Information and Privacy Commissioner,
Ontario, Canada

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

# PHIPA DECISION 186

Complaint HA21-00178

A Hospital

August 16, 2022

**Summary:** The complainant submitted a correction request under the *Personal Health Information Protection Act* to the hospital to correct his medical history information found in his electronic medical record. The hospital denied the complainant's request citing sections 55(8) and 55(9). The adjudicator finds that the complainant did not demonstrate that the information in the record was incomplete or incorrect for the purpose the hospital uses the information. As a result, the hospital's decision to not make the requested corrections is upheld.

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

## OVERVIEW:

[1] This decision addresses the hospital's denial of the complainant's request under section 55(1) of the *Personal Health Information Protection Act* (*PHIPA*) for correction of medical history information found in the complainant's electronic medical record (EMR).

[2] The records relate to two incidents when the complainant was brought to the hospital under a Form 1[1] by police officers, who were called by the complainant's family.

[3] In November 2018, the complainant was initially seen by a nurse in the hospital's emergency department (ED) and subsequently examined by an ED physician. The ED

[1] Application by Physician for Psychiatric Assessment under the *Mental Health Act*.

physician ordered a psychiatry consult and the complainant was subsequently discharged at the expiry of the Form 1. The records which relate to the complainant's stay at the hospital consist of notations made by the ED nurse and doctor, a psychiatry consult report and discharge summary.

[4] In October 2019, the complainant was seen by a mental health crisis team in the hospital's ED department who prepared a crisis team assessment report. Based on my review of the report, it appears that a social worker, ED physician, and psychiatrist contributed to the notations. In addition, the report contains a summary of the complainant's November 2018 hospital stay.

[5] After receiving a copy of his EMR, the complainant submitted a correction request under *PHIPA* to the hospital. The complainant requested that the hospital remove any notations referring to "gout", "delusional disorders", "aggressive behaviour", and "marijuana or tobacco use".

[6] In response, the custodian issued a decision, dated October 12, 2021 citing sections 55(8) and 55(9)(b) of *PHIPA* denying the correction request. The decision stated, in part:

> … your request has been denied as per the sections 55(8) and 55(9) (b) of the Act. You are therefore advised that your Request for Correction to PHI for the records of has been denied as per the same sections.
>
> Enclosed is a copy of section 55 of the Act for your convenience and information.
>
> I would like to advise you of your options at this time. You have the option of filing a "Statement of Disagreement" (*PHIPA,* Section 55(11)) with the decision of your request.

[7] The complainant filed a complaint with the Information and Privacy Commissioner of Ontario (IPC) and a mediator was appointed to explore resolution with the parties. During mediation, the hospital agreed to revisit its decision and consider a November 13, 2019 decision issued by the Consent and Capacity Board (CCB) related to the complainant's October 2019 hospital stay.

[8] On January 18, 2022, the hospital issued a revised decision letter, again denying the complainant's correction request, citing section 55(9)(b).

[9] On February 23, 2022, the hospital notified the mediator that the complainant requested that a lockbox[2] be applied to a specified portion of the records. In addition,

[2] The term "lock box" is not defined in *PHIPA*. It is a term commonly used to describe the right of individuals to withhold or withdraw their consent to the collection, use or disclosure of their personal health information for health care purposes and to provide express instructions to custodians not to use or disclose their

the hospital said that the complainant also requested access to an "audit log of the documented diagnoses and records". In response, the hospital confirmed that the requested lockbox was placed and that the complainant was granted access to the responsive audit log.

[10] The custodian also told the mediator that the complainant provided a letter explaining his reasons why he believed information contained in the records were inaccurate.[3] The custodian responded that it would review the complainant's letter.

[11] On March 14, 2022, the custodian issued its third and final decision letter, again denying the correction request, citing section 55(9)(b).

[12] The complainant remained unsatisfied with the hospital's correction decision. As no further mediation was possible, the file was transferred to the adjudication stage of the complaints process in which an adjudicator may decide to conduct a review.

[13] After reviewing the file, I sent a letter to the complainant advising him that my preliminary assessment was that there were no reasonable grounds for a review under section 57(3) and (4) of *PHIPA*. The complainant was given an opportunity to provide written representations in response to my letter.

[14] In response, the complainant submitted written representations in support of his position that the hospital should make the requested corrections.

[15] After reviewing the complaint file along with the complainant's written representations, I find that there are no reasonable grounds for a review under section 57(3) and 57(4)(a) because the complainant has not met the initial onus of establishing a right of correction under section 55(8). Given my finding, it is not necessary that I also determine whether the exception at section 55(9)(b) applies to the records.

## DISCUSSION:

### Should the complainant's correction complaint proceed to a review under *PHIPA*?

[16] I have the authority under sections 57(3) and (4) of *PHIPA* to decide to conduct a review of a complaint. These provisions state, in part:

> 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 affected within the time period specified, the

personal health information for health care purposes without consent (see sections 19, 20(2), 37(1)(a), 38(1)(a) and 50(1)(e) of *PHIPA*).

[3] In this letter, the complainant provided a document labelled "Reasons for Decision Highlighted", in which portions of the CCB decision which the complainant believes support the correction request are highlighted.

> Commissioner may review the subject-matter of a complaint made under this Act if satisfied that there are reasonable grounds to do so.
>
> The Commissioner may decide not to review the subject matter of the complaint for whatever reason the Commissioner considers proper.

[17] There is no dispute that the information the complainant seeks to correct constitutes his 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,

[18] There is also no dispute that the hospital is a "health information custodian" as defined in section 3(1) of *PHIPA*,[4] and that the complainant was given access to his health records before making his correction request.

[19] The sole issue in this complaint is whether the hospital has a duty to correct the complainant's PHI 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.

[20] Section 55(9)(b) of *PHIPA* sets out an exception to the obligation to correct records of PHI in this complaint, as follows:

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

[21] Read together, these provisions set out the criteria pursuant to which an individual

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[4] Under section 3(1)4.i. of *PHIPA.*

is entitled to a correction of their records of PHI. The purpose of section 55 of *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*.

## ***Analysis and Decision***

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

[22] In all cases where a complaint regarding a custodian's refusal to correct records of PHI is filed with the IPC, the individual seeking the correction has the onus of establishing that the "record is incomplete or inaccurate for the purposes for which the custodian uses the information" pursuant to section 55(8).

[23] 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.

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

[25] Previous IPC decisions have found 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.[5]

[26] In addition, the IPC has found that the custodian is not required to grant the correction request if the individual seeking the correction does not provide the custodian with the information necessary to enable it to correct the record.[6]

[27] The complainant argues that any references in the records suggesting that he had "any delusional disorder or any other mental disorder" should be removed to prevent him from being subjected to further incorrect diagnoses. In support of his position, the complainant refers to a CCB decision that he states found that he "was not suffering under any delusional disorders or any other mental disorders at any time and was required to be released from involuntary detention immediately." The complainant also says that the CCB decision also confirms that at "no time was [he] taking any medication

[5] *PHIPA* Decisions 36, 39 and 40.
[6] *PHIPA* Decisions 36 and 39.

or suffering from any mental disorder or aggressive behaviour." I have reviewed the CCB decision provided by the complainant and note that the panel concluded that the statutory criteria for involuntarily detention were not met. The panel also concluded that the complainant was capable to make decisions about a proposed treatment and as a result the presumption of capacity was restored regarding the proposed treatment and the complainant was subsequently released from involuntary detention.

[28] The complainant also requests that any reference in the records to "aggressive behaviour", "marijuana or tobacco use" be removed on the basis that the notations were not substantiated by the writers. The complainant states:

> The lies and allegations that were reported by family members and used as the justification of my involuntary detention were never investigated, and instead were taken as fact and added to my medical history in bad faith…

[29] The complainant suggests that his family members provided hospital staff with false information in order to avoid repaying personal loans. In support of his position, the complainant referred to the CCB decision in which the panel accepted the complainant's evidence that family members owed him money.

[30] The complainant also provided two rapid drug urine screen tests which he says prove that his family members provided false information about him using marijuana. Finally, though the complainant requested that any reference to him having "gout" be removed from the records, his written representations in response to my preliminary assessment did not make submissions on this point.

[31] I have reviewed the complaint file, including the documentation the complainant provided with his written representations along with the records themselves and find that the requested corrections need not be made as the complainant has not established that those portions of the records are "incomplete or inaccurate for the purposes for which the hospital uses the information" as required by section 55(8).

[32] The complainant 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). However, his submissions do not address this specific issue. Instead, the complainant argues that the medical history information he seeks to correct contains unsubstantiated information provided by his family members. However, the evidence offered by the complainant does not explain how the information at issue is "incomplete or inaccurate for the purposes for which the hospital uses the information", which in this case, was to document information gathered by the writers during his hospital stay.

[33] In my view, evidence regarding the complainant's subsequent release from the hospital, whether it be by way of a hospital discharge or CCB decision to rescind an involuntary treatment order does not establish that the records are incomplete or

inaccurate for the purposes for which the hospital uses the information. Again, the records were created to document the complainant's admissions to the hospital, including any information gathered by or provided to the hospital.

[34] The complainant argues that the hospital should not have "taken as fact" information his family members provided the hospital. The complainant says that the hospital should have investigated the information provided by his family members before placing him in involuntary detention. However, issues relating to complaints about the conduct or decision-making of hospital staff are well outside the scope of the complainant's right to seek a correction of his PHI.[7]

[35] Having regard to the above, I find that the hospital is not obliged to grant the correction request on the basis that the complainant has failed to establish that the record is incomplete or inaccurate for the purpose for which the hospital uses the information. Given my finding, it is not necessary that I also determine whether the complainant provided the hospital with the information necessary to correct the record.

[36] In addition, it is not necessary that I also determine whether the exception under section 55(9)(b), relied on by the hospital, applies.

### *Decision*

[37] As set out above, sections 57(3) and 57(4) set out my authority to decline to review a complaint. For the reasons stated above, I have decided not to review this complaint on the basis that there are no reasonable grounds to do so as the complainant has not met the initial onus under section 55(8).

[38] I issue this decision in satisfaction of the notice requirement in section 57(5).

## NO REVIEW:

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

Original signed by: August 16, 2022

Jennifer James
Adjudicator

[7] In addition to providing individuals with a right to request a correction of their PHI, *PHIPA* gives individuals the right to attach a statement of disagreement to the record conveying their disagreement with any information contained in the record.