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Just What is your "Personal Information"? Has the Privacy Commissioner Struck the Right Balance in IMS Health?

By Paul Jones

Although many patients are not aware of it, each time that they have a prescription filled in much (but not all) of Canada, the pharmacist provides that information to IMS Health, anonymized as to the patient, but not as to the doctor. IMS Health then aggregates the information and sells it at a good profit to pharmaceutical companies, who provide it to their sales representatives to assist them in convincing doctors to prescribe the manufacturers' products. The manufacturers also use it to assess the performance of their sales representatives. No consent to such collection, use and disclosure is obtained from the doctor or the patient.

Privacy lawyers were not surprised that with the coming into force of the federal *Personal Information Protection and Electronic Documents Act* ("PIPEDA") on January 1, 2001 that this practice would soon be the subject of a complaint to the federal Privacy Commissioner. Both the Canadian Medical Association and the Canadian Pharmacists Association have had policies in place for several years stating that consent should be required.

The real surprise was on October 2, 2001, when the Privacy Commissioner released his opinion in the matter, saying that information about doctors' prescribing habits was not "personal information" as defined in PIPEDA (a copy of the opinion letter may be obtained from www.privcom.gc.ca). This means that not only is the individual doctor's consent not required, but also that doctors do not have a right of access under PIPEDA to the information that IMS Health collects about them.

In PIPEDA, "personal information" is defined broadly as "...information about an identifiable individual, but does not include the name, title or business address or telephone number of an employee of an organization." The Privacy Commissioner decided that although information about a doctor's prescribing habits , characterized as a "work product", is information about an identifiable individual, it is not "personal information" because the purpose of PIPEDA, as set out in Section 3, is to set out privacy rules that balance the right of privacy with "...the need of organizations to collect, use or disclose personal information for purposes that a reasonable person would consider appropriate in the circumstances". He then goes on to state that if work product information is "personal information" it "...could have the effect of precluding many kinds of legitimate commercial consumer reporting...", and gives as an example the ingredients and spicing used by a chef, such as might be reported by a restaurant critic.

Did the Privacy Commissioner strike the right balance between the individual right of privacy of doctors and legitimate commercial consumer reporting in IMS Health? This writer thinks that he neglected to examine the effects of the use of such information on doctors and their patients; misconstrued the nature of consumer selection in health care; and over-weighted the effect on IMS Health of requiring that the doctor's consent be obtained.

There are a number of definitions of privacy employed by legal scholars. In general these reflect two related but distinct concerns. One is control of how one's personal information is used. The other is limiting access to an individual. No court has yet ruled on any aspect of PIPEDA, but the Supreme Court of Canada has previously dealt with privacy concepts in *R. v. Dyment*, [1988] 2 S.C.R. 417, regarding the use of evidence from a blood sample taken without consent.

In excluding such evidence, the Court balanced the value of such evidence and the need for law enforcement against the harm that its use would do to the administration of justice because of the violation of the individual's right to privacy. In ruling the evidence inadmissible, the Court said that privacy in relation to information is based on the notion of the dignity and integrity of the individual, and is the individual's to communicate or retain as the individual chooses. Further situations abound where "...the reasonable expectations of the individual that the information shall remain confidential to the persons to whom, and restricted to the purposes for which, it is divulged must be protected" (para.33).

In other situations the Privacy Commissioner has considered the assessment of an employee's work product to be protected personal information (see *Your Privacy Responsibilities: A Guide for Businesses and Organizations*, second paragraph). Doctors in private practice are not of course employees. They are highly trained and specialized individuals in whose knowledge and skill the patient places great reliance. Assessment of that knowledge and skill is a very sensitive issue, both to the patient and to the individual doctor.

For this and other reasons doctors are required to belong to a self-regulating professional body that undertakes a variety of such assessments, based on the principles of natural justice. In suggesting that doctors' prescribing habits are not personal information because they are needed for "legitimate commercial consumer reporting" with respect to doctors, the Privacy Commissioner is in effect overriding the regulatory structures and rights of doctors currently in place. These concerns do not appear to have been weighed in the Privacy Commissioner's letter. And this letter gives no indication that he weighed the concerns expressed by the Canadian Medical Association and the Canadian Pharmacists Association in their policies.

Further it can be argued that the Privacy Commissioner has incorrectly applied the consumer reporting model to doctors and health care. Consumers do not generally select doctors by a review of the specific elements of their practice such as drug prescribing, in part because most consumers would feel manifestly unqualified to evaluate such information. Rather doctors are selected on general criteria (such as bedside manner and overall reputation) and significant trust is placed in the doctor to act in the patient's best interest. Specifically when prescribing drugs the doctor is expected to select the medication that is best for the patient, free of influences from representatives of the pharmaceutical manufacturer. Doctors are not selected and judged in the same manner as chefs, restaurants and auto mechanics.

If the information regarding doctors' prescribing habits was actually used to assist consumers in selecting doctors, at worst it might lead to errors in selection based on the incorrect assessment of the information by unqualified individuals. In fact it does not appear that consumers generally use the reports that IMS Health produces. Rather the reports are used by drug manufacturers to assist them in influencing the doctor to choose their product. There is a significant risk that on occasion such influence may be contrary to the interests of the patient.

Finally, would categorizing doctors' prescribing habits as "personal information" truly lead to commercial harm? In a recent seminar on privacy law, a lawyer who acts for IMS Health suggested that if the Privacy Commissioner's opinion had gone the other way, the result would have been "catastrophic". Unfortunately the evidence from Europe, where privacy laws are stronger, does not support such a conclusion.

In Germany the data protection rules require that it be impossible for users of the reports to identify individual pharmacies, let alone doctors. Therefore IMS Health developed, in consultation with the manufacturers, its own data reporting units to guarantee anonymity (known as the "1860 Brick Structure"). IMS has become so dominant in the provision of such data that the European Commission on July 3, 2001 not only found that IMS Health was abusing such position in refusing to licence its competitors to use its claimed copyright in the 1860 Brick Structure, but also attempted to order an interim licence while IMS Health appealed its decision (the interim order was lifted in late October-this is also one of the leading cases on the compulsory licensing of intellectual property for competition purposes).

In the United Kingdom, where IMS Health has its regional office for Europe, Africa and the Middle East, the National Health Service regards doctors' prescribing habits as personal information, and consent is regularly obtained by modest payments to the charity of choice for doctors and pharmacists. The debate there has been with respect to the two general privacy

concerns and whether the anonymized patient information is still subject to a fiduciary duty of confidentiality to the patient that prevents its use (privacy as information control) or whether the anonymization has removed such restrictions (privacy as a limit on intrusion or accessibility). In *R. v. Department of Health, ex parte Source Infomatics Ltd.* in 1999, the Court of Appeal choose the latter.

In summary the opinion in IMS Health has not fully weighed all the factors and evidence that should be balanced to characterize information according to the purposes of PIPEDA, and the professionals interested as in this issue may still pursue their remedies, either individually or as a group.

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Paul Jones practises privacy, distribution, intellectual property and competition law in the Toronto office of Miller Thomson LLP.