The Obligation of Information Sharing - What Physicians and Other Regulated Health Care Professionals Should Know

Families can be key sources of important collateral information in medical assessments, especially for mental health problems where a person's reliability as a historian can be compromised by their illness. Unfortunately, potentially critical caregiver-physician communication often fails to occur due to a mistaken belief that privacy laws prevent all communication with caregivers without explicit consent.

This is incorrect. In most cases, patient hesitation to share health information relates to specific sensitive information like drug use or sexual history. Clarifying which information a patient wishes to keep private can open doors to communicating information caregivers are most interested in such as diagnosis and the treatment plan. Even in cases where a patient refuses to share any information, physicians ***can always listen*** to caregivers without sharing any health information. Physicians are always permitted to :

1. provide information that is publicly available to a trusted caregiver about healthcare *[1]*
2. listen to caregiver families; this does not violate confidentiality (confidentiality in law applies to what the physician may tell a caregiver not what a caregiver may tell the physician) *[2]*
3. accept collateral (i.e., medically relevant) information from trusted caregivers that is necessary to provide timely and appropriate care *[3]*
4. protect the source of collateral information when there is a risk of serious harm to the treatment or recovery of the individual, or harm to the mental or physical health of another individual *[4]* **.**
5. provide general information such as location, presence and condition to trusted caregivers unless expressly denied by the patient *[5]*
6. provide information without consent to avert or minimize significant danger*, [6]*
7. collect information from others if the information is reasonably necessary for providing health care or assisting in providing health care to the individual and it is not reasonably possible to collect, directly from the individual , direct collection would prejudice the safety of the individual or another person, or to assemble family history.*[7]*
8. make a capacity determination if there is reason to do *so* [8]
9. appoint a substitute decision maker (SDM) if the patient is or becomes incapable of understanding the situation or information or understanding the consequences of not consenting to disclose information to the caregiver *[9]*

[1] s.37 PHIA
[2] NSH Information Sharing Guidelines
[3] s.31c, d, e PHIA
[4] s.72 (1)(f) and (g) PHIA
[5] s.37 PHIA]
[6] s.38(1)(d) PHIA (criteria is "significant danger" as of April 1, 2026)
[7] s.31c, d, e PHIA
[8] s. 3b., s. 18, s. 19, s. 20 PHIA
[9]. 21(1) PHIA, s.17 and 18 IPTA

Related Professional Standards for Physicians

CMPA: **Duty to Report and Duty to Warn and Protect**

Under certain circumstances, physicians may be legally and ethically obliged to disclose confidential information for purposes of warning a third party (e.g. police) to prevent harm (i.e. have permission to warn), based on their professional, ethical, and clinical judgment. For example, privacy legislation may allow physicians to disclose an individual's personal health information, without consent, to avert a serious or significant risk of bodily harm to a person or group, although the specific conditions that must be met vary slightly from one province or territory to the next. In addition, the Canadian Medical Association (CMA)'s Code of Ethics states that a physician may disclose a patient's personal health information to a third party without consent where "the maintenance of confidentiality would result in a significant risk of substantial harm to others or, in the case of incompetent patients, to the patients themselves."

CMPA: https://www.cmpa-acpm.ca/en/education-events/good-practices/medico-legal-matters/**duty-to-report**

CMPA: Collateral Information

Collateral information can typically come from a family member or close friend of your patient.
How you handle collateral information will depend on circumstances. It can be helpful to determine the answer to two questions regarding the information received.

1. Is the information credible?
2. If so, is there any action that needs to be taken?

When answering these questions, use your judgment to consider the following factors:

- The relationship between your patient and the person providing the information
- The person's involvement in your patient's care, and their familiarity with your patient's health
- The context in which the information is being provided

Give thought to the rationale of the person providing the information, and consider whether it is corroborated by other elements of the patient's health and history. Where possible, it can be helpful to undertake your own assessment of the patient to gauge the validity of the information.
If you determine the information is not credible or actionable, it may not be necessary to include it in the medical record. **However, be sure to document any action taken in regard to information provided by a third party.**
Privacy legislation generally permits the collection of collateral information only **if it is reasonably necessary for the provision of healthcare, and if collecting the information directly from the patient is not reasonably possible**. For example, it is often appropriate and necessary to collect collateral information from family members in circumstances where the patient is mentally unwell and threatening to harm themselves. Although it may be appropriate in these types of cases to collect collateral information, you are generally not permitted to share any patient information with the person providing the information without consent or other legal authority.
Receiving collateral information can become a greater challenge when the person providing the information asks you not to share with the patient the fact that they are the source of the information. **While there is no duty of confidentiality to the third party, there may be some exceptions in privacy legislation that permit or require withholding any information that could lead to the identity of the person who disclosed the information and the physician thinks it would be reasonable for the individual's identity to be kept confidential.**

CMPA : https://www.cmpa-acpm.ca/en/advice-publications/browse-articles/2023/there-s-something-you-should-

know-about-your-patient-handling-**collateral-information**

CMPA: **Assessing Decisional Capacity**

An individual who is able to understand the nature and anticipated effect of a proposed medical treatment and alternatives, and to appreciate the consequences of refusing treatment, is generally considered to have the necessary capacity to give valid consent.

An individual who is able to understand the nature and effect of refusing to consent to disclose personal health information (exclude trusted caregivers), and the consequences of refusing to disclose (being isolated from their trusted caregivers), is generally considered to have the capacity to refuse consent to the disclosure.

When a patient seems incapable of consenting or understanding the required information, it is a good practice never to make this assumption without proper assessment.

It is prudent for physicians to document in the medical record the basis for the conclusion of a capacity test. This may include reference to the elements of the applicable test for capacity, the dates and results of any capacity assessments performed, and any second opinions sought.

When a patient is confirmed as being incapable of giving consent, the responsibility for non-urgent care generally falls to a substitute decision-maker, who can be designated by legislation in certain jurisdictions, or by the patient through an advance directive or power of attorney for personal care.

CMPA: https://www.cmpa-acpm.ca/en/advice-publications/browse-articles/2011/is-this-patient-capable-of-consenting