When is a Custodian Not a Custodian?

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Introduction

How physicians may collect, use, and disclose a patient's personal health information is an issue which has plagued legislatures and the justice system for decades. While it cannot be denied that the disclosure of such health information, when done properly, enhances the care and management provided by the health care system, a sensitive balance must be maintained which recognizes the patient's legitimate concerns regarding privacy, confidentiality, and human dignity.

At the forefront of this precarious balancing act is the nature of the relationship between the physician and the patient. In 1992, this issue came before the Supreme Court of Canada in *McInerney* v. *MacDonald*.[1] La Forest J. delivered the Court's unanimous decision and found that while the physician may own the chart within which the patient's information resides, the information itself is owned by the patient. The relationship between the physician and the patient, in relation to that information, is described as a fiduciary one:

> As discussed earlier, information about oneself revealed to a doctor acting in a professional capacity remains, in a fundamental sense, one's own. The doctor's position is one of trust and confidence. The information conveyed is held in a fashion somewhat akin to a trust. While the doctor is the owner of the actual record, the information is to be used by the physician for the benefit of the patient. The confiding of the information to the physician for medical purposes gives rise to an expectation that the patient's interest in and control of the information will continue.[2]

The *McInerney* decision was rendered at a time when a patient's health information was still recorded on paper charts. However, the Court recognized the increasing complexity of medical treatment, and the scope of health care professionals involved in a patient's care at any given time:

> Medical records continue to grow in importance as the health care field becomes more and more specialized. As L. E. Rozovsky and F. A. Rozovsky put it in *The Canadian Law of Patient Records* (1984), at pp. 73-74:
>
> > The twentieth century has seen a vast expansion of the health care services. Rather than relying on one individual, a physician, the patient now looks directly and indirectly to dozens and sometimes hundreds of individuals to provide him with the services he requires. He is cared for not simply by his own physician but by a veritable army of nurses, numerous consulting physicians, technologists and technicians, other allied health personnel and administrative personnel.
>
> While a patient may, in the past, have relied primarily upon one personal physician, the trend now tends to favour referrals to a number of professionals. Each of the pieces of information provided by this "army" of health care workers joins with the other pieces to form the complete picture.[3]

The complexity surrounding the collection, use, and disclosure of health information has only increased as

the medical field has transitioned into the electronic age. A patient's health information may now be instantaneously collected, accessed, and transmitted through a few simple key strokes. Due to this growing concern, the Alberta legislature enacted the Alberta *Health Information Act*[4] in 1999, a mere seven years after the release of the *McInerney* decision. In the course of drafting the legislation, the patient's "ownership" of his or her health information took a back seat to the role which health service providers, such as physicians, who are defined as "custodians under the *HIA*, play in relation to that information.

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It is the authors' thesis that in spite of the lack of clear reference in the *HIA* to the patient's inherent interest in the health information being collected, used, and disclosed, the fiduciary relationship referenced in *McInerney* continues to be a guiding principle in determining the duties and responsibilities of physicians under the *HIA*. In this paper, we will attempt to more accurately define the role of custodian and distinguish it from the concurrent role of affiliate.

HIA Background

The fiduciary relationship that arises between a physician and their patient relative to the latter's health information is subject to legislative guidance. However, this is not to subvert the legal principles governing the physician's duties. As Justice La Forest stated in *McInerney*:

> I find it unnecessary to rectify the patient's interest in his or her medical records and, in particular, I am not inclined to go so far as to say that a doctor is merely a "custodian" of medical information. The fiduciary duty I have described is sufficient to protect the interest of the patient.[5]

The use of the word "custodian" in the above reference is ironic, given the *HIA*'s focus on the health service providers' gathering, use, and disclosure of health information. In retrospect, it may have been wiser to entitle the legislation the "*Custody of Health Information Act*," as the *HIA* deals largely with concepts of collection, use, and disclosure and, more importantly, who can perform these actions. Under the *HIA*, the individuals or bodies performing these actions are characterized as either "custodians" of health information, or "affiliates" of those custodians.

Affiliates are, essentially, individuals or bodies who have a relationship with a custodian, whereby the affiliate provides services for or on behalf of that custodian. Affiliates must not use or disclose health information except in accordance with the affiliate's duties to the custodian.[6] Given this, it is clear that pursuant to the *HIA*, it is the role of the custodian that is of paramount importance.

This of course begs one to ask the question, what exactly is a custodian?

One would think that a piece of legislation that focuses on the duties and responsibilities of custodians would clearly define that term. Although the *HIA* purports to define "custodian," more accurately, it tells you <u>who</u> a custodian is by listing such entities at length. Included in the definition is a reference to those "health service providers designated in the regulations as a custodian."[7] The regulations, however, designate a lengthy list of health service providers, which includes over twenty different Colleges, Associations, panels, committees, and boards.[8] From the above list, one is presumably supposed to glean what characteristics a custodian should have.

Along the same vein, the *HIA* also tells you what relationships lead to the characterization of "affiliate" without actually telling you what an affiliate is, or what characteristics they should hold.[9]

Despite the onerous restrictions and responsibilities leveled on custodians, nowhere in the *HIA* is there a precise definition telling the reader what a custodian

is, or what characteristics or attributes make one a custodian. Compounding the problem, neither our courts nor the Office of the Information and Privacy Commissioner appear to have judicially considered this critical point. Yet, it remains a pressing issue given the rapid changes in the means by which health information is being collected, used, and disclosed. The rules of engagement place all the responsibility for these actions on the shoulders of the custodians of the information, yet do not precisely tell us who they are, leaving us with more questions than answers.

Why is this important?

Under the *HIA*, custodians have significant duties and responsibilities vis-à-vis health information. These responsibilities are founded in the physician-patient relationship and concurrent duties of confidentiality. They include a duty to protect and ensure the accuracy of the health information.[10] It is axiomatic that it is difficult, if not impossible, to fulfill those duties and obligations if you do not have custody of the information because you have been relegated to the role of affiliate.

This becomes especially contentious in situations where corporate custodians, such as Alberta Health Services (AHS) or Alberta Health & Wellness (AHW), suggest that employed or contracted health care providers are, by definition, affiliates solely as a result of the contractual or employment relationship, without regard to the actual circumstances surrounding the collection, use, or disclosure of the health information. The rationale behind AHS and AHW's position is likely rooted in concerns regarding the risk of inappropriate use or disclosure of health information, and the need to control that risk by assuming custody of the information.

The result, however, is that a health service provider, such as a physician, who finds themselves under contract with a corporate custodian is required to abdicate his or her "custodial" status and the responsibilities and duties that go with that status. This is, of course, a risky proposition for the physician if, in fact, the stamping of affiliate status turns out to be wrong, and the physician has lost control of the patient's health information.

Custodian vs. Affiliate

Even though the *HIA* focuses on the collection, use, and disclosure of health information by custodians and affiliates, one must still remember that pursuant to the *McInerney* decision, the patient continues to maintain an ownership interest in their health information, and the physician continues to owe a fiduciary duty to that owner. That duty is important in determining whether to characterize a physician as a custodian, or as an affiliate of another custodian.

It is also important to remember that even in the context of the unsatisfactory definition of "custodian" in the *HIA*, physicians are clearly designated as such.[11] Can, however, a physician be both a custodian and an affiliate?

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Section 1(3) of the *HIA* states that "a custodian who is an affiliate of another custodian is deemed not be to be a custodian *while acting in the capacity of an affiliate*."[12] That last phrase may be the key to assessing the distinction between custodial and affiliate status. As such, in determining whether a physician is a custodian or an affiliate, one must look at the capacity that the individual is acting in, not just the legal relationship between the two parties.

It seems obvious then, that in assessing whether a physician is serving as a custodian of health information or as an affiliate to a custodian, one must examine the nature of the relationship between the health care provider and the patient. In that regard, it is helpful to look outside the four corners of the *HIA*.

The *Oxford English Dictionary* defines custodian as "a person who has responsibility for or looks after

something."[13] This is of some assistance, as clearly in the context of the HIA the custodian has defined duties and responsibilities relative to health information (which is the "something" that the custodian is looking after). The same dictionary defines "custody" as the "protective care or guardianship of someone or something,"[14] thus, injecting the fiduciary notions of "protection" or "guardianship" back into the mix.

From this, one can infer that a custodian under the *HIA* must be acting in a protective role, and must have responsibility for the integrity and accuracy of the health information. In fact, those duties are expressly adopted in the *HIA*.[15]

So, in the context of a patient's visit to an acute care facility, who is the custodian of the health information? The *HIA* would suggest that a physician exercising the right to admit and treat patients at a hospital is an affiliate of the hospital's owner (i.e. AHS)[16] and that the hospital owner is, in fact, the custodian of that patient's health information. The patient is seen by a physician or other health care provider who is considered to be an employee or contractor of the hospital owner. The actual data is stored in the hospital's database so, arguably, the hospital owner is responsible for the integrity and security of the health information. In this instance, the hospital would presumably be considered the custodian of the information.

Arguably, however, the physician who actually provides the care is responsible for the accuracy of the health information and may be more than just an affiliate. Can they both be custodians? Is there such a thing as "joint custody"?

In an ambulatory care environment, the patient may be coming to see a particular caregiver. In that instance, the caregiver must be responsible for the integrity, accuracy, and security of the health information generated as a result of the encounter. But what if the ambulatory care facility is owned by AHS or another corporate custodian? Do they have responsibility as well?

Further, is custodial status "now and forever"? Can a physician be a custodian during the encounter, but when finalized information is downloaded to an electronic medical record, does the status of custodian transfer to the party managing the record?[17] These are all questions without clear answers for now. Clear answers are essential, however, as patients' health information becomes more and more exposed to collection, use, and disclosure.

Judicial Considerations

Can a Physician be a Custodian and an Affiliate at the Same Time?

The issue of whether an affiliate of a custodian can be an affiliate for some, but not other, purposes was discussed by the Alberta Court of Appeal in *Innovative Health Group Inc. v. Calgary Health Region*.[18] In that case,

Since the HIA applied to "health information", its "focus is on the nature of the information, not on the manner in which it is organized for filing or medical treatment purposes or the person about whom the information was collected.

the Calgary Health Region (CHR) had contracted with a number of physiotherapy clinics (the Clinics) to provide physiotherapy services to city residents. CHR undertook to audit the Clinics and required disclosure of patient health records, however, the Clinics refused to release any patient files where CHR had only partially funded the treatments.

CHR argued that since the Clinics were affiliates of CHR under contract, the collection and disclosure of health information by the Clinics should be considered the collection and disclosure by CHR. As such, CHR maintained that the Clinics should be ordered to provide CHR with all of the patient files, regardless of whether some of the information had been collected for treatments which were not funded by CHR.

The Court disagreed with this stance, holding that since the *HIA* applied to "health information", its "focus is on the *nature* of the information, not on the *manner* in which it is organized for filing or medical treatment purposes or the person about whom the information was collected."[19] Thus, it is logical to conclude that for the purposes of

the *HIA*, one may distinguish between different types of information found in the same patient file.

With respect to the nature of affiliates, the Court held that:

> the *HIA's* definition of affiliate suggests two ways, that it is possible to be an affiliate for one purpose but not for another. For one thing, an affiliate is defined as an organization providing services to a custodian *under contract*. It is unlikely that the Legislature intended to regulate the relationship between a custodian and its affiliate outside the terms of their contract. Any other view could lead to an absurdity. For example, a volunteer at a hospital is an affiliate when engaged in that role. If she were treated as an affiliate for all purposes, health information she paid for from her dermatologist would be deemed to have been disclosed to the hospital. This result seems intrusive and beyond what the Legislature intended. For another thing, the definition speaks of an affiliate "in relations to a custodian". Again, this suggests that the affiliate/custodian relationship is defined by their contract. [20]

As a result, the *HIA* did not entitle CHR to access health information relating to treatments which were not funded by CHR, as the Clinics were not affiliates of CHR at the time the information was collected. Instead, the Clinics were only acting as CHR's affiliates when they were treating the latter's employees pursuant to the contract. When acting outside of the contract with CHR, the Clinics did not fall within the scope of "affiliate".

The ability of a health services provider to operate as both an affiliate and a custodian is also supported by the Information and Privacy Commissioner's *Investigation Report Concerning the Disclosure of Health Information Using Alberta Netcare*, Investigation Report H2008-IR-001[21] where it was held that AHW fulfilled two separate and distinct roles in the operation of Alberta Netcare:

> First, AHW is a custodian as defined in section 1(1)(f)(xiii) of the HIA. As such, AHW is bound by the *Health Information Act* and is limited to collecting, using and disclosing health information in accordance with that statute.
>
> Secondly, AHW operates as an information manager (IM) for custodians using Alberta Netcare and is bound by the terms of the Alberta Netcare Information Mangment Agreement (IMA).
>
> AHW is a custodian when it is fulfilling its mandate to set provincial health policy and manage the health system and when operating some provincial registries and clinical data repositories. AHW is an information for other custodians when it provides the information management and information technology (IM/IT) services required to operate Alberta Netcare.[22]

The Information and Privacy Commissioner's focus then turned to what role CHR was exercising at the time the health information was disclosed. In determining this, the Commissioner looked specifically at the section of the *HIA* in question and held that:

> As section 46 of the HIA is tied to authorities granted by section 27 of the HIA and section 27 views the Minister and Department as custodians, this is the role they held when making requests for information under section 46.[23]

Despite the fact that the *Innovative Health* case and the above Investigation Report do not deal with physicians specifically, there is no reason why the same reasoning should not also apply to them. A number of factors can be gleaned from the above. Namely:

1) A health services provider that is considered an affiliate for some purposes may not necessarily be considered an affiliate for all purposes; and

2) To determine in what capacity a health services provider is acting, one must look to:

    a) the contract between the alleged affiliate and the alleged custodian;

    b) what exactly the alleged affiliate was doing at the time of the breach and the wording of the section of the HIA that was allegedly breached.

When is a physician a custodian versus an affiliate?

The issue of whether a physician working under contract at a privately owned institution should be considered an affiliate or a custodian was considered by the Information and Privacy Commissioner in its *Report on the Investigation into a Complaint Regarding Disclosure and Collection of Health Information*, Investigation Report H0057.[24] In this report, the complainant had been receiving health services from a physician, based out of his private clinic, but was subsequently admitted to a hospital run by the Lakeland Regional Health Authority (LRHA), where the physician also held privileges. The complainant alleged that the physician, while treating the patient at the LRHA, wrongly disclosed and collected her health information without proper consent.

LRHA raised the issue of whether the physician's alleged wrongful collection and disclosure of the health information occurred as an affiliate of LRHA, or as a custodian in his own right. The Commissioner examined the LRHA Medical Staff Bylaw which provided that the physician held active privileges as a "Regional Active Consulting". The Bylaw specified that "a member of the Active Category may 'perform professional services for Patients to the extent permitted by the Privileges granted."[25] LRHA clarified that the privileges granted to the physician included the right to admit and treat patients.[26]

Based on the above, the Commissioner held that:

> The HIA says that a health services provider is an affiliate of a custodian when they have the right to admit and treat patients at a hospital. I find that the Doctor is an affiliate of Lakeland in this situation, as he has privileges to admit and treat patients at the William J. Cadzow Health Centre. However, the Doctor is also a custodian in his own right as a health services provider who is paid under the Alberta Health Care Insurance Plan to provide health services (HIA section 1(1)(ix)), which he does out of Lac la Biche Associated Medical Clinic.
>
> ...The Doctor's relationship with Lakeland as an affiliate is limited. The activities of the Doctor within the Associated Medical Clinic occur as a custodian in his own right. The Doctor is an affiliate of Lakeland when providing health services through his right to admit and treat. That is, the Doctor is an affiliate of Lakeland while he exercises the privileges granted to admit and treat a patient.[27]

It should be noted that the Commissioner based his opinion solely on the legal relationship between the physician and LRHA. He did not explore what the physician was doing, beyond whether he was "treating or admitting", or for whom.

Finally, in the *Investigation Report Concerning the Disclosure of Health Information and Collection of Personal Information*, Investigation Report H2009-IR-001, the Information and Privacy Commissioner held that:

> Instead of attributing responsibility for the management of health information to the owners of the information, the HIA attributes accountability for the management of health information to custodians that exercise custody or control of health information. While custody and control are not defined within the body of the HIA, the concept of "custody" implies physical possession of the record, while the concept of "control" implies the ultimate authority to manage the information. It is possible for a custodian to have physical possession of a record, but to not exercise the ability to control what happens to that record. Likewise, it is possible for a custodian to have relinquished physical custody of a record, but to have retained the responsibility to control what happens with the record. Physical possession of a record is simply one factor which must be considered when determining custodianship under the HIA.[28]

The Complainant's physician ran his own clinic within the Lamont Health Care Centre (the Centre) where the complainant was also an employee. A complaint was brought when the complainant learned that the physician had provided her file to the Centre without her consent. The physician and Centre's defence was that prior to the physician commencing business in the Centre, the Centre had purchased all of the medical files belonging to the previous physicians and was thus charged with storing and maintaining all medical files located within the Centre. As such, the physician and Centre both maintained that the Centre was the

custodian of the complainant's file, and had a right to request and obtain same.

To determine who had "custody or control" over the files, the Commissioner adopted a number of factors to assess whether the Centre, who had possession of the records, was actually in control of the records. Namely:

1. *Was the record created by an officer or employee of the institution?*
2. *What use did the creator intend to make of the record?*
3. *Does the institution have possession of the record either because it has been voluntarily provided by the creator or pursuant to a mandatory statutory or employment requirement?*
4. *If the institution does not have possession of the record, is it being held by an officer or employee of the institution for the purposes of his or her duties as an officer or employee?*
5. *Does the institution have a right to possession of the record?*
6. *Does the content of the record relate to the institution's mandate and functions?*
7. *Does the institution have the authority to regulate the record's use?*
8. *To what extent has the record been relied upon by the institution?*
9. *How closely is the record integrated with other records held by the institution?*
10. *Does the institution have authority to dispose of the record?*[29]

When the facts were analyzed in the context of the above factors, it became clear that, although the Centre may have had physical custody of the complainant's health information, it did not have the requisite control. The physician was not an employee of the Centre and the records were produced so as to ensure that the physician could bill and receive compensation from Alberta Health Care Insurance Plan for the provision of services. As such, the Commissioner focused less on the contract between the parties, and more on who had actual custody or control of the health information.

The College of Physicians & Surgeons of Alberta's *Physicians' Office Medical Records* Policy may also shed some light on this issue. It states that

> records and notes created by a physician working in or employed by a hospital, an institution, or a company, belong to that hospital, institution, or company, unless specific arrangements are made to the contrary.[30]

This is in comparison to those records produced by the physician's own clinic which, according to the above Policy, "belong as property to the physician who produced them."[31]

Based on the above, there are a few principles which may be taken away:

a) While the physician or hospital may have ownership of the physical record, the patient continues to be the beneficial owner of the information contained in the record. This principle, enunciated by the Supreme Court in *McInerney*[32] in 1992, remains unchanged.

b) According to policies set out by the College of Physicians & Surgeons of Alberta, a hospital will be the owner of all records produced by physicians providing health services within that facility. This is also consistent with the *HIA*'s definition of "affiliate" including physicians exercising the right to admit and treat patients at a hospital[33] which would, by definition, make the facility owner the custodian.

c) Whether a custodian has "control or custody" of the record is emphasized throughout the *HIA*. Although the custodian may relinquish one, it does not necessarily mean that they have relinquished the other. Due to this, simply because a physician employed by a hospital has custody of the record while they are seeing the patient, does not necessarily mean that they are exercising the requisite amount of control over the record. As such, when trying to determine if a physician should be considered an affiliate or a custodian it would be useful to consider the factors for control enunciated in the Information and Privacy Commissioner's *Investigation Report Concerning the Disclosure of Health Information and*

Collection of Personal Information, Investigation Report H2009-IR-001, discussed above.

d) A physician can be both an affiliate and a custodian under the *HIA*. Specifically, the case law and Investigation Reports clarify that the physician will be a custodian when treating and admitting patients in his own clinic, despite the fact that he may also be an affiliate when working under contract at a hospital.

e) A physician, when "exercising the right to admit and treat patients at a hospital" will be considered an affiliate. This specific delineation of affiliate status implies that physicians are affiliates only in very limited circumstances, and if a physician is disclosing or collecting health information outside of this scope, they no longer enjoy "affiliate" status. Examples of this may include:

- physicians who are using or collecting health information for a purpose outside of the field of medicine (i.e. for a fundraising purpose) while working for a hospital;
- physicians who exceed their privileges as granted by the hospital;
- physicians whose status has been switched to "inactive" by the hospital; or
- physicians who use or collect confidential information for a malicious purpose.

In all of the above situations, the physicians would not be collecting or using the information for the purpose of "treating or admitting patients." As such, it would be difficult for the physician to argue that he or she should be considered an affiliate.

Conclusion

As stated at the outset, Alberta's *HIA* deals with the collection, use, and disclosure of health information by custodians or those acting on their behalf. Determining exactly what a custodian is, however, continues to be a challenge. Health service providers, and specifically physicians, collect, use, and disclose information daily. However, given the duties and responsibilities associated with the custodian's role, it is increasingly important for physicians to understand the capacity in which they perform those functions.

Given the lack of precise definition in the *HIA*, it will be left to the Information and Privacy Commissioner or, ultimately, the Courts to provide guidance in that regard. The dual concepts of "custody" and "control" must be considered in that determination. At the root of the analysis, however, remains the continuing fiduciary obligation of the physician to the patient. Arguably, given the nature of that duty and the physician's ongoing responsibility to the patient, the default should be to custodial status.

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Endnotes

1 [1992] 2 SCR 138 at para 22, 93 DLR (4th) 415 [*McInerney*].
2 *Ibid* at para 22.
3 *Ibid* at para 15.
4 *Health Information Act,* RSA 2000 c H-5 [*HIA*].
5 *Supra* note 1 at para 25.
6 *HIA, supra* note 5, ss 28, 43.
7 *Ibid,* s 1(1)(f).
8 Health Information Regulation, Alta Reg 70/2011, s. 2.
9 *HIA, supra* note 4, s 1(1)(a).
10 *Ibid,* ss 60, 61.
11 *Ibid,* s 1(1)(f)(xiv); Health Information Regulation, *supra* note 8 2(2)(e).
12 *HIA, ibid,* s. 1(3) [emphasis added].
13 2d ed, sv "custodian".
14 *Ibid* sv "custody".
15 *HIA, supra* note 4, ss 60, 61.
16 *Ibid,* s 1(1)(iii).
17 *Ibid,* s 66(1). Under this section, a party managing an electronic medical record is referred to as an Information Manager and also fall within the definition of "affiliate" in the *HIA*.
18 *Innovative Health Group Inc. v. Calgary Health Region,* 2006 ABCA 184, 384 AR 378 at para 17 [*Innovative Health*].
19 *Ibid* at para 18 [emphasis in original].
20 *Ibid* at para 20 [emphasis in original].
21 Information and Privacy Commissioner of Alberta, *Investigation Report Concerning the Disclosure of Health*

Information Using Alberta Netcare, Investigation Report H2008-IR-001 (Alberta: Office of the Information and Privacy Commissioner of Alberta, 2008).

22 *Ibid* at para 39.

23 *Ibid* at para 42.

24 Information and Privacy Commissioner of Alberta, *Report on the Investigation into a Complaint Regarding Disclosure and Collection of Health Information,* Investigation Report H0057 (Alberta: Office of the Information and Privacy Commissioner of Alberta, 2003).

25 *Ibid* at para 16.

26 *Ibid* at para 16.

27 *Ibid* at paras 17, 19.

28 Information and Privacy Commissioner of Alberta, *Investigation Report Concerning the Disclosure of Health Information and Collection of Personal Information,* Investigation Report H2009-IR-001 at para 34 (Alberta: Office of the Information and Privacy Commissioner of Alberta, 2000).

29 *Ibid* at para 35.

30 College of Physicians & Surgeons of Alberta, *Physicians' Office Medical Records* at 3, on line: College of Physicians & Surgeons of Alberta <http://www.cpsa.ab.ca/Libraries/Policies_and_Guidelines/Physicians_Office_Medical_Records.sflb.ashx>.

31 *Ibid* at 3.

32 *Supra* note 1.

33 *HIA, supra* note 5, s 1(1)(iii).