CONFIDENTIALITY AND PUBLIC SAFETY: MANAGING INFORMATION DISCLOSURE CONFLICTS BETWEEN HOSPITALS AND THE POLICE IN BRITISH COLUMBIA

By

R. KYLE FRIESEN

B.A. (Honours), Carleton University, 1981
LL.B., University of Victoria, 1984

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Project Sponsor, RCMP Inspector Paul N. Cheney

Faculty Supervisor, RRU, George Irani, Ph.D.

James Bayer, Ph.D.
Dean, Peace and Conflict Studies, RRU

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Abstract

Confidentiality and the protection of information privacy are fundamental principles of medicine dating back to the Hippocratic Oath in 400 B.C. In contrast to this ancient privacy principle is the occasional investigative need of law enforcement agencies for access to hospital patients' personal information. My thesis explores the conflict that exists throughout North America from this intersection of privacy rights and law enforcement needs, with the laws and policies in British Columbia and Canada as the research focus.

What legal and ethical obligations do health care providers have to protect the privacy of patient information when law enforcement agencies want access to it? Health care providers in hospitals have a mixture of mandatory and discretionary powers to disclose patient information when responding to requests by law enforcement agencies. The patient information disclosure conflict arises from two competing cultures: medical advocacy, informational self-determination and personal protection versus law enforcement and public protection. Hospitals can observe their duties of confidentiality and privacy as medical advocates for patients, while responding to many of the investigative disclosure needs of law enforcement agencies.

The outcome of current negotiations between health care providers in hospitals and the police will be mutual understanding of the duty to protect the confidentiality and privacy of patient information, balanced with the need for timely and legal disclosure of patient information that is relevant to active police investigations, as recognized by statute law, court rulings, and the codes of ethics for health care providers. At what point does the hospital patient's right to privacy surrender to the right of the state to know? The police and hospital communities are now developing a disclosure protocol which finds that balance point. The success or failure of the disclosure protocol will be evident when police visit hospital emergency rooms in pursuit of investigative information, and both the police and health care providers understand what information can and cannot be provided, and when it can be provided.

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This thesis contains my opinions developed during academic work at Royal Roads University, Victoria, British Columbia. It does not necessarily represent the views of the Department of Justice Canada or the Royal Canadian Mounted Police (RCMP).

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Confidentiality and public safety: Managing information disclosure conflicts between hospitals and the police in British Columbia

All that may come to my knowledge in the exercise
of my profession or outside of my profession
or in daily commerce with men, which
ought not to be spread abroad, I will
keep secret and will never reveal.

-- Hippocratic Oath, 400 B.C.

There is a time for everything and
a season for every activity under heaven…
a time to be silent and
a time to speak….

-- Ecclesiastes, 3:1,7

1. Introduction: The hospital-police disclosure conflict in British Columbia

Confidentiality and privacy of personal medical information are fundamental principles of medicine dating back to the physicians' Hippocratic Oath of 400 B.C. (Graham, 2000, p. 2841). In contrast to these ancient privacy principles is the occasional investigative need of the police for access to hospital patients' personal information. This thesis studies the conflict that exists at this intersection of privacy rights and law enforcement needs, with the civil and criminal laws and policies in British Columbia and Canada as the research focus. My thesis explores the limits of patients' privacy rights over their personal medical information ("patient information") when the police require access to that information for criminal investigations.

The years 2001-2002 have seen a new round of discussions between health care providers and police in the Capital Regional District (Victoria and area) of British Columbia in relation to patient information disclosure. After several years of dormancy, both sides moved quickly between November 2001 and June 2002 to produce a conflict management disclosure protocol. It is this protocol that is the action research focus in my thesis. In these negotiations,

the health care providers were represented by the Vancouver Island Health Authority (VIHA). The police agencies were represented by me, with the able assistance of Staff Sergeant Bruce Brown and Corporal Tim Dixon (now retired) of the Royal Canadian Mounted Police (RCMP).

The duties of confidentiality and privacy and the investigative need for patient information are not absolutes; therefore, any conflict management protocol must highlight the discretionary disclosure pathways that already exist within the health care providers' "codes of ethics" and the British Columbia Freedom of Information and Protection of Privacy Act, R.S.B.C. 1996, c. 165, and the legal limitations on police powers. These are some of the sources of the stakeholders' interests and values. Conflict management need not be a zero-sum game where the success of one stakeholder is matched equally by the failure of another. The success or failure of the conflict management protocol will be evident when police visit hospital emergency rooms in pursuit of investigative information, and both the police and health care providers know what information can and cannot be provided, and when it can be provided.

Gostin and Turek-Brezina (1995, p. 1) have noted that "health care information is perhaps the most intimate, personal, and sensitive of any information maintained about an individual. As the U.S. health care system grows in size, scope, and integration, the vulnerability of that information also will increase unless protective measures are instituted." The conflict management protocol must recognize and respect this sensitivity.

The hospital-police information disclosure conflict has remained largely unresolved since 1994. I foresee that my thesis will be a channel to create greater understanding of the stakeholders' interests and obligations. If the police and health care providers in hospitals understand their respective interests, values, roles and obligations, then I suggest that parties in conflict will be more receptive to each other. My thesis explores a proposed patient information disclosure protocol that will show the hospital and police communities what must be disclosed, what may be disclosed, and what must not be disclosed. Most importantly, this protocol will

explain some of the circumstances under which the "must disclose", "may disclose" and "must not disclose" options apply.

2. The research question

The research question that I wish to explore is what legal and ethical obligations require health care providers to protect the privacy of patient information when the police want access to it, and what legal limitations exist on police powers to ask for patient information? Where these interests come into conflict, can hospitals and police agree on a conflict management disclosure protocol to govern access to patient information and thus manage the conflict?

3. Hypotheses

H1: Health care providers in hospitals have a mixture of mandatory and discretionary powers to disclose patient information when responding to access requests by the police. Hospitals can observe their duties of confidentiality and privacy as medical advocates for patients, while satisfying the legitimate disclosure needs of the police for law enforcement investigations. In these ways, both stakeholders can preserve their interests and values.

H2: The conflict management disclosure protocol negotiated by the VIHA and the police on Vancouver Island will balance the need for confidentiality and privacy with the protection of public safety.

4. Outline of thesis

In Chapter 6 of my thesis, I offer an explanation of who is in conflict, and what they are in conflict about. Chapter 7 reviews the history of the information disclosure conflict between health care providers and the police. Chapter 8 introduces the stakeholders in the conflict: health care providers and the police on Vancouver Island. Chapter 9 discusses the significance of the topic, and explains why it is worthwhile to attempt to manage this conflict. Chapter 10

explores the four options for conflict management, with interest-based negotiations being the recommended option. Chapter 11 discusses conflict theory as it applies to the hospital-police environment. Chapter 12 explores the nature of the conflict on the "front lines": the hospital emergency rooms where police may interact with health care providers. Chapter 13 presents the draft conflict management disclosure protocol and how it guides health care providers in their discretionary disclosure decisions.

As a supplement to the Chapter 13 discussion of the conflict management protocol, chapters 14, 15 and 16 review the sources of the stakeholders' interests and values: case law from Canadian courts; the health care providers' medical codes of ethics; and disclosure obligations imposed by statute. Chapter 17 discusses the statutory duty to report injuries in some jurisdictions, which contrasts with the discretionary reporting power of health care providers, as discussed in Chapter 18. Chapter 19 reviews the application of action research methodology to the study of the hospital-police disclosure conflict. Chapter 20 summarizes the final consultations of police-side participants in response to the draft conflict management disclosure protocol which is found in Appendix One of this thesis.

5. Theoretical framework: a preview

The hospital-police information disclosure conflict is an intergroup conflict between two formally-structured professions: health care providers and the police. If there was any doubt about the professional status of police in Canadian society, that doubt has faded with the arrival of the Canadian Charter of Rights and Freedoms and the rising complexity of criminal law.

I have approached the hospital-police conflict by viewing it as a fundamental collision between the right to privacy and confidentiality for hospital patients with the state's duties of public order and safety. My thesis explores this conflict by reviewing the theories of informational self-determination and privacy. The first means you have the right to determine who accesses and uses your personal information. The second means that you have the right

to be left alone by the state. Both these rights have limitations and exceptions. Therein lies the conflict.

6. Discussion: who is in conflict, and over what?

My interest is to better understand the conflict between health care providers and the police when they discuss the disclosure of patient information. For the purposes of this thesis, "health care providers" include doctors, nurses, and administrators who work in hospitals on Vancouver Island. These hospitals are components of the VIHA. "Health care providers" do not include doctors, nurses and administrators who work in private medical clinics or private medical offices outside hospitals. "Patients" are persons who receive medical treatment in hospitals. They may be victims of crime, as well as suspects, witnesses, or interested parties to an offence.

What information about patients is at stake here? Police may need to know whether a person is a patient in a hospital in order to interview that person about a criminal offence or motor vehicle accident. The question posed by police may be as simple as "is Mr. X a patient in the hospital?" In another scenario, police may want to know whether someone has presented himself or herself in the emergency ward with injuries consistent with a particular offence (e.g., gunshot wounds, or bodily injuries from a motor vehicle accident). Police may need this information to determine whether a person missing from a motor vehicle accident was thrown from the vehicle, then later made their way to hospital for treatment. Police may need to know when a patient will be discharged from hospital so that police may interview or arrest that patient. Finally, police may need to seize evidence in relation to that patient.

Seizure of evidence in hospitals may involve medical information from patients' records. It may include seizure of evidence such as patients' clothing and personal effects, or the taking of DNA samples from patients' blood, hair follicles, fingernails, and bandages. Many of these seizures require judicially-authorized search warrants to permit the introduction of this often-

crucial evidence into the investigative and prosecution processes. Some of the hospital-police disclosure conflict arises from uncertainty over what information about patients can be disclosed "now", and what information may or must be disclosed later, perhaps in response to a search warrant.

The patient information disclosure conflict arises from two competing cultures: medical advocacy, informational self-determination and personal protection versus law enforcement and public safety. I suggest that hospitals can observe their duties of confidentiality and privacy as medical advocates for patients, while satisfying many of the investigative disclosure needs of the police, as long as the medical care owed to those patients is not unduly affected by the needs of the police. In relation to this balancing of interests and values, under what circumstances must hospitals protect the privacy of patient information, and under what circumstances must hospitals disclose patient information to the police?

The College of Physicians and Surgeons of British Columbia (2000, p. M-10) recognizes the medical advocacy role for physicians that co-exists with physicians' "responsibility to the law":

> ...physicians have been instructed on many occasions that they have a primary responsibility to protect the patient's health record and medical information, and that they have to assume the role of patient advocate when unwarranted or unauthorized access to that record is sought by other healthcare providers or individuals.

The mere presence of police in hospitals may be sufficient to affect, perhaps in non-measurable ways, the behaviour of patients. For some patients, the presence of police in their hospital rooms may be disturbing, either because they do not want police attention or due to the other emotional factors at play in the treatment and healing processes. This is an example of the Heisenberg (1958) "uncertainty principle" in action, where the presence of an observer may cause a change in the behaviour of something or someone being observed. Police and health care providers must consider at what point the intrusiveness of the police presence begins to

unduly interfere with medical care. This is the balance that police and health care providers must achieve.

There is no single balance point for all patients. Some patients and health care providers may not object to urgent, direct contact with police during minor surgical operations such as stitching up facial cuts (personal communication with RCMP Staff Sergeant Bruce Brown, January 30, 2002). Others may object to all contact with the police for their own mixture of reasons. Merz, Sankar and Yoo (1998, p. 247) recognized these differences in patients' expectations of privacy:

> ... there are open questions about what patients believe and desire regarding the protection of information in their medical records. Patients, on average, may not want or expect the degree of protection of their private information afforded by extant medical ethics or legal policies. Other patients may be quite protective of their information, and may take whatever steps they can to limit access to, or to limit the content of, their records.

Before my thesis explores how to reconcile these conflicting interests and values, it is important to review the history of the hospital-police disclosure conflict in Canada.

7. History of the conflict

The Report of the Commission of Inquiry into the Confidentiality of Health Information by Mr. Justice Krever (1980, vol. 2, pp. 77-78) describes the hospital-police disclosure conflict in Canada in terms that remain relevant decades later:

> On various occasions, police officers have attempted to obtain health information from hospitals throughout the province [of Ontario], without patient authorization. Sometimes, when they were refused such information, some officers became abusive and, although rarely, threatened to charge the unco-operative hospital employee with obstructing justice. ... The fact is that the chief point made was applicable to almost all the police forces across Ontario, although on isolated occasions only.

I have encountered anecdotal evidence over the past six years concerning "front line" conflicts between health care providers and police officers in relation to confidential medical information about patients. My involvement with this conflict began in mid-1996 when I was a

mediator with the Office of the Information and Privacy Commissioner of British Columbia. In that role, I was responsible for mediating information access disputes and investigating privacy complaints in relation to the twelve municipal police departments in British Columbia. Under the Freedom of Information and Protection of Privacy Act, hospitals and the municipal police departments are "public bodies" whose collection, use and disclosure of personal information is strictly regulated by that Act.

The Freedom of Information and Protection of Privacy Act of British Columbia came into force in three tiers. The second tier included hospitals and the twelve municipal police departments in B.C.; this tier came under the legislation in 1994. The arrival of what is commonly known as the FOIPP Act brought new awareness of hospitals' duties of confidentiality and privacy for patients and their personal information, and a looming concern about the need to manage the hospital-police disclosure channel.

In 1996, I decided to promote a discussion paper on the hospital-police disclosure conflict, to be signed by the Information and Privacy Commissioner of British Columbia (Flaherty, 1998, September). The intent of this discussion paper, which I co-authored with the Information and Privacy Commissioner and one of my colleagues, was to demystify the legal and policy grounds for mandatory, discretionary, and prohibited disclosures of patient information by health care providers in hospitals. After two years of determining the interests and values of various stakeholders, the Information and Privacy Commissioner released this discussion paper under his name to the community in September 1998. The discussion paper explored the privacy and disclosure interests of health care providers and the police, as those interests are reflected in the Freedom of Information and Protection of Privacy Act and the health care providers' codes of ethics. However, the patient information disclosure conflict did not end with the release of this discussion paper.

In my position with RCMP Legal Services since 1998, I have continued to encounter frustrations and conflict in relation to hospital-police patient information disclosures. The police

may require access to patients and patient information where patients are suspects, victims, witnesses or interested parties to an offence. Health care providers have duties of confidentiality and privacy to those in their medical care. The intersection of these competing needs and interests has generated the conflict over the past decade. I have spoken to the RCMP and municipal police departments throughout British Columbia, Yukon and in Ottawa on this topic, and every meeting has produced reports of sometimes-dysfunctional relations between health care providers and police for the disclosure of patient information.

The persistence and universality of this conflict make it worthwhile to attempt to manage it. When a conflict has endured for so long, albeit at a low level, the costs to the stakeholders suggest that resolution or management would be beneficial. For the hospital-police disclosure conflict, the costs of leaving the conflict unmanaged have not been quantified. With the 2001-2002 meetings between the stakeholders, the parties suddenly became aware that it might be possible to manage many of the circumstances that have generated this conflict.

8. The stakeholders

Action research participants in this thesis included:

- Detachment Commanders for each of the 30 RCMP detachments within the RCMP Island District (Vancouver Island and area);
- Major crimes investigative Section and Unit Commanders within the RCMP on Vancouver Island who have regular contact with health care providers; and,
- Chief Constables of the five municipal non-RCMP police departments on Vancouver Island (Saanich, Central Saanich, Esquimalt, Victoria and Oak Bay).

These participants are some of the stakeholders in the management of the hospital-police patient information disclosure conflict. During my action research, I had direct personal contact with them. I had indirect contact with health care providers throughout Vancouver Island via my contacts with police personnel. My police participants have been and will be the conveyers of

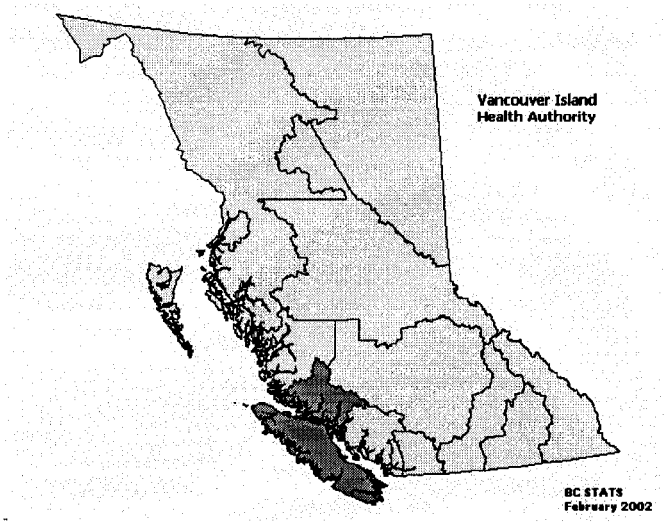
the draft conflict management disclosure protocol into their local hospital contacts throughout Vancouver Island. These hospital contacts also received a draft of the protocol from the VIHA negotiation team.

This thesis gave me an important opportunity to participate in the management of a significant conflict. My role as the police negotiator meant that I could not be an impartial, non-participating observer. Similarly, I was not a neutral third-party mediator. Therefore, my thesis is written from the perspective of an active participant where I represented and promoted the interests and values of the police community.

My police-side role also limited my ability to consult the health care providers' constituents. This meant that I did not consult the hospitals throughout the VIHA. Instead, this consultation process on the hospital side was conducted by the VIHA. Conversely, the VIHA left the consultation of police-side constituents or participants to me.

Vancouver Island is part of the Province of British Columbia along the Pacific Ocean coastline, with approximately 12,400 square miles (32,000 square kilometres) of territory and 703,052 residents of a total British Columbia population of 4,095,934 residents (Vancouver Island Health Authority, 2002, n.p.; Statistics Canada, 2001 census). There are approximately 1,150 police officers assigned to Vancouver Island in the five municipal police departments and within the RCMP Island District. The Vancouver Island Health Authority (2002, n.p.) has 17 acute care facilities, four diagnostic and treatment centres, and 4,960 residential care beds on Vancouver Island. Vancouver Island offers a representative sample of British Columbia for the development and assessment of a disclosure protocol to manage the conflict associated with hospital-to-police information disclosures. I suggest that successful implementation of a conflict management disclosure protocol for Vancouver Island will lead to the adaptation and implementation of that protocol to other parts of British Columbia with few or no revisions.

Map One (Ministry of Health Services, 2002, n.p.) below shows the Vancouver Island Health Authority within British Columbia, in the dark grey-shaded area. This territory corresponds with the policing territory of the RCMP Island District.



During my research for this thesis, I spoke informally with staff of the current Information and Privacy Commissioner of British Columbia, given their ultimate review role in response to complaints about inappropriate or unauthorized disclosure of patient information by hospitals. The Vancouver Island Health Authority consulted directly with the Information and Privacy Commissioner, despite the Commissioner's general policy of not issuing "advance rulings" on issues before they formally arrive at his office via a privacy complaint. This early consultation allowed the stakeholders to increase their confidence in the suitability of the conflict management disclosure protocol. If a privacy complaint were to arise in the future from a hospital patient in relation to a hospital-to-police disclosure, the Information and Privacy Commissioner's investigation presumably would focus more on the appropriateness of the disclosure and less on the substantive components of the protocol.

9. Significance of the topic

The health care providers' *proactive* "duty to warn" is well-documented in the medical literature, which requires health care providers to breach confidentiality and initiate contact with

the police to warn about risks posed by a patient, including risks associated with contagious diseases. In these proactive disclosure cases, the police may not be aware of the patient and the risks until the hospital makes first contact.

By contrast, the medical, legal and privacy literature does not sufficiently discuss *reactive* contacts between health care providers and the police where the police are investigating a criminal offence and the police initiate the interaction with the hospital. My thesis may help complete the literature concerning the patient information disclosure conflict for reactive cases where there may not be a threat or risk to the public, children or vulnerable persons that would require a proactive disclosure by the hospitals.

In the hospital-police disclosure conflict, both sides agree that management of this conflict is necessary, and both sides have expressed willingness to negotiate a disclosure management protocol. The protocol will be the basis for operational policies and training in each RCMP Detachment, the five municipal police departments, and all hospitals.

On the hospital side, I need to understand the interests and values of health care providers. If interest-based negotiations are to successfully manage some conflicts on the front lines, the interests and values of the patients' medical guardians must be considered when developing options for conflict management. The outcome of negotiations between health care providers in hospitals and the police will be shared understanding of the duties to protect the privacy and confidentiality of patient information, balanced with the need for timely and legal disclosure of patient information that is relevant to active police investigations and the protection of public safety.

The parties cannot agree to sidestep the privacy and confidentiality duties of health care providers. Similarly, the parties cannot agree to evade the legal restrictions on law enforcement collection of evidence. Omitting the first would destroy informational self-determination for patients and degrade the health care providers' duties as medical advocates. Health care providers might face disciplinary action by the medical professional regulatory bodies, as well as

privacy complaint investigations by the Information and Privacy Commissioner of British Columbia. Omitting the second would not serve the police because they must obtain evidence that will be admissible in criminal prosecutions. If the police were to seize evidence from patient-suspects without warrants, or without informed consent, or outside the scope of the conflict management disclosure protocol, that evidence might later be excluded at trial, thus weakening or defeating the investigation and subsequent prosecution. Therefore it was mutually beneficial to the stakeholders to create a conflict management disclosure protocol that protects the interests and values of both sides. No stakeholder would benefit from straying outside the bright lines established by the legislation, the case law and the health care providers' codes of ethics.

Reporting a patient erodes the duty of confidentiality that is central to the professional practice of medicine (Steinecke, 1995, p. 49). However, health care providers must recognize that their professional duties are shaped by a mixture of legislation, codes of ethics, policies and traditions that do not establish absolute duties of confidentiality and privacy. In the appropriate circumstances, the police have a legitimate "need to know".

The British Columbia Medical Association (2001, November, p. 1) notes that maintaining confidentiality is a fundamental responsibility of a physician, and is a central part of the doctor-patient relationship. Personal health information is ultimately owned by the patient. Physicians act as accountable guardians of medical information they collect, protecting its disclosure through appropriate consent.

Kleinman and Baylis (1997, p. 521) (see also Kessler, 1993; Kagle and Kopels, 1994) stated:

> The understanding that the physician will not disclose private information about the patient provides a foundation for trust in the therapeutic relationship. ... Without an understanding that their disclosures will be kept secret, patients may withhold personal information. This can hinder physicians in their efforts to provide effective interventions or to pursue certain public health goals. For example, some patients may not feel secure in confiding a drug or alcohol dependence and thus may not have the benefit of treatment. Others may refrain

> from disclosing information that could alert the physician to the potential for harm or violence to others.

The potential reluctance of patients to disclose to their health care providers is a significant interest that must be acknowledged by the police and health care providers when developing the conflict management disclosure protocol.

Kleinman and Baylis (1997, p. 521) recognize the application of informational self-determination to patients' medical information:

> Respect for the confidentiality of patient information is not based solely on therapeutic considerations or social utility, however. Of equal, if not greater, importance is the physician's duty to respect patient autonomy in medical decision-making. Competent patients have the right to control the use of information pertaining to themselves. They have the right to determine the time and manner in which sensitive information is revealed to family members, friends and others.

The significance of timely, legal access to patient information becomes clearer when considering the mandatory, proactive disclosure requirements of provincial legislation for cases of child abuse under the Child, Family and Community Service Act , R.S.B.C. 1996, c. 46 (section 14), and for medical conditions that affect driving ability under the Motor Vehicle Act , R.S.B.C. 1996, c. 318 (section 230), and for "duty to warn" cases under the Freedom of Information and Protection of Privacy Act (section 25) where individual or public safety is at stake. Kondro (1996, June 29, p. 1827) notes that:

> Other exemptions to the principle of patient-doctor privilege already exist. Doctors are now obliged to report patients who are medically unfit to drive or fly an aeroplane, are suspected of child abuse [and elder abuse], have specified infectious diseases, and colleagues' sexual abuse of patients.

These statutory disclosure requirements demonstrate that patient confidentiality is not absolute. The state has determined that in these exceptional circumstances, the right to medical confidentiality must yield to the state's duty to ensure public safety.

Ferris, Barkun, Carlisle, Hoffman et al. (1998, p. 1473) have explored the conflict faced by health care providers in relation to disclosure of patient information:

> Physicians may thus feel caught between 2 principles, confidentiality and public safety – and may be uncertain as to their duty. This lack of clarity could lead to confusion about the appropriateness of various actions and, in some cases, to divergence in practice.

This appears to be the case in British Columbia today: inconsistent patient information disclosure practices throughout the province. The conflict acquires greater complexity where there is no statutory duty to warn arising from a threat or risk to children or vulnerable people, but only that the police wish to investigate a criminal offence and patient information may be relevant to that investigation. The People's Medical Society Newsletter (Keep it confidential, 1996, p. 1) offers a harsh view of privacy and confidentiality in practice:

> Despite written and unwritten laws designed to protect the confidentiality of medical information, strict confidentiality doesn't exist. It never has. Doctors and other health-care professionals discuss cases with one another; doctors and hospitals pass information to researchers, marketers and government statisticians; health insurers sometimes share information with employers. In short, patient confidentiality is more myth than reality, and the reality is that the situation is likely to become worse as medical record keeping enters the electronic age.
> ...
> The typical paper medical record is viewed by as many as 77 different people during an average hospital stay, according to the ACP Observer (November 1995).

An important question to consider at this point is how the police and health care providers can understand the limits within which their conflict management disclosure protocol must exist. I suggest that it is necessary to determine the parties' interests and values, as described in the medico-legal privacy literature. Then, I must review the Canadian court decisions and relevant legislation to determine how the courts have established the limits of search and seizure without warrants and the limits of medical confidentiality. The parties cannot propose or consider a conflict management disclosure protocol that exists outside the "zone of possible agreement" (Sebenius, 1992, pp. 18, 21) or range of overlapping interests, established by the courts, legislation and codes of ethics. The courts' rulings, legislation and codes create fences within which all disclosure protocols and disclosure decisions must operate.

10. Options for conflict management

There are at least four options for management of the hospital-police information disclosure conflict.

- First, the parties can leave the conflict and relationship as they have existed over the past ten years. The conflict and the occasionally dysfunctional relationship between health care providers and the police would remain unchanged, relying on an expression of power to determine which side prevails in each disclosure encounter.
- Second, the parties could agree that the police should obtain a judicially-authorized search warrant for all patient medical information, regardless of the sensitivity and intrusiveness of the information and request. This would be a significant barrier to police investigations and would result in a higher disclosure standard for information requests than that now required by the Canadian case law and legislation.
- Third, the Legislative Assembly of British Columbia could enact a law that compels health care providers to disclose information about patients who have suffered gunshot or knife wounds, or who have serious injuries resulting possibly from criminal activity. My thesis explores this option, but notes that this approach is not found in Canada. Appendix Three explores some of these laws in several United States jurisdictions.
- Fourth, the parties can use interest-based negotiations to develop a disclosure protocol that governs the requests for, and disclosures of, patients' medical information to police. This is the approach chosen by the parties in 2001-2002. It has the greatest potential to manage this longstanding conflict, and to transform the relationship between health care providers and police from occasionally adversarial into frequently cooperative and always consultative.

The conflict management disclosure protocol in the fourth option is an intervention model that recognizes the interests and values of all stakeholders, and fits within the limits established by legislation, the health care providers' codes of ethics, and Canadian case law. This is the model chosen by health care providers and the police to intervene in the conflict and manage patient information disclosures. This is the model that allowed the stakeholders to examine their respective issues, interests and options, all of which lead to the conflict management protocol. Before the commencement of these interest-based negotiations, the stakeholders' entrenched positions often resulted in impasse on the front lines.

Ury, Brett and Goldberg (1988, n.p.) noted that interest-based negotiation is "problem-solving negotiation ... because it involves treating a dispute as a mutual problem to be solved by the parties." The stakeholders could have chosen other dispute management processes. However, the relationship between the stakeholders is too important and enduring to rely on anything other than a respectful interest-based process that acknowledges the importance of the other side's values and the health care providers' discretionary disclosure authority. The interest-based approach best fits my first hypothesis, and allows for the continuing validity of my second hypothesis, both of which call for a balancing of interests between the stakeholders.

Jandt and Pedersen (1996, p. 4) noted "conflict management strategies are different from conflict resolution. Conflict management brings conflict under control, whereas conflict resolution attempts to terminate the conflict." I suggest that it is not possible to resolve or terminate the hospital-police conflict. The exercise of discretion in disclosure decisions by health care providers means that police may be denied access to patient information in some cases. Therefore, the conflict can be managed and understood within the confines of the conflict management protocol, but never entirely resolved. A complete cessation of conflict might require a rights-based protocol that conclusively provides all the answers for all disclosure scenarios, without allowing for discretion. Despite the attractiveness of the fourth option, the hospital-police disclosure conflict does not provide for certainty of disclosure decisions and so

the stakeholders were not able to deliver a "black and white" set of answers for all disclosure scenarios.

Costantino and Sickles Merchant (1996, p. 49) offer their "dispute systems design" (DSD) that creates interest-based conflict management processes "with stakeholders, not for them". In the hospital-police conflict, the stakeholders did not rely on external third parties to develop or impose a rights-based dispute resolution mechanism on them. Instead, the parties assembled the conflict management protocol (see Appendix One) after carefully-paced explorations of their mutual and separate interests and values (DSD first principle; Costantino and Sickles Merchant, pp. 46 and 59). As noted by Costantino and Sickles Merchant (p. 57):

> Embracing these [mutual] values generates conflict management systems characterized by flexible approaches to resolution, appreciative inquiry into the pattern of disputes, and substantial efforts to address and eradicate systemic causes of conflict.

The challenge for the stakeholders will be to achieve widespread acceptance of the conflict management protocol among their constituent groups: on the VIHA side, the doctors, nurses and health care administrators; on the police side, the RCMP and the five municipal police departments on Vancouver Island. The extensive consultations of the stakeholders' constituents was intended to achieve "buy in" from the earliest negotiations on the hospital-police conflict. The negotiators told their constituents that the protocol was coming, asked for their opinions, then let them see and test an early draft starting in February 2002 (DSD fourth principle; Costantino and Sickles Merchant, pp. 46 and 60). The early drafts let the stakeholders' constituents overcome an inhibition for learning that may have arisen from the presumption that the health care providers' codes of ethics were absolute barriers to disclosure of patients' information. Flaherty's (1998, September) discussion paper was a major step towards the removal of this inhibition, letting the parties know in 1998 that a zone of agreement was possible for this enduring conflict.

The conflict management model chosen by the stakeholders provides a significant level of constituent participation in the development and application of the conflict management disclosure protocol. Interactions between the stakeholders' negotiators in 2001-2002 ensured that dialog would continue after implementation of the protocol. This participative conflict management model will allow for what Argyris and Schön (1978, p. 27) have called "deutero-learning" or second-order learning:

> When an organization engages in deutero-learning, its members ... reflect on and inquire into previous contexts for learning. ... They discover what they did that facilitated or inhibited learning, they invent new strategies for learning, they produce these strategies, and they evaluate and generalize what they have produced. The results become encoded in individual images and maps and are reflected in organizational learning practice.

Based on the deutero-learning concept, the conflict management disclosure protocol must be a living document that changes as the stakeholders learn from their conflict management experiences. These are what I classify as internal forces of change. External forces of change also will affect the protocol and the stakeholders' relationship. These external forces may arise from changes in legislation, new case law from the courts on search, seizure and privacy, and from changes to the codes of ethics if they evolve in new directions.

11. Conflict theory: mutually-exclusive interests and values, or a "zone of possible agreement"?

Successful conflict management must be grounded on a theoretical analysis. The hospital-police disclosure conflict is an intergroup conflict that arises from the intersection of two strongly-defined cultures: police and health care providers. Theoretical analysis of this conflict will prepare a base on which a conflict management disclosure protocol can reflect the interests and values of both these cultures.

Tajfel (1970, pp. 96-102) noted that the perception of belonging to a group was sufficient to produce intergroup discrimination or "ingroup favoritism". Membership in a police organization or a health care providers' organization requires extensive training and formal

indoctrination into a profession. This takes both groups beyond Tajfel's mere "perception of belonging to a group" to exclusive membership in organizations that are distinct from the rest of society. The creation of strong social identities within health care providers' organizations and police agencies may have facilitated the "us versus them" attitudes that have contributed to the hospital-police conflict. To overcome this polarization, the conflict management protocol must reframe the internal views of stakeholders into "we are part of a team" that has separate but inter-dependent needs. By this, I mean that the hospitals' duties to provide competent medical care, privacy and confidentiality can co-exist with the need to prevent harm and ensure public safety. The conflict management protocol can assist in lowering barriers that surround the stakeholders, so that members can see and understand the values and interests of members on the other side.

Boulding (1990, pp. 176-177) has studied intergroup conflicts and how conflicts arise between insiders and outsiders:

> Those who share a common view of the world and common rituals and beliefs tend to form a community to practice the rituals ... and to propagate and persuade people of these common beliefs. ... Each believer sees the non-believer as a threat to the validity of the believer's own beliefs. If somebody does not agree with me, then either I must be wrong or they must be wrong.

In line with this is Brown's (1993, p. 164) statement that the "parties with different theses withdraw from one another ... organizational members tend to protect or are encouraged to protect the organization." Intergroup conflicts have arisen between other formally defined groups, including law societies (lawyers) versus societies of notaries public, and physicians versus naturopaths and homeopaths. However, these examples involve conflicts over similar work: who will provide legal services, and who will provide medical services. The hospital-police intergroup conflict is different because it involves a conflict between different societal sectors where each side may believe that it cannot deliver its mandate if it cedes to the other side. The purpose of interest-based negotiations between such conflicting sectors is to explore

how each sector can protect its mandate and deliver its services, while co-existing cooperatively with other sectors.

Belak (1998, n.p.) referred to several definitions of "group", including "a number of persons near, placed, or classified together", and a

> social unit that consists of a number of individuals (1) who, at a given time, have role and status relationships with one another, stabilized in some degree and (2) who possess a set of values or norms regulating the attitude and behavior of individual members, at least in matters of consequence to them.

Belak (1998, n.p.) described how conflict arises between distinct groups:

> Intergroup relations between two or more groups and their respective members are often necessary to complete the work required to operate a business. ... Dysfunctional conflict ... is confrontation or interaction between groups that harms the organization or hinders attainment of goals or objectives.
> ...
> Any given group embodies various qualities, values, or unique traits that are created, followed, and even defended. These clans can then distinguish "us" from "them." Members who violate important aspects of the group, and especially outsiders, who offend these ideals in some way, normally receive some type of corrective or defensive response. Relationships between groups often reflect the opinions they hold of each other's characteristics.

Fisher's (1994, p. 48) work on ethnic conflict has application to the hospital-police intergroup conflict. Fisher noted that "intergroup conflict is particularly debilitating and resistant to resolution when it entrenches itself over time to the point of being intractable." The hospital-police conflict has evolved over time, but not to the point of being intractable in all hospital-police interactions. The parties must come together in negotiations to better understand their obligations and legal limits. According to Fisher (1994, p. 48): "All parties involved in conflict management should be clear on their philosophical underpinnings so that their behavior can be so evaluated and discrepancies identified, clarified, and resolved."

Fisher (1994, p. 50) offers several stages of conflict analysis, the first of which requires the parties to "jointly identify, distinguish, and prioritize the essential elements of the conflict in a way that leads to shared empathic understanding." The stakeholders in the hospital-police conflict unknowingly followed Fisher's stages of analysis from November 2001 to mid-2002 in

the development of the conflict management protocol. Fisher (pp. 50-51) recommended that the parties engage:

> ... in directly focusing on the most contentious issues in their conflict. Confrontation involves an orientation of collaborative problem solving in which the parties search for mutually acceptable mechanisms to deescalate the conflict and improve their relationship.

Fisher (1994, pp. 54-57) suggested several principles of conflict confrontation, some of which were successfully applied by the hospital-police negotiators:

1. The parties must engage in face-to-face interaction under norms of mutual respect, share exploration, and commitment to resolution without a fixed agenda but with a progression of topics.
2. Conflict confrontation must take place under the facilitative conditions of intergroup conflict, including equal status, high acquaintance potential, positive institutional supports, a cooperative task and reward structure, and the involvement of competent and well-adjusted individuals.
3. Confrontation must follow the strategies of collaboration, including seeing the conflict as a mutual problem to be solved and working to maximize the gains of both parties.

The hospital-police negotiators applied the Fisher and Costantino-Sickles Merchant design principles during the several rounds of face-to-face, written and telephone negotiations from November 2001 to mid-2002, with the resulting sudden breakthrough in early 2002 in the first of several drafts of the conflict management disclosure protocol. Earlier negotiations with the stakeholders indicated that common ground exists between confidentiality for patient information, patient privacy, and the investigative needs of the police. The challenge for the hospital-police negotiating team was to identify that common ground, and then operationalize it in a conflict management disclosure protocol, followed later by policies and training.

According to Burton's needs theory (1993, p. 55), this is a conflict and not a one-time dispute that might be resolved by adjudication. Burton proposes that we must determine the

type of conflict before trying to resolve it. I suggest that the patient information disclosure conflict arises from the intersection of fundamental interests and values between the health care and police communities. The interests and values are not mutually exclusive, but anecdotal experience indicates that some health care providers and police officers have taken absolute positions that prevent easy resolution of disclosure conflicts. In the face of uncertainty and inadequate knowledge of disclosure law, the default positions may be "no disclosure" on the part of health care providers, and "demand everything now" on the part of the police (Krever, 1980, vol. 2, p. 77).

What are the interests and values of each side? Health care providers want to ensure uninterrupted medical care that respects the confidentiality and privacy of patients and their medical information. The police want to ensure timely access to information that is relevant to law enforcement investigations and the protection of public safety, and to ensure that all evidence gathered is admissible in criminal court. The challenge for the parties is to develop a conflict management disclosure protocol that reflects the interests and values of both sides.

Fisher (1994, p. 50) offers conflict analysis guidance that is relevant for the police and hospital communities as they draw together in a negotiated resolution:

> The phase of conflict analysis involves the initial and mutual exploration, differentiation, and clarification of the sources of conflict and the processes of interaction that characterize both its history and current expression. This phase initiates a "phenomenological unravelling" of the conflict in which the parties jointly identify, distinguish, and prioritize the essential elements of the conflict in a way that leads to shared empathic understanding.

This was the process followed by the parties from November 2001 to mid-2002. I participated in negotiation sessions where we explored the interests, values and needs of both sides in relation to patient information disclosure requests. Fisher's "mutual exploration of the sources of the conflict" proved to be extremely valuable for the parties, resulting in the rapid development of the conflict management disclosure protocol.

The conflict management protocol must preserve the fundamental, underlying values of the health care providers: privacy and confidentiality of patient information. At the same time, the protocol must allow for access to patient information for law enforcement investigative purposes, as recognized by statute law, court rulings, and the various codes of ethics for health care providers. The patient information disclosure conflict arises from two competing cultures: first, medical advocacy, informational self-determination (Flaherty, 1989, pp. 46-47; 1998, September, p. 3) and personal protection; and second, law enforcement and public safety. In simple terms, at what point does the hospital patient's right to privacy surrender to the right of the state to know? How can we achieve a balance between the "private interest" of patients with the multiple "public interests" in protecting the security of the patient, victims, witnesses and other interested parties? To make things more complex, the public interests are represented by the police, for law enforcement purposes, and by the hospitals, for the privacy and confidentiality of health care. The private interest rests with the patient-suspect whose privacy and presumed innocence is protected by the Charter of Rights and Freedoms, statute law, and court rulings.

In 1890, Warren and Brandeis were among the first to describe the "right to privacy". Their early academic exploration of privacy concluded that (p. 213): "It is the unwarranted invasion of individual privacy which is reprehended, and to be, so far as possible, prevented." More recently, Flaherty (1989; 1998, April; 1998, September, p. 3) offered the theory of "informational self-determination" which sets the privacy standard for patient information, yet recognizes its inherent limitations:

> First, individuals should control their own personal information as much as possible; this is the principle of informational self-determination, usually expressed through individual consent. Secondly, the right information should be disclosed to the right people at the right time for the right purposes; in short, the "need to know" principle is a valuable tool for determining what personal information should be disclosed to whom and when. The problem, of course, is to put such an aphorism into practice.

Alan Westin (1967) is the leading privacy expert in the United States today. His classic work, *Privacy and Freedom*, gave this definition of privacy in relation to informational self-determination (p. 7): "Privacy is the claim of individuals, groups, or institutions to determine for themselves when, how, and to what extent information about them is communicated to others...". The Virtual Privacy Office (2002, n.p.) offers a restatement of informational self-determination: "everyone has the right to know who is knowing what about him at what time". This theory was amplified in the West German Federal Constitutional Court in 1983 where the Court stated (Virtual Privacy Office, 2002, n.p.):

> This Fundamental Right insofar authorizes each individual to determine on the circulation and the use of his own personal data. A limitation of this Right on "Informational Self-Determination" will only be allowed in the case of prevalent public interest.

Law enforcement access to patient information can be one of those prevalent public interests, where the investigative need of the state outweighs the private needs of a patient's confidentiality and privacy. Access by law enforcement personnel to patients' medical information, where authorized, gives legitimate access to persons who are outside the medical "circle of confidentiality" (Merz, Sankar, and Yoo, 1998, p. 241) beyond which informational self-determination fades away. Informational self-determination is one of two theories that underlie health care providers' codes of ethics. The other is the ancient tradition reflected in the Hippocratic Oath.

Given that the duties of confidentiality and privacy and the investigative need for patient information are not absolute, the conflict management protocol must highlight the discretionary disclosure pathways that already exist within the health care providers' codes of ethics and the Freedom of Information and Protection of Privacy Act, all within the limits set by the courts. Both stakeholders can have their interests and needs recognized in the development of a "third culture" (Casmir and Asunción-Lande, 1989, p. 294) that conjoins the hospital and police cultures in a "product of the harmonization of composite parts into a coherent whole." I suggest

that the negotiations that lead to the draft conflict management disclosure protocol, and the protocol itself, are the first steps in the creation of this coherent whole. Broome's (1993, p. 104) description of the third culture reflects the process now underway between health care providers and police:

> [The] third culture can only develop through interaction in which participants are willing to open themselves to new meanings, to engage in genuine dialogue, and to constantly respond to the new demands emanating from the situation. The emergence of this third culture is the essence of relational empathy and is essential for successful conflict resolution.

I intend to use the conflict management disclosure protocol to increase the mutual understanding of stakeholders' beliefs and values. At the end of the process, I suggest that the creation of Casmir and Asunción-Lande's third culture will be a strong indicator of success in conflict management for the health care and police communities. If it is done correctly, the disclosure protocol will constructively blend the missions of the two communities.

12. Conflict on the front lines: what happens in the emergency room?

Over the past several years, I have reviewed the opinions of police officers who have dealt with the hospital-police disclosure issue since the arrival of the B.C. Freedom of Information and Protection of Privacy Act in 1994 for hospitals. This Act created mandatory and discretionary disclosure authorities which have created a degree of uncertainty for some health care providers and the police. I have found a range of experiences throughout British Columbia, from routine disclosure and complete cooperation, to reluctance to grant access to patient information in the absence of a judicially-authorized search warrant. Without certainty over what can, may or cannot be disclosed, the parties may take polarized positions: hospital staff may deny access to all patient information; police may seek unrestricted and immediate access to patient information.

The hospital-police disclosure conflict occurs largely on the "front lines" in hospital emergency rooms and patient wards. The Ontario Medical Association (2001, n.p., endnote 14) has noted the conflict that may arise where physicians and nurses are cast into the police assistance role:

> ...the OMA does not believe that physicians should be made a part of the law enforcement apparatus of Ontario. Personally identifiable health information should be provided to officers and other officials only upon warrant or similar authorization. When canvassing physician opinion on the government's proposed legislation on mandatory reporting of gunshot and stab wounds in the summer of 2000, the OMA discovered that many health care providers are placed under extreme pressure by police officers seeking confidential patient information for law enforcement purposes.

Flaherty (1998, September, p. 5) noted that "there is no legal duty in Canada to assist police in an investigation, and it is not an offence to refuse to assist the police. However, it is an offence to obstruct police in a lawful investigation." As noted by Flaherty, police should obtain a court order or search warrant before requesting disclosure of actual records containing patients' personal information or records of biological samples. "Records" include paper and electronic documents and the recorded results of laboratory analysis. Biological samples include blood, urine, and tissue.

Flaherty (1998, September, p. 12) discussed how police may request the location of a specific patient in order to make an immediate arrest. If the hospital declines to reveal the location of a patient-suspect, the police have occasionally threatened to search the health care facility. A general search of a hospital would likely disrupt some of the patients and hospital staff in the delivery of medical care. Therefore, Flaherty concluded that if a health care provider determines that staff and/or patients would be unduly disturbed, or would be at risk from the individual concerned, health care providers may disclose the suspect's whereabouts to police using the discretionary disclosure authority in section 33(n) of the Freedom of Information and Protection of Privacy Act.

Health care providers sometimes are assaulted or threatened by patients and their families. Flaherty (1998, September, p. 12) concluded that disclosure of the details of the assault to an investigating police officer does not constitute an unreasonable invasion of the patient's privacy. "Health care providers are not prevented from reporting to police that a staff member has been victimized, simply due to the fact that the suspect is a patient. Similarly, identifying a patient as the party responsible for an assault is not a breach of patient confidentiality."

Here are some of the common disclosure scenarios from the front lines of hospital-police disclosure:

- Requests by police for access to patients' medical records. Non-medical access to records normally requires a search warrant or court order.
- Requests by police for the scheduled date and time of a patient's release from hospital. The police may want to interview or arrest the patient at his or her time of release.
- Police seizure of a patient-suspect's clothing. This clothing may have DNA, hair and fibres, or chemical residues that are relevant to a police investigation.
- Police access to interview a patient who is receiving medical care. This may include urgent interviews during emergency medical treatments, if this access does not unduly affect the delivery of that medical care.
- Police requests for a patient's medical status. Police may need to know whether a motor vehicle accident caused a fatality, or whether a person is conscious and capable of giving a statement.
- Requests by police to confirm the presence of a patient-suspect or patient-victim in a hospital. Police may need to interview or arrest a patient-suspect, or they may need to provide protection to a victim who faces continuing threats to his or her safety.

- Requests by a patient-suspect or patient-victim who may want the police to have access to all information, including personal information about themselves, so that they may be cleared of suspicion. Patients can give informed consent for disclosure of their personal information to the police, putting into action their informational self-determination.

The outcome of negotiations between health care providers in hospitals and the police will be mutual understanding of the duties to protect the confidentiality and privacy of patient information, balanced with the need for timely and legal disclosure of patient information that is relevant to active police investigations, as recognized by statute law, court rulings, and the codes of ethics for health care providers. The police and health care providers have developed a conflict management disclosure protocol which respects that balance for police access to patients, patient information (including blood, bodily fluids, human tissue, body parts, and bandages), and patients' personal property (including clothing and personal belongings).

The stakeholders need to understand the point at which the hospital patient's right to privacy yields to the state's right to know. That is the purpose of the disclosure protocol. Interest-based explorations between the stakeholders have been productive in 2001-2002; as noted by Fisher and Ury (1981, p. 51): "If you want the other side to take your interest into account, explain to them what those interests are." The meetings between the stakeholders in the hospital-police disclosure conflict followed this approach.

To this point, my thesis has introduced the stakeholders and the nature and location of their conflict. The next chapter discusses the conflict management disclosure protocol that the stakeholders have designed to manage that conflict.

13. Disclosure protocol for management of hospital-police information disclosure conflicts

Representatives of the Vancouver Island Health Authority and the RCMP met in November 2001 to discuss the on-going disclosure hospital-police conflict. On one side of the table was the VIHA, representing the patient information disclosure interests of health care providers at all hospitals in the Vancouver Island Health Authority jurisdiction. On the other side was the police, represented by me as the negotiator for the RCMP. I was assisted by two RCMP members with operational policing experience relating to the hospital-police disclosure conflict. The initial meeting dealt with the Capital Health Region (Victoria), and subsequent meetings and discussions expanded the scope to all of Vancouver Island and a portion of the coastal mainland of British Columbia within the VIHA's and the RCMP Island District's jurisdictions. The conflict management disclosure protocol arose from this series of meetings.

One early focus of the hospital representatives was "fishing expeditions" that police officers were alleged to occasionally make in search of patients' medical information. This term refers to unfocused enquiries about hospital patients by police, similar to this: "have you treated anyone for 'X' injury in the past month?" The November 2001 meeting explored the different perspectives of what a "fishing expedition" might be. From the hospital perspective, hospital administrators were concerned about random, intrusive forays into patients' medical information and status in the absence of "directed police investigations" of specific criminal offences. The reference to "fishing" comes from the nature of that activity: dropping a line into the water, hoping that something will come along and become hooked, and almost any fish will do.

From the police perspective, general questions about the presence of any patients who have been treated for gunshot and knife wounds over the past week make good investigative sense, even though they are less focused than "is 'Mr. X' here tonight receiving treatment for gunshot or knife wounds suffered at 123 Main Street?" The police perspective is less random

"fishing" and more targeted "hunting" because the police are usually seeking something specific about a particular person.

In the November 2001 meeting and subsequent discussions in January 2002, the VIHA and police representatives discussed various scenarios that have caused conflict in the past. These included:

- floor-by-floor, room-by-room searches by police that could unduly disrupt medical care and the privacy of other patients;
- motor vehicle accidents where witnesses reported seeing injured drivers, passengers or pedestrians who later cannot be found at the scene of the accident;
- alcohol or drug-impaired persons who leave a hospital, intending to drive a motor vehicle;
- a mentally competent person requests that hospital staff notify the police, but family members with the patient attempt to override the patient's wishes and ask the hospital to not contact police;
- direct access by police to patients for interviews and questioning;
- seizure of clothing, bandages, and medical samples from suspects; and
- swabbing of blood and other fluids from the external skin and clothing of suspects, without search warrants.

The hospital and police representatives agreed to research the legal requirements for police access to patient information in the above scenarios. The outcome of the research was all-party agreement on the legal requirements for police requests, and the subsequent production of a conflict management disclosure protocol. The stakeholders examined several drafts of the protocol, leading to the current draft 11 which is Appendix One to my thesis.

The conflict management protocol is the equivalent of stopping pollution upstream, rather than cleaning up the adverse effects of pollution downstream. The conflict management

protocol is designed to manage conflict at its source (i.e., front-line interactions between police officers and health care providers in hospitals), rather than let downstream antagonistic interactions occur where neither side has an adequate understanding of the other's needs. The value of the conflict management protocol will be evident if it proves to be less resource-consuming than allowing the existing relations to continue where conflicts usually remain unresolved until the next day when senior staff are available to sort things out.

The negotiation sessions provided a safe environment in which the stakeholders were able to explore interests, values and case law precedents. The stakeholders were able to propose and test solutions which now appear in the conflict management protocol. Some of the conflictual issues were resolved during the January 2002 meeting, and others required legal research and inter-stakeholder discussions before their resolution.

Following the January 2002 meeting, I consulted the Area Chiefs of Police for Vancouver Island, a committee that represents the five municipal police departments and the RCMP detachments in the southern portion of Vancouver Island. I presented a draft of the conflict management protocol to the Area Chiefs on February 21, 2002. The Area Chiefs responded on March 21, 2002 with their unanimous support and endorsement of the conflict management protocol, even though this was an early draft of the protocol. Even if the protocol could be an accurate and complete reflection of the law and the stakeholders' interests, it is vitally important to consult these stakeholders to ensure their early understanding, acceptance and endorsement of the protocol that will govern their relations with health care providers for the next several years.

During the negotiation meetings, there was no third party mediator or "neutral" to moderate the discussions. Instead, the stakeholders met face-to-face in a small room to explore how to manage the hospital-police conflict. My concern as the police-side negotiator was to be at the negotiating table alongside police officers with recent operational experience in the hospital-police interface. This meant police officers with considerable experience in asking

health care providers for information about patients for law enforcement investigations. With an abundance of policing, legal, health care and information disclosure experience around the table, the negotiators were able to ask "what if" questions and receive immediate and constructive feedback. It would not have been sufficient to have discussed the pure application of legal disclosure principles without being able to test the validity and application of those principles to real world scenarios. The real world access for the negotiators was an important strength of our negotiation process.

The conflict management protocol is a publicly-accessible internal document of the Vancouver Island Health Authority. When it has been approved by the VIHA, it will guide health care providers within the VIHA in their disclosure of patient information to police. Despite its "internal" status, the protocol will be a common reference guide for police. In their face-to-face interactions, police and health care providers will be able to refer to the protocol and make disclosure requests and decisions based on guidance in the protocol. I suggest that this will be a vast improvement over the historical conflicts where the absence of a common "song sheet" resulted in occasionally intense disagreements between the stakeholders.

The conflict management disclosure protocol is titled "Release of Patient Information to Law Enforcement Personnel in Urgent / Emergent Situations (in the Absence of Patient Consent, Court Order or Search Warrant)". The first section provides VIHA health care providers with background information on "specific circumstances that override an individual's right to privacy when personal information will be shared with individuals with an authorized requirement for that information" (protocol, section 1.0). This introduction leads the VIHA health care providers into a discussion of the exercise of discretion to disclose patient information (protocol, section 2.1) in circumstances where there is no mandatory duty to warn. Health care providers must exercise their discretion to disclose in every case, even where the exact scenario that they are considering is listed in Appendix C of the protocol where suggested responses are provided.

The protocol (sections 2.2 and 3.4) notes that only "designated individuals" can authorize the disclosure of patients' medical information. This is an important issue because only those with the appropriate background and training should disclose sensitive personal information to the police. Conversely, the police need to know that at all VIHA hospital facilities, there will always be someone available to act as a "designated individual" to permit timely disclosure decisions. The protocol will be of little value to the stakeholders if no one within the VIHA hospitals is available to make disclosure decisions when faced with urgent police requests.

The protocol distinguishes between "urgent" requests and "emergent" requests. The former require disclosure within four to six hours. The latter require disclosure immediately. Now that this distinction formally exists within the protocol, police must be prepared to place their disclosure requests in one category or the other, and be prepared to state why.

The protocol (section 4.0) requires police to describe their requests for patient information with sufficient detail. The "Request for Information by Police" form (protocol, Appendix B) now is the standardized form which police will complete to request disclosure of patients' information. During the 2002 negotiations between the stakeholders, the police raised concerns about police officers being asked to "stand in line" and fill out forms while a law enforcement emergency is underway. In most cases, being asked to fill out the form will not hinder or unduly delay a police investigation. However, the stakeholders were able to foresee situations where there would be no time to fill out a form before asking for disclosure and receiving patients' information. In these cases, the police and health care providers can complete the disclosure paperwork as soon as possible after the event (protocol, Appendix B, note 1).

During the 2002 negotiations, the police negotiation team raised the issue of confidential police investigations where it would not be appropriate to immediately notify patients that the police were asking for their personal information. Some police investigations could be

compromised if the patient-suspect were to become aware prematurely that the police were asking about him or her, thus giving the patient-suspect an opportunity to conceal or dispose of evidence, escape from the hospital, or alert criminal accomplices. Mere awareness that the police are asking about a patient may be enough to tell that patient "the police are on to you", even if no patient information is disclosed to the police. Therefore, the stakeholders agreed to add section 4.6 to the protocol which requires health care providers to place the police request form (for confidential police investigations) in a sealed envelope, to be attached to the patient's health record. If the patient later requests access to his or her personal information under the Freedom of Information and Protection of Privacy Act, or via other information access procedures, the patient will not automatically become aware of the prior interest by police. Not all police requests will fall within the "confidential" category.

Appendix C to the protocol offers 11 disclosure scenarios that police and health care providers may encounter. The list is not exhaustive, but attempts to include the most common scenarios. Here are the eleven scenarios, along with the requirement or non-requirement for a search warrant to obtain each category of patients' information:

1. (a) Police request invasive blood or bodily fluid samples or the record of a suspect's hospital treatment: a search warrant is required.

1. (b) Police request the release of a suspect's clothing and wish to take blood or bodily fluids swabs on the external surface of the suspect's body: a search warrant is not required.

2. Police wish to obtain a victim's personal effects: search warrant is not required.

In the absence of consent by the victim for scenario 2, hospitals will ask the police to sign a waiver of liability that transfers civil liability to the police for any subsequent claim for loss of personal property. During negotiations between the stakeholders, the hospitals did not want to be liable for patients' expensive clothing, currency and jewellery that might become lost or damaged after transfer to the police.

3. Police arrive with a search warrant but wish to view laboratory results and the entire chart, which goes beyond the strict limits of the search warrant: no disclosure for this additional information without a new warrant.
4. Police want to know the extent of a patient's injuries and medical prognosis: a search warrant is not required if the request is made to determine the urgency of applying criminal investigative resources and/or to determine the nature of criminal charges.
5. Police request information about whether anyone has been admitted or treated in the past few days where the patient matches a particular physical description and the police provide details of the offence: a search warrant is not required for a "yes or no" response by the hospital to police.

In scenario 5, hospitals want as much information as possible from the police about why the police are requesting information about a patient on an urgent or emergent basis. Note 6 in scenario 5 reflects the concerns expressed about this by the VIHA during the 2002 negotiations.

6. Police describe an offence under investigation and request the name of anyone with a suspicious injury who has been admitted in the past few hours: no disclosure without a search warrant, unless the police provide more details about the offence, the suspected injuries or an explanation of why they cannot provide more details about their investigation.

Note 9 for scenario 6 reflects the hospitals' concerns about "fishing expeditions" where police appear to request patient information without linking their request to specific offences or investigations. This reluctance to disclose general information about gunshot wounds, knife wounds and other "suspicious injuries" contrasts with the mandatory reporting duties imposed on health care providers by legislation in some American jurisdictions (see Appendix Three).

7. Police want to arrest a patient during an active law enforcement investigation. Police have asked nursing staff to notify them of a patient's impending discharge: no search warrant is required for this disclosure.

Section 33(n) of the *Freedom of Information and Protection of Privacy Act* gives health care providers the general discretion to notify police of impending discharge dates and times for patients, as well as times when police can have access to patients for interviews, to make arrests, and to take patients into custody. As long as the health care providers are confident that the proposed police-patient interaction will not unduly harm the patient's medical care, then health care providers may grant this access to the patient.

8. Police wish to interview a competent youth or adult patient in the course of an active investigation: no search warrant is required.

Scenario 8 was an important discussion point in the 2002 negotiations. Some patients may request "no visitors" during their hospital stays, and some may expressly state that they do not want to talk to the police. The issue then was whether health care providers should relay the message of "I won't talk to police" to the police, or whether the police should be allowed direct contact with the patient to explain their investigative interests. The very significant agreement between the stakeholders is described in notes 11 and 12 for scenario 8 in the protocol:

> [11]Unless there are medical reasons that preclude the patient from being interviewed at the time, the care provider (typically the RN) will accompany the police officer to the patient's bedside to enable the police to present their request to interview the patient. Police will be given a reasonable opportunity to obtain verbal consent to be interviewed from the patient. Once consent is obtained the care provider may then leave but must document the interaction and the verbal consent in the patient's health record. For youth suspects (under the age of 18) the police will ensure that the youth completes the Section 56 Young Offenders Act Form for a Youth person Charged with, or Suspected of, an Offence.
>
> [12]If patient consent is NOT obtained after a reasonable opportunity to do so, then the police will stop the interview and leave. The care provider will document the refusal in the health care record. If the patient refuses consent to be interviewed the police may choose to arrest the patient. If the patient has been arrested, the care provider will no longer attend except for medical purposes.

Notes 11 and 12 reflect the role of health care providers as the medical guardians of patients. This direct access for police ensures that health care providers shield patients from legitimate police investigations only where the isolation is vital to the patient's medical care.

Scenarios 9, 10 and 11 describe specific categories of information disclosure requests. The stakeholders included these categories to provide guidance for the following injuries and events:

9. Non-accidental brain injuries due to suspected shaking of an infant: no search warrant is required to interview family members who may be suspects. However, "police must seek verbal consent from these individuals to be interviewed and advise them of their rights to seek legal counsel" if they have been arrested or detained.

10. A child is in the emergency room with suspicious injuries due to possible child maltreatment. A police officer accompanies the social worker attending the child and requests copies of the photographs taken of the child: no search warrant or court is required for disclosure of the photographs to police.

According to note 13 in the protocol for scenario 10, "photographs are routinely taken in cases of suspected abuse, for medical and forensic evidence collection purposes."

11. A patient in the emergency room discloses that she was sexually abused by a relative the previous evening. Police do not require a search warrant to conduct invasive collections of forensic evidence, if the patient-victim gives informed consent in writing.

Note 14 in the protocol for scenario 11(a) states "consent may be obtained from the [teenaged patient] if it is determined she is competent to make her own health care decisions. In the absence of competency, consent may be obtained from the parent or guardian."

The above descriptions of the eleven scenarios indicate that the protocol provides considerable detail and discussion. As noted earlier, the list is not exhaustive but represents the stakeholders' best efforts to provide comprehensive disclosure guidance to health care providers who interact with police.

Now that the conflict management protocol has been presented, it is important to explore the interests, values and Canadian law that exist behind the disclosure principles in the protocol. First, I will explore the Canadian court decisions that establish the boundaries for the conflict management protocol. Second, I will explore the codes of ethics for health care providers that arise from those court decisions and statute laws. Finally, I will explore some of the statute laws that create an expectation of privacy for patients and their personal information.

14. Why privacy?: A review of the Canadian case law

As noted above, the Canadian case law from various courts establishes a fence or boundary within which the conflict management disclosure protocol must operate. The parties created the protocol with the following significant court rulings in mind. During negotiations in 2001-2002, the parties were aware that a disclosure protocol could not exist outside the boundaries set by these court decisions. Much of the stakeholders' discussions focused on the limits of privacy, confidentiality and law enforcement access that are established by the court decisions described below. Therefore, chapters 14, 15 and 16 of my thesis are the foundations of the protocol.

Privacy means the right to be let alone. This applies to intrusions against people and against their personal information. Hutchinson, Morton and Bury (1993, p. 1-1) noted that "with the advent of the Canadian Charter of Rights and Freedoms ... property has been dislodged as the organizing principle around which this area of the law should be rationalized." In its place the protection of privacy, or more particularly, a person's reasonable expectation of privacy, has

been substituted as the purpose of the Charter's guarantee against unreasonable search or seizure.

Section 8 of the Charter of Rights and Freedoms states that "everyone has the right to be secure against unreasonable search or seizure". In *Hunter v. Southam Inc.*, [1984] 2 S.C.R. 145 (at p. 160), the Supreme Court of Canada held that the protection against search and seizure is not absolute. If the circumstances of a case create a "reasonable expectation of privacy", then the state will require prior judicial authorization (i.e., a search warrant) to search and seize. In the hospital patient scenario, this means that if patients have a reasonable expectation of privacy that is attached to them or their personal information, the police will require a search warrant to seize those patients' personal information and personal possessions. The American equivalent of section 8 is the Fourth Amendment to the Constitution of the United States of America, the constitutional protection against unreasonable searches and seizures by the state.

Who are the beneficiaries of this right to privacy? In the hospital patient scenario, there are two parties who benefit: the patient-victim; and the patient-suspect. For the patient-victim, the right to doctor-patient confidentiality keeps the state at the hospital door unless an overriding public interest exists to breach that confidentiality. Hospitals sometimes attempt to preserve that confidentiality by requesting search warrants before granting access to medical records. The hospitals are acting as the medical guardians of their patients' privacy, but not as their legal guardians. In my review of the hospital-police disclosure conflict, I did not encounter any evidence to suggest a power imbalance between the medical guardians and the power of the state, as represented by the police. Each side has a formidable ability to request, disclose and deny access to patients' medical information, depending on the circumstances of each disclosure request.

For the patient-suspect, his or her Charter rights are activated whenever he or she faces jeopardy in the criminal prosecution process. This means that where the seizure of a patient-

suspect's medical records could result in criminal charges, the patient-suspect has a right against unreasonable search and seizure. Where there is a reasonable expectation of privacy for the patient-suspect's medical information, the police cannot avoid the requirement for search warrants. If the police were to seize a patient's records without warrants or other legal justification, the seized evidence might be held inadmissible at the subsequent criminal trial. Search warrants may be required by hospitals due to Charter constraints, or because hospitals have created a reasonable expectation of privacy for its patients. Even if the police are not strictly required to obtain a warrant, hospitals might set new "high tide marks" by demanding warrants before disclosing patients' personal information.

The Freedom of Information and Protection of Privacy Act, section 33(n) gives discretion to record holders who are "public bodies", including hospitals, to disclose personal information. However, this statutory permission to disclose is not a guarantee that the evidence obtained from the public body will be admissible in criminal prosecutions. Therefore, the police should always obtain a search warrant to authorize the seizure of personal information where there is a reasonable expectation of privacy for that information in relation to the person facing criminal jeopardy. The section 33(n) permission to disclose is not an automatic assurance that the disclosed information will be admissible in court as evidence against a person accused of a criminal offence. It is an important interest for the police to ensure the admissibility of evidence, thus taking a potential prosecution-defence conflict off the table in court.

If there is a danger that the suspect will remove or destroy evidence, the police can seize that evidence as part of their "search incident to arrest". See *Regina v. Grant*, [1993] 3 S.C.R. 223 (S.C.C.); *Regina v. Stillman* (1997), 113 C.C.C. (3d) 321 (S.C.C.); and *Regina v. Caslake* (1998), 121 C.C.C. (3d) 97 (S.C.C.). *Stillman* implicitly recognizes the difference between taking a patient-suspect's blood, hair and dental impressions (intrusive collection, requiring a warrant) versus swabbing the blood of a victim that has been splashed on a patient-suspect (relatively non-intrusive collection, not requiring a warrant). The former requires a

warrant for the seizure of evidence that will not change over time; the latter evidence is in a category that does not require warrants for the seizure of fragile, transitory evidence.

In *Regina v. Dersch*, [1993] 3 S.C.R. 768, the Supreme Court of Canada recognized the difference between the disclosure of medical records (warrant may be required) and mere confirmation of a patient's presence in the hospital (warrant not required) (p. 778):

> While there may be instances of doctors and hospitals releasing neutral medical information, such as the presence of the patient in the hospital, in this case the appellant had a reasonable expectation that the specific medical information revealed by Dr. Gilbert, including the blood alcohol test results, would be kept confidential by the doctors and the hospital.

The "no warrant rule" described in *Regina v. Dersch* for simple confirmation of a patient's presence in a hospital is now reflected in the protocol (Appendix C, scenario 7, note 10).

In *Regina v. Worth*, [1989] O.J. No. 1301 (Ontario High Court of Justice; affirmed (1989), 54 C.C.C. (3d) 223*n* (Ontario Court of Appeal)), the Ontario High Court of Justice considered the conflict between the physician's duty of confidentiality to his or her patient and the overriding power of a search warrant (n.p.):

> The authorities suggest that members of the medical profession owe a duty of confidentiality to their patients and that they may not disclose any information without the consent of the patient unless required to do so by law. This duty, however, does not extend to courts of law in criminal matters. When testifying, any information which a doctor obtains from an accused is not privileged and may be admissible.
>
> The issue in this case is, of course, not whether privilege attaches to the statements made by the applicant to doctors and hospital staff but rather, whether the seizure of the medical reports pursuant to the search warrants breaches the right of confidentiality arising from the doctor-patient relationship. ...
>
> The duty of confidentiality owed to the applicant was not breached in this case as the records were required to be released by law pursuant to the order of Justice of the Peace Levers.

Glancy, Regehr, and Bryant (1998, n.p.) have discussed how physicians should handle their patients' medical records, knowing that some of those records will be disclosed to police:

> ... any treatment records of a patient who is charged with a criminal offence may end up in the hands of the police and subsequently in open court. Treatment records should therefore always be written with the due care that this expectation

> prompts. Clinicians must be careful not to jot down statements or notes that would not be suitable for production in court. These records are not to be considered private musings or reminders.
> ...
> When psychiatrists are faced with a search warrant for their records, they should assert their right to retain legal counsel to ensure that the privacy interests of other clients are protected and that the records are first copied and then sealed pending a proper determination of a court that the records are not privileged. However, common sense dictates that not every police officer will understand his or her obligations to provide such an opportunity therefore, psychiatrists should assert the claim of confidentiality to the fullest extent possible.

The above is a brief review of the privacy and confidentiality principles that arise from the Canadian case law. These are the guidelines within which the negotiated protocol must exist and were key points during the stakeholders' discussions. Based on this review of the Canadian case law, the literature, the Freedom of Information and Protection of Privacy Act, and the health care providers' codes of ethics, the stakeholders were able to produce the draft conflict management disclosure protocol at Appendix One.

15. Codes of ethics for health care providers

Codes of ethics for health care providers are primary sources of the interests and values that are central to the hospital-police disclosure conflict. Physicians and nurses are guided in their professional practices by codes of ethics. These codes deal with a range of issues, including confidentiality and privacy. The codes establish high standards for privacy and confidentiality, but do not create absolute rules against disclosure of patients' medical information to law enforcement agencies. According to McConnell (1994, March, p. 47):

> Codes of medical ethics issued by professional organizations typically contain statements affirming the importance of confidentiality between patients and health-care practitioners. Seldom, however, is the confidentiality obligation depicted as absolute. Instead, exceptions are noted, the most common of which is that health-care professionals are justified in breaching the confidence of a patient if required by law to do so.
> ...
> The point instead is that physicians also have an obligation to keep information about their patients confidential. The obligations of confidentiality and obedience to the law can, in certain circumstances, conflict. Those who claim that physicians may breach patient confidentiality whenever required to do so by law

> are saying that the obligation to obey the law is always more important than, and takes precedence over, the obligation of confidentiality. But such a position is too simplistic.

Medical codes of ethics guide health care providers in their collection, use and disclosure of patient information and their delivery of medical services. These codes do not absolutely prohibit disclosure of patients' personal information. Instead, they permit the disclosure of patients' personal information in limited circumstances, particularly where disclosure is required or permitted by law (Flaherty, 1998, September, p. 17).

For doctors, the Code of Ethics of the Canadian Medical Association, Article 22 (1996, p. Code), restates patients' right to confidentiality:

> 22. Respect the patient's right to confidentiality except when this right conflicts with your responsibility to the law, or when the maintenance of confidentiality would result in a significant risk of substantial harm to others or to the patient if the patient is incompetent; in such cases, take all reasonable steps to inform the patient that confidentiality will be breached.

For nurses, the Registered Nurses Association of British Columbia (RNABC) has issued the Standards for Nursing Practice in British Columbia (1998, p. 8). Clinical Practice Indicator #5 of Standard 4 is relevant here: "Acts as an advocate to protect and promote a client's right to autonomy, respect, privacy, dignity and access to information." Registered nurses in British Columbia must comply with the Canadian Nurses Association *Code of Ethics for Registered Nurses* (2002, August). The value of *confidentiality* states (p. 8):

> Nurses safeguard information learned in the context of a professional relationship, and ensure it is shared outside the health care team only with the person's informed consent, or as may be legally required, or where the failure to disclose would cause significant harm.

Flaherty noted that all registered nurses in British Columbia must also comply with the International Council of Nurses *ICN Code of Ethics for Nurses* (2000, p. 2). Section 1 of the Code states: "The nurse holds in confidence personal information and uses judgement in sharing this information." Even when the health care provider must disclose patient information, the patient's confidentiality and privacy should be protected as much as possible in the

circumstances. Both the amount of information disclosed and the number of people to whom disclosure is made should be restricted to the minimum necessary to prevent harm to the patient and his or her interests.

The Lancet (2001, August 25, p. 598) has restated the need for doctor-patient confidentiality:

> ... because patients must be confident of a private and secure relationship with their doctor, it needs to be more difficult for third parties to gain access to their records. If, for instance, patients feel they cannot be candid with their doctors because police and intelligence agents can obtain their records without a warrant, clinical care will be compromised. Sound privacy regulation must strike a balance between legitimate needs for information and strong safeguards for its protection.

In summary, health care providers' codes of ethics are not absolute. Within reasonable limits, health care providers can disclose patients' medical information to police for some law enforcement investigations. The conflict management protocol exists within this disclosure channel. During negotiations in 2001-2002, the stakeholders recognized that the codes of ethics set important standards within which the conflict management disclosure protocol must function. Along with the legislation and court case law, the codes of ethics are always relevant during disclosure decisions.

16. Proactive disclosures of patient information: the duty to warn

What happens when health care providers know that a patient poses a threat or risk to someone or something? Ferris et al. (1998, n.p.) have explored the physician's duty to warn about patients who pose a substantial risk to others, and how this duty to warn arises from two landmark court rulings from California in the mid-1970s. Section 2.1 of the conflict management protocol refers to the duty to warn, as described by Ferris et al.:

> It is well accepted in law that there are occasions when a physician's duty to the public outweighs the principle of confidentiality, and the duty to warn about potentially violent patients is one such occasion. This is a common-law rather than statutory duty. The legal definition of "duty to warn" was first introduced in a 1976 landmark decision by the California Supreme Court [*Tarasoff v. Regents of*

> *University of California*, 118 Cal Rptr 129, 529 P 2d 553 (Sup Ct 1974)], in which it was held that "the privilege [of confidentiality] ends where the public peril begins."
> ...
> The original decision in this case (*Tarasoff I*, 1974) stated, "When a doctor or psychotherapist, in the exercise of his professional skill and knowledge, determines or should determine, that a warning is essential to avert danger . . . he incurs a legal obligation to give a warning." A subsequent appeal led to the *Tarasoff II* decision, a key component of which is referred to as the *Tarasoff* principle: "When a psychotherapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger." [*Tarasoff v. Regents of University of California*, 131 Cal Rptr 14, 551 P 2d 334 (Sup Ct 1976)] This duty might call for a therapist to warn the intended victim or someone likely to apprise the victim, to notify the police or to take whatever other steps are reasonably necessary.

The Supreme Court of Canada has reviewed the American jurisprudence on the duty to warn arising from doctor-patient interactions. In *Smith v. Jones*, [1999] 1 S.C.R. 455, the Supreme Court considered the scope of solicitor-client privilege and the public safety exception to this important privilege and commented in passing on doctor-patient privilege (paragraph 74): "... even the fundamentally important right to confidentiality is not absolute in doctor-patient relationships...."

The proactive duty to warn described above is imposed on hospitals and the twelve municipal police departments in British Columbia by section 25, and to a lesser extent by section 33(p), of the Freedom of Information and Protection of Privacy Act. In practice, this means that hospitals must notify the police, the public or hospital staff and other patients where a patient poses a "risk of significant harm" to an identifiable individual or group of people. This statutory disclosure obligation overrides the duties of confidentiality and privacy in the health service providers' codes of ethics and hospital policies. Taken together, sections 25 and 33(p) provide hospitals with mandatory and discretionary authorities that permit the disclosure of patients' information to police in "risk to the public" scenarios. If hospitals can show that they have made every reasonable effort to warn those at risk, then they should enjoy increased protection against lawsuits brought by those who have suffered injury or loss caused by

dangerous patients. The intent of the warning is to provide timely information to those at risk, so that they can take steps to minimize their vulnerability.

Kondro (1996, June 29, p. 1827) reported on the Ontario College of Physicians and Surgeons' decision to require physicians to report patients who threaten to harm another person or group:

> ... the safety of potential victims is of paramount importance. Doctors will be compelled to inform police (and potentially, the victim, "in appropriate circumstances") if a patient voices an intention to kill or cause "serious harm".
>
> ... the mandatory whistle-blowing plan exempts idle chatter or fantasies about violence from being reported. Doctors will only be obliged to report threats that might feasibly be acted on. Police must be notified "if the threat is directed at a person (or a group of people), there is a specific plan that is concrete and 'doable', and the method for carrying out the threat is available to the person".

In summary, the conflict management protocol and subsequent policies and training must reflect the mandatory duty to warn. The protocol has not changed any aspect of the mandatory duty to warn. For this part of the hospital-police disclosure conflict, the Legislative Assembly of British Columbia and the Canadian courts have resolved the conflict in favour of disclosure and public notification, rather than confidentiality and privacy. Discussions between the stakeholders have enhanced awareness of this important duty, which lead to the inclusion of section 2.1 of the conflict management protocol:

> ... situations will arise where s. 25 of the Act requires and s. 33(p) of the *Act* permits **proactive disclosure** of personal information to police, both in the circumstances of a known police investigation or, in compelling circumstances, before an investigation has commenced, where there is significant fear of harm to anyone's health or safety. In addition health authority professionals have a duty, at common law, to notify the police without delay in order to protect the patient, the public or third parties where the health authority perceives a compelling risk of harm to patients, the public, or other staff.

17. Statutory duty to report injuries

One solution to the hospital-police conflict would be to impose a mandatory duty on health care providers to report categories of injuries to police. This would remove the existing

discretion that health care providers enjoy in their relations with police. However, there is no legislation in Canada that requires health care providers to report gunshot wounds, knife wounds or serious skin burns to law enforcement agencies. This issue arose in the 1980 Ontario Commission of Inquiry into the Confidentiality of Health Information (Krever, 1980). Mr. Justice Krever considered the practicality of such a requirement in his report (vol. 2, p. 92):

> I have also been asked to recommend that physicians be required to report to the police all injuries that are consistent with the commission of a crime. I cannot do so. A requirement of that kind would make physicians statutory informers.

Mr. Justice Krever considered the balance between medical privacy and law enforcement efficiency (vol. 2, p. 92):

> As a society, we accept the need to balance the preservation of privacy and freedom with police efficiency. That is why search warrants are required and why the police must have reasonable and probable cause for obtaining them before a subject's privacy may be invaded. On the other hand, to prohibit physicians and hospitals from giving information to the police, no matter what the circumstances may be, seems to me be equally objectionable.

The outcome of Mr. Justice Krever's deliberations was recommendation 21 of his report (vol. 2, pp. 92-93) that:

> ... no legislation be enacted that would require hospitals or health-care facilities, the employees of hospitals or health-care facilities, physicians or other health-care workers to report to the police gunshot wounds, stab wounds or any other injuries indicating the commission of a crime or of a statement by a patient of any intention to commit a crime.

This contrasts with several United States jurisdictions that have mandatory reporting requirements for health care providers in relation to these categories of injuries. These American jurisdictions have resolved the hospital-police conflict in favour of the police and the public interest, rather than patients and their private interests. The Canadian exception is where information and privacy legislation imposes a duty to warn in relation to those injuries, meaning that there are reasonable grounds to anticipate additional harm. In some situations, there may be compelling moral and practical reasons for reporting such injuries to police (Flaherty, 1998, September, p. 5). Appendix Three contains a discussion of several United States jurisdictions

with mandatory reporting laws that require health care providers to report gunshot wounds, knife wounds and other injuries consistent with criminal activities to law enforcement agencies.

For now in British Columbia, mandatory reporting of gunshot and knife wounds does not form part of the law or the conflict management protocol between police and health care providers. Rather than establish reportable classes of injuries, the Canadian tradition has left the decision to report within the discretion of health care providers. Therefore, the conflict management protocol must emphasize that health care providers will exercise discretion to disclose on a case-by-case basis (protocol, section 2.1).

18. The Freedom of Information and Protection of Privacy Act: discretion to disclose

Under section 33(n) of the Freedom of Information and Protection of Privacy Act, public bodies such as hospitals have the discretion not to disclose personal information to other public bodies or law enforcement agencies if the request relates to an investigation that is not focused and "where personal information is sought on suspicion, surmise or guesses". (Ministry of Government Services, Government of British Columbia, 2002, p. 17). As part of exercising discretion, hospitals may consider a range of criteria, such as codes of ethics for health care professionals, and, in particular, the public interest in detecting, investigating, and preventing criminal activity. If they decide to disclose, health care providers should release only the personal information that is necessary to satisfy their obligations under the law, a court order, a warrant, or under the Act (Flaherty, 1998, September, p. 4). If hospitals exercise their discretion and disclose "in good faith" patients' medical information to police, hospitals are protected by section 73 from civil litigation actions by those patients.

In mid-2002, the Office of the Information and Privacy Commissioner of British Columbia provided the Vancouver Island Health Authority with feedback on the draft conflict management disclosure protocol. This feedback focused on the need to preserve and highlight the discretion

that health care providers must exercise when disclosing patients' medical information to police. Health care providers cannot surrender or abandon their discretion just because a protocol is in place. In the absence of a mandatory disclosure scenario (e.g., a court order or search warrant), the protocol still requires the exercise of discretion based on a full evaluation of the circumstances of each case (protocol, section 2.1). The discretionary power to disclose is therefore an important interest of the health care providers.

The conflict management disclosure protocol cannot limit the discretion of health care providers. This means that the protocol cannot provide black-and-white answers for disclosure in all cases. Instead, the protocol can present scenarios and typical disclosure requests from police, then provide suggested answers. After reading the protocol, health care providers must exercise discretion by reviewing the unique circumstances of each request. If health care providers exercise discretion by considering all relevant circumstances in each case, then their decisions may be subject to lesser or no criticism. The protocol cannot provide automatic answers; this may disappoint stakeholders who might have expected a magic list of disclosure answers for all cases.

19. Action research methodology

During the research for this thesis, I used four research methodologies to gather data from stakeholders. First, a literature review and case law searches explored the history and depth of the hospital-police conflict, drawing upon opinions from the police, hospital, and information and privacy communities. The literature review was the most efficient way to determine the interests and values of health care providers and the police. It would have been possible to conduct a large number of extensive interviews to collect the opinions of individuals on either side. However, this work already has been done through the Canadian case law, the federal and provincial legislation, codes of ethics, the medico-legal literature, and the Information and Privacy Commissioner of British Columbia's 1998 study. Therefore, there was

no need to conduct what might be called "starting point interviews" to draw out interests and values from raw data. In addition, all of my research participants had seen and commented on earlier drafts of the conflict management protocol in Appendix One.

Second, discussions with police officers (RCMP and municipal police) throughout British Columbia permitted a review of the statutes, policies and practices that may have contributed to the conflict over the past decade. It was important to have this continuous consultation underway with police constituents or participants, before during and after the negotiation meetings between the stakeholders. Continuous cyclical consultation and testing of the draft protocol in real world hospital-police disclosure conflicts demonstrated the value of action research for my thesis. Stringer (1996, p. 17) described action research as "... a constant process of observation, reflection, and action. ... [A]ction research is not a neat, orderly activity that allows participants to proceed step by step to the end of the process." I would add consultation to the quotation from Stringer's description of action research.

Third, a survey questionnaire gave the police-side participants an opportunity to comment on the suitability of draft 11 of the conflict management disclosure protocol. All of these participants had previously discussed the hospital-police disclosure conflict with me, and all had reviewed a previous draft of the protocol in early 2002. The survey questionnaire was a last-minute consultation process to ensure their current awareness of the negotiations, and to give all participants a voice in the process. I had anticipated that the questionnaire would be a major source of my data, but the rapid development of the disclosure protocol and early consultations with stakeholders and participants meant that little was left to collect by the time the questionnaire went out to the police-side participants.

Fourth, the most important research methodology was my active participation as the police negotiator. This methodology allowed open-ended discussions on a range of historically contentious disclosure issues. It also provided immediate feedback from the negotiators around the table so that all parties were able to shape their presentations based on the collective

knowledge within the room. The other three methodologies discussed above were information-gathering processes. The fourth methodology allowed the stakeholders to assess the validity of that information. I suggest that the face-to-face meetings were a primary reason for the rapid development of the protocol, arising from an atmosphere of trust.

Costantino and Sickles Merchant (1996, p. 54) have noted the value of stakeholder involvement in the design of conflict management systems. I would like to extend this to involvement of research participants or constituents who were a subset of the stakeholders at the negotiating table. Costantino and Sickles Merchant wrote:

> When the system's stakeholders are involved collaboratively in the design process, they become true partners in identifying, understanding, and managing their disputes – and have a more vested responsibility for the successful operation of the conflict management system.

I conducted all research for my thesis in British Columbia. No other educational institutions other than Royal Roads University, or jurisdictions other than British Columbia, were involved. The RCMP approved a research agreement under section 8(2)(j) of the Privacy Act, R.S.C. 1985, c. P-21, to give me access to personal information during my research. However, my research did not require access to personal information about identifiable persons in police investigative files or hospital patient information. Instead, my focus was on the information disclosure experiences of police officers when they have requested patient information from health care providers in hospitals on Vancouver Island.

In relation to the second methodology, my action research allowed me to contact the 30 detachments of the RCMP in the Island District, plus selected investigative units of the RCMP, plus the five non-RCMP municipal police departments on Vancouver Island. The conflict management disclosure protocol now under development through my RCMP Legal Services duties was distributed to those police contacts in July 2002, to seek their comments on the suitability of the protocol for their local hospital-police relationships.

In my professional duties with RCMP Legal Services, I have personally met with and discussed earlier drafts of the conflict management disclosure protocol with RCMP officers across British Columbia, with the Chief Constables of Vancouver Island municipal police departments, and with the Vancouver Island Health Authority. Additionally, I presented earlier drafts of the disclosure protocol during my regular training seminar for police supervisors at the Justice Institute of British Columbia (sessions held in Victoria and New Westminster). All of these participants were aware that I am working on this disclosure conflict both for my professional duties and for my thesis at Royal Roads University.

When I sent the draft disclosure protocol to each of the police contacts and the former Information and Privacy Commissioner, I asked for their informed, written consent for their participation in my research. I conducted this research in my dual role as Legal Counsel to the RCMP and as an RRU graduate learner. I was required to conduct this research even if my thesis had been on an unrelated topic. My police contacts would have been encouraged by the police command structure to respond to my RCMP Legal Services enquiries, even without this thesis and the research requirement for informed consent. Therefore, the purpose of the informed consent was to notify my participants that their feedback would be used not only within RCMP Legal Services but also for my thesis, if they consented to this.

I did not directly contact health care providers throughout British Columbia due to my RCMP Legal Services role in this conflict, except for my on-going negotiation contacts within the Vancouver Island Health Authority. In designing the proposal for my thesis, I anticipated that I would not be able to maintain my unbiased status as a researcher in the health care participants' view, because they know that I am the lawyer and negotiator for the police community on this issue, with my long-standing role on the police side in this conflict.

20. Feedback from police participants

In July 2002, I offered the police participants a final chance to review the conflict management disclosure protocol. Few participants responded, perhaps because they had indicated their satisfaction with the protocol during previous briefings. However, this final commentary opportunity was essential to maximize the "buy in" by stakeholders on both sides of the conflict.

The research questionnaire to police participants began with two introductory paragraphs (see Appendix Two for the complete questionnaire):

> This questionnaire asks you, in your role as a police officer, about your patient information disclosure experiences with health care providers (doctors, nurses, and hospital administrators) who work in hospitals on Vancouver Island. For all questions in this questionnaire, the word "patient" includes suspects, victims and witnesses who are receiving medical treatment in hospital.
>
> Please limit your comments to your experiences with hospital-based health care providers on Vancouver Island over the past two (2) years. Please do not provide comments in relation to patient information disclosure by doctors, nurses and administrators who work in private medical clinics, private doctors' offices, or private nurse practitioners, or non-traditional health care providers such as naturopathic and homeopathic physicians and mid-wives.

Here are some of the police participants' comments:

> The hospitals' responses have varied greatly. Usually if we have a medical release form signed it is not a problem, although when faxing a medical release form on one occasion, there was a suggestion by the hospital that perhaps the signature of the patient had been "forged". We have had roadblocks placed in front of us by administrative types when we have wanted to get samples from unconscious or comatose patients. The nurses and doctors were not the problem, it was the administrators.
>
> Some initial confusion on both sides with respect to how the request could be made. Formal requests happen so rarely that familiarity with the issue is low.

Question 8 in the questionnaire asked participants whether hospital-police relations concerning the disclosure of patient information to police improved, worsened or remained the same over the past two years. Here are extracts from participants' comments:

> ... it has become more difficult to obtain patient information in that the hospitals see themselves as "protecting" the patients from police intrusion, and that they are becoming more and more concerned about their own civil liability.
>
> [hospital-police relations have] worsened on some levels, probably because privacy legislation has heightened bureaucratic paranoia about cooperating with law enforcement. Generally, line staff on both sides work well together, disputes only happen in the unhappy event that senior managers become involved.

Question 10 in the questionnaire asked participants whether the disclosure protocol would improve, worsen, or not change the current information-sharing relations that their police detachment, unit or section has with their local hospital(s). Here is one participant's comment:

> This disclosure protocol will improve the information sharing in that it will eliminate a lot of the questions and the examples clearly outline the majority of the examples we frequently deal with at the hospitals.

Question 11 in the questionnaire gave participants the opportunity to add additional comments in relation to the disclosure of patient information by hospitals to police on Vancouver Island. Here are extracts from participants' comments:

> Typically, the first response to privacy legislation was an attempt to close off all channels of informal information and find a suitably high-ranking manager who could take a leisurely approach to police requests. Over time I would suggest that line staff have again begun to exchange information freely because they perceive the obvious advantages of doing so.
>
> ... the VIHA protocol isn't bad and it gives at least some direction to the after-hours staff we typically deal with. Interestingly, one of the real flashpoints are needle stick cases, where the hospital won't disclose whether the addict is HIV, Hepatitis C, etc.

The latter comment raises an important issue not directly considered by the conflict management disclosure protocol: disclosure of a patient's HIV or hepatitis status where a police officer has been exposed to the patient's blood or other bodily fluids. In the absence of written informed consent by the patient-suspect or patient-victim, police officers have had to endure months of prophylactic medical care, just in case they have been exposed to the HIV and/or hepatitis viruses. It may require provincial legislation to impose mandatory blood tests upon patients who have purposely or inadvertently exposed their blood and bodily fluids onto police officers and health care providers. The current state of the law can result in a long wait before

the police officer can know if he or she has been infected by a life-threatening disease. Any proposal to require mandatory blood testing without a patient's consent would fall outside the scope of a negotiated protocol between the police and health care providers.

The consulting of police participants within the RCMP and the five municipal police departments does not end with this questionnaire. Instead, the questionnaire is an intermediate step in the continuous evolution of hospital-police disclosure relations. When unforeseen new circumstances arise, the stakeholders can enhance the protocol with new disclosure scenarios and policy guidance. Where the protocol is adequate but communications break down between the stakeholders on the front lines, the stakeholders can review the sufficiency of resources and training of personnel.

Conflict management design requires consideration of the incentives and rewards for the stakeholders after implementation of the dispute management system (Costantino and Sickles Merchant, 1996, p. 189). I suggest that in the hospital-police disclosure conflict, consultation has shown the stakeholders that their requests and disclosures will respect and reflect their interests and values. Health care providers will know that they can disclose personal information without an unreasonable fear of professional censure, or privacy complaint investigations by the Information and Privacy Commissioner of British Columbia, or civil litigation actions against them. The police will know what to ask for, when to ask for it, and whom to ask for disclosure of patient information. The incentives and rewards will therefore be a smoothing of relations in a previously conflictual environment.

21. Summary and conclusions

The purpose of a thesis is to state a hypothesis, review the literature, and collect and analyze data to test the hypothesis. At the end of this process, it is possible to determine whether the hypothesis is valid or deficient in some way. My first hypothesis was:

> Hospitals can observe their duties of confidentiality and privacy as medical advocates for patients, while satisfying the legitimate disclosure needs of the police for law enforcement investigations.

The hospital-police negotiations from November 2001 to mid-2002 have confirmed the validity of my first hypothesis. The parties have successfully negotiated a conflict management protocol that respects health care providers' duties as medical advocates and privacy guardians, while simultaneously recognizing and protecting law enforcement agencies' right to information for criminal investigations.

The validity of my second hypothesis will be determined over the next two years, as police and health care providers test the conflict management protocol on the emergency ward "front lines". My second hypothesis stated:

> The conflict management disclosure protocol negotiated by the VIHA and the police on Vancouver Island will balance the need for confidentiality and privacy with the protection of public safety.

In 2002, I have been able to use draft 11 and earlier drafts of the protocol to resolve conflicts between health care providers and the RCMP in several areas of British Columbia that fall outside the VIHA's jurisdiction. My consultations with police-side stakeholders suggest that the protocol will do much to reduce and manage the conflict that almost every police officer recognizes from recent personal experience. Therefore, I am confident that my second hypothesis will be validated.

My thesis has reviewed the interests and values of health care providers and the police. One test of the conflict management disclosure protocol is whether it reflects those interests and

values. I suggest that the protocol successfully reflects all of the following interests and values presented in the conflict theory and the medico-legal literature:

- informational self-determination for hospital patients and their personal information, subject to clearly-defined limits;
- doctor-patient confidentiality;
- privacy of personal information and privacy in the medical care environment;
- full and proper exercise of discretion in response to all requests by police, except for mandatory disclosure scenarios;
- no undue interference by police in the delivery of medical care to patients;
- timely access to patients' medical information for legitimate law enforcement investigations and the protection of public safety; and,
- safeguards to ensure admissibility of evidence seized by police from hospitals in subsequent criminal prosecutions.

My thesis has confirmed that there are two sources of the conflict under review. First, the intersection of two public interests generates conflict: the public interest of medical privacy and confidentiality with the public interest of public safety. Second, the intersection of the public interest of preventing harm and ensuring public safety with the private interest of protecting the legal rights of individual patient-suspects. These intersections have been the primary sources of my learning during the research and writing of my thesis.

The conflict management disclosure protocol is another step towards the management of a longstanding intergroup conflict. The next steps will be operational policies and training for the police and health care providers to implement the disclosure protocol. Each side should completely understand what the other side can ask for and receive, under virtually all the circumstances that arise in hospital emergency wards. Situations that were not foreseen by the disclosure protocol can be referred to a working group composed of representatives of the

stakeholders. This working group can determine how to respond to these new situations. The protocol can be modified or enlarged as required when the stakeholders discover its inadequacies. Therefore, the disclosure protocol is a living document that can adapt to changes in the Canadian case law, the legislation, and the increasing expectation of privacy and confidentiality for patients' medical information.

The Vancouver Island conflict management disclosure protocol is a model for use throughout British Columbia. Over the next two years, I intend to work with hospital and police representatives to share the protocol with the RCMP and hospitals elsewhere in British Columbia. The legislation, codes of ethics, policies and practices are the same throughout the province, so all regions of the province should benefit from the work done on Vancouver Island. My intent is to ensure that hospital-police interactions provide consistency in patient information disclosure results, regardless of geographic area or demographic differences, throughout British Columbia. The exercise of discretion will inevitably result in some disclosure differences, but there should be obvious trends across the province.

Successful negotiation of a patient information disclosure protocol is just the first step towards conflict management. Conflict management will be achieved only if the parties implement the protocol through their local operational and administrative policies, followed by effective staff training. The cost to the stakeholders for the protocol, from negotiation to implementation and training, will hopefully be offset by improved stakeholder relations and general goodwill in the medium to long term.

If the disclosure protocol successfully manages the hospital-police conflict, the "third culture" anticipated by Casmir and Asunción-Lande (1989, p. 294) will have arrived. Instead of conflict in the emergency room, there will be a mutual understanding and knowledge of what to ask for and what to disclose. Conflict will be well-managed, if not completely resolved. Over the next year, I will review the advice from Costantino and Sickles Merchant (1996, p. 10):

"Measuring the effectiveness of conflict management involves looking at the results of dispute resolution efforts, the durability of the resolutions, and the impact on relationships."

My research experience during the evolution of the hospital-police disclosure conflict has shown me that a conflict theory, a review of the medico-legal literature, and intensive negotiations can deliver an interest-based dispute resolution protocol for the management of a long-standing conflict. However, the development and implementation of a conflict management protocol, or a disclosure statute, or a disclosure policy, is not a complete solution to the hospital-police disclosure conflict in itself. If you do not have qualified and trained personnel to apply the protocol or statute or policy, despite the apparent excellence and comprehensiveness of that protocol, you will have done little to manage or resolve the conflict.

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Appendix One: hospital-police disclosure conflict protocol (draft 11)

1.0 General Administrative

1.5 Corporate – Legal / Ethical

1.5.3 Release of Patient Information to Law Enforcement Personnel in Urgent / Emergent Situations (in the Absence of Patient Consent, Court Order or Search Warrant)

1.0 Introduction / Purpose

Police occasionally come to a health care facility, without a search warrant, court order or patient consent and request timely access to the personal information of a patient / former patient / client (hereafter referred to as patient). While law enforcement personnel have the legal authority under the *Criminal Code* of Canada and other related laws, including section 26 of the British Columbia *Freedom of Information and Protection of Privacy Act*, (the *Act)*, to collect personal information during the actual investigation of offenses under those laws, individuals addressing the request have a responsibility, in accordance with the *Act,* to balance the competing interests of protecting a patient's privacy rights with the law enforcement personnel's legal authority to collect personal information.

The Vancouver Island Health Authority (VIHA) recognizes that patient information obtained in the health care context must be protected from disclosure to persons not entitled to receive the information (see Corporate Policy 1.5.1 *Privacy Rights and Confidentiality of Personal Information Policy* for further direction in this regard). VIHA further recognizes there are specific circumstances that override an individual's right to privacy when personal information will be shared with individuals with an authorized requirement for that information. While patient consent is the preferred form of disclosure and should be obtained wherever possible, the **purpose** of this policy and procedure is to provide designated individuals within VIHA with a framework, based on section 33 of the *Act*, for consistently managing **urgent / emergent requests** from law enforcement personnel for disclosure of a patient's personal information to them **in the absence of patient consent, court order, or search warrant**. This policy and procedure will primarily address the application of section 33(n): Disclosure of personal information to assist in an investigation by a policing agency.

2.0 Policy

2.1 Discretionary Disclosure

Section 33 of the *Act* outlines a variety of discretionary guidelines to all public bodies about when they may or may not choose to disclose personal information. In particular, section 33(n) grants a health authority the **discretion** to disclose personal information to assist with an investigation of a specific case that is underway or an investigation from which a legal

proceeding will likely result. Law enforcement personnel must provide proof that there is a directed, bona fide investigation, i.e., a focused, active investigation in which there is a case file number or, in emergent situations, that a file number can subsequently be provided to the health authority. Designated staff and physicians must be satisfied that the usual processes for obtaining information, such as warrants, court orders or direct consent are not reasonable in the circumstances (see procedure for assistance in determining whether the explanation provided would be considered reasonable).

It should be noted that situations will arise where s. 25 of the Act requires and s. 33(p) of the Act permits **proactive disclosure** of personal information to police, both in the circumstances of a known police investigation or, in compelling circumstances, before an investigation has commenced, where there is significant fear of harm to anyone's health or safety. In addition health authority professionals have a duty, at common law, to notify the police without delay in order to protect the patient, the public or third parties where the health authority perceives a compelling risk of harm to patients, the public, or other staff. An example of this would be a patient with a known history of violence toward others who threatens to harm another individual or individuals, or a patient who, because of health concerns, should not be driving and indicates an intention to drive. This policy does **not** further address proactive disclosure of personal information.

2.2 Designated Individuals Respond

Only designated individuals will authorize release of patient information to law enforcement personnel who request patient information on an urgent / emergent basis.

2.3 Adequate Authorization

In the absence of patient consent, disclosure of personal information to law enforcement agencies will occur only in accordance with the provisions of the *Act,* other related legislation (e.g. Criminal Code), the VIHA Privacy Rights and Confidentiality of Personal Information Policy (Corporate 1.5.1) and the various professional bylaws / privacy codes and standards of practice that inform caregivers' daily practice.

2.4 "Need to Know" Rule

A designated individual of the VIHA will only disclose the necessary "need to know" information to the right recipient at the right time for the right purpose. In other words, if disclosure is authorized, only disclose that information which is necessary to satisfy our obligations with respect to the investigation. There is no general rule on disclosure that applies to all cases therefore each case must be carefully considered on its merits. If in doubt about what to disclose, consult with the local Information and Privacy officer, or the Office of the Regional Manager, Information and Privacy for guidance.

3.0 Definitions

3.1 Personal Information

Personal information is information about an identifiable individual provided to, collected or created by the VIHA that exists regardless of form and includes, but is not limited to the following:

(a) The individual's name, address or telephone number,
(b) The individual's race, national or ethnic origin, colour, or religious or political beliefs or associations,
(c) The individual's age, sex, sexual orientation, marital status or family status,
(d) An identifying number, symbol or other particular assigned to the individual,
(e) The individual's fingerprints, blood type or inheritable characteristics,
(f) Information about the individual's health care history, including a physical or mental disability,
(g) Information about the individual's education, financial, criminal or employment history,
(h) Anyone else's opinions about the individual, and
(i) The individual's personal views or opinions, except if they are about someone else.

3.2 Urgent Requests

Urgent requests are those where there is evidence of a compelling requirement to promptly (within 4-6 hours) release personal information (e.g. requesting information regarding knowledge of injuries and prognosis to determine nature of charges and criminal investigative resources).

3.3 Emergent Requests

Emergent requests are those where there is evidence of a compelling and life-threatening requirement to immediately release personal information. (e.g. unconscious, mortally wounded individual – release required for location of next of kin).

3.4 Designated individual

A designated individual is a person with the vested authority under this policy to approve disclosure of specific forms of personal information to law enforcement personnel. Designated individuals (DI) may include staff charged with managing patient registration, placement and health records functions, the most responsible physician, administrative on-call staff, information and privacy officers, risk manager or office of the regional manager, information and privacy. Physicians who are approached while on duty within a VIHA facility may refer the request to the previously noted designated individual or manage the request in accordance with the following procedure.

4.0 Procedure for Designated Individuals Responding under Section 33(d) or 33(n) of the Act, to Urgent / Emergent Requests from Law Enforcement Personnel for Patient Information

1. Direct urgent / emergent enquiries from law enforcement personnel to a designated individual within VIHA. See Appendix A for a listing of site specific contacts and locations for South, Central and North Island, VIHA.

2. Requests must be submitted by police in writing to the DI by completing the *Request for Information by Police* form (see Appendix B). Verbal requests will only be considered in **emergent** situations where there is evidence of a compelling requirement to immediately release personal information (see point #5 for process).

3. The written request must:
   a) Identify police officer's name, badge and phone number;

b) Document that a bona fide investigation is underway, i.e., a focused investigation with an established case file number. (Note: in emergent situations a case number may not yet be available, such as an accident where police know when and where it took place, and are now searching for an individual who left the accident scene);
c) Include name or description of the individual whose information is being sought, if known to police;
d) Identify what specific information is requested;
e) Identify how the information is relevant to the investigation. Section 33(n) discussion from the province's *Freedom of Information and Protection of Privacy Act* Policy and Procedures manual indicates "Personal information should not be disclosed if the request relates to an investigation that is not focused and where information is sought on suspicion, surmise or guesses" (see Appendix C for examples of this).
f) Provide reasons why obtaining a search warrant or court order is not required or reasonable in the circumstances.

Note: A warrant or order would not be required if VIHA is exercising its discretion to disclose under s. 33(n) which permits disclosure to a law enforcement agency to assist in an investigation undertaken with a view to a law enforcement proceeding or from which a law enforcement proceeding is likely to result.

Acceptable situations where a search warrant or court order is not required or reasonable include:

- for notification of next of kin or caregiver (if a patient is unconscious or deceased);
- to determine extent of injuries to assist police in determining whether they will be conducting a criminal investigation and therefore require additional investigative resources, and timely access to court order or warrant is not possible;
- to determine expected prognosis for nature of charges, if any; and
- for release of victim's personal effects (excluding personal health record) and clothing (see Appendix C for examples of situations when a warrant would or would not be required).

4. Determine the officer's authority to request information (officer to identify the specific legislation (e.g. the *Criminal Code* or *Controlled Drugs and Substances Act* (CDSA) and the type of offense under investigation (e.g. assault));

5. Place a copy of the completed *Request for Information by Police* form on the patient's health record. If the request is made verbally, ensure you document in the health record, the compelling reasons (e.g. emergent need to locate next of kin or to determine prognosis so as to immediately secure the crime scene) that justify the verbal request.

6. If police advise that the investigation is confidential, place the *Request for Information by Police* form (number #xxxx) (see Appendix B) in a sealed envelope marked "Confidential – Only For Review by Information and Privacy Officer upon receipt of Access Request" and append to the health record. If the patient or third party subsequently requests access to records related to the patient, the records,

including the *Request for Information by Police* Form must first be screened by a designated Information and Privacy Officer within the Health Authority to determine if exceptions to disclosure exist (e.g., s. 15 – Harm to Law Enforcement).

Appendix A (VIHA, draft 11)

DESIGNATED INDIVIDUALS CONTACT LISTING

During **normal business hours** (0800-1600 Monday – Friday) urgent inquiries from law enforcement officers made to staff in all patient or related care areas (including Emergency) within a VIHA facility should be directed to the following **designated individuals:**

[text deleted here]

Outside of regular business hours, urgent enquiries for patient information at all SI, CI and NI VIHA facilities should be referred to the individual in charge of the facility (typically entitled the Patient Care Coordinator (PCC), Administrator on Call, or the "In Charge" individual depending on the specific facility).

Appendix B (VIHA draft 11) Form # _____

REQUEST FOR PERSONAL INFORMATION ABOUT AN IDENTIFIABLE INDIVIDUAL BY POLICE IN URGENT / EMERGENT[1] SITUATIONS *

In the absence of informed consent, court order, or search warrant

1. Name / description of patient / focus of investigation[2]:
   _____
   _____
2. Specific information requested:
   _____
   _____
   _____
3. Describe how information is relevant to investigation or rationale as to why police cannot disclose further details:
   _____
   _____
   _____
4. Authority for the investigation (Officer to identify specific legislation, e.g., *Criminal Code* or *Controlled Drugs and Substances Act* and type of offense): _____
5. Case file number (if available): _____
6. Reasons why search warrant or court order not required or reasonable:
   _____
7. Is the investigation confidential? Yes _____ No _____

8. Identification of officer making request:
   _____
   Name (please print)

   _____ _____
   Badge number Phone number

   _____ _____
   Signature Date

9. I hereby _____consent or _____refuse this disclosure of personal information under
   _____of _____
   identify section identify relevant Act

   _____
   Signature: Designated Individual

10. If approved, information released by: _____
    Name (please print) _____ Date: _____

1 In situations where the emergent nature of the request does not allow for immediate form completion, hospital and law enforcement staff must do so as soon as possible/practical.

[2] In situations where there is disclosure of more than one individual's personal information, forward completed form to the office of the Regional Manager, Information and Privacy for retention.

*NOTE: Form completion NOT required for seizure of exhibits (e.g. clothing, personal effects, bodily fluid swabs

Appendix C (VIHA draft 11)

Examples are based on situations that have arisen in the past, however, this is not an exhaustive listing. Designated individuals receiving and managing the request for information must review the information provided by police on the Request for Information by Police form and exercise professional judgment based on that information.

Can patient information be disclosed without consent, search warrant or court order?

1. a) A murder has occurred and **suspect** is in hospital being treated. Police request invasive (example: extracting a blood sample) blood / body fluid samples or the record of suspect's hospital treatment. [1] A warrant is needed when an invasive procedure is required to obtain the sample from a suspect or a victim or the record of the suspect's hospital treatment. Police do not require a warrant if the suspect or victim gives informed consent in writing. b) Police request the release of **suspect's** clothing and wish to take blood / bodily fluids swabs on the external surface of the suspect's body. [2] Police do not require a warrant to take clothing or non-invasive samples from suspects, victims and witnesses. This means that the police do not require a warrant to swab blood or other bodily fluids that have been splashed or deposited on the body, clothes or personal belongings of a victim, suspect or witness.	NO [1] YES [2] s. 33(d)
2. Police wish to obtain a **victim's** personal effects. [3]Police do not require a warrant to seize a **victim's** personal effects. There are no expectations of privacy attached to victims' personal effects that would be sufficient to require police to obtain a warrant to seize a victim's personal effects. Police are entitled to seize evidence in relation to a crime, where that evidence is in "plain view". Hospitals will ask police to sign a waiver of liability for the release of victims' valuables (including currency), in the absence of consent by the victim. This waiver will acknowledge that the police will accept any and all civil liability that may arise from the seizure of the victim's personal effects.	YES [3] s. 33(d)
3. Police arrive with warrant but wish to view lab reports and entire chart, which goes beyond purview of warrant. [4]Police can receive information outlined in initial warrant and either return with warrant covering additional request or contact Health Records during regular business hours.	NO[4] s. 33(e)
4. Patient unconscious in ICU and police wish to know extent of injuries and prognosis. [5]No warrant required if request is made to determine urgency of applying criminal investigative resources and/or to determine nature of charges.	YES[5] s. 33(n)
5. Police request information as to whether anyone was admitted in past few days of a particular physical description and provide details of the offense under investigation (i.e., not a "fishing expedition").	

[6]Police should provide more information about the matter under investigation to clearly indicate WHY they are requesting the information on an urgent / emergent basis or rationale as to why they cannot disclose further details. Document this on the *Request for Information by Police* form. VIHA may provide a "Yes" or "No" response as to whether anyone was admitted. [7]If police further request the name or other personal information about the individual(s), police should provide compelling rationale as to the need for immediate release of information that meets the tests as outlined in 3.2 and 3.3 of the policy. [8] In the absence of compelling rationale for disclosure, a warrant would be required.	YES[6] s. 33(n) YES[7] s. 33(p) NO[8] s. 33(n)
6. Police request names of anyone with a <u>suspicious injury</u> (e.g. stab wound) who has been admitted in the past x hours and identify the offense under investigation. [9]If police haven't provided details and are not specific, there is no obligation for staff to disclose anything. Police should provide such information as 'injuries consistent with…' and information more directed to the event, rationale for the urgent / emergent need for disclosure, or rationale as to why they cannot disclose further details. Document this on the *Request for Information by Police* form.	NO[9] s. 33(n)
7. Police want to arrest a patient (and thus have an active investigation underway). Police have asked nursing staff to notify them of patient's impending discharge. [10]Staff should contact VIHA Security and inform them of the police request. Security are then to contact police directly and notify them of the impending discharge. In many cases the patient may pose a threat to public safety as they may have plans to retaliate for their injuries. <u>Note</u>: when a police officer requests the location of a specific patient in order to make an <u>immediate arrest, staff may disclose the suspect's whereabouts to police.</u>	YES[10] s. 33(n)
While there are no issues of disclosure of patient information with examples 8 and 9a, they address whether <u>access to the patient</u> and/or family is appropriate. 8. Police wish to interview competent youth or adult patient (victim, suspect and/or witness) in the course of an active investigation. [11]Unless there are medical reasons that preclude the patient from being interviewed at the time, the care provider (typically the RN) will accompany the police officer to the patient's bedside to enable the police to present their request to interview the patient. Police will be given a reasonable opportunity to obtain verbal consent to be interviewed from the patient. Once consent is obtained the care provider may then leave but must document the interaction and the verbal consent in the patient's health record. For youth suspects (under the age of 18) the police will ensure that the youth completes the Section 56 *Young Offenders Act* Form for a Youth person Charged with, or Suspected of, an Offence. [12]If patient consent is NOT obtained after a reasonable opportunity to do so, then the police will stop the interview and leave. The care provider will document the refusal in the health care record. If the patient refuses consent to be interviewed the police may choose to arrest the patient. If the patient has been arrested, the care provider will no longer attend except for medical purposes.	YES[11,12]

9. An infant, brought to ER with vomiting and loss of consciousness by her mother, is admitted to PICU with what appears to be a non-accidental brain injury due to a suspected shaking incident. Police wish to interview a) the parents; b) Emergency room and PICU staff and physicians involved with the child. a) [17]Family members or caregivers are often suspects in this situation. While no warrant or court order is required to interview suspects, police must seek verbal consent from these individuals to be interviewed and advise them of their rights to seek legal counsel. In the absence of consent, police may choose to arrest the suspects. b) [18]No warrant or court order is required for police to interview staff about comments made by family members about the state of the child and circumstances surrounding the admission to hospital, i.e., issues specific to the matter under investigation. Disclosure may occur if police require immediate information to determine if the sustained injuries are consistent with suspected child maltreatment; determine the need for additional investigative resources and/or ensure timely access to forensic evidence.	YES[17] YES[18] s. 33(n)
10. A child is in ER with bruising to her thighs, ears and shoulder blades. The Ministry of Children and Family Development (MCFD) is notified of her suspicious injuries and possible child maltreatment. A police officer accompanies the MCFD social worker attending the child and requests copies of the photographs taken by AV services. [13]No warrant or court order is required. Photographs are routinely taken in cases of suspected abuse, for medical and forensic evidence collection purposes.	YES[13] s. 33(n)
11. A 14 year old in ER has disclosed that she was sexually abused by her uncle the previous evening. a) Police attend and following a complete forensic examination of the teen, request invasive blood / body fluid samples. [14]A warrant is needed when an invasive procedure is required to obtain the sample from a suspect or a victim. Police do not require a warrant if the suspect or victim gives informed consent in writing. Consent may be obtained from the teen if it is determined she is competent to make her own healthcare decisions. In the absence of competency, consent may be obtained from the parent or guardian. b) In the ER, the teen spontaneously discloses to the VIHA Child Life worker, various specifics of the alleged abuse. Police request i) to obtain a statement from the worker regarding the child's disclosure to her and ii) a copy of the worker's notes, in the VIHA health record, of the teen's disclosure. i) [15]S. 33(n) permits the worker to disclose the details of her conversation in the absence of a warrant or court order if police provide compelling reasons why timely access to the information is essential, e.g., if the information provided to the worker will assist the police in determining whether additional investigative resources are immediately required to secure potential crime scene evidence. ii) [16]In the absence of consent from a competent teen, or the parent or guardian if the teen is not competent to give consent, a warrant to review the VIHA health record notes of the child life worker is required.	NO[14] s. 33(e) YES[15] s. 33(n) NO[16] s. 33(e)

Copyright disclaimer from the Vancouver Island Health Authority, August 26, 2002 for Appendix One:

Developed By:

Date Developed:

Date Sent:

Appendix Two: survey research questionnaire for police on Vancouver Island

ROYAL ROADS UNIVERSITY – CONFLICT ANALYSIS AND MANAGEMENT
RESEARCH QUESTIONNAIRE: THE HOSPITAL-POLICE DISCLOSURE CONFLICT

This questionnaire asks you, in your role as a police officer, about your patient information disclosure experiences with health care providers (doctors, nurses, and hospital administrators) who work in hospitals on Vancouver Island. For all questions in this questionnaire, the word "patient" includes suspects, victims and witnesses who are receiving medical treatment in hospital.

Please limit your comments to your experiences with hospital-based health care providers on Vancouver Island over the past two (2) years. Please do not provide comments in relation to patient information disclosure by doctors, nurses and administrators who work in private medical clinics, private doctors' offices, or private nurse practitioners, or non-traditional health care providers such as naturopathic and homeopathic physicians and mid-wives.

1. **In your role as a police officer, have you or your police officer subordinates requested patient information from a Vancouver Island hospital during a police investigation of an offence under the *Criminal Code*, or the *Controlled Drugs and Substances Act*, or the *Motor Vehicle Act*?**

   YES

   NO (if your answer is "NO", please skip all remaining questions. Print your name, rank, title and detachment / unit / section information at the bottom of the Research Consent Form and return the Research Consent Form and this questionnaire by mail or fax to Kyle Friesen)

2. **Did you receive the patient information that you requested from the hospital? When and how did you receive it?**

3. **Describe the hospital's response(s) to your request(s) for patient information.**

4. **Did you have, or did you require, a search warrant to obtain patient information at the hospital?**

5. **Does your RCMP Detachment / municipal police department have formal or informal disclosure arrangements with your local hospital(s) for police access to patient information?**

6. **If your reply to question 5 is "YES", is there a police liaison person at the hospital or someone who has authority to respond to police requests for patient information?**

7. **Does your local hospital(s) have a policy for the disclosure of patient information to police?**

8. **Have hospital-police relations concerning the disclosure of patient information to police improved, worsened or remained the same over the past two years?**

9. **Please review the attached draft protocol from the Vancouver Island Health Authority for the disclosure of patient information to police. Would the draft protocol meet your police investigational needs in relation to patients in hospitals? If "no", what would you add, change or delete in the protocol?**

10. **Would the disclosure protocol improve, worsen, or not change the current information-sharing relations that your police detachment, unit or section has with your local hospital(s)?**

11. **Do you have any additional comments in relation to the disclosure of patient information by hospitals to police on Vancouver Island?**

Thank you for your assistance with this research project. Please return the signed Research Consent Form and the completed questionnaire to Kyle Friesen by **Tuesday, August 06, 2002** by fax or mail or Internet E-mail. If you need assistance with this questionnaire, please call Kyle Friesen.

Fax: c/o RCMP Legal Services Vancouver (604.264.3131)

Mail: Kyle Friesen
RCMP Legal Services,
Department of Justice Canada

Internet:

Appendix Three: United States jurisdictions with mandatory reporting laws

In the State of Massachusetts, there are three medical conditions that must be reported to public agencies: gunshot and knife wounds, and serious burn injuries. The Risk Management Foundation of the Harvard Medical Institutions (2001, n.p.) offers this chart of reporting requirements:

CONDITION	REPORT TO	REPORTED BY	TIME FRAME	REPORTING MECHANISM
Gun shot: Bullet wound, powder burn, or any other injury arising from or caused by discharge of any gun, firearm, pistol, BB gun or air rifle.	Police authorities Dept. of Public Health Dept. of Public Safety	Treating physician or hospital manager	Immediately	Written form (see Massachusetts General Laws, c. 112, s. 12A; URL: http://www.state.ma.us/legis/laws/mgl/112-12A.htm
Knife wound: If criminal activity is thought to be involved.	Police authorities Dept. of Public Health Dept. of Public Safety	Treating physician or hospital manager	Within 24 hours	Written form (see Massachusetts General Laws, c. 112, s. 12A; URL: http://www.state.ma.us/legis/laws/mgl/112-12A.htm
Burn injury: Affecting > 5% of patient's skin surface area.	Police authorities Dept. of Public Health Dept. of Public Safety State Fire Marshall	Treating physician or hospital manager	Within 14 days	Written report describing etiology of the injury. Department of Public Health maintains the reports as public records. (see Massachusetts General Laws, c. 112, s. 12A; URL: http://www.state.ma.us/legis/laws/mgl/112-12A.htm

The Centers for Disease Control and Prevention (1995, p. 160) noted that:

> Since 1927, physicians in Massachusetts have been required to report to law enforcement authorities all gunshot wounds (GSWs) and all violence-related sharp instrument wounds (SIWs). GSWs are defined as "all injuries resulting from, or caused by, the discharge of a gun, pistol, BB gun, or other air rifle or firearm." Violence-related SIWs are defined as nonself-inflicted "wounds or injuries caused by a knife or sharp or pointed instrument if, in the physician's judgment, a criminal act was involved."

Barber, Ozonoff, Schuster, Hume (1996, n.p.) have noted that:

> Discussing weapon injuries as a health issue might raise eyebrows among public health professionals more accustomed to a traditional disease model. Why is public health addressing an issue previously considered the domain of police, courts, and criminologists? Throughout the 20th century, as infectious disease has declined in the United States, injury has taken its place as the leading cause of death for young people ages 1 to 44, leading to a reconfiguration of public health priorities. Injury prevention and chronic disease prevention have joined infectious disease control as key components of the public health commitment to preventing premature mortality and excess morbidity.
> ...
> Massachusetts law for decades has required physicians to report stabbings and shootings to police. While compliance under the old system was very poor, it was, at least, a starting point. Even when not in compliance, hospital personnel were aware of their obligation to report to state and local police.

The Florida State Legislature has enacted similar legislation that imposes mandatory reporting requirements on health care providers (Daire, 2000, n.p.; State of Florida, 1999, section 790.24):

> Any physician, nurse, or employee thereof and any employee of a hospital, sanitarium, clinic, or nursing home knowingly treating any person suffering from a gunshot wound or life threatening injury indicating an act of violence, or receiving a request for such treatment, shall report the same immediately to the sheriffs department of the county in which said treatment is administered or request therefor received. Any person willfully failing to report such treatment or request therefor is guilty of a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

In the State of Iowa, the Iowa Code, §147.111, requires any person who treats persons suffering from a gunshot, stab wound, or other serious bodily injury which may have resulted from a criminal offense, to report to a law enforcement agency where the crime was committed or treatment was given.

In the State of Washington, the State Legislature is now considering a Bill that would impose mandatory reporting of gunshot wounds. The Digest of HB 1730-S, as of House 2nd Reading on March 12, 2001, states:

> ... any health care practitioner ..., including personnel of a hospital, clinic, or other health care facility who knowingly treats any person suffering from a gunshot wound, or who receives a request for such treatment, shall report within a reasonable time the existence of the gunshot wound to an appropriate law

> enforcement agency. However, no report is necessary if a law enforcement officer is present with the victim while treatment is being administered. Authorizes a hospital, clinic, or other health care facility to designate an individual to make the report. The report shall be made as soon as possible, but no later than the time of the victim's release from the facility.
>
> Provides that a person required to make a report or who participates in judicial proceedings resulting from the report, acting in good faith, is immune from any civil liability which might otherwise result from these actions.

The Washington State Legislature's summary of House Bill 1730 states:

> Current law does not provide for immediate notification of law enforcement agencies by physicians or hospital emergency room attendants treating gunshot wounds to assist law enforcement if the circumstance is a result of illegal activity.
> ...
> Gunshot trauma is declared to be a significant public health problem which warrants mandatory reporting for purposes of monitoring, assessment, and the development of prevention strategies.

In the State of Texas, the Health and Safety Code, Subchapter E. "Reports of Gunshot Wounds and Controlled Substance Overdoses", Section 161.041: "Mandatory Reporting of Gunshot Wounds", imposes mandatory reporting of gunshot wounds:

> A physician who attends or treats, or who is requested to attend or treat, a bullet or gunshot wound, or the administrator, superintendent, or other person in charge of a hospital, sanitorium, or other institution in which a bullet or gunshot wound is attended or treated or in which the attention or treatment is requested, shall report the case at once to the law enforcement authority of the municipality or county in which the physician practices or in which the institution is located.

EndAbuse: Family Violence Prevention Fund (2001, n.p.) reported that "thirteen states have enacted domestic violence reporting laws or reporting laws for gunshot and/or life threatening injuries only. They are California, Colorado, Florida, Kansas, Kentucky, Maine, Minnesota, Missouri, New Hampshire, Rhode Island, Texas, Vermont and Washington state."

VANCOUVER ISLAND health authority

CONFIDENTIAL: ☑ YES ☐ NO
URGENT: ☑ YES ☐ NO

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FACSIMILE COVER LETTER

Client Relations Office
2101 Richmond Avenue
Victoria, BC
V8R 4R7

FAX:

DATE: Aug. 26/02

TO: NAME:

DEPT/COMPANY: Legal Counsel, RCMP Legal Services

TELEPHONE: FAX:

NUMBER OF PAGES: COVER + 1

FROM:

Phone:

- ☐ Barb Leggett, Coordinator, Freedom of Information
- ☐ Kari Marshall, Coordinator, Client Relations (South Island)
- ☐ Carol Karr, Coordinator, Client Relations (South Island)
- ☐ Cathy Yaskow, Regional Manager, Information & Privacy (VIHA), Client Relations (South Island)

MESSAGE: As requested, my authorization.

Cheers, Cathy

This letter confirms the authorization of R. Kyle Friesen to use the Vancouver Island Health Authority's "*Release of Patient Information to Law Enforcement Personnel in Urgent / Emergent Situations (in the Absence of Patient Consent, Court Order or Search Warrant*" as part of his major project for the partial requirements of a Master of Arts (Conflict Analysis and Management) degree at Royal Roads University (RRU).

In addition, this letter confirms the authorization of R. Kyle Friesen to use the Vancouver Island Health Authority's "*Release of Patient Information to Law Enforcement Personnel in Urgent / Emergent Situations (in the Absence of Patient Consent, Court Order or Search Warrant*" (case scenarios only) as part of his written and oral presentation at the University of Massachusetts Boston in the October 24-26, 2002 conference titled "*Conflict Studies: The New Generation of Ideas*".

I understand that this Royal Roads University major project will be available to other learners and scholars and approve the use and copy of the documents. The requested permission extends to any future revisions and editions of the major project, including non-exclusive world rights in all languages, and to the prospective publication of my dissertation by UMI.

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Name of copyright holder: Vancouver Island Health Authority - Cathy L. Yaskow

Title: Regional Manager, Information and Privacy

Signature: _____

Date: August 26, 2002

Organization: Vancouver Island Health Authority

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ISBNNumber: **ISSNNumber:**

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It is understood that the material will be included in Mr. Friesen's thesis and presentation at the University of Massachusetts. Mr. Friesen's thesis will also be available to learners and scholars through the National Library of Canada and the Learning Resource Centre of Royal Roads University.

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for **Frank Hudson**
Director

Approval Date: 10/3/2002