Information and Privacy Commissioner,
Ontario, Canada

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

PHIPA DECISION 138

Complaint HA18-29-2

Dr. A. J. Wahby

January 26, 2021

Summary: The complainant submitted four requests under section 55(1) of the *Personal Health Information Protection Act, 2004* (*PHIPA*) to his family physician to have corrections made to a number of entries in his medical records. The physician agreed to correct some but not all of the information set out in the complainant's requests. For the information that he did not agree to correct, the physician referred to section 55(8) of *PHIPA* which sets out the duty to correct and cited the application of the exception to that provision at section 55(9)(b) for professional opinions or observations made in good faith. In this decision, the adjudicator finds that the physician does not have a duty under section 55(8) to correct the personal health information because the exception in section 55(9)(b) applies. She dismisses the complaint and no order is issued.

Statutes Considered: *Personal Health Information Protection Act, 2004,* SO 2004, c 3, sections 3(1), 4(1), 55(1), 55(8), 55(9), 55(11), 57(3) and 57(4).

Decisions Considered: PHIPA Decisions 37, 39, 43, and 108.

BACKGROUND:

[1] This complaint arises from a number of correction requests made by the complainant to his family physician (the physician or the custodian) under section 55(1) of the *Personal Health Information Protection Act, 2004* (*PHIPA* or the *Act*).

[2] The complainant suffered injuries as a result of a motor vehicle accident which necessitated regular consultations with his physician. The physician documented the consultations as chart notes in the complainant's medical record. The complainant

requested that a number of corrections be made to several identified chart notes.

[3] The physician issued a decision in response to the complainant's requests.[1] The physician agreed to correct some but not all of the personal health information that the complainant requested be corrected. In his decision, the physician stated, in part:

> With respect to your visit on March 4, 2015 ….The visit was specifically related to your car accident. It is not uncommon for [a] physician to note all the conditions that a patient suffers in order to maintain the continuity of care of the record.

[4] The complainant filed a complaint with the Information and Privacy Commissioner, Ontario (the IPC or this office) regarding the physician's decision not to grant all of his correction requests. This office opened file HA18-29-2 to address his concerns.

[5] During the mediation stage of the complaint process, the complainant clarified his request. He identified eight chart notes by date and detailed the specific corrections he wanted the physician to make to each of them. The clarified request was provided to the physician for consideration.

[6] After some mediation had occurred, the complainant advised the mediator that he is satisfied with the physician's response to the majority of the corrections he requested be made to the personal health information in his medical records. Specifically, he is satisfied with the physician's response to his request that corrections be made to the chart notes identified in items 1 and 3 to 8 of his clarified request. However, he advised the mediator that he continues not to be satisfied with the physician's response to item 2 of his clarified request, which sets out his concerns with respect to entries made in a chart note prepared during his consultation with the physician on March 4, 2015. Those concerns were confirmed at mediation as follows:

> **Record**: Chart note dated 15-3-4:
>
> **Requested Corrections**:
>
> Record states:
>
>> a) "continues to c/o lower back pain" – The complainant wants this struck from the record.

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[1] Initially, the physician failed to respond to the complainant's requests and the complainant filed a complaint with this office on that basis. This office opened a deemed refusal complaint (HA18-29) which was subsequently closed when the physician issued a decision.

> b) "decreased ROM of back in all directions" – The complainant wants this struck from the record.
>
> c) "no pain on straight leg raising" – The complainant wants this struck from the record.
>
> d) The complainant advised that his blood pressure was taken during this appointment – The complainant wishes to have this information added to the record.

[7] As mediation continued, the physician considered the complainant's continued concerns with respect to the corrections he wanted made to chart note 15-3-4. The physician responded by letter, stating:

> As noted in my previous letter dated January 28, 2019, there is no entry in the record dated 15-3-4 of "continues to c/o lower back pain."
>
> ….
>
> In the recording,[2] I asked about injuries from the motor vehicle accident and you indicated that it was your neck and shoulder on your right side, your left arm at the elbow and from your butt cheeks around your left hip to your groin. You also described the mechanism of the injury being a twisting position while being involved in a rear-end collision. My interpretation of this complaint was lower back pain. My statement of "*decreased ROM of the back in all directions*" is based on my professional observation of you during the appointment. As such, I believe that these aspects of the record are accurate and consistent of professional observations made in good faith and I am not willing to strike them out.
>
> I am willing to add "blood pressure was good but pulse was a bit fast" to the record as a late entry. I am also willing to strike out "*No pain on straight leg raising."*

[8] As the physician agreed to strike the reference to "no pain on straight leg raising" from chart note 15-3-4 and include an entry indicating that the complainant's blood pressure was taken during the consultation on March 4, 2015, parts c) and d) of item 2 of the complainant's clarified correction request were resolved. However, the complainant continues to take the position that the phrases "continues to c/o lower back pain" and "decreased ROM of back in all directions" in parts a) and b) should be struck from the chart note.

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[2] "The "recording" is an audio recording of the complainant's visit on March 4, 2015.

[9] To support his position that the two remaining corrections should be made to chart note 15-4-3, the complainant provided further documents for the physician to consider. These documents included an email explanation, chart notes, prescriptions, referrals for physiotherapy and an ultrasound, as well as the details of a personal exercise program recommended by a physiotherapist. The physician considered the additional information that the complainant provided to him and issued a supplemental decision dated April 3, 2019, which stated, in part:

> I have reviewed and considered the information provided by you to [the mediator] on May 10, 2019. I do not feel that any further corrections to the March 4, 2015 record are required based on the information provided in your email. I am firm in my position that the balance of the visit note is a contemporaneous record, is accurate, complete and consists of professional observations that were made in good faith. I would draw your attention to ss. 55(9) of [*PHIPA*].

[10] Following the complainant's receipt of the physician's supplemental decision explaining why, despite the complainant's provision of additional supporting documentation, the physician advised that he is not prepared to make the first two requested corrections to the chart note from 15-3-4. The complainant then provided the physician with copies of chart notes from 13-6-20 and 13-7-11 which the complainant argues supports his requests to have his personal health information in chart note 15-3-4 corrected.

[11] The physician responded, stating:

> I have outlined my position in my previous correspondence; in particular, my letter dated April 3, 2019. It remains unchanged. I continue to believe that the record is accurate, consists of professional observations made in good faith and no further corrections are required.

[12] The complainant advised the mediator that he is not satisfied with the doctor's response to his correction requests relating to the first two corrections he wants made to chart note 15-3-4. As a result, the complaint moved to the adjudication stage of the process, where an adjudicator may conduct a review.

[13] I considered the circumstances surrounding this complainant, the information provided during mediation, as well as the information set out in the Mediator's Report that was issued at the close of the mediation stage. I also considered the documents provided by the parties during mediation, as well as the audio record of the complainant's visit to the physician on March 4, 2015, which the physician provided to this office (with the complainant's consent), after mediation had concluded.

[14] My preliminary assessment was that I might exercise my discretion under sections 57(3) and (4) of *PHIPA* not to conduct a review into the matter as it appeared that there were no reasonable grounds to review the subject-matter of the

complainant.[3] I set out the relevant legislative provisions and conveyed my reasons for my preliminary assessment in a letter sent to the complainant requesting written submissions that I would consider before making a final decision on the matter.

[15] Following receipt of the complainant's representations, I determined that I would conduct a review and seek submissions on the matter, from both parties. I invited the physician to respond to a Notice of Review setting out the relevant legislative provisions on the issue of correction and also to the representations submitted by the complainant in response to my preliminary assessment. The physician provided representations which I shared with the complainant, in their entirety. The complainant then provided representations in response to the Notice of Review and the physician's representations. I determined the complainant's representations did not need to be shared with the physician.[4]

[16] In this decision, I find that the physician does not have a duty under section 55(8) of *PHIPA* to correct the personal health information that the complainant seeks to have corrected because it consists of the physician's professional opinions or observations, made in good faith, as contemplated by the exception to the duty to correct set out in section 55(9)(b). Based on my findings, I uphold the physician's decision not to make the requested corrections and I dismiss the complaint with no order.

RECORD:

[17] Remaining at issue are two corrections that the complainant seeks to have corrected to a chart note detailing a consultation with the physician on March 4, 2015. It is identified as chart note 15-3-4. The complainant seeks to have the phrase "continues to c/o lower back pain" and the phrase "decreased ROM of back in all directions" struck from the chart note.

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[3] Section 57(3) and (4) of *PHIPA* state, in part:

> **Commissioner's review**
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> (3) If the Commissioner does not take an action described in clause (1)(b) or (c) or if the Commissioner takes an action described in one of those clauses but no settlement is effected within the time period specified, the Commissioner review the subject-matter of a complaint made under this Act if satisfied that there are reasonable grounds to do so.
>
> **No review**
>
> (4) The Commissioner may decide not to review the subject matter of the complaint for whatever reason the Commissioner considers proper [...].

[4] Representations were shared between the parties in accordance with this office's sharing procedures, as set out in *Practice Direction Number 3* of the IPC's *Code of Procedure under* PHIPA.

DISCUSSION:

[18] There is no dispute that the physician is a "health information custodian" under section 3(1) of *PHIPA* and that the record at issue is the complainant's personal health information under section 4(1) of *PHIPA*.

[19] The sole issue to be determined in this complaint is whether the physician has a duty to correct the complainant's record of personal health information in accordance with his request.

Does the physician 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 the phrases "continues to c/o lower back pain" and "decreased ROM of back in all directions" in chart note 15-3-4?

[20] The purposes of *PHIPA* are set out in section 1, and include, 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 [*PHIPA*].

[21] Section 55(1) of *PHIPA* permits an individual who has received access to their personal health information to request that a custodian correct a record "if the individual believes that the record is inaccurate or incomplete for the purposes for which the custodian has collected, uses or has used the information…"

[22] Section 55(8) of *PHIPA* 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 *PHIPA*] 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.

[23] Section 55(9) of *PHIPA* sets out exceptions to the duty to correct records. In this case the physician relies on the exception at section 55(9)(b) to deny some of the requested corrections. It reads:

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

[24] 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(8) 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).

Section 55(9)(b): exception for professional opinion or observations

[25] 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. This approach is consistent with the approach taken to similar provisions in other jurisdictions.[5]

[26] Where a "professional opinion or observation" is involved, section 55(8) does not impose a duty to grant a correction that amounts to a substitution or change to the custodian's "professional opinion or observation," unless it can be established that the professional opinions or observations were not made in good faith. Moreover, a request for correction or amendment should not be used to attempt to appeal decisions or professional opinions or observations with which a complainant disagrees, and cannot be a substitution of opinion, such as the complainant's view of a medical condition or diagnosis.[6]

[27] 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, as explained below, once the custodian has established that the information qualifies as a "professional opinion or observation," the onus shifts to 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 satisfies this office that the information is incorrect or inaccurate under section 55(8), a finding that the exception in section 55(9)(b) applies means that corrections need not be made.[7]

[28] The determination of whether the exception at section 55(9)(b) applies involves a two-part analysis. The first question is whether the personal health information in the record is a "professional opinion or observation." The second question is whether the "professional opinion or observation" was made "in good faith."

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[5] See for example Orders H2004-004, H2005-006 and H2005-007 of the Information and Privacy Commissioner of Alberta.
[6] PHIPA Decision 43.
[7] *Ibid.*

(1) Is the personal health information in the record a "professional opinion or observation" about the complainant?

[29] In order for section 55(9)(b) to apply, the physician must establish that the personal health information in the records must qualify as either a "professional opinion" or a "professional observation."

The complainant's position

[30] In his representations submitted in response to my preliminary assessment, the complainant reiterated his position, set out above, that several notations in the chart note of 15-3-4 must be corrected.

[31] First, he points to line one of the chart note which states:

> Also c/o left hip, elbow pain, lower back pain. All these he relates back to his MVA when he was rear ended by a pick up truck.

[32] The complainant disputes that he complained of "lower back pain" at the consultation on March 4, 2015, or at any consultation with the physician.

[33] Second, line three of the chart note states:

> Decreased range of motion of the back in all directions.

[34] The complainant submits that he was not aware that he was being assessed for range of motion at the consultation on March 4, 2015 and that he was not asked to bend in any direction.

[35] Third, line four of the chart note states:

> No pain on straight leg raising.

[36] The complainant submits that "[t]here were no instructions to do straight leg raising. I never did any straight leg raising. It never happened." The complainant acknowledges that the physician has already agreed to strike this statement from the chart note after reviewing the audio record provided by the complainant. However, the complainant submits that the fact that the physician did not offer any explanation with respect to the error and subsequent agreement to strike it from the chart note demonstrates that the physician knowingly falsified the chart notes by including this notation. The latter part of this submission is relevant to the second part of the test that must be met for the exception at section 55(9)(b) to apply, whether the professional opinion or observation was made in good faith. I will discuss it below.

The physician's response

[37] The physician submits that the information that the complainant wants corrected

in chart note 15-3-4 consists of "professional opinions or observation" that he made in good faith when examining the complainant. Specifically, he submits that he prepared the chart note dated 15-3-4 by applying his professional knowledge and skills based on the information provided by the complainant and his own professional observations of the complainant during the appointment. He submits that in doing so, he used and relied upon his training and experience as a family physician.

[38] The physician explains that during the consultation on March 4, 2015, he asked the complainant about his injuries from the motor vehicle accident and the complainant described the pain that he felt and explained how the injury occurred as he was forced into a twisting motion during a rear-end collision. The physician submits that based on the information provided by the complainant together with his training an expertise as a family physician, he assessed that the complainant was suffering from left hip and lower back pain.

[39] The physician also states that observations about range of motion are not limited to formal testing measuring degrees of movement in specific directions. He states that range of motion can be generally observed by a family physician as the patient ambulates into and around the examination room, including gets on and off an examination table, turning, moving in and out of the sitting position, their posture, etc. The physician submits that a family physician learns with training and experience that these types of observations provide valuable information about a patient's health.

[40] The physician submits that in recording in the chart note of the consultation on March 4, 2015, that the complainant "c/o … lower back pain" and suffered from "[d]ecreased range of motion of the back in all directions," in both respects he was documenting professional opinion or professional observation based on what he saw, heard or noticed during the appointment. He submits that his comments of decreased range of motion of the back in all directions, and tenderness in the lumbosacral region, would be indicative of lower back pain. He submits that there is nothing in the chart note that records an opinion or observation about the complainant "feigning restricted range of motion." The physician also notes that he previously agreed made the correction regarding the notation about "straight leg raising" and it has been struck from the record.

[41] The physician concludes his representations by stating that in considering the complainant's request for correction he reviewed and has considered all of the information available to him including the audio recording of the consultation, an email from the complainant, chart notes, prescriptions, an x-ray requisition, referrals for physiotherapy and the details of the complainant's personal exercise program. He submits that there is nothing in any of this information that demonstrates to his satisfaction that the corrections should be made. He submits he believes the records are complete and accurate for the purposes of his care and treatment of the complainant as his family physician.

<u>Analysis and finding: the personal health information to be corrected is the physician's professional opinions or observations</u>

[42] As noted above, it is the custodian that bears the onus of satisfying me that the information that the complainant seeks to have corrected is a "professional opinion or observations" as contemplated by the exception at section 55(9)(b). Only those observations and opinions that require a health information custodian or an agent to exercise or apply special knowledge, skills, qualifications, judgment or experience relevant to their profession should be defined as "professional observations" or "professional opinions" within the meaning of section 55(9)(b).[8]

[43] In the circumstances of this complaint, I accept that the personal health information to be corrected consists of the physician's professional opinions or observations.

[44] The first notation that the complainant wishes to have corrected from chart note 15-3-4 is that he complained of lower back pain. He submits that this should be struck from the record as he made no such complaint. I note that the reference to a complaint of lower back pain was not included in the chart note on its own but figures among a list of various complaints the physician discerned the complainant was suffering from during the consultation. I accept the physician's submission that the reference to lower back pain in the chart note arises from his application of his professional knowledge and skill to the information communicated to him by the complainant during the consultation and records his professional opinion of the types of pain the complainant was experiencing based on those communications.

[45] The second notation that the complaint wants to have corrected in chart note 15- 3-4 is the physician's reference to his decreased range of motion in all directions. I accept the physician's submission that this notation records his professional opinion and observation based on his observation of the complainant's movement during the consultation and the application of his special knowledge, skills, qualifications, judgement or experience as a family physician to that observation.

[46] Accordingly, I find that the physician's notations in chart note 15-3-4 that the complainant seeks to have corrected are the physician's "professional opinions or observations" about the complainant, based on his assessment of the complainant during the consultation on March 4, 2015. I accept that these opinions or observations are derived from the exercise or application of special knowledge, skills, qualifications, judgment or experience as a family physician and to correct this information would substitute or rewrite the physician's opinions or observations gathered during the course of the consultation.

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[8] PHIPA Decisions 36, 37, and 43.

(2) For any personal health information in the records qualifying as a "professional opinion or observation," was the professional opinion or observation made "in good faith?"

[47] Once a custodian has established the information the complainant seeks to have corrected qualifies as a professional opinion or observation, for section 55(9) to apply, it is up to the complainant to establish that the professional opinion or observation was not made "in good faith."

[48] Court decisions have stated that a finding that someone has not acted in good faith can be based on evidence of malice or intent to harm another individual, as well as serious carelessness or recklessness. The courts have also stated that persons are assumed to act in good faith unless proven otherwise. Therefore, the burden of proof is on the individual seeking a correction to establish that the professional opinion or observation was not made in "good faith."[9] In this review, the onus lies on the complainant.

<u>The complainant's position</u>

[49] The complainant submits that the chart notes of 15-3-4 were not made in good faith. As noted above, the complainant submits that the fact that the physician agreed to strike the reference in the notes to "straight leg raising" without offering any explanation as to why or how this was included in the record in error demonstrates that the physician knowingly falsified the chart notes by including this notation.

[50] The complainant also submits that chart note 15-3-4 falsely describes him as complaining of lower back pain, gives the appearance that the physician performed an examination confirming that no lower back pain exists, and also falsely gives the impression that he feigned restricted range of motion. He submits that the chart note of 15-3-4 is comprised of false and deceptive entries and was not made in good faith.

<u>The physician's response</u>

[51] With respect to the complainant's allegation that the physician's professional opinion or observations was not made in good faith, the physician states that there is no evidence of any malice or intent to harm the complainant on his part. The physician categorically denies that in his chart note on 15-3-4 he knowingly recorded false or deceptive entries and submits that there is no evidence to support this allegation. He submits that the complainant appears to assume that the physician holds the opinion that the complainant feigned the impact of his injuries but states that this is not

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[9] *Finney v. Barreau du Québec,* [2004] 2 SCR 17, 2004 SCC 36 (CanLII) at 39, where the Supreme Court of Canada found that the concept of "bad faith" is not limited to intentional fault but must be given a broader meaning that encompasses serious carelessness or recklessness. See also PHIPA Decision 43.

accurate and is not supported by the entries in the record.

The complainant's reply

[52] In reply, the complainant reiterates that he believes that the entries in chart note 15-3-4 about him complaining of lower back pain and decreased range of motion of the back in all directions were written with "malice and ill intent." The complainant submits that the physician was attempting to deny him pain medication and the malicious entries were a result of the physician's displeasure at learning that someone other than the physician was renewing the complainant's pain medication. He appears to suggest that drug store receipts itemizing medications that he purchased, including pain medication, support his allegations. Copies of the itemized list of medications he received from the drug store were enclosed with his representations.

Analysis and finding: the physician's professional opinions or observations were made in good faith

[53] Having considered the evidence provided by the complainant, I find that the complainant has not met the onus of establishing that the professional opinions or observations recorded in chart note 15-3-4 were not made in good faith.

[54] The complainant believes that the drug store receipts itemizing the medications that he purchased supports his position that the notes recorded in chart note 15-3-4 were not made in good faith. I disagree. The receipts indicate that he was prescribed pain medication; they do not demonstrate that the physician acted with something other than good faith, let alone with malice or an intent to harm, or with serious carelessness or recklessness in his record of the consultation in chart note 15-3-4.

[55] The complainant also believes that the fact that the physician agreed to strike the phrase "[n]o pain on straight leg raising" from the chart note, during mediation, without providing an explanation as to why it was included in the record in the first place demonstrates that the physician "knowingly falsified the chart notes by including this notation." I do not accept that the physician's agreement, during mediation, to make one of the corrections requested by the complainant without explanation supports a conclusion that the physician did not act in good faith with respect to his professional opinions or observations recorded in chart note 15-3-4.

[56] In my view, I have been provided with insufficient evidence to conclude that the physician acted with malice or an intent to harm the complainant or that he acted with serious carelessness or recklessness when he made the specific professional opinions or observations that are recorded in chart note 15-3-4. I find that the physician's professional opinions or observations in chart note 15-3-4 were made in good faith.

Conclusion

[57] In conclusion, I find that the personal health information that the complainant

continues to want corrected in chart note 15-3-4 consists of professional opinions or observations that the physician made in good faith about the complainant. Consequently, I find that the exception at section 55(9)(b) applies to this information and the physician does not have a duty to correct it under section 55(8).

Statement of Disagreement

[58] From the information before me it is not clear whether the complainant has been informed of his right to attach a statement of disagreement to chart note 15-3-4 under section 55(11). That section reads, in part:

> A notice of refusal under subsection (3) or (4) must give the reasons for the refusal and inform the individual that the individual is entitled to,
>
> > (a) prepare a concise statement of disagreement that sets out a correction that the health information custodian has refused to make;
> >
> > (b) require that the health information custodian attach the statement of disagreement as part of the records that it holds of the individual's personal health information and disclose the statement of disagreement whenever the custodian discloses information to which the statement relates;
> >
> > (c) require that the health information custodian make all reasonable efforts to disclose the statement of disagreement to any person who would have been notified under clause 10(c) if the custodian had granted the requested correction; and
> >
> > (d) make a complaint about the refusal to the Commissioner under Part VI.

[59] The complainant is advised that he is entitled to submit a statement of disagreement to the physician, under section 55(11) of *PHIPA*. That statement of disagreement would be included in the complainant's records of personal health information and would form part of his records going forward.

[60] If the physician did not advise the complainant of his right under section 55(11) to attach a statement of disagreement to his record, he is reminded of his obligation to do so under section 55(11) and is reminded to comply with this obligation going forward.

ORDER:

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

Original Signed by:	January 26, 2021

Catherine Corban
Adjudicator