the psychologist has reason to believe is considered confidential by those persons, except as required or justified by law."[11] The CMA's *Code of Ethics* sets out that a physician "will keep in confidence information derived from his patients, or from a colleague, regarding a patient and divulge it only with the permission of the patient except when the law requires him/her to do so."[12] These *Codes* attempt to ensure that sensitive matters are kept private with the consequence of disclosure being punishment for professional misconduct. Moreover, outside the medical sphere, doctors and hospitals can become defendants in civil actions for breach of confidentiality.[13]

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[11] The Canadian Psychological Association, *Canadian Code of Ethics for Psychologists*, (1991) at standard I.38 (hereinafter *Code of Ethics for Psychologists*).

[12] The Canadian Medical Association, *Code of Ethics*, at rule 6.

[13] For example, in *Peters-Brown* v. *Regina District Board of Health*, [1996] 1 W.W.R. 337, a plaintiff sued and won when a hospital breached her confidentiality by posting her name on a list of previously identified cases with infectious body fluids.

Similar to the CPA and CMA professional codes, *The Model Code for the Protection of Personal Information: A National Standard for Canada*[14] sets out the minimum requirements for the protection of personal information. The objective of the *Model Code* is to assist organizations in developing and implementing policies and practices to be used in managing personal information.[15] The *Model Code* stipulates that an organization is responsible for personal information under its control and should designate parties who are accountable for the organization's compliance with the principles enclosed in the *Code*.[16] Such principles are to ensure that security safeguards appropriate for the sensitivity of the information shall be implemented to protect personal information.[17] Safeguards include locked filing cabinets, restricted access to offices, passwords and encryption. Therefore, health institutions[18] would be well advised to implement these minimum standards.

b) Statutory Duty

Protecting confidential information from unauthorised disclosure is also a legal requirement imposed by legislation. *The Health Promotion and Protection Act*[19] requires health professionals to maintain confidentiality. The purpose of this Act is to prevent the spread of disease and the promotion and protection of health. This occurs through the maintenance of confidentiality because patients

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[14]D. Mathers, ed., *Model Code for the Protection of Personal Information*, 1st ed. (Rexdale: March 1996) (hereinafter *Model Code*).
[15]*Ibid.* ss. 1.1-1.3.
[16]*Ibid.* s. 4.1.
[17]*Ibid.* s. 4.7.
[18] For the sake of simplicity, I will use "health institutions" to refer to institutions, crisis centres, clinics and hospitals.

will be less reluctant to tell their doctors the truth, if they know the information is privileged. The relevant section states that no person should disclose the name of a person, or any other information that will or is likely to identify a person who has a infectious disease, a reportable disease or a fatal disease.[20] As well, the *Mental Health Act*[21] stipulates that no person shall disclose, transmit or examine a clinical record.[22] However, this is subject to a few exceptions, as discussed below.

c) Common Law Duty

Custodians of records also have a common law duty to protect health information. The Supreme Court has recognised a doctor's trust relationship with his/her patients: "[the patient] is forced to reveal information of a most intimate character and to permit invasions of his body if he is to protect his life or health."[23]

Furthermore, the Supreme Court of Canada has determined that a physician-patient relationship is fiduciary[24] in nature.[25] This idea of a fiduciary relationship indicates the courts' recognition of a doctor's obligation to her or his patient to maintain confidentiality. Clearly, a doctor's obligation to maintain confidentiality hinges on the nature of the relationship. Similarly, the courts have

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[19]R.S.O. 1990, c. H-7.
[20]*Ibid.* s. 39(1).
[21]R.S.O. 1990, c. M-7 (hereinafter *MHA*).
[22]*Ibid.* s. 35(2).
[23]*Dyment*, *supra* note 1 at 433.
[24]In dissent, Mme Justice Wilson noted in *Frame* v. *Smith*, [1987] 2 S.C.R. 99 at 136, a fiduciary obligation has three characteristics: 1) the fiduciary has scope for the exercise of some discretion or power, 2) the fiduciary can unilaterally exercise that power or discretion so as to affect the beneficiary's legal or practical interests, and 3) the beneficiary is pecuniarly vulnerable to or at the mercy of the fiduciary holding the discretion or power.

recognised that a counsellor-patient relationship shares a like categorisation. Counsellors have a duty to maintain confidentiality and secure all material that is under the control of the centre; this material is not be disclosed except where required by law.[26] Therefore, regardless of the type of relationship, disclosure must occur if it is required by law. This controversial exception varies depending on the circumstances in each case.

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[25]Justice La Forest recognised this in his judgment of *McInerney* v. *MacDonald,* [1992] 2 S.C.R. 138 (hereinafter *MacDonald*).

[26]*R.* v. *Carosella*, [1997] 1 S.C.R. 80 at para 3. In this judgment, the particular sexual assault centre had a stipulation in its agreement with the government, who was funding their centre, to maintain confidentiality.

GENERAL ACCESS ISSUES

IV. GENERAL ACCESS ISSUES:

The *Model Code* states that personal information shall not be used or disclosed for purposes other than those for which they are collected, except with the consent of the individual or as required by law.[27] The legal requirements vary considerably depending on: i) who requests access, ii) the purpose for the access, and iii) by what authority he or she requests access to the records. Each of these issues shall be canvassed.

a) Patients:

If a health care professional wishes to use a patient's record for research or the purpose of study, the patient's consent is required. The patient's consent must be informed[28] and preferably in written form so that a record of the consent exists.

Upon request, an individual shall be given access to his or her information.[29] This general access applies to health institutions. However, it must be remembered that the record is not the patient's. Rather, the physician holds ownership of the medical records while the information in the record is the subject of a fiduciary trust.[30] The doctor has the discretion to deny the patient

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[27] *Model Code, supra* note 14 at s. 4.5.

[28] The test for informed consent was outlined by the court as having the following requirements: 1) there was consent, express or implied 2) the giver of the consent had the authority to give the consent in question 3) the consent was voluntary in the sense that it was not the product of oppression, coercion, or other external conduct which negated the freedom to choose 4) the giver of the consent was aware of the nature of the conduct to which he or she was being asked to consent 5) the giver of consent was aware of his or her right to refuse consent 6) the giver of consent was aware of the potential consequences of giving the consent. [*R.* v. *Wills* (1992), 52 O.A.C. 321 (Ont. C.A.).]

[29] *Model Code, supra* note 14 at s. 4.9 .

[30] *MacDonald, supra* note 25.

access to the records if the physician reasonably believes it is not in the patient's best interests to inspect the documents. However, the onus is on the physician to satisfy this requirement.[31] A patient is entitled to all information in his/her file; this entitlement includes those notes made by other doctors which the doctor considered in administering advice or treatment.[32] As well, the patient is required to pay for copies of health records.[33]

b) Common Law Reporting Obligations

The duty to maintain confidentiality may be overridden when a third party or the patient has or may potentially suffer harm. For example, disclosure *may*[34] be acceptable without consent when there is a duty to warn third parties. In the United States, a California court recognised that health care professionals have a duty to warn if they have reason to believe that a patient may threaten or cause harm to another person.[35] In this case, a psychiatric out-patient stated to his therapist that he intended to kill a woman. Although the therapist called the campus police, the young man was only detained and the woman was later murdered. The court held that the woman should have been warned directly.

The California decision was cited with approval by the Alberta Court, Queen's Bench in *Wenden* v. *Trikha*.[36] In *Wenden*, the court sought to answer the

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[31] *Ibid.*, at 139.
[32] *Ibid.*, at 159.
[33] *Traverse* v. *Turnbull,* [1995] N.S.J. No. 489 (N.S.S.C.).

[34] I say "may" because Canadian courts have not yet examined this issue at great length.
[35] *Tarasoff* v. *Regents of the University of California*, 131 Cal. Rptr. 14 (1976).
[36] [1991] A.J. No. 612 (hereinafter *Wenden*).

question of a psychiatrist's duty. The Court held that a hospital which treated mentally ill patients owed a duty of care to a person other than its staff or patients, if it was foreseeable that harm would likely occur to such a person as a result of the behaviour of the mentally ill patient. This duty is owed provided that there is some further ingredient (i.e., naming the third party) which established a relationship between the hospital and the third party. Hence, *Wenden* places a higher test on psychiatrists than the more broad California decision. Furthermore, the CMA has suggested that in certain circumstances it may not be unethical to disclose to a patient's partner, without a patient's consent, AIDS related information. However, it has been argued that due to policy considerations such disclosure is illegal.[37]

c) Statutory Reporting Obligations

Another occasion in which health care professionals must disclose health records is when a professional must report to the Children's Aid Society where child abuse is suspected. Subsection 72(3) of the *Child and Family Services Act*[38] states that a health care professional must report child abuse, together with the information on which it is based, if he or she has reasonable grounds to suspect that a child is suffering from abuse. Therefore, if a health care custodian believes

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[37] D. Carswell, "Disclosure by a Physician of AIDS-Related Patient Information: An Ethical and Legal Dilemma" (1989) 68 No. 2 *The Canadian Bar Review* 225. Because this issue has not been thoroughly examined, it is difficult to conclusively determine what a physician should do in such circumstances.

[38] R.S.O. 1990, c. C-11 (hereinafter *CFSA*).

a child is abused and the information that he or she bases this belief on is provided in the child's health records, the records must be disclosed.

d) Authorities:

Counsellors and doctors are often compelled to disclose health information to authorities for the purpose of criminal and civil proceedings. The proper procedure for obtaining production of hospital records is set out in the *Canadian Criminal Code*[39] and *The Rules of Civil Procedure*[40].

i) Search Warrants

In criminal law, the first step to record disclosure is obtaining a search warrant. This warrant is issued by a justice of the peace and is based on sworn evidence by a peace officer. This evidence must give the justice reasonable grounds to believe that a search will afford evidence related to that offence. A search warrant must contain the following requirements: i) an adequate description[41] of the things to be seized; ii) an adequate description of the offence being investigated; and iii) it must accurately specify a location to be searched. A warrant is limited to confiscation of things "in a building, receptacle or place", computer files[42], prints or impressions[43] and blood samples or bodily samples relevant to the related offence[44]. The *Criminal Code* stipulates that nothing in the

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[39] *Canadian Criminal Code*, R.S.C. 1985, c. C. 46 (hereinafter *Criminal Code*).
[40] *The Rules of Civil Procedure*, R.R.O. 1990, Reg. 194 (hereinafter *Civil Procedure*).
[41] There are exception to this rule where things are in plain view they too can be seized. But the thing must be discovered inadvertently after a lawful entry and must be immediately apparent as evidence of a crime.

[42] *Ibid.* ss. 487(2.1) and (2.2).
[43] *Ibid.* s. 487.091(1).
[44] *Ibid.* s. 256.

granting of a warrant shall be construed to permit interference with the bodily integrity of any person.[45] As well, searches must occur during the day unless exigent circumstances exist.[46]

Once a warrant is issued a hospital or clinic can bring an application to quash the warrant. However, the basis of the application cannot be that the duty of confidentiality is breached.[47]

ii) Subpoena[48]

The compelling of production of records is an issue subject to the most controversy. The *Criminal Code*[49] and case law stipulates the requirements to grant production of third party records. The Supreme Court of Canada established that for records to be disclosed a judge must be satisfied that the information is likely to be relevant.[50] This is a low threshold and allows the court to examine the documents in order to determine the propriety of their disclosure. If a subpoena is granted, a custodian of health records can file a notice of application for an order quashing the subpoena.[51] It must be remembered that

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[45] *Ibid.* s. 487.01(2).
[46] *Ibid.* s. 488.
[47] *R.* v. *Worth* (1989), 54 C.C.C. (3d) 215 (Ont. S.C.).
[48] Pursuant to s. 700(1) of the *Criminal Code*, a subpoena is only available where records are in the custodian's possession related to the subject matter of the legal proceeding.
[49] ss. 278.1 to 278.91 sets out the requirements, conditions and procedure for production of third party records.
[50] *O'Connor, supra* note 6.
[51] In *A. (L.L.)* v. *B.(A.)*, [1995] 4 S.C.R. 536 (hereinafter *B.(A)*) the respondent served subpoenas on the appellants commanding them to bring all records, including medical and counselling records, relating to the proceedings to court. The Crown filed a notice of application for an order quashing the subpoenas.

even if the production of records is ordered, the record may not be admissible in court.[52]

The ramifications of subpoenas have been cause for distress among some health care professionals. For example, the *CPA* suggests to collect only information which is germane to the purpose for which consent has been obtained.[53] This has been a growing trend among the health care system.[54] Similarly, rape crisis centres and sexual assault centres have been discouraging the recording of the confidential information of their clients. The courts have acknowledged that there is no special obligation on therapists and counsellors to retain or create records.[55] However, strong support suggests that confidence in our justice system would be undermined if the courts condoned conduct where third parties destroyed records or discouraged the recording of information.[56] The reason for this minimal record keeping is the fear that disclosure would cause irreparable harm to the client-counselling relationship. Conversely, production of records that corroborates the claimant's position can be of assistance in mounting evidence to secure a conviction.

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[52] The court inquires as to the relevancy of the information and its balancing of the competing interests. (*B.(A)*, *supra* note 52 at 541.)
[53] *Code of Ethics for Psychologists*, *supra* note 11 at standard I.32 .
[54] In *MacDonald*, *supra* note 25 at 155, Justice La Forest recognised that doctors may respond to mandatory disclosure by keeping less through notes. However, he suggested that doctors may be liable for professional misconduct if this occurred.
[55] In dissent, *Carosella*, *supra* note 26 at para 13.
[56] *Ibid.* at para 56, in *Carosella* a crisis centre destroyed the notes of a complainant before it was subpoenaed; this was held to violate an accused's *Charter* right to make a full answer and defence.

iii) Order for Production:

In civil proceedings, if a party brings a motion, a court may order production of documents for inspection that is in possession, control or power of a person. The courts must be satisfied that: i) documents are not privileged, ii) the documents are relevant to a material issue in the action, and iii) it would be unfair to require a party to proceed to trial without having discovery of the documents.[57] Anyone who is interested in the confidentiality of the records should be notified that the opposing party is seeking an order for production of the records. If the relevancy of the documents are uncertain, a court may inspect the documents to determine that issue.[58]

It is interesting to note that a British Columbia Court[59] denied a third party access to a psychologist's clinical records on the basis that the notes were the doctor's hand-written notes and could be misinterpreted. Although the notes were relevant to the proceedings, the potential for misunderstanding would have caused serious prejudice to the case. Because the court did not have the power to order the doctor to edit his notes, disclosure was inappropriate. Ontario courts have not made a distinction between a doctor's personal notes and a doctor's notes for her or his records.

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[57] *Civil Procedure, supra* note 40 at rule 30.10(1).
[58] *Ibid.* rule 30.01(3).
[59] *Spencer* v. *Poulin* (1996), 21 B.C.L.R. (3d) 374.

e) Legal Proceedings:

A party's access to health records for the purpose of legal proceedings is up to the discretion of the court or the patient.[60] Clearly, with the consent of the patient, a party can access the records. However, without this consent the discretion is entirely in the court's hands. Section 130 of the *Courts of Justice Act*[61] states that a court is able to exercise its discretion in the circumstances and take into account the circumstances of medical disclosure by the plaintiff. The court considers the balancing of *Charter* values such as the right to full answer and defence, the right to privacy and the right to equality without discrimination, in concert with the relevance and materiality of the evidence, seeking of the truth and the interests of justice when exercising its discretion.[62]

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[60]An example of the court exercising its discretion can be found in *G. (D.M.)* v. *G.(S.D.)* (1990), 72 O.R. (3d) 774 (Master). Here, the where production of psychiatric records may have had an adverse effect on a party, the court exercised its discretion to refuse production, notwithstanding the relevance of the documents.

[61]R.S.O., 1990, c. C-43.

[62]*R.* v. *Barbosa*, [1994] O.J. No. 2064; *B.(A.)*, *supra* note 52.

MINORS HEALTH RECORDS

V. MINORS HEALTH RECORDS

Access to minor health records is generally similar to the above process with a few exceptions. It is more complex because of society's desire to preserve the vulnerability of youth.

a) Access by Parents:

A person entitled to custody of a child has the rights and responsibilities of a parent and must exercise those rights and responsibilities in the best interests of the child.[63] One of these rights is to access health information in order to ensure the best decision is made for the child with respect to his or her health.[64] However, custodians of records should be wary of releasing records if a competent minor objects to the release of information. For example, if a minor had an abortion, she likely would not want this information released to her parents. Health custodians should exercise their discretion in situations such as these.

As well, parents often make decisions for their child. As a substitute decision-maker, parents are allowed access and disclosure to the child's health records.[65]

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[63] *Children's Law Reform Act* , R.S.O. 1990, c. C-12, s. 20(2).
[64] *Ibid.* s. 20(5).
[65] A substitute decision-maker is a person who is authorized, such as a parent of the incapable person, or a children's aid society, to give or refuse consent to treatment on behalf of a person who is incapable with respect to treatment (*Health Care Consent Act*, S.O. 1996, c. C-2, ss.9 and 20 (1)(v) (hereinafter *Health Care Consent Act*).

b) Access by Minor Patient:

Logically, a minor patient can obtain access to his or her records through parental consent. However, if a minor is capable of giving or refusing consent to treatment, he or she also will have disclosure and access rights to the information.

c) Access by Children's Aid Society:

If the child is a ward of the Crown, the Children's Aid Society ("CAS") has the same rights as a parent. CAS is not an arm of the state and does not have police powers or a relationship with the police.[66]

d) Non-Custodial Parents:

Difficulties often arise when a parent, who does not have custody of the child, requests access to health information. A parent may request disclosure of records for the purpose of a custody battle. Custodians of records should be careful not to disclose records if there is the suspicion that the parent does not have custody of the child. In one case, disclosure of a family clinic record was denied to a father who wanted an expert to view the records and assess the mental condition of the child and parenting skills of the mother. Here, four conditions of privilege were met: i) the records originated in confidence between the clinic, and child and mother that they would not be disclosed, ii) an element of confidentiality was essential to full and satisfactory maintenance of relations between clinic and child and mother, iii) it was contrary to public interest to compel a clinic to violate its

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[66] *R.* v. *M.(S.)* (1991), O.J. No. 3374 (Ont. Gen. Div.).

confidentiality, and iv) the injury that would arise to the child by disclosure was greater than the benefit to be gained.[67] If the clinic's records were released, the custodial parent may complain of breach of confidentiality. This breach could lead to liability on the part of health care professionals.

Moreover, non-custodial parents do not necessarily have the right to make decisions in the best interests of the child. Legislation states that if a non-custodial parent has access to a child, he or she has a right to be given health information on that child.[68] However, one should be wary of overriding a custodial parent's objection. If the non-custodial parent wishes, he or she can apply for an order granting production of the records. Nonetheless, it is possible that the parent who has only access rights may give or refuse consent to treatment as a substitute decision-maker for the child.[69]

e) Minors as Substitute Decision-Makers:

A person who is at least sixteen years old may refuse or give consent to treatment provided he or she is not the incapable person's parent. If the minor is less than sixteen and the parent of the patient-child, the custodian of records would obtain consent for disclosure of records from that parent provided that he or she is capable and has custodial rights.

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[67] *Michaud* v. *Michaud* (1988), O.J. (Ont. Prov. Ct.) James J. (hereinafter *Michaud*)

[68] *CLRA*, *supra* note 64 at s. 20(5).

[69] This role is only available provided the custodial parent is unavailable. *Health Care Consent Act*, *supra* note 65 at s. 20(1)(vi).

MENTAL HEALTH RECORDS

VI. MENTAL HEALTH RECORDS

a) General

Similar to minor health records, disclosure of mental health records varies depending on the circumstances. The *CPA's Code of Ethics* states that information which is confidential can be shared with others only with the informed consent of the patient, or if the individuals involved cannot be identified, except as justified by law, or in circumstances of actual or possible serious physical harm or death.[70] The latter section of this standard has been addressed in the discussion of common law reporting obligations. However, obtaining informed consent is a complex issue because it hinges on the competency of the patient.

b) Mentally Competent

A mentally competent person has the ability to comprehend the subject matter of the consent and is able to appreciate the consequences of giving or refusing that consent. The person responsible for the administration or management of the psychiatric facility may disclose or permit the examination of a record with the consent of a mentally competent patient.[71] If a request is made in writing, a patient may examine and copy their own clinical record.[72] However, this is not absolute. Upon the advice of the physician, the responsible person may

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[70] *Code of Ethics for Psychologists*, *supra* note 11 at standard I. 40.
[71] *MHA*, *supra* at note 21 at s. 35(3)(a).
[72] *Ibid.* ss. 36(1) and (2).

apply[73] to the Consent and Capacity Board to withhold all or parts of the health record.[74]

A psychiatric facility does not necessarily need the consent of the person if it is for the purpose of public health administration. Specifically, a regulation[75] to the Act provides that the *MHA* does not apply to disclosure by a physician or a health officer of the Canadian Red Cross Society ("CRCS") if there are reasonable grounds to believe the patient has received a blood transfusion from the CRCS or has donated blood to the CRCS and the application concerns HIV or Hepatitis C. This is a clear example of how the legislature and courts are attempting to balance privacy and public interests.

c) Mentally Incompetent

If a patient is mentally incompetent, health records may be disclosed with the consent of the patient's substitute decision-maker[76] or an appointed[77] representative.[78] However, the patient may also apply to the Board to determine whether the patient is incompetent for the purpose of accessing records or giving consent for disclosure.[79]

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[73] Please note: notice of this application must be given in writing to the patient together with the grounds on which it is based. (*MHA*, *supra* note 21 at s. 36(5)).
[74] *Ibid.* s. 36(4).
[75] *Mental Health Act*, R.R.O. 1990, O.Reg. 338\96.
[76] *MHA*, *supra* note 21 at s. 1. Section 1 defines a substitute decision-maker as a person who would be authorised under the *Health Care Consent Act* to give or refuse consent to a treatment on behalf of the patient, if the patient were incapable with respect to the treatment under that Act.
[77] *Ibid.* ss. 36.1(1) and (2) states that a person who is at least sixteen years of age and is mentally competent may appoint a representative.
[78] *Ibid.* ss. 35(3)(b)(i) and (ii).
[79] *Ibid.* s. 36(14).

d) Other Circumstances

Section 35(3) of the *MTA* outlines many circumstances where records can be disclosed. For example, if the patient has died and the personal representative of the patient would like to see records, or a lawyer acting on behalf of the psychiatric facility would like to see the records, he or she is able to do so. As well, a clinical record can be used as research, study or statistical material.[80] This is provided that the name of the patient and any means of identifying the patient is removed from the record before it is used.

As discussed above, disclosure of the clinical record can be made pursuant to a summons,

order, direction, or notice with respect to a matter that may be an issue in court.[81] Altogether, the provisions of the MTA provide exceptions to the general rule due to the sensitivity of the matters.

[80] *Ibid.* s. 35(4).
[81] *Ibid.* s. 35(5).

PROPOSED CHANGES

VII. PROPOSED CHANGES:

Canadian law is currently undergoing significant changes in an attempt to balance a patient's right to privacy and the needs of society. For example, the *Personal Health Information Protection Act*[82] sets out practices for the collection, protection, use and disclosure of personal information. This legislation attempts to apply to a wide range of individuals and organizations that collect, use and disclose health information. The proposed legislation outlines circumstances in which access may be refused and requires that custodians apply to the Health Information Privacy Commissioner before refusing access to information on the basis of the potential for harm to the individual or another person.[83] The *Personal Health Information Protection Act* seeks to maintain a balance between a patient's expectation of privacy and the need to preserve and protect public safety. It has been suggested that this new legislation would be very beneficial to the police. It would give police more power to make decisions concerning the custody and release of information if the disclosure is made for the purpose of that decision. Also, police would have greater access to information which is essential to their investigation.

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[82]This legislation is currently in draft form only, and it has not been introduced in the Legislature.
[83]Ann Cavoukian, "Safeguarding Health Information" (1998) 18 No. 4 *Health Law in Canada* 115 at 116.

The *Personal Health Information Protection Act* also addresses the issue of the duty to inform about patients who pose a serious risk of harm to others.[84] Again, this is an area of the law which is not fully developed.

In addition, the *Child and Family Services Act*[85] is in the process of undergoing changes. Section 178 of the *CFSA* recognises the confidentiality of and access to records. Section 180 states that no service provider or employee of a service provider shall disclose a person's record to any person except where consent is given or the provider is compelled by the courts. Other sections which have been added to the *CFSA* allow disclosure of information where consent from children under sixteen is given,[86] as well as disclosure with consent for persons over sixteen.[87] As well, the Act outlines the requirements for consent and who can obtain access to records without consent .

Another addition to the *CFSA* discusses access to records. It states that a person who is twelve years of age or older has a right on request to be given access to his/her own records, or the records of a child who is in his/her lawful custody and is under the age of sixteen years. These sections are not yet in force. However, once they are, it would seem that this area of the law will be more easily understood.

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[84]Lorraine E. Ferris, "In the Public Interest: Disclosing Confidential Patient Information for the Health or Safety of Others" (1998) 18 No. 4 *Health Law in Canada* 119.
[85] R.S.O. 1990, c. C-11 (hereinafter *CFSA*)
[86]*Ibid.* s. 181(1).
[87]*Ibid.* s. 181(3).

CONCLUSION

VIII. CONCLUSION:

There is no doubt that the courts place value on the trust relationship between patient-doctor or patient-counsellor. However, the Canadian legal system strains this relationship by providing exceptions to disclosure of records. The objective of disclosure is not to exploit the victim or subject the patient to more suffering. Rather, like the value our society places on privacy, our society also gives great weight to truth and justice. How to balance these two polar, yet parallel qualities, is a dilemma that each custodian of health records will encounter. It is up to the courts to determine how to even the scales and compromise Canadian values while not offending either the patient and the justice system.