**INFORMATION AND PRIVACY COMMISSIONER OF ALBERTA**

# Investigation Report Concerning Collection and Use of Health Information and the Destruction of Personal Information

**Investigation Report H2011-IR-001 & F2011-IR-001**

**May 25, 2011**

**Alberta Health Services**

**(Investigations H3184 and F5360)**

## Introduction

[1] On November 24, 2009, the Information and Privacy Commissioner (the "Commissioner") received a complaint from an individual (the "Complainant") alleging that his health information had been collected and used by employees of the former Calgary Health Region (CHR), now Alberta Health Services (AHS), in contravention of the *Health Information Act* (HIA).

[2] The Complainant was admitted to the Foothills Medical Centre (FMC) in January 2006 pursuant to an admission certificate under the *Mental Health Act* (MHA). The Complainant states that his father was contacted by a nurse from the FMC without his permission and against his wishes on the day on which he was admitted to the hospital. He also states that a physician at the FMC obtained his consent to collect limited information about him from his father, his friend and his general practitioner (GP) on the second day of his stay in the hospital, but that the information collected went beyond the scope of the consent he provided. The Complainant raised the issue that video recordings that could have substantiated complaints about his care were destroyed after 30 days. The Complainant was also involuntarily admitted to the Peter Lougheed Centre (PLC) in March 2006 under the MHA after going there to "get a second opinion". He states that staff at the PLC obtained and used his records from the FMC without his consent while he was a patient at the PLC.

[3] The Commissioner authorized me to conduct an investigation under section 85(e) of the HIA. Section 85(e) of the HIA allows the Commissioner to investigate whether health information has been collected, used, disclosed or created by a custodian in contravention of that Act.

[4] During the course of conducting my investigation, I determined that the information collected through video recording was not the Complainant's health information as any potentially recorded information did not relate to the provision of a health service. I advised the Commissioner of this finding and he subsequently authorized me to investigate the Complainant's concerns about the destruction of the video recordings under section 53(1)(a) of the *Freedom of Information and Protection of Privacy Act* (the FOIP Act). Section 53(1)(a) allows the Commissioner to conduct investigations to ensure compliance with rules relating to the destruction of records.

[5] This report lays out the findings and recommendations resulting from my investigations.

**Background**

[6] The Complainant voluntarily went to the Emergency Department of the Foothills Medical Centre (FMC) on January 17, 2006 and was subsequently certified under the *Mental Health Act* (MHA)[1]. When a patient is initially certified under the MHA, a facility can care for, observe, examine, assess, treat, detain and control the person named in the certificate for a period of 24 hours from the time the person arrives at the facility. If a second admission certificate is issued for the individual within that initial 24 hour period, the facility is then authorized to care for, observe, examine, assess, treat, detain and control the person named in the certificate for an additional 30 days from the date on which the second certificate was issued.

[7] The Complainant disputes this certification and does not believe that he posed a risk of harm to himself or anyone else during this period.

[8] The Complainant alleges that a nurse contacted his father without his permission on January 17, 2006 and collected information about him. The Complainant states that when asked for permission to contact others he refused to allow the nurse to contact anyone regarding the issues he was seeking treatment for. The Complainant states that he only provided his father's contact information to the FMC for emergency contact purposes and that the nurse decided to contact his father to collect collateral information "against [his] will and with no valid reason". A psychiatric assessment conducted by the nurse on January 17, 2006 indicates that the nurse collected information from the Complainant's father on that date.

[9] The Complainant also states that a psychiatrist at the FMC told him that she needed to speak with three people who would confirm that he was not a threat to himself or others before she would be able to cancel the admission certificate that had been issued under the MHA. The Complainant states that he provided the psychiatrist with a limited consent for this purpose on January 18, 2006 but that he learned after being discharged from the hospital that the psychiatrist had collected much more information than he believed he had consented to. The January 18, 2006 Multidisciplinary Progress Record documents that the psychiatrist collected health information from the Complainant's father, friend and general practitioner (GP) on that date. The Complainant believes that these actions directly led to the breakdown of his relationship with his family and family physician.

[10] The Complainant states that he attempted to obtain access to video recordings made of him while at the FMC, but was told by CHR that all video recordings are destroyed after 30 days. The Complainant believes that these videotapes will refute the observations made by the health professionals that provided treatment and care to him and will prove that he should not have been certified under the MHA. The Complainant believes that the CHR was not authorized to destroy these records.

[11] The Complainant went to the Peter Lougheed Centre (PLC) on March 2, 2006 to obtain a second opinion, and was subsequently involuntarily admitted to that facility until March 15, 2006 under the MHA. The Complainant believes that staff at the PLC inappropriately obtained access to his records from the FMC and used them without his consent during this period. The exchange of information between the FMC and PLC is

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[1] A patient has been certified and becomes a formal mental patient under the *Mental Health Act* when two physicians have issued admission certificates for the individual. An admission certificate document that a physician has reached the opinion that the person examined is suffering from a mental disorder, is in a condition presenting or likely to present a danger to himself or others and is unsuitable for admission to a facility other than as a formal patient.

documented in the Complainant's PLC chart. He believes this exchange of information negated his ability to receive an unbiased second medical opinion.

[12] The Complainant raised other concerns related to the health services provided to him during these admissions and his certification under the *Mental Health Act* (MHA). On December 9, 2009, I wrote to the Complainant and established the issues I would be considering in this investigation. I advised the Complainant in that same letter that our Office does not have jurisdiction to address his concerns about the care and treatment he received while a patient at the FMC and PLC, the conduct of health service providers nor do we have jurisdiction to review whether or not his certification under the MHA was appropriate. I advised the Complainant of the review bodies that may be able to be of assistance to him in relation to these elements of his complaint.

[13] Finally, the Complainant was provided with an opportunity to review and comment on a draft of this Investigation Report and wishes it to reflect that he disputes the accuracy of the observations of the health services providers contained herein. He does not believe that the report accurately reflects what happened to him in the hospital. While I acknowledge the Complainant's position, I have confirmed through another review that the information considered as part of my investigation accurately reflect the health services providers' professional opinions and observations in relation to the Complainant. While the Complainant may dispute the opinions and observations of those involved in his care, their opinions and observations are accurately reflected in this report.

**Application of the HIA and the FOIP Act**

[14] This complaint was received in 2009 and relates to activities which occurred in 2006. Both the *Health Information Act* (HIA) and the *Freedom of Information and Protection of Privacy Act* (the FOIP Act) have been amended since that time. This report considers the collection, use and disclosure of information within the legislative regime in force at that time.

[15] The HIA applies to "health information" in the custody or under the control of a "custodian".

[16] "Health information" is defined in section 1(1)(k) of the HIA to include "diagnostic treatment and care information", "health services provider information" and "registration information"[2]. I have reviewed the records provided by the Complainant in support of his allegations about the unauthorized collection of his health information. These records contain a mixture of diagnostic treatment and care information, health services provider information and registration information. I have reviewed the information at issue in this case and confirm that it is the Complainant's health information.

[17] The term "custodian" is defined in section 1(1)(f) of the HIA, and includes:

> *(f) "custodian" means*
>
> *…*
>
> *(iv) a regional health authority established under the Regional Health Authorities Act;*
>
> *…*

[18] The complaint relates to the collection and use of health information in early 2006. At that time, the FMC and PLC were both hospitals operated by the Calgary Health

[2] These terms are further defined in sections 1(1)(i), 1(1)(o) and 1(1)(u) of the *Health Information Act* and section 3 of the *Health Information Regulation.*

Region (CHR). The CHR was a regional health authority established under the *Regional Health Authorities Act* (RHAA) and, as such, was a custodian as defined in section 1(f)(iv) of the HIA. On April 1, 2009, the nine separate regional health authorities were amalgamated to become a single regional health authority, Alberta Health Services (AHS). When CHR's operations were assumed by AHS, AHS became the custodian of the Complainant's health information and is the custodian that responded to this investigation.

[19] As the information collected about the Complainant is health information and the Calgary Health Region was a custodian, I find that the *Health Information Act* (HIA) applies to the collection and use of the Complainant's health information.

[20] The HIA only applies to health information in the custody or under the control of a custodian. In order for information to be health information, it must relate to the provision of a health service to an individual. In the course of conducting this investigation, I was advised by AHS that any video recordings of the Complainant made during his admissions would not have included recording the provision of a health service given the nature of video surveillance at its acute care sites. This raised the possibility that the destruction of the videotapes did not occur under the HIA but rather occurred under the *Freedom of Information and Protection of Privacy Act* (the FOIP Act).

[21] In order to allow me to fully consider the potential destruction of the Complainant's personal information and to determine which of these laws apply, the Commissioner extended my authority in this case to consider whether or not videotapes containing the Complainant's personal information were destroyed in contravention of the FOIP Act.

[22] The FOIP Act applies to "personal information" in the custody or under the control of a "public body".

[23] "Personal information" is defined in section 1(n) of the FOIP Act as recorded information about an identifiable individual. A video recording of an individual is the individual's personal information if the individual is identifiable in the video.

[24] The term "public body" is defined in section 1(p)(vii) to include a "local public body". The term "local public body" is defined in section 1(j) to include a "health care body". The term "health care body" is defined in section 1(g) and includes a provincial health board established under the RHAA. I have previously established that the CHR was a regional health authority under the RHAA. As such, I find that the CHR was also a public body under the FOIP Act.

[25] I have found that CHR is a custodian under the HIA and a public body under the FOIP Act. I must now consider which of these statutes apply to video surveillance footage taken at the FMC and PLC.

[26] The Complainant has stated that he was placed under audio and video surveillance while in treatment areas at both facilities. I asked AHS about the use of surveillance cameras at the FMC in January 2006 and the PLC in March 2006. AHS advised me that motion activated video cameras recorded public areas in the emergency department, pharmacy, giftshop and parkade at both facilities. Cameras did not operate in areas where health services were provided. The cameras operated on a time lapse capture, where one video image was recorded every 12 seconds. None of the cameras recorded audio.

[27] AHS strongly refutes the Complainant's belief that he was recorded in treatment areas although they concede that the Complainant's image was recorded when he passed through the emergency department, pharmacy, giftshop or parkade at the FMC and PLC. AHS states that it did not collect the Complainant's health information through video recordings at the hospital because it did not collect information during the provision of a health service to the individual. It states that the only time the Complainant would have been subject to video surveillance was while he was in a public area of the hospital and that any collection of information in these circumstances would have been a collection of personal information under the FOIP Act. I agree with AHS on this point – in order for information to be health information, it must be information collected during or related to the provision of a health service. No health service is being provided to an individual when they walk through a parkade, wait in a public waiting area or shop in a hospital giftshop. I did not find any evidence to suggest that the Complainant was recorded in any fashion outside of these areas. I specifically did not find evidence of the use of surveillance cameras in treatment areas at these hospitals in 2006.

[28] I agree with CHR that any information collected through video surveillance would not have related to the provision of a health service. As such, it cannot be health information that is subject to the HIA. I therefore find that the FOIP Act applies to the destruction of any of the Complainant's personal information collected through video surveillance at the FMC and PLC.

**Issues**

[29] The issues to be considered in this investigation are:

1. Did CHR collect the Complainant's health information in contravention of the HIA?
    a. Did the nurse collect the Complainant's health information in contravention of the HIA on January 17, 2006?
    b. Did the psychiatrist collect the Complainant's health information in contravention of the HIA on January 18, 2006?

2. Did CHR destroy the Complainant's personal information in contravention of the FOIP Act when it destroyed video recordings after 30 days?

3. Did staff at the FMC use health information in contravention of the HIA when they obtained the Complainant's health information from the FMC?

**Analysis**

Issue 1 – Did CHR collect the Complainant's health information in contravention of the HIA?

[30] The Complainant has raised two issues related to the collection of his health information. The first issue is that a nurse with Psychiatric Assessment Services collected his health information from his father on January 17, 2006. The Complainant states that he did not provide his father's contact information to the hospital for the purpose of collecting his health information; he states he provided this information only for emergency contact purposes. The second issue the Complainant raised is that the psychiatrist did not adhere to the terms of the consent he provided and collected too much information from his father, his friend and his GP on January 18, 2006. The Complainant believes he only authorized collection about whether or not these people felt he was a threat to himself or others. As the circumstances surrounding each collection

of health information are distinct, I must consider each collection as a separate sub-issue.

*Issue 1A – Did the nurse collect the Complainant's health information in contravention of the HIA on January 17, 2006?*

[31] The Complainant voluntarily went to the Foothills Medical Centre (FMC) emergency department on January 17, 2006 and requested that he be given a drug test to prove that he had been drugged by his ex-girlfriend's father. The Complainant also advised staff at the emergency department that he was being directed to harm himself and others while under the influence of these drugs. A physician at FMC completed a "Form 1 Admission Certificate" (an admission certificate) for the Complainant under the *Mental Health Act* (MHA) that day and referred the Complainant to Emergency Department Psychiatric Assessment Services.

[32] A nurse on the Psychiatric Assessment Service completed a formal assessment on the Complainant on January 17, 2006. The Complainant states that the nurse asked for his permission to contact others to obtain additional information about his health during this assessment. The Complainant states:

> *"I would not allow [the nurse] to speak with anyone regarding these issues. I could tell she was not being objective to my situation and wanted to discredit me with others. [The nurse] decided to contact my father against my will, with no valid reason.*

[33] The Complainant states that he only provided his father's contact information during the admission process after he was promised that it would only be used to contact his father in an emergency. The Complainant states that he was told an emergency would be "a life threatening situation such as a heart attack or a very bad reaction to medication."

[34] The Complainant's reluctance to allow for others to be contacted is documented in the Psychiatric Assessment of January 17, 2006, where the nurse conducting the assessment wrote under the heading "Collateral Information"[3] that the Complainant would not give the full names and phone numbers of friends. The nurse follows this by indicating she spoke with the Complainant's father and describes the father's observations of the Complainant's behaviors. The Complainant presumes that the psychiatric nurse obtained his father's contact information from the admission forms and used it when he would not provide her with the contact information during their interview. AHS does not dispute that the nurse collected the Complainant's health information from his father on January 17, 2006.

[35] While the Complainant has not expressly raised it as an issue, I must determine whether or not AHS had authority to collect the Complainant's health information before I can turn my mind to the assessment of direct versus indirect collection.

[36] The Complainant's health information was collected from his father during the course of completing a psychiatric assessment, which had been ordered by the physician who determined that the Complainant needed to be detained, assessed and treated under the provisions of the MHA. The purpose of this assessment was to assess, diagnose and develop a treatment plan for the Complainant's illness.

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[3] Collateral information is the term generally used by health care providers to refer to information collected from third parties. In a mental health setting, it is often used to supplement and evaluate information provided by the patient.

[37] Section 20(b) of the HIA allows a custodian to collect health information if the information relates directly to and is necessary to enable the custodian to carry out a purpose that is authorized under section 27. Section 27(1) of the HIA authorizes a custodian to use health information to provide health services. Assessing, diagnosing and treating an illness are all elements of a "health service" provided to an individual as defined in section 1(1)(m) of the HIA.

[38] AHS collected the Complainant's health information on January 17, 2006 for the purposes of assessing, diagnosing and treating the Complainant's illness. The collection of health information for these purposes is authorized by section 20(b) of the HIA. I therefore find that AHS had authority to collect the Complainant's health information and can now consider whether or not the indirect collection of health information was authorized in this case.

[39] Section 22(1) of the HIA states that health information must be collected from the individual who is the subject of the information unless section 22(2) of the Act authorizes indirect collection.

[40] AHS believes it had authority to indirectly collect the Complainant's health information under sections 22(2)(c) and 22(2)(d) of the HIA. These provisions read:

> *22 (2) A custodian may collect individually identifying health information from a person other than the individual who is the subject of the information in the following circumstances:*
>
> *…*
>
> *(c) where the custodian believes, on reasonable grounds, that collection from the individual who is the subject of the information would prejudice*
>
> *(i) the interests of the individual,*
>
> *(ii) the purposes of collection, or*
>
> *(iii) the safety of any other individual,*
>
> *or would result in the collection of inaccurate information;*
>
> *(d) where collection from the individual who is the subject of the information is not reasonably practicable;*

[41] In responding to my questions about the application of these provisions of the Act, AHS states that the health services providers responsible for the Complainant's care on January 17, 2006 identified that the patient potentially posed a risk of imminent harm to others as well as to himself and that he suffered from homicidal/suicidal ideations and delusional thoughts. AHS stated that the health services providers determined that the collection of collateral information was necessary to determine whether or not the patient actually presented a potential risk to himself or others and was likely to act on his delusions. The providers determined that the required assessment could not reasonably be conducted solely on the basis of information provided by the Complainant given the nature of his presentation on that day. They believed it unlikely that they would be able to collect accurate information from the Complainant about the potential threat he posed to himself or others and that the only way this could reasonably be assessed would be to collect information about the Complainant's behaviors and symptoms from others who had had a chance to interact with him over time. AHS believes that the indirect collection of health information was permitted for all these reasons.

[42] The psychiatric assessment completed by the nurse indicates that the Complainant's father advised that his family was very worried abut the Complainant, and that they had repeatedly encouraged the Complainant to "get help" but that the Complainant had refused. The Complainant's father told the nurse about his

observations of the Complainant's behaviors, including responding to noises in the middle of the night. The Complainant's father stated he never heard or saw the Complainant responding to any hallucinations, but that he often recounted nighttime invasions the next day. The Complainant's father advised the nurse that this behavior was relatively new and that it began after the Complainant broke up with his girlfriend. The Complainant's father denied any knowledge of the Complainant voicing any homicidal or suicidal ideations.

[43] The nature of the psychiatric assessment being conducted by the nurse was such that to collect information only from the Complainant would be to only partially investigate the potential for harm. The health services providers involved in the Complainant's care believed that they would not reasonably be able to collect accurate information from the Complainant. They also required information about the Complainant's behaviors and presentations that could not reasonably be collected from him. For example, the Complainant could not reasonably be expected to speak to his father's observations of his behavior. To illustrate this point, the Complainant stated that people were coming into his home while he slept, drugging him and suggesting he harm himself or others. The Complainant lived with his father at the time – when the nurse collected information from the father on this point, she was attempting to determine if the Complainant's statements were based in fact or were symptoms of an illness. The nurse could not collect information from the Complainant about his father's observations as the Complainant could not be relied upon to provide accurate information about his father's observations.

[44] Section 22(2)(c) of the HIA allows a custodian to indirectly collect health information where direct collection would result in the collection of inaccurate information. Section 22(2)(d) of the HIA allows indirect collection where collection from the individual who is the subject of the information is not reasonably practicable. In my opinion, AHS's authority to indirectly collect health information in these circumstances is clear. The Complainant was, at the time the nurse conducted the assessment, subject to a certificate under the *Mental Health Act*. A physician had made the professional decision that the Complainant was suffering from a mental disorder, posed a risk of harm to himself or someone else and needed to be detained as a formal mental patient. The certificate allowed AHS to detain, assess and treat the patient for a period of 24 hours. An essential part of AHS's assessment of the Complainant was to determine whether or not the patient posed a risk of harm to himself or others. I agree with AHS that there was a reasonable likelihood that direct collection would result in the collection of inaccurate information in these circumstances. I also agree that AHS needed to collect some health information that the Complainant simply could not provide and, therefore, that direct collection was also not practicable.

[45] I find that AHS was authorized to indirectly collect the Complainant's health information on January 17, 2006.

*Issue 1B – Did the psychiatrist collect the Complainant's health information in contravention of the HIA on January 18, 2006?*

[46] The Complainant also alleges that his health information was collected inappropriately by a psychiatrist on January 18, 2006.

[47] The Complainant states that the psychiatrist advised him that she would cancel the admission certificate and release him from the hospital if he allowed her to speak with three people who confirmed that he was not a threat to himself or others. The Complainant states that he provided the psychiatrist with his written consent to discuss whether or not he was a threat to himself or others with his father, his friend and his

general practitioner (GP). He believes that the psychiatrist collected more information from these individuals than he had authorized.

[48] A multi-disciplinary progress note (the progress note) dated January 18, 2006 indicates that the psychiatrist was evaluating whether or not a second admission certificate[4] should be issued when she contacted the Complainant's father, friend and GP that day. After collecting the information, the psychiatrist completed a second admission certificate, which refers to information collected from the father and the friend. AHS does not dispute that the psychiatrist collected the Complainant's health information from his father, friend and GP on January 18, 2006.

[49] Before I can consider whether or not AHS collected too much health information, I must establish if AHS had authority to collect the Complainant's health information and, if so, whether it was reasonable to collect that health information indirectly.

[50] I concluded that the collection of the Complainant's health information for the purpose of providing a health service to him on January 17, 2006 was authorized. The purposes for which health information was collected on January 18, 2006 are the same as the reasons that health information was collected on January 17, 2006. I therefore find that AHS was authorized to collect the Complainant's health information on January 18, 2006 for the purpose of providing a health service to him.

[51] Having established that the collection of health information was authorized, I can now consider the indirect collection of health information.

[52] AHS advised me that the Complainant authorized the psychiatrist to collect health information from his father, his friend and his GP and that the authorization was documented on a form. It is AHS's position that the indirect collection of his health information was permitted by section 22(2)(a) of the HIA, which reads:

> *22(2) A custodian may collect individually identifying health information from a person other than the individual who is the subject of the information in the following circumstances:*
>
> > *(a) where the individual who is the subject of the information authorizes collection of the information from someone else;*
> >
> > *…*

[53] I asked AHS to provide me with the form that documents the Complainant's authorization for the psychiatrist to collect the Complainant's health information indirectly. AHS provided me with three forms that read:

> *"I, (Complainant's name), authorize the Calgary Health Region to disclose the following health and or personal information (psych. assess't + treatment planning).*
>
> *The following may be disclosed to (the father, the friend, the GP) for the following purposes only (psych. assess't + treatment planning).*
>
> *I understand why I have been asked to disclose this information and am aware of the risks or benefits of consenting or refusing to consent to disclose this information. I also understand that I may revoke this consent at any time by submitting a written revocation document to the Calgary Health Region"*

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[4] A second admission certificate is sufficient authority to care for, observe, examine, assess, treat, detail and control the person named in the certificate for a period of 30 days from the time the certificate is issued.

[54] A separate form had been issued for the father, the friend and the GP. None of the forms indicate an expiry date but all have been signed by the Complainant and witnessed by the psychiatrist. The information appearing in brackets above was hand written onto the form.

[55] I asked for copies of the authorization forms to determine what limitations, if any, the Complainant placed on the collection of his health information from these sources. What I found when I reviewed the form is that the form is a consent to disclose health information to the father, the friend and the GP under section 34 of the HIA. The forms do not contain any form of an authorization to collect health information from these sources

[56] When I advised AHS that the forms did not reflect the Complainant's authorization for the indirect collection of health information, AHS maintained its position that it had the Complainant's authorization to collect health information indirectly whether or not it was recorded on the form. AHS states that the Complainant verbally authorized the psychiatrist to collect health information from the father, the friend and the GP and that the HIA does not require that such an authorization be provided in writing. AHS states that to require express written authorization every time health information is to be collected indirectly would be burdensome and would not reflect the shifting nature of the consent process in healthcare.

[57] I agree with AHS on these points, and note that the HIA does not require a custodian to obtain express authorization for every instance of the indirect collection of health information. The HIA clearly establishes that health information should be collected from the individual who is the subject of the information but acknowledges that there are some circumstances where direct collection is not appropriate. In these cases, health information can be collected indirectly if the individual authorizes the indirect collection or the HIA says that indirect collection can occur. In my opinion, this strikes a necessary balance between a custodian's need to collect health information for authorized purposes and a patient's need to exercise a controlling interest in that health information.

[58] The HIA does not require written authorization for the indirect collection of health information. It is therefore conceivable that authorization for indirect collection could be provided verbally. That being said, I believe that there are circumstances where obtaining written authorization would be advisable or where extra care must be taken to document an individual's expression of authorization. These include situations where authority to collect information indirectly without authorization is questionable, where there is a probability that an individual will contest the authorization after the fact or where the authorization is expressly limited. In these sorts of situations, a custodian is more likely to have its decision to collect indirectly questioned and will find itself in a position where it must demonstrate that indirect collection was, in fact, authorized by an individual. Without sufficient documentation, I suspect that a custodian will never be in a position to prove that such authorization was given.

[59] In the case currently before me, the Complainant's reluctance to allow for others to be contacted about his care and to allow for the indirect collection of health information is well documented. There are at least three places in the patient chart where the Complainant has expressly refused to allow for third party contact. The health services providers involved in his care were aware of his concerns and decided that his authorization to allow for indirect collection would need to be obtained. AHS staff attempted to document the Complainant's express written authorization on the forms

used. The Complainant believed that he was authorizing limited indirect collection on these forms.

[60] Although AHS's intent to collect health information indirectly through authorization by the Complainant is clear, the use of "consent to disclose" forms as opposed to authorization to collect forms renders this moot. AHS finds itself in a position of being unable to prove that the Complainant authorized the indirect collection of his health information or to demonstrate that it noted and considered the limitations on indirect collection stipulated by the Complainant. As such, AHS is unable prove that the Complainant authorized indirect collection under section 22(2)(a) of the HIA.

[61] As AHS is unable to rely upon section 22(2)(a), I must consider whether or not other provisions of the HIA authorize the indirect collection of health information. I believe that AHS can rely on the authority of sections 22(2)(c) and 22(2)(d) for the collection of health information from the father and friend and section 22(2)(g) for the collection of health information from the GP. Section 22(2)(c) allows for the indirect collection of health information where direct collection is likely to result in the collection of inaccurate information. Section 22(2)(d) allows for the indirect collection of health information where collection from the individual who is the subject of the health information is not reasonably practicable. Section 22(2)(g) allows for the indirect collection of health information where the disclosure of that information is permitted under Part 5 of the Act.

[62] In my consideration of the previous issue, I established that the health services providers involved in the Complainant's care needed to collect health information about him that he was simply not in a position to provide. He could not provide information about how long others had been observing symptoms of his illness. He could not describe other parties' observations of his behavior. He could not tell the psychiatrist whether or not his father and his friend believed him to be a threat to his own safety or the safety of others. The health services providers believed that the information provided by the Complainant in response to these questions would be inaccurate given the nature of the illness they suspected. The Complainant's presentation did not materially change between January 17 and 18, 2006. I am satisfied that the health services providers faced the same challenges in the direct collection of health information from the Complainant on January 18th as they did on January 17th . I do not believe that the direct collection of this information from the Complainant on January 18th was any more practicable or likely to result in the collection of accurate information than it was on January 17th.

[63] With respect to the collection of health information from the Complainant's GP, the HIA allows a custodian to collect health information indirectly where the disclosure of the information is authorized by Part 5 of the Act. Part 5 of the HIA establishes when a custodian can disclose health information. The Complainant's GP, as a custodian, is permitted under section 35(1)(a) of the HIA to disclose health information to another custodian for the purpose of providing a health service. In this case, this means that the GP was permitted to disclose the Complainant's health information to AHS for the purpose of providing health services to the Complaint. As the GP was permitted to disclose the information to AHS for the purpose of providing a health service to the Complainant, AHS was allowed by section 22(2)(g) of the HIA to collect that health information indirectly.

[64] I believe that AHS had grounds in this case to collect the Complainant's health information indirectly, even without his authorization. That being said, I do not believe that this will be the case all of the time, as it is conceivable that some individuals who have been certified under the MHA will be able to provide accurate information and there

will be circumstances where the collection of information from the individual will be practicable. This will be highly dependant on the circumstances of each case.

[65] Health care providers involved in the collection of health information need to be able to understand when patient authorization is required and when it is not. They must also understand what constitutes appropriate documentation of such authorization as they may need to rely on it in the future. I do not believe that AHS did a reasonable job of advising the Complainant of the rationale for the indirect collection of health information in this case, nor did it appropriately document the Complainant's express authorization. I believe that AHS's approach to soliciting and obtaining authorization for the collection of collateral information in this case contributed to the Complainant's confusion about his control over his information and privacy rights. I will be making a number of recommendations to AHS in this regard.

[66] However, my concerns about process aside, I find that AHS ultimately had authority to indirectly collect the Complainant's health information from his father, his friend and his GP. Having established that AHS was authorized to collect the Complainant's health information indirectly, I can now consider whether or not the psychiatrist collected too much health information.

[67] Section 58(1) of the HIA requires a custodian to collect only the amount of health information required to allow them to carry out the intended purpose. It reads:

> *58(1) When collecting, using or disclosing health information, a custodian must, in addition to complying with section 57, collect, use or disclose only the amount of health information that is essential to enable the custodian or the recipient of the information, as the case may be, to carry out the intended purpose.*

[68] The Complainant's father provided the psychiatrist with information about his observations of the Complainant's behavior. The father stated that the Complainant was not behaving in a threatening fashion, nor did he believe him to be a physical threat to anyone.

[69] The friend told the psychiatrist that the Complainant had been telling him of bizarre recollections for the past 3 – 4 months, but that he did not recall any threats and that the Complainant's self-care had been good.

[70] The GP provided more detailed information including a description of the Complainant's beliefs of persecution, nighttime interrogations and abduction. The GP stated that a previous psychological evaluation had confirmed that the Complainant suffered from delusions. The GP advised that the Complainant refused to follow-up with mental health services. The GP advised that the Complainant told him that his ex-girlfriend was considering getting a restraining order against him and that there was some question as to possible damage to a motor vehicle[5].

[71] I believe that the requirements of the MHA bear consideration when looking at the indirect collection of health information in this case. The MHA requires the physician to

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5 The Complainant believes that the individuals in question did not make these statements to the psychiatrist. The Complainant has requested that AHS correct this information, but has been refused on the basis that the statements accurately reflect the psychiatrist's observations and understandings of what she was told by the individuals on the day in question. AHS's decision to refuse to correct these statements has been confirmed under case file H3256. Of particular note, the Complainant states that he never told his GP that his girlfriend was considering a restraining order, although the psychiatrist has confirmed that this is an accurate reflection of her understandings of what was told to her by the GP.

declare that the patient is suffering from a mental disorder, is in a condition presenting or likely to present a danger to himself or others and is unsuitable for admission to a facility other than as a formal patient when issuing a certificate. A physician is required to document the reasons for his decision, including a description of the facts that he observed and the facts that were communicated to him by others. The form used for this purpose states that these two sections must be completed. To certify a patient, a physician must have made his own observations of the patient, and must have considered relevant facts as communicated to him by others. A physician cannot certify a patient in the absence of his own observations leading him to form an opinion of the potential for harm, nor can he certify a patient without an examination of the facts provided to him by others.

[72] After conducting the telephone interviews with the father, the friend and the GP, the psychiatrist determined that it was necessary to complete a second admission certificate for the Complainant, which allowed for him to be detained and treated for an additional 30 days. The psychiatrist noted her observations in section (i) of the admission certificate she completed after speaking with the father, the friend and the GP. I will not document those here as they are not relevant to the complaint. In section (ii) she notes:

- Friend states patient c/o (complained of) invasion in hotel room when (friend's name) present. Did not occur.
- Father states patient c/o (complained of) abduction/torture/drugged (self and father). Did not occur. Patient sent letters to dentist he believes involved in (illegible), telephone calls to ex-girlfriend re: same, both deny.

[73] The Complainant acknowledges that the psychiatrist collected his health information for the purpose of determining whether or not he was a threat to himself or others but contends that too much health information was collected. It appears to me that the Complainant wanted his father and his friend to be asked whether or not they believed him to be a threat to himself or others. Instead, the psychiatrist took a more exploratory approach to her questioning and did not limit her questions to the direct questions that the Complainant expected.

[74] The question the psychiatrist was being asked to consider was whether or not the Complainant was at risk for harm. This question is significantly broader than whether or not the Complainant or others felt he was at risk of harm. In asking the friend and the father questions about specific scenarios the Complainant described to her, it is apparent that the psychiatrist was attempting to understand the extent of the Complainant's perceived delusions and illness. She asked questions to get a better picture of the Complainant's function over time. She indirectly asked questions to determine how likely the Complainant was to act on impulses. The reason that psychiatrist asked these questions in the manner that she did was because she was collecting health information from non-medical professionals. The psychiatrist had the medical knowledge and expertise to determine whether or not the Complainant was at an increased risk of harming himself or others. The friend and the father did not. The psychiatrist asked the questions that she did to collect the information she needed to make a professional medical opinion as to the potential risk of harm.

[75] It is reasonable that the psychiatrist collected the information she did to assess the potential for harm. I have reviewed the records that document the collection of health information from the father, friend and GP and find no evidence of excessive collection. While the psychiatrist obviously asked the father, friend and GP for more information than their opinion of the Complainant's risk of harm to himself or others, she did not ask for information that was unrelated to the assessment that she needed to conduct. The

psychiatrist limited her collection of health information to that which was required to fulfill the intended task.

[76] I find that the psychiatrist's collection of the Complainant's health information on January 18, 2006 was authorized.

*Issue 2* – Did CHR destroy the Complainant's personal information in contravention of the FOIP Act when it destroyed video recordings after 30 days?

[77] The second issue that the Complainant raised in his letter to the Commissioner was that recorded images from the hospital surveillance system are not retained for longer than 30 days. The Complainant believes that reviewing the recordings of his time at the hospital would substantiate complaints he made about his care and disprove the health services providers' observations of him that were ultimately used to certify him under the MHA. It is his position that his "normal" behaviour while passing through the hospital common areas stands in contrast to the behaviours described in his medical records. He believes that having evidence of his normal conduct in public areas of the hospital would refute the observations of the health services providers that were ultimately used to certify him under the MHA. The Complainant also states that there was audio recording equipment in the treatment rooms he occupied.

[78] I have already described the limited use of surveillance cameras at the FMC and PLC when establishing that the FOIP Act applies to the destruction of this information as opposed to the HIA. I have already stated that I found no evidence to confirm the Complainant's belief that he was subject to surveillance or recording while in treatment areas at either of these facilities.

[79] AHS concedes that it is possible that Complainant's image was recorded when he passed through the emergency department, pharmacy, giftshop or parkade of these facilities. As part of this investigation, I confirmed with AHS that none of the videos of these areas made while the Complainant was a patient were retained beyond the 30 day period. At the end of the documented retention cycle, the videotapes were securely destroyed. This means that any and all video image made of the Complainant during his periods of hospitalization were destroyed before the end of April 2006.

[80] AHS advised me that CHR had completed a privacy impact assessment (PIA) on the use of video surveillance at acute care sites in 2006. This PIA unequivocally states that the provision of health services will not be subject to surveillance and describes the collection of personal information for the purpose of maintaining a safe and secure environment for patients and staff. It also identifies the risks to privacy that are introduced by the use of video surveillance and describes how these risks are to be managed. CHR positioned the destruction of tapes in 30 days as a method through which the increased risks to privacy inherent to the use of video surveillance can be minimized. CHR stated that it intended to retain the information only long enough to determine that the recordings were of no use to them for the stated purpose of pursuing law enforcement matters. CHR stated that it intended to minimize the potential risks to privacy by recording only video images and specifically excluding recording of treatment areas.

[81] AHS provided a Departmental Policy on "Acute Care Site Video Surveillance" with the PIA. This policy clearly states that video footage will be destroyed after 30 days unless a portion of the video needs to be retained for a longer period of time due to a court proceeding and/or pending/ongoing investigation. After the 30 day period, the videotapes are to be destroyed in a safe and secure manner.

[82] The Commissioner's power in relation to conducting investigations into the destruction of records under the FOIP Act are found in section 53(1)(a), which reads:

> *53(1) In addition to the Commissioner's powers and duties under Part 5 with respect to reviews, the Commissioner is generally responsible for monitoring how this Act is administered to ensure that its purposes are achieved, and may*
>
> > *(a) conduct investigations to ensure compliance with any provision of this Act or compliance with rules relating to the destruction of records*
> >
> > > *(i) set out in any other enactment of Alberta, or*
> > > *(ii) set out in a bylaw, resolution or other legal instrument by which a local public body acts or, if a local public body does not have a bylaw, resolution or other legal instrument setting out rules related to the destruction of records, as authorized by the governing body of a local public body,*

[83] When the Commissioner authorized me to investigate this element of the complaint, he authorized me to determine whether or not the CHR had complied with rules related to the destruction of records.

[84] I determined during my investigation that CHR did not pass a bylaw or resolution related to maintaining video recordings of surveillance activities. CHR management did; however, approve a policy that stipulates that the video recordings arising from surveillance at its acute care sites were to be destroyed after 30 days if the videotape was not required for law enforcement or investigation. Such a policy constitutes authorization from the CHR governing body to destroy video surveillance recordings after 30 days if the videotape is not required for law enforcement purposes.

[85] CHR's policy states that recordings not required to proceed with a law enforcement investigation would be destroyed after 30 days. When CHR destroyed the videotapes made during the Complainant's inpatient admissions after 30 days, it was adhering to its own duly approved policy related to the destruction of personal information. I therefore find that CHR did not contravene the FOIP Act when it destroyed videotapes from the FMR for the period of January 2006 and from the PLC for the period of March 2006.

*Issue 3 - Did staff at the FMC use health information in contravention of the HIA when they obtained the Complainant's health information from the FMC?*

[86] The Complainant voluntarily presented at the Peter Lougheed Centre (PLC) on March 2, 2006 where he was admitted until discharge on March 15, 2006. As with his previous admission, the Complainant was subject to two Admission Certificates under the *Mental Health Act* (MHA) during this time.

[87] After an initial assessment, the emergency room physician treating the Complainant directed staff to obtain historical medical information from the Complainant's January 2006 admission to the FMC. The FMC responded to the physician's request by faxing 12 pages of medical records to the PLC, including a discharge summary, emergency report, history and physical, psychiatric assessment and physician's consultation report. The Complainant believes that the FMC should not have provided this information to the PLC without his consent. He believes that the exchange of this information between the facilities fettered his ability to obtain an unbiased second opinion. He states that he was told by a Calgary Health Region employee that a hospital requires his explicit consent before sharing information with another hospital.

[88] I have previously established the FMC and PLC were both facilities operated by the former Calgary Health Region. As the CHR was the custodian of records generated at both facilities, the release of health information from one facility to the other within the health region constituted a "use" of health information as opposed to a "disclosure" of that information[6].

[89] AHS told me that the PLC physician requested the information from the FMC to assist with treatment decisions and to avoid duplication of health services. I asked AHS what its authority was to use the information in question for this purpose. AHS stated that it has authority under section 27(1) of the HIA, which reads:

> *27(1) A custodian may use individually identifying health information in its custody or under its control for the following purposes:*
>
> *(a) providing health services;*
>
> *...*

[90] The term "health service" is defined in section 1(1)(m) of the HIA. A health service is a service provided to an individual for the purpose of protecting, promoting or maintaining physical and mental health, preventing illness and diagnosing and treating illness.

[91] The physician requested the Complainant's health information from the FMC for the purpose of assessing and treating the Complainant. He needed to know what diagnosis had been made during the Complainant's previous hospitalization for the same complaint. He also needed to know what treatments had been ordered for the Complainant during that time. This is not to say that the physician was in any way bound to follow the same course of treatment that had been prescribed by the FMC or arrive at the same diagnosis. It is possible that the physician could have considered the information provided by the FMC along with his own observations and arrived at a different position with respect to diagnosis and treatment.

[92] I agree with AHS that it was authorized by section 27(1)(a) of the HIA to use the Complainant's health information for the purpose of providing a health service to him. Section 27 of the HIA does not require the consent of the individual to use health information for the stated purposes. Despite what he may have been told by others, neither the PLC nor the FMC were legally required to obtain the Complainant's consent before exchanging information that was required to provide a health service to him. It is outside the jurisdiction of this Office to speak to whether or not the exchange of this information resulted in a deviation from an appropriate standard of care that the Complainant was entitled to receive.

[93] I find that AHS did not contravene the HIA when staff at the PLC obtained information related to the Complainant's previous hospitalization at the FMC without his consent.

**Recommendations**

[94] At the conclusion of my investigation, I made the following recommendations to AHS:

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6 The distinction between use and disclosure of health information is further discussed in Investigation Report H2008-IR-001. A custodian uses health information when that information is maintained within its organizational boundaries. A custodian discloses health information when it is shared with someone else outside of the organization.

1. AHS should develop an authorization form that is to be used by staff when relying on section 22(2)(a) of the HIA as authority to collect health information indirectly

2. AHS should develop guidelines for the indirect collection of health information and make these guidelines available to staff

3. AHS should develop a training and awareness strategy that describes how staff that in work areas that rely regularly on the indirect collection of health information (mental health, pediatrics, etc) will be advised of the guidelines and authorization forms

4. AHS must provide these materials to the Information and Privacy Commissioner for review and comment within 60 days of the public release of this Investigation Report

[95] Release of this Investigation Report has been delayed at the request of the Complainant, although the investigation was concluded in June 2010. AHS accepted my recommendations on June 16, 2010 and advised me of a broader project that would review and revise patient-centered communication materials that address the collection of health information. AHS integrated my recommendations into this project and provided the materials to me for review and comment before the materials were rolled out in early September 2010. I appreciate AHS's acceptance of my recommendations and their patience awaiting release of this report.

**Conclusion**

[96] The Complainant alleged that his health information was inappropriately collected and used by health services providers providing treatment and care to him during two periods of hospitalization in early 2006. The Complainant believes that his consent for the indirect collection of health information was not obtained and that the terms of his consent, when given, were exceeded.

[97] The HIA does not require consent when health information is collected or used for the purpose of providing a health service to an individual. The elements of the complaint that relate to the unauthorized collection and use of health information are unfounded.

[98] That being said, I found some merit in the complaints about the indirect collection of health information. It is clear to me that the Complainant believed that he had the right to refuse to allow his care team to contact others for the purpose of collecting his health information. His position refusing to allow for others to be contacted or wishing for that contact to be very limited is well documented in his chart. I do not question AHS's authority to ultimately collect the information it needed to provide health services to the Complainant and to collect some of that information from sources other than the Complainant. What I do question is the decision to proceed to engage in indirect collection while allowing the Complainant to believe that his consent for indirect collection was required and that his wishes related to this were being respected.

[99] My recommendations arising from this case are intended to provide AHS staff with greater clarity on the circumstances where they can rely on legal authority to indirectly collect health information as opposed to these circumstances where patient authorization is required. It is my hope that in better educating staff on these points they will, in turn, be better positioned to respond to questions or challenges to the collection of health information raised by patients during the course of providing health services.

Submitted by

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