Information and Privacy Commissioner,
Ontario, Canada

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

PHIPA DECISION 60

HA15-27

Dr. Byron M. Hyde

October 31, 2017

Summary: The complainant submitted a correction request under the *Personal Health Information Protection Act* to Dr. Byron M. Hyde to correct two records. The doctor agreed to correct some information but denied the remainder of the correction requests citing sections 55(8) and 55(9). The complainant did not demonstrate that the information in the records is incomplete or inaccurate for the purposes for which the doctor uses the information. As a result, the doctor's decision not to make the requested corrections is upheld.

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

BACKGROUND:

[1] The complainant submitted a correction request under the *Personal Health Information Protection Act* (*PHIPA* or the *Act*) to Dr. Byron M. Hyde (the custodian) asking him to correct her medical records. The complainant enclosed with her letter of request marked-up copies of her medical records with the requested corrections, redactions and additions indicated, as well as her reasons in support of the requested changes. She also asked that, in response to her request, the custodian provide her with a "severed, corrected record showing only the corrected chart".

[2] The custodian, through his legal counsel, responded to the request by sending the complainant a letter advising that he is not required to correct the records under section 55(8) as the records are not incomplete or inaccurate for the purposes for which

he uses the information.

[3] The custodian also took the position that some portions of the records which the complainant seeks to correct contain the custodian's professional opinions or observations provided in good faith and thus qualify for the exception to the duty to correct at section 55(9)(b). The custodian's lawyer states:

> [Y]ou have made significant deletions to the information contained in the document which consist of [the custodian's] observations made and recording of conversations held during your appointments with him. Accordingly, it is [the custodian's] position that the information contained in the record consists of his professional opinions and observations that he has made in good faith about you as his patient over the course of your physician-patient relationship and is not subject to correction.

[4] The custodian advised the complainant that she may submit a Statement of Disagreement which would be attached to the record.

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

[6] During mediation, the mediator had discussions with the parties but they were unable to reach a settlement. As a result, the matter was transferred to the adjudication stage of the complaint process and a Notice of Review setting out the facts and issues in this complaint was sent to the parties. In response, the parties provided written representations to this office.

[7] The file was subsequently transferred to me for completion. In this decision, I find that the complainant has failed to establish that the records are incomplete or inaccurate for the purpose for which the information is used. Accordingly, the custodian is not required to correct the records under section 55(8). As a result of my finding, it is not necessary that I also determine whether the exception at section 55(9)(b) also applies to some portions of the records.

RECORDS:

[8] The records at issue consist of two computer generated reports:

- Patient/Profile Report or Chart, printed November 6, 2014[1]

  This 15-page document was prepared by the custodian and is in table format form. The first column contains the custodian's notes regarding his final

[1] This record differs from the record in PHIPA Decision HA14-59 where the complainant questioned the reasonableness of Dr. Hyde's $825.00 fee for a 141-page report.

conclusions along with basic information about the complainant. The second column identifies the complainant's history of illness and family history. The third column contains the custodian's notes of any abnormal findings by tests. The fourth column contains the custodian's notes of normal findings by test along with information about the complainant's life history and physician/medication history.

The custodian's decision letter describes this record as a "medico-legal report"[2].

- Subjective Objective Assessment Plan (SOAP report)

  This 5-page document was prepared by the custodian and documents his patient encounters with the complainant on three specified dates in October 2013, November 2013 and June 2014.

SUMMARY OF THE CORRECTION REQUESTS:

[9] In his representations, the custodian agrees to correct 5 of the complainant's correction requests to the SOAP report.[3] These corrections consist of typographical errors the custodian advises would render this portion of the report inaccurate for the purposes for which the report is used, an incorrect entry relating to a report received from another doctor, an incomplete sentence and references the custodian made about the complainant's family status. Accordingly, these corrections are no longer at issue in this complaint.

Patient/ Profile Report

[10] The complainant seeks to add numerous entries to the profile report. The complainant advises that the copy of the profile report she received in response to her request under *PHIPA* is missing entries which were included in earlier copies of the report provided to her. The complainant advises that the July 6, 2014 version of the profile report is the "most complete" and she seeks to have the deleted entries reinstated. In addition, the complainant requests that additional information be added to the report and that it be re-organized in chronological order.

SOAP report

[11] The complainant seeks numerous deletions, corrections and additions to the

[2] The parties do not agree that this record is a medical-legal report. The complainant made extensive submissions setting out her position that she did not request the custodian to prepare a medical-legal report. The issue of whether or not the complainant requested Dr. Hyde to prepare this report is not relevant to the issues I am to determine.

[3] The custodian identified the corrections as proposed replacement #4 on page 5 of his representations, proposed deletion #13 on page 13 of his representations, proposed change #21 on page 17 of his representations and some of the proposed deletions #33-37 on page 21 of his representations.

SOAP report. The complainant's correction requests are set out in her marked up copy of the report in which she attached a 1-page document entitled "Schedule A- Additional Records" where she requests that the custodian add additional entries to document subsequent patient encounters. The complainant identifies specific entries in her profile report which she wants copied and inserted to create additional entries to the SOAP report. The complainant's correction requests to the SOAP report are also set out in a 7-page document she prepared entitled "Appendix A : SOAP Note Corrections".[4]

[12] Many of the deletions requested by the complainant seek to redact entire sentences and in some cases paragraphs of the report. In other cases, the complainant seeks to correct typographical or grammatical errors.

Complainant no longer pursuing the correction of typographical errors in the records

[13] In her representations, the complainant states that she is no longer pursuing correction to the typographical errors she identified in her correction request. She advises that she thought it was a simple matter to identify and make these corrections concurrently with her request to correct other portions of the record. However, at this point she does not want the typographical errors "to be a source of distraction from the substantive correction issues raised". Accordingly, the remaining typographical errors identified by the complainant are no longer at issue.

DISCUSSION:

[14] The parties agree that the information the complainant seeks to correct constitutes her 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,

[4] The complainant also provided a copy of a 10-page document entitled "Schedule B: Dr. Hyde's "SOAP" Records", dated October 22, 2013 which was prepared in support of the complaint she filed with the CPSO.

[15] 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.

[16] The parties also do not dispute that the doctor 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 her correction request.

[17] The sole issue in this complaint is whether the doctor has a duty to correct the complainant's PHI contained in the records. 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.

[18] 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.

[19] 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*.

[20] 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.

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

[22] 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.

[23] Depending on the circumstances of the correction request, the information that the individual is seeking corrected and the reasons for the custodian's refusal to correct the records, this office may approach the analysis initially under section 55(8) or under section 55(9). In the case before me, I will commence my analysis under section 55(8).

Submissions of the parties

[24] The custodian submits that the complainant has failed to establish that her correction requests seek to correct information that is incomplete or inaccurate for the purposes for which the information is used. Accordingly, the custodian takes the position that he is not required to make the requested corrections. The custodian's decision letter denying the complainant's correction requests stated:

> In your corrections, you have made minor grammatical and typographical changes which do not affect the completeness or accuracy of the information. It is [the custodian's] position that these corrections are not required to be made under the *Act*.
>
> You have also set out a request that information contained in the patient profile/report prepared by [the custodian] at your request should be included in the SOAP notes. It is [the custodian's] position that this is an inappropriate request. An individual record contained in your patient file does not need to be reflective of the entirety of the patient's medical care or health status. The medical chart is to be read as a whole. You have been a patient with [the custodian] since 2008 and he has continued to monitor and document your health in your medical chart since that time. Accordingly, [the custodian] has knowledge of your previous care, and

> updates your records at each attendance and retains test results as they are received. [The custodian] can review his SOAP notes, and any other notes, results and records in the course of his attendances with you.
>
> Further, the patient profile/report was prepared by [the custodian] at your request, and is not a document that is contemporaneously kept up to date or which reflects the date of each attendance. This should address your concern that the profile/report sets out the date of a test result, and not the date of the appointment or the date on which [the custodian] reviewed or recorded his summary.
>
> It is [the custodian's] position that the information contained in your record is appropriate for the purpose for which [the custodian] collects and uses the information, which is the ongoing treatment of [you] as his patient.

[25] The complainant submits that significant amounts of information the custodian entered into the profile report was subsequently removed by him. In her representations, the complainant states:

> Given the evidence available, there should be no serious dispute that extensive medical records which were prepared earlier by [the custodian] have been removed from his medical chart and that medical records were created by [him] months after the professional contact, after complaints had been made against him.
>
> I am not seeking correction because I disagree with the professional opinion I was given. I am seeking:
>
> (a) the correction of my medical chart to ensure the records and opinions I was ***actually*** given are ***re-instated*** into my medical record; and
>
> (b) the deletion of medical chart entries which contain inaccurate information and/or opinions which did not or could not have reflected information given or opinions formed on the purported dates.
>
> The latter were prepared by [the custodian] months after the fact, in the face of complaints that had already been submitted to the Information and Privacy Commissioner ("IPC") and to the College of Physicians and Surgeons ("CPSO"), contrary to his assertion that they were made contemporaneously. [Emphasis in the Original]

[26] The complainant also states:

> Whether [the custodian] honestly believes that the notes he made a year after the fact were correct, and thus based on faulty recollection, or

> whether he did so knowing they were false should have no bearing on the request for correction. They are still inaccurate.

[27] In support of her position, the complainant provided copies of profile reports previously provided to her which she advises contain additional information than what is contained in the profile report she seeks to have corrected. She argues that the July 2014 profile report is the "most complete" version as it contains entries that have been deleted in subsequent reports. The complainant submits that "[m]ost, if not all, of the redactions are of information which was helpful to my legal claims".

[28] The complainant submits that the July 2014 profile report "contains a very different version of events" than what is reflected in the SOAP report or the custodian's response to the CPSO. The complainant states:

> … it appears that the "Profile Report" entries which were deleted have been replaced with "SOAP" entries which minimize my health issues and attempt to portray me as angry with the world and refusing reasonable suggestions to obtain psychiatric treatment.
>
> These entries have simply disappeared from my medical record without a trace, but for the fact that I and others were given copies of the earlier chart. It is submitted that there can be no reasonable presumption or inference that these redactions occurred in good faith. To do so is prohibited, and protections are supposed to be in place to ensure that this does not occur, and traced should there be any doubt. As such, they should be reinstated to the record.

[29] The complainant also takes issue with the format of the profile report and submits that the custodian's record keeping practices are not in compliance with CPSO requirements.[5] The complainant proposes that the information to be corrected should be arranged in chronological order.

[30] Finally, the complainant complains that the custodian refused to provide a copy of the profile report to third parties. In addition to communicating its correction decision to the complainant on February 6, 2015, the custodian's lawyer advised the complainant that it received a request from one of her insurers for a copy of her medical records for a specific time period. The complainant was also advised that the custodian provided the insurer with copies of her medical records but that:

> … documents such as the table-format patient profile/report were not provided as it constituted a medico-legal report prepared by the custodian at your request and, in his view, would not constitute a record subject to production in the scope of the request from [the insurer], although it

[5] In her representations, the complainant references the CPSO's Policy Statement #4-12 entitled "Medical Records".

> reiterated and summarized information from that timeframe. The source of the information contained in the profile/report would have been included in the materials sent to [the insurer], should they have fallen within the requested timeframe.

Decision and Analysis

[31] I find that the custodian is not required to make the requested corrections because the complainant has not demonstrated that the records are incomplete or inaccurate for the purposes for which the custodian uses the information.

[32] 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.

[33] In interpreting these provisions of the *PHIPA*, it is 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.

[34] The following discussion in *Guide to the Ontario Personal Health Information Protection Act*[6] 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]

[35] Previous decisions from this office have found that the above statement is

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

applicable to interpreting the custodian's duty to correct under section 55(8).[7] As a result, 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.[8]

[36] With respect to the correction requests made by the complainant in this matter, I find that the custodian is not obliged to grant the correction requests because the complainant has not demonstrated that the records are incomplete or inaccurate for the purposes for which the custodian uses the information.

[37] The complainant's extensive submissions contain detailed comparisons between the profile report at issue and copies of the chart printed at earlier dates. The complainant argues that any deletions or inconsistencies in the charts are evidence of the custodian preparing medical records not contemporaneously with his patient encounter with her. The complainant also argues that the custodian deleted some information contained in the profile report in order to seek an advantage in defending himself in complaints she filed against him.

[38] Throughout her submissions, the complainant raises other concerns about the care she received from the custodian and advises that she has filed a complaint with the CPSO to address some of these concerns. She also frequently references the CPSO's policy on medical records and argues that this office should require the custodian to correct the records to ensure that they contain contemporaneous notations of the custodian's patient encounters with her. I note that the CPSO's Policy Statement #4-12 states:

> Clinical notes are notes that are made contemporaneously with a physician-patient encounter. A good clinical note benefits patient care by encouraging accurate and comprehensive records, assisting in the organization of reports, and facilitating rapid and easy retrieval of information from the record.
>
> Clinical notes must capture all relevant information from a patient encounter. This requires physicians to reflect on the care provided for a specific patient and document nuances of the encounter. Templates and checklists may be helpful tools for physicians, but may not, on their own, meet the requirements for a complete clinical note.
>
> One of the most widely recommended methods for documenting a patient encounter is the Subjective Objective Assessment Plan (SOAP) format. It

[7] PHIPA Decisions 36, 39 and 40.
[8] PHIPA Decision 36.

> can also be easily adapted to gather and document information obtained during other specific types of encounters such as psychotherapy … While the College recommends that physicians use the SOAP format, other documentation methods are acceptable as long as they capture all of the elements of SOAP …

[39] The complainant appears to take the position that her request to correct the profile report are not significant as she only seeks to reinstate notations the custodian previously made in earlier versions. Similarly, the complainant suggests that her request to transplant some of the custodian's notations from the profile report to create additional entries in the SOAP report simply brings the record in line with CPSO's policy.

[40] Although the CPSO's policy on clinical notes may be helpful in understanding the nature and purpose of clinical notes, it is not my role to determine whether the custodian met his professional obligations. My review is limited to determining whether or not the custodian *is required* under section 55(8) to correct the records.

[41] Having regard to the submissions of the parties, I am not satisfied that the complainant has established that the records are "incomplete or inaccurate for the purposes for which the custodian uses the information" pursuant to section 55(8).

SOAP Report

[42] In my view, the SOAP entries, which appear to be in the format recommended but not required by the CPSO, are comprised of the custodian's clinical notes of his patient encounters with the complainant. The complainant does not argue that the information she seeks to correct in the SOAP entries are incomplete or inaccurate for the purposes which the custodian uses the information. Instead she argues that the content and format of the custodian's clinical records serve her poorly.

[43] The complainant takes the position that organizing the information in chronological order along with adding entries in the SOAP report would ensure that third parties requesting her medical records would obtain a more complete picture of her presenting problems. However, this is not the use or purpose of the SOAP report. The SOAP entries were created by the custodian to document three patient encounters with the complainant. The fact that other patient encounters occurred which were not documented in the same format is not evidence that the SOAP entries that do exist are incomplete or inaccurate for the purposes they were created. I agree the custodian's position that a record in a patient chart or file does not need to reflect the "entirety of the patient's medical care or health status" but that the medical chart is to be read as a whole.

Patient/ Profile Report or Chart

[44] Turning now to the complainant's argument that the profile report is incomplete or inaccurate for the purpose the custodian uses this record, again the complainant

argues that the content and format of this record serve her poorly as it does not provide a comprehensive chronological review of the care she received from the custodian.

[45] The parties do not agree as to the purpose for which the custodian created the profile report. In his decision letter, the custodian submits that the report was prepared in response to her request for a "medico-legal report". A medical-legal report would appear to fit CPSO's definition of a third party report.[9] The custodian also submits that given the purpose of the report, it is "not a document that is contemporaneously kept up to date or which reflects the date of each attendance". However, the custodian also states that he uses the information for his "ongoing treatment" of the complainant.

[46] The complainant submits that neither she nor her legal representatives requested that the custodian prepare the profile report. Having reviewed the complainant's submissions, it appears that she takes the position that the profile report more closely resembles an electronic patient chart and argues that various corrections should be made to organize the information in chronological order and reinstate any entries deleted over time.

[47] I have reviewed the profile report and find that, as a stand-alone document, it does not appear to be a third party report. This finding is relevant in determining whether the complainant has established that the profile report is incomplete or inaccurate for the purpose the custodian uses the report. As previously mentioned, the profile report is a 15-page document with information organized in table-format. The first column contains the custodian's notes regarding his final conclusions along with basic information about the complainant. The second column identifies the complainant's history of illness and family history. The third column contains the custodian's notes of any abnormal findings by tests. The fourth column contains the custodian's notes of normal test findings along with information about the complainant's life history and physician/medication history. In my view, the profile report appears to summarize and organize various historical information about the complainant along with the results of various tests and the custodian's diagnosis and conclusion about specific presenting problems. It appears to be a tool which the custodian uses to organize various test results and other information relating to the complainant. Accordingly, despite the parties' disagreement as to original purpose of the profile report, I am

[9] In its Policy Statement #2-12 entitled *Third Party Reports*, the CPSO states:

> At times, physicians may be asked to provide medical information, or to give a professional opinion for a third party process such as for applications for insurance benefits, or in respect of workplace issues, attendance in educations programs, or legal proceedings. Physicians may be asked to prepare a report, write a letter or complete a form. For the purposes of this policy, these are referred to collectively as 'third party reports'. Third party reports may relate to a physician's patient, or to individuals with whom physician's do not have a treating relationship. The request for the report may come from the physician's patient directly, or from an external party, such as a representative from an insurance company or lawyer.

satisfied that the custodian uses it to provide care to the complainant. In my view, the complainant's evidence that the profile report has been amended several times over the years is consistent with the custodian's use of the report. Similar to the SOAP entries, the profile report is just one part of the complainant's medical chart and is not to be read as a comprehensive report detailing the patient's medical care.

Summary

[48] I find that the complainant has failed to establish that the records are incomplete or inaccurate for the purposes for which the custodian uses the information. As the complainant has not met the initial onus under section 55(8), the custodian is not required to correct the records. Given my finding, it is not necessary that I also determine whether the exception under section 55(9) applies.

NO ORDER:

For the foregoing reasons, no order is issued.

Original Signed By: October 31, 2017
Jennifer James
Adjudicator