

Bill 5: *The Mental Health Amendment and Personal Health Information Amendment Act*

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I. INTRODUCTION

In 2018, Bill 5 was introduced in the Manitoba legislature by the Conservative party of Manitoba in response to several tragedies in recent years.¹ The Bill deals with patients' personal medical information, which falls under provincial jurisdiction. Bill 5 lowers the threshold for when certain healthcare workers may disclose personal medical records when the health or safety of the patient or the public is at risk. It does so by amending both *The Mental Health Act*² (MHA) and *The Personal Health Information Act*³ (PHIA). Currently under both Acts, confidential medical information may only be disclosed without a person's consent if there is a serious and immediate threat to the health or safety of the person the information is about or another person.⁴ If Bill 5 is passed, medical directors (under the MHA) and trustees (under PHIA) would be able to disclose confidential medical information without the patient's consent to a third party, if they believe disclosure is necessary to prevent or lessen a risk of serious harm to either the patient or another person.⁵

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¹ Bill 5, *The Mental Health Amendment and Personal Health Information Amendment Act*, 4th Sess, 41st Leg, Manitoba, 2018 (second reading 6 December 2018) [Bill 5].

² *The Mental Health Act*, SM 1998 c 36, CCSM c M110 [MHA].

³ *The Personal Health Information Act*, SM 1997 c 51, CCSM c P33.5 [PHIA].

⁴ MHA, *supra* note 2, s 36(2)(e)(ii); PHIA, *supra* note 3, s 22(2)(b).

⁵ Bill 5, *supra* note 1, s 1-2.

The area of confidentiality of personal medical information is a contentious area due to the multitude of interests at play. Public and academic discussions often break the issue down as being a tension between autonomy of the individual and the public interest or responsibility for others; however, the situation is often more complex.

Bill 5 represents a substantial shift in medical privacy law in Manitoba, and to date the depth of discussions in the Legislative Assembly have not reflected this. There has been no discussion on how the new legislation would function in contexts other than informing family members that vulnerable individuals will be discharged. There has also been no in-depth discussion on whether a change to the law was actually needed, and no discussion of other more-precise methods of achieving the goal of the amendment. This lack of discussion is concerning as the law, as the Bill stands, would have a greater scope than the professed intention of the Legislature.

If the law needs to be changed, then a narrowly defined and specific family exception needs to be adopted, rather than following other provinces and lowering the threshold for disclosure of several general exceptions. In addition to this proposed alternative to Bill 5, this article will set out the legal framework of the *MHA* and *PHIA*, give an account of origin and history of Bill 5, analyze the current language of the Bill, and review the academic discussions on this contentious topic.

II. THE LEGAL FRAMEWORK

Personal health information is recorded information about an identifiable individual that, for example, relates to the individual's health and health care history.⁶ Disclosure of personal health information is governed by the *MHA*, *PHIA*, and *The Freedom of Information and Protection of Privacy Act (FIPPA)*.⁷ Several purposes of the *MHA* are to provide rules for treatment of persons suffering from mental disorders and the disclosure

⁶ *PHIA*, *supra* note 3, s 1 for full definition.

⁷ *The Freedom of Information and Protection of Privacy Act*, SM 1997, c 50, CCSM c F175 [FIPPA]. FIPPA is more general still when it comes to protecting personal information and has very little interaction with *PHIA* and *MHA* for the purposes of this paper.

of clinical records compiled and maintained in mental health facilities.⁸ Clinical records would consist of mental health information as well as other personal health information shared between facilities. Meanwhile, *PHIA* governs the use, disclosure, and collection of personal health information more generally.⁹ If there is a discrepancy between the two, the *MHA* prevails.¹⁰

Generally, a person must expressly consent to their medical information being shared to third parties.¹¹ An individual is able to give consent if they understand the purpose of disclosure and the consequences of giving or refusing consent.¹² Consent must also be voluntary and without misrepresentation.¹³ Under the *MHA*, a person at least 16-years-old is presumed to be mentally competent to make treatment decisions and thereby, is presumed to be capable of consenting or refusing to consent to disclosure of their medical records.¹⁴

Several exceptions exist to the general rule requiring consent before disclosure of personal medical information or clinical records. These exceptions include disclosure to other healthcare workers caring for the individual for the purposes of treating the individual; for the purpose of contacting a relative or friend of an individual who is injured, incapacitated or ill; or to any person to prevent or lessen a serious and immediate threat to the health or safety of the individual, another individual or the public.¹⁵ It is the last of these exceptions that Bill 5 seeks to amend.

⁸ *MHA*, *supra* note 2, s 1 definition of “clinical record” and “facility”; Man Reg 135/99, s 1 and Schedule.

⁹ *PHIA*, *supra* note 3, s 2.

¹⁰ *Ibid*, s 4(3).

¹¹ *Ibid*, ss 22(1), 20(1), 19.1(4), 19.1(1); *MHA*, *supra* note 2, s 36(1).

¹² *Ibid*, ss 19.1(1)-19.1(2).

¹³ *Ibid*.

¹⁴ *MHA*, *supra* note 2, s 2. This presumption would also apply to disclosure under *PHIA*. See *PHIA*, *supra* note 3, s 4(3).

¹⁵ *PHIA*, *supra* note 3, s 22(2); *MHA*, *supra* note 2, s 36(2).

III. LANGUAGE OF BILL 5

Since the purposed amendments of Bill 5 are seemingly so small, it is worthwhile to delve into its language. Bill 5 will amend section 36(2)(e)(ii) of *The Mental Health Act* and section 22(2)(b) of *The Personal Health Information Act*.¹⁶ Also, in the French version of Bill 5, s 22(2)(b)(i) of PHIA will be changed to “*un risqué d’atteinte à la santé ou à,*” bringing it in line with the English version.¹⁷ Apart from this, there is no substantial difference between the English and French versions. This would be the first time these specific sections will be amended. Below is a comparison between the current legislation and the legislation with the proposed amendments if Bill 5 is passed:

Current version:

The Mental Health Act

36(2) The medical director of a facility in which a clinical record is maintained may disclose information in the record without the patient’s consent of consent on the patient’s behalf under subsection (1), if the disclosure is

(e) to any person, if the medical director reasonably believes that the disclosure is necessary to prevent or lessen

ii) a serious and immediate threat to the mental or physical health or the safety of the patient or another person

The Personal Health Information Act

22(2) A trustee may disclose personal health information without the consent of the individual the information is about if the disclosure is

(b) to any person, if the trustee reasonably believes that the disclosure is necessary to prevent or lessen

(i) a risk of harm to the health or safety of a minor, or

(ii) a serious and immediate threat to the health or safety of the individual the information is about or another individual, or to public health or public safety

¹⁶ Bill 5, *supra* note 1.

¹⁷ *Ibid*, s 2.

With proposed amendments:

The Mental Health Act

36(2) The medical director of a facility in which a clinical record is maintained may disclose information in the record without the patient's consent of consent on the patient's behalf under subsection (1), if the disclosure is

(e) to any person, if the medical director reasonably believes that the disclosure is necessary to prevent or lessen

ii) a risk of serious harm to the mental or physical health or the safety of the patient or another person

The Personal Health Information Act

22(2) A trustee may disclose personal health information without the consent of the individual the information is about if the disclosure is

(b) to any person, if the trustee reasonably believes that the disclosure is necessary to prevent or lessen

(i) a risk of harm to the health or safety of a minor, or

(ii) a risk of serious harm to the health or safety of the individual the information is about or another individual, or to public health or public safety¹⁸

Bill 5 is written in plain language; however, the language is broad and difficult to define. For example, the Bill does not define “risk of serious harm” and this has developed into a point of contention in the Legislative Assembly.¹⁹ Such a broad power of discretion could result in arbitrary decisions to disclose, which are influenced by the decision-maker's own personal views, priorities, and understanding of social justice. Most importantly, with the continued use of the words “any person,” the Bill goes beyond the purported purpose of changing the law to give family members notice when vulnerable individuals are released from the hospital.²⁰ The Bill lowers the threshold for personal health information being disclosed to

¹⁸ MHA, *supra* note 2, s 36(e)(ii); PHIA, *supra* note 3, s 22(2)(b).

¹⁹ Bill 5, *The Mental Health Amendment and Personal Health Information Amendment Act*, 41-4 No 12B (6 December 2018) at 467 (Mr. Wab Kinew).

²⁰ Bill 5, *supra* note 1.

anyone, under the right circumstances, including authorities and even employers. This does not coincide with the purported purpose of the Bill and it is not reflected in the discussions of the Bill in the Legislative Assembly. As will be discussed later on, there is a much more precise way of achieving the purpose of the Bill without lowering the threshold for disposing personal health information to anyone else.

IV. ORIGIN AND LEGISLATIVE HISTORY OF BILL 5

Although Bill 5 is short enough to fit on a Post-It note, it has a long, complex history. The Bill appears to be a response to tragedy and seems to be highly influenced from equivalent legislation in other provinces after the provincial government conducted a statutory review in 2017.

Several years ago, a young man named Reid Bricker, after years of struggling with mental health issues, was discharged from hospital very late one night. Shortly afterwards, he took his own life.²¹ His family had not been notified of his discharge. After this tragedy, his mother, Bonnie Bricker, became an advocate for greater mental health services and sought to change the current legislation.²² Newspapers have extensively covered the Bricker's story and Ms. Bricker's advocacy. Their story has been repeatedly linked to the introduction of the Bill.²³ As will be discussed later on in the

²¹ Aidan Geary, *CBC News* "Mom who lost son to suicide praises mental health report's advice around privacy law" (15 May 2018), online: <cbc.ca/news/canada/manitoba/bonnie-bricker-mental-health-report-1.4663228> [perma.cc/6SVF-B5C7]. During introduction of the Bill, Minister Friesen explicitly mentioned Bonnie Bricker's story and credited her advocacy for these issues. Bill 5, *The Mental Health Amendment and Personal Health Information Amendment Act*, 1st reading 41-4No 12B (6 December 2018) at 463 (Hon Jon Gerrard).

²² CBC News, "Bonnie Bricker Speaks out at Mental Health Forum in Winnipeg" *CBC News* (7 April 2016), online: <cbc.ca/news/canada/manitoba/bonnie-bricker-speaks-out-1.3526320> [perma.cc/5KFP-KWGC].

²³ Geary, *supra* note 26; Sam Thompson, "Proposed Manitoba Law Could Save Lives, Say Families of At-Risk Patients" *Global News* (5 December 2018) online: <globalnews.ca/news/4733127/proposed-manitoba-law-could-save-lives-say-families-of-at-risk-patients/> [perma.cc/DZ86-M2CC]; Joel Schesinger, "Finding Light in the Darkness: Community and Connection Integral to Preventing Suicide" *Winnipeg Free Press* (9 June 2017), online: <winnipegfreepress.com/arts-and-life/life/health/finding-light-in-the-darkness-442833443.html> [perma.cc/4RQ7-SXVG]; Larry Kusch, "Province Tables Bill to Alter Privacy Rules, Let Health Workers Alert At-Risk

paper, the Bricker family story shaped the legislation and the discussions around it.

In 2017, the Manitoba Ombudsman issued a report on *PHIA* with recommendations for legislative reform.²⁴ The Ombudsman reported that the requirement in the current legislation for the serious threat to also be an immediate threat could be difficult for a trustee to determine at the time. As a result, this could inhibit disclosure based on serious health or safety concerns about a person, if they could not reasonably conclude the threat was immediate.²⁵ The report recommended that the Legislature amend *PHIA* to permit a trustee to disclose when they reasonably believed that disclosure was necessary to prevent or lessen a risk of serious harm to the health or safety of an individual.²⁶ A trustee could still consider the immediacy of the risk as a factor in deciding disclosure, but it would no longer be necessary.²⁷ Interestingly, the report explicitly recommended no amendment which would allow disclosure about suspected criminal activity.²⁸ However, if such amendments were implemented, it recommended that the Alberta law be used as a model because it required disclosure about the possible commission of a crime to protect health and safety of the public and limited what information could be disclosed.²⁹

Bill 5 is not the first attempt at lowering the threshold for disclosing health information without consent. In 2016, a Liberal MLA introduced a

Patients' Contacts" *Winnipeg Free Press* (12 April 2018), online: <winnipegfreepress.com/local/province-tables-bill-to-alter-privacy-rules-let-health-workers-alert-at-risk-patients-contacts-501932041.html> [perma.cc/XDQ4-KTTH].

²⁴ Manitoba, Ombudsman, "2017 Review of the Personal Health Information Act: Comments from Manitoba Ombudsman". Also in 2017, the Minister of Health, Seniors, and Active Living issued a discussion paper to the public as part of the statutory review. In that paper, the public was asked whether the Legislature should expand the disclosure provisions to prevent or lessen a serious and immediate threat and to report suspected criminal activity. See "A Review of The Personal Health Information Act: Tell us what you think" at 23-25, online: <gov.mb.ca/health/phia/docs/review.pdf> [perma.cc/4VCV-N8HX].

²⁵ Ombudsman, *supra* note 24 at 19.

²⁶ *Ibid* at 20.

²⁷ *Ibid*.

²⁸ *Ibid* at 21.

²⁹ *Ibid*.

Private-Member Bill to do just that.³⁰ Interestingly, the Conservatives opposed this Bill. Conservative MLAs raised several arguments at that time. Several Members argued that the right balance between privacy and safety had to be established in this type of legislation.³¹ Implicitly, it seems they did not think the proposed Bill found that balance. Also, one member argued that the amendments might do harm because of the stigma against mental illness and individuals not wanting to share their struggle even with family members.³² The Bill failed to pass second reading on November 7th, 2017. However, just two years later, the Conservative Party reversed its position and introduced Bill 5.

Cameron Friesen, The Minister of Health, Seniors and Active Living, introduced Bill 5 on December 4, 2018. In describing the Bill, he said that the amendments would “address the concern that current legislation prevented health-care providers from notifying an individual’s family or support network of information that could prevent tragedies, such as someone taking their own life after being discharged from a health-care facility.”³³ He said the Bill would achieve this while respecting the autonomy and privacy of that person as fully as possible.³⁴ In addition to these amendments, Friesen advocated for the education and training of health-care workers on the amendments and their powers. The Minister argued education would lessen the prevailing “PHIA phobia.” He described this phobia as being one where health-care workers would refuse to do what they thought was best for the patient, namely disclosing personal health information, because they believed there was probably a legal obstacle that prevented them and there would be recourse, either legal or from their regulatory bodies, if they disclosed information.³⁵ The broader language of the Bill would hopefully lessen this phobia and give healthcare workers more room to do what they thought was best for the patient. Unsurprisingly,

³⁰ Bill 209, “The Mental Health Amendment and Personal Health Information Amendment Act”, 2nd Sess, 41st Leg, Manitoba, 2017, s 1-2.

³¹ Bill 209, *The Mental Health Amendment and Personal Health Information Amendment Act*, 41-4 No 80A (7 November 2017) at 3500 (Mrs. Sarah Guillemard).

³² *Ibid* at 3502.

³³ Bill 5, *The Mental Health Amendment and Personal Health Information Amendment Act*, 41-4 No 10B (4 December 2018) at 353 (Hon Cameron Friesen).

³⁴ *Ibid*.

³⁵ *Ibid* at 464.

possible better results for patients was not opposed during Legislative debates.

Overall, debates in the Legislative Assembly were tame and amiable, but also brief given the potential impact of the Bill. During second reading, there was agreement with the principle of the Bill. Legislative members accepted without question the proposition that previous tragedies could not have been prevented under the existing provisions without Bill 5. However, there was still a limited discussion and critique from several members. One interesting aspect of the debate was the sense of urgency from a Liberal MLA to have rules of procedure suspended and the Bill passed before the Christmas season.³⁶ The Liberal MLA referred to numerous tragedies in the past – which, he argued, could be prevented with immediate passage of the amendments – in order to persuade the Assembly to enact the legislation that day, without further input from the public.³⁷ This was not adopted by the Assembly, and parliamentary procedure won the day.

A few legislative members brought up several critiques of the Bill during debates. The first had to do with the substance of the Amendment itself. By lowering the threshold from a “serious and immediate threat” of harm or safety to a “risk of serious harm” it would create a more subjective standard in the exercise of discretion.³⁸ Second, with this added discretion, one member argued that the Assembly should consider adding an appeal mechanism and accountability measures for when information was wrongfully released.³⁹ Third, without further action from the Province, disclosure did not assure safety of that person.⁴⁰ The member did not specify what further action should be taken. On a related note, the member argued that it may be difficult for many Regional Health Authorities to provide the necessary education of the changing laws to their employees when their budgets are being cut.⁴¹ Finally, the member briefly raised the privacy issue,

³⁶ Bill 5, *The Mental Health Amendment and Personal Health Information Amendment Act*, 41-4 No 12B (6 December 2018) at 456 (Hon Jon Gerrard).

³⁷ *Ibid* at 456, 467, 477-479.

³⁸ *Ibid* at 467 (Mr. Wab Kinew).

³⁹ *Ibid* at 469, 472.

⁴⁰ *Ibid* at 470.

⁴¹ *Ibid* at 473.

particularly in the modern state of surveillance and information security.⁴² This last concern is at the heart of the controversy for legislation of this sort and has been the subject of academic commentary for years.

Despite these critiques, Bill 5 passed second reading and was referred to committee.⁴³ The Bill went to committee on May 13, 2019, and on June 3, 2019, Bill 5 passed third reading with no amendments and received royal assent.

V. EQUIVALENT LEGISLATION IN OTHER PROVINCES

Both the Ombudsman report and Cameron Friesen referred to other Canadian jurisdictions with a lowered threshold for disclosure in certain circumstances.⁴⁴ Six other provinces have lower thresholds. Although no province was hailed to be a model for drafters of Bill 5, Manitoba seems to have followed New Brunswick and Newfoundland with the threshold of “risk of serious harm to health or safety.”⁴⁵ For the remaining provinces, see the following table:

PEI	To reduce “risk of significant harm to health or safety” ⁴⁶
British Columbia	“compelling circumstances that affect health or safety” ⁴⁷
Saskatchewan	To reduce “a danger to health or safety” ⁴⁸
Ontario	To reduce “a significant risk of serious bodily harm” ⁴⁹

⁴² *Ibid* at 471.

⁴³ *Ibid* at 467.

⁴⁴ *Ibid* at 20; Gerrard, *supra* note 36 at 465.

⁴⁵ *Personal Health Information Privacy and Access Act*, SNB 2009, c P-7.05, s 34(d); *Personal Health Information Act*, SNL 2008, c P-7.01, s 34(l).

⁴⁶ *Health Information Act*, RSPEI 1988, c H-1.41, s 22(5)(d).

⁴⁷ *Personal Information Protection Act*, SBC 2003, c 63, s 18(1)(k).

⁴⁸ *The Health Information Protection Act*, SS 1999, c H-0.021, s 27(4)(d).

⁴⁹ *Personal Health Information Protection Act*, SO 2004, c 3, Sch A, s 40(1).

Alberta	where it is “necessary to respond to an emergency that threatens the life, health, or security of an individual or the public” ⁵⁰
Northwest Territories	To reduce or avoid: <ul style="list-style-type: none"> a) An imminent threat to the health or safety of the individual or another individual; b) A risk of serious harm to the health or safety of the individual or another individual; or c) An imminent or serious threat to public safety⁵¹
Yukon	To “reduce risk of serious harm to the health or safety of any other individual, or will enable the assessment of whether such a risk exists” ⁵²
Nunavut	“when necessary to protect the mental or physical health or safety of any individual” ⁵³
Quebec	Only where a “situation threatens the life, health or safety of the person concerned.” ⁵⁴
Nova Scotia	To “avert or minimize an imminent and significant danger to the health or safety of any person or class of persons” ⁵⁵

VI. POLICY ISSUES – ACADEMIC LITERATURE

Many authors have argued that personal medical information, including mental health information, is especially sensitive in nature. It has achieved this status due to its association with the dignity of the person and the need to remove any barriers to seeking medical attention. Medical conditions and conditions relating to mental health still carry stigma and possible release of this information could keep some individuals from

⁵⁰ *Personal Information Protection Act*, SA 2003, c P-6.5, s 17(c.3)(i).

⁵¹ *Health Information Act*, SNWT 2014, c 2, s 58(1).

⁵² *Health Information Privacy and Management Act*, SY 2013, c 16, s 58(h).

⁵³ *Consolidation of Access to Information and Protection of Privacy Act*, SNWT 1994, s 48(q).

⁵⁴ Act respecting Access to documents held by public bodies and the Protection of personal information, CQLR, c A-2.1, s 59(4), 59.1.

⁵⁵ *Personal Health Information Act*, SNS 2010, c 41, s 38(d).

seeking help.⁵⁶ It is easy to imagine scenarios where this would be the case. Surveys have also shown that the public shares this concern. However, some surveys have shown the public is more concerned with protection of their financial information than their personal health information.⁵⁷

Despite the amenable discussions in the Legislative Assembly, the academic discussions on this point have been heated at times. Several principles are prevalent throughout the academic and public discussions, including principles of autonomy, beneficence, public benefit, as well as numerous ethical theories and justifications for strict confidentiality or greater discretionary disclosure.⁵⁸ The discussion usually leads to a stand-off between the different camps, with personal preference, experience, ethics, and moral codes dictating where one lands in the debate. The controversial topic is often broken down into a simple tension between an emphasis on perceived responsibility for others and an emphasis on perceived autonomy of the individual.⁵⁹

Several authors have argued that the ethical principle of autonomy dictates that medical information should be strictly protected.⁶⁰ Autonomy has been interpreted to include self-determination, liberty, and free will.⁶¹ Autonomy is also called “respect for the person” because it is meant to

⁵⁶ Paul Appelbaum, “Privacy in Psychiatric Treatment: Threats and Responses” (2002) 159:11 *American J of Psychiatry* 1809-1818; Robert Gellman, “Prescribing Privacy: The Uncertain Role of the Physician in the Protection of Patient Privacy” (1984) *NC L Rev* 255 (Available on HeinOnline). These policy issues were also brought up during discussions of Bill 209 in the Assembly. See Guillemard, *supra* note 28 at 3500-3501.

⁵⁷ Wilhelm Peekhaus, “Personal Health Information in Canada: A comparison of Citizen Expectations and Legislation” (2008) 25 *Government Information Q* 669 at 682; Andrew Rohm & George Milne, “Just What the Doctor Ordered: The Role of Information Sensitivity and Trust in Reducing Medical Information Privacy Concern” (2004) 57 *J Business Research* 1000 at 1006.

⁵⁸ Bernadette McSherry, “Third Party Access to Shared Electronic Mental Health Records: Ethical Issues” (2004) 11:1 *Psychiatry, Psychology & L* 53 at 54.

⁵⁹ Bernadette McSherry, “Confidentiality of Psychiatric and Psychological Communications: The Public Interest Exception” (2001) 8:1 *Psychiatry, Psychology & L* 12 at 15.

⁶⁰ *Ibid.*

⁶¹ Kwang-Kuo Hwang, “Morality ‘East’ and ‘West’: Cultural Concerns” in James D Wright, 2nd ed, *International Encyclopedia of the Social & Behavioral Science* (Oxford: Elsevier, 2015); McSherry “Third Party Access”, *supra* note 54 at 55.

promote the idea of the right of the individual to determine their own life.⁶² In the context of health decisions and control of information, this translates to individuals having the right to make their own decisions about their health and who has access to their medical information with no interference.⁶³ The presumption of capacity in the *MHA* bolsters this idea of independency and autonomy.⁶⁴

Another common argument for limiting disclosure of personal medical information is based on the presumption of the importance of the relationship between a health professional and the patient. If health professionals become known as confidence-violators, patients may lie, play-down problems, or avoid seeking medical treatment altogether.⁶⁵ A relationship of trust and confidence is even more important in the context of mental health. Given the still-prevailing stigmatization of mental illness, the consequences could be even greater if health professionals become known as confidence-violators.⁶⁶

A final argument for strict confidentiality is not based on the consequences of an action, but on the moral rightness of the action itself. Some authors have argued that there is a universal moral duty to avoid passing on what someone has said in confidence.⁶⁷ This duty guides the healthcare worker to keep a patient's confidence and can lead to the conclusion that disclosure should never occur without a patient's consent.⁶⁸ Legislation, however, has made it impossible to employ such a strict model.

The argument for greater discretion boils down to this: greater discretion, if executed appropriately, can save lives. Two additional points support the argument for greater discretion. The first is the professional and moral duty of healthcare workers to do what is best for their patients.⁶⁹

⁶² McSherry "Third Party Access", *supra* note 58 at 55.

⁶³ *Ibid.*

⁶⁴ *MHA*, *supra* note 2, s 2.

⁶⁵ Michael Kottow, "Medical Confidentiality: An Intransigent and Absolute Obligation" (1986) 12 *J Medical Ethics* 117 at 120.

⁶⁶ Nicolas Rilsch et al, "Stigma and Disclosing One's Mental Illness to Family and Friends" (2014) 49:7 *Social Psychiatry Psychiatric Epidemiology* 1157.

⁶⁷ John King-Farlow & Paul Langham, "Confidentiality: Medical Ethics and Professional Morality" (1981) 10 *Philosophical Papers* 9 at 10.

⁶⁸ *Ibid.*

⁶⁹ McSherry, "Confidentiality", *supra* note 59 at 15; Clancy Catelin, "Between Consent

Intrinsically linked to this is the argument that physicians owe a duty to do no harm to the patient and the larger community.⁷⁰ These arguments conflict with the current individualistic view of people and with the presumption in most legislation that the individual is capable of making their own decisions. People who argue for greater discretion see the individual's interest in preserving their life and safety, as well as their family's and the public's interest, as overriding the individual's interest in autonomy and privacy. Currently, the prevailing opinion in the medical community is that life should trump privacy, in this context.⁷¹ This sentiment was echoed in the Legislative Assembly during discussions of the Bill.⁷²

VII. ANALYSIS

Privacy legislation, particularly in the context of healthcare, is a difficult area for legislatures. One of the reasons this area of law is so contentious is because there are so many different interests involved, including those of the patient, family and loved ones of patient, trustees and healthcare workers, and the public. According to the academic discussion, the patient's main concern is autonomy, control of their healthcare and information, and being able to make their own decisions. However, it can easily be argued that a patient also wants to be free from danger. Family and loved ones of the patient are concerned about the safety of the patient. They also want to be informed in order to enable them to better support and care for the patient. Their interest may on occasion naturally conflict with the autonomy and privacy of the patient. Trustees and healthcare workers also want to do the best for their patients; and so, their interests may also conflict with the patient's autonomy. Trustees and workers also need to understand the rules surrounding confidentiality and disclosure. Their powers must be clearly outlined, and they must understand those powers.⁷³ The public has several interests including public safety and suicide prevention. In addition, the

and a Hard Place: The Disclosure of Personal Health Information to Families" (2018) 39 Windsor Rev Legal & Social Issues 105 at 122.

⁷⁰ *Ibid.*

⁷¹ Catelin, *supra* note 61 at 117.

⁷² Friesen, *supra* note 33 at 464.

⁷³ To prevent "PHIA-phobia."

public has an interest in keeping trust in the medical profession. Trust is maintained by preventing unethical disclosures of personal medical information and preventing arbitrary exercises in discretion to disclose. Has the Manitoba Legislative Assembly struck the right balance between protecting the individual's privacy and the broader public interest in keeping people safe?

There is no arguing that Bill 5 arose from the best intentions; it stems from terrible tragedies in the province which everyone wants to prevent, if possible. However, as representatives of the whole of the Province, the Legislative Assembly has a duty to consider whether those tragedies could have been avoided under the existing legislation. The Assembly also has a duty to ensure that the current proposed changes do not do more harm than good. There is an argument that those tragedies, particularly the case of Reid Bricker, could have been avoided under the current law that needs to be addressed by the Legislative Assembly. Perhaps only greater education of healthcare workers is needed. Perhaps better discharge protocols need to be implemented to ensure vulnerable patients are not discharged. Or perhaps healthcare staff are simply too over-worked, and this is what needs to be addressed by the Legislature. However, if the benefits of changing the current law outweigh the costs, then it needs to be done with great care.

The idea of creating a more substantial family exception to the current privacy laws is intriguing. A family exception stands as a counter-argument to the dominant individualistic model in decision-making of the last several decades. It also may better represent the reality of family influence in decision-making of individuals in a culturally diverse province like Manitoba. However, there may be a better way of accomplishing this goal than the current Bill 5.

Instead of the proposed amendments, which simply lower the threshold to disclosing to any third party when there is a risk of serious harm, the Province could create a special exception for disclosure to family and loved ones when there is a risk of harm. This could be done by creating a separate provision or by amending current section 22(2)(c) of PHIA.

Current version:

The Personal Health Information Act

22(2) A trustee may disclose personal health information without the consent of the individual the information is about if the disclosure is

- (c) for the purpose of
 - (i) Contacting a relative or friend of an individual who is injured, incapacitated or ill⁷⁴

Proposed version:

The Personal Health Information Act

22(2) A trustee may disclose personal health information without the consent of the individual the information is about if the disclosure is

- (c) for the purpose of
 - (ii) Contacting a relative or friend of an individual who is injured, incapacitated or ill;
 - (iii) Contacting the family of an individual where that individual poses a serious risk to themselves or others.

An identical amendment would need to be created under the *MHA*. Under this version, the family exception would be created while maintaining the individual's privacy as much as possible from other third parties. Family would be defined to include immediate and extended family members – to include aunts, uncles, cousins, and grandparents. Similar to Bill 5, this proposed amendment removes the requirement that the serious risk be “immediate.” There would be no point to any amendment if it remained because the current provisions could be used to contact family members of vulnerable individuals. Removing the word “immediate” lowers the threshold for disclosure; however, by limiting disclosure to family members, the risk of harm from an unwarranted disclosure is significantly reduced.

Even with this narrow construction, there is still a risk that disclosure may cause more harm than good. If the medical director or trustee does not understand the dynamics in a family, disclosing that the individual is vulnerable may open them up to more harm. One way of preventing this type of harm is having a patient disclose upon admission who they would like the trustee to call if they are in trouble. This may be different than the next-of-kin information collected for medical purposes that the trustee would otherwise use and may reduce the chance of negative consequences

⁷⁴ *PHIA*, *supra* note 3, s 22(2)(c)(i).

arising due to disclosure without consent. Some may argue that this construction is too narrow to provide proper protection for vulnerable individuals in the medical system. However, it must be remembered that discharging patients who are believed to be a danger to themselves is not generally the practice in the medical profession.⁷⁵

VIII. CONCLUSION

The issue of protecting personal medical information has been debated for decades. To many, it seems legislation and policy has been chipping away at privacy for just as long. Those in favour of greater privacy argue that it is protection in an unbalanced power-relationship with the state or it is their right as an individual to make their own choices about their life. Those in favour of greater discretion to disclose argue it is the responsibility of healthcare workers to do what is best for their patients, which almost always means protecting and preserving life, and that it benefits the public as well as the individual. Where you stand on the issue appears to be dictated by preferences and experience.

A family exception to the general rule against disclosure of personal medical information without consent seems to make sense. However, with any proposed legislation, politicians must balance the potential benefits with the potential harms. More importantly though, politicians must be sure that a proposed Bill will do what they say it will. Bill 5 fails on the latter count.

The overly-broad language of the amended provision opens up Manitobans to great harm in unwarranted disclosures of personal medical information. It is simply too easy to imagine situations where things could go wrong. Also, I do not think merely educating medical workers would necessarily prevent unwarranted disclosures. The amended provisions as they stand now is highly subjective and open to misuse, albeit unintentional misuse. Finally, with no accountability mechanisms in place or requirement on medical staff to inform patients when their information has been disclosed without their consent, the amendment poses too great a danger to the privacy rights of Manitobans.

To achieve the meritorious goal of Bill 5, I would recommend a narrowly constructed and specific family exception to the general rule against disclosure. That way, vulnerable individuals will hopefully get the

⁷⁵ *Ombudsman, supra* note 24 at 20.

support they need, while maintaining their own and other Manitobans' privacy as much as possible. This would, unfortunately, mean not following other provinces as a precedent. However, I would argue a well-thought-out Manitoba piece of legislation can be better than a cut-and-paste precedent from another province.