Information and Privacy Commissioner,
Ontario, Canada

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

PHIPA DECISION 188

Complaint HA20-00025

Dr. Christopher Blue

October 18, 2022

Summary: The complainant submitted a correction request under the *Personal Health Information Protection of Privacy Act* to a physician seeking the removal of a letter from her medical file. The physician denied the complainant's request citing sections 55(8) and 55(9)(b). The adjudicator finds that the complainant did not demonstrate that the information in the record was incomplete or incorrect for the purpose the physician uses the information. As a result, the custodian's decision to not make the requested correction is upheld.

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

BACKGROUND:

[1] This decision addresses a physician's denial of the complainant's correction request under section 55(1) of the *Personal Health Information Protection Act* (*PHIPA*).

[2] The background of this complaint is that the complainant attended the physician's office after being referred by her general practitioner. The physician (the custodian) refused to see the complainant on the day of her scheduled appointment, which was communicated to the complainant by administrative staff.

[3] The custodian subsequently sent a letter to the general practitioner containing his explanation as to why he made the decision to cancel the complainant's appointment, despite the referral. In the letter, the custodian alleged that the

complainant had attended his office to seek a prescription for a narcotic or controlled substance where she already had obtained a prescription from another physician; the custodian used the term "double- doctoring." In support of his "double-doctoring" allegation, the custodian's letter also referenced information the custodian says that the complainant told his staff.

[4] The complainant obtained a copy of the custodian's letter through an access request and subsequently submitted a request under *PHIPA* to correct the custodian's letter. The complainant asked the custodian to retract[1] the letter or write another letter to be placed in her file.

[5] The custodian issued a decision to the complainant refusing her correction request. In the decision letter, the custodian stated that he would not remove the letter at issue because:

> The College of Physicians and Surgeons of Ontario ("CPSO") has guidelines for the treatment of medical records, which establish that a medical document is a legal document and cannot be altered or destroyed, unless the time for maintaining the medical record has passed (See e.g., CPSO Policy Statement #4-12: Medical Records).

[6] The custodian also took the position that he does not have a duty to correct the complainant's personal health information under section 55(8) of *PHIPA* because the letter is not "incomplete or inaccurate for the purposes for which the custodian uses the information."

[7] In a subsequent letter, the custodian informed the complainant of her entitlement under section 55(11) to have a Statement of Disagreement attached to the record.

[8] The complainant subsequently filed a complaint with the Information and Privacy Commissioner of Ontario (IPC), which stated:

> [The custodian] wrote a fictitious letter to my medical file based on a false assumption made by his assistant and then he charged OHIP for an appointment that I did not have with him. [The custodian] has since refunded OHIP and has admitted that he did not see me as a patient. I have simply requested that the [CPSO] remove the letter from my file but they are not allowed to do this... I also asked that [the custodian] write a letter to negate the first letter...He refuses to resolve the issue despite the fact that he never saw me as a patient. My concern is that my General Practitioner is close to retirement and even though he was not concerned about [the custodian's] defamatory letter because he knows me, a new

[1] The complainant used the term "negating" in her correction request.

> doctor who doesn't know me could be given a false impression. This could affect my treatment in the future and that is not ok with me.

[9] A mediator was assigned to the complaint file. The mediator explored settlement with the parties but the parties were unable to reach a settlement. Accordingly, the file was transferred to the adjudication stage of the complaints process in which an adjudicator may conduct a review. A review proceeded and the parties were invited to provide written representations in support of their positions, which they did. The parties' representations were shared in accordance with the confidentiality criteria set out in the IPC's *Code of Procedure for Matters under the Personal Health Information Protection Act*, *2004*. In his representations, the custodian takes the position that if it is found that he has a duty to correct the complainant's PHI under section 55(8), the exception under section 55(9) would apply.

[10] For reasons that follow, I find that the custodian is not required to make the requested correction to the record because the complainant has not met the initial onus of establishing a right of correction under section 55(8). Given my finding, it is not necessary that I also determine whether the exception at section 55(9)(b) applies.

DISCUSSION:

[11] There is no dispute that the information the complainant seeks to have corrected constitutes her personal health information (PHI). PHI is defined in section 4(1) of *PHIPA*, in part as follows:

> "personal health information", subject to subsections (3) and (4), means identifying information about an individual in oral or recorded form, if the information,
>
> > (a) relates to the physical or mental health of the individual, including information that consists of the health history of the individual's family,
> >
> > (b) relates to the providing of health care to the individual, including the identification of a person as a provider of health care to the individual,

[12] There is also no dispute that the custodian is a "health information custodian" as defined in section 3(1) of *PHIPA*,[2] and that the complainant was given access to her health record before making her correction request.

[13] The sole issue in this complaint is whether the custodian has a duty to correct the complainant's PHI in the records. Section 55(8) of *PHIPA* provides for a right of

[2] Under section 3(1)1 of *PHIPA.*

correction to records of PHI in some circumstances. It states:

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

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

> Despite subsection (8), a health information custodian is not required to correct a record of personal health information if, it consists of a professional opinion or observation that a custodian has made in good faith about the individual.

[15] Read together, these provisions set out the criteria pursuant to which an individual is entitled to a correction of their records of PHI. The purpose of section 55 of *PHIPA* is to impose a duty on health information custodians to correct records of PHI that are inaccurate or incomplete for the purposes for which they use the information, subject to the exceptions set out in section 55(9) of the *PHIPA*.

Analysis and Decision

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

[16] In all cases where a complaint regarding a custodian's refusal to correct records of PHI is filed with the IPC, the individual seeking the correction has 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).

[17] Section 55(8) requires the individual asking for correction to:

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

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

[18] If the above is established, the question becomes whether or not any of the exceptions that are set out in section 55(9) apply.

[19] Previous IPC decisions have found that not all PHI contained in records held by health information custodians needs to be accurate in every respect. If a request is made to correct inconsequential bits of information that have no impact on the purposes for which the custodian uses the information, and the custodian is not relying

on the information for a purpose relevant to the accuracy of the information, the custodian is not required to correct the information.[3]

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

Representations of the parties

[21] The custodian submits that the complainant has failed to meet the onus under section 55(8) because she has failed to establish that the record is incomplete or inaccurate for the purposes for which the custodian uses the information, and has also failed to provide him the information necessary to enable him to correct the records. The custodian says that the letter in question is accurate in that it reflects his interaction with the complainant in April 2017 and his staff's interaction in May 2017 when she attended his office. The custodian says the letter was prepared to provide the complainant's general practitioner an explanation as to why he canceled the complainant's scheduled appointment. In support of his position, the custodian states:

> It appears that [the complainant] interprets the Letter to suggest that I saw her as a patient when I did not. I believe the Letter is clear that this was not the case. In the Letter I state, "I had initially met [the complainant] several weeks ago as she approached me at a public town hall meeting." I go on to describe that interaction and how I could not accept the referral and see her as a patient. I believe it is clear through both my language and the context of the letter that I did not see [the complainant] as a patient.
>
> The letter is dated July 13, 2017 because this is when I finalized the consultation note and sent it to [the general practitioner]. This is not a reference to a further appointment.
>
> [The complainant] has provided no information in her communications with me or with the [IPC] that I have seen to demonstrate that the Letter is inaccurate for the purposes for which it is used. I used this consult note to explain to [the general practitioner] my decision-making for why I would not see [the complainant] as a patient. It is also a record of my decision- making for my own records. The language used in the letter is accurate medical language. For those purposes (and for any other purpose) the record is entirely accurate.
>
> Further, and in any event, even if the Letter was inaccurate, [the complainant] has not provided me with the information necessary to

[3] *PHIPA* Decisions 36, 39 and 40.
[4] *PHIPA* Decisions 36 and 39.

> correct the Letter. She has only stated that it needs to be corrected, suggesting that it is inaccurate and that it addresses an appointment that did not take place.

[22] The complainant submitted two letters and an email, all authored by her, in response to my invitation for representations.[5] The complainant also provided letters from others in support of her submission that the custodian wrongly accused her of "double- doctoring."

[23] The first letter of support is from her general practitioner, who wrote to the custodian directly upon his receipt of the letter the complainant seeks to be corrected.[6] In that letter, the general practitioner states "what could easily be interpreted as double doctoring was not." The complainant also provided a letter from another physician who had provided telemedicine to the complainant.[7] This physician sent a letter to the complainant's general practitioner confirming her understanding that the complainant attended the custodian's office in an effort to find a doctor that could see her in person on a regular basis as opposed to the telemedicine appointments this physician was only able to offer the complainant.

[24] The complainant says that the custodian should be required to retract the letter in question, or in the alternative, write another letter retracting ("negating") the letter in question on the basis that the "double doctoring" allegation is "totally inaccurate." The complainant argues that she has provided the IPC with two letters which state that she was not "attempting to double doctor." In addition, the complainant says that one of the two letters also provides an explanation as to why she had two providers at the time she attended the custodian's office.

[25] In her representations, the complainant explains that she has experienced difficulty in obtaining consistent access to a physician and her desire to find a physician who was available for in-person appointments. The complainant says that she is entitled to an apology for the poor treatment she received when she attended the custodian's office, including the manner his staff communicated with her and the custodian's refusal to speak to her directly that day.

[26] The complainant also appears to question the appropriateness of the physician writing a letter given that no appointment took place. The complainant stated in her email to the IPC that:

> [the custodian] made no observations at all because he never saw me on the day of my schedule[d] appointment therefor[e] he has no opinion in this matter. The assumptions or opinions made by his assistant should be

---

[5] Letters, dated October 28, 2020 and received November 5, 2020 and email, dated October 29, 2020.
[6] The general practitioner's letter is dated April 16, 2018.
[7] This letter is dated May 1, 2018 and is addressed to the complainant's general practitioner.

> negated by virtue of the fact that two doctors wrote letters in an effort to let [him] know that I was in fact not attempting to "Double Doctor" at all.

[27] Finally, the complainant takes the position that the fact that the physician initially charged OHIP for the cancelled appointment speaks to his "character and behavior."[8] The complainant also submitted evidence regarding an unrelated matter in support of her allegation about custodian's character.

Decision and Analysis

[28] I have reviewed the complaint file, including the documentation the complainant provided with her written representations and find that the requested correction need not be made as the complainant has not established that the record is "incomplete or inaccurate for the purposes for which the custodian uses the information" as required by section 55(8).

[29] The complainant has 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). However, her submissions do not specifically address the custodian's use of the information at issue. Instead, the complainant focusses on the harm she believes she may experience if the letter is included in her medical history. The evidence offered by the complainant does not explain how the information at issue is "incomplete or inaccurate for the purposes for which the custodian uses the information", which I accept in this case, was to document his reasons for refusing to see her at her scheduled appointment.

[30] In my view, the complainant's evidence does not establish that the record is incomplete or inaccurate for the purposes for which the custodian uses the information. Instead the complainant's evidence challenges the custodian's decision to cancel her appointment and the manner in which he and his staff decided to communicate the decision to her. Issues relating to the conduct or decision-making of the custodian or his staff are outside the scope of the correction complaint before me. Similarly, the complainant's allegations about the custodian's character is not relevant in determining whether or not the complainant has discharged the onus in section 55(8).

[31] In this case, the record was created to document the custodian's interaction with the complainant, including any information gathered by or provided to the custodian or his staff and his reason for refusing to see the complainant. Whether the complainant was in fact double-doctoring or not is not the issue. The custodian wrote the letter to

---

[8] In his representations, the custodian says that OHIP was inadvertently billed for the appointment but that the charge was reversed. The custodian also says that the billing issue was addressed in a complaint the complainant filed against him to the College of Physicians and Surgeons (the college). The IPC does not have the authority to review the billing issue. In addition, section 36(3) of the *Regulated Health Professions Act* bars the IPC from considering any documentary evidence prepared for a college proceeding.

explain why he did not see her that day. The complainant's disagreement with the contents of the records does not establish that the records are incomplete or inaccurate *for the purposes for which the custodian uses the information.*

[32] For the above reasons, I find that the custodian is not obliged to grant the correction request on the basis that the complainant has failed to establish that the record is incomplete or inaccurate for the purpose for which the custodian uses the information, and the requirements of section 55(8) are therefore not met. Given my finding, it is not necessary that I also determine whether the exception under section 55(9)(b) applies.

[33] Though I have found that the custodian is not required to make the requested correction, *PHIPA* gives the complainant the right to attach a statement of disagreement to the record conveying her disagreement with information contained in the record.[9]

NO ORDER:

For the foregoing reasons, no order is issued.

Original Signed by: October 18, 2022
Jennifer James
Adjudicator

[9] Section 55(11) of *PHIPA* states:

> 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;