Information and Privacy Commissioner,
Ontario, Canada

Commissaire à l'information et à la protection de la vie privée,
Ontario, Canada

PHIPA DECISION 46

HA16-21

Dr. Nili Kaplan-Myrth, MD, CCFP, PhD

June 9, 2017

Summary: The complainant submitted a number of correction requests to the custodian under the *Personal Health Information Protection Act* (the *Act*). The custodian made some corrections and refused to make others. Following mediation, two of the correction requests remained outstanding. The custodian takes the position that the correction requests are frivolous or vexatious within the meaning of section 55(6) of the *Act* and, in the alternative, that the complainant has not demonstrated that the records are inaccurate or incomplete in order to justify making corrections under section 55(8). In this order, the adjudicator finds that the correction requests are not frivolous or vexatious, but also finds, in the circumstances, that the complainant has not met the requirements of section 55(8). Accordingly, no order is issued.

Statutes considered: *Personal Health Information Protection Act, 2004* sections 55(1), (6) and (8); Regulation 460 (made under the *Freedom of Information and Protection of Privacy Act*), section 5.1.

Decisions considered: PHIPA Decisions 36, 43.

BACKGROUND:

[1] Under the *Personal Health Information Protection Act* (the *Act*), the complainant submitted a number of requests for the correction of her personal health information to Dr. Nili Kaplan-Myrth (the custodian). The custodian made several corrections in response to the requests, but the complainant was not satisfied and communicated this, in writing, to the custodian. The custodian made further changes but the complainant

was not satisfied and filed a complaint with this office.

[2] The complaint was assigned to a mediator under section 57(1)(c) of the *Act*. During mediation, the custodian made further corrections, but continued to refuse several of the complainant's correction requests. The custodian claims that these requests are frivolous or vexatious within the meaning of section 55(6) of the *Act*, and in addition, that the records are neither inaccurate or incomplete under section 55(8).

[3] Before the conclusion of mediation, the complainant confirmed that she wishes to pursue two of her correction requests. These two requests relate to a single appointment with the custodian. They may be summarized as follows:

1. Use of "mental health"

Re [identified date] entry, which reads as follows:

counselling/primary care mental health

Correction requested: Strike out the words, "mental health"

2. Decision to increase dosage

Re [identified date] entry, which reads as follows:

She is upset today that we increased her [named medication]

Correction requested: Strike out "we" and replace with "I" or "M.D." Alternatively, strike out "we increased" and add "was increased" at the end of the sentence (the record would then read: "She is upset today that ~~we increased~~ her [named medication] was increased.")

[4] Mediation could not resolve the remaining issues, which therefore proceeded to the adjudication stage of the complaints process. The adjudicator initially assigned to this appeal issued a Notice of Review and invited the custodian to provide representations, which she did. The adjudicator then provided a Notice of Review and a complete copy of the custodian's representations to the complainant, and invited her to provide representations, which she did. Both the custodian and the complainant provided affidavits with their representations.

[5] This complaint was subsequently transferred to me to complete the review.

[6] It is not disputed that the records are the complainant's personal health information within the meaning of section 4 of the *Act*, and that the custodian is a health information custodian within the meaning of section 3.

RECORDS:

[7] The records are printouts of electronic patient appointment notes made by a physician (the custodian).

DISCUSSION:

Issue A: Are the complainant's correction requests "frivolous or vexatious" within the meaning of section 55(6) of the *Act*?

[8] Section 55(1) of the *Act* permits an individual who has received access to his or her personal health information to request that a custodian correct a record "if the individual believes that the record is inaccurate or incomplete for the purposes for which the custodian has collected, uses or has used the information . . .".

[9] In this complaint, the custodian alleges that the correction requests are frivolous or vexatious under section 55(6) of the *Act*. This section states:

> A health information custodian that believes on reasonable grounds that a request for a correction under subsection (1) is frivolous or vexatious or is made in bad faith may refuse to grant the request and, in that case, shall provide the individual with a notice that sets out the reasons for the refusal and that states that the individual is entitled to make a complaint about the refusal to the Commissioner under Part VI.

[10] Based on the language of section 55(6), it is apparent that, in a complaint relating to a custodian's decision that a correction request is "frivolous or vexatious," the onus of demonstrating that there are reasonable grounds to believe that this is the case falls on the custodian.

[11] The *Act* does not define the terms, "frivolous," "vexatious" or "bad faith," nor are these terms defined in Regulation 329/04 made under the *Act*.

[12] However, both the *Freedom of Information and Protection of Privacy Act* ("*FIPPA*") and the *Municipal Freedom of Information and Protection of Privacy Act* ("*MFIPPA*") refer to "frivolous or vexatious" requests. Section 5.1 of Regulation 460, made under *FIPPA*, provides some indication of the meaning of these terms. It states:

[13] A head of an institution that receives a request for access to a record or personal information shall conclude that the request is frivolous or vexatious if,

> (a) the head is of the opinion on reasonable grounds that the request is part of a pattern of conduct that amounts to an abuse of the right of access or would interfere with the operations of the institution; or

> (b) the head is of the opinion on reasonable grounds that the request is made in bad faith or for a purpose other than to obtain access.

[14] Section 5.1 of Regulation 823, made under *MFIPPA*, contains exactly the same wording. Although these provisions are mandatory, unlike the discretionary language of section 55(6) of the *Act*, these definitions are helpful for understanding the meaning of these terms in the *Act*.

[15] The custodian refers to correspondence from the complainant in an attempt to support her position that the requests are "frivolous or vexatious." The custodian claims that:

- the complainant's correspondence addresses the custodian by her first name;
- the complainant alleges that the custodian does not know the difference between a narcotic and a sedative, is "overwhelmingly anxious" to prevent the complainant from using a particular medication, and is "fixated" on addiction;
- the complainant alleges that her pharmacist knows more about medication than the custodian;
- the complainant alleges that the custodian is "unlawful, unprofessional and disrespectful," treated her against her wishes, is in need of a "massive adjustment" of her attitude, showed contempt for the complainant as a patient and showed contempt for the law, and created notes that are "manipulatively misleading";
- the complainant refers to the custodian as an "incompetent practitioner"; and
- the complainant alleges that the custodian made "egregious errors."

[16] The custodian also cites the complainant's objections to the custodian's description of a previously corrected error as a "typo," and her reference to "serious and unexplained errors."

[17] The custodian also alleges that the nature of the complainant's issues and the "tone of her correspondence" have ". . . created a toxic relationship whereby literally the pronouns and syntax [the custodian] used in her medical notes are up for outraged criticism from the [c]omplainant."

[18] The custodian also submits that if the complainant "is unhappy with the medication prescribed to her, or seeks to maintain the allegation that she was improperly prescribed medication, this is simply not the format for such complaints."

[19] As well, the custodian submits that making the corrections would unduly interfere with the operations of her medical practice.

[20] A finding that a request is frivolous or vexatious is serious because it may deprive a requester of the right to make requests for access to, and correction of, their personal health information. Such a finding requires evidence and must not be made lightly.

[21] In this case, although the complainant provided representations on this issue, it is not necessary for me to refer to them as the custodian has failed to demonstrate that the correction requests are frivolous or vexatious under section 55(6), for the reasons that follow.

[22] The notion that calling a doctor by his or her first name might support a "frivolous or vexatious" finding is, frankly, absurd.

[23] The complainant has dropped her correction request in relation to the use of the word, "typo," but her reasons for objecting to it were rationally stated and, although the custodian may find the comments distasteful, they do not use aggressive or offensive language.

[24] The evidence also shows that the complainant made a number of pointed comments and allegations in her correspondence with the custodian. Again, in my view, the complainant's criticisms are rationally stated and, although the custodian may find them distasteful, they do not use aggressive or offensive language.

[25] While I agree that a correction request may not be the ideal "format" for dealing with an allegation that medication was improperly prescribed, the complainant has advanced her reasons for believing that the records are incomplete or inaccurate as contemplated by section 55(1), and in my view she is entitled to have these arguments considered in the context of a correction complaint.

[26] I am also not satisfied that making the requested corrections would interfere in any material way with the operations of the custodian's medical practice.

[27] There is nothing in the custodian's representations or the evidence before me, including the correspondence of the complainant, to substantiate a conclusion that the complainant has engaged in abusive behaviour, or a pattern of conduct that amounts to an abuse of the complainant's rights under the *Act*, or that the correction requests were made in bad faith, or for a purpose other than to secure a correction of the points in the records with which the complainant disagrees.

[28] In the circumstances of this complaint, I find that the correction requests are not "frivolous or vexatious."

Issue B: Does the custodian have a duty to make the requested corrections under section 55(8)?

[29] In the alternative to the claim that the complainant's correction requests are

frivolous or vexatious within the meaning of section 55(6), the custodian refuses to correct the records on the basis the complainant has not met the requirements of section 55(8) of the *Act*. This section states:

> The health information custodian shall grant a request for a correction under [section 55(1) of the *Act*] if the individual demonstrates, to the satisfaction of the custodian, that the record is incomplete or inaccurate for the purposes for which the custodian uses the information and gives the custodian the information necessary to enable the custodian to correct the record.

[30] Section 55(8) sets out a duty on health information custodians to correct a record of an individual's personal health information where the record is inaccurate or incomplete for the purposes for which the custodian uses the information (subject to the limited and specific exceptions set out in section 55(9) of the *Act*, which have not been claimed by the custodian in this complaint).

[31] In particular, section 55(8) requires that the individual making the request for correction:

1. demonstrate, to the satisfaction of the custodian, that the record is incomplete or inaccurate for the purposes for which the custodian uses the information, and

2. give the custodian the information necessary to enable the custodian to correct the record.

[32] The text of section 55(8) makes it clear that the burden of proof in a correction request (and complaint) falls on the person requesting the correction.[1]

[33] I will review both of the outstanding correction requests in turn.

1. Use of "mental health"

Re [identified date] entry, which reads as follows:

counselling/primary care mental health

Correction requested: Strike out the words, "mental health"

[34] When the complainant submitted this revised correction request during mediation, she provided the following reason for doing so:

> The complainant has indicated that the Custodian made this correction in several other entries as per the complainant's request for correction

[1] See PHIPA Decisions 36, 43

> however did not in this instance. In the instances where the change was made, the Custodian noted the following explanation, "[note: this is the header used by [the custodian] for all counselling with patients and does not necessarily reflect a mental health issue of the patient's]"
>
> The complainant is of the view that in light of the Custodian's notation regarding her use of the heading "mental health", this heading is not meaningful when used by the Custodian.

[35] The custodian submits that there is no inaccuracy in the use of the words, "mental health," which are part of a heading. She submits further that this is a heading she uses for her clinical notes for all counselling with patients. She says that its use does not indicate a diagnosis of a mental heath issue.

[36] The custodian states further that, in this instance, the subject matter of the complainant's visit did relate to mental health. She says that because the medications that were under discussion are used primarily to treat depression and anxiety, they have implications for any patient's mental health.

[37] Moreover, the custodian submits that it was obvious from the record that she was concerned with the potential for dependency, which falls under the rubric of mental health. She also indicates that although she agreed to remove the words, "mental health" in other instances where the heading appears, as it was not strictly speaking necessary or directly applicable to the subject matter of a particular visit, removal of the term in this instance would "materially detract from the use of the record."

[38] The custodian also submits that she is entitled to some modicum of professional deference in respect of how she keeps her clinical notes and that it is not the purview of the complainant to second guess her use of headings.

[39] The complainant, in her submissions, expands on the reason for requesting the change that I have reproduced above. She says that using the "mental health" label stigmatizes a patient and might make a reader "question whether the patient is reliable, credible and psychologically stable."

[40] The complainant asserts that the reason for this particular appointment was to challenge the doctor concerning an increased dosage of one of her medications. She accuses the custodian of not recording this in her notes, but on my reading, the custodian did so, and the notation is the subject of the second correction request under consideration in this decision, as discussed below.

[41] The complainant also criticizes the custodian for inconsistency in not using the term in her notes on another appointment. She points out that the medications in question were not prescribed to her to treat mental health issues. She refers to disagreements between herself and the custodian concerning what medications were appropriate for her to be taking. The complainant asserts that the custodian's addiction

concerns were unsubstantiated, and that she never received any "mental health" counselling from the custodian.

[42] In addition, the complainant notes that the only possible use for the records at this point, since the doctor-patient relationship has ended, would be to communicate them to another physician. For that purpose, the complainant submits, the notes must be accurate. Although that is one way that the notes could be used, I disagree that, in the circumstances of this complaint, no other future use is possible. In any event, it is important that notes containing personal health information be accurate, and that is the purpose of the correction provisions in the *Act*.

[43] Viewed as a totality, the submissions of the custodian and the complainant amount to a disagreement as to the purpose and content of the appointment in question. Clearly, there was some discussion of the appropriate dosage for one of the medications. The complainant was critical of the custodian with respect to the dosage change. The custodian had concerns about the addictive potential of the medications the complainant was taking.

[44] In my view, in all of the circumstances, it was reasonable for the custodian to reflect her own concerns about the addictive potential of the medications, which the notes indicate were discussed at the appointment, by using the title, "counselling, primary care/mental health."

[45] The complainant's disagreement with this characterization, however vehemently stated, does not amount to proof that the record is incomplete or inaccurate for the purposes for which the custodian uses the information.

[46] Accordingly, I will not order the custodian to make the requested change.

2. Decision to increase dosage

> Re [identified date] entry, which reads as follows:
>
> *She is upset today that we increased her [named medication]*
>
> Correction requested: Strike out "we" and replace with "I" or "M.D." Alternatively, strike out "we increased" and add "was increased" at the end of the sentence (the record would then read: "She is upset today that ~~we increased~~ her [named medication] was increased.")

[47] When the complainant submitted this revised correction request during mediation, she provided the following reason for doing so:

> The complainant acknowledges that her original correction request asked the custodian to explain why she used the term, "we" as opposed to "I" and did not specifically indicate this error as a request to correct. The

> complainant agrees to make a new request if the Custodian requires her to, however would like the Custodian to consider including it within this complaint.

[48] In the custodian's affidavit, she states that:

> . . . because I practise mutually respectful medicine and do not tell my patients that they must increase or reduce their dosages, when I write "we" in a medical record, it almost invariably refers to an agreement between my patient and myself. In other words, I make recommendations and we discuss the matter together. This was in fact the case in this instance.

[49] The complainant submits that notations about another appointment prove that the custodian attempted to change the complainant's medication on that other occasion without her consent. On this basis, she suggests that the custodian's statement that she practises mutually respectful medicine is not credible. While a decision by the custodian to unilaterally change prescribed medication in a way that had been rejected by the complainant is one possible view of the notations the complainant refers to, the notes are cryptic and brief, and refer to a different appointment than the one under consideration here. Under the circumstances, I am not prepared to draw the inference suggested by the complainant based on the notes of the other appointment.

[50] In her affidavit, the complainant asserts that she never agreed to change the dosage of the medication referred to in the notes she seeks to have corrected. She also states that she had the pharmacy question the change, which was then reversed.

[51] Again, the submissions and evidence of the custodian and the complainant amount to a disagreement about the way the prescribed dosage was changed. The complainant argues that one version of the suggested correction is "neutral." I disagree. Any version of this suggested correction is significant.

[52] In effect, the complainant accuses the custodian of unethical behaviour. If I order the custodian to "correct" this aspect of the record, which would significantly alter the description of how the change in the prescribed dosage occurred, I would be endorsing the complainant's view in this regard. This could have consequences that go beyond the findings in this decision.

[53] In my view, it would not be appropriate to make such a finding in a correction complaint under the *Act* where, as here, the evidence is contradictory. In her affidavit, the custodian affirms that in this instance, she made recommendations and discussed the matter with the complainant. In her representations and affidavit, the complainant is adamant that she never agreed to any changes in dosage.

[54] As already noted, the complainant bears the onus of proof that the criteria for changing the record are established.

[55] Under the circumstances, I conclude that the complainant has not demonstrated that the record is incomplete or inaccurate for the purposes for which the custodian uses the information.

[56] Accordingly, I will not order the custodian to make the requested change.

NO ORDER:

For the foregoing reasons, no order is issued.

Original Signed by: June 9, 2017

John Higgins
Adjudicator