ALBERTA

OFFICE OF THE INFORMATION AND PRIVACY COMMISSIONER

ORDER H2016-03

January 27, 2016

COVENANT HEALTH

Case File Number H5965

Office URL: www.oipc.ab.ca

Summary: An individual made a correction request to Covenant Health (the Custodian) under the *Health Information Act* (HIA).

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 Custodian learned about an apparent error in the Applicant's records as it related to a procedure undertaken at a hospital operated by the Custodian. The Custodian corresponded with the Applicant, with the view of ensuring the Applicant's other records with the Custodian were correct.

After several letters, the Custodian decided to treat the Applicant's most recent letter as a correction request under the HIA. The Custodian made one change regarding a scheduled hospital visit that had not taken place, but refused to make any other changes.

The Adjudicator determined that the information in a CT scan report (except the patient information) and notes taken during a 1990 hospital stay constituted professional opinions or observations. The Adjudicator found that the Custodian was not required to correct these records.

The Adjudicator found that much of the information to which the Applicant requested a correction was factual information. However, the Applicant did not meet her burden of showing 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, 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 numerous instances of what she believes to be errors about her medical condition and treatment history.

[para 2] The Custodian learned about an apparent error in the Applicant's records as it related to a procedure undertaken at a hospital operated by the Custodian. The Custodian corresponded with the Applicant, with the view of ensuring the Applicant's other records with the Custodian were correct.

[para 3] After several letters, the Custodian decided to treat the Applicant's latest letter (dated December 11, 2013) as a correction request under the HIA. The Custodian made one change to the Applicant's records regarding a scheduled hospital visit that did not take place, but refused to make any other 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 her medical records in the custody and control of 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 ISSUE

[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 correspondence 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 did not make a formal request for correction to the Custodian; however, the Custodian states that it decided to treat the Applicant's December 11, 2013 letter (and previous correspondence) as a correction request under HIA. In his affidavit, the Custodian's Coordinator of Information and Privacy (Coordinator) states that he reviewed the Applicant's December 11, 2013 letter as well as her previous correspondence with the Custodian and summarized her concerns in an itemized list (provided at paragraph 18 of his affidavit).

[para 9] Having reviewed the Applicant's letter dated December 11, 2013, and other correspondence, I agree that the Coordinator's summary is an accurate description of the Applicant's concerns regarding errors or omissions in her medical records.

[para 10] In some cases, the Applicant has clearly pointed to errors that she wants corrected; however, in other cases, although the Applicant provides lengthy narratives of various events, she does not clearly state what corrections or amendments she is asking for. For example, much of the December 11, 2013 letter consists of allegations against various doctors and details of her medical history but it is not always clear what changes she wants made to her records. Nevertheless, the Coordinator has addressed all the concerns that could be understood as correction requests from that letter and other correspondence; as the Custodian has treated the Applicant's correspondence as a correction request and has responded under section 13 of the HIA, I find that the Applicant's correspondence does constitute a request for correction.

[para 11] 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 made by letter dated January 13, 2014, to the Applicant's correction request.

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

[para 12] 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 13] 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 14] I will accordingly first consider whether the information at issue is a professional opinion or observation.

[para 15] 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 16] 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 it properly exercised its discretion when refusing to correct or amend the information (Order H2005-006 at para. 42).

[para 17] 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 18] The Applicant's December 11, 2013 letter disputes many items in her medical records from a certain hospital, relating to a visit in 1990. She disputes the accuracy of references to her medical history (specifically past diagnoses) in those records, and the accuracy of the list of clothing and jewelry she wore at the time she was admitted to that hospital.

[para 19] Having reviewed a copy of these records, it appears that some of the information was recorded by health care practitioners as a result of conversations with the Applicant. In other words, the health care practitioners seem to have recorded their observations about the Applicant's medical history based on a conversation with the Applicant while she was in the hospital. There are also records from an ambulance attendant who treated the Applicant on the way to the hospital. It is unclear from the records whether the attendant obtained the information from the Applicant or possibly her spouse, who seems to have been present at the time. In any event, the notes were clearly taken as a result of a conversation about the Applicant's health with either the Applicant or her spouse (or both).

[para 20] Regarding the notes recorded by the ambulance attendant, physicians, and other hospital staff, relating to the Applicant's 1990 hospital stay, the Custodian states:

> [w]hen a physician or other health care provider is recording opinion and observation, this is subjective in nature and not capable of concrete proof. For instance, there is no way of factually ascertaining precisely what an applicant told health service providers or verifying whether the events, feelings or thoughts described by an applicant actually occurred. When health service providers make notation in hospital records, the recorded information relates to their understanding of what they were told rather than to the truth of what they were told. They consist of the authors' views of what an applicant (or others) said. (At para. 58 of the Custodian's initial submission)

[para 21] 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 recording of the Applicant's medical history made during a conversation is an *observation* of the health care practitioner recorded at the time of the consultation; therefore, I find that this information is a professional observation. I make this finding based on the context of the notes, which indicates that the information was obtained in the course of a conversation with the Applicant and/or (in the case of the ambulance attendant's notes) her spouse.

[para 22] Other information about the Applicant's medical history appears to have been obtained from a source other than the Applicant (possibly other medical files of the Applicant). Whether the Applicant has been diagnosed with a condition in the past, as revealed by her

medical history in her medical files, is not an opinion or observation of the Custodian. It is only when the health care practitioner is recording that information in the course of making professional observations about the Applicant that the recorded information is an observation or opinion of the practitioner. Other information such as the clothing worn by the Applicant when she was admitted is factual information.

[para 23] Most of the remaining items disputed by the Applicant (listed in the affidavit in the Custodian's initial submission) consist of factual information. The 2004 CT scan report contains a professional opinion or observation of the radiologist writing the report, but the patient identifying information (such as the name, date of birth, etc.) is factual. The Applicant is concerned that the CT scan belongs to another person (in other words, the patient-identifying information is in error). She is also concerned that 2005 and 2012 CT scan reports refer to this 2004 report that she believes is not hers. With respect to the 2005 report, the reference to the 2004 report is part of the observations of the radiologist; the 2004 report was compared to the 2005 report, which led the radiologist to make a professional observation about the comparison. Therefore, that reference to the 2004 report is not factual but part of the professional observation. With respect to the 2012 CT scan report, the copy of the report provided to me does not contain a reference to the 2004 report. The Custodian also states that there is no reference to a 2004 report in the 2012 report. Lastly the Applicant asserts that the patient chart number recorded on the 2012 CT scan report is not her chart number, which is factual information.

[para 24] The Applicant disputes whether her December 8, 2005 visit with a physician (which the Applicant agrees took place) constituted a "consultation." This seems to be a dispute about semantics rather than a factual question. Whether or not the Applicant would call her visit with the physician a "consultation", the Applicant agrees that she saw the physician on this date. Therefore, I find that there is no error or omission that could be corrected with respect to that information. However, the Applicant's assertion that she did not see the same physician on December 21, 20115 (item (e) in the affidavit) is factual information.

[para 25] I will first consider the whether the information that I have found constitutes a professional opinion or observation meets the remainder of the test outlined above, at paragraph 15. With respect to the factual information, I will consider whether the Applicant has met her burden of showing that there is an error or omission later in this order.

Is the professional opinion or observation that of a health services provider 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.

[para 27] The information constituting a professional opinion or observation is information recorded by an ambulance attendant, physicians, hospital staff and radiologists. In each case, the notes clearly relate to the diagnosis and treatment of the Applicant by health care professionals. The information is also clearly about the Applicant.

Finding regarding a CT scan report and notes taken in relation to the Applicant's 1990 hospital stay

[para 28] I find that the information in the 2005 CT scan report constitutes professional opinions or observations under section 13(6)(a). The Custodian may therefore refuse to correct or amend the information.

[para 29] I also note that the 2005 CT scan report is a record that was not created by the Custodian, and that the Custodian may refuse to correct the records on that basis under section 13(6)(b).

[para 30] I also find that the notes taken by the ambulance attendant, physicians and other hospital staff relating to the Applicant's 1990 hospital stay constitute professional opinions or observations under section 13(6)(a). The Custodian may therefore refuse to correct or amend that information.

Finding regarding patient identifying information on CT scan reports and other factual information

[para 31] I found above that the patient identifying information to which the 2004 CT scan relates is factual information, as is the patient chart number on the 2012 CT scan report, and much of the information the Applicant has objected to in the 1990 hospital records. I also found that whether the Applicant saw a particular physician on December 21, 2005 is also factual. The Applicant bears the burden of showing that these records contain an error or omission.

[para 32] Regarding the 2004 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 Applicant provided me with a copy of a referral from one physician to the specialist physician that ordered the CT scan; the date of the Applicant's appointment with the specialist physician is in 2005. Presumably the Applicant offers this as evidence that the 2004 CT scan ordered by the specialist physician could not relate to her as she was not his patient at that time. However, it is possible that the Applicant was referred to the specialist physician in both cases, and that she has a copy of only the second referral (in other words, it is possible that the Applicant's required a referral each time she saw the specialist physician, not just the first time she saw the specialist physician. The fact that the 2004 and 2005 CT scans were over a year apart supports this possibility). The Applicant also states that the CT scan refers to her as blood type "O", which is not her blood type.

[para 33] The Custodian states that the Coordinator spoke to the specialist physician in November 2013. In his affidavit, the Coordinator states that the specialist physician provided the Coordinator with a copy of the requisition relating to the 2004 CT scan and that requisition referred to the patient's age being the same as the age of the Applicant in 2004 (which is a different age than that of the patient whose name appeared on one copy of the CT scan report). Further, the specialist physician confirmed that he has never treated the patient whose name appeared (erroneously) on one copy of the CT scan report. (The CT scan report with the other patient's name has been removed from the Applicant's file as well as from the file of that other

patient). The Custodian has also explained that the “O” the Applicant believes refers to blood type actually refers to “outpatient”. This explanation is supported by the report itself, which lists “O” under “Patient Type”, not blood type.

[para 34] The Applicant provided me with a copy of the 2004 CT scan report that contained another patient’s name, as well as a copy of the same CT scan report with her name. The Applicant argues that the first copy (with another name) was removed from the Applicant’s file as part of a “cover up” for another physician. The Applicant offers no further explanation for this allegation, or support for it. I realize that the Applicant is in a difficult position of proving a negative insofar as she has the burden of showing that the CT scan report has been erroneously attributed to her. However, I find that the explanation offered by the Custodian, which is based on conversations with the Applicant’s treating physician and some supporting documentation the physician provided, is more credible than the Applicant’s, which relies solely on her recollection as to when she first had a CT scan. Therefore, I find that there is no error or omission to correct regarding the 2004 CT scan report.

[para 35] The Applicant has also argued that the 2012 CT scan report refers to the wrong chart number. The Applicant has not explained why she believes this chart number is wrong, or what she believes the correct chart number to be. I find that she has not met her burden of showing an error or omission regarding this information.

[para 36] The Applicant has made several allegations of factual errors in the records from a certain hospital visit in 1990. Initially, the Applicant denied that this record of a hospital related to her (Applicant’s letter to the Custodian, date stamped November 15, 2013 at Tab C of the Custodian’s initial submission). In response, the Custodian provided the Applicant with a copy of the records relating to that stay (letter from the Custodian to the Applicant dated December 6, 2013, at Tab E of the Custodian’s initial submission). The Applicant seems to have accepted that the records of the hospital stay relate to her, but now objects to various pieces of information in the records, including references to past diagnoses and what she was wearing at the time she was admitted.

[para 37] In his affidavit, the Coordinator states:

> [w]hen the [Custodian] receives a request for correction or amendment relating to the opinions and observations of medical staff such as physicians, it is the general practice of Information & Privacy to request the comments of the relevant physician responsible for creating and signing the records. However, due to the passage of nearly twenty-five years since the creation of records, [the Custodian] was not able to communicate with any of the health professionals authoring records related to the Applicant’s 1990 [hospital] visit (at para. 20).

[para 38] The Custodian argues that the Applicant has

> … provided no evidence to support her views or assertions [that the records contain factual errors] other than irrelevant newspaper and other documentation regarding medication and medical conditions. In essence, the Applicant merely relies on her recollection of these matters as it stood in 2013, many years after the events were

> contemporaneously recorded by health service providers. [The Custodian] was provided no evidence to show any error in these records as recorded by the authors of the records at the time, and [the Custodian] determined that it would not be reasonable to correct hospital records on the basis of such bare assertions (at paragraph 48 of the Custodian's initial submission)

[para 39] With regard to the past diagnoses, 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 references to various past diagnoses are in error. If these diagnoses are erroneous, the Applicant ought to be able to provide some support for that claim, such as a note from a health care practitioner currently treating the Applicant. Without some evidence to support her claims, I cannot find that the Custodian's records contain errors or omissions.

[para 40] With respect to the Applicant's allegation that the list of clothing and jewelry she was wearing at the time of admission to the hospital was not accurate, the Applicant has not provided me with any reason to accept her recollection in preference to what was recorded about this by the hospital employee at the time of admission. On the balance of probabilities, I find that there is no error or omission regarding that information.

[para 41] Lastly, with respect to whether the Applicant saw a particular physician on December 21, 2005, the Coordinator states in his affidavit that he spoke with that physician, who confirmed that he was present at a medical test the Applicant had underwent that day, and considered that visit to be a consultation. As with the CT scan report, discussed above, the Applicant is in a difficult position of proving a negative insofar as she has the burden of showing that she did not meet with the physician on the day she underwent a medical test. Presumably, the physician was relying on his records when he told the Coordinator that he was present during the Applicant's medical test, although this wasn't expressly stated. Nevertheless, the Applicant agrees that she underwent the medical test on December 21, 2005, at which the physician states he was present. It may be the case that the physician was present during the test but did not have a discussion with the Applicant; this would be consistent with the Applicant's allegation that her visit with the same physician on December 8, 2005 was not a "consultation" even though she agrees she saw that physician on that date (discussed at paragraph 24). I find that the explanation offered by the Custodian is more credible than the Applicant's, in part because the Applicant's explanation relies solely on her recollection and in part because the Applicant agrees that she had the medical test at which the physician states he was present. On the balance of probabilities, I find that there is no error or omission regarding that information.

Exercise of discretion

[para 42] 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 43] I accept the Custodian's explanation that the information in the CT scan reports notes, and the information relating to the Applicant's 1990 hospital stay is information that constitutes a professional opinion or observation based on the actual scans. Therefore, I find the Custodian properly exercised his discretion to refuse to correct or amend the Applicant's records.

[para 44] Finally, the Applicant did not meet her burden of showing that any of the factual information she disputed 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 45] I make this Order under section 80 of the Act.

[para 46] 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