Protecting Personal Health Information – General Consultation Survey Report

Introduction

The College of Physicians and Surgeons of Ontario (the "College") is currently reviewing its *Confidentiality of Personal Health Information* policy.

As part of this review, the College has developed an updated draft of the policy (retitled *Protecting Personal Health Information*) and a draft *Advice to the Profession Document,* which were released for external consultation from September to November 2019.

Invitations to participate in the consultation were sent via email to a broad range of stakeholders, including all Ontario physicians. In addition, a general invitation to provide feedback was posted on the College's website and social media platforms. Feedback was collected via regular mail, email, an online discussion forum, and an online survey.

This report summarises only the stakeholder feedback that was received through the online survey.

Caveats

Participation in this survey was voluntary. As such, no attempt has been made to ensure that the sample of participants is representative of any sub-population.

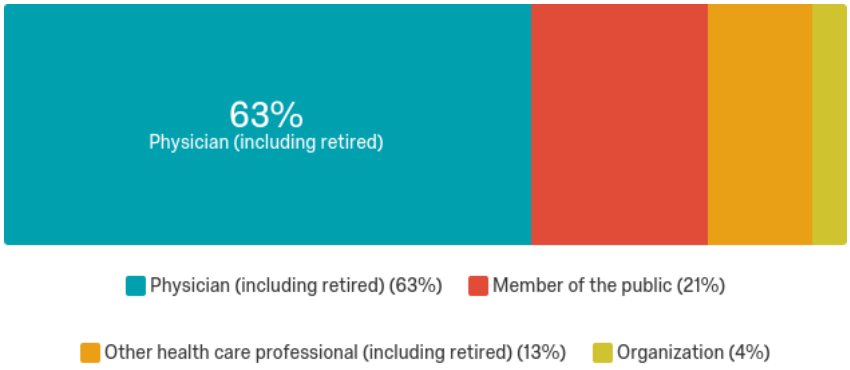
In the interest of space, stakeholder feedback to open-ended questions has been summarised to capture key themes and ideas.

Who we heard from

A total of 21 responses were received in response to this consultation.

The vast majority of respondents were from Ontario (96%).

Respondent Demographics



Organizational responses included Sustainable Consulting Group.

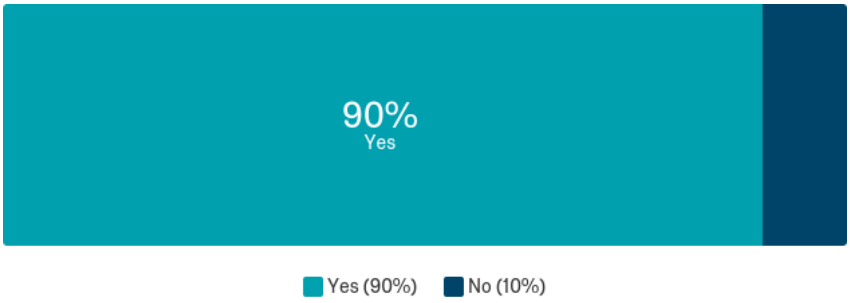
The following questions were posed to all respondents:

Q1. The draft policy provides the following updated definition of the term "circle of care:"

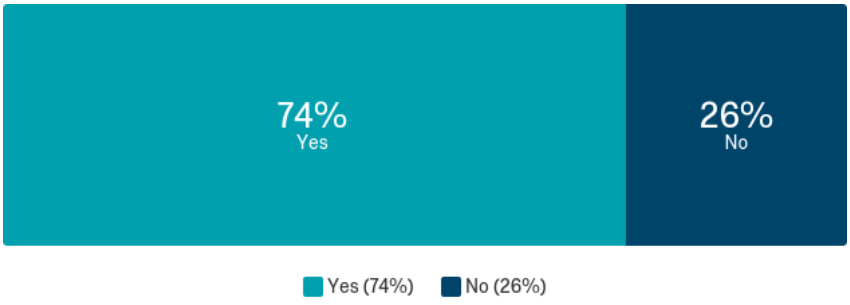
The group of health care providers treating a patient who need the patient's personal health information in order to provide health care. A person outside a patient's circle of care would include:

- **a person or entity who is not a health care provider (e.g. family, friends, the police, an insurance company, or the patient's employer); and**
- **another health care provider, including a physician, where the PHI is being provided for a purpose other than providing health care to the patient (e.g. for market research).**

In your view is the definition of "circle of care" clear? (n = 20)



Q2. Does this definition provide enough information to determine who is within the patient's circle of care? (n = 19)



Q3. What, if anything, do you think is unclear about the definition of "circle of care?" (Optional) (n = 5)

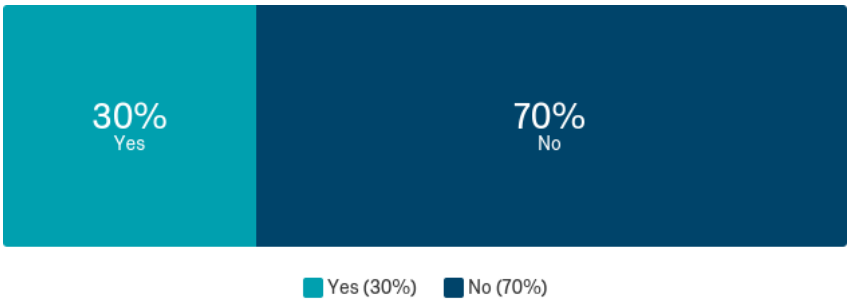
Physician responses included:

- Which of the patient's family members are included or excluded in the "circle of care;"
- Whether or not one in the "circle of care" has the patient's personal health information (PHI);
- There are always exceptions (e.g. looking up the culture and sensitivity results of the relative of a septic patient presenting with similar symptoms in order to target therapy); and

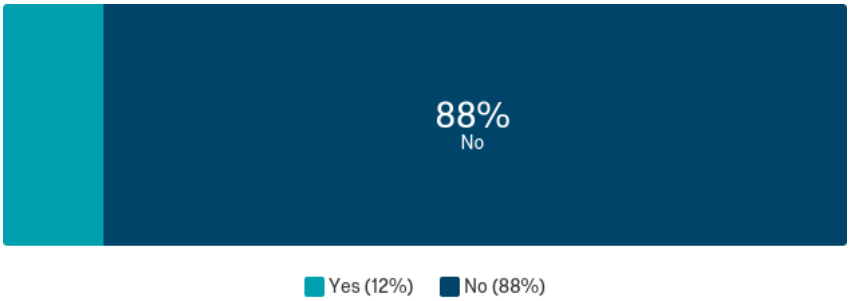
- If the patient recognises third party health care providers could have access to their PHI.

Q4. The draft policy uses the term "lockbox" to describe "a patient's express instruction to withhold or withdraw their consent to share all or part of their personal health information with another health care provider."

Were you aware of the term "lockbox" prior to today? (n = 20)



Q5. Do you think that the term "lockbox" is commonly used? (n = 17)



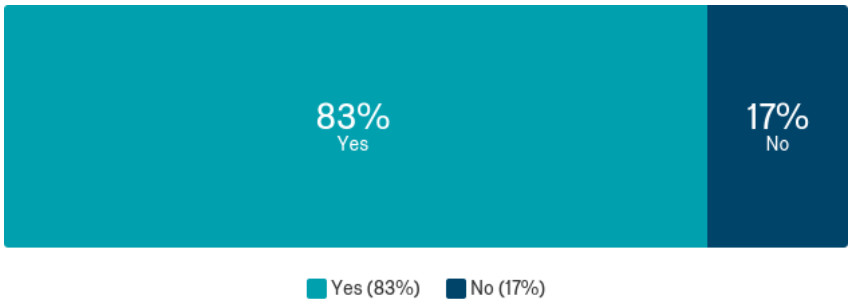
Q6. Are you aware of any other terms that are more commonly used to describe the concept of a "lockbox?" If so, please describe below. (Optional) (n = 10)

Other terms used to describe the concept of a "lockbox" included:

- Block/restriction;
- Break the glass;
- Consent directive;
- Locked or blocked health records;
- Marking a chart or note private or restricting access to particular employees;
- Patient health care will; and
- Privacy.

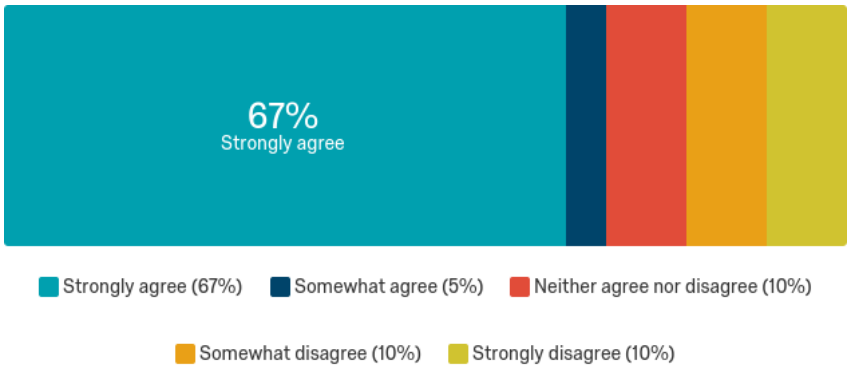
One physician respondent felt that the rapidly changing nature of technology precludes the use of a standard term. Another physician respondent suggested using "lay person terminology" such as "the patient expresses a limit on the personal health information that they give permission to be shared."

Q7. Is the definition of "lockbox" set out above clear? (n = 18)



Q8. The draft policy requires physicians to obtain the patient's consent before communicating with the patient electronically, whether the communication is secure or unsecure.

Do you agree or disagree that this is a reasonable expectation? (n = 21)



Q9. Please feel free to elaborate on your answer to the question above. (Optional) (n = 7)

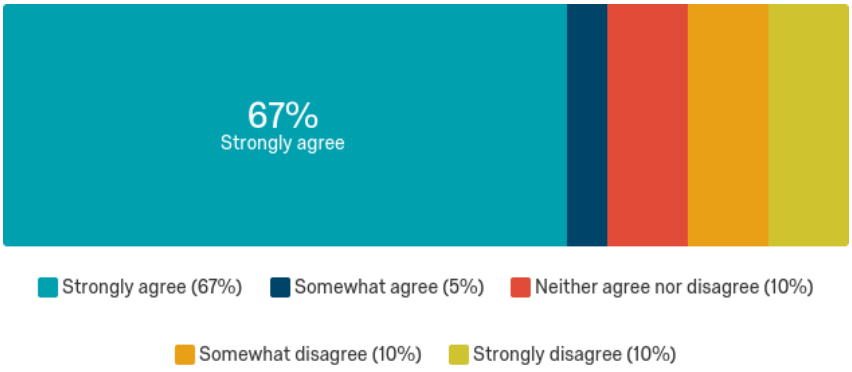
Physician responses included:

- It is not unusual for a patient to initiate email contact with their physician;
- Clarify if "express" consent must be written or if verbal consent is sufficient (e.g. if a patient provides their email address to a physician, they are implying consent to email them);
- Patients in abusive or controlling situations may not have control over who has access to their inbox so consent should be required for every electronic communication; and
- Since e-messaging is available through some electronic medical record (EMR) systems (a secure message accessible through a secure portal) why would this method first require a patient's consent?

One organizational respondent indicated patient preference should be established for each method of communication and a secure method of communication should be used.

Q10. The draft policy also leaves it in the discretion of the physician as to whether to use unsecure electronic communication with patients, taking into account the particular circumstance and the contemplated use.

Do you agree or disagree that this is a reasonable expectation? (n = 21)



Q11. Please feel free to elaborate on your answer to the question above. (Optional) (n = 5)

Physician responses included:

- Many patients (especially older patients) cannot manage the technology of secure electronic communication;
- Potential "privacy" issues should not be a barrier to quality care; and
- The patient should be advised the form of communication is not secure.

One health care provider indicated communication should always be secure.

One organizational respondent felt unsecured means of communication should only be used in an absolute emergency where all other secure options have failed or been exhausted.

Q12. The draft policy sets out some specific examples of how a patient's personal health information may be shared or disclosed, including by in-person or telephone conversations being overheard, voicemail messages left for a patient being accessed by another person, and faxes and emails being misdirected.

Have you experienced any other particular challenges or concerns, either as a health care provider or member of the public, with respect to protecting patients' personal health information? (Optional) (n = 11)

Physician responses included:

- The only information that should be available through Clinical Viewer are those which make a difference in a resuscitation (e.g. blood results; medications; imaging; and operative reports);
- If patient consent is required for follow-up information to a referred physician after consent was given at the initial referral;
- Voicemails left on a patient's home number that could be accessible to other family members;

- Language and cultural barriers; and
- Patients may refuse other health care providers to be provided with feedback about their condition which forces the physician to rely solely on the patient's report for details.

The draft policy sets out expectations about the secure use of technology in managing personal health information, including through security of communications/electronic communication, security of mobile devices, and photographs and video recordings taken for the purpose of patient care.

Q13. What other areas regarding the use of technology in medical practice, if any, would you like further information or guidance about? Please elaborate below. (Optional) (n = 8)

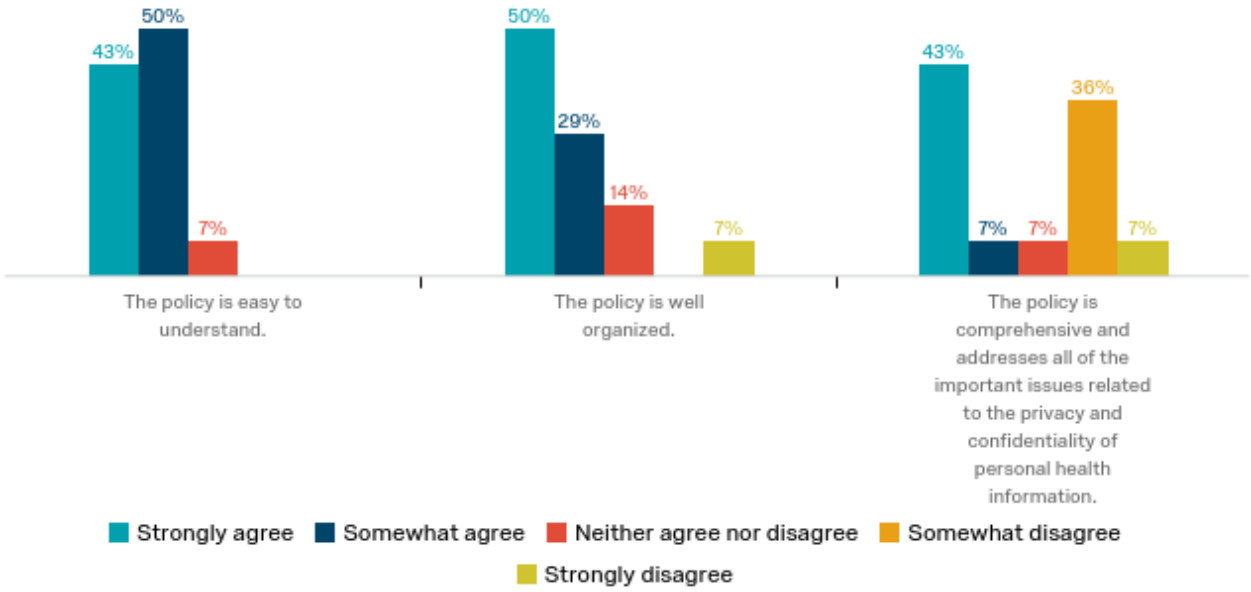
Physician respondents requested further information on the following:

- If anything other than zipping and password protection is required when emailing;
- Guidelines for the growing service of telemedicine and its security; and
- More information on the use of audio-visual recordings for teaching purposes.

One health care provider requested information regarding the legality of emailed prescriptions as there can be no "original" copy and therefore requires reaching out to the physician to have the prescription rewritten.

The following questions were only posed to respondents who indicated that they read the draft *Protecting Personal Health Information* policy:

Q14. We'd like to understand whether the draft policy is clear and comprehensive. Please indicate the extent to which you agree or disagree with the following: (n = 14)



Q15. How can we improve the draft policy's clarity? Please feel free to elaborate on your answers above or touch on other issues relating to clarity. (Optional) (n = 5)

Physician responses included:

- Responsibilities regarding training for staff and to clarify the physician's responsibility if their staff commits a privacy breach;
- Expand the draft policy for family health organizations (FHOs); and
- Incorporate "quality patient care" throughout the draft policy.

Q16. How can the draft policy be made more comprehensive? (Optional) (n = 4)

Physician responses indicated the following should be included in the draft policy to improve comprehensiveness:

- Address staff and employees;
- Clarify what happens when records are requested by law;
- Information on access and corrections; and
- Include precise guidance on who the custodian is in shared EMR enterprises.

The following questions were only posed to respondents who indicated that they read the draft *Advice to the Profession* document:

Q17. Are there issues or topics you think the draft *Advice to the Profession* document should address further? (Optional) (n = 3)

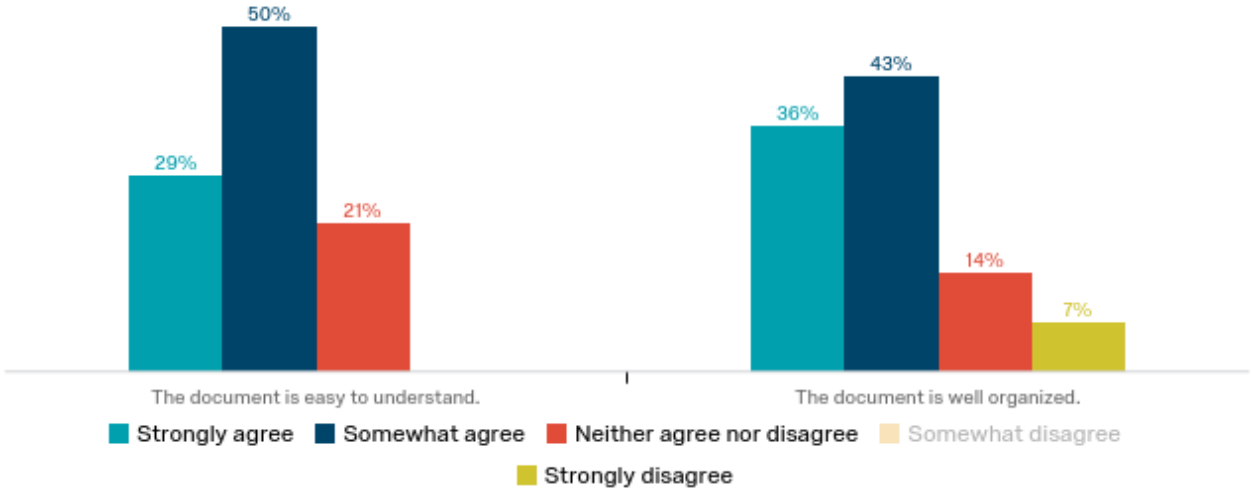
Physician respondents indicated the draft *Advice to the Profession* document should further address:

- Training (e.g. Privacy and Security Training from OntarioMD) for both staff and physicians;
- Discrepancies or "grey areas" (e.g. a hospital advises physicians not to share patient information by hospital email, but it is the de facto method of communication among many physicians); and
- Advice for physicians who share an EMR within an FHO enterprise.

Q18. Is there any information in the draft *Advice to the Profession* document that you think is unhelpful or unnecessary? (Optional) (n = 2)

- One physician respondent felt the section related to permitted disclosures introduces police investigations without further explanation and suggested including basic advice.
- Another physician respondent felt more examples should be provided to include what does and does not constitute "circle of care" (e.g. if an after-hours physician servicing all FHO patients is considered to be within potential patients' "circle of care").

Q19. We'd like to understand whether the draft document is clear. Please indicate the extent to which you agree or disagree with the following: (n = 14)



The following question was posed to all respondents:

Q20. If you have any additional comments that you have not yet provided on either the draft policy or advice to the profession document, please provide them below, by email, or through our online discussion forum. (Optional) (n = 1)

- One physician respondent indicated the language surrounding consent from minors requires clarification and suggested including an example of the situation described in the draft policy *(6. Consent from Minors; lines 82—83).*