Information and Privacy Commissioner,
Ontario, Canada

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

PHIPA DECISION 135

Complaint HA15-21

Royal Victoria Regional Health Centre

November 30, 2020

Summary: The complainant submitted a correction request to the Royal Victoria Regional Health Centre (the hospital) under section 55(1) of the *Personal Health Information Protection Act* (*PHIPA*), asking that the hospital make 23 corrections to a consultation note prepared by a psychiatrist. The hospital refused to make the requested corrections. The complainant filed a complaint about the hospital's decision to this office, and an adjudicator decided to conduct a review under *PHIPA*. During the review, both the complainant and the hospital claimed, for different reasons, that the hospital may not be a "health information custodian" as that term is defined in section 3(1), with respect to the consultation note. In addition, the complainant claimed that the hospital attached a statement of disagreement to the consultation note without her consent. In this decision, the adjudicator finds that the hospital is the "health information custodian" as defined in section 3(1), with respect to the consultation note. In addition, he finds that the hospital is not required to correct some of the complainant's personal health information in the consultation note because it consists of professional opinions or observations that the psychiatrist made in good faith about the complainant under the exception in section 55(9)(b). He also finds that the hospital does not have a duty under section 55(8) to correct other personal health information in the consultation note because it is not incomplete or inaccurate. Finally, he finds that whether the hospital's decision to attach a statement of disagreement to the consultation note complies with the requirements in section 55(11) is moot because the hospital has agreed to remove it. He dismisses the complaint and no order is issued.

Statutes considered: *Personal Health Information Protection Act, 2004*, ss. 2 (definition of "agent"), 3(1), 3(3), 55(1), 55(3), 55(8), 55(9)(b) and 55(11).

Decisions considered: PHIPA Decisions 15, 36, 37 and 43.

BACKGROUND:

[1] The complainant had two appointments with a psychiatrist at the Royal Victoria Regional Health Centre (the hospital) for a mental health assessment. She explained to the psychiatrist that she was involved in court proceedings and that it was being alleged she suffered from a psychiatric illness. The complainant claimed that she did not have a psychiatric illness and asked the psychiatrist to make a diagnosis to confirm that this was the case.

[2] After seeing the complainant, this psychiatrist eventually prepared a three-page consultation note, which summarizes what the complainant told her and includes the complainant's past medical history, past psychiatric history, family history and personal history. This record also contains two further sections entitled, "Mental Status Exam" and "Impression and Plan."

[3] The complainant obtained access to a copy of the consultation note under the *Personal Health Information Protection Act (PHIPA)*. She then submitted a correction request to the hospital under section 55(1) of *PHIPA*, asking that the hospital make 23 corrections to the consultation note.

[4] In response, the hospital sent a decision letter to the complainant that fully denied her correction request. It further informed her that in accordance with section 55(11)(b) of *PHIPA*, she had the right to request that the hospital treat the information she provided in her correction request as a "statement of disagreement" and have it attached to the consultation note.

[5] Over the next several months, the complainant continued to write to the hospital, asking it to make the requested corrections to the consultation note. In response, the hospital wrote back to her and reiterated its previous decision to deny her correction request. In addition, it wrote a letter to her which stated that ". . . we have attached your signed correction letter to a statement of disagreement and added this package to your personal health record."

[6] The complainant then filed a complaint with this office, which assigned a mediator to assist the parties in resolving the complaint. During mediation, the hospital issued a revised decision letter to the complainant that addressed each of the 23 corrections that she had requested be made to the consultation note. It denied some of the complainant's requested corrections because "there is no missing information" and denied others because the information is "a professional opinion or observation that a custodian has made in good faith about the individual," which is a reference to the exception in section 55(9)(b) of *PHIPA*.

[7] The complainant advised the mediator that she was no longer pursuing part 1 of her correction request. However, she was not satisfied with the hospital's decision to refuse to make the corrections identified in parts 2 to 23 of her request.

[8] This complaint was not resolved during mediation and was moved to the adjudication stage of the complaint process, where an adjudicator may conduct a review. I decided to conduct a review and sought and received representations from both the hospital and the complainant on the issues to be resolved.

[9] It appears that the parties agree that the consultation note is a record of the complainant's "personal health information," as that term is defined in section 4 of *PHIPA*. However, in their representations, both the complainant and the hospital submit, for different reasons, that the hospital may not be a "health information custodian" with respect to the consultation note. Consequently, a preliminary issue that must be resolved in this review is whether the hospital is a "health information custodian," as that term is defined in section 3(1) of *PHIPA*, with respect to that record of personal health information.

[10] The complainant also claims that she informed the hospital that she did not want a statement of disagreement attached to the consultation note. As a result, another issue is whether the hospital's decision to attach a statement of disagreement to the consultation note complies with the requirements in section 55(11) of *PHIPA*.

[11] In this decision, I find that:

- the hospital is the "health information custodian," as that term is defined in section 3(1) of *PHIPA*, with respect to the consultation note prepared by the psychiatrist;
- the hospital is not required to correct the personal health information that the complainant seeks to have corrected in parts 20, 21 and 23 of her request, because it consists of professional opinions or observations that the psychiatrist made in good faith about the complainant under the exception in section 55(9)(b);
- the hospital does not have a duty under section 55(8) to make the corrections to the consultation note requested by the complainant in parts 2 to 19 and 22 of her request because her personal health information is not incomplete or inaccurate; and
- whether the hospital's decision to attach a statement of disagreement to the consultation note complies with the requirements in section 55(11) of *PHIPA* is moot because the hospital has agreed to remove it.

[12] Based on these findings, I dismiss the complaint and no order is issued.

RECORD:

[13] The record that the complainant seeks to have corrected is a three-page

consultation note prepared by a psychiatrist who saw her.

ISSUES:

A. Is the hospital a "health information custodian," as that term is defined in section 3(1) of *PHIPA*, with respect to the consultation note prepared by the psychiatrist?

B. Does the hospital have a duty to make the requested corrections under section 55(8)? Does the exception to the duty to correct at section 55(9)(b) apply to any of the information in the record?

C. Did the hospital's decision to attach a statement of disagreement to the consultation note comply with the requirements in section 55(11) of *PHIPA*?

DISCUSSION:

A. Is the hospital a "health information custodian," as that term is defined in section 3(1) of *PHIPA*, with respect to the consultation note prepared by the psychiatrist?

[14] Section 55(1) of *PHIPA* states that if a "health information custodian" has granted an individual access to a record of their 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.

[15] The duty to respond to a correction request lies on the same "health information custodian." Section 55(3) states:

> As soon as possible in the circumstances but no later than 30 days after receiving a request for a correction under subsection (1), the health information custodian shall, by written notice to the individual, grant or refuse the individual's request or extend the deadline for replying for a period of not more than 30 days if,
>
> > (a) replying to the request within 30 days would unreasonably interfere with the activities of the custodian; or
> >
> > (b) the time required to undertake the consultations necessary to reply to the request within 30 days would make it not reasonably practical to reply within that time.

[16] After being granted access to the consultation note that was prepared by the psychiatrist, the complainant submitted her correction request to the hospital. However,

in their representations, both the complainant and the hospital submit, for different reasons, that the hospital may not be a "health information custodian" with respect to the consultation note prepared by the psychiatrist. In particular:

- The complainant suggests that the psychiatrist who prepared the consultation note should be viewed as the "health information custodian" with respect to the consultation note and should have responded to her correction request, not the hospital.
- The hospital cites PHIPA Decision 15 and submits that it may not qualify as a "health information custodian" with respect to the consultation note, because this record was prepared for the purpose of court matters and not for a health care purpose.

[17] For the reasons that follow, I find that the hospital is a "health information custodian", as that term is defined in section 3(1) of *PHIPA*, with respect to the consultation note prepared by the psychiatrist.

Complainant's position

[18] The complainant filed her correction request under *PHIPA* with the hospital, which acted as the "health information custodian" in responding to her request. However, in the representations that she submitted in this review, she suggests that the psychiatrist who prepared the consultation note should be viewed as the "health information custodian" with respect to this record and should have responded to her correction request. She states, in part:

> Did the hospital . . . consider [the psychiatrist's] views before they responded, or are they speaking on behalf of her professional opinion? *The PHIPA explains that the professional that formed the opinion by observation respond to the correction request as the Health Information Custodian: why [has] the hospital taken on the role of the custodian?*
>
> [emphasis added]

[19] In response, the hospital states that the complainant advised the hospital's privacy coordinator on the telephone that she did not want the psychiatrist to be consulted on her request for corrections. It provided me with a letter that it sent to the complainant which confirmed in writing that she did not want the hospital to contact the psychiatrist. In addition, it provided me with a subsequent letter that it received from the complainant in which she acknowledged that the hospital is the "health information custodian."

[20] The term, "health information custodian" is defined in section 3(1) of *PHIPA*, which states, in part:

> "health information custodian", subject to subsections (3) to (11), means a person or organization described in one of the following paragraphs who has custody or control of personal health information as a result of or in connection with performing the person's or organization's powers or duties or the work described in the paragraph, if any:
>
> 1. A health care practitioner or a person who operates a group practice of health care practitioners.
>
> . . . .
>
> 4. A person who operates one of the following facilities, programs or services:
>
> i. A hospital within the meaning of the *Public Hospitals Act*, a private hospital within the meaning of the *Private Hospitals Act*, a psychiatric facility within the meaning of the *Mental Health Act* or an independent health facility within the meaning of the *Independent Health Facilities Act*.
>
> . . . .

[21] At first glance, it appears that depending on the circumstances, either the hospital or the psychiatrist could fall within the definition of "health information custodian" with respect to the consultation note prepared by the psychiatrist.

[22] The hospital is a "hospital" within the meaning of the *Public Hospitals Act*[1] and it therefore falls within the definition of a "health information custodian" in paragraph 4(i) of section 3(1) of *PHIPA*. In addition, with respect to the complainant's personal health information, the heading of the consultation note states that this record comes from the hospital's "Health Records Department," which indicates that the hospital is an organization that has custody and control of the complainant's personal health information under the opening wording of the definition of "health information custodian" in section 3(1).

[23] The psychiatrist is a health care practitioner[2] and if she operated a private practice outside the hospital and had custody and control of the complainant's personal health information in that capacity, she would likely be viewed as a person who falls within the definition of a "health care custodian" in paragraph 1 of section 3(1) of

---

[1] R.S.O. 1990, c. P.40

[2] Paragraph (a) of the definition of "health care practitioner" in section 2 of *PHIPA* includes a person who is a member within the meaning of the *Regulated Health Professions Act, 1991* and who provides health care. "Medicine" is a regulated profession under that Act which includes physicians such as psychiatrists.

PHIPA.

[24] However, in the particular circumstances that exist here, the psychiatrist was working at the hospital when she saw the complainant. Section 3(3) excludes certain persons from the definition of a "health information custodian", including the following:

> Except as is prescribed, a person described in any of the following paragraphs is not a health information custodian in respect of personal health information that the person collects, uses or discloses while performing the person's powers or duties or the work described in the paragraph, if any:
>
> > 1. A person described in paragraph 1, 2 or 5 of the definition of "health information custodian" in subsection (1) *who is an agent of a health information custodian.*
> >
> > [emphasis added]
> >
> > . . . .

[25] A person described in paragraph 1 of the definition of "health information custodian" in section 3(1) includes a "health care practitioner." Because the psychiatrist is a "health care practitioner," I find that in accordance with paragraph 1 of section 3(3), she was not a "health care custodian" if she was acting as an "agent" of the hospital when she saw the complainant.

[26] The term "agent" is defined in section 2 of *PHIPA*. It states:

> "agent", in relation to a health information custodian, means a person that, with the authorization of the custodian, acts for or on behalf of the custodian in respect of personal health information for the purposes of the custodian, and not the agent's own purposes, whether or not the agent has the authority to bind the custodian, whether or not the agent is employed by the custodian and whether or not the agent is being remunerated;

[27] I find that the psychiatrist fits the definition of an "agent" in section 2, because she is a person that, with the authorization of the hospital, acted for or on behalf of the hospital in respect of the complainant's personal health information for the purposes of the hospital, and not her own purposes. Consequently, in accordance with paragraph 1 of section 3(3), she was not a "health information custodian" when she collected, used and disclosed the complainant's personal health information.

Hospital's position

[28] The hospital does not dispute that it falls within the definition of a "health information custodian" in paragraph 4(i) of section 3(1) of *PHIPA* and that the

psychiatrist fits the definition of an "agent" in section 2. However, as noted above, it cites PHIPA Decision 15 and submits that it might not qualify as a "health information custodian" in this case, because the consultation note was prepared the purpose of court matters and not for a health care purpose.

[29] In PHIPA Decision 15, the issue before the adjudicator was whether a psychologist who prepared a custody and access assessment report was a "health information custodian" as defined in section 3(1) of *PHIPA*. The psychologist was retained by the parents to conduct an assessment under section 30 of the *Children's Law Reform Act*.[3] One parent later requested corrections to this record.

[30] In her decision, the adjudicator canvassed a number of provisions in *PHIPA*, including the definition of "health information custodian" in section 3(1), the definition of the terms, "health care practitioner" and "health care" in section 2, and the implied consent provision in section 20(2). She also cited a previous IPC decision in HC-050014-1[4], a decision of the Federal Court of Appeal in *Wyndowe v. Rousseau*[5], and public guidance provided by the Ministry of Health and Long-Term Care in relation to the definition of "health care."[6]

[31] She found that the definition of "health care practitioner" in section 3(1) is premised on the fact that the health care practitioner must be providing health care. Further, "health care," as defined in section 2 of *PHIPA*, must be for a "health-related purpose." In addition, she found that the service provided by the psychologist was not for a health-related purpose, but rather for the purpose of assisting the parents to develop a parenting plan which would function in the best interests of the child. As a result, she concluded, based on the particular facts before her, that the psychologist was not a "health information custodian," as defined in section 3(1) of *PHIPA*, for the purpose of preparing the custody and access assessment report.

[32] The issue that I must determine is whether the psychiatrist, in acting as an agent of the hospital, provided "health care" to the complainant and prepared the consultation note for a "health-related purpose." If she did not, the hospital is not a "health information custodian," as that term is defined in section 3(1) of *PHIPA*, with respect to the consultation note.

[33] In the particular facts of the case before me, the complainant had two

---

[3] R.S.O. 1990, Chapter C.12.
[4] The Adjudication Summary of this decision is available at: https://www.ipc.on.ca/resource/hc-050014-1/.
[5] 2008 FCA 39.
[6] Ontario, Ministry of Health and Long-Term Care, *Personal Health Information Protection Act, 2004: An Overview for Health Information Custodians*, (August 2004), at 37: http://www.health.gov.on.ca/english/providers/project/priv_legislation/info_custodians.pdf.

appointments with the psychiatrist. She explained to the psychiatrist that she was involved in court proceedings and that it was being alleged that she suffered from a psychiatric illness. The complainant claimed that she did not have a psychiatric illness and asked the psychiatrist to make a diagnosis to confirm that this was the case. After seeing the complainant, the psychiatrist eventually prepared a three-page consultation note, which states, in part, that she was unable to obtain the "collateral information" required to make a diagnosis.

[34] In my view, these facts are distinguishable from those before the adjudicator in PHIPA Decision 15. In the latter case, the service provided by the psychologist was not provided for any health-related purpose, but rather for the purpose of assisting the parents to develop a parenting plan. However, in the case before me, the complainant visited the psychiatrist and asked her to make a mental health diagnosis, which falls within the definition of "health care" in section 2 of *PHIPA*. This provision, states, in part:

> In this Act,
>
> > "health care" means any observation, examination, assessment, care, service or procedure that is done for a health-related purpose and that,
> >
> > > (a) is carried out or provided to *diagnose*, treat or maintain an individual's physical or mental condition,
> > >
> > > [emphasis added]

[35] The complainant's apparent goal was to obtain a record of her personal health information showing that she was not suffering from a psychiatric illness and to possibly use it to support her position in a court proceeding. However, the primary purpose of her visits to the psychiatrist was to obtain a mental health diagnosis. The fact that she had the intention to possibly put a record of her personal health information to use in a court proceeding does not derogate from the fact that the psychiatrist, in acting as an agent of the hospital, delivered "health care" to the complainant and prepared the consultation note for a "health-related purpose."

Conclusion

[36] For the foregoing reasons, I find that the hospital is the "health information custodian," as that term is defined in section 3(1) of *PHIPA*, with respect to the consultation note prepared by the psychiatrist.

B. Does the hospital have a duty to make the requested corrections under section 55(8)? Does the exception to the duty to correct at section 55(9)(b) apply to any of the information in the record?

[37] Section 55(8) of *PHIPA* provides for a right of correction to records of personal health information in specific 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.

[38] Section 55(9) then sets out the following exceptions to a health information custodian's obligation to correct a record of personal health information:

> 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.

[39] Read together, these provisions set out the criteria under which an individual is entitled to a correction of their records of personal health information. The purpose of section 55(8) 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).

[40] Neither of the parties has claimed that the section 55(9)(a) exception applies to the consultation note, and that provision is therefore not at issue in this review. However, the hospital claims that most of the information in the consultation note that the complainant wants corrected consists of "professional opinions" that the psychiatrist had made in good faith about the complainant, which is a reference to the exception in section 55(9)(b). Consequently, I have decided to commence my analysis under section 55(9)(b), because if even the complainant meets the requirements of section 55(8), the hospital is not required to correct her personal health information in the consultation note if it falls within the section 55(9)(b) exception.

Section 55(9)(b): Professional opinion or observation

[41] As set out above, section 55(9)(b) states that 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."

[42] 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. 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.[7]

[43] Where the health information custodian claims that section 55(9)(b) applies, it has the burden of proving that the personal health information 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 means that the corrections need not be made.[8]

[44] The determination of whether the exception at section 55(9)(b) applies involves a two-part analysis. The first question is whether the personal health information is a "professional opinion or observation." The second question is whether the "professional opinion or observation" was made "in good faith."

(1) Is the personal health information in the consultation note a "professional opinion or observation" about the complainant?

[45] In order to fall within section 55(9)(b), the hospital must satisfy me that the complainant's personal health information is a "professional opinion or observation." Section 55(9)(b) applies only where the information at issue consists of either a "professional opinion" or a "professional observation." 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).[9]

[46] The hospital submits that the personal health information that the complainant

---

[7] PHIPA Decision 43.
[8] *Ibid.*
[9] PHIPA Decisions 36, 37 and 43.

seeks to have corrected in the following parts of her request consists of the psychiatrist's "professional opinion" for the purposes of the section 55(9)(b) exception: parts 4 to 10 and 12 to 23.

[47] The information that the complainant seeks to have corrected in part 4 of her request is found in the opening paragraph of the psychiatrist's consultation note, which is addressed to the referring physician and advises him why the psychiatrist delayed dictating the note. In my view, advising another physician about why a consultation note relating to a patient was dictated late is an explanation, not a "professional opinion or observation" about the patient. Consequently, I find that such information does not fall within the section 55(9)(b) exception.

[48] The information that the complainant seeks to have corrected in parts 5 to 10 and 12 to 19 of her request is found in the section of the consultation note which contains the psychiatrist's summary of what the complainant told her and includes the complainant's past medical history, past psychiatric history, family history and personal history. In my analysis under section 55(8) below, I find that the hospital is not required to correct this information because the complainant has failed to establish that it is "incomplete or inaccurate." Consequently, it is not necessary to assess whether this information also falls within the section 55(9)(b) exception.

[49] The information that the complainant seeks to have corrected in parts 20 to 23 of her request are in two sections of the consultation note entitled, "Mental Status Exam" and "Impression and Plan." Both sections contain the psychiatrist's comments about the complainant. The complainant disputes the accuracy and completeness of these comments.

[50] In particular, the psychiatrist's comment that the complainant seeks to have corrected in part 22 of her request is that the complainant did not bring a particular individual with her for follow-up appointments. In my view, a factual statement such as this is not a "professional opinion or observation," about the individual and I find that such information does not fall within the section 55(9)(b) exception.

[51] However, I find that the psychiatrist's comments that the complainant seeks to have corrected in parts 20, 21 and 23 of her request are the psychiatrist's "professional opinions or observations" about the complainant, based on her assessment of the complainant's conduct and behaviour. It is clear from the substance of these comments, including the terminology used by the psychiatrist, that these opinions or observations are derived from the exercise or application of special knowledge, skills, qualifications, judgment or experience relevant to the profession of psychiatry. I will now assess whether these "professional opinions or observations" were made "in good faith" for the purposes of section 55(9)(b).

(2) Did the psychiatrist make her professional opinions or observations about the complainant in good faith?

[52] I have found that the psychiatrist's comments in the consultation note that the complainant seeks to have corrected in parts 20, 21 and 23 of her request are the psychiatrist's "professional opinions or observations" about the complainant. As noted above, 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." That onus lies on the complainant in this review.

[53] A finding that a custodian has not made a professional opinion or observation in "good faith" about an individual under section 55(9)(b) can be based on evidence of malice or intent to harm, as well as serious carelessness or recklessness.[10]

[54] In her representations, the complainant states the following:

> In the Review Summary, I learned that the onus is on the individual seeking a correction (me) to establish that the professional opinion . . . was not made in good faith.
>
> Has [the psychiatrist] considered the errors I found in my personal health record after it was transcribed by the hospital when she finally returned it after moving it to her [original] office after two years?
>
> Please review the attached representation titled, My Mental Custody Battle, Parts II and III for confirmation that the professional opinion was not made in good faith, under *PHIPA* section 55(8).
>
> Did the hospital (RVRHC) consider [the psychiatrist's] position before they responded, or are they speaking on behalf of her professional opinion. The *PHIPA* explains that the professional that formed the opinion by observation responds to the corrections requests as the Health Information Custodian: why is the hospital taking on the role of the custodian? Does this constitute "bad faith" under *PHIPA* Section 55(8)?

[55] I have reviewed and considered the complainant's representations on this issue, including Parts II and III of the section entitled "My Mental Custody Battle." Some of the evidence provided by the complainant focuses on the conduct of the psychiatrist,

---

[10] PHIPA Decision 43. See also *Finney v. Barreau du Québec*, [2004] 2 SCR 17, 2004 SCC 36 (CanLII) at 39, in which the Supreme Court of Canada found that the concept of "bad faith" is not limited to intentional fault but must be given a broader meaning that encompasses serious carelessness or recklessness.

particularly after the two appointments. However, the issue to be resolved here is whether the psychiatrist made her professional opinions or observations in the consultation note "in good faith" for the purposes of the section 55(9)(b) exception, not whether she subsequently conducted herself professionally in dealing with the complainant.

[56] Similarly, although the complainant suggests the fact that the hospital responded to her correction request rather than the psychiatrist might constitute "bad faith," this has nothing to do with whether the psychiatrist's professional opinions or observations about the complainant in the consultation note were made in "good faith" for the purposes of the section 55(9)(b) exception.

[57] The complainant has not provided any evidence to show that the psychiatrist acted with malice or an intent to harm the complainant or that she acted with serious carelessness or recklessness in making those specific professional opinions or observations about the complainant in the consultation note. In my view, the complainant has not met the onus of establishing that these professional opinions or observations were not made in good faith.

[58] In short, I find that the personal health information that the complainant seeks to have corrected in parts 20, 21 and 23 of her request consists of professional opinions or observations that the psychiatrist made in good faith about the complainant. Consequently, the section 55(9)(b) exception applies to this information, and the hospital is not required to correct it.

Section 55(8): Duty to correct

[59] 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 has the onus of establishing the following:

1. that the record is incomplete or inaccurate for the purposes for which the custodian uses the information, and
2. that it gave the custodian the information necessary to enable the custodian to correct the record.[11]

[60] With respect to the "purposes for which the custodian uses the information" in section 55(8), the hospital states that it maintains records of personal health information, including consultation notes, for all registered visits to the hospital, regardless of the patient's purpose in visiting. It submits that the purpose for which it uses the personal health information in the consultation note prepared by the

---

[11] PHIPA Decision 36.

psychiatrist is to maintain a record of care. It further submits that any record of personal health information could also be used for the following purposes:

- obtaining payment for treatment;
- conducting risk management activities;
- improving the quality of hospital services;
- supporting the hospital's research and educational programs; and
- complying with legal and regulatory requirements.

[61] The complainant submits that her personal health information in the consultation note is incomplete or inaccurate for the purposes for which the hospital uses the information, and that in her correction request, she provided the hospital with the information necessary to correct this record, as required by section 55(8). Specifically, in parts 2 to 19 and 22 of her correction request, she identifies the personal health information that she believes is incomplete or inaccurate and explains why. I will now examine each part of the complainant's correction request and assess whether she has met the onus set out in section 55(8).

Parts 2 and 3

[62] At the top of the consultation note, there is a section that says, "DATE SEEN:" which contains no dates. In addition, there is another section that says, "DATE OF SERVICE: 27-Sept-2012."

[63] The complainant claims that the consultation note is based on two appointments she had with the psychiatrist (on September 27, 2012 and October 11, 2012) for an assessment, but submits that this record is incomplete because only the first date is mentioned. To support her position, she attached a letter that she received from the psychiatrist's office which states that, "[Complaint's name] was seen by Dr. [name of psychiatrist] on September 27, 2012 and October 11, 2012."

[64] The hospital acknowledges that the complainant had two visits with the psychiatrist but submits that it is unclear whether the consultation note summarizes all visits.

[65] The consultation notes contains four parts: (1) an introductory section; (2) a section that contains the psychiatrist's summary of what the complainant told her and includes the complainant's past medical history, past psychiatric history, family history and personal history; (3) a section entitled "Mental Status Exam" which is based in part on her observations of the complainant; and (4) a section entitled, "Impression and Plan."

[66] The consultation note is a record of the complainant's visit to the psychiatrist for

a mental health assessment. Although the complainant had two visits with the psychiatrist, the evidence before me shows that the consultation note was only intended to be a record of the complainant's visit on September 27, 2012.

[67] As noted above, the "DATE OF SERVICE" section of the consultation note indicates that this record is for health care services provided to the complainant on September 27, 2012. There is evidence in the complainant's correction request that the consultation note is a record of personal health information that the psychiatrist collected from her on that date.

[68] For example, part 21 of her correction request relates to a paragraph in the "Mental Status Exam" section of the consultation note in which the psychiatrist stated that, "The patient arrived 30 minutes late and was somewhat hyper." In her correction request, the complainant characterizes this summary as containing "distorted" facts and states that, "I arrived at the [hospital] five to ten minutes behind schedule for our first appointment on *the 27th of September 2012*; it was my first trip to the hospital since it had been renovated, and I got lost." [emphasis added]

[69] In my view, it is clear from this evidence that the complainant's personal health information in the "Mental Status Exam" section of the consultation note was collected from her during the September 27, 2012 visit. As noted above, the part before the "Mental Status Exam" section contains the psychiatrist's summary of what the complainant told her and includes the complainant's past medical history, past psychiatric history, family history and personal history. It is evident from the chronology of the consultation note that the psychiatrist collected all of this information from her before conducting the "Mental Status Exam." Consequently, I find that this personal health information was also collected from the complainant during her visit on September 27, 2012.

[70] There is no evidence before to show that any of the personal health information in the consultation note was collected from the complainant at her subsequent visit on October 11, 2012. In my view, this shows that the consultation note is intended to be a record of the complainant's visit to the psychiatrist on September 27, 2012 and not the subsequent visit of October 11, 2012.

[71] In these circumstances, I find that the complainant has not established that the part of the consultation note showing that the psychiatrist provided health care services to the complainant on September 27, 2012, is "incomplete or inaccurate," as required by section 55(8). I find, therefore, that the hospital does not have a duty under section 55(8) to make the corrections to the consultation note that were asked for by the complainant in parts 2 and 3 of her correction request.

Parts 4 and 22

[72] Part 4 of the complainant's correction request relates to the psychiatrist's explanation in the first paragraph of the consultation note as to why she was late in

preparing this record. The explanation suggests that the reason for the delay was that the complainant never brought a caseworker to an appointment before the psychiatrist left her practice at the hospital. As a result, the psychiatrist did not have the "collateral information" she needed to complete the note. Part 22 of the complainant's correction request relates to the first paragraph on page 3 of the consultation note, where the psychiatrist repeats that the complainant did not bring a caseworker to a follow-up appointment.

[73] The complainant alleges that the psychiatrist's explanation as to why she was late in preparing the consultation note is false. She states that she attempted to contact the psychiatrist about making arrangements to being a caseworker but the psychiatrist did not respond because she had left her practice at the hospital and returned to her previous workplace. The complainant submits that even though the psychiatrist blames her for being at fault for the delay in dictating the consultation note, this was not the case.

[74] As part of her correction request, the complainant provided the hospital with correspondence that she apparently sent to the psychiatrist on two occasions (letters dated November 7, 2012 and January 23, 2013). In the first letter, she asked for the psychiatrist's assistance with getting the caseworker to attend. In the second letter, she asked to book an appointment, as agreed to with the caseworker.

[75] The hospital reiterates the psychiatrist's statement that she did not dictate the consultation note because she had been waiting for the complainant to provide "collateral information" to complete the note, and also because she left the facility before this information was provided by the complainant. It submits that this part of the psychiatrist's consultation note does not appear to be incomplete.

[76] I am not convinced that the complainant's personal health information in those parts of the consultation note is "incomplete or inaccurate," as required by section 55(8). In my view, the psychiatrist's statement that the complainant did not bring a caseworker to a follow-up appointment is accurate. The fact that the psychiatrist did not mention that the complainant attempted to contact her to make arrangements for bringing a caseworker to an appointment could be construed as lacking context, but I am not persuaded that it means that the complainant's personal health information in those parts of the consultation note meets the threshold of being "incomplete."

[77] In short, I find that the hospital does not have a duty under section 55(8) to make the corrections to the consultation note that were asked for by the complainant in parts 4 and 22 of her correction request.

Parts 5 to 10 and 12 to 19

[78] The information that the complainant seeks to have corrected in parts 5 to 10 and 12 to 19 of her request is found in the section of the consultation note which contains the psychiatrist's summary of what the complainant told her and includes the

complainant's past medical history, past psychiatric history, family history and personal history.

[79] For example, in the first paragraph on page 2 of the consultation note, the psychiatrist summarizes what the complainant told her about drinking alcohol and a stroke she had that may have been related to alcohol use. In part 12 of her correction request, the complainant's characterizes the psychiatrist's summary as containing "distorted" facts and provides additional information about her alcohol use and the stroke she suffered.

[80] On the same page of the consultation note, the psychiatrist summarizes what the complainant told her about her "family history" and states that the complainant denied any family history of several mental illnesses, including schizophrenia. In part 16 of her correction request, the complainant states that she has "new information" and provides some additional information that a family member provided to her about various mental illnesses in the family.

[81] The psychiatrist also summarizes what the complainant told her about her "personal history," and mentions that the complainant worked as "front desk personnel" at a hotel. In part 18 of her correction request, the complainant characterizes this summary as containing "distorted" facts and provides additional information about her education and employment history, including the fact that she was promoted to the position of dining room supervisor at the hotel.

[82] I have reviewed parts 5 to 10 and 12 to 19 of the complainant's correction request and the corresponding parts of the consultation note that she believes are "incomplete or inaccurate," as stipulated in section 55(8). The psychiatrist's summary of the complainant's past medical history, past psychiatric history, family history and personal history is based on the information that the complainant provided to her at the time of the appointment. In her correction request, the complainant is providing additional information that she apparently did not provide to the psychiatrist at that time.

[83] In my view, the test in section 55(8) is intended to address whether a health information custodian or agent completely and accurately recorded personal health information from a patient at the time they collected that information. In most circumstances, it is not meant to give patients the right to correct a record of their personal health information after the fact if they failed to provide a health information custodian with complete and accurate information at the time that information was collected and recorded.

[84] Based on the evidence before me, I am satisfied that the consultation note contains a complete and accurate summary of what the complainant told the psychiatrist at her appointment about her past medical history, past psychiatric history, family history and personal history. I find, therefore, that the hospital does not have a duty under section 55(8) to make the corrections to the consultation note that were

asked for by the complainant in parts 5 to 10 and 12 to 19 of her correction request.

Part 11

[85] At the top of the consultation note, there is a section that says, "DISC DATE: 15/11/13." The complainant characterizes this information as a "possible error" and asks why this date is more than a year after her two appointments.

[86] The hospital submits that this discharge date is not an error. It states that the discharge date recorded on the consultation note represents the date of the complainant's discharge from the Outpatient Mental Health Program due to inactivity with respect to patient visits. It explains that in 2013, its system was set to automatically discharge "inactive re-occurring outpatient accounts" from its outpatient program after no activity for 400 days, although it has now been increased to 999 days.

[87] The complainant's last visit to the hospital was on October 11, 2012 and the discharge date in the consultation note is on November 15, 2013, which is 400 days later. In these circumstances, I find that the complainant has not established that the discharge date in the consultation note is "incomplete or inaccurate," as required by section 55(8). I find, therefore, that the hospital does not have a duty under section 55(8) to make the correction to the consultation note that was asked for by the complainant in part 11 of her request.

Conclusion

[88] For the foregoing reasons, I uphold the hospital's decision to deny the corrections to the consultation note requested by the complainant.

C. Did the hospital's decision to attach a statement of disagreement to the consultation note comply with the requirements in section 55(11) of *PHIPA*?

[89] After denying her correction request, the hospital sent a letter to the complainant which stated that ". . . we have attached your signed correction letter to a statement of disagreement and added this package to your personal health record." In her representations, the complainant claims that she informed the hospital that she did not want a statement of disagreement attached to the consultation note.

[90] In circumstances in which a custodian refuses a correction request, section 55(11) of *PHIPA* gives individuals the right to prepare a concise statement of disagreement and requires the custodian to attach it to the record of their personal health information. Section 55(11) states, in part:

> A notice of refusal under subsection (3) or (4) must give the reasons for the refusal and inform the individual that the individual is entitled to,
>
> (a) prepare a concise statement of disagreement that sets out the correction that the health information custodian has refused to make;

> (b) require that the health information custodian attach the statement of disagreement as part of the records that it holds of the individual's personal health information and disclose the statement of disagreement whenever the custodian discloses information to which the statement relates;
>
> (c) require that the health information custodian make all reasonable efforts to disclose the statement of disagreement to any person who would have been notified under clause (10) (c) if the custodian had granted the requested correction;
>
> . . . .

[91] In my view, it is clear from the wording of section 55(11) that the right to have a concise statement of disagreement attached to a record of personal health information resides with the individual to whom the personal health information relates. A custodian cannot attach a statement of disagreement to a record without that individual's consent.

[92] The hospital states that although the IPC mediator asked the hospital to attach the statement of disagreement to the consultation note, it will now remove it. In these circumstances, I find that the issue of whether the hospital's decision to attach a statement of disagreement to the consultation note complies with the requirements in section 55(11) of *PHIPA* is now moot.

ORDER:

For the foregoing reasons, I dismiss the complaint and no order is issued.

Original signed by ______________________ November 30, 2020

Colin Bhattacharjee
Adjudicator