Information and Privacy Commissioner,
Ontario, Canada

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

PHIPA DECISION 258

Complaint HA23-00059

St. Mary's General Hospital

October 9, 2024

Summary: The complainant asked a hospital to remove personal health information from records of his visits to a hospital's pacemaker clinic. The custodian denied the correction request, but later added information to one of the visit notes that addressed some of the complainant's concerns. In her decision, the adjudicator finds that the hospital provided an adequate response to the complainant's correction request. She finds no purpose would be served by conducting a review of the complaint because deletion of personal health information is not permitted as part of a patient's right to seek correction of records under the *Act*.

Statutes Considered: *Personal Health Information Protection Act, 2004*, S.O. 2004, sections 55 and 57.

BACKGROUND:

[1] This decision addresses a complaint under the *Personal Health Information Protection Act, 2004* (the *Act*) to the Information and Privacy Commissioner of Ontario (IPC) about a hospital's refusal of the complainant's request to remove portions of his personal health information from the hospital's records. The records document two visits to the hospital's device clinic, occurring in May and November of 2021.

[2] In his correction request, the complainant asked for the removal of the following:

- all references to a consultation with a named doctor (the first doctor) at his May 2021 visit;

- all references to high blood pressure;
- all discussions of risks and benefits of a pacemaker upgrade; and
- all references to a meeting and telephone call with another named doctor (the second doctor) regarding a pacemaker upgrade.

[3] In response, the hospital issued a decision letter, denying the correction request. It stated that hospital staff had met with the relevant clinicians. These clinicians reported that the information was not inaccurate and reflected their observations and clinical assessments made when providing care to the complainant. The hospital relied on the exception at section 55(9)(b) to the duty to correct at section 55(8) of the *Act*, asserting that the hospital is not required to correct a record of personal health information that consists of a professional opinion or observation that a custodian has made in good faith about the individual.

[4] The complainant was dissatisfied with the hospital's decision and filed a complaint with the IPC. In that complaint, he stated that based on the existing entries, staff at another hospital interpreted his chart to say that he had refused a pacemaker upgrade. The complainant further stated that this affected his treatment at the other hospital.

[5] During mediation, the complainant clarified his concerns regarding the records of his visits. He stated that during his May 2021 appointment, the first doctor did not speak with him. Instead, the first doctor only spoke to the nurse practitioner and signed some papers before leaving. Because of this, the complainant believed that the opinion in his records, though attributed to the doctor, is that of the nurse practitioner.

[6] The complainant also stated the records include a high blood pressure reading. The complainant asserted this reading was an isolated instance, and provided evidence to show he did not suffer from high blood pressure.

[7] Regarding his requested correction of the notes from the November 2021 appointment, the complainant stated there were no discussions regarding upgrading his pacemaker, and that he did not have any meeting or call with the second doctor regarding a pacemaker upgrade.

[8] In response, the hospital stated that the nurse practitioner had since added a note to the complainant's chart to address his concerns about the May 2021 visit. This note addressed the disputed high blood pressure reading, noting that it was an isolated reading and not enough for a diagnosis. The nurse's note also stated that there had only been a brief mention of a device upgrade at the May 2021 visit, and that no in-depth, detailed discussion of that treatment option took place.

[9] Regarding the complainant's concerns about the first doctor's involvement, the hospital stated that the doctor reviewed the complainant's chart prior to the

appointment, and that the nurse practitioner consulted with the doctor.

[10] Regarding the requested corrections to the November 2021 visit summary, the hospital stated the second doctor confirmed that the complainant's chart is accurate. The second doctor also stated that he met with the complainant, and that the note in the complainant's chart was proof of the patient-provider encounter.

[11] The complainant remained unsatisfied with the hospital's response. He asked that his complaint proceed to the adjudication stage of the complaint process, where an adjudicator may decide to conduct a review.

[12] After reviewing the materials in the file, the adjudicator made a preliminary assessment that there were no reasonable grounds for a review. She notified the complainant of her preliminary assessment and gave the complainant an opportunity to provide written representations in response to her preliminary assessment if he disagreed.

[13] The complainant submitted representations, stating that he is satisfied with the hospital's response regarding the inclusion of references to consultation with the first doctor and the high blood pressure reading.

[14] The complainant remains dissatisfied with the inclusion of references to a discussion about a device upgrade and a follow up call or meeting within the records. In support of his position that the hospital should make the remaining requested corrections, the complainant maintains that there was no discussion with the second doctor of the risks and benefits of a pacemaker upgrade at the November 2021 visit and no telephone call at any time afterwards. The complainant states that his current doctor and pacemaker clinic staff have informed him that there is nothing wrong with his pacemaker. The complainant also notes that he suffered negative consequences because of that information remaining in his medical records.

[15] The file was then transferred to me. I reviewed the materials on file, including the preliminary assessment and the complainant's representations provided in response. I agree with the former adjudicator's preliminary assessment and determined that I did not need to hear further from the parties before making my decision.

[16] In this decision, I find that the hospital responded adequately to the complaint in the circumstances, and that no useful purpose would be served by conducting a review because the complainant seeks remedies that are not available under the *Act*. In the result, I exercise my discretion under sections 57(3) and (4) of the *Act* not to review this matter and I dismiss the complaint.

DISCUSSION:

[17] There is no dispute that the hospital is a "health information custodian" under

section 3(1) of the *Act* or that the records contain the complainant's personal health information as defined in section 4(1).

[18] The sole issue in this complaint is whether the hospital has a duty to correct the complainant's records of personal health information in accordance with the complainant's request.

[19] I have the authority under sections 57(3) and (4) to decide whether to conduct a review of a complaint. These sections state, in part, that:

> (3) If the Commissioner does not take an action described in clause (1)(b) or (c) or if the Commissioner takes an action described in one of those clauses but no settlement is effected within the time period specified, the Commissioner may review the subject-matter of a complaint made under this Act if satisfied that there are reasonable grounds to do so.[1]
>
> (4) The Commissioner may decide not to review the subject-matter of the complaint for whatever reason the commissioner considers proper, including if satisfied that,
>
> > (a) the person about which the complaint is made has responded adequately to the complaint…

Should the complaint proceed to a review under the *Act*?

[20] Section 55(1) of the *Act* permits an individual to request that a custodian correct a record of personal health information 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.

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

> The health information custodian shall grant a request for correction under subsection (1) if the individual demonstrates, to the satisfaction of the custodian, that the record is incomplete or inaccurate for the purposes

[1] Sections 57(1)(b) and (c) read as follows:

> 57 (1) Upon receiving a complaint made under this Act, the Commissioner may inform the person about whom the complaint is made of the nature of the complaint and,
>
> …
>
> (b) require the complainant to try to effect a settlement, within the time period that the Commissioner specifies, with the person about which the complaint is made; or
>
> (c) authorize a mediator to review the complaint and to try to effect a settlement, within the time period that the Commissioner specifies, between the complainant and the person about which the complaint is made.

> for which the custodian uses the information and gives the custodian the information necessary to enable the custodian to correct the record.

[22] Section 55(9) sets out exceptions to the duty to correct records. It states that, despite section 55(8), a custodian is not required to correct a record of personal health information if it consists of a record that was not originally created by the custodian and the custodian does not have sufficient knowledge, experience or authority to correct the record (section 55(9)(a)), or if the record consists of a professional opinion or observation that a custodian made in good faith about the individual (section 55(9)(b)).

[23] Read together, these provisions set out the hospital's duty to correct records of personal health information that are inaccurate or incomplete for the purposes for which the hospital uses the information, provided that the complainant meets the two requirements set out in section 55(8) (and if so, then subject to the exceptions set out in section 55(9)(a) and (b)).

[24] Section 55(10) sets out how corrections are to be made. If it is possible to record the correct information in the record, section 55(10)(a)(i) specifies that the incorrect information is to be struck out "in a manner that does not obliterate the record." There is no right under the *Act* to have the incorrect information in a record removed, replaced, or amended in such a manner that the incorrect information is completely obliterated. This information must remain legible.

[25] Section 55(10) provides a constraint on the orders that adjudicators may make regarding correction of personal health information. As noted by the previous adjudicator in her preliminary assessment, if an adjudicator were to conduct a review and ultimately find that there was a duty to correct the information in the medical chart, the adjudicator could only order the custodian to strike out the incorrect information in such a way that the original entry would remain legible.

[26] The IPC has previously held that no useful purpose is served by reviewing a complaint in circumstances where a complainant seeks to have deletions made to their medical records, which is not a remedy that is available under the *Act*.[2] I agree with this approach and adopt it regarding this complaint, as the previous adjudicator did in reaching her preliminary decision.

Analysis and decision

[27] As noted above, the complainant states that he is satisfied with the custodian's response to his first two correction requests, relating to his blood pressure reading and consultation with the first doctor. The remaining requested corrections are for the removal of discussions of risks and benefits of a pacemaker upgrade and the removal of references to a meeting and telephone call with the second doctor. Both the May 2021 and November 2021 visit notes remain at issue, and I will address each separately.

[2] See, for example, PHIPA Decision 171.

May 2021 visit notes

[28] The May 2021 visit notes state that if medication does not improve a complainant's symptoms "then we will discuss the risks and benefits of device upgrade." In her preliminary assessment, the previous adjudicator noted that the nurse practitioner added a note to that record stating that there was only a "brief mention" of a pacemaker upgrade. The nurse practitioner's note states that there was no in-depth discussion of a pacemaker upgrade, as they had not yet determined if the upgrade was required.

[29] The previous adjudicator's view on this point, as set out in her preliminary decision, was that the amendment to the complainant's chart provides clarification on the extent of the discussion regarding an update to his pacemaker. While the complainant requested that the reference to the discussion be deleted, section 55(10) does not permit the existing personal health information to be deleted. I agree with the previous adjudicator's view that even if the complainant were to demonstrate that the hospital was required to grant his correction request, the custodian's response of adding an annotation to the complainant's chart addressing the May 2021 office visit meets the requirements of section 55(10) of the *Act*.

November 2021 Visit Notes

[30] The November 2021 visit notes state that the second doctor discussed the risks and benefits of a pacemaker upgrade with the complainant. They conclude with the statement that "[we] will chat again about [the complainant's] final plan when he has made up his mind."

[31] After receiving the correction complaint, the hospital contacted the second doctor about the discussion. The doctor's position was that he met with the complainant and the fact that their discussion was documented is contemporaneous evidence that the meeting took place. The second doctor also stated that the complainant's chart is accurate.

[32] Under section 55(8), the onus is on the individual to demonstrate that the record is inaccurate for the purposes for which the custodian uses the information for the duty to correct to apply. The complainant asserts that no discussion of a pacemaker upgrade took place, based on his own recollection of the encounter. He also states that no phone call took place at any time later, and states that his telephone records support this position. To support its position, the custodian cites both the physician's recollection, as well as the documentation in the records from the time of the visit. Given that the only evidence cited by the complainant regarding the discussion that took place during the November appointment was his recollection, the previous adjudicator's preliminary view was that the complainant would not be able to establish that the custodian had a duty under section 55(8) to grant the requested correction.

[33] In addition, from my review of the file, it appears that none of the parties are claiming that a follow-up phone call occurred. The November 2021 visit notes include a stated intention on the part of the physician to "chat later" but do not document a call. While I accept the complainant's statement that no follow up call occurred, this does not contradict the statement that is in the records – namely, that the second doctor intended to speak to the complainant about this matter at some point in the future.

[34] Having reviewed the records, the preliminary assessment, and the complainant's representations, I am of the view that were I to enter into a review of this matter, the complainant would not be able to establish the custodian's duty to correct as set out in section 55(8) of the *Act*. The statement that no follow up call took place is not relevant to the question of the whether the record is inaccurate for the purposes for which the custodian uses it. Beyond this point, the complainant and the doctor have different accounts of what occurred during the November 2021 meeting, and with only the complainant's recollection to support a request to correct that information, the duty to correct is not established.

[35] Further, even if the complainant was able to establish the duty to correct and that the exception relied upon by the custodian under section 55(9)(b) does not apply, the custodian's duty to correct does not include the removal of personal health information in the complainant's chart.

[36] In accordance with my authority under sections 57(3) and 57(4)(a) of the *Act* and for these reasons, I have decided not to conduct a review into this complaint.

NO REVIEW:

For the foregoing reasons, no review of this matter will be conducted under Part VI of the *Act.*

Original Signed by: October 9, 2024

Jennifer Olijnyk
Adjudicator