ALBERTA

OFFICE OF THE INFORMATION AND PRIVACY COMMISSIONER

ORDER H2015-06

December 21, 2015

DR. STEPHEN DENSON

Case File Number H5967

Office URL: www.oipc.ab.ca

Summary: The Applicant made a correction request under the *Health Information Act* (HIA) to Dr. Denson (the Custodian), who had provided health services to the Applicant.

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 discovered that a CT scan report in her medical records had another person's name on it at one time.

The Custodian's records relative to the Applicant included references to CT scan reports. The Applicant believes some of these references were to CT scans of the other person whose name is similar to hers. The Applicant wrote to the Custodian with a list of specific requests for changes to her medical records.

The Custodian responded to the Applicant's request with a letter addressing the Applicant's various concerns but refusing to make any amendments or corrections to her health information in his records.

The Applicant requested a review by this office of the Custodian's response.

The Adjudicator determined that the information in the CT scan reports (except the patient information) and ultrasound reports constituted professional opinions or observations and that these reports were created by custodians other than the Custodian to

whom the Applicant made her correction request. For these reasons, the Adjudicator found that the Custodian was not required to correct these records.

The Adjudicator found that a statement in a letter written by the Custodian, to which the Applicant objected, was a factual statement rather than opinion or observation. She also found that the patient information in the 2004 CT scan is factual information. However, the Applicant did not show that any of this information contained an error to be corrected.

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.

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 discovered that a CT scan report with another person's name on it had been present at one time in her medical records.

[para 2] Dr. Denson had provided health services to the Applicant, and his records relative to the Applicant included references to CT scan reports. The Applicant believes some of these references were to CT scans of the other person whose name is similar to hers. The Applicant made a request under the *Health Information Act* (HIA) requesting that certain information be corrected in her medical records. Specifically, she asserted that a 2004 CT scan report had been erroneously attributed to her, and referred to in later records (the Applicant states that she had a CT scan performed in 2005). The Applicant also states that a 2005 ultrasound report refers to a past ultrasound performed in 2001, which is not hers. The Applicant also requests a correction to a letter from the Custodian to another physician dated October 27, 2005 which states that the Applicant had a condition that had previously been known about.

[para 3] The Applicant's request included several other allegations of errors that were not associated with any particular records.

[para 4] The Custodian responded to the Applicant's request with a letter addressing the Applicant's various concerns but refusing to make any amendments or corrections to her health information in his records.

[para 5] The Applicant requested a review by this office of the Custodian's response. The Commissioner authorized an investigation in an attempt to settle the matter. This was not successful, and the Applicant requested an inquiry.

II. INFORMATION AT ISSUE

[para 6] The information at issue consists of the Applicant's health information contained in records in the custody or control of the Custodian that the Applicant has requested be corrected.

III. ISSUE

[para 7] 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 8] 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?

Order H2007-006, which states (at paras. 51-52):

> … An applicant making a request for correction or amendment must provide enough clarity to enable a custodian to respond to the request. …
>
> In my view, an applicant's written description of errors and omissions is not the same thing as a written request for correction or amendment under section 13(1) of HIA. A custodian's response to a written description of errors and omissions, even where the response agrees to make or refuses to make certain corrections, does not necessarily mean that an applicant has made a request for correction or amendment under HIA. The custodian's response is not determinative, but is a factor to consider.

[para 9] As noted above, the Applicant made a correction request to the Custodian dated October 29, 2013, with a letter attached. In her request form and attached letter she noted that a 2004 CT scan had been erroneously attributed to her, and referred to in later records (the Applicant states that she had a CT scan performed in 2005). She also noted that a 2005 ultrasound report refers to a past ultrasound performed in 2001, which is not hers. The attached letter also requests a correction to a letter from the Custodian to another physician dated October 27, 2005 which states that the Applicant had a condition that had previously been known about. That 2005 letter from the Custodian was provided with her request. All of these items are sufficiently clear to constitute a correction request under section 13 of the HIA.

[para 10] The Applicant's request for inquiry states that she wants the above-noted records removed entirely from her medical file. Although this wasn't clear from her correction request, the Custodian's submissions also speak to the request for removal of the records. The Custodian correctly points out that section 13 of the HIA does not contemplate the removal of entire medical records. I will therefore consider whether these records ought to be corrected, rather than removed.

[para 11] In her request for correction, the Applicant makes complaints about several other things that had been said to her, done, or not done by the Custodian (or other physicians). These complaints are not linked to any particular record and it is not clear what the Applicant is asking for. I note that, in his response to the Applicant, the Custodian addressed each of these concerns raised and attached medical records that

supported his responses (the Custodian's response was provided to me by the Applicant but any attached medical records were not). The fact that the Custodian responded to each of the Applicant's concerns does not make those concerns a proper request for correction under section 13 of the HIA. I find that, with the exception of the correction requests noted above (at paragraph 9), the remainder of the Applicant's October 29, 2013 letter is not sufficiently clear to constitute a correction request.

[para 12] In correspondence with this office, the Applicant has mentioned other errors the Custodian has made; however, this inquiry is limited in scope to a review of the Custodian's response to the Applicant's correction request made by letter dated October 29, 2013.

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

[para 13] 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 14] 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 15] I will accordingly first consider whether the information at issue is a professional opinion or observation.

[para 16] 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 17] The Custodian has the burden of proving the information is a professional opinion or observation (Order H2004-004).

[para 18] 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 notice, and the action or process of closely observing or monitoring (Order H2004-004).

[para 19] The Custodian provided me with a copy of a 2005 ultrasound report relating to the Applicant, which referred to, and compared, a past 2001 ultrasound. The record is not of the ultrasound itself, but the resulting report created by a radiologist. The report is clearly the radiologist's professional opinion or observation of what he observed in the ultrasound.

[para 20] The same can be said for the September 2004 and November 2005 CT scan reports (copies of which were also provided by the Custodian). The records each are comprised of a report written by a radiologist based on the CT scan (which is not itself part of the report). The 2005 report refers to the 2004 CT scan relating to the Applicant.

[para 21] The Applicant appears to deny that the 2004 CT scan relates to her. The information identifying the patient (the name etc.) on the CT scan report is factual information about the patient. I will consider whether that portion of the scan report contains errors that ought to be corrected.

[para 22] The letter from the Custodian to another physician dated October 27, 2005 asks the receiving physician to assess the Applicant. It states that the Applicant had a known condition that has progressed; the Applicant appears to object to this statement on the basis that she had not known about the condition until 2004. The date that a condition became known is factual information; however, whether or not it has progressed may be a professional opinion. In any case, the Applicant appears to object to the statement that the condition had been previously known, not whether it has progressed. I will consider whether that information ought to be corrected.

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

[para 23] 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 was a treating physician of the Applicant. Therefore, the Custodian was providing a health service as defined in HIA. Further, the radiologists authoring the various CT scan and ultrasound reports were providing a health service to the Applicant.

[para 24] Although the Applicant claims that the 2004 CT scan is that of another patient (with a name very similar to the Applicant's), The Custodian states that his records relating to the Applicant do not contain any documents with a patient name other than the Applicant's. Further, the record provided to me by the Custodian has the Applicant's name on it, not the name of the other patient; all the records appear to relate to the Applicant.

<u>Finding regarding CT scans and ultrasound reports</u>

[para 25] I find that the information in the various CT scan and ultrasound reports constitute professional opinions or observations under section 13(6)(a). The Custodian may therefore refuse to correct or amend the information.

[para 26] The Custodian has also argued that the CT scan and ultrasound reports are records that were not created by the Custodian, and that the Custodian may refuse to correct the records on that basis under section 13(6)(b). I agree with this argument, and find the Custodians refusal may also be based on this provision.

Finding regarding the patient information in the 2004 CT scan and Custodian's letter of October 27, 2005

[para 27] I found above that the patient information to which the 2004 CT scan relates is factual information, as is the information the Applicant objected to in the Custodians letter of October 27, 2005. The Applicant bears the burden of showing that these records contain an error or omission.

[para 28] Regarding the CT scan, the Applicant believes that the CT scan relates to another patient, whose name is similar to the Applicant's. She states that she did not have a CT scan performed in 2004. The Custodian's response to the Applicant's correction request (letter dated November 27, 2013) states that the 2004 CT scan he has on the Applicant's file contains the Applicant's correct name and date of birth. The Custodian explains in his letter that he spoke with an individual at the College of Physicians and Surgeons who was involved in the Applicant's investigation. This individual told the Custodian that the original 2004 CT scan contained a typographical error in that it had been attributed to a different patient with a name similar to the Applicant's; therefore, the patient information at the top of the page was wrong (name, date birth, and admit date), but the scan was that of the Applicant. The Custodian further explains that this error had been corrected soon after the scan had been performed. The Custodian provided me with a copy of the 2004 CT scan report, which contains the Applicant's correct identifying information. While the Applicant does not recall having a CT scan in 2004, I find that the Custodian's explanation is credible. Further, I confirm that the 2004 CT scan report contains the Applicant's name and identifying information. Therefore, I find that that there is no error or omission in that record.

[para 29] Regarding the October 27, 2005 letter, the Applicant states that the reference to a "known" condition is in error as she did not know about the particular condition until 2004. Since the Custodian wrote the letter in 2005, it appears that the statement that the condition had been known prior to the writing of the letter is correct. Therefore, there is nothing in the letter to correct or amend.

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 information in the CT scan report and ultrasound reports is information that constitutes a professional opinion or observation based on the actual scans and ultrasound. I further agree that these reports were created by custodians other than the Custodian to whom the Applicant made her correction request. Therefore, I find the Custodian properly exercised his discretion to refuse to correct or amend the Applicant's records.

[para 32] Finally, the Applicant did not meet her burden of showing that the Custodian's letter of October 27, 2005, or that the patient information in the 2004 CT scan report contains errors or omissions. Therefore, the Custodian's exercise of discretion to not correct an error or omission does not arise as an issue.

V. ORDER

[para 33] I make this Order under section 80 of the Act.

[para 34] 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