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**HEALTH CARE PROFESSIONALS AND THE  
PRIVACY RIGHTS OF PATIENTS**

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# HEALTH CARE PROFESSIONALS AND THE PRIVACY RIGHTS OF PATIENTS

## I. INTRODUCTION

Over the past decade Canadian health care providers have taken advantage of rapidly evolving technology to replace paper files with electronic medical records. Ontario's *Personal Health Information Protection Act* ("*PHIPA*")<sup>1</sup> was passed in 2004, partially in recognition of the challenges a new era of e-information presented to health care providers. The Act sets out a comprehensive set of rules for the collection, use and disclosure of personal health information. Underlying *PHIPA* is the desire to balance the interests of individual patients in accessing and maintaining confidentiality over their health information and the use of such information by health care providers in facilitating the effective provision of care.

The pendulum in health care has swung from a culture in which medical information was primarily viewed as the purview of health care professionals and health care institutions to one in which the rights of patients are seen as paramount. The rights of patients to access their health records and to control the use of those records is the emphasis of this legislation, and the focus of media attention when these rights are jeopardized.

Unfortunately, the pendulum has caught a number of health care professionals in its swing. Occasionally this is because the health care professional has knowingly violated patient rights for their own purposes. More often, however, it is because of a lack of training or misunderstandings on the part of health care professionals or their employers as to appropriate use of patient health information. While the act allows health information to be used for purposes that go beyond the care and treatment of the individual patient for the benefit of the institution or society generally this is neither well understood or defined. Policies are either unclear or not consistently taught and enforced. For example although accessing personal health information for educating

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1 *Personal Health Information Protection Act*, S.O. 2004, c 3 [*PHIPA*].

health care professionals is a permitted use under the Act many institutions have no policies to specify when this is permissible. The education of health care professionals through exposure to outcomes in specific cases has been a lengthy tradition in the health care professions. Experience is the best teacher. It would be very unfortunate if opportunities for learning are lost through too rigid an application of patient privacy.

Practices inconsistent with the requirements of patient confidentiality also exist in many institutions. For example, due to the layout of many emergency departments and outpatient areas, confidential health information is frequently available to anyone within earshot. Furthermore, through electronic health records system patient information is made widely available to employees often without adequate controls on access.

In spite of these systemic problems, there is often an overreaction when complaints of an alleged breach are made. This in turn leads to individual health care practitioners being singled out for sanction. While it is important that the rights of patients be safeguarded, this should not come at the expense of the lost career and reputation of individual professionals. Neither should it undermine the effective operation of health care system. These interests, individual *versus* group, need to be balanced in a nuanced manner that minimizes harm and enhances quality patient care. The experience to date of the nursing profession in particular suggests that a reasonable balance has yet to be achieved and these health care professionals are the ones most likely to bear the brunt of the imbalance.

The paper reviews the origins of *PHIPA* and explains how its provisions apply to health care professionals. It provides an overview of recent cases where nurses and other professionals have been subjected to legal action before regulatory bodies, administrative bodies, labour arbitrators, and civil courts due to privacy breaches. The paper concludes with a call for a more nuanced approach to be taken by judges and other decision-makers which recognizes the reality of health professionals' practice as well as the benefit and need for health information to be used for education of professionals and other purposes consistent with the better administration of health care generally.

For a health care professional, the implications of allegedly breaching the privacy rights of patients can be extremely serious. They may find that they are subject to quadruple jeopardy. Firstly, under the *PHIPA*, a health care professional, may be the subject of an order of the Commissioner and/or be prosecuted for certain offences set out under the Act. Secondly, in the employment context, many employers have adopted a "zero tolerance" approach to violations of patient privacy. Employment terminations for allegedly breaching patients' rights have frequently been upheld as justified regardless of the seriousness of the breach, and in spite of an employee's length of employment and otherwise good record. The usual approach of progressive discipline is ignored. Thirdly, health care professionals are often reported to their governing colleges for alleged breaches of patient privacy. Most of the professional colleges have published ethical and professional standards which recognize the importance of maintaining patient confidentiality. Finally, although there have been no findings to date, health care professionals may be subject to liability in the civil courts for breaches of privacy.

## **II. APPLICATION OF *PHIPA* TO HEALTH CARE PROFESSIONALS**

### **(a) Provisions of the Act**

The introduction of the *Personal Health Information Protection Act* is closely tied to amendments that were made in 2004 to the *Personal Information Protection and Electronic Documents Act* ("*PIPEDA*").<sup>2</sup> The latter is federal legislation that, as of 2004, applies to all organizations within a province that collect, use, or disclose personal information during the course of commercial activities. *PIPEDA* captures personal health information unless the province has "substantially similar" privacy legislation in place.<sup>3</sup> *PHIPA* excludes Ontario from *PIPEDA*'s jurisdiction and allows the privacy of health information to be regulated at the provincial level.

*PHIPA* imposes legal and administrative requirements on health care professionals, institutions and facilities which meet the definition of "health information custodian"

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2 *Personal Information Protection and Electronic Documents Act*, S.C. 2000, c 5.

3 *Ibid* at s. 26(2).

under Section 3(1) of the Act. These requirements apply with respect to records of personal health information over which health information custodians have custody or control. The definition of "personal health information," under Section 4(1) of the Act is broadly inclusive of all aspects of a patient's health status and care and includes information about eligibility for care, donations of body parts, health numbers and identity of substitute decision makers. Other individuals are also captured by the Act, such as the agents of health information custodians, recipients of personal health information from custodians, and persons who provide services to custodians to enable them to use electronic means to handle personal health information.<sup>4</sup>

*PHIPA* distinguishes between the "collection", "use" and "disclosure" of health information. Disclosure captures the release of information to others while use means to "handle or deal with" the information<sup>5</sup>. There are certain permitted and non-permitted uses of health information. Agents of health information custodians are also permitted to use health information but, like custodians, are not permitted to disclose it.<sup>6</sup> Of critical importance is the legal obligation on health information custodians to safeguard against the theft, loss and unauthorized use or disclosure of personal health information. They must take steps to meet this obligation by creating and implementing privacy policies and procedures.<sup>7</sup>

Section 37(1) of the Act provides a list of permitted uses of health information. A health information custodian may use personal health information about an individual without their consent<sup>8</sup> for a variety of reasons including:

- the purpose for which it was collected, namely, the provision of care;<sup>9</sup>

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4 *Supra* note 1, ss. 17(1), 10(4).

5 *Ibid*, s. 2.

6 *Ibid*, s. 6.

7 *Ibid*, s.12.

8 Ontario Ministry of Health and Long-Term Care, *Personal Health Information Protection Act, 2004: An Overview for Health Information Custodians* (August 2004) at 20.

9 *Supra* note 1, s. 37(1)(a).

- planning, delivering evaluation and monitoring programs or services that the custodian provides;<sup>10</sup>
- the purpose of risk management, error management, or for the purpose of improving or maintaining the quality of care, programs or services;<sup>11</sup>
- educating agents to provide health care;<sup>12</sup> and,
- research conducted by a health information custodian that has been approved by a research ethics board.<sup>13</sup>

When health information custodians use patients' personal health information, the amount of information they may use is limited to that which is "reasonably necessary" to fulfill the intended purpose of the use.<sup>14</sup> The Act allows health information custodians to provide information to their agents who in turn are allowed to use the information for the same purposes that the custodians themselves can use it.<sup>15</sup>

#### **(b) Circle of Care**

The "circle of care" is a phrase that has been used to describe those allowed to share the personal health information of a patient. While often used in the discussion of rights and responsibilities under *PHIPA* "circle of care" is neither contained in nor defined by the Act. This has led to an indiscriminate use of the phrase to cover a variety of contexts.

In the information video distributed by the Privacy Commissioner for educational purposes "circle of care" is used to describe the disclosure of information between institutions or organizations involved in the provision of care to a patient (i.e. the health information custodians referred to in Section 3(1) of *PHIPA*). These custodians are allowed to receive, handle and disclose personal health information regarding a patient

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10 *Ibid*, s. 37(1)(c).

11 *Ibid*, s. 37(1)(d).

12 *Ibid*, s. 37(1)(e).

13 *Ibid*, ss. 37(1)(j), 37(3).

14 *Ibid*, ss. 30(2), 37(1)(a)-(b).

15 *Ibid*, s. 38(2).

without written consent from the patient in certain circumstances. The example used in the video is the sharing of information between a home care provider and the patient's family doctor. In other words, the concept refers to the permissibility of distinct health care providers in the patient's circle of care sharing health information and work as a team to provide care and make decisions based on the basis of all available information. This includes information such as laboratory work and professional consultation with health care providers (*Guide to the Ontario Personal Information and Protection Act*, Irwin Law, 2005. p. 216-217). The circle of care concept used in this context facilitates the provision of care and sanctions disclosure of information without the explicit patient consent that would have previously been required.

The term "circle of care" however has also been adopted to restrict the use of information within the four walls of the health care provider. With this application of the concept, the health information regarding a patient who comes to the emergency department (ER) of a hospital with a trauma can be shared by the nurses in the emergency department who provide direct care to patient. They would fall within the patient's "circle of care" as would the physicians, the respiratory technologists and others involved in the patient's direct care. However, once the patient has left the emergency department the ER nurses may no longer be considered to be in the circle of care and would not be allowed to follow up on the patient for whom they had provided care. Moreover, other ER nurses, not on shift when the patient came to the hospital would not be allowed to know anything about the case. This would of course limit the educational opportunity for both groups of nurses in learning how to respond to future traumas of a similar nature. It would also prohibit a nurse from following up with a patient with whom she had developed a therapeutic relationship.

Furthermore, although trauma cases often get admitted to the Intensive Care Unit (ICU) of the hospital, a strict application of the circle of care theory would prohibit the nurses in the ICU from accessing any information regarding the patient until the patient was actually admitted to their unit. This use of "circle of care" to restrict, rather than enlarge the sharing of information, could be inconsistent with the best management of ICU resources as well as potentially limiting the ability of ICU nurses to prepare as

necessary to provide the best possible care for the individual patient. Intensive Care Units operate with a limited number of beds which are usually filled to capacity with the sickest patients in the hospital. If a trauma case or cardiac emergency comes to the ER it is important that the nurses in the ICU be in the best position to respond by anticipating the need to transfer other patients from the ICU to other floors as necessary. However, in applying the concept of "circle of care" to create a silo around each patient's information, the institutional ability to respond is detrimentally impacted.

Applying the concept of "circle of care" indiscriminately muddies the distinction between the disclosure of information between health care providers and use of information within a single health care provider. The legislation creates different rules for the sharing of information within health care providers as compared to the sharing of information between health care providers. The provisions of *PHIPA* anticipate that information will be used within an institution for purposes other than the direct provision of care to an individual patient. *PHIPA* provides for the expanded use of personal health information within a facility or health care institution. As stated above these additional permitted uses include the:

- planning or delivering programs or services that the custodian provides;
- risk management, error management or to improve or maintain the quality of care;
- educational purposes.

By limiting the use of personal health information to only those within the circle of an individual's "circle of care," the other permitted uses are potentially undermined or eliminated altogether. Unduly limiting the sharing of information can also have a profoundly negative impact on the lives and careers of health care professionals accused of improper access or use of health information. An overview of the case law concerning health care professionals and their access and use of personal health information is provided below.



### III. CASES

#### (a) Regulatory

In Ontario, regulatory bodies have imposed disciplinary penalties on health care professionals for personal health information privacy breaches. Discipline in this regard does not find its source simply in provisions of *PHIPA* but also in different provincial health care Acts such as the *Nursing Act* and its regulations which contain professional standards regarding patient confidentiality. Since *PHIPA* came into force, seven disciplinary proceedings have been heard by the College of Nurses of Ontario regarding privacy breaches of health information.<sup>16</sup> An additional number of other less serious cases have been dealt with at the investigation stage without referral to the Discipline Committee.

The penalties typically faced by nurses in disciplinary proceedings have included suspending the Member's certificate of registration for a period ranging from 30 days to upwards of 4 months in the most serious cases. The Member may also be required to attend meetings with a Nursing Expert and review the *Confidentiality and Privacy, Personal Health Information* practice standard and complete questionnaires regarding it. In addition, College Members are oftentimes directed to provide the disciplinary decision to any employers for a period of one to two years. This can have a very prejudicial effect on their ability to find employment.

While many of the proceedings involved nurses that accessed the personal health records of individuals known to them in a personal capacity, others did not. In *College of Nurses of Ontario v. Hooker*, the College Member admitted to accessing the personal health records of patients who received care during the SARS crisis at the Hospital where she was employed. The Member also admitted to accessing the health records of physicians who worked at the Hospital. The patients in question were not patients for

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16 *College of Nurses of Ontario v Kaufman*, 2012 CanLII 99767; *College of Nurses of Ontario v Billesberger*, 2011 CanLII 99785; *College of Nurses of Ontario v Smith*, 2008 CanLII 89811;; *College of Nurses of Ontario v Hooker*, 2006 CanLII 81736; *College of Nurses of Ontario v Leroux* (2005) – 9984311 <http; .; *Unnamed* (2004).

whom the Member had any professional responsibilities. By way of explanation, the Member stated that she accessed the records to check if the patients had been diagnosed for SARS, in part out of curiosity, but also out of concern. The Member and other staff were concerned that appropriate precautions were not being taken by the Hospital to deal with the SARS crisis. The Member was dismissed from her employment as a result of these privacy breaches. With respect to discipline at the College level, it was ordered that the Member's certificate of registration be suspended for 30 days and that she meet with a practice consultant at the College to review issues of patient confidentiality.

**(b) Administrative**

The *Personal Health Information Protection Act* contains provisions concerning the administration and enforcement of the Act. Should a patient have a privacy complaint, they may bring it to the province's Information and Privacy Commissioner. The Privacy Commissioner may in turn take a number of actions. The Commissioner may require that the complainant try to effect a settlement with the person about whom the complaint is made.<sup>17</sup> The Commissioner may also authorize a mediator to review the complaint and to try to effect a settlement between the parties.<sup>18</sup> Failing those efforts, the Commissioner may proceed to the adjudicative stage and exercise his or her statutory investigative powers to review the matter and issue an order. The Commissioner's orders require compliance. The Commissioner may also issue fines up to \$250,000 for privacy breaches.<sup>19</sup>

In one case before the Commissioner, a nurse at the Ottawa Hospital accessed the records of a patient not under her care.<sup>20</sup> The patient was the estranged wife of the nurse's current partner, a man who was also employed at the Ottawa Hospital. The patient and her estranged husband were involved in rancorous divorce proceedings.

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17 *Supra* note 1, s. 57(1)(b).

18 *Ibid*, s. 57(1)(c).

19 *Ibid*, s. 72(2).

20 *PHIPA Order HO-002*, Information and Privacy Commissioner/Ontario (July 2006) online: <[http://www.ipc.on.ca/images/Findings/up-HO\\_002.pdf](http://www.ipc.on.ca/images/Findings/up-HO_002.pdf)> [HO-002].

When admitted to the Hospital, the patient raised her concern with Hospital staff that her health information might be accessed by either the nurse in question or her estranged husband given the nature of the personal dispute between them. While the Hospital took some steps to prevent improper access, such as placing a "VIP flag" on the patient's record warning that her records were being closely monitored for potential violations, the patient's personal health information was nonetheless accessed by the nurse in question on at least ten occasions over a six week period. Knowledge of this breach came to the complainant's attention when her estranged husband mentioned specifics about a chronic health problem which otherwise would have been unknown to him. Further, due to the "VIP flag", an audit indicated that unauthorized access to the complainant's records had occurred and an investigation attributed the access to the nurse.

In the Commissioner's decision, she reviewed the relevant provisions of *PHIPA* as it relates to use of personal health information. She found that the nurse was an agent of a health information custodian – in this case the Hospital – and that inappropriate use and disclosure of the patient's health information had occurred. She further found that the Ottawa Hospital did not comply with Section 12(1) of *PHIPA* which requires that personal health information be protected against theft, loss and unauthorized use or disclosure. In addition, the Commissioner found that Hospital staff had failed to follow privacy policies which led to the breach in question. The Commissioner ordered: (1) a review and revision of Hospital practices, procedures and protocols relating to patient health information and privacy; (2) implementation of a protocol to ensure that reasonable and immediate steps are taken by the Hospital when notified of an actual or potential breach of an individual's privacy; and (3) education of all employees and or agents of the Hospital as to their duties under *PHIPA*.

In another similar case,<sup>21</sup> a diagnostic imaging technologist accessed a patient's records on six separate occasions and disclosed the contents of those records without the patient's consent. At the time of the decision, the technologist was the former

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21 *PHIPA Order HO-010*, Information and Privacy Commissioner/Ontario (July 2006) online: <<http://www.ipc.on.ca/images/Findings/ho-010.pdf>>

spouse of the complainant's current spouse. The technologist did not have a proper reason to access the patient's records. The Ottawa Hospital terminated the employment the technologist and conducted an investigation that confirmed the technologist's conduct.

In the Commissioner's decision, she found that despite the fact that the Hospital had comprehensive privacy policies and protocols in place,<sup>22</sup> further measures should be taken in order for it to comply with Section 12(1) of *PHIPA*. In particular, the Commissioner took issue with the fact that "[t]here are generally no technological restrictions in place at the Hospital that would limit the access of a staff member to only those electronic records of personal health information relating to the individuals to whom that staff member is assisting in providing health care".<sup>23</sup> The Commissioner ordered that the Ottawa Hospital: (1) revise its policies, procedures and information practices; (2) add a provision requiring an agent or employee who has contravened *PHIPA* to sign a confidentiality undertaking and non-disclosure agreement; (3) provide a written report of the privacy breach to the College of Nurses of Ontario; (4) issue a communiqué regarding both the present Order and Order HO-002 to all Hospital staff and agents stating that all breaches will be reported to their professional regulatory colleges; (5) include the present Order and HO-002 in all future training programs; (6) carry out privacy retraining for all agents and employees in the technologist's department; and finally, (7) amend and implement certain other procedural protocols to address privacy concerns.

Significantly, in neither of the cases referenced above were fines imposed on the health information custodians regarding the privacy breaches.

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22 This included: *Administrative Policy and Procedure Manual – ADM II 260; Protecting Patient's Privacy* procedure; *Process for Investigating Privacy Breaches and/or Complaints*; a *Confidentiality Agreement* and a *Confidentiality Pledge*. Many of these policies and provisions were put in place after Order HO-002 was released.

23 *Supra* note 20 at 13-14.

**(c) Labour Arbitration**

When health care professionals are alleged to have breached patient privacy, their continued employment is put in jeopardy. In the context of labour arbitration jurisprudence in Ontario, a "zero tolerance" approach has emerged. This approach has been used to override the usual progressive discipline principle under which Employers are first required to give employees a warning and or suspension before proceeding to the ultimate sanction.

In *Ontario Nurses' Association and North Bay Health Centre (McLellan Grievance) (North Bay)*,<sup>24</sup> the Grievor had been a Registered Nurse with the Health Centre since 1999. Up to the point of her termination, she had an unblemished disciplinary record. In 2011, it came to light that the Grievor had accessed the individual patient health records of 5804 individuals over a seven year period of time, making over 12,000 inquiries.<sup>25</sup> In some cases the Grievor accessed the health records of fellow employees but for the overwhelming majority of accesses, the patients were unknown to the Grievor and not under her care at the Health Centre. Most of the accesses had a duration of seconds rather than minutes. There was no evidence that the Grievor disclosed the contents of the health records at any point.

In an investigatory meeting with the Employer, the Grievor was asked about why and how often she accessed the personal health information of individuals who were not her patients. The Grievor explained that she accessed records routinely, choosing patients randomly for "learning purposes", "curiosity" and to look at "interesting diagnoses".<sup>26</sup> In explaining her actions further, the Grievor stated that she began her practice of looking at patient health records after she observed her former teacher doing so with patients in the ER department of the Centre. The Grievor stated she "learned a lot by looking at labs and patient conditions" and was able to use some of the information she learned to

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24 *North Bay Health Centre v Ontario Nurses' Assn (McLellan Grievance)*, [2012] OLAA No 11, 216 LAC (4<sup>th</sup>) 38 (Ont Arb) (Abramsky).

25 *Ibid* at para 11.

26 *Ibid* at paras 7-8.

improve her practice for patients on her unit.<sup>27</sup> The Grievor was dismissed from her employment for these alleged privacy breaches.

In seeking the Grievor's reinstatement, the Union argued that the Grievor was a health information custodian and as such, under Section 37(1)(d) of *PHIPA*, she was entitled to access the personal health information of patients, without their consent, for educational purposes.<sup>28</sup> This argument was rejected by Arbitrator Abramsky and the termination was upheld. In reaching this conclusion, the Arbitrator found that the Grievor, as a nurse, was an agent and not a health information custodian, and as such, she could not use health information for educational purposes.<sup>29</sup> The Arbitrator did not address other sections of the Act, such as Section 17(2) and Section 37(2) which permit an agent to use personal health information on behalf of a health information custodian if permitted. A distinction was drawn between those accesses which were made out of curiosity, and those made for educational purposes, with the former being more egregious and capable of justifying the Grievor's termination.

In *Bluewater Health v. Ontario Nurses' Association (Hardy)*,<sup>30</sup> one of the two Grievors was a part-time nurse at the Hospital and accessed the medical records of four individuals not under her care or her unit and to whom she had no known connection. In three of the cases, the access lasted only two seconds and in the other case six seconds. As per the Hospital's policy, nurses were only to access the records of those patients under their care even though the electronic system in place allowed access to all records at the Hospital. A "zero tolerance" policy was in place regarding breaches of the Hospital's privacy policies and procedure. The Grievor was terminated when these privacy breaches were discovered during a routine audit. The Union argued that the accesses were accidental given their short duration.

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27 *Ibid* at paras 24-25.

28 *Ibid* at para 34

29 *Ibid* at para 66.

30 *Bluewater Health v Ontario Nurses' Assn (Hardy Grievance)*, [2010] OLAA No 660, Nos A/Z001084, A/Z001085 (Ont Arb) (Rayner).

The Grievor's termination was upheld. Arbitrator Rayner wrote: "[t]he vulnerability of patients to misuse is obvious and the need for strict enforcement of confidentiality is recognized by the Act, the Standard and the Hospital's policies. [...] Deviation from a "zero tolerance" approach should only occur when there are extremely compelling circumstances to support mitigation. I found no such circumstances in the case."<sup>31</sup>

The second Grievor had accessed the records of two patients, her severely disabled daughter and her father who was ill. That Grievor was reinstated due to what the Arbitrator found to be compelling circumstances.<sup>32</sup>

Several other arbitration cases concern nurses who accessed the personal health information of patients with whom they had some personal relationship or personal knowledge.<sup>33</sup>

In *Timmins & District Hospital v. O.N.A.*,<sup>34</sup> the mental health records of the former spouse of the Grievor's son and mother of the Grievor's grandchild were accessed. The patient was not under the care of the Grievor. The Grievor was terminated and at arbitration, the termination was upheld. The Arbitrator found that there were no compelling mitigating factors that warranted discipline short of discharge. This conclusion was supported by the Arbitrator's view that the Grievor demonstrated a lack of insight, recognition or remorse relating to the incident which was deliberate and done for personal reasons.

The recent case of *Georgian Bay General Hospital and OPSEU, Local 367 (J. (K.)) Re*<sup>35</sup> suggests that Arbitrators may be willing to depart from the "zero tolerance" approach seen in the termination cases cited above. The Grievor, an Allied Health Assistant,

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31 *Ibid* at para10.

32 *Ibid* at para 15.

33 *Timmins & District Hospital v Ontario Nurses' Assn (Peever Grievance)* [2011] O.L.A.A. No. 222, 208 LAC (4th) 43 (Ont Arb) (Marcotte) [*Timmins*]; *Georgian Bay General Hospital v Ontario Public Service Employees' Union, Local 367 (K.J. Grievance)* [2014] OLAA No149, 119 CLAS 7 (Ont Arb) (Sheehan) [*Georgian Bay*].

34 *Timmins, ibid.*

35 *Georgian Bay, supra* note 32.

accessed the personal health records of a close friend and disclosed the contents of the records to others. An audit revealed that the Grievor had also accessed the health records of immediate family members on more than thirty occasions over a twelve year period. The Grievor was terminated in accordance with the Hospital's "zero tolerance" policy for privacy breaches. At arbitration, the Grievor was reinstated without back pay and with no loss of seniority.<sup>36</sup> Arbitrator Sheehan was of the opinion that the explanations provided by the Grievor as to why she accessed the records of family and a close personal friend revealed that the substitution of a lesser penalty was warranted. In large part, the Grievor stated that with respect to her family members she had been requested by them to access the records. As for the accesses related to her close friend, they occurred within the context of a highly emotional scenario and disclosure was only made to the family and friends of the patient. Notwithstanding the serious and improper nature of the Grievor's actions, the Arbitrator found that strict adherence to a "zero tolerance" approach was incompatible with the just cause standard and the case at hand called for deviation from it.

Other Canadian provinces have issued similar arbitration decisions concerning health care professionals who are accused of privacy breaches. The jurisprudence reveals that some provinces are willing to take a more flexible approach, whereas others have adopted an approach that is more in line with the decisions of Ontario arbitrators.

In a Newfoundland arbitration decision, *Eastern Regional Integrated Health Authority and NAPE (Butler) Re*,<sup>37</sup> the Grievor was a clerical employee that provided support to the Medicine/Ambulatory Care Program. She was terminated after an audit revealed that she had accessed the personal health information of patients, many of whom were known to her in a personal capacity, over a period of approximately five months. Although the Grievor's job duties did not require her to access patient health information, she testified that she was sometimes forwarded requests by doctors'

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36 *Ibid* at para 79.

37 *Newfoundland and Labrador Assn of Public and Private Employees v Eastern Regional Integrated Health Authority (Butler Grievance)* [2012] NLLAA No 9, 225 L.A.C. (4th) 1 (Nfld Arb) (Oakley).



secretaries to perform checks of medical records and had never been disciplined for fulfilling these requests.<sup>38</sup>

At the time of her termination the Grievor stated that she did not understand her actions to be wrongful, and that she had no malicious intent.<sup>39</sup> Many of the accesses were in relation to friends' medical records, and were made at their request. In addition, she did not disclose the information to anyone else.<sup>40</sup> Further, the Hospital's privacy policy did not establish a "zero tolerance" standard. Rather, it stated that the disciplinary penalty for privacy breaches could include termination of employment.<sup>41</sup>

In his decision, Arbitrator Oakley found that the Grievor's actions amounted to a serious breach, but that the seriousness was mitigated by certain factors, including her personal relationship to the patients in question, a lack of malice or personal gain and the fact that she did not disclose the information to others.<sup>42</sup> As such, and in following the longstanding principle of progressive discipline, the Arbitrator found it was appropriate to reinstate the Grievor. In substituting the discharge, it was found that the appropriate penalty was an eight month suspension without pay or benefits or accumulation of seniority.<sup>43</sup>

In Saskatchewan, two recent arbitration decisions concerned the termination of health professionals for privacy breaches.

In *Prairie North Health Region and HSAS (McHattie), Re* (2014),<sup>44</sup> the Grievor, a physical therapist with 25 years of service with the Employer, was terminated for accessing patient health information for learning purposes. An audit revealed that in the

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38 *Ibid* at para 28.

39 *Ibid* at para 49.

40 *Ibid* at para 58.

41 *Ibid* at para 57.

42 *Ibid* at para 63.

43 *Ibid* at para 73.

44 *Health Sciences Assn of Saskatchewan v Saskatchewan Assn of Health Organizations (McHattie Grievance)*, 240 L.A.C. (4th) 1, 117 CLAS 306 (Sask Arb Bd).

course of a ten month period, the Grievor had accessed the personal health information of 99 individuals who were not under her care. In particular, the Grievor testified that she made these accesses out of "medical curiosity" and the "need to understand" the medical diagnosis of the patients in question.<sup>45</sup> In one incident, the Grievor accessed the health records of a prominent member of the community after he passed away suddenly at the Hospital where the Grievor was employed.

In accordance with the Hospital's privacy policies, the Grievor was terminated. The Grievor testified that she had not read the Hospital's privacy policies and that she did not think accessing the personal health information was wrong, so long as the information stayed with her, was not written down, or shared.<sup>46</sup> The Union argued that the Employer failed to provide adequate confidentiality training, and that failure, as well as other factors, militated in favour of the Grievor's reinstatement.

The Board was not satisfied that the Grievor lacked knowledge that her actions were wrong. Its reasoning was that for some accesses, the patient had no medical predisposition. Even in cases where a medical predisposition did exist, the medical issue had nothing to do with the Grievor's speciality of knees and joints. The Board found that "it is not logical [that] the Grievor accessed medical information online for learning purposes in disciplines other than her own".<sup>47</sup> The Board described the Grievor's conduct as forming a pattern of behaviour that spoke to her lack of respect for the confidentiality of personal health information – something the Board found "appalling".<sup>48</sup> Consequently, the Grievor's termination was upheld.

In *R. Qu'Appelle Health Region and CUPE, Local 3967 (Koch), Re*,<sup>49</sup> the Grievor, a Health Records Clerk, was reinstated after she accessed the records of a pregnant work colleague who received treatment at the Grievor's place of employment. When the

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45 *Ibid* at para 4.

46 *Ibid* at paras 69-76.

47 *Ibid* at para 227.

48 *Ibid* at para 246.

49 *R Qu'Appelle Health Region and CUPE, Local 3967 (Koch), Re* 101 CLAS 121, 2010 CarswellSask 920 (Sask Arb Bd).

name of a work colleague appeared on a day surgery chart at the Hospital, the Grievor accessed her colleague's personal health records out of curiosity and apparent concern. The records revealed that she had suffered a miscarriage. The Grievor shared this information with other colleagues while in the record clerks' office, which resulted in "gossip" about the colleague. The privacy breach was ultimately reported to a supervisor. In response, the Grievor was terminated and other staff who took part in the office discussion were disciplined.<sup>50</sup> In a previous decision, it was determined that the Grievor's termination was not warranted.<sup>51</sup> The present case concerned what discipline should be substituted for the termination. The Board concluded that the importance of confidentiality had been "brought home" to the Grievor and that she was unlikely to breach confidentiality again. As such, a three month suspension without pay was substituted for the Grievor's termination.<sup>52</sup>

**(d) Civil**

In 2012, the Ontario Court of Appeal recognized the novel privacy tort of intrusion upon seclusion. *Jones v. Tsige*<sup>53</sup> concerned the Defendant's unauthorized access of the Plaintiff's banking records. The Plaintiff was in a common law relationship with the Defendant's former husband. In recognizing that the access was improper and the requirements of the novel tort were met, damages in the amount of \$10,000 were awarded to the Plaintiff.

To prove the tort of intrusion upon seclusion, it must be shown that there was an intentional or reckless conduct by the defendant which invades, without lawful justification, the plaintiff's private affairs or concerns. The tort covers intrusions into matters such as one's financial or health records, sexual practices and orientation, employment, as well as intrusion into one's diary or private correspondence. A reasonable person standard applies in that the invasion must objectively be viewed as

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50 *Ibid* at para 66.

51 *Ibid* at paras 69-70.

52 *Ibid* at paras 99-100.

53 *Jones v Tsige*, 2012 ONCA 32, [2012] OJ No 148 (Ont CA).

highly offensive causing distress, humiliation or anguish. With respect to damages, proof of harm to a recognized economic interest is not necessary. As such, damages are most appropriately characterized as being in the nature of "symbolic" or "moral" damages.<sup>54</sup>

In the context of privacy of health care information, only one civil action pleading the tort of intrusion upon seclusion has been launched. In *Hopkins v. Kay*,<sup>55</sup> it was alleged that approximately 280 patient records of the Peterborough Regional Health Centre were intentionally and wrongfully accessed by seven Hospital employees without the consent of the patients over the course of one year.<sup>56</sup> The Plaintiffs claimed that they suffered psychological damages as a result of the breach of privacy.<sup>57</sup> The Hospital brought a motion seeking that the claim be dismissed on the basis that it disclosed no reasonable cause of action.<sup>58</sup>

Counsel for the Hospital and staff who were alleged to have committed the privacy breaches argued that the Information and Privacy Commissioner's complaint process provided for in *PHIPA* is the appropriate means to deal with the Plaintiffs' privacy complaints. It was submitted that the Act is comprehensive and stipulates that it is only after an order by the Commissioner is made that a proceeding may be brought in the Superior Court. Any claims in that regard would be limited to \$10,000 for mental anguish where proof of damages is established. The Plaintiffs had not undergone this process and as such it was argued that the Court did not have jurisdiction to hear their claim.<sup>59</sup>

It was argued by counsel for the Plaintiffs that the tort of intrusion upon seclusion had clearly been made out in *Jones v. Tsige* and that *PHIPA* does not "occupy the field". In

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54 *Ibid* at paras 70-73.

55 *Hopkins v Kay*, 2014 ONSC 321, 119 OR (3d) 251 (Ont Sup Ct).

56 *Ibid* at paras 1, 7.

57 *Ibid* at para 9.

58 *Ibid* at para 3.

59 *Ibid* at paras 10-11 referencing *PHIPA*, *supra* note 1, ss. 62, 65(1),65(3).

*Jones*, the federal privacy legislation, *PIPEDA*, was applicable and contained similar provisions to that of *PHIPA*. The Court of Appeal nevertheless knowingly recognized the common law tort despite the provisions of the statute. On this basis, it was argued that it cannot be plain and obvious that the Plaintiffs' claim would fail.<sup>60</sup>

The Ontario Superior Court agreed with the Plaintiffs. Justice Edwards stated that *Jones v. Tsighe* determined that there is a common law right to proceed with a claim based on the tort of intrusion upon seclusion. At the time of writing, the Ontario Court of Appeal was scheduled to hear the Peterborough Regional Health Centre's appeal.

The concern regarding civil action arises in part from a requirement under *PHIPA* that Health Information Custodians advise individuals of any inappropriate accesses to their records.<sup>61</sup> While the health professional has no input into the notification that is given they may find themselves a defendant in the resulting civil action.

#### **IV. CONCLUSION**

While protecting privacy of personal health information is of high importance, it should not be unconditional. Rather, it must be recognized that rigid constraints on health professionals and "zero tolerance" privacy policies with respect to the use of personal health information may ultimately impact negatively on the quality of care patients receive.

The provisions of *PHIPA* that recognize the value in using personal health information for educational and other systemic purposes have unfortunately been obscured by an emphasis on patient privacy interests.

The practice of nursing and the knowledge required for it is not static; nurses must commit to career-long learning. While formal education opportunities are available, it is appropriate, helpful and lawful for nurses and other health care professionals to gain

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60 *Ibid* at paras 20-23.

61 *Ibid*, s. 12(2) and 16(2)

knowledge through their employment and to use that knowledge to better their practice to the ultimate benefit of their patients.

In addition, strict privacy policies often overlook the practical realities of a health professional's daily practice. In this sense, those policies and the permitted use provisions of *PHIPA* itself are too narrow. For example, health care professionals may need to consult patient records in order to properly manage units under their supervision. Where "zero tolerance" policies are in place, quality patient care may be compromised.

While some steps have been taken to address the concerns raised above, such as proposed statutory amendments,<sup>62</sup> other measures can be taken to ameliorate the current situation of health care professionals.

By recognizing that the right to privacy is not absolute, health information custodians should fulfill their obligation to both educate their agents and staff, and implement appropriate privacy policies in accordance with *PHIPA*. In meeting this obligation, the onus is on the health information custodian to make expectations regarding the confidentiality of health information abundantly clear. In doing so, some legal challenges will be prevented.

Further, at the adjudicative level, judges and decision-makers must also take a nuanced approach which recognizes the conditional aspect of patient privacy and which takes into account the realities of daily health care practice and the benefit of ongoing education.

If this approach is adopted, the interests of patients and health care professionals may be brought into harmony – a goal that ultimately serves the interests of all Canadians.

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62 Bill 78, *An Act to amend certain Acts with respect to electronic health records*, 2<sup>nd</sup> Sess, 40<sup>th</sup> Leg, Ontario, 2013 (second reading 28 April 2014).

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Liz appears before all levels of the courts and administrative tribunals. She represented Mayor Hazel McCallion at the Mississauga Inquiry. In 2008, she was counsel at the Coroner's inquest into the murder of Nurse Lori Dupont and the suicide of Dr. Marc Daniel at Hotel Dieu Grace Hospital, in Windsor, a case that has led to significant amendments to the *Occupational Health and Safety Act* regarding violence in the workplace. Liz acted as counsel to interested parties before the Grange Inquiry into deaths at The Hospital for Sick Children and the SARS Commission conducted by Justice Campbell. Liz is well known for her work representing nurses and other professionals in a wide range of settings, including arbitrations, professional discipline/regulation, medical malpractice, inquests, inquiries and criminal proceedings.