Information and Privacy Commissioner,
Ontario, Canada

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

PHIPA DECISION 39

HA14-45-2

University Health Network – Toronto General Hospital

January 19, 2017

Summary: The complainant submitted a correction request under the *Personal Health Information Protection Act* to the University Health Network - Toronto 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 a small portion of the record upon its receipt of substantiating documentation from the complainant. The hospital denied the remainder of the correction requests. The adjudicator finds that most of corrections sought by the complainant seek to correct the physician's good faith professional opinions or observations and as a result the exception at section 55(9)(b) applies to this information. In addition, the complainant failed to establish a right of correction under section 55(8) for the remaining information. Accordingly, the hospital's decision not to make the requested corrections is upheld.

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

Decisions 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).

Cases Considered: PHIPA Decisions 36 and 37.

BACKGROUND:

[1] The complainant submitted a correction request under the *Personal Health*

Information Protection Act, 2004 (the *PHIPA*) to the University Health Network – Toronto General Hospital (the hospital) to correct a discharge summary prepared over 20 years ago. The request contained a number of correction requests to the discharge summary.

[2] The hospital sent a letter to the complainant explaining that it denied the correction request on the basis that it did "… not consider the information that has been recorded to be inaccurate or incomplete for the purposes for which it was collected and used". The hospital also takes the position that *PHIPA* does not require it to make corrections concerning "information that is irrelevant to [the complainant's] care" or consists of a professional opinion or observation made in good faith.

[3] The hospital advised the complainant that it would attach his Statement of Disagreement to the record.

[4] The complainant filed a complaint with this office and a mediator was assigned to the matter.

[5] During mediation, the mediator had discussions with the parties and the hospital agreed to correct the date of birth and the description of the complainant's living arrangements contained in the record upon its receipt of substantiating documentation from the complainant.

[6] At the end of mediation, the complainant confirmed that he continued to seek correction of the record and the matter was transferred to the adjudication stage of the complaint process.

[7] 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 to this office.

[8] In this decision, the hospital's decision not to make the requested corrections to most of the record is upheld as the good faith professional opinion and observation exception at section 59(b) applies to this information. As the complainant failed to establish that the remaining information at issue was inaccurate or incomplete for the purposes of which the information is used, the hospital is not required to correct this information under section 55(8).

RECORDS:

[9] The record at issue is a two-page discharge summary.

ISSUES:

A. Does the "professional opinion or observation" exception at section 55(9)(b) apply to any portions of the record?

B. If the exception does not apply, has the complainant established that these portions are incomplete or inaccurate for the purposes for which the hospital uses the information under section 55(8)?

SUMMARY OF THE CORRECTION REQUESTS:

[10] The complainant requested that the following 7 items be corrected in the discharge summary:

1. Information contained under the heading "Identification", describing the complainant's date of birth and family living arrangement at the time of his admission. The hospital agreed to correct this information upon its receipt of substantiating documentation, which to date has not been provided by the complainant.

2. Information contained under the heading "Reason for Admission" describing the reason for the complainant's admission to the hospital. The complainant disagrees with the stated reasons and provides another explanation.

3. Information under the heading "History of Present Illness" describing the complainant's mental state and history for a period of two weeks prior to admission. The complainant asserts that all the information in this paragraph is incorrect.

4. Information under the heading "Past Psychiatric History" describing the complainant's mental state and history for a period of approximately two years prior to admission. The complainant disagrees with the writer's summary of his psychiatric history and provides another explanation.

5. Information under the heading "Mental Status Examination" describing the results of the writer's physical examination and observations of the complainant. The complainant disagrees with the writer's description.

6. Information under the heading "Course in Hospital" describing medical testing and medicine administered to the complainant during his hospitalization.

7. Information under the heading "Final Diagnosis" describing the writer's diagnosis. The complainant disagrees with the diagnosis and provides another explanation.

DISCUSSION:

[11] 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,

[12] 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.

[13] 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.

[14] 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.

[15] 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.

[16] 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 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).

[17] 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.

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

[19] 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.

[20] Given the nature of the information contained in the record, I have decided to commence my analysis under section 55(9)(b).

A. Does the "professional opinion or observation" exception at section 55(9)(b) apply to any portions of the record?

[21] The hospital submits that the information the complainant seeks to correct constitutes the professional opinions or observations of the psychiatrist who prepared the discharge summary. The hospital takes the position that the record "accurately reflect[s] the views or opinion of the author at the time the information was recorded".

[22] The complainant's correction request seeks to correct the psychiatrist's final diagnosis along with other information, opinions or observations contained in the record. The complainant states that the psychiatrist's diagnosis is "incorrect" and advises that his hospital stay which is the subject of the discharge summary in question was his second hospitalization at the hospital that year. He advises that he was also admitted to the hospital a few months prior and seen by a different physician, who is identified in the portion of the discharge summary which describes his psychiatric history.

[23] The complainant submits that the physician he saw earlier in the year "misdiagnosed [his] condition and provided incorrect treatment which resulted in a deterioration of [his] health and subsequent hospitalization shortly after discharge". The complainant takes the position that the writer of the discharge summary at issue was influenced by the earlier diagnosis.

[24] The complainant also appears to take the position that the hospital should correct his date of birth along with the reference to his living situation contained in the record without the need for him to produce substantiating documentation. In support of this position, the complainant states:

> Given the fundamental basis of the rationale provided by the [hospital] for not objecting to correcting factual errors [such as my date of birth and reference to my living arrangements] there would be no requirement to provide documented evidence to verify the [above] factual corrections

[25] The hospital's representations contained the following response:

> The complainant appears to suggest that the findings of the physician who completed the discharge summary were informed by this alleged misdiagnosis however the [discharge summary] merely states that the complainant has seen [the named physician] previously. The complainant has provided no evidence to suggest that his illness was in fact misdiagnosed or that [the psychiatrist preparing the discharge summary] relied on such a misdiagnosis in recording his observations and opinion[s].

Decision and Analysis

[26] 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.

[27] 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.

[28] 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?"

[29] In order to qualify for the application of section 55(9)(b), I must find that the PHI is a "professional opinion or observation". In PHIPA Decisions 36 and 37 I found that section 55(9)(b) applies only where the information at issue consists of either a "professional opinion" or a "professional observation". I also found 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 opinions" within the meaning of section 55(9)(b). These conclusions are consistent with the purpose of this provision, within the overall scheme of *PHIPA.*

[30] In this case, the discharge summary was prepared by a physician, specializing in psychiatry. Much of the information the complainant seeks to have corrected contains the psychiatrist'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 comments, observations and diagnoses the complainant seeks to have corrected.

[31] 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.

[32] Having regard to the submissions of the parties and the material before me, I

find that most of the PHI the complainant seeks to correct qualifies as the psychiatrist's professional opinion or observation, within the meaning of section 55(9)(b). In particular, I find that the information itemized from 2 to 7 in the summary of the complainant's correction request contains "professional opinions or observations". The complainant's request to correct this information, in effect, seeks to substitute or rewrite the psychiatrist's opinions or observations contained in the discharge summary. 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.

[33] This finding is consistent with the approach taken in PHIPA Decisions 36 and 37, similar provisions in other jurisdictions and previous decisions from this office dealing with correction requests of investigatory records.[1]

[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 qualifies 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.[2] 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 hospital's representations state:

> In the absence of any documentation proving otherwise, we can only assume that the opinions and statements were made in good faith based on the [psychiatrist's] experience and judgement at the time they were recorded.

---

1 See Orders H2004-004, H2005-006 and H2005-007 from the Alberta Information and Privacy Commissioner's office (the AIPC). 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.

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

[37] The complainant's representations do not specifically address this issue. However, the complainant submits that the physician who initially diagnosed him during his hospital stay a few months prior to the one which is the subject of this review "…was being supervised by a more experienced physician" who underwent addiction rehabilitation sometime after the discharge summary was prepared.

[38] In response, the hospital submits that the complainant's evidence regarding the more experienced physician "has no bearing" on the issues to be determined in this complaint.

[39] In my view, the complainant's evidence relating to physicians not responsible for preparation of the record at issue is not relevant to the determination of whether the writer's professional opinion or observations were made in good faith. Accordingly, the complainant has adduced insufficient evidence to rebut the presumption of good faith. 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 discharge summary acted in bad faith. As there is no evidence of malice, intent to harm, serious carelessness or recklessness on the part of the writer of the discharge summary, I find that the exception at section 55(9)(b) applies in the circumstances of this appeal.

Summary

[40] I find that most of the information the complainant seeks to correct contains the good faith professional opinions and observations of the psychiatrist who prepared the discharge summary. Accordingly, the exception under section 59(9)(b) applies to this information. This means that even if the complainant were to establish that this information 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).

[41] However, there is insufficient evidence to conclude that the exception at section 55(9)(b) extends to the portions of the record that contains information about the complainant's date of birth and living arrangements as referenced in item 1 of the summary of the complainant's correction request. Accordingly, I will go on to determine whether the complainant has established a right of correction for this information under section 55(8).

B. If the exception does not apply, has the complainant established that these portions are incomplete or inaccurate for the purposes for which the hospital uses the information under section 55(8)?

[42] The remaining information at issue consists of small portions of the record referencing the complainant's date of birth and living situation at the time of his hospitalization.

[43] The hospital's position is two-fold. In its correction decision, the hospital advised the complainant that *PHIPA* does not require it to correct his date of birth or the description of his living situation. However, the hospital advised that it would correct this information upon its receipt of substantiating documentation from the complainant. The complainant takes the position that the hospital should correct this information without the need for him to produce substantiating documentation.

[44] In my view, the circumstances in this complaint are similar to the circumstances in PHIPA Decision 36. In that decision, the complainant took the position that he should not be required to provide substantiating documentation in support of his correction request. In that decision, I stated:

> I find that the hospital is not obliged to grant the correction request because the complainant has not demonstrated that the record, which was prepared over 15 years ago, is incomplete or inaccurate for the purposes for which the hospital uses the information. In addition, the complainant has not provided the hospital with the information necessary to enable the hospital to correct the record.
>
> There is no question that the accuracy of records containing personal health information is essential to the effective provision of health care. However, the correction provisions of *PHIPA* are limited by the requirement that the individual requesting the correction "demonstrate to the satisfaction of the custodian, that the record is incomplete or inaccurate for the purposes for which the custodian uses the information." The accuracy of the information that is requested to be corrected is therefore connected to the purposes for which the information is used.
>
> In interpreting these provisions of the *PHIPA*, I find it helpful to have regard to section 11(1), which requires health information custodians that use PHI about an individual to take "reasonable steps to ensure that the information is as accurate, complete and up-to-date as is necessary for the purposes for which it uses the information." The duty to use accurate information under section 11(1) can be viewed as the corollary to the duty to correct inaccurate information under section 55(8). In both, the purpose for which the information is used is key to understanding the scope of the duty.
>
> The following discussion in *Guide to the Ontario Personal Health Information Protection Act* elaborates on the relationship between the accuracy of personal health information and the purposes of its use, in section 11(1):
>
> > [The] obligations regarding the use and disclosure of personal health information include an important limitation. Through

> PHIPA's inclusion of the phrase "as is necessary for the purposes" of the use or disclosure, the accuracy, completeness, and up-to-date character of the information is tied to the purposes of the use and disclosure. As a result, the personal health information upon which a health information custodian relies need not be accurate or complete in every respect. It may be inaccurate or incomplete in a way that is not significant to the custodian because the custodian is not relying on it for a purpose relevant to the inaccuracy or omission. [my emphasis]

I agree with the above statement, which I also find applicable to interpreting the custodian's duty to correct under section 55(8). As a result, I am satisfied that not all PHI contained in records held by health information custodians needs to be accurate in every respect. If a request is made to correct inconsequential bits of information that have no impact on the purposes for which the custodian uses the information, and the custodian is not relying on the information for a purpose relevant to the accuracy of the information, the custodian is not required to correct the information.

[45] I adopt the reasoning in PHIPA Decision 36 and apply it to the circumstances of this complaint. Here, the complainant did not provide the hospital with substantiating documentation to enable it to correct the record. In addition, the complainant's evidence fails to establish that the record is incomplete or inaccurate for the purposes for which the hospital uses the information. Accordingly, I find that *PHIPA* does not require the hospital to correct the complainant's date of birth or description of his living situation contained in the record.

[46] Having regard to the above, I find that the complainant has failed to establish a right of correction under section 55(8).

NO ORDER:

1. For the foregoing reasons, no order is issued

Original signed by
Jennifer James
Adjudicator

January 19, 2017