ALBERTA

OFFICE OF THE INFORMATION AND PRIVACY COMMISSIONER

ORDER H2013-01

March 28, 2013

DR. MOHAMED ABDEL-KERIEM

Case File Number: H4037

Office URL: www.oipc.ab.ca

Summary: In 2002, Dr. Mohamed Abdel-Keriem (the Custodian) manually transcribed the Applicant's chart notes from his pen computer onto his tablet computer and then had his pen computer re-formatted. In 2010, the Applicant made an access request to obtain a copy of her original chart from the Custodian. The Custodian responded, providing the Applicant with a print out of her chart from his tablet computer. The Applicant complained to the Office of the Information and Privacy Commissioner (this Office) stating that she wanted a copy of her original chart (which was stored on the pen computer). The Applicant did not believe that her original chart did not exist or if it had been destroyed, she felt the Custodian had not met his obligations to protect the information. Finally, the Applicant argued that the Custodian was required to submit a privacy impact assessment (PIA) when he transferred information from his pen computer to his tablet computer.

The Adjudicator found that the Applicant's original chart no longer existed because the Custodian had disposed of his pen computer after he transcribed the Applicant's chart notes from his pen computer onto his tablet computer. The Adjudicator also found that the Custodian had met his obligations to protect against the Applicant's health information being lost and to ensure its accuracy and completeness. Finally, the Adjudicator found that the Custodian was not required to submit a PIA when he transferred the Applicant's chart from the pen computer to the tablet computer.

Statutes Cited: AB: *Alberta Evidence Act* s.41.3; *Alberta Rules of Court; Health Information Act* R.S.A. 2000, c. H-5 ss. 1, 7, 10, 60, 61, 64, 80, and 107.

Authorities Cited: AB: H2009-IR-006.

I. BACKGROUND

[para 1] From June 1, 1998 to May 24, 2003, the Applicant was a patient of Dr. Mohamed Abdel-Keriem (the Custodian), a psychiatrist.

[para 2] According to the Custodian, at the beginning of the Applicant's treatment, he made his chart notes using a "pen" computer (original chart notes). Sometime in 2002, the Custodian acquired a "tablet" computer. He soon discovered that he would not be able to transfer data on his pen computer directly to his tablet computer nor was he able to print off a copy of what was on his pen computer. Therefore, in late 2002 and early 2003, the Custodian manually transcribed his chart notes from his pen computer onto his tablet computer (electronic chart notes). When this transcription was complete, the Custodian had his pen computer professionally reformatted and disposed of the pen computer, thereby destroying the original chart notes. He then used his tablet computer to record all of his chart notes.

[para 3] On November 26, 2004, pursuant to the *Health Information Act* (the Act) the Applicant requested a copy of her chart from the Custodian. The Custodian responded by setting up a meeting on December 6, 2004 with the Applicant to discuss any concerns she may have. According to the Applicant, at this meeting the Custodian advised her that she could not have a copy of her chart because it contained too much information about the Applicant's husband (who had also attended many of the Applicant's sessions with the Custodian).

[para 4] On June 5, 2005, the Applicant complained to the College of Physicians and Surgeons of Alberta (CPSA) about the quality of care that the Custodian provided to her. The Applicant also sent the CPSA a "Request to Access Health Information Form" requesting, through the CPSA, all information in the Custodian's possession relating to herself and her husband. The form was signed by both the Applicant and her husband.

[para 5] As part of the investigation, the Custodian provided the CPSA a copy of the Applicant's chart. When the Custodian was manually transcribing the Applicant's chart notes into his tablet computer, the computer automatically generated a date at the top of the page which corresponded with the date of transcription, not the treatment session date. According to the Custodian, believing that the Applicant would be upset by the computer generated date, he decided to handwrite the chart notes from his tablet on to letterhead and provided that version of the chart to the CPSA (handwritten chart notes).

[para 6] On November 22, 2005, the CPSA dismissed the Applicant's complaint. According to the Applicant, on December 7, 2005, a copy of the handwritten chart was sent to the Applicant by the CPSA.

[para 7] On reviewing the handwritten chart, the Applicant became convinced that the chart was inaccurate and on January 5, 2006 she filed a second complaint with the CPSA

claiming that the Custodian had produced a fraudulent copy of the Applicant's medical record. During the course of this investigation, which was eventually closed and the Applicant's request for appeal denied, the Applicant learned that the original chart notes were destroyed and that only the electronic chart notes and the handwritten chart notes existed.

[para 8] In December of 2010 the Applicant requested a complete copy of her chart from the Custodian. The request was received by the Custodian on January 17, 2011. The Custodian provided the Applicant with a copy of the electronic chart notes. The Applicant was apparently looking for the original chart notes and, therefore, returned the records sent to her by the Custodian. On January 24, 2011, she filed a complaint with the Office of the Information and Privacy Commissioner (this Office). In the request for review received by this Office on January 27, 2011, the Applicant speaks only of the January, 2011 access request and the Custodian's failure to provide her with the original chart notes. She also says she believes that the Custodian manipulated the dates in the electronic chart notes.

[para 9] The Commissioner authorized mediation but it was not successful in resolving the issues between the parties. The Applicant requested an inquiry. I received initial and rebuttal submissions from both parties.

II. INFORMATION AT ISSUE

[para 10] The information at issue in this inquiry consists of the contents of the Applicant's original, handwritten and electronic chart notes as well as all other information contained in the Applicant's chart.

III. ISSUES

[para 11] The Notice of Inquiry dated July 10, 2012, set out the 3 main issues in this Inquiry as follows:

1. Did the Custodian comply with his duty under section 10 of the Act to make every reasonable effort to assist the Applicant and to respond to her openly, accurately and completely?

2. Did the Custodian comply with his obligations under section 60(1) and 61 of the Act, which requires that a custodian must take reasonable steps to maintain technical and physical safeguards that will protect against any reasonably anticipated threat to the security or integrity of health information or of loss of health information, and must make a reasonable effort to ensure that health information in its custody or control that it uses or discloses is accurate and complete?

3. When the Custodian transcribed the data from his pen computer to a tablet computer, did he have an obligation under section 64 of the Act, which

> require a privacy impact assessment in the event of a proposed change to administrative practices and information systems relating to collection, use and disclosure of health information, and if so, did he comply with this obligation?

[para 12] It was also made clear in the Notice of Inquiry that section 7 and section 107(1) of the Act would not be dealt with in the inquiry. The Applicant believes that these issues ought to be considered in this inquiry and a large portion of her submissions focuses on these issues. Therefore, I will comment on them as preliminary issues.

IV. DISCUSSION OF ISSUES

Preliminary Issue 1: Section 7 of the Act

[para 13] Section 7 of the Act states:

> *7(1) An individual has a right of access to any record containing health information about the individual that is in the custody or under the control of a custodian.*
>
> *(2) The right of access to a record does not extend to information in respect of which a custodian is authorized or required to refuse access under section 11, but if that information can reasonably be severed from a record, an individual has a right of access to the remainder of the record.*
>
> *(3) The right of access to a record is subject to the payment of any fee required by the regulations.*

[para 14] The Notice of Inquiry states:

> This inquiry will *not* address whether [the Custodian] met his obligation to provide access to records under section 7 of the Act. There is nothing to contradict [the Custodian's] attestation that the original records no longer exist. In dealing with an access request, this office cannot deal with the failure to provide access to records that were not in existence at the time of the request, regardless of the reasons why they were not in existence.

[para 15] The Applicant's submissions were lengthy and at some points during the submissions she appears to argue that the original chart notes may still exist and are being hidden by the Custodian. Yet, in other parts of her submission, she states that no one denies that the original chart notes have been destroyed and still, in other parts of her submissions she states that the original chart notes were in existence at the time of her November 26, 2004 and June 5, 2005 access requests.

[para 16] As detailed in the background section of this order, the Applicant made three access requests for her chart from the Custodian. The first was in 2004. The next was through the CPSA in 2005 and the last was in 2010. When the Applicant requested a

review of the Custodian's response to her access request in 2011, there was no mention of the 2004 or 2005 access requests.

[para 17] The Applicant provided no evidence that the original chart notes still exist. The Custodian, on the other hand, provided Affidavit evidence that the original chart notes were destroyed sometime after he completed transcribing the notes from his pen computer to his tablet computer. Based on the information and evidence before me, I have no reason to believe that the original chart notes existed at the time the Applicant made her access request in December of 2010.

[para 18] As for the Applicant's assertion that the original chart notes existed at the time of her 2004 and 2005 access requests, this is not relevant for this inquiry because the Applicant asked for a review of the access request made in 2010.

Preliminary Issue 2: Section 107(1) of the Act:

[para 19] Section 107(1) of the Act states:

> *107(1) No custodian or affiliate of a custodian shall knowingly*
>
> > *(a) alter, falsify or conceal any record, or direct another person to do so, with the intent to evade a request for access to the record, or*
> >
> > *(b) destroy any record that is subject to this Act, or direct another person to do so, with the intent to evade a request for access to the record.*
> > *…*

[para 20] The Notice of Inquiry states:

> This inquiry will also *not* address the Applicant's allegations under section 107(1) of the HIA. The Applicant has not suggested that [the Custodian] falsified, altered or destroyed records *in order to evade a request for access* to such records. Rather, her allegations relate to her belief that records were falsified or destroyed in order to mislead [the Custodian's] professional association when he was responding to her complaint against him. That is a matter beyond the jurisdiction of this office.

[para 21] The Applicant submits that she is suggesting the Custodian of destroying the original chart and falsifying the electronic and handwritten charts in order to evade her access request of 2004.

[para 22] As I mentioned above, the Applicant's request for review does not make mention of her 2004 access request. In any event, the thrust of the Applicant's submission is that the Custodian fraudulently changed her chart in order to make her look like a non-compliant patient which would, presumably, assist him when defending the Applicant's allegations to the CPSA that the Custodian did not provide her with an adequate standard of care. It was only after her complaints had been dealt with by the

CPSA that the Applicant made another access request for the original chart notes and complained to this Office when they were not delivered.

[para 23] I find the following quote from the Applicant's submission helpful in finding that her complaint was not that the Custodian had altered her chart for the purpose of evading her access request but for the purpose of evading discipline by the CPSA:

> After finding that my health record had been compromised, I closely examined the record and found it to be a forgery, which explained the cool reception I had received from the patient advocate when I spoke to her. I had read through the record several times and each time I held distain for the person portrayed in it. It also spoke volumes as to why the CPSA dismissed my complaint. I did not think it fair that the CPSA had completed an investigation into my complaint on false information and wanted to rectify this, so I carried on preparing my Appeal.
>
> Within the health record, I found [the Custodian] had taken ownership of my life and changed it to benefit himself…He changed the doctor/patient relationship making me non-compliant…As well, [the Custodian] deliberately eliminated e-mails which I had sent pleading for his proffered referral with a colleague…
>
> On the advice of the CPSA's Registrar of Complaint's, I filed a second complaint with the CPSA, on January 5, 2006. I stated that [the Custodian] had produced a fraudulent health record in order to invalidate my standard of care complaint against him…
> …
> I claimed that [the Custodian] knowingly and intentionally denied any accountability for having provided substandard care by shifting all the blame on me. He depicted me, within the health record, as an extremely difficult patient who constantly went against his professional advice, contrary to what had actually transpired. In this second complaint, I reiterated that it was this comprised and inaccurate health record used by the CPSA in which my complaint against [the Custodian] had been dismissed.
>
> (Applicant's initial submission, pages 29-30)

[para 24] The Applicant also states that there are inconsistencies between the handwritten chart notes and the electronic chart notes. She drew my attention to the inconsistencies, which appear to have been transcription errors. However, in any event, her argument regarding the discrepancies between the two versions of the charts seems to be not that the records were altered to evade an access request, but that they show that the record was fraudulent and not a "true copy" of the original.

[para 25] Based on the Applicant's submission, I find section 107 of the Act is not applicable to this inquiry as the Applicant's request for inquiry was regarding her 2010 access request and not her 2004 access request. In any event, even if the Applicant had asked this Office to review her 2004 access request, the Applicant's argument is that the Custodian altered her chart notes in order to avoid discipline by the CPSA as a result of her standard of care complaint. Therefore, taking into account either access request, section 107 of the Act is not applicable. As the Notice of Inquiry correctly states, I have no jurisdiction to review the decisions of the CPSA.

Preliminary Issue 3: CPSA complaints:

[para 26] It is clear from the Applicant's submissions that she did not feel that the CPSA's inquiry process was fair nor were its findings regarding her complaints. In fact a significant portion of the Applicant's rebuttal submissions relate to evidence she provided the CPSA but does not feel was given adequate weight.

[para 27] The Applicant also submits:

> The OIPC also needs to look at procedural fairness and whether the CPSA made a finding affecting my rights as due [to] me under the HIA.
>
> (Applicant's rebuttal submissions, page 39)

[para 28] As well, multiple times throughout the Applicant's submissions, she makes reference to the Custodian not abiding by policies and procedures of the CPSA.

[para 29] This Office deals with access and privacy complaints and custodians' obligations under the Act. I have no jurisdiction to review or make findings regarding the CPSA's process or findings. If the Applicant wished to have the CPSA's decision reviewed further, this was not the proper forum. Further, the CPSA's findings have no bearing on this inquiry. Therefore, I will not be commenting on the proceedings or findings of the CPSA in this Order, but will limit my findings to the issues stated in the Notice of Inquiry.

A. Did the Custodian comply with his duty under section 10 of the Act to make every reasonable effort to assist the Applicant and to respond to her openly, accurately and completely?

[para 30] Section 10 of the Act states:

> *10 A custodian that has received a request for access to a record under section 8(1)*
>
> *(a) must make every reasonable effort to assist the applicant and to respond to each applicant openly, accurately and completely,*
>
> *(b) must create a record for an applicant if*
>
> *(i) the record can be created from information that is in electronic form and is in the custody or under the control of the custodian, using its normal computer hardware and software and technical expertise, and*
>
> *(ii) creating the record would not unreasonably interfere with the operations of the custodian, and*

> *(c) must provide, at the request of an applicant and if reasonably practicable, an explanation of any term, code or abbreviation used in the record.*

[para 31] The Notice of Inquiry went on to explain:

> This issue relates to the Applicant's allegations that [the Custodian's] explanations as to why he did not have copies of the original medical records are not true.

[para 32] As I noted in the background section of this Order, the Custodian's evidence is that the Applicant's original chart notes were kept on a pen computer. When he acquired a tablet computer, he decided to transfer the Applicant's chart notes to his tablet. He discovered that this could only be accomplished by manually transcribing the notes onto the tablet. Once this transcription was complete (sometime in 2003), he had the pen computer professionally reformatted and destroyed.

[para 33] In her submissions regarding this specific issue, the Applicant goes into detail about the history of her other two access requests (in 2004 and 2005) and the lack or lateness of response from the Custodian. She submits that in 2010 she requested a copy of her original chart notes. The Applicant then states:

> On January 24, 2011, I was sent a copy of the rewritten "electronic" record, which I refused to accept. I wanted a copy of the "original," which is within my rights, including copies of all e-mails and faxes which I sent and letter from third parties. I brought this matter to the OIPC.
>
> (Applicant's initial submissions, page 104)

[para 34] Given the Applicant's submissions, the content of the Request for Review and the way this issue is crafted, I will confine my findings specifically to the Applicant's 2010 access request and her allegations that the Custodian is not being truthful in why he does not have a copy of the original medical record.

[para 35] The Applicant states that the Custodian could have erased or modified the computer generated date that the top of the tablet page and so there was no need to handwrite the chart notes. The Custodian argues that there is no evidence that the electronic copy of the chart notes is different from the original chart notes and that refuting the Applicant's point about changing the date on the page would require expert testimony for which this Office's procedures do not have a mechanism.

[para 36] There is nothing preventing parties from presenting expert reports as evidence in an inquiry. In any event, I do not believe that an answer to the Applicant's allegations requires expert evidence. As well, the Applicant's allegations go to whether the Custodian was lying about his motivation in re-writing her chart. For instance, the Applicant states:

> The original was destroyed (or has been hidden), because if it were produced, it would not resemble the two health records which [the Custodian] has written and I now have in my possession.
>
> (Applicant's initial submission, page 108)

[para 37] This issue, as stated in the Notice of Inquiry, is whether the Custodian's explanations as to why he no longer has the Applicant's original chart was true or not. The motivation behind the Custodian handwriting the electronic notes is not an issue in this inquiry.

[para 38] More on point, the Applicant submits that she believes that the data could have been transferred electronically between the pen computer and the tablet computer and that there was no need to manually transfer the chart notes. The Applicant did some internet research on this point and her findings indicate that, depending on the model of tablet, the data could have been transferred electronically. The Custodian maintains throughout his submissions that he found that he was unable to do this. He may be mistaken and it was possible to migrate the data between the devices. I am not aware of the Custodian's experience or level of skill with computers or if he contacted anyone to get advice in this regard. However, I believe, on a balance of probabilities, that if he knew how to electronically transfer his chart notes to his tablet computer directly from his pen computer rather than manually entering each chart note for all of the patient charts that he had on his pen computer, he would have done so.

[para 39] The Custodian further submits that he was unable to print a copy of the original chart notes from the pen computer directly and so it was not possible to keep a hardcopy of the original chart. The Applicant finds it suspicious that the Custodian has not shared this fact until this inquiry.

[para 40] The Applicant also believes that the Applicant has sworn a false Affidavit. She takes issue with the fact that the Custodian referred to the copy of the electronic chart as a, "true copy of the complete health record in my possession relating to the treatment of my former patient…" She feels that the electronic record cannot be a true copy because it has not been certified to be so by a Notary Public and because it does not meet what she feels is the definition of a true copy as found in the *Alberta Evidence Act* and the *Alberta Rules of Court*. She also feels that the Custodian's statement that the electronic chart is a true copy of the original chart gives the, "…'illusion' that he has done a proper data transfer."

[para 41] As far as this inquiry is concerned, nothing turns on these points. However, I do not believe that in order for someone to claim that a copy of a document is a true copy, they need to have a Notary Public's stamp. I also do not think that the Custodian was giving the "illusion" of having done a proper data transfer when he swore that he transferred the data from one computer to another. The *Alberta Rules of Court* are also not applicable to this inquiry. Further, the evidence that the Custodian provided to me in support of his submissions in this inquiry were not electronic records. He provided submissions and an Affidavit. Therefore, I do not believe that the provisions of the

Alberta Evidence Act cited by the Applicant are applicable. In any event, the Custodian has made it clear in his submissions and with a sworn Affidavit that he manually transferred the original chart notes from his pen computer to his tablet computer. While the Applicant does not regard this as compelling evidence, it is still evidence, "capable of supporting a finding that the electronic record is what the person claims it to be" as required by section 41.3 of the *Alberta Evidence Act*.

[para 42] The Applicant also submits that the Custodian did not transfer the data in 2002/2003 but likely re-wrote her chart notes (both the handwritten and electronic charts) sometime after her 2004 meeting with the Custodian to discuss her 2004 access request and treatment. The Applicant further surmises that the handwritten chart and electronic chart were probably created when the CPSA sent the Custodian the Applicant's second "Request for Health Information" form to him in 2005. The Applicant bases her argument primarily on the fact that there is a notation dated in 1998 that reveals information that the Applicant claims that she did not know until 2004. Based on this chart entry and other transcription errors, the Applicant concludes the Custodian must have re-written the chart sometime after 2004.

[para 43] As noted above, the issue of whether the Custodian complied with section 10 of the Act relates to the allegations that the Applicant makes that the Custodian is not being truthful in explaining why the original chart notes do not exist. Therefore, for the purposes of this inquiry, I do not think anything turns on the 1998 notation because the issue, as I understand it, is whether the Custodian's explanation of why the original chart does not exist is truthful not how the Applicant believes the Custodian falsified her chart notes.

[para 44] The Custodian's reasons for not having the original chart are stated in a sworn Affidavit. He swears that he had his pen computer professionally re-formatted and then disposed of the computer. In order to find that the Custodian's reason for not being able to produce the original chart is not truthful, I would have to find that the Custodian swore a false Affidavit. This is a serious allegation and one in which I would have to find that the Custodian was not credible. While the Applicant may be convinced that the Custodian swore a false Affidavit, I am not. Nothing in the Applicant's submissions is compelling evidence that this is the case. In fact, in some portions of her submissions she seems to concede the point that the Custodian had his pen computer destroyed. The Applicant's main argument is that the Custodian's motivation behind destroying the original chart is not truthful. That is not the issue. The issue is whether the Custodian is being truthful when he states that he had his pen computer re-formatted and disposed of. I have no reason to believe that the Custodian is not telling the truth about what happened to the Applicant's original chart.

[para 45] On the basis of the information and evidence before me, I find that the Custodian's explanation of why he did not have copies of the original chart to be the truth.

B. Did the Custodian comply with his obligations under section 60(1) and 61 of the Act, which requires that a custodian must take reasonable steps to maintain technical and physical safeguards that will protect against any reasonably anticipated threat to the security or integrity of health information or of loss of health information, and must make a reasonable effort to ensure that health information in its custody or control that it uses or discloses is accurate and complete?

[para 46] Section 60(1) of the Act states:

> *60(1) A custodian must take reasonable steps in accordance with the regulations to maintain administrative, technical and physical safeguards that will*
>
> *(a) protect the confidentiality of health information that is in its custody or under its control and the privacy of the individuals who are the subjects of that information,*
>
> *(b) protect the confidentiality of health information that is to be stored or used in a jurisdiction outside Alberta or that is to be disclosed by the custodian to a person in a jurisdiction outside Alberta and the privacy of the individuals who are the subjects of that information,*
>
> *(c) protect against any reasonably anticipated*
>
> *(i) threat or hazard to the security or integrity of the health information or of loss of the health information, or*
>
> *(ii) unauthorized use, disclosure or modification of the health information or unauthorized access to the health information,*
>
> *and*
>
> *(d) otherwise ensure compliance with this Act by the custodian and its affiliates.*

[para 47] The Applicant argues that the Custodian did not protect against the reasonably anticipated threat to the security or integrity of her health information. Specifically, she states that by manually transferring her chart notes from the pen computer to the tablet computer and then destroying the pen computer, the Custodian failed to protect not only the integrity of her original chart notes but the meta data that would have been associated with her chart notes on the pen computer. She states that the meta data acts as a safeguard against unauthorized modification of health information and that:

> [w]ithout the safeguards in place, it allowed [the Custodian] to make 'unauthorized modifications,' whereby [the Custodian] intentionally forged a health record in [the Applicant's name].
>
> (Applicant's initial submission, page 110)

[para 48] As well, the Applicant submits that there are discrepancies between the handwritten and electronic versions of her chart, which is evidence that the Custodian failed to protect the integrity of her health information.

[para 49] The Custodian argues that the fact that his pen computer software was not compatible with his tablet computer software was not a "reasonably anticipated" threat or hazard. While the Custodian did not anticipate that the software on the two computers would be incompatible, I believe that when the Custodian realized that the data could not be electronically transferred, there was a reasonably anticipated potential threat to the integrity of the information or the loss of health information, that needed to be addressed. However, as I will explain further below, I also believe that the Custodian took reasonable steps to protect against this potential threat to the integrity of the information or the loss of information, by manually transcribing the information onto his tablet computer.

[para 50] The Applicant argues that the integrity of the information was compromised and that some information was lost. I agree that there was a loss of meta data when the Custodian manually transferred the Applicant's chart notes and destroyed his pen computer. I am using the term "meta data" in this context to mean information that a computer system collects about how the system was used. This could include information about what text was inputted into the system, when the Applicant's chart was accessed and when it was modified.

i. Did the Custodian fail to take reasonable steps to protect against a loss of "health information"?

[para 51] Section 60 of the Act deals with the loss of "health information". Health information is defined in section 1(k) of the Act as follows:

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

[para 52] Meta data is not, in and of itself, health information as defined by the Act; however, meta data can capture health information, depending on the information put into the electronic document and the features of the system itself. In this case, the information that was inputted was text onto a pen computing system. While the meta data might capture the Applicant's name or portions of her chart notes, which could be health information, this information is all apparent in the text of the chart. Therefore, even if the pen computer's meta data captured this information and that meta data was lost when the Custodian disposed of this pen computer, the health information was not lost, since it was transcribed into the Custodian's tablet computer. The format was lost, but not the information. As health information was not lost, it cannot be said the Custodian failed to take reasonable steps to protect against such a loss. In other words, the steps the Custodian chose to take – transcribing the original chart notes to the tablet computer –

were reasonable to protect against any reasonably anticipated loss of the Applicant's health information.

ii. Did failure to protect against loss of the meta data amount to a threat to the integrity of the health information?

[para 53] The Applicant's arguments also relate to the integrity of the health information. These arguments are primarily that without the meta data, the Custodian cannot provide the Applicant with convincing evidence that her chart notes were not modified by him after the fact. She argues that the pen computer was an electronic medical record (EMR) and that it was important to keep the meta data because it captured audit logs and other information that our Office has found to be part of the record and important to maintain (see H2009-IR-006).

[para 54] The Custodian argues that the pen computer was not an EMR because there was no integration for shared access as there is with, for example, Alberta NetCare. (Alberta NetCare is an Electronic Health Record (EHR) which provides centralized access to limited health information by authorized users throughout the province.)

[para 55] An EMR differs from an EHR in that the former is a localized or clinical electronic record. It contains information such as chart notes, prescriptions, lab results, administrative information and all other information that one would expect to find in a complete paper file. However, EMRs may be accessible and modifiable by more than one person even in a localized setting; it may be accessible by different doctors, or other health care professionals, practicing in the same office or clinic. Thus where a Custodian is using an EMR, there is certainly a need to maintain the meta data, including audit logs. As the Portfolio Officer in Investigation Report H2009-IR-006 stated:

> Audit logs are an essential safeguard in electronic health records systems, including EMRs. These logs, when properly implemented, can allow a custodian to determine who has accessed and viewed health information within their EMR with a very high level of certainty. They also play a critical role in maintaining the reliability and integrity of data, as changes to information are also logged. Poorly implemented audit logging functionality renders the control ineffectual.
>
> (H2009-IR-006 at para 33)

[para 56] However, the Custodian's pen computer did not have these shareable features. As it is one document in the Applicant's medical record, accessible only by using the pen computer, it was more akin to a note pad. It was not a system of recording and storing the Applicant's entire medical record but simply a device used to record chart notes. There is no evidence that the Custodian allowed multiple users to use his pen computer. In fact, the Custodian submits that the records were not being shared with or accessed by any other health professionals. Therefore, I do not think that there is a requirement for the Custodian to keep the meta data, and specifically the audit logs, for the purposes for which such data should be kept in relation an EMR (to identify which of multiple users accessed and modified the health information).

[para 57] I acknowledge the Applicant's point may be that the meta data would show whether and when the Custodian had himself altered the documents. However, section 60(1)(c)(i) and (ii) require a custodian to have safeguards to protect against reasonably anticipated threats to the integrity of the health information or unauthorized modification. It would not be logical to write legislation that requires custodians to keep meta data to protect against threats they anticipate may be occasioned by their own dealings with the data, and I do not believe the legislation was meant for this purpose. Furthermore, in this case, the Applicant argues that the original chart is the correct chart and the reason that the Custodian has not produced it is because it would show the electronic chart to be a forgery. Therefore, the alterations the Applicant alleges were done would have been done on the new tablet computer and not on the old pen computer. I have accepted the latter was destroyed after the original transcription was completed. It appears the dates of the transcription appeared on the face of the new transcribed document (which was the very problem the Custodian was attempting to address by re-transcribing it onto paper). Thus, in this case, there was no need to preserve the originals in order to preserve information about the alleged alterations that would, had they occurred, have post-dated the original transcriptions. Therefore, the meta data that was lost was not an important safeguard necessary to protect the integrity of the Applicant's health information.

[para 58] Finally, in her rebuttal submissions and in response to the Custodian's initial submission that he was not required to keep the pen computer after the chart notes had been transcribed, the Applicant states that she believes that the Custodian had a legal obligation to keep the pen computer. She cites recommendations by the Canadian Medical Protection Association. The recommendations may be a good guide for custodians regarding data retention, but they are not binding on this inquiry, and I cannot impose an obligation on a custodian beyond what is in the Act.

[para 59] Based on the evidence before me, I find that the Custodian took reasonable measures to protect against the loss of and the threat to the integrity of the Applicant's health information.

[para 60] Section 61 of the Act states:

> *61 Before using or disclosing health information that is in its custody or under its control, a custodian must make a reasonable effort to ensure that the information is accurate and complete.*

[para 61] The Custodian further argues that he made reasonable efforts to ensure that the chart notes were accurate and complete. He acknowledges that there were transcription errors between the electronic chart notes and the handwritten chart notes but notes that the CPSA found the errors to be minor. The Custodian further argues that there is no evidence that his "efforts were any less reasonable" when he manually transferred the data from his pen computer to his tablet computer.

[para 62] The Applicant submits that the differences between the electronic chart notes and the handwritten chart notes were far from minor. As well, she notes that she cannot

verify the accuracy of the electronic chart because the Custodian destroyed the original chart.

[para 63] As I found above, I accept the Custodian's evidence that he manually transcribed the Applicant's chart. I also accept his evidence that, beyond any possible transcription errors, the electronic chart was accurate and complete. Section 61 of the Act requires a Custodian to make reasonable efforts – perfection is not required. While I agree with the Applicant that I cannot determine beyond any doubt that the electronic chart is identical or reasonably similar to the original chart because the original chart was destroyed, the reverse is also true in that it cannot be said, with certainty that the electronic chart differs from the original chart. Based on the evidence before me, I find that the Custodian did make reasonable efforts to ensure that the chart notes were accurate and complete.

C. When the Custodian transcribed the data from his pen computer to a tablet computer, did he have an obligation under section 64 of the Act, which require a privacy impact assessment in the event of a proposed change to administrative practices and information systems relating to collection, use and disclosure of health information, and if so, did he comply with this obligation?

[para 64] Section 64 of the Act states:

> *64(1) Each custodian must prepare a privacy impact assessment that describes how proposed administrative practices and information systems relating to the collection, use and disclosure of individually identifying health information may affect the privacy of the individual who is the subject of the information.*
>
> *(2) The custodian must submit the privacy impact assessment to the Commissioner for review and comment before implementing any proposed new practice or system described in subsection (1) or any proposed change to existing practices and systems described in subsection (1).*

[para 65] The Applicant argues that the Custodian was required to provide this Office with a privacy impact assessment ("PIA") before transferring the information from his pen computer to his tablet computer. The Custodian argues that the provisions of the Act were new when he transferred the data, that there was no privacy risk in transferring the data, and that the records at issue were not electronic medical records and as such there was no requirement for a PIA.

[para 66] The age of the Act at the time of the data transfer would not excuse the Custodian from meeting his obligations under the Act. However, I do not believe that the Custodian had an obligation to submit a PIA when he transcribed the Applicant's chart notes from his pen computer to his tablet computer, because there was no change in his practice. He continued to take chart notes on a mobile device just as he had before the

Act came into effect. There was no change to an administrative practice (for example allowing another individual access to the Applicant's chart notes) or information system (for example implementing an EMR) relating to the collection, use, or disclosure the information and therefore, no effect on the privacy of the Applicant. The device may have changed but the Custodian's system did not. As the Custodian correctly points out, to require a PIA in this instance would be akin to obligating a custodian to submit a PIA whenever a custodian needed to upgrade or change a desk top computer.

[para 67] Based on the information before me, I find that the Custodian had no obligation to submit a PIA pursuant to section 64 of the Act when he transcribed the Applicant's chart notes from his pen computer onto his tablet computer.

V. ORDER

[para 68] I make this Order under section 80 of the Act.

[para 69] I find that the Custodian complied with sections 10, 60(1), and 61of the Act.

[para 70] I find that the Custodian did not have an obligation to submit a privacy impact assessment to this Office pursuant to section 64 of the Act when he transcribed information from his pen computer to his tablet computer.

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Keri H. Ridley
Adjudicator