NORTHWEST TERRITORIES
INFORMATION AND PRIVACY COMMISSIONER
Review Recommendation 16-141
File: 15-135-4
January 19, 2016

BACKGROUND

In June of 2015, I received a complaint from an individual (who shall be referred to herein as A.B. for ease of reference) who felt that his personal health information had been inappropriately collected, used and disclosed by the employees of the health authority for whom he worked.

A.B. was an employee of the health authority. He was on medical leave and under the care of a physician as a result of work related stress issues. On the evening in question, A.B. was experiencing high anxiety and symptoms of depression while at home. He was concerned about his own safety and says that he sought out C.D., a co-worker and friend for help and to talk to. At the time, A.B. was describing hallucinations and was expressing paranoid ideations. C.D. encouraged A.B. to go to the hospital but A.B. resisted. C.D. called another co-worker and friend of A.B.'s to help. Eventually, A.B. agreed to go to the hospital. When he and C.D. got there, the second co-worker (E.F.) was already there and had brought along yet another friend/co-worker (G.H.).

A.B. was checked into the outpatient department and assessed by the nurse in charge. He was then seen by the doctor. At some point, C.D. says that he talked with the doctor about why he had brought A.B. into the hospital and why he was concerned about A.B.'s safety and well-being. These conversations took place both in A.B.'s presence and away from A.B.. Once C.D. had assured himself that A.B. was in good hands, he left the hospital.

A.B. says that he was extremely agitated and anxious and "possibly unable to make educated decisions regarding my healthcare". He feels that his emergency contact/next of kin should have been called at this point, but that did not happen. He says that

instead, the doctor “consulted” with C.D. and E.F. about the treatment plan. He notes that he was not asked for, nor did he provide his consent to the doctor to discuss his health status with either C.D. or E.F.

As a result of the discussion between the doctor and C.D. and E.F., a complaint was made to A.B.’s professional association and A.B.’s employer was notified of A.B.’s medical issues.

In his letter of complaint, A.B. made the following comments:

> The reason I presented to the outpatient department is irrelevant. My medical information should not have been shared by any staff without my consent. I feel that my rights as a patient that day were violated as no other patient, employee of the health authority or not, would have their medical information shared amongst off-duty staff and used against them as a punishment for seeking medical attention.

A.B. argues that it was inappropriate for either the doctor or either of his two friends to report the incident to his professional association. He says that he was off work, on medical leave and under the care of a doctor and had removed himself from active duty to seek medical help for his stress, anxiety and depression. There was, therefore, no basis for any of those involved to report him. However, he was reported and had his license suspended as a result, which in turn lead to the loss of his home and his inability to return to work for over a year.

THE HEALTH AUTHORITY’S SUBMISSIONS

The Health Authority has provided an explanation as well as a number of statements from those involved in the incident which resulted in A.B.’s admission to hospital. Some of the salient points of their response are as follows:

1. With respect to A.B.'s concern about the doctor's "consultation" with C.D. and E.F., the Health Authority says that it is "common practice for Practitioners to ask accompanying family and/or friends what is happening with" the patient, particularly where the patient is not entirely lucid.

2. The Health Authority is satisfied that the only medical staff with whom A.B.'s medical information was discussed or shared once he arrived at the hospital were those who had direct responsibility for his care. That said, when an individual seeks medical assistance, a process is activated whereby a number of people become involved in the patient's care, some directly and others less so. By way of example:

    a) when someone arrives at the hospital, the unit clerk or charge nurse will enter information into the hospital computer system to start an event;
    b) the charge nurse will assess the patient and provide this information to the practitioner;
    c) the practitioner may want diagnostic services, and staff responsible would be given the necessary information to carry out the duties of their jobs and ensure that they are providing the service to the right patient;
    d) if an admission is required, the patient and their outpatient chart are transferred to the floor nurse, who carries out the admission process;
    e) the admission process also starts a dietary process which tells the dietary staff certain information about the patient and his/her needs;
    f) by the nature of their jobs, housekeeping staff will see patients in their rooms;
    g) the unit clerk will know who is in each patient room because that person is responsible for various processes at the nursing desk, including the management of the call bell system;
    h) homecare checks into the computer system each morning to see if any of their clients were admitted overnight;
    i) if a patient that is also a staff member is transferred out of the community, requiring medical travel, the Department of Human Resources is notified

so that they can authorize the process and arrange for return transportation;

j) when the transferred patient is transferred back to the hospital the discharge planner from the transferring hospital will call the hospital patient care co-ordinator to facilitate the transfer;

k) if the patient is transferred back to their home with follow up appointments, the speciality clinic will be contacted to facilitate the follow up;

l) medical records will be placed on the patient's chart upon discharge to process information and file the information into the patient's chart.

Consent for all of these exchanges of information was, in this case, implied.

3. With respect to the allegation that either the attending physician or one of his friends (C.D. or E.F.) filed a complaint about A.B. to his professional association and reported the incident to his employer it is acknowledged that both C.D. and E.F. submitted formal complaints of "alleged professional misconduct". Within days of those complaints being filed, the Health Authority informed A.B. that it was recommending that he surrender his license voluntarily. Within a week of the complaints, the Health Authority was informed by the professional association that A.B.'s license had been suspended.

4. Neither C.D. nor E.F. were on duty at the time of the incident, but accompanied A.B. as friends. Both of them deny that they "received" any personal health information "through access to hospital files or personnel". Any information they received about A.B.'s health issues came directly from A.B. They both say that they provided information to the physician, both in A.B.'s presence and apart from A.B. and that A.B. explicitly acquiesced to their presence and the discussions that took place with medical personnel on duty.

5. Both C.D. and E.F. submit that, although neither of them were on duty at the time of the incident in question, they each still had a professional obligation "to report any questionable professional conduct" as per the rules of their profession. Those rules specifically require, on a mandatory basis, a member to report another member if he feels that the other member is unfit to practice due to physical or mental disorder, or when the continued practice of a member might constitute a danger to persons in his/her care. After consulting legal advice, both determined that they had no choice but to report the matter to the professional association.

6. The physician does admit that, when asked by C.D. and E.F. what was going to happen to A.B., he told them that A.B. was going to be admitted. Beyond that, he says he did not provide either of them with any of A.B.'s personal health information.

DISCUSSION

As a preliminary matter, I note that this event and this complaint arose before the *Health Information Act* came into effect in October of 2015. Therefore, the applicable legislation is the *Access to Information and Protection of Privacy Act*. That said, as with any privacy breach, one of the most important reasons for a review is to address any policy or procedural issues which contributed to the breach or perceived breach with a view to changing those factors to prevent similar breaches in the future. To this end, I will make my recommendations with the *Health Information Act* provisions in mind.

This case raises issues about the collection, use and disclosure of personal health information. It highlights the difficulties that can arise, particularly in small communities, where those employed in the health care system are also friends or even acquaintances of a patient. The scenario presented by this case is, I am sure, repeated time and again in our health care system. In small communities such as ours, this cannot be helped.

It is important to this case that A.B., by his own admission, invited C.D. to assist him in his time of need. Furthermore, I am satisfied from all of the information collected that A.B. also acquiesced, at the time, to having C.D. and E.F. privy to the information that was being discussed. There is no suggestion that G.H. had any discussions with any of the medical personnel treating A.B. that evening. Most of the discussions that did take place involving A.B.'s friends appear to have occurred in A.B.'s presence and with A.B.'s consent. There is nothing to suggest that the discussions that the physician had with C.D. and E.F. in private were other than routine information gathering from "family and friends" so that the physician could fully assess and treat A.B. at the time. In other words, the physician's collection of personal information from C.D. and E.F. was both consented to by the patient and was required for the physician to treat him. C.D. and E.F. did not receive the information which they imparted to the physician as medical practitioners, but as friends of A.B. and it is clear that that is the role they were playing that evening. There is no evidence before me that either C.D. or E.F. further disclosed any of the information they became privy to that evening except for their statements to A.B.'s professional association, which I will discuss below. The information which they provided to the physician was provided completely outside of their role as employees of the health authority. I am satisfied that neither of them improperly collected, used or disclosed A.B.'s personal information in their dealings with the health authority and its employees when they assisted A.B. in taking him to the hospital. Furthermore, I am satisfied that in the circumstances, the physician was justified in concluding that A.B. had provided either his express or implied consent to collect A.B.'s information from C.D. and E.F., particularly as A.B. was present during some of the discussions and indicated that he didn't have any problems with C.D. or E.F. being present during those discussions.

It is not quite so obvious, however, that the disclosure of information by C.D. or E.F. to A.B.'s professional association falls within the same silo. Both C.D and E.F. acknowledge that they filed "complaints" or "reports" to A.B.'s professional association because they felt that they were ethically obligated to do so under the ethical dictates their own professional associations. They were no longer, at this point, simply acting as

“friends” of the patient. They were acting in their professional capacities. This creates a different dynamic.

The *Access to Information and Protection of Privacy Act* is quasi-constitutional in nature. It prevails over most other legislated and other public obligations unless there is a specific carve out. There is no “carve out” for ethical obligations imposed by other Acts or Regulations, let alone by professional organizations. As a result, under ATIPP, those working in the medical sector in a professional capacity would have to be careful to balance their obligations to maintain the privacy of another medical professional (whether as a patient or as a practitioner) and the ethical obligations imposed upon them by their professional associations. In this case, I would suggest that if the physician had filed a report with the professional association (which he says he was going to do before he was informed that C.D. and E.F. had done so), using the information he became privy to as a result of his attendance upon A.B. on the day he sought emergency medical aid, the physician would have been in breach of the *Access to Information and Protection of Privacy Act* unless he could justify the disclosure as being necessary to protect the mental or physical health or safety of the public or a member of the public. The head of the health authority (presumably upon receiving a report from the physician) could also have disclosed the information if he/she was of the opinion that the public interest in disclosure outweighed the invasion of privacy that would result from the disclosure. Whether the situation in question would have justified a disclosure of personal health information by the physician or by the head of the health authority is, in my opinion, questionable in that A.B. was off work on medical leave at the time and receiving treatment for stress related illness. In the end, no such report was made to the professional association by the physician who treated A.B..

C.D. and E.F. did, however, report A.B. to his professional association. In doing so they did not use information which they obtained as a result of their employment. The information which they used was information they had because A.B. requested their assistance as friends. Both C.D. and E.F. were off duty at the time they received the relevant information and neither participated in A.B.’s direct medical care when they

arrived at the hospital. In the circumstances, it cannot be said that they obtained the information which they disclosed to the professional association as a result of their employment with the health authority. They became privy to A.B.'s personal information as private citizens and A.B.'s friends. The *Access to Information and Protection of Privacy Act* imposes access and privacy obligations only on public bodies and those acting in the course of their employment for public bodies. They do not apply to the private sector, nor to private citizens. C.D. and E.F., therefore, were not subject to the restrictions imposed on public bodies by the *Access to Information and Protection of Privacy Act* and the information they disclosed to the professional association was not disclosed contrary to any legislation.

It should be noted that the *Health Information Act* now specifically includes a provision, section 49, which allows a health information custodian to disclose personal health information about an individual "for the purposes of a complaint, inquiry, investigation or review under an Act, or under the legislation of a province or another territory...to a person or organization with authority under the Act or other legislation to inquire into, investigate or review the conduct of, or the quality or standard of service provided by, a health service provider". This section would likely have applied in this case to authorize the disclosure of A.B.'s personal health information to his professional association.

CONCLUSIONS AND RECOMMENDATIONS

While I sympathize with A.B. and the position he found himself in after confiding in his friends, the *Access to Information and Protection of Privacy Act* simply does not apply in this case. The discussions which C.D. and E.F. had with the physician at the hospital were consented to, at the time, by A.B.. C.D. and E.F. were not acting in their capacity as employees of the health authority at the time, but in their capacity as private citizens helping a friend. Private citizens are not restricted in the disclosure of information under the *Access to Information and Protection of Privacy Act*. The physician's collection of that information was necessary to assess A.B.'s condition and to provide him with appropriate medical care.

In terms of the complaints made to A.B.'s professional association, again, C.D. and E.F. were acting in their capacities as private citizens and using information which they had come into possession of as friends of A.B., and not as a result of their role as employees of the health authority. They did not, therefore, breach the provisions of the *Access to Information and Protection of Privacy Act* in disclosing that information to the professional association.

I therefore make no recommendations specific to the collection, use or disclosure of A.B.'s personal health information.

I would, however, recommend that the health authority (and all other health authorities in the Northwest Territories) take the time to create some policies and procedures around the reporting of professional staff to their professional associations, particularly when the information relates to the professional as a patient rather than to the professional in his or her work capacity.

Elaine Keenan Bengts
Information and Privacy Commissioner