Information and Privacy Commissioner,
Ontario, Canada

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

PHIPA DECISION 291

Complaint HA23-00025

MacKenzie Health – Cortellucci Vaughan Hospital

July 18, 2025

Summary: A patient's son sought a review of the hospital's decision to deny his request to correct a discharge summary. The hospital refused to make the requested corrections claiming that the information the complainant seeks to correct falls within the professional opinions or observations exception under section 55(9).

The adjudicator determines that no review is warranted under sections 57(3) and 57(4)(a) of the *Act* because there are no reasonable grounds to review the complaint and the hospital has responded adequately to the complaint. The complaint is dismissed.

Statutes Considered: *Personal Health Information Protection Act, 2004*, 55(8), 55(9)(b), 57(3) and 57(4)(a).

OVERVIEW:

[1] This decision addresses the complainant's request to correct a discharge summary relating to his mother's hospital stay.

[2] After submitting a request to MacKenzie Health – Corellucci Vaughan Hospital (the custodian or hospital) for records of his mother's personal health information, the complainant received medical records, including a six-page discharge summary dated

April 3, 2022 (summary).[1] The complainant subsequently filed a correction request to the hospital seeking corrections to the summary.

[3] The hospital issued a correction decision in which it granted three of the requested corrections in full. The hospital refused to grant the remaining requested corrections citing section 55(9)(b). The complainant filed a complaint with the Information and Privacy Commission of Ontario (IPC), and a mediator was assigned to the file.

[4] During mediation, the complainant provided a letter to the mediator outlining 10 outstanding correction requests and confirmed that he continues to pursue correction requests 2 to 11.[2] In that letter, the following outstanding issues were identified:

- Request 2: The complainant says that only "moderately elevated blood pressure values" are reflected in the summary though medical charts show "extreme highs and lows." He requests a correction to the statement that his mother's blood pressure is "well controlled." He asserts that the proposed correction would better reflect the elevated blood pressure readings taken and documented in her medical chart.

- Request 3: The complainant requests that the portion of the discharge summary which states "I spoke with her son over the phone for 35 minutes and PCC was with me" be removed as it gives a reader the impression that the doctor was dealing with a difficult family member. He says that most of the time was spent explaining facts to the doctor which she would not accept which led to the prolonged length of the call. He asserts that the statement does not directly relate to his mother's medical condition and thus cannot be said to be a professional opinion or observation. In addition, he says that the statement is inaccurate and incomplete.

- Request 4: The complainant requests that the portion of the record which states that nitro patches were used in relation of a panic attack be changed to reflect that the nitro patch was provided to treat a hypertensive crisis. He says that the blood pressure values taken that night support his argument that the nitro patches were administrated to address a hypertensive crisis. He says that that his mother's condition appeared to "fit the textbook definition of a hypertensive crisis." He also seeks to have the following sentence added to the summary: "The patient experienced a hypertensive crisis/emergency or urgency and had a blood pressure reading of 193/112." He says that these changes would benefit future care providers.

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[1] In the circumstances of this complaint, there is no dispute between the parties that the records contain the "personal health information" of the complainant's mother as defined in section 4(1) and that the complainant is entitled to make requests under the *Act* on his mother's behalf.

[2] In the same letter, the complainant confirmed that his correction request related to request 1 was now resolved. The hospital agreed during mediation to correct a dictation error related to request 1.

- Requests 5 and 6: The complainant requests that the statements that the doctor "made sure information is accurate as documented in chart" and "What I wasn't sure of I told him I'll get back to him once I confirm it" be removed. He says that these statements cannot be said to be professional opinion or observation as it does not relate to patient care as it describes a conversation with a family member. In addition, he says that the statement is inaccurate and incomplete as it does not accurately reflect the interaction the doctor had with him.

- Request 7: The complainant requests that the time "at midnight" contained in the summary to describe when the nitro patches were applied be changed to "at around 1 am" to be consistent of the information in his mother's medical chart. He also requests that the summary be changed so that specific, as opposed to general times, be referenced every instance where it is mentioned that a nitro patch was applied.

- Request 8: The complainant requests that the statement "We made no changes to her meds" be expanded to make clear which medicines are being referred to. He says that the statement in question is sandwiched between references to other medications in the summary. He also says that the record is written in a "scattered fashion" and the statement in question could lead to misinterpretation and inaccuracies.

- Request 9: The complainant requests that all references in the record which states that his mother "refused" a type of medication be changed to reflect that she "couldn't tolerate" the medicine in question. He says that the correction would make clear that she declined taking the medicine because she was already aware that she would not tolerate the dosage being administered and not leave the reader with the impression that she was uncooperative.

- Request 10: The complainant requests that the statement the "discharge summary is representative of the conversation [the doctor] had with the patient and son" be removed. He says that the doctor's statement is inaccurate and incomplete. In addition, he says that the statement does not relate to a professional opinion or observation as it does not relate to direct patient care. He asserts that the statement should be removed given that he and the doctor can not agree how to describe their interaction.

- Request 11: The complainant requests that the notation that his mother "refused" [another type of medication] be changed to reflect that she declined the dosage hospital staff sought to administer. He requests that the statement be changed by adding that the "Patient refused to take 2 tabs when she noticed…".

[5] In response, the hospital issued a further decision letter confirming that it continues to rely on section 55(9)(b) to deny the outstanding correction request. No further mediation was possible, and the file was transferred to the adjudication stage of

the complaints process in which an adjudicator may decide to conduct a review.

[6] After reading the complaint file[3], I wrote to the complainant advising him of my preliminary assessment that his complaint should not proceed to the review stage. The complainant was invited to provide written representations in response to my preliminary assessment before I made my final decision. The complainant submitted written representations in response.

[7] In this decision, I find that the complaint should not proceed to a review under the *Act* because there are no reasonable grounds to conduct a review (section 57(3)) and the hospital has responded adequately to the complaint (57(4)(a)).

DISCUSSION:

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

[8] Sections 57(3) and 57(4)(a) of the *Act* set out the IPC's authority to review or not to review a complaint. These sections state:

> (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.
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> (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,
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> > (a) the person about which the complaint is made has responded adequately to the complaint;

[9] After reading the complainant's written representations along with the contents of the complaint file, I exercise my discretion not to review the subject-matter of this complaint finding that there are no reasonable grounds to conduct a review. I am also satisfied that the hospital has responded adequately to the complaint. I explain my reasons below.

The relevant legislation

[10] Section 55(1) of the *Act* sets out the right of an individual to request a correction to records of the individual's personal health information. This section states:

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[3] This includes my consideration of a 22-page letter, dated June 27, 2023 the complainant addressed to the mediator requesting that his complaint matter be transferred to adjudication.

> 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.

[11] Section 55(8) sets out a duty on the part of a health information custodian to grant a request for correction where certain conditions are met. However, section 55(9) provides exceptions to the duty to correct in some circumstances.

[12] Section 55(8) of the *Act* states:

> 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.

[13] If the requirements of 55(8) are established, the question becomes whether or not any of the exceptions that are set out in section 55(9) apply. In the circumstances of this complaint, the custodian claims that the exception at section 55(9)(b) applies. This section states:

> 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.

The complainant has not discharged the onus in section 55(8)

[14] The issue to be determined in this complaint is whether the discharge summary contains information which is *incomplete or inaccurate for the purposes for which the custodian uses the information* not whether the complainant agrees with the notations contained in the record.

[15] Section 55(8) provides that the individual seeking the correction has the onus of establishing whether or not the "record is incomplete or inaccurate for the purposes for which the custodian uses the information".

[16] The complainant says that had the doctor's notations included additional information a more fulsome picture of his mother's stay at the hospital would have been captured in the discharge summary relating to her condition and medication prescribed to her (correction requests 2, 4, 7, 8, 9 and 11). In support of this position, the complainant referred to information he says is contained in the other medical records the hospital provided him. The complainant also refers to research materials.

[17] In addition, the complainant says that the portions of the summary which describe interactions he or his mother had with hospital staff (correction requests 3, 5, 6 and 10) leaves the impression that they were uncooperative.

[18] The complainant asserts that "… great care must be taken to ensure a patient's record is factually correct" and cites section 11(1) of the *Act*. Section 11(1) states:

> A health information custodian that uses personal health information about an individual shall take reasonable steps to ensure that the information is as accurate, complete and up-to-date as is necessary for the purposes for which it uses the information.

[19] There is no question that the accuracy of records containing personal health information is essential to the effective provision of health care. However, the correction provisions of the *Act* are limited by the requirement in section 55(8) that the individual requesting the correction must "demonstrate to the satisfaction of the custodian, that the record is incomplete or inaccurate for the purposes for which the custodian uses the information."

[20] In addition, previous decisions of this office have found that the obligations set out in sections 11(1) and 55(8) does not mean that all personal health information contained in records held by health information custodians need to be accurate in every respect. If a request is made to correct inconsequential bits of information that have 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.[4] It may be inaccurate or incomplete in a way that is not significant to the custodian because the custodian is not relying on it for a purpose relevant to the inaccuracy or omission.[5]

[21] In his representations in response to my preliminary assessment, the complainant states:

> You express specifically that some of the information I'm seeking to correct is not relevant in light of how the Hospital may use that information. I would argue that no one, not even the Hospital, this Doctor or any other, can fully know or anticipate whether and how the Hospital or any other caregiver may use the information in question at any point in the future and what factor that information, especially if incomplete and inaccurate, may play in the Patient's care and ultimate outcome.
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> What we know for a fact, is that the information has been used by doctors at this Hospital and at other health facilities, and those doctors have

[4] See for example PHIPA Decisions 36, 99, 195, and 235

[5] *Guide to the Ontario Personal Health Information Protection Act,* Halyna Perun et al. (Toronto: Irwin Law Inc., 2005)

> specifically cited some of the records in question, and the incomplete and inaccurate information contained within, when speaking with myself and the Patient. The fact that the information was read by other doctors and cited, means it was accessed and thus, by definition, used by the Hospital and other doctors for some purpose, whatever that purpose may have been and however, if at all, it played a factor in the Patient's care.
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> Although it can't be said with absolute certainty, given the examples from the past, there is an extremely high probability that the information will be used again in the Patient's future care for some purpose, whatever that purpose may be. Some care provider may review that information and not factor it into their care decisions, or they may form an opinion of the Patient and their family members and use that information tailor their approach, perhaps negatively, or they may miss the context that the patient is susceptible to extreme blood pressure spikes and perhaps not put protocols in place to monitor for that in the event of another hospital admission, which could have dangerous consequences…

[22] Having read and considered the entire complaint file, including the written representations the complainant submitted during the mediation and adjudication stage, I find that the complainant's evidence fails to establish a reasonable basis that the information at issue contained in the discharge summary is "incomplete or inaccurate for the purposes for which the hospital uses the information" as required by section 55(8) of the *Act*.

[23] I maintain my view, expressed in the preliminary assessment, that the possibility of future caregivers having a negative inference from their reading of the summary is not relevant for the purpose for which the hospital uses the information. The wording in section 55(8) is clear. The individual seeking the correction has the onus of establishing whether or not the "record is incomplete or inaccurate for the purposes for which the custodian uses the information".

[24] Accordingly, it is the hospital's use of the information that is relevant not whether the information is read or accessed by others. The accuracy of the information that is requested to be corrected is connected to the purposes for which the information is used by the hospital.[6]

[25] The record before me is a six-page computer generated document entitled "Discharge Summary." The first two pages of the summary contain information related to the patient's discharge such as what medications the doctor recommends the complainant's mother is to start, continue and stop upon being discharged from the hospital. The third page contains results of tests administered by the hospital and the doctor's conclusions. The last three pages contain notes under the title "Summary and

[6] PHIPA Decision 36.

Discharge Plan". Finally, the end of the document contains a statement that the discharge summary not only captures discussions the doctor preparing it had with the complainant and his mother but also the doctor's "interpretation" of other health care provider's notes, investigations and recommendations related to the care the complainant's mother received during her hospital stay.

[26] The hospital's use of the record before me is to summarize the complainant's mother's hospital stay and document its reasons for her discharge. The purpose of the discharge summary is not to document a comprehensive history of the complainant's mother's hospital stay. Instead, the discharge summary is to provide a concise description of the patient's medical condition upon admission, treatments/tests the patient received during their hospital stay and the doctor's instructions to the patient upon discharge.[7] Having regard to the purpose of the record along with the complainant's evidence, I find no reasonable basis to support a finding that the complainant has discharged the onus in section 55(8). Accordingly, I find the custodian does not have a duty to correct the information under section 55(8).

[27] Given my finding, it is not necessary that I also determine whether the complainant gave the hospital the information necessary to enable it to correct the record. It is also not necessary that I determine whether the professional opinion or observation made in good faith exception at section 55(9)(b) applies.

[28] With no duty to correct the discharge summary, I find there are no reasonable grounds to conduct a review (section 57(3)) in the circumstances of this complaint. In addition, I am satisfied that the hospital responded adequately to the correction request related to this complaint (57(4)(a)).

[29] For the reasons set out above, I decline to conduct a review and dismiss the complaint.

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[7] See The College of Physicians and Surgeons (CPSO) Transitions in Care Policy. Section 9 of the policy states:

> The most responsible physician must include in the discharge summary the information necessary for the health-care provider(s) responsible for post-discharge care to understand the admission, the care provided, and the patient's post discharge health care needs. While physicians must use their professional judgment to determine what information to include in the discharge summary, it will typically include:
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> a. Relevant patient and physician identifying information;
> b. Reason(s) for admission;
> c. Any diagnoses or differential diagnoses at discharge;
> d. A summary of how active medical problems were managed (including major investigations, treatments, or outcomes);
> e. Medication information, including any changes to ongoing medication and the rationale for these changes;
> f. Follow-up care needs or recommendations; and
> g. Appointments that have or need to be scheduled, any relevant and outstanding outpatient investigations, tests, or consultation report

Other issues

[30] In the materials the complainant filed in support of his correction request, the complainant asks that the IPC investigate his allegation that the dosage his mother was to receive during her hospital stay was doubled. The complainant also raises other concerns regarding the care his mother received during her hospital stay. The IPC does not have the authority to review the conduct of medical staff. Accordingly, I did not address the complainant's allegations in this decision.

[31] Though I have found that the hospital is not required to make the requested corrections, the *Act* gives the complainant the right to attach a statement of disagreement to the discharge summary conveying disagreement with information contained in the record.[8]

NO REVIEW:

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

Original Signed by: July 18, 2025

Jennifer James
Adjudicator

[8] 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;