Information and Privacy Commissioner,
Ontario, Canada

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

PHIPA DECISION 36

HA14-46-2

Centre for Addiction and Mental Health

November 29, 2016

Summary: The complainant submitted a correction request under the *Personal Health Information Protection Act* to the Centre for Addiction and Mental Health. The complainant submits that the psychological report prepared by a physician who worked at the hospital approximately 15 years ago contains a number of errors. The hospital agreed to correct the complainant's date of birth contained in the record but denied the remainder of the correction requests. The complainant did not demonstrate that the information in the report is incomplete or inaccurate for the purposes for which the hospital uses the information, and the hospital's decision not to make the requested corrections is upheld.

Statutes Considered: ***Personal Health Information Protection Act, 2004,*** sections 3(1), 4(1), 55(8), and 55(9).

Decisions Considered: Order H2004-004, 2004 CanLII 72339 (AB OIPC); Order H2005-006, 2006 CanLII 80852 (AB OIPC); and Order H2005-007, 2006 CanLII 80867 (AB OIPC); Order H2013-04, 2013 CanLII 88078 (AB OIPC) and Order H2016-03, 2016 CanLII 11568 (AB OIPC).

BACKGROUND:

[1] The complainant submitted a correction request under the *Personal Health Information Protection Act*, 2004 (the *PHIPA*) to the Centre for Addiction and Mental Health (the hospital) to correct a psychological report prepared approximately 15 years ago. The complainant's request contained a total of 66 correction requests to the psychological report.

[2] The hospital sent a letter to the complainant advising that it would only correct the complainant's date of birth. The hospital denied the remainder of the complainant's correction requests on the basis that they "…consist of professional opinions or observations about [the complainant] that were made in good faith, and the records are accurate and complete for the purposes for which the information is used".

[3] The hospital advised the complainant that he may submit a Statement of Disagreement which would be attached to the record.

[4] The complainant filed a complaint with this office and a mediator was assigned to the matter.

[5] During mediation, the mediator had discussions with the parties but they were unable to reach a settlement. Accordingly, the matter was transferred to the adjudication stage of the complaint process.

[6] I decided to commence a review by sending a Notice of Review setting out the facts and issues in this complaint to the parties. In response, the parties provided written representations to this office.

[7] In this decision, I find that the complainant failed to establish that the record is incomplete or inaccurate for the purposes for which the information is used. Accordingly, the hospital is not required to correct the record under section 55(8). I also find that much of the information the complainant seeks to correct qualifies as professional opinions or observations.

RECORDS:

[8] The record at issue is a 9-page Psychological Report.

SUMMARY OF THE CORRECTION REQUESTS:

[9] The complainant requested that the following 66 items[1] be corrected in the Psychological Report:

> 1-5. Information contained under the heading "Clinical Overview", describing the complainant's program of study, how many times the complainant was hospitalized over a specified period of time and reasons for previous psychological testing and hospital admission. The complainant seeks to correct the name of his program of study, reasons and duration of psychological testing and/or hospitalization.

[1] The requested corrections are described in detail and categorized by number from 1 to 66 in the mediator's report and Notice of Review the parties received from this office. This decision discusses the correction requests in general terms to ensure that the privacy of the complainant is protected.

6-11. Information contained under the heading "Psychiatric History", describing past medical episodes. The complainant seeks to correct the description, duration and impact of the medical episodes.

12-14. Information under the heading "Treatment History", describing reasons for a past hospitalization and diagnosis. The complainant seeks to correct this information.

15-26 Information under the heading "Developmental History", containing background information about the complainant's childhood, such as any incidents of abuse, his parents' relationship, identification of siblings and family medical history. Some of the corrections requested by the complainant include his age at various milestones, the timing of specific events in his parents' relationship with one another and the type of abuse he suffered.

27-33. Information describing the complainant's educational and vocational history under the heading "Educational/ Vocational History". The complainant seeks to correct the name of his program of study, academic performance, number of university acceptances obtained, dates he returned to school and length of time employed at various workplaces.

34-43. Information describing the complainant's significant interpersonal relationships under the heading "Interpersonal Relationships". The complainant seeks to correct the length of time, seriousness and impact of the romantic relationship described in this section.

44-66. The physician's assessment and diagnosis under the headings "Results of Structured Interviews", "Psychological Test Results", "Summary and Conclusions" and "Recommendations". The complainant seeks to correct the physician's description of the details and causes of past medical episodes along with the physician's description of the test results and diagnosis.

DISCUSSION:

[10] There is no dispute between the parties that the information at issue constitutes the complainant's personal health information (PHI). PHI is defined in section 4(1) of *PHIPA*, in part as follows:

> "personal health information", subject to subsections (3) and (4), means identifying information about an individual in oral or recorded form, if the information,

> (a) relates to the physical or mental health of the individual, including information that consists of the health history of the individual's family,
>
> (b) relates to the providing of health care to the individual, including the identification of a person as a provider of health care to the individual,

[11] Section 4(3) adds to this discussion, covering mixed records that contain both personal health information as described in section 4(1) and other information about an individual:

> Personal health information includes identifying information that is not personal health information described in subsection (1) but that is contained in a record that contains personal health information described in that subsection.

[12] The parties also do not dispute that the hospital is a "health information custodian" as defined in section 3(1) of *PHIPA*, and that the complainant was given access to his health records before making his correction request.

[13] The sole issue in this complaint is whether the hospital has a duty to correct the complainant's PHI contained in the record. Section 55(8) of *PHIPA* provides for a right of correction to records of PHI in some circumstances. It 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.

[14] Section 55(9) of *PHIPA* sets out exceptions to the obligation to correct records, as follows:

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

[15] Read together, these provisions set out the criteria pursuant to which an individual is entitled to a correction of his or her records of PHI. The purpose of section

55 of the *PHIPA* is to impose a duty on health information custodians to correct records of PHI that are inaccurate or incomplete for the purposes for which they use the information, subject to the exceptions set out in section 55(9) of the *PHIPA*.

[16] In all cases where a complaint regarding a custodian's refusal to correct records of PHI is filed with this office, 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" pursuant to section 55(8). Section 55(8) requires the individual asking for correction to:

> a) demonstrate to the satisfaction of the custodian, that the record is incomplete or inaccurate for the purposes for which the custodian uses the information, and
>
> b) give the custodian the information necessary to enable the custodian to correct the record.

[17] If the above is established, the question becomes whether or not any of the exceptions that are set out in section 55(9) apply.

[18] Where the custodian claims that section 55(9)(b) applies, the custodian bears the burden of proving that the PHI 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 observation", the onus is on the individual seeking a correction to establish that the "professional opinion or observation" was not made in good faith.

Positions of the parties

[19] The hospital agreed to correct the complainant's date of birth but denied the remainder of the complainant's correction requests. In support of its position, the hospital states:

> [A] duty to correct did not exist for [the complainant's] remaining requests because the records consist of professional opinion or observations about him that were made in good faith, and the records are accurate and complete for the purposes for which the information is used.

[20] The complainant submits that the report contains the errors summarized above which should be corrected in the same manner his date of birth was corrected. The complainant refers to the incorrect date of his birth as a "factual error". The complainant submits that the hospital took an inconsistent approach by correcting his date of birth without requiring substantiating documentation and not correcting other similar types of errors in the record. In support of this position, the complainant states:

> [g]iven the fundamental basis of the rationale provided by the institution for "not objecting to correcting factual errors such as [the] date of birth"

> there would be no requirement to provide documented evidence to verify the [other] factual corrections requested …

[21] Despite the concerns the complainant raised about "factual" errors in the report, his main concern is the psychiatrist's diagnosis and recommendations contained in the report. The complainant submits there are many errors in the sections of the report which describe his psychiatric treatment and developmental history which formed the basis for the psychiatrist's "incorrect conclusions". The complainant provided copies of scholarly articles which challenge the validity of interviews as an effective diagnostic tool. The complainant also provided recent articles which state that the same mental health condition the psychiatrist diagnosed him with many years ago is one that has been subject to frequent misdiagnosis.

[22] The complainant also raised questions about the psychiatrist's memory and observations given that approximately 2 weeks expired between the time he was interviewed and when the report was prepared. In addition, the complainant questioned whether it was appropriate that the psychiatrist was assisted by a student.

[23] Finally, in support of his position that the psychological report contains an incorrect diagnosis, the complainant submits that a physician who reviewed his medical history more recently arrived at the conclusion that "… it would be impossible for someone who was correctly diagnosed with [the psychiatrist's final diagnosis in the psychological report] to remain untreated for the condition for such a great length of time". In support of this position, the complainant provided reference letters to highlight his own academic and work achievements, which include his completion of a rigorous post-secondary program.

Decision and Analysis

[24] Apart from the above-noted reference material, the complainant provided no evidence to the hospital to support his correction request. As indicated, he believes that, since the hospital agreed to correct his date of birth without any extraneous evidence from him, he is entitled to correction of other information without submitting any additional information. I find that the hospital is not obliged to grant the correction request because the complainant has not demonstrated that the record, which was prepared over 15 years ago, is incomplete or inaccurate for the purposes for which the hospital uses the information. In addition, the complainant has not provided the hospital with the information necessary to enable the hospital to correct the record.

[25] 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 *PHIPA* are limited by the requirement that the individual requesting the correction "demonstrate to the satisfaction of the custodian, that the record is incomplete or inaccurate for the purposes for which the custodian uses the information." The accuracy of the information that is requested to be corrected is therefore connected to the purposes for which the information is used.

[26] In interpreting these provisions of the *PHIPA*, I find it helpful to have regard to section 11(1), which requires health information custodians that use PHI about an individual to 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." The duty to use accurate information under section 11(1) can be viewed as the corollary to the duty to correct inaccurate information under section 55(8). In both, the purpose for which the information is used is key to understanding the scope of the duty.

[27] The following discussion in *Guide to the Ontario Personal Health Information Protection Act*[2] elaborates on the relationship between the accuracy of personal health information and the purposes of its use, in section 11(1):

> [The] obligations regarding the use and disclosure of personal health information include an important limitation. Through PHIPA's inclusion of the phrase "as is necessary for the purposes" of the use or disclosure, the accuracy, completeness, and up-to-date character of the information is tied to the purposes of the use and disclosure. As a result, the personal health information upon which a health information custodian relies need not be accurate or complete in every respect. 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. [my emphasis]

[28] I agree with the above statement, which I also find applicable to interpreting the custodian's duty to correct under section 55(8). As a result, I am satisfied that not all PHI contained in records held by health information custodians needs 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.

[29] With respect to the correction requests made by the complainant in this matter, I find that the hospital is not obliged to grant the correction request because the complainant has not given the custodian the information necessary to enable the custodian to correct the record, nor demonstrated that the record is incomplete or inaccurate for the purposes for which the hospital uses the information.

[30] Even if the complainant had met the initial onus under section 55(8) for any of the information contained in the record, I find that the exception at section 55(9)(b) would, in any event, apply to much of the information the complainant seeks to correct, for the reasons that follow.

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[2] Halyna Perun et al. (Toronto: Irwin Law Inc., 2005)

Does the "professional opinion or observation" exception at section 55(9)(b) apply?

[31] As set out above, section 55(9)(b) states that a health information custodian is not required to correct a record of PHI "…if it consists of a professional opinion or observation that a custodian has made in good faith about the individual". 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.

[32] Thus, 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 a complainant's view of a medical condition or diagnosis.

[33] The determination of whether the exception at section 59(9)(b) applies involves a two-part analysis. The first question is whether the PHI is a "professional opinion or observation." The second question is whether the "professional opinion or observation" was made "in good faith".

[34] In order to qualify for the application of section 55(9)(b), I must find that the PHI is a "professional opinion or observation". One question that arises in interpreting this phrase is whether the adjective "professional" only modifies the noun "opinion" or whether it also modifies the noun "observation." In other words, must both an opinion and an observation be "professional" in nature to be covered by section 55(9)(b)? In considering this question, I must read these words in a grammatical and ordinary sense, harmoniously with the scheme of *PHIPA*, the object of the statute and the intention of the Legislature.[3] I note that courts have typically held, as a matter of grammatical construction, that an adjective preceding a series of two or more nouns modifies the series of nouns and not simply the first noun, thus supporting the conclusion that the phrase covers "professional opinions" and "professional observations". Such a construction is also consistent with the purpose of this provision, in giving individuals the right to seek correction of opinions and observations made by health professionals. I thus conclude that section 55(9)(b) applies only where the information at issue consists of either a "professional opinion" or a "professional observation".

[35] I also find that only observations and opinions derived from the exercise or application of special knowledge, skills, qualifications, judgment or experience relevant to the profession should be defined as "professional observations" or "professional opinions" within the meaning of section 55(9)(b). Again, this conclusion is consistent with the purpose of this provision, within the overall scheme of the *PHIPA*.

[36] In this case, the psychological report was prepared by a psychiatrist working at

[3] Elmer A. Driedger, The Construction of Statutes, 2nd ed., Toronto, Butterworths, 1983, at 87.

the hospital, who was assisted by a clinical psychology practicum student. For the purpose of my review, I will refer to the psychiatrist as the writer of the report though the report was signed by both the supervising psychiatrist and clinical student.

[37] The report indicates that the complainant was referred to the psychiatrist for a "psychological assessment". The report is based on psychological testing, clinical interviews and other medical reports prepared by 4 different physicians, including the referring psychiatrists. The report also contains information about the complainant's program of study, history of hospitalization and treatment, personal and family history, educational and vocational history, personal relationships along with the physician's assessment and diagnosis.

[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.

[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.

[40] My conclusion with respect to the matters covered by "professional observation" is consistent with the approach taken to similar provisions in other jurisdictions. The Alberta Information and Privacy Commissioner's office (the AIPC) has interpreted the words "professional," "opinion" and "observation," in the context of correction complaints made under section 13 of Alberta's *Health Information Act* (*HIA*). The AIPC has defined "professional" to mean "of or relating to or belonging to a profession," and has described an "opinion" as something subjective in nature and that is "a belief or assessment based on grounds short of proof; a view held as probable".[4] In the same orders, the AIPC also found that an "observation" is subjective in nature and means a "comment based on something one has seen, heard or noticed, and the action or process of closely observing or monitoring".

[41] The AIPC has also stated, in Order H2005-007:

> A request for correction or amendment should not amount to rewriting the records in the [complainant's] own words. A request for correction or amendment should not be used to attempt to appeal decisions or opinions

[4] See Orders H2004-004, H2005-006 and H2005-007.

> or observations with which [the complainant] disagrees and cannot be a substitution of opinion, such as the [complainant's] view of a medical condition or diagnosis.

[42] Having regard to the submissions of the parties and the material before me, I find that much of the PHI the complainant seeks to correct qualifies as the psychiatrist's professional opinion or observation. The complainant's request to correct this information, in effect, seeks to substitute or rewrite the psychiatrist's opinions or observations contained in the psychological report.

[43] Given that the complainant has failed to establish that the report is incomplete or inaccurate for the purposes for which the hospital uses the information, it is not necessary that I make a determination as to whether the professional opinions or observations contained in the report were made in good faith. Accordingly, I find that the hospital does not have a duty to correct the record under section 55(8).

[44] In addition to providing individuals with a right to access their PHI, *PHIPA* gives individuals the right to attach a statement of disagreement to the record conveying their disagreement with any information contained in the record. Here, the complainant filed a statement of disagreement with the hospital during the inquiry process which the hospital attached to the record.

NO ORDER:

1. For the foregoing reasons, no order is issued

Original Signed By: November 29, 2016
Jennifer James
Adjudicator