ALBERTA

OFFICE OF THE INFORMATION AND PRIVACY COMMISSIONER

ORDER H2015-05

December 21, 2015

DR. JASON P. BAYNE

Case File Number H5966

Office URL: www.oipc.ab.ca

Summary: An individual made a correction request to Dr. Jason P. Bayne (the Custodian) under the *Health Information Act* (HIA), who had provided health services to the Applicant.

The Applicant in this inquiry had reviewed her Patient Chart History in the course of an unrelated investigation. In doing so, the Applicant discovered what she believes to be numerous errors about her medical condition and treatment history in her medical records.

The Applicant wrote to the Custodian pointing out what she believes to be particular errors in her information in his custody, including in a letter the Custodian wrote to another physician. The Applicant asked the Custodian to remove from her medical records the information she regards as erroneous or not related to her, including information provided by particular other doctors.

Dr. Bayne reviewed her request and declined to make any changes. The Applicant requested a review by this office of the Custodian's response.

The Adjudicator determined that some of the information the Applicant had requested be corrected were professional opinions or observations that the Custodian was not required to correct pursuant to section 13(6)(a). Some information was found to be factual information (not opinion or observation); however, the Applicant did not meet her burden

of showing that the information was erroneous. The Adjudicator therefore upheld the Custodian's refusal to correct the information.

Statutes Cited: AB: *Health Information Act*, R.S.A. 2000, c. H-5, ss. 1, 13, 80.

Authorities Cited: AB: Orders H2004-004, H2005-006, H2005-007, H2007-006, H2013-04.

I. BACKGROUND

[para 1] The Applicant in this inquiry had made a complaint to the College of Physicians and Surgeons of Alberta, which resulted in an investigation. In the course of that investigation, the Applicant reviewed records in her Patient Chart History and discovered what she believes to be numerous errors about her medical condition and treatment history in her medical records, including which doctors she has seen and spoken to, the date on which she underwent a CT scan, various medical conditions from which she suffers, and her Chart number. The Applicant believes the errors are related, in part, to confusion with the medical record of another person whose name is similar to hers. (A CT scan report with the other person's name on it had been present at one time in her medical records).

[para 2] Dr. Bayne (the Custodian) had provided health services to the Applicant. The Applicant wrote to the Custodian pointing out what she believes to be particular errors in her information in his custody, including in a letter the Custodian wrote to another physician. The Applicant asked the Custodian to remove from her medical records the information she regards as erroneous or not related to her, including information provided by particular other doctors, pursuant to section 13 of the *Health Information Act* (the HIA).

[para 3] The Custodian reviewed her request and declined to make any changes. The Applicant requested a review by this office of the Custodian's response.

II. INFORMATION AT ISSUE

[para 4] The information at issue consists of the Applicant's health information contained in a consultation letter written by the Custodian, parts of which the Applicant has requested be corrected.

III. ISSUE

[para 5] Per the Notice of Inquiry, dated July 21, 2015, the issue in this inquiry is:

> **Did the Custodian properly refuse to correct or amend the Applicant's health information, as authorized by section 13 of the Act?**

IV. DISCUSSION OF ISSUES

[para 6] Section 13 of HIA states:

> *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.*
>
> *(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.*
>
> *(3) If the custodian agrees to make the correction or amendment, the custodian must within the 30-day period or any extended period referred to in subsection (2)*
>
> > *(a) make the correction or amendment,*
> >
> > *(b) give written notice to the applicant that the correction or amendment has been made, and*
> >
> > *(c) notify any person to whom that information has been disclosed during the one-year period before the correction or amendment was requested that the correction or amendment has been made.*
>
> *(4) The custodian is not required to provide the notification referred to in subsection (3)(c) where*
>
> > *(a) the custodian agrees to make the correction or amendment but believes that the applicant will not be harmed if the notification under subsection (3)(c) is not provided, and*
> >
> > *(b) the applicant agrees.*
>
> *(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.*
>
> *(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*
> >
> > *(b) a record that was not originally created by that custodian.*
>
> *(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.*

Does the Applicant's letter constitute a request for correction?

[para 7] Order H2007-006, which states:

> … An applicant making a request for correction or amendment must provide enough clarity to enable a custodian to respond to the request. …

[para 8] The Applicant's request to the Custodian for corrections to her health information (dated November 1, 2013) states that she has located errors in a letter written by the Custodian to another physician (recipient physician). She indicated that the chart number is not hers, that she did not have a number of conditions attributed to her in that letter, that she doesn't take the medication mentioned in the letter, and that she *did* provide a list of allergies to medication in contrast to what the letter said. She stated that the recipient physician is not her doctor and therefore the letter ought not to have been sent to that recipient.

[para 9] The Applicant became a patient of the Custodian when another physician retired (the retired physician); the Applicant stated in her November 1, 2013 letter that the retired physician had erroneous records (a CT scan belonging to another patient) in his files; as those files presumably are now in the custody of the Custodian, it may be that the Applicant was requesting that the Custodian remove that erroneous CT scan report (although this is not clear in the Applicant's November 1 letter).

[para 10] The Applicant's November 1 letter ends with a request that the Custodian send her proof "of removing [the retired physician], [the recipient physician] and [the Custodian] out of my medical records."

[para 11] The Custodian argues that the Applicant's latter request (removing physicians from her health records) amounts to removal of health records relating to the Applicant, which is not within the scope of a correction request under section 13. I agree. Further, the Custodian cannot correct to whom his letter was sent; whether the letter ought to have been sent to that recipient is also not within the scope of section 13.

[para 12] With respect to the points at paragraph 8, it is clear that the Applicant is requesting specific corrections be made to the Custodian's letter. It is less clear whether the Applicant was asking the Custodian to remove an erroneous CT scan report from his files; however, the Custodian has responded to that part of the Applicant's request so I will consider whether that response was appropriate.

[para 13] In correspondence with this office, the Applicant has mentioned other errors the Custodian has made; however, this inquiry is limited in scope to the Custodian's response to the Applicant's correction request made by letter dated November 1, 2013.

Did the Custodian properly refuse to correct or amend the Applicant's health records?

[para 14] In Order H2005-006, former Commissioner Work outlined a two-step process for determining whether section 13(6) applies to information that is subject to a request for correction or amendment. The first step is to consider whether all or part of the information at issue consists of a professional opinion or observation under section 13(6)(a) of the Act. If so, the custodian is not required to make a correction or amendment.

[para 15] If the information at issue is not a professional opinion or observation, the second step is to determine whether there are errors or omissions under section 13(1). If so, it may be corrected or amended, subject to the custodian's exercise of discretion.

[para 16] I will accordingly first consider whether the information at issue is a professional opinion or observation.

[para 17] 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 that of a health services provider, and
- The professional opinion or observation must be about the applicant.

Is the information a professional opinion or observation?

[para 18] The Custodian has the burden of proving the information is a professional opinion or observation (Order H2004-004). If it does not consist of a professional opinion or observation, it is the Applicant who has the burden of proving that there is an error or omission in her health information (Order H2004-004 at para. 12). If there is an error or omission in the Applicant's health information, it is the Custodian who has the burden of proving that he properly exercised her discretion when refusing to correct or amend the information (Order H2005-006 at para. 42).

[para 19] A 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 (Order H2005-006, at para. 64). "Professional" means a belief or assessment based on grounds short of proof, a view held as probable (Order H2004-004). "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 20] The Custodian states that he is a vascular surgeon, and that the Applicant had been referred to him for a consultation. The Custodian saw the Applicant, after which he wrote a consultation letter reporting "his findings, professional opinions, and recommended plan of management for [the Applicant's condition]." (Initial submission, para. 5) The letter the Applicant requests be amended is this consultation letter. The consultation letter indicates that the recipient physician had requested the consultation; the Custodian states that it is standard practice for a consulting physician to provide the results of a consultation to the physician requesting the consultation, "in order to ensure continuity of care." (Initial submission, para. 6)

[para 21] The Custodian argues that the various conditions that the Custodian noted in the consultation letter, which the Applicant objects to, were "the result of [the Custodian's] professional opinions and observations, based on his own assessment of the

patient and a review of professional opinions and observations recorded in her Chart by other health services providers." (Initial submission, page 10)

[para 22] Much of the Custodian's consultation letter consists of professional opinion or observation. However, the Custodian refers to past diagnoses of the Applicant, which he appears to have obtained from medical records. The Applicant objects to the references the Custodian made to her having been diagnosed with carotid stenosis, hypercholesterolemia, hypothyroidism, or having had a stroke. Whether the Applicant has been diagnosed in the past with a condition is not an opinion or observation of the Custodian.

[para 23] The CT scan report contains a professional opinion or observation of the radiologist writing the report, but the patient information (which appears to be the Applicant's concern) is not. Neither is the chart number a professional opinion or observation. I will consider whether the Applicant has met her burden of showing that there is an error or omission in this information, later in this order.

[para 24] The Custodian refers to the Applicant as possibly suffering from mild dementia; the context of that reference makes it clear that the Custodian is recording observations about the Applicant, rather than referring to past diagnoses.

[para 25] The Custodian's letter also refers to a list of medications the Applicant has been prescribed and/or that she takes; it also notes that the Applicant did not mention allergies to medications. The Applicant objects to two of the listed medications, stating that she was prescribed one and doesn't take it (Synthroid), and that she doesn't take the other (aspirin). It is not clear from the consultation letter whether the Custodian obtained this information from the Applicant's medical records or whether she informed the Custodian about these medications herself. Whether the Applicant was prescribed medication is a fact, rather than an opinion or observation. However, whether she *takes* medication seems to be an observation based on a discussion with the Applicant. In other words, the Custodian seems to have recorded his observations about the Applicant's intake of medication based on their conversation during the consultation. In Order H2013-04, I accepted an argument that a professional opinion or observation included circumstances in which a custodian "recorded his understanding of what he was told by the Applicant, and that the Custodian's assessment of the Applicant was based on these understandings" (at para. 27). The Applicant does not object to the fact that she was prescribed certain medications, only whether or not she takes them. While it may seem to be a small distinction, I find that the prescription is a *fact*, but the Custodian's recording of whether the Applicant takes all medications prescribed to her is an observation recorded at the time of the consultation. I make this finding based on the context of the letter, which indicates that the information was obtained in the course of a conversation with the Applicant. The same finding applies to the statement that the Applicant is not allergic to any medications.

Is the professional opinion or observation a health services providers' and is it about the Applicant?

[para 26] A health service provider is defined in section 1(1)(n) of HIA as an individual who provides health services. Under section 1(1)(m) of the Act, health services includes a service provided for the purpose of diagnosing and treating illness. The Custodian is a vascular surgeon who consulted on the Applicant's medical condition(s). The letter the Applicant requested be corrected is the consultation letter sent to the referring physician. The Custodian was providing a health service as defined in HIA.

[para 27] I find that the information in the consultation letter is a professional opinion or observation under section 13(6)(a). The Custodian may therefore refuse to correct or amend the information.

Patient (identifying) information in the CT scan report, chart number and past diagnoses

[para 28] I noted above that the patient information in the CT scan report is not a medical opinion or observation. However, the Custodian has confirmed that he does not have a copy of the CT scan report that the Applicant has alleged is erroneous; therefore, there is no record to correct or amend.

[para 29] With regard to the past diagnoses referenced in the consultation letter, the Applicant bears the burden of showing that there is an error or omission (as noted above). The Applicant has provided copies of various medical records; however, none of these address whether the Custodian's consultation letter erred in referring to past diagnoses of a stroke, hypercholesterolemia, or hypothyroidism. The Applicant also did not provide any reason for her belief that the chart number recorded in the consultation letter does not relate to her, or what she believes the chart number should be. Without some evidence to support her claims, I cannot find that the Custodian's letter contains errors or omissions.

Exercise of discretion

[para 30] In Orders H2005-006 and H2005-007, former Commissioner Work stated:

> 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 31] I accept the Custodian's explanation that the relevant information in the consultation letter constitutes the Custodian's observations and opinions of the Applicant at the time the letter was created and as such does not contain an error or omission to be corrected under section 13(1). I also accept his explanation that his files regarding the Applicant do not contain the CT scan report the Applicant says is erroneous. Finally, the Applicant did not meet her burden of showing that the consultation letter contains errors

or omissions with respect to past diagnoses. Therefore, the Custodian's exercise of discretion to not correct an error or omission does not arise as an issue.

V. ORDER

[para 32] I make this Order under section 80 of the Act.

[para 33] I find that the Custodian properly refused to correct or amend the items for which the Applicant requested a correction.

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Amanda Swanek
Adjudicator