Information and Privacy Commissioner,
Ontario, Canada

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

PHIPA DECISION 41

Complaint HA14-80

Thunder Bay Regional Health Sciences Centre

January 24, 2017

Summary: The complainant submitted a correction request under the *Personal Health Information Protection Act, 2004* to the Thunder Bay Regional Health Sciences Centre (the hospital). The complainant submits that the record containing his personal health information prepared by the hospital is incorrectly dated. The hospital denied the complainant's request for correction. In this decision, the adjudicator declines to make an order and finds that the complainant did not demonstrate that the information in the record is inaccurate, nor that it is inaccurate or incomplete for the purposes for which the hospital uses the information. The adjudicator upholds the hospital's decision not to make the requested correction.

Statutes Considered: *Personal Health Information Protection Act, 2004*, section 55(8).

Decisions Considered: PHIPA Decision 36.

BACKGROUND:

[1] The complainant submitted a request to the Thunder Bay Regional Health Sciences Centre (the hospital) under the *Personal Health Information Protection Act, 2004* (*PHIPA*) to correct an error he was of the view was made in his record of personal health information. The record was in relation to a visit the complainant made to the hospital's Emergency Department. The complainant's request advised that the date of the visit, which appears on each page of the record was incorrect, and that it should be changed to another specified date.

[2] The hospital met with the complainant and denied the request, advising him that

the record was accurate and did not require correction.

[3] The complainant subsequently filed a complaint to this office regarding the hospital's decision to deny his correction request.

[4] During the mediation of the complaint, the hospital issued a written decision in response to the complainant's request. The hospital denied the request for correction, claiming the application of section 55(8) of *PHIPA*. The hospital advised the mediator that the record was accurate because the date (located on each page of the record) is not entered manually but is automatically pre-populated. The hospital also advised the mediator that it had conducted an audit of the complainant's record of personal health information, which confirmed that no changes had been made to it. The hospital also confirmed in writing to the complainant that it had attached, per his request, a statement of disagreement to his record of personal health information.

[5] The complaint then moved to the adjudication stage of the complaints process, where an adjudicator may conduct a review. I decided to conduct a review in which I sought and received representations from the complainant and the hospital, which were shared between the parties. The parties agree that the hospital is a health information custodian for the purposes of section 3(1) of *PHIPA*, and that the record contains the complainant's personal health information as defined in section 4(1) of *PHIPA*.

[6] In this decision, I find that the complainant failed to establish that the record is inaccurate. The complainant has also failed to establish it is inaccurate or incomplete for the purposes for which the information is used. Consequently, the hospital is not required to correct the record under section 55(8).

RECORDS:

The 10-page record of personal health information is an emergency department record.

DISCUSSION:

[7] The sole issue in this complaint is whether the hospital has a duty to make the requested correction under section 55 of *PHIPA*. One of the enumerated purposes of *PHIPA* is that individuals have a right to require the correction or amendment of personal health information about themselves, subject to limited and specific exceptions as set out in it.[1]

[8] Section 55(8) of *PHIPA* provides for a right of correction to records of personal health information in some circumstances. It states:

> The health information custodian shall grant a request for correction under subsection (1) if the individual demonstrates, to the satisfaction of

[1] See section 1(c) of *PHIPA*.

> 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.

[9] 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.

[10] Read together, these provisions set out the criteria pursuant to which an individual is entitled to a correction of his or her records of personal health information. The purpose of section 55 of *PHIPA* is to impose a duty on health information custodians to correct records of personal health information 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 *PHIPA*.

[11] In all cases where a complaint regarding a health information custodian's refusal to correct records of personal health information 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 health information custodian uses the information* pursuant to section 55(8). As previously stated, section 55(8) requires the individual requesting a correction to:

- Demonstrate to the satisfaction of the health information custodian, that the record is incomplete or inaccurate for the purposes for which the custodian uses the information, and
- Give the health information custodian the information necessary to enable the custodian to correct the record.

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

[13] Where the health information custodian claims that section 55(9) applies, it bears the burden of proving that the personal health information at issue consists of *professional opinion or observation* about the individual. However, once the health information 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.

Representations

[14] The hospital states that upon receipt of the request for correction, it conducted an investigation and reviewed all of the information available and relevant to the request. The hospital advised that all of the documentation confirms that the date of attendance at the hospital was the date that is indicated in the record, and that there was no information available to support a request for correction of that date. In particular, the hospital submits that the pages comprising the record are generated from two different computer systems with a pre-populated date function. The hospital states that it also conducted an audit, which confirmed that the record had not been altered. Further, the hospital advises that there was no activity in the complainant's electronic record of personal health information on the date he claims he attended the emergency department, and that an audit of those records confirmed they had not been altered or adjusted.

[15] The hospital also provided this office and the complainant with copies of the Emergency Room Patient Daily Listing reports for both dates (the date on the record and the date the complainant states he attended the emergency department). These reports, the hospital advises, are generated from the Meditech system and list all of the patients who attended the emergency department on those dates.[2] These reports confirm that the complainant was registered as a patient in the emergency department on the date that appears on the record and not on the date the complainant claims is correct. The hospital goes on to state:

> In addition to further confirmation of the date of the complainant's attendance, these reports also illustrate the sequential assignment of patient numbers on registration in the Emergency Department. Where there are gaps in the sequence, related records have been reviewed and it has been confirmed the *gap* is related to a patient other than the complainant. These additional materials have not been provided as they are personal health information of other patients.

[16] The complainant submits that he attended a walk-in clinic on a specified date due to intense pain and swelling in his left thumb. The physician at the walk-in clinic suggested that the complainant attend the local emergency department to obtain an x-ray. The complainant states that he attended the hospital's emergency department on that date and not six days later, which is the date indicated in the record at issue. To support his position that he had provided adequate evidence that he did not attend the hospital on the date indicated in the record, he provided:

- a report from the walk-in clinic on the specified date;

[2] The hospital severed all of the patients' names, with the exception of the complainant's name.

- an excerpt from an audio interview he had with the Thunder Bay Police (the police), in which he advises them that he attended the emergency department on the specified date;

- an email sent by him to the police, in which he advises them that he attended the emergency department on the specified date; and

- a cell phone tracking history verified by TBAYTEL which indicates that data usage from his cell phone number was 6 kilometres away from the hospital on the date and time that hospital claims he was in the emergency department.

[17] The complainant further submits that the hospital should have back-up files from the Meditech and Sectra Pacs systems, which may provide evidence of his attendance at the emergency department on the specified date; however, the hospital has refused to provide him with access to these back-up tapes. The complainant requests that the back-up tapes be independently verified.

[18] With respect to the patient daily list the hospital provided, the complainant submits that there are anomalies, such as certain patients attending the emergency department on both dates, or attending twice in the same day, or where sequential patient numbers attended the hospital on the same day.

[19] The complainant takes the position that his record which was created on the date he actually attended the emergency department was switched with another patient's record who was in the emergency department on the date that is indicated in the record. The complainant argues that this switch was done maliciously by hospital staff at the direction of others.

[20] In reply, the hospital states that it will not be providing the complainant with back-up tapes because:

- There is no way to sever the complainant's record from other patients' records;

- The complainant would require specialized equipment in order to read the tapes including a server, tape drives and EMC networker;

- The tapes are serialized and tape indices would have to be reconstructed; and

- The only way the back-up tapes can be utilized or viewed is to use specialized equipment and software, hundreds of expert hours and the collaboration of the vendors at an estimated cost of over one hundred thousand dollars.

[21] With respect to the patient daily list, the hospital submits that it is not uncommon for patients to attend the emergency department on multiple dates, or multiple times on the same day. Similarly, the hospital argues, it is not out of the ordinary for new sequential patient numbers to be assigned for patients coming to the

emergency department. Lastly, the hospital submits that its internal investigation has not identified any inaccuracies in the record, or reasons to conclude it is inaccurate or incomplete for the purpose for which it was created.

Analysis and finding

[22] I find that the hospital is not required to grant the correction request because the complainant has not demonstrated that the record 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 it to correct the record.

[23] Recently, in PHIPA Decision 36, Adjudicator Jennifer James set out the approach to be applied when interpreting section 55(8) of *PHIPA*. Adjudicator James stated:

> 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 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.

[24] Adjudicator James went on to find that she was satisfied that not all personal health information contained in records held by a health information custodian needs to be accurate in every respect. She also found that where the health information custodian is not relying on the information for a purpose relevant to the accuracy of the information, it is not required to correct the information.

[25] Adopting Adjudicator James' approach and applying it to the circumstances of this complaint, I find that the hospital is not required to make the correction requested by the complainant because he has not demonstrated that the record is inaccurate for the purposes for which the custodian uses the information.

[26] I am satisfied with the explanation provided by the hospital as to how dates are

generated in records of personal health information and with respect to the accuracy of the date of the record, particularly in light of the fact that it has conducted audits of each of the two dates, finding no irregularities in the record.

[27] Conversely, I find that the evidence provided by complainant has not demonstrated that the record is inaccurate. While I accept that he attended at a walk-in clinic on the specified date, that does not lead to the conclusion that he attended at the hospital's emergency department on the same date. Further, the complainant's audio and email statements to the police about the date he attended the emergency department are self-serving and not determinative, and the cell phone tracking record, at most, confirms that the cell phone was in another location. Finally, the complainant's position that his record was deliberately switched with that of another patient is implausible. For all of these reasons, I find that the hospital does not have a duty to correct the records under section 55(8) of *PHIPA*.

NO ORDER:

1. For the foregoing reasons, no order is issued

Original Signed By: January 24, 2017
Cathy Hamilton
Adjudicator