Information and Privacy Commissioner,
Ontario, Canada

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

PHIPA DECISION 45

Complaint HA14-48

May 5, 2017

Summary: The complainants, on behalf of their daughter, submitted a correction request to the hospital alleging that multiple errors had been made in their daughter's medical records. The hospital made some of the requested corrections to the records but denied most of them asserting the records were accurate and claiming the professional opinions and observations exception at section 55(9)(b) of the *Personal Health Information Protection Act* also applied. No review of the complaint is warranted in accordance with sections 57(3) and 57(4)(a).

Statutes Considered: *Personal Health Information Protection Act, 2004*, sections 55(1), 55(3), 55(5), 55(8), 57(2), 57(3) and 57(4)(a).

Decisions Considered: PHIPA Decisions 32, 37 and 38.

Cases Considered: *Yukon Francophone School Board v Yukon (Attorney General)* 2015 SCC 25 (CanLII); *Committee for Justice and Liberty v National Energy Board*, [1978] 1 SCR 369.

BACKGROUND:

[1] This complaint arises from the complainants' concern that their daughter's medical records (the records) relating to a single hours-long visit to the hospital require correction. The complainants obtained access to the records on three separate occasions within a seven-month period. They initially filed a multi-part correction request with the hospital under the *Personal Health Information Protection Act* (*PHIPA*) regarding the first two copies of the records. They then met with a hospital representative to review the records and their concerns, and received a third copy of the records.

[2] The complainants subsequently filed a complaint with the Office of the Information and Privacy Commissioner (IPC) seeking a review of their correction request and alleging that the third copy of the records also contained errors and inconsistencies. After filing their complaint, the complainants submitted a lengthy letter to the IPC detailing alleged inconsistencies in the records, and they followed this with another letter in which they raised additional concerns about the third copy of the records, including allegations that the hospital made unauthorized changes and included false information therein.[1]

[3] In response to the correction request for the first two copies of the records, the hospital advised the complainants that it made four changes as described below. It denied the remainder of the complainants' requested corrections based on its view that the portions of the records that the complainants want corrected are accurate and complete, and consist of professional opinions or observations made in good faith. In its decision letter, the hospital advised the complainants of their ability to submit a statement of disagreement that could be attached to the records in question.

[4] Mediation was attempted but was not successful. At the conclusion of the mediation, a Mediator's Report setting out the records and issues remaining in dispute and to be adjudicated was sent to the parties for their review and comment. The parties were advised that the Mediator's Report would be provided to the adjudicator. The complainants' additional concerns about the third copy of the records were included in the Mediator's Report because they related to records and issues already before the IPC.[2] After receiving the Mediator's Report, the hospital provided additional information to the IPC, including its responses to the complainants' additional concerns. The complaint was then moved to the adjudication stage of the IPC's process for *PHIPA* complaints.

[5] After reading the complaint file, I sent the complainants a letter setting out the hospital's additional information and its responses to their additional concerns and advising them of my preliminary view that their complaint does not warrant a review pursuant to section 57(4)(a) of *PHIPA*. In my letter, I invited the complainants to provide written submissions to explain why their complaint should proceed to a review under *PHIPA* if they disagreed with my preliminary view. The complainants provided a lengthy response and a package of supporting materials.

[6] Having considered the complainants' response and the entire complaint file, including the hospital's response to the correction request and to the Mediator's Report, I accept the hospital's position. I find that the complaint does not warrant a review

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[1] The complainants sent numerous letters to the IPC throughout the processing of this complaint. I reviewed all of this correspondence, but I will not list or describe it here as it is not necessary for the purposes of this decision.

[2] The complainants take the position that their concerns should have been treated as a new and separate complaint by the IPC; this was not considered necessary or appropriate given that the existing complaint about the correction request included all three copies of the records.

under *PHIPA* in accordance with sections 57(3) and 57(4)(a) because there are no reasonable grounds for a review and the hospital has responded adequately to the complaint.

DISCUSSION:

[7] There is no dispute and I find that, the hospital is a "health information custodian" under paragraph 4.i. of section 3(1) of *PHIPA* and the records at issue are "personal health information" under section 4(1)(a) of *PHIPA.*

[8] The complainants' correction request and submissions relate to section 55(8) of *PHIPA*, which sets out the obligation on health information custodians to correct records of personal health information (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.

[9] Section 55(9)(b) of *PHIPA* sets out the following exception to the obligation to correct records:

> Despite subsection (8), a health information custodian is not required to correct a record of health information if,
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> > (b) it consists of a professional opinion or observation that a custodian has made in good faith about the individual.

[10] The IPC recently considered sections 55(8) and (9) in PHIPA Decision 37, which held that:

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

> . . .
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> 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.[3]

[11] I adopt the interpretation and approach taken in PHIPA Decision 37 in this complaint.

Preliminary Matter – application of section 55(5)

[12] In their submissions to me, the complainants take the position that section 55(5) of *PHIPA* applies in the circumstances of this complaint. Sections 55(1) and (5) read:

> 55(1) If a health information custodian has granted an individual access to a record of his or her personal health information and 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, the individual may request in writing that the custodian correct the record.
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> (5) A health information custodian that does not grant a request for a correction under subsection (1) within the time required shall be deemed to have refused the request.

[13] Section 55(5) deals with deemed refusal situations – cases in which a health information custodian has not granted a request for correction within the time required by *PHIPA*. At this stage of the process, and given the history of this matter, there is no useful purpose in conducting a review of this issue. The hospital provided a written response to the request, albeit after the 30-day time period required by section 55(3) of *PHIPA*. It did so after ongoing communications with the complainants about the correction request,[4] including a meeting with the complainants three weeks after they filed their correction request to review the records and their concerns about the records, and to provide the complainants with a third copy of the records. The hospital

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[3] At paragraph 17.

[4] These communications are documented in PHIPA Decision 32 (at paragraph 16) in which I addressed another complaint filed by the complainants relating to the same single hours-long hospital visit at issue in this complaint.

devoted a considerable amount of time and effort to addressing the complainants' correction request and the numerous concerns they expressed in relation to the hospital visit and its aftermath. Given that the hospital has now fully responded to the correction request, it would serve no useful purpose to review the application of section 55(5) of *PHIPA* and, as a result, I reject the complainants' assertion that I must do so.

Corrections made by the hospital

[14] The hospital made the following four corrections to the records as requested by the complainants:[5]

1. The date of the Cardiac Diagnostic Requisition was added by Dr. C.
2. The statement of "Marfan's syndrome" was changed to "The patient was under investigation for Marfan syndrome and had not been diagnosed with Marfan syndrome." This correction was made by Dr. R on the CT Thorax-Abdomen-Pel.
3. The statement "Marfan" was changed to "Under investigation for Marfan." This correction was made to the Computerized Tomography by Dr. C.
4. The crossed out notation on dissection that appears in the Emergency Records was initialed and dated by Dr. C.

Issue raised by the complainants regarding correction 4

[15] In their submissions to me, the complainants assert that they did not request that the notation at correction 4 be initialed and dated by Dr. C and they argue that the date included by Dr. C is misleading because it is not the date that the notation was crossed out. In their correction request, the complainants note the crossed out notation and suggest that it differs from the results of an echocardiogram and CT scan which indicate there was no dissection. At the end of their correction request, the complainants ask for a record of "insertion dates" and of the "date and time of each entry." The hospital's response, to have Dr. C initial the crossed out notation as its author and date it on the date that she initialled it, is satisfactory and there are no reasonable grounds to conduct a review of this issue.

Corrections denied by the hospital

1. The hospital denies the following requested corrections on the basis that the information is accurate and complete and that the requested corrections 5 through 8 consist of a professional opinion or observation made in good faith in accordance with section 55(9)(b) of *PHIPA*:

[5] The requested corrections, described in detail in my letter to the complainants, are discussed in general terms here and anonymized to protect the privacy of the complainants and their daughter.

2. The complainants assert that the notation "clinical history of tearing chest pain radiating to the back" that appears on the Diagnostic Imaging Report is incorrect.

3. The complainants request that the "tearing chest pain" and "tearing pain" notations be removed from the records, including from the request form for the CT, because their daughter did not make these statements and did not experience these symptoms.

4. The complainants assert that the notation "C/P NYD" in the Emergency Record is incorrect because Dr. C explained at the end of the hospital visit that their daughter's pain was "musculoskeletal" but this wasn't recorded in the record.

    a. The complainants assert that the Pediatric ECG Interpretation signed electronically by Dr. W and obtained by them in the second and third copies of the records:

    b. Contains an incorrect diagnosis of "thoracic pain" even though their daughter did not experience thoracic pain.

    c. Is missing the values for "sinus rhythm" and "consider right atrial enlargement," which appear in the copy of this record that they obtained in the first copy of the records.

5. Includes the comments "right axis deviation, abnormal anterior repolarization, intraventricular conduction defect" and "abnormal ECG," which do not appear in the first copy of the records.

6. The complainants allege that the documentation of informed consent on the Contrast Media Injection Form is erroneous because their informed consent was not obtained. They ask that the documentation of informed consent be corrected.

7. The complainants ask that Dr. C's notes in the Emergency Record for the 9:40am entry be removed because Dr. C did not see their daughter until at least 10:45am that day.

8. The complainants assert that the Progress Notes erroneously document that Dr. C discussed the effects and risks of radiation with them and answered their questions about it even though that did not occur. They ask that the notes be corrected to reflect the absence of this discussion.

[16] In respect of correction 8 above, the hospital explains that the ECG in the first copy of the records is the preliminary report that was generated at that date and was not yet interpreted by a physician, whereas the copy of the ECG provided in the second copy of the records is the final report signed by the physician where interpretation of

the chart can be found. The hospital confirms that this ECG relates to the patient and that these reports were generated according to its standard practice. It adds that the "thoracic pain" notation was not corrected as it is a professional opinion or observation made in good faith. The hospital explains that it denies the complainants' request regarding correction 9 on the basis that its policies and procedures for obtaining informed consent were followed; the patient was given a complete explanation of the exam using age appropriate language; she had an opportunity to ask questions and appropriate answers were provided, and her understanding was validated before proceeding with the exam; and it complied with the *Health Care Consent Act.* The hospital explains that it denies the request for correction 10 because this entry is a medical order notation made in accordance with a preliminary order requested by the ER triage nurse of Dr. C, which was done in the regular course of business. Finally, the hospital denies correction 11 asserting that Dr. C made the note contemporaneously with the discussion and the note is accurate.

[17] In their submissions to me, the complainants repeat their concerns and insist that the records should be changed to reflect their view of what happened during the incidents referenced in the above corrections. Their submissions on corrections 5 through 8(a) challenge the validity of the notations based on the complainants' insistence that their daughter did not experience the symptoms documented in the records. The complainants also complain that Dr. C, who noted "tearing chest pain" in the records, did not examine their daughter.[6] The complainants also submit that the hospital "committed fraud." I understand this to mean that the complainants believe the hospital intentionally included incorrect information in their daughter's records. The complainants' disagreement with some of the information contained in the records does not support or establish that the hospital intentionally included incorrect information in the records.

[18] Regarding corrections 9 and 11, the complainants assert that a CT Screening Form should have been completed for their daughter, and that its absence from the records establishes that informed consent was not obtained and that the records are incorrect. The complainants provide a blank copy of a CT Screening Form asserting that it is a mandatory form that must be completed by the patient, and accusing the hospital of failing to provide one to them. They contend that their daughter did not require a CT scan; that all of the tests prior to the CT scan were normal and did not support a CT scan procedure. They allege that the hospital deliberately changed the PHI in the records to support the justification of a CT scan.

[19] Section 55(8) requires the complainants to demonstrate "to the satisfaction" of the hospital "that the record is incomplete or inaccurate for the purposes for which" the hospital "uses the information." The hospital's decision to deny corrections 5 through 11 and its reasons for doing so, indicate it does not accept that these particular parts of

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[6] The complainants assert that Dr. C did not examine their daughter in their submissions on this issue, but they confirm that Dr. C did see their daughter in their submissions on correction 10.

the records are incomplete or inaccurate and that the complainants have not satisfied it as required under section 55(8). Having reviewed the records, I agree with the hospital's decision. The hospital has provided clear explanations for why it believes the records are accurate and complete for its purposes. The complainants have not provided any evidence, other than their own assertions, to doubt the accuracy or completeness of the records at issue in corrections 5 through 11. A correction request cannot be a substitution of the hospital staff's notes for the complainants' opinions and views on what should have been documented in the records when the records are not inaccurate or incomplete. I accept the hospital's explanations and its position that these parts of the records are accurate and complete for its purposes. No review of the hospital's denial of requested corrections 5 through 11 is warranted.

Allegations that do not raise issues of incompleteness or inaccuracy within the meaning of section 55(8)

[20] The remaining issues the complainants raise in this complaint do not appear to be correction requests. These issues include their assertions that:

- hospital staff did not ensure that their daughter was well hydrated (a requirement noted in the CT Request Form) and that this was not noted in the records
- they were told by Dr. C that their daughter could not eat or drink anything despite the hydration requirement noted in the CT Request Form
- because all of the medical tests prior to the CT scan were normal, a "Priority 1" request for a CT was not warranted
- the hospital did not measure their daughter's height and weight, but rather, relied on the estimated measurements that they provided and recorded these estimates on the CT Request Form
- the records are not in the exact same order in all three copies of records and this inconsistency needs to be corrected
- certain measurements are recorded in the imperial system rather than the metric system and this needs to be corrected
- the obstruction of fax transmission information in one copy of a specific record that does not appear in a different copy of that same record amounts to removal of information from the records which needs to be addressed by the hospital
- the inclusion of page numbering by the hospital on the face of the second and third copies of the records, which was done for administrative purposes, constitutes a change or addition to the records that needs to be addressed

- the printing dates that appear on some pages of the records and that vary for each copy of the records is an inconsistency that needs to be corrected

- the inclusion of additional pages of records between the first copy (comprising 24 pages), the second copy (comprising 32 pages), and the third copy (comprising 39 pages) is an error and an inconsistency that the hospital needs to account for beyond advising the complainants that as additional records became available from various units and staff within the hospital, they were added to their daughter's file.

[21] These issues appear to be requests that the complainants' assertions, impressions and positions be recorded and reflected in the records. Some of these issues relate to the complainants' dissatisfaction with the services provided by the hospital and the treatment decisions made by certain health professionals who attended to their daughter. Such standard of practice and treatment concerns do not fall within the jurisdiction of the IPC.

[22] Further, some of these allegations do not raise issues of incompleteness or inaccuracy within the meaning of section 55(8):

- the complainants' concern that measurements were recorded in the imperial system rather than the metric system even though the complainants were the ones who provided these imperial measurements to the hospital and the hospital recorded them

- the complainants' insistence that the different printing dates that appear on some pages of the records and vary for each copy of the records are inconsistencies, despite the fact that these different printing dates clearly and simply correspond to the date the pages were printed for inclusion in each of the three copies; for example, a printing date corresponding to the timing of the first copy of the records appears on records contained in that copy, while printing dates corresponding to the dates of the second and third copies appear on the records contained in the second and third copies respectively

- the complainants' criticism of the hospital for including additional documentation in the records as they became available following the visit, which is in line with the hospital's obligation under section 11(1) of *PHIPA* to take reasonable steps to ensure that the records are as accurate, complete and up-to-date as is necessary.

[23] With respect to these alleged errors and inconsistencies raised by the complainants, I find that the complainants have not satisfied the onus of establishing that the "record is incomplete or inaccurate for the purposes for which the custodian uses the information" pursuant to section 55(8) of *PHIPA*. There are no reasonable grounds to review these remaining issues.

[24] In light of my finding on section 55(8), it is not necessary for me to address the hospital's claim of section 55(9)(b).

Fraud, bias and other issues raised by the complainants

[25] In their submissions to me responding to my letter setting out my preliminary view that a review is not warranted, the complainants argue that the section 55(9)(b) exception does not apply to this complaint and I am incorrect in applying it. They argue that my analysis is flawed. They also argue that I have not conducted an analysis of the corrections made by the hospital. They allege that I failed to consider the content of their submissions relating to "fraudulent information in the PHI." They also accuse me of being "with prejudice" and the IPC of being "in violation of section 57(2)" of *PHIPA.* Finally, they accuse the IPC of "deliberately neglecting [their] concerns about their daughter's worsening health."

Fraud

[26] I addressed the fraud allegation to some extent at paragraph 18 above. As I advised the complainants in my letter, to the extent they are alleging actual fraud, which is an offence under the Criminal Code of Canada, such an allegation is more appropriately investigated and addressed by the police. I also noted to the complainants that if their concern about fraud relates to their allegation that the hospital provided inaccurate records to the College of Physicians and Surgeons of Ontario and/or the College of Nurses of Ontario in response to their complaints to these regulatory bodies, they may direct their concern to these regulatory bodies directly as part of their related complaints. The complainants provide no evidence of fraud other than their own assertions and I will not consider the allegation further.

Section 57(2)

[27] Section 57(2) of *PHIPA* addresses "dealings without prejudice" and states:

> If the Commissioner takes an action described in clause 1(b) or (c) but no settlement is effected within the time period specified,
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> > (a) none of the dealings between the parties to the attempted settlement shall prejudice the rights and duties of the parties under this Act;
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> > (b) none of the information disclosed in the course of trying to effect a settlement shall prejudice the rights and duties of the parties under this Act; and
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> > (c) none of the information disclosed in the course of trying to effect a settlement and that is subject to mediation privilege shall be used or disclosed outside the attempted settlement, including in

> a review of a complaint under this section or in an inspection under section 60, unless all parties expressly consent.

[28] The complainants' reference to section 57(2) is a bald allegation without any details or explanation. No information that would qualify as the type of information captured by sections 57(2)(a), (b) and/or (c) was disclosed to me by the mediator. As noted above, the Mediator's Report, which was prepared at the conclusion of the mediation, was provided to me. The mediator advised the complainants that the Mediator's Report would be provided to me. The mediator also gave the complainants an opportunity to comment on the Mediator's Report and they did not raise any allegations of prejudice or mediation privilege at that time. Without any information on what the complainants allege, I find no violation of section 57(2) of *PHIPA*.

Bias

[29] With respect to their suggestion that I am biased in favour of the hospital, the test for a reasonable apprehension of bias, as recently confirmed by the Supreme Court of Canada in *Yukon Francophone School Board v Yukon (Attorney General)*,[7] is undisputed and was first articulated by the Supreme Court of Canada as follows:

> [W]hat would an informed person, viewing the matter realistically and practically – and having thought the matter through – conclude. Would he think that it is more like than not that [the decision-maker], whether consciously or unconsciously, would not decide fairly.[8]

[30] At paragraph 25 of the *Yukon* ruling, the Court stated:

> Because there is a strong presumption of judicial impartiality that is not easily displaced (*Cojocaru v. British Columbia Women's Hospital and Health Centre*, 2013 SCC 30 (CanLII), [2013] 2 S.C.R. 357, at para. 22), the test for a reasonable apprehension of bias requires a "real likelihood or probability of bias"[.]

[31] Applying this test to the circumstances of this complaint, I find that the complainants have not displaced the presumption of impartiality in administrative decision-making. The complainants' allegations amount to a disagreement with my preliminary assessment to not conduct a review of their complaint. This is not sufficient to ground an allegation of a reasonable apprehension of bias. As expressed in my letter, my assessment was preliminary only. I explained the reasons for my preliminary assessment to the complainants and provided them with the opportunity to respond to

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[7] 2015 SCC 25 (CanLII) at para 20 (*Yukon*).

[8] *Committee for Justice and Liberty v National Energy Board*, [1978] 1 SCR 369, at p 394, per de Grandpre J. (dissenting). The test was subsequently endorsed and clarified by the Supreme Court, for example, in *Wewaykum Indian Band v Canada*, [2003] 2 SCR 259, at para 60 and *Baker v Canada (Minister of Citizenship and Immigration)*, [1999] 2 SCR 817, at para 46, among others.

it. As an inquisitorial body, the IPC has found it practical to provide parties with its preliminary views so that parties have the opportunity to comment and provide representations. This is done to ensure that parties to IPC proceedings, which are generally conducted in writing, get a full appreciation of the issues in dispute and are afforded natural justice. The complainants have been given due process in this matter. An informed person, viewing the matter realistically and practically and having thought the matter through, would not find it likely that I would be unfair in deciding this complaint based solely on the fact that I formed a preliminary assessment. Accordingly, I dismiss the complainants' bias arguments.

Other issues

[32] The complainants complain about the use of correction fluid on the Authorization to Release Information Contained in the Clinical Record; specifically, that the hospital corrected the record improperly by not preserving the original content of it through its use of correction fluid. In response, the hospital confirmed that the use of correction fluid is not a permitted practice and that it followed up with the staff member about this improper action to ensure that the staff member understands and will follow the proper correction procedure. I addressed this issue in PHIPA Decision 38 which resulted from another complaint brought by the complainants, and therefore, I need not address it again here.

[33] The complainants also complain that the Discharge Advice from the Emergency Department is missing from the records and that their copy of it contains statements they allege are erroneous. The hospital advised the complainants that it does not have a copy of this document and it asked them for a copy of it so that it may consider their correction request. I invited the complainants to provide a copy of this record if they wish to pursue their correction request for this record, however, they did not. Without a copy of the record, I am not able to address any concerns the complainants may have about this record.

[34] Finally, I do not accept the complainants' attempt to link the IPC's processing of the complaint (and the two other complaints that the complainants filed with the IPC about the same single hours-long hospital visit) to their daughter's health. There is no evidence to support the complainants' contention that their daughter cannot receive appropriate medical treatment until the alleged errors are corrected, and I will not address this issue further.

Conclusion

[35] Sections 57(3) and (4)(a) set out my authority to decline to review a complaint as follows:

> 57(3) If the Commissioner does not take an action described in clause 1(b) or (c) or if the Commissioner takes an action described in one of

> those clauses but no settlement is effected within the time period specified, the Commissioner may review the subject-matter of a complaint made under this Act if satisfied that there are reasonable grounds to do so.
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> 57(4) The Commissioner may decide not to review the subject-matter of the complaint for whatever reason the Commissioner considers proper, including if satisfied that,
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> (a) the person about which the complaint is made has responded adequately to the complaint[.]

[36] In accordance with my authority under sections 57(3) and (4)(a) of *PHIPA* and for the reasons set out above, I decline to review this complaint because there are no reasonable grounds to commence a review of the subject matter of the complaint and the hospital adequately responded to the complaint. I issue this decision in satisfaction of the notice requirement in section 57(5) of *PHIPA.*

[37] The complainants retain the statutory right under section 55(11) of *PHIPA* to submit a concise statement of disagreement setting out the corrections that the hospital has refused to make and require the hospital to attach the statement to the records.

NO REVIEW:

1. For the foregoing reasons, no review of this matter will be conducted under Part VI of *PHIPA.*

Original Signed By: May 5, 2017

Stella Ball
Adjudicator