Information and Privacy Commissioner,
Ontario, Canada

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

PHIPA DECISION 131

Complaint HA18-38

A Hospital

October 8, 2020

Summary: The complainant submitted a correction request under section 55(1) of the *Personal Health Information Protection Act* (*PHIPA*) to a hospital regarding a report created as a result of her visit to the hospital's emergency room. The hospital denied the correction request citing sections 55(8) and 55(9)(b). The adjudicator finds that some of the information the complainant seeks to correct consists of the physicians' good faith professional opinions or observations and as a result the exception at section 55(9)(b) applies to this information. In addition, the complainant failed to establish a right of correction under section 55(8) for the remaining information she sought to be corrected. As a result, the hospital is not required to correct any of the record and no order is issued.

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

Decisions Considered: PHIPA Decisions 36 and 37.

BACKGROUND:

[1] The complainant submitted a correction request under the *Personal Health Information Protection Act* (*PHIPA*) to the Ottawa Hospital - Civic Campus (the custodian or hospital) seeking a correction to a 4-page Psychiatry Consultation Letter (record) related to visit she made to the hospital's emergency room.

[2] The complainant explained that she attended the hospital's emergency room at the suggestion of a police officer after she filed a criminal complaint.

[3] The custodian issued a decision to the complainant denying her request to correct the record. The complainant filed a complaint about the custodian's decision to this office and a mediator was assigned to the file.

[4] During mediation, the mediator explored settlement with the parties and the complainant confirmed that she wanted the hospital to make three corrections to the record. The custodian agreed to make two of the requested corrections.

[5] However, the custodian denied the complainant's request to strike out the terms "psychosis or pre-psychosis" on the basis that the "professional opinion or observation" exception in section 55(9)(b) applied. The custodian agreed to attach a Statement of Disagreement to the record in accordance with section 55(13).

[6] At the end of mediation, the complainant continued to take the position that the terms "psychosis or pre-psychosis" should be removed from the record. The complainant also submitted that additional information should be added to the record.

[7] As the parties were unable to reach a settlement, the file was transferred to the adjudication stage of the complaint process and a Notice of Review setting out the facts and issues in the complaint was sent to the parties. In response, the parties provided submissions which were shared in accordance with *Practice Direction Number 3* and the IPC's *Code of Procedure for Complaints under PHIPA*.

[8] In this decision, the hospital's decision not to make the requested corrections to the doctors' professional opinions or observations is upheld as the exception in section 55(9)(b) applies to this information. Accordingly, the hospital is not required to correct this information under section 55(8).

[9] The complainant also failed to establish that the remaining information at issue was inaccurate or incomplete for the purpose of which the information is used, the hospital is also not required to correct this information under section 55(8).

RECORD AND SUMMARY OF CORRECTION REQUEST:

[10] The record at issue is a 4-page Psychiatry Consultation report, dated August 3, 2017. The complainant requests that the terms "psychosis or pre-psychosis" struck out throughout the entire record.

[11] In addition, during the mediation process the complainant requested that several amendments be added to the record. The requested amendments are set out in detail in the Notice of Review I sent to the parties. The amendments seek to add background information regarding various criminal allegations the complainant made against family members referenced in the record. In addition, the complainant requests that additional information about the reason she attended the hospital's emergency room the day in question be added to the record.

DISCUSSION:

[12] There is no dispute, and I agree that the hospital is a health information custodian under section 3(1) of *PHIPA*. Further, the parties agree and I confirm that the record contains the complainant's personal health information (PHI)[1] as defined in section 4(1) of *PHIPA*.

[13] Accordingly, the sole issue before me is whether the hospital is required to make corrections to the record as requested by the complainant.

Does the hospital have a duty to make the requested corrections?

[14] Section 55(8) provides for a right of correction to records of PHI in some circumstances. It states:

> The health information custodian shall grant a request for a correction under subsection (1) if the individual demonstrates, to the satisfaction of the custodian, that the record is incomplete or inaccurate for the purposes for which the custodian uses the information and gives the custodian the information necessary to enable the custodian to correct the record.

[15] Section 55(9) sets out exceptions to the obligation to correct records, as follows:

> Despite subsection (8), a health information custodian is not required to correct a record of personal health information if,
>
> (a) it consists of a record that was not originally created by the custodian and the custodian does not have sufficient knowledge, expertise and authority to correct the record; or
>
> (b) it consists of a professional opinion or observation that a custodian has made in good faith about the individual.

[16] Read together, these provisions set out the criteria pursuant to which an individual is entitled to a correction of his or her records of PHI. The purpose of section 55 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).

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[1] 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,

[17] In all cases where a complaint regarding a custodian's refusal to correct records of PHI is filed with this office, the individual seeking the correction has the onus of establishing whether or not the "record is incomplete or inaccurate for the purposes for which the custodian uses the information" pursuant to section 55(8). Section 55(8) requires the individual asking for correction to:

a. demonstrate to the satisfaction of the custodian, that the record is incomplete or inaccurate for the purposes for which the custodian uses the information, and

b. give the custodian the information necessary to enable the custodian to correct the record.

[18] If the above is established, the question becomes whether or not any of the exceptions that are set out in section 55(9) apply. In this case, the hospital submits that the "professional opinion or observation" exception in section 55(9)(b) applies.

[19] Where the custodian claims that section 55(9)(b) applies, the custodian bears the burden of proving that the PHI at issue consists of a "professional opinion or observation" about the individual. However, once the custodian has established that the information qualifies as a "professional opinion or observation", the onus is on the individual seeking a correction to establish that the "professional opinion or observation" was not made in good faith.

Submissions of the parties

[20] The complainant takes the position that any references in the record using the terms "psychosis or pre-psychosis" to describe her should be removed. The complainant also submits that additional information should be added to the record.

[21] The complainant's submissions focus on her belief that she was misdiagnosed by hospital doctors which led to incorrect or insufficient information being notated in the record. The complainant submits that the combination of her learning disability, other medical conditions and the circumstances under which her mental health was assessed led to an incorrect diagnosis. The complainant's main criticism is that the staff psychiatrist who signed the record was not the doctor who examined her. The complainant states:

> …I believe I did not have adequate time with [the resident doctor] to allow her to fully understand me and explain the matters and the issues I was discussing, and to convey those issues properly to [the staff psychiatrist]. I believe that had [the doctors] taken the time to both meet with me and fully understand the issues and the matters I was speaking about, they would not have made the same incorrect diagnosis.

[22] The complainant went on to state that she has seen various psychologists and psychiatrists and has "never received a diagnosis of psychosis." In support of her position, the complainant provided copies of various medical reports. One of the reports provided by the complainant was a letter from her current psychologist. This psychologist indicates that he would not use the terms "psychosis or pre-psychosis" to describe the complainant. The

letter also collaborates the complainant's submission that she presently has a learning disability and has been diagnosed with other medical conditions.

[23] The hospital submits that neither the staff psychiatrist nor the resident doctor are presently affiliated with the hospital. At the time the record was created, the staff psychiatrist had treated patients at the hospital for over a decade. The hospital stated that the resident was supervised by the staff psychiatrist.

[24] The hospital does not dispute the complainant's recollection that the staff psychiatrist did not meet with her. The hospital notes that the resident, who dictated the record, conducted the examination of the complainant. The hospital also notes that while the record contains the professional opinions and observations of the doctors involved, they did not provide a "diagnosis" of psychosis or use the words "psychosis or pre-psychosis." The hospital states that the record merely contains a sentence which states that the "early stage of a psychotic illness" was suspected. I note that the record also contains another reference to "psychosis" but the term is immediately followed by a question mark.

[25] A copy of the letter from the complainant's current psychologist was provided to the hospital. In response, the hospital stated:

> [The psychologist's] opinion is essentially that the complainant does not present with psychosis.
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> A psychologist's opinion is not demonstrative of bad faith on the part of the [supervising psychiatrist and resident doctor]. The clinicians simply have different opinions, based on different assessments, by clinicians with different training, at different times, and in different contexts.
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> Healthcare professionals frequently differ in their professional opinion.

Analysis and Decision

The section 55(9)(b) exception applies to the doctors' professional opinions or observations

[26] Depending on the circumstances of the correction request, the information that the individual is seeking corrected and the reasons for the custodian's refusal to correct the records, this office may approach the analysis initially under section 55(8) or under section 55(9). In the case before me, I will commence my analysis under section 55(9)(b).

[27] 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.

[28] 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.

[29] 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"

[30] The complainant requests that any reference contained in the record using the terms "psychosis or pre-psychosis" to describe her be removed. The complainant's submissions in support of her position focus on the circumstances of her examination and the reasons she believes that she and the doctors in question were not able to reach a "mutual understanding" about her condition.

[31] PHIPA Decisions 36 and 37, which have been adopted in other correction decisions[2] of this office 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."[3]

[32] Accordingly, the question here is whether the PHI the complainant seeks to correct accurately represents the professional opinions or professional observations of the doctors at the time at which those observations and opinions were recorded. In this case, the complainant attended the hospital's emergency room three years ago and was examined by a fifth year psychiatrist resident. The resident doctor was supervised by the staff psychiatrist and was responsible for dictating the record. Named of the staff psychiatrist and resident are posted on the record and the record contains a notation that the "case was discussed with [the staff psychiatrist]."

[33] I am satisfied that the doctors in question possessed special qualifications,

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[2] See for example PHIPA Decisions 43, 47 and 71.
[3] PHIPA Decision 71.

knowledge, judgment and experience in medicine. In addition, I am satisfied that they applied their professional knowledge in documenting their examination and/or supervision of the examination of the complainant. Accordingly, I find that the notation "early stage of a psychotic illness" or any other reference to "psychosis or pre-psychosis" in the record amounts to an exercise of the doctors' professional knowledge and judgment which constitutes their "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 doctors' opinions or observations about her in the record.

[34] I will now go on to determine whether the doctors' professional opinions or observations contained in the record were made in good faith.

The doctors' professional opinions or observations were made "in good faith"

[35] Court decisions have stated that a finding that someone has not acted in good faith can be based on evidence of malice or intent to harm another individual, as well as serious carelessness or recklessness. The courts have also stated that persons are assumed to act in good faith unless proven otherwise. Therefore, the burden of proof rests on the individual seeking to establish that a person has not acted in good faith to rebut the presumption of good faith.[4]

[36] The complainant argues that the doctors' professional opinions or observations were made in bad faith because the staff psychiatrist did not physically examine her. In addition, the complainant submits that the manner in which the staff psychiatrist refused to meet with her in person after she had questions about the record demonstrates that the he did not act in good faith. Finally, the complainant alleges that the staff psychiatrist relied on information an ex-partner provided him outside the examination room. The complainant states that the fact that the staff psychiatrist "will not work with me, despite his failing to explain why, and his general failure to seek to understand my learning disability and my condition, are not indicative of a good faith opinion."

[37] The complainant appears to take the position that the fact that she was "seen" by a resident doctor as opposed to the supervising staff psychiatrist gives rise to evidence of serious carelessness or recklessness. However, the only evidence offered by the complainant in support of this position is that she thinks they misdiagnosed her.

[38] In addition, the complainant alleges that the staff psychiatrist relied on information from her ex-partner but did not elaborate on what information the staff psychiatrist allegedly collected and how it informed his professional opinion or observation. I also note that the complainant's submissions say little about the resident doctor's role in the creation of the record. Though it is undisputed that the resident doctor conducted the examination and dictated the record, the complainant's submissions focus on the staff psychiatrist's role, which was supervisory in nature.

[39] Having regard to the complainant's submissions, the circumstances of the complaint

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

and the record itself, I see no evidence of malice, intent to harm, serious carelessness or recklessness on the part of these doctors. I conclude that there is insufficient evidence before me to support a finding that the doctors acted in bad faith.

[40] As a result, 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 is not required to correct the professional opinions or observations of the doctors contained in the complainant's record of PHI.

The complainant has not discharged the onus in section 55(8) for the remaining corrections at issue

[41] The remaining corrections requested by the complainant ask the hospital to amend the record by adding further details about various criminal allegations the complainant made against family members. The complainant also requested that additional information about the reason she attended the hospital's emergency room the day in question be added to the record.

[42] As stated above, under section 55(8) of the *Act*, an individual seeking correction to records of personal health information must demonstrate, to the satisfaction of the custodian, that the record is incomplete or inaccurate for the purposes for which the custodian uses the information.

[43] This office's approach in interpreting section 55(8) was set out in PHIPA Decision 36 and has been consistently adopted in other decisions[5] from this office. These decisions hold that not all PHI contained in records held by health information custodians need to be accurate in every respect. These decisions have found that 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.

[44] I have reviewed the complaint file, the additional documentation provided by the complainant along with the record itself, and the complainants' submissions, and find that the remaining corrections need not be made as the complainant has not established that those portions of the record are "incomplete or inaccurate for the purposes for which the hospital uses the information" as required by section 55(8). In my view, the requested remaining corrections seek to correct inconsequential information that has no impact on the purposes for which the hospital uses the information.

[45] Since the complainant has not established the first condition of section 55(8), I find that the hospital is not obliged to correct the remaining 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 fulfilling the second condition of section 55(8).

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[5] See for example PHIPA Decisions 39, 40, 59, 81, and 85.

Summary

[46] I find that information the complainant seeks to correct relating to the doctors' diagnosis consists of the good faith professional opinions or observations of the staff psychiatrist and resident doctor. Accordingly, I find that the exception under section 55(9)(b) applies to this information and the hospital is not obliged to make the requested corrections. Given my finding, it is not necessary that I determine whether the complainant has also met the initial onus under section 55(8) for these corrections.

[47] However, I went on to determine whether the complainant met the initial onus under section 55(8) when considering whether the hospital had a duty to correct the record by adding the background information requested by the complainant. I find the complainant failed to establish that the record was incomplete or inaccurate for the purposes for which the hospital uses the information. As such, the complainant did not meet the initial onus under section 55(8) and the hospital is not required to make the remaining requested corrections.

[48] I note that in the circumstances of this complaint, the complainant already exercised her right to require the hospital to file a Statement of Disagreement and the hospital has confirmed that this has been done.

NO ORDER:

For the foregoing reasons, no order is issued.

Original signed by
Jennifer James
Adjudicator

October 8, 2020