Information and Privacy Commissioner,
Ontario, Canada

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

PHIPA DECISION 206

Complaint HA21-00238

Jeffery Mark Kelland

April 18, 2023

Summary: The complainant requested, under section 55(1) of the *Personal Health Information Protection Act, 2004* (*PHIPA*), that her former family physician (the physician) make corrections to a record of her personal health information, a progress note. The physician denied the correction request stating that the conditions necessary to require a correction in *PHIPA* had not been met. He also relied on the exception to that duty which permits him to refuse to correct professional opinions or observations made in good faith. In this decision, the adjudicator upholds the physician's refusal to correct the progress note, finding that the exception to the duty to correct, at section 55(9) of *PHIPA*, applies to the personal health information at issue. She dismisses the complaint.

Statutes Considered: *Personal Health Information Protection Act, 2004*, S.O. 2004 c. 3, Sched. A, sections 55(1) and (8), 9(b), (11) and (12).

Decisions Considered: PHIPA Decisions 36, 37 and 71.

BACKGROUND:

[1] This decision addresses a physician's denial of the complainant's request to have corrections made to her medical record under section 55(1) of the *Personal Health Information Protection Act* (the *Act* or *PHIPA*).

[2] The complainant made an access request to her former physician (the physician), under *PHIPA,* for a copy of her patient medical record. In her review of the

records that were provided to her, the complainant identified a progress note that included statements made about her mental health and incidents of self-harm. The complainant advised the physician that the statements recorded in the progress note were inaccurate and made a request under *PHIPA* to have them removed from her medical records.

[3] The physician treated this request as a request for correction under the *Act* and issued a decision denying the complainant's correction request on the basis of "insufficient particulars." The complainant filed a complaint with the Information and Privacy Commissioner of Ontario (IPC).

[4] The IPC assigned a mediator to explore the possibility of a mediated resolution between the parties. During mediation, the complainant advised that she responded to the physician's decision by email, outlining her perspective of what occurred at the appointment during which the statements that she wished to have corrected (or more specifically, struck from the progress note), were recorded. She advised that she sent a second email to the physician, the day after the first, providing him with additional information that she believes supports her position that the information in the notes taken by the physician is untrue. The complainant also noted that she asked that her emails to the physician be included in her medical record as a statement of disagreement.

[5] The custodian provided a response to the complainant's emails advising that he maintains the statements made in the progress note are his professional opinion made in good faith. However, he stated that he would add a page next to the notes that the complainant asked to have corrected, as a statement of disagreement, containing the information that the complainant provided in her emails, specifically, her reasons for why she believes that the statements are untrue. The physician advised that he would make reasonable efforts to disclose the statement of disagreement to anyone to whom he disclosed the progress note, unless doing so would reasonably be expected to have an effect on the ongoing provision of health care or other benefits. The custodian confirmed that he would provide the statement of disagreement to the complainant's new family physician, as the complainant's medical records had recently been provided to that physician.

[6] During mediation, it was clarified that the progress note records the details of a discussion at an appointment between the physician and the complainant about a referral form that the physician sent, several days prior to the discussion, to another medical institution referring the complainant for psychiatric care. It was established that, in the referral form, which includes a standardized list of possible medical conditions experienced by the individual to whom the referral relates, the physician checked off two such conditions; the progress note includes reference to the conditions identified by the physician in the referral form. During the appointment documented in the progress report, the referral form was discussed and the complainant stated that the information in the referral form – and therefore also in the progress note at issue in

this complaint – was not true.

[7] The complainant advised the mediator that not only does she wish to have the statements in the progress note corrected but she also wants to have corrections made to the referral form.

[8] The mediator asked the physician about the referral form. The physician advised that he had not retained a copy of the referral form and it was no longer in his custody or under his control. The mediator communicated this to the complainant. The complainant agreed that the referral would not be at issue in the complaint and that the complaint would only address the progress note. Accordingly, the referral form is not at issue in this appeal.

[9] At the conclusion of mediation, the complainant advised that she was not satisfied with the physician's response as she wants her medical record corrected by having the statements struck from the progress note. The physician advised the mediator that he maintains his decision not to correct the progress note and relies on section 55(9) of *PHIPA* because the statements record his professional opinions and observations made in good faith.

[10] As the parties were unable to reach a mediated resolution, the file was transferred to the adjudication stage of the complaint and I conducted a review under sections 57(3) and (4) of *PHIPA*.

[11] During my review, I sought and received representations from both the physician and the complainant. These representations were shared in accordance with the IPC's confidentiality criteria set out in its *Code of Procedure for Matters under the Personal Health Information Protection Act, 2004.*

[12] For the reasons that follow, I uphold the physician's refusal to correct the progress note based on the exception at section 55(9)(b) of *PHIPA*. I dismiss the complaint.

[13] I acknowledge that, in the course of this review, the complainant made arguments about the referral form that was the subject of the visit documented in the progress note. As stated above, this record was addressed in mediation and removed from the scope of the appeal. It is not before me. Although I will refer to the referral note in this order, I will not make any finding on it.

RECORDS:

[14] The record at issue is a progress note in the complainant's medical record that is dated November 28, 2017. The information that is at issue is several statements written in that note which reference a discussion between the physician and the complainant about a referral made by the physician, several days earlier, for the complainant to

receive psychiatric care from a local medical institution.

DISCUSSION:

Duty to correct

[15] In this complaint, the parties do not dispute that the physician is a "health information custodian" as defined in section 3(1) of *PHIPA* and that the progress note at issue is a record of the complainant's personal health information as defined in section 4(1) of *PHIPA*.

[16] The sole issue to be determined in this appeal is whether the physician has a duty, under *PHIPA*, to correct the progress note in accordance with the complainant's request.

[17] The purposes of *PHIPA* are set out in section 1, and include the right, at paragraph (c):

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

[18] Section 55(1) of *PHIPA* permits an individual who has received access to their personal health information to request that a custodian correct a record "if the individual believes that the record is inaccurate or incomplete for the purpose for which the custodian has collected, uses or has used the information…."

[19] The purpose of section 55 of the *Act* is to impose a duty on health information custodians to correct a record of an individual's personal health information where the record is inaccurate or incomplete for the purposes for which the custodian uses the information, subject to the limited and specific exceptions set out in section 55(9) of the *Act*.

[20] Section 55(8) of *PHIPA* provides for a right of correction to records of personal health information in some circumstances. It states:

> The health information custodian shall grant a request for a correction under subsection (1)[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.

[1] Section 55(1) provides that "If a health information custodian has granted an individual access to a record of his or her 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."

[21] Section 55(9) of *PHIPA* sets out exceptions to the duty to correct records. In this case the custodian relies on the exception at section 55(9)(b) to refuse to correct the record. That section 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.

[22] Read together, sections 55(8) and 55(9) set out the criteria pursuant to which an individual is entitled to a correction of a record of her own personal health information.

[23] In this case, the physician has refused the complainant's request for correction both on the ground that the complainant has failed to satisfy the requirements of section 55(8) (i.e., to demonstrate that the record is incomplete or inaccurate for the purposes for which the custodian uses the information…), and that the exception at section 55(9) applies (i.e., that the record consists of a good faith professional opinion or observation).

[24] Depending on the nature of the correction request, the information that the individual seeks to have corrected, and the reasons for the physician's refusal of the request, the IPC may approach the analysis in a correction complaint initially under section 55(8) or 55(9).[2] In this case I will begin by determining whether the exception at section 55(9) applies.

[25] For the reasons that follow, I find that the exception at section 55(9)(b) applies in the circumstances. It is therefore unnecessary for me to consider whether the complainant has satisfied the requirement of section 55(8). The wording of section 55(9) makes it clear that even if the complainant satisfies the IPC that the information is incorrect or inaccurate within the meaning of section 55(8), a finding that an exception in section 55(9) applies will result in a finding that the custodian has no duty to correct.

Section 55(9)(b): exception for professional opinion or observations

[26] 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. This approach is consistent with the approach taken to similar provisions in

[2] PHIPA Decision 36.

other jurisdictions.[3]

[27] Where a "professional opinion or observation" is involved, section 55(8) does not give a right to request a correction that amounts to a substitution or change to the custodian's "professional opinion or observation," unless it can be established that the professional opinions or observations were not made in good faith. Moreover, 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 the complainant's view of a medical condition or diagnosis.

[28] Where the custodian claims that section 55(9)(b) applies, 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 the custodian has established that the information qualifies as a "professional opinion or observations," the onus is on the individual seeking a correction to establish that the "professional opinion or observation was not made in good faith.

[29] Therefore, section 55(9)(b) 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."

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

[30] In order for section 55(9)(b) to apply, the personal health information must either 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*.

[31] The progress note at issue in this complaint is a record prepared by the physician, who was the complainant's family physician at the time. It documents a visit by the complainant during which a discussion was had about a referral that the physician made to another medical institution. The progress note states that the physician indicated in the referral form that the complainant was experiencing two specified conditions.

The parties' representations

[32] The physician notes that the statements in the progress note that the

[3] See for example Orders H2004-004, H2005-006 and H2005-007 of the Information and Privacy Commissioner of Alberta.

complainant wishes to have corrected reflect his professional opinions or observations which, based on the reasoning expressed by the adjudicator in PHIPA Decision 71, are subjective and can be based on grounds that are short of proof. He submits that, as also established in PHIPA Decision 71, his professional opinions or observations are characterized by a belief based on something he has seen, heard or noticed. The custodian explains that based on his assessment of the complainant he formed an opinion that she was exhibiting the conditions described in the referral form and therefore the progress note.

[33] To support his position that his opinions or observations reflected in the progress note qualify as being "professional," the physician submits that as an experienced family physician, registered with the College of Physicians and Surgeons of Ontario, he had the necessary qualifications, knowledge, judgment and experience in medicine necessary to form the opinions or observations that it contains. He submits that it is within the scope of a family physician's practice to make a referral to a specialist or other health care provider and it is routine for family physicians to assess and treat their patients' mental health during their regular appointments. He submits that his training and experience were sufficient for him to assess the complainant's mental health in order to make the referral and compile a progress note during an appointment at which the complainant's mental health was assessed. He submits that his opinions and observations made in the complainant's records of personal health information were grounded in the application of his training and experience as a family physician and his assessment of the complainant as his patient, which led him to conclude that a referral for psychiatric medical care was necessary. He submits that the progress note discussed the symptoms recorded in the referral form which required the expertise of a medical professional and therefore, its content qualifies as his professional opinion or observation made within the scope of his practice.

[34] The complainant submits that the statements at issue in the progress note are not only inaccurate but false. She submits that she wants that information struck from her medical records to make it clear that she never described her condition to the physician in the way that the physician described it in the referral form or the progress note. She also submits that the physician could not have observed the behaviour at issue because it never occurred.

[35] The complainant further submits that nowhere in her medical records prior to the referral, is there any reference to her experiencing the conditions described by the physician; she submits that the physician "did not chart about it even once in 14 years." She notes, in particular, that none of the earlier progress notes that record visits with the physician, including one from a visit that occurred just more than a month earlier than the progress note at issue, make any such references. She submits that the first reference by the physician to the conditions arose in the referral form, a record created six days before the progress note.

[36] In her representations, the complainant further states that, in addition to the

progress note, she would like the referral form completed by the physician to be corrected. She submits that she would like clear documentation clarifying that at no point did she tell the physician that she was experiencing the conditions described by the physician. She argues that because the referral form required the physician merely to check boxes, these notations and the other references in the progress note are not subjective professional opinions because there was never any physical evidence to support them. She submits that this is mistaken information and the physician has refused to correct it.

Analysis and findings with respect to whether the statements consist of professional opinions or observations

[37] I note that in her representations the complainant submits that not only does she wish to have statements in the progress note corrected but she also wishes to have the referral form corrected. As indicated above, in the background to this decision, the referral form itself is not a record that is before me in this complaint. During mediation the physician advised that he had not retained a copy and the complainant agreed that the referral would not be at issue in the complaint. Despite this, the physician attached a copy of the referral form was attached to his representations.[4] Although the referral form is not before me, I note that it contains similar information to that which the appellant seeks to have corrected in the progress note.

[38] As indicated above, the purpose of the section 55(9)(b) exception is to preserve "professional opinions or observations," *accurate or otherwise,* that have been made in good faith. Therefore, the application of section 55(9)(b) does not turn on whether the personal health information is objectively true or accurate; the exception may apply to personal health information even if that information is inaccurate, provided that the information qualifies as a "professional opinion or observation," made "in good faith." In this case, I find that the information that the complainant seeks to have corrected in the progress note qualifies as the physician's professional opinion or observation within the meaning of section 55(9)(b), for the following reasons.

[39] In my view, the statements in the progress note are an obvious application of professional judgment and experience on the part of the physician, a regulated health professional. I am satisfied that the physician's statements represent an exercise of his professional knowledge and skills in the course of information-gathering to arrive at a clinical judgment. I acknowledge the complainant disputes the accuracy of the opinions or observations made by the physician. However, this does not mean that they were not professional in nature. Whether or not these statements are inaccurate does not affect their classification as professional opinions or observations within the meaning of

[4] In his representations, the custodian advised that although he no longer has a copy of the referral form in his own records, for the purposes of this appeal, when preparing his representations, he contacted the medical institution to which the referral was made and obtained a copy of the form.

section 55(9)(b).[5]

The professional opinions or observations were made "in good faith."

[40] If there are reasonable grounds to conclude that the professional opinions or observations made by the custodian were not made "in good faith" within the meaning of section 55(9)(b), the section 55(9)(b) exception to the duty to correct cannot apply.

[41] Courts 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 persons are assumed to act in good faith unless proven otherwise. Therefore, the burden of proof rests on the individual seeking to establish that a person has acted in the absence of good faith to rebut the presumption of good faith.[6] Accordingly, in the context of section 55(9)(b) of the *Act*, the burden rests on the individual seeking the correction, here, the complainant, to establish that the physician did not make the professional opinion or observation in good faith.

The complainant's representations

[42] The complainant states that she does not believe that the physician made the statements in the progress notes in good faith. She submits that a lie is not ever told in good faith. The complainant submits that the statements are lies because, as noted above, the progress notes that record visits with the physician just more than a month previously do not contain similar statements about the conditions included in the referral form and the progress note. She also submits that the physician could not have observed any evidence of the conditions at issue because she did not ever engage in behaviour characteristic of either condition. The complainant submits that the physician should be required to support his statements and be asked directly if he saw any evidence of the conditions.

Analysis and finding on whether the professional opinions or observations were made in good faith

[43] Having considered the evidence provided by the complainant, I find that there is insufficient evidence to conclude that the physician acted with malice or an intent to harm the complainant or that he acted with serious carelessness or recklessness when he made the specific professional opinions or observations that the complainant wishes to have corrected. I find that the complainant has not met the onus of establishing that the professional opinions or observations recorded in the progress note were not made in good faith. Therefore, I find that the physician's professional opinions or observations in the complainant's medical records were made in good faith.

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[5] PHIPA Decisions 36, 37 and 193.

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

Conclusion

[44] In conclusion, I find that the personal health information that the complainant requests be corrected in the progress note dated November 28, 2017 consists of professional opinions or observations that were made in good faith. Therefore, the exception at section 55(9)(b), to the duty correct at section 55(8), applies and the physician is not required to make the requested corrections to the progress note.

Statement of disagreement

[45] Sections 55(11) and (12) of *PHIPA* give an individual whose correction request has been refused the right to prepare and to have attached to the record a statement of disagreement that sets out her requested corrections to the record. I accept that the complainant has exercised her right in this regard.

[46] From the physician's representations, it is my understanding that information from two emails that the complainant sent to the him outlining why she wants the information corrected was documented in an additional page attached to the progress note and included in her file as a statement of disagreement. As the complainant has not objected to the manner in which the physician addressed the inclusion of a statement of disagreement in her file, I will not comment on it.

[47] It is also my understanding that the physician has made all reasonable efforts to disclose the statement of disagreement to any person to whom the physician has already disclosed the progress note, specifically the complainant's new family physician.

NO ORDER:

For the foregoing reasons, I dismiss the complaint.

Original signed by: April 18, 2023

Catherine Corban
Adjudicator