ALBERTA

OFFICE OF THE INFORMATION AND PRIVACY COMMISSIONER

ORDER H2017-01

June 28, 2017

ALBERTA HEALTH SERVICES

Case File Numbers:
H5579, H5580, H5614, H5615, H5616, H5861, H5862, H5863, H5920, H5933, H5998, H6041, H6049, H6050, H6051, H6052, H6053, H6054, H6115, H6116, H6117, H6118, H6159, H6160, and H6171

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Summary: Pursuant to the *Health Information Act*, the Applicant made a correction request to Alberta Health Services (Custodian). Specifically, the Applicant requested chart notes from a particular unit be deleted, replaced, or his statements of disagreement be appended in their totality. The Custodian refused the Applicant's request for correction because it believed that the notes constituted a professional opinion or observation made by a health care provider.

The Adjudicator found that section 13(6)(a) of the Act applied and that the Custodian properly exercised its discretion not to make the Applicant's correction request. Further, because the Applicant requested a review by this Office, the Custodian was not obligated to append the Applicant's statements of disagreement to the records.

Statutes Cited: AB: *Health Information Act*, R.S.A. 2000, c. H-5, ss. 1, 13, 14, and 80.

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

Cases Cited: *Grove v. Office of the Information and Privacy Commissioner* (June 10, 2016), Edmonton 1403 02800 (A.B.Q.B.)

I. BACKGROUND

[para 1] The Applicant was a patient of a facility run by Alberta Health Services (the Custodian) wherein he regularly received medical treatments. The Applicant alleges that he was mistreated by nurses and staff at the facility during the course of his treatment. Nurses at the facility regularly made notes in the Applicant's medical file about interactions they had with the Applicant during his treatments.

[para 2] After receiving a copy of his medical file, the Applicant requested some progress notes be removed or, in the alternative, corrected, because they were inaccurate or not related to his medical condition and therefore, were not properly on his medical file. He made several correction requests to the Custodian which were denied. As a result, the Applicant requested that the Office of the Information and Privacy Commissioner (this Office) review the Custodian's responses to his correction requests. Mediation was not successful in resolving these matters and the Applicant requested inquiries. As all the information which the Applicant wishes to have corrected is of the same nature, and the response to the Applicant from the Custodian was the same, it was decided that all the Applicant's correction requests should be heard in one inquiry. I received submissions from both parties.

II. RECORDS AT ISSUE

[para 3] As this inquiry relates to correction requests, there are no records directly at issue. However, the information the Applicant requests be corrected are various progress notes from his medical file.

III. ISSUE

[para 4] The Notice of Inquiry dated September 23, 2016 state the issue in this inquiry as follows:

> 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

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

[para 5] As noted above, the Applicant made a correction request relating to progress notes found in his medical file. The Custodian refused to correct the records as requested by the Applicant because it believed that the progress notes constituted a professional opinion or observation made by a health services provider about the Applicant (section 13(6) of the Act). Section 13 of the Act 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.

[para 6] When the Custodian refused the Applicant's correction request, the Applicant was advised that pursuant to section14 of the Act that he could either have the Commissioner review its decision or append a statement of disagreement not exceeding 500 words in length. Section 14 of the Act states:

> *14(1) Where a custodian refuses to make a correction or amendment under section 13, the custodian must tell the applicant that the applicant may elect to do either of the following, but may not elect both:*
>
> > *(a) ask for a review of the custodian's decision by the Commissioner;*
> >
> > *(b) submit a statement of disagreement setting out in 500 words or less the requested correction or amendment and the applicant's reasons for disagreeing with the decision of the custodian.*
>
> *(2) An applicant who elects to submit a statement of disagreement must submit the statement to the custodian within 30 days after the written notice of refusal has been given to the applicant under section 13(5) or within any extended period under section 15(3).*
>
> *(3) On receiving the statement of disagreement, the custodian must*
>
> > *(a) if reasonably practicable, attach the statement to the record that is the subject of the requested correction or amendment, and*
> >
> > *(b) provide a copy of the statement of disagreement to any person to whom the custodian has disclosed the record in the year preceding the applicant's request for the correction or amendment.*

[para 7] The Applicant provided me with copies of all of the progress notes he wishes to be deleted. Alternatively, he would like the notes replaced with his versions or have his statements of disagreement appended in their entirety.

[para 8] The Applicant elected to have the Commissioner review the decisions of the Custodian to not correct the records which has led to this inquiry. Therefore, the Custodian is not obligated to append any statements of disagreement to the records. As a result, the focus of this inquiry is whether the Custodian properly refused to correct the records as requested by the Applicant.

[para 9] I read all of the progress notes provided by the Applicant along with his statements of disagreement. In each case, his statements largely focus on the background leading up to the note in question or contain explanations of his behavior that differ from those of the author. There appears to be one series of progress notes that particularly upset the Applicant dealing with a note which indicated that the Applicant stated he

owned guns, when, in fact, the Applicant had not owned guns for some time. It is clear from the chart notes themselves and the Applicant's statements of disagreement that his relationship with some staff at the facility where he received regular treatment was seriously strained. However, what is often not clear, is what specific information in the chart note the Applicant wanted corrected. It often appears that he wanted more detail added to explain, for instance, why he refused something offered to him and his disagreement is not about what was put in the chart note (that he refused something that was offered).

[para 10] After reviewing the Applicant's submissions, I gather his three main arguments as to why his corrections request should be granted (which I will deal with below) are as follows:

1. The progress notes contain factually inaccurate and defamatory information;
2. The progress notes were not done by professionals; and
3. The progress notes were personal notes and not medical and do not belong on a medical file.

[para 11] On the other hand, the Custodian believes that the progress notes are professional opinions or observations recorded by health care service providers about the Applicant and therefore fall under section 13(6)(a) of the Act, and that the remainder of the information records active treatment provided to the Applicant. It also pointed to several past orders from this Office that set out the appropriate test for the application of section 13(6)(a) of the Act and establish that the Custodian has the burden of proof regarding section 13(6)(a) of the Act.

[para 12] In order for section 13(6)(a) of the Act to apply the following test must be met:

1. There must be either a professional opinion or observation;
2. The professional opinion or observation must be a health service providers';
3. The professional opinion or observation must be about the applicant.

(Order H2005-07 at para 52)

[para 13] As stated by the Custodian, it is its burden to prove that this test has been met (Order H2004-004).

i. Were the notes a professional opinion or observation?

[para 14] In Order H2005-006 the former Commissioner was dealing with a doctor's notes that were taken during or after visits with the applicant. The Commissioner found that:

> For the most part the information in the Physician Notes consists of Dr. O's recording of what he saw, heard or noticed during the Applicant's visits to his office and consists of views or assessments based on grounds short of proof. The information that Dr. O

> derived from the sessions with the Applicant is not verifiable information. That information speaks to Dr. O's understanding of what he was told rather than to the truth of what he was told. These notations are intended to be the author's views, not the Applicant's views, of what the Applicant said.
>
> ...
>
> I accept the position of Dr. O that most of the information at issue is either a professional opinion or an observation or, alternatively, is a mixture of professional opinion or observation. I accept the Affidavit evidence of Dr. O that the information recorded is an accurate reflection of his understanding and views at the time the record was created. Right or wrong, these are Dr. O's professional opinions or observations, which are not necessarily the same as the Applicant's views.
>
> (Order H2005-006)

[para 15] As noted above, the Applicant argues that what was recorded was not an accurate reflection of what happened or what he said. The Custodian argues that the authors were contacted where possible and verified the accuracy of the notes. In support of its position, the Custodian provided an affidavit which stated that the authors who were contacted, stood by their charting, and felt that their charting was a valid professional opinion or observation.

[para 16] As explained by the former Commissioner, the notes are an accurate reflection of the authors' understanding of what was said or what happened. These reflections may be right or (certainly in the Applicant's opinion) may be wrong; however, they are still the opinions or observations of the nurses or the manager. As a result, I find that part one of the test has been met.

ii. Were the opinions or observations made by the health care provider?

[para 17] Regarding the second part of the test, Health Service Provider is defined by section 1(1)(n) of the Act as follows:

> *1(n) "health services provider" means an individual who provides health services;*

[para 18] "Heath services" are defined by section 1(1)(m) of the Act as follows:

> *1(m) "health service" means a service that is provided to an individual for any of the following purposes:*
>
> > *(i) protecting, promoting or maintaining physical and mental health;*
> >
> > *(ii) preventing illness;*
> >
> > *(iii) diagnosing and treating illness;*

(iv) rehabilitation;

(v) caring for the health needs of the ill, disabled, injured or dying,

but does not include a service excluded by the regulations;

[para 19] While the Applicant argues that the progress notes were not entered by professionals, this argument seems to focus on his belief that he was treated unprofessionally by the staff at the clinic he attended and so, in entering these progress notes, the staff was acting unprofessionally, not that they do not meet the definitions set out above.

[para 20] For the most part, the authors of the chart notes were nurses providing the Applicant with treatment. On one occasion the note is written by a social worker and on another, by a registered dietician. The nurses, social worker, and registered dietician were providing the Applicant a health service, either by specifically treating the Applicant's illness or coordinating and caring for the health needs of the Applicant.

[para 21] I note, however, that some of the notes were authored by the manager of the unit, or in one case, by a unit aide. I do not believe that these individuals were directly involved in administering the Applicant's treatments; however, they were directly involved in coordinating and facilitating the treatment, and as such would have been involved in caring for the health needs of the Applicant.

[para 22] As well, I note that some of the manager's notes detailed interactions that the Applicant had with nursing and other medical staff that she was informed about. In these instances, even though she was not documenting her own opinions and observations, the manager was documenting opinions and observations of a nurse or doctor (a health care professional as noted above) and therefore, these progress notes would still meet the second part of the test.

[para 23] As a result, I find that the second part of the test has been met.

iii. Were the observations or opinions about the Applicant?

[para 24] All of the notes were about the Applicant and his treatment or observations about his behavior. Therefore the last part of the test has been met.

iv. Did the Custodian properly exercise its discretion?

[para 25] Section 13(6)(a) of the Act is a discretionary provision, and as such, the Custodian must establish that it properly applied the section to the records.

[para 26] In Orders H2005-006 and H2005-007, the former Commissioner 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.
>
> (Order H2005-006 and H2005-007)

[para 27] The Custodian states that the notes contain professional observations or opinions that are accurately reflected and therefore its discretion not to correct those notes was properly exercised. Given my findings above, I agree with the Custodian's position and find that the Custodian properly exercised its discretion.

v. Further arguments by the Applicant

[para 28] As I mentioned above, in addition to the arguments I have already canvassed, the Applicant argues the progress notes were more akin to incident reports rather than medical progress reports and ought not to be in his medical file.

[para 29] It is true that most of the progress notes provided to me by the Applicant were about the Applicant's behavior and detailed interactions with the Applicant and were not specifically about administering a treatment. It is clear from the notes provided and the Applicant's submissions that the relationship between the Applicant and some members of the staff at the clinic he attended for treatment was strained. He accuses these staff members several times in his submissions of abusive behavior and unfair treatment. He made his feelings in this regard known to certain members of the staff. In addition, according to the Applicant, in response to this unfair treatment, he would behave in certain ways, such as refusing blankets and medication offered to him and requiring treatment to be ended at a specified time, even though it was started late and therefore, he was not receiving the recommended amount of treatment. To put it another way, the strained relationship between the Applicant and some of his caregivers resulted in issues with his treatment. There are also other progress notes relating to concerns the Applicant had about the cost of travel for medical appointments, and concerns about his mental well-being. In my view, all observations about the Applicant's behavior while he was at the clinic that are not about the actual administration of treatment are properly in the Applicant's progress notes because they are observations made by a health services provider and do relate to the Applicant's health.

[para 30] Finally, the Applicant argues that the orders cited by the Custodian are more than 10 years old and of little application to this inquiry. He also notes that he thinks it is very important that I review and assess the applicability of Order H2013-04 to this inquiry.

[para 31] In Order H2013-04, the applicant requested a correction to a report written by a psychiatrist following an assessment. Like the Applicant in this inquiry, the

applicant in Order H2013-04 disagreed with several statements made by the doctor, including observations that he felt had little to do with the condition for which he was being assessed. The Adjudicator in Order H2013-04 found that the report constituted an opinion or observation of a health care provider. She stated:

> In the current case, the Custodian created a short Report based on a conversation with the Applicant that appears to have been approximately an hour in duration. The Custodian did not record the Applicant's remarks verbatim, but rather recorded the Custodian's own observations based on the Applicant's remarks. As in Order H2005-006, in my view the Report is intended to be the Custodians views of the conversation. I also accept the Custodian's argument that the 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.
>
> I find that the information in the Report that the Applicant requested be corrected (other than the factual items, discussed above) are the Custodian's professional opinions and observations.
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> (Order H2013-04 at paras 27-28)

[para 32] I find that the facts in this inquiry relate closely to those in Order H2013-04, which supports the decisions I made above. This Order was upheld on Judicial Review by the Court of Queen's Bench in an oral decision, a copy of which I will provide to the parties along with this Order.

[para 33] Given my findings above and noting the Court's approval of Order H2013-04, I find that the chart notes that the Applicant requested be corrected were observations or opinions of a health services provider and therefore section 13(6)(a) of the Act applies to the information.

V. ORDER

[para 34] I make this Order under section 80 of the Act.

[para 35] I find that the Custodian properly refused the Applicant's correction requests.

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Keri H. Ridley
Adjudicator