ALBERTA

OFFICE OF THE INFORMATION AND PRIVACY COMMISSIONER

ORDER H2005-007

July 14, 2006

CAPITAL HEALTH

Review Number H0350

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Summary: The Applicant alleged that Capital Health ("CH" 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 CH properly exercised its discretion in refusing to correct or amend the information and confirmed CH's decision not to correct or amend the Applicant's health information in the Hospital Records under section 13 of HIA.

Statutes Cited: AB: *Health Information Act*, R.S.A. 2000, c. H-5, ss. 1(1)(a)(iii), 1(1)(i), 1(1)(k)(i), 1(1)(m), 1(1)(n), 13, 13(1), 13(6)(a), 14(1), 14(1)(a) and 80(3)(d).

Orders Cited: AB: Orders H2005-006, H2004-004, 2000-007, 2000-001, 98-010, 97-020.

I. BACKGROUND

[para 1] The Applicant alleged that Capital Health ("CH" 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"). CH previously made corrections or amendments to the Applicant's health information in the Hospital Records but refused to make further corrections or amendments, saying there are no errors or omissions under section 13(1) and additionally, the information consists

of professional opinions or observations made by a health services provider about the Applicant under section 13(6)(a) of HIA.

[para 2] The Applicant asked me to review CH'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. All parties provided written submissions. CH and the Affected Party ("the Psychiatrist") provided Affidavit evidence; CH provided the Hospital Records. The written submissions were exchanged among the parties.

[para 3] At the Inquiry, all parties provided oral evidence and oral argument. The Applicant provided two further documents that were marked as exhibits. CH provided further written argument. The Inquiry was held in conjunction with the inquiry for Review Number H0657 and Order H2005-006, involving the same Applicant and the Psychiatrist who is the Affected Party at the Inquiry. The Applicant and the Affected Party provided one written submission for both inquiries.

II. RECORDS AT ISSUE

[para 4] I will refer to the records at issue as the "Hospital Records". The Hospital Records consist of six hospital discharge summaries, which are variously referred to as the hospital records, patient records, health records, medical summaries and hospital discharge summaries. The Affected Party completed all of the summaries in issue, with the exception of one summary that was completed by another CH physician and copied to the Affected Party.

[para 5] CH provided the records at issue in a separate booklet as part of its written submission. The Hospital Records consist of a total of 16 pages, as follows:

- April 14, 1993 - May 17, 1993 (3 pages),
- July 21, 1993 – July 29, 1993 (2 pages),
- October 12, 1993 – October 26, 1993 (1 page),
- November 15, 1993 – December 3, 1993 (2 pages),
- November 7, 1994 – November 25, 1994 (5 pages), and
- November 2, 1995 – November 13, 1995 (3 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 September 11, 2003 request to CH.

[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 CH'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(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.

[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 CH'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 seven pages of the "Summary of Facts" pertain to the Hospital Records. In the "Summary of Facts" the Applicant provides 110 bulleted descriptions of alleged "inaccuracies" in the Hospital Records and asks the Custodian to "amend and correct" the information as requested.

[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] CH provided a copy of the Applicant's September 11, 2003 request for correction or amendment in the Hospital Records as part of its written submission. The covering page of the request is a "Request to Correct or Amend Health Information" form, where the Applicant states:

> I have attached & highlighted the hospital discharge summaries, and included the supporting documentation as to why these are incorrect. The information on my Hospital Discharge Summaries are [sic] inaccurate.

[para 15] The Applicant's request to CH begins with a six-page description of alleged errors or omissions in the Hospital Records and a 142-page attachment. The Applicant lists numerous alleged inaccuracies to be corrected, prescribes information to be added to the record and asks several questions about the Hospital Records. The Applicant's request to CH is 149 pages in length.

Alleged Inaccuracies

[para 16] I will provide some examples of the allegations of inaccuracies in the Applicant's "Summary of Facts" as well as the responses of the Custodian and the Affected Party. The Applicant provides 17 bulleted points (1½ pages) of alleged errors or omissions that pertain to the first record (2½ pages of information) in the Hospital Records.

[para 17] The first paragraph of the first hospital discharge summary of April 14-May 17, 1993 states:

> She was transferred away from her family to [name of town] in order to take on working in a program and office out there. This left her away from her family and with little, if any, other supports. As well there were a number of difficulties between personnel in the office that she had difficulty coping with. As a result of that, she became progressively more isolated and unable to cope. She subsequently became depressed and returned home on disability leave with severe depressive symptoms.

[para 18] The Applicant's first bullet in the "Summary of Facts" that pertains to the above summary alleges the following "inaccuracies":

> I was not in any program nor was I transferred. I was opening a new office during my company's busiest time without support staff and encountered some staffing issues. I worked long overtime hours and traveled to [name of province] every few weeks on weekends. A two-month leave of absence was recommended (August 21, 1992). I followed the medical advice and returned to [name of town] for this leave (Exhibits: I, J, P, D, G).

[para 19] In response, in its further written submission, CH replies:

> "Program" Dr. [name of doctor's] terminology and understanding of [name of Applicant's] description of her job.

[para 20] The next sentence in the hospital discharge summary of April 14-May 17, 1993 states:

> She was seen by her GP in [name of town], with arrangements made for her to follow up with a psychologist. Over that period of time, it became apparent that one of the difficulties she was facing was recollection of post-traumatic stress disorder …

[para 21] The second bullet in the Applicant's "Summary of Facts" alleges that the above information contains the following "inaccuracies":

> I was diagnosed with Depression and Anxiety by the GP, psychologists and other physicians prior to seeing Dr. [name of doctor], December 1992 (Exhibits: J, P). I continued to provide assistance and [sic] to my office and was still working at home. Dr. [name of doctor] diagnosed Post Traumatic Stress Disorder (Exhibits: B, P, D, I4).

[para 22] In response, in its further written submission, CH replies:

> PTSD [Post-Traumatic Stress Disorder] diagnosis. Dr. [name of doctor] indicated that in his discussions with [name of Applicant's] previous caregivers, PTSD was offered by them as a diagnosis they had been considering based on their observation of [name of Applicant].

[para 23] The hospital discharge summary of April 14-May 17, 1993 says:

> Husband also works regularly and is currently a truck driver.

[para 24] In the "Summary of Facts", the Applicant says:

> This statement is false. My spouse has never been a truck driver. Contradicts Chart Note (Exhibit B) noted on (Exhibits: D, C, E7).

[para 25] In oral evidence at the Inquiry, the Psychiatrist said this notation was an accurate description of his understanding at the time the record was made, although he subsequently learned that the Applicant's husband was not a truck driver. The Psychiatrist said he thought they "cleared up" this matter as he even met with the Applicant's husband about this issue. In oral evidence, the Applicant said perhaps this confusion arose because she has a male friend who is a truck driver, whom she often mentioned during her visits.

[para 26] The Applicant alleges the "inaccuracies" include the following omissions in the hospital discharge summary of April 14-May 17, 1993:

> Medications differ. There is not any mention of the same psychologist's telephone conversation; attending me or her attendance to Hospital Case Conferences. There is not any mention of being molested when I was 8; the CT scan conducted; of the photographs being requested or reviewed (Exhibit N2); the video-taping conducted …, the previous drug reactions to [names of medications] (Exhibits P, K); or of the increasing or changing medications contradicting (Exhibit B).

[para 27] In response, in its further written submission, CH replies:

> No difference noted. References to lab work and medications are made within the context of the summary. Detailed information is documented elsewhere in the chart. In the professional opinion of Dr. [name of doctor], the information he provided in the summary is the information that was relevant to the synopsis of the treatment given.

[para 28] In its written submission, CH says:

> 23. With respect to the Applicant's request that additional information be added to her health record the Custodian submits that the information she requests to have added is already included in the health record itself. The discharge summaries are, by definition, summaries of the information elsewhere in the chart and do not set out the entirety of the information described elsewhere. The information that the Applicant requests to have added to the discharge summaries is already present in the Applicant's health record and therefore, there are no omissions.

[para 29] The hospital discharge summary of April 14-May 17, 1993 states:

> FINAL DIAGNOSES: POST-TRAUMATIC STRESS DISORDER. DISSOCIATIVE DISORDER. MAJOR DEPRESSIVE ILLNESS.

[para 30] In the "Summary of Facts" in regard to the above information, the Applicant alleges:

> Differ from the information provided from "Initial Patient & Discharge Information – Discharge Diagnosis" (Exhibit D). Contradicts (Exhibits: N, B, P). These Diagnosis disappeared after medications and treatment was discontinued (Exhibit J2). It should be

> also noted that there have not been any further hospitalizations for these types of issues/diagnoses after medications and treatment was discontinued (Exhibit J2).

[para 31] In its further written submission, CH replies:

> The diagnosis noted on each document are the diagnoses that were determined at that time.

[para 32] I will now provide some examples from the end of the Hospital Records, where the sixth and last hospital discharge summary dated November 2-13, 1995, states:

> Her history has been well documented on other occasions, but on this occasion the episodes of depression were subsequent to a period of work where she was placed in a position well beyond her capabilities. She was isolated in [name of province] where …., was harassed at work and subsequently broke down.

[para 33] In the "Summary of Facts" in regard to the above information, the Applicant alleges:

> I was not placed in a position beyond my capabilities and received a second company award. My previous supervisor confirmed my qualifications and capabilities on October 3, 2005 (Exhibit G). I was never harassed at work. I had staffing issues noted that were previously noted (Exhibits: E, G2).

[para 34] In response, in its further written submission, CH replies:

> The information documented is based on the physician's understanding of the information presented by the patient at the time.

[para 35] The hospital discharge summary, dated November 2-13, 1995, states:

> DISCHARGE MEDICATIONS: … Prozac ...

[para 36] In the "Summary of Facts", in regard to the above information, the Applicant alleges:

> Discharge Medications inaccurate as attached. Discharge medications not noted.

[para 37] In response, in its further written submission, CH replies:

> Medications are correct.

[para 38] In her Affidavit, the CH employee who handled the Applicant's request says:

> The information documented in the Discharge Summaries reflect what the health services providers understood to be the facts/issues, based on clinical observations of the patient and/or based on what the patient expressed at the time or information provided by the patient at the time. The information was recorded by the health services providers to

make treatment decisions. The documentation reflects the treatment decisions and diagnoses made by the health services providers. The observations, assessments, and/or treatment decisions and diagnoses are those made at the time by the health services providers and remain supported by the professional opinion of the health services providers who provided the care. Your disagreement with those understandings, observations, assessments, treatment decisions, and/or diagnoses as supported by the professional opinion of the health services providers does not constitute or necessitate a "correction" or "amendment" to the health record.

Reference to lab work and medications in the Discharge Summaries are made within the context of the summaries. Detailed or additional information regarding medications or tests/procedures administered during the hospital stay are documented elsewhere within the health record. …

Your concern regarding alleged differences between the discharge diagnoses on the Discharge Summaries does not constitute or necessitate a "correction" or "amendment" to the health record. The full diagnoses are documented in the Discharge Summaries. In addition, it is important to note that a diagnosis could change between admissions.

[para 39] In oral evidence, the Psychiatrist said the chart notes were his main source of information to complete the hospital discharge summaries. In his Affidavit, the Psychiatrist 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.

7. My clinical notes are an accurate reflection of what I observed and understood at the time of recording the notes.
…

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].

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. 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 40] In his written submission, the Psychiatrist states:

> 16. Dr. [name of doctor] 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. [name of doctor] 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. [name of doctor] at the time, Dr. [name of doctor] disputes that error of fact.

[para 41] The first four hospital discharge summaries say the Applicant was discharged from hospital on the medication, Prozac. The fifth discharge summary says the Applicant was on Prozac over the last two years. The exhibits provided by the Applicant show that the doctor's orders for the sixth admission include an order for Prozac; the treatment notes say the Applicant refused the medication while in hospital and the order for Prozac was discontinued for the time the Applicant was in hospital. As indicated above, Prozac is in the list of medications in the sixth hospital discharge summary.

Legal Argument

[para 42] The Applicant says there are errors or omissions in the Hospital Records and CH 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 the physicians as to what she said and as to what the physicians understood her to say.

[para 43] CH and the Affected Party disagree with the Applicant and say 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. CH and the Affected Party argue that these records are professional opinions or observations under section 13(6)(a) of HIA, so a custodian is entitled to refuse to correct or amend the information.

[para 44] The Psychiatrist 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." In his written submission, the Psychiatrist states:

> 25. In Dr. [name of doctor's] submission, each of the amendments and corrections requested by the Applicant relate to either a professional opinion by Dr. [name of doctor] 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. [name of doctor] changed or amended, Dr. [name of doctor] 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. [name of doctor's] submission that the information at issue in this inquiry is comprised of accurate descriptions of professional opinions and observations formed by Dr. [name of doctor] during the course of his therapeutic relationship with his patient, the Applicant.

[para 45] CH and the Affected Party say this is a case where the integrity of the records should be maintained. The Affected Party refers to the purpose of the records being created and says:

> 19. Similarly, [name of Applicant] asks Dr. [name of doctor] 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 46] The Affected Party says that examinations for discovery are the proper forum to seek additional information that is relevant to litigation. He argues that it is not appropriate for a Plaintiff patient to be asking for a relevant health record to be altered in the midst of legal proceedings, by amending the information or by adding additional information "under the guise of amending or correcting health information" under HIA.

[para 47] In his written submission, the Affected Party 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. [name of doctor]. 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. [name of doctor] submits that it would be improper to make any amendments or corrections to the chart.

[para 48] In his written submission, the Psychiatrist 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, CH 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). The Psychiatrist 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 49] 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 50] 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 make a correction or amendment to health information.

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

[para 51] 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 52] I have previously interpreted section 13(6)(a) of HIA in Orders H2004-004 and H2005-006, so there is no need to repeat those discussions here. I have said that the following three requirements must be met for section 13(6)(a) of HIA to apply (Orders H2004-004 (para 17), H2005-006 (para 44)):

- 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 53] 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 Orders H2004-004 and H2005-006, 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 (paras 21 and 46 respectively). I adopt that reasoning here and find that the Custodian has the burden of proof under section 13(6)(a) of the Act.

Professional Opinion or Observation

[para 54] 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 (Orders H2004-004 (para 19), H2005-006 (para 47)). Opinions and observations are subjective in nature.

[para 55] The Applicant says the information in the hospital discharge summaries contains "inaccuracies" and CH should correct or amend the information. CH and the Affected Party say the information at issue in the Hospital Records is an accurate description of professional opinion or observation under section 13(6)(a) of HIA and a custodian is allowed to refuse to correct or amend the information.

[para 56] The Psychiatrist's Affidavit evidence is that the information at issue is an accurate description of what was seen, heard or noticed by the physicians. Most of the information at issue is subjective in nature and is not capable of concrete proof. For example, there is no way of factually ascertaining precisely what the Applicant told the physicians or of verifying whether the events, feelings or thoughts described by the Applicant actually occurred.

[para 57] For the most part, the information at issue in the Hospital Records consists of the physicians' recordings of what they saw, heard or noticed during the Applicant's hospitalizations and consists of assessments based on grounds short of proof. I accept the argument that the information the physicians derived from the Applicant is not verifiable; the information speaks to the authors' understandings of what they were told rather than to the truth of what they were told. These notations are intended to be the authors' views, not the Applicant's views, of what the Applicant said.

[para 58] I accept the arguments of CH and the Affected Party that most of the information at issue is either a professional opinion or observation or, alternatively, is a mixture of opinion and observation. I accept the Affidavit evidence of the Affected Party that the information recorded accurately reflects the views of the authors at the time the record was created. Right or wrong, these are the physicians' professional opinions or observations, which are not necessarily the same as the Applicant's views.

[para 59] Information that consists of professional opinion or observation does not stand for the truth of its contents, but rather for the view or understanding of the author. Most of the information at issue consists of professional opinions or observations that were made by health services providers 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 60] CH says that the professional opinions or observations in the Hospital Records were made by a physician who was a "health services provider" as defined in section 1(1)(n) of the Act. The physicians were 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.

[para 61] The physicians who completed the records at issue were affiliates of a custodian, in that they were health services providers with the right to admit and treat patients in a hospital pursuant to section 1(1)(a)(iii) of HIA. These matters are not in dispute and I find that the second requirement under section 13(6)(a) of the Act is satisfied.

[para 62] The third requirement in section 13(6)(a) of HIA is also met as the professional opinions or observations in the Hospital Records are about the Applicant. Therefore, I find that CH has discharged its 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 63] 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) 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.

[para 64] I have previously interpreted section 13(1) of HIA in Orders H2004-004 and H2005-006, so there is no need to repeat those discussions here. I have previously said that the following two requirements must be met for section 13(1) of HIA to apply (Order H2004-004 (para 8), Order H2005-006 (para 70)):

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

[para 65] 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, there must first be a proven 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 66] 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 Orders H2004-004 and H2005-006, 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 and para 72 respectively). I adopt that reasoning here.

[para 67] CH and the Affected Party both say the Applicant has the burden of proof under section 13(1) of HIA and has failed to show that there are any errors or omissions in the Hospital Records. 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 68] "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 69] In Orders H2004-004 and H2005-006 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 and para 75 respectively). "Correct" means to set right, amend, or substitute the right thing for the wrong thing (Orders H2004-004 (para 11), H2005-006 (para 75)).

[para 70] I have previously said that "fact" means a "thing that is known to have occurred, to exist, or to be true; an item of verified information" (Orders H2004-004 (para 42), H2005-006 (para 76)). A fact is information that can be determined objectively (Order H2005-006 (para 76)).

[para 71] I have already determined that most of the information at issue in the Hospital Records consists of the physicians' impressions and perceptions of what the Applicant told them and is professional opinion or observation under section 13(6)(a) of HIA. However, there are some exceptions in the Hospital Records to the second-hand information that the physicians received solely from the Applicant.

[para 72] The information about the discharge medications that were ordered and the laboratory tests that were conducted in hospital is verifiable first-hand information that was not obtained solely from the Applicant. I find that where the physicians had first-hand knowledge about the discharge medications and the laboratory tests, then that information is fact.

[para 73] In their written and oral submissions, the parties disagree about every single issue raised by the Applicant. The only area of partial agreement is that the Applicant's husband is not a truck driver. However, the Psychiatrist says this entry is not an error as this was an opinion or observation and at the time the information was recorded this accurately reflected his understanding of what the Applicant had told him.

[para 74] The Hospital Records are consistent with the physician chart notes and for example, indicate that the Applicant was prescribed medications that included Prozac over a period of time. There are no evident errors or omissions that pertain to the laboratory tests. I am not persuaded from the argument and the evidence provided by the Applicant that there are errors or omissions in the Hospital Records.

[para 75] I accept the position of CH and the Affected Party that the Applicant has failed to discharge her burden of proof to show that the Hospital Records 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 Hospital Records. Therefore, I find that the second requirement under section 13(1) of HIA is not met.

E. Exercise of Discretion

[para 76] 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 under section 13(6)(a) of the Act, a custodian properly exercises its discretion when it refuses to correct or amend that information, as there is no error or omission and therefore nothing to correct or amend.

[para 77] 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 78] Furthermore, CH did not arbitrarily refuse to make any corrections or amendments and previously made amendments to the Hospital Records. A custodian is properly exercising its discretion when refusing to correct or amend health information in the above circumstances. For all of the above reasons, I accept CH's argument that it has properly exercised its discretion. Therefore, I find that CH properly refused to correct or amend the Applicant's health information in the Hospital Records under section 13(6)(a) and section 13(1) of HIA.

[para 79] The information at issue has been relied upon as the record of the health services that were provided to the Applicant a long time ago. The Hospital Records are beyond the usual 10-year retention period for hospital records. The record pertains to quasi-judicial and judicial proceedings brought by the Applicant against the Affected Party. These factors weigh towards maintaining the historical integrity of the record.

VI. ORDER

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

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

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

[para 81] I have found that the information at issue is not subject to correction or amendment due to the circumstances of this case. This finding should not be taken to mean that psychiatric health records are beyond correction or amendment under the Act**.** 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