NORTHWEST TERRITORIES
INFORMATION AND PRIVACY COMMISSIONER

Review Recommendation 12-110
12-163-4
October 12, 2012

THE REQUEST FOR REVIEW

In May I received a letter from the Complainant (who will be referred to in this report as "A.B." for ease of reference) who was concerned about how his personal health information was being used or disclosed by his personal physician. The Complainant has a history of mental health issues, for which he was on medication. At one point, A.B. voluntarily checked himself into the hospital because of heightened symptoms of his disorder. While in the hospital, a psychiatrist in the hospital (not A.B.'s regular doctor) worked with him and by the time he was discharged, all of his medications had been discontinued.

Several days after his discharge, A.B. attended an appointment with his regular physician. A.B. alleges that the visit was less than pleasant for him and that the doctor made accusatory comments about A.B.'s time in the hospital, disparaged his appearance, belittled the psychiatrist who had worked with him in the hospital and made negative comments about his character. The doctor also told him that prior to A.B.'s checking himself into the hospital, members of his family had been to see him, separately, as "they were concerned about my mental health" and that one of them even brought pictures of A.B. to show the doctor as evidence of A.B.'s state of health. When A.B. asked why he had not been contacted when his family members had come in to speak to him, the doctor indicated that all he had done was to advise them to get A.B. to make an appointment.

A.B. asked to see his chart, where, he says, there were no notes made of the conversations with his family members. He was also surprised to see that the doctor had changed his diagnosis from "depression" to "anti social personality disorder", despite the fact that the physician is not a psychiatrist qualified to make such a diagnosis.
A.B.'s primary concern was that the doctor had, apparently, discussed A.B.'s health with family members without A.B.'s knowledge, permission or consent and that those discussions were not recorded in his chart. He also raised issues, however, about his doctor's lack of professionalism, the change in his diagnosis as recorded in his chart and generally the way in which he was treated by his doctor after his hospital visit.

THE DEPARTMENT'S RESPONSE

In addressing A.B.'s concerns, Yellowknife Health and Social Services confirmed that the doctor in question had, in fact, met with members of A.B.'s family. The doctor, however, denied that he had discussed A.B.'s health with the family members. Rather, he says, they were "merely seeking medical advice for their own care and well being". An independent review of the doctor's notes with respect to those visits indicated that the family members had indeed made appointments and sought advice, and were provided with treatment options related to their own individual health concerns.

THE APPLICANT'S FURTHER ARGUMENT

After reading the submissions received from Yellowknife Health and Social Services, A.B. responded. He provided what he felt was further evidence of his allegations that the doctor's conversations with family members went further than simply dealing with their own health concerns. He indicates that one of those family members admitted outright that he had seen the doctor on one occasion and had spoken to him on the telephone a second time about A.B.. The same family member admitted, as well, that he was aware that another family member had also spoken to the doctor about A.B. In both instances, it appears that the doctor's response to both family members was that A.B. "was not well".

A.B. also suggested that, after speaking with family members, and while A.B. was still in the hospital, the doctor phoned the hospital and asked about having A.B. "certified" under the *Mental Health Act*. A.B. feels that this is further evidence that information received from family members caused his doctor to escalate matters.

DISCUSSION

Notwithstanding the public body's statement that A.B.'s family members were seeing the doctor to discuss their own health issues, I am satisfied that there were, most likely, some discussions between the doctor and the family members about A.B. that were not recorded in A.B.'s chart or in any of the family member's charts. That said, there is nothing to suggest that the doctor initiated those conversations. It is far more likely that they were initiated by the family members. A physician, obviously, cannot control what comes out of the mouth of a patient. If

family members choose to raise concerns about another member of the family, the physician cannot prevent that from happening. However, how the physician responds is within his power. In this case, the only thing that we can say with any certainty is that the doctor responded only by indicating that he felt that A.B. needed to get some help - that A.B. needed to see a doctor. There is nothing in what A.B. has told us that suggests that the doctor said anything more than that or that he provided the family members with any details about the Complainant's condition other than to confirm what they already knew....that A.B. was in need of help.

While a doctor cannot predict or control what comes out of a patient's mouth, he can control how he responds. Doctors have to be very careful in these circumstances to ensure that they do not inadvertently disclose any details about a third party's condition, unless of course, consent has been given. Furthermore, they must be careful to discourage further conversations about the third party. The *Access to Information and Protection of Privacy Act* provides rules not only for how personal information can be used and disclosed by a public body, but also how that information can be collected. Section 40 provides that:

> 40. No personal information may be collected by or for a public body unless
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> (a) the collection of the information is expressly authorized by an enactment;
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> (b) the information is collected for the purposes of law enforcement; or
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> (c) the information relates directly to and is necessary for
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> (i) an existing program or activity of the public body, or
> (ii) a proposed program or activity where collection of the information has been authorized by the head with the approval of the Executive Council.

Section 41 goes on to provide that:

> 41.(1) A public body must, where reasonably possible, collect personal information directly from the individual the information relates to unless
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> (a) another method of collection is authorized by that individual or by an enactment
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> (b) the information may be disclosed to the public body under Division C of this Part;
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> (c) the information is collected for the purpose of law enforcement;

(d) the information is collected for the purpose of collecting a fine or a debt owed to the Government of the Northwest Territories or a public body;

(e) the information concerns the history, release or supervision of an individual under the control or supervision of a correctional authority;

(f) the information is collected for the purpose of providing legal services to the Government of the Northwest Territories or a public body;

(g) the information

(i) is necessary in order to determine the eligibility of an individual to participate in a program of or receive a benefit, product or service from the Government of the Northwest Territories or a public body and is collected in the course of processing an application made by or on behalf of the individual the information is about, or

(ii) is necessary in order to verify the eligibility of an individual who is participating in a program of or receiving a benefit, product or service from the Government of the Northwest Territories or a public body and is collected for that purpose;

(h) the information is collected for the purpose of informing the Public Trustee about potential clients;

(i) the information is collected for the purpose of enforcing a maintenance order under the Maintenance Orders Enforcement Act; or

(j) the information is collected for the purpose of hiring, managing or administering personnel of the Government of the Northwest Territories or a public body.

None of these provisions would justify the collection of personal health information from a third party without that person's consent, other than in an emergency situation or where there is an immediate concern for the life or safety of either the third party or another person. When physicians are faced with someone offering gratuitous personal health information about a third party, it is incumbent upon the physician to stop the conversation as quickly as possible.

From what I have in front of me in this case, it appears that this is probably what the physician did. There is simply not enough for me to conclude that the physician stepped over the line by "collecting" A.B.'s personal health information. Nor does it appear that he had an active

discussion with the family members about A.B.'s situation. From all accounts, including A.B.'s, the doctor responded to the information provided by the family members by suggesting that A.B. needed help...something that everyone already knew and which did not disclose any more of A.B.'s personal health information.

As for A.B.'s other complaints about the way his physician treated him after his hospital visit, those are issues well beyond my jurisdiction and I do not intend to comment in any way. There are other forums to deal with these kinds of issues.

CONCLUSIONS AND RECOMMENDATIONS

I completely understand the Complainant's angst about the possibility that his sensitive personal health information has been discussed with members of his family without his permission or consent, even to the limited extent that appears to have occurred in this case. There are, however, some things beyond the control of a doctor in his office seeing patients. A doctor cannot control what comes out of the mouths of his patients, nor can he prevent a patient from expressing concerns about a family member. What he can do is to shut down a conversation about a family member and refuse to participate in the discussion or to provide any details about the patient. That appears to be what happened in this case. There is simply not enough to conclude that the physician in this case engaged in a discussion with the family members about A.B.'s detailed medical condition beyond acknowledging the information imparted.

This case does, however, serve as a reminder to all medical professionals dealing with patients, especially in small communities. It is very likely that one doctor will be treating members of the same family or friends or acquaintances. They will inevitably be faced with situations in which patients attempt to draw them into conversations about someone else's medical condition. Because human beings are social animals, the natural inclination is to provide comment or join the conversation. For medical health professionals, this inclination must be controlled and managed. Yellowknife Health and Social Services, and all other health authorities in the Northwest Territories, would be well advised to remind their physicians and other staff about engaging in such discussions, and provide them with strategies to end such conversations quickly.

In the circumstances, I make no recommendations.

Elaine Keenan Bengts
Information and Privacy Commissioner