Information and Privacy Commissioner,
Ontario, Canada

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

PHIPA DECISION 285

Complaint HA23-00272

Unity Health Toronto

June 20, 2025

Summary: The complainant made a request under the *Personal Health Information Protection Act* to a health information custodian, asking the custodian to correct his personal health information on an MRI report.

The custodian denied the request, stating that it did not have a duty under section 55(8) of the *Act* to make the correction.

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 3(1), 4(1), 55(1), (8), (9) (b), and (11).

Decisions Considered: PHIPA Decision 197.

Cases Considered: *Finney v. Barreau du Québec*, 2004 SCC 36.

BACKGROUND:

[1] The complainant made a request under the *Personal Health Information Protection Act* (the *Act*) to Unity Health Toronto (the custodian) to correct records of his personal health information relating to an MRI he was given after seeking care at the custodian's emergency department. The complainant states that the records from his visit incorrectly

state that he only complained of cervical spine pain; he maintains that he informed health care staff that he was also experiencing upper thoracic spine pain. The complainant states that the MRI was described as only relating to his cervical spine, when it ought to have also covered the thoracic part of his spine.

[2] The custodian denied the correction request, stating that it was not satisfied that the record was incomplete or inaccurate. In its decision letter, the custodian did not cite the sections of the *Act* it relied upon to deny the complainant's request.

[3] The complainant filed a complaint with the Information and Privacy Commissioner of Ontario (the IPC). During the mediation of this complaint, the custodian stated that it relied upon section 55(8) of the *Act* to deny the correction request, and provided additional reasons for its decision:

> In summary, it was not believed that your MRI report was incomplete or inaccurate. In response to your request, the physician later iterated that the clinical information indicated on the MRI requisition clearly stated "cervical pain, weakness R arm, injury a few months, xr imaging negative, rule out spinal cord injury". As a result of the MRI requisition, the cervical spine MRI was done as requested, however a thoracic spine was not requested and therefore was not done. The physician concluded that there were no thoracic spine images available for them to report on.

[4] As mediation did not resolve the complaint, the file was transferred to adjudication where an adjudicator may conduct a review. I was assigned this file, and I decided to conduct a review. I sought and received representations from both the complainant and the custodian.[1] In its representations, the custodian clarified that it relied upon both section 55(8) and 55(9)(b) in making its decision.

[5] 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 records, because the exception to the duty to correct at section 55(9)(b) of the *Act* applies. I dismiss the complaint.

RECORD:

[6] The record at issue is a two-page MRI Cervical Spine Routine Results Report (the MRI report).

[1] Representations were shared in accordance with the IPC's *Code of Procedure for Matters under the Personal Health Information Protection Act, 2004*.

PRELIMINARY MATTER:

[7] Before addressing the correction complaint, I note that the complainant's representations allege that the custodian was not forthcoming with documentation. However, the only issue before me in this complaint is whether the custodian has a duty to make the requested corrections to the MRI report. If the complainant wishes to obtain further records of his personal health information from the custodian, he may make an access request under the *Act* for those records.

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 MRI report contains the complainant's personal health information, as defined under section 4(1) of the *Act*.

[9] The sole issue to be determined is whether the custodian has a duty to make the correction requested by the complainant, which he set out as:

> I visited [the emergency department of the custodian] on Oct. 18, 2023. I explicitly told triage, the medical student who saw me, and the first ED doctor who saw me that I was experiencing pain/discomfort from my neck down to my shoulder blades. I explicitly stated that the pain was in my lower cervical and upper thoracic spine. An MRI was performed on the same day but the report omits my complaint of thoracic spine pain and instead states in the clinical history that I only complained of cervical spine pain. This is wrong and the MRI report from [named doctor] only covers the cervical spine. I now request that the report be corrected to cover my thoracic spine and include the confirmation [the named doctor] gave me by phone today that the MRI covered my thoracic spine and nothing is wrong with it.

[10] The above correction request indicates that at that time he made his request, the complainant thought that the imaging had been taken of both his cervical and thoracic spine, but only the cervical portion had been recorded. Since that time, the complainant has had additional correspondence with the hospital, including during mediation of this complaint, and it appears that the complainant no longer asserts that the MRI was done on both his cervical and thoracic spine. Rather, based on the complainant's representations, addressed in detail below, his current position appears to be that the MRI should have included his thoracic spine but did not due to negligence or carelessness of the custodian's staff. The complainant wishes for this alleged error to be reflected in the MRI report.

[11] 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."

[12] 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[2]. It reads:

> 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.

The Parties' Representations

[13] While the correction request relates to the MRI report, the custodian provided some background information regarding the complainant's emergency department visit and the resulting MRI requisition form. The custodian acknowledges that its records show that the complainant mentioned thoracic spine pain when he presented to the emergency department.[3] However, the custodian states that the emergency room doctor ordered an MRI of the cervical spine only, based on his professional medical opinion. The custodian states that this opinion was informed by the physical/neurologic exam that doctor conducted on the complainant and was supported by his knowledge and experience in neuroanatomy.

[14] The custodian notes that radiologists do not complete a physical assessment of a patient or have direct contact with the patient. This is the role of the referring physician – in this case, the emergency department doctor. The custodian states that it is standard practice for radiologists to carry out the orders as set out in requisition forms. The custodian states that, in this case, the radiologist and the medical imaging team used the background information in the MRI requisition form to inform care by conducting, and later analyzing, the cervical MRI ordered.

[15] Given this, the custodian states that the MRI report is not incomplete or inaccurate for the purposes for which it was used, such that there is no duty to correct this report pursuant to section 55(8). The custodian further states that the complainant has not demonstrated that the MRI report was inaccurate or otherwise provided factual information supporting such a correction.

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[2] 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."

[3] Per the custodian, the triage note documented by an emergency room nurse refers to "worsening neck and upper [thoracic] spine pain/pressure" and the emergency room doctor's consult note states "patient stated increased tenderness in upper thoracic paraspinal area."

[16] The custodian also states that the content of the MRI report represents the radiologist's professional opinion made at the time the care was provided, in the form of the MRI imaging. The custodian states that the radiologist used his clinical judgment to determine the information that was relevant to the patient's care based on the information that was provided to him and then determined what was appropriate to document in the MRI report. The custodian states that this care and documentation is in line with the standard of care, and that there are no reasonable grounds to conclude that the radiologist did not document this information in good faith.

[17] The complainant's view is that the MRI report was authored by both the radiologist (for the results) and the emergency room physician (for the clinical history). The complainant states that the emergency room doctor provided incorrect and/or incomplete information within the clinical history section. As evidence of this, the complainant states that the day before the emergency room visit at issue, he visited the hospital complaining of spinal pain and was given a requisition documenting that he complained of both cervical and thoracic spine pain.

[18] The complainant states that when he went to the emergency department during the visit at issue, he told a medical student about the pain in his cervical and thoracic spine, and that this student took notes on this. The complainant states that the when the student and the emergency department physician discussed his case, the physician spoke dismissively of his complaints and then only saw him briefly. However, the complainant states that when the emergency department physician saw him, he advised that doctor that he was suffering thoracic spine pain.

[19] The complainant asserts that the MRI report is inaccurate for the purposes for which it is used. The complainant states that the MRI report is used to inform the patient and subsequent health care providers, who depend on such reports being accurate. The complainant puts forward that the failure to record the areas of his spine for which he reported pain within the MRI report creates the impression that he did not report pain in his thoracic spine, and that this could interfere with subsequent medical treatment.

[20] The complainant also alleges that the radiologist and the emergency room physician did not act in good faith in drafting the MRI report, as they failed to accurately record the areas of his spine where he reported pain. The complainant describes this as "seriously careless" behaviour that is incompatible with "good faith" as set out by the Supreme Court of Canada in *Finney v. Barreau du Québec* (*Finney*).[4] The complainant states that the failure to include his thoracic pain implies that these physicians did not review his medical records from the previous day's visit, which the complainant asserts "would be seriously careless and negligent."

[4] 2004 SCC 36.

Analysis and Findings

[21] 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).[5] 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

[22] 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.[6]

[23] 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.

[24] 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.

[25] 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 opinion or observation in good faith.[7]

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[5] PHIPA Decision 36.

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

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

Does the personal health information qualify as a "professional opinion or observation?"

[26] 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*.

[27] The sole record at issue is a two-page MRI cervical spine routine results report. It lists the exam date and the MRI technique, as well as a brief two-line clinical history for the patient, which – as the complainant points out – does not mention thoracic spine pain. The majority of the report is composed of the findings section, which specifically addresses various vertebrae, as well as generally describing the patient's spinal condition. The report concludes with a summary of the key points from the findings.

[28] From my review of the MRI report, I am satisfied that the personal health information it contains constitutes the radiologist's "professional opinions" or "professional observations" as required by the first part of the two-part analysis for the exception at section 55(9)(b) to apply. In my view, the professional opinions or observations in the MRI report arise from the application of the radiologist's professional judgment and experience, including ordering the requisitioned scan, determining the background information relevant to the report, and interpreting and documenting the medical imaging results.

[29] I do not agree with the complainant's assertion that the MRI report was authored by both the radiologist and the emergency department physician. Part of documenting a professional opinion or observation includes determining relevance of information. The radiologist chose to include of a brief summary of the reasons for the emergency department's referral within the MRI report. Including this in the MRI report reflects the radiologist's choice in composing the report and does not indicate in any way that the MRI report was authored by the emergency department physician.

[30] Moreover, the application of the section 55(9)(b) exception does not turn on whether the personal health information at issue is objectively true or accurate. The section 55(9)(b) exception may apply to personal health information, even if that information is inaccurate or incomplete, where that information qualifies as a "professional opinion or observation," made in good faith. I am satisfied that the contents of the MRI report chronicle the radiologist's professional knowledge and experience in conducting and interpreting medical imaging results. The fact that these results may not include all of the areas of pain raised by the complainant in the visit that led to this imaging does not affect the nature of the information in the MRI report, which consists of professional opinion or observation within the meaning of section 55(9)(b).

Was the professional opinion or observation made "in good faith?"

[31] The second part of the two-part analysis to determine whether section 55(9)(b) applies requires that there be reasonable grounds to conclude that the professional opinions or observations containing the personal health information that the complainant seeks to have corrected were made "in good faith." If the individual can establish that the professional opinions or observations were not made in good faith, then the section 55(9)(b) exception to the duty to correct cannot apply.

[32] The complainant alleges that the radiologist did not review his records from the day before his emergency room visit and states that this failure to do so would be "seriously careless and negligent."

[33] The complainant's representations focus on the standard to establish lack of good faith. The complainant cites PHIPA Decision 197, in which the adjudicator noted that court cases have determined 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 complainant also cites *Finney,* in which Justice Lebel noted that "[gross] or serious carelessness is incompatible with good faith."[8]

[34] I take no issue with the complainant's position that serious carelessness or recklessness can undergird a finding of lack of good faith; this position is consistent with decisions of both the courts and this office. However, I am not satisfied that the complainant has established that the radiologist acted with serious carelessness or recklessness in relation to the MRI report.

[35] Based on my review of the records in this case, the medical imaging department received a requisition for an MRI scan of the complainant's cervical spine and then conducted the specified scan. The radiologist interpreted the scan imaging results, providing his opinions and observations on those results in the MRI report. However, the complainant asserts that the radiologist's professional obligation was not limited to completing the requisition in this way. Rather, the complainant asserts that radiologists are obliged, at minimum, to review the recent medical history of patients receiving medical imaging. He states that to do otherwise would be seriously careless or negligent.

[36] As noted above, in the context of section 55(9)(b) of *PHIPA*, the burden rests on the individual seeking the correction to establish that the custodian did not make the professional opinion or observation in good faith. In this case, the custodian has stated that it is standard practice for radiologists to carry out the orders as set out in requisition forms. The complainant asserts otherwise but has not provided me with evidence to substantiate his position. As such, I find that the complainant has not provided evidence sufficient to establish that serious carelessness or recklessness amounting to bad faith on the part of the radiologist in arriving at the professional opinions or observations set out

[8] *Finney* at para. 40.

in the MRI report. I therefore 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 MRI report under section 55(8) of the *Act*.

[37] 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 MRI report, conveying his disagreement with the information contained in that record.[9]

NO ORDER:

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

Original Signed by: June 20, 2025
Jennifer Olijnyk
Adjudicator

[9] 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