Information and Privacy Commissioner,
Ontario, Canada

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

PHIPA DECISION 190

Complaint HA19-00300

Trillium Health Partners

October 24, 2022

Summary: The complainant sought a review of the hospital's decision to refuse her request, under the *Personal Health Information Protection Act*, to correct her records of personal health information related to her hospital admission. The complainant sought removal of a form, signed by a physician, requiring her to undergo a psychiatric assessment, and removal of references to her having schizophrenia and suicidal thoughts. The hospital relied on the exception at section 55(9)(b) (professional opinions or observations made in good faith) of *PHIPA* to the duty to correct in section 55(8).

In this decision, the adjudicator finds that the hospital does not have a duty to make the requested corrections under section 55(8) of *PHIPA* because the complainant has not demonstrated that the information is incomplete or inaccurate for the purposes for which the hospital uses the information. As a result, she does not need to consider the exception at section 55(9)(b).

Statutes Considered: *Personal Health Information Protection Act, 2004*, SO 2004, c 3, Sched A, sections 3(1)4i, 4(1)(a), 4(1)(b) and 55(8); *Mental Health Act*, RSO 1990, c M7, section 15.

BACKGROUND:

[1] This complaint arises from the refusal of Trillium Health Partners (Trillium) to make corrections requested by the complainant, under the *Personal Health Information Protection Act* (*PHIPA*), to records relating to her hospital admission (hospital visit) following her call to the paramedics for assistance.

[2] After her hospital visit, the complainant requested access to and obtained copies of Trillium's records of her personal health information. She then submitted a request that Trillium correct two records of personal health information from her hospital visit, the Form 1[1] and the Patient Triage Record. In her correction request, the complainant stated that the Form 1 should be removed from her records because it was based on false information, and that references to her having schizophrenia and being suicidal should be removed from the Patient Triage Record because they are not accurate.

[3] In response, Trillium issued a decision letter refusing the requested correction. Trillium explained that it had contacted the health care providers involved in the complainant's care but they declined to make any changes. The decision letter included, as attachments, responses from a doctor and a triage nurse. The response from the doctor addressed the Form 1 record and stated, "Patient had a history of suicidal attempts, was brought in for concerns of safety and well being with a history where she called EMS [emergency medical services] stating she was having 'suicidal thoughts'." The response from the triage nurse stated that the Patient Triage Record contained notes that were "as per EMS and police reports." Trillium did not specify which section of *PHIPA* it relied on to deny the complainant's correction request.

[4] The complainant was not satisfied with Trillium's decision and she filed a complaint about it with the Information and Privacy Commissioner of Ontario (the IPC). In her complaint letter, the complainant submitted that her records required correction because she was taken to Trillium by ambulance for abdominal pain and symptoms of low magnesium; not for concerns about her mental safety and wellbeing or suicidal thoughts. She asserted that she was placed on a Form 1 due to a communication error between the paramedics, the triage nurse and the emergency room doctor, and since the Form 1 was completed in error, it should be removed from her records. She stated that although she called crisis support at the Canadian Mental Health Association (CMHA) prior to calling the paramedics, Trillium's doctor did not speak with CMHA and would not have known about her mental health history.[2] The complainant also asked that the notation of schizophrenia be removed from her medical history in the Patient Triage Record because she has never been diagnosed with schizophrenia. Finally, the complainant noted that the Patient Triage Record says that she had not been compliant with her medications for the year prior to her hospital visit, even though she had been.

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[1] A "Form 1 – Application by Physician for Psychiatric Assessment" is an application by a physician, under section 15 of the *Mental Health Act*, for a person to undergo a psychiatric assessment to determine whether that person needs to be admitted for further care in a psychiatric facility, as an involuntary or voluntary patient, or if they should be discharged.

[2] The complaint also stated that the complainant had never seen Trillium's doctor before her hospital visit, and, since her records are "lockboxed," there was no way for the doctor to know if she had a history of suicide attempts. The complainant raised this concern during the mediation stage of the complaint as well. She asserted that the doctor could only know about her mental health issues if he had breached her privacy by accessing her records without her consent. The appellant's allegation of a possible breach under *PHIPA* is not an issue that is properly before me in this correction complaint. Accordingly, I will not address it further in this decision.

[5] In support of her position, the complainant provided a progress note, written by a CMHA staff member (the CMHA Progress Note), about her call to the CMHA crisis support line. The CMHA Progress Note states that the complainant reported physical symptoms and concerns, was aware that she needed medical attention, did not want emergency medical services, and feared the police would also attend. It also states that the complainant denied immediate mental health concerns but was extremely anxious about going to the hospital.

[6] In support of her assertion that she was placed on a Form 1 in error, the complainant included a letter from the Peel Regional Paramedic Services (the Paramedic Services Letter). The Paramedic Services Letter was sent to the complainant in response to her advising the paramedic services that information provided by the paramedics inappropriately led to her being placed on a Form 1. The Paramedic Services Letter states that they reviewed the complainant's call for assistance and confirmed that, although their dispatcher and the CMHA crisis support worker did not ask for the police to attend, the paramedics who responded to the complainant's call did ask for the police to attend. The Paramedic Services Letter also confirmed that the patient care report provided by the paramedics to Trillium stated that the complainant "did not report having schizophrenia."

[7] The IPC attempted to mediate the complaint. During mediation, the complainant resubmitted her correction request to Trillium and attached the CMHA Progress Note and the Paramedic Services Letter in support of her request.

[8] In response to the complainant's resubmitted correction request, Trillium sent a letter to the complainant stating that the requested correction was not made and containing written responses from the doctor and the triage nurse. The doctor's response stated, "At this point I cannot retract or make any changes to the care that was given to [the complainant] during her ER visit." The nurse's response stated, "As I was just the triage nurse I only relayed what paramedics told me therefore I cannot change that."

[9] Also, during mediation, Trillium issued a supplementary decision letter to the complainant denying her correction request. In its letter, Trillium submitted that it was denying the complainant's correction request under section 55(9)(b) of *PHIPA*, which 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." Trillium also advised the complainant that she was entitled to prepare a concise statement of disagreement that sets out the refused correction, and that Trillium would attach it to her records and disclose it whenever it discloses records to which the statement relates.[3]

[3] This part of Trillium's decision complies with the notice requirement at section 55(11)(a) and (b) of *PHIPA*, which states:

[10] The complainant disagreed with Trillium's supplementary decision letter and maintained that the Patient Triage Record should be corrected and the Form 1 should be removed from her chart.

[11] Because the complaint could not be resolved at the mediation stage, it was moved to the adjudication stage of the complaint process. I conducted a review of the complaint under *PHIPA* and obtained written representations from the complainant and Trillium on the issues set out below.

[12] For the reasons that follow, I find that Trillium has no duty to correct the records under section 55(8) and I uphold its refusal to correct the records.

RECORDS:

[13] The records at issue are the Form 1 and Patient Triage Record from the complainant's hospital visit. The complainant requests that the Form 1 be removed entirely from her records, and that the references to her having schizophrenia and being suicidal be removed from the Patient Triage Record.

DISCUSSION:

[14] There is no dispute that, as a public hospital, Trillium is a health information custodian under *PHIPA*.[4] There is also no dispute that the records contain the complainant's personal health information as defined in sections 4(1)(a) and (b) of *PHIPA*, which read:

> "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,

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> (11) 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[.]

[4] Section 3(1)4i of *PHIPA*.

> (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[.]

[15] The sole issue in this complaint is whether Trillium has a duty to correct the complainant's personal health information in the records. Section 55(8) of *PHIPA* provides for a right of correction to records of personal health information in some circumstances, and it is relevant in this complaint. Section 55(8) reads:

> 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.

[16] The purpose of section 55(8) of *PHIPA* is to impose a duty on health information custodians to correct records of personal health information that are incomplete or inaccurate for the purposes for which they use the information, subject to the exceptions set out in section 55(9) of *PHIPA*. Section 55(9)(b) of *PHIPA* sets out an exception to the obligation to correct records of personal health information and reads:

> 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.

[17] There is no right under *PHIPA* to have incorrect information in a record removed, replaced, or amended in such a manner that the incorrect information is completely obliterated — it must remain legible. Section 55(10) 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. Accordingly, I cannot consider the complainant's request that the Form 1 be removed from her hospital records. However, I will consider the correction of information in the Form 1 that the complainant asserts is inaccurate.

[18] Regarding the corrections the complainant seeks to her Patient Triage Record, as the individual seeking the correction, she 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) of *PHIPA*. Section 55(8) requires the individual asking for the 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.

[19] If the application of section 55(8) is established, the next determination is whether either of the exceptions in section 55(9) applies.

[20] Previous IPC decisions have found that there is no requirement that all personal health information contained in records held by health information custodians be accurate in every respect. And that, if a request is made for correction of information that has 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.[5]

The parties' representations

[21] In its representations, Trillium confirms that although it has invited the complainant to add a statement of disagreement to her medical chart, she has not done so. Trillium also repeats its reliance on section 55(9)(b) in refusing the complainant's correction request and states that both the doctor and nurse confirmed that the information at issue accurately reflects the information they received from the paramedics.

[22] In her representations, the complainant does not address section 55(8) directly. She argues that Trillium's decision to place her on a Form 1 was based on a miscommunication between the paramedics and the nurse, and was not made in good faith. She states that the CMHA Progress Note and the Paramedics Services Letter support her position. She notes that her hospital records show that she was found not to meet the criteria to remain on the Form 1 during her hospital visit and that she is not schizophrenic. The complainant also remarks on the stigma that people with mental health issues have to deal with on a daily basis, and on the assumptions she believes hospital staff made about her.

Analysis and finding

[23] I have examined the records that the complainant seeks to have corrected and the entire complaint file, and I have considered the parties' complete representations, including all of the representations and materials the complainant provided throughout the complaint process. For the reasons that follow, I conclude that Trillium is not required, by section 55(8) of *PHIPA*, to make the requested corrections.

[24] Although Trillium does not address section 55(8) directly in its representations, its position is that the complainant has not established that it has a duty to correct the Form 1 or the Patient Triage Record. I agree. The complainant's representations do not demonstrate that the Form 1 or the Patient Triage Record are "incomplete or inaccurate

[5] See, for example, *PHIPA* Decisions 36, 39 and 40.

for the purposes for which the custodian uses the information."

[25] For the most part, the complainant's representations amount to disagreement with the accuracy of certain notations in the Form 1 and the Patient Triage Record. For example, the complainant asserts that she has never been diagnosed with schizophrenia, that the paramedics stated that she "did not report having schizophrenia," and that the notation in the Patient Triage Record that she had not been compliant with her medication for the past year is inaccurate. The doctor and the nurse who saw the complainant during her hospital visit and prepared the Form 1 and the Patient Triage Record state that these records accurately reflect the information they gathered and the treatment they provided. Based on my examination of all of the materials before me, I accept the doctor's and the nurse's statements and I agree with Trillium's refusal to correct the information relating to these assertions. 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* – that purpose being to document the information available in order to inform treatment.

[26] The complainant also asserts that the doctor had no basis to make notes about her mental health issues or history. However, the doctor examined and observed the complainant during her hospital visit. Further, the doctor and the triage nurse obtained information from the paramedics and the police. I see nothing improper in the hospital noting the information it had available to it from those sources and using that available information to help inform treatment decisions.

[27] The complainant also argues that the Form 1 and the Patient Triage Record are inaccurate because Trillium later cancelled the Form 1 and discharged her from its care. I do not accept that this is evidence of inaccurate information; rather, it represents one of the possible outcomes of a Form 1 application. As explained in footnote 1 above, a Form 1 is an application by a physician under the *Mental Health Act* for a person to undergo a psychiatric assessment to determine whether that person should be admitted for further care in a psychiatric facility or discharged. The fact that the complainant was discharged and not admitted for further care establishes that the complainant underwent a psychiatric assessment.

[28] Finally, the CMHA Progress Note and Paramedic Services Letter that the complainant provides in support of her position do not establish that the Form 1 and Patient Triage Record are inaccurate. The CMHA Progress Note confirms that the complainant reported that she did not have immediate mental health concerns when she called the CMHA crisis support line, but she was extremely anxious about going to the hospital and concerned about the police being called. The Paramedic Services Letter confirms that, while the dispatcher and the crisis support worker did not contact the police, the paramedics did call the police to attend to the complainant.

[29] I acknowledge and sympathize with the complainant's concerns about the stigma

that comes with suffering from mental health issues. However, I am not persuaded that the records are incomplete or inaccurate for the purposes for which Trillium uses the records, as required to establish the application of the duty to correct in section 55(8) of *PHIPA*. Accordingly, I find that Trillium is not obligated to grant the correction because the complainant has not satisfied the requirements of section 55(8). Given my finding, I need not determine whether the exception under section 55(9)(b) of *PHIPA* applies.

[30] I note that the complainant retains the right to prepare a concise statement of disagreement that sets out the corrections that Trillium has refused to make, and to require Trillium to attach the statement of disagreement as part of the records that it holds of her personal health information and disclose the statement of disagreement whenever it discloses information to which the statement relates.

NO ORDER:

For the foregoing reasons, I issue no order.

Original Signed by: October 24, 2022

Stella Ball
Adjudicator