ALBERTA

OFFICE OF THE INFORMATION AND PRIVACY COMMISSIONER

ORDER H2021-03

April 8, 2021

DR. AWS ALHERBISH

Case File Number 008729

Office URL: www.oipc.ab.ca

Summary: Under section 13(1) of the *Health Information Act* (the HIA), the Applicant requested Dr. Aws Alherbish (the Custodian) correct or amend her health information. The Custodian refused to make the requested changes, and, prior to review of the refusal, did not provide a written response to the Applicant's request. The Applicant sought a review of how the Custodian handled the request.

The Adjudicator noted that the Custodian failed to comply with the timeline to provide a written reply to a request for correction stipulated under section 13(5) of the HIA, and also failed to notify the Applicant of the choice between seeking review and submitting a statement of disagreement as required by section 14(1) of the HIA. Since the Custodian eventually provided a written response and the matter was reviewed by the Office of the Information and Privacy Commissioner, these sections did not need to be considered further.

The Adjudicator found that the Custodian properly refused to correct health information that consisted of professional opinions and observations under section 13(6)(a) of the HIA. The Adjudicator also found that, with regard to one requested correction, the Applicant failed to establish that there was an error or omission in her health information under section 13(1) of the HIA.

The Adjudicator found that the Applicant established that there was one error in her medical information in the form of a statement about her past medical history. The

Adjudicator considered possible future consequences if the information was not corrected and the effect on the accuracy and completeness of the Applicant's medical information if it were. The Adjudicator concluded that the Custodian properly refused to correct the Applicant's health information on the basis that there was little risk that the Applicant's medical history would be misunderstood, and that correcting or amending the information may deprive others viewing it of a proper understanding of it.

Statutes Cited: AB: *Health Information Act*, R.S.A. 2000 c H-5, ss. 1(i)(i), 1(k)(i), 1(n), 1(m), 1(m)(iii), 13(1), 13(5), 13(6)(a), 14(1), and 80.

Authorities Cited: AB: Orders 97-002, H2004-004, H2005-006, and H2020-05.

I. BACKGROUND

[para 1] On June 30, 2017, the Applicant underwent an exercise stress test administered by Dr. Aws Alherbish (the Custodian). The Custodian then prepared a report (the Report) detailing conclusions about the Applicant's health, based upon the results of the stress test and an oral consultation.

[para 2] On January 31, 2018, the Applicant wrote to the Custodian, requesting that he make corrections to the Report. The Applicant's letter listed six items of concern stemming from treatment received from the Custodian and the content of the Report. On February 20, 2018, the Custodian offered the Applicant a consultation appointment to discuss the concerns, which the Applicant declined. Arrangements were made for the Custodian to discuss matters with the Applicant over the telephone, but the Applicant never received a call.

[para 3] On April 17, 2018, this Office received a request for review of the Custodian's response to the Applicant's concerns. Investigation and mediation were authorized to try to resolve the issues, but did not.

[para 4] In the course of attempting to resolve this matter, the Custodian provided a written response to the Applicant's request for corrections by letter dated May 28, 2019. The Custodian refused to make to any changes.

[para 5] Since the issues remained unresolved, the matter proceeded to inquiry.

II. ISSUE

Issue A: Did the Custodian properly refuse to correct or amend the Applicant's health information as authorized by section 13 of the HIA?

III. DISCUSSION OF ISSUES

Applicable Law

[para 6] Section 13(1) of the 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.*

[para 7] Section 13(5) of the HIA states that a custodian must provide written notice and reasons why the custodian refused to make corrections within 30 days of the receipt of a request:

> *(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.*

[para 8] Section 14(1) of the HIA states that where a custodian refuses to make a correction or amendment, it must notify an applicant of the choice to either submit a statement of disagreement, or ask for a review of the custodian's decision:

> *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.*

[para 9] It is evident that the Custodian failed to comply with sections 13(5) and 14(1) of the HIA. However, since a written notice of refusal has since been given to the Applicant and the matter has been reviewed by this Office, there is no need to consider these matters any further.

[para 10] For section 13(1) of the HIA to apply, two requirements must be met: (1) there must be health information about the applicant, and; (2) there must be an error or omission in the applicant's health information (Order H2004-004 at para. 8). As an applicant is usually in the best position to show that there is health information about him or her, and that there is an error or omission in it, the applicant has the burden of proving that these two requirements are met (Order H2004-004 at para. 12).

[para 11] If an applicant establishes that section 13(1) of the HIA applies, the custodian must then justify its decision to refuse to make a correction or amendment, and show that

it properly exercised its discretion when refusing to correct or amend the applicant's health information (Order H2005-006 at para. 42).

[para 12] If an applicant does not establish that section 13(1) of the HIA applies, the custodian has properly exercised discretion to refuse to correct or amend information. (Order H2005-006 at para. 83).

[para 13] Section 13(6)(a) of the HIA states that a custodian may refuse a request to correct or amend health information in respect of a professional opinion or observation about the applicant:

> *(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*

[para 14] In Order H2005-006, former Commissioner Work outlined a two-step process for determining whether section 13(6) of the HIA 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 HIA. If so, the custodian has properly exercised its discretion to refuse to correct or amend information, since there is nothing to correct or amend. (Order H2005-006 at para. 83).

[para 15] The three requirements that must be met in order for section 13(6)(a) of the HIA to apply were set out in Order H2004-004 at 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.

Application of the law to the Applicant's Concerns

[para 16] Of the six concerns listed in the Applicant's January 31, 2018 letter to the Custodian, only the second, third, and fourth involve the content of the Report. The first and fifth relate to what may generally be referred to as matters of bedside manner related to physician-patient interactions. The sixth consists of the Applicant's interpretation of the results of the stress test. Since these concerns do not relate to errors or omissions in the Applicant's health information, they are outside of the scope of this inquiry, and I do not consider them here. The second, third, and fourth concerns are within the scope of the inquiry and are discussed in turn, below.

The Applicant's Second Concern

[para 17] The Applicant's second concern is in regard to the description of the reason why she was referred for an exercise stress test, given in the Report. The Report states,

> She was referred for [symptom] which is getting worse. She thinks she has [condition].

[para 18] The Applicant states that at the time of the stress test, she was suffering from the symptom that the Custodian states was given as the reason for the referral for the test. The Applicant notes that other physicians have diagnosed her with the condition that the Report stated that she "thinks she has." The Applicant does not allege that attributing the symptom or condition to her is erroneous. Rather, the Applicant asserts that the language in the Report creates an "unwarranted implication" that she is only *imagining* that she has the condition attributed to her when, in fact, it has been diagnosed.

[para 19] For the reasons that follow, I find that the information the Applicant wants to have corrected is professional opinion or observation about the Applicant, and that the Custodian was therefore entitled to refuse to correct it, pursuant to section 13(6)(a) of the HIA. My findings for each branch of the test for the section are below.

- *There must be either a professional opinion or observation*

[para 20] The type of information that constitutes professional opinions and observations was reviewed in Order H2005-006. The former Commissioner stated at paras. 47 and 48:

> I have previously said that "professional" means of or relating to or belonging to a profession and "opinion" means a belief or assessment based on grounds short of proof, a view held as probable. "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 19). The opinion or observation is that of the author or the writer of the information at issue.
>
> 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).

[para 21] The former Commissioner went on to consider whether alleged inaccuracies in information recording what a patient said to a custodian were opinions or observations. The former Commissioner concluded, at paras. 64 and 65:

> Dr. O's evidence is that the information at issue is what he saw, heard or noticed about his patient. Most of the information at issue is subjective in nature and is not capable of concrete proof, as there is no way of factually ascertaining whether the events, feelings or thoughts

> described by the Applicant actually occurred or of verifying precisely what the Applicant said to Dr. O during the patient visits. In any event, 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.
>
> 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.

[para 22] It is evident upon reading the Report, and the submissions of the parties, that the content of the Report stems from the interaction between the Custodian and the Applicant in the course of providing the exercise stress test, and consulting with the Applicant afterward.

[para 23] The Custodian states that, as a physician, he uses the best knowledge of the "clinical scenario" at the time when he conveys his findings, as happened in this case, when he dictated the Report. The Custodian further states that he was informed by the Applicant that the condition attributed to her was the reason why she was referred to him for the stress test. The information thus appears to be the Custodian's observations about the Applicant, and opinions about her medical status, based upon the Custodian's understanding of the "clinical scenario" at the time, to use the Custodian's words.

[para 24] The Custodian is a Fellow of the Royal College of Physicians and Surgeons of Canada, and an MBBS. He made his observations and formed his opinions as a medical professional. The information is thus professional medical opinions or observations.

- *The professional opinion or observation must be that of a health services provider*

[para 25] "Health services provider" is defined in section 1(n) of the HIA as "an individual who provides health services."

[para 26] "Health service" is defined in section 1(m) of the HIA:

> *(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 27] The Custodian administered the exercise stress test for the purposes of determining whether the Applicant had a condition that was causing the symptoms. During the consultation afterwards, the Custodian also reviewed the Applicant's medication. Such activities were for the purposes of diagnosing and treating illness, and are thus health services per section 1(m)(ii) of the HIA. As the person who provided the service, the Custodian is a health services provider per section 1(n) of the HIA.

- *The professional opinion or observation must be about the applicant*

[para 28] It is clear that the Custodian's opinions and observations are about the Applicant.

[para 29] In respect of the above, I find that under section 13(6)(a) the Custodian was entitled to refuse to correct information relating to the Applicant's second concern. As such, he also properly exercised discretion to refuse to make a correction or amendment.

The Applicant's Third Concern

[para 30] The Applicant's third concern is that the Custodian erroneously stated part of her medical history in the Report, indicating she has a past medical history of a condition that she does not have. The Report states of the Applicant,

> She is a [number] year-old lady with a past medical history of [condition 1], [condition 2], and [condition 3]…

[para 31] The condition disputed by the Applicant is condition 2.

[para 32] Unlike the information in the Applicant's second concern, this statement does not appear to be the Custodian's opinion or observation.

[para 33] In Order 97-002 at para. 42, the former Commissioner described a "fact" as a "thing that is known to have occurred, to exist, or to be true; an item of verified information."

[para 34] Whether or not the Applicant has a past medical history of a certain condition should be verifiable by reviewing the Applicant's medical records. The question of whether the Applicant has a history of a particular condition is thus a matter of fact rather than being a matter of the Custodian's opinion or observations. Since there are no opinions or observations at issue, I consider whether the statement of the Applicant's medical history constitute an error or omission in the Applicant's health information.

[para 35] There is no doubt that the information is the Applicant's health information. It is diagnostic, treatment, and care information as described in section 1(i)(i) of the HIA, which is health information as described in section 1(k)(i) of the HIA. The next question is whether there is an error in the Applicant's health information.

[para 36] The Applicant asserts that she does not have the medical history described in the Report.

[para 37] The Custodian does not directly address the Applicant's assertion that he erroneously reported her medical history; while he does not confirm there is an error, he does not deny that there is one either. The Custodian states that he used the best knowledge of the "clinical scenario" at the time when he dictated the Report. Using the "best knowledge" does not preclude the possibility that the Custodian included an error in the Applicant's health information.

[para 38] Considering that, as stated by the former Commissioner in Order H2004-004 at para. 12, the Applicant is in the best position to know their own information, I find that the Applicant's assertion is sufficient to establish on the balance of probabilities that there is an error in the Applicant's health information, and section 13(1) applies.

[para 39] I now consider whether the Custodian properly exercised his discretion to refuse to correct the information.

[para 40] The purpose and focus of the right to request a correction to health information in the HIA was discussed in Order H2020-05. The Adjudicator stated at paras. 45 to 47:

> 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 [sic] 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.
>
> 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.

> 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 41] The Adjudicator in Order H2020-05 went on to describe three questions she felt were relevant to a custodian deciding whether to refuse or agree to correct or amend health information. She stated, at para. 50:

> 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 42] I agree with the approach taken by the Adjudicator in Order H2020-05, and that the three questions posed above set out relevant considerations for determining whether information should be corrected.

[para 43] Both parties made submissions that address these considerations.

[para 44] In his submission, the Custodian explains that the purpose of the stress test is to determine the presence or absence of ischemia. Further, he states that he refused to correct information as a matter of preserving the integrity of medical records, and that any errors or omissions pose little risk to the Applicant in the future:

> 1. A clinician uses his best knowledge of the clinical scenario at the time of dictation to relay the information. It is not uncommon for the dictated information to prove different or variable in the future. Nevertheless, it is not expected from clinicians to go back and edit those previous letters, as they should be read within the context of the time when they were dictated. For example: If I call a chest pain "Angina" and an Angiogram proves that wrong in the future, I wouldn't and neither I'm expected go back and correct my note. [sic]
>
> * * *
>
> 5. My dictation, which is only available in our database and not on Netcare as stated by the applicant, has in my estimation no adverse or safety consequences to the patient.

[para 45] The Applicant's concerns focus on the effect that inaccurate health information could have on her in the future. She states in her submissions,

> The misrepresentations of my medical history and condition, and the representation of my informed choice as to treatment being simply described as "negative attitude", certainly has potential for negative consequences for me, particularly when third parties, as for instance a travel insurance provider, investigates an application for coverage. It could conceivably influence health care providers in situations such as overseas travel where my family physician was not immediately accessible for medical history.

[para 46] The Applicant also states that the Report has been provided to her family physician; as such it is viewable outside of the Custodian's clinic.

[para 47] Upon considering the dual concerns of preserving the integrity of health records and the possible negative effects on the Applicant in the future, I find that the Custodian properly refused to make a correction or amendment to the statement about the Applicant's medical history.

[para 48] The statement appears in a report detailing the results of the stress test along with some background information about the Applicant's medical history. The Report does not describe the whole of the Applicant's prior medical history, nor does it purport to overwrite it. It was prepared by the Custodian and not the Applicant's regular physician, who would be in a better position than the Custodian to know the Applicant's medical history. The Applicant's medical history, as recorded earlier in her life, is still intact and can speak to the conditions with which she has and has not been diagnosed. The presence of a contrary statement in the Report seems to pose little risk of creating misunderstanding of the Applicant's medical history.

[para 49] I also consider that it may be important in the future to preserve the Report as is. In its current form, the Report provides a clear record of the Custodian's understanding of the Applicant's "clinical scenario" at the time of the stress test, including her medical history. Changing the Custodian's statement about the Applicant's medical history alters the premises for his conclusions about the Applicant, which would leave anyone reviewing the Report with an incomplete or inaccurate picture of how and why the Custodian reached those conclusions.

[para 50] Given the minimal risk of creating misunderstanding about the Applicant's medical history, and the benefits of preserving the Report as is, I find that the Custodian properly refused to correct or amend the statement about the Applicant's medical history.

The Applicant's Fourth Concern

[para 51] The Applicant's fourth concern is that, in the Report, the Custodian failed to acknowledge that available evidence for his preferred prescriptions for her have negative indications for safety and efficacy. The Report states,

> However, upon talking to her, she has a negative stance against those medications despite explaining to her the evidence and she does not want to be on any of them.

[para 52] I understand the Applicant to be arguing that this is an omission from the Report.

[para 53] The information that the Applicant alleges is omitted is unspecified "evidence" regarding certain prescriptions, said to have negative indicators for safety and efficacy. That is the whole of the Applicant's argument. Without more, I cannot see how the mere existence of "evidence" about a prescription drug constitutes an error or omission in the Applicant's health information.

[para 54] I note that while the Applicant's letter to the Custodian requesting corrections to her health information indicates that the Applicant feels the "evidence" should be included in the Report, later in her submissions, the Applicant takes issue with the Custodian's reference to a "negative attitude" toward medication on her part. This appears to be a reference to the term "negative stance", used in the Report. Since there was no request to correct the term "negative stance" in the Applicant's letter requesting correction, the Custodian cannot be said to have refused to correct or amend it, and for that reason, it is outside of the scope of this inquiry.

[para 55] I note further that the statement is clearly the Custodian's opinion and observation of the Applicant, and that he would be entitled to refuse to correct it in any case.

IV. ORDER

[para 56] I make this Order under section 80 of the HIA.

[para 57] I confirm the Custodian's decision not to correct or amend the Applicant's health information.

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John Gabriele
Adjudicator
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