Office of the
Saskatchewan Information
and Privacy Commissioner

REVIEW REPORT 137-2018

Saskatchewan Health Authority

August 7, 2019

Summary: Dr. Suzanne Meiers received a transcribed report that should have been sent to Dr. Pamela Meiers instead. This privacy breach was a result of the dictating physician neglecting to dictate the first name of the physician who was to receive the report, the transcriptionist for guessing at which physician should receive the report, and for quality assurance for not detecting these errors. The Information and Privacy Commissioner (IPC) made a number of recommendations including the Saskatchewan Health Authority (SHA) and 3sHealth follow-up with physicians who make dictation errors. Further, he recommended that the SHA and 3sHealth develop a strategy to minimize the mixing up of physician names in dictated and transcribed reports.

I BACKGROUND

[1] On July 28, 2018, Dr. Suzanne Meiers (Dr. S. Meiers) reported to my office that a transcribed report containing personal health information was sent to Dr. S. Meiers in error. The report was meant to be sent to Dr. Pamela Meiers (Dr. P. Meiers).

[2] Through a shared services agreement, 3sHealth provides transcription services on behalf of the Saskatchewan Health Authority (SHA). Therefore, the transcribed report was sent by the SHA in error to Dr. S. Meiers.

[3] On July 19, 2018, my office notified the SHA that it would be undertaking an investigation.

II DISCUSSION OF THE ISSUES

1. Is *The Health Information Protection Act* (HIPA) engaged?

[4] HIPA is engaged when three elements are present: 1) personal health information, 2) a trustee, and 3) personal health information is in the custody or control of the trustee.

[5] First, subsection 2(m) of HIPA defines "personal health information" as follows:

> 2 In this Act:
> ...
> (m) "personal health information" means, with respect to an individual, whether living or deceased:
> (i) information with respect to the physical or mental health of the individual;
> (ii) information with respect to any health service provided to the individual;
> (iii) information with respect to the donation by the individual of any body part or any bodily substance of the individual or information derived from the testing or examination of a body part or bodily substance of the individual;
> (iv) information that is collected:
> (A) in the course of providing health services to the individual; or
> (B) incidentally to the provision of health services to the individual; or
> (v) registration information;

[6] Based on a review, I find that the transcribed report contains personal health information.

[7] Second, the term "trustee" is defined by subsection 2(t)(ii) of HIPA as follows:

> 2 In this Act:
> ...
> (t) "trustee" means any of the following that have custody or control of personal health information:
> ...
> (ii) the provincial health authority or a health care organization;

[8] Based on the above definition, I find that the SHA qualifies as a trustee.

[9] Third, in my office's Investigation Reports 151-2017, 208-2017, 233-2017, 235-2017 and 152-2017, 219-2017, I found that 3sHealth is an information service provider (IMSP) for the SHA. Therefore, I find that the SHA has custody or control over the personal health information in the transcribed report.

[10] Based on the above, I find that HIPA is engaged.

2. Did a privacy breach occur?

[11] A privacy breach occurs when personal health information is collected, used, and/or disclosed in a way that is not authorized by HIPA.

[12] The term "disclosure" means the sharing of personal health information with a separate entity that is not a division or a branch of the trustee organization. Before disclosing personal health information, a trustee should ensure it has authority to do so under HIPA.

[13] In this case, the SHA disclosed personal health information to Dr. S. Meiers due to an error. This would be an unauthorized disclosure under HIPA. Therefore, I find that a privacy breach has occurred.

3. Did the SHA respond to this privacy breach appropriately?

[14] My office suggests that trustees undertake the following five steps when responding to a privacy breach:

- Contain the breach,
- Notify affected individual(s),
- Investigate the privacy breach,
- Prevent future privacy breaches,
- Write an investigation report.

[15] Below is an analysis of each step.

Contain the breach

[16] To contain the privacy breach is to ensure that the personal health information is no longer at risk. This may include recovering the record(s), revoking access to personal health information, and/or stopping the unauthorized practice.

[17] In this case, Dr. S. Meier's office indicated to my office, in an email dated July 18, 2018, that it had deleted the transcribed report.

[18] I find that the breach has been contained.

Notify the affected individuals

[19] Notifying the affected individual(s) of the privacy breach is important so that they can determine how they have been impacted and take steps to protect themselves. A notification should include the following:

- A description of what happened,
- A detailed description of the personal information or personal health information that was involved,
- If known, a description of possible types of harm that may come to them as a result of the privacy breach,
- Steps that the individuals can take to mitigate harm,
- Steps the organization is taking to prevent similar privacy breaches in the future,
- The contact information of an individual within the organization who can answer questions and provide further information,
- A notice that individuals have a right to complain to the Office of the Information and Privacy Commissioner,
- The contact information of the Office of the Information and Privacy Commissioner, and
- Where appropriate, recognition of the impacts of the breach on affected individuals and an apology.

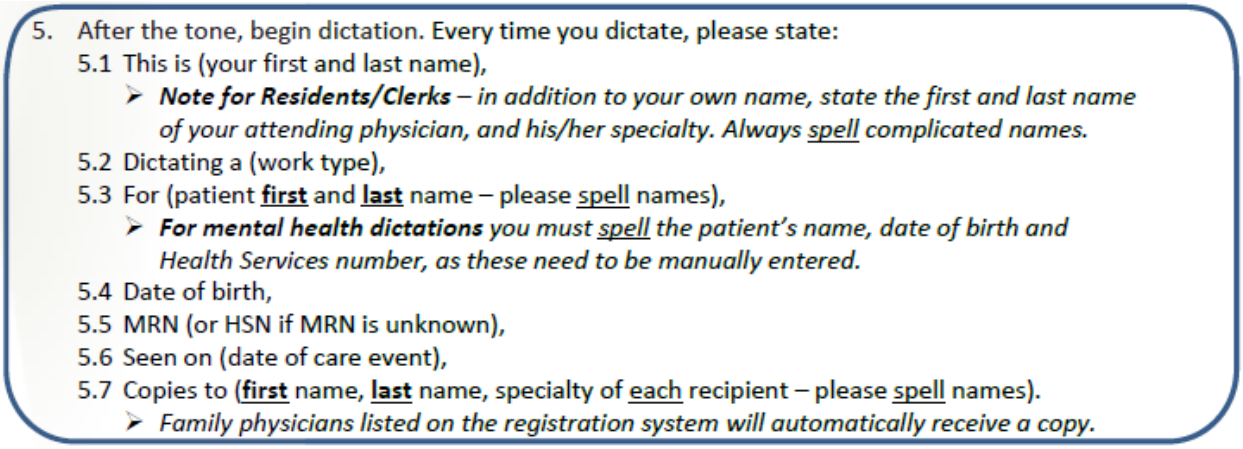
[20] In its investigation report, the SHA identified that there was one affected individual. It sent a letter dated July 30, 2018 to the affected individual containing the above elements. I find that the SHA has notified the affected individual.

Investigate the privacy breach

[21] Investigating the privacy breach to identify the root cause is key to understanding what happened and to preventing similar privacy breaches from occurring in the future. In its investigation report, the SHA identified three stages in which errors occurred, which led to the privacy breach. These three stages were at the dictation stage, the transcription stage, and the quality assurance stage. Below is a summary.

[22] A medical student completing the clerkship phase of the University of Saskatchewan's (U of S) College of Medicine Undergraduate Medical Education program dictated the report. However, this medical student did not dictate the first name.

[23] The Provincial Dictation and Transcription Services, created by the SHA and 3sHealth, has a manual called the Saskatchewan Dictation Manual ("Dictation Manual"). Page 4 of the Dictation Manual provides that Residents or Clerks are to dictate the first and last name of the attending physician. It says:



5. After the tone, begin dictation. Every time you dictate, please state:
   - 5.1 This is (your first and last name),
     - ***Note for Residents/Clerks*** *– in addition to your own name, state the first and last name of your attending physician, and his/her specialty. Always spell complicated names.*
   - 5.2 Dictating a (work type),
   - 5.3 For (patient **first** and **last** name – please spell names),
     - ***For mental health dictations*** *you must spell the patient's name, date of birth and Health Services number, as these need to be manually entered.*
   - 5.4 Date of birth,
   - 5.5 MRN (or HSN if MRN is unknown),
   - 5.6 Seen on (date of care event),
   - 5.7 Copies to (**first** name, **last** name, specialty of each recipient – please spell names).
     - *Family physicians listed on the registration system will automatically receive a copy.*

[24] Therefore, the medical student did not comply with the Dictation Manual.

[25] Once, the report was dictated, the report was sent to transcription services at 3sHealth. The medical transcriptionist did not confirm which Dr. Meiers was to receive the transcribed report. The medical transcriptionist incorrectly selected "Dr. Suzanne Meiers".

[26] Finally, once the report was transcribed, the report was sent through Quality Assurance (QA). Unfortunately, even at this stage, the error was not caught. The report was then sent to Dr. S. Meiers, who reported the privacy breach to my office.

[27] I find that the SHA has investigated this privacy breach.

Prevent future privacy breaches

[28] Preventing future breaches means to implement measures to prevent similar breaches from occurring.

[29] The SHA contacted Provincial Dictation and Transcription Services at 3sHealth. 3sHealth followed up with the vendor (M*Modal). 3sHealth asked that M*Modal remind their staff that when the person dictating a report only gives a last name and there are multiple physicians that could be selected, their staff members should add a QA note stating that the medical transcriptionist is unsure which physician should be receiving the report. Then, QA can investigate the matter.

[30] In an email dated July 19, 2018, M*Modal advised 3sHealth that it has followed up with the medical transcriptionist and the QA editor. It said it would also send a reminder to the entire group. I find that the SHA has taken reasonable steps towards minimizing similar privacy breaches in the future.

[31] As noted earlier in this Report, errors occurred not only at the transcription stage and the QA stage, but also at the dictation stage. Neither the SHA nor 3sHealth followed up with the medical student (or the U of S' College of Medicine). I recommend that the SHA and 3sHealth follow-up with the medical student and the U of S' College of Medicine to ensure that the medical student is aware that they must dictate both the first and last name of the attending physician and any other physician who is to receive the report.

[32] In my office's Investigation Reports 151-2017, 208-2017, 233-2017, 235-2017 and 152-2017, 219-2017, my office had recommended that the former Regina Qu'Appelle Regional Health Authority (RQRHA) and the Saskatoon Regional Health Authority (SRHA) along with 3sHealth, track incidents of when reports are being sent to the wrong physician. Both the RQRHA and SRHA indicated to my office that 3sHealth is tracking such information.

[33] In the course of this investigation, 3sHealth provided my office with a spreadsheet that lists incidents of when a report was sent to the incorrect physician from the end of July 2017 to June 2019. This spreadsheet shows there can be many different root causes of why reports

were sent to the incorrect physician, including the dictating physician errors and medical transcriptionist errors. Dictating physician errors include:

- Dictating only the last name (and not the first name) of the physician who is to receive the report;
- Erroneously entering another physician's ID into the system instead of their own physician ID;
- Requesting a copy of the report be sent to a specific physician but upon receiving the report, the other physician states that the patient is not theirs; and
- Selecting the incorrect physician to receive the report in the mobile app used for dictating reports.

[34] Medical transcriptionist errors include:

- Selecting the wrong physicians even when the dictating physician has provided full information;
- Guessing incorrectly at who the physician is when the dictating physician has not provided full information;
- Selecting the wrong patient even though the physician provided the patient's full name;
- Selecting the incorrect family physician even after confirming patient registration information; and
- Adding a physician to receive the report in error.

[35] Based on this spreadsheet by 3sHealth, I observed the following:

- From the end of July 2017 to December 2017, there were 32 reports that were sent to the incorrect physician due to errors by the dictating physician and 21 reports due to errors by medical transcriptionists.

- From January 2018 to December 2018, there were 141 reports that were sent to the incorrect physician due to errors by the dictating physician and 85 reports due to errors by medical transcriptionists.

- From January 2019 to June 2019, there were 134 reports that were sent to the incorrect physician due to errors by the dictating physician and 70 reports due to errors by medical transcriptionists.

[36] When I consider the information above, I note that the percentage of breaches due to medical transcriptionist's errors is decreasing while the percentage of breaches due to dictation errors is increasing. In 2017, dictation errors contributed to 60.38% of the

breaches while medical transcription errors contributed to 39.62% of the breaches. In 2018, dictation errors contributed to 62.39% of the breaches while medical transcription errors contributed to 38.61% of the breaches. In 2019, dictation errors contributed to 65.69% of the breaches while medical transcription errors contributed to 34.3% of the breaches. Therefore, more attention and efforts should be placed on reducing dictation errors.

[37] I recommend that both the SHA and 3sHealth continue their work in following up with transcriptionists and QA to minimize breaches due to medical transcription errors. I also recommend that the SHA and 3sHealth follow-up with physicians who have made dictation errors so they have an opportunity to improve and hopefully not repeat their errors. If dictation errors involve medical students or resident physicians, then I recommend that the SHA and 3sHealth follow-up with both the medical student/resident physician and the U of S College of Medicine to ensure resident physicians understand and follow the Dictation Manual. I also recommend that the SHA take proactive measures to communicate to its physicians the importance of dictating in accordance with the Dictation Manual.

[38] My office has issued six investigation reports on privacy breaches on similar privacy breaches reported to us by Dr. S. Meiers. These investigation reports are as follows:

- Investigation Report 041-2018, 203-2018,
- Investigation Report 305-2017,
- Investigation Report 152-2017, 219-2017,
- Investigation Report 014-2018, 016-2018,
- Investigation Report 151-2017, 208-2017, 233-2017, 235-2017, and
- Investigation Report 083-2018, 084-2018.

[39] These investigation reports have the common theme of Dr. S. Meiers and Dr. P. Meiers (and, in the case of Investigation Report 305-2017, Dr. C. Meier) be confused for one another. These privacy breaches are not isolated to Dr. S. Meiers, Dr. P. Meiers, and Dr. C. Meier. Of the 1414 incidents listed on the spreadsheet my office received from 3sHealth, there were approximately 140 incidents (or approximately 10% of the incidents) where privacy breaches occurred because of physicians who have the same or similar spelled or sounding first and/or last names. Below are some examples of the approximately 140 incidents:

- Dr. A. Harrington is often mistaken for Dr. M. Harington and vice-versa. They both have similarly spelled last names.
- Dr. Marla Davidson has been mistaken for Dr. Marilyn Davidson and vice-versa as they have the same first initial and same last name,
- Dr. Alice Wong and Dr. Alex Wong have similar sounding first names and have been confused for one another,
- Dr. David Warden can be confused for Dr. David Ward and vice-versa,
- Dr. A. Shariff has been mistaken for Dr. M. Shareef,
- Dr. H. Moolla, Dr. M. Moolla, Dr. Z. Moolla can be mixed up with Dr. A. Moola, Dr. F. Moola, or Dr. A. Mulla, or Dr. S. Meuller,

[40] In one case, a physician's name was mistaken for the name of an organization and a privacy breach occurred as a result. The transcribed report was meant for Dr. Grace Ho but the transcribed was sent to Grace Hospice Care instead.

[41] I recommend that SHA and 3sHealth develop a strategy to minimize the mixing up of physician names in dictated and transcribed reports. This can include requiring dictating physicians to spell, and not pronounce, physicians names. Or this can include providing transcriptionists and QA with a list of commonly mixed up names on a monthly basis so their attention is heightened to double-check these commonly mixed up names prior to sending out reports. Finally, QA should be investigating and following up with dictating physicians who are not following the Dictation Manual – this includes errors such as not dictating the first name, last name, and/or specialty of the physician who is to receive the report. It may also be helpful if the Dictation Manual is updated so that dictating physicians must also include the location of the receiving physician.

Write an investigation report

[42] Documenting the trustee's investigation into breaches is a method to ensure that the trustee follows through with plans to prevent similar breaches in the future.

[43] The SHA provided my office with its internal investigation report into the breach, how it responded to the breach, and the steps it will take to prevent similar privacy breaches in the future.

III FINDINGS

[44] I find that HIPA is engaged.

[45] I find that a privacy breach has occurred.

[46] I find that the privacy breach has been contained.

[47] I find that the SHA has notified the affected individual.

[48] I find that the SHA has investigated this privacy breach.

[49] I find that the SHA has taken reasonable steps towards minimizing similar privacy breaches in the future.

IV RECOMMENDATIONS

[50] I recommend that the SHA and 3sHealth follow-up with the medical student and the U of S' College of Medicine to ensure that the medical student is aware that they must dictate both the first and last name of the attending physician and any other physician who is to receive the report.

[51] I recommend that both the SHA and 3sHealth continue their work in following up with transcriptionists and QA to minimize breaches due to medical transcription errors.

[52] I also recommend that the SHA and 3sHealth follow-up with physicians who have made dictation errors so they have an opportunity to improve and hopefully not repeat their errors.

[53] If dictation errors involve medical students or resident physicians, then I recommend that the SHA and 3sHealth follow-up with both the resident physician and the U of S' College of Medicine to ensure resident physicians understand and follow the Dictation Manual.

[54] I recommend that the SHA take proactive measures to communicate to its physicians the importance of dictating in accordance with the Dictation Manual.

[55] I recommend that SHA and 3sHealth develop a strategy to minimize the mixing up of physician names in dictated and transcribed reports, as described at paragraph [41].

Dated at Regina, in the Province of Saskatchewan, this 7th day of August, 2019.

Ronald J. Kruzeniski, Q.C.
Office of the Saskatchewan Information and Privacy Commissioner