Office of the Access to Information and Privacy Commissioner
New Brunswick

Commissariat à l'accès à l'information et à la protection de la vie privée
Nouveau-Brunswick

REPORT OF THE COMMISSIONER'S FINDINGS

Personal Health Information Privacy and Access Act

Breach Notification:	2015-2307-H-661
Privacy Complaint Matter:	2015-2357-H-668
Date:	May 13, 2016

"*Case about access to a patient's file by a physician while of a mistaken belief of implied consent*"

INTRODUCTION and BACKGROUND

1. This Report of Findings is issued by the Access to Information and Privacy Commissioner under section 73 of the *Personal Health Information Privacy and Access Act* ("the *Act*"). The Report follows an investigation carried out pursuant to notification by the Horizon Health Network ("Horizon") of a possible unauthorized access involving a physician's access to a patient's electronic health record and a resulting complaint filed with our Office by that individual.

2. Horizon specified in its notification to our Office that an individual suspected that her personal health information may have been accessed without permission and she requested that Horizon conduct an audit to determine whether it was the case, and if so, to determine by whom.

3. The audit did in fact confirm that the individual's electronic patient record had been accessed in March of 2014. The audit results also revealed the physician (a general practice doctor) had accessed the electronic record from his home computer by remote access and that he had been "in" the record for almost 4 minutes.

4. That information was given to the individual, along with the identity of the doctor, namely Dr. S. Paulin ("the Doctor"), along with the date and time of the access, its duration, modules reviewed, etc.

5. Horizon then undertook its internal investigation to determine if the access could have been justified, i.e., otherwise authorized given all of the circumstances of the case. This is Horizon's usual process.

6. Notification to the Commissioner in such cases is mandatory under subsection 49(1) of the *Act* for any custodian involved:

> 49(1) A custodian shall
> …
>> (c) notify the individual to whom the information relates and the Commissioner, in the manner prescribed by the regulations, at the first reasonable opportunity if personal health information is
>> …
>> (iv) disclosed to or accessed by an unauthorized person.

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7. As a result, and in accordance with a set process established by both Regional Health Authorities in this Province, Horizon, a 'custodian' and subject to the *Act*, notified the Commissioner on February 13, 2015 and the individual in question filed a formal complaint on March 12, 2015 under section 68 of the *Act*.

8. Once advised of this matter by Horizon and also having received a formal complaint by the individual whose personal health information had been accessed by the doctor, we undertook our own independent investigation.

Our Investigation Process

9. We conduct independent investigations of possible privacy breach cases involving personal health information, at first, in parallel to those of either two Regional Health Authorities (RHA) in this Province although we arrive at independent findings at the completion of our work.

10. As the independent oversight Office tasked with access to information and protection of privacy in both the public and health care sectors, our role is to carry out administrative investigations with a view to make findings of facts and provide recommendations that will promote compliance with the *Acts* and ensure that rights of access and privacy are respected. We neither determine nor rule on civil liability or criminal culpability.

11. Each RHA is equipped with a protocol to detect, discover and examine closely any alleged case of privacy breach in their facilities. Those results are then communicated to the Commissioner where it is believed that personal health information has been lost, stolen, or mishandled either by accident or intentionally. Our investigation is therefore supplied with the facts gathered by the RHA involved in a *Reporting of Privacy Breach* form, a form that we have developed to capture the facets of a privacy breach that enables us to begin our own review of the case.

12. This reporting form contains specific questions as to when the alleged breach occurred and by whom, how and why it took place, how many people were involved and how many individuals have been affected. Answers to those questions become the basis upon which the Commissioner can begin her investigation without having to attend on site to ask those same questions of the personnel involved.

13. Of course in some cases, the Commissioner must delve in further and this can require on-site visits and interviews with those who can provide additional facts. We point out

that it is the statutory responsibility of all those involved or who can provide assistance in an investigation of an alleged privacy breach to comply with the Commissioner's investigation (also being an offence under subsection 76(1) of the *Act* not to do so).

14. For an alleged improper access to health information, such as in this case, we determine the veracity of the facts provided to us so that we can independently determine whether or not a privacy breach occurred, and if so, whether it was accidental or intentional.

15. Where a breach did occur, but the health care provider did not intend to violate privacy but was otherwise not well aware of the rules and patient's statutory right to privacy, the Commissioner will examine those measures already in place that need to be corrected to avoid recurrence, and recommend any further measures with a view to ensure that the health care provider clearly understands his or her statutory obligations and has agreed to comply with the *Act's* rules regarding privacy.

16. On the other hand, where a breach did occur and the health care provider was aware of the patient's rights but acted with intention or carelessness to violate the patient's privacy, then the Commissioner will recommend more serious measures to stop such actions and ensure that the patient's health care information remains protected.

In this case

17. We first set out to collect the facts of this case to determine whether there was any veracity to the allegation of unauthorized access or whether there was justification for the physician to have accessed the patient's record without permission, having regard to all of the circumstances.

18. We first point out that it was very difficult to obtain the cooperation of the Doctor in this case. The Doctor was invited to attend to answer questions, but would not do so without attending with his legal counsel. As our investigations are confidential until such time as the Commissioner shares her findings, we do not allow outside counsel to attend our interviews.

19. As for the individual who complained about the privacy breach ("the Complainant"), she attended at our Offices on two occasions and provided the Commissioner with a lengthy version of the facts and supporting documentation. We found the Complainant to be forthright in providing us with her versions of the facts of this case.

20. The Doctor decided not to meet with us without presence of legal counsel. We did, however, receive the Doctor's written comments on his version of the facts but did not meet and therefore did not have the benefit of asking him questions. Through legal counsel, the Doctor gave written representations contained in 18 pages of typewritten notes.

21. Having received the information required to conduct our review of this case, we examined thoroughly all of the facts collected and received from both parties involved, including that of Horizon's internal investigation. The initial results of Horizon's investigation showed that the Doctor did not have the Complainant's consent to look into or review the Complainant's patient file. We understand that a later finding by Horizon's By-Law Section 10 Committee (made up of physicians) found that there had been no breach of privacy.

22. We point out, however, that such findings were pursuant to Horizon Policy on the subject matter of privacy, as opposed to a finding of breach of privacy under the *Act.* Only the Privacy Commissioner can arrive at findings as to whether or not a breach of privacy has taken place under the *Act*.

FINDINGS OF FACTS

23. In our assessment of all of the facts, we found that the Doctor and the Complainant presented versions as to what took place in similar fashion, but critical aspects were clearly not the same. In our view, each party depicted what had taken place from their differing perspective and interests at play, which is natural. Our role remained to examine all of the facts separately and in combination to each party's representations in order to really sort out especially the doctor-patient relationship between the Complainant and the Doctor.

24. In doing so, we were able to dismiss those facts that were not relevant to the case and those that were of particular pertinence to that relationship which had led the Doctor to use his access privileges and look in the Complaint's health care electronic file without first asking her permission and without informing her he had done so.

25. Prior to the date on which the alleged breach took place, there existed a professional working relationship between the Complainant in question and the Doctor. They were colleagues and worked in the same location although in different fields of expertise.

Their workplace involved other care providers who dispensed health care services as a team.

26. The complainant and the Doctor began working together in the fall of 2011 and by all accounts, they had a collegial relationship, communicating with each other during their work day on a regular basis and to discuss specific cases. We note for the record, however, that their working relationship was not a respectful one where the two parties came to disagree in how health care services should be provided in certain cases. That fact was not that relevant to our investigation, except to shape the tenor of the parties' relationship.

27. In fact, the complainant and the Doctor developed a loosely put together doctor-patient relationship as a result of one colleague asking another colleague, who happens to be a physician, to assist her in obtaining convenient access to health care treatment. For his part, the Doctor was amenable and did assist the Complainant by assessing and giving her treatment at their workplace.

28. The Doctor was aware that the Complainant had a family physician and we find that the Doctor did not at any time assume that role.

29. What is clear is that the Complainant asked the Doctor about advice while they were both at work and he obliged. Where they differ is that she did not ask the Doctor to provide care, outside a single event in 2012. What is clear is that the Complainant spoke to the Doctor about health issues and that he provided medical advice on several occasions during their work relationship as a consulting or after-hours physician. The facts show that the Doctor arranged a hospital visit for her in 2012. The Doctor also provided some medication for her in 2014.

30. The case now takes us to March of 2013 where the Doctor admitted to having accessed his colleague's electronic medical record.

31. It is not entirely clear but possible that the Doctor was told by colleagues at work that the Complainant had been hospitalized.

32. The Doctor accessed the Complainant's patient electronic health record the evening she was hospitalized after finishing his duties at his private clinic. The Doctor accessed her patient file by remote access from his laptop (or home computer).

33. This type of access is a privilege provided by Horizon to allow the Doctor to practice medicine in the region. "Open access" privileges to all patients in the area are given to family physicians due to the nature of their role and to work in the emergency rooms at local hospitals.

Results of the audit

34. The results of the audit carried out by Horizon confirmed that that the Doctor accessed the complainant's patient file:
- on Monday, March 11, 2013
- at 10:05 pm
- from a remote access server (.i.e. either home or laptop computer)
- and accessed many modules in the patient chart:
  - The Visit History
  - Patient care notes (often nurses' notes)
  - The emergency department data
  - The orders to review medication
  - Consultations or investigations that had been prescribed or ordered
  - The medical record forms
  - The laboratory data
- and that his access lasted for a total of 3 minutes and 49 seconds.

35. In his legal counsel's written representations, the Doctor is said to have reviewed these modules to allow him to provide additional care to the Complainant when she would be returning to work, based on his belief that he anticipated she would consult with him again.

After March 2013

36. The facts are clear that the Doctor never mentioned to the Complainant having accessed her patient file upon her return to work in late March of 2013. In fact, they met and had a conversation about her hospitalization and at no point did the Doctor let her know that he had accessed her patient file.

37. The Complainant reported to us that no part of that conversation raised suspicions for her that the Doctor had accessed her patient chart.

38. It was only much later, namely a year and a half later in November of 2014 that the Complainant became suspicious that her electronic medical record might have been accessed on the basis that some of her colleagues were talking about her in ways she knew she had not shared openly (she had a "feeling" that something was not quite right).

39. This is when the Complainant asked that an audit be conducted (to find out if access had occurred, and if so, by whom). She was very surprised to learn of the results of the audit that it was the Doctor who had accessed her patient file.

40. The Complainant was adamant that she never gave the Doctor consent to access her file and that she never gave him the impression that he could assume the role of the physician who would be providing her treatment on a regular basis, adding that it was well known by both that she had a family physician for that very purpose.

41. That assertion is supported by the fact that the Doctor was not called upon by the Complainant or by any attendant at the Emergency for his assistance or for him to attend the hospital to provide advice or to approve the care being provided to the Complainant when she was hospitalized.

42. The facts show that the Doctor himself neither attended nor contacted the hospital to find out about the status of the Complainant's health.

43. The Doctor did not speak with the Complainant that evening, although indicating to us in his written representations that he was concerned for her health.

44. The question was therefore whether the Doctor had used his access privileges appropriately to access the Complainant's patient record in March of 2013 having regard to these circumstances.

45. Again, the Doctor admitted to having accessed the Complainant's file in preparation for discussing her care upon her return to work, as he explained to Horizon and as he indicated in his written representations to the Commissioner.

46. The Doctor offered as explanation for his actions in his written representations to us that he had the Complainant's express consent to "use" her personal health information to provide health care to her, or "in the very least" it was reasonable for him to assume

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that he had the Complainant's implied and knowledgeable consent to "**use**" her personal health information to continue to provide her with care.

47. The Doctor clearly stated that he needed to know the information in the Complainant's electronic medical record to continue to provide safe medical services; however, he also clearly stated that *he was going to discuss* the Complainant's hospitalization with her upon her return.

48. In our view, this is accurate to the approach adopted by the Complainant and the Doctor whenever she sought a consult from the Doctor in the past.

49. For those times where the Doctor was asked for advice prior to March 2013, it was the Complainant herself who asked to see him and it was her who provided the Doctor with her personal health information. The Doctor was never asked nor given permission to consult her file, as the Complainant gave him the information he needed in any event. The Doctor confirms this fact by having stated in his representations to Horizon and to us that he was going to discuss the hospitalization with her directly and then provide her the advice she needed.

50. We reiterate that both the Complainant and the Doctor confirmed that they met and had a conversation about her hospitalization when she returned to work but at no point did the Doctor let her know that he had accessed her patient file. The Doctor relied on the information she provided to him during that meeting to continue to advise her, same approach as he had relied on in the past.

51. Based on these facts, we can appreciate why the Complainant was surprised to learn the Doctor had accessed her file as she too relied on that approach when she sought advice from him.

52. The Doctor admitted that he had express or implied consent to use her personal health information, but the question remained in this case whether he had express or implied consent to access her patient file containing her entire personal health information.

FINDINGS OF LAW

53. In providing further explanations about the access issue which forms the basis for the complaint of breach of privacy, the Doctor considered himself as acting within the

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Complainant's *circle of care*. He relied on her circle of care to give him the authority to access her personal health information without her consent.

54. In our view, this point is critical to the present case and we explore in detail what is meant by the *circle of care* in the field of health care, but also how it fits within the regulated world of privacy rights of a modern health care system.

55. Circle of care is being relied upon by the Doctor to indicate that he need not have had her express consent to access her file, due to their previous relationship as a consulting physician. The Complainant for her part is clear that the relationship never extended to the Doctor being in her circle of care.

56. In other words, the Doctor was accessing the information to assist in giving medical advice rather than putting mind to whether or not the Complainant would have wanted him to do so, and to see all of her medical background. This is where the circle of care meets the principle of privacy head on.

57. Privacy as a concept can be a complex one as privacy means different things to different people. In our experience, the notion of an individual's privacy is one of the underlying reasons why health care providers often run into questions about whether or not they actually have a patient's consent, be it knowledgeable, implied or continuing, in order to access and use the patient's personal health information.

The Act, privacy and the circle of care

58. When the *Act* was passed into law and put into effect, many wondered how this regulation would affect their professional practices, their patient or client relationships, their health care industry.

59. Many feared the legislation signified a change in how they dealt with patients, and that fear led them to ignore the law and continue dispensing health care on the basis of past practices, including a demonstrable right to know about a patient or a client when part of the group that provides treatment to that person, i.e., being part of that individual's circle of care.

60. The issue was heightened when health care providers relied on *circle of care* to justify many instances of accessing patient information without consent even when these professionals were no longer or had never been a part of that patient's circle of care

when they looked into the patient's records. It was not clear to them when the circle of care begins and when it stops, as this relates to the consent of the Complainant at the centre of the care.

61. We noticed some confusion in the health care sector about the well-established practice of *circle of care* and how it takes its rightful place in the regulated world requiring patient consent as a statutory obligation.

62. For this reason, this Report will be very helpful in providing this much needed clarification, not to mention in arriving at the finding whether or not the Doctor was entitled to rely on the circle of care as authority to have gained the Complainant's implied consent to access her file.

63. To provide good guidance to health care providers and the general public alike in better understanding the heightened importance and codified right of giving consent, and in addressing the application of the circle of care within that very context, we prepared a document in 2013 entitled "Privacy and the circle of care – or, the circle of consent".

64. Health care providers use and share an individual's personal health information based on the need to pursue additional care or treatment for the Complainant by relying on the concept of *circle of care*.

65. In some cases, circle of care is referred to when health care providers use the individual's health information even when the individual has not specifically consented to the additional care or treatment. As such, health care providers refer to the *circle of care* as the implied consent of the individual, and this enables them to pursue treatment beyond that to which the individual initially consented.

66. The expression *circle of care*, however, has not been referred to, identified, or included in the *Act*.

67. Instead, legislators set out to describe those instances where implied consent of the individual could lawfully be said to exist.

68. This is in direct contrast to assuming implied consent to access and use personal health information without first ensuring that consent actually exists. In other words, the *Act* stipulates that consent must be sought, and, the *Act* further explains those cases where consent can be reasonably implied when not given expressly.

Codified right to privacy

69. The law as it exists today in New Brunswick grants the right of privacy to all individuals.

70. The right to privacy is based on the notion that personal health information belongs to the individual rather than for someone else to decide with whom and when to share it in order to attain a result.

71. The individual's right to privacy is, in turn, based on the lawful principle of an individual's right to know.

72. The *Act* therefore requires of those who work in our health care system today to respect the individual's right to know by ensuring they explain to the individual:

- why his or her personal health information must be collected (for what purpose)
- what will be done with the information once it has been collected
- whether the information will be shared with others in order to accomplish the purpose
- If the personal information is to be shared, must inform with whom it will be shared, why (for what purpose), when and how much of the information will be shared.

73. In short, the legislation emphasizes the fact that personal health information belongs to the individual to whom the information relates, not to the health care provider who collects the information in a file or chart, and that consent is an essential component of the handling of such sensitive data.

74. Proof of this is found in the components of the legislation, which dedicates the entire Part 3 to CONSENT, from describing its elements, to defining types of consent, such as knowledgeable or implied consent.

75. An individual must be informed about what will happen with his or her information before it is collected, used and shared, and must be asked to give consent wherever possible. Except in few and described limited circumstances will consent not be required at the outset such as in emergency medical situations.

76. All health care providers in this Province are subject to the *Act*.

77. Therefore, health care providers must respect the patient's codified right to privacy (right to know) by obtaining *knowledgeable consent* before collecting, accessing, using or disclosing an individual's personal health information.

78. Knowledgeable consent is set out in section 18 of the *Act* and means that the individual:
a) understands why his or her information is being (and will be) collected, used or shared, as well as with whom it will be shared;

b) is aware that his or her consent can be refused or withdrawn; and,

c) is able to appreciate the reasonably foreseeable consequences of giving, refusing or withdrawing consent.

79. With knowledgeable consent, the individual feels secure that his or her personal health information will be shared only with those who need to know, and is likely more confident in providing accurate and complete health history (that is so essential to providing the best care possible). This is reflected in the *Act*'s overall stated purposes in section 2 that include setting rules to protect the confidentiality of personal health information to protect privacy of those to whom the information relates, ensuring accountability of those who handle this sensitive data, and establishing measures in which the data will be kept safe.

80. Consequently, an individual's right to provide knowledgeable consent before the handling of his or her personal health information is a fundamental cornerstone of the right to privacy. Circle of care relies upon implied consent, however. We illustrate the distinction from the perspective of privacy rights.

81. For instance, a patient requires a metal pin insert for a badly broken leg, and physiotherapy will be helpful to continue with the healing process of the injured leg post-surgery. The patient's consent for the surgery is obtained at the outset; however, no one mentions to the patient the recommended physiotherapy after surgery. In such a case, the circle of care argument does not support hospital staff sharing the patient's chart with staff at the physiotherapy clinic because the patient's implied consent cannot be said to exist and cannot be relied upon by staff. It is not reasonable for staff to believe that the patient ought to have known that his information would be shared with physiotherapists at the hospital <u>when this therapy was never discussed with him.</u> The patient has a right to know who would access and use his information and for what reason.

82. Therefore, to respect privacy, health care providers must respect the parameters of the individual's knowledgeable consent obtained throughout the course of the individual's care but within the parameters of ***knowledgeable consent***. In many instances, circle of care will be applicable, but where it is reasonable to doubt that implied consent is present, chances are the patient is not aware and must be consulted prior to proceeding.

83. Parts 3 and 4 of the *Act* provide rules on how to protect privacy by ensuring that consent in implied or is continuing: on a *NEED TO KNOW* basis.

84. Before handling a patient's personal health information, health care providers must:
    - collect only as much personal health information as they need to know;
    - use only as much as they need to know in order to do their tasks;
    - share the information only with those who need to know (those authorized to receive it and use it).

85. It follows that during care, access to the patient's personal health information may be required by a physician on a need to know basis.

86. The *Act* states that implied consent can only exist with the essential element that the consent first obtained is knowledgeable, and second, one can only rely on implied consent for a purpose related to the initial knowledgeable consent. In other words, the use or sharing of information must be tied to the purpose for which the individual initially consented in order for the health care provider to rely on implied consent.

87. Third, if the health care provider relies on implied consent, it must be reasonable to infer, given the circumstances, that the individual's consent is *continuing*. That is, the health care provider must reasonably believe that the individual's knowledgeable consent would extend to cover the use or sharing in question.

88. In summary, a health care provider may correctly assume to have the individual's implied consent when all three elements are present:
    1) knowledgeable consent already exists,
    2) use or sharing of the information relates to the purpose for which the knowledgeable consent was originally obtained, AND
    3) it is reasonable to infer in the circumstances that the consent would *continue* to include the use or sharing in question.

89. We point out that this approach reflects what takes place on a daily basis in the medical field. Physicians and nurses are trained on the principles of consent and of the importance of obtaining consent from patients before they provide care. The *Act* has not changed this important facet but instead has improved upon it by ensuring that patient consent is sought at every possible opportunity when it is reasonable to do so.

90. If facts are clear that a patient's consent is continuing, this means that consent is present. In those cases where someone is introduced into the circle of care but it is not clear that consent is continuing based on an objective view of the circumstances, or that it is not reasonable to assume that consent is continuing, then prudence is required and consent from the patient should be clarified.

91. The *Act* does not trump common sense or good judgement on this assessment, it emboldens it. The *Act* does not tell how physicians dispense care; it aims to protect privacy of those who receive it through consent.

92. We provide an example that illustrates when it is reasonable to rely upon implied consent or when it is not.

A patient is admitted to the hospital because of a tumour. At admission, the patient relays to staff the history of her symptoms, including those akin to clinical depression. Staff enters these notes in the patient's chart. The physician who will treat the tumour is given the chart containing notes about the tumour and about signs of depression. The physician did not perform intake at admission and has not yet spoken with the patient (consent was therefore not obtained directly by the physician). The physician would like to arrange for a consult with a psychologist about the patient's depression that the physician knows should be part of the patient's overall care. Without first talking to the patient, the physician can rely upon the patient's implied consent and share the patient's information with the psychologist if: the physician *reasonably believes* that the patient was informed during admission, of the possibility that she was suffering from depression, and that she might be referred to someone regarding her depression i.e., that her personal health information might be shared with others (*for instance, a psychologist or for treatment of his depression*) the physician *reasonably believes* that the patient knew her personal information might be used for that purpose (possible treatment for depression) and the patient did not refuse or did not withdraw her consent at the time this was explained to her.

The physician is not certain but wants to proceed in the best interests of the patient to treat her depression.

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The patient, however, may not have wanted to see a psychologist. Or, the patient may not have wished to consult with the psychologist at that hospital for personal reasons (ex: the psychologist in question is the patient's neighbor).

As we observe, what is reasonable will depend upon the facts of each case. Reliance solely upon circle of care without reflection about consent in this example may be problematic.

One should not assume to have the implied consent of the patient or client where the facts show it was not reasonable to make this assumption or to have such a belief.

The patient's right to privacy required the physician to pause for a moment and seek consent from the patient before sharing the patient's information with the psychologist. This was a reasonable thing to do in those circumstances.

Application to the present case

93. The case at hand has clearly demonstrated to us that the lines may become blurry when doctors are being asked questions about health from their colleagues at their workplace. They are asked to give advice based on the personal health information provided by the colleague during those conversations and/or meetings.

94. The doctor-patient relationship is established but less clear than in those cases where the individual makes an appointment and attends at a physician's practice or clinic to seek medical care. Care is provided in both instances but the relationship may be less defined *from the perspective* or in terms of what the patient consents to, i.e., how much information the patient consents to being shared with the colleague-doctor.

95. All of the information provided at the workplace consult is provided then and there directly by the colleague, as opposed to during an examination at the physician's office where the physician can access and refer to the patient's chart alongside the patient.

96. What constitutes consent may be clear to one but not the other, resulting in both parties becoming surprised to learn that consent was not that which the other intended to give or believed existed.

97. This is exactly what took place in this case.

98. These are the facts that we know of this case that are not refuted by either the Complainant or the Doctor.

99. The Complainant sought the convenience of a colleague's time and attention as a physician to obtain medical advice and care. She gave consent to the Doctor to use the personal health information she gave him during those consultations. For his part, the Doctor relied on the Complainant's express consent to discuss her personal health information with her during those consults. The Doctor was not required to access her chart, as the Complainant was comfortable in sharing with him that which he needed at those times.

100. As a result, the Complainant was clear in her mind as to the consent she gave him: consent to use the personal health information she gave him in return for advice and prescriptions in some cases on the spot. It was clear to her that she did not give him consent to access her health record.

101. The Doctor knew he had the Complainant's consent to collect from her and use her personal health information when he spoke with her in order to give advice (and order prescriptions) during those consults. It was clear to him that he had her express consent during those times. He also knew that he was not her family physician, but considered himself part of her circle of caregivers. This is why the Doctor believed he could access her health record despite the fact that she had not given him consent to do so. He believed that she would have implied he could in the circumstance of her hospitalization.

102. In our view, from the perspective of the Complainant's consent and that of the doctor-patient relationship they developed as colleagues, the facts do not show that this was a reasonable belief. It was not reasonable for him to access her file knowing full well she was going to discuss the matter in any event with him upon her return, thereby giving him the medical information he would need if and when asked at the workplace to provide further advice, just as the parties had done many times before.

103. The Doctor could not correctly assume to have the Complainant's implied consent because not all three elements existed when he accessed her file:

- knowledgeable consent already existed but only to use the information she provided,
- use or sharing of the information related to giving advice when asked directly by the Complainant, and her knowledgeable consent was originally obtained for that purpose only,

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- there were no facts to support the notion that the Doctor could infer in the circumstances that her consent would *continue* to include access to her information outside her presence. She had always given him the information directly.

104. We do recognize the laudable reason for a physician wishing to find out more about his colleague he has treated in the past and wishing to be helpful when he is able to discuss the situation with her later.

105. Having said this, however, we remain of the view that these same facts, viewed objectively, could not justify or authorize the Doctor to have gained access to the Complainant's entire electronic health record without her consent.

COMMISSIONER'S FINDINGS - NO RECOMMENDATION

106. Given all our comments, facts and findings above, we conclude that the Doctor mistakenly believed he was authorized to access the Complainant's electronic medical record on March 11, 2013, and thereby caused a breach of the Complainant's privacy.

107. We also find that the breach was not intentional having regard to all the circumstances of this case. We are satisfied, based on our independent review of the facts, that there was no proof of ill intent on the part of the Doctor, and that he was simply acting out of interest for his colleague at that time in 2013, albeit under the mistaken belief he had the Complainant's implied consent as part of her circle of care to access her file contrary to the rules of the *Act* requiring her consent for the protection of her privacy.

108. We understand that since our investigation, the Doctor has reviewed Horizon's Privacy policies, the *Act*, and that he has completed privacy-related training. Clearly, having gone through this exercise and investigation must have been difficult. We are confident that the Doctor will have come away from this case having a greater appreciation for patient privacy, and or the importance of consent before accessing patient information in all cases.

109. For the Complainant, we trust that our findings and all of our comments in this Report will also prove satisfactory in knowing that privacy is a right, that her privacy was important and should have been respected.

110. Finally, we know that many health care professionals struggle with the rules of the *Act*, believing it is meant to change the delivery of health care. To the contrary, reliance on the circle of care for patients will and should continue, as long as they continue to recognize that the patient and the patient's consent are at the centre of that circle.

111. A patient's own personal health information belongs to the patient, and the patient alone.

Dated at Fredericton, New Brunswick, this ________ day of May, 2016.

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Anne E. Bertrand, Q.C.
Access to Information and Privacy Commissioner