Revue de droit de l'Université de Sherbrooke

RDUS

CONFIDENTIALITY AND ACCESSIBILITY OF MEDICAL INFORMATION: A COMPARATIVE ANALYSIS

Bartha Knoppers

Volume 12, numéro 2, 1982

URI : https://id.erudit.org/iderudit/1110298ar
DOI : https://doi.org/10.17118/11143/19548

Aller au sommaire du numéro

Éditeur(s)

Revue de Droit de l'Université de Sherbrooke

ISSN

0317-9656 (imprimé)
2561-7087 (numérique)

Découvrir la revue

Citer cet article

Knoppers, B. (1982). CONFIDENTIALITY AND ACCESSIBILITY OF MEDICAL INFORMATION: A COMPARATIVE ANALYSIS. *Revue de droit de l'Université de Sherbrooke*, *12*(2), 395–431. https://doi.org/10.17118/11143/19548

Résumé de l'article

Les difficultés relatives à la confidentialité et à l'accès du patient à l'information médicale ont fait l'objet d'études particulières aux niveaux provincial et fédéral. Cet article s'avère une discussion de solutions de la *common law* canadienne, de la législation québécoise de même que du droit fédéral en *statu nascendi*. Ainsi, notre analyse permet de constater que la confidentialité de l'information médicale est reconnu en *common law* canadienne et dans le droit civil québécois alors que le droit corollaire d'accès du patient à son dossier médical est victime d'interprétations nettement contradictoires. Ces contradictions sont animées par l'opposition entre l'approche cherchant à restreindre l'accès du patient en fonction de critères médicaux et le principe de l'accès prioritaire au dossier médical. Nous sommes donc ici en présence d'une question de nécessité ou d'adéquacité de la législation, d'une interrogation relative aux critères médicaux, et, de façon plus globale, de la question de la vie privée d'un individu et surtout de son autonomie.

CONFIDENTIALITY AND ACCESSIBILITY OF MEDICAL INFORMATION: A COMPARATIVE ANALYSIS

par Bartha KNOPPERS*

Les difficultés relatives à la confidentialité et à l'accès du patient à l'information médicale ont fait l'objet d'études particulières aux niveaux provincial et fédéral. Cet article s'avère une discussion de solutions de la common law *canadienne, de la législation québécoise de même que du droit fédéral en* statu nascendi. *Ainsi, notre analyse permet de constater que la confidentialité de l'information médicale est reconnu en* common law *canadienne et dans le droit civil québécois alors que le droit corollaire d'accès du patient à son dossier médical est victime d'interprétations nettement contradictoires. Ces contradictions sont animées par l'opposition entre l'approche cherchant à restreindre l'accès du patient en fonction de critères médicaux et le principe de l'accès prioritaire au dossier médical. Nous sommes donc ici en présence d'une question de nécessité ou d'adéquacité de la législation, d'une interrogation relative aux critères médicaux, et, de façon plus globale, de la question de la vie privée d'un individu et surtout de son autonomie.*

* Teaching Fellow, Faculty of Law, McGill University.

SUMMARY

INTRODUCTION

> "*Prima facie*, the patient has the right to require that the secret shall not be divulged; and that right is absolute unless there is some paramount reason which overrides it. Such reasons may arise, no doubt, from the existence of facts which bring into play overpowering considerations connected with public justice; and there may be cases in which reasons connected with the safety of individuals or of the public, physical or moral, would be sufficiently urgent to supersede or qualify the obligations *prima facie* imposed by the confidential relation"[1].

It is symptomatic of the difficulty of striking a balance between the competing demands of public and private interests, between openness and privacy, or in the larger sense, between the protection of society and the protection of the individual, that the release of the Report of the Krever Commission on the *Confidentiality of Health Information*[2] should coincide with the discussion surrounding the presentation of the Federal bill on *Access to Information and Privacy*[3] and the Paré Report on *Information and Freedom* in Quebec[4].

As stated by Justice Krever in his *Report*, "The rise of the information society has created anxiety about the use of information"[5]. There is no need to detail here the frightening impact of modern information retrieval systems on both the seemingly mundane facts, and the intimate aspects, of human life. Taking the term "medical records" to include "all information in any form about the health or physical or mental condition of the persons to whom it refers", the implications are enormous[5a].

---

1. *Halls* v. *Mitchell*, (1928) S.C.R. 125, 136 (per Mr. Justice Duff).
2. *Report of the Commission of Inquiry into the Confidentiality of Health Information*, 3 vols, Chairman: The Honorable Mr. Justice Krever, Ontario, 1980.
3. *Bill C-43, An Act to Enact the Access to Information Act and the Privacy Act, to Amend the Federal Court Act and the Canada Evidence Act, and to Amend Certain other Acts in Consequence Thereof*, (2nd reading).
4. *Rapport de la Commission d'études sur l'accès du citoyen à l'information gouvernementale et sur la protection des renseignements personnels*, (président: J. Paré), Gouvernement du Québec, 1981. See also *Public Government for Private People*, (The Report of the Commission on Freedom of Information and Individual Privacy), 3 vols, Queen's Printer, Ontario, 1980.
5. *Krever Report*, *op. cit.*, note 2, 1.

5a. *Ibid.*, 11; See also E. PICARD, *Liability of Doctors and Hospitals*, Toronto, Carswell, 1978, p. 25: "The type of information which is protected is broad and includes not only that concerning the patient and his illness but also knowledge about the patient's family."

Ironically enough, the issues of secrecy and disclosure of medical information are attracting public attention at the same time that the principle of informed consent to treatment is expanding[6], a principle arising as it does out of the same respect for both the autonomy and inviolability of the human person and for his integrity and unique personality.

As a starting point in approaching the issues of secrecy and disclosure, one can either accept the proposition that in the absence of competing interests, free and uninhibited disclosure is the rule[7], or presume as Justice Krever did, that "our society values privacy for health information, creating a need for the observance of, or respect for, confidentiality"[8].

If one accepts the first proposition, the right to information is primary, and the right to confidentiality, an exception. Under the second proposition however, the right to protection of one's private life overrides the right to access, the latter right serving as an exception to the general rule of privacy. Considering the technical means available to collect, store and retrieve information, we will adopt the position that the right to privacy and its protection are of primary concern, for there would be a diminishing need for the protection of privacy if such information were not indiscriminately released in the first place. The issues of secrecy and disclosure must therefore be examined within this larger sphere, that is, within this emerging concept of the need for and right to privacy – "the claim of individuals, groups or institutions to determine for themselves when, how and to what extent information about them is communicated to others"[9]. At the same time, one must question whether the expansion of the principle of informed consent is in fact, reconciliable with any theory of denial of access to one's own medical records.

These two issues of privilege and access are reflected in many areas related to the physician-patient relationship. For the purposes of our study however, we will confine ourselves to confidentiality and accessibility of medical information within the physician-patient

---

6. See especially with regards to the common law, the recent decisions of the Supreme Court of Canada in *Hopp* v. *Lepp*, (1980) 13 C.C.L.T. 60; (1981) 112 D.L.R. (3d) 67 (S.C.C.); *Reibl* v. *Hughes*, (1980) 14 C.C.L.T. 1; (1981) 114 D.L.R. (3d) 1 (S.C.C.).
7. J. LONDON, "Privacy in the Medical Context", in D. GIBSON, *Aspects of Privacy Law*, Toronto, Butterworths, 1980, p. 281.
8. *Krever Report*, *op. cit.*, note 2, 7.
9. *Ibid.*, 6 adopting the definition of A.F. WESTIN, *Privacy and Freedom*.

relationship. For that reason, issues arising, from the criminal law[10] and the law of evidence, affecting the admission of medical records as an exception to the hearsay rule[11], or from the production of medical records in discovery proceedings[12] or in court[13] will not be discussed. Neither will the special considerations affecting psychiatrists and mental patients[14], or minors, or even the interests of relatives or insurance companies following the death of the patient, be covered in this paper. Finally, statutory obligations to reveal certain medical information in the case of communicable or infectious diseases, child battering and professional or administrative audits are also not of concern to us here. Nevertheless, all of the areas excluded will be referred to where they are illustrative of concepts or criticisms relevant to our subject.

The common law of Canada and the civil law of Quebec will form the basis of our study, but where it is of interest or useful by way of contrast, we will turn to the common law of England or the

10. Of particular interest is the conflict between the police informer privilege and physician-patient confidentiality as presented in the recent case involving the Krever Commission, *Re Inquiry into the Confidentiality of Health Records in Ontario*, (1979) 98 D.L.R. (3d) 77 (Ont. C.A.) which has been appealed to the Supreme Court of Canada. See also *R.* v. *Sauvé*, (1965) S.C. 129 where it was held that the civil law and not the common law applied with respect to privilege in criminal cases; *contra*: *R.* v. *Potvin*, (1971) 16 C.R.N.S. 233 (Que. C.A.). It is generally agreed that there is no privilege under the criminal law anywhere in Canada.

11. *Ares* v. *Venner*, (1970) 14 D.L.R. (3d) 4, 16 (S.C.C.): "Hospital records, including nurses' notes, made contemporaneously by someone having a personal knowledge of the matters then being recorded and under a duty to make the entry or record should be received in evidence as *prima facie* proof of the facts stated therein." See also *Cavanaugh* v. *MacQuarrie*, (1979) 9 C.C.L.T. 113 (N.S.S.C.).

12. P. MORRISON, "Production of Hospital Records: Any Time at All?", (1980) 2(2) *Advocates Quarterly* 193.

13. See generally, PICARD, *op. cit.*, note 5a, 26; L. ROZOVSKY, *Canadian Hospital Law*, 2d ed., Ottawa, Can. Hosp. Assoc., 1979, p. 87; G. SHARPE & G. SAWYER, *Doctors and the Law*, Toronto, Butterworths, 1978, p. 95; A. BERNARDOT and R.P. KOURI, *La responsabilité civile médicale*, Sherbrooke, Les Éditions Revue de Droit Université de Sherbrooke, 1980, p. 148.

14. *Morrow* v. *Royal Victoria Hospital*, (1972) C.S. 114 (Que.); *R.* v. *Potvin*, (1971) 16 C.R.N.S. 233 (Que. C.A.); *Dembie* v. *Dembie*, (unreported) April 16, 1963 (Ontario) referred to in PICARD, *op. cit.*, note 5a, 31 and in SHARPE & SAWYER, *op. cit.*, note 13, 105; *R.* v. *Hawke*, (1974) 3 O.R. (2d) 210 (H.C.); *Re S.A.S.*, (1977) 1 *Legal Medical Quarterly* 139; Marriage counsellors, *G.* v. *G.*, (1964) 1 O.R. (2d) 361; *Shakoto* v. *Shakoto*, (1977) 27 R.F.L. 1.

civil law of France for comparison. This comparative study will, therefore, consist of a synthesis of, firstly, the existing state of the law affecting the confidentiality of, and access to, medical records (Part I), and, secondly, of the many criticisms and proposals put forward in this area with a view to a unified approach to reform (Part II).

PART I: A PATCHWORK OF PIECEMEAL PROTECTION

> "It is, perhaps, not easy to exaggerate the value attached by the community as a whole to the existence of a competently trained and honourable medical profession; and it is just as important that patients, in consulting a physician, shall feel that they may disclose the facts touching their bodily health, without fear that their confidence may be abused to their disadavantage"[15].

There is no doubt that the well-being of a patient is closely related to the mutual trust and confidence so essential to the physician-patient relationship. Whether the obligation to secrecy be seen in its historical context[16], or in the prevailing Codes of Ethics[17], its modern counterpart, the right to access to health information about oneself, is but an extension of the same basic respect for patient autonomy and human dignity. These two aspects however, have taken different contours and have been accorded varying degrees of protection depending on whether one examines confidentiality and access within the physician-patient relationship in its private context (Chapter A), or within the framework of the public health care facilities (Chapter B).

CHAPTER A: Medical Records in Private Practice

Within the private context of the doctor-patient relationship, the obligation to secrecy of the doctor and the "right to know" of the patient have not been equally balanced. This imbalance and the inconsistencies it creates with regard to the same person and the same information concerning his health, is even more striking when one

15. *Halls* v. *Mitchell*, (1928) S.C.R. 125, 128.
16. "Whatever, in connection with my professional practice, or not in connection with it, I see or hear, in the life of men, which ought not to be spoken abroad, I will not divulge, as reckoning that all such should be kept secret." (*Hippocratic Oath*).
17. The ethical physician ... will keep in confidence information derived from his patient, or from a colleague, regarding a patient and divulge it only with the permission of the patient except when the law requires his to do so. (*Code of Ethics*, Canadian Medical Association).

compares the common law (Section I) and the civil law (Section II) jurisdictions existing side by side in Canada.

Section I: Common Law

The history of common law remedies for disclosure of medical information is a quaint and interesting one, involving as it does questions of physician privilege and marital disputes[18]. These cases paved the way for a general recognition of confidentiality arising from the relationship of physician-patient, subject, however, to an exception for testimony before the courts. Still today, under the common law of England and Canada, there is no testimonial privilege before the courts[19], though there is a trend towards protecting medical information received in the psychiatric or marital counselling context[20].

Turning then, firstly, to the issue of confidentiality, we find that the courts have discussed the physician's duty to secrecy either within the context of professional responsibility or in terms of proprietary interests.

The duty to secrecy goes well beyond the confines of professional ethics and is implied form the confidential nature of the relationship itself, that is, an implied term of the contract between the patient and the doctor[21].

---

18. For an excellent review of the subject generally and of its history, see S. RODGERS-MAGNET, "Common Law Remedies for Disclosure of Confidential Medical Information", (Appendix I) in *Krever Report*, *op. cit.*, note 2, 297. The most famous case, the "Trial of the Duchess of Kingston", (1776) 20 *Howell's State Trials* 335 (trial on a criminal charge of bigamy) was followed by *AB* v. *CD*, (1851) 14 *Dunlop* 177 (private action taken by an elder of a Presbyterian Church against a physician for revelation of antenuptial fornication), and by *Kitson* v. *Playfair*, *The Times*, 21-27 March 30, 1896 (a case where a physician inferred adultery following the miscarriage of his sister-in-law and discussed the case with relatives).

19. *A.G.* v. *Mulholland*, (1962) 2 Q.B. 477, 489 (Lord Denning MR):

> "Take the ... medical men. None of these is entitled to refuse to answer when directed to by a judge. ... The judge will respect the confidences which each member of these honourable professions receives in the course of it, and will not direct him to answer unless not only it is relevant but also it is a proper and, indeed, necessary question in the course of justice to be put and answered."

20. See *supra*, notes 13 and 14.

21. S. FREEDMAN, "Medical Privilege", (1954) 32(1) *Can. Bar Rev.* 1, 13: "... over and beyond the dictates of professional etiquette, there is a legal duty on the doctor to maintain secrecy. Such a duty arises from the confidential character of the relationship. It is an implied term of the contract between the patient and doctor."; A. SAMUELS, "The Duty of the Doctor to Respect the Confidence of the Patient", (1980) 20(1) *Med. Sci. Law* 58:

Under the *Health Disciplines Act*[22] of Ontario, professional misconduct is defined as the giving of

> "information concerning a patient's condition or any professional services performed for a patient to any person other than the patient without the consent of the patient unless required to do so by law"[23].

Thus, the obligation admits to two exceptions; where the patient consents or where the law requires disclosure.

Few courts however, have discussed the purely professional responsibility aspects concerning privacy in the medical context[24]. In the Ontario case of *R.* v. *Hawke*, it was stated that, "The doctor to whom (the patient) speaks has taken an oath of secrecy based on concepts older than our common law. He is responsible in damages if he violates that relationship"[25]. A recent case involving the release of information to the Krever Commission made it quite clear that the regulation and definition of professional misconduct applies to both physicians in private practice and those under the direction or control of a hospital board, regardless of the fact that penal consequences attach to the breach of the duty when hospital records are concerned[26].

> "The doctor's duty of confidentiality is moral or ethical, arising out of the relationship of doctor and patient. A breach may lead to a finding of serious professional misconduct, with very grave professional consequences. The duty is also legal, arising out of contract, express or implied or from the common law."

This duty of confidentiality under the common law has recently been reaffirmed in an observation of J. PIGEON speaking for the majority of the Supreme Court of Canada, *A.G. Quebec and Keable* v. *A.G. Can.*, (1978) 43 C.C.C. (2d) 49; (1979) 1 S.C.R. 218; 90 D.L.R. (3d) 161, 187: "... The medical director of a hospital cannot release a doctor from his obligation of confidentiality towards his patient, only the latter may release him from his duty."

22. *The Health Disciplines Act*, 1974, S.O. 1974, c. 47.
23. *Ibid.*, s. 26(21).
24. FREEDMAN, *loc. cit.*, note 21, 11: "It is noteworthy that there is hardly any English or Canadian case law directly on the subject."; RODGERS-MAGNET, *loc. cit.*, note 18, 298: "... few actions alleging unwarranted disclosure of medical information have been brought ... despite a case history dating back to at least 1776 ..."; ROZOVSKY, *op. cit.*, note 13, 96.
25. *Supra*, note 14, 226.
26. *Re Inquiry into the Confidentiality of Health Records in Ontario*, (1979) 98 D.L.R. (3d) 77, 723: "... the public policy designed to protect the confidentiality of the physician-patient relationship is as clearly expressed in the *Health Disciplines Act, 1974* as it is in the *Public Hospitals Act* ... There is no reason to differentiate the position of physicians in private practice from those who are engaged by a hospital."

In the New Zealand case of *Furniss* v. *Fitchett*, such a duty of confidentiality was found to be included within the doctor's duty of care to his patient[27]. As will be seen later, it is submitted that this is the proper approach.

Interestingly enough, the courts have often described the duty more in proprietary terms rather than those of professional responsibility. Thus, the principle of qualified privilege was upheld by the Supreme Court of Canada, which stated in that regard that "a secret so acquired is the secret of the patient, and, normally, is under his control, and not under that of the doctor"[28]. It is submitted that this question of proprietary rights belies the question of responsibility, be it the physician's for his patient or the patient or his own health. These are arguments both for and against patient ownership, such discussion usually creating an artificial division between ownership of the information (the patient) and that of the record itself (the doctor)[29].

The question of ownership however, usually arises in relation to our second question of access, and patient inspection of his records. While, as we will see, the position with respect to hospital records is quite clear, patient access to a doctor's office records, in the absence of litigation, is uncertain[30]. In general, the reasons behind this withholding of information from the patient are fourfold:

Firstly, it is feared that the patient would, through lack of comprehension, misinterpret much information and come to false con-

27. *Furniss* v. *Fitchett*, (1958) N.Z.L.R. 396 (release to a husband of a physician's certificate indicating a diagnosis of his wife's condition as paranoia later used in a matrimonial dispute).

28. *Halls* v. *Mitchell*, (1928) S.C.R. 125, 136.

29. PICARD, *op. cit.*, note 5a, 290:

> "The position with respect to a doctor's office records of a patient is less clear. Like the hospital, the doctor is the owner of the records, but the patient may still be entitled to the information contained in them. This is based on the theory that the information in the record is part of what the patient 'purchases' from the doctor. Of course, the opposing argument is that the patient is paying only for services and treatment, not information, and therefore has no access to the information as a matter of right (SPELLER, *Law Relating to Hospitals and Kindred Institutions*, 359 (1971) England)."

LONDON, *loc. cit.*, note 7, 285: "It is generally acknowledged that the physician or health care institution owns the tangible medical record itself. In many jurisdictions that principle is statutorily confirmed. Ownership of the medical information itself, whether or not recorded tangibly, is less clear."

30. PICARD, *op. cit.*, note 5a, 290.

clusions. Secondly, the medical community would prefer to offer an explanation and summary of the patient's record in the best possible circumstances. Thirdly, it is feared that such access or release would be harmful to the therapy or course of treatment of the particular patient. Fourthly, there is very great concern that direct patient access would affect the quality of such records, to the extent that the physician may not be so frank or personal in his remarks or comments[31].

On the other hand, one author has argued that there are policy reasons for making the patient's record available to him, for,

> "... in many cases, without this information an injured patient would have no way of discovering the events which led to his misfortune, and it would be manifestly unfair not to compel the disclosure of the information by those who know"[32].

Another author has labelled this problem, "the positive privacy issue", that is, "the right to know one's private self in the light of all available information"[33]. Furthermore,

> "[w]hether this right to know is labelled a property interest in the information, an implied contractual term of the professional relationship or, simply, a norm of professional behavior, its substance derives from the concept that each of us is in our own unique way competent and deserving to establish our own course"[34].

In England, while some authors have argued for full disclosure, the courts and legislature however, have been particularly restrictive. As stated earlier, the privilege from disclosure of communications before a court of law *does not* extend to communications between a party and his medical adviser[35]. Yet, most decisions have discussed this issue in relation to the production of hospital records which we will come to later. Nevertheless, it is interesting to note that arguments similar to those raised in Canada have been upheld against the release of medical records[36]. Furthermore, since the passage of the *Administration of Justice Act, 1970*[37], the court can order the

31. SHARPE and SAWYER, *op. cit.*, note 13, 108-9; *Davidson* v. *Lloyd Aircraft Services Ltd.*, (1974) 3 All E.R. 1; *Deistung* v. *South Western Metropolitan Regional Hospital Board*, (1975) 1 All E.R. 573.
32. PICARD, *op. cit.*, note 5a, 290.
33. LONDON, *loc, cit.*, note 7, 285.
34. *Ibid.*, 286.
35. G. DWORKIN, "Medical Records – Discovery, Confidentiality and Privacy", (1979) 42 *M.L.R.* 88.
36. *C.* v. *C.*, (1946) 1 All E.R. 562; See also SAMUELS, *loc. cit.*, note 21.
37. *Administration of Justice Act, 1970*, 40 Halsbury's Statutes (3rd ed.) 1101, ss. 31 and 32. Before the coming into force of this Act, it was impossible to

production of documents in a claim for personal injuries. Until very recently, this was held to mean release to the patients' medical advisor, not to his legal advisors and seemingly, not the patient himself[38]. On the whole however, it can be said that "[i]n private medical institutions, and in respect of private patients in NHS institutions, the records belong to the doctor"[39].

In summary, the common law of Canada, by sanctioning disclosure of physician-patient communications in court, diminishes the extent of the physician's duty of secrecy. In addition, neither the actual framework of an action for breach of this duty[40], nor the patients' ownership or right of access to those records in the office of the private physician is clearly spelled out. Turning then to the civil law, we find a much greater protection afforded to such medical information.

Section II: Civil Law

The contrast between the common law and civil law obligation to secrecy in the context of the physician-patient relationship is perhaps best illustrated by a preliminary examination of the French civil law.

---

compel production of medical records much in advance of trial. On this issue see, R.G. LEE, "Disclosure of Medical Records", *NLJ* (July 19, 1979), 702; R. WACKS, *The Protection of Privacy*, London, Sweet & Maxwell, 1980.

38. *McIvor* v. *Southern Health and Social Services Board*, (1978) 2 All E.R. 625 where Lord Diplock speaking for the House of Lords overruled previous jurisprudence confining the production of medical records to the medical advisors only and dismissed the four arguments (*supra*, note 31) arguing against disclosure, thus allowing "for the production of the documents to the applicant or, if he is legally represented, to his solicitor in the action or proposed action." (p. 628). Section 32 of the *Administration of Justice Act, 1970* requires that the documents be "produced to the applicant".

39. SAMUELS, *loc. cit.*, note 21, 64.

40. *Ibid.*, 59:

> "The duty of confidence on the part of the doctor is legally enforceable by the patient, e.g. by injunction or damages. Disclosure without justification *prima facie* constitutes breach of contract and breach of common law duty.
>
> ... In an action for defamation following disclosure the defendant doctor would be able to plead qualified privilege if he acted in good faith without malice and made disclosure only to a person having a legal, moral or social interest in receiving the communication."

See also RODGERS-MAGNET, *loc. cit.*, note 18, who discusses actions for defamation, breach of contract, breach of confidence, breach of privacy, breach of statute and negligence.

While, as stated earlier, there is no testimonial privilege before the common law courts in England and Canada, the social and public importance of trust and confidentiality between the physician and his patient in France, is evidenced by the fact that the obligation to professional secrecy is protected under art. 378 of the French Penal Code[41]. In this manner, what was once a simple matter of moral and professional ethics[42], became under French law an absolute juridical norm[43]. So important is this privilege that for a long time, only the physician could exercise it, that is, he could refuse to divulge information obtained in his professional capacity regardless of the instructions of his patient[44].

Whether one accepts this traditional interpretation of this obligation as an absolute duty admitting no exceptions because of its roots in the notion of public order[45] or as a relative one, flowing

41. Article 378 of the French Penal Code punishes with an imprisonment of one to six months and a penalty of 500F to 3000F "les médecins ... dépositaires des secrets qu'on leur confie, qui, hors les cas où la loi les oblige ou les autorise à se porter dénonciateurs, auront révélé ces secrets."

42. M. GRMEK, "L'origine et les vicissitudes du secret médical", (1969) 29(3) *Cahiers Laennec* 5.

43. In favor of an absolutist position, see generally M. MUTEAU, *Du secret professionnel d'après la loi et la jurisprudence*, Paris, 1870; BROUARDEL, *Le médical*, 2e éd., 1893; ANZALAC, "Les seules exceptions au principe du secret médical", (1971) *Gaz. Pal.* (Doctr.) 113; *contra*: "En réalité et précisément parce qu'une telle rigueur eût conduit à des résultats absurdes, la formule du secret général et absolu ne restera jamais qu'une formule." (BLONDET, "Cas de conscience en matière de secret médical", in *IIe Congrès de morale médicale*, Grenoble, 22 mai 1957: *J.C.P.* 1957, II, 10246).

44. On the evolution and history of medical secrecy in France, see *inter alia*, J.L. BAUDOUIN, *Le secret professionnel en droit comparé (Québec, France, Common Law)*, Thèse en droit, Paris, 1965; P. LOMBARD, "Secret médical ou secret de polichinelle" dans *Le médecin devant ses juges*, Paris, Laffont, 1973, pp. 171-187; L. KORNPROBST, "Le secret professionnel médical" dans *Le contrat de soins médicaux*, Paris, Sirey, 1960, pp. 158-73.

45. *Supra*, note 43; See also J. HONORAT et L. MELENNEC, "Vers une relativisation du secret médical", *J.C.P.* 1979. I. 2936 who reduces this legalistic position based on a strict reading of article 378 to three propositions:

> "Le secret est intangible. Ayant été institué par la loi, il ne peut y être apporté d'exception que par une disposition formelle de sens contraire;
>
> L'obligation au silence échappe à la volonté des parties. Le malade, en particulier, n'a pas le pouvoir de relever le médecin, même s'il estime que la révélation serait conforme à ses intérêts;

from the contractual nature of the physician-patient relationship[46], there is no doubt that in France, the secrecy and confidentiality of medical information obtained in the physician-patient relationship is of paramount importance.

Nevertheless, even this strict approach of the French civil law has recently come under scrutiny by the courts[47]. In fact, the emergence of the notion of respect for the rights of the patient to information and to the control of such information, fostered the evolution from the principle of absolute secrecy where not even the patient could authorize his physician to reveal medical information, to a relativist position permitting certain exceptions[48].

In addition, it has been argued that since on the one hand, illness or incapacity now brings with it certain social and economic benefits and compensation, and on the other hand, necessitates some form of public control and access to information, medical facts are now of both a private and social nature[49]. Considering, therefore, the balance to be sought between the respect to be accorded to the consent of the patient, and the right of the doctor to defend himself, re-

---

Le médecin, inculpé ou poursuivi, à la demande de son client, ne peut se défendre en invoquant des faits, normalement couverts par le secret."

46. For a good review of the contractual position based on the theory of an implied stipulation arising from the nature of the contract, see N.J. MAZEN, "Le secret des praticiens de la santé, mythe ou réalité?" (1975) 2 *Gaz. Pal.* (Doctr.) 468.

47. *Ibid.*, "... la jurisprudence semble s'engager résolument vers une conception relative du secret ..."; HONORAT and MELENNEC, *loc. cit.*, note 45.

48. HONORAT and MELENNEC, *ibid.* There is a divergence between the civil and administrative courts and the criminal courts. While the former are moving towards a relativist position especially with regards to the production of medical records. "... (L)'obligation de respecter le secret médical est édictée dans l'intérêt du malade. Elle ne saurait être opposée à celui-ci quand la détermination de ses droits dépend des renseignements demandés"; the latter is still holding to its absolutist position except for a certain relevation with regard to the right of a physician to defend himself in court (légitime défense). (Cass. Crim., 20 décembre 1967: *D.* 1969. 309). See however, the recent and very interesting decision of the Cour d'appel de Lyon, 17 janvier 1980, *Gaz. Pal.*, 1981.1.9, note N.J. MAZEN, where a physician in bringing a complaint against a patient was found to have violated professional secrecy in not limiting his complaint "... aux seuls faits précis lui portant préjudice sans illustrer ses dires de considérations puisées dans les confidences reçues."

49. *Ibid.*, "... si le fait médical est un fait intime, il est tout autant un fait social. Les progrès mêmes de la médecine l'obligent à se doter d'un support technique et financier, qui y introduit nécessairement un élément collectif et, à travers lui, une certaine publicité."

cent French jurisprudence has tended towards a relaxing of the absolutist position.

The civil law of Quebec has inherited this debate between the absolutist-public order and relativist-contractual origins of the duty of secrecy[50]. Under the *Medical Act* of 1909[51] providing for the professional corporation of physicians and surgeons and again in 1941, the duty was framed as follows: "No physician may be compelled to declare what has been revealed to him in his professional character"[52].

The courts however, tended to adopt an intermediary position and in the 1935 case of *Mutual Life Insurance Co. of New York* v. *Jeanotte-Lamarche*[53], the obligation to secrecy was held to be both one of general application and of public interest, and yet a relative one, the patient remaining the master of his secret.

Thus, the text of the 1965 revision of the Civil Code of Procedure provided in article 308 that if the patient so requests, the physician is bound to testify. At the same time, where the patient did not consent, his medical history could not be revealed in court[54]. Nevertheless, in 1968, the case of *Descarreaux* v. *Jacques* weakened this position[55]. In that case, the Quebec Court of Appeal considered the testimonial privilege of article 308 to be an exception to art. 295 imposing an obligation to testify and thus, the physician could give testimony concerning his patient even without his patient's consent, the law not having created an absolute prohibition[56].

---

50. BERNARDOT et KOURI, *op. cit.*, note 13, no. 222, p. 149: "À ce sujet, les auteurs ont opté pour deux conceptions diamétralement opposées. Pour les uns, l'obligation du confident serait la résultante d'un contrat le liant à son patient. Pour les autres, ladite obligation aurait pour seul fondement l'ordre public."

51. *Medical Act,* 1909, 9 Edw. VII, c. 55, s. 1.

52. R.S.Q. 1941, c. 264, s. 60(2); *Loi médicale*, 1973, c. 46, a. 40; L.R.Q., c. M-9, a. 42.

53. *Mutual Life Insurance Co. of New York* v. *Jeanotte-Lamarche*, (1935) 59 B.R. 510.

54. *Code de procédure civile*, 1965, art. 308:

> "De même, ne peuvent être contraints de divulguer ce qui leur a été révélé confidentiellement en raison de leur état ou profession ... les médecins ... à moins, dans tous les cas, qu'ils n'y aient été autorisés, expressément ou implicitement par ceux qui leur ont fait ces confidences..."

55. *Descarreaux* v. *Jacques*, (1969) B.R. 1109.

56. Voir P. LAMARCHE, "*Descarreaux* v. *Jacques*: un commentaire", (1970) 16 *McGill Law Journal* 399; R. DUQUETTE, "La responsabilité médicale: soins

Then in 1975, this equivocal position was remedied by article 9 of the *Charter of Human Rights and Freedoms* which stated:

> "Every person has a right to nondisclosure of confidential information.
>
> No person bound to professional secrecy by law and no priest or other minister of religion may, even in judicial proceedings, disclose confidential information revealed to him or by reason of his position of profession, unless he is authorized to do so by the person who confided such information to him or by an express provision of law.
>
> The tribunal must, *ex officio*, ensure that professional secrecy is respected"[57].

Some jurists argued however, that the purpose of this article was thwarted in that the obligation was limited to such secrecy by law, thus superimposing article 9 on existing law (i.e. art. 308 C.p.c.), but not replacing it. Hence, since article 42, of the *Medical Act* is but a repetition and confirmation of article 308 C.p.c., the physician is, according to the interpretation of the court in *Descarreaux*, free to reveal his patient's confidences[58]. Such a neutralising effect on the extent and importance of article 9 of the *Charter* does not coincide with the other principles enunciated in the *Charter* and the similar prohibition contained in the *Code of Ethics* governing physicians[59]. This interpretation, while a rejection of *Descarreaux*, is more respectful of the underlying philosophical base of the obligation to secrecy, an obligation that would be meaningless were the physician free to reveal his patient's confidences at will[60].

---

médicaux proprement dits et confidentialité", (1974-75) 3 *R. du B.*; Conf'd *Ross-Veilleux* v. *Ross-Deschênes*, (1976) C.S. 745, 746:

> "Dans la province de Québec, les lois ne prévoient aucune sanction contre le médecin qui dévoile des confidences, comme c'est le cas par exemple en France où l'obligation au secret a un caractère absolu. Ici, le médecin est donc seul maître du secret; il ne se rend coupable d'aucun délit s'il choisit de parler."

57. *Charte des droits et libertés de la personne*, L.R.Q., c. C-12, art. 9.
58. L. DUCHARME, "Le secret professionnel et le projet de loi concernant les droits et libertés de la personne", (1975) 35 *R. du B.* 228. This author holds that article 9 only imposes an obligation to secrecy only upon those professionals charged with such a legal obligation. Since article 42 of the *Loi mdant divulguer les faits dont il a eu personnellement connaissance, Ibid.*, p. 461.
59. *Règlement concernant le Code de déontologie*, (1980) 112 G.O.Q., 1877, no 18, 16/04/80, 304.
60. BERNARDOT and KOURI, *op. cit.*, note 13, no 232, 156; and L. BORGEAT, "Le secret professionnel devant les tribunaux québécois", (1976) 36 *R. du B.* 148 who argues that under article 56(3) of the *Charter*, "law" includes a "regulation" thus encompassing within the ambit of the secret (art. 9) all the regulations passed pursuant to the *Code des professions* of Quebec.

It should also be noted that like the French civil law[61], the Quebec courts recognize that the scope and extent of the privilege contains all information received from a patient, that is, both what is revealed and what the physician himself has learned[62]. To interpret "everything that has been revealed to him" otherwise, would render the protection afforded to the patient devoid of all meaning, while at the same time denying the importance of the medical data compiled by the physician with the consent of his patient[63]. In addition, this obligation to secrecy extends to other professionals working with the physician such as nurses[64].

A violation of this obligation would give rise as under the common law, to an action for damages where there is no contract between the physician and his patient, or where there is a contract, for breach of contract[65]. While, therefore, the obligation to ensure confidentiality is expressly provided for under the civil law of Quebec, the right of access of the patient to his records in the private office of his physician is less clear.

The right of access of patients to their medical records outside of the public health care facilities is not expressly provided for by law[66]. Article 44 of the *Charter of Human Rights and Freedoms* states: "Every person has a right to information to the extent provided by

---

61. See KORNPROBST, *loc. cit.*, note 44; MAZEN, *loc. cit.*, note 46.

62. J.L. BAUDOUIN, "Le secret professionnel en droit québécois et canadien", (1974) 5 *R.G.D.* 7: "D'une part, les révélations du patient au médecin par acte volontaire; d'autre part, les constatations pratiquées par le médecin lui-même sans l'intervention active de son patient."

63. *Ibid.;* A. POPOVICI, *Le secret du médecin et le secret du fonctionnaire*, Cours #39 de la Formation professionnelle du Barreau, 1979, pp. 46 à 60; BERNARDOT and KOURI, *op. cit.*, note 13, no 224, 150.

64. POPOVICI, *id.*, 51-2. See *Hart* v. *Thérien*, (1879) 5 R.J.Q. 267 (C.A.).

65. BERNARDOT and KOURI, *op. cit.*, note 13, no 223, 150 foresee either an action for breach of contract under article 1065 C.c. or in the absence of a contract under article 1053; POPOVICI, *id.*, 59 finds the recourses "assez illusoire, sauf cas extrêmes".

66. P. MOLINARI, "Aperçu de certains droits accessoires à la prestation des services de santé au Québec," dans *Le droit à l'information et le droit à la confidentialité*, I.D.E.F. XIII Congrès, Paris, 1980, p. 9:

> "Les obligations des médecins sont ... moins étendues. En ce qui concerne l'obligation générale de favoriser l'éducation et l'information du public, ils ne sont pas tenus, comme les autres professionnels du secteur, de la matérialiser dans l'exercice de leur profession en posant les actes qui s'imposent pour assurer cette fonction. Ils ne sont pas non plus tenus de fournir aux bénéficiaires les informations nécessaires à la compréhension et à l'évaluation des services rendus ou à rendre ..."

law"[67]. Yet neither the *Medical Act* nor the regulations respecting the keeping and making of records specifically provides for patient access. One author has maintained that,

> "...records which the physicians maintain for each of their patients at their private offices (outside of the hospital centre) do not constitute medical records under the Act nor the Regulations of an Act respecting health services and social services ... [t]he obligations resulting from the possession of records may differ according to whether they are medical reports kept by a physician at his private office or records preserved in a hospital centre"[68].

A recent case[69] however, is more specific and expressly provides that the principles underlying article 7 were to ensure the protection of the interests of the patient[70]. The plaintiff in this case was seeking to obtain her medical records from the private office of her physician subsequent to difficulties obtaining insurance benefits and employment. The court granted her request noting that it would seem logical that the person in whose name and interest and about whom the medical record was made, should have access to it[71].

In closing, both the common law of Canada and the civil law of Quebec do not seem to offer an adequate or complete protection or control as concerns medical information obtained in the privacy of the physician-patient relationship, the common law denying testimonial privilege and both the common law and the civil law failing to clearly provide specifically for statutory protection or access to private office records. Turning then to an examination of the relation between the patient and the public health care facilities, we find a much greater degree of statutory protection and control.

CHAPTER B: Medical Records in Public Health Care Facilities

It goes without saying that under the present health insurance schemes operative in Canada, the necessity of administrative and

---

67. *Supra*, note 57.
68. J.G. FRECHETTE, *Access to Medical Record Information: The Legal Aspect*, 2nd ed., Assoc. qué. des archivistes médicales, 1978, pp. 69-70.
69. *Reid* v. *Belzile*, C.S. Hull, no 550-05-000421-80, June 18, 1980.
70. *Ibid.*, 5:

> "Dans le cas d'un dossier médical, l'intérêt primordial est celui du patient. C'est lui, en général, qui peut délier le médecin de son secret professionnel; en outre, les lois spéciales particulières et les ordonnances des tribunaux, peuvent intervenir."

71. *Ibid.*:

> "Il nous semble logique de conclure, que le principal intéressé, a le droit de consulter son dossier médical ou d'en faire une copie ..."

financial controls creates a greater risk of divulgation of medical information to those other than the patient[72]. Limiting ourselves to the relationship between the patient and the hospital, our examination of the pertinent legislation and jurisprudence will reveal that the confidentiality of medical information is provided for by statute, but under the common law (with the exception of two provinces), there is no recognized right of patient access to his own health information (Section I). In the Province of Quebec however, there exist not only provisions ensuring the respect of confidientiality, but also access provisions and a remedy for refusal (Section II).

Once again, in this area, we find two opposing systems of values, the one wishing to protect the patient (or in a less favourable light, reflecting the traditional paternalism of the medical profession), and the other, arguing for reciprocity of information between the patient and health-care providers, both positions claiming to be based on the patient's best interests.

Section I: Common Law

Under the common law of Canada, an examination of the legislature followed by the jurisprudence, will reveal the prevailing confusion as to the interpretation and use of the applicable statutes both with regard to the extent of confidentiality, the access of third parties to medical information, and the right of access of the patient himself.

As we have already seen, in Ontario, the *Health Disciplines Act, 1974* defines professional misconduct as a breach of confidentiality in the physican-patient relationship[73]. Furthermore, the board of every public hospital has an obligation not to permit any person to remove, inspect or receive information from its medical records[74]. Since

72. See generally *Krever Report, op. cit.*, note 2, for a description of the administrative professional and financial audits provided for by law in particular, the disclosure of extensive information concerning patients' treatment and condition under the government's health insurance plan. In fact, where a claim under such insurance is submitted on a patient's behalf, "the legislation deems that the patient has authorized this disclosure of information." (p. 405) (*The Health Insurance Act, 1972*, S.O. 1972, c. 91, s. 33(1)).

73. *Supra*, p. 7.

74. *The Public Hospitals Act, 1974*, S.O. 1974, c. 47, reg. 729, s. 48:

"A board (of a public hospital) may permit

...

(c) a person who presents a written request signed by,

under the common law the patient has no automatic right of redress based on a breach of privacy, such legislation at best serves to create an offence and not necessarily the right to obtain redress on the part of the patient[75].

Furthermore, the medical record is the property of the hospital and is to be kept in the custody and safekeeping of the administration[76]. We have seen that a distinction can be drawn between ownership of the records and the information itself[77]. According to Mr. Justice Krever, the fact that "the hospital owns the record" is not an answer to the patient's claim of entitlement to inspect the record or obtain a copy of it[78]. In addition, such records are compellable before the courts. This court order may take place prior to or during trial and irrespective of whether the hospital is a party to the dispute[79].

While in Alberta and Nova Scotia[80], the patient himself has a statutory right of access to his hospital records, in Ontario, such access is permissive not mandatory, that is, a board of a public hospital

---

(i) the patient,
(ii) where the record is of a former patient, deceased, his personal representative; or
(iii) the parent or guardian of an unmarried patient under eighteen years of age;

...

to inspect and receive information from a medical record and to be given copies therefrom."

75. ROZOVSKY, *op. cit.*, note 13, 96.
76. *The Public Hospitals Act, 1974*, S.O. 1974, c. 47, s. 11.
77. *Supra*, p. 9; DWORKIN, *loc, cit.*, note 35, 90 (England):
"... property in the records is vested in the health authorities (and) there is no common law right for the patient to recover and see his own record. However, it is possible to use a copyright analogy to argue that there is a difference between the property in the physical material in which the medical notes are recorded, in which the patient does not have a proprietary interest, and the information thereon, in which the plaintiff does have an interest."
78. *Krever Report*, *op. cit.*, note 2, 472.
79. ROZOVSKY, *op. cit.*, note 13, 91; MORRISON, *loc, cit.*, note 12; *Cavanaugh v. MacQuarrie*, (1979) 9 C.C.L.T. 113 (N.S.S.C.); *Unger v. Sun Alliance and London Assurance Company Ltd.*, (1977) 3 W.W.R. 569.
80. See *Krever Report*, *op. cit.*, note 2; See for example: *Hospitals Act*, R.S.N.S. 1967, c. 249 (am.), 63; *The Alberta Hospitals Act*, R.S.A. 1970, c. 174, s. 50(14):
"(1) The records and particulars of a hospital concerning a person or patient in the hospital or a person or patient formerly in the hospital shall be

"may" permit a person to inspect the medical record[81]. Neither does the section provide for any procedure, either in the courts or otherwise, whereby production can be compelled or a refusal reviewed. Moreover, professional misconduct is further defined as the failure to provide a patient with a "report" or "certificate"[82]. Yet this provision cannot be interpreted so as to purport to give the patient a right of access to his own record.

Moreover, our review of the cases will reveal that the courts have not discussed whether the "person" to whom permission may be given to inspect his records can be the patient himself, or only his representative. According to Mr. Justice Krever, the term "person" "...includes the patient himself and is not confined to third persons who may be permitted by the board to see the record upon the production of the patient's signed, written request"[83].

The case law illustrates this ambiguity. In a 1978 case[84], it was held that although a hospital has a proprietary interest in the medical records of a patient, the patient's representative was entitled to copies thereof, even though an action had been commenced against the hospital. As stated by the court:

> "It seems ... much more logical that hospital records should be available without the necessity of having to commence an action draft pleadings in the dark, making allegations in ignorance of the contents of the hospital records

---

confidential and shall not be made available to any person or agency except with the consent or authorization of the person or patient concerned.

...

(4) If a hospital or a qualified medical practitioner refuses to make available the records and particulars of a person upon request by that person or upon authorization of that person or agency... then the person requesting the records and particulars or authorized to receive the same may make application to a county court judge and such judge shall in his discretion determine whether the records and particulars shall be made available and to what extent."

81. *Supra*, note 71.

82. *The Health Disciplines Act, 1974*, reg. 577/75, s. 26: (professional misconduct)

"failing to provide within a reasonable time and without cause any report or certificate requested by a patient or his authorized agent in respect of an examination of treatment..."

83. *Krever Report, op. cit.*, note 2, 472. Moreover, "most hospitals prefer the individual to channel his or her request through a third party, usually a lawyer."

84. *Strazdins* v. *Orthopaedic & Arthritis Hospital Toronto*, (1978) 7 C.C.L.T. 117 (Ont. H.C.).

and, in that manner, attempt to build up sufficient grounds to ask for production of the records"[85].

Then in a more recent decision[86], it was held that the Supreme Court of Ontario had no jurisdiction to compel the hospital to release a medical record to the personal representative of a deceased patient as the language (ie "may") of the *Public Hospital Act* is permissive, not mandatory. The court did however, express the opinion that as a matter of principle, the hospital *ought* to do so since the "hospital should not require the intervention of the courts before releasing the records to persons with such an obvious and legitimate interest in them"[87].

This problem is a serious one, as the situation in England demonstrates. The English courts, until recently, have held that while a plaintiff and his lawyers were able to discuss medical matters with their medical adviser who could answer questions by reference to the record, the plaintiff and his lawyers were not permitted to read them[88]. In addition, a solicitor had to offer a *prima facie* reason for his request for disclosure and with the client's consent, a guarantee not to proceed against the hospital[89]. Then, in a 1978 decision, the House of Lords[90] held the words "produced to the applicant" be given their clear meaning, and that such disclosure was not to be limited to the patient's medical advisor.

Finally, the question arises whether quite apart from judicial proceedings, a patient has or should have a general legal right to see his own medical record. The "greater awareness of the notion of truly informed consent to surgical procedures ... could be matched by a recognition that the patient who asks for full information should be entitled to it"[91].

On this aspect, the Krever *Report* is particularly revealing as to the hesitancy of the medical profession to provide the patient directly with information concerning his own health and medical treatment[92].

85. *Ibid.*, p. 118.
86. *Re Mitchell and St. Michael's Hospital*, (1980) 29 O.R. (2d) 185.
87. *Ibid.*, p. 189.
88. DWORKIN, *loc. cit.*, note 35, 88.
89. See *supra*, cases cited in note 31 and also note 37.
90. *McIvor* v. *Southern Health and Social Services Board*, (1978) 2 All E.R. 625.
91. DWORKIN, *loc. cit.*, note 35, 90.
92. In this respect see the revealing interview between Mr. Justice Krever and the administrator of a large community hospital in Metropolitan Toronto as to why the latter would not send a patient his own records. (*Krever Report*, *op. cit.*, note 2, vol. II, 160).

The extensive breaches of confidentiality to third parties revealed in this *Report* contrast rather unfavourably with the extreme reticence with regard to revealing the same information to the most concerned and interested party - the patient himself. In fact, this paradoxical situation is as much the result of the piecemeal legislation just described, as a reflection of the changing public attitudes to patient's rights. But before studying the reforms necessary to effect a balance, we will analyze the situation in Quebec with respect to the confidentiality of medical information and access to records in public health care facilities.

Section II: Civil Law

"The medical records of the recipients in an establishment shall be confidential. No person shall give or take verbal or written communication of them or otherwise have access to them, even for an inquiry, except with the express or implied consent of the recipient, or on the order of a court, or in other cases provided for by the law or the regulations. The same shall apply to the records of recipients receiving social services from an establishment.

...

A recipient to whom an establishment refuses access to his record or refuses to give written or verbal communication of it may, on summary motion, apply to a judge of the Superior Court, Provincial Court, Court of the Sessions or Social Welfare Court or to the Commission, to obtain access to or communication of it, as the case may be.

The judge shall order such establishment to give such recipient access to his record, or communication of it, as the case may be, unless he is of opinion that it would be seriously prejudicial to the health of such recipient to examine his record"[93].

The above article 7 of the Quebec *Act Respecting Health Services and Social Services*, accords not only confidentiality to medical information in an establishment but also enshrines its corollary, the right of access of a patient to his medical record. Furthermore, the *Act* explicitly limits the exceptions to the express or implied consent of the patient, to an order of the court or authorization of law. The recent regulations made pursuant to the *Professional Code* affirm both the confidentiality and access provisions[94].

---

93. 1977, c. 48, s. 7; 1972, c. 42, s. 3; 1975, c. 61, s. 1; 1977, c. 48, s. 2; L.R.Q., c. S-5, s. 7.

94. *Règlement concernant le Code de déontologie*, (1980) 112 G.O.Q., II, 1877:
"3.04: Le médecin peut cependant divulguer les faits dont il a eu personnellement connaissance, lorsque le patient ou la loi l'y autorise, lorsqu'il y a une raison impérative et juste ayant trait à la santé du patient ou de son entourage.

In addition, it is interesting to note the changing attitudes of the Quebec courts and legislator towards the production of medical records in court[95]. As late as 1967, the court interpreted articles 399 and 400 of the Civil Code as restricting the production of medical records to situations where a medical examination had been ordered[96]. In addition, anterior medical records could not be produced[97]. Two years later, the court changed its position and permitted the parties to receive the medical records preceding the complaint, though they could not be produced in court[98]. Nevertheless, the point remains unsettled[99].

On the whole however, the debate over hospital records in Quebec has centered on the proprietary issue. The court decisions have been split on the matter holding in one case that since the secret was the patient's, so was his record[99a], and in another, that the confidentiality and the property of the medical record was the hospital's[100]. Later in the same year, the medical record was held to

---

4.01: Sur demande du patient, le médecin doit remettre au médecin, à l'employeur, à l'établissement ou à l'assureur que le patient lui indique, les informations pertinentes du dossier médical qu'il tient à son sujet ou dont il assure la conservation.

4.02: Sauf quand cela est préjudiciable à la santé du patient, le médecin doit respecter le droit de ce patient de prendre connaissance des documents qui le concernent dans tout dossier constitué à son sujet et d'obtenir une copie de ces documents."

95. DUQUETTE, *loc. cit.*, note 56.

96. *Genest* v. *Thibault*, (1967) C.S. 232, 234: "En permettant la production du dossier médical, on s'exposerait donc à autoriser indirectement ce que la loi défend directement, c'est-à-dire violer le secret médical." Article 400 of the Civil Code of Procedure states:

"A court may order a hospital to allow a party to examine and make copies of the medical record of the person whose examination has been authorized or whose death gave rise to an action under article 1056 of the Civil Code."

97. *Ibid.*, "Considérant qu'aucune disposition légale n'oblige à communiquer un dossier médical antérieur aux faits donnant ouverture au droit réclamé."

98. *L.* v. *Robert*, (1969) R.P. 41 (C.S.).

99. See *Société Centrale d'Hypothèque et de Logement* v. *Pagé*, (1977) C.A. 560 (no production); *Contra*: *Erdile* v. *Raymer*, (1977) C.S. 226.

99a. *Gauthier* v. *Hôpital de Chicoutimi*, (1974) R.P. 269 (C.S.).

100. *Hôpital Laval* v. *McClish*, (1975) C.S. (Quebec), no 200-05-000005-756: "Quant au droit de propriété, je suis d'avis que l'hôpital est propriétaire de tous les documents qui sont utilisés aux fins de constituer un dossier médical, que ce soit au sens large du mot, ou que ce soit le dossier d'archives."

be the common property of the patient and the hospital[101]. The court in this case interpreted article 7 as permitting a hospital to communicate a medical record to its insurer for the purposes of preparing its defence without having to obtain either the consent of the patient suing or an authorization of the court.

Emphasizing that article 7 imposes an obligation to secrecy on the hospital within the limits of the specific exceptions as regards the divulgation of such information to third parties, the hospital like the doctor was held to have the right to defend itself[102].

This case is also noteworthy in that it draws a parallel between the right of access of a hospital to the medical record in the case of litigation and that of a doctor, a parallel not found elsewhere in the jurisprudence or legislation. Surely the doctor would not have to attempt to obtain the consent of the patient though theoretically he would still need the authorization of the court. The court in this case specifically applied the right of a defence, and hence access to the patient's hospital record, to both the contract between the patient and the hospital and the patient and his treating physician[103].

Two questions remain unanswered however. Firstly, article 7 which speaks of "persons" who are prohibited access without the consent of the recipient undoubtedly refers to third parties. It goes on

---

101. *Société d'Assurance des Caisses Populaires* v. *Association des Hôpitaux de la Province de Québec et autres*, (1975) C.S. 158, 163: "Entre l'hôpital et le patient, il existe un droit de propriété partagé quant au dossier médical."

102. *Ibid.*, 162: "... il faut restreindre la portée de l'article dans son interprétation et la limiter à la prohibition de divulguer les dossiers médicaux en autant que les tiers sont concernés et non en ce qui a trait à un débat engagé entre l'hôpital et le patient relativement à un contrat de soins."

103. *Ibid.*:

> "La situation relative à l'obligation au secret, dans sa conséquence juridique, et dans le contexte de difficultés qui se soulèvent entre l'hôpital et le patient, ne diffère pas de celle qui se présente entre médecin et patient, parties également liées en vertu d'un contrat de soins. Bien que l'obligation au secret, dans le premier cas, et le privilège du secret dans le second, comportent des divergences, sur le plan de la confidentialité, le tribunal est d'avis que les deux situations sont les mêmes, lorsque le cadre de la confidentialité est réduit, au niveau strictement contractuel entre les parties, au droit du patient d'exercer un recours et au droit correspondant de l'autre partie de se défendre et de repousser une poursuite, avec les seuls moyens qui lui sont disponibles, soit le dossier médical."

See also DUQUETTE, *loc. cit.*, note 56 who considers any suit concerning medical liability to be an implicit renunciation of the confidentiality of the medical record.

to say that if a recipient is refused access to his record or is refused written or verbal communication of it, he may apply to the court[104]. Furthermore, the regulations pursuant to the *Professional Code* require that the physician forward the medical record to another physician, employer, establishment, or insurer upon the request of the patient and do not mention direct access by the patient. Another paragraph states the right of the patient to *know* what is in his record[105].

As mentioned, article 7 in its fourth paragraph permits a patient to apply to the court where he is refused access to his record. The court can order the establishment to grant access unless it considers that it "would be seriously prejudicial to the health of such recipient to examine his record"[106].

The leading Quebec authority in this area however, transposes this criterion which the court may or may not accept, to the hospital centre. Thus, while a physician cannot refuse or authorize patient access, he can determine on the basis of objective medical grounds the possible grave danger to the health of the patient[107]. Yet, it is submitted that such an interpretation would greatly compromise the right of access and is at variance with the right of the patient to authorize the release of his medical record to a person designated by him regardless of physician authorization. In fact, the legal right of access would be held in suspension awaiting medical approbation. Thus, one jurist sees in the fact that article 7 sets no restrictions on the reasons for which a recipient may want access to his record as a gradual evolu-

---

104. *Supra*, note 93.

105. *Supra*, note 93.

106. *Supra*, note 94. See (1977) C.A.S. *Décision de la Commission des affaires sociales* 335; (1980) C.A.S. *Décision de la Commission des affaires sociales*, 912.

107. FRECHETTE, *op. cit.*, note 68, 37-43. The author posits as a rule that "the patient has a right to obtain medical information if he has obtained written authorization from his treating physician". (p. 37) Such a requirement is not mentioned in the *Act*. The author has however, made the very worthwhile and practical suggestion to the effect that each medical dossier include a form containing the following question: "Would the knowledge by the patient of the contents of his/her medical record be gravely prejudicial to his/her health?"

See also R. BOUCHER et al, "La responsabilité hospitalière", 15 *C. de D.* 219, 507: "Il reviendra... au *juge* de décider dans chaque cas" (emphasis added) and at 507: "Quant au quatrième alinéa de l'article 7, d'une obligation de résultat. Cette obligation est claire et seul un cas fortuit ou une force majeure pourrait, sans qu'il y ait faute, empêcher le centre hospitalier de donner au patient accès à son dossier".

tion towards a respect for the autonomy of the person and his right to information[108].

Comparing then the two legal traditions existing side by side in Canada, it is evident that both the secrecy and accessibility of medical information are not adequately protected under the common law. Not only is there no testimonial privilege before the courts but the confidentiality of, and access to, medical information is not fully ensured either by statute or by way of a common law action. The findings published in the Krever Report bear testimony to such failure. Paradoxically, it is in the common law jurisdiction that the patient's right to information before making a decision to undergo treatment or surgery is being expanded and yet the same patient has no direct access to his own medical record.

Under the civil law of Quebec both the secrecy and accessibility of medical information is statutorily enshrined but some confusion remains on the question of who "owns" the medical record, on the obligations of a physician in private practice and as to whether in practice, the patient has direct access to his medical record. It is moreover, possible that the same abuses and infringement of confidentiality are present in Quebec.

For these reasons, there is an increasing effort towards reform on both provincial and federal levels, a reform based on an understanding of the reciprocity, mutual trust and frankness forming the basis of a new model of the medical relationship.

PART II: TOWARDS A NEW MODEL OF THE MEDICAL RELATIONSHIP

The inadequacy of the piecemeal provisions referring to the confidentiality and disclosure of health information has been glaringly exposed in the detailed report of Mr. Justice Krever. The horrifying extent of infringement on the confidentiality of such information by insurance companies, private investigators, lawyers and physicians seems rather paradoxical when compared to the paternalistic protection of such information when the patient himself seeks disclosure.

On the one hand, such encroachment on individual human dignity and rights may be the result of the fact that in Canada, there

108. MOLINARI, *loc. cit.*, note 66: "D'un droit d'accès concédé par les juges pour permettre de meilleures preuves judiciaires et pour faciliter l'introduction de recours, le législateur a évolué vers un droit de la personne à l'information, vers le droit d'une personne autonome de comprendre sa situation médicale."

is no constitutionally guaranteed right to privacy or access, or, on the other hand, it may well be the reflection of entrenched attitudes with regard to the nature of the physician-patient relationship.

The changing nature of this relationship and the increasing importance of the information communicated within and without its confines, is gradually gaining recognition whether it be through the efforts of provincial courts and jurists (Chapter A) or in a larger sphere, by proposed federal legislation respecting the emergence of the concept of a "right" to privacy and a "right" of access to health information about oneself (Chapter B).

The use of data banks for storage and retrieval, of the social insurance number as an identifier, and generally the need for administrative control of the quality of care, illustrate the importance of this issue. The possibilities of abuse are already with us. In fact, it is not only medical information itself that is at stake, but the question of power. For, as stated by Mr. Justice Krever,

> "Knowledge is power. Knowledge, that is, that the other person does not have, is surely power over that person. Does the therapeutic relationship truly require that a physician have power over his or her patient?"[109].

CHAPTER A: Recent Developments in the Common Law and Civil Law

Only recently has the insufficiency of both the statutory remedies and the protection afforded by the courts to medical information come to be public attention. On the one hand, this may be due to the fact that in the great majority of cases the victim of an unwarranted disclosure is unlikely to know about the disclosure and the measure of damages is so low as not to make any civil action worthwhile. On the other hand it may be because existing legislation, in addition to being haphazard, is not explicit or broad enough. Both the common law of the Canadian provinces (Section I) and the civil law of Quebec (Section II) are making some progress towards the rectification of this situation.

Section I: Common Law

It is interesting to note that having examined the degree to which traditional common law actions protect the right to confidentiality, the British *Younger Commission on Privacy* concluded that an action for breach of confidence assured greater protection of privacy than

109. *Krever Report, op. cit.*, note 2, 10.

any of the other, existing common law remedies[110]. The main advantage of such an action would be that it generates rights against third parties[111], but it has not been fully developed outside of the field of commercial information and uncertainties remain as to its application[112].

In the case of *Slavutych v. Baker*[113], the Supreme Court of Canada applied the doctrine to prevent the University of Alberta from using a tenure report clearly marked confidential in proceedings for dismissal.

As held recently in Ontario, underlying provincial legislation relating to the confidentiality of medical information "... is the *public policy* expressed therein that the patient's right to confidentiality shall be preserved, and that no such information shall be disclosed in the absence of the patient's consent unless recourse to any lawful procedure provided for is first taken"[114].

Despite, therefore, the uncertainties surrounding its application, as indicated in the Krever Report, "... the development of this right of action will be of a certain interest both in the particular situation of breach of confidence and in developing protection for privacy in general"[115].

Another possibility under the common law for unwarranted disclosure of medical information is an action in negligence. In a 1958 New Zealand case[116], the doctor's duty of care towards his patient was considered to include the obligation of confidentiality. In this respect, the physician was held to stand in a special fiduciary relationship to his client, and since it was reasonably foreseeable that the report would come to the patient's attention, he owed a duty to

110. RODGERS-MAGNET, *loc. cit.*, note 18, 325. See also *Report of the Committee on Data Protection*, Cmnd. 7341 (1978) (Chairman: Sir Norman Lindop). The Lindop Committee accepted the view that the medical record should remain confidential but concluded that the right of a patient to inspect his medical record should be included in the general rule of access. It stated that "the climate of opinion is moving in the direction of greater openness." (para. 24.06).

111. *Ibid.*

112. *Ibid.*

113. *Slavutych* v. *Baker*, (1975) 55 D.L.R. (3d) 224. (American case law has applied it to the disclosure of medical information).

114. *Re Inquiry into the Confidentiality of Health Records in Ontario*, (1979) 98 D.L.R. (3d) 77, 715 (emphasis added).

115. RODGERS-MAGNET, *loc. cit.*, note 18, 327.

116. *Furniss* v. *Fitchett*, (1958) N.Z.L.R. 396.

take reasonable care to ensure that his opinion as to her mental condition was not disclosed. An action in negligence not only avoids the problems of other common law actions but allows for the full slate of tortious damages. Furthermore, the determination of what is reasonable lends the necessary element of flexibility[117].

Finally, as with an action for breach of confidence, it is not clear to what degree the right of privacy protects confidential medical information[118]. Recent legislation specifically providing for the recognition of a right of privacy exists in three common law provinces[119]. The usefulness of these provisions in the area of medical information may be somewhat limited however, as only the Manitoba legislation does not require wilful violation. Yet, all three provinces provide a broad, general definition of privacy, and more interestingly state that a breach of privacy is actionable without proof of damage[120].

Since it is no longer possible however, to assume that patient records will remain a private matter, Mr. Justice Krever expressed the hope that a similar right of action without proof of damages be enacted in Ontario. Such an action would presume damages of $10,000 unless the actual damages were greater. Moreover, "a statutory right of action would be a significant symbol of the value our society attaches to the right of privacy"[121].

Turning then, to the right of access to medical information, we have seen that a recent Ontario decision has held that it had no authority under the *Public Hospital Act* to compel a hospital to release a medical record to the personal representative of a deceased former patient, though as a matter of principle, it conceded that the hospital *ought* to do so[122]. By way of contrast, the *Alberta Hospitals Act* places on the respondent the onus of showing why disclosure not be made to the patient when, following refusal of access, the patient

117. RODGERS-MAGNET, *loc. cit.*, note 18, 334-6.

118. *Ibid.*, pp. 328-332; P. BURNS, "The Law and Privacy: the Canadian Experience", 54 *Can. Bar Rev.* 1.

119. *Privacy Act*, S.B.C. 1968, c. 39; *Privacy Act*, S.M. 1970, c. 74; *The Privacy Act*, 1974, S.S. 1973-74, c. 80.

120. It is interesting to note that under the Manitoba and Saskatchewan statutes, *ibid.*, hospital records are the property of the hospital, while physician's records are the property of the physician.

121. *Krever Report*, *op. cit.*, note 2, 530.

122. *Re Mitchell and St. Michael's Hospital*, (1980) 29 O.R. (2d) 185.

applies to the court for an order directing the release of information[123].

Mr. Justice Krever went further and recommended that patients have a legal right of access, that is, to *inspect* and receive their records. Given the context and general framework of Mr. Justice Krever's recommendation, it can be assumed that the right to "inspect" would include the right to correct misinformation. To allay the fear of possible harm to the patient, in cases where physicians or health-care institutions wish to deny access and thus be exempt from the general rule, he suggests that the decision be left to an impartial Health Commissioner[124].

Furthermore, by establishing access as the general rule and by providing for an impartial and objective mechanism by which refusal to give access may be examined, a prophylactic effect will be created, and "will make it more likely that hospitals and physicians will not refuse disclosure out of traditional paternalistic habits of thought but will do so only in cases in which they sincerely believe that it would be harmful to patients to see their records"[125].

Should the courts become more receptive of the common law actions or should Mr. Justice Krever's recommendations be implemented, the common law would, like the civil law of Quebec, come closer to moving from the principle of secrecy and accessibility of medical information to its realization.

Section II: Civil Law

Despite its more extensive statutory provisions, and despite the fact that physicians in Quebec are granted testimonial privilege, the principles of confidentiality and accessibility of medical information have suffered the same inroads as under the common law. Statutory reporting obligations, court orders, administrative and financial audits, or as with the recent automobile insurance plan, the requirement of the release of all pertinent medical records (past and present)

123. *Alberta Hospitals Act*, R.A.S. 1970, c. 174, s. 35(8). According to Mr. Justice Krever, such a position has a serious shortcoming since an "application to a court, even by way of originating motion, is expensive and might well be beyond the ability of an interested patient to afford". (*Krever Report, op. cit.*, note 2, 488). See however, the recent case of *Lindsay* v. *D.M.*, (1981) 3 W.W.R. 703 (Alta. C.A.) where the former patient of a mental hospitals was held to have a special right of access unless the hospital could show compelling reasons to the contrary.

124. *Ibid.*, p. 489.

125. *Ibid.*, p. 461.

for the obtaining of compensation for bodily injuries[126] are but a few examples of the limitations placed on these principles[127]. In addition, as under the common law, the difficulty of discovering unwarranted disclosures and of proving and recovering significant damages combine to undermine their effectiveness[128].

In response to this situation, one author has proposed making article 9 of the *Charter*, which is at present only declaratory, an offence under s. 87 (a) of the *Charter*[129]. Other jurists have argued for the allocation of more discretionary powers to the judge as is presently done in the case of government officials[130].

A better approach however would seem to be one which, while recognizing the social necessity for some control[131], establishes that the right to confidentiality and accessibility is that of the patient, not a privilege accorded by the medical profession[132]. Thus, the fact that the patient submits himself to surgery or treatment does not constitute a total abdication of his right to privacy, intimacy, dignity and honor[133].

---

126. *Loi sur l'assurance-automobile*, L.R.Q., c. A-25, 1979, a. 62.

127. MOLINARI, *loc. cit.*, note 66, 24:

> "Même si toutes les exceptions à la confidentialité et au secret paraissent justifiées lorsqu'on les examine séparément, qu'elles soient motivées par les nécessités du fonctionnement de l'appareil judiciaire, professionnel ou administratif ... il reste que prises comme un ensemble, elles constituent une brèche très importante, qui force à énoncer le droit du bénéficiaire de services à confidentialité et au secret professionnel comme un droit limité, restreint."

128. POPOVICI, *op. cit.*, note 63, 59.

129. *Ibid.*

130. BERNARDOT and KOURI, *op. cit.*, note 13, no 233, p. 156; DUQUETTE, *loc. cit.*, note 56; J.L. BAUDOUIN, "Nouveaux aspects du secret professionnel", (1965) 25 *R. du B.* 562, 570.

Article 308 of the Quebec *Civil Code of Procedure* states:

> "Similarly, government officials cannot be obliged to divulge what has been revealed to them in the exercise of their functions provided that the judge is of the opinion, for reasons set out in the affidavit of the Minister of deputy-minister to whom the witness is answerable, that the disclosure would be contrary to public order."

131. HONORAT and MELENNEC, *loc. cit.*, note 45.

132. MAZEN, *loc. cit.*, note 46, 469:

> "... il ne s'agit pas du privilège de certaines professions, mais de la protection du patient objet de l'acte de soins. Ainsi toute personne qui, de par sa profession en rapport avec une activité de soins, aura la possibilité ou sera dans la nécessité de pénétrer dans la vie d'autrui pourra se rendre coupable de la violation du devoir de se taire."

133. *Ibid.*; BERNARDOT and KOURI, *op. cit.*, note 13, no 227, 152.

A recent case serves as an illustration of a growing awareness in Quebec of these larger implications[134]. The court in that case considered the respect of one's private life as a fundamental right of the person, a right acting as a restraint on the interference of the State in the private life of its citizens[135].

In this respect, the proposals of the Quebec Civil Code Revision Office provide more explicit protection for personal privacy than that presently found under the *Charter of Human Rights and Freedoms*[136]. Furthermore, like the *Charter*, the proposals allow for punitive damages as a remedy and extend it to the general law of obligations.

Moreover, concerning the right of access, since article 7 of the *Act respecting Health Services and Social Services* provides for access but not explicitly for correction or completion, it fails in respect of establishing patient control over information. Again the proposals of the Civil Code Revision Office would remedy this situation by creating a general right of access coupled with the right to correct and complete misinformation and to erase non-pertinent information without prejudice to other recourses[137].

---

134. *Reid* v. *Belzile*, C.S. Hull, no 550-05-000421-80, June 18, 1980.

135. The court relied heavily on the excellent article of P. GLENN, "Le droit au respect de la vie privée", (1979) 39 *R. du B.* 905.

136. CIVIL CODE REVISION OFFICE, *Report on the Quebec Civil Code*, vol. 1, 1977, p. 4, art. 12:

> "Every person has the right to privacy."

Article 13:

> "No person may invade the privacy of another without his consent or unless he is expressly authorized by law.
>
> In particular, no person may:
>
> 2. voluntarily intercept or use any private communication;
>
> 6. use any correspondence, manuscript or other personal document belonging to another;
>
> 7. divulge confidential information concerning the private life of another, contained in a file administered by the State or by another person."

137. *Ibid.*, p. 5, art. 14:

> "Every person has a right of access to any file concerning him which the law requires be kept.
>
> When the information contained in that file is false, incomplete or not pertinent to the purpose of those who hold it, the person concerned may have the information removed or corrected, without prejudice to his other rights."

See also BERNARDOT and KOURI, *op. cit.*, note 13, no 464, 307:

Finally, the *Paré Report* is but the latest demonstration of this direction towards greater openness. It not only adopted the principle of a general overriding right of access, but also recommended that any legislation or professional code establishing restrictions on the right of access be reconsidered within two years or cease to have effect. The professions involved would, therefore, be given the opportunity to substantiate the rationale for the restrictions to access surrounding medical information. Like the *Krever Report*, it suggests that an establishment may communicate such information to an intermediary in this case, a physician chosen by the patient[138].

The implementation of these proposals would provide a more comprehensive framework for the duty of the physician to respect confidentiality and accessibility in his relationship with his patient. No longer would these principles constitute obligations imposed on the physician but rather constitute the correlative rights of the patient. Both the right to confidentiality and the right to access would then be absorbed into the larger sphere of the right to privacy of the patient, a right that has recently attracted the concern and attention of the federal government.

CHAPTER B: The Emergence of the Right to Privacy and the Right of Access

A brief overview of current federal proposals for reform (Section I) reveals the gradual progress being made towards the recognition of the necessity for a more comprehensive approach to the problem of medical information. At the same time, such legislation would enshrine a general right to privacy and access to government

---

"Il y a certes des situations où le patient a un intérêt réel dans la rectification d'un item d'information du dossier. C'est le cas par exemple lorsque l'employeur se voit accorder un droit d'accès aux informations qui y sont contenues. Une fois établi que le dossier comporte une ou plusieurs erreurs, le centre hospitalier se doit de corriger ces fautes dans les plus brefs délais à défaut de quoi, il peut être responsable des inconvénients occasionnés par son écart de conduite."

138. *Supra*, note 4, *Proposition de loi*, art. 46:

"Toute disposition d'une autre loi qui autorise un organisme public à refuser de communiquer un renseignement communicable en vertu du présent chapitre cesse d'avoir effet (insérer ici la date postérieure de deux ans à celle de la sanction de la présente loi)."

Article 86:

"Lorsque l'exercice du droit d'accès porte sur un renseignement nominatif à caractère médical, l'organisme public peut le communiquer à la personne concernée par l'intermédiaire d'un médecin que cette dernière désigne à cette fin."

information. Though less explicit then the American legislation and yet bolder that the timorous English approach, such proposals demonstrate the recognition of the need to redress the balance between public and private interests, between public or professional control over an individual and the control of that individual himself over decisions and information relating to his well being and health (Section II). Indeed, it is also in the public interest that this latter right be protected and respected.

Section I: Current Federal Legislative Trends

The movement towards reform of matters within federal jurisdiction such as *Criminal Code* prosecutions, and the *Canada Evidence Act*, is of recent origin. Its evolution was considerably hampered by the general acceptance under the common law of Canada of Wigmore's criteria for the determination of common law privilege[139]. The failure to realize the social benefit and importance of confidentiality inherent in the physician-patient relationship limited the application of such criteria to the lawyer-client relationship[140].

In 1975 however, in its *Report on Evidence*, the Law Reform Commission of Canada embodied criteria similar to that of Wigmore in its recommendation of a *general* professional privilege[141]. Thus subject to the discretion of the court, disclosure before a court of law

---

139. SHARPE and SAWYER, *op. cit.*, note 13, 106 summarize Wigmore's criteria as follows:
    (1) The communications must originate in a confidence that they will not be disclosed.
    (2) This element of confidentiality must be essential to the full and satisfactory maintenance of the relation between the parties.
    (3) The relation must be one which in the opinion of the community ought to be sedulously fostered.
    (4) The injury that would incure to the relation by the disclosure of the communications must be greater than the benefit thereby gained for the correct disposal of litigation.

140. PICARD, *op. cit.*, note 5a, 29-31.

141. LAW REFORM COMMISSION OF CANADA, *Report on Evidence* (1977), (Proposed Evidence Code), s. 41:
    "A person who has consulted a person exercising a profession for the purpose of obtaining professional services, or who has been rendered such services by a professional person, has a privilege against disclosure of any confidential communication reasonably made in the course of the relationship if, in the circumstances, the public interest in the privacy of the relationship outweighs the public interest in the administration of justice."

depended on the balance between the prejudice caused by disclosure and the benefit derived by the administration of justice. A qualified privilege would depend on whether the public interest in the privacy of the relationship outweighs the public interest in the administration of justice.

Then in 1978, Part IV of the *Canadian Human Rights Act* entitled "Protection of Personal Information" became operational. The general objectives of this legislation are particularly of interest as they illustrate the aims of providing individuals with the right to receive information and know the uses to which it is being put, control the way it is held, regulate its storage and collection and obtain a right of access[142].

In order to further the protection of privacy and in order to make the *Act* consistent with a new bill entitled the *Access to Information Act* and the *Privacy Act* (Bill C-43)[143], further amendments were introduced in 1980. Within the limits of our discussion, it should be noted that under the proposed *Privacy Act*, personal information includes information relating to the medical history of an individual.

This comprehensive legislation proposes "to extend the present laws of Canada that protect the privacy of individuals with respect to personal information about themselves held by a government institution and that provide individuals with a right of access to such information"[144].

Without going into details, it is interesting to note that on the one hand, the burden of proof is on the government in cases where access in denied and yet on the other hand, access to medical information can be denied where "a duly qualified medical practitioner or psychologist certifies that examination of the information by the individual would be contrary to the best interests of the individual"[145]. Present practice somewhat mitigates the effect of such an inroad into

142. MINISTER OF JUSTICE and ATTORNEY GENERAL, *Privacy Legislation*, (Cabinet Discussion Paper) June 1980, 1.

Section 2(b) of the *Canadian Human Rights Act*, 1976-77, c. 33 at present reads as follows:

> "The privacy of individuals and their right of access to records containing personal information concerning them for any purpose including the purpose of ensuring accuracy and completeness should be protected to the greatest extent consistent with the public interest."

143. *Bill C-43*, *supra*, note 3 (First Reading, July 17, 1980).

144. *Ibid.*, s. 2 (*Privacy Act*).

145. *Ibid.*, s. 29.

the general right of access in that the individual concerned has the right to have the information that is being withheld examined by a physician or psychologist of his choice and a copy must be made available to such a person.

What might create real difficulties however, is the discrepancy between the two official versions of the Bill. For while the English version speaks of the "best interest of the patient", the French version speaks of possible harm to the patient, a much narrower test of restriction to access[146].

By way of comparison, the purpose of the American *Federal Privacy of Medical Information Act*[147] is "to protect the privacy of patients by establishing rules for the use and disclosure of medical information maintained by medical care facilities". Such rules were considered necessary because of the growing use of medical information by those who are not directly engaged in providing medical services to patients[148]. More important for our purposes is the recognition that,

> "[t]he uncontrolled use of medical information will ultimately impair the value of the medical records by making patients unwilling to communicate with their doctors and by making doctors unwilling to record important information. In order to prevent this, patients and doctors must be given assurances that privacy rights will be respected. Also, record keepers must be told when they can permit the use of medical information for particular purposes without fear of liability"[149].

Finally, the current English position would seem to be the view that a judge has a discretion to permit a witness to refuse to disclose information "where disclosure would be in breach of some ethical or social value and non-disclosure would be unlikely to result in serious injustice in the particular case in which it is claimed"[150]. One author

146. *Id.*: "... la prise de connaissance par l'individu concerné des renseignements qui y figurent porterait préjudice à celui-ci".

147. 96th Congress, 2nd Sess., Rept. 96-832, Part 1, 1980.

148. *Ibid.*, p. 10.

149. *Ibid.*, p. 29. While under the *Act*, "a patient is specifically given the right to inspect and to have a copy of medical information about himself maintained by a medical care facility. The facility may deny inspection if it determines in the exercise of reasonable medical judgment that inspection would cause sufficient harm to the patient so as to outweigh the desirability of permitting access. A patient may designate a third party to review any information withheld under this standard. Furthermore, the legislation only covers institutional care providers. Privacy protections for practitioner records are left to the States."

150. SHARPE and SAWYER, *op. cit.*, note 13, 107. See also SAMUELS, *loc. cit.*, note 21, 64-5.

however, finds the English law on confidentiality to be ambiguous and argues for a statutory code and a legal recognition of a general duty of confidentiality[151].

These developments attest to the fact that medical care is no longer a private responsibility but a public, social one. The growing mass of information collected on an individual is often beyond his knowledge or control. As patients themselves however, become increasingly informed and concerned about their role in the physician-patient relationship and the future of information concerning their health, the nature of the physician-patient relationship itself must be reexamined.

Section II: Confidentiality and Accessibility in the Remaking of the Physician-Patient Relationship

The correlation between the expanding doctrine of informed consent and the right of access is an interesting development, pointing as it does to the irony of a patient refusing surgery (perhaps to his detriment) on the basis of medical information and yet lacking the right to run the risk of examining his own records – an irony well – documented in the Krever Report.

In a relationship often characterized as fiduciary, that is, based on mutual trust and confidence, reciprocity implies an exchange. The personal privacy of the patient which he entrusts to a certain extent to the physician must be met with a corresponding openness and full disclosure. Reciprocity of information may well be the first step towards healing the current malpractice malaise. Personal privacy and access to medical information are not incompatible partners but interchangeable rights.

Perhaps the emphasis has been misplaced all along. The concern should not be with physician liability in the actual medical techniques but rather on the protection of the rights of the individual patient. Considering that the importance of the communication element of the physician-patient relationship has, until recently, been neglected and inadequately protected in vague, confidentiality provisions, a general overriding rule of privacy and access with a reversed burden of proof is one step towards redressing this imbalance. For the patient, the art of medical science does not form the only basis for his relationship with his physician and cannot outweigh his need, his right, to his autonomy, to his inviolability, and most importantly, to his self-determination.

151. SAMUELS, *loc. cit.*, note 21, 64-5.