Information and Privacy Commissioner,
Ontario, Canada

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

PHIPA DECISION 170

Complaint HA20-00155

St. Thomas Elgin General Hospital

January 20, 2022

Summary: An individual submitted a correction request under the *Personal Health Information Protection Act* to St. Thomas Elgin General Hospital, seeking correction to a consulting doctor's report about him because he believed it to be inaccurate. The hospital denied the correction request, pursuant to the exception for good faith professional opinion or observation in section 55(9)(b) of *PHIPA*. The adjudicator finds that section 55(9)(b) applies and she upholds the hospital's decision not to make the requested correction. No order is issued.

Statutes Considered: *Personal Health Information Protection Act, 2004,* sections 55(1), 55(9)(b) and 55(11).

Decisions Considered: PHIPA Decisions 36 and 37; Alberta IPC Order H2005-007.

BACKGROUND:

[1] This decision determines the issues raised by an individual's request to his local hospital, St. Thomas Elgin General Hospital (the hospital), to have a correction made under the *Personal Health Information Protection Act* (*PHIPA* or the *Act*) to his personal health information. The basis of the correction request is the individual's objection to a consulting doctor's differential diagnosis in a Holter monitor[1] report (the report).

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[1] Used to help diagnose possible cardiac issues, a Holter monitor is a small, portable electrocardiogram device that measures heart rate and rhythm over a 24 or 48 hour period.

[2] As background, the individual submitted the correction request under *PHIPA* in August 2019, seeking to have the report corrected by removing the phrase "to be screened for anxiety/depression" from the record. In October 2019, the hospital informed the individual that the requested "amendments" had been made.

[3] However, in July 2020, the individual viewed a copy of the report and discovered that the phrase had not been removed. The doctor had instead amended the report to include an addendum stating, "Please note, some of my differential [diagnosis] for palpitations listed above does not imply diagnosis" (the addendum). After seeing the addendum, the individual exchanged email communications with the hospital about the report in an effort to seek a satisfactory resolution to his concerns. He provided the hospital with a statement of disagreement to be added to the report, as he was entitled to do under section 55(12) of *PHIPA*, and the hospital attached it to his electronic health record (EHR), as discussed in greater detail below.

[4] As the individual was not fully satisfied by the hospital's response, he (now the complainant) filed a complaint under *PHIPA* with the Information and Privacy Commissioner of Ontario (the IPC) regarding the hospital's decision to refuse to correct the record. A mediator was appointed to explore the possibility of resolving the issues in the complaint. During mediation, the complainant argued that the correction he had originally requested – removal of the phrase "to be screened for anxiety/depression" – should be made, rather than deleting the words "some of" from the addendum, as he had subsequently suggested to the hospital as a means of resolving his concerns, before he filed the complaint with the IPC.[2]

[5] In response, the hospital explained that when the hospital received the complainant's correction request, the doctor reviewed the request, and prepared the addendum in response. When the complainant notified the hospital that he wanted the addendum "corrected" to add text indicating that he has never been a patient of the doctor and that they did not meet during the Holter monitor study, this was also reviewed by the doctor. However, the doctor declined to make the correction on the basis of his belief that the existing report, with the addendum, accurately describes his interpretation of the Holter monitor study. The hospital then confirmed its position that it was not granting the complainant's correction request, relying on sections 55(8) and 55(9)(b) of the *Act*.

[6] As no further mediation was possible, the complaint moved to the adjudication stage of the complaints process where an adjudicator may conduct a review. I decided

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[2] The complainant provided, as an attachment to his representations, his original August 2019 correction request wherein he sought the removal of the objectionable phrase ("to be screened for anxiety/depression") from the report. As the complainant was advised during this review, removal of text from a medical record is not a possible outcome to a correction request under *PHIPA*. Section 55(10)(a)(i)(A) of *PHIPA* states that upon granting a request for a correction, the health information custodian shall make the requested correction by recording the correct information in the record and striking out the incorrect information in a manner that does not obliterate the record.

to conduct a review and began it by sending a Notice of Review outlining the issues in the complaint to the hospital, initially, to seek representations. I received the hospital's representations, which I shared with the complainant, along with a copy of a Notice of Review. The complainant provided representations for my consideration.

[7] In this decision, I find that the exception in section 55(9)(b) of *PHIPA* applies and I uphold the hospital's refusal to correct the record.

RECORDS:

[8] The record that is the subject of the correction request is a one-page Holter monitor report.

DISCUSSION:

[9] There appears to be no dispute between the parties, and I find, that the hospital is a health information custodian as defined in section 3(1) of the *Act*, and that the record at issue contains the complainant's personal health information as defined in section 4(1) of the *Act*.

[10] Although the complainant argued in his representations that the doctor who created the report is the health information custodian in this complaint, I am satisfied that the doctor is an agent of the hospital for the purposes of the record at issue. Accordingly, it is the hospital not the doctor that is the health information custodian of the complainant's personal health information and was required to respond to his correction request in relation to it.[3]

[11] Accordingly, the sole issue before me is whether the hospital is required to grant the correction to the report requested by the complainant under section 55(1).

The hospital does not have to make the requested correction to the report under section 55 of *PHIPA*

[12] One of the purposes of the *Act* set out in section 1 is to:

[3] According to the definition in section 2 of *PHIPA*, an "'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[.]" See also the definition of "health information custodian" in section 3(1) and the exception from that definition for "agents" in paragraph 1 of section 3(3) of *PHIPA*.

> (c) provide individuals with a right to require the correction or amendment of personal health information about themselves, subject to limited and specific exceptions set out in [*PHIPA*].

[13] Section 55(1) of *PHIPA* permits an individual who has received access to a record of personal health information to request that a health information custodian correct the record "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…"

[14] Section 55(8) of the *Act* provides for a right of correction to records of an individual's own personal health information in some circumstances. Section 55(8) states:

> The health information custodian shall grant a request for a correction under [section 55(1) of the *Act*] 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] There are exceptions to the duty to correct a record of personal health information found in section 55(9) of the *Act*, which states:

> 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 establish the criteria pursuant to which an individual is entitled to correction of a record of their own personal health information.

[17] Where a complaint regarding a custodian's refusal to correct records of personal health information is made to the IPC, the individual seeking the correction bears the onus of establishing that the "record is incomplete or inaccurate for the purposes for which the custodian uses the information" pursuant to section 55(8) of the *Act*. If the onus is met and the right to correction is established, the question becomes whether or not any of the exceptions in section 55(9) apply. Where a custodian claims that section 55(9)(b) applies, as the hospital does here, the custodian bears the burden of proving that the personal health information at issue consists of a "professional opinion or observation" about the individual. However, once this is established, the onus is on the individual seeking a correction to establish that the "professional opinion or

observation" was not made in good faith.

[18] Depending on the circumstances of the correction request and the reasons for the custodian's refusal to correct the records, the IPC may approach the analysis initially under section 55(8) or under section 55(9). In this complaint, because I find that the exception in section 55(9)(b) of the *Act* applies, I do not need to decide whether section 55(8) is established.

The parties' representations

The hospital

[19] The hospital explains that, upon receipt of the complainant's correction request, it consulted with the doctor, a specialist in internal and critical care medicine, who interpreted the Holter monitor study and wrote the report. The hospital submits that the doctor explained that he had included the disputed language in the report ("to be screened for anxiety/depression") in good faith as a possible cause for palpitations the complainant had been experiencing. According to the hospital, the doctor's recommendation for follow up (screening) was not a diagnosis.

[20] In response to the question of whether the personal health information at issue consists of a "professional opinion or observation" for the purpose of section 55(9)(b), the hospital submits that the doctor who interpreted the Holter report and created the record did so using his professional skill and judgment. The hospital asserts that "[t]he report was created in his typical fashion and was based on his professional opinion as a practicing doctor since 2015."

[21] The hospital also maintains that there is no evidence to suggest the doctor was not acting in good faith. The hospital acknowledges the complainant's concern that he had not met or been examined by the doctor, before he (the doctor) interpreted the Holter monitor study, but says the doctor does not dispute this, and regardless, he prepared the report in good faith using his clinical skill and judgment.

[22] The hospital provides other submissions defending the doctor's practice of medicine and referring to positive patient feedback about his care that are not necessary to set out for the purpose of deciding whether correction to the record at issue is required under the *Act*.

[23] The hospital states that the complainant communicated his concerns about the report and provided a statement of disagreement which, it says, has been placed in the complainant's permanent health record. In response to my questioning about the steps taken to attach the complainant's statement of disagreement to his EHR in accordance with section 55(11), the hospital explained that it made numerous inquiries with other hospitals in the region as to how to "pin" (attach) the statement of disagreement to the addendum in the complainant's EHR. The hospital states that while the system does not permit uploading of Word or PDF documents into the EHR, this was addressed by

creating a miscellaneous note with a "Statement of Disagreement disclaimer" that appears with the report on the EHR informing the reader that they should contact the hospital for more information on the statement of disagreement, which forms part of the complainant's permanent health record.

The complainant

[24] Although my finding in this decision is based on section 55(9)(b), I have set out some of the complainant's representations on section 55(8) because they help describe his concerns about what he views as inaccurate and misleading content in the report.

[25] The complainant states that he was referred to the hospital for a Holter monitor study, not a consultation with the doctor. He maintains that the report is inaccurate because the doctor was solely tasked with interpreting the Holter monitor study, not providing a diagnosis, including the differential diagnosis that he views as inappropriate. The complainant is concerned that the hospital and the other regional hospitals that are on the same EHR system now have access to an incomplete and "dangerously inaccurate" report about him, which "could lead to possible overshadowing of relevant medical issues." The complainant asserts that he did provide the hospital (and doctor) with the necessary information to correct the record, both in the conversation he had with the doctor in August 2019 and by means of the form he submitted to the Patient Relations/Privacy Office at the hospital in October 2019.

[26] The complainant specifically challenges the hospital's statement in its representations that the doctor did not make a diagnosis. He provides a copy of an email in which a hospital staff member refers to the sentence at issue in the report as an opinion of the doctor that was a differential diagnosis.[4] The complainant submits that this fact, combined with the wording of the addendum – "some of my differential is not to imply a diagnosis" – means that the doctor did, in fact, make a diagnosis. The complainant submits that when the report was prepared, the doctor "only possessed 4 years as a practicing doctor" and he says that hospital administrative staff told him that it was "typical fashion" for the doctor to make similar comments on many Holter monitor reports.[5]

[27] On the question of whether there are reasonable grounds for concluding that the doctor's professional opinion was not made in good faith, the complainant responds by referring to a conversation he had with the doctor in August 2019 after he (the complainant) learned of the content of the report. The complainant says that he explained his medical history to the doctor, and he submits that the doctor agreed to correct the report. The complainant refers to the hospital's "Patient Relations/Privacy Office" having affirmed that the correction was made in October 2019.[6] The

[4] As "Exhibit 1" to his representations.
[5] Also as "Exhibit 1": the email from the hospital's Manager of Risk, Privacy and Patient Relations alludes to the fact that the doctor "recommends this [screening] for numerous patients…"
[6] Attached as "Exhibit 6" to the complainant's representations.

complainant relates his dismay in July 2020 upon discovering that, not only had a corrected report not been provided to his family physician earlier that year as requested, but that the requested correction had not been made at all. The complainant adds that when he received a copy of the report and addendum a month later, the revision to it that he had been expecting was "missing".

[28] The complainant concludes that, as he was not a patient of the doctor, the doctor's actions in recording the differential diagnosis were "contrary to standard medical practice", as well as "reckless and not in good faith." The complainant submits that in order to make a differential diagnosis, a doctor must, at the very least, record a patient's medical history, run medical diagnostic tests, and perform a physical examination – none of which the doctor did in this case.[7]

[29] Although the complainant also provided submissions on the exception in section 55(9)(a), given my finding below on section 55(9)(b), I will not set them out.

[30] Regarding the fact that his statement of disagreement cannot be pinned to the Holter monitor report in his EHR and that only a note, minus the details, signifying his objection to it, is possible, the complainant decries the doctor's "unsolicited medical opinion" being disseminated to all regional hospitals with the hospital's help, and without his knowledge or consent, and asserts that it is a violation of his privacy. The complainant submits that the hospital's alleged failure to protect his privacy, combined with its failure to "seamlessly convey [his] disagreement" with the doctor is reprehensible.

Analysis and findings

[31] The sole issue for me to decide in this complaint is whether the requested correction to the complainant's Holter monitor report should be made in accordance with *PHIPA*. There is no privacy complaint before me, and so I will not address the complainant's concerns about the dissemination of the report to other regional hospitals.

[32] As stated above, section 55(1) of *PHIPA* creates an entitlement for individuals to request correction of their PHI. Paraphrasing the language of that provision, the complainant's concern is that the doctor's differential diagnosis is "inaccurate … for the purposes for which the hospital or his other doctors … use or may use the information." More specifically, what the complainant views as an incorrect and inappropriate differential diagnosis in the Holter monitor report may be relied on to his detriment by other doctors and compromise his future health care. However, the complainant's disagreement with the differential diagnosis and his view that it is wrong or unjustified is not sufficient to negate the application of the exception to the correction requirement

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[7] The complainant's concerns about the situation led him to file a complaint against the doctor with the College of Doctors and Surgeons of Ontario (the CPSO), but that complaint is not relevant to my decision here about whether the complainant's right to correction of the report has been established under *PHIPA.*

found in section 55(9)(b).

[33] As stated above, section 55(9)(b) of *PHIPA* provides 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." 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 own view of a medical condition or diagnosis.[8]

[34] 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 that the complainant seeks to have corrected consists of a "professional opinion or observation." The second question is whether the "professional opinion or observation" was made "in good faith." PHIPA Decisions 36 and 37, issued by Adjudicator Jennifer James, established the two-part test. It has been adopted in many IPC decisions,[9] and I do so here.

The personal health information qualifies as a "professional opinion or observation"

[35] In order for section 55(9)(b) to apply, the personal health information must qualify as either a "professional opinion" or a "professional observation." Only those observations and opinions that require a health information custodian or an agent to exercise or apply special knowledge, skills, qualifications, judgment or experience relevant to their profession should be defined as "professional observations" or "professional opinions" within the meaning of section 55(9)(b) of the *Act*. This interpretation is consistent with the purpose of the exception within the overall scheme of *PHIPA*.[10]

[36] In arriving at this interpretation of the exception in section 55(9)(b) of *PHIPA*, Adjudicator James also considered decisions of the Alberta Information and Privacy Commissioner that interpreted the words "professional," "opinion," and "observation," in the context of correction complaints under Alberta's *Health Information Act* (*HIA*). In Order H2005-007, for example, former Commissioner Franklin Work explained that:

> [O]pinions and observations are subjective in nature. Opinions, even those based on the same set of facts, can differ. Dr. X may see a patient

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[8] PHIPA Decisions 36, 37, 71, and 138. See also Orders M-777, MO-1438 and PO-2549 decided under *MFIPPA* and *FIPPA*, from which the IPC's approach to correction under *PHIPA* has been drawn, in part.
[9] For example, PHIPA Decisions 39, 43, 47, 71 and others.
[10] As cited above, footnote 8.

> and form the opinion that the patient has the flu. Dr. Y may see the same patient and form the opinion that the patient has a cold. HIA does not compel custodians to resolve these differences of opinion by forcing physicians to change their opinions under the guise of correction.[11]

[37] Based on my review of the parties' representations and past IPC decisions that have considered the correction issue, including PHIPA Decision 36, I find that the personal health information the complainant seeks to correct accurately represents the professional opinion of the doctor who recorded it. The parties both expressed their views about whether what was recorded by the doctor in the report constituted a diagnosis or not: the hospital says the suggestion for screening in follow up was not a diagnosis, and the complainant disputes that. Regardless, while the complainant is troubled that the doctor "essentially made a diagnosis," without ever seeing him or providing care to him otherwise, I am satisfied that the differential diagnosis, which is intended to represent an alternate explanation for the symptoms a patient is experiencing, is a professional opinion, reflecting the exercise of the doctor's clinical reasoning based on his professional knowledge, skill and judgment. Further, the fact that the doctor may offer the same differential diagnosis and screening suggestion for other patients does not affect my conclusion that the personal health information at issue here represents a professional opinion.

[38] Since I am satisfied that the personal health information the complainant seeks to have corrected consists of the "professional opinion or observation" of the doctor who interpreted the complainant's Holter monitor study, I find that part one of the test for the application of the exception in section 55(9)(b) is met.

[39] I must now determine whether the professional opinion or observation contained in the report was made in good faith.

The professional opinion or observation was made in good faith

[40] 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 individuals are assumed to act in good faith unless proven otherwise. Therefore, the burden of proof rests on the person seeking to establish that the individual has acted in the absence of good faith to rebut the presumption of good faith.[12] Accordingly, in the context of

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[11] Alberta IPC Order H2005-007 at para 48. As noted, this approach to correction under *PHIPA* shares similarities with the approach to correction requests under *MFIPPA and FIPPA*. When reviewing correction requests related to opinions and observations in records of an investigatory nature under those acts, it is not the truth of the recorded information that is determinative of whether a correction request should be granted, but rather whether or not what is recorded accurately reflects the observations and views of the individual whose impressions are set out in the record. See Orders MO-3042, MO-3251, PO-2258 and PO-2549.

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

section 55(9)(b) of the *Act*, the burden rests on the complainant to establish that the doctor did not make the professional opinion or observation in good faith.

[41] The complainant alleges that the doctor's professional opinion was not formed in good faith because there was no doctor-patient relationship between them, no taking of medical history and no physical examination done before the doctor recorded the objectionable differential diagnosis. Because of this, the complainant believes the doctor's actions to be "reckless and not in good faith." Neither the hospital nor the doctor dispute that the complainant and doctor had not met before the doctor interpreted the Holter monitor study, but they maintain nevertheless that the report was prepared in good faith. Based on my review of the circumstances, I agree that there is insufficient evidence to suggest otherwise.

[42] There is no question that some of the communication surrounding the complainant's correction request was unfortunate. For example, there is the email sent to the complainant by hospital administrative staff two months after he submitted his correction request advising him that "… the amendments that you requested have been made to your chart."[13] This turned out to be incorrect, of course, as the complainant learned the following year. However, while these events may have been regrettable and distressing for the complainant, they do not establish an absence of good faith on the doctor's part in the formation of his professional opinion, the differential diagnosis, and the recording of it in the report. Neither the complainant's submissions nor the circumstances described above are sufficient to rebut the presumption of good faith on the part of the doctor. As the complainant has not provided sufficient evidence to rebut the presumption of good faith, I find that the second part of the test for the exception in section 55(9)(b) to apply has been met in the circumstances of this complaint.

[43] Given my finding that the personal health information the complainant seeks to correct consists of the good faith professional opinion of the doctor, the exception in section 55(9)(b) of *PHIPA* applies and the hospital is not required to make the requested correction under section 55(8). As a result, I uphold the hospital's decision to refuse to correct the complainant's personal health information in the report.

[44] In addition to providing individuals with a right to access their personal health information, section 55(12) of *PHIPA* gives individuals the right to attach a statement of disagreement to the record conveying their disagreement with any information contained in the record. In the complaint before me, the complainant has exercised this right. Although the hospital encountered some technological difficulties in "pinning" the complainant's statement of disagreement to the report in his EHR, I have reviewed the format and content of the addendum to the report, and the corresponding caveat, and I am satisfied that the statement of disagreement is attached to, and forms part of, the complainant's electronic health record, thereby meeting the hospital's obligations under *PHIPA*.

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[13] "Exhibit 6" to the complainant's representations.

ORDER:

For the foregoing reasons, no order is issued.

Original signed by January 20, 2022

Daphne Loukidelis
Adjudicator