Information and Privacy Commissioner,
Ontario, Canada

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

# PHIPA DECISION 67

Complaint HA17-18

Toronto Central Local Health Integration Network

January 16, 2018

**Summary:** The complainant submitted a 62-part correction request under the *Personal Health Information Protection Act* to the Toronto Central Local Health Integration Network (the custodian). The custodian agreed to make two of the requested corrections but denied the remainder. The custodian denied 15 of the requested corrections under section 55(8) and 45 under section 55(9)(b). The complainant appealed the custodian's decision to this office. The adjudicator finds the complainant failed to establish a right of correction under section 55(8) for some of the information at issue. The adjudicator also finds that the remaining information the complainant seeks to correct constitutes the good faith professional opinions or observations of the individuals preparing the report and the exception under section 55(9)(b) applies to it.

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

**Decisions Considered:** PHIPA Decisions 36, 37 and 39.

## BACKGROUND:

[1] In October 2016, the complainant, represented by her sibling, sought correction under the *Personal Health Information Protection Act* (*PHIPA* or the *Act*) to her personal health information held by the Toronto Central Local Health Integration Network, formerly known as the Toronto Central Community Care Access Centre (the custodian or CCAC). In her request, the complainant identified 62 items she believes the custodian should correct.

[2] On December 16, 2016, the custodian issued a response to the correction request stating,

> The large majority of your requests relate to a RAI ["Resident Assessment Instrument"] Assessment (also known as the Home Care MDS report) conducted by the social worker on September 4, 2013. The assessment was based upon the social worker's good faith opinions, findings, observations, and information received from [the complainant's] family members who were involved in her care at the relevant time, which is normal procedure during a RAI assessment.
>
> ….
>
> Under section 55(9)(b) of the *Act*, an exception to a duty to correct exists where the record of personal health information consists of a professional opinion that a custodian has made in good faith about an individual. We rely upon this section in response to the majority of your requests as set out in the attachment.

[3] The custodian provided the complainant with a detailed list of her 62 requested corrections and its corresponding response to each concern. Of the 62 items, the custodian denied 15 on the basis of section 55(8) and 45 were denied on the basis of section 55(9)(b) of the *Act*. The custodian agreed to correct two references in the records under section 55(10)(a)(i)(A) of the *Act*.

[4] The complainant filed a complaint to this office. A mediator was appointed to seek a resolution. During mediation, the complainant identified the following reasons for her correction request:

- The records at issue are inaccurate and, while certain records may consist of professional opinions, they were not made in good faith
- The custodian did not act in good faith
- There was "serious carelessness" on the part of the custodian
- The custodian's decision letter contained "false and misleading information"

[5] The custodian claimed the complainant did not demonstrate to its satisfaction that the records are incomplete or inaccurate for the purposes for which it uses the records. In addition, the custodian confirmed its position that the records contain professional opinions or observances made in good faith. Accordingly, the custodian advised the mediator it would not change its decision.

[6] The complainant confirmed she was not satisfied with the custodian's decision and would like it to correct the records in accordance with her original request.

[7] The complaint was not resolved at mediation and it was transferred to the adjudication stage of the complaints process where an adjudicator may conduct a review. I decided to conduct a review and began by providing the custodian with the opportunity to make submissions in response to the issues set out in a Notice of Review. The custodian submitted representations.

[8] I then invited the complainant to make submissions in response to the Notice of Review and the custodian's representations, which were shared in full. The complainant submitted representations.

[9] In this decision, I uphold the custodian's decision to not make the requested corrections because the custodian is not required to correct the information under section 55(8) or the good faith professional opinion and observation exception at section 59(9)(b) applies.

## RECORDS:

[10] The complainant identified the following records to be the subject of her correction request:

- Program Assignment Tool
- Minimum Data Set Home Care (MDS Report)
- "Trigger Listing & CAP Information" (Section V: Client Assessment Protocol Summary of the MDS Report)
- Personal Health Profile
- MAPLe Report
- Client Notes Report
- Informed Decision-Making and Capacity Evaluation Guide for Admission to a Long-Term Care Home, specifically Part C: Analysis Table, Part D: Rights Information and Part E: Additional Comments
- Behavioural Assessment Tool
- Report dated November 28, 2013

## DISCUSSION:

[11] As a preliminary matter, I confirm that the custodian is a *health information custodian* as defined in section 3(1) of the *Act*. Further, there is no dispute that the

information the complainant seeks to be corrected is her *personal health information*, within the meaning of section 4(1) of the *Act*.

**Does the custodian have a duty to make the requested corrections under section 55 of the *Act*?**

[12] 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] In this case, the complainant, represented by her sibling, requests corrections to her personal health information.

[13] Section 55(8) of the *Act* provides for a right of correction to records of personal health information in some circumstances. This section states,

> The health information custodian shall grant a request for 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.

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

> 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.

[15] 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).

[16] In all cases where a complaint regarding a custodian's refusal to correct records of personal health information is filed with this office, the individual seeking the correction bears 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). As

[1] See section 1(c) of the *Act*.

previously stated, section 55(8) requires the individual requesting a correction to:

- 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

- Give the custodian the information necessary to enable the custodian to correct the record.

If the above is established, I must decide whether any of the exceptions in section 55(9) apply in the circumstances of this appeal.

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

[18] The custodian submits it met its duty to make corrections under section 55 of the *Act*. The custodian confirms that it made two corrections to the records but that the remaining corrections are not required. The custodian submits the requested corrections that are the subject of this complaint are not necessary because

1. The corrections do not relate to information upon which the custodian will rely; and

2. The information at issue is accurate and/or constitutes professional opinions and observations made in good faith.

[19] The custodian states the records "largely relate" to a 2013 RAI assessment of the complainant's care needs and capacity evaluation with respect to a care facility. The custodian states that the two primary records at issue are an assessment and a capacity evaluation. The custodian states a CCAC social worker conducted the assessment and evaluation in September 2013 and created the associated documents to assist their assessment of the complainant's community care needs and possible long-term placement.

[20] The custodian states the RAI is a standardized, evidence-based assessment tool used to assess the care needs of adult patients in hospital and community settings for in-home and placement services since 2002. The custodian states the RAI is used across all CCAC's and it measures an individual's functioning and quality of life by assessing their needs, strengths, preferences and facilitates referrals when appropriate. The custodian states a health professional bases the RAI on their observations and information provided by both the client and family members who reside with the client

and/or assist with the client's care.

[21] In this case, the custodian submits that the social worker based the RAI on their good faith opinions, findings, observations and information the complainant's family members provided. The custodian states that the family members who provided information were involved in the complainant's care at the relevant time.

[22] The custodian also submits that the capacity evaluation was conducted as part of the consideration for admission to long-term care. The custodian states an evaluation of capacity with respect to the admission to a care facility under the *Health Care Consent Act* is distinct from an assessment of capacity performed by an assessor under the *Substitute Decisions Act*. Further, when a power of attorney requires a physician to assess capacity for physical care, this requirement does not apply to capacity evaluations under the *Health Care Consent Act* regarding capacity to make an admission decision, which may be performed by any member of a health professional college.

[23] The custodian states that the complainant disputed the decision-making process around the capacity evaluation. However, the custodian submits that one internal review and two independent reviews, one conducted by the Ministry of Health and Long-Term Care and the other by an independent legal specialist the CCAC retained, concluded the decision-making and assessment process were appropriate.

[24] The CCAC also notes that the records are

> … point-in-time specific, meant to be accurate at the time they were recorded. They do not purport to be accurate for any other point in time and, as is the case with every TC CCAC client, do not preclude a change in the [complainant's] circumstances or status over time. If the [complainant] were to require an assessment in the future, a new assessment would be conducted at that time and the TC CCAC would not rely on the opinions or observations recorded in 2013.

[25] The CCAC attached a complete summary of the information subject to the complainant's correction request and the CCAC's response to each of her 62 requested corrections. To summarize, the CCAC submits that some of the corrections are not required under the *Act* because the records are no longer in use and will not be used again. The custodian refers to PHIPA Decision 36, which states,

> 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.[2] [emphasis added by the custodian]

The CCAC reiterates that the records at issue are subject to a specific assessment for a specific time and will not be relied upon again. The custodian states the only purpose the records now serve is to document the assessments as they were conducted in 2013. Therefore, the CCAC submits that modifying the records now by including the complainant's corrections will distort the records.

[26] In any case, the custodian submits that even if the information was relevant and relied upon, the duty to correct does not apply in this case because the information is either accurate or constitutes professional opinion and/or observations made in good faith. The custodian submits the complainant's requested corrections amount to disagreement with the information and opinions shared by the third parties. The custodian submits the social worker dutifully recorded the information shared with her. As such, the information should not be subject to correction under the *Act*.

[27] The custodian submits that section 55(9)(b) applies to 45 of the requested corrections. The custodian submits the social worker made observations and collected information before forming professional opinions. The custodian states the social worker documented these opinions in detail in the records. Finally, referring again to PHIPA Decision 36, the custodian submits that the complainant is attempting to use the *PHIPA* correction mechanism to substitute her opinion for the social worker's professional opinion from 2013. The custodian submits this is inappropriate and outside the scope of the *Act*.

[28] Despite this position, the custodian indicates it is willing to attach a statement of disagreement to the health record pursuant to section 55(11) of the *Act*.

[29] In her representations, the complainant maintains her position that the records contain incorrect information and the custodian should correct it. The complainant, through her representative, submits that she is a vulnerable individual victimized by the false information contained in her personal health records. The complainant submits that the incorrect health information resulted in her being "forced" into a long-term care institution. The complainant states she is "deeply concerned" that the information contained in the personal health records will expose her to "potential medical mistreatment and harm should it be relied upon in the future" if it is not corrected.

[30] In response to the CCAC's claim that it no longer uses the records, the complainant submits the personal health records at issue are used by the CCAC to maintain an accurate record of her health status, health assessments and health care plan in 2013. The complainant submits the CCAC continues to *use* the information because it is the custodian of the information. The complainant submits that her

[2] PHIPA Decision 36 at para. 29.

requests are not "corrections of inconsequential bits of information." Rather, the complainant submits she seeks "important corrections that will have a significant impact on the purpose of the record and its accuracy." In addition, the complainant submits the custodian continues to *use* the information for the purposes of maintaining an accurate record.

[31] The complainant submits the CCAC did not act in good faith. Rather, the complainant submits the CCAC's conduct was "seriously careless and/or reckless" during the creation and modification of her health records. The complainant identifies incidents in which, she submits, the CCAC or its representatives were reckless, and attached an appendix with a detailed account of each incident. Similarly, the complainant identifies a number of incidents or situations in which, she submits, the CCAC or its representative "acted with serious carelessness" and failed to comply with professional standards or established policies. Moreover, the complainant submits that a CCAC assessor deliberately recorded incorrect information in her health records.

[32] The complainant provided a number of documents to support her position, including an itemized list of her correction requests, a timeline of her correction requests and this complaint and other information. The complainant submits that this information supports her position that the records at issue are "subject to continued use." With regard to the itemized response to each requested correction, the complainant submits the CCAC failed to respond in detail. Instead, the complainant submits the CCAC made "generic statements" and did not fully consider her request.

[33] Finally, regarding the statement of disagreement offered by the custodian, the complainant submits this is not a satisfactory compromise. The complainant submits that medical practitioners will be compelled to give weight and consideration to the assessment, opinions and observations contained in these records if the institution does not correct them. The complainant, through her representative, reiterates that she suffered significant harm due to the incorrect information contained in the records.

## Analysis and Findings

[34] I reviewed and considered the correction requests, the custodian's decision and the parties' submissions. I find the CCAC is not required to grant the correction requests that remain at issue in this complaint.

### *Section 55(8)*

[35] The CCAC denied 15 of the complainant's concerns under section 55(8). I reviewed and considered these items and the evidence before me. In my view, the complainant did not provide sufficient evidence to support her correction requests and did not establish that the portions of the records she wishes to have corrected are "incomplete or inaccurate for the purposes for which the custodian uses the information" as required by section 55(8) of *PHIPA*.

[36] PHIPA Decision 36 sets out the approach to be applied when interpreting section 55(8) of *PHIPA*. Specifically, the adjudicator states,

> 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.
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> 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 [personal health information] 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.

The adjudicator then found that not all personal health information contained in records held by a health information custodian needs to be accurate in every respect. The adjudicator also found that where the health information custodian does not rely on the information for a purpose relevant to the accuracy of the information, it is not required to correct the information.

[37] The approach in PHIPA Decision 36 has been adopted in subsequent decisions[3] and I will adopt it here. Applying PHIPA Decision 36 to the circumstances of this complaint, I find that the custodian is not required to make the corrections requested by the complainant. Specifically, I find the complainant did not demonstrate that the records are incomplete for the purposes for which the CCAC uses the information.

[38] In my view, the majority of the corrections at issue amount to clarifications or disagreements in opinion between the complainant and the individual who created the record. For example, the complainant requests a number of corrections to a Program Assignment Tool. However, the CCAC indicates a third party provided this information during a telephone assessment and the CCAC representative took the notes accurately. Based on my review of the requested corrections and the record, it appears the complainant wishes to substitute the third party's opinion with her own. Given these circumstances and in the absence of evidence that the CCAC representative did not record the call properly, I find the CCAC is not required to make the requested

[3] See PHIPA Decisions 41 and 59 for examples.

corrections under section 55(8).

[39] Similarly, the complainant requests a number of corrections or updates on a November 28, 2013 report. However, as the CCAC indicates in its decision, the information contained in the report was accurate at the time and cannot be updated to reflect information that was available afterwards. Therefore, I find the custodian does not have a duty to correct the records under section 55(8) of *PHIPA*.

[40] In addition to providing individuals with a right to access to their personal health information, the *Act* gives individuals the right to attach a statement of disagreement to the records conveying their disagreement with any information contained in them. The custodian offered this option to the complainant, but she rejected it. In any case, I confirm this option is available to the complainant.

### *Section 55(9)(b)*

[41] The custodian denied 45 of the complainant's correction requests under section 55(9)(b) of *PHIPA*. I reviewed the 45 concerns, the records and the parties' submissions. Based on this review, I find that section 55(9)(b) applies to the information subject to the 45 requested corrections. 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 adjudicator in PHIPA Decision 39 considered the application of section 55(9)(b) and states as follows:

> 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.
>
> 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**.[4] [emphasis added]

[42] The determination of whether the exception at section 55(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."

[4] PHIPA Decision 39 at para. 26-27.

*Does the PHI qualify as a "professional opinion or observation"?*

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

[44] A social worker conducting an assessment and capacity evaluation of the client prepared the information subject to the complainant's requested corrections. Much of the information the complainant seeks to have corrected consists of the social worker's observations, assessments and opinions regarding the complainant's skills, behaviours and capabilities. Also included are the social worker's record of information provided by other individuals involved in the complainant's assessment and capacity evaluation. I reviewed the records along with the submissions of the parties and am satisfied that the social worker who prepared the information subject to the complainant's requested corrections applied their professional knowledge and skills in making the observations, assessments and opinions the complainant seeks to have corrected.

[45] Accordingly, I find that the 45 correction requests subject to section 55(9)(b) qualify as a social worker's professional opinions or observations within the meaning of that section. The complainant's correction requests, in effect, seek to substitute or rewrite the social worker's opinions or observations contained in their assessments and evaluations. Given my findings, the complainant has no right to a correction unless she can establish the professional opinions or observations in question were not made in good faith.[5]

[46] I must now consider whether the professional opinions or observations contained in the records at issue were made in good faith.

*If the PHI qualifies as a "professional opinion or observation", was it made "in good faith"?*

[47] 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 acted in the absence of good faith to rebut the presumption of good faith.[6] Accordingly, in the context of section

[5] This finding is consistent with the approach taken in PHIPA Decisions 36, 37, 39 and 43.
[6] *Finney v. Barreau du Québec*, [2004] 2 SCR 17, 2004 SCC 36.

55(9)(b), the burden rests on the individual seeking the correction to establish that the custodian did not make the professional opinions or observations in good faith.

[48] The complainant takes the position that the custodian acted in bad faith in preparing and maintaining the records. She submits that the CCAC's conduct was "seriously careless and/or reckless" during the creation and modification of the complainant's health records. The complainant identifies incidents in which, she submits, the CCAC or its representatives were reckless, and attached an appendix with a detailed account of each incident. Similarly, the complainant identifies a number of incidents or situations in which, she submits, the CCAC or its representative "acted with serious carelessness" and failed to comply with professional standards or established policies. Moreover, the complainant submits a CCAC assessor deliberately recorded incorrect information in her health records.

[49] The custodian submits that the professional opinions and observations were made in good faith. To support its claim, the custodian states that it conducted an internal review, and that the Ministry of Health and Long-Term Care and an independent legal specialist each conducted independent reviews of the CCAC's decision-making process regarding the complainant's assessment and evaluation. The CCAC states the reviews concluded that the decision-making and assessment process were appropriate.

[50] I reviewed the parties' submissions and the information subject to the complainant's correction requests. I find the complainant did not provide me with sufficient evidence to establish that the custodian and specifically the social worker made professional opinions or observations in bad faith. The complainant makes a number of allegations regarding the CCAC's recklessness, carelessness and misrepresentations. I reviewed the complainant's allegations, but find she did not provide sufficient evidence to support them. In my view, the complainant's allegations relate to her desire to substitute or rewrite the professional opinions or observations contained in the records at issue. Furthermore, with respect to certain allegations she made in relation to a specific social worker, the custodian advises that the ministry and an independent external reviewer reviewed this individual's evaluation and concluded it was appropriate. Based on the evidence before me, I find there is insufficient evidence to rebut the presumption of good faith. There is no evidence of malice, intent to harm, serious carelessness or recklessness on the part of the social worker who conducted the client's assessment and capacity evaluation in 2013.

[51] In summary, the 45 requested corrections denied by the custodian on the basis of section 55(9)(b) contain the good faith professional opinions and observations of the individuals who prepared the records at issue. Accordingly, the exception under section 55(9)(b) applies to the information that is the subject of these 45 requested corrections. This means that even if the complainant were to establish that the information was inaccurate or incomplete for the purpose for which it is used by the custodian, the custodian is not obligated to make the requested corrections under

section 55(8).

## NO ORDER:

1. For the foregoing reasons, no order is issued

Original signed by: January 16, 2018

Justine Wai
Adjudicator