Office of the
Saskatchewan Information
and Privacy Commissioner

REVIEW REPORT 125-2017

Saskatoon Regional Health Authority

October 11, 2017

Summary: The Applicant requested that the Saskatoon Regional Health Authority (SRHA) make several amendments to her personal health information. Through the course of the review, SHRA made one amendment to the Applicant's personal health information. The Commissioner found that notations were sufficient for the rest of the requests either because SRHA demonstrated that there was no errors or because the Applicant requested amendments to professional observations. He also found that SRHA could have done more to assist the Applicant in explaining symbols to the Applicant. He recommended that the SRHA follow best practices in making amendments and notations.

I BACKGROUND

[1] On April 24, 2017, the Saskatoon Regional Health Authority (SRHA) received a request from the Applicant to amend her personal health information.

[2] On May 25, 2017, SRHA responded to her request indicating that the physicians who created the records were contacted and they believed the personal health information was accurate and complete. The response advised the Applicant that no changes would be made.

[3] On June 15, 2017, the Applicant, who was dissatisfied with SRHA's response, requested a review from my office.

[4] My office contacted SRHA and provided advice regarding the use of notations pursuant to section 40 of *The Health Information Protection Act* (HIPA). On June 22, 2017, SRHA sent the Applicant a second response indicating that, even though the changes she requested were not made, a notation was made in her chart.

[5] My office provided notification on June 27, 2017 to both the Applicant and SRHA of my intention to undertake a review. They were both invited to make submissions with respect to their positions. The Applicant indicated that she did not want to make a further submission and all of the information my office would require was included in her request to my office.

II RECORDS AT ISSUE

[6] The Applicant requested amendments to two records. She requested one amendment to a one page *EMERGENCY/OUTPAITIENT REGISTRATION* form from October 2012.

	Information in the record	***Applicant alleges***
1	"very drunk"	Alleges she was not intoxicated

[7] The rest of the amendments are contained on four pages of records created as a result of an emergency department visit at SRHA in December 2016. The Applicant requests amendments to the following information found in this record:

	Information in the record	***Applicant alleges***
2	A reference to lack of recent blood work	She alleges she gets monthly blood work done
3	An observation that the Applicant was shaking and had a bloody nose while in the emergency department	She alleges she was not shaking and did not have a bloody nose
4	Indication that Applicant arrived to emergency department in a private vehicle	She alleges she did not own a private vehicle and walked to the emergency department
5	An observation that the Applicant had "pressured speech"	She alleges she did not have pressured speech

6	An assessment that "New onset or change in headache pattern >50 years of age"	She alleges she was 61 at the time of the visit
7	An observation that the Applicant told a tangential story about thyroid being zapped multiple times by SaskTel workers	She alleges it was Shaw workers
8	An observation that the Applicant denied having chest pains	She alleges she went to the emergency department because of chest pains.

III DISCUSSION OF THE ISSUES

1. Does HIPA apply in these circumstances?

[8] HIPA applies in full when three elements are present. The first element is personal health information, the second element is a trustee, and the third element is the personal health information in the custody or control of the trustee.

[9] 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;

[10] The record in question is information collected in the course of providing health services to the Applicant. Further, it is information about her physical health and information about a health service that was provided. Therefore, it qualifies as personal health information pursuant to subsection 2(m)(i), (ii) and (iv)(A) of HIPA.

[11] SRHA qualifies as a trustee pursuant to subsection 2(t)(ii) of HIPA, which provides:

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

[12] Finally, the records were created by physicians and other staff that work in the emergency department for SRHA. The records were in the custody and control of SRHA. HIPA applies in these circumstances

2. Has SRHA responded appropriately to the Applicant's request for amendment?

[13] Section 40 of HIPA provides:

> **40**(1) An individual who is given access to a record that contains personal health information with respect to himself or herself is entitled:
>
> (a) to request amendment of the personal health information contained in the record if the person believes that there is an error or omission in it; or
>
> (b) if an amendment is requested but not made, to require that a notation to that effect be made in the record.
>
> (2) A request for amendment must be in writing.
>
> (3) Within 30 days after a request for amendment is received, the trustee shall advise the individual in writing that:
>
> (a) the amendment has been made; or

(b) a notation pursuant to clause (1)(b) has been made.

(4) Subject to subsection (6), where a trustee makes an amendment or adds a notation pursuant to clause (1)(b), the trustee must, where practicable, give notice of the amendment or notation to any other trustee or person to whom the personal health information has been disclosed by the trustee within the period of one year immediately before the amendment was requested.

(5) A trustee that receives a notice pursuant to subsection (4) must make the amendment or add the notation to any record in the custody or control of the trustee that contains personal health information respecting the individual who requested the amendment.

(6) A trustee is not required to notify other trustees where:

(a) an amendment or a notation cannot reasonably be expected to have an impact on the ongoing provision of health services to the individual; or

(b) the personal health information was disclosed to the other trustees for any of the purposes or in any of the circumstances set out in subsection 27(2).

(7) An amendment required to be made pursuant to this section must not destroy or obliterate existing information in the record being amended, other than registration information.

[14] Subsection 40(1)(a) of HIPA provides an individual with the right to request a trustee to amend his/her personal health information where the individual believes there has been an error or omission. Subsection 40(1)(b) of HIPA requires a trustee to make a notation on file if the correction was requested but not made.

[15] An error is a mistake or something wrong or incorrect. An omission means that something is missing, left out or overlooked.

[16] The following criteria should be considered when an amendment has been requested:

a. the information at issue must be personal health information;
b. the information must be inexact, incomplete or ambiguous; and
c. the amendment cannot be a substitution of opinion.

a. ***Was the information in question personal health information?***

[17] As noted above, the information in question qualifies as personal health information pursuant to subsection 2(m)(iv)(A) of HIPA.

b. Was the information inexact, incomplete or ambiguous?

[18] I will address each of the Applicant's specific requests for an amendment in turn.

	Information in the record	***Applicant alleges***
1	"very drunk"	Disputes she was intoxicated

[19] The Applicant has taken issue with a note on the record that indicates she was "very drunk" when she was present in the emergency department. SRHA has indicated that the results of blood tests taken at that time of the visit indicate high ethanol levels in her blood stream which is an indication she was intoxicated. No amendment is required on this record. However, pursuant to subsection 40(1)(b) of HIPA, SRHA has made a notation that there was a request for an amendment.

	Information in the record	***Applicant alleges***
2	A reference to lack of recent blood work	She alleges she gets monthly blood work done

[20] During the course of this review, SRHA made this amendment.

	Information in the record	***Applicant alleges***
4	Indication that Applicant arrived to emergency department in a private vehicle	She alleges she did not own a private vehicle and walked to the emergency department

[21] The record indicates that the Applicant arrived at the emergency department by private vehicle. The Applicant disputes this because she claims that she did not own a vehicle at the time of the visit. She said she walked to the emergency department for this visit.

[22] SRHA said that the nurse that cared for the Applicant recorded that she arrived by private vehicle because that is what she was led to believe. Neither the Applicant nor SRHA provided further information that persuades me how the Applicant arrived at the emergency department. SRHA should make a notation on the record.

	Information in the record	***Applicant alleges***
6	An assessment that "New onset or change in headache pattern >50 years of age"	She alleges she was 61 at the time of the visit

[23] The Applicant also takes exception to a comment where the physician was assessing the Applicant's symptoms in relation to headache patterns for those over 50 years of age. The physician uses the greater-than symbol (>) and the number 50 in this phrase. The Applicant alleges that it is incorrect because she was 61 years of age during the visit, not 50. My office confirmed with SRHA that the greater-than symbol means to suggest the Applicant was over 50. There is no need for amendment; nevertheless, SRHA has made a notation, pursuant to subsection 40(1)(b) of HIPA.

[24] I also note that SRHA had a duty to assist the Applicant pursuant to subsection 35(2) of HIPA which provides:

> 35(2) On the request of an applicant, a trustee shall:
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> (a) provide an explanation of any term, code or abbreviation used in the personal health information; or
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> (b) if the trustee is unable to provide an explanation in accordance with clause (a), refer the applicant to a trustee that is able to provide an explanation.

[25] Although the Applicant did not explicitly request an explanation, the Applicant's request for amendment was a clear prompt that an explanation could have helped the Applicant understand her personal health information. Neither of SRHA's two responses to the Applicant's amendment requests explained this symbol, or gave much information about SRHA's decisions regarding the Applicant's requests. Doing so may have avoided the review with my office. I find that SRHA did not meet the duty to assist.

	Information in the record	*Applicant alleges*
3	An observation that the Applicant was shaking and had a bloody nose while in the emergency department	She alleges she was not shaking and did not have a bloody nose
5	An observation that the Applicant had "pressured speech"	She alleges she did not have pressured speech
7	An observation that the Applicant told a tangential story about thyroid being zapped multiple times by SaskTel workers	She alleges it was Shaw workers
8	An observation that the Applicant denied having chest pains	She alleges she went to the emergency department because of chest pains

[26] The final four amendment items requested by the Applicant, as listed above, are observations. SRHA explained that the attending physician was contacted and confirmed the record was correct. My office specifically asked SRHA about the last amendment requested because one part of the record notes that her chief complaint was chest pains. Another part of the record indicated she denied having chest pains. SRHA explained that initially when being triaged in the emergency department, the Applicant stated to a nurse that she had chest pain. However, several hours later, she stated to the physician that she was mostly concerned about her thyroid.

[27] The Office of the Information and Privacy Commissioner for Newfoundland and Labrador (Report AH-2014-001) and the Office of the Information and Privacy Commissioner for Alberta (Order H2005-006) have considered these issues. The first step in the process to determine whether factual observations that was obtained solely from the patient during a visit are correct is determine whether it is independently or objectively verifiable. I have done this with other requested amendments in this report but have found that these four cannot be independently verified.

[28] The Commissioners explained that if there was a discrepancy between what a patient said he or 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.

[29] I cannot determine with certainty if health professionals properly captured what the Applicant described on the night she visited the emergency department or what health professionals observed. It is well known that individuals often vary widely in their recollection of the same incident.

[30] This kind of information, then, falls into the category of professional observation which is not normally subject to correction, unless an error can be independently verified. The Commissioners noted that there are compelling policy reasons for not requiring trustees to correct or amend opinions and observations. 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. 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.

[31] 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.

[32] The notes on the record and the confirmation by the attending physician who collected the personal health information satisfy me that an amendment is not warranted. Again, a notation has been made pursuant to subsection 40(1)(b) of HIPA.

[33] When SRHA first responded to the Applicant's request, it made no mention of the notation it had made. It was not until my office received the Applicant's request for review that it informed her of the notation at our request. SRHA informed my office that its process is to place the sheet requesting amendment on the front of the record if a notation was requested but not granted.

[34] In past reports I have commented that best practice is that a notation should be made on the record near the information in question. A notation should include the date, who requested the amendment, what the requested amendment was and a signature of the decision maker. Trustees should build ways to incorporate notations in their electronic record systems. Trustees should also record the reason why the notation instead of the amendment was made. A policy and procedure should also outline what is required when a notation is made.

[35] In this case, SRHA did not make a notation directly on the record. I recommend that SRHA change the manner in which it made the notations to reflect best practices.

[36] I am aware the SRHA will be merged into the Saskatchewan health authority and I would encourage SRHA staff to make what changes they can now and then encourage the new health authority to make similar changes and develop policies and procedures that will apply to the entire province.

IV FINDING

[37] I find that SRHA did not meet the duty to assist the Applicant in understanding her personal health information.

V RECOMMENDATION

[38] I recommend that SRHA change the manner in which it made the notation to reflect best practices.

Dated at Regina, in the Province of Saskatchewan, this 11th day of October, 2017.

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