ALBERTA

OFFICE OF THE INFORMATION AND PRIVACY COMMISSIONER

ORDERS F2019-19 and H2019-01

May 23, 2019

ALBERTA HEALTH SERVICES

Case File Number 002373

Office URL: www.oipc.ab.ca

Summary: The Applicant made an access request to Alberta Health Services (AHS) for "all records in any form regarding [the Applicant] related to the care of my mother […] (now deceased)".

AHS provided a response to the Applicant under the *Freedom of Information and Protection of Privacy Act*. It withheld some information regarding the Applicant's mother under section 17(1) (disclosure harmful to personal privacy), 24(1)(b) (advice to officials), and 27(1)(a) (privileged information).

The Applicant requested review by the Commissioner of AHS's severing decisions and the adequacy of its search for responsive records.

The Adjudicator determined that the majority of the severed information fell within the terms of the *Health Information Act* (HIA), rather than the FOIP Act, as it was about the Applicant's mother's health and the health services provided to her. As a result, sections 24(1)(b) and 27(1)(a) of the FOIP Act could not apply to the information in the records.

The Adjudicator determined that the information AHS had severed under section 24(1)(b) and 27(1)(a) could not be withheld from a patient or the executor of a patient's estate under the HIA.

The Adjudicator considered the significance of the fact that the HIA does not list solicitor-client privilege as a basis for withholding records from an Applicant, as well as the fact that the HIA does not expressly state that it overrides or abrogates solicitor-client privilege. In this regard, she determined that the duty of utmost fidelity that a physician owes to a patient at common law precludes a physician from asserting solicitor-client privilege as against the patient in relation to the patient's health records.

Statutes Cited: AB: *Health Information Act* R.S.A. 2000, c. H-5 ss. 1, 2, 3, 7, 11, 27, 80, 104; *Freedom of Information and Protection of Privacy Act*, R.S.A. 2000, c. F-25, ss. 4, 10, 17, 20, 24, 27, 72, 84; *Regional Health Authorities Act*, R.S.A. 2000, c. R-10, ss. 3; Regional Health Authority Membership Regulation, A.R. 164 /2000, s. 3

Authorities Cited: AB: Orders F2010-015, H2011-001, F2015-29, H2018-01 **ON:** PO-3872-I

Cases Cited: *Covenant Health v. Alberta (Information and Privacy Commissioner)*, 2014 ABQB 562 (CanLII); *Alberta (Information and Privacy Commissioner) v. University of Calgary*, [2016] 2 SCR 555, 2016 SCC 53 (CanLII); *Canada v. Solosky*, 1979 CanLII 9 (SCC), [1980] 1 S.C.R. 821; *Halls v. Mitchell*, [1928] SCR 125, 1928 CanLII 1 (SCC); *McInerney v. MacDonald*, [1992] 2 SCR 138, 1992 CanLII 57 (SCC); *M. v. Drew (Estate of)*, 2003 ABCA 231; *John Doe v. Ontario (Finance)*, 2014 SCC 36 (CanLII)

I. BACKGROUND

[para 1] On September 16, 2015, the Applicant made a request for access to his deceased mother's health information as the executor of the estate. Case file 002374 was opened to address this access request.

[para 2] On September 17, 2015, the Applicant made a request for records to Alberta Health Services (AHS). In this request, he requested many of the same records that he had requested in the access request for which case file 002374 was opened, but he stated:

> I am seeking the following records containing my personal information pursuant to my access rights under the *Freedom of Information and Protection of Privacy Act*: all records in any form regarding myself related to the care of my mother […] (now deceased) at the Calgary South Health Campus between the dates of July 2, 2014 to and including July 02, 2015. I believe the following personnel may be in possession of such records […]
>
> […]
>
> All records including all personnel assisting in the reduction in the Goals of Care letter authored by Dr. […] addressed to [the Applicant] dated June 15, 2015 […]

[para 3] The Applicant provided the names of the Custodian's employees he believed had created or held responsive records. He also provided descriptions of particular categories of records he was seeking from specific employees and assigned item numbers to these categories. He also described an incident in which he had been

involved and requested records related to an investigation conducted by AHS regarding the incident. On AHS's "Request to Access Information under the Freedom of Information and Protection of Privacy Act" form, which the Applicant completed, the Applicant indicated he was requesting his personal information.

[para 4] Other than the requirement that the requested records contain information about the Applicant, the two access requests describe the same records authored by the same employees of AHS. However, the Applicant did not stipulate that he was acting as the executor of his mother's estate in relation to the access request that is the subject of case file 002373, although he did so in relation to case file 002374. (Order H2018-01 addressed case file 002374. In that order, I directed AHS to conduct a new search for responsive records. In relation to 002373, I am asked to review AHS's search for responsive records and to review whether it severed information appropriately.)

[para 5] AHS responded under the *Freedom of Information and Protection of Privacy Act* (the FOIP Act), stating:

> I am responding to your request of September 17, 2015. Your request reads:
>
> 1. All records related to the following incident:
> ON September 6, 2014 I, [the Applicant], found an empty vial and used needle in washroom, room 660090 on Unit 66. After notifying Charge Nurse, […], security officer […] requested a statement from me and indicated an investigation would follow. I am requesting the officer notes of […], as well as all records from all Security personnel and other personnel involved in the investigation, review or involvement of this matter.
>
> 2. All records respecting a formal complaint I made dated March 30, 2015 re: RN known as […] and LPN […]. This complaint was submitted to […] on, Senior Operating Officer and […], Manager Cardiac Services, South Health Campus and was forwarded to the Patient Relation Department. It is believed […], Patient Concerns Consultant were involved in this investigation;
>
> 3. All records related to an AHS letter provided to me, [the Applicant], by [AHS employees], signed by [AHS employees] dated June 03, 2015 re: Request for Alberta Health Services Care Team of [the Applicant's mother];
>
> 4. All records regarding me authored by Ethics Committee personnel or Board members related to the reduction of the Goals of Care from R2 to Ml for [the Applicant's mother]. These records include any legal opinions or advice from AHS legal counsel or personnel and recordings or notes in any form involving the Ethics Committee, as well as the following personnel in attendance
>
> 5. All records including all personnel assisting in the reduction of the Goals of Care letter authored by Dr. […] addressed to [the Applicant] dated June 15, 2015;
>
> 6. All records regarding me authored in respect of a meeting of AHS personnel including […] and legal representation including [an AHS lawyer] and [a lawyer from Bennett Jones] on Saturday June 20, 2015 at 0730 am on Unit 66 of South Health Campus.
>
> The time period you have specified is from July 2, 2014 to July 2, 2015 inclusive.

AHS explained that it was withholding some information from the Applicant under sections 17 (disclosure harmful to personal privacy), 20 (disclosure harmful to law enforcement), 24 (advice from officials), and 27 (privileged information) of the FOIP Act. It provided the remainder of the records to the Applicant.

[para 6] The Applicant requested review by the Commissioner of the Public Body's response to the access request.

[para 7] The Commissioner authorized a senior information and privacy manager to investigate and attempt to settle the matter. At the conclusion of this process, the Applicant requested an inquiry. The Commissioner delegated her authority to conduct the inquiry to me.

[para 8] The parties exchanged submissions and AHS provided me with a copy of the records at issue.

[para 9] After I reviewed the submissions of the parties and the records at issue, I wrote the parties and raised the issue that the FOIP Act might not be the governing legislation with regard to all the records, particularly those over which AHS was claiming privilege. I asked the parties for submissions as to which Act applied.

[para 10] After I received the submissions of the parties, I issued a revised notice of inquiry and provided the parties with the opportunity to make submissions regarding the revised issues. The revised issues for inquiry are the following:

> 1. Did Alberta Health Services (AHS) meet its duty to the Applicant as provided by section 10(1) of the FOIP Act (duty to assist applicants)? In this case, the Commissioner will also consider whether AHS conducted an adequate search for responsive records.
>
> […]
>
> 2. Does the HIA apply to some or all of the information to which AHS applied provisions of the FOIP Act?
>
> 3. If the HIA applies to records, is AHS authorized to withhold information on the basis of solicitor-client privilege?
>
> 4. Assuming the FOIP Act applies, is AHS authorized to withhold information about [the Applicant's mother] from the executor of her estate on the basis of section 17 (disclosure harmful to personal privacy)?
>
> 5. Assuming the HIA applies, is AHS authorized to withhold information about [the Applicant's mother] from the executor of her estate on the basis that it is her health information?
>
> 6. Assuming that there is authority for AHS to withhold information on the basis of solicitor-client privilege, I ask that it provide evidence to support the claim of privilege over record 94. If its position is that there is a common interest between itself and the author of the email with regard to any advice the email contains, it should do so with the support of evidence from the email's author and any case law of which it is aware.

7. If the FOIP Act applies to the information severed by AHS under section 24(1)(b), did AHS properly apply this provision?

8. If the HIA applies to the information AHS severed under section 24(1)(b), can this information be withheld from the Applicant?

9. If the FOIP Act applies to the information severed under section 20(3), did AHS properly apply this provision? If the HIA applies to this information, can this information be withheld from the Applicant?

[para 11] As part of its submissions, AHS informed me that it was no longer relying on section 20 of the FOIP Act to withhold information from the Applicant.

II. INFORMATION AT ISSUE

[para 12] The information AHS severed from the records is at issue.

III. ISSUES

Issue A: Does the HIA apply to some or all of the information to which AHS applied provisions of the FOIP Act?

Issue B: If the HIA applies to records, is AHS authorized to withhold information on the basis of solicitor-client privilege?

Issue C: Assuming the FOIP Act applies, is AHS authorized to withhold information about [the Applicant's mother] from the executor of her estate on the basis of section 17 (disclosure harmful to personal privacy)?

Issue D: Assuming the HIA applies, is AHS authorized to withhold information about [the Applicant's mother] from the executor of her estate on the basis that it is her health information?

Issue E: If the FOIP Act applies to the information severed by AHS under section 24(1)(b), did AHS properly apply this provision?

Issue F: If the HIA applies to the information AHS severed under section 24(1)(b), can this information be withheld from the Applicant?

Issue G: Did AHS meet its duty to the Applicant as provided by section 10(1) of the FOIP Act (duty to assist applicants)? In this case, the Commissioner will also consider whether AHS conducted an adequate search for responsive records.

IV. DISCUSSION OF ISSUES

Issue A: Does the HIA apply to some or all of the information to which AHS applied provisions of the FOIP Act?

[para 13] AHS argues:

> It is submitted that the applicant's access request deals with information relating to information pertaining to himself and his interactions with AHS; it does not deal with information relating to health information, as defined by section 1(1)(k) of the *Health Information Act* ("HIA"). In particular, the applicant requested all records relating to a particular incident in which he had some involvement, all records relating to a complaint he had made to AHS, and all records related to a specified correspondence and meeting. It is respectfully submitted that those matters are outside the definition of "health information."

[para 14] AHS's arguments do not take into account the breadth of the Applicant's access request or the manner in which it is tied to his mother's health information. The Applicant's access request was not confined to information about an incident in which he was involved; it encompassed information about him relating to his mother's health care and the decision to change her goals of care from R2 to M1.

[para 15] Section 4 of the FOIP Act establishes that the FOIP Act applies to all information in the custody or control of a public body, with the exception of certain types of records, which it enumerates. One such exception is subject 4(1)(u), which states:

> *4(1) This Act applies to all records in the custody or under the control of a public body, including court administration records, but does not apply to the following:*
>
> > *(u) health information as defined in the Health Information Act that is in the custody or under the control of a public body that is a custodian as defined in the Health Information Act.*

[para 16] If information is health information, and it is in the custody or control of a public body that is a custodian, then the FOIP Act does not apply to the information, but the HIA does. AHS is a public body that is a custodian as defined in the HIA, within the terms of section 4(1)(u). As a result, if the information it has severed is health information, the HIA, rather than the FOIP Act, applies to the information.

[para 17] Section 1(1)(k) of the HIA defines the term "health information" for the purposes of the Act. It states:

> *1(1) In this Act,*
>
> > *(k) "health information" means one or both of the following:*
> >
> > > *(i) diagnostic, treatment and care information;*
> >
> > > *(ii) registration information […]*

[para 18] "Diagnostic, treatment and care information" is defined by section 1(1)(i) of the HIA. This provision states, in part:

1(1)(i) "diagnostic, treatment and care information" means information about any of the following:

> *(i) the physical and mental health of an individual;*
>
> *(ii) a health service provided to an individual, including the following information respecting a health services provider who provides a health service to that individual […]*
>
> *(iii) the donation by an individual of a body part or bodily substance, including information derived from the testing or examination of a body part or bodily substance;*
>
> *(iv) a drug as defined in the Pharmacy and Drug Act provided to an individual;*
>
> *(v) a health care aid, device, product, equipment or other item provided to an individual pursuant to a prescription or other authorization;*
>
> *(vi) the amount of any benefit paid or payable under the Alberta Health Care Insurance Act or any other amount paid or payable in respect of a health service provided to an individual,*

and includes any other information about an individual that is collected when a health service is provided to the individual, but does not include information that is not written, photographed, recorded or stored in some manner in a record;

[para 19] The term, "health service", to which section 1(1)(i)(ii) refers, is defined by section 1(1)(m) of the HIA in the following terms:

1(1) In this Act,

> *(m) "health service" means a service that is provided to an individual for any of the following purposes:*
>
> > *(i) protecting, promoting or maintaining physical and mental health;*
> >
> > *(ii) preventing illness;*
> >
> > *(iii) diagnosing and treating illness;*
> >
> > *(iv) rehabilitation;*
> >
> > *(v) caring for the health needs of the ill, disabled, injured or dying,*
>
> *but does not include a service excluded by the regulations[…]*

[para 20] Under section 1(1)(m), a service is a "health service" if it is provided to an individual for any of the purposes enumerated in the provision and is not excluded by the regulations.

[para 21] The Applicant has requested records containing his own information. However, most of the information in the records about the Applicant is recorded in the

context of AHS providing health care services to his mother. Other aspects of the Applicant's access request are solely for his mother's health information.

[para 22] In *Covenant Health v. Alberta (Information and Privacy Commissioner)*, 2014 ABQB 562 (CanLII), Wakeling J. stated:

> There is no reason to conclude from the *Health Information Act* as a whole, including the statement of purpose in s. 2, that the information about B may not in some circumstances be A's health information. Had the Legislative Assembly wished to enact a more restricted definition of health information it could have stated that personal information about one may not be the health information of another. There is no such statement in the *Health Information Act*. The *Freedom of Information Act*, says just the opposite. Section 4(1)(u) of the *Freedom of Information Act*, in effect, states that personal information which is health information under the *Health Information Act* is for all purposes treated as health information.
>
> Using this standard to determine whether any of the information in the records of Covenant Health about Ms. McHarg is classified as health information under the *Health Information Act*, the adjudicator must ask two questions. First, is there any information in Covenant Health's records about Ms. McHarg that relates to or may directly affect the physical and mental health of Ms. McHarg's parents or a health service provided by Covenant Health to Ms. McHarg's parents? Second, if so, was this information collected when Covenant Health provided a health service to her parents?

[para 23] The Court in *Covenant Health* determined that information about other individuals is the health information of a patient if the information relates to the physical and mental health of patients or affects the physical and mental health of patients or is about a health service provided to patients.

[para 24] In its submissions dated February 1, 2019, AHS argued:

> While the interpretation of the last part of section 1(1)(i) [of the HIA] has been expanded so as to include information of a third party that may constitute health information of another individual, it is submitted that the line of reasoning in the Covenant decision is inapplicable in this instance. Furthermore, the information at issue is not otherwise captured by the definition of health information.

[para 25] I disagree that the *Covenant Health* decision can be distinguished as AHS argues. The Court in *Covenant Health* held that information about, relating to, or affecting, patient health, including the information of a third party, falls within the definition of "health information" within the terms of the HIA. As was the case in *Covenant Health*, the Applicant has requested information about himself in the context of visiting a parent who was receiving long-term care services from a custodian that is also a public body. The Applicant in this case has also requested his mother's health information in his capacity as executor of his mother's estate; however, where the Applicant has requested information about himself from AHS, the facts of this case are similar to those of *Covenant Health*. As noted above, the Court provided the following instruction for determining when information, including information about an applicant, is subject to the FOIP Act or the HIA:

> First, is there any information in Covenant Health's records about Ms. McHarg that relates to or may directly affect the physical and mental health of Ms. McHarg's parents or a health service provided by Covenant Health to Ms. McHarg's parents? Second, if so, was this information collected when Covenant Health provided a health service to her parents?

[para 26] As discussed in the *Covenant Health* decision, information responsive to a request for personal information and which documents an individual's interactions with a public body that is a custodian may be patient health information and exempt from provisions of the FOIP Act.

[para 27] The Public Body severed information from records 3, 4, 5, 6, 7, 8, 10, 12, 15, 20, 21, 25, 26, 27, 29, 31, 32, 36, 37, 39 – 40, 46, 47, 48, 50, 51, 53, 57, 58, 59, 61, 62, 63, 64, 65, 68, 71, 72, 73, 74, 75, 77, 78,79, 82, 83, 84, 85, 86, 90, 91, 93, 94, 95, 96, 97, 98, 99, 105, 106, 107, 109, 110, 114 – 115, 116, 117 – 118, 119, 120 under provisions of the FOIP Act. In order to determine whether these records are subject to the FOIP Act, and may be severed under its provisions, or whether the HIA applies, I will review the severed information and ask whether the information is about "diagnostic, treatment and care" information, or alternatively, relates to such information or affects patient health

Records 57, 58, 61, 62, 71, 72, 73, 74, 75, 77, 78, 79, 82, 83, 84, 85 – 86, 94, 95, 96, 97 – 98, 99, 105, 106, 109 – 110, 114 – 115, 116, 117 – 118, 119 – 120

[para 28] AHS severed information from records 57, 58, 61, 62, 71, 72, 73, 74, 75, 77, 78, 79, 82, 83, 84, 85 – 86, 94, 95, 96, 97 – 98, 99, 105, 106, 109 – 110, 114 – 115, 116, 117 – 118, and 119 – 120 on the basis that the information is subject to solicitor-client privilege. It applied section 27(1)(a) of the FOIP Act, which permits a public body to withhold privileged information from an applicant, to sever information. In contrast, the HIA does not contain provisions permitting a custodian, including a custodian such as AHS that is also a public body, to withhold health information from an applicant on the basis of privilege. As one Act authorizes withholding information on the basis of privilege, while the other does not, it is necessary to determine which one applies.

[para 29] The lawyer whose advice is contained in records 57, 58, 61, 62, 71, 72, 73, 74, 75, 77, 78, 79, 82, 83, 84, 85 – 86, 94, 95, 96, 97 – 98, 99, 105, 106, 109 – 110, 114 – 115, 116, 117 – 118, and 119 – 120 swore an affidavit to establish that the records are privileged. She states:

> I, […] of the City of Edmonton, in the Province of Alberta, MAKE OATH AND SAY:
>
> That I was Legal Counsel in the Health Law team in Alberta Health Services ("AHS") and as such I have personal knowledge of the matters hereinafter deposed to, except where stated to be based on information and belief, in which case I verily believe the same to be true.
>
> That I was legal counsel with regard to an end of life matter in June 2015.

From the foregoing, from the records, and from the lawyer's evidence in the remainder of her affidavit, I understand that the lawyer provided legal advice to AHS physicians and administrators regarding the issues surrounding the end of the Applicant's mother's life.

[para 30] Record 79 contains a table entitled "Risk Management Concerns", which provides further context to the nature of the communications between the lawyer and employees of AHS. This table was provided to the Applicant. This table states, beside the heading "Quality and Patient Safety":

> The patient's care team and the patient's agent have not been able to arrive at a consensual resolution for changing the goals of care and because of this a conflict is likely to occur if further resuscitative efforts are required.

Next to the heading "Policy, External, and Public Confidence", the documents states: "[The Applicant] has suggested he will seek legal counsel to uphold the R2 status of his mother. It is unclear if he has initiated this process at this time." Under the heading "Mitigation Action or Tactics", next to this statement, the record states:

> AHS Legal is connecting with the CMPA [Canadian Medical Protective Association] to determine available options. The Dispute Prevention and Resolution in Critical Care Settings Procedure Checklist has been initiated at the South Health Campus. AHS legal counsel and the CMPA have been engaged by the SHC physicians for assistance with this matter.

As AHS disclosed the subject matter of the legal advice in the records – assisting physicians to change the designation status of the Applicant's mother from R2, I will refer to the subject matter of the legal advice in my reasons.

[para 31] From my review of the records to which the Public Body applied section 27(1)(a) of the FOIP Act, I find they contain information about the physical and mental health of the Applicant's mother. That this is so is also reflected in counsel's assertion that the subject matter of the records is an "end of life matter". In essence, the discussions in these documents were for the purpose of assessing care and ensuring that steps were taken to give appropriate care given the Applicant's mother's physical and mental health.

[para 32] Information about changes to the goals of care – one of the categories of information requested in this access request – is information documenting changes to the kinds of treatment a patient may receive in certain circumstances. If a patient is designated "R2", then the patient is "expected to benefit from and is accepting of any appropriate investigations / interventions that can be offered including attempted resuscitation, intubation and ICU care, but excluding chest compression". If a patient is designated "M1", then "all clinically appropriate medical and surgical interventions directed at cure and control of condition(s) are considered excluding the option of attempted life-saving resuscitation followed by ICU care" . According to the Goals of Care Designation Order form[1], a physician, or the designated "most responsible health practitioner" must sign the form. These two different designations contemplate different treatment plans and may result in different outcomes in the event the patient's health

[1] https://www.albertahealthservices.ca/frm-103547.pdf

declines. That the goals of care are tied to patient health is made clear from AHS's Advance Care Planning and Goals of Care Designation Procedure[2], which states:

> Goals of care conversations shall take place, where clinically indicated with the patient, as early as possible in the patient's course of care and/or treatment. These discussions explore the patient's wishes and goals for clinically indicated treatment framed within the therapeutic options that are appropriate for the patient's clinical condition.

[para 33] From the foregoing, I conclude that a significant factor in determining the goals of care is the patient's clinical condition; in other words, selecting the appropriate goals of care designation requires, at least in part, consideration of a patient's physical and mental health and the effect of treatment on the patient's health. In addition, changing the goals of care designation from R2 to M1 results in a change to the level of life-saving health services provided to a patient and may, accordingly, reduce the life expectancy of a patient.

[para 34] I find that information about changing the goals of care is information about changing the health services a patient will receive, and is therefore diagnostic, treatment and care information within the terms of section 1(1)(i)(i) and (ii) of the HIA. As a result, such information is "health information" within the terms of section 1(1)(k) of the HIA.

[para 35] For the foregoing reasons, I find that information about changing the goals of care designation, where it appears in the records, is diagnostic, treatment and care information of the Applicant's mother, as it is information about her mental and physical health (section 1(1)(i)(i) of the HIA) and about the health services provided to her (section 1(1)(i)(ii) of the HIA). Further, I conclude that information in records where the purpose of the author is to change the goals of care, or to facilitate doing so, is diagnostic, treatment and care information within the terms of the HIA, even when the record is not created by a health professional[3].

[para 36] If the interpretation of the Court in *Covenant Health* is applied – that information is health information if it relates to a health service or affects the health of a patient, then the information in records 57, 58, 61, 62, 71, 72, 73, 74, 75, 77, 78, 79, 82,

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[2] https://extranet.ahsnet.ca/teams/policydocuments/1/clp-advance-care-planning-hcs-38-01-procedure.pdf

[3] The HIA does not require that a health service be provided by a medical professional in order for information about that service to qualify as "health information"; rather, section 1(1)(n) defines "health service provider" as "an individual who provides health services".

In Order H2015-04/F2015-39, the Adjudicator commented, "I do not go so far as to say what the surveillance camera records can never be health information. If a health care professional reviewed the recording for the purpose of ascertaining something about a person's health condition at the time, it could then (but not before) properly be regarded as information about the health of the person. (Thus, the original or primary purpose of the recording is not necessarily the critical factor.)" I do not interpret the Adjudicator as suggesting that health information may be created only by health care professionals. This decision dealt with the circumstances under which information collected or recorded for a non-medical purpose might be regarded as health information. It appears that the Adjudicator meant to refer to "health service provider" within the terms of the Act, in contrast to being limited to a person with some sort of official "health professional" designation.

83, 84, 85 – 86, 94, 95, 96, 97 – 98, 99, 105, 106, 109 – 110, 114 – 115, 116, 117 – 118, 119 – 120 may be viewed as being subject to the HIA on that analysis as well, given that these records contain information relating to a patient's health and may be viewed as affecting a patient's health.

[para 37] In arriving at the conclusion that the information AHS has severed is health information and subject to the HIA, I have also considered whether some of the information in records 57, 58, 61, 62, 71, 72, 73, 74, 75, 77, 78, 79, 82, 83, 84, 85 – 86, 94, 95, 96, 97 – 98, 99, 105, 106, 109 – 110, 114 – 115, 116, 117 – 118, 119 – 120 could be construed as non-health information to which the FOIP Act could apply. I note that in Interim Order PO-3872-I, a decision of the Office of the Information and Privacy Commissioner of Ontario, the Adjudicator determined that some of the information in a record was health information, to which an applicant was entitled; however, the Adjudicator also found that portions of the records were subject to solicitor-client privilege and subject to an exception under the FOIP Act. She noted:

> The appeal was then transferred to the adjudication stage of the appeals process, where an adjudicator conducts an inquiry. During the inquiry, the ministry issued a supplementary decision to the appellants, disclosing six records under the *Personal Health Information Protection Act* (*PHIPA*) in whole, that had previously been disclosed in part. The ministry advised that the records, which it originally claimed contained "personal information" actually contained one of the appellants' "personal health information," and the ministry did not claim any of the exemptions in *PHIPA* to these records. As a result of the disclosure of these records in their entirety, they (for which section 21(1) had been originally claimed) and section 21(1) are no longer at issue.
>
> Initially, I sought and received representations from both parties on the possible application of section 19(a) of the *Act* to the records, the ministry's exercise of discretion, and its search for records responsive to the request. I received representations from the ministry and the appellants.
>
> I then provided the parties with the opportunity to provide representations on new issues, namely the possible application of the *Personal Health Information Protection Act* (*PHIPA*) to the records at issue. I received further representations from the ministry and the appellants regarding the possible application of *PHIPA* to the records.
>
> For the reasons that follow, I find that the records contain the personal health information of one of the appellants, but that the records are not dedicated primarily to her personal health information. As a result, under *PHIPA*, the appellants' right of access is limited to only personal health information that can reasonably be severed. I also find that the records, including the personal health information, are exempt from disclosure under sections 49(a) and 19(a) of the *Act*, whether applied directly under the *Act* or through the flow-through provisions in section 52(1)(f)(ii)(A) of *PHIPA*. I uphold the ministry's exercise of discretion, but not the ministry's search for records. I order the ministry to conduct a further search for records held by the Minister of Health and Long-term Care.

[para 38] As in the present case, the institution in the foregoing case was a public body, in addition to being a custodian of health information. It also provided a portion of its response to the Applicant under health legislation and the remainder under the FOIP Act.

[para 39] The Adjudicator in Order PO-3872-I considered whether the record was dedicated to an applicant's health information to determine whether the entire record was subject to health information legislation, or whether only parts of the record were.

[para 40] From my review of the records over which AHS has asserted privilege, I am unable to identify any portions of the records that are not written for the purpose of addressing the Applicant's mother's health and/or care needs. Information addressing a patient's health and care needs is health information within the terms of section 1(1)(k) of the HIA, by application of sections 1(1)(m) and 1(1)(i). This holds true, whether a patient's health and care needs are discussed by two physicians, or by a physician and a lawyer, as the HIA contains no requirement that a medical professional create a record before the Act will apply to it. Rather, the reason for creating the record – to provide health services – will bring the record within the scope of the HIA, provided the record is in the custody or control of a custodian.

[para 41] In addition, the HIA does not permit a custodian to use health information for purposes not authorized by section 27. Section 27 states:

> *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;*
>
> *(b) determining or verifying the eligibility of an individual to receive a health service;*
>
> *(c) conducting investigations, discipline proceedings, practice reviews or inspections relating to the members of a health profession or health discipline;*
>
> *(d) conducting research or performing data matching or other services to facilitate another person's research*
>
> *(i) if the custodian or researcher has submitted a proposal to a research ethics board in accordance with section 49,*
>
> *(ii) if the research ethics board is satisfied as to the matters referred to in section 50(1)(b),*
>
> *(iii) if the custodian or researcher has complied with or undertaken to comply with the conditions, if any, suggested by the research ethics board, and*
>
> *(iv) where the research ethics board recommends that consents should be obtained from the individuals who are the subjects of*

> *the health information to be used in the research, if those consents have been obtained;*
>
> *(e) providing for health services provider education;*
>
> *(f) carrying out any purpose authorized by an enactment of Alberta or Canada;*
>
> *(g) for internal management purposes, including planning, resource allocation, policy development, quality improvement, monitoring, audit, evaluation, reporting, obtaining or processing payment for health services and human resource management.*
>
> *(2) A custodian referred to in section 1(1)(f)(iii), (iv), (vii), (ix.1), (xii) or (xiii) may, in addition, use individually identifying health information in its custody or under its control to carry out the following functions within the geographic area in which the custodian has jurisdiction to promote the objectives for which the custodian is responsible:*
>
> *(a) planning and resource allocation;*
> *(b) health system management;*
> *(c) public health surveillance;*
> *(d) health policy development.*

[para 42] Section 27 of the HIA does not contain explicit authority for a custodian to use patient health information or to use patient health information for purposes authorized by the FOIP Act. If section 27 authorizes the use of health information for a purpose, then the custodian may use the information for that purpose. There is no mechanism by which health information may be transformed from health information subject to the HIA into information subject to the FOIP Act, unless a public body obtains the health information by means of a Court order, by statutory authority, or from a patient who submits the health information to the public body. As set out in Order H2011-001, an order addressing AHS's collection and use of patient health information the purpose of conducting a human resources investigation in relation to the patient:

> AHS is a public body that is a custodian as defined in the HIA. Thus, by virtue of section 4(1)(u) – which carves health information that is in the custody and control of a custodian out of the FOIP Act – the information collected by the AHS as custodian, from the Complainant directly, is excluded from the FOIP Act. As a result, the provisions of the FOIP Act that specifically authorize collection of personal information by public bodies for personnel management cannot be taken as authorizing the collection of this health information, which was in the custody or control of a custodian, for personnel management purposes.

[para 43] Section 27(1)(f) of the HIA authorizes a custodian to use health information to carry out any purpose authorized by an enactment of Alberta. Section 39(1)(a) of the FOIP Act, which is an enactment of Alberta, authorizes a public body to use information that falls under that Act for the purposes for which it was collected. Arguably, using health information to obtain legal advice about care in some

circumstances would be using it for one of the purposes for which it was collected, or a consistent purpose(in the event such advice becomes necessary) within the terms of the FOIP Act. However, this FOIP provision has no bearing, since information that is health information under the HIA is excluded from the scope of the FOIP Act by section 4(1)(u). For the same reason that the FOIP Act does not authorize accessing and using health information for personnel management purposes, as was the case in Order H2011-001, it does not authorize accessing and using health information for the same purpose for which it was collected.

[para 44] The same principle holds true for the use of health information in order to obtain legal advice. For a use of health information to be authorized under the HIA, the use must be authorized by a provision of section 27 of the HIA. Using patient health information to give and receive legal advice regarding changing the goals of care designation is authorized by section 27 if doing so amounts to "providing health services" within the terms of section 27(1)(a), or determining eligibility or suitability for a health service within the terms of section 27(1)(b). However, if patient health information is used to provide a legal opinion for purposes other than those permitted by section 27, then using that information for such purposes would contravene the use provisions of the HIA.[4]

[para 45] I find that the HIA did not cease to apply to the Applicant's mother's health information and that her health information remains subject to the HIA. Moreover, I find that the purpose in seeking and obtaining legal advice in this case was for purposes falling within the terms of section 27(1)(a) and (b) of the HIA – that is, to provide health services and to ensure that appropriate health services were being provided to a patient.

[para 46] For the foregoing reasons, I conclude that the information severed from records 57, 58, 61, 62, 71, 72, 73, 74, 75, 77, 78, 79, 82, 83, 84, 85 – 86, 94, 95, 96, 97 – 98, 99, 105, 106, 109 – 110, 114 – 115, 116, 117 – 118, 119 – 120 is health information subject to section 1(1)(k) of the HIA, and is not information to which the FOIP Act applies by operation of section 4(1)(u) of the FOIP Act.

Records 3, 4, 5, 6, 7, 8, 10, 12, 15, 20, 25, 29, 31, 36, 37, 39, 46, 47, 48, 64, 65, 68, 70 72, 78, 79, 82, 90, 91, 93, 94, 95, 96, 99, 102, 103, 104, 106, 107, 108, 109, 110, 111, 113, 114, 116, 118, 119 and 120

[para 47] From my review of the records to which AHS applied section 24(1)(b) of the FOIP, I agree that records 3 – 4, 5, 8, 10, and 12 contain information that is subject to the FOIP Act, rather than the HIA. I make these findings on the basis that the records are not about an individual's health or the health services being provided to an individual. Rather, the information in these records is confined to the general operations of AHS or to patient care generally.

[4] If a custodian is a party to litigation, then section 3 permits the custodian to collect, use, or disclose health information without consent in accordance with the procedural rules of the litigation.

[para 48] I view records 6, 7, 15, 20, 21, 25, 26, 27, 29, 31, 36, 37, 39 – 40, 45, 46, 47, 49, 51, 53, 54, 63, 68, 77, 78, 79, 82, 90, 91, 93, 94, 95, 96, 99, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 113, 114, 118, 119, and 120 differently. I find that these records either consist of information about the Applicant's mother's health, the health services she was receiving, or the steps taken to change the Applicant's mother's goals of care designation or were created for the purpose of providing her with health services.

[para 49] Viewed in isolation, the information severed from record 104 appears not to contain information about the health of the Applicant's mother or services being provided to her. However, records 105 and 110 provide additional context and make it clear that the information in record 104 documents a step to be taken in order to change the goals of care designation for the Applicant's mother. The information is therefore "about a health service" and is therefore "diagnostic, treatment and care information" within the terms of section 1(1)(i)(ii) and "health information" within the terms of section 1(1)(k).

Issue B: If the HIA applies to records, is AHS authorized to withhold information on the basis of solicitor-client privilege?

[para 50] Not only does the HIA "carve out" health information from the collection and use provisions of the FOIP Act, as discussed above, it carves out health information from the exceptions to the right of access set out in Part 1 of the FOIP Act. While section 27(1)(a) of the FOIP Act authorizes a public body to sever information on the basis of solicitor-client privilege, the HIA does not contain a parallel provision authorizing a custodian to withhold privileged health information from a requestor. Section 7 of the HIA acknowledges a patient's right to gain access to the patient's own health information, subject to section 11. Section 11 of the HIA contains an exhaustive list of exceptions to the right of access; however, privilege, including solicitor-client privilege, is not among the exceptions to a patient's right of access.

[para 51] AHS argues:

> The courts have consistently upheld and enforced the common law rule that solicitor-client privileged records should be protected from disclosure because solicitor-client privilege is one of the cornerstones of the justice system, without which clients could not seek the receive the legal advice they require. The Supreme Court of Canada in *Blank v. Canada (Minister of Justice)*, 2006 SCC 39 ("Blank") at para. 26 summarized the role of solicitor-client privilege this way:
>
> > The solicitor-client privilege has been firmly entrenched for centuries. It recognizes that the justice system depends for its vitality on full, free and frank communication between those who need legal advice and those who are best able to provide it. Society has entrusted to lawyers the task of advancing their clients' cases with the skill and expertise available only to those who are trained in the law. They alone can discharge these duties effectively, but only if those who depend on them for counsel may consult with them in confidence. The resulting confidential relationship between solicitor and client is a necessary and essential condition of the effective administration of justice.

> Further, the court confirmed that solicitor-client privilege is absolute in scope and permanent in duration. The principle of "once privileged, always privileged" applies to solicitor-client privilege. (*Blank*, para. 37)
>
> The Supreme Court of Canada has elevated solicitor-client privilege from a rule of evidence to the level of a constitutional right protected under the Canadian Charter of Rights and Freedoms (Canada (Attorney General) v. Federation of Law Societies of Canada, 2015 SCC 7, at paras. 82 – 83). Speaking for the Court, Justice [Cromwell] stated: solicitor-client privilege must be as close to absolute as possible to ensure public confidence and retain relevance." (*R. v. McClure*, [2001] 1 S.C.R. 445, at para. 35; University of Calgary, at para. 43)

[para 52] The position of AHS is that the status of solicitor-client privilege as a substantive, constitutional right authorizes withholding records 57, 58, 61, 62, 71, 72, 73, 74, 75, 77, 78, 79, 82, 83, 84, 85 – 86, 94, 95, 96, 97 – 98, 99, 105, 106, 109 – 110, 114 – 115, 116, 117 – 118, and 119 – 120 from the Applicant. In other words, even though the HIA requires that access be given to the Applicant, the common law dictates that the information be withheld.

[para 53] AHS also argues:

> A clear and unambiguous legislative intent to abrogate privilege is required in order to set it aside. AHS submits that silence does not meet this threshold. There is no evidence of any legislative intent to modify solicitor-client privilege in HIA, in either the preamble or elsewhere.

[para 54] The Applicant argues:

> I agree with the position of the OIPC Adjudicator in the March 04, 2019 correspondence referencing page 2, paragraph 2 and 3. Acting on behalf of my mother through a Personal Directive discussions occurred and the foundation of these interactions was my mothers' health and her care. During these related interactions AHS personnel created documentation which ultimately contributed to decisions regarding care and the withdrawal of care for [the Applicant's mother].
>
> [Counsel for AHS] emphasizes that AHS repeats and relies on this correspondence (paragraphs 1-16) in the February 01, 2019 correspondence. I reference this letter on page 1 point 2 a sworn Affidavit by counsel, […] is specified. This Affidavit is in relation to withdrawal of care and end of life health decisions whereby I was excluded contrary to AHS policy and protocols. Of note, this Affidavit and legal opinion was in regards to the later stages of life during June 2015 for [the Applicant's mother] and not her entire hospitalization. Frequently, AHS legal counsel has relied on solicitor-client privilege for the entire hospitalization. These were health decisions for [the Applicant's mother], not information exclusive to personal decisions; therefore, would the HIA apply contrary to the interpretation by AHS personnel?

[para 55] I take AHS's point that the Supreme Court of Canada determined in *Alberta (Information and Privacy Commissioner) v. University of Calgary*, [2016] 2 SCR 555, 2016 SCC 53 (CanLII) that the Legislature must refer to solicitor-client privilege expressly in a statute if it intends to abrogate the privilege. Otherwise, a Court will not give effect to the Legislature's intent. In that case, the Court noted:

> Third, given its fundamental importance, one would expect that if the legislature had intended to set aside solicitor-client privilege, it would have legislated certain safeguards to ensure that

> solicitor-client privileged documents are not disclosed in a manner that compromises the substantive right. In addition, there is no provision in *FOIPP* addressing whether disclosure of solicitor-client privileged documents to the Commissioner constitutes a waiver of privilege with respect to any other person. The absence from *FOIPP* of any guidance on when and to what extent solicitor-client privilege may be set aside suggests that the legislature did not intend to pierce the privilege.

[para 56] In the foregoing case, the Court held that the executive branch of government – "public bodies" within the terms of the FOIP Act – have substantive rights in relation to public records in their custody over which they claim privilege. As the Legislature of Alberta did not state expressly that it was referring to solicitor-client privilege when it referred to "any privilege of the law of evidence" the Court concluded that the Legislature did not intend to interfere with the executive branch's substantive rights and determined that the Commissioner has no authority to review privileged records when determining whether privilege has been appropriately applied under the FOIP Act.

[para 57] Section 11 of the HIA, which enumerates the circumstances in which a custodian may refuse to provide a patient with the patient's own health information, does not permit a custodian to withhold health information on the basis of solicitor-client privilege. Further, the HIA does not refer to waiver of solicitor-client privilege should health records be provided to a patient who is the subject of them. As a result, if it were the case that the HIA abrogates solicitor-client privilege because of this omission, *University of Calgary* may require section 7 of the HIA to be construed as excluding health information that is subject to solicitor-client privilege from the patient's right of access to the patient's own health records or to be interpreted so as not to abrogate solicitor-client privilege.

[para 58] The question, then, is whether granting the Applicant access to records 57, 58, 61, 62, 71, 72, 73, 74, 75, 77, 78, 79, 82, 83, 84, 85 – 86, 94, 95, 96, 97 – 98, 99, 105, 106, 109 – 110, 114 – 115, 116, 117 – 118, and 119 – 120 would abrogate solicitor-privilege.

[para 59] The test to establish whether communications are subject to solicitor-client privilege is set out by the Supreme Court of Canada in *Canada v. Solosky*, 1979 CanLII 9 (SCC), [1980] 1 S.C.R. 821. Speaking for the Court, Dickson J. (as he then was) said:

> … privilege can only be claimed document by document, with each document being required to meet the criteria for the privilege--(i) a communication between solicitor and client; (ii) which entails the seeking or giving of legal advice; and (iii) which is intended to be confidential by the parties.

[para 60] I agree with AHS that the records contain communications involving a lawyer in her capacity as a legal advisor, although, as will be discussed below, I find that the communications were not confidential in relation to the patient whose health and treatment were the subject of the communications at issue.

[para 61] In *Halls v. Mitchell*, [1928] SCR 125, 1928 CanLII 1 (SCC), Duff J. (as he then was), speaking for the majority, described the relationship between a doctor and a patient, stating:

> We are not required, for the purposes of this appeal, to attempt to state with any sort of precision the limits of the obligation of secrecy which rests upon the medical practitioner in relation to professional secrets acquired by him in the course of his practice. Nobody would dispute that a secret so acquired is the secret of the patient, and, normally, is under his control, and not under that of the doctor. *Prima facie*, the patient has the right to require that the secret shall not be divulged; and that right is absolute, unless there is some paramount reason which overrides it. Such reasons may arise, no doubt, from the existence of facts which bring into play overpowering considerations connected with public justice; and there may be cases in which reasons connected with the safety of individuals or of the public, physical or moral, would be sufficiently cogent to supersede or qualify the obligations *prima facie* imposed by the confidential relation.

[para 62] In *McInerney v. MacDonald*, [1992] 2 SCR 138, 1992 CanLII 57 (SCC) the Supreme Court of Canada determined that the relationship between physician and patient is fiduciary; that is, a doctor owes a duty of utmost good faith to a patient and must hold the patient's information in confidence. Laforest J., speaking for the Court, stated:

> When a patient approaches a physician for health care, he or she discloses sensitive information concerning personal aspects of his or her life. The patient may also bring into the relationship information relating to work done by other medical professionals. The policy statement of the Canadian Medical Association cited earlier indicates that a physician cannot obtain access to this information without the patient's consent or a court order. Thus, at least in part, medical records contain information about the patient revealed by the patient, and information that is acquired and recorded on behalf of the patient. Of primary significance is the fact that the records consist of information that is highly private and personal to the individual. It is information that goes to the personal integrity and autonomy of the patient. As counsel for the respondent put it in oral argument: "[The respondent] wanted access to information on her body, the body of Mrs. MacDonald." In *R. v. Dyment*, 1988 CanLII 10 (SCC), [1988] 2 S.C.R. 417, at p. 429, I noted that such information remains in a fundamental sense one's own, for the individual to communicate or retain as he or she sees fit. Support for this view can be found in *Halls v. Mitchell*, 1928 CanLII 1 (SCC), [1928] S.C.R. 125, at p. 136. There Duff J. held that professional secrets acquired from a patient by a physician in the course of his or her practice are the patient's secrets and, normally, are under the patient's control. In sum, an individual may decide to make personal information available to others to obtain certain benefits such as medical advice and treatment. Nevertheless, as stated in the report of the Task Force on *Privacy and Computers* (1972), at p. 14, he or she has a "basic and continuing interest in what happens to this information, and in controlling access to it".
>
> A physician begins compiling a medical file when a patient chooses to share intimate details about his or her life in the course of medical consultation. The patient "entrusts" this personal information to the physician for medical purposes. It is important to keep in mind the nature of the physician-patient relationship within which the information is confided. In *Kenny v. Lockwood*, 1931 CanLII 184 (ON CA), [1932] O.R. 141 (C.A.), Hodgins J.A. stated, at p. 155, that the relationship between physician and patient is one in which "trust and confidence" must be placed in the physician. This statement was referred to with approval by LeBel J. in *Henderson v. Johnston*, 1956 CanLII 125 (ON SC), [1956] O.R. 789, who himself characterized the physician-patient relationship as "fiduciary and confidential", and went on to say: "It is the same relationship as that which exists in equity between a parent and his child, a man and his wife, an attorney and his client, a confessor and his penitent, and a guardian and his ward" (p.

> 799). Several academic writers have similarly defined the physician-patient relationship as a fiduciary or trust relationship; see, for example, E. I. Picard, *Legal Liability of Doctors and Hospitals in Canada* (2nd ed. 1984), at p. 3; A. Hopper, "The Medical Man's Fiduciary Duty" (1973), 7 *Law Teacher* 73; A. J. Meagher, P. J. Marr and R. A. Meagher, *Doctors and Hospitals: Legal Duties* (1991), at p. 2; M. V. Ellis, *Fiduciary Duties in Canada* (1988), at p. 10-1. I agree with this characterization.
>
> In characterizing the physician-patient relationship as "fiduciary", I would not wish it to be thought that a fixed set of rules and principles apply in all circumstances or to all obligations arising out of the doctor-patient relationship. As I noted in *Canson Enterprises Ltd. v. Boughton & Co.*, 1991 CanLII 52 (SCC), [1991] 3 S.C.R. 534, not all fiduciary relationships and not all fiduciary obligations are the same; these are shaped by the demands of the situation. A relationship may properly be described as "fiduciary" for some purposes, but not for others. That being said, certain duties do arise from the special relationship of trust and confidence between doctor and patient. Among these are the duty of the doctor to act with utmost good faith and loyalty, and to hold information received from or about a patient in confidence. (Picard, *supra*, at pp. 3 and 8; Ellis, *supra*, at pp. 10-1 and 10-12, and Hopper, *supra*, at pp. 73-74.) When a patient releases personal information in the context of the doctor-patient relationship, he or she does so with the legitimate expectation that these duties will be respected.
>
> The physician-patient relationship also gives rise to the physician's duty to make proper disclosure of information to the patient; see *Reibl v. Hughes*, 1980 CanLII 23 (SCC), [1980] 2 S.C.R. 880, at p. 884; and *Kenny v. Lockwood*, *supra*, at p. 155. The appellant concedes that a patient has a right to be advised about the information concerning his or her health in the physician's medical record. In my view, however, the fiducial qualities of the relationship extend the physician's duty beyond this to include the obligation to grant access to the information the doctor uses in administering treatment. This approach has been taken by one stream of American cases. In *Emmett v. Eastern Dispensary and Casualty Hospital*, 396 F.2d 931 (D.C. Cir. 1967), Robinson J. held, at p. 935, that the fiducial qualities of the physician-patient relationship impose a duty on the physician "to reveal to the patient that which in his best interests it is important that he should know". Thus, in that case, the decedent patient's son was entitled to inspect the decedent's medical records. Similarly, in *Cannell v. Medical and Surgical Clinic*, 315 N.E.2d 278 (Ill. App. Ct. 1974), the court, having referred to the decision in *Emmett*, held that the fiducial qualities of the physician-patient relationship require the disclosure of medical data to a patient or his agent upon request, and that the patient need not engage in legal proceedings to obtain the information.
>
> The fiduciary duty to provide access to medical records is ultimately grounded in the nature of the patient's interest in his or her records. As discussed earlier, information about oneself revealed to a doctor acting in a professional capacity remains, in a fundamental sense, one's own. The doctor's position is one of trust and confidence. The information conveyed is held in a fashion somewhat akin to a trust. While the doctor is the owner of the actual record, the information is to be used by the physician for the benefit of the patient. The confiding of the information to the physician for medical purposes gives rise to an expectation that the patient's interest in and control of the information will continue.

[para 63] In *N.M. v. Drew (Estate of)*, 2003 ABCA 231, the Alberta Court of Appeal considered the extent to which medical privilege applies to communications between a patient and physician when the patient has commenced a lawsuit. Côtè J., speaking for the majority, said:

> The Supreme Court of Canada says that the patient's suit does <u>not</u> waive or remove the medical privilege:

> "I accept that a litigant must accept such intrusions upon her privacy as are necessary to enable the judge or jury to get to the truth and render a just verdict. But I do not accept that by claiming such damages as the law allows, a litigant grants her opponent a licence to delve into private aspects of her life which need not be probed for the proper disposition of the litigation."
>
> (*A.M.* v. *Ryan*, *supra*, at 180 (S.C.R.), para. 38)
>
> Both R. 218.8 and the modern cases on the scope of R. 200(1)(c)(i) date from the 1990s. The earlier cases on interviewing physicians may have to be re-examined in light of the 1997 *Ryan* decision, *supra*, and those amendments to the Alberta Rules of Court.
>
> Therefore, I have trouble drawing any broad conclusion from the ambiguous aphorism that "there is no property in a witness". It is a slogan, not a statute. A treating doctor is not a bystander, but the patient's fiduciary: see the *McInerney* case, *supra*. To a degree, there is property in him or her. There certainly is property in a treating physician's information. The whole approach of the Supreme Court of Canada in the *Ryan* case, *supra*, is to recognize medical privilege and strike a balance between competing interests.
>
> Furthermore, some cases base interviews intruding into medical confidences on a narrow foundation. The appellant relied upon authorities which emphasize the interests and convenience of only four people: the two parties, and the two counsel. Most authorities say much less about the dangers, costs, and uncertainties to the physician, some of which I outline below in Parts F, G, H and J. Nor do the reported cases weigh the offsetting advantages of protecting the patient-physician confidentiality. Those work powerfully in the other direction. We endanger the public if we discourage patients from seeking treatment, for fear that everything be some day disclosed should an accident later befall them and they have to sue someone. The Supreme Court of Canada says that we keep patient records and communications secret to encourage disclosure between doctor and patient: *McInerney*, *supra*, at paras. 27 and 28; *A.M.* v. *Ryan*, *supra*, at 173-78 (S.C.R.). It also says that the patient's right to preserve professional secrets is absolute, unless there is some paramount reason to divulge them: *ibid.*

[para 64] In the foregoing case, the Alberta Court of Appeal held that a patient's records are confidential. Further, at paragraph 18 the Court confirmed that the patient "owns the confidence". In other words, it is for the patient to decide whether the patient's health records may be kept in confidence or disclosed. The Court considered medical privilege to be absolute, except in limited circumstances, as disclosing medical records without consent could have the deleterious effect of discouraging patients from seeking medical treatment.

[para 65] The Supreme Court of Canada in *McInerney* considered information received from or about a patient to be privileged. It considered that physicians are the owners of records, but have a fiduciary obligation to a patient to use the information for the benefit of the patient. The Court considered that the fiduciary obligation of a physician to a patient also imposes a duty on the physician to grant the patient access to the information used in providing treatment.

[para 66] In this case, the legal advice provided by the lawyer was intended to assist physicians to change the goals of care designation. The lawyer also communicated with AHS administration; however, these communications were ultimately intended to provide advice to the treating physician. The patient's health information (details of her physical and mental health and stay in the hospital) was used by the physicians and the lawyer so that legal advice regarding providing appropriate treatment could be given and received.

As noted above, the legal advice is also health information, given that it was used in providing treatment and the purpose of it was to provide a health service. In *McInerney*, the Supreme Court of Canada held that a physician has a fiduciary obligation to grant a patient access to such information. Under the common law, then, the legal advice in this case is under the patient's control.

[para 67] The Court cases I have cited confirm that a patient has control over the patient's health information and that health information includes statements made to a physician, information in the physician's custody *about* the patient's health, and the information used by a physician to provide treatment to a patient. At common law, a physician has a duty of utmost good faith to a patient, which includes providing records to a patient, unless doing so would result in harm to the public or the patient. Within this statutory and common law framework, and given the nature of the advice – changing the goals of care designation – it does not appear that the physicians who sought legal advice and the lawyer who provided it could reasonably expect to keep their communications confidential from the patient.

[para 68] Adam Dodek sets out the test for determining whether communications are confidential, as follows:

> Ultimately, to show a reasonable expectation of confidentiality, the client must subjectively intend to keep her communications confidential, and this intention must be objectively reasonable in all the circumstances.[5]

As noted above, a lawyer who provided some of the legal advice contained in the records, swore an affidavit for the inquiry. This affidavit does not refer to expectations of confidentiality; however, as she asserts that in her opinion the records are subject to solicitor-client privilege, I infer that she believes the communications in records 57, 58, 61, 62, 71, 72, 73, 74, 75, 77, 78, 79, 82, 83, 84, 85 – 86, 94, 95, 96, 97 – 98, 99, 105, 106, 109 – 110, 114 – 115, 116, 117 – 118, and 119 – 120 to have been confidential and that she believes the physicians and administrators she advised also hold this belief.

[para 69] However, it is not enough to believe communications to be confidential; this belief must also be objectively reasonable in the circumstances. As discussed above, at common law, physicians have a duty of utmost good faith to a patient and hold patient health information for the benefit of the patient. Further, they must make patient health information available to a patient unless doing so would harm the patient or a third party. Finally, the patient has a right to the patient's own health information, and it is for the patient to decide whether to disclose such information. Given this framework, it would be unreasonable for physicians to expect that patient health information, including information about treatment decisions and the implementation of such decisions, may be kept in confidence from the patient. To put the point differently, it is not objectively reasonable to assume that communications are confidential if someone else (the patient) has a proprietary or beneficial interest in them and has the authority to decide whether the communications are confidential or not.

[5] Adam Dodek, *Solicitor-Client Privilege*, (Markham; LexisNexis Canada, 2014) p. 150

[para 70] As discussed above, a patient's health records are subject to medical privilege belonging to the patient, and the physician holds patient records in trust for the patient, with the result that the physician must use health information for the benefit of the patient. AHS lacks authority both at common law and under the HIA to use patient information to obtain a legal opinion regarding patient treatment for its own private purposes; rather, at common law, the legal advice obtained must be for the benefit of the patient. Under the HIA, providing legal advice to assist in implementing changes to the goals of care is a health service as defined by section 1(1)(m)(v). If AHS acts as the client of a solicitor when seeking advice about implementing changes to the goals of care, it must, under the common law and the HIA, do so for the benefit of the patient. In other words, it may seek advice regarding changing the goals of care and have custody of the advice it received regarding implementing changes, but its interest is that of a fiduciary, and the patient is the beneficial owner of the advice. To put the point differently, the patient was the solicitor's client, rather than AHS or its affiliates.

[para 71] I acknowledge that in some cases, discussions may be held between physicians or custodians and lawyers regarding legal authority for decision making in relation to the care of a patient, to ensure the physicians or custodian are acting appropriately and within the law and whether they would be immune from claims that might be made against them in relation to the care provided. Whether or not that is so, at the very same time, the subject matter of the advice would be how treatment decisions are going to be made, and which treatment could lawfully be provided, which ultimately would influence what treatment would be, and whether treatment decisions would or would not need to involve the patient or the patient's representative. I do not believe that in such circumstances, the interests of the decision makers in the advice can be prioritized over the beneficial interests of the patient as to how the patient would be medically treated and of the patient's role in that decision. If there is a conflict between the custodians' interest in the information and the patient's, I cannot see that the former should prevail, particularly given the seriousness of the consequences of the advice to the patient and the patient's health.

[para 72] Under the statutory scheme created by the HIA, there is no authority for a custodian to withhold patient health information on the basis of its own or its affiliates' expectations of confidence. Rather, the HIA creates a right of access for patients to their health information, subject only to the exceptions in section 11. In this, the HIA reflects the common law.

[para 73] Returning to the *University of Calgary* decision, I do not believe that case applies so as to limit a patient's access to the patient's health records. While AHS is also a public body with the attendant substantive, or "quasi-constitutional" rights the Court in University of Calgary recognized as belonging to public bodies, in this case, AHS's role as custodian of health information is engaged. The case law I have reviewed establishes that it is the patient that has substantive rights in the patient's health information. In my view, the HIA does not abrogate solicitor-client privilege, as this privilege does not apply as against a patient requesting the patient's health records.

[para 74] For the foregoing reasons, I find that the information severed from records 57, 58, 61, 62, 71, 72, 73, 74, 75, 77, 78, 79, 82, 83, 84, 85 – 86, 94, 95, 96, 97 – 98, 99, 105, 106, 109 – 110, 114 – 115, 116, 117 – 118, and 119 – 120 under section 27(1)(a) of the FOIP Act may not be withheld from the Applicant and I will direct them to be disclosed.

[para 75] As I find that the records are not privileged as against the applicant, I need not address the question of whether the common interest exception to waiver applies in relation to record 94.

Issue C: Assuming the FOIP Act applies, is AHS authorized to withhold information about [the Applicant's mother] from the executor of her estate on the basis of section 17 (disclosure harmful to personal privacy)?

Issue D: Assuming the HIA applies, is AHS authorized to withhold information about [the Applicant's mother] from the executor of her estate on the basis that it is her health information?

[para 76] I have decided to address issues C and D together.

[para 77] In relation to Issue C, AHS argues:

> It is submitted that in the context of section 17 of the FOIP Act pertaining to severed information about the deceased, the release of such information would not be an unreasonable invasion of the deceased's privacy given the role of a personal representative. However, records dealing with the personal aspects of third parties (such as Records 36 and 70 in the present case) would still be subject to section 17.

[para 78] With regard to the same information, AHS argues in relation to Issue D:

> At the time of the request in September 2014 [*sic*], the applicant was not the personal representative of [the Applicant's mother]. However, given the decision in Order H2018-01[…], it is established that a personal representative would have access to a deceased's records, subject to a custodian relying on section 11 of HIA to withhold records, if such provisions apply.

[para 79] From the foregoing, I understand that AHS is no longer relying on section 17 of the FOIP Act to sever the Applicant's mother's information from the records. As a result, I intend to direct AHS to give the Applicant access to this information, as it has not yet granted access to this information, despite its decision that section 17 does not apply.

[para 80] AHS continues to rely on section 17 of the FOIP Act to sever third party information from records 36 and 70. I turn now to whether AHS has appropriately severed this information.

Record 36

[para 81] Record 36 contains an email documenting a complaint made by the Applicant regarding his mother's care. The email documents the nature of the complaint and the steps taken to resolve the complaint. The email also documents the care being given to the Applicant's mother that gave rise to the complaint. The severed information is a statement attributed to the Applicant about a health services provider.

[para 82] I disagree with AHS that the severed information is subject to the FOIP Act. Rather, the record is about the health services being given to the Applicant's mother by the health services provider whose information has been severed. Under section 1(1)(i) of the HIA, "diagnostic, treatment and care information" includes information respecting a health services provider. As a result, the information falls within the terms of section 1(1)(k) of the HIA and is health information.

[para 83] I am unable to identify a provision of section 11 of the HIA that would authorize AHS to sever the information regarding the health services provider.

[para 84] In addition, for the reasons that follow, the result would be the same if I had found that the FOIP Act applies.

[para 85] Section 17 sets out the circumstances in which a public body may or must not disclose the personal information of a third party in response to an access request. It states, in part:

> *17(1) The head of a public body must refuse to disclose personal information to an applicant if the disclosure would be an unreasonable invasion of a third party's personal privacy.*
>
> *17(2) A disclosure of personal information is not an unreasonable invasion of a third party's personal privacy if*
>
> *[…]*
>
> *(f) the disclosure reveals financial and other details of a contract to supply goods or services to a public body […]*
>
> *(4) A disclosure of personal information is presumed to be an unreasonable invasion of a third party's personal privacy if*
>
> *[…]*
>
> *(g) the personal information consists of the third party's name when*
>
> *(i) it appears with other personal information about the third party, or*
>
> *(ii) the disclosure of the name itself would reveal personal information about the third party[…]*

(5) In determining under subsections (1) and (4) whether a disclosure of personal information constitutes an unreasonable invasion of a third party's personal privacy, the head of a public body must consider all the relevant circumstances, including whether

[…]

(i) the personal information was originally provided by the applicant.

[para 86] Section 17 does not say that a public body is never allowed to disclose third party personal information. It is only when the disclosure of personal information would be an unreasonable invasion of a third party's personal privacy that a public body must refuse to disclose the information to an applicant under section 17(1). Section 17(2) (not reproduced) establishes that disclosing certain kinds of personal information is not an unreasonable invasion of personal privacy.

[para 87] When the specific types of personal information set out in section 17(4) are involved, disclosure is presumed to be an unreasonable invasion of a third party's personal privacy. To determine whether disclosure of personal information would be an unreasonable invasion of the personal privacy of a third party, a public body must consider and weigh all relevant circumstances under section 17(5), (unless section 17(3), which is restricted in its application, applies). Section 17(5) is not an exhaustive list and any other relevant circumstances must be considered.

[para 88] Section 17(1) requires a public body to withhold information once all relevant interests in disclosing and withholding information have been weighed under section 17(5) and the conclusion is reached that it would be an unreasonable invasion of the personal privacy of a third party to disclose his or her personal information.

[para 89] Once the decision is made that a presumption set out in section 17(4) applies to information, it is necessary to consider all relevant factors under section 17(5) to determine whether it would, or would not, be an unreasonable invasion of a third party's personal privacy to disclose the information.

[para 90] The information at issue is about an affiliate of AHS, acting in her personal capacity. However, the information is contained in a statement attributed to the Applicant. While the information is clearly information subject to section 17(4)(g) as it contains the affiliates name, and information about her, the information was supplied by the Applicant within the terms of section 17(5)(i). Section 17(5)(i) weighs in favor of disclosing personal information. In this case, I find it weighs strongly in favor of disclosure, as the Applicant presumably remembers what he said, with the result that there is no measurable benefit to privacy that would be achieved by severing the information.

[para 91] In addition, I note that the statement would also be the Applicant's personal information, if it were the case that the FOIP Act applied, as it informs the reader of a statement he made in particular circumstances. Section 2 of the FOIP Act establishes that a purpose of the FOIP Act is to give an individual access to the individual's own personal information. In order F2011-01, it was held that to be a relevant consideration within the terms of section 17(5) that the severed information was also about the requestor.

[para 92] Assuming that the FOIP Act applies, and I have found above that it does not, I would find that the relevant factors in this case weigh in favor of disclosing the information severed from record 36.

Record 70

[para 93] AHS severed a cell phone number of a staff lawyer from record 70. In Order F2018-36 I held the following regarding cell phone numbers:

> There is no presumption or rule that a cell phone number is personal information. A cell phone number will be personal information if it is about an identifiable individual acting in a personal capacity. For example, I note that in Order PO-3016, a decision of the office of the Information and Privacy Commissioner of Ontario, the Adjudicator held:
>
> > In my view, portions of the emails sent by police and the investigation notes (Records 1c, 1f and 3) do not constitute the "personal information" of any identifiable individual. I note that the police emails contain one of the officer's work cell phone number and describe the actions the police took upon arrival on the scene. I also note that portions of the investigation notes capture the investigator's efforts to schedule meetings and obtain evidence from individuals acting in their professional capacities. As a general rule, information associated with an individual in a professional, official or business capacity will not be considered to be "about" the individual [Orders P-257, P-427, P-1412, P-1621, R-980015, MO-1550-F and PO-2225].
> >
> > The ministry takes the position that the incident report and audio statement (Records 7 and 8) contain the personal information of the appellant's partner. I note that the information contained in these records were gathered in the course of the appellant's partner's professional duties and do not include information about her which is personal in nature. In my view, the information contained in the records which relate to the appellant and the patient which were provided by the appellant's partner, police, ministry EMS staff or dispatch constitutes the personal information of the appellant and the patient only. These individuals did not provide the information at issue in their personal capacities.
> >
> > I will order the ministry to disclose certain portions of Records 1c, 1f and 3 because they do not contain the "personal information" of any identifiable individual and thus personal privacy provisions in the *Act* cannot apply to this information […]
>
> The reasoning in the foregoing case was adopted most recently in Order F2018-07. This reasoning is consistent with the approach adopted by this office and summarized in Order F2013-51, cited above.

> Clearly, if a cell phone number or direct line number conveys something about an employee as an identifiable individual, then the cell phone or direct line number is personal information. For example, a statement such as "the user of this cell phone number is married and owes thousands of dollars in back taxes" or a document that allows a reader to infer those facts about the user of the cell phone number, is information about an identifiable individual and would be personal information under the FOIP Act. However, a statement such as "Please contact me at this cell phone number so that I may provide assistance to you on behalf of the organization I represent", does not, without more, reveal personal information about an employee or contractor as an identifiable individual.
>
> I am unable to agree with the Public Body that the direct lines and work cell phone numbers it severed could be said to be personal information, as opposed to information about professional duties. If the Public Body had elected to provide evidence as to why it believes that the cell phone numbers may have been used in a personal context, then it might be possible to state with certainty whether some of the cell phone numbers constitute information about the Public Body's employees acting in a personal capacity or not. From the telephone numbers appearing in the records that were made available for my review, I was unable to identify any telephone numbers that could be construed, on the basis of the evidence, as the personal information of the user of the number.
>
> On the evidence before me, I cannot find that the telephone numbers are the personal information of the representatives of the Public Body to whom they are assigned and I will order the Public Body to give the Applicant access to the cell phone and direct line numbers.

[para 94] From my review of record 70, I find that the cell phone number was provided so that a representative of AHS could discuss AHS business with the lawyer. I am unable to identify a personal dimension to the cell phone number. Given this finding, if it is the case that the FOIP Act applies to record 70, I find it does not authorize withholding the cell phone number. I will therefore direct AHS to give the Applicant access to the cell phone number.

Issue E: If the FOIP Act applies to the information severed by AHS under section 24(1)(b), did AHS properly apply this provision?

[para 95] I found above that records 3 – 4, 5, 8, 10, and 12 contain information subject to the FOIP Act. I turn now to the question of whether AHS properly applied section 24(1)(b) to sever information from them.

[para 96] Section 24(1) states, in part:

> *24(1) The head of a public body may refuse to disclose information to an applicant if the disclosure could reasonably be expected to reveal*
>
> *(a) advice, proposals, recommendations, analyses or policy options developed by or for a public body or a member of the Executive Council,*
>
> *(b) consultations or deliberations involving*
>
> *(i) officers or employees of a public body,*

> *(ii) a member of the Executive Council, or*
>
> *(iii) the staff of a member of the Executive Council*[…]

[para 97] In Order F2015-29, the Director of Adjudication interpreted sections 24(1)(a) and (b) of the FOIP Act and described the kinds of information that fall within the terms of section 24(1)(b). She said:

> A consultation within the terms of section 24(1)(b) takes place when one of the persons enumerated in that provision solicits information of the kind subject to section 24(1)(a) regarding that decision or action. A deliberation for the purposes of section 24(1)(b) takes place when a decision maker (or decision makers) weighs the reasons for or against a particular decision or action. Section 24(1)(b) protects the decision maker's request for advice or views to assist him or her in making the decision, and any information that would otherwise reveal the considerations involved in making the decision. Moreover, like section 24(1)(a), section 24(1)(b) does not apply so as to protect the final decision, but rather, the process by which a decision maker makes a decision.

[para 98] I agree with the analysis of the Director of Adjudication as to the purpose and interpretation of sections 24(1)(a) and (b), and agree these provisions apply to information generated when a decision maker asks for advice regarding a decision, or evaluates a course of action. I note too that this interpretation is consistent with *John Doe v. Ontario (Finance)*, 2014 SCC 36 (CanLII) in which the Supreme Court of Canada commented on the purpose of the "advice and recommendation" exception in Canada's various freedom of information regimes. The Court held:

> In my opinion, Evans J. (as he then was) in *Canadian Council of Christian Charities v. Canada (Minister of Finance)*, 1999 CanLII 8293 (FC), [1999] 4 F.C. 245, persuasively explained the rationale for the exemption for advice given by public servants. Although written about the equivalent federal exemption, the purpose and function of the federal and Ontario advice and recommendations exemptions are the same. I cannot improve upon the language of Evans J. and his explanation and I adopt them as my own:
>
> To permit or to require the disclosure of advice given by officials, either to other officials or to ministers, and the disclosure of confidential deliberations within the public service on policy options, would erode government's ability to formulate and to justify its policies.
>
> It would be an intolerable burden to force ministers and their advisors to disclose to public scrutiny the internal evolution of the policies ultimately adopted. Disclosure of such material would often reveal that the policy-making process included false starts, blind alleys, wrong turns, changes of mind, the solicitation and rejection of advice, and the re-evaluation of priorities and the re-weighing of the relative importance of the relevant factors as a problem is studied more closely. In the hands of journalists or political opponents this is combustible material liable to fuel a fire that could quickly destroy governmental credibility and effectiveness. [paras. 30-31]
>
> Political neutrality, both actual and perceived, is an essential feature of the civil service in Canada (*Osborne v. Canada (Treasury Board*, 1991 CanLII 60 (SCC), [1991] 2 S.C.R. 69, at p. 86; *OPSEU v. Ontario (Attorney General)*, 1987 CanLII 71 (SCC), [1987] 2 S.C.R. 2, at pp. 44-45). The advice and recommendations provided by a public servant who knows that his work might one day be subject to public scrutiny is less likely to be full, free and frank, and is more

> likely to suffer from self-censorship. Similarly, a decision maker might hesitate to even request advice or recommendations in writing concerning a controversial matter if he knows the resulting information might be disclosed. Requiring that such advice or recommendations be disclosed risks introducing actual or perceived partisan considerations into public servants' participation in the decision-making process.
>
> Interpreting "advice" in s. 13(1) as including opinions of a public servant as to the range of alternative policy options accords with the balance struck by the legislature between the goal of preserving an effective public service capable of producing full, free and frank advice and the goal of providing a meaningful right of access.

[para 99] AHS notes that in *Covenant Health,* Wakeling J. rejected this office's interpretation of section 24(1)(b), stating at paragraphs 142 - 143:

> […] The Oxford English Dictionary (2d ed. 1989) definition of "deliberation" presents a comparable meaning: "1. The action of deliberating, or weighing a thing in the mind; careful consideration with a view to a decision. …2. The consideration and discussion of the reasons for [and] against a measure by a number of councillors."
>
> These dictionary meanings and the context of the enactment support the finding that a consultation or deliberation does not exist until two or more officers or employees of a public body discuss an issue which the public body may at some future time or must now resolve and the issue is one any or all of the officers or employees can reasonably be expected to discuss. The position the participants hold and other factors may be taken into account in the objective analysis.

[para 100] In my view, the decision of the Supreme Court of Canada, in *John Doe (supra),* renders the foregoing position untenable. In that case, the Court tied the exceptions for advice and deliberations in Canada's freedom of information statutes to the need to protect the process by which government develops policy and makes decisions. Moreover, if it were the case that any discussions between employees would be withheld under section 24(1), regardless of whether the discussion contributed to a governmental decision or policy making process, the right of access would be nugatory, given that any government communication could meet this criterion.

Records 3 and 4

[para 101] AHS severed a portion of an email that appears on records 3 – 4. I am unable to identify any information in this email that falls within the terms of section 24(1)(a) or (b) of the FOIP Act. The email documents something that happened and the steps taken to address it. There is no indication that the author of the email is seeking advice or giving it as part of a decision or policy making process. Further, there is no indication that there is any action required or decision to be made by the recipient of the email. The email appears to have been intended to provide information only.

[para 102] For the foregoing reasons, I find that section 24(1) does not apply to records 3 and 4.

Record 5

[para 103] AHS severed portions of an email written by a registered nurse to AHS administrators regarding an incident that had taken place. AHS provided the first part of the email to the Applicant.

[para 104] From my review of the severed information, and from my review of the context created by the other responsive records, I am unable to find that the severed information is a consultation or deliberation, or that it contains information subject to 24(1) of the FOIP Act. Rather, the information appears intended to bring factual information to the attention of the administration. The severed information does not propose or suggest a course of action or seek input in determining one.

[para 105] For the reasons above, I find that section 24(1) has not been demonstrated as applying to record 5.

Record 8

[para 106] Record 8 contains an email written about the matter discussed in record 5. The email appears intended to report facts. I am unable to identify any information falling within the terms of section 24(1) in this email, given that the email does not appear intended to guide a course of action or to seek advice in determining one.

Record 10

[para 107] AHS severed a portion of an email appearing on record 10 under section 24(1)(b). The information severed is factual. The information does not appear intended to guide a course of action or to seek advice in determining one. Rather, the email is intended to report facts. That being said, the facts reported may be the personal information of an individual about whom the facts are being reported. While AHS did not apply section 17 to this information, it would appear that the information is about one of its employees acting in a personal capacity and that the employee would be identifiable to others, from the facts provided in the email. Further, it would appear that the presumptions created by sections 17(4)(a), (d), and (g) of the FOIP Act could apply to the information.

[para 108] As section 17(1) is a mandatory provision, I have decided that AHS should have the opportunity to consider whether it applies, and I will direct it to make that determination.

Record 12

[para 109] AHS severed parts of two sentences from an email on record 12 on the basis that the information is a consultation or deliberation. I am unable to find that the severed information is consultative or deliberative. The disclosed portion of the email indicates that it is for information purposes only, and I agree with that characterization. I am also unable to find that the information is intended to guide a course of action or to seek assistance in determining a course of action.

[para 110] For the foregoing reasons, I find that section 24(1) does not apply to record 12.

[para 111] To conclude, I find that section 24(1) does not apply to records 3 – 4, 5, 8, 10, and 12 and I must direct AHS to disclose them, but for the information severed from record 10. I intend to direct AHS to consider whether section 17 of the FOIP Act applies to the information it severed from record 10.

Issue F: If the HIA applies to the information AHS severed under section 24(1)(b), can this information be withheld from the Applicant?

[para 112] As discussed above, I find that the information severed from records 6, 7, 15, 20, 21, 25, 26, 27, 29, 31, 36, 37, 39 – 40, 45, 46, 47, 49, 51, 53, 54, 63, 68, 77, 78, 79, 82, 90, 91, 93, 94, 95, 96, 99, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 113, 114, 118, 119, and 120 is health information subject to the *Health Information Act*. In its submissions of April 15, 2019, AHS stated:

> It is submitted that section 11(1)(d) of the HIA would apply in the event that the HIA applies. The test for the application of section 11(1)(d) is similar to that of section 24(1)(b) of the FOIP Act […]

[para 113] From its submissions, I understand that AHS relies on section 11(1)(d) of the HIA to withhold the information to which it applied section 24(1)(b) from the Applicant, in the event that I find that the FOIP Act does not apply to the information. As I have found that the FOIP Act does not apply to records 6, 7, 15, 20, 21, 25, 26, 27, 29, 31, 36, 37, 39 – 40, 45, 46, 47, 49, 51, 53, 54, 63, 68, 77, 78, 79, 82, 90, 91, 93, 94, 95, 96, 99, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 113, 114, 118, 119, and 120, I turn now to the question of whether the information severed from them meets the terms of section 11(1)(d) of the HIA.

[para 114] Section 11(1) states, in part:

> *11(1) A custodian may refuse to disclose health information to an applicant*
>
> *(c) if the disclosure could reasonably be expected to reveal*
>
> *(i) advice, proposals, recommendations, analyses or policy options developed by or for a member of the Executive Council, or*
>
> *(ii) consultations or deliberations involving a member of the Executive Council or the member's staff,*
>
> *(d) if the disclosure could reasonably be expected to reveal advice, proposals, recommendations, analyses or policy options developed by or for a custodian referred to in section 1(1)(f)(iii), (iv) or (vii), or*

[para 115] Section 1(1)(f) of the HIA defines the term "custodian". Sub clause (iii) of section 1(1)(f) applies to "a provincial health board established pursuant to regulations made under section 17(1)(a) of the *Regional Health Authorities Act*", while sub clause (iv) refers to "a regional health authority established under the *Regional Health Authorities Act*". (Sub clause vii has been repealed.) As a result section 11(1)(d) applies to advice, proposals, recommendations, analyses, or policy options developed by or for a provincial health board or by or for a regional health authority.

[para 116] Section 3 of the *Regional Health Authorities Act* establishes regional health authorities, such as AHS. It provides the following:

> *3(1) Each health region shall be administered by a regional health authority.*
>
> *(2) A regional health authority shall consist of the number of persons provided for under the regulations who are appointed or elected in accordance with the regulations.*
>
> *(3) A regional health authority is a corporation consisting of its members.*

[para 117] The Regional Health Authority Membership Regulation states:

> *3(1) The Minister shall appoint all of the members of a regional health authority.*
>
> *(2) With respect to each regional health authority, the Minister*
>
> *(a) shall designate one of the members as chair, and*
>
> *(b) may designate one of the members as vice-chair.*
>
> *(2.1) If the Minister has not designated a vice-chair, the members may designate a vice-chair from among themselves, but the designation ceases to be effective when a designation made by the Minister under subsection (2)(b) takes effect.*
>
> *(3) The members may designate the other offices of the regional health authority and appoint from among themselves persons to those offices and prescribe their duties.*

[para 118] AHS is a regional health authority and is therefore a corporation consisting of its members, the board of directors. It is one of two types of custodian that may withhold health information on the basis that it would reveal advice, proposals, recommendations, analyses, or policy options developed by it or on its behalf.

[para 119] As set out in the *Regional Health Authorities Act*, a reference to AHS is a reference to the members of a body corporate, who are appointed by the Minister under the Regional Health Authority Membership Regulation.

[para 120] AHS has relied on section 24(1)(b) of the FOIP Act to sever information. Section 24(1)(b) applies to consultations or deliberations involving a member of the Executive Council or officers or employees of a public body. As the information at issue does not involve a member of the Executive Council or the member's staff, I assume it has done so on the basis that the information consists of what it considers to be consultations or deliberations involving its employees. While section 11(1)(c) of the HIA permits a custodian to sever health information that would reveal consultations or deliberations involving a member of the Executive Council or the member's staff, there is no authority under the HIA to sever consultations or deliberations that do not involve a member of the Executive Council or the member's staff. As a result, AHS's argument that it may sever information under section 11 that it views as consultations or deliberations involving its employees must fail.

[para 121] I have also considered whether any of the severed information could be construed as advice, proposals, recommendations, analyses or policy options developed by AHS within the terms of section 11(1)(d), provided the information could otherwise be characterized as advice, proposals, recommendations, analyses or policy options. On the evidence before me, I am unable to do so. There is no indication that any of the information severed under section 24(1)(b) meets the requirement that the information be "developed by or for" AHS's board of directors[6].

[para 122] For the reasons above, I intend to direct AHS to give the Applicant access to records 6, 7, 15, 20, 21, 25, 26, 27, 29, 31, 36, 37, 39 – 40, 45, 46, 47, 49, 51, 53, 54, 63, 68, 77, 78, 79, 82, 90, 91, 93, 94, 95, 96, 99, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 113, 114, 118, 119, and 120.

Issue G: Did AHS meet its duty to the Applicant as provided by section 10(1) of the FOIP Act (duty to assist applicants)? In this case, the Commissioner will also consider whether AHS conducted an adequate search for responsive records.

[para 123] In Order H2018-01, I directed AHS to conduct a new search in relation to case file 002374. As noted above, that case file was opened to address the adequacy of AHS's response to the Applicant's request for his mother's health records in his capacity as administrator of her estate. I reviewed AHS's search and directed it to conduct a new search for records responsive to points 4 and 5 of the Applicant's access request.

[para 124] Having compared the two access requests, I find that they encompass largely the same information. This is because the Applicant sought records containing his personal information that *related to the care of his mother*. Essentially, any information

[6] I interpret the term "for" as meaning "for the benefit of" or "at the direction of". Past orders of this office have held that the term "for", where it appears in the phrase "by or for", means "on behalf of". (See F2010-015 at paragraph 11).

responsive to the access request for which case file 002373 was opened, as it relates to the Applicant's mother's care, would also be responsive to the access request for which case file 002374 was opened.

[para 125] AHS submitted an account of the search it conducted for responsive records. The account is dated June 23, 2016, and was originally prepared for the SIPM appointed by the Commissioner to investigate and attempt to settle the matter. I am satisfied from my review of the steps AHS took to search for and locate responsive records containing the Applicant's name that it conducted a reasonable search. Any issues that are outstanding in relation to AHS's search for the Applicant's mother's health records may be addressed in the inquiry relating to case file 002374, which is ongoing.

[para 126] As a recommendation, I suggest that AHS request an applicant's authority to request someone else's personal information or health information when it notices that an access request encompasses such information. In this case, the Applicant is the executor his mother's estate, and was entitled under both the FOIP Act and the HIA to make a request for her information, whether personal information or health information. However, this access request, unlike the access request with regard to case file 002374, does not mention this fact, although it is now clear that they were made for the same purpose and in the same capacity.

[para 127] AHS did not communicate its requirement that the Applicant demonstrate that he was the administrator of his mother's estate, with the result that it responded to the Applicant as if he were not acting in that capacity. Because of this, AHS spent time severing information that did not require severing, while the Applicant did not receive a timely response. AHS is in a position to know what it requires before it may provide information; an applicant is not in such a position if AHS does not communicate the requirements. Requiring proof of legal authority to make an access request for someone else's information when the access request is made could improve AHS's ability to assist applicants in the future.

V. ORDER under the FOIP Act

[para 128] I make this Order under section 72 of the FOIP Act with regard to the information I have found to be subject to that Act.

[para 129] I order AHS to provide the Applicant with the information severed from records 3, 4, 5, 8, and 12 under section 24(1)(b).

[para 130] I order AHS to review record 10 and to determine whether section 17(1) applies to the information it severed under section 24(1)(b). If it decides that it does not, it should provide the information it severed from record 10 to the Applicant. If it decides that it does, then it must make a decision to apply this provision and provide a response to the Applicant to that effect.

[para 131] I order AHS to provide the Applicant with access to the records to which it applied section 17 of the FOIP Act.

VI. ORDER under the HIA

[para 132] I make this Order under section 80 of the HIA, with regard to that information I have found to be subject to that Act.

[para 133] I order AHS to give the Applicant access to the health information to which it applied section 24(1)(b) and section 27(1)(a) of the FOIP Act, but for record 10.

[para 134] I order AHS to inform me within 50 days of receiving these orders that it has complied with them.

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Teresa Cunningham
Adjudicator