

## **GLOSSARY of COMMON TERMS**

### ***The Health Information Protection Act (HIPA)***

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What follows is a list of common terms used in our HIPA regime in Saskatchewan. A few of these terms are defined in section 2 of HIPA. Many of these terms have meanings that are well established in Canadian jurisprudence and in decisions/Orders of privacy oversight agencies developed over the last 27 years. It may be useful for trustees to become familiar with the meaning these terms have for purposes of HIPA oversight.

**ACCESS** is the right of an individual (or his or her lawfully authorized representative per section 56 of HIPA) to view or obtain copies of records in the custody or control of a trustee. This is subject to limited exceptions in section 38 of HIPA. This is a fundamental element of HIPA and one which all trustees must organize to facilitate. This is quite different than the discretionary decision to disclose personal health information (phi) to a third party.

The ‘least amount of information necessary for the purpose’ and the ‘need-to-know’ rules do not apply when responding to an access request under HIPA. Access and access obligations have been discussed extensively in Reports [H-2006-001](#) (Saskatoon Regional Health Authority), [H-2007-001](#) (Saskatchewan Cancer Agency) and [H-2008-002](#) (Dr. Val Harding). See also the OIPC [Report on Management of Access Requests from Patients to Saskatchewan Regional Health Authorities](#) (December 2009).

**APPLICANT** refers to an individual who has made an access request for his/her phi to a trustee.

**CIRCLE OF CARE** is not a statutory term and has different meanings depending on whether you are considering the federal PIPEDA Awareness Raising Tools (PARTS) document or provincial literature re: HIPA. This phrase may help explain HIPA in very basic terms to a layperson. Our view is that it is unhelpful when it comes to training of health care workers in trustee organizations. Trustees and trustee employees require a more nuanced understanding of when and how sharing of phi can occur. The weaknesses of ‘circle of care’ are as follows:

- (1) It puts the focus on a variety of roles and persons within trustee organizations as to whether they are or are not a member of the ‘club’ instead of focusing on the patient and the particular care transaction in question. The better approach is to utilize the ‘need to know’ principle in section 23 of HIPA which focuses not on the provider as much as it does on the individual patient and the health needs presented in any particular health transaction.

- (2) It suggests a static kind of entitlement to information. In fact, the circle of care should likely change, even for the same patient, if the patient seeks treatment on Day 1 for a fractured femur and then returns to the same facility on Day 2 for a dietary issue or a mental health problem. There will perhaps be an entirely different group of health workers dealing with the injury on Day 2 than treated the fracture on Day 1. Every member of the Day 2 health care team may not be entitled to all of the phi collected, used or disclosed on Day 1. A number of trustee organizations in their policies and training material have developed long lists of suggested or possible circle of care members. In our experience this is often misunderstood as a kind of green light for sharing phi among all of those members without regard to the particular patient and the particular health transaction.
- (3) The circle of care in the training material and policy of a number of trustee organizations is restricted to trustees and their employees. In our view this is unduly restrictive. Reliance on need-to-know permits disclosure in appropriate circumstances to non-trustees. Using the need-to-know principle, it is not uncommon that even non-trustees may, from time to time, require certain phi in the course of the diagnosis, treatment or care of the patient (e.g. a police officer who is transporting a sick individual to a different care facility, an adult child providing temporary housing for a senior being discharged from an acute care facility or even a teacher or day care worker who needs to monitor a child for certain adverse drug reactions).

In our experience, a much better practice is to focus on the patient's particular needs and the particular health transaction. This can be done by concentrating on which individuals/roles have a demonstrable need-to-know (per section 23 of HIPA) for some or all of the patient's phi.

**COLLECTION** is defined by HIPA as to “gather, obtain access to, acquire, receive or obtain phi from any source by any means” (section 2(b) of HIPA).

**COMPLAINANT** refers to an aggrieved individual who makes a formal complaint to a trustee's Privacy Officer or to the Commissioner to investigate an alleged breach of privacy or contravention of HIPA by that trustee pursuant to section 52 or 42(c) of HIPA.

**CONFIDENTIALITY** is the protection of phi once obtained against improper or unauthorized use or disclosure. This is just one aspect of privacy and is not synonymous with ‘privacy.’

**CONSENT** in HIPA provides any trustee with 3 different options:

- (1) express consent (highest standard),
- (2) implied consent with a right to opt out (a national standard for purposes of the electronic health record), and
- (3) no consent or in section 27(2) described as “deemed consent”. Except for three limited circumstances where express consent is required by statute [ss. 18.1(3)(b)(i), 27(5)(b) and 29 (1)], trustees must determine, in accordance with their ethical codes and standards and the circumstances and urgency of the health service, which option is most appropriate. In a number of scenarios in an emergency room or ICU, no consent may be the most appropriate option. In the treatment of a diabetic patient where the patient must play a large role in his/her own treatment plan, express consent would be more appropriate. Given the prejudice that attaches to the use of phi for employment purposes, express consent should always be required for section 26(3) of HIPA as well.

The best practice is to consider consent in terms of cascading thresholds. Start by considering the highest standard and the one most consistent with a patient-centred system which would be express consent. Only if express consent would not be appropriate in the particular circumstances should the trustee then consider whether implied consent would be appropriate. In the event that implied consent would not be appropriate in the circumstances, then the trustee should consider deemed consent or no consent. Trustees should be mindful that deemed consent completely disempowers the patient and is the hardest form of consent to reconcile with a patient-centred health care system except for limited circumstances. These limited circumstances would normally be urgency, involve an unconscious patient, or there exists imminent risk to the health or safety of a patient. Deemed consent should never be invoked casually or as a default approach to dealing with patients and their wishes.

**CONTROL** is a term used to indicate records that are not in the physical custody of the trustee but are still within the influence of that body via another mechanism (i.e. contracted service, trustee employees working remotely, etc.). See Report [F-2008-002](#) (Ministry of Justice and Attorney General). The control question normally only arises if there is no ‘custody’ of the phi in question.

**CUSTODY** is the physical possession of a record by a trustee.

**DISCLOSURE** is exposure of phi to a separate entity, not a division or branch of the trustee in custody or control of that information. For example, when a health region shares information with a family member, an insurer, media, Ministry of Health, SK Cancer Agency, Saskatchewan Workers' Compensation Board, lawyer, police, etc. this amounts to a disclosure. Occasionally this will be mandatory (*The Gunshot and Stab Wound Mandatory Reporting Act* and *The Public Health Act, 1994*) but in most cases this requires the exercise of discretion on the part of the trustee. That discretion must be exercised mindful of the rule to disclose the least amount of phi necessary for the purpose.

**DUTY TO ASSIST** means responding openly, accurately and completely to an individual requesting access to their own phi. It does not allow a patient/client to specify which employee in a trustee organization explains terms in a health record. This has been considered in Report [H-2006-001](#) (Saskatoon Regional Health Authority) and [H-2008-001](#) (Saskatoon Regional Health Authority).

**PERSONAL HEALTH INFORMATION (phi)** includes information about one's physical or mental health and/or information gathered in the course of receiving a health service from a trustee. It includes information in an independent medical examination report (see Report [H-2008-002](#) [Dr. Val Harding]). For full definition see section 2(m) of HIPA.

**POLICIES AND PROCEDURES FOR TECHNICAL, PHYSICAL AND ADMINISTRATIVE SAFEGUARDS** refer to the reasonable measures that a trustee must take to protect phi in its custody or control. This is required by section 16 of HIPA. In Investigation Report [H-2005-002](#) (SK Cancer Agency - Prevention Program for Cervical Cancer), we determined that these policies and procedures must be in writing. The OIPC has indicated in the past that the Canadian Health Informatics Association (COACH) guidelines represent best practices. See also ISO/ISE 17799 Information Technology - Security techniques – Code of Practice for information security management. These best practices evolve over time. For example, for portable computing devices such as laptops and PDFs, encryption is now seen as a requirement to meet the reasonableness threshold for phi. See also [Privacy Breach Guidelines](#), [Best Practices - Mobile Device Security](#) and [Privacy Considerations - Faxing Personal Information and Personal Health Information](#), all available at [www.oipc.sk.ca](http://www.oipc.sk.ca).

**PRIVACY** is a broad concept which involves the right of the individual to exercise a measure of control over his or her phi. It involves the decision of the individual about what phi will be disclosed to a trustee and for what purposes. Privacy captures both security and confidentiality which are subsets of privacy.

**PRIVACY BREACH** happens when there is an unauthorized collection, use or disclosure of phi, REGARDLESS OF WHETHER THE PHI ENDS UP IN A THIRD PARTY'S POSSESSION.

**REASONABLE FEES**, as permitted by section 39 of HIPA, were considered in Reports [H-2006-001](#) (Saskatoon Regional Health Authority) and [H-2008-001](#) (Saskatoon Regional Health Authority). The Commissioner has indicated that 50 cents per page is excessive for copying material and that a \$50 fee to open a patient file is unreasonable constituting an excessive application fee. We have recommended to regional health authorities that fees should be aligned with those they can charge under LA FOIP. We also questioned a \$500 fee charged by a health region for a Psychological Assessment Report in response to an access request.

**REVIEW** is the process by which the OIPC considers either a decision or failure of a trustee to provide an applicant with access to his or her phi.

**SECONDARY PURPOSE** refers to the use or disclosure of phi for a purpose other than that for which it was originally collected (i.e. research, use for health system planning, fundraising, etc.). Typically, the primary purpose is for diagnosis, treatment and care only.

**SEVERING** is the exercise by which portions of a document are blacked out pursuant to section 38 (1) of HIPA before that document is provided to an applicant.

**SURROGATE** refers to someone other than the individual exercising rights or powers under HIPA on behalf of the individual. This is defined by section 56 of HIPA.

**TRANSPARENCY OBLIGATIONS** refers chiefly to sections 9, 10 and 16 of HIPA. These obligations require trustees to provide information to patients/clients about how the trustee collects, uses and discloses his/her phi, the patient's/client's right of access to correction and their right to appeal to the OIPC if dissatisfied with the response of the trustee.

**TRUSTEE** includes only those bodies or health care professionals particularized in section 2(t) of HIPA that have custody or control of phi.

**USE** indicates the internal utilization of phi by a trustee and includes sharing of the phi in such a way that it remains under the control of that trustee. For example, in a regional health authority and its facilities, the sharing of information between employees, volunteers and contractors, including physicians with privileges, constitutes 'use' of the phi since the sharing happens under the control of the regional health authority. It is also defined by section 2(u) of HIPA.

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