Information and Privacy Commissioner,
Ontario, Canada

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

PHIPA DECISION 103

Complaint HA19-00081

A Hospital

November 4, 2019

Summary: The complainant submitted a correction request under section 55(1) of the *Personal Health Information Protection Act* to a hospital with respect to information related to her admission to the hospital. The hospital denied the correction request citing section 55(9) of the *Personal Health Information Protection Act*. The adjudicator finds that no review is warranted in accordance with sections 57(3) and 57(4)(a).

Statutes Considered: *Personal Health Information Protection Act, 2004*, sections 3(1), 4(1), 55(8), 55(9), 57(3) and 57(4)(a).

BACKGROUND:

[1] This decision addresses the hospital's denial of requests under section 55(1) of the *Personal Health Information Protection Act* (*PHIPA*) for correction of the complainant's records of personal health information (PHI) relating to her admission to the hospital.

[2] After receiving access to the Form 1, ED Note – Physician,[1] and Discharge Summary, the complainant requested that the hospital remove any reference describing her as delusional or paranoid in the records. The complainant submitted three separate correction requests to the hospital over a short period of time, each time seeking similar

[1] Emergency Department notes prepared by the attending physician.

corrections.

[3] The hospital responded by issuing one decision to the complainant denying the three correction requests citing section 55(9)(b). In its decision, the hospital stated:

> [the] Request to Correct Personal Health Information has been denied by [names of two doctors] for the following reason:
>
> > *Consists of a professional opinion or observation that a custodian has made in good faith about the individual – PHIPA 55(9)(b)*

[4] The hospital also advised the complainant that it would attach a Statement of Disagreement and provided her a blank form on which to write that statement.

[5] The complainant filed a complaint with this office and a mediator was assigned. However, the parties were unable to reach a settlement and the matter was transferred to the adjudication stage of the complaint process.

[6] After reviewing the complaint file,[2] I sent a letter to the complainant advising her that my preliminary view was that her complaint did not warrant a review under sections 57(3) and (4) and gave her an opportunity to provide representations.

[7] In response, the complainant submitted written representations questioning the conduct of the emergency department doctor and police who brought her to the hospital. The complainant argues that the conduct of these individuals led to her being held at the hospital overnight against her will. The complainant advises that she filed complaints with the Ontario Independent Police Review Director (OIPRD) and the College of Physicians and Surgeons Ontario (CPSO). The complainant also advises that she has contacted the Ministry of Health to discuss her concerns about her admission to the hospital.

[8] My jurisdiction is limited to matters relating to the complainant's correction request filed under *PHIPA*. Accordingly, I do not have the jurisdiction to, nor will I, make any comments or recommendations regarding the conduct of the police officers or doctors referred to in the complainant's submissions.

[9] After reviewing the complaint file along with the complainant's submissions, I find that there are no reasonable grounds for a review under section 57(3) and 57(4)(a) because the complainant has not met the initial onus of establishing a right of correction under section 55(8). In any event, even if the complainant had satisfied the

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[2] The complaint file includes documents the complainant submitted to this office with her complaint form including her statement of disagreement, a letter from her family doctor and a three-page email entitled Appendix A containing her written submissions.

onus under section 55(8), I find that the "professional opinion or observation" exception at section 55(9)(b) applies and that the hospital adequately responded to the complaint.

DISCUSSION:

Should the complainant's correction complaint proceed to a review under *PHIPA*?

[10] I have the authority under sections 57(3) and (4) of *PHIPA* to decide whether this office should conduct a review of a complaint. These provisions state, in part:

> (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.
>
> (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,
>
> (a) the person about which the complaint is made has responded adequately to the complaint;

[11] There is no dispute that the information the complainant seeks to correct constitutes her 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] There is also no 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 her health records before making her correction request.

[13] The sole issue in this complaint is whether the hospital has a duty to correct the

complainant's PHI in the records. 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.

[14] Section 55(9)(b) of *PHIPA* sets out the relevant exception to the obligation to correct records of PHI in this complaint, as follows:

> Despite subsection (8), a health information custodian is not required to correct a record of personal health information if, … 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 PHI. The purpose of section 55 of the *PHIPA* is to impose a duty on health information custodians to correct records of PHI that are inaccurate or incomplete for the purposes for which they use the information, subject to the exceptions set out in section 55(9) of the *PHIPA*.

Analysis and Decision

The complainant has not discharged the onus in section 55(8)(a)

[16] 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).

[17] 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] Previous decisions from this office have found 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.[3]

[20] In addition, this office has found that the custodian is not required to grant the correction request if the individual seeking the correction does not provide the custodian with the information necessary to enable it to correct the record.[4]

[21] In this matter, the complainant has requested that any references in the records describing her as delusional or paranoid be removed from the records. The complainant submits that the police arrived at her residence on a non-emergency call and took her to the hospital against her wishes. She submits that this started a chain of events which resulted in her spending two days in a psychiatric ward. The complainant submits that while she was at the hospital, the attending emergency doctor spoke to the police, instead of her. In her submissions, the complainant stated:

> Because of the lies the police told, the ER doctor completed a Form 1[5] me, and I was put in restraints even though I never resisted. I was put in the psych ward, and because the "shrink" was busy it took two days to get out. The shrink called my family doctor and he released me in fifteen minutes.

[22] In support of her position, the complainant provided a copy of a letter from her family doctor that predates the day the police attended her residence and took her to the hospital. The letter indicates that the complainant was diagnosed with a specific disorder. The complainant submits that she provided the police with a copy of this letter when they attended her residence but they took her to the hospital anyway. It appears that the complainant is arguing that her disorder could explain some of the behaviors the police reported observing. However, it does not appear that the letter addresses issues relating to the complainant's mental health.

[23] I have reviewed the complaint file, the complainant's submissions[6] records themselves and find that the requested corrections need not be made because the complainant has not established that those portions of the records are "incomplete or inaccurate for the purposes for which the hospital uses the information" as required by section 55(8).

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[3] PHIPA Decisions 36, 39 and 40.
[4] PHIPA Decisions 36 and 39.
[5] Form 1 is an "Application by Physician for Psychiatric Assessment." The Form 1 allows a doctor to hold an individual in a psychiatric facility for up to 72 hours in order for the individual to undergo a psychiatric assessment.
[6] This includes the complainant's submissions in response to my letter and materials filed with her complaint form.

[24] In my view, the bulk of the evidence submitted by the complainant addresses issues related to the services she received from the police. The complainant submits that the police erroneously assessed the situation when they attended her residence and then subsequently provided incorrect information to the emergency doctor. The complainant raises questions about the emergency doctor's conduct because he did not allow her to speak for herself during his examination. However, as noted above, I do not have the jurisdiction to address issues relating to the police's or doctor's conduct.

[25] In making my decision, I also considered the circumstances of the complainant's admission to the hospital. The complainant does not dispute that the police brought her to the hospital under the authority of the *Mental Health Act*. In Ontario, the *Mental Health Act* permits police officers to apprehend individuals if the officer has reasonable grounds to believe that a person is acting in a disorderly manner and is a threat *or* at risk of causing harm to themselves or others. Once the apprehension is made, the officer escorts the individual to an examination by a physician, typically to a hospital emergency department. In this case, the emergency doctor subsequently placed the complainant in a psychiatric hold to allow time for her to undergo a psychiatric assessment.

[26] The records consist of the Form 1 and ED Note prepared by the emergency room doctor and the Discharge Summary prepared by the hospital psychiatrist. The complainant requests that any reference in the records which describes her as delusional or paranoid be removed from the records. However, the complainant 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) and her submissions do not address this issue. As I noted above, the complainant does not dispute that she was apprehended by the police under the *Mental Health Act* and subsequently placed on a psychiatric hold by the emergency doctor. In my view, the records would be incomplete or inaccurate if they did not contain the doctors' notations about the complainant's mental health status given the circumstances. Having regard to the above, I find that the complainant has not provided sufficient evidence to demonstrate that the records are incomplete or inaccurate for the purposes for which the hospital uses the information.

[27] Having regard to the above, I find that the hospital is not obliged to grant the correction request on the basis that the complainant has failed to establish that the record is incomplete or inaccurate for the purpose for which the hospital uses the information. Given my finding, it is not necessary that I also determine whether the complainant provided the hospital with the information necessary to correct the record.

In any event, the "professional opinions or observations" exception in section 55(9)(b) applies

[28] 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.

[29] 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.

[30] 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."

The complainant's PHI qualifies as a "professional opinion or observation."

[31] PHIPA Decisions 36 and 37, which have been adopted in other correction decisions of this office, including PHIPA Decisions 43, 47 and 71, applied established principles of statutory interpretation to the wording used in section 55(9)(b). In PHIPA Decisions 36 and 37, I concluded that for PHI to fit within the exception in section 55(9)(b), it must consist of a "professional opinion" or "professional observation." Accordingly, 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). In addition, there is a temporal consideration to this determination in the sense that the time for assessing whether or not what is recorded accurately reflects the opinions or observations of the professionals whose impressions are set out in the record is the time at which those observations and opinions are recorded, not afterwards or in hindsight. Whatever developments there may have been afterwards, including opportunities to verify the PHI collected, does not determine the first part of the test under section 55(9)(b) of *PHIPA*; that is, whether the PHI consists of "professional opinions or observations."[7]

[32] Accordingly, the question here is whether the PHI the complainant seeks to correct accurately represents the professional opinion or professional observation of the doctors at the time at which those observations and opinions were recorded. In this case, the Form 1, ED Note and Discharge Summary were prepared by an emergency doctor and psychiatrist working at the hospital. I am satisfied that the doctors possessed special qualifications, knowledge, judgment and experience in medicine. In addition, I am satisfied that they applied their professional knowledge in documenting

[7] PHIPA Decision 71.

their examination of the complainant. Accordingly, I find that the doctor's observations describing the complainant as delusional and/or paranoid were derived from the exercise of their professional knowledge and judgment and that they constitute "professional opinions and observations" for the purpose of section 55(9)(b). In my opinion, the complainant's request to correct this information seeks to substitute or rewrite the doctor's opinions or observations about her in the records.

The "professional opinion or observation" was made "in good faith."

[33] 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 not acted in good faith to rebut the presumption of good faith.[8]

[34] In her submissions, the complainant raised a number of complaints relating to how she was treated by the police and the emergency doctor. She also advised that she filed complaints with the relevant regulatory bodies. While the complainant's submissions persuasively convey that the events leading up to her apprehension by the police and admission to the hospital under a psychiatric hold were traumatic for her, the evidence that she filed complaints is not sufficient, on its own, to rebut the presumption of good faith on the part of the doctors who prepared the medical reports she wants corrected.

[35] Having regard to the complainant's submissions, the circumstances of the complaint and the records themselves, I conclude that there is not sufficient evidence before me to support a finding that the emergency doctor and psychiatrist acted in bad faith. As there is no evidence of malice, intent to harm, serious carelessness or recklessness on the part of these doctors, I find that the exception to the duty to correct at section 55(9)(b) applies in the circumstances of this complaint and that the hospital was not required to correct the complainant's record of PHI.

Decision

[36] As set out above, sections 57(3) and 57(4)(a) set out my authority to decline to review a complaint. For the reasons stated above, I have decided not to review this complaint on the basis that there are no reasonable grounds to do so as the complainant has not met the initial onus under section 55(8). In any event, even if the complainant had satisfied the onus under section 55(8), I am satisfied that the exception at section 55(9)(b) applies and I am satisfied that the hospital has responded

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

adequately to the complaint.

[37] I issue this decision in satisfaction of the notice requirement in section 57(5).

NO REVIEW:

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

Original Signed By: November 4, 2019
Jennifer James
Adjudicator