Information and Privacy Commissioner,
Ontario, Canada

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

PHIPA DECISION 209

Complaint HA21-00014

A Hospital

June 12, 2023

Summary: The complainant sought a review of a hospital's decision to refuse her request, under the *Personal Health Information Protection Act*, to correct her records of personal health information that referred to her suffering from mental illness. The hospital refused the correction request under the section 55(9)(b) (professional opinions or observations made in good faith) exception to the duty to correct in section 55(8) of the *Act*.

In this decision, the adjudicator exercises her discretion, under sections 57(3) and 57(4)(a) of the *Act*, not to conduct a review of the complaint because there are no reasonable grounds to do so and the hospital has responded adequately to the complaint.

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

BACKGROUND:

[1] This decision addresses a complaint filed with the Information and Privacy Commissioner of Ontario (the IPC) under the *Personal Health Information Protection Act* (the *Act*) by an individual whose correction request was refused by a hospital.

[2] In 2019, the complainant submitted a request to the hospital for the correction of her personal health information. The complainant wrote that she disagreed with an assessment in her records, made by a specified physician in 2003, that she had a mental illness (the record at issue).

[3] In response, the hospital issued a decision letter denying the correction request. To deny the correction request, the hospital relied on the exception at section 55(9)(b) to the duty to correct at section 55(8) of the *Act*, asserting that it is not required to correct a record of personal health information that consists of a professional opinion or observation that a custodian has made in good faith about the individual. The hospital stated that it had consulted the physician who had made the assessment and the physician had determined that "there was insufficient evidence to support making the requested corrections." The hospital advised the complainant of her right to submit a statement of disagreement setting out her requested corrections and it provided a copy of a statement of disagreement form for her to complete. The hospital stated that, if the complainant submitted a statement of disagreement, the hospital would append it to and maintain it with the record at issue, and would provide it to any healthcare providers who had previously received the record at issue.

[4] The Chief Privacy Officer of the hospital also spoke with the complainant in December 2019 and confirmed that:

- the hospital had appended a letter from the complainant, dated May 2004, in which she described her objections to the physician's assessment of mental illness and set out the corrections she wanted made (the 2004 letter), directly to the record at issue in her paper chart

- the record at issue is maintained in paper format only and is not available electronically; the hospital's records indicate that the complainant's patient chart containing this record has not been accessed

- if the complainant submits a statement of disagreement, the hospital can add it to her electronic patient account; it can also add the 2004 letter to her electronic patient account

- the complainant may make a consent directive to restrict access to her electronic patient account and her paper chart, and the hospital provided a consent directive request form for her reference

- if she wishes to have the record at issue permanently and securely destroyed, she could submit a formal written request and the hospital would consider whether the record at issue is eligible for destruction.

[5] In February 2020, the hospital sent the complainant a letter restating her ability to submit a statement of disagreement, make a consent directive to limit and restrict access to her patient records (in paper and electronic format), or formally request destruction of the record that she feels is inaccurate. In its letter, the hospital wrote that it has fully responded to her request for correction and it referred her to the IPC if she wished to complain about the hospital's response to her request for correction.

The IPC complaint

[6] The complainant was dissatisfied with the hospital's decision and she filed a complaint about it with the IPC. The IPC attempted to mediate the complaint. During mediation, the hospital agreed to the complainant's request to attach a copy of her 2004 letter to the records as a statement of disagreement and, in September 2021, confirmed that it had appended her 2004 letter to her paper and electronic chart.

[7] In response, the complainant wrote to the hospital in October 2021, alleging that her records had been "tampered with" for a fourth time, and asking the hospital to implement her correction request in a specific way. The complainant also asked the hospital to "expunge" a 2003 entry in her electronic health record, and remove her name from a specific crisis outreach and support program.

[8] In November 2021, the hospital sent the complainant a letter in response. It stated that it had placed the 2004 letter in the complainant's paper chart and removed it from her electronic chart. The hospital also confirmed that the record at issue is not available in the complainant's electronic chart. Finally, the hospital confirmed that the complainant's electronic medical record contains records authored by staff of the crisis outreach and support program, which is a partnership between the hospital's mental health workers and specially trained police officers. The hospital explained that the complainant's contact with the program occurred due to her contact with the police. The hospital again invited the complainant to make a consent directive to restrict access to her medical records.

[9] In December 2021, the complainant advised the IPC that she believed the hospital had taken reasonable steps to resolve her concerns, however, she wished to visit the hospital to examine her paper and electronic records to confirm her understanding. The complainant then contacted the hospital to make an appointment to view her records on site, however, the hospital told her that patient visits were not permitted during the pandemic. Instead, the hospital offered to provide her with a copy of her paper and electronic chart (by regular mail or courier), but she declined. The hospital also offered to apply a consent directive to all her records (paper and electronic), however, the complainant stated that she wished to inspect the records on site before deciding whether to make a consent directive. The hospital also explained that a consent directive could be made without her viewing her physical chart; however, she wished to view her chart and said that she would be in contact with the hospital again in the future.

[10] In January 2022, the hospital advised the IPC that it had spoken to the complainant about her wish to view her chart on site, however, pandemic related restrictions remained in place and it was not able to book an appointment for her. The hospital repeated its offer to facilitate the complainant's examination of the record at issue by providing a copy of her paper and electronic chart, but she again declined the hospital's offer.

[11] In March 2022, the hospital again wrote to the IPC. It stated that it had considered the complainant's request to view her corrected records in person and determined that it would have to treat that as a release of information request. The hospital stated that, to move the request forward, it required the complainant to submit a request for her patient records, identifying the records to which she seeks access. The hospital stated that it would then issue an access decision in accordance with the relevant provisions of the *Act*. The complainant remained unsatisfied with the hospital's response and asked that her complaint proceed to the adjudication stage of the complaint process.

DISCUSSION:

Preliminary assessment not to conduct a review

[12] As the adjudicator of this complaint, I have the authority under sections 57(3) and 57(4)(a) of the *Act* to review or not to review of the subject matter of this complaint. These sections state:

> (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 may review the subject-matter of a complaint made under this Act if satisfied that there are reasonable grounds to do so.
>
> (4) The Commissioner may decide not to review the subject-matter of the complaint for whatever reason the Commissioner considers proper, including if satisfied that,
>
> > (a) the person about which the complaint is made has responded adequately to the complaint[.]

[13] After examining the documents in the complaint file, and considering the circumstances of the complaint and the relevant legislative provisions, my preliminary assessment was that the complaint should not proceed to a review because there are no reasonable grounds to conduct a review and the hospital has adequately responded to her complaint. I sent the complainant a letter[1] advising her of my preliminary assessment and explaining my reasons for it.

---

[1] I sent the complainant two letters advising her of my preliminary assessment. My first letter stated that the complainant had confirmed to the IPC, on December 6, 2021, that the hospital had responded to her correction request to her satisfaction and the correction issue was thus resolved. The complainant then provided submissions to me stating that, in fact, she was not satisfied with the hospital's response and that the correction was not resolved. As a result, I sent the complainant a second preliminary assessment letter addressing the correction request and correction provisions of the *Act*. For readability, and because this decision refers to the contents of both preliminary assessment letters, I refer to these two letters as one letter.

[14] In my letter, I referred the complainant to sections 55(8) and 55(9)(b) of the *Act*, which set out criteria pursuant to which an individual is entitled to a correction of her records of personal health information. They state:

> (8) 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.
>
> (9) 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 the custodian has made in good faith about an individual.

[15] I advised the complainant of my preliminary assessment that she has not established that the hospital has a duty to correct the personal health information in the records at issue under section 55(8) because she has not demonstrated, to the hospital's satisfaction, that the record is inaccurate or incomplete for the purposes for which the hospital uses the information. And that, even if she had established that the hospital has a duty to correct, the exception in section 55(9)(b) of the *Act* would apply to the personal health information at issue because the physician's assessment of her mental health qualifies as a "professional opinion or observation" made in good faith.

[16] In my letter, I also advised the complainant that that there is no right in the *Act* to have the incorrect information in a record removed, replaced, or amended in such a manner that the incorrect information is completely obliterated – it must remain legible.

[17] I invited the complainant to provide submissions if she disagreed with my preliminary assessment. The complainant provided submissions, which I address, below.

The complainant's submissions

[18] In her submissions to me about why she disagrees with my preliminary assessment, the complainant does not directly address the statutory provisions to which I referred her. Instead she repeats her assertions about the errors she thinks her records contain. She lists six "clerical corrections" that she seeks to have made to her records, five of which are requests to "erase" personal health information and one of which is to "add medical history" that she provides in her submissions. She also describes injuries that she has sustained and claims that the medical history contained in her hospital records is not her medical history.

[19] In addition to specifying the corrections she wants made, the complainant asks me to tell the hospital to allow her to correct the records herself, alone. She states that

she has concerns about a specific hospital staff member and she explains the basis for her concerns. She also alleges that the hospital staff member and the physician mistreated her and did not act in good faith. Although I do not set out all of the complainant's assertions and comments from her submissions here, I confirm that I have read and considered the complainant's complete submissions.

There are no reasonable grounds to conduct a review

[20] As I explained to the complainant in my letter, section 55(8) of the *Act* imposes a duty on the hospital to correct records of personal health information if the complainant satisfies the hospital that the records are inaccurate or incomplete for the purposes for which the hospital uses the information.

[21] As the individual asking for the correction, section 55(8) of the *Act* requires the complainant to demonstrate to the hospital's satisfaction that the record she wants to correct is "incomplete or inaccurate for the purposes for which the custodian uses the information." Although the complainant asserts that the physician's assessment is wrong, the complainant does not provide evidence to support her assertion that the record she wants corrected is incomplete or inaccurate for the purposes for which the hospital uses the information. The complainant's assertion with nothing more is not sufficient to satisfy her onus under section 55(8) of the *Act.* I find that the complainant has not established that section 55(8) of the *Act* applies and, as a result, the hospital is not required to grant her correction request.

[22] Even if I were to accept that the complainant has established the duty to correct under section 55(8), the information that the complainant wants corrected is a professional opinion and observation of a physician, which falls under the exception to the duty at section 55(9)(b) the *Act*. As I advised the complainant in my preliminary assessment letter, the purpose of section 55(9)(b) is to preserve "professional opinions or observations," accurate or otherwise, that have been made in good faith. While the complainant alleges a lack of good faith on the part of the physician, she provides no evidence to support her allegation. The complainant's correction request amounts to a substitution of opinion that aims to replace the physician's opinion with the complainant's opinion and, therefore, the exception at section 55(9)(b) of the *Act* applies.

The hospital has responded adequately to the complaint

[23] In addition, I am satisfied that the hospital has responded adequately to the correction request and complaint. The hospital attached the 2004 letter to the record at issue in the complainant's paper chart as a statement of disagreement, as the complainant requested. Also, the hospital did not include the 2004 letter in the complainant's electronic records, as the complainant requested. The hospital declined to remove personal health information from the complainant's records; this is appropriate because the *Act* does not permit the erasure of personal health information in records.

Nor does the *Act* permit the complainant to correct the records, in person, herself.

[24] I have found that the complainant has not established that the hospital has a duty to correct her personal health information under section 55(8) of the *Act*, that the information the complainant wants corrected would fall under the exception to that duty at section 55(9)(b), and that the hospital responded adequately to the complaint.

[25] In accordance with my authority under sections 57(3) and 57(4)(a) of the *Act*, and for the reasons set out above, I decline to review the subject-matter of this complaint because there are no reasonable grounds to do so and because the hospital has responded adequately to the complaint. I issue this decision in satisfaction of the notice requirement in section 57(5) of the *Act*.

Final note

[26] Finally, in her submissions to me, the complainant repeatedly refers to the College of Physicians and Surgeons of Ontario (CPSO) and a CPSO matter regarding her concerns about the care that she received from the physician at the hospital. The CPSO is a regulatory body with different oversight and complaint processes than the IPC. While the CPSO may address the complainant's concerns about the quality of the care she received at the hospital, the IPC cannot. Since I have no authority to address these concerns of the complainant, I do not repeat them here.

NO REVIEW:

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

Original Signed By: June 12, 2023

Stella Ball
Adjudicator