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ALBERTA

OFFICE OF THE INFORMATION AND PRIVACY COMMISSIONER

ORDER H2005-006

July 14, 2006

DR. JAMES W. OSINCHUK

Review Number H0657

Office URL: http://www.oipc.ab.ca

Summary: The Applicant alleged that Dr. Osinchuk ("Dr. O" or "the Custodian") improperly refused to correct or amend her health information in contravention of section 13 of the *Health Information Act* ("HIA"). The Commissioner found that there was no error or omission proven under section 13(1) and that the information was a professional opinion or observation under section 13(6)(a) of HIA. The Commissioner found that Dr. O properly exercised his discretion and confirmed Dr. O's decision not to correct or amend the Applicant's health information in the Physician Notes under section 13 of HIA.

The Commissioner also found that Dr. O's response to the Applicant was a deemed refusal under section 13(7) of HIA, as he did not respond within the time set out in section 13(2) of HIA. Dr. O ultimately responded to the Applicant, so the Commissioner did not make an order on this issue.

Statutes Cited: AB: *Health Information Act*, R.S.A. 2000, c. H-5, ss. 1(1)(f)(ix), 1(1)(i), 1(1)(k)(i), 1(1)(m), 1(1)(n), 13, 13(1), 13(2), 13(5), 13(6)(a), 13(7), 14(1), 14(1)(a), 80(3)(d); *Freedom of Information and Protection of Privacy Act*, R.S.A. 2000, c. F-25, s. 36(2).

Authorities Cited: Canadian Medical Association, *Health Information Privacy Code*, CMA, Ottawa, October 1998, p. 10; Philip Beck, "The Confidentiality of Psychiatric Records and the Patient's Right to Privacy", *CPA Position Statement*, Canadian Psychiatric Association, December 2000, pp.

2-3; College of Physicians and Surgeons of Alberta, *Physicians' Office Medical Records*, CPSA Policy, Revised August 2005, pp. 1-2.

Cases Cited: *Egli et al v. Egli et al*, 2003 BCSA 1716 (CanLII) (BC SC); *R. v. West*, 2001, 45 C.R. (5th) 307 (Ont. SC).

Orders Cited: AB: Orders H2004-004, 2000-018, 2000-007, 2000-001, 98-010, 97-020, 97-002; **ONT**: Orders PO-2079 and MO-1518.

I. BACKGROUND

[para 1] The Applicant alleged that Dr. James W. Osinchuk ("Dr. O" or the "Custodian") improperly refused to correct or amend her health information in contravention of section 13 of the *Health Information Act*, R.S.A. 2000, c. H-5 ("HIA" or the "Act"). Dr. O refused to make corrections or amendments to the Physician Notes, saying there are no errors or omissions under section 13(1) and the information consists of professional opinions or observations under section 13(6)(a) of HIA.

[para 2] The Applicant asked me to review Dr. O's response to the request for correction or amendment, but the Applicant was not satisfied with the outcome of the mediation that I authorized. The matter was set down for inquiry and an oral inquiry was granted at the Applicant's request. The parties both provided written submissions. Dr. O provided Affidavit evidence and the Physician Notes. The written submissions were exchanged between the parties.

[para 3] At the Inquiry, the parties provided oral evidence and oral argument. The Applicant provided two further documents that were marked as exhibits. The Inquiry was held in conjunction with the inquiry for Review Number H0350 and Order H2005-007, involving the same Applicant and Dr. O as an affected party in that inquiry, as well as Capital Health. The Applicant and Custodian each provided one written submission for both inquiries.

II. RECORDS AT ISSUE

[para 4] I will refer to the records at issue as the "Physician Notes". The Physician Notes are variously referred to as Dr. O's physician notes, chart notes, medical treatment notes, clinical notes, physician office records, medical records and clinic records, which the Applicant asked Dr. O to correct or amend. The records in the Physician Notes are mostly Dr. O's clinical treatment or chart notes. The Physician Notes also include six notations of telephone calls, seven letters to disability insurers, two forms to Revenue Canada and two letters to other health services providers.

[para 5] Dr. O provided the records at issue in two binders labeled as "Volume 1" and "Volume 2". Volume 1 consists of tabs 1-14 and Volume 2 consists of tabs 15-98. Tab 1 is a copy of the Applicant's request to Dr. O. The first record at issue is dated

December 3, 1992 (tab 2) and the last record at issue is dated May 21, 1996 (tab 98). The Physician Notes consist of 97 separate records within 180 pages.

III. INQUIRY ISSUE

[para 6] The issue before the Inquiry is:

- Did the Custodian properly refuse to correct or amend the Applicant's health information under section 13 of HIA?

IV. PRELIMINARY ISSUE

[para 7] In her written and oral submissions, the Applicant raised a number of issues that fall outside of the correction or amendment request that is the subject of the Inquiry. My jurisdiction at the Inquiry and the scope of this Order are restricted to the correction or amendment issue raised by the Applicant in her November 15, 2004 request to Dr. O.

[para 8] I do not have jurisdiction at the Inquiry to make decisions about the Applicant's other issues raised in her submissions that go beyond the request for correction or amendment that is before me under section 13 of HIA. Section 80(3)(d) of HIA allows me to confirm a decision not to correct or amend health information or to specify how health information is to be corrected or amended. My authority in this case is restricted to reviewing Dr. O's decision under the Act not to correct or amend the Applicant's health information.

V. DISCUSSION OF INQUIRY ISSUE

ISSUE: Did the Custodian properly refuse to correct or amend the Applicant's health information under section 13 of HIA?

A. General

[para 9] The relevant parts of section 13 of HIA read:

> 13(1) An individual who believes there is an error or omission in the individual's health information may in writing request the custodian that has the information in its custody or under its control to correct or amend the information.
>
> 13(2) Within 30 days after receiving a request under subsection (1) or within any extended period under section 15, the custodian must decide whether it will make or refuse to make the correction or amendment.
>
> .....

> 13(5) If the custodian refuses to make the correction or amendment, the custodian must within the 30-day period or any extended period referred to in subsection (2) give written notice to the applicant that the custodian refuses to make the correction or amendment and of the reasons for the refusal.
>
> 13(6) A custodian may refuse to make a correction or amendment that has been requested in respect of
>
> (a) a professional opinion or observation made by a health services provider about the applicant, or …
>
> 13(7) The failure of the custodian to respond to a request in accordance with this section within the 30-day period or any extended period referred to in subsection (2) is to be treated as a decision to refuse to make the correction or amendment.

[para 10] When a custodian refuses to correct or amend an applicant's information under section 13, section 14(1) of HIA gives an applicant the choice of either asking me to review the custodian's decision or submitting a statement of disagreement to the custodian. The Applicant elected to ask me to review Dr. O's decision under section 14(1)(a) of HIA. This then precludes submitting a statement of disagreement to the custodian.

B. Argument and Evidence

[para 11] The Applicant provided her written submission in four duotang booklets. The Applicant labeled the first booklet as "Book One - Index", which is divided into 27 tabs. Book One consists of an "Overview" (tab 1), 24 tabs of letters and faxes (tabs 2-25), a "Summary of Facts" (tab 26) and an "Exhibit List" (tab 27).

[para 12] The "Summary of Facts" is a 49-page description of the "inaccuracies" that the Applicant says exist in her health information. Approximately 42 pages of the "Summary of Facts" pertain to the Physician Notes. In the "Summary of Facts" the Applicant provides bullets describing the alleged "inaccuracies" in the Physician Notes and the manner in which the Custodian is to "amend and correct" the information.

[para 13] The Applicant labeled the second booklet as "Book Two – Exhibits A-K2", the third booklet as "Book Three – Exhibits L2-K4" and the fourth booklet as "Book Four – Exhibits L4-F7". These three booklets include a total of 149 exhibits, which the Applicant numbers from Exhibit A to Exhibit F7. For the most part, the exhibits are organized in chronological order with the first exhibit dated November 26, 1992 and the last exhibit dated May 21, 1996.

[para 14] Dr. O provided a copy of the Applicant's November 15, 2004 request for correction or amendment to the Physician Notes as part of his written submission. The covering letter from the Applicant to Dr. O states:

> Please find enclosed related documentation for changes/amendments/corrections to my personal chart file that has not been addressed in my request.

[para 15] The Applicant's request to Dr. O begins with a 16-page, single spaced, 8-point font description of the alleged errors or omissions in the Physician Notes. The Applicant lists a number of alleged "inaccuracies" in each of the 97 separate records in the Physician Notes. The Applicant's request also includes a 271-page attachment of the information to be corrected or amended or added to the record to address the "inaccuracies". The Applicant's request to Dr. O is 289 pages in length.

Alleged Inaccuracies

[para 16] In oral argument, the Applicant said the Physician Notes say that November 29, 1992 is the date when her relationship with Dr. O began, but she did not meet him until December 3, 1992. In response in oral evidence, Dr. O said he regards the doctor-patient relationship as beginning on the date he receives the referral. Therefore the date is accurate. Exhibit A in the Applicant's submission contains a copy of the referral letter that was sent to Dr. O, which is dated November 29, 1992.

[para 17] I will provide some specific examples of what the Applicant alleges are "inaccuracies" in the Physician Notes. The Applicant's "Summary of Facts" provides 15 bulleted points describing what she alleges are "inaccuracies" in the first record in the Physician Notes, which is a three-page record. The first paragraph in the Physician Notes dated December 3, 1992 states:

> Her husband is employed occasionally as a carpenter with [name of organization] when work is available.

[para 18] The first bullet in the Applicant's "Summary of Facts" that pertains to the December 3, 1992 record alleges the following errors in the above information:

> My husband is a Carpenter's Superintendent employed full-time with [name of organization] which at times there has been a shortage of available work locally.

[para 19] The Physician Notes, dated December 3, 1992, continue as follows:

> She was offered a position in [name of town and province].

[para 20] In the fifth bullet of the "Summary of Facts", the Applicant alleges the following errors in the above information:

> Due to the inability of securing fulltime employment in [name of town], I accepted a position with my former employer Jan 1992 (Exhibit G). Our family was in process of a family move, whereas my spouse was completing the renovations on our home to allow for the sale of the house and my daughter was completing grade 12 and applying for colleges for September (Exhibit G2). I was opening a new office during my company's busiest time without support staff. I worked long overtime hours and traveled to [name of province] every few weeks on weekends, when I became ill (Exhibits: P, D).

[para 21] The Physician Notes, dated December 3, 1992, continue as follows:

> …she had fled back to [name of province].

[para 22] In the sixth bullet of the "Summary of Facts", the Applicant alleges the following errors in the above information:

> I had not "fled back to Alberta," but suffered from burnout and depression, was provided a 2-month leave of absence recommended by the treating physician and returned to my house and family as they had not yet relocated (Exhibits: I, P).

[para 23] The Physician Notes, dated December 3, 1992, continue as follows:

> DIAGNOSIS: Post Traumatic Stress Disorder; Borderline Personality Disorder.

[para 24] In the eighth bullet of the "Summary of Facts", the Applicant alleges the following errors in the above information:

> Contradicts Canada Life (Exhibit A4), differs from Letter to Dr. [name of doctor] and Group Referral form of same date; Differs from documents provided to my Company (Exhibit U), Disability Company (Exhibit P2), Revenue Canada (Exhibit T2), Canada Pension (Exhibit T2), Hospital Discharge Summaries (Exhibit G2), other medical professionals (Exhibit P), etc.

[para 25] The Physician Notes, dated December 3, 1992, continue as follows:

> It is planned to increase doses of [name of drug] to the highest possible dosage. …She had been on Prozac previously without success complaining of side effects after using this medication for three days.

[para 26] In the ninth bullet of the "Summary of Facts", the Applicant alleges the following errors in the above information:

> I was never prescribed Prozac. I was previously prescribed [name of drug] and encountered adverse effects (Exhibits: K, D, M, P).

[para 27] The above excerpts provide examples of the alleged "inaccuracies" in a three-page record in the Physician Notes. This is the first record of the 97 records in the Physician Notes that the Applicant alleges contain "inaccuracies".

[para 28] In his Affidavit, Dr. O states:

> 5. I kept clinical notes for my sessions with [name of Applicant]. These notes included my observations and opinions as well as recording things [name of Applicant] would say to me which I found relevant.
>
> 6. Over the time that I saw [name of Applicant], I treated her for symptoms of anxiety, major depression, Dissociative Disorder, Post Traumatic Stress Disorder and Multiple Personality Disorder. These diagnoses changed over time and were based on the professional opinions I reached from my sessions with her.

…

16. As stated above, my clinical notes represent a recording of my observations, impressions and understanding of [name of Applicant's] issues during my treatment of her. They include a recording of what I have heard and seen in my office. Furthermore, those observations, impressions and understandings informed my opinions on diagnoses and treatment of [name of Applicant].

…

19. The entries in my clinical chart (notes, Medical Reports, Revenue Canada forms and consult letters) accurately reflect what I heard or saw in my office, and my medical opinions and observations at the time they were recorded and, as such, I refuse to correct or amend the information requested by [name of Applicant].

[para 29] In his written submission, Dr. O states:

2. On February 6, 1998, the Applicant commenced a lawsuit against Dr. Osinchuk and another physician. As a result of that litigation, Dr. Osinchuk's clinic chart was produced as part of an Affidavit of Documents sworn on January 13, 1999. The original chart has remained with Dr. Osinchuk's solicitors since at least January 1999.

…

16. Dr. Osinchuk states that the facts as recorded in his chart notes are those directly reported to him by the patient during treatment sessions or as understood by him at that time. To the extent that a specific fact, for example, whether the Applicant's husband is a truck driver or a carpenter, may have been incorrectly recorded in any given entry, Dr. Osinchuk understood that fact to be true at the time that he recorded it. If the Applicant now denies that she made the statement as recorded by Dr. Osinchuk at the time, Dr. Osinchuk disputes that error of fact.

…

25. In Dr. Osinchuk's submission, each of the amendments and corrections requested by the Applicant relate to either a professional opinion by Dr. Osinchuk or an observation made by him in the course of providing treatment to the Applicant.

26. For those instances where the Applicant seeks to have the diagnoses or other professional opinions of Dr. Osinchuk changed or amended, Dr. Osinchuk submits that those opinions and diagnoses were honestly held by him at the time of recording them and, therefore, they should not be changed. It is Dr. Osinchuk's submission that the information at issue in this inquiry is comprised of accurate descriptions of professional opinions and observations formed by Dr. Osinchuk during the course of his therapeutic relationship with his patient, the Applicant.

[para 30] In oral evidence, Dr. O said he obtained all of the information at issue in the Physician Notes directly from the Applicant, mostly during patient visits to his office. He said that he makes chart notes for every patient visit. Dr. O said that he prepares the chart notes mainly for his own clinical reference, but the chart notes were his main source of information to compile the letters to disability insurers, forms to Revenue Canada and the letters to other health services providers that are also at issue.

[para 31] At the time the Applicant was his patient, Dr. O said that his practice was to first listen intently to his patient during the office visit. After the visit he prepared handwritten notes in shorthand form and at the first opportunity, he dictated the notes. The dictation was transcribed and the typewritten chart notes were then placed in the patient's clinic record, which are now part of the Physician Notes.

Legal Argument

[para 32] The Applicant says there are errors or omissions in the Physician Notes and that Dr. O should correct or amend the information under section 13(1) of HIA. In oral argument the Applicant conceded that this is a "he said, she said" kind of situation, where it is her word against Dr. O's as to what she said during the office visits and as to what Dr. O understood her to say during those visits.

[para 33] Dr. O disagrees with the Applicant and says the health information at issue is not subject to correction or amendment under section 13(1) of HIA as the information is complete and accurate. Dr. O argues that these notes are professional opinions or observations under section 13(6)(a) of HIA, so he says he is entitled to refuse to correct or amend the information.

[para 34] Dr. O says that all of the information at issue falls within the definition of "professional opinion or observation" as that term is defined in Order H2004-004 (para 19) and as "professional opinion" as defined in Order 97-020. Dr. O says all of the information at issue consists of professional opinion or observation under section 13(6)(a) of HIA as the information recorded was "directly reported to him by the patient during treatment sessions or as understood by him at that time."

[para 35] Dr. O argues that the information in an opinion or observation cannot be considered to be an error or omission when it is an accurate reflection of the views or observations of the author at the time it was recorded, whether or not it is supported by fact, as the truth or falsity of the views is not the issue. Dr. O cites previous Orders from my office in support of this principle (Orders H2004-004 (para 20); 2000-007 (para 16) and Ontario Orders PO-2079 and MO-1518).

[para 36] Dr. O argued that where a record contains an accurate description of the writer's opinion or observation, the record cannot be corrected as to that opinion or observation, because there is no error. Additionally, it was argued that where an opinion or observation is involved, an applicant cannot use a correction to substitute the applicant's view or change the custodian's opinion or observation; Order H2004-004 (para 20) was cited as authority for this principle.

[para 37] Additionally, Dr. O says the integrity of the Physician Notes should be maintained in this case. In his Affidavit, he states:

> 17. Changing my clinical notes now would be tantamount to changing history, as my notes would then no longer reflect the thoughts, opinions, observations, impressions and understanding I held and accurately recorded at the time.
>
> 18. Similarly, adding records which I did not have on my chart at the relevant times would alter the record of what I knew and relied on at the time I was treating [name of Applicant].
>
> 19. Similarly, [name of Applicant] asks Dr. Osinchuk to add hospital records and other documents to her chart. The treatment chart is intended to be a record of observations, plans and care provided to [name of Applicant]. If a document did not form a part of her health record at the time certain diagnostic and treatment decisions were made, it would be inappropriate to add them to the record now. Furthermore, the addition of documents in this context is not an amendment or correction.

[para 38] In his written submission, Dr. O states:

> 20. Requests to provide further records are not requests to amend or correct health information. A complete copy of the Applicant's chart has been provided to her through the lawsuit which she has brought against Dr. Osinchuk. No further documents or records exist.
> …
>
> 27. In addition, the documents which the Applicant seeks to correct or amend are currently the focus of a lawsuit. In such circumstances, Dr. Osinchuk submits that it would be improper to make any amendments or corrections to the chart.

[para 39] Dr. O says that examinations for discovery are the proper forum to seek additional information or clarification of information that is relevant to litigation. He argues that it is not appropriate in the midst of legal proceedings for a Plaintiff patient to be asking a Defendant physician to alter a relevant health record, either by amending the information or by adding additional information "under the guise of amending or correcting health information" under HIA.

[para 40] In his written submission, Dr. O says the amendments or corrections requested by the Applicant are "voluminous" and even if it is found that there are errors or omissions that are subject to correction, he is not required to make corrections or amendments that would amount to editing in the particular fashion prescribed by the Applicant (Orders 2000-007 (para 23), 2000-001 (para 23), 98-010, 97-020). Dr. O also argued that there is a dispute about whether there is an error or omission and therefore the information is not subject to correction or amendment under HIA (Orders H2004-004 (paras 11 and 15), 97-020).

[para 41] I will use a two step process to address the issues in the case before me. First, I will consider whether any of the information at issue consists of a professional opinion or observation under section 13(6)(a) of HIA. If the information is a professional opinion or observation, that information is not subject to correction or amendment, as a custodian can refuse to make a correction or amendment under section 13(6)(a) of HIA regardless of whether there is an error or omission. The burden of proof under section

13(6)(a) of HIA is to show that the information consists of a professional opinion or observation.

[para 42] Second, with respect to the information that is not professional opinion or observation, I will consider whether there are errors or omissions under section 13(1) of HIA. If the information contains an error or omission of fact that information may be subject to correction or amendment. Therefore, a custodian must justify a decision to refuse to make a correction or amendment under section 13(1) of HIA. The burden of proof under section 13(1) of HIA is to show that the information contains an error or omission. A custodian must properly exercise discretion when refusing to correct or amend health information.

C. Application of Section 13(6)(a) (Professional Opinion or Observation)

[para 43] As stated, my first step will be to consider whether any of the information at issue consists of professional opinion or observation under section 13(6)(a) of HIA. A custodian is allowed to refuse to correct or amend information that is a professional opinion or observation under section 13(6)(a) of HIA.

[para 44] I have previously interpreted section 13(6)(a) of HIA and said that the following three requirements must be met in order for this provision to apply (Order H2004-004 (para 17)):

- There must be either a professional opinion or observation,
- The professional opinion or observation must be a health services providers', and
- The professional opinion or observation must be about the applicant.

[para 45] The Act is silent regarding which party has the burden of proof to show that the information consists of professional opinions or observations under section 13(6)(a) of HIA. In Order H2004-004, I said that a custodian has the burden of proof under section 13(6)(a) of HIA, as the party who refuses to correct an applicant's information is in the best position to speak to the reasons for refusing to make a correction or amendment (para 21). I adopt that reasoning here.

[para 46] Dr. O says that he has the burden of proof under section 13(6)(a) of HIA to show why he has refused to correct the information in the Physician Notes. I find that Dr. O is in the best position to speak to the reasons for refusing to correct or amend the Applicant's information under section 13(6)(a) of HIA. Therefore, in this case I find that the Custodian has the burden of proof under section 13(6)(a) of the Act.

Professional Opinion or Observation

[para 47] I have previously said that "professional" means of or relating to or belonging to a profession and "opinion" means a belief or assessment based on grounds short of proof, a view held as probable. "Observation" means a comment based on something one has seen, heard, or noticed, and the action or process of closely observing

or monitoring (Order H2004-004, para 19). The opinion or observation is that of the author or the writer of the information at issue.

[para 48] Opinions and observations are subjective in nature. Opinions, even those based on the same set of facts, can differ. Dr. X may see a patient and form the opinion that the patient has the flu. Dr. Y may see the same patient and form the opinion that the patient has a cold. HIA does not compel custodians to resolve these differences of opinion by forcing physicians to change their opinions under the guise of correction. For example, in Order H2004-004, I said the physician's notations of "paranoid" and "personality disorder" were professional opinions and the physician's notation of "unable to get along with people" was a professional opinion or observation that the physician could refuse to correct (para 24).

[para 49] Section 13(6)(a) of HIA allows a custodian to refuse to correct or amend a professional opinion or observation, but a custodian is not prohibited from making such a correction or amendment. This provision stands in contrast to the parallel provision in section 36(2) of the *Freedom of Information and Protection of Privacy Act*, R.S.A. 2000, c. F-25 ("FOIP"), which says that "a public body must not correct an opinion, including a professional or expert opinion". When considering FOIP principles in the context of the parallel HIA provisions, this difference needs to be kept in mind.

Records: Ethical and Professional Standards

[para 50] The Canadian Medical Association ("CMA") Privacy Code provides guidance to Canadian physicians and says:

> 7.2 The recording of statements of fact, clinical judgements and determinations or assessments should reflect as nearly as possible what has been confided by the patient and what has been ascertained, hypothesized or determined to be true using professional judgement (Canadian Medical Association, *Health Information Privacy Code*, CMA, Ottawa, October 1998, p. 10).

[para 51] The Canadian Psychiatric Association ("CPA") endorses the CMA Privacy Code and provides record keeping guidelines for psychiatry, as follows:

> Psychiatric records contain important information that contributes to establishing a diagnosis and treatment plan for patients suffering from emotional disorders. As a rule, records include not only historical information about the patient, but also his or her recollections, fantasies, feelings, fears, and preoccupations from the past as well as in the present. As such, psychiatric records differ from many other types of medical records.
>
> Psychotherapy notes may not be verbatim, systemic, or all-inclusive. They tend to identify themes or develop hypotheses; their content may be highly selective or impressionistic. Particularly when notes are written in the context of certain forms of psychodynamic therapy, the therapist may include speculation and analogy as well as verifiable, factual data. What is recorded is usually determined solely by the exigencies of diagnosis and treatment. (emphasis added)
>
> In psychotherapy, the therapist attempts to meet the patient at some point in his or her subjective experience of the world. Psychotherapy as a process attempts to address

> subjective as well as objective reality and may not discriminate between historical fact and fantasy; it strives to be open and non-judgemental. These factors influence both the content and structure of psychiatric records and limit their usefulness within other contexts (Philip Beck, "The Confidentiality of Psychiatric Records and the Patient's Right to Privacy", *CPA Position Statement*, Canadian Psychiatric Association, December 2000, pp. 2-3).

[para 52] The College of Physicians and Surgeons of Alberta ("CPSA") has this to say to physicians about the correction of medical records:

> Alterations to Medical Records - From time to time an error may occur in the entry of data into a medical record. ….. A patient has the right to demand correction of erroneous records where the issue is about a factual matter that can be proven. That right does not extend to demanding a change in a statement of professional opinion by a physician with which the patient may disagree, but which the physician, after further reflection, is unwilling to alter. The Health Information Act, however, requires the physician to notify the patient of that refusal and give the reasons for refusing. The patient may put his/her opinion in writing; the physician must then attach that statement to the record (College of Physicians and Surgeons of Alberta, *Physicians' Office Medical Records*, CPSA Policy, Revised August 2005, pp. 1-2).

Common Law

[para 53] The courts have grappled with whether information is fact, observation or opinion. In *Egli et al v. Egli et al*, 2003 BCSA 1716 (CanLII) BC SC, Justice Garson, discussed the difference between observations and opinions in health records, as follows:

> I will first examine the case law which in following *Ares v. Venner* developed an apparent distinction between somewhat mechanical observations which are admissible under *Ares v. Venner*, compared to more subjective opinions, such as psychiatric opinions, which are not admissible as business records. Second, I examine the authorities in which some courts have preferred to treat the issue not as an admissibility question but as a question of weight (para 11).

[para 54] In *Egli*, Justice Garson considered the view that there are a range of opinions, which fall on a continuum:

> In *R. v. West*, 2001, 45 C.R. (5th) 307 (Ont. SC), Hill J. suggests that opinions are on a continuum – at one end are opinions like those of the nurses in *Ares v. Venner,* and at the other are expert opinions (para 14).

[para 55] *R. v. West,* 2001, 45 C.R. (5th) 307 (Ont. SC), dealt with whether a forensic report, which had been prepared by a biologist who had since deceased, was admissible in evidence for the truth of its contents or alternatively was inadmissible as hearsay evidence. Justice Hill stated:

> There is of course a continuum of subjective opinionism with observations positioned at one end and conclusions clearly steeped in expert skills at the other. In some instances, observations of the expert declarant, while informed by a measure of special knowledge or expertise, are arguably little more than the expression of opinion permitted by a lay

witness; *Ares v. Venner*, supra (skin colour and relative temperature of skin); *H.(S.)*, supra (emotional condition of patient); *Regina v. Skrzydlewski*, supra (observations of patient behaviour); *Conley v. Conley*, supra (physical movements of subjects and opportunity for togetherness). On the other hand, some opinion statements are almost wholly the product of application of specialized skill and experience as in the hard science of forensic pathology: *Regina v. Larsen*, supra (cause of death as asphyxia) (para 63).

[para 56] In applying the concept of a continuum of subjective opinion to the facts of this case, I find that most of the information at issue in Dr. O's Physician Notes falls at the end of the continuum that is described in the common law cases as "subjective opinionism" such as psychiatric opinion. However, other information at issue falls at the opposite end of the continuum and is more comparable to "mechanical observations" such as skin colour, relative skin temperature, emotional condition of the patient and patient behaviour that are mentioned in the above jurisprudence. This latter end of the continuum is an "observation" under HIA.

[para 57] In his Affidavit, Dr. O says the entries "are an accurate reflection of what I observed and understood at the time of recording the notes" and "represent a recording of my observations, impressions and understanding. … Furthermore, those observations, impressions and understandings informed my opinions on diagnoses and treatment".

[para 58] Also in his Affidavit, Dr. O also says the information is "a recording of what I have heard and seen in my office" and formed the basis of his opinions. In oral evidence, Dr. O said the Physician Notes accurately reflect his perceptions, impressions and understandings of what the patient said to him.

[para 59] Most of the information at issue is based on what Dr. O understood his patient to have told him during patient visits to his office and psychotherapy sessions. The information includes details in the Applicant's life as related to Dr. O. The information includes the Applicant's past and current relationships with others as well as feelings, emotions, perceptions and experiences.

[para 60] For the most part the information in the Physician Notes consists of Dr. O's recording of what he saw, heard or noticed during the Applicant's visits to his office and consists of views or assessments based on grounds short of proof. The information that Dr. O derived from the sessions with the Applicant is not verifiable information. That information speaks to Dr. O's understanding of what he was told rather than to the truth of what he was told. These notations are intended to be the author's views, not the Applicant's views, of what the Applicant said.

[para 61] So, for example, Dr. O wrote in the Physician Notes that the Applicant's husband was employed as a carpenter. The Applicant says that she told Dr. O her husband is/was a "Carpenter's Superintendent". There are three possible explanations that come to mind for this discrepancy:

1. Dr. O did not hear the Applicant correctly;

2. Dr. O did hear the Applicant correctly but shortened what he heard to "carpenter" in his notes; or
3. The Applicant said "carpenter" and that is what Dr. O recorded.

[para 62] There is no way of knowing which explanation is right. If it was necessary to do so, one could make a decision, on balance of probabilities, as to which explanation is right. But it is not necessary here because we do know, beyond dispute, that Dr. O recorded that the Applicant's husband was a carpenter. This recording is Dr. O's view; this notation represented Dr. O's perception, interpretation, impression or understanding of what the Applicant told him.

[para 63] This is different than if Dr. O had dictated that the Applicant's husband was a "Carpenter's Superintendent" and whoever transcribed the dictation got it wrong and typed in "carpenter". The record would then not be accurate in terms of Dr. O's observations and opinions. This is a difficult distinction to make.

[para 64] Dr. O's evidence is that the information at issue is what he saw, heard or noticed about his patient. Most of the information at issue is subjective in nature and is not capable of concrete proof, as there is no way of factually ascertaining whether the events, feelings or thoughts described by the Applicant actually occurred or of verifying precisely what the Applicant said to Dr. O during the patient visits. In any event, professional opinion or observation does not go to the truth of its contents, but rather to the impressions, perceptions, views and understandings of the author.

[para 65] I accept the position of Dr. O that most of the information at issue is either a professional opinion or an observation or, alternatively, is a mixture of professional opinion or observation. I accept the Affidavit evidence of Dr. O that the information recorded is an accurate reflection of his understanding and views at the time the record was created. Right or wrong, these are Dr. O's professional opinions or observations, which are not necessarily the same as the Applicant's views.

[para 66] Thus, I find that most of the information at issue consists of professional opinions or observations made by a health services provider about the Applicant. Therefore, I find that the first requirement under section 13(6)(a) of HIA, that there must be a professional opinion or observation, is satisfied.

Health Services Provider & About the Applicant

[para 67] Dr. O says that the professional opinions or observations in the Physician Notes were made by a "health services provider" as defined in section 1(1)(n) of the Act. As a physician, he was providing a "health service" under section 1(1)(m) of HIA, which entails promoting physical and mental health, preventing illness and diagnosing and treating illness. It is not in dispute that Dr. O was a custodian pursuant to section 1(1)(f)(ix) of HIA. Therefore, I find that the second requirement under section 13(6)(a) of the Act is satisfied.

[para 68] The third requirement in section 13(6)(a) of HIA is also met as the professional opinions or observations in the Physician Notes are about the Applicant. Therefore, I find that Dr. O has discharged the burden of proof to show that all of the criteria in section 13(6)(a) of HIA are satisfied.

D. Application of Section 13(1) (Error or Omission)

[para 69] As I have previously indicated, having separated the opinion and observation which a custodian can refuse to correct from the rest, the second step will be to consider whether the balance of the information at issue contains errors or omissions under section 13(1) of HIA. Section 13(1) of HIA says that an applicant has the right to request a correction or amendment where the applicant believes there is an error or omission in their health information. I have previously interpreted section 13(1) of HIA in Order H2004-004, so there is no need to repeat that discussion here.

[para 70] I have previously said that the following two requirements must be met in order for section 13(1) of HIA to apply (Order H2004-004, para 8):

- There must be health information about the applicant, and
- There must be an error or omission in the applicant's health information.

[para 71] Section 13(1) of the Act only comes into play when the above two criteria are met. In order for a custodian to correct or amend under section 13(1) of HIA, it must be proven that there is an error or omission in the information. Conversely, where there is no proven error or omission, the health information is not subject to correction or amendment under section 13(1) of HIA.

[para 72] The Act is silent regarding which party has the burden of proof to show that there is an error or omission under section 13(1) of HIA. In Order H2004-004, I said that an applicant has the burden of proof under section 13(1) of HIA, as an applicant is in the best position to show where there has been an error or omission in that person's own information (para 12). I adopt that reasoning here.

[para 73] Dr. O says the Applicant has the burden of proof under section 13(1) of HIA and has failed to show any errors or omissions in the Physician Notes. In this case, I find that the Applicant has the burden of proof to show that there is an error or omission under section 13(1) of HIA in this case, because the Applicant is in the best position to show where there is an error or omission in her own health information.

Health Information

[para 74] "Health information" under HIA includes "diagnostic, treatment and care information" (section 1(1)(k)(i)). "Diagnostic, treatment and care information" includes information about the physical and mental health of an individual, a health service provided to an individual and any other information about an individual that is

collected when a health service is provided to the individual (HIA section 1(1)(i)). It is not in dispute that the information at issue is the Applicant's health information under HIA. I am satisfied that the first requirement under section 13(1) of HIA is met.

Error or Omission

[para 75] In Order H2004-004 under HIA, I previously said that an "error" is a mistake, or something wrong or incorrect; an "omission" is something that is missing, left out or overlooked (para 10). "Correct" means to set right, amend, or substitute the right thing for the wrong thing (Order H2004-004, para 11).

[para 76] In Order 97-002, the former Commissioner said "fact" means a "thing that is known to have occurred, to exist, or to be true; an item of verified information" (para 42). That interpretation is adopted in a number of Orders issued from my Office. In Order 97-002, the former Commissioner said a fact is information that could be determined objectively (para 43).

[para 77] For example in Order 2000-018, the information that was found to be an error of fact was an incorrect summary of a physician's diagnosis in a clinical assessment report. The two errors of fact were: first, reference to the applicant's tenderness as being at "C5 to C7" whereas the physician's diagnosis said it was at "C5 to T7"; and second, reference to certain syndromes contributing to a pain syndrome complex whereas the physician's diagnosis said those syndromes did not contribute much to the pain syndrome complex (para 17).

[para 78] It is important to note that, in Order 2000-018, the record did not correctly reflect the physician's diagnosis. The record showed "C5 to C7". The diagnosis was "C5 to T7". This information can be corrected. Had the diagnosis actually been "C5 to C7" then the record must stand, even if the diagnosis was wrong. There are other legal remedies for missed diagnoses.

[para 79] I have already determined that most of the information at issue in the Physician Notes consists of professional opinion or observation under section 13(6)(a) of HIA. However, there are some exceptions in the Physician Notes to the second-hand information that Dr. O received from the Applicant.

[para 80] The date the relationship began and the medications and the laboratory tests that Dr. O ordered is verifiable first-hand information that Dr. O did not obtain solely from the Applicant. I find that the information that pertains to the date the relationship began and the medications and the laboratory tests that were ordered by Dr. O were based on Dr. O's first-hand knowledge, and therefore is fact.

[para 81] The Physician Notes are consistent with the hospital records of Capital Health that, for example, indicate the Applicant was prescribed a variety of medications that included Prozac over a period of time. The Physician Notes accurately reflect the laboratory tests that Dr. O ordered and the date when the doctor-patient relationship

began. I am not persuaded from the argument and evidence provided by the Applicant that there are errors or omissions of fact in the Physician Notes.

[para 82] I accept the position of Dr. O that the Applicant has failed to discharge her burden of proof to show that the Physician Notes contain errors or omissions under section 13(1) of HIA. I find that the Applicant has not provided sufficient evidence to show that there are errors or omissions in the Physician Notes. Therefore, I find that the second requirement under section 13(1) of HIA is not met.

E. Exercise of Discretion

[para 83] When an applicant has not discharged the burden of proof to show that there are errors or omissions, a custodian properly exercises its discretion when it refuses to correct or amend that information under section 13(1) of HIA. When the information consists of a professional opinion or observation that is accurately recorded, a custodian properly exercises its discretion when it refuses to correct or amend that information under section 13(6)(a) of the Act, as there is no error or omission and therefore nothing to correct or amend.

[para 84] A request for correction or amendment should not amount to rewriting the records in the applicant's own words. A request for correction or amendment should not be used to attempt to appeal decisions or opinions or observations with which an applicant disagrees and cannot be a substitution of opinion, such as the applicant's view of a medical condition or diagnosis. A custodian properly exercises its discretion to refuse to correct or amend in these circumstances.

[para 85] A custodian properly exercises its discretion when refusing to correct or amend health information in the above circumstances. For all of the above reasons, I accept Dr. O's argument that he properly exercised his discretion. Therefore, I find that Dr. O properly refused to correct or amend the Applicant's health information in the Physician Notes under section 13(6)(a) and section 13(1) of HIA.

[para 86] The information at issue has been relied upon as the record of the medical treatment that was provided to the Applicant a long time ago. The Physician Notes are beyond the usual 10-year retention period for physician records. This record was involved in professional disciplinary proceedings in the past and currently pertains to medical malpractice proceedings brought by the Applicant against the Custodian. These factors weigh towards maintaining the historical integrity of the record.

[para 87] There are compelling policy reasons for not requiring custodians to correct or amend opinions and observations under HIA. The integrity of a health services provider's records is important, not only for the patient's rights, but also for the health care system. Suppose I am a doctor. A patient presents herself to me. I observe the following symptoms and conditions and form the following opinion:

Observation A

Observation B
Observation C
Therefore: Diagnosis X

[para 88] If the patient, or anyone else, can require me to change or correct any of my observations, it undermines or even makes nonsense of my diagnosis. If the patient wants to sue me for my diagnosis, he/she will not have important evidence of possible errors or omissions on my part. If the hospital or professional regulatory body wants to see if I went wrong or where I went wrong, any alteration to the above will prevent them from doing so.

F. Application of Section 13(7) (Deemed Refusal)

[para 89] Section 13(2) of HIA requires a custodian to decide whether to make or refuse to make the correction or amendment within 30 days after receiving a request or within any extended time period. When a custodian fails to respond to a request in accordance with section 13(2), the response is treated as a decision to refuse to make the correction or amendment under section 13(7) of HIA; that is, as a deemed refusal.

[para 90] Dr. O concedes that he did not respond to the Applicant's request within the 30-day time period or within any extended period as required by section 13(2) of HIA. Therefore, I find Dr. O's lack of response within the time period under section 13(2) to be a deemed refusal under section 13(7) of HIA. However, since Dr. O did ultimately respond to the Applicant, I do not intend to make an order on this issue.

VI. ORDER

[para 91] Pursuant to my authority under section 80(3)(d) of HIA*:*

- I find that Dr. O properly refused to correct or amend the Applicant's health information under section 13(6)(a) of HIA. Therefore, I confirm Dr. O's decision not to correct or amend the Applicant's health information under section 13(6)(a) of HIA.

- I find that Dr. O properly refused to correct or amend the Applicant's health information under section 13(1) of HIA. Therefore, I confirm Dr. O's decision not to correct or amend the Applicant's health information under section 13(1) of HIA.

[para 92] I have found that the information at issue is not subject to correction or amendment in the circumstances of this case. This finding should not be taken to mean that health records prepared by psychiatrists are beyond correction or amendment under the Act**. I want to reaffirm, in the strongest way, para 7.2 of the CMA Privacy Code which states:**

> 7.2 The recording of statements of fact, clinical judgements and determinations or assessments should reflect as nearly as possible what has been confided by the patient and what has been ascertained, hypothesized or determined to be true using professional judgement (Canadian Medical Association, *Health Information Privacy Code*, CMA, Ottawa, October 1998, p. 10).

[para 93] I thank the parties for their well-organized submissions and records and for their articulate written and oral argument during the Inquiry.

Frank Work, Q. C.
Information and Privacy Commissioner