ALBERTA

OFFICE OF THE INFORMATION AND PRIVACY COMMISSIONER

ORDER H2020-05

July 24, 2020

ALBERTA HEALTH SERVICES

Case File Numbers 002868 and 003393

Office URL: www.oipc.ab.ca

Summary: The Applicant was treated at a hospital in his community and then the University of Alberta Hospital Emergency Department for an open tibia / fibula fracture. At his community hospital, a physician wrote the following statement on the Applicant's chart: "supposedly was hit by a vehicle (whilst pointing a gun @ them)". A physician at the University of Alberta hospital also made a chart note regarding the Complainant pointing a gun.

The Applicant made a request to Alberta Health Services (AHS) that it delete both these statements. He also complained that AHS had not collected the information that was the source of the statement directly, as required by the *Health Information Act* (HIA), and that it had not used his health information in accordance with that Act.

The Adjudicator found that AHS's collection and use of the Complainant's information was in compliance with the HIA, given the emergency department setting in which the information was collected and used. However, she noted that if it were the case that the information could be used or disclosed in the future, and AHS was unable to establish the truth of the statements, AHS should take steps to ensure that they are not accessible, or amend them to warn future users that the information may not be sufficiently reliable for use or disclosure unless reasonable steps are first taken to ensure their accuracy.

Statutes Cited: AB: *Health Information Act*, R.S.A. 2000, c. H-5, ss.1, 13, 14, 18, 22, 27, 61, 80 **ON:** *Personal Health Information Act*, S.O. 2004, c. 3, Sch. A, s. 55

Authorities Cited: AB: Order H2005-006 **NL**: AH-2014-001

I. BACKGROUND

[para 1] The Applicant wrote to Alberta Health Services (AHS) and stated that it should delete the following statement from a record of a visit he made to local hospital: "Supposedly was hit by a vehicle (whilst pointing a gun @ them)." The Applicant stated in his letter to AHS that he did not point a gun at anyone before being hit by a vehicle. The Applicant also requested that the two references to a gun be removed from the University of Alberta Emergency Department's records.

[para 2] AHS refused the Applicant's request in relation to his community hospital, stating:

> Our office received a response from Dr. […], Physician, [Applicant's community] Hospital Emergency Department confirming that she refuses to correct the information as requested . Dr. […] has informed our office that the facts in the record written on [the Applicant's] chart are consistent with the information that was provided by ambulance staff or the RCMP.

[para 3] The Custodian refused the Applicant's request in relation to the University of Alberta Emergency Department, stating:

> This letter is in response to your Request to Correct or Amend Health Information under the *Health Information Act* ("the *Act*). You requested a correction as follows:
>
> *The statement that I "pulled* a *gun on another party" is incorrect and should be deleted.*
>
> Our office received a response from Dr. […], Emergency Physician, University of Alberta Hospital Emergency Department confirming that she refuses to correct the information as requested. Dr. […] has informed our office that the facts in the history written on [the Applicant's] chart are consistent with the history that was taken from the reports from the [Applicant's community] Hospital. [The Applicant] refused to provide any history when he was admitted to the UAH emergency department.

[para 4] The Applicant also complained that AHS had collected the information that was the subject of his correction request indirectly, rather than directly.

[para 5] The Commissioner authorized a senior information and privacy manager to investigate and attempt to settle the matter. At the conclusion of this process, the Applicant requested an inquiry.

[para 6] The Commissioner agreed to conduct an inquiry and delegated her authority to conduct the inquiry to me.

[para 7] AHS made submissions for the inquiry, but the Applicant provided no additional submissions or evidence beyond that contained in his requests for review and inquiry.

II. ISSUES

ISSUE A: Did AHS collect the Applicant's health information in contravention of section 20 (collection of individually identifying health information) of the HIA?

ISSUE B: Did AHS collect the Applicant's health information in contravention of section 22 (duty to collect health information from subject individual) of the HIA?

ISSUE C: Did AHS use the Applicant/Complainant's health information in contravention of section 25 (prohibition re use of health information) of the HIA?

ISSUE D: If AHS used the Applicant/Complainant's health information, did it comply with the requirements of section 61 (duty to ensure accuracy of health information) of the HIA?

ISSUE E: Did AHS properly refuse to correct or amend the Applicant's health information, under section 13 (correction or amendment of health information) of the HIA?

III. DISCUSSION OF ISSUES

ISSUE A: Did AHS collect the Applicant's health information in contravention of section 20 (collection of individually identifying health information) of the HIA?

ISSUE B: Did AHS collect the Applicant's health information in contravention of section 22 (duty to collect health information from subject individual) of the HIA?

Background

[para 8] From the evidence and submissions of the parties, I understand that the events leading to the Applicant's receipt of care from AHS and his request for correction are the following:

1. The Applicant called 911 in his community. When EMS arrived, the Applicant told them that his neighbours had run over his legs with their car. He then crawled to his trailer and dialed 911. EMS found the Applicant to have an open tibia / fibula fracture. The EMS documented the Applicant's account and his injuries in a report, which the Applicant submitted for the inquiry.
2. EMS took the Applicant to the emergency room at the local hospital. The physician at the local hospital wrote "supposedly hit by a car (whilst pointing a gun at them)" in her notes. This physician apparently has no recollection as to who made this reference initially, but believes it to be either EMS or the RCMP. This physician did not provide evidence for the inquiry; however, AHS referred to

statements she made in its submissions as to indicating that the source was either EMS or the RCMP.

3. The Applicant was transported to the emergency room at the University of Alberta Hospital, which is more than 200 km away from his community. A note was made in the Applicant's chart regarding a gun. In a statement made for this inquiry, the physician indicated that this note was written after speaking with the EMS employees who brought the Applicant to the University of Alberta Hospital Emergency Department.
4. The Applicant requested deletion of both notes on the basis that they are not true.

Analysis

[para 9] Section 18 of the HIA prohibits the collection of health information unless doing so is authorized by a provision of the HIA. It states:

> *18 No custodian shall collect health information except in accordance with this Act.*

[para 10] Section 22 of the HIA requires custodians to collect health information from the individual who is the subject of the information, except in the circumstances it enumerates. This provision states, in part:

> *22(1) A custodian must collect individually identifying health information directly from the individual who is the subject of the information unless subsection (2) applies.*
>
> *(2) A custodian may collect individually identifying health information from a person other than the individual who is the subject of the information in the following circumstances:*
>
> > *[…]*
> >
> > *(c) where the custodian believes, on reasonable grounds, that collection from the individual who is the subject of the information would prejudice*
> > *(i) the interests of the individual,*
> > *(ii) the purposes of collection, or*
> > *(iii) the safety of any other individual*
> > *or would result in the collection of inaccurate information;*
> >
> > *(d) where collection from the individual who is the subject of the information is not reasonably practicable […]*

[para 11] The Applicant argues:

> The above noted information was collected contrary to s. 22 of the HIA in that the information was not collected from the Applicant, and the provisions of (2) did not apply.

[para 12] AHS argues:

> Section 22(2)(d) […] allows indirect collection where collection from the individual, who is subject of the information, is not reasonably practicable.
>
> Regarding the […] collection the attending physician indicated on the Ambulatory Client Care Record that the Applicant smelled of alcohol, was initially uncooperative, swore at the physician and at a time belligerent.
>
> As to the UAH collection of information, the attending physician stated that the patient refused to give any information and thus the information was taken from EMS.
>
> The type of injury and the need of an immediate medical transfer indicates that this was an emergent medical situation.
>
> Given the emergent nature of the Applicant's injury and his uncooperative behaviour it is submitted that in both circumstances both sections 22(2)(c) and 22(2)(d) are engaged.

[para 13] The information that is the subject of the correction request is "health information" within the terms of section 1 as AHS collected the information in the course of providing a health service to the Applicant. As such, the information falls within the terms of "diagnostic, treatment and care" information by application of section 1, and is health information. If the information were not health information, then the information could not be the subject of a complaint or correction request under the HIA. Had AHS not made the notation in the Applicant's chart in the course of providing treatment, the information would not be health information.

[para 14] The ambulance attendants documented that the Applicant told them he was intoxicated. The Applicant has not sought correction of those statements, so I will accept that this was the case at the time the EMTs treated him. However, despite this, the records also indicate that the Applicant was able and willing to communicate to the EMTs about his injuries and explain how they were caused. The ambulance attendants' report makes no reference to the Applicant pointing a gun at anyone or to the RCMP being on the scene.

[para 15] The initial reporting regarding the Applicant states that he told EMTs that his neighbours had run over his legs with a car. He then crawled to his trailer and called 911. The initial examination revealed an open tibial / fibial fracture on the Applicant's right leg, an open wound on his right foot, and soreness when palpating his left foot. The Applicant's open fracture was splinted, and he was taken from the trailer by spine board to the emergency department in his community, and then was ultimately transferred to the University of Alberta Hospital. As the Applicant's counsel noted in the request for inquiry, these records make no reference to the Applicant threatening anyone with a gun. I also note that the record created by the EMTs makes no reference to EMTs speaking with anyone other than the Applicant. Similarly, the notes of the physician at the community hospital do not refer to speaking with anyone other than the Applicant.

[para 16] Reproduced above, AHS argues that sections 22(2)(c) and (d) authorized the collection of health information from a source other than the applicant. AHS provided

a statement from the physician who made the notation at the University of Alberta Emergency Department. She states:

> This patient refused to provide any history regarding his visit to the emergency room and therefore, the history was taken from the Emergency Medical Services report to Emergency staff when they delivered the patient to us from [the Applicant's community]. I was present at the patient handover in the Emergency Room and the facts in the history written on the chart are consistent with what EMS reported.

[para 17] AHS also argues:

> On April 21, 2016 the attending physician at [the Applicant's community] Hospital stated to the Information and Privacy Coordinator that this information was provided to her by EMS staff or the RCMP and not by the patient. This information was deemed relevant by the physician to chart, under the circumstances which existed at the time, given the patient's apparent state and mechanism of injury. It was relevant to the safety of the patient and to those treating the patient and assisted in providing context for the subsequent course of events and treatment, given the patient's state.

[para 18] Section 22(2)(c) applies when obtaining health information directly from the individual who is the subject of the information would result in prejudice to the interests of the individual, the purposes of collection, the safety of another individual, or would result in the collection of inaccurate information. There is no evidence before me to support the likelihood of any of these outcomes resulting had AHS obtained the information in question from the Applicant. AHS argues that the Applicant did not answer the attending physicians' questions, which is not a circumstance addressed by section 22(2)(c). Moreover, the EMTs did obtain information from the Applicant when they first treated him, and there is nothing to suggest that obtaining information in this manner correlates in any way to prejudice or a risk of harm.

[para 19] Section 22(2)(d) authorizes the collection of health information if it is impracticable to collect the health information from the individual who is the subject of the information

[para 20] In an emergency department setting, I accept that information is gathered and recorded as it is made available, in case the information may be necessary for the provision of appropriate treatment and to ensure the safety of patients. There may not be time to evaluate information to determine whether it is actually relevant or whether the collection meets the direct collection requirements of the HIA before gathering it. For example, a family member or EMT may offer information that seems relevant, even though the patient is capable of communicating the information and has not authorized the family member or EMT to provide it. A custodian may then collect this information in the course of providing emergency services and it may satisfy the requirement that collecting directly is not practicable. If a patient's injuries are severe and painful, as appears to have been the case here, it may also not be practicable to collect information directly for that reason.

[para 21] AHS has not provided evidence as to the source of the reference to the gun, or its use of the word "supposedly" in the Applicant's chart. But again, this is likely

due to the way information is gathered in an emergency department setting. There is not one patient in emergency, but many, and health services providers must collect information as it comes to them, and lack the time to evaluate it to ensure that it is truly relevant to treatment prior to recording it. Information is recorded because it *may* be relevant. The University of Alberta physician recalls hearing EMTs make the statement she recorded; at the time it was recorded it was potentially relevant. The physician at the Applicant's community hospital does not recall the original source of the information; again, this may be due to the emergency setting. However, within the context of the report, it appears she considered it relevant to the nature of the Complainant's injuries.

[para 22] While the Applicant was initially able to provide information to the EMTs who first provided emergency treatment at his home, it may be that by the time he arrived at the University of Alberta emergency department, several hours later, he was less able to communicate, given the length of the trip, the lateness of the hour, and the nature of his injuries. The notes from his local hospital also indicate he was sedated there. It was therefore practicable for both physicians to ask the EMTs for information, in seeking all relevant information, and not practicable to obtain the information from the Applicant.

[para 23] For the reasons above, I find that section 22(2)(d) authorizes the indirect collection of the information that is the subject of the complaint and correction request.

ISSUE C: Did AHS use the Applicant's health information in contravention of section 25 (prohibition re use of health information) of the HIA?

ISSUE D: If AHS used the Applicant health information, did it comply with the requirements of section 61 (duty to ensure accuracy of health information) of the HIA?

[para 24] Section 27 lists the uses for which a custodian may use health information. It states, in part:

> *27(1) A custodian may use individually identifying health information in its custody or under its control for the following purposes:*
>
> *(a) providing health services […]*

[para 25] AHS did not make submissions as to whether it used the information that is the subject of the complaint. However, as "use" is defined in the HIA as "including reproducing the information" it would appear that the act of entering the information on a chart at the University of Alberta emergency department constitutes a "use".

[para 26] As discussed above, I find that the physician collected the information in the course of, and context of, providing emergency health services. Documenting the information received on a medical chart is a way to create a medical record of the conditions treated, the treatment given, and the circumstances in which treatment was given. Medical services providers may consult the chart in order to provide appropriate treatment in the future or to determine whether the treatment was appropriate; however, a

medical chart is also a record of treatment and the circumstances in which treatment was given that may be used for legal purposes.

[para 27] In this case, the information that is the subject of the complaint was likely not relevant, ultimately, to the type of care provided and how it was provided. However, the information was recorded as part of providing health services and documenting the health services provided. As a result, I find that the information was used in accordance with section 27, and therefore section 25, as it was used for the purpose of providing health services.

[para 28] Section 61 of the HIA 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 29] The information in question is the statement "Supposedly was hit by a vehicle (whilst pointing a gun @ them)" and the reference to a gun in the University of Alberta emergency department records.

[para 30] It is clearly impossible for a custodian to ensure that every piece of health information used is accurate and complete, given that "health information" includes any information collected in the course of providing a health service, which includes any statements made by a patient. In the case of emergency treatment, a health services provider may have to record and make decisions based on the information provided, without knowing whether it is true.

[para 31] In my view, section 61 is best interpreted as requiring information to be accurate and complete *enough* for the purposes for which it will be used or disclosed. The requirement that a custodian take *reasonable* steps to ensure accuracy and completeness, suggests that the standards of accuracy and completeness are not absolute, but rather, specific to the situation. In other words, what steps are reasonable to ensure accuracy may depend on the nature of the information and the purpose for which it will used or disclosed. Information to be used in order to provide medical services, such as surgery, may require more extensive steps to ensure accuracy than information that is recorded in the course of a medical visit that is not likely to be used or disclosed for any purpose in the future. However, in both cases the standard is not perfection, but what is reasonable in the circumstances in which the information is used.

[para 32] In the case before me, the health services provider from the community hospital indicated to AHS that she wrote what she was told by EMTs or the RCMP in order to record all potentially relevant information regarding the Applicant's case. There was no opportunity for the health services provider to verify whether the statement was true. Instead, she prefaced the information with "supposedly" which is normally a sign to a reader that the writer is not necessarily persuaded that the Applicant was hit by a car while pointing a gun at someone. Alternatively, if she was quoting an EMT or a member

of the RCMP, it is a sign that the EMT or RCMP member did not necessarily believe that the Applicant was hit by a car while pointing a gun at someone.

[para 33] In this case, I find that the steps the health services provider took to ensure the accuracy and completeness of the information were reasonable, given the emergency circumstances in which it was recorded.

ISSUE E: Did AHS properly refuse to correct or amend the Applicant's health information, under section 13 (correction or amendment of health information) of the HIA?

[para 34] Section 13 gives an individual the ability to request correction of the individual's health information. It 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 35] Section 13 does not require a custodian to correct health information, unless the custodian agrees to do so. Instead, section 13 requires a custodian to respond to the request within set time frames, and to inform the applicant whether the requested correction or amendment be made, or whether the custodian has refused to make the correction or amendment.

[para 36] Section 14 explains the procedure for refusing to make a requested correction. It 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 37] The HIA creates a right to request correction or amendment of health information. It also creates a duty in a custodian to make a decision and respond to the correction request within a specified time period. However, the HIA contains no criteria as to when health information should be corrected and it contains no requirement that a custodian correct or amend health information, even if health information is demonstrated to be inaccurate or incomplete.

[para 38] This legislative silence is in contrast to Ontario's *Personal Health Information Protection Act*, which imposes a duty on custodians to correct inaccurate health information. Section 55(8) of that Act states:

> *55(8) The health information custodian shall grant a request for a correction under subsection (1) if the individual demonstrates, to the satisfaction of the custodian, that the record is incomplete or inaccurate for the purposes for which the custodian uses the information and gives the custodian the information necessary to enable the custodian to correct the record.*

Ontario's legislation explains the circumstances in which health information must be corrected and what an applicant must do in order to require the custodian to make a correction.

[para 39] Section 80 of Alberta's HIA establishes the Commissioner's powers at the conclusion of an inquiry. With respect to correction requests, it states:

> *80(3) If the inquiry relates to any other matter, the Commissioner may, by order, do one or more of the following:*
>
> > *(d) confirm a decision not to correct or amend health information or specify how health information is to be corrected or amended […]*

[para 40] Section 80(3)(f) empowers the Commissioner to order the destruction of health information found to have been collected or created in contravention of the HIA. In relation to inquiries regarding correction decisions, the Commissioner is empowered to specify the manner in which information will be corrected. I do not interpret the Commissioner's power to specify the manner of correction to include the ability to order destruction or deletion, given that section 80(3)(f) limits the ability to order destruction to circumstances in which information was improperly collected. The HIA does not set out criteria for the Commissioner to consider in making a decision regarding corrections or the manner in which health information may be corrected.

[para 41] In Order AH-2014-001, the former Information and Privacy Commissioner of Newfoundland noted that it is not possible to request destruction of health records as part of a correction request. He stated:

> Eastern Health appears to have responded appropriately, and in accordance with subsection 62(1) of *PHIA*, to the Complainant's initial request to remove the disputed record from his file. Eastern Health is correct in saying that it cannot simply remove the record. That would amount to destroying the record, and there is no provision in *PHIA* that permits a custodian to simply destroy a record in circumstances such as these. I find that Eastern Health was therefore correct to treat the request as a request for correction.

[para 42] In an inquiry regarding a correction, what criteria should be applied? AHS suggests that the Applicant has a burden of proving that the statement that is the subject of the access request is not true. The Applicant argues that AHS has no evidence that the statement is true, and that it should remove the statement for that reason. He also asserts that the statement is not true.

[para 43] I do not agree with the parties that the purpose of an inquiry necessarily involves determining the truth of health information or that it imposes duties on the parties to do so. It is unclear how one would go about proving that the statement "supposedly hit by a car (whilst pointing a gun at them)" is true or untrue, given the many potential interpretations to which the statement is open, in addition to its unexplained origin and lack of context. Moreover, the HIA gives an applicant the right to request an amendment. Amending text generally means making minor changes to it that *improve* the text, such as amendments to make a text fairer, clearer, more accurate or up to date. The substance of text may be correct, but even so, the text may still be capable of being amended.

[para 44] In Order H2005-006, former Commissioner Work noted that opinions may be corrected or amended under the HIA. He said:

> Opinions and observations are subjective in nature. Opinions, even those based on the same set of facts, can differ. Dr. X may see a patient and form the opinion that the patient has the flu. Dr. Y may see the same patient and form the opinion that the patient has a cold. HIA does not compel custodians to resolve these differences of opinion by forcing physicians to change their opinions under the guise of correction. For example, in Order H2004-004, I said the physician's notations of "paranoid" and "personality disorder" were professional opinions and the physician's notation of "unable to get along with people" was a professional opinion or observation that the physician could refuse to correct (para 24).
>
> Section 13(6)(a) of HIA allows a custodian to refuse to correct or amend a professional opinion or observation, but a custodian is not prohibited from making such a correction or amendment. This provision stands in contrast to the parallel provision in section 36(2) of the *Freedom of Information and Protection of Privacy Act*, R.S.A. 2000, c. F-25 ("FOIP"), which says that "a public body must not correct an opinion, including a professional or expert opinion". When considering FOIP principles in the context of the parallel HIA provisions, this difference needs to be kept in mind.

In the foregoing order, former Commissioner Work found that a custodian will properly exercise discretion to refuse to correct a professional medical opinion. However, he left it open that other kinds of opinions contained in health records may be the subject of correction or amendment.

[para 45] In Order AH-2014-001, the Information and Privacy Commissioner of Newfoundland reviewed a correction request in which a requestor sought to correct a health services provider's statement that the request smoked marijuana daily. The Commissioner noted:

> This situation illustrates perfectly the dilemma faced by custodians when confronted with such requests for correction of the record, and it illustrates why the legislatures in Newfoundland and Labrador, in Alberta and in other jurisdictions have chosen to direct that custodians handle such requests in a different way. Rather than treating a request for correction as a kind of adversarial trial proceeding, in which the custodian (or the Commissioner at the complaint stage) must determine, on the basis of evidence presented to it, which version of events is most likely to be true, the legislature has chosen to create a procedure that focuses instead on both the integrity and the transparency of the clinical record-keeping process.

[para 46] Alberta's health information correction process is similarly focused on protecting the integrity of health records. In other words, the process is one in which it may be as important to preserve the errors in medical reporting as it is to ensure information is accurate.

[para 47] Section 2(e) of the HIA establishes that a purpose of the HIA is to provide individuals with a right to request correction or amendment of health information about themselves. What value would such a right have if the need to preserve the authenticity of health records will, in almost all cases, require leaving a record in its original state? In my view, the right to request correction or amendment is directed at the future use to which health information may be put, rather than to correct past mistakes. The right to request correction may be seen, in part, as supporting section 61, as it allows applicants to request that custodians make reasonable efforts to ensure that health information that could be used or disclosed in the future is reasonably accurate and complete.

[para 48] As was discussed in the case cited above, even when a record contains a documented error, the original record should not necessarily be changed, as the error is part of the authentic record and may be needed as evidence. For example, if a health services provider documents that he or she treated a patient's left arm, when in fact it was the right that was treated, the health services provider has made an error. However, if one were to simply obliterate the reference to the left, and replace it with "right", as a result of receiving a correction request, evidence of poor record keeping potentially affecting the quality of care, as well as evidence of the error, would be lost. At the same time, to avoid future confusion, if the record were to be used to provide treatment in the future, or disclosed for the purposes of establishing a patient's entitlement to benefits, the version of the record to be shared would need to be amended or corrected to ensure that the patient's future care or legal entitlements are not adversely affected by the error. Correction or amendment would be necessary in such a case to ensure that custodians relying on the record in the future comply with section 61.

[para 49] Errors in health records or health information that, while not technically incorrect, result in ambiguity or incompleteness, can result in a decrease in the quality of health services if such information is relied on in the provision of health services. As a result, while the integrity of the original health record should be maintained and preserved, amended or corrected versions of the record could be made available for subsequent use or disclosure, so as to support the purpose for which the record will be used or disclosed.

[para 50] In my view, therefore, when evaluating a request for correction or amendment, the following questions should be asked:

1. Is the information likely to be used in the future? For example, is the information located in a paper record to which no one has access, or is the information part of an electronic health record accessible by many health service providers?
2. If it is likely that the information will be used or disclosed in the future, for what purpose is the information likely to be used or disclosed? For example, could the information be used to provide medical treatment in the future?
3. Is the information sufficiently accurate and complete to be reasonably used for those purposes? For example, could the information in question as it is written have a negative effect on treatment in the future or result in unfairness?

[para 51] If it is foreseeable that the information may be used in the provision of treatment, and there is an error, omission, or inaccuracy in the records that could affect the treatment given if a custodian relies on it, or the manner in which health services are given, then the custodian should correct or amend the information or take steps to ensure that it is sufficiently accurate for the purposes for which it foresees the record could be used. In making this determination, it should find out the Applicant's reasons for seeking correction and amendment, and address these in its decision. In other words, a custodian should find out why the applicant believes the information to be inaccurate or incomplete and why the applicant believes that the information could lead to negative or undesirable consequences. However, in some cases, the concerns leading to the request may be self-evident.

Is the health information sufficiently accurate and complete for future use?

[para 52] AHS has provided differing accounts and theories of the statement in its submissions.

[para 53] Thus, the submissions say the following:

> On April 21, 2016 the attending physician at [Applicant's Community] Hospital stated to the Information and Privacy Coordinator that this information was provided to her by EMS staff or the RCMP and not by the patient. This information was deemed relevant by the physician to chart, under the circumstances which existed at the time, given the patient's apparent state and mechanism of injury. It was relevant to the safety of the patient and to those treating the patient and assisted in providing context for the subsequent course of events and treatment, given the patient's state.

[para 54] In the subsequent paragraph of its submissions, AHS indicates that the statement was written by a University of Alberta Hospital physician who obtained the information from EMS staff, who delivered the Applicant as a patient to that hospital.

> On March 4, 2016 the attending physician at the UAH Emergency Department made the following statement: "This patient refused to provide any history regarding his visit to the emergency room and therefore the history was taken from the Emergency Medical Services report to Emergency staff when they delivered the patient to us from [his community hospital]. I was present at the patient handover in the Emergency Room and the facts in the history written on the chart are consistent with what EMS reported. [my emphasis]

[para 55] AHS asserts:

> 1.The information recorded at the [the Applicant's community] hospital was consistent with the information either received from the RCMP or EMS; and,
> 2. The UAH records reflect the information it received from the [Applicant's community] Hospital.
> [my emphasis]

[para 56] AHS submitted a statement from a physician who provided treatment to the Applicant at the UAH on the occasion in question. She states:

> I distinctly remember this case and am unprepared to withdraw the statement in question indicated on this patient's health record from the UAH Emergency visit date October 17, 2015.
>
> This patient refused to provide any history regarding his visit to the emergency room and therefore, the history was taken from the Emergency Medical Services report to Emergency staff when they delivered the patient to us from [the Applicant's community]. I was present at the patient handover in the Emergency Room and the facts in the history written on the chart are consistent with what EMS reported. I would make the amendment to the record to indicate that "history was provided by EMS due to patient's reluctance to discuss how he obtained his injuries".

[para 57] The health services provider from the University of Alberta Hospital Emergency Department indicates that she obtained the information she recorded from EMS directly, rather than that she obtained information that had been recorded by a different physician at the Applicant's community hospital.

[para 58] Elsewhere in its submissions, AHS describes the information that is the subject of the Applicant's requests for review and inquiry as an "opinion" of either EMS employees or the RCMP:

> In the first instance, the information initially recorded was from an opinion made by EMS or the RCMP and was charted as an observation as it was relevant to treatment. The information recorded at the UAH, it is submitted, came from a record that was not originally at the UAH.

[para 59] The Applicant attached a letter from the RCMP, which states: "It is the opinion of the investigator that a motor vehicle collision did not occur on this date and was not responsible for the injuries he sustain." [*sic*]

[para 60] The Applicant argues:

> The Applicant […] requested that following statement contained in the records created at the [Applicant's community] Hospital and the University of Alberta Hospital be corrected:
>
> > Supposedly was hit by a vehicle (whilst pointing a gun @ them).
>
> The Applicant states, unequivocally, that he did not at any time point a gun at anybody prior to being struck by a motor vehicle.
>
> The public body has not suggested that any of its employees personally observed or had knowledge of the Applicant pointing a gun at the time he was hit by a motor vehicle.
>
> The Public Body cannot specifically identify the source of the information that the Applicant had been pointing a gun at the time he was hit by a vehicle, but claims that it was provided by either ambulance staff or the RCMP.
>
> There is nothing in the ambulance records, attached, which would indicate that ambulance staff were given any information that the Applicant had been pointing a gun at the time he was hit by a vehicle.
>
> A letter from the RCMP is attached indicating that "it is the opinion of the investigator that a motor vehicle collision did not occur on this date and was not responsible for the injuries he sustain". This conclusion on the part of the RCMP cannot be reconciled with the information appearing on the Applicant's health records.

[para 61] AHS's submissions reflect uncertainty as to the source of the information that was recorded and its nature, given that it is unknown whether the source is EMS or the RCMP. AHS's submissions are also unclear as to whether the information at issue was intended to record facts, or to record an opinion. If it was an opinion, it is unknown how or why the opinion was formed or whose it was.

[para 62] However, I accept that information may have come in rapidly in the course of providing emergency treatment to the Applicant, and that AHS is not currently in a position to reconcile the various theories it has presented regarding the information.

[para 63] AHS does not know whether the information it recorded accurately reflects the Applicant's activities at the time he received his injuries. The information regarding the gun was not recorded to treat his injuries, according to AHS's arguments, but from concerns regarding security in the course of providing treatment. AHS's use of the information for the purpose of documenting immediate concerns in the course of providing treatment was appropriate, given the emergency setting. However, is unclear whose view of events is being recorded and questioned in the statement. Is the term "supposedly" being used to cast doubt on an account given by the RCMP, the EMTs, or the Applicant? Who are the "they" in the statement? Does the person who offered the account that is the subject of the statement have first-had or second-hand knowledge of what happened, or any knowledge at all? Who provided the statement in the first place? Does the statement accurately record what was originally said, or does it record what someone thought was said?

[para 64] While I find that the statement is accurate enough for the purposes of documenting emergency treatment and the circumstances in which it was given, should this information be used or disclosed for any other health-care-related purpose, the information might not be sufficiently complete or accurate.

[para 65] If the information were to be used in the future to provide medical treatment, then it could potentially have a negative effect on the way medical services are provided to the Applicant. If another health services provider were to read the statements regarding the Applicant pointing a gun, the health services provider might consider it as authoritative and alert security or take similar precautions before providing services to the Applicant, given that the statement suggests that the Applicant may have engaged in criminal gun violence. If steps such as this were regularly taken on the basis of the note, then the Applicant might become reluctant to seek medical treatment when it is necessary to do so.

[para 66] If it is possible that the information at issue could be taken into account by other health services providers in deciding how to provide treatment, then the information should be amended to reflect that AHS does not know the source of the information and is unable to confirm the accuracy of the contents. Alternatively, if it is possible to maintain the information in the chart, but ensure that the information is not used or disclosed by health services providers for any other purpose, then AHS need not amend the information.

[para 67] I acknowledge that the University of Alberta Emergency Department physician proposed amending the note to indicate "history was provided by EMS due to patient's reluctance to discuss how he obtained his injuries". It is not clearly the case, on the evidence before me, that the Applicant was reluctant to discuss how he received his injuries. The report of the EMTs who first provided treatment documents that the Applicant explained how he received his injuries. The report of the physician at the Applicant's community hospital also indicates that he explained how he obtained his injuries, but became upset after being refused water. He was then sedated, which may have affected his ability to communicate at the University of Alberta Hospital. I am unable to find, on the evidence before me, that the Applicant was not telling the truth when he first spoke with the EMTs who treated him. In addition, the proposed amendment would not resolve the potential unfairness or harm that could result to the Applicant should the information at issue be taken into account in providing health services to him in the future.

[para 68] I note that the physican also stated:

> In the future, I would encourage the patient to participate in his medical care through discussion with medical staff. This may prevent repeat instances such as this from occurring again.

[para 69] I agree that it is of paramount importance that patients participate in their medical care by speaking with health services providers. At the same time, I am unable to say that the Applicant did not attempt to do so initially. While AHS has asserted that the

Applicant was not communicative when he arrived at the University of Alberta Emergency Department, this may be due to the trauma of his injuries, the length of the ambulance trip to the hospital, and the lateness of the hour, or the sedative he was given. One of the reasons that society relies heavily on emergency medical service providers is that they provide life saving treatment when people are diminished in their capacities. If the Applicant was less than civil or cooperative at the time he was treated, as AHS asserts, that does not mean he is always that way when seeking health care services.

[para 70] If there is a possibility that the statements that are the subject of the correction requests could be reviewed and relied upon when the Applicant seeks health services in the future, including with the amendment proposed by the health services provider who recorded it, then the goal of encouraging the Applicant to communicate freely with health service providers may not be met, as the statement and the proposed amendment may result in the Applicant being treated with unnecessary suspicion. If there were clear evidence that the Applicant threatened anyone with a gun, then the statement would not necessarily require amendment. However, AHS has not been able to provide any evidence as to the original source of the information in the statement or its reliability. As a result, if there is a possibility that the statements could be used in the future when the Applicant seeks health services, they may require amendment, as the information could negatively affect the way health services are provided to the Applicant in the future.

Conclusion

[para 71] To summarize, I have found that AHS's collection and use of the health information at issue was in compliance with the collection and use provisions of the HIA. I have also found that AHS used the Applicant's health information in compliance with section 61 of the HIA. My conclusions regarding these issues turn on the emergency setting in which AHS collected and used the Applicant's health information. However, should the information at issue be used in the future to provide health services, the subsequent use may not meet the requirements of section 61.

[para 72] With regard to the Applicant's request that the information at issue be deleted, I lack the authority to order the destruction of this information, given that it was collected in compliance with the HIA.

[para 73] With regard to the Applicant's request that the information be corrected or amended, I conclude that if there is any likelihood that the information could be used again when future health services are being provided, the information should either be corrected or amended to reflect that the original source of the information is unknown, and that reasonable steps must be taken to ensure its accuracy prior to using or disclosing it. If, however, there is no possibility that the information could be used or disclosed again, AHS need not take any steps to correct or amend it.

III. ORDER

[para 74] I make this Order under section 80 of the Act.

[para 75] I order AHS to determine whether there is any likelihood that the statements at issue could be accessed and then used or disclosed in the future. If it determines that there is any possibility that the information could be used again, then AHS should take steps to ensure that the information is not accessible, or to amend it to warn future users that the information may not be sufficiently reliable for use or disclosure unless reasonable steps are first taken to ensure its accuracy.

[para 76] I order AHS to notify me within fifty days of receiving this order that it has complied with it.

_____

Teresa Cunningham
Adjudicator
/kh