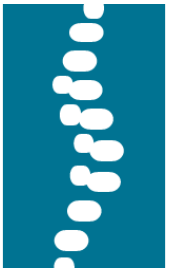
Association des chiropraticiens du Nouveau-Brunswick



New Brunswick Chiropractors Association

Policy Respecting the Ownership, Maintenance and Retention of Patient Files

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1. Intent of Policy

In all areas respecting personal health, the adoption of standardized practices can contribute to the overall quality of patient care; this is equally true when dealing with patient files. This policy seeks to protect chiropractors by eliminating uncertainties surrounding the ownership and handling of patient files, all the while protecting the public interest by ensuring reasonable access to patient information.

2. The *Personal Health Information Privacy and Access Act*

The *Personal Health Information Privacy and Access Act*[1] (the "Act") was created in order to safeguard and enforce the rights of the public with regards to accessing patient files held by health care practitioners. The Act goes on to set out the remedies available when custodians, staff or others contravene the provisions therein.

It is very clear that the Act seeks to protect the interests of the public and was not crafted to protect chiropractors' interests. Members are therefore advised to consult the Personal Health Information Privacy and Access Act and be aware of its provisions.

3. Definitions

"Custodian" as defined by the Act means "an individual or organization that collects, maintains or uses personal health information for the purpose of providing or assisting in the provision of health care or treatment or the planning and management of the health care system or delivering a government program or service" and includes, namely, health care providers.

"Personal health information" as defined by the Act means "identifying information about an individual in oral or recorded form if the information

> (a) relates to the individual's physical or mental health, family history or health care history, including genetic information about the individual,
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> (b) is the individual's registration information, including the Medicare number of the individual,
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> (c) relates to the provision of health care to the individual,
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> (d) relates to information about payments or eligibility for health care in respect of the individual, or eligibility for coverage for health care in respect of the individual,

1 SNB 2009, c P-7.05.

(e) relates to the donation by the individual of any body part or bodily substance of the individual or is derived from the testing or examination of any body part or bodily substance,

(f) identifies the individual's substitute decision-maker, or

(g) identifies an individual's health care provider.

As it pertains to chiropractors, it must be stipulated that "personal health information" includes any x-rays taken of the individual.

4. Applicable Case Law

With the decision of McInerney v MacDonald,[2] the Supreme Court of Canada clarified that as between a doctor and patient, the physical patient file belongs to the doctor; the patient is not entitled to the file itself.[3] The Court justifies this as follows:

Medical records play an important role in helping the physician to remember details about the patient's medical history. The physician must have continued access to the records to provide proper diagnosis and treatment. Such access will be disrupted if the patient is able to remove the records from the premises. Accordingly, the patient is entitled to reasonable access to examine and copy the records, provided the patient pays a legitimate fee for the preparation and reproduction of the information. Access is limited to the information the physician obtained in providing treatment. It does not extend to information arising outside the doctor-patient relationship.[4]

The relationship between a doctor and patient is analogous to that of a chiropractor and his or her patient, meaning that chiropractors can rely on the position taken by the highest court in the country with respect to the ownership of patient files.

5. Patient Access to Files

The most relevant provisions under the Act, being sections 7 to 14, give the individual the right to request, examine or receive a copy of his or her personal health information held by a custodian, be it in electronic or physical format. Such a request must contain sufficient information to allow for the file to be located, otherwise, help in completing the request and providing the required information must be offered by the custodian to the individual.

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2 [1992] 2 S.C.R. 138, [1992] S.C.J. No. 57.
3 Ibid at para 38.
4 Ibid.

The individual is to be permitted to examine a file at no cost, but the custodian may require the individual to pay a reasonable fee for searching, preparation, copying and delivery services. Patients should be kept apprised of any changes in the location of their chiropractor and/or his or her records so as to ensure they have continued access to their patient file if needed.

6. Duties of a Custodian

A custodian may collect personal health information if they have obtained the individual's consent and the collection is necessary for a lawful purpose. They shall collect only that information which is necessary to accomplish the purpose for which it is used and shall, furthermore, only disclose personal health information as authorized by the Act.

Commonly, each chiropractor chooses to be the custodian of his or her own patient files, but this may vary; in group settings one custodian may be designated as responsible for all requests for access to personal file information. In the absence of such a designation, the individual may rightfully assume that their current chiropractor is the custodian to whom they would make a request for access to information.

Upon receiving a request for access to a file, the custodian has 30 days in which to respond. The Act does allow for an additional 30 day time extension, as outlined in section 10(6), where:

- The request for access does not contain sufficient information to identify the file;
- The individual making the request does not respond to a request for clarification by the custodian as soon as practicable;
- The individual's file or some part thereof is being translated for a unilingual physician treating the individual;
- Given the large number of records requested, responding within the 30 day period would unreasonably interfere with the custodian's operations;
- There is insufficient time within the 30 day period to notify a third party or consult with another custodian before permitting the file to be examined or copied; or
- The individual requests records that relate to a lawsuit begun by Notice of action or a Notice of Application.

Before allowing access to or releasing a copy of file contents, the custodian must first be satisfied of the identity of the individual making the request in order to ensure the protection of confidentiality.

If the custodian is unable to provide the requested file documents, they must, within the 30 day time limit, inform the individual that the information does not exist or cannot be located, or, inform them that the documents requested are being refused, if such is the case. Reasons that may justify a refusal include the following:

- If knowledge of the information could reasonably be expected to endanger the health or safety of the individual or another person;
- If disclosure of the information would reveal personal health information about another person who has not consented to the disclosure; and
- If disclosure of the information could reasonably be expected to identify a third party, other than another custodian, who supplied the information in confidence under circumstances in which confidentiality was reasonably expected.

For the list in its entirety, please refer to section 14 of the Act. It should be noted that, where possible, the information being refused to the individual should be separated from the remainder of the patient file, which may then be provided to the individual.

If a custodian is unable to provide access to or a copy of the personal health information requested because said information is held by another custodian, or because another custodian was the first to collect the information, the request may be transferred within 10 days, provided that notice is given to the individual in writing. The custodian receiving the transferred request shall have 30 days in which to respond.

7. Consent to Disclose File Information

As previously mentioned, a custodian may collect personal health information if they have obtained the individual's consent and the collection is necessary for a lawful purpose. Consent, generally, must be the consent of a capable individual or of someone authorized to consent on their behalf. The individual must understand to what they are consenting and shall consent only with regards to personal health information. The consent may be withdrawn or withheld, shall not be obtained through deception or coercion, and may be either express or implied.

Section 18(1) of the Act states clearly that unless it would be unreasonable in the circumstances, a custodian is entitled to assume that he or she has the individual's implied consent to collect or use the individual's personal health information or to disclose a copy of it to another custodian for the purpose of providing health care to the individual.

A custodian would need to obtain express consent from the individual before they may disclose a copy of personal health information to the media, a visitor to a health care facility, or for the purpose of research, among other things.

It merits emphasis that the custodian, in disclosing personal health information, should only disclose a copy of the relevant file information and never the original documents themselves. Members should refrain from providing original records to patients or third parties.

8. Storage of Files

All patient files must be stored in a safe and secure environment, whether that be at a chiropractic clinic or in off-site storage so as to ensure the confidentiality and maintain the integrity of the documents. Reasonable steps to prevent against damage, theft, or unauthorized disclosure must be taken by the custodian; this entails consideration not only of their physical storage but also of their technological security. Questions custodians ought to ask themselves include:

- Do filing cabinets and/or storage units lock securely?
- Are there alarm systems in place?
- Do all staff members have access to patient files? Should they?
- Have staff been appropriately trained with respect to files?
- Are confidentiality agreements in place with staff?
- Are electronic files password protected?
- Is there a firewall or other protective software in place?
- Is electronically-stored data backed up securely?
- If stored off-site, is the area chosen particularly prone to natural damage (i.e. flood, fire)?
- Is there an agreement in place with the storage facility respecting the storage, management and confidential nature of the documents?

9. Retention and Destruction of Records

It is a chiropractor's duty as a custodian to ensure that patient files are available to be accessed by the patient, retained the appropriate length of time, and disposed of properly. While the Act does not directly address the length of time patient files ought to be retained, they should only be retained for the time necessary to fulfill the purpose for which it was collected. That having been said, from a legal perspective, custodians should retain patient files for a minimum of 15 years following their last consultation with a patient. This figure finds its basis in the *Limitation of Actions Act*,[5] which allows for a lawsuit to be commenced within two years from the date of discovery of the claim, or 15 years from the date on which the act or omission on which the lawsuit is based occurred (often referred to as the ultimate general limitation period). The notable exception to this 15 year rule arises when dealing with minors because, by law, the 15 year time limit cannot begin to run until the minor reaches the age of 19. Therefore, custodians should retain patient records of minors for a minimum of 15 years from the date of their 19th birthday.

The disposal of patient files requires particular care and attention: proper shredding must be ensured in order to protect the patients' confidentiality.

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5 SNB 2009, c L-8.5.

When destroying personal health information, a record must be maintained of whose information is destroyed, a summary of the contents of the files, the time period to which the information related, the method of destruction and the name of the person responsible for supervising the secure destruction.

It is prudent for custodians to maintain an ongoing schedule of retention and destruction so as to ensure compliance with applicable legislation and/or regulations. Schedules should contemplate all forms in which personal health information is stored, including paper files, electronic files, and microfiche, if applicable.

10. Transfer, Sale or Termination of Practice

In a group practice setting, it is advisable to have a written agreement establishing responsibility for maintaining and transferring personal health information in the event of a transfer, sale, or termination of the practice. This can prevent stressful situations when it comes to events such as the retirement, leave of absence, or even death, of a partner, as well as the sale or dissolution of a practice.

When a practice is sold or transferred, there must never be a lapse in custodianship of patient files. The custodianship may change hands from one chiropractor to another but should be done by executing a written agreement acknowledging the transfer.