Information and Privacy Commissioner,
Ontario, Canada

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

PHIPA DECISION 248

Complaint HA22-00110

LifeMark Health

June 20, 2024

Summary: The complainant submitted a twelve-part correction request under the *Act* to a health information custodian for the correction of her personal health information within a psychotherapy consultation report. The custodian denied the request on the basis that it did not have a duty under section 55(8) of the *Act* to make the corrections. In this decision, the adjudicator upholds the custodian's refusal to correct the report, finding that the exception to the duty to correct at section 55(9)(b) of the *Act* 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), (8), (9)(b), and (11).

Decisions Considered: PHIPA Decision 36.

BACKGROUND:

[1] The complainant made a correction request under the *Personal Health Information Protection Act* (the *Act*) to LifeMark Health (the custodian). She asked that the custodian make twelve corrections to a Psychotherapy Consultation Report containing her own personal health information pursuant to section 55(1) of the *Act*.

[2] The custodian denied the correction request in full. The custodian's decision did not identify which sections of *PHIPA* they were relying on in making this denial, but did note the following:

> Please note that under *PHIPA*, correction requests can be denied in cases where the record is not deemed "incomplete or inaccurate for the purposes for which they use the health information" and also in cases that "the record contains professional opinions or observations that were made in good faith".
>
> As such there will be no change to your report, as it is not deemed incomplete or inaccurate for the purpose it is used for and as it contains professional opinions and observations that were made in good faith.

[3] In its decision, the custodian stated that the consultation documented in the Psychotherapy Consultation Report had been done for "intake/treatment planning purposes for a third-party payor referral," noting that the referral itself was for the purpose of the complainant's return to work. The decision further stated that no diagnosis was rendered as part of that process, and that "the assessment was complete and accurate for the purpose of its intended use/referral question/source."

[4] The complainant filed a complaint with the Information and Privacy Commissioner of Ontario (the IPC). During the mediation of this complaint, the complainant stated that she requested corrections to the report because she felt that it did not accurately reflect the assessment that occurred and could lead to inappropriate treatment recommendations. The custodian confirmed that it would not be making the requested corrections, stating that their decision not to do so was based on sections 55(8) and 55(9) of the *Act*.

[5] As mediation did not resolve the complaint, the matter was transferred to adjudication where an adjudicator may conduct a review. The adjudicator assigned to this complaint file decided to conduct a review and sought representations from both the custodian and the complainant. The file was then transferred to me. I reviewed the parties' representations and determined that I did not need to hear from them further before making my decision.

[6] In this decision, I find that the custodian does not have a duty under section 55(8) to correct the complainant's personal health information in the report, because the exception to the duty to correct at section 55(9)(b) of the *Act* applies. I dismiss the complaint.

RECORD:

[7] The record at issue consists of a four-page Psychotherapy Consultation Report, dated April 18, 2022 (the report).

DISCUSSION:

[8] There is no dispute between the parties, and I find, that the custodian is a health information custodian as defined in section 3(1) of the *Act*. I also find that the report contains the complainant's personal health information under section 4(1) of the *Act*.

[9] The sole issue to be determined is whether the custodian has a duty to make the corrections requested by the complainant. The requested corrections are:

- That the complainant advised the psychotherapist of physical and developmental diagnoses that she believes to be relevant to the assessment, and which were not mentioned in the Report. [Corrections 1 and 2]

- That the psychotherapist failed to note relevant information provided during the assessment in the Report, including: the complainant's need to ask for her wife's assistance on details; that the complainant's wife agreed with the complainant that her symptoms are not the result of anxiety and depression; and the full list of symptoms that the complainant shared. [Corrections 3-5]

- That the psychotherapist did not record that the complainant's answers to a questionnaire were due to physical, not mental, health symptoms. [Correction 6]

- That the complainant stated that she was coping well, but the complainant asserts that the psychotherapist documented the opposite. [Correction 7]

- That the psychotherapist incorrectly captured various physical conditions or issues as aversion to or fear of leaving her home. [Corrections 8-10]

- That the complainant disagrees with the psychotherapist's comments on the utility of treatment options. [Correction 11]

- That the complainant disagrees with the psychotherapist's statement that the complainant had anxiety and depression symptoms. [Correction 12]

[10] Section 55(1) of the *Act* provides for a right of correction to records of personal health information in some circumstances. It 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, used or has used the information."

[11] This right is subject to the exceptions set out in section 55(9) of the *Act*. Only section 55(9)(b) is relevant in this complaint[1]. It reads:

[1] Section 55(9)(a) provides an exception to the right of correction in cases where the record of personal health information "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."

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

Representations

[12] The custodian states that the purpose of the psychotherapy consultation was to "briefly assess mental health symptomology and related barriers" and propose treatment, to support a return to work. They note that the report reflects all issues flagged by the complainant, and that it is standard practice to summarize the client's presentation and concerns. They take the position that the record is not inaccurate or incomplete.

[13] The custodian also provides reasons why it denied the various corrections requested. For the corrections where the complainant had noted a failure to include information that she had provided, the custodian points out other portions of the report where similar information was mentioned, and also notes that they do not list all symptoms within these types of reports. In instances where the complainant states that the report did not reflect what she had said, the custodian states that the report captured the assessor's clinical interpretation and that these were not direct quotes from the complainant.

[14] The custodian states that the registered psychotherapist who conducted the consultation provided their professional opinions and observations in the report. The custodian states that these were made in good faith, with no reason to believe the psychotherapist "acted with malice, intent to harm, or with serious carelessness or recklessness."

[15] As noted above, the complainant made a complaint to the IPC because she believes that the report did not accurately reflect what had occurred during the assessment. Her request for corrections includes her reasons for seeking each listed correction. The complainant was not able to make representations during the adjudication stage, citing medical reasons, but did state "the report includes some language that claims to be statements from [the complainant] when it was not." She believes that the report should have made clear that the noted statements were professional opinion, rather than something that she (the complainant) said. In my analysis, I will consider both the reasons the complainant provided within her correction request and her later concerns about confusion in attribution of statements.

[16] In its reply representations, the custodian states that it is its standard practice to summarize the client's presentation and concerns, and that "statements within the report are summary/interpretation of all data coupled with clinical judgement." The custodian notes that these reports often do not include direct quotes from clients, and that when they do, they use quotation marks. Regarding the specific passages the complainant

raised attribution concerns with, the custodian states that these were made in good faith and were an accurate representation of the assessor's impression based on the statements made and symptoms reported by the complainant.

Analysis and Findings

[17] Depending on the nature of the correction request, the information that the individual seeks to have corrected, and the reasons for the custodian'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)(b) applies. If it does, there is no duty to make a correction under section 55(8), and no need to further address the duty to correct under that section.

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

[18] 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 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 other jurisdictions.[3]

[19] 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.

[20] 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.

[21] 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." Regarding the latter question, the burden rests on the individual seeking the correction to establish that the health information custodian did not make the professional

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[2] PHIPA Decision 36.

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

opinion or observation in good faith.[4]

[22] 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*.

[23] The report at issue in this complaint is a record prepared by a psychotherapist on behalf of the custodian. It is based on a video conference between the psychotherapist and the complainant, for the purpose of mental health assessment and possible treatment, with the goal of supporting the complainant's return to work. The report itself includes sections on confidentiality/informed consent, a description of the complainant's presentation during the interview, the complainant's history, and the complainant's medications. It also includes the results of questionnaires administered to the complainant, the potential barriers for the complainant's return to work, and recommendations to support this return to work.

[24] The complainant's requested corrections fall throughout the various sections of the report. Some of these seek to correct matters that are clearly the psychotherapist's professional opinion or observation, such as the complainant's disagreement with the psychotherapist's recommendation of a treatment option. Others are more descriptive of the complainant's experiences and situation, as communicated during the assessment.

[25] This range of information is similar to what was at issue before the adjudicator in PHIPA Decision 36. In that case, the adjudicator described the contents of a psychological assessment that a complainant sought to have corrected as follows:

> [38] I find that the parts of the report that contain the psychiatrist's assessment and diagnosis falls squarely into the category of "professional opinion or observation." Examples of this type of information are the writer's description of past medical episodes and diagnoses in addition to the writer's discussion of the results of his assessment and testing.
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> [39] Other parts of the report contain descriptions of the complainant's childhood, interpersonal relationships, family dynamics, work history and other background matters. Although these types of observations are about background matters, rather than clinical matters they may also qualify as "professional observations" if they are not merely a transcription of the information conveyed by the complainant, but involve judgment and discernment and therefore, the exercise of special knowledge, skills, qualifications, judgment or experience by a professional.

[4] See, for example, PHIPA Decisions 37 and 67.

[26] Similar reasoning applies to the case at hand. The complainant's first six requested corrections largely seek to add information that the psychotherapist did not include in the report. Part of documenting a professional opinion or observation includes determining relevance of information. In this case, the psychotherapist was utilizing her skills and knowledge to conduct an assessment, and in doing so, chose what information was relevant to the assessment.

[27] The last two corrections apply to the recommendations section of the report, in which the complainant disputes both the utility of a recommended treatment and that she is experiencing anxiety and depression symptoms. Recommendations for treatment and assessment of symptoms are clearly matters of professional opinion or observation.

[28] The remaining requested corrections are found in the section of the report relating to potential barriers for return to work. These are the statements that the complainant identified as potentially being attributed to her. Having reviewed these statements within the context of the report, I agree with the custodian that these are the psychotherapist's professional observations regarding the complainant's situation and how that may impact her return to work.

[29] Overall, I am satisfied that the psychotherapist who authored the report applied their professional knowledge and skills in making the observations and opinions that the complainant seeks to have corrected. In my view, the complainant's request to correct this information seeks to substitute or rewrite the psychotherapist's opinions or observations found in the report.

[30] Accordingly, the complainant has no right of correction, unless the professional opinions or observations were not made in good faith. As noted above, the burden rests on the individual seeking the correction to establish this.

[31] Neither the complainant's reasons for requesting the corrections (as set out in the correction request) nor her representations allege bad faith on the part of the custodian. The custodian states that there is no known history or relationship between the psychotherapist and either the complainant or the insurer that would impair her judgment or create a conflict of interest. The custodian states that the psychotherapist acted in accordance with the custodian's policies and procedures, and that there is no reason to believe that the psychotherapist "acted with malice, intent to harm, or with serious carelessness or recklessness."

[32] I find that there is no evidence before me that indicates that the psychotherapist's professional observations or opinions were made in bad faith. I find that the exception at section 55(9)(b) applies in the circumstances of this complaint and, accordingly, the custodian does not have a duty to correct the record under section 55(8) of the *Act*.

[33] Though I have found that the custodian is not required to make the requested corrections, the *Act* gives the complainant the right to attach a statement of disagreement

to the Report, conveying her disagreement with the information contained in that record.[5]

NO ORDER:

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

Original signed by: June 20, 2024

Jennifer Olijnyk
Adjudicator

[5] Section 55(11) of the *Act* 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