

# *Exploiting the Fiduciary Relationship: The Physician as Information Intermediary in Assisted Human Reproduction*

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## **Introduction**

The *Assisted Human Reproduction Act* [AHRA] will impose new information disclosure requirements on physicians in the context of assisted reproductive technologies [ARTs].<sup>1</sup> In doing so, the AHRA exploits the trust relationship between physician and patient. The AHRA requires physicians to collect a wide range of highly sensitive information from those involved in ARTs and forces physicians to disclose this information to a government agency, the Assisted Human Reproduction Agency of Canada [Agency], which may use the information for a number of non-therapeutic purposes. As a result, the Agency will indirectly receive highly sensitive patient information – information which would be difficult, if not impossible, for the Agency to collect directly. Although it may be appropriate for a physician to disclose patient information to a third party under certain circumstances,<sup>2</sup> the changes to the nature of the physician’s role under the AHRA are troubling. Indeed, this relationship and the broad purposes for which patient information may be used by the Agency have caused concern among those who work with ARTs. Some have speculated that the “majority of patients wouldn’t agree to give information to a government agency,” and indeed that these information provisions “will prevent some patients from seeking AHR procedures” altogether.<sup>3</sup> There may be some merit to these concerns. The information requirements imposed by the Agency raise important questions about how the role of the

physician vis-à-vis her patient will change, and whether it will challenge the trust inherent in the physician-patient relationship.

## **The AHRA’s Information Provisions: The Physician as Information Intermediary**

The AHRA’s information collection, use and disclosure provisions exploit the relationship of trust between physician and patient.<sup>4</sup> One of the hallmarks of this relationship is the free flow of information from patient to physician.<sup>5</sup> The AHRA seeks to use this relationship in order to gain access to certain patient information that would otherwise be held in confidence by the physician. Specifically, the AHRA will require physicians to collect, use and disclose health reporting information from donors of reproductive material and those undergoing assisted human reproduction procedures, in other words their patients.<sup>6</sup> Physicians will, in turn, be required to disclose certain health reporting information to various third parties for a number of purposes.<sup>7</sup> Most notable, and the focus of this paper, is disclosure to the Agency.

The relationship between the physician and Agency is a key component of the AHRA. The AHRA exploits the trust relationship between the physician and patient so that the Agency has access to information which would be difficult if not impossible to collect directly from patients. In effect, the AHRA forces the physician to act as



an information intermediary for the Agency.<sup>8</sup> The *AHRA* requires the physician to disclose information collected in the therapeutic context to the Agency for a number of broadly-stated purposes unrelated to the well-being of the patient, described below. Although the details have been left to the regulations, which are not yet published, it is possible that all of the information collected from a patient will be disclosed by his or her physician to the Agency. The Agency has an expansive mandate which may require significant patient information to fulfil.

The information that flows between the patient and the physician in the context of ARTs, and ultimately the Agency, is highly sensitive and wide-ranging. According to the *AHRA*, “health reporting information”

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includes one’s “identity, personal characteristics, genetic information and medical history.”<sup>9</sup> This type of information is considered to be among the most sensitive information about an individual because it “goes to the personal integrity and autonomy of the patient.”<sup>10</sup> The consequences of disclosing health information are serious. As the former Federal Privacy Commissioner has observed, a “violation of health care privacy can be catastrophic for the individual...could change your entire life, and deny you a whole range of opportunities.”<sup>11</sup> Some of these consequences are addressed below.

The patient information collected from the physician may be used by the Agency for a number of broadly-stated purposes unrelated to the patient’s well-being.<sup>12</sup> First and foremost, the Agency has a mandate to create and supervise a personal health information registry which will contain both identifying and non-identifying information.<sup>13</sup> The Agency has wide latitude with respect to the use of information found in the registry. Importantly, the Agency may disclose non-identifying

information relating to the donor of the reproductive material (sperm or ova) to the person undergoing the AHR procedure and the offspring conceived using this material.<sup>14</sup> In addition, the Agency may, on application by any two individuals who have reason to believe that one or both of them were conceived by ARTs, disclose to them whether it has information on whether they are genetically related and if so the nature of the relationship.<sup>15</sup> This is intended to address, in part, the risk that two related persons may unknowingly engage in sexual intercourse.<sup>16</sup>

Notably, the Agency’s mandate vis-à-vis this information extends far beyond these important and limited purposes which appear to be for the safety and well-being of those using these technologies.<sup>17</sup> The Agency may use health reporting information found in the registry, as well as additional information otherwise relating to ARTs, for several other purposes.<sup>18</sup> These include the administration and enforcement of the *AHRA*; the identification of health and safety risks; monitoring potential and actual abuses of human rights; considering ethical issues associated with assisted human reproduction technologies; and for any other matter to which the *AHRA* applies.<sup>19</sup> There may be a number of “other matters” for which a patient’s health reporting information may be used and disclosed because the Agency enjoys several broad powers under the *AHRA*. The Agency administers and enforces the *AHRA*; advises the Minister of Health on a wide range of topics relating to assisted human reproduction and the *AHRA*; monitors and evaluates developments in assisted human reproduction technologies; consults with persons and organizations within Canada and internationally; and provides information to the Canadian public and the professions about assisted human reproduction.<sup>20</sup>

The precise nature of the physician’s role as an information intermediary for the Agency will be set out in the regulations. Accordingly, this is an opportune moment to reflect on the physician’s new role in the *AHRA*. In particular, given the nature of these various relationships, the sensitivity of the information, and the breadth of the non-therapeutic purposes for which this information may be used by the Agency, it is important to consider the possible consequences of exploiting the physician-patient relationship in the manner contemplated by the *AHRA*.



## Exploiting the Fiduciary Relationship: Potential Consequences

In my view, exploiting the fiduciary relationship between the physician and patient so as to transform the physician into an information intermediary for the Agency represents an important shift in the traditional role of the physician, and may challenge the trust upon which the physician-patient relationship is founded. The physician's role as an information conduit may violate patient privacy and undermine the physician's duties of confidentiality and loyalty, which are core components of the fiduciary duty owed by the physician to the patient. This may, in turn, weaken the physician-patient relationship. As the precise scope of the information sharing between the physician and the Agency remains to be seen, this section considers the potential consequences of these information provisions on the fiduciary relationship between physician and patient.

Health information is vital to the therapeutic relationship. For a patient to receive appropriate medical treatment from his or her physician, the patient must disclose all relevant information to the physician.<sup>21</sup> To ensure that the patient discloses what is widely recognized as "highly private and personal" information to her physician, she must trust that her privacy will be protected and that the physician will hold this information in confidence.<sup>22</sup> Privacy and confidentiality, though distinct concepts, are inextricably connected. Professors Caulfield and Ries explain: "[w]hile privacy concerns the right of an individual to control who has access to her personal information, confidentiality refers to the obligation of one to preserve the secrets of another, such as the physician's duty of confidentiality owed to a patient."<sup>23</sup> Both privacy and confidentiality are necessary aspects of the relationship of trust upon which the physician-patient relationship is founded.

Privacy is an elusive concept.<sup>24</sup> In this context, privacy is a claim allowing an individual to determine when and how information about him or herself is shared with others.<sup>25</sup> When it comes to protecting the privacy of information, health information is often said to be "worthy of the highest degree of protection."<sup>26</sup> Fair information practices are widely considered to be fundamental to the protection of individual privacy in Canada.<sup>27</sup> Indeed, they form the foundation of the Canadian Medical Association's Health Information Privacy Code, which is produced by physicians to protect their patients' privacy, the confidentiality and security

of their patients' health information, and to preserve the trust and integrity of the therapeutic relationship.<sup>28</sup> Fair information practices and the fiduciary duty are notionally related, as the protection of patient privacy is a core component of each. When fair information practices are not respected the patient's privacy is not adequately protected.

As I discuss more fully elsewhere, the provisions of the *AHRA* governing the collection, use and disclosure of health reporting information do not adequately protect patient privacy.<sup>29</sup> The physician's role as an information intermediary for the Agency for broadly stated purposes is problematic. Requiring the physician to collect health reporting information from the patient and disclose it

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to the Agency is inconsistent with two fair information practices: consent and reasonable collection. The collection of health reporting information under the *AHRA* is not sufficiently transparent to ensure that the patient can provide meaningful consent because it is unclear whether the information is required by the physician for therapeutic purposes or by the Agency.<sup>30</sup> Moreover, the purposes for which this information can be used are often vague and ambiguous.<sup>31</sup> Further, section 14 of the *AHRA* ties consent to services;<sup>32</sup> in other words, it requires that those using ARTs consent to the collection, use and disclosure of health reporting information as a condition of receiving services from the physician.<sup>33</sup> Finally, the *AHRA* may require the physician to over-collect information from patients in order to fulfill the Agency's non-therapeutic purposes in a manner that is inconsistent with the reasonable collection principle.<sup>34</sup> This failure to protect patient privacy may have a negative impact on the physician-patient relationship.



That the privacy of health reporting information is a central component of the physician-patient relationship is confirmed by the fact that the treatment of health information falls squarely within the scope of the fiduciary duty owed by a physician to her patient.<sup>35</sup> In *McInerney v. MacDonald*, the Supreme Court of Canada confirmed that the fiduciary duty arising from the physician-patient relationship extends to the collection, use and disclosure of health information.<sup>36</sup> As a fiduciary, the physician is under a duty to preserve the confidentiality of the patient's health information and to use the information collected from the patient in his or her best interest. The Court in *McInerney* explained:

The information conveyed is held in a fashion somewhat akin to a trust. While the doctor is the owner of the actual record, *the information is to be used by the physician for the benefit of the patient*. The confiding of the information to the physician for medical purposes *gives rise to an expectation that the patient's interest in and control of the information will continue*.<sup>37</sup>

These duties are imposed on physicians because of the inherently vulnerable position of the patient and the fact that "were it not for these needs, and the expectation that the provider can help patients meet them...the information would remain private."<sup>38</sup>

Where the patient perceives that she has lost control of the information she disclosed in the therapeutic context because the physician is not maintaining its confidentiality or the physician is using the information in a manner that is not in the patient's best interest, trust in the relationship may be eroded, and the physician's effectiveness to treat the patient will be diminished.<sup>39</sup> Indeed, the Supreme Court of Canada has long recognized the importance of a patient confiding information to her physician, and has acknowledged that the "ability of the doctor to provide effective treatment is closely related to the level of trust in the relationship."<sup>40</sup> Absent this protection, one commentator notes that "the efficacy of medical treatment would be severely undermined."<sup>41</sup>

The physician's duties of confidentiality and loyalty are not absolute. In certain circumstances there may be a reason or purpose that overrides a physician's duty of confidentiality and loyalty.<sup>42</sup> As the Court explained in *Halls v. Mitchell*, "there may be cases in which reasons connected with the safety of individuals or of the public,

physical or moral, would be sufficiently cogent to supersede or qualify" the duty owed to the individual patient.<sup>43</sup> Indeed, there are several well-recognized statutory exceptions, including public health,<sup>44</sup> safe driving,<sup>45</sup> and child welfare legislation, to name a few.<sup>46</sup> Generally, these are justified on the basis that the public benefit in disclosure outweighs the patient's personal right to privacy and confidentiality.

In my view, the role of the physician as an information intermediary pursuant to the *AHRA* challenges important aspects of the relationship of trust upon which the physician-patient relationship is founded. The disclosure of patient information by the physician to the Agency

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for broad and, at times, ambiguous purposes is a significant exception to the physician's duty of confidentiality. Although the precise details have been left to the regulations, it is likely, given the broad definition of health reporting information and the expansive duty of the Agency, that a considerable amount of patient information, including one's family history and genetic information, will be disclosed by the physician to the Agency. As a result, once the patient discloses her health reporting information to the physician and ultimately to the Agency, she will have little, if any, control over its dissemination. The dissemination of the patient's information may have serious consequences. Consider, for example, an individual who discloses her recreational drug use to her fertility doctor. She may not be concerned about disclosure of this information to her physician or to the offspring. However, she may be worried that once the information is disclosed to the Agency, the information may be further disseminated to the state and possibly to law enforcement officials, which she worries may ultimately result in criminal charges.<sup>47</sup>



Further, the health reporting information collected and disclosed by the physician to the Agency is generally for non-therapeutic purposes – that is, not for the benefit of the patient. Rather the patient’s information will be used for the benefit of third parties, whether the offspring, the Minister of Health, the Canadian public, professionals in the field, or other individuals who may use these technologies in the future as described above. This is not to say that some of these purposes may not be worthwhile or beneficial, but they cannot be said to be for the benefit of the patient. More importantly, this shift in purpose changes the very nature of the physician-patient relationship; the physician is transformed from the trusted steward of health information for the patient into an information conduit for the state.

As a result, the physician’s role as information intermediary for the Agency may challenge the fiduciary relationship and may interfere with the proper functioning of the physician-patient relationship. The collection of information by the physician for the Agency may, in fact, negatively impact the physician-patient relationship. Where the trust between the physician and patient is undermined, the patient may be inhibited from disclosing relevant information to the physician, which may, in turn, negatively impact her health.<sup>48</sup> Further, it is possible that in the absence of sufficient trust between physician and patient, some will simply avoid using these technologies altogether. These are the very fears expressed by the physicians and other health care professionals discussed at the outset.

Take, for example, a woman, B, who suffers from systemic lupus erythematosus (SLE), which is a chronic, non-hereditary condition. B fears discrimination based on her condition, and thus has not told anyone, including her family. B wishes to donate her ova to her sister, C, who is suffering from early onset menopause. B must undergo ovarian hyperstimulation in order for her ova to be harvested. The physician who will undertake this procedure advises her that the *AHRA* requires physicians to pass along some of B’s health reporting information to C, who is the recipient of her ova, as well as to the Agency for a variety of purposes.<sup>49</sup> B is willing to disclose this information to her physician but she does not want to disclose her condition to C or to the Agency. B is worried that without sufficient guarantees of confidentiality her health information may be inadvertently disclosed. B is concerned that should her employer discover her condition, she will not be promoted or, worse yet, she

may lose her job.<sup>50</sup> Because B cannot trust that the physician will keep her condition confidential, the trust necessary for the proper functioning of the relationship is absent. Ultimately, B decides not to tell her doctor that she suffers from lupus. B’s failure to disclose results in a serious threat to her health, as ovarian hyperstimulation exacerbates the symptoms of lupus, sometimes fatally.<sup>51</sup>

One of the principal reasons for overriding patient confidentiality is protecting the health and safety of those using these technologies.<sup>52</sup> The *AHRA* seeks to achieve this objective by conferring a broad mandate on the Agency, as described above. There is certainly some merit to the Agency using relevant patient information in pursuit of these objectives. However, it appears that the legislation is endorsing an overbroad approach which may not strike the right balance between the public interest and the interests of the patient. A careful consideration of the risks and benefits of disclosure must be undertaken in drafting the regulations to ensure a proper balance is struck.

## Conclusion

The physician-patient relationship is one built on trust which encourages and requires the free flow of information, in confidence, from patient to physician in order to function effectively. The *AHRA*’s information collection, use and disclosure requirements exploit this relationship. The *AHRA* requires that information collected by the physician in the therapeutic relationship be disclosed to the Agency for broadly stated purposes. In doing so, the *AHRA* creates a new role for the physician as an information intermediary for the state. The exploitation of the relationship between physician and patient may have a significant impact on the trust upon which it is founded. Although the regulations have not yet been published, the framework set out in the *AHRA* foreshadows some potential problems in terms of patient privacy and the physician’s duties of confidentiality and loyalty. The role of physician as an information intermediary for the Agency is appropriate in certain circumstances and for certain non-therapeutic purposes. However, in drafting the regulations, careful consideration must be given to the potential consequences of this role for the integrity of the physician-patient relationship.

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## Endnotes

- 1 *Assisted Human Reproduction Act*, S.C. 2004, c. 2 [AHRA].
- 2 See e.g. *Personal Health Information Protection Act*, S.O. 2004, c. 3, Sch. A, s. 39(1)(c); *Child and Family Services Act*, R.S.O. 1990, c. C.11, s. 72.
- 3 Health Canada, *Workshop on the Licensing and Regulation of Controlled Activities under the AHR Act and the Obligations of Licensees Regarding Health Reporting Information* (Ottawa: Health Canada, 2007), online: Health Canada <[http://www.hc-sc.gc.ca/hl-vs/alt\\_formats/hpb-dgps/pdf/reprod/2007-licensing-autorisation-obligations/2007-licensing-autorisation-obligations-eng.pdf](http://www.hc-sc.gc.ca/hl-vs/alt_formats/hpb-dgps/pdf/reprod/2007-licensing-autorisation-obligations/2007-licensing-autorisation-obligations-eng.pdf)> at 27.
- 4 *Supra* note 1, ss. 14-19. These provisions complement existing federal and provincial privacy legislation. The details of this framework have been left to the regulations (s. 15(2)). Although the term “licensee” is not statutorily defined (s. 40), a licensee is an individual who undertakes a controlled activity, including an assisted reproduction procedure such as donor insemination or in vitro fertilization, and therefore could include a number of different health care professionals, including physicians, pharmacists and nurses. However, the licensee is most often a physician.
- 5 Ellen I. Picard & Gerald B. Robertson, *Legal Liability of Doctors and Hospitals in Canada*, 4<sup>th</sup> ed. (Toronto: Thomson Carswell, 2007) at 17.
- 6 *Supra* note 1, s. 3. The AHRA also requires that health reporting information be collected from offspring created using these technologies. The nature and scope of information collection from the offspring is beyond the scope of this paper.
- 7 *Ibid.*, s. 15. For example, s. 15(2)(a) requires the physician to disclose information to the Agency, to the extent required by the regulations. Sections 15(2) and (3) of the AHRA require the physician to disclose health reporting information for administration of a health insurance plan; in compliance with a subpoena; pursuant to health and safety laws; and to another licensee where there has been a transfer of reproductive material or an embryo. Section 15(4) of the AHRA requires that the physician must also disclose to a person undergoing an AHR procedure using donated reproductive material the non-identifying health reporting information of the donor. Section 15(5) of the AHRA requires the physician to disclose non-identifying health reporting information for research or statistical purposes.
- 8 This notion of an information intermediary is developed in Ian R. Kerr, “The Legal Relationship Between Online Service Providers and Users” (2001) 35 *Can. Bus. L.J.* 419.
- 9 *Supra* note 1, s. 3. For an extensive description of what this information may include in the context of AHR procedures, see Vanessa Gruben, “Assisted Reproduction Without Assisting Over-Collection: Fair Information Practices and the Assisted Human Reproduction Agency of Canada” *Health L.J.* [forthcoming in 2009].
- 10 *McInerney v. MacDonald*, [1992] 2 S.C.R. 138 at 148, [1992] S.C.J. No. 57.
- 11 George Radwanski, “Address” (Address to the Legislative Assembly of Ontario, Standing Committee on General Government, 8 February 2001), online: Office of the Privacy Commissioner of Canada <[http://www.priv.gc.ca/speech/02\\_05\\_a\\_010208\\_e.cfm](http://www.priv.gc.ca/speech/02_05_a_010208_e.cfm)>.
- 12 For a description of the Agency’s role, see Glenn Rivard & Judy Hunter, *The Law of Assisted Human Reproduction* (Markham: LexisNexis Butterworths, 2005).
- 13 *Supra* note 1, s. 17.
- 14 *Ibid.*, s. 18(3).
- 15 *Ibid.*, s. 18(4).
- 16 *Supra* note 12 at 62.
- 17 Indeed, this is one of the overarching objectives of the AHRA: *supra* note 1, s. 2.
- 18 As a result of the broad definition of “health reporting information,” the information that may be used in satisfaction of these purposes may be both identifying and non-identifying information: *supra* note 1, s. 3.
- 19 *Ibid.*, s. 18(1).
- 20 *Ibid.*, s. 24.
- 21 *Supra* note 5 at 16.
- 22 Mary Marshall & Barbara von Tigerstrom, “Health Information” in Jocelyn Downie, Timothy Caulfield & Colleen Flood, eds., *Canadian Health Law and*



- Policy*, 2d ed. (Markham: Butterworths, 2002)157 at 157.
- 23 Timothy Caulfield & Nola M. Ries, "Consent, Privacy and Confidentiality in Longitudinal Population Health Research: The Canadian Legal Context" (2004) 12 Supplement Health L.J. 1 at para. 29.
- 24 Daniel J. Solove, *Understanding Privacy* (Cambridge, Mass.: Harvard University Press, 2008) at 1-8.
- 25 Alan F. Westin, *Privacy and Freedom* (New York: Atheneum, 1967) at 7.
- 26 Elaine Gibson, "Is there a Privacy Interest in Anonymized Personal Health Information?" (2003) 11 Supplement Health L.J. 97 at 98.
- 27 Fair information practices seek to balance an individual's right to privacy and interests of organizations in collecting, using and disclosing information. That these principles are foundational is evidenced by their direct or indirect incorporation in several statutory and non-statutory privacy instruments, most notably the *Personal Information Protection and Electronic Documents Act*, S.C. 2000, c. 5 [PIPEDA].
- 28 Canadian Medical Association, "CMA Health Information Privacy Code," online: Canadian Medical Association <[http://www.cma.ca/index.cfm/ci\\_id/3216/la\\_id/1.htm](http://www.cma.ca/index.cfm/ci_id/3216/la_id/1.htm)> [CMA "Privacy Code"].
- 29 Gruben, *supra* note 9.
- 30 Canadian Standards Association, *Model Code for the Protection of Personal Information* (Mississauga: Canadian Standards Association, 2003), online: Canadian Standards Association <<http://www.csa.ca/standards/privacy/code/Default.asp?language=English>> at principle 4.3.2 [CSA Code]. This principle requires organizations to make a reasonable effort to ensure that individuals are advised of the purposes for which the information will be used.
- 31 *Ibid.*
- 32 *Supra* note 1.
- 33 *Supra* note 30 at principle 4.3.3.
- 34 The reasonable collection principle is founded on the CSA Code, *supra* note 30, and s. 5(3) of the PIPEDA, *supra* note 27.
- 35 For example, the CMA "Privacy Code" is premised on the importance of health information in the physician-patient relationship: *supra* note 28.
- 36 *Supra* note 10. This concept of information holders as "trustees" also finds some support in privacy legislation: *supra* note 26 at 112.
- 37 *McInerney, ibid.* at 150-51 [emphasis added].
- 38 *Supra* note 28 at principle 2.2(c).
- 39 Mark Vincent Ellis, *Professional Fiduciary Duties* (Scarborough: Carswell, 1995) at 10-12. See also Bernard Dickens & Rebecca J. Cook, "Law and Ethics in Conflict Over Confidentiality?" (2000) 70 International Journal of Gynecology & Obstetrics 385; V.I.O. Agyapong, R. Kirrane & R. Bangaru, "Medical confidentiality versus disclosure: Ethical and legal dilemmas" (2009) 16 Journal of Forensic and Legal Medicine 93.
- 40 *Supra* note 10 at 152. See also *Halls v. Mitchell*, [1928] S.C.R. 125, [1928] 2 D.L.R. 97.
- 41 Mark Vincent Ellis, *Fiduciary Duties in Canada*, looseleaf (Don Mills: DeBoo, 2008) at 10-12.2.
- 42 *Supra* note 10 at 154.
- 43 *Halls, supra* note 40 at para. 18.
- 44 For example in Ontario, see *Health Protection and Promotion Act*, R.S.O. 1990, c. H.7, s. 25.
- 45 For example in Ontario, see *Highway Traffic Act*, R.S.O. 1990, c. H.8, s. 203.
- 46 For example in Ontario, see *Child and Family Services Act, supra* note 2, s. 72. For a general discussion see Elaine Gibson, "Health Information: Confidentiality and Access" in Jocelyn Downie, Timothy Caulfield & Colleen Flood, eds., *Canadian Health Law and Policy*, 3d ed. (Markham: LexisNexis, 2007) 223 at 251.
- 47 The principal concern in this context is whether the patient's worries about disclosure to the Agency and ultimately the state will result in non-disclosure to the physician or avoidance of health care services. Whether information disclosed to the Agency could, in fact, give rise to criminal charges is an interesting question. However, a full examination of this issue is beyond the scope of this paper. In *R. v. Jarvis*, the Supreme Court of Canada considered the privacy interest of the taxpayer in information disclosed to tax officials for the purpose of an audit which ultimately gave rise to charges of tax evasion. The Court concluded that collection by tax officials for one purpose and then subsequent use for a secondary criminal purpose was consistent with ss. 7 and 8 of the *Charter: R. v. Jarvis*, 2002 SCC, [2002] 3 S.C.R. 757.
- 48 The negative consequences of disclosing information to third parties in certain circumstances have been demonstrated in empirical studies. For example, Rodriguez *et al.* have conducted studies demonstrating that mandatory reporting of domestic violence by health care professionals may threaten the safety and well-being of abused women and may create



barriers to their seeking help and communicating with health care professionals about domestic violence: Michael A. Rodriguez *et al.*, "Mandatory Reporting of Domestic Violence Injuries to the Police: What Do Emergency Department Patients Think?" (2001) 286 *Journal of the American Medical Association* 580. See also Jang *et al.*, who issued a survey which demonstrated that 75% of physicians feel that reporting a patient as an unsafe driver negatively impacts the physician-patient relationship: Raymond W. Jang *et al.*, "Family Physicians' Attitudes and Practices Regarding Assessments of Medical Fitness to Drive in Older Persons" (2007) 22 *Journal of General Internal Medicine* 531. Further, some have expressed concerns that the mandatory registry of diabetic patients created by the New York City Department of Health and Mental Hygiene will have a negative impact on the physician-patient relationship, and that the involvement of a governmental agency "is likely to lead to a breach of trust that could cause patients to avoid medical visits and laboratory tests, thus fostering greater nonadherence and interfering with the physician's ability to work effectively with the patient": Paula M. Trief & Richard A. Ellison, "Mandated Diabetes Registries Will Not Benefit Persons with Diabetes" (2008) 168 *Archives of Internal Medicine* 799 at 800; Janlori Goldman *et al.*, "New York City's Initiatives on Diabetes and

HIV/AIDS: Implications for Patient Care, Public Health, and Medical Professionalism" (2008) 98 *American Journal of Public Health* 807.

- 49 *Supra* note 1, s. 15(4) (physician must disclose the donor's non-identifying information to the person undergoing the procedure) and s. 18(3) (Agency shall, on request, disclose health reporting information relating to a donor of human reproductive material or of an *in vitro* embryo to a person undergoing an assisted human reproduction procedure using that human reproductive material or embryo, to a person conceived by means of such a procedure, and to descendants of a person so conceived, but the identity of the donor shall not be disclosed without the donor's written consent). As discussed above, the extent of the information to be disclosed by the physician to the Agency will be set out in the regulations: s. 15(2)(a).
- 50 Patrik S. Florencio & Erik D. Ramanathan, "Secret Code: the Need for Enhanced Privacy Protections in the United States and Canada to Prevent Employment Discrimination Based on Genetic and Health Information" (2001) 39:4 *Osgoode Hall L.J.* 77.
- 51 P. Casoli, B. Tumiatì & G. La Sala, "Fatal exacerbation of systemic lupus erythematosus after induction of ovulation" (1997) 24 *Journal of Rheumatology* 1639.
- 52 *Supra* note 1, s. 2; *supra* note 12 at 71-2.

