Information and Privacy Commissioner,
Ontario, Canada

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

PHIPA DECISION 37

HA14-44-2

William Osler Health Centre - Etobicoke General Hospital

November 29, 2016

Summary: The complainant submitted a correction request under the *Personal Health Information Protection Act* to Etobicoke General Hospital. The complainant submits that the discharge summary prepared by a physician working at the hospital contains a number of errors including an incorrect diagnosis. The hospital agreed to correct the complainant's date of birth contained in the record but denied the remainder of the correction requests. This decision finds that the discharge summary contains the physician's good faith professional opinions or observations. Accordingly, the exception at section 55(9)(b) to the hospital's duty to correct records applies in the circumstances of this complaint and the hospital's decision is upheld.

Statutes Considered: ***Personal Health Information Protection Act, 2004*****,** sections 3(1), 4(1), 55(8), and 55(9).

Cases Considered: Order H2004-004, 2004 CanLII 72339 (AB OIPC); Order H2005-006, 2006 CanLII 80852 (AB OIPC); and Order H2005-007, 2006 CanLII 80867 (AB OIPC).

BACKGROUND:

[1] The complainant submitted a 10-part correction request under the *Personal Health Information Protection Act*, *2004* (*PHIPA*) to William Osler Health Centre - Etobicoke General Hospital (the hospital) to correct a discharge summary created over twenty years ago.

[2] The hospital sent a letter to the complainant denying the correction request. The

complainant filed a complaint with this office and a mediator was assigned to the matter.

[3] The mediator had discussions with the parties and the complainant agreed to resubmit his correction request to provide the hospital with additional information. The hospital subsequently issued a revised decision to the complainant. In that decision, the hospital advised the complainant it does not object to correcting his date of birth as recorded in the discharge summary. However, the hospital denied the remainder of the complainant's correction request. The hospital also informed the complainant that he was entitled to file a statement of disagreement that would be attached to the discharge summary.

[4] At the end of mediation, the hospital confirmed it was relying on section 55(8) and the exceptions at sections 55(9)(a) and (b) to deny the correction request. The complainant continued to seek numerous corrections to the record and the matter was transferred to the adjudication stage of the complaint process.

[5] I decided to conduct a review and sent a Notice of Review setting out the facts and issues in this complaint to the parties. In response, the parties provided written representations.

[6] In this decision, I find that the information the complainant seeks to correct qualifies as professional opinions or observations provided in good faith. As a result, the exception in section 55(9)(b) applies and the hospital is not required to correct the record.

RECORD:

[7] The record at issue is a one-page discharge summary.

SUMMARY OF THE CORRECTION REQUESTS:

[8] The complainant requested that the following 10 items[1] be corrected in the discharge summary:

> 1. Information contained under the heading "Final Diagnosis" identifying a mental health condition. The complainant submits that he was misdiagnosed and seeks to correct this information.

[1] The requested corrections are described in detail and categorized by number from 1 to 10 in the mediator's report and Notice of Review the parties received from this office. This decision discusses the correction requests in general terms to ensure that the privacy of the complainant is protected.

> 2-5. Information contained under the heading "Presenting Problem", describing the complainant's state of mind when he was admitted to the hospital. Also contains information the writer of the report indicates the complainant provided staff about his medical history and presenting problems. The complainant disagrees that he received assistance to complete any hospital forms and disagrees with the writer's description of his medical history and presenting problems.
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> 6-10. Information contained under the heading "Mental Status Examination" describing the complainant's mental state and speech along with information the writer indicates the complainant provided staff during his care at the hospital. Also included is the writer's comments, observations and diagnosis of the complainant's mental and physical state.

DISCUSSION:

[9] The parties agree that the information at issue constitutes the complainant's personal health information (PHI). PHI is defined in section 4(1) of *PHIPA*, in part as follows:

> "personal health information", subject to subsections (3) and (4), means identifying information about an individual in oral or recorded form, if the information,
>
> (a) relates to the physical or mental health of the individual, including information that consists of the health history of the individual's family,
>
> (b) relates to the providing of health care to the individual, including the identification of a person as a provider of health care to the individual,

[10] Section 4(3) adds to this discussion, covering mixed records that contain both personal health information as described in section 4(1) and other information about an individual:

> Personal health information includes identifying information that is not personal health information described in subsection (1) but that is contained in a record that contains personal health information described in that subsection.

[11] The parties also do not dispute that the hospital is a "health information custodian" as defined in section 3(1) of *PHIPA*, and that the complainant was given access to his health records before making his correction request.

[12] The sole issue in this complaint is whether the hospital has a duty to correct the complainant's PHI contained in the record. Section 55(8) of *PHIPA* provides for a right

of correction to records of PHI in some circumstances. It states:

> The health information custodian shall grant a request for a correction under subsection (1) 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.

[13] Section 55(9) of *PHIPA* sets out exceptions to the obligation to correct records, as follows:

> Despite subsection (8), a health information custodian is not required to correct a record of personal health information if,
>
> (a) it consists of a record that was not originally created by the custodian and the custodian does not have sufficient knowledge, expertise and authority to correct the record; or
>
> (b) it consists of a professional opinion or observation that a custodian has made in good faith about the individual.

[14] Read together, these provisions set out the criteria pursuant to which an individual is entitled to a correction of his or her records of PHI. The purpose of section 55 of the *PHIPA* is to impose a duty on health information custodians to correct records of PHI that are inaccurate or incomplete for the purposes for which they use the information, subject to the exceptions set out in section 55(9) of the *PHIPA*.

[15] In all cases where a complaint regarding a custodian's refusal to correct records of PHI is filed with this office, the individual seeking the correction has the onus of establishing whether or not the "record is incomplete or inaccurate for the purposes for which the custodian uses the information" pursuant to section 55(8). Section 55(8) requires the individual asking for correction to:

> a) 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
>
> b) give the custodian the information necessary to enable the custodian to correct the record.

[16] If the above is established, the question becomes whether or not any of the exceptions that are set out in section 55(9) apply.

[17] Where the custodian claims that section 55(9)(b) applies, the custodian bears the burden of proving that the PHI at issue consists of a "professional opinion or observation" about the individual. However, once the custodian has established that the

information qualifies as a "professional opinion or observation", the onus is on the individual seeking a correction to establish that the "professional opinion or observation" was not made in good faith. If the exception applies, it does not matter whether or not the individual has met the onus in section 55(8) because even if the complainant satisfied this office that the information is incorrect or inaccurate under section 55(8), a finding that the exception in section 55(9)(b) applies will resolve the complaint.

[18] Depending on the circumstances of the correction request, the information that the individual is seeking corrected and the reasons for the custodian's refusal to correct the records, this office may approach the analysis initially under section 55(8) or under section 55(9). In the case before me, it is unnecessary to determine whether or not the complainant has met the onus under section 55(8) because even if he has, the exception in section 55(9)(b) applies.

Positions of the parties

[19] The discharge summary relates to the complainant's stay at the hospital over two decades ago. Based on the representations of the hospital, it appears that the complainant was admitted to the hospital after being seen by an emergency room physician working at the hospital. The complainant was also seen by another physician specializing in psychiatry, who it appears examined the complainant, reviewed the complainant's patient chart and prepared the discharge summary.

[20] The hospital takes the position that the complainant seeks to correct information which qualifies as professional opinions or observations of the psychiatrist who prepared the report. The hospital submits that the report contains the psychiatrist's professional opinions or observations about the complainant, some of which are based on the emergency room physician's professional observations or opinions about the complainant. The discharge summary also contains the psychiatrist's final diagnosis.

[21] The psychiatrist's diagnosis appears to be the complainant's main impetus in requesting a correction to the record. The complainant submits that he was misdiagnosed at that time and advises that his condition was correctly diagnosed years later.

[22] The complainant submits that a physician who reviewed his medical history more recently arrived at the conclusion that "… it would be impossible for someone who was correctly diagnosed with [the psychiatrist's final diagnosis in the discharge summary] to remain untreated for the condition for such a great length of time". In support of this position, the complainant provided reference letters to highlight his own academic and work achievements, which include his completion of a rigorous post-secondary program.

Does the "professional opinion or observation" exception at section 55(9)(b) apply?

[23] As set out above, section 55(9)(b) states that a health information custodian is not required to correct a record of PHI "…if it consists of a professional opinion or observation that a custodian has made in good faith about the individual". The purpose of section 55(9)(b) is to preserve "professional opinions or observations," accurate or otherwise, that have been made in good faith. This purpose is based on sound policy considerations, including the need for documentation that may explain treatments provided or events that followed a particular observation or diagnosis.

[24] Thus, a request for correction or amendment should not be used to attempt to appeal decisions or professional opinions or observations with which a complainant disagrees and cannot be a substitution of opinion, such as a complainant's view of a medical condition or diagnosis.

[25] The determination of whether the exception at section 59(9)(b) applies involves a two-part analysis. The first question is whether the PHI is a "professional opinion or observation." The second question is whether the "professional opinion or observation" was made "in good faith".

1. Whether the PHI qualifies as a "professional opinion or observation?"

[26] In order to qualify for the application of section 55(9)(b), I must find that the PHI is a "professional opinion or observation". One question that arises in interpreting this phrase is whether the adjective "professional" only modifies the noun "opinion" or whether it also modifies the noun "observation." In other words, must both an opinion and an observation be "professional" in nature to be covered by section 55(9)(b)? In considering this question, I must read these words in a grammatical and ordinary sense, harmoniously with the scheme of *PHIPA*, the object of the statute and the intention of the Legislature.[2] I note that courts have typically held, as a matter of grammatical construction, that an adjective preceding a series of two or more nouns modifies the series of nouns and not simply the first noun, thus supporting the conclusion that the phrase covers "professional opinions" and "professional observations". Such a construction is also consistent with the purpose of this provision, in giving individuals the right to seek correction of opinions and observations made by health professionals. I thus conclude that section 55(9)(b) applies only where the information at issue consists of either a "professional opinion" or a "professional observation".

[27] I also find that only observations and opinions derived from the exercise or application of special knowledge, skills, qualifications, judgment or experience relevant to the profession should be defined as "professional observations" or "professional

[2] Elmer A. Driedger, The Construction of Statutes, 2nd ed., Toronto, Butterworths, 1983, at 87.

opinions" within the meaning of section 55(9)(b). Again, this conclusion is consistent with the purpose of this provision, within the overall scheme of *PHIPA.*

[28] In this case, the discharge summary was prepared by a physician, specializing in psychiatry. The portions of the report the complainant seeks to have corrected contain the writer's description of the complainant's mental state when he was admitted to the hospital. Also included are the psychiatrist's observations and diagnosis based on her examination of the complainant. I have reviewed the record along with the submissions of the parties and am satisfied that the psychiatrist who prepared the discharge summary applied her professional knowledge and skills in making the comments, observations and diagnoses the complainant seeks to have corrected.

[29] The physician's qualifications, including specializing in psychiatry, are relevant to determining whether her opinions or observations regarding the complainant arise from the use of professional knowledge, skills, qualifications and judgments. Also relevant is the fact that the psychiatrist was using her professional qualifications to express her opinion or observations.

[30] Accordingly, I am satisfied that the parts of the discharge summary the complainant seeks to have corrected constitute the professional opinions and observations of the psychiatrist preparing the report.

[31] This finding is consistent with the approach taken to similar provisions in other jurisdictions.[3] The Alberta Information and Privacy Commissioner's office (the AIPC) has interpreted the words "professional," "opinion" and "observation," in the context of correction complaints made under section 13 of Alberta's *Health Information Act* (*HIA*). The AIPC has defined "professional" to mean "of or relating to or belonging to a profession," and has described an "opinion" as something subjective in nature and that is "a belief or assessment based on grounds short of proof; a view held as probable".[4] In the same orders, the AIPC also found that an "observation" is subjective in nature and means a "comment based on something one has seen, heard or noticed, and the action or process of closely observing or monitoring".

[32] The AIPC has also stated, in Order H2005-007:

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[3] This approach is also consistent with the principles this office has applied in appeals determining whether an institution should correct a record containing the requester's personal information under sections 36(2) and 47(2) of the *Municipal Freedom of Information and Protection of Privacy Act (MFIPPA)* and its provincial equivalent the *Freedom of Information and Protection of Privacy Act (FIPPA)*. Past orders from this office (For example Orders MO-3042, MO-3218, MO-3251, PO-2258 and PO-2549), under those acts, have held that when dealing with opinions and observations in records of an investigatory nature, it is not the truth of the recorded information that is determinative of whether a correction request should be granted, but rather whether or not what is recorded accurately reflects the observations and views of the individuals whose impressions are set out in the record.

[4] See Orders H2004-004, H2005-006 and H2005-007.

> A request for correction or amendment should not amount to rewriting the records in the [complainant's] own words. A request for correction or amendment should not be used to attempt to appeal decisions or opinions or observations with which [the complainant] disagrees and cannot be a substitution of opinion, such as the [complainant's] view of a medical condition or diagnosis.

[33] In conclusion, having regard to the submissions of the parties and the material before me, I find that the PHI the complainant seeks to correct qualifies as the psychiatrist's professional opinion or observation, within the meaning of section 55(9)(b). The complainant's request to correct this information, in effect, seeks to substitute or rewrite the psychiatrist's opinions or observations contained in the psychological report. Given my findings, the complainant has no right to a correction unless it can be established that the professional opinions or observations in question were not made in good faith.

[34] I will now determine whether the professional opinions or observations contained in the discharge summary were made in good faith.

2. If the PHI does qualify as a "professional opinion or observation," was it made "in good faith?"

[35] Court decisions have stated that a finding that someone has not acted in good faith can be based on evidence of malice or intent to harm another individual, as well as serious carelessness or recklessness. The courts have also stated that persons are assumed to act in good faith unless proven otherwise. Therefore, the burden of proof rests on the individual seeking to establish that a person has acted in the absence of good faith to rebut the presumption of good faith.[5] Accordingly, in the context of section 55(9)(b), the burden rests on the individual seeking the correction to establish that the custodian did not make the professional opinion or observation in good faith.

[36] The parties' submissions did not specifically address this issue. However, the information before me does not rebut the presumption of good faith in the circumstances of this complaint. In arriving at this decision, I took into account the contents of the record which describe the circumstances in which the complainant sought treatment from the hospital along with the absence of evidence suggesting that the writer of the report acted in bad faith. As there is no evidence of malice, intent to harm, serious carelessness or recklessness on the part of the hospital and/or writer of the discharge summary, I find that the exception at section 55(9)(b) applies in the circumstances of this complaint.

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[5] *Finney v. Barreau du Québec, [2004] 2 SCR 17, 2004 SCC 36 (CanLII)*

Summary

[37] I find that the information the complainant seeks to correct contains the professional opinions and observations of the psychiatrist who prepared the discharge summary, which were made in good faith. Accordingly, the exception under section 55(9)(b) applies. This means that even if the complainant were to establish that the information at issue was inaccurate or incomplete for the purpose for which it used by the hospital, I find that the hospital is not obligated to make the requested corrections under section 55(8). As a result, the hospital does not have a duty to correct the record under section 55(8).

[38] In addition to providing individuals with a right to access their PHI, *PHIPA* gives individuals the right to attach a statement of disagreement to the record conveying their disagreement with any information contained in the record. Here, the complainant filed a statement of disagreement with the hospital during the inquiry process which the hospital attached to the record.

NO ORDER:

For the foregoing reasons, no order is issued.

Original Signed by: November 29, 2016

Jennifer James
Adjudicator