Healing, not Squealing: Recent Amendments to Alberta's Health Information Act

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Introduction

Disclosure of personal health information by health professionals to police is an issue that is becoming the subject of increasing discussion and legislative reform in Canada. For example, Ontario's provincial government brought legislation into force in 2005 requiring the reporting of gunshot wounds.[1] The new federal *Quarantine Act* allows for disclosure of personal information (including health information) to peace officers in circumstances where they are investigating specific offences under the *Criminal Code*.[2] And in Alberta, an amendment to the *Health Information Act*[3] [*HIA*] has recently come into force that permits disclosure of health information by custodians[4] to police to "protect public health and safety."[5] In this essay, we relate the legislative history of this amendment and argue that it is both unwise and unconstitutional.

The Amendment

The relevant provision of the amended *HIA*, s. 37.3, is worded as follows:

(1) A custodian may disclose individually identifying health information referred to in subsection (2) without the consent of the individual who is the subject of the information to a police service or the Minister of Justice and Attorney General where the custodian reasonably believes
- (a) that the information relates to the possible commission of an offence under a statute or regulation of Alberta or Canada, and
- (b) that the disclosure will protect the health and safety of Albertans.

(2) A custodian may disclose the following information under subsection (1):
- (a) the name of an individual;
- (b) the date of birth of an individual;
- (c) the nature of any injury or illness of an individual;
- (d) the date on which a health service was sought or received by an individual;
- (e) the location where an individual sought or received a health service;
- (f) whether any samples of bodily substances were taken from an individual.

Under this section, information relating to a health services provider from whom health services were sought or received may also be disclosed without the consent of that health care professional.[6]

Legislative History

Prior to the amendment, the *HIA* permitted custodians of health information to disclose personal health information to police as follows:

- service with a subpoena, warrant or other court order (s.35(1)(i));
- an investigation of an offence surrounding life-threatening injuries to a person if the individual suffering from the injuries does not object to such disclosure (s.35(1)(j)); or
- to avert or minimize an imminent danger to a person's health or safety (s.35(1)(m)).[7]

Police have expressed frustration with their perceived lack of ability to obtain health information since the implementation of this legislation.[8] They have lobbied for changes to broaden the circumstances in which they can acquire information without the need to obtain a warrant, and made submissions to the Select Special Health Information Act Review Committee [Select Special Committee] which considered the amendments to be made to the *HIA*.[9] Specifically, they requested the addition to the *HIA* of a provision similar to that found in other Alberta privacy legislation which allows personal information to be disclosed to the police to assist with an investigation.[10] The provisions found in the *Personal Information Protection Act* [*PIPA*] and the *Freedom of Information and Protection of Privacy Act* [*FOIP*] are extremely broad. They allow police to potentially obtain personal information (including health information under the jurisdiction of those two statutes) without first obtaining a warrant or establishing individualized suspicion. If this request had been granted, it would have meant similar potential to obtain health information governed by the *HIA*.[11]

In the alternative, police asked that custodians be given the discretion to release registration information[12] as defined by the *HIA*. The provision of registration information to police would make the task of obtaining a warrant for further health information far easier in certain circumstances. For example, if an individual was suspected of impaired driving, but was taken to hospital from the scene of a motor vehicle collision for treatment, being able to confirm that she was at a particular hospital could be used together with evidence of the attending officer to obtain a warrant to procure further information.

The police made three sets of arguments justifying their proposals. In our view, none is convincing. First, they submitted that since they have access to personal information under other provincial legislation, it is inconsistent to not also have access under the *HIA*. As we develop in more detail below, however, health information is a particularly intimate category of personal information, and the law has long been sensitive to the dangers posed when health practitioners share it with police.

Second, they argued that before the enactment of the *HIA*, they could lawfully obtain much of this personal information from health care professionals. In their submission, the enactment of the *HIA* sharply curtailed what had been acceptable practice. This is simply inaccurate. Though the practice of health professionals and institutions *may* have been to provide information to police in a variety of circumstances,[13] the common law was more restrictive of disclosure of health information to police than the pre-amendment *HIA*. In fact, the *HIA* essentially codified two instances of acceptable disclosure that existed at common law (court order and disclosure in the public interest in safety[14]) and created a new category which expanded the circumstances in which personal health information could be disclosed to police (investigating life threatening injuries[15]).

Third, the police gave a number of examples purporting to show that the *HIA* prevented reasonable access to health information. They suggested, for example, that the *HIA* prevented disclosure when police were looking for a missing person without any evidence of any offence having been committed. However, while the *HIA* did not provide for health information to be released in such a case, neither would have amendments requested by police. In another example, police suggested that the *HIA* curtailed their ability to investigate cases of suspected child abuse. Other legislation already existed, however, permitting disclosure in such cases.[16] In the most compelling example cited, that of the suspected impaired driver as discussed above, access to the information sought could be gained without changes to the legislation; for instance, by ensuring that a police officer accompanied the suspect to the hospital.

Comments on the Amendments as Passed

The Bill that emerged from the Select Special Committee and was enacted into law did not include the specific amendments requested by police. It did, however, greatly expand the circumstances in which certain types of individually identifying registration, and diagnostic, treatment and care information may be disclosed to police without the consent of the individual to whom the information relates. While the Bill did not include a broad provision like that under *FOIP* or *PIPA*, it also provided much more than mere registration

information. This was despite submissions from many groups of healthcare professionals, regional health authorities and others, arguing in large part against any change in the disclosure provisions and showing support for the previous status quo.[17] It also appeared to dismiss the findings of a survey of Albertans conducted in 2003 by the Office of the Information and Privacy Commissioner in which 86% of the respondents stated that consent should be obtained before personal health information was disclosed to the police.[18]

As indicated above, the amendment to the *HIA* set out in s. 37.3 gives custodians a discretion, rather than an obligation, to disclose this information when they "reasonably believe" that: (*i*) the information relates to the "possible" commission of an offence; *and* (*ii*) the disclosure will protect "health and safety."

Assisting with law enforcement is not the proper role of health care professionals and, thus, not a justifiable reason to breach the ethical duties owed to their patients.

The legislation provides no guidance, however, as to how health care providers are to make these decisions. As we discuss in more detail below, to require them to assess whether they reasonably believe that an offence may have been committed places a burden on them that they may not be trained to discharge. Such an inquiry also changes the nature of the provider/patient interaction. The health care professional's proper focus is to provide appropriate treatment to the injured or ill individual—not determine if an injury may have been the result of a criminal or other illegal act.

It is also unclear how practitioners are to assess whether disclosure will protect the "health and safety of Albertans." What exactly does this refer to? One possibility is that it refers only to the risk of a specific and tangible future harm to others. If this is correct, the amendment has done very little to alter the status quo. The ability or duty to disclose to protect others from harm already existed in many forms in the *HIA* and in other legislation. As mentioned, the *HIA* already gave custodians the discretion to disclose to anyone (including police) to avert an imminent danger to a person's health or safety.[19] Other legislation also mandates or permits disclosure in cases of children in need of protection,[20] individuals with communicable diseases,[21] unfit drivers,[22] and other situations. While these statutes do not always allow information to flow directly to police, they do provide means to address the risk of harm to the health and safety of individuals.

Another possibility, however, is that the amendment permits custodians to disclose when they reasonably believe that it will help to prevent the *general* harms generated by criminal activity. The amendment can be read, in other words, as authorizing disclosure to increase the likelihood that offenders will be brought to justice. This would contribute to the "health and safety of Albertans" by incapacitating and deterring potential future offenders. This raises constitutional issues dealing with the aim of this amendment which will be discussed later in this paper.

Regardless of which of these interpretations is correct, in considering whether to disclose under s. 37.3 of the *HIA*, and thereby breaching the duty of confidentiality owed to patients, health services providers must give great weight to their ethical and legal obligations. Professional codes of ethics typically state that the patient's best interests are the primary concern, and that disclosure of confidential health information should only be made if ethics and the law require it.[23] For example, in the *Code of Ethics* of the Canadian Medical Association, the primary ethical obligation is to "consider first the well-being of the patient."[24] It is difficult to imagine many cases where disclosure of health information to police without a patient's consent would be best for that individual. From an ethical point of view, a breach must be justifiable out of a serious concern for the health or safety of the individual or others. As such concerns have already been provided for in law (as discussed above), this new section appears to be aimed at assisting law enforcement and not at protecting directly the health and safety of Albertans. Assisting with law enforcement is not the proper role of health care professionals and, thus, not a justifiable reason to breach the ethical duties owed to their patients.

Health care providers should also keep in mind their common law fiduciary duty to act "with the utmost good faith and loyalty" towards their patients and "hold information received from or about a patient in confidence."[25] As with

the ethical duties owed, this is an overriding obligation that must be kept in mind when exercising any form of discretion.

In deciding whether to disclose information under section s. 37.3, health care professionals must also reflect on the obligations imposed by other sections of the *HIA*. For example, s. 58(1) requires custodians to disclose only that information which is necessary for the recipient's intended purpose.[26] Police advocated before the Select Special Committee for a provision to permit disclosure of sufficient information to obtain a warrant.[27] A health care professional is not in a position to judge how much or what type of information an officer needs in any given set of circumstances in order to do so.

Another duty imposed by the *HIA* is that "in deciding how much health information to disclose, a custodian must consider as an important factor any expressed wishes of the individual...."[28] While providers are not under a legal obligation to ascertain their patient's wishes before making such disclosure, providers' (or at least physicians') ethical obligations might plausibly mean that the discretion to disclose provided in s. 37.3 will rarely, if ever, be exercised. The CMA *Code of Ethics* provides that if disclosure is to be made as provided by law, all reasonable steps must be taken to let the patient know that there will be a breach of their confidentiality.[29]

It seems, then, that despite the broad wording of the discretion granted by s. 37.3, its proper exercise should result in few (if any) disclosures.[30] There is good reason to believe, however, that the discretion will often be exercised improperly. While discretion is an inevitable and often beneficial aspect of law,[31] it is also vulnerable to abuse, especially when decision-makers are required to consider matters beyond their areas of knowledge, training, and expertise. Faced with a direct and forceful request from police for information relating to a serious crime, we believe that many health professionals will simply defer to police authority and expertise without fully considering their ethical and legal obligations to their patients. This is evidenced by the fact that, even in the absence of a specific authority to disclose, health practitioners have been known to disclose health information to police in violation of existing duties. As Frank Work, the Privacy Commissioner of Alberta, said in his submissions to the Select Special Committee:

> I've...heard stories about hospital staff feeling bullied or intimidated by law enforcement authorities to hand over information. They're not sure whether or not they should.... They don't know what to do. My submission to you is that health care providers shouldn't be put in that position. They're there to deal with patients.[32]

The Right Balance?

Section 37.3 has not struck the right balance between the protection of confidential health information and the ability of police to obtain such information to assist them in investigating offences. Effective law enforcement is obviously critical to a well functioning society. There are compelling reasons, however, why we should be reluctant to allow health care providers to help perform this function. Individuals go to physicians and other health care providers when they are ill or injured. In many cases, the information that individuals provide to health professionals to enable their treatment, as well as the information generated by the treatment itself, is highly sensitive. It is for this reason that people need to have a high degree of trust in their health care providers. It is also why people expect that their medical information will be used only for legitimate medical purposes. If health care professionals are asked to step away from their role as fiduciaries to their patients and into the role of law enforcers (as this section asks them to do), the trust between provider and patient will be eroded. The law should not ask this of health service providers in the name of convenience or expedience—the stakes are too high.

Indeed, health care professionals have voiced strong opinions regarding the damage to the therapeutic relationship and to health care that might result from the possibility of disclosure to law enforcement.[33] Knowing that health information may be disclosed to police might lead some to avoid seeking treatment for serious medical problems. This may be of particular concern to disadvantaged members of society, who are more likely than the average person to fear that sensitive health information (such as an addiction to illegal drugs, HIV status, or the receipt of an injury flowing from illegal activity) could be disclosed to police or other authorities.

Is the Amendment Constitutional?

In addition to being bad policy, s. 37.3 is also constitutionally suspect. In a recent essay in the *Health Law Review*,[34] Wayne Renke assessed the constitutionality of a proposal to

require health information custodians to report to police all instances of "gunshot wounds, stabbings, and severe beatings" [Gunshot Proposal].[35] He concluded that if passed, such legislation would likely be found to be both outside the competence of the provincial legislature and an infringement of s. 8 of the *Charter*. We have come to the same conclusions with respect to s. 37.3 of the *HIA*.

Division of Powers

While the provinces are entitled to regulate in the realms of both health[36] and the administration of the criminal justice process,[37] in so doing they cannot tread on Parliament's exclusive authority to pass laws in relation to criminal procedure.[38] As in other division of powers cases, the question is whether the "pith and substance" of the law (assessed in terms of both its purpose and effect) relates to a provincial or federal head of power.[39]

The provinces may not, however, pass laws designed to further the investigation of a specific criminal offence, as this would usurp Parliament's exclusive authority over criminal procedure.

At first blush, it may appear that s. 37.3 is a valid exercise of the provincial health power. Unlike the Gunshot Proposal, it does not require health information custodians to provide any information to police. As discussed, it instead gives custodians a discretion to disclose health information when they reasonably believe both that it relates to an offence and that its release will protect individuals' health and safety. Section 37.3, moreover, does not give police any investigative powers. If a custodian decides not to disclose information, police will only be able to obtain it under the authority of one of the search powers given to them by Parliament.[40] The release of information pursuant to such an authority is an inevitable and uncontroversial exception to the *HIA*'s non-disclosure rule.[41]

The problem, however, is that the type of disclosure authorized by s. 37.3 does not appear to further any of the province's legitimate health care concerns. As with the Gunshot Proposal, the provision is specifically designed to help police investigate crime. It serves neither "individuals' health interests [nor] the interests of the health system."[42] It is true, of course, that allowing police to obtain health information may help to deter crime, which contributes to people's health and safety. As discussed, the Constitution permits provinces to further this objective. Yet this logic would sustain any provincial attempt to give police greater powers to investigate crime. The fact that a law may incidentally have an impact on an area of provincial or shared constitutional responsibility is immaterial.[43] If its direct and primary effect is outside its constitutional competence, it is *ultra vires*.

Contrast s. 37.3 with s. 35(1)(m) of the *HIA*, which, as discussed, permits disclosure "to any person if the custodian believes, on reasonable grounds, that the disclosure will avert or minimize an imminent danger to the health or safety of any person." Unlike s. 37.3, this provision specifically and directly addresses the province's constitutionally legitimate concern for the health and well-being of its citizens. While information disclosed under the provision may eventually be used in the investigation and prosecution of criminal offences, its "pith and substance" is health preservation, not criminal justice.

If s. 37.3 cannot be sustained by the province's health power, can it be supported by its authority over the administration of the criminal justice system? As interpreted by the Supreme Court of Canada, s. 92(14) of the *Constitution Act, 1867* gives the provinces wide latitude to investigate and address criminal wrongdoing. The Court has used the provision to uphold provincial laws establishing coroners' inquests,[44] as well as commissions of inquiry into organized crime,[45] police abuses,[46] and wrongful convictions.[47] The provinces may not, however, pass laws designed to further the investigation of a specific criminal offence, as this would usurp Parliament's exclusive authority over criminal procedure.[48] This is precisely what s. 37.3 does—its chief (if not sole) purpose and effect is to facilitate individual criminal investigations and prosecutions.

The Supreme Court of Canada has also made it clear that only Parliament can give police investigative powers, including powers of search and seizure.[49] In Renke's view,

the (constitutionally impermissible) effect of the Gunshot Proposal was to give police "a warrantless search and seizure mechanism that supplements police powers under the *Criminal Code*."[50] We agree. While the proposal did not purport to create a search power, by requiring custodians to transmit identifying health information to police, it would have effectively given police access to information that they would (in at least some cases) not have been able to obtain otherwise.

The situation with s. 37.3 is somewhat different. Because it does not mandate the disclosure of any information, it could be argued that it does not give police any additional investigative powers. Its practical effect, however, is to do precisely that. As discussed, health practitioners are currently prohibited from disclosing personal health information to police by virtue of statute, common law, and professional ethics. Like the Gunshot Proposal, s. 37.3 may thus give police access to information that they would not otherwise have been able to obtain.

The constitutional dangers of collusion between health care practitioners and police were highlighted by Justice La Forest in *Colarusso*.[51] Though he ultimately decided the case on *Charter* grounds, he warned that it would be constitutionally impermissible for provincial authorities (in that case, coroners) to use their powers to collect and use personal health information to facilitate police investigations.[52] In exercising the discretion afforded by s. 37.3, health information custodians will inevitably disclose information that police could not have obtained without using (and conforming to the strictures of) their *Criminal Code* search and seizure powers. In La Forest's view, this kind of complicity is not permitted by the constitutional division of powers.[53]

Section 8 of the Charter

Section 8 of the *Canadian Charter of Rights and Freedoms* gives "everyone" the "right to be secure against unreasonable search or seizure."[54] Like other *Charter* rights, s. 8 can be infringed by both legislation (federal and provincial) and the decisions of (federal and provincial) government actors.[55] While most health care providers (such as hospital employees) are not structurally part of government for *Charter* purposes, the *Charter* may nonetheless apply when they make discretionary decisions related to the pursuit of governmental objectives, such as law enforcement or the provision of medically necessary services.[56] Health care providers would also likely be considered state agents for the purposes of the *Charter* when they disclose constitutionally-protected information to police.[57] In either case, there would be a very strong argument that the *Charter* applies when health information custodians give police identifying health information under s. 37.3 of the *HIA*.

It seems to us, however, that these arguments are unnecessary and redundant, for s. 37.3's reporting provisions themselves violate s. 8. To establish such a violation, it must be shown, first, that a state agent has invaded a "reasonable expectation of privacy" (*i.e.* that it is a constitutionally-protected "search" or "seizure"); and, second, that such intrusion is "unreasonable."[58]

There is little question that at least some of the information subject to disclosure under s. 37.3 would attract a reasonable expectation of privacy. From the earliest stages of its s. 8 jurisprudence, the Supreme Court of Canada has recognized the dangers of allowing health information to flow freely from practitioners to police. In *Dyment*, for example, a physician collected a sample (for medical purposes) of free-flowing blood from an accident victim without his consent.[59] The physician later gave the blood sample to police. In holding that this transaction violated the patient's reasonable expectation of privacy, Justice La Forest observed that confidentiality ensures that people will not be deterred from seeking critical treatment out of fear that incriminating information will be disclosed to police.[60]

The Supreme Court of Canada has set out a number of factors to be considered in making reasonable expectation of privacy decisions,[61] but the most important in the context of informational privacy is whether the intrusion invades the "biographical core of personal information which individuals in a free and democratic society would wish to maintain and control from dissemination to the state."[62] Some categories of information subject to disclosure under s. 37.3, including "the nature of any injury or illness of an individual" and "whether any samples of bodily substances were taken from an individual," would always satisfy this test and, thus, attract a reasonable expectation of privacy.[63] The other categories (the individual's name and date of birth; the date on which a health service was sought or received by an individual; and the location where an individual sought or received a health service) will also often attract such an expectation.

Consider the situation where a witness tells police that an unidentified individual has been shot and transported to a hospital. Police call nearby hospitals and ask for the name of anyone who has recently received treatment for a gunshot

wound. If that information is disclosed, the police will have obtained intimate information about an identifiable individual without that person's consent. This is not information, moreover, that they would have been entitled to obtain in the absence of s. 37.3. The *HIA* prohibits custodians from releasing personally identifying health information, and in most circumstances, police are not entitled to require witnesses and suspects to identify themselves.

The question becomes, then, whether the invasion of privacy occasioned by s. 37.3 is unreasonable. In most circumstances, reasonableness requires police to obtain a warrant based on reasonable and probable grounds to believe that an offence has been committed and that the search will disclose evidence relating to that offence.[64] Before they can disclose health information under s. 37.3, custodians must reasonably believe that "the information relates to the possible commission of an offence." Courts have interpreted the use of the term "reasonable" as equivalent to reasonable and probable grounds, i.e. "the point where credibly-based probability replaces suspicion."[65] Section 37.3 does not require, however, that police obtain a warrant. As the Court explained in *Hunter*, the warrant requirement ensures that the reasonable and probable grounds decision is made "in an entirely neutral and impartial manner."[66] At a minimum, this requires that the decision-maker be someone who is "capable of acting judicially."[67]

Further, the information that can be disclosed under s. 37.3 is much more likely to be intimate, personal, and stigmatizing than the business and commercial information subject to disclosure in the administrative search cases.

Health information custodians do not satisfy this test. To ensure that the privacy interests of individuals are fairly balanced against the crime control interests of the state, the person authorizing the search must be independent of and immune from undue influence from agents of the executive branch of government. They must also, one would think, have expertise in applying criminal procedure standards to varying and difficult factual scenarios. Health care practitioners have neither of these attributes. They are not legally trained. And while not technically part of government, unlike judges they are not institutionally insulated from police influence. As discussed, given the myriad obligations on health care providers to preserve the confidentiality of patients' health information, from a strictly legal perspective, disclosure should be rare. In reality, however, it is very likely to be frequent.

It is clear, then, that s. 37.3 does not meet the test of prior authorization set out in *Hunter*. But while warrantless searches are presumptively unreasonable,[68] the Supreme Court has upheld them in a variety of situations. Broadly speaking these cases fall into two categories: (*i*) searches conducted for purposes other than criminal investigation;[69] and (*ii*) searches conducted for criminal purposes in exigent or otherwise exceptional circumstances.[70] Section 37.3 falls into neither of these categories.

As discussed, the purpose and effect of s. 37.3 are to facilitate criminal investigations. Unlike the situation in many of the Supreme Court's "administrative search" cases, s. 37.3 is not part of a mandatory reporting scheme vital to the efficacy of a tightly-regulated trade or industry.[71] Further, the information that can be disclosed under s. 37.3 is much more likely to be intimate, personal, and stigmatizing than the business and commercial information subject to disclosure in the administrative search cases. The courts have been much more reluctant to depart from the strict *Hunter* standards in the former circumstances than in the latter.

Nor is s. 37.3 analogous to cases where warrantless searches have been upheld in the purely criminal sphere. Here, the courts have generally insisted on the presence of exigent circumstances.[72] Such circumstances typically exist where there is "an imminent danger of the loss, removal, destruction, or disappearance of the evidence."[73] Exigency may also encompass situations where police must act urgently to prevent serious bodily harm.[74] The disclosures permitted by s. 37.3 are not limited to either of these circumstances. Indeed, the *HIA* already provides for non-consensual disclosure in the latter case.[75]

There are other circumstances where the courts have countenanced warrantless searches. In most of these cases, however, courts have found that requiring prior authorization would be exceptionally burdensome on police yet have only

a minimal impact in protecting suspects' privacy interests.[76] Section 37.3 exhibits neither of these attributes. As Renke points out, "recorded health information is not fleeting."[77] If police have reasonable grounds to believe that it is relevant to a criminal investigation, they can apply for a warrant. This is no more burdensome than the myriad occasions where the police seek constitutionally-protected information about a suspect held by a third party.

Section 37.3's impact on privacy is much greater, moreover, than in cases where courts have permitted warrantless searches. When police conduct a search for evidence incident to arrest, for example, the suspect will have already experienced the severe invasion of privacy occasioned by the arrest itself. The arrest will also usually be accompanied by a search of the suspect's body and belongings for weapons. The search for evidence that accompanies this increases the intrusiveness of the encounter only very modestly, if at all. To require police to obtain a warrant to search for evidence in these circumstances would be pointless. The disclosures authorized by s. 37.3, in contrast, are not preceded by any other violation of privacy by police. In these circumstances, requiring a warrant would serve as a real check on the capacity of police to intrude on privacy without adequate justification.

> *We recommend that professional associations and regional health authorities implement directives and procedures to strictly limit the disclosure of health information to police.*

Conclusion

Crime is a serious problem in our society. It is understandable that police would want to use every tool at their disposal to suppress criminal wrongdoing. One can also understand that in some circumstances, health care providers may believe that disclosing individually identifying health information without consent may help police achieve this important goal. However, as reflected in common, statutory, and constitutional law, as well as health care providers' ethical standards, there is a broad consensus in Canada that, in the absence of a court order, disclosures to police must be strictly limited to situations where there is an imminent need to protect the health or safety of others. In authorizing disclosure in a much broader range of circumstances than this, s. 37.3 of the *HIA* radically and unjustifiably ruptures this consensus.

The objectives of privacy laws are often stated in abstract and theoretical terms, such as the need to protect and enhance people's dignity, autonomy, security, or freedom. While these goals undoubtedly inform the law relating to the protection of health information, that law is also designed to achieve a more concrete and practical aim: ensuring that people are not dissuaded from obtaining critical medical treatment out of fear that their personal information will be used against them. This fear may be especially acute when there is reason to believe that information may be shared with authorities for the purpose of investigating and prosecuting criminal offences.

We therefore recommend that s. 37.3 be repealed. If this does not occur, then the negative effects of the law could be mitigated in two ways. First, the constitutionality of the law could be challenged in the courts. Affected organizations, such as health regions and professional associations, could apply to a court for a declaration of constitutional invalidity. Alternatively, such a declaration could be sought by a criminal defendant prosecuted on the basis of information obtained under s. 37.3.[78]

Second, we recommend that professional associations and regional health authorities implement directives and procedures to strictly limit the disclosure of health information to police. As discussed, when exercised in conformity with existing ethical and legal obligations, the discretion granted by s. 37.3 should be exercised extremely rarely, if ever. To minimize the risk of improper disclosure, front-line health care providers should therefore be instructed to *never* release health information directly to police, unless: (*i*) the patient consents;[79] (*ii*) the police present a valid warrant or other legal authorization compelling disclosure;[80] or (*iii*) it is clear that disclosure would avert or minimize an imminent risk to the health and safety of others.[81] If health care authorities believe that disclosure to police may occasionally be warranted in other circumstances, they should ensure that

the decision to disclose is made only by a senior administrator who has received legal advice.

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1. *Mandatory Gunshot Wounds Reporting Act*, 2005, S.O. 2005, c. 9.
2. *Quarantine Act*, S.C. 2005, c. 20.
3. *Health Information Act*, R.S.A. 2000, c. H-5, as am. by *Health Information Amendment Act, 2006*, S.A. 2006, c. 18 [*HIA*].
4. See s. 1(1)(f) of the *HIA* to note the defined scope of custodian in the legislation, *ibid.*
5. *Ibid.*, s. 37.3.
6. *Ibid.* As the *HIA* governs three types of health information (registration information, diagnostic, treatment and care information, and health services provider information), it is of significance to note that this new section touches on all three kinds.
7. The 2006 amendments to the *HIA* repealed the life-threatening injuries provision (s. 35(1)(j)). Sections 35(1)(i) and 35(1)(m) remain in force. *HIA, supra* note 3.
8. See Bonnie Bokenfohr, Police Experience with the Health Information Act: The Edmonton Police Service's Submissions to the Select Special Health Information Act Review Committee (2005) 14:1 Health Law Review 9; Alberta, Legislative Assembly, Select Special Health Information Act Review Committee, *Oral Submissions* (24 August 2004) at HR-131, online: Legislative Assembly of Alberta <http://www.assembly.ab.ca/ISYS/LADDAR_files/docs/committees/hr/legislature_25/session_4/20040824_1200_01_hr.pdf> [August 24 Oral Submissions].
9. Submissions were made by the Edmonton Police Service (written submission 10), the Calgary Police Service (written submission 46) and the Lethbridge Regional Police Service (written submission 12). See Alberta, Legislative Assembly, Select Special Health Information Act Review Committee, *Final Report* (October 2004) at 44, online: Legislative Assembly of Alberta <http://www.assembly.ab.ca/HIAReview/hiawebreport.pdf>. On August 24, 2004, an oral submission was made on behalf of the Edmonton Police Service and a representative of the Calgary Police Service appeared to answer questions, August 24 Oral Submissions, *ibid.*
10. *Personal Information Protection Act*, S.A. 2003, c. P-6.5, s. 20(f) (An organization may disclose personal information about an individual without the consent of the individual but only if one or more of the following are applicable: (f) the disclosure of the information is to a public body or a law enforcement agency in Canada to assist in an investigation (i) undertaken with a view to a law enforcement proceeding, or (ii) from which a law enforcement proceeding is likely to result.); *Freedom of Information and Protection of Privacy Act*, R.S.A. 2000, c. F-25, s.40(1)(q) (40(1) A public body may disclose personal information only (q) to a public body or a law enforcement agency in Canada to assist in an investigation (i) undertaken with a view to a law enforcement proceeding, or (ii)from which a law enforcement proceeding is likely to result).
11. Health information is defined in the *HIA* in s. 1(1)(k) to include diagnostic, treatment and care information, health services provider information, and registration information. While it is not restricted to health information in the custody or control of a custodian under the *HIA*, the scope of the *HIA* does not cover information relating to health services that are not within the scope of the Act. *HIA, supra* note 3.
12. See s.1(1)(u) of the *HIA* for the definition of registration information. *Ibid.*
13. In *Canada (Solicitor General) v. Ontario (Royal Commission of Inquiry into the Confidentiality of Health Records)* [1981] 2 S.C.R. 494, 128 D.L.R. (3d) 193 at para. 9, Justice Laskin C.J. noted that the breach of confidentiality of the health information contained in records of numerous patients led to an Inquiry. In legal proceedings emanating from the Inquiry, more than one level of court commented upon the duty owed by health professionals to their patients to protect their health information unless they are required to disclose as a result of the due process of law.
14. In *McInerney v. MacDonald*, [1992] 2 S.C.R. 138, [1992] S.C.J. No. 57 at para. 28 [*McInerney*], Justice La Forest notes that the duty of confidentiality is not

an absolute one and quotes from *Halls v. Mitchell*, [1928] S.C.R. 125 to confirm that in some cases, the safety of individuals or the public would allow a breach of this duty. In the *HIA*, the discretion to disclose to avert imminent danger to any person was legislated in s. 35(1)(m). *HIA*, *supra* note 3. See also *Re Inquiry into Confidentiality of Health Records in Ontario* (1979), 24 O.R. (2d) 545, 98 D.L.R. (3d) 704 at 714, rev'd (on other grounds) [1981] 2 S.C.R. 494, 128 D.L.R. (3d) 193.

15. *Ibid.*, s. 35(1)(j).
16. *Child, Youth and Family Enhancement Act*, R.S.A. 2000, c. C-12.
17. Groups which made submissions against expanding disclosure to police and/or supporting the status quo included the Health Boards of Alberta (a group made up of regional health authorities and others), August 24 Oral Submissions, *supra* note 8 at HR-147; the Calgary Health Region, August 24 Oral Submissions, *supra* note 8 at HR-124; the Aspen Health Authority, August 24 Oral Submissions, *supra* note 8 at HR-113; the Alberta Medical Association, August 24 Oral Submissions, *supra* note 8 at HR-129; the Pharmacists' Association of Alberta, August 24 Oral Submissions, *supra* note 8 at HR-114 and the Alberta Long Term Care Association, Alberta, Legislative Assembly, Select Special Health Information Act Review Committee, August 25 Oral Submissions at HR-185, online: Legislative Assembly of Alberta <http://www.assembly.ab.ca/ISYS/LADDAR_files/docs/committees/hr/legislature_25/session_4/20040825_1200_01_hr.pdf> [August 25 Oral Submissions]. While the Capital Health Authority did not clearly oppose this, they stated that the HIA seems to have created the right balance between protecting individual privacy and the duty of the police to protect and preserve the peace. August 24 Oral Submissions, supra note 8 at HR -118. Note that there was support from some of these groups for allowing greater disclosure to police regarding abuse of narcotics prescribed under the Triplicate Prescription Program - a separate issue that was being debated.
18. Alberta, Office of the Information and Privacy Commissioner of Alberta, *OIPC Stakeholder Survey, 2003: Highlights Report* (March 2003) at 3, online: Office of the Information and Privacy Commissioner of Alberta <http://www.opic.ab.ca/ims/client/upload/survey_2003.pdf>.
19. See *HIA*, *supra* note 3, s. 35(1)(m).
20. *Supra* note 16.
21. *Public Health Act*, R.S.A. 2000, c. P-37.
22. *Traffic Safety Act*, R.S.A. 2000, c. T-6.
23. See *e.g.* Canadian Medical Association, *Code of Ethics* (2004) s. 35, online: CMA <http://policybase.cma.ca/PolicyPDF/PD04-06.pdf> (Disclose your patients personal health information to third parties only with their consent, or as provided for by law ....). The codes of conduct of other health professions contain a similar rule. See Ellen I. Picard & Gerald B. Robertson, *Legal Liability of Doctors and Hospitals in Canada*, 3d ed. (Scarborough, Ont.: Carswell, 1996) at 15, n. 98.
24. *Code of Ethics*, *ibid.* at 1.
25. *McInerney*, *supra* note 14 at paras. 19-20.
26. *Supra* note 3, s. 58(1).
27. August 24 Oral Submissions, *supra* note 8 at HR-132.
28. *Supra* note 3, s. 58(2).
29. *Code of Ethics*, *supra* note 23 at s. 35.
30. Ironically, at the time s. 37.3 came into force, the provision allowing disclosure to police investigating life threatening injuries was repealed (s.35(1)(j)), *supra* note 3.
31. See generally *R. v. Beare*, [1988] 2 S.C.R. 387 at 410, 55 D.L.R. (4th) 481.
32. Oral submission to the Select Special Committee on August 25, 2004, by Mr. Frank Work, Privacy Commissioner for the Province of Alberta. The Commissioner did suggest that a compromise might be to allow disclosure of limited types of registration information only to police. See August 25 Oral Submissions, *supra* note 17 at HR-166.
33. The Final Report of the Select Special Health Information Act Review Committee... should make any reasonable physician recoil in horror.... I am directed by education, experience and ethics to provide medical care to those who require it. I have neither the training, knowledge, nor -inclination to act as an adjunct to law enforcement.... I believe the goals of a just society include reduction of criminal activity and improved health through understanding, education and compassion. People must be able to consider their physicians, or other healthcare providers, as a source of aid and compassion. Without that guarantee, there can be no trust. Without trust, there can be no therapeutic relationship. Without the therapeutic relationship, there is little chance of change for the better. Mat Rose, A Practitioner's Response to the Final Report of the Select Special Health Information Act Review Committee (2005) 14:1 Health L. Rev. 12 at 12-13.

34. Wayne Renke, The Constitutionality of Mandatory Reporting of Gunshot Wounds Legislation (2005) 14:1 Health L. Rev. 3.
35. Select Special Committee Report, *supra* note 9 at 31. Note that this proposal emerged from the same committee that proposed the s. 37.3 amendment to the *HIA*.
36. The provincial power to regulate health matters stems from s. 92(16) of the *Constitution Act, 1867*, 30 & 31 Victoria, c. 3 (U.K.), which authorizes legislation relating to matters of a "merely local or private Nature in the Province." See also *Schneider v. The Queen*, [1982] 2 S.C.R. 112, 139 D.L.R. (3d) 417.
37. The provincial power over police and other aspects of criminal justice finds its source in s. 92(14): "The Administration of Justice in the Province." *Constitution Act, 1867, ibid.*
38. *Ibid.*, s. 91(27), which gives to Parliament the authority to legislate in relation to the "Criminal Law ... including the Procedure in Criminal Matters."
39. See generally *Reference re Firearms Act (Can.)*, [2000] 1 S.C.R. 783, 185 D.L.R. (4th) 577 at paras. 3-4.
40. In most cases, this will require police to convince a judge that it is probable that the information they are seeking will provide evidence of an offence. *See e.g. Criminal Code*, R.S.C. 1985, c. C-46, ss. 487, 487.012 [*Criminal Code*].
41. *Supra* note 3, s. 35(1)(i). This provision permits custodians to disclose health information to comply with a subpoena, warrant or order issued or made by a court, person or body having jurisdiction to compel the production of information or with a rule of court that relates to the production of information.
42. Renke, *supra* note 34 at 4.
43. See *A.G. Que. and Keable v. A.G. Can.*, [1979] 1 S.C.R. 218, 90 D.L.R. (3d) 161 [*Keable*]; *Di Iorio v. Montreal (City) Common Jail*, [1978] 1 S.C.R. 152, 73 D.L.R. (3d) 491 [*Di Iorio*]; *Starr v. Houlden*, [1990] 1 S.C.R. 1366, 68 D.L.R. (4th) 641 [*Starr*].
44. See *Faber v. The Queen*, [1976] 2 S.C.R. 9, 65 D.L.R. (3d) 423. Note, however, that the Supreme Court has questioned whether some of the investigative powers given to coroners may impermissibly trench upon Parliament's criminal law power. See *R. v. Colarusso*, [1994] 1 S.C.R. 20, 110 D.L.R. (4th) 297 at 69-73.
45. See *Di Iorio, supra* note 43.
46. See *Keable, supra* note 43; *O'Hara v. B.C.* [1987] 2 S.C.R. 591, 45 D.L.R. (4th) 527.
47. See *MacKeigan v. Hickman*, [1989] 2 S.C.R. 796, 61 D.L.R. (4th) 688.
48. See *Starr, supra* note 43.
49. See *Scowby v. Glendinning*, [1986] 2 S.C.R. 226 at 238-43, 32 D.L.R. (4th) 161; see also *R. v. Hoffmann-La Roche Ltd. (Nos. 1 and 2)* (1981), 33 O.R. (2d) 694 at 724, 125 D.L.R. (3rd) 607 (C.A.).
50. Renke, *supra* note 34 at 4.
51. *Supra* note 44 at 69-73.
52. *Ibid.*
53. *Ibid.*
54. Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), c. 11 [*Charter*].
55. Section 32(1) of the *Charter* states as follows:
    This Charter applies
    (a) to the Parliament and government of Canada in respect of all matters within the authority of Parliament including all matters relating to the Yukon Territory and Northwest Territories; and
    (b) to the legislature and government of each province in respect of all matters within the authority of the legislature of each province.
56. See *Eldridge v. British Columbia (Attorney General)*, [1997] 3 S.C.R. 624, 151 D.L.R. (4th) 577. See also *R. v. Lerke* (1986), 43 Alta. L.R. (2d) 1, 24 C.C.C. (3d) 129 (C.A.).
57. See *R. v. Dersch*, [1993] 3 S.C.R. 768, 158 N.R. 375; *R. v. Dyment*, [1988] 2 S.C.R. 417, 55 D.L.R. (4th) 503 [*Dyment*]; *R .v. Pohoretsky*, [1987] 1 S.C.R. 945, 39 D.L.R. (4th) 699.
58. *Hunter v. Southam Inc.*, [1984] 2 S.C.R. 145, 11 D.L.R. (4th) 641 [*Hunter* cited to S.C.R.].
59. *Dyment, supra* note 57.
60. *Ibid.* at 433-34. See also *Colarusso, supra* note 44; *Dersch, supra* note 57.
61. See generally *R. v. Tessling*, [2004] 3 S.C.R. 432; *R. v. Edwards*, [1996] 1 S.C.R. 128, 26 O.R. (3d) 736.
62. *R.. v. Plant*, [1993] 3 S.C.R. 281 at 293.
63. See generally *R .v. Mills*, [1999] 3 S.C.R. 668 at para. 89, 180 D.L.R. (4th) 1.
64. See *Hunter, supra* note 58.
65. *Ibid.* at 167.
66. *Ibid.* at 162.
67. *Ibid.*
68. *Ibid.* at 161.
69. See *e.g. R. v. Simmons*, [1988] 2 S.C.R. 495, 55 D.L.R. (4th) 673 (customs regulation); *R. v. Monney*, [1999] 1 S.C.R. 652, 171 D.L.R. (4th) 1 (customs regulation); *British Columbia Securities Commission v. Branch*, [1995] 2 S.C.R. 3, 123 D.L.R. (4th) 462 [*Branch*] (securities regulation); *Thomson Newspapers Ltd. v. Canada (Director of Investigation and Re-*

search, Restrictive Trade Practices Commission), [1990] 1 S.C.R. 425, 67 D.L.R. (4th) 161 [*Thomson*] (competition regulation); *Comité paritaire de lindustrie de la chemise v. Potash*, [1994] 2 S.C.R. 406, 115 D.L.R. (4th) 702 [*Comité*] (employment regulation); *R. v. McKinlay Transport Ltd.*, [1990] 1 S.C.R. 627, 68 D.L.R. (4th) 568 [*McKinlay Transport*] (tax regulation); *R. v. Jarvis*, 2002 SCC 73, [2002] 3 S.C.R. 757 [*Jarvis*] (tax regulation); *R. v. Ling*, 2002 SCC 74, [2002] 3 S.C.R. 814 (tax regulation); *Weatherall v. Canada (Attorney General)*, [1993] 2 S.C.R. 872, 105 D.L.R. (4th) 210 (prison discipline); *R. v. M. (M.R.)*, [1998] 3 S.C.R. 393, 166 D.L.R. (4th) 261 (school discipline); *R. v. Godoy*, [1999] 1 S.C.R. 311, 41 O.R. (3d) 95 (911 emergency response).

70. See *e.g. R. v. Grant*, [1993] 3 S.C.R. 223, 159 N.R. 161 [*Grant*] (exigent circumstances); *R. v. Ladouceur*, [1990] 1 S.C.R. 1257, 108 N.R. 171 (impaired driving); *Hufsky v. The Queen*, [1988] 1 S.C.R. 621, 84 N.R. 365 (impaired driving).
71. See *Branch, Thomson Newspapers, Comité paritaire, McKinlay Transport; and Jarvis, supra* note 69.
72. See *Grant, supra* note 70.
73. *Ibid.* at 241-42.
74. See *e.g. Criminal Code, supra* note 40, ss. 184.4(*b*), 529.3.
75. Section 35(1)(*m*) ("if the custodian believes, on reasonable grounds, that the disclosure will avert or minimize an imminent danger to the health or safety of any person"). *Supra* note 3, s. 35(1)(m).
76. See *e.g. R. v. Bernshaw*, [1995] 1 S.C.R. 254, 176 N.R. 81 (breath sampling for impaired driving); *R. v. Beare, supra* note 31 (fingerprinting); *R. v. Caslake*, [1998] 1 S.C.R. 51, 155 D.L.R. (4th) 19 (search incident to arrest); *R. v. Golden*, 2001 SCC 83, [2001] 3 S.C.R. 679 (strip search incident to arrest); *R. v. Mann*, 2004 SCC 52, [2004] 3 S.C.R. 59 (search incident to detention).
77. *Supra* note 34 at 5.
78. Another option for criminal defendants (though less useful from a public interest perspective) would be to challenge the admissibility of evidence obtained under s. 37.3 under section 24(2) of the *Charter*, which requires judges to exclude evidence obtained in a manner that infringed a *Charter* right "if it is established that, having regard to all the circumstances, the admission of it in the proceedings would bring the administration of justice into disrepute." *Charter, supra* note 54.
79. This would include situations where the patient is incapable of consent but it is determined that disclosure is in his or her best interests. See *HIA, supra* note 3, s. 35(1)(n).
80. *Ibid.*, s. 35(1)(i).
81. *Ibid.*, s. 35(1)(m).