OFFICE OF THE INFORMATION AND PRIVACY COMMISSIONER
NEWFOUNDLAND AND LABRADOR

Report AH-2014-001

August 5, 2014

Eastern Health

Summary: The Complainant requested correction of certain personal health information in a clinical report written by an Eastern Health specialist. Specifically, the Complainant claimed that he had not made statements, attributed to him in the report, about his experience with pain relief medications and about his use of marijuana for pain relief. Eastern Health refused to grant the request for correction, and the Complainant therefore filed a complaint with this Office. As this was the first occasion on which the Commissioner had been called upon to address the provisions of the *Personal Health Information Act* dealing with the correction of personal health information, the Commissioner adopted the framework of analysis used by the Alberta Commissioner in dealing with substantially similar legislative provisions. Applying that analysis, the Commissioner found that the disputed portions of the clinical report consisted of "professional observation" within the meaning of section 62 of the *Personal Health Information Act,* and concluded that the custodian was not required to correct such information. However, the custodian was required to annotate the record with the correction that had been requested but not made.

Statutes Cited: *Personal Health Information Act,* SNL 2008, Chapter P-7.01, sections 5, 60, 61, 62, 63, 73, 74, 83; *Alberta Health Information Act*, RSA 2000, Chapter H-5, section 13.

Authorities Cited: Alberta OIPC Order H2005-006 (2006).

I BACKGROUND

[1] On August 14, 2012 the Complainant filed with our Office a complaint that Eastern Regional Health Authority ("Eastern Health") had refused his request to correct certain personal health information in an Eastern Health record. In his complaint he stated that an Eastern Health medical specialist (who will be referred to in this Report as "the Specialist"), made statements in a clinical report that are factually incorrect. The report was written for the Complainant's family doctor following a scheduled appointment in February 2012 at an Eastern Health clinic, and was also posted in Eastern Health's electronic health records system ("Meditech"). Specifically, the Specialist wrote that during the appointment, the Complainant had made certain statements about his acquisition and daily use of marijuana for pain relief, and also about his dissatisfaction with the pain relief medication Atasol 30.

[2] The Complainant, having reviewed the clinical report, denied making either of those statements, and in March 2012 asked Eastern Health to remove that record from his medical file. Eastern Health replied in April 2012 that under the *Personal Health Information Act ("PHIA")* Eastern Health was not permitted to remove information from a health record, but instead was permitted to handle such a complaint as a request for correction.

[3] On April 18, 2012, the Specialist electronically added a two-point addendum to his report of February 2012, in which he wrote that the statements referenced in the clinical report, about usage of marijuana and about Atasol 30, were made by the Complainant during the appointment, and that the Complainant now states this information to be incorrect. (I note that in Eastern Health's electronic health records system, there is only one version of the report, which is the version that includes the Specialist's addendum.)

[4] On July 20, 2012 the Director of Health Information and Informatics for Eastern Health wrote to the Complainant refusing to grant his request for correction of the disputed information. The Complainant then filed his complaint with this Office.

[5] Eastern Health provided our Office with relevant documentation and correspondence. An investigator from this Office had several discussions with the Complainant, and also conducted

interviews with the Specialist and with the Director of Health Information and Informatics at Eastern Health. However, the complaint could not be resolved informally, and accordingly on January 15, 2014 the parties were advised that the complaint had been referred for formal investigation pursuant to section 67 of *PHIA,* and were asked to make written representations in support of their positions. Submissions were received from Eastern Health on January 28, 2014, and from the Complainant on January 29, 2014.

II SUBMISSION OF EASTERN HEALTH

[6] It is Eastern Health's position that the clinical report written by the Specialist, and the subsequent addendum to the report, also made by the Specialist, are both "professional observations made in good faith" as that expression is used in *PHIA*. It is also Eastern Health's position that the report and the addendum represent the Specialist's understanding of what he was told during the February 2012 clinic visit. It is Eastern Health's position that it is therefore not required to make the requested correction, pursuant to section 62 of the *Personal Health Information Act*.

[7] Eastern Health is of the view that in the circumstances of this case, the appropriate resolution is that the record in question should be annotated with the correction that was requested but not made.

[8] Eastern Health also suggested that, if the result of the Commissioner's review is to recommend that an annotation be attached to the disputed record, containing the correction that was requested but not made, then a formal report by this Office is not necessary, since that same remedy has already been offered to the Complainant by Eastern Health.

III SUBMISSION OF THE COMPLAINANT

[9] The Complainant's submission, first of all, is that he did not say the words ascribed to him by the Specialist. He has maintained this position since his first complaint letter of March 19, 2012, in which he states:

1. *First of all, I unequivocally deny having said to* [the Specialist] *that I smoke four to five joints of marijuana per day or that I buy it from the "market"; neither did he mention to me his own personal views on medical marijuana licencing (or lack thereof), and nor did I ask him to prescribe it to me. The only mention of marijuana was made by me when I said that I had previously tried it.*

2. *Secondly,* [the Specialist] *states, "He sometimes takes Atasol 30's but he is sick of it, and the marijuana gives him a lot of pain relief." Again, I deny mentioning anything whatsoever about Atasol 30's to* [the Specialist]. *It is not that I might have mentioned it, or that I forget having mentioned it – I never mentioned Atasol 30's at all.*

[10] The Complainant took the view that either the Specialist is confusing his medical information with another patient's medical information, or the Specialist is being vindictive because the Complainant had, on the occasion of the appointment, refused to fill out the Specialist's 32 point "Brief Pain Inventory" questionnaire.

[11] The Complainant considered the Specialist's report to be "…malicious, false, defamatory and illegal." He considered the erroneous information to be misleading and harmful. He asked that the report be retracted, and that the Specialist apologize. The Complainant also offered to submit to a drug test to show that neither marijuana nor Atasol 30's would be found in his blood.

[12] The Complainant submits that the Specialist's acknowledged note-taking practices, his hand-written clinical notes, and his clinical report are at odds with one another, since the hand-written notes make no mention of marijuana, whereas the report has several sentences about it.

[13] The Complainant argues that his case is strengthened by the fact that he has provided this Office with personal drug testing results that, he says, show that he has not used marijuana.

[14] Finally, the Complainant alleges that since the complaint was made, the Specialist has accessed the Complainant's medical file without authorization, and that this was a breach of his privacy that this Office should deal with.

IV DISCUSSION

[15] This is the first time since the coming into force of the *Personal Health Information Act* that this Office has had occasion to produce a Report dealing with a refusal by a custodian to make a requested correction to personal health information. For that reason, I wish to discuss the background, the requirements of the *Act,* and the steps involved in the process, in somewhat more detail than might be necessary on subsequent occasions.

[16] The issue to be resolved in this investigation is whether the custodian has responded appropriately to the request for correction in accordance with the *Act*. In order to reach a conclusion, it is necessary to determine: whether the information in dispute is "personal health information"; who is the custodian responsible for dealing with this information and responding to a request for correction; and whether the custodian's response is appropriate given the facts and the requirements of the *Act*.

[17] The *Personal Health Information Act,* section 5, defines personal health information, in part, as follows:

> *5. (1) In this Act, "personal health information" means identifying information in oral or recorded form about an individual that relates to*
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> *(a) the physical or mental health of the individual, including information respecting the individual's health care status and history and the health history of the individual's family;*
>
> *(b) the provision of health care to the individual, including information respecting the person providing the health care;*
>
> *(g) information about the individual that is collected in the course of, and is incidental to, the provision of a health care program or service or payment for a health care program or service;*

[18] The disputed paragraph from the Specialist's February 13, 2012 clinical report reads as follows:

> *He is not allergic to anything medication wise. He smokes marijuana every day, four to five joints, and he buys it from the market. His main problem is that he has to buy it from the*

market but I told him I do not believe in marijuana and I therefore do not give any licence for this. Otherwise, he sometimes takes Atasol 30's but he is sick of it, and the marijuana gives him a lot of pain relief.

[19] The rest of the clinical report consists of background, diagnosis and discussion of prognosis and treatment options, which are not the subject of any dispute.

[20] The addendum to the report, added by the Specialist on April 18, 2012, reads as follows:

The following addendum is being made to my report for February 13, 2012.

1. *The dosage and the frequency of marijuana used was disclosed by the patient during the appointment. He later stated this to be incorrect.*
2. *Although my notes from the clinic appointment states that the patient uses Atasol 30's for the treatment of chronic pain, he later stated this to be incorrect. He states that he did not mention Atasol 30's.*

[21] First, information relating to an individual's use of medication for pain control or relief, no matter whether that medication might be Atasol 30, marijuana, or some other product, is clearly information "relating to the health of the individual" within the meaning of paragraph 5(1)(a) (above). The clinical report containing the disputed information also constitutes information "relating to the provision of health care" to the Complainant, and it also consists, in part, of information "collected in the course of the provision of a health care program." Therefore, for all of those reasons I find that the clinical report, including the information in dispute, and including the addendum, constitutes personal health information under the *Act*.

[22] The person or organization responsible for the collection, use, protection and correction of personal health information under *PHIA* is referred to as a custodian. Subsection 4(1) of the *Act* defines a custodian of personal health information as:

"… a person described in one of the following paragraphs who has custody or control of personal health information as a result of or in connection with the performance of the person's powers or duties …."

The definitions in the succeeding paragraphs include a regional health authority, such as Eastern Health. A health care professional, such as the Specialist in this case, may under certain circumstances also be a custodian. However, subsection 4(2) of the *Act* also provides that an employee of a custodian, when acting in the course of his or her employment, is not considered to be a custodian. In that situation it is the employer who is the custodian; the employee is not. Thus in the circumstances of this case, the custodian of the Meditech records containing the information that is the subject of the request for correction is Eastern Health. Although the Specialist dictated the report and in that sense created the record, the Specialist was at the time acting in the course of employment with Eastern Health. The report, posted to the Meditech system, is in the custody and control of Eastern Health. I find that the custodian of the report, responsible for handling the request for correction, is Eastern Health.

[23] The provisions of *PHIA* governing the correction of personal health information are somewhat lengthy, and are found in sections 60 – 63. Section 60 first sets out how a request for correction may be made:

> *60. (1) Where a custodian has granted an individual access to a record of his or her personal health information and the individual believes that the record is inaccurate or incomplete, he or she may request that the custodian correct the information.*
>
> *(2) A request under subsection (1) may be made orally or in writing.*

The Complainant's request, although originally a request for the clinical report to be removed from his medical file, has been properly treated by Eastern Health as having been made in accordance with this provision.

[24] Sections 61 and 62 provide that a custodian must respond to a request for correction, and set out the rules governing that response, including time limits for the response and the requirements for what the response must contain:

> *61. (1) A custodian shall respond to a request for correction under subsection 60(1) without delay and in any event not more than 30 days after receiving the request.*
>
> *(2) Notwithstanding subsection (1), a custodian may extend the time limit set out in that subsection for an additional 30 days where*

(a) meeting the time limit set out in subsection (1) would unreasonably interfere with the operations of the custodian; or

(b) the information that is the subject of the request for correction is located in numerous records so that the request cannot be completed within the time limit set out in subsection (1).

(3) A custodian that extends the time limit under subsection (2) shall

(a) give the individual making the request under subsection 60(1) written notice of the extension, together with reasons for the extension; and

(b) respond to the individual's request as soon as possible and in any event not later than the expiration of the time limit as extended.

62. (1) In its response under section 61, the custodian

(a) shall grant the request for correction where the individual making the request under subsection 60(1)

(i) 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

(ii) gives the custodian the information necessary to enable the custodian to correct the record; or

(b) may refuse the request for correction where

(i) the record was not originally created by the custodian and the custodian does not have sufficient knowledge, expertise and authority to correct the record,

(ii) the information which is the subject of the request consists of a professional opinion or observation that a custodian has made in good faith about the individual, or

(iii) the custodian believes on reasonable grounds that the request is frivolous, vexatious or made in bad faith.

(2) Where a custodian fails to respond to a request for correction within the time period referred to in subsection 61(1) or (2), he or she shall be considered to have refused the request for correction, and the individual making the request may appeal that refusal to the Trial Division under Part VII or request a review of the refusal by the commissioner under Part VI.

[25] 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.

[26] Section 63 governs what the custodian must do if it agrees to make the request for correction, and how the correction is to be made and, alternatively, sets out what the custodian must do if it refuses to make the requested correction. In either case, there are requirements to notify others:

> *63. (1) Where a custodian grants a request for a correction under paragraph 62(1)(a), he or she shall*
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> *(a) make the requested correction*
>
> *(i) by recording the correct information in the record and*
>
> *(A) striking out the incorrect information in a manner that does not obliterate the record, or*
>
> *(B) where it is not possible to strike out the incorrect information, by labelling the information as incorrect, severing the incorrect information from the record, storing the incorrect information separately from the record, and maintaining a link in the record that enables a person to trace the incorrect information, or*
>
> *(ii) where it is not possible to record the correct information in the record, by ensuring that there is a practical system in place to inform a person accessing the record that the information in the record is incorrect and to direct the person to the correct information;*
>
> *(b) provide written notice to the individual making the request for correction under subsection 60(1) of an action taken under paragraph (a); and*
>
> *(c) provide written notice of the requested correction, to the extent reasonably possible, to a person to whom the custodian has disclosed the information within the 12 month period immediately preceding the request for correction unless the custodian reasonably believes that the correction will not have an impact on the ongoing provision of health care or other benefits to the individual or where the individual requesting the correction has advised that notice is not necessary.*
>
> *(2) Where a custodian refuses to grant a request for correction under paragraph 62(1)(b), he or she shall*

> *(a) annotate the personal health information with the correction that was requested and not made and, where practicable, notify a person to whom the information was disclosed within the 12 month period immediately preceding the request for correction of the notation unless the custodian reasonably expects that the notation will not have an impact on the ongoing provision of health care or other benefits to the individual or the individual requesting the correction has advised that notice is not necessary; and*
>
> *(b) provide the individual requesting the correction with a written notice setting out the correction that the custodian has refused to make, the refusal together with reasons for the refusal, and the right of the individual to appeal the refusal to the Trial Division under Part VII or request a review of the refusal by the commissioner under Part VI.*

[27] Sections 62 and 63 of *PHIA* provide that a custodian of health information must, when presented with a request for correction, do one of two things. Either it may grant the request for correction (in which case the correct information must be placed in the record, without, however, wiping out the incorrect information) or (if it refuses to correct the information) it must annotate the record with the correction that was requested but not made.

[28] The question then becomes whether Eastern Health made the appropriate choice in refusing, rather than granting, the request for correction. Subsection 62(1) of *PHIA* provides, in paragraph (a), that the custodian shall grant the request where the person making the request demonstrates, to the satisfaction of the custodian, that the record is incomplete or inaccurate. While at first glance that provision appears to be mandatory, in that it uses the term "shall," it appears to me that the use of the underlined phrase above means that the decision is entirely in the hands of the custodian, as an exercise of discretion.

[29] However, subsection 62(1) goes on to specify how that discretion may be exercised by the custodian. It provides, in paragraph (b), that the custodian may refuse to grant a request for correction if one or another of several circumstances applies, including:

> *(ii) the information which is the subject of the request consists of a professional opinion or observation that a custodian has made in good faith about the individual;*

[30] It is clause (ii) that Eastern Health cites and on which it relies as the justification for its refusal to correct the record.

[31] Since this is the first occasion on which this Office has had to interpret and apply these provisions of *PHIA*, there is no previous Report from this Office to which I can refer. There are, however, similar legislative provisions in other provinces that have been the subject of reported decisions on requests for correction of personal health information. One such provision is found in the Alberta *Health Information Act,* R.S.A. 2000, c. H-5 *("HIA")* section 13, the relevant portions of which read as follows:

> *(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.*
>
> . . . .
>
> *(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.*

[32] It can be seen that the above language is substantially similar to that of paragraph 62(1)(b) of *PHIA*. (The provision in *PHIA*, however, adds that the professional opinion or observation must be made "in good faith about the individual" - an expression which I will consider in due course.)

[33] The language of section 13 of the Alberta *HIA* has been discussed in a number of orders issued by that province's Information and Privacy Commissioner at the time, Frank Work, Q.C. One such case, in which the facts are quite similar to those in the case before me, was discussed in Order H2005-006, issued on July 14, 2006. In that case, the Applicant alleged that Dr. James Osinchuk ("Dr. O") who was himself the custodian in that situation, improperly refused to correct or amend her health information in contravention of section 13 of the *HIA*. Dr. O refused to make corrections or amendments to his Physician Notes, saying there were no errors or omissions under subsection 13(1) and the information consisted of professional opinions or observations under paragraph 13(6)(a) of the *HIA*.

[34] The Physician Notes in dispute in that case were all part of Dr. O's file about the Applicant, made mainly during patient visits to his office, initially hand-written but later dictated and transcribed. The notes consisted of personal health information and related background information about the Applicant, and were used for the doctor's clinical record, and as the basis for ongoing diagnosis and treatment. The doctor stated that he obtained all of the information at issue directly from the Applicant.

[35] The Applicant alleged numerous errors or inaccuracies in the Notes. For example, her husband's occupation was mis-stated as "carpenter" when it should have been "carpenter's superintendent." For another, the Notes stated the patient had used a particular medication without success; the Applicant stated she had never been prescribed that medication. And on a certain date the Notes recorded a particular diagnosis, which the Applicant stated was different from the diagnosis recorded on a different date.

[36] Dr. O took the position that those entries in his clinical chart accurately reflected what he had heard or seen in his office during an appointment with the Applicant, and that the facts he recorded were those directly reported to him by the patient, or as understood by him at the time. Similarly, views expressed by him, such as diagnostic conclusions, were his medical opinions and observations at the time they were recorded.

[37] Commissioner Work found that Dr. O had properly exercised his discretion, and confirmed Dr. O's decision not to correct or amend the Applicant's health information in the Physician Notes under section 13 of *HIA*. The Commissioner, following his own interpretation of the same provisions in previous orders, used a two-step process to address the issues. The first step was to consider whether any of the information at issue consisted of "a professional opinion or observation" under paragraph 13(6)(a) of *HIA*.

[38] The Commissioner stated (at paragraphs 47-48 of Order H2005-006):

> *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).*

[39] If the information is a professional opinion or observation, that information would not be subject to correction or amendment, since under paragraph 13(6)(a) of *HIA* a custodian can refuse to make a correction or amendment regardless of whether there may be an error or omission.

[40] In the Dr. O case, Commissioner Work found that much of the information in dispute fell into the category of **professional opinion**, such as psychiatric or medical diagnosis. Having reached that conclusion, the Commissioner declined to order any correction or amendment to such information.

[41] In other instances, the information at issue was based solely on what the patient had told him during a visit – for example, whether the husband was employed as a carpenter. The Commissioner explained that if there was a discrepancy between what the patient said she told the doctor, and what the doctor recorded in the notes, there were three possible explanations:

(1) The doctor did not hear the patient correctly;
(2) The doctor heard the patient correctly but wrote something different in the notes;
(3) The patient said what the doctor recorded.

[42] The difficulty, as explained by Commissioner Work, is that all too often there is no way of determining which explanation is right. Rather than trying to make a decision based on a balance of probabilities, the preferred approach is to understand that what the doctor recorded in his notes represents his perception, interpretation, impression or understanding of what the patient told him.

This kind of information, then, also falls into the category of **professional observation** and therefore is also not subject to correction.

[43] As Commissioner Work states, in paragraph 87 of Order H2005-006:

There are compelling policy reasons for not requiring custodians to correct or amend opinions and observations under HIA. The integrity of a health services provider's records is important, not only for the patient's rights, but also for the health care system.

[44] Indeed, as Commissioner Work goes on to note, if a patient, or anyone else, could compel a doctor to change or correct any of his or her observations, then it would undermine or even make nonsense of the diagnosis. This has consequences not only for the utility of any treatment recommended or provided by the doctor, but also for the later assessment of possible errors or omissions in treatment, by hospitals or professional regulatory bodies.

[45] There is a second step in the process set out by Commissioner Work. One must next look at any remaining information in the disputed record that does <u>not</u> consist of professional opinion or observation, and determine whether in that remaining information there are errors or omissions of fact within the meaning of subsection 13(1) of *HIA*. If there are, then those errors or omissions may be subject to correction.

[46] This step in the process focuses primarily on factual information that was not obtained solely from the patient during a visit, but which is independently or objectively verifiable. Thus, for example, dates of visits may be confirmed by administrative records kept by someone other than the doctor, and laboratory tests or prescriptions may be separately and independently recorded. To give another example, a summary of another practitioner's findings may contain errors not found in the original. Such factual errors or omissions can confidently be corrected, because independent verification is possible.

[47] The language of the Alberta statutory provision is similar in all relevant respects to the language I am required to interpret in *PHIA*. Therefore I am confident that I can apply similar reasoning, and a similar analytical process, to that used by Commissioner Work which I have summarized above.

[48] Eastern Health provided our Office with all relevant documentation and correspondence. I have reviewed all of that documentation, as well as the information gathered by the investigator from this Office who was responsible for the initial investigation of this complaint, and who attempted to resolve the complaint informally. I have also carefully considered the written submissions provided by the Complainant and by Eastern Health.

[49] The investigator from this Office had several discussions with the Complainant about his recollections of what took place during the appointment with the specialist, as well as about his medication history and current medication regime. All of that information is as set out in the Complainant's submissions.

[50] The investigator then conducted interviews with the Specialist and with the Director of Health Information and Informatics at Eastern Health. In particular, the investigator questioned the Specialist in detail about his method of conducting clinical appointments with patients and his practices for recording information. The Specialist explained that it is his invariable practice to make brief notes during each appointment, and to dictate his clinical report immediately following the appointment, before seeing the next patient. He had no explanation to offer for the discrepancy between the Complainant's recollections and his report.

[51] Earlier in this report I set out the disputed paragraph from the clinical report written by the specialist, in paragraph [18] above. I will not reproduce the entire clinical report here, because it contains a great deal of personal health information, and to disclose it here would risk compromising the anonymity of the Complainant. I will therefore simply summarize the content of the rest of the report.

[52] The first paragraph of this clinical report is a reference to the Pain Inventory Form, and consists entirely of information collected from the Complainant during the visit. It is consistent with what the Complainant himself has recounted about that part of the visit.

[53] The second paragraph is a summary of the Complainant's relevant medical history. During our investigation the Specialist confirmed that this information came directly from the patient at the time of the clinic visit. While the specialist had access to the information about the patient contained in the Meditech system at the time of the appointment, the entire paper chart does not come with the

patient to the appointment. Therefore the oral history-taking at the appointment is an integral part of the process.

[54] The Complainant does not dispute the accuracy of the information in either of these two paragraphs. However, it is clear that the information contained in both paragraphs consists of information that the Specialist states he obtained directly from the Complainant during the visit. Therefore, applying the first part of the two-part test suggested by Commissioner Work, I find that the information in those two paragraphs is properly characterized as "professional observation."

[55] The fourth and last paragraph of the report consists entirely of a discussion of the diagnosis of the Complainant's medical disorder, along with some comments on alternative treatments. The Specialist is here applying his medical expertise to an assessment of the facts about the patient and offering his opinion about the likely effectiveness of certain treatments. The Complainant does not dispute any of the information in this paragraph. However, applying Commissioner Work's two-step process, this paragraph is properly characterized as "professional opinion."

[56] The third paragraph is the one in dispute. It reads as follows:

> *He is not allergic to anything medication wise. He smokes marijuana every day, four to five joints, and he buys it from the market. His main problem is that he has to buy it from the market but I told him I do not believe in marijuana and I therefore do not give any licence for this. Otherwise, he sometimes takes Atasol 30's but he is sick of it, and the marijuana gives him a lot of pain relief.*

[57] It is clear from the context that all of the information contained in this paragraph is based on what the Specialist says the patient told him during the course of the clinic visit. This is confirmed by what the Specialist has stated in the addendum that he subsequently added to the clinical report, and also by the statements the Specialist made in later correspondence about this matter, and statements made to our investigator in their meeting. That is, the Specialist states that the information about Atasol 30 and marijuana came from statements made by the Complainant to the Specialist during the course of the visit. Therefore it falls into the category of "professional observation."

[58] I hasten to add that in the above paragraph, I am not saying that I have concluded that the information in the clinical report about Atasol 30 and marijuana is correct. Equally, I am also not

saying that I have concluded that this information was in fact told by the Complainant to the Specialist. Rather, up to this point I have simply concluded that the information in dispute is properly characterized as professional observation.

[59] The Complainant argues, in his submission, that the clinical report is at odds with the Specialist's handwritten notes, which the Specialist jotted down during the visit and which are contained in the Complainant's file. The Complainant correctly states that those notes, which I have examined, contain no mention of marijuana. On review, however, it is apparent, first of all, that the notes contain references to some facts that are reproduced in the subsequent clinical report, such as the patient's lack of allergies, or dates of injuries, but which are not in dispute. There are also other references in the clinical report that are not found in the notes, such as the sites of the patient's physical injuries, but which are also not in dispute. However, the notes also contain references to some facts that are in dispute, such as the use of Atasol 30, and the expression "sick of it."

[60] In my experience these seeming inconsistencies are not uncommon in the context of note-taking by professional interviewers in many different fields. Their notes are not always intended to be verbatim recordings, or even complete. Rather, they often function simply as means of jogging the interviewer's memory during the process of report-writing, and different individuals have their own styles of note-taking for this purpose. Overall, in the present case it is difficult to conclude that the presence or absence of a reference to marijuana in the handwritten notes proves anything, one way or another, about whether the alleged statements were made.

[61] The Complainant has submitted to Eastern Health, and to this Office, the results of blood work dated May 12, 2012 and later, which screened negative for 42 drugs, including marijuana and Atasol 30. He argues that this shows that he does not use those drugs, and therefore his version of what was said in the clinical visit should be regarded as more credible. However, as a matter of logic, the presence or absence of a positive blood test result in May cannot be used to prove whether or not the Complainant used those drugs prior to February, nor can it be used to prove whether or not the Complainant made statements about marijuana use during the clinical appointment.

[62] There was no one else present at the appointment who could confirm one person's version of the events that took place during the visit. There is nothing that I am aware of in the specialist's background, in the circumstances surrounding the appointment, or in the specialist's note-taking

practices, to lead me to believe that he has made a mistake. I do not have evidence, despite the Complainant's assertions, that would enable me to reach a conclusion about which of these conflicting statements, about what was said during the clinical visit, to accept as accurate.

[63] Clause 62(1)(b)(ii) of *PHIA* qualifies the expression "professional opinion or observation" by stating that it must be "made in good faith about the individual." Therefore, apart from the issue of accuracy, I am required to assess whether there is, in the circumstances, evidence on which I can reasonably conclude that the disputed paragraph of the clinical report was not written in good faith.

[64] The Complainant, in his submissions, alleges that the disputed statements made in the Specialist's clinical report are deliberately false and malicious. He suggests that the motive for this malice lies in the fact that the Complainant refused to complete the Specialist's "Brief Pain Inventory" questionnaire at the beginning of the appointment. This incident is alluded to in the first paragraph of the clinical report.

[65] There is, however, no evidence before me, other than the allegation of the Complainant, to lead me to conclude that the Specialist was angry or upset about the patient's refusal to fill out the form. It appears from all accounts that the Specialist simply used the oral interview portion of the appointment as an opportunity to gather the information that he would have obtained from the questionnaire. There is nothing on which I can base a reasonable conclusion that the Specialist falsified the disputed paragraph of his report, and so I cannot conclude that the disputed paragraph of the clinical report was not written in good faith.

[66] I must stress, however, that similarly there is nothing that I am aware of in the background of the Complainant, or in the circumstances, to lead me to believe either that the Complainant has made a mistake in his recollection of the details of the appointment, or that he is deliberately not telling the truth. As a result, I do not have sufficient evidence to conclude which of the two versions of what happened and what was said during the course of the clinic appointment may be correct.

[67] 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.

[68] It focuses on integrity by insulating health care professionals from outside interference in formulating and recording their professional observations and diagnostic opinions (subject, as indicated above, to the requirement of good faith). It accomplishes this by permitting custodians to refuse to agree to requests for correction of such observational and opinion information. It simultaneously ensures transparency, by mandating a correction process that requires that in either case, the record will always contain both the original content and the information about the requested correction. The only difference is that in the case of a correction, the custodian labels the original information as incorrect, and clearly states what it considers the correct information to be. Conversely, where the custodian refuses to correct the record, the annotation must state what the requested correction is, that it has refused to make it, and why.

[69] In summary, in the circumstances of the present case I am not required to determine, on the basis of the evidence, which version of the disputed events is most likely to be correct. I have concluded that the entire clinical report in question consists of "professional observation" and "professional opinion." There may be elements of the report that could qualify as independently verifiable facts, but they are not in dispute, and I find that the portion in dispute consists entirely of statements of professional observation. I have no reasonable basis for concluding that those observations were not made in good faith. The *Personal Health Information Act* permits the custodian in such circumstances to refuse to correct the record, and I have no basis on which to recommend that a correction be made.

[70] The Complainant in his submissions has also alleged that the Specialist has accessed the Complainant's medical file without authorization and that this was a breach of his privacy that this Office should deal with. In addition to making his complaint to this Office, the Complainant has also filed a complaint with the College of Physicians and Surgeons of Newfoundland and Labrador, making allegations against the Specialist arising out of the same circumstances.

[71] I have reviewed the documentation and correspondence provided to me by the Complainant, involved in the College proceeding. It appears to me that if there was any unauthorized access by the

Specialist to the Complainant's personal health information, as alleged, it did not take place in the course of or as a result of, the request for correction or the complaint to this Office. Rather, it took place in the context of the complaint to the College of Physicians and Surgeons.

[72] The College of Physicians and Surgeons complaint process is provided for under a completely different legislative framework, in which this Office has no role to play. I have no jurisdiction to determine any issue arising out of that process, and so I will make no comment on it.

[73] In paragraph [8] above I noted that Eastern Health had suggested in its submissions that there was no need of a formal Report from this Office. It is true that, under section 67 of *PHIA,* I have the authority to decide not to conduct a review under various circumstances, including when I am satisfied that the custodian has responded adequately to the complaint. However, given that this is the first occasion on which this Office has been called upon to deal with a request for correction of personal health information, I have decided that it is appropriate, for the assistance of health care custodians generally, to issue a Report illustrating the analytical framework we have adopted and how we intend to deal with such matters in future.

[74] The only course of action remaining for me, then, is to observe that Eastern Health is required by section 63 of *PHIA* to annotate the record with a note setting out the correction that the Complainant has requested. Eastern Health has in fact offered to do that. As part of this procedure, Eastern Health is then required under section 63 of *PHIA* to notify other persons (such as the Complainant's family doctor) to whom the disputed information was disclosed in the 12 months immediately preceding the request for correction, of the correction that has been requested but has not been made.

V CONCLUSION

[75] I have concluded that I have no basis for deciding that Eastern Health is wrong in refusing to correct the record, and that therefore as the custodian it has responded appropriately to the Complainant's request for correction, in accordance with the *Act*.

VI RECOMMENDATIONS

[76] Given my conclusion, above, I make no recommendation that Eastern Health correct the record as requested by the Complainant.

[77] I do, however, wish to note that if Eastern Health does not correct the disputed record it is then required to annotate the record with the correction that was requested and not made, in accordance with section 63 of the *Act,* and to notify certain persons in accordance with that section.

[78] I further note that pursuant to section 74 of *PHIA,* Eastern Health is not required, in response to this Report, to give written notice of its decision to the Complainant and to this Office, since this Report does not contain any recommendation under subsection 72(2).

[79] Therefore, pursuant to subsection 73(1) of the *Act* I hereby advise the Complainant that he has the right, within 30 days of his receipt of this Report, to appeal Eastern Health's refusal to correct the record, under section 83 of the *Act*, to the Supreme Court (Trial Division).

[80] Dated at St. John's, in the Province of Newfoundland and Labrador, this 5th day of August, 2014.

E. P. Ring
Information and Privacy Commissioner
Newfoundland and Labrador