COLLEGE OF PHYSICIANS & SURGEONS OF ALBERTA

IN THE MATTER OF
A HEARING UNDER THE *HEALTH PROFESSIONS ACT*,
R.S.A. 2000, c. C-7

AND IN THE MATTER OF A HEARING REGARDING
THE CONDUCT OF DR. CRAIG HODGSON

DECISION OF THE HEARING TRIBUNAL OF THE COLLEGE OF PHYSICIANS & SURGEONS OF ALBERTA

I. INTRODUCTION

The Hearing Tribunal held a hearing, virtually through Zoom, into the conduct of Dr. Craig Hodgson on August 12, 2020.

The members of the Hearing Tribunal were:

- Dr. Erica Dance of Edmonton as Chair;
- Dr. Stacy Davies of Calgary as physician member; and
- Mr. James Clover of Sherwood Park as public member.

Ms. Ayla Akgungor acted as independent legal counsel for the Hearing Tribunal.

In attendance at the hearing were:

- Mr. Craig Boyer, legal counsel for the Complaints Director of the College of Physicians & Surgeons of Alberta (the "College");
- Dr. Craig Hodgson, Investigated Member; and
- Mr. Daniel Morrow, legal counsel for the Investigated Member.

Ms. Ashley Reid, an articling student working with Mr. Boyer, was present as an observer.

II. PRELIMINARY MATTERS

There were no objections to the composition of the Hearing Tribunal or the jurisdiction of the Hearing Tribunal to proceed with a hearing nor were there any other matters of a preliminary nature.

III. ALLEGATION

1. That on or about May 25, 2016, Dr. Hodgson did access Alberta Netcare information regarding [redacted] without the actual or implied consent of [redacted]

IV. EXHIBITS

The following exhibits were submitted jointly by both parties:

Exhibit 1 - Exhibit Book containing tabs 1 to 6:

1. Notice of hearing dated July 20, 2020;
2. Complaint form from [redacted] (aka [redacted]) dated March 31, 2017;
3. Letter of response from Dr. C. Hodgson dated April 12, 2017;
4. Patient chart for [redacted] from Associate Medical Clinic with annotations by [redacted];
5. Letter from Dr. C. Hodgson to College dated January 8, 2020; and
6. Netcare Access Log for [redacted] for period from February 2012 to November 2016 with annotation by [redacted]

Exhibit 2 - Agreed Statement of Facts

The Agreed Statement of Facts contains the following key facts:

1. In 2015, Dr. Hodgson's practice consisted of a panel of approximately 700 patients.
2. Dr. Hodgson provided medical care to [redacted] (now [redacted]) between January 17, 2007 and October 31, 2011. Although [redacted] last attended with Dr. Hodgson on October 31, 2011, as of May 2016 she was still listed as a patient in Dr. Hodgson's Electronic Medical Record ("EMR").
3. Similarly, as of May 2016, [redacted] former husband ([redacted]) and their two children were listed as patients having files in the EMR.
4. [redacted] attended a medical appointment with Dr. Hodgson on May 24, 2016, which resulted in a specimen being sent for pathology.
5. The Netcare Access Log indicates that [redacted]' Netcare account was accessed on May 25, 2016 at 09:59:58 with Dr. Hodgson's username (the "Access").
6. The audit log lists "View – Patient Demographics" and "View – Microbiology" both at 09:59:58 indicating the Access was momentary.
7. Dr. Hodgson has no recollection of the Access.
8. Dr. Hodgson believes that he likely opened the EMR file for [redacted] by mistake, having meant to instead open the EMR file for [redacted] after searching the EMR by the last name that both patients formerly had in common. He then likely clicked on the Alberta Netcare ("Netcare") button and looked momentarily for what he thought would provide [redacted]'s results before realizing his error.
9. Dr. Hodgson did not use or disclose any individually identifying health information of [redacted] either during or following the Access, beyond what was necessary to respond to the Complaint.

V. SUBMISSIONS

Counsel for the Complaints Director

Mr. Boyer presented submissions on behalf of the Complaints Director. He started by explaining that under the Health Professions Act (the "HPA"), the Complaints Director is given authority to determine if there is sufficient evidence of unprofessional conduct to refer the matter to a hearing. In this case Mr. Boyer stated that the Complaints Director would not have referred this particular matter to a hearing if it were not for specific circumstances which made the Complaints Director feel that a hearing was the most appropriate route for resolving this complaint.

Mr. Boyer presented context by referring to cases which he felt were relevant. The first was another complaint made by the same complainant, [redacted], about another physician, Dr. A. In that case, the complainant's complaint was dismissed, and she requested a review by the Complaint Review Committee (CRC) of the College as per section 68(1) of the HPA. Mr. Boyer shared the CRC decision with the Hearing Tribunal and reviewed the case in brief. He stated that in that case, Dr. A. was working in a rural emergency department and was using Netcare. Dr. A. stepped away from the computer but did not

log off Netcare. A [redacted], who was the new partner of the complainant's ex-husband, accessed the health records of the complainant and her children using Dr. A.'s open Netcare login. The Complaints Director dismissed the complaint against Dr. A. as he did not feel Dr. A. had accessed records inappropriately himself and that it was a simple mistake of not logging off Netcare appropriately, which did not amount to unprofessional conduct. The CRC reviewed the decision and referred the matter to a hearing as per section 68(5)(a) of the HPA stating that given "the consequences of the error that occurred, the CRC believes that public confidence would be diminished if the CRC decided to dismiss the Complaint". Mr. Boyer stated that the Complaints Director felt the same course of events would take place in this case if he were to dismiss this complaint outright, and therefore felt that the most appropriate course of action would be to refer it to a hearing directly to have it adjudicated in accordance with the legislation

Mr. Boyer also discussed the case of Dr. Jiwa, 2020 CanLii 45163 (AB CPSDC). In that case, the complainant had surgery to remove a cyst on her ovary. During the surgery, it was determined that the cyst was also attached to part of the fallopian tube. Accordingly, Dr. Jiwa took the medically appropriate step of removing the affected part of the fallopian tube as well. The surgical resident prepared the operative report but did not describe the removal of part of the fallopian tube. The complainant later obtained the operative report and filed a complaint of unprofessional conduct alleging a failure to create an accurate operative report. In that case, the Hearing Tribunal felt that it was a mistake but not a serious one so as to amount to unprofessional conduct.

Mr. Boyer also referred to an Alberta Court of Appeal decision in *Sussman v. College of Alberta Psychologists,* 2010 ABCA 300 where the investigated member was charged with failing to maintain appropriate clinical encounter notes. In that situation, the Court of Appeal stated that upholding that charge would be equivalent to a "zero tolerance" approach which is unattainable.

Mr. Boyer then explained the details of the current case in front of the Hearing Tribunal. He explained that Dr. Hodgson is a Family Physician who at one time cared for [redacted], her ex-husband [redacted], and their children. Both parties agree to the fact that Dr. Hodgson momentarily accessed [redacted] Netcare records once, on May 25, 2016. Mr. Boyer reported that there was no evidence of repeated access or multiple records reviewed which differentiates this circumstance from that of the nurse accessing records in Dr. A's case noted earlier. This case was also different than the case of Dr. Watrich , 2013 CanLII 14735 (AB CPSDC), who accessed Netcare to check the health records of her partner's previous spouse and their children. In Dr. Hodgson's case, Mr. Boyer asserted that his was a simple error, and used the analogy of an office with paper files where one might reach for a certain file but pull the wrong one off the shelf, open it, realize that it is the wrong chart and put it back on the shelf.

Mr. Boyer submitted that the burden of proof is on the Complaints Director to establish, on a balance of probabilities, the conduct that happened and the standard of practice against which it is judged. Here, Mr Boyer asserts that the conduct is markedly below what would amount to unprofessional conduct and the evidence is not sufficient to discharge the Complaint's Director's burden. Mr. Boyer further submitted that to accept [redacted]' complaint as amounting to unprofessional conduct would be to create an unreasonable standard of perfection.

Counsel for Dr. Hodgson

Mr. Morrow started by stating that he accepted and supported the submissions made by Mr. Boyer. Specifically, he agreed that the evidentiary burden is on the College to prove unprofessional conduct,

which was not met in this case. To further support his position, Mr. Morrow referred the Hearing Tribunal to the HPA where the relevant definitions of unprofessional conduct are at section 1(pp)(ii) and (iii) and to the College's Code of Conduct provisions on Confidentiality and Respect for Others. In the Code of Conduct section on confidentiality it states that physicians will "[k]now and comply with applicable legislation regarding confidentiality and health information", which in this case is the Health Information Act (the "HIA"), that governs the handling of a patient's health information.

Mr. Morrow reviewed the Newfoundland and Labrador Court of Appeal decision in *Walsh v. Council for Licensed Practical Nurses*, 2010 NLCA 11 which reminds the Hearing Tribunal of its roles, which are to find the facts, identify the standard of conduct that is expected, and then apply the standard to the established events which have occurred. With reference to the *Walsh* case, Mr. Morrow noted the difference between aspirational standards and those standards which are reasonably expected to give rise to disciplinary consequences. He drew attention to the following statements at paragraph 45 of *Walsh*: "Sometimes as well, statements of aspiration are commingled with statements that are intended to constitute standards for action. Aspirational statements are often not intended to have disciplinary consequences…. Ethical rules are meant to aim for perfection. They call for better conduct not through the imposition of various sanctions but through compliance with personally-imposed restraints". Referring back to the College's Code of Conduct, Mr. Morrow asserted that the statement "As a physician, I will regard the confidentiality and privacy of patients" is an aspirational statement not capable of being discerned with the level required to give rise to a disciplinary consequence.

The charge against Dr. Hodgson was that he accessed Netcare information regarding [redacted] on one occasion and the Agreed Statement of Facts notes that Dr. Hodgson has no personal recollection of the access or his reason for it. After reflecting on this matter and reviewing the chart of [redacted]' former husband, [redacted], Dr. Hodgson noted that he attended to [redacted] the day prior to the Netcare access, on May 24, 2016 and had sent a specimen to pathology at that visit. Dr. Hodgson therefore believes that he inadvertently checked [redacted] Netcare file, who at that time went by the last name [redacted], when he had intended to check [redacted]'s file instead. Mr. Morrow highlighted that Dr. Hodgson did not use or disclose any health information of [redacted], and that there is no evidence that he accessed the record for any improper motive or purpose. Mr. Morrow submits that these facts should hold significant weight in the Hearing Tribunal's decision.

Mr. Morrow drew attention to the specifics of the HIA, specifically noting sections which contemplate unanticipated access. In section 60(1) it is noted that a "custodian must take reasonable steps in accordance with the regulations to maintain administrative, technical and physical safeguards that will (c) protect against any reasonably anticipated (ii) unauthorized use, disclosure or modification of the health information or unauthorised access to the health information". Mr. Morrow asserted that the use of the words "reasonably anticipated" implies that there may be situations where unauthorized access is not anticipated and that even with appropriate safeguards, unauthorized access may occur. Mr. Morrow highlighted that the Privacy Commissioner has jurisdiction under the HIA to decide if there has been a contravention of the act. At the time of the hearing, Mr. Morrow stated that there had been no inquiry from the Office of the Information and Privacy Commissioner in this matter. Further, Mr. Morrow reviewed the duty custodians have to notify where there has been an unauthorized access. In section 60.1(2) it states that notice is required "if there is a risk of harm to an individual as a result of the loss or unauthorized access or disclosure" and specifies what to consider in assessing whether there has been harm. Mr. Morrow summitted that this section indicates that the legislation contemplates that some errors in access might occur but that not every instance of unauthorized access is required to be reported to the Commissioner or the individual whose information was accessed. In this case, Mr.

Morrow asserts there is no evidence that the momentary access caused any harm to [redacted] nor did it require a report to the Commissioner or the patient. Mr. Morrow noted that neither the HIA nor the College's Code of Conduct incorporate a standard of perfection.

Mr. Morrow completed his submissions by referencing a number of other cases which he felt were relevant here. First was the case of Dr. Toane who was accused of unprofessional conduct after he made a statement in his chart referring to the patient being assaulted by her husband, which he failed to attribute to the patient thereby suggesting that he had first-hand knowledge of the events. The Council of the College of the Physicians and Surgeons of Alberta hearing the concern found him not to be guilty of unprofessional conduct after considering arguments which included that Dr. Toane had made a "simple mistake" in omitting a few words to correct the attribution.

The Hearing Tribunal was again directed by Mr. Morrow to the Jiwa case, as well as the Alberta Court of Appeal decision in *Sussman*, as well as a decision of the Yukon Court of Appeal in *Reddoch v. the Yukon Medical Council*, 2001 YKCA 13. All of these cases highlight that some amount of blatancy or cavalier disregard is required to find an error that reaches the level of unprofessional conduct. Mr. Morrow submitted that not every departure from a rule derived from a standard of practice amounts to unprofessional conduct in all cases and that "unintentional, non-negligent and harmless conduct does not meet that threshold".

In the Alberta Court of Queen's Bench decision of *DD v. Wong Estate* 2019 ABQB 171, Mr. Morrow highlighted Justice Renke's comment, "Reasonable people are sometimes wrong, sometimes make what turn out to have been mistakes. We recognize that there is such a thing as a reasonable mistake. Error alone does not attract liability. Liability is made out only if the error was "culpable" or blameworthy".

Finally, Mr. Morrow referred to the burden of proof required to satisfy the balance of probabilities test. Mr. Morrow agreed with Mr. Boyer that the burden of proof placed on the College has not been met in this case. He asserted that this was supported by the Supreme Court of Canada decision in *F.H. v. McDougall*, 2008 SCC 53 and later in *Ontario (College of Physicians and Surgeons of Ontario) v. Rabiu*, 2020 ONCPSD 15 decisions which included the statement "evidence must always be clear, convincing and cogent in order to satisfy the balance of probabilities test".

Mr. Morrow concluded by stating that "the evidence establishes that this was most likely an honest and understandable error on the part of Dr. Hodgson that does not rise to the level of unprofessional conduct. It is my submission that this honest human error does not meet the threshold for professional misconduct and therefore the charge should be dismissed".

VI. FINDINGS AND REASONS

The Hearing Tribunal accepted the submissions of both parties that there was insufficient evidence of unprofessional conduct in this case and dismissed the charge against Dr. Hodgson. While the unauthorized access of [redacted]' health information was confirmed, the Hearing Tribunal did not feel that it rose to the level of unprofessional conduct.

To come to this decision, the Hearing Tribunal carefully reviewed the evidence provided jointly by both parties, and the submissions made by each party. The Hearing Tribunal accepted that the course of events was as submitted by Dr. Hodgson through his legal counsel. Specifically, he checked [redacted]' Netcare file in error when he had meant to check the file of her ex-husband as they shared the same last

name and the time and Dr. Hodson had seen [redacted] in his clinic the day prior and ordered tests requiring follow up in Netcare after the visit.

The Hearing Tribunal noted that the unauthorized access was brief and minimal in nature. There was no evidence presented of any untoward reason for checking [redacted]' file, nor any evidence that her personal health information was shared or exploited in any way. As such, there appeared to be no harm to the patient or to the public as a result of this unauthorized access. The Hearing Tribunal accepted the submission that this was an "honest mistake" on the part of Dr. Hodgson, and one which could easily be made by any physician in similar circumstances.

The Hearing Tribunal reviewed the supplied case law in support of the notion that mistakes or errors will not always amount to unprofessional conduct. The Hearing Tribunal agrees that there are "aspirational" standards to which the profession might hold itself, in this case to protect the privacy of patients for example, but that not every breach of these aspirational standards should result in disciplinary consequences. In this case the burden, which is to demonstrate that Dr. Hodgson's behavior rose to the level of being considered unprofessional and which rests with the College, was not met.

Given the ease of access to electronic medical records, and the vast amount of personal health information in those records, it is important for patients to feel comfortable that their privacy is protected. As such, the Hearing Tribunal supports patients who request more information about their health records and specifically to see how is accessing their Netcare records. In her complaint, the complainant requested a reason for Dr. Hodgson's access. While not the direct focus of the hearing, the Hearing Tribunal hopes that the reasons outlined here satisfy the complainant's concern.

Signed on behalf of the Hearing Tribunal by the Chair

Dated: September 14, 2020

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Dr. Erica Dance