Information and Privacy Commissioner,
Ontario, Canada

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

PHIPA DECISION 99

HA15-37

Dr. Philip Solomon

September 23, 2019

Summary: The complainant made a request to a physician for access to her record of personal health information under the *Personal Health Information Protection Act*. She subsequently made a correction request to the physician, who refused to correct his records but agreed to use the complainant's notes as addendums to her record of personal health information. The complainant filed a complaint with this office, regarding the physician's response to her request for corrections, as well as claiming that the physician's search for records responsive to her access request was not reasonable. In this decision, the adjudicator finds that the physician's search for records was reasonable. She also finds that the complainant did not demonstrate that the information in the records is incomplete or inaccurate for the purposes for which the physician used the information, and the physician's decision not to make the requested corrections is upheld. The complaint is dismissed.

Statutes considered: *Personal Health Information Protection Act, 2004*, SO 2004, c 3, Schedule A, as amended, sections 53, 54, 55(8) and 55(9)(b).

Decisions considered: PHIPA Decisions 18, 36 and 37.

BACKGROUND:

[1] The requester made a request under the *Personal Health Information Protection Act* (the *Act*) for access to records of her personal health information in the custody or control of Dr. Philip Solomon (the Custodian). After receiving the records, the requester wrote to the Custodian, requesting a correction to her record of personal health information.

[2] The requester (now the complainant) then filed a complaint with this office. In her complaint, the complainant stated that she had received her record of personal health information, but that the file was incomplete, that the Custodian had not conducted a reasonable search for records and that the Custodian had not addressed her request for correction of her personal health information.

[3] During the intake stage of the complaint, the Custodian issued a response to the requester's correction request. In a letter he wrote to the complainant, the Custodian stated:

> … I have agreed to review your concerns and make additional addendum reports at Mackenzie Health to reflect the information you provided. I will use your notes to create addendum reports, but reserve the right to make notes that I believe capture the events as I saw them, while you were under my care. I have also agreed to attach the notes you provided relating to your care at my clinic to your office medical records.

[4] Also during intake, the Custodian issued another decision letter regarding both the access request and the request for correction, stating:

> I have provided you will full access to your medical records by providing you with a copy of your complete medical records. This included copies of all office clinical notes (including any clinical photographs that I had on record) and all hospital records provided to me by Mackenzie Health. The office and hospital records have been provided to you in full.
>
> You have also requested changes to your office clinical notes and hospital records. You provided me with change requests in writing on [date]. I have agreed to attach to the office clinical notes your written requests for changes and all of your comments relating to your case. I believe this is the best way to provide your perspective of the events. I have addressed your concerns relating to your hospital records by writing addendum reports.

[5] The complaint then moved to the mediation stage. During the mediation, the Custodian provided the complainant with an electronic copy of her health records. The complainant provided a list to the mediator of responsive records that she believed were in the custody or control of the Custodian but were not provided to her. The Custodian took the position that these records were previously provided to the complainant, or that they did not exist or were not in his custody or control.

[6] At the mediator's request, the complainant also provided a list of the corrections she sought to her records of personal health information, and these were submitted to the Custodian for his consideration. The Custodian maintained his refusal to make the requested corrections, on the basis that the records are not incomplete or inaccurate, and that they consist of his professional opinions and observations made in good faith.

[7] As no further mediation was possible, the complaint was transferred to the adjudication stage of the complaints process under section 57(3) of the *Act*, in which an adjudicator may conduct a review. The adjudicator assigned to the file commenced her review by seeking the representations of the Custodian on the issue of the reasonableness of his search for records only. The Custodian provided representations.

[8] She then sought representations from the complainant on the issues of reasonable search and the correction request, indicating that at a later stage of the review, she may seek the Custodian's submissions in response to the complainant's representations on her correction request. The complainant provided representations in response.

[9] The file was then transferred to me to complete the review. I sought, and received representations from the Custodian on the issue of the complainant's request for correction to her record of personal health information.

[10] For the reasons that follow, I find that the Custodian's search for records was reasonable, and that the Custodian is not required to correct the complainant's record of personal health information. No order is issued and the complaint is dismissed.

RECORDS:

Reasonable Search

[11] The complainant believes there are eight categories of records that are responsive to her request made under the *Act*, but that were not provided to her by the Custodian.

Correction Request

[12] The complainant seeks corrections to records of her personal health information dated as follows:

- March 11, 2014;
- March 24, 2014;
- April 7, 2014;
- April 10, 2014;
- April 22, 2014;
- May 12 and 13, 2014;
- June 2 and 3, 2014;

- June 13, 2013 (sic);
- July 15, 2014; and
- August 5 and 6, 2014.

DISCUSSION:

Preliminary Issues

[13] There is no dispute between the parties that the information at issue constitutes the complainant's personal health information. Personal health information is defined in section 4(1) of the *Act*, 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,

[14] Section 4(3) adds to this discussion, covering 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.

[15] The parties also do not dispute that the physician is a "health information custodian" as defined in section 3(1) of the *Act*.

Issue A: Did the Custodian conduct a reasonable search for records?

[16] As the complainant claims that additional records exist beyond those identified by the Custodian, the reasonableness of the Custodian's search is an issue in this complaint. In particular, the complainant has identified eight categories of records that she believes are responsive to her request made under the *Act*, but that were not provided to her by the Custodian.

[17] In order to determine whether the Custodian has conducted a reasonable search for records of personal health information as required by the *Act*, he was asked the following questions:

1. Did the Custodian contact the complainant for additional clarification of the request? If so, please provide details including a summary of any further information the complainant provided.

2. If the Custodian did not contact the complainant to clarify the request, did he:

   a. choose to respond literally to the request?

   b. choose to define the scope of the request unilaterally? If so, did the Custodian outline the limits of the scope of the request to the complainant? If yes, for what reasons was the scope of the request defined this way? When and how did the Custodian inform the complainant of this decision? Did the Custodian explain to the complainant why he was narrowing the scope of the request?

3. Please provide details of any searches carried out including: by whom were they conducted, what places were searched, who was contacted in the course of the search, what types of files were searched and finally, what were the results of the searches? Please include details of any searches carried out to respond to the request.

4. Is it possible that such records existed but no longer exist? If so please provide details of when such records were destroyed including information about record maintenance policies and practices such as evidence of retention schedules.

5. Do responsive records exist which are not in the Custodian's possession? Did the custodian search for those records? Please explain.

[18] The adjudicator assigned to the file asked the Custodian to provide this information in the form of an affidavit signed by the person or persons who conducted the actual search.

Representations

[19] The complainant submits that the Custodian has not conducted a reasonable

search for records responsive to her access request under the *Act*, and that she believes that further records exist. In particular, the complainant submits that there should be an "adverse events report" submitted to the FDA or MERZ.[1] In support of her position, the complainant submits that there is a letter (included with her representations) that indicates that the Custodian reported the adverse event to MERZ, and that there were several communications between the Custodian and MERZ, but no further documentation capturing these communications, other than one clinic note authored by the Custodian. In addition, the complainant states that she has requested that the Custodian contact MERZ to request "any previous adverse events" pertaining to a particular facial filler, and provide her with that information.

[20] The complainant then goes on to argue that it was she who reported the adverse event to MERZ, and that the Custodian ignored her request for him to report the adverse event, leading her to believe that the Custodian does not know what he injected into her face. The complainant further submits that she requested product background information from the Custodian, and that he refused to disclose that to her.

[21] The complainant also submits that she has not been provided with a clinic note, dated April 10, 2014 and that he never recorded her symptoms on this date, and only gave her a prescription for a face cream. The complainant further submits that she was not provided with all of the photographs related to her appointment on March 24, 2014. Lastly, the complainant submits that there are text messages between herself and the Custodian that have not been provided to her.

[22] The complainant does not identify any further categories of records that she believes exist, but were not disclosed to her.

[23] The Custodian submits that the complainant most recently made a request for her medical records in the context of her complaint to this office. The Custodian did not seek clarification to respond to this request as the assumption was that the complainant was requesting all of her personal health information. The request was interpreted broadly.

[24] The Custodian further submits that, through his staff, he conducted a reasonable and thorough search for the complainant's medical records. The Custodian maintains a physical file for all his patients' medical records, including the complainant. The patient files include outgoing, incoming, and internal documentation, including correspondence, clinical notes, correction requests, referrals, consultation notes, and hospital records, among other medical documentation. In order to respond to this request, the Custodian's medical secretary and office manager retrieved the complainant's physical file and reviewed it to ensure she had the complete physical chart. There are no other

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[1] MERZ is a pharmaceutical company.

physical places where medical records are maintained in the Custodian's office other than in the patient's file. The office manager discussed the request with the Custodian and, with his approval, she facilitated the scanning of the chart which was provided electronically to the complainant (over 1600 pages). The office manager is an experienced staff member having worked in the medical field for 25 years and with the Custodian for over 12 years. One of her responsibilities is maintaining patient files. To respond to the request, the office manager also printed and added to the file correspondence that was not yet included in the complainant's medical file, which was then disclosed to the complainant.

[25] The Custodian goes on to argue that it is not possible that records existed but no longer exist. He submits that he has professional obligations which require him to maintain his records for a minimum of ten years, and at all times has complied with those obligations.

[26] The Custodian further submits that the complainant likely has medical records with other physicians and institutions, but he and his staff are not permitted to seek or obtain those records without the complainant's consent.

[27] The Custodian reiterates that he has provided the complainant her entire medical file, and that despite the complainant's assertions that particular records exist, they simply do not exist. In addition, the Custodian submits that there are no "adverse event reports" to/from the FDA or MERZ. Details of conversations and all information relating to adverse event reporting are contained in the medical records that were provided to the complainant. In addition, all photographs and clinical notes were provided to the complainant.

[28] The Custodian also provided an affidavit, sworn by the office manager. She swears that the practice in the Custodian's office is to maintain a physical file for his patients' medical records. Patient files include outgoing, incoming, and internal documentation, including correspondences, clinical notes, correction requests, referrals, consultation notes, hospital records, among other medical documentation, as relevant.

[29] The affiant also swears that in order to respond to the complainant’s request for her medical file, she retrieved the complainant's physical file and reviewed it to ensure she had the complete file. She goes on to state that there are no other physical places where medical records are maintained in our office other than in the patient's file. She also states that she ensured copies of correspondences were included in the medical file, and if they were not, she printed them and included them in the file.

[30] With respect to any text messages between the Custodian and the complainant, the Custodian submits that he was not able to retrieve the text messages because his iPhone broke. However, he also advised that he was in the process of attempting to retrieve the text messages and would disclose them to the complainant, if they were able to be retrieved.

[31] Subsequent to submitting these representations to this office, the Custodian wrote to the complainant, advising the complainant that he was able to retrieve the text messages through a secure service provider with the use of forensic technology and analytics. The Custodian included a USB key containing the text messages with the letter sent to the complainant.

Analysis and findings

[32] This office has extensively canvassed the issue of reasonable search in orders issued under the *Freedom of Information and Protection of Privacy Act* and its municipal counterpart. It has also addressed the issue of reasonable search under the *Act* in, for example, PHIPA Decision 18, in which Adjudicator Catherine Corban found that the provisions concerning reasonable search in response to an access request in the public sector access statutes are substantially similar to those contained in the *Act*. Adopting and applying the approach taken by Adjudicator Corban, the principles outlined in orders of this office addressing reasonable search under those statutes are instructive to my review of this issue under the *Act*. In the discussion that follows, I will accordingly refer to orders of this office addressing reasonable search under those statutes.

[33] Where a requester under the *Act* claims that additional records exist beyond those identified by a Custodian, the issue to be decided is whether the Custodian has conducted a reasonable search for records as required by sections 53 and 54 of the *Act*. If I am satisfied that the search carried out was reasonable in the circumstances, I will uphold the Custodian's decision. If I am not satisfied, I may order further searches.

[34] The *Act* does not require the Custodian to prove with absolute certainty that further records do not exist. However, the Custodian must provide sufficient evidence to show that it has made a reasonable effort to identify and locate responsive records.[2] To be responsive, a record must be "reasonably related" to the request.[3]

[35] Under the *Act*, a reasonable search is one in which an experienced employee knowledgeable in the subject matter of the request expends a reasonable effort to locate records which are reasonably related to the request.[4] A further search will be ordered if the Custodian does not provide sufficient evidence to demonstrate that it has made a reasonable effort to identify and locate all of the responsive records within its custody or control.[5]

[36] Having carefully reviewed all of the evidence before me, including both parties'

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[2] Orders P-624 and PO-2559.
[3] Order PO-2554.
[4] Orders M-909, PO-2469 and PO-2592.
[5] Order MO-2185.

complete representations, I am satisfied that the search conducted by the Custodian for records responsive to the complainant's request was reasonable and is in compliance with his obligations under the *Act*.

[37] I find that the Custodian has provided sufficient evidence to demonstrate that he made a reasonable effort to identify all responsive records within his custody and control. Based on the information before me, I accept the Custodian's argument that he interpreted the access request broadly, and that his office manager located the complainant's record of personal health information, ensured it was complete and then disclosed it to the complainant in hard copy. I am also satisfied that during the mediation of the complaint, the complainant was provided with an electronic copy of her record of personal health information. I am also satisfied that during the review of this complaint, the Custodian arranged for the retrieval of any text messages sent between himself and the complainant, which he then disclosed to her. For all of these reasons, I am satisfied that the Custodian's search for responsive records was reasonable.

[38] Under the *Freedom of Information and Protection of Privacy Act* and its municipal counterpart, although a requester will rarely be in a position to indicate precisely which records the Custodian has not identified, the requester still must provide a reasonable basis for concluding that such records exist.[6] In PHIPA Decision 18, Adjudicator Corban found that this requirement was equally applicable in determining whether a Custodian conducted a reasonable search under the *Act*. I agree with and adopt this approach, and in the circumstances of this complaint, I find that the complainant has not provided a reasonable basis to conclude that additional records relating to her and the Custodian exist. For example, while there was communication between the Custodian and MERZ, which was disclosed to her, this does not lead to the conclusion that there must have been an "adverse events report" completed. In addition, in her representations, the complainant seeks access to previous adverse events involving other patients that have been reported to MERZ. I find that this type of information would be outside the scope of the complainant's request. The complainant has also not satisfied me that records responsive to any of the other categories of records exist.

[39] The evidence before me suggests that the Custodian took the requisite reasonable efforts to attempt to respond to the complainant's access request and inquiries regarding his search for her record of personal health information. For these reasons, I am satisfied that the Custodian has discharged his onus and has demonstrated that he has conducted a reasonable search in compliance with his obligations under the *Act*.

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[6] Order MO-2246.

Issue B: Does the Custodian have a duty to make the requested corrections under section 55(8)? Does the exception to the duty to correct at section 55(9)(b) apply to any of the information in the records?

[40] The purposes of the *Act* are set out in section 1, and include the right, at paragraph (c):

> to provide individuals with a right to require the correction or amendment of personal health information about themselves, subject to limited and specific exceptions set out in [the *Act.*]

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

> The health information custodian shall grant a request for a correction under [section 55(1) of the *Act*] 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.

[42] Section 55(9) of the *Act* sets out exceptions to the duty to correct records. In this review the Custodian relies on the exception at section 55(9)(b) to deny some of the requested corrections. This section 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.

[43] Read together, these provisions set out the criteria pursuant to which an individual is entitled to a correction of a record of his or her own personal health information. The purpose of section 55 of the *Act* is to impose a duty on health information custodians to correct a record of an individual's personal health information where the record is inaccurate or incomplete for the purposes for which the custodian uses the information, subject to the limited and specific exceptions set out in section 55(9) of the *Act*.

[44] In all cases where a complaint regarding a custodian's refusal to correct records of personal health information 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). In particular, section 55(8) requires that the individual making the request for correction:

1. 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

2. give the custodian the information necessary to enable the custodian to correct the record.

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

[46] 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 observation," the onus is on the individual seeking a correction to establish that the "professional opinion or observation" was not made in good faith.

Representations

[47] In her representations, the complainant sets out the discrepancies/errors she believes are contained in the records dated March 11, 2014, March 24, 2014, April 7, 2014, April 10, 2014, April 22, 2014, May 12 and 13, 2014, June 2 and 3, 2014, June 13, 2013 (sic), July 15, 2014 and August 5 and 6, 2014. The

March 11, 2014

[48] The record incorrectly identifies the location where the filler was injected. Post injection protocol was not discussed, and she experienced swelling, redness and pain immediately, eventually experiencing numbness.

March 24, 2014

[49] The record incorrectly states that she said that the burning sensation was resolving, and that her skin had settled down. States she advised the Custodian that she had throbbing pain.

April 7, 2014

[50] The record fails to document a number of symptoms she was experiencing and is incorrect in stating that the filler consisted solely of hyaluronic acid.

April 10, 2014

[51] This record includes a prescription for face cream and nothing else. The record fails to include the complainant's symptoms and concerns.

April 22, 2014

[52] The record incorrectly states that the complainant was happy with the current results.

May 12 and 13, 2014

[53] The actual visit to the Custodian was on May 12, 2014, not May 13, 2014. The complainant then lists symptoms she was experiencing, but that are not included in the record, and that the record incorrectly states that she said that the burning on the right side had settled.

June 2 and 3, 2014

[54] The record incorrectly states that the photographs were reviewed, when they were not and that the complainant said she had iced her face, when she had not. The complainant also states that the Custodian was unresponsive and did not answer her questions and concerns.

June 13, 2013 (sic)

[55] The record incorrectly states that the complainant was given a consent to treatment form by the Custodian.

July 15, 2014

[56] The complainant left the Custodian's office due to experiencing extreme burning and redness on her face. She states that she was seen by the Custodian in the parking lot, and was asked to return when the practice was less busy. The record does not reflect some clinical information that the Custodian discussed with her.

August 5 and 5, 2014

[57] The record incorrectly states that the complainant refused treatment, and that she was experiencing discomfort in both ears, when, in fact, the discomfort was only in one ear.

[58] The complainant further argues that the Custodian tampered with her medical records by writing deceiving notes, and then led her to believe that he would correct her records. The complainant goes on to argue that the Custodian did not act in good faith, as "these embarrassing shameful untruthful clinic notes could have devastating outcome (sic) for me the patient."

[59] The Custodian submits that the complainant made a request to the Custodian to make changes to his clinical notes, and that he agreed to make addendums "as he saw fit." The addendums, the Custodian notes, were made in an attempt to include the complainant's narrative in her medical records, and were not necessarily corrections to

the records. The Custodian also submits that he confirmed in writing to the complainant that he would make addendums. He also advised the complainant that he would attach her other correction requests to her records.

[60] Following the complaint to this office, this office sent a copy of the complainant's correction requests to the Custodian, who responded by way of letter, stating that he had considered the correction requests, and was of the view that the records are not incomplete or inaccurate, and they reflect the Custodian's professional opinions and observations made in good faith.

[61] The Custodian submits that the complainant has not demonstrated that the information subject to the correction request is incomplete or inaccurate for the purposes for which the custodian used the information, which was to provide continuity of care, and to ensure appropriate follow up and management. In addition, the Custodian argues that the complainant has not provided him with information necessary to correct the record even it were inaccurate.

[62] In any event, the Custodian submits that the information subject to the correction request falls within the exception in section 55(9)(b) of the *Act* because the information consists of his professional opinions and observations. The Custodian goes on to submit that the visits with the complainant were documented contemporaneously to account for what happened in the medical appointment, including the treatment that was provided. The Custodian then details the content of each of the notes for which the complainant has requested corrections. The notes include the following types of professional opinions and observations:

- descriptions of the medical treatment provided;
- information communicated to the complainant;
- clinical assessments;
- clinical observations;
- prescriptions;
- management plans;
- summaries of the complainant's concerns; and
- professional opinions.

[63] The Custodian goes on to argue that his professional opinions and observations were made in good faith. The Custodian states:

> First, [the Custodian] vehemently disagrees that he documented his professional opinions and observations in the absence of good faith. To

> the contrary, [the Custodian] at all times acted in good faith. [The Custodian] regularly made himself available to [the complainant] to discuss her care concerns. He provided her ongoing and extensive follow up care following the onset of her symptoms. He sought second opinions, and made referrals to a variety of specialists to try and ascertain the cause of her symptoms. Referrals were made to a plastic surgeon, cosmetic dermatologist, otolaryngologist, facial pain specialist, infectious diseases specialist, manufacturer and a dermal filler specialist.

[64] Lastly, the Custodian argues that the complainant is under the mistaken impression that to "correct" medical records must be to refer to only her interpretation, and that failing to do so means that the Custodian's professional opinion and observations were not prepared in good faith. The Custodian submits that is not the test, and there are no reasonable grounds to conclude that his professional opinions and observations were not made in good faith.

Analysis and findings

[65] I find that the Custodian is not obliged to grant the complainant's correction request because the complainant has not demonstrated that her record of personal health information is incomplete or inaccurate for the purposes for which the Custodian uses the information. In PHIPA Decision 36, Adjudicator Jennifer James interpreted the correction provisions of the *Act*. In doing so she stated:

> 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.
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> 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.

> The following discussion in Guide to the Ontario Personal Health Information Protection Act[7] 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]
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> 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.

[66] I agree with and adopt the approach taken by Adjudicator James. I find that the Custodian is not obliged to grant the complainant's correction request because she has not demonstrated that her record of personal health information is incomplete or inaccurate for the purposes for which the Custodian uses the information. 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 in section 55(9)(b) would apply to the information the complainant seeks to correct.

[67] Section 55(9) states that 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 purpose of section 55(9)(b) is to preserve professional opinions or observations, whether they are accurate or not, that have been made in good faith. This purpose is based on policy considerations, including the need for documentation that may explain treatments

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

provided or events that follow a particular observation or diagnosis.

[68] As a result, a request for correction should not be used to attempt to change 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, diagnosis or quality of care.

[69] A two-part analysis is applied when considering whether the exception in section 55(9)(b) applies. The first question is whether the personal health information is a "professional opinion or observation," while the second question is whether the professional opinion or observation was made "in good faith."

[70] In PHIPA Decision 36, Adjudicator James interpreted the phrase "professional opinion or observation" in the context of the *Act*. She stated:

> 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.[8] 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".
>
> 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*.

[71] Applying Adjudicator James' interpretation of the phrase "professional opinion or observation," I find that the personal health information in the records that the

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

complainant wishes to be corrected was prepared by the Custodian. The Custodian prepared this information in the course of providing medical care to the complainant. I further find that this information falls squarely into the category of professional opinion or observation. Examples of the type of information are the Custodian's observations upon examination of the complainant, as well as his discussion of the results of his assessment and treatment, all of which involve the exercise of special knowledge, skill, qualifications, judgement or experience by a professional.

[72] I have considered the representations of both parties, as well as reviewed the record itself. I find that the personal health information that the complainant seeks to correct qualifies as the Custodian's professional opinion or observation. In my view, the complainant is seeking to substitute or rewrite the Custodian's opinions or observations contained in her record of personal health information.

[73] Turning to the second part of the analysis, the question is whether the Custodian's professional opinion or observation was made "in good faith." In PHIPA Decision 37, Adjudicator James found that 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. If the exception applies, it does not matter whether or not the individual has met the onus in section 55(8) because even if the complainant satisfied this office that the information is incorrect or inaccurate under section 55(8), a finding that the exception in section 55(9)(b) applies will resolve the complaint.[9]

[74] Adopting the approach taken in PHIPA Decision 37, and based on my consideration of the information before me, I find that this information does not rebut the presumption of good faith in the circumstances of this complaint. In arriving at this decision, I took into account the contents of the records which describe the circumstances in which the complainant sought treatment from the Custodian, along with the absence of evidence from the complainant suggesting that the Custodian acted in bad faith in writing the content of the complainant's record of personal health information. As there is no evidence of malice, intent to harm, serious carelessness or recklessness on the part of the Custodian in writing the content of the complainant's record of personal health information, and because the complainant has not met her onus to show that the Custodian's professional opinions or observations were made in "bad faith," I find that the exception at section 55(9)(b) applies in the circumstances of this complaint. Accordingly, I find that the Custodian does not have a duty to correct the record under section 55(8).

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[9] She also found that, 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).

[75] In addition to providing individuals with a right to access their personal health information, the *Act* gives individuals the right to attach a statement of disagreement to the record conveying their disagreement with any information contained in the record. The complainant may choose to file a statement of disagreement with the Custodian.

NO ORDER:

1. For the foregoing reasons, no order is issued.

Original Signed By: September 23, 2019

Cathy Hamilton
Adjudicator