Patient Safety Incidents and Protection of Quality Assurance Activities: Legislative and Jurisprudential Responses in Canada

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Patient safety incidents (PSIs), also called adverse events, are an ongoing challenge for Canadian health institutions such as hospitals. Sharing information and gathering data about these incidents is an important element in a strategy to reduce their occurrence. In order to encourage the sharing of information and open discussions within health institutions, Canadian provinces and territories have developed a statutory evidentiary framework protecting quality of care information from use in legal proceedings. These qualified privilege laws operate in a context in which underlying policies reveal a tension between, on the one hand, the benefit of full disclosure to patients and, on the other, the need to encourage health care providers and institutions to discuss PSIs fully and to make positive systemic changes to improve patient safety. This article reviews Canadian qualified privilege laws pertaining to quality of care information and the judicial treatment they have been given

Les incidents touchant la sécurité des patients, aussi appelés événements indésirables, représentent un défi constant pour les établissements de santé canadiens, y compris les hôpitaux. Le partage d'information et la collecte de données concernant ces incidents sont des éléments importants dans le cadre d'une stratégie visant à en réduire la fréquence. Afin d'encourager le partage de l'information et des discussions ouvertes au sein des établissements de santé, les provinces et territoires canadiens ont développé un cadre législatif protégeant les renseignements sur la qualité des soins d'une utilisation lors de procédures judiciaires. Ces lois qui accordent une immunité relative s'inscrivent dans un contexte qui révèle une tension entre deux considérations de politique générale, soit le bénéfice de la divulgation complète au patient d'une part et, d'autre part, la nécessité d'encourager les professionnels de la santé et les établissements de la santé à discuter en profondeur des in-

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in order to assess whether the legislation and its judicial interpretation favour one policy objective over the other, or whether a more nuanced approach has been adopted. The article argues that the "balancing of interests" approach adopted by legislators and courts is appropriate and should be encouraged, as it is the best way, at least at this time, to support efforts to improve patient safety while recognizing patients' informational needs following a patient safety incident.

cidents touchant la sécurité des patients et à apporter des changements systémiques et bénéfiques pour améliorer leur sécurité. Cet article examine les lois canadiennes régissant l'immunité relative concernant les renseignements sur la qualité des soins ainsi que leur traitement judiciaire afin de déterminer si cette législation et son interprétation judiciaire favorisent davantage un des deux objectifs de politique générale, ou si une approche nuancée a été adoptée. Cet article soutient que la mise en équilibre des intérêts, approche adoptée par les législateurs et les tribunaux, est appropriée et devrait être encouragée, puisqu'il s'agit du meilleur moyen – du moins à l'heure actuelle – pour soutenir les efforts visant à améliorer la sécurité des patients tout en reconnaissant le besoin de ces derniers d'obtenir l'information rattachée à un incident suite à sa survenue.

Introduction

The importance of patient safety within hospitals and other health care settings was highlighted in the well-known *To Err Is Human* report published by the American Institute of Medicine in late 1999.[1] In Canada, the 2004 Canadian Adverse Events Study (CAES)[2] and the more recent Canadian Paediatric Adverse Events Study (CPAES)[3] have both confirmed that patient safety incidents (PSIs)[4] are an ongoing challenge for Canadian health institutions.[5] Indeed, the CAES concluded that an estimated 7.5% of

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1 Committee on Quality of Health Care in America, Institute of Medicine, *To Err Is Human: Building a Safer Health System*, ed by Linda T Kohn, Janet M Corrigan & Molla S Donaldson (Washington: National Academy Press, 1999) [*To Err Is Human*].

2 G Ross Baker et al, "The Canadian Adverse Events Study: The Incidence of Adverse Events among Hospital Patients in Canada" (2004) 170:11 CMAJ 1678 [Baker et al, "CAES"].

3 Anne G Matlow et al, "Adverse Events among Children in Canadian Hospitals: The Canadian Paediatric Adverse Events Study" (2012) 184:13 CMAJ E709.

4 This is the term that will be retained here and, at times, the term "adverse event" will be used as a synonym. The literature on patient safety relies on a variety of terms to which different definitions are given. The World Health Organization (WHO) has also suggested definitions. A patient safety incident is defined by the WHO as "an event or circumstance which could have resulted, or did result, in unnecessary harm to a patient." Distinctions are then made between "harmful incidents," which result in harm to the patient; "no harm incidents," which affect patients but without causing discernible harm; and "near misses," which describe PSIs that never reach the patient. See World Health Organization, *More Than Words: Conceptual Framework for the International Classification for Patient Safety, Version 1.1*, Technical Report (Geneva: WHO, 2009) at 15–16, online: <www.who.int/patientsafety/implementation/taxonomy/icps_technical_report_en.pdf>. The latest *Canadian Incident Analysis Framework* has adopted the WHO terminology and, for reasons of consistency, so will the present paper. See Canadian Patient Safety Institute, *Canadian Incident Analysis Framework* (Edmonton: CPSI, 2012) at 8–9, online: <www.patientsafetyinstitute.ca/English/toolsResources/IncidentAnalysis/Documents/Canadian%20Incident%20Analysis%20Framework.PDF> [*Canadian Incident Analysis Framework*].

5 Not to mention a huge economic burden. See Canadian Patient Safety Institute, *The Economics of Patient Safety in Acute Care*, Technical Report, by Edward Etchells et al (Edmonton: CPSI, 2012) at 21, online: <www.patientsafetyinstitute.ca/English/research/commissionedResearch/EconomicsofPatientSafety/Docu

patients admitted to acute care hospitals in Canada suffered a PSI and that 36.9% of these incidents were judged preventable,[6] while the CPAES revealed that the weighted rate of adverse events in Canadian academic paediatric centres and community hospitals was 9.2%.[7]

One of the key conclusions of the *To Err Is Human* report is that most safety incidents in health care settings are caused by a combination of human error and underlying factors,[8] including organizational structures, policies, levels of funding, and institutional culture. Thus, according to the report, PSI reduction can be achieved, at least in part, through a system-wide approach rather than through a culture of "blame and shame" that places emphasis on individual responsibility.[9] The notion of systemic errors has been widely embraced and, for the past decade, there has been increased emphasis on capturing, monitoring, and measuring PSIs through incident reporting systems, patient safety indicators, and, more recently, trigger tools.[10]

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ments/Economics%20of%20Patient%20Safety%20-%20Acute%20Care%20-%20Final%20Report.pdf> (estimating the economic burden of adverse events in Canada in 2009–2010 as $1.1 billion).

6 Baker et al, "CEAS", *supra* note 2 at 1683.

7 Matlow et al, *supra* note 3 at E712.

8 *To Err Is Human*, *supra* note 1 at 55–56. The "Swiss cheese model" is often used to describe this phenomenon. Specific occurrences at the "sharp end" of a system, i.e., the locus of interaction between a health professional and a patient, are not the only cause of adverse events; rather, latent or "blunt end" factors such as policy, technology, and administrative decisions are the root causes of an undesirable outcome. As explained by Robert M Wachter, *Understanding Patient Safety*, 2nd ed (New York: McGraw Hill Medical, 2012) at 21–22, online: <accessmedicine.mhmedical.com/content.aspx?bookid=396&Sectionid=40414534>, the model "highlights the need to focus less on the (futile) goal of trying to perfect human behavior and more on aiming to shrink the holes in the Swiss cheese … and create multiple overlapping layers of protection to decrease the probability that the holes will ever align and let an error slip through." The Swiss cheese model was first proposed by JT Reason, *Human Error* (New York: Cambridge University Press, 1990).

9 *To Err Is Human*, *supra* note 1 at 56. Of course, the recognition of the need for a system-wide approach does not eliminate entirely the need for other mechanisms such as internal sanctions or professional oversight, which, in some cases, can be more appropriate responses to errors by health care providers.

10 For a description of these processes, see Wachter, *supra* note 8, especially chapters 1, 3, 14. See also Kaveh G Shojania, "The Frustrating Case of In-

Indeed, once PSIs are detected, methods such as root cause analysis, administrative data analysis, and morbidity and mortality conferences can be used to provide vital information to help understand and hopefully prevent future undesirable outcomes. Quality of care initiatives become opportunities to learn from PSIs, with the ultimate goal of improving patient care.

Most measures to detect adverse events require the participation of health professionals, administrators, and other staff, who are called upon not only to report and input data but also to investigate, analyze, and interpret the information gathered in order to eventually develop strategies to reduce PSIs. Even if quality of care initiatives increasingly rely on electronic systems and e-triggers, human intervention remains essential. For instance, in many reporting systems, data entries about a patient safety event are followed by a clinical review where staff must determine whether a true PSI has in fact occurred.[11]

In order to encourage health care providers to share information and participate in data gathering processes, many jurisdictions, in Canada and elsewhere,[12] have felt the need to strengthen the statutory evidentiary frame-

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cident-Reporting Systems" (2008) 17:6 BMJ Qual Saf 400 at 401; Richard Thomson & Alison Pryce, "Patient Safety: Epidemiological Considerations" in Brian Hurwitz & Aziz Sheikh, eds, *Health Care Errors and Patient Safety* (Chichester, UK: Wiley-Blackwell, 2009) 207 at 210, online: <onlinelibrary.wiley.com/book/10.1002/9781444308150> (where error measurement methods are summarized in a useful table).

11 DO Farley et al, "Adverse-Event-Reporting Practices by US Hospitals: Results of a National Survey" (2008) 17:6 BMJ Qual Saf 416 at 416 (describing the essential components of an effective system including staff participation).

12 See Joan Gilmour, *Patient Safety, Medical Error and Tort Law: An International Comparison*, Final Report [to Health Canada] (Ottawa: Health Policy Research Program, 2006) at 63–66, 99–101, 168–69, 194–95, online: Osgoode Hall Law School <apps.osgoode.yorku.ca/osgmedia.nsf/0/094676DE3FAD06A5852572330059253C/$FILE/FinalRepFin_Full.pdf> (examining statutory interventions in Canada, the United States, Australia, and New Zealand). See also Jocelyn Downie et al, *Patient Safety Law: From Silos to Systems*, Final Report [to Health Canada] (Ottawa: Health Policy Research Program, 2006), online: Queensland University of Technology <eprints.qut.edu.au/62121/1/HLI_Patient_Safety-Main_Report_(final).pdf> (discussing the situation in Denmark, New Zealand, Australia, United Kingdom, and the United States). In the United States, *The Patient Safety and Quality Improvement Act of 2005*, Pub L No 109-41, 119 Stat 424, creates an evidentiary privilege to protect

work protecting quality of care information from use in legal proceedings. The focus of the statutes is not on PSIs as such, but rather on quality of care activities generally, of which PSIs are of course a part. In Canada, "qualified privilege" laws can be found in each province and territory.[13]

Although qualified privilege laws have existed for some time in Canada – usually as part of legislation on evidence – the *To Err Is Human Report* led to a renewed interest in patient safety initiatives, and many provinces were thus encouraged to review existing legislative measures. Important modifications were brought in the laws of evidence of many jurisdictions – for example, Alberta in 2000, Saskatchewan in 2006, Manitoba in 2008, and Prince Edward Island in 2011. In Nova Scotia and Ontario, legislation has been adopted to deal specifically with the protection of quality of care information.[14]

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information submitted voluntarily to designated organizations that compile information on medical errors. See Charles M Key, "The Role of PSQIA Privilege in Medical Error Reduction" (2008) 21:1 The Health Lawyer 24.

[13] See full list, *infra* note 20. The relevant legislation is discussed briefly in *Canadian Incident Analysis Framework*, *supra* note 4 at 120–24. See also Gilmour, *supra* note 12; Canadian Patient Safety Institute, "Appendix B: Review of Provincial, Territorial and Federal Legislation and Policy Related to the Reporting and Review of Adverse Events in Healthcare in Canada", by G Ross Baker et al (Edmonton: CPSI, 2007) at B6–B7, B34–B43, online: Fasken Martineau <www.fasken.com/files/Publication/b64114ad-8b04-4fe3-9888-0e5531939f3d/Presentation/PublicationAttachment/73222cfe-7cef-4d60-9fd7-165b52760585/CAERLS%20Consultation%20Paper%20AppendixB.pdf> [Baker et al, Canadian Patient Safety Institute, "Review"]; Deborah Gregory, "Adverse Health Event Management: International and Canadian Practices" in Newfoundland and Labrador, Task Force on Adverse Health Events, *Background Documents*, *Volume II: Additional Reports* (St John's: Office of the Queen's Printer, 2008) 187 at 205, 224. Finally, there is an excellent review of the legislation applicable to Ontario in Halyna Perun, Michael Orr & Fannie Dimitriadis, *Guide to the Ontario Personal Health Information Protection Act* (Toronto: Irwin Law, 2005) at 607–45.

[14] Nova Scotia has very recently adopted the *Quality-improvement Information Protection Act*, SNS 2015, c 8 [*QIPA – NS*]; this act repeals and replaces sections 60 and 61 of the *Evidence Act*, RSNS 1980, c 154 [*Evidence Act – NS*], which previously addressed the qualified privilege. On 16 September 2015, the Ontario government introduced Bill 119, *An Act to amend the Personal Health Information Protection Act, 2004*, 1st Sess, 41st Parl, Ontario, 2015, to make certain related amendments and to repeal and replace the *Quality of Care Information Protection Act*, *2004*, SO 2004, c 3, Schedule B [*QCIPA 2004 – ON*].

At this juncture, it is useful to recall the key policy choices related to the protection of quality of care information. As noted at the time of the enactment of Ontario's *Quality of Care Information Protection Act, 2004*, the objective of such protection is to "encourage health professionals to share information and hold open discussions that can lead to improved patient care and safety."[15] Thus, the policy rationale is "to encourage candidness and the free flow of information in circumstances in which that is regarded as socially beneficial."[16] The policy is based on the public interest in optimal quality of care, which is achieved, at least in part, through detailed analysis of PSIs and their aftermath.

However, there are arguments against such a choice. The main counterpoint to the policies favouring protecting quality of care activities from disclosure is the ethical/legal obligation to disclose PSIs and system failures to patients.[17] This is based on the notion that patients who are injured should

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It should be noted that although Bill 119 will repeal the current legislation, the basic framework and most of the current provisions of the *Quality of Care Information Protection Act*, *2004* will be incorporated unchanged into the new legislation. According to the Bill, the new Act will be known as the *Quality of Care Information Protection Act, 2015*. When discussing Ontario's *Quality of Care Information Protection Act*, *2004*, this article will refer to the current (i.e. 2004) legislation (i.e., the 2004 *Act* as amended through 2015) and it will highlight the provisions of Bill 119 only insofar as they will bring about significant changes if adopted.

15 Ontario, Legislative Assembly, Standing Committee on General Government, "Bill 31, Health Information Protection Act, 2003", *Official Report of Debates (Hansard)*, 38th Parl, 1st Sess, No G-2 (26 January 2004) at G-7 (Hon George Smitherman) [Ontario Bill 31 Standing Committee Deliberations]. The importance of patient safety is also noted in the "object" of the Québec legislation, *An Act respecting health services and social services (HSSS – QC)*, *infra* note 20, s 2(8.1), which refers "to ensur[ing] users the safe provision of health services and social services."

16 David M Studdert & Mark W Richardson, "Legal Aspects of Open Disclosure: A Review of Australian Law" (2010) 193:5 Med J Aust 273 at 273.

17 For discussion on the issue of disclosure, see Canadian Patient Safety Institute, Disclosure Working Group, "Canadian Disclosure Guidelines: Being Open and Honest with Patients and Families" (Edmonton: CPSI, 2011), online: <www.patientsafetyinstitute.ca/English/toolsResources/disclosure/Documents/CPSI Canadian Disclosure Guidelines.pdf>; Elaine O'Connor et al, "Disclosure of Patient Safety Incidents: A Comprehensive Review" (2010) 22:5 Int J Qual Heath Care 371; Tracey M Bailey & Nola M Ries, "Legal Issues in Patient

benefit from a wide access to information related to the incident at the root of the harm caused. Indeed, the ability to build a strong legal case is linked to accessing as much relevant information as possible. Another key policy consideration is compensation. In the absence of a "no-fault" system for medical injuries, civil liability provides a means to be indemnified. Lastly, there is also the notion that full disclosure helps to maintain trust in the health care system and health care providers.[18] From a public interest perspective, disclosure contributes to the integrity of both the judicial and health systems: access to justice for litigants and safety when receiving care. Thus, qualified privilege laws operate in a context where underlying policies reveal a tension between, on the one hand, the benefit of full disclosure to patients and, on the other, the need to encourage health care providers and institutions to discuss PSIs fully and to make positive systemic changes to improve patient safety.

In this context, this article reviews Canadian qualified privilege laws pertaining to quality of care information and the judicial treatment they have been given in order to assess whether the legislation and its interpretation favour one policy objective over the other, or whether a more nuanced approach is being adopted. Thus, Part I describes and compares provincial and territorial qualified privilege laws and examines the cases which have discussed them over the last fifteen years.[19] This material is considered in some detail, not only in order to provide a good overview of the Canadian legisla-

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Safety: The Example of Nosocomial Infection" (2005) 8 Healthc Q (Special Issue) 140; Michael Waite, "To Tell the Truth: The Ethical and Legal Implications of Disclosure in Medical Error" (2005) 13 Heath LJ 1; Gilmour, *supra* note 12 at 62–68; Gerald B Robertson, "When Things Go Wrong: The Duty to Disclose Medical Error" (2002) 28:1 Queen's LJ 353. See also *Hospital Management*, RRO 1990, Reg 965, s 2(4)–(5), which provides for mandatory disclosure of critical incidents to a number of entities and individuals, including patients.

18 Gilmour, *supra* note 12 at 63.

19 The decisions analyzed below were identified through legal databases and cover the period from January 2000 to September 2014, with a few pre-2000 cases discussed when appropriate. Most are judicial decisions but a few come from administrative tribunals – typically information and privacy commissions. Most of the decisions flow from PSIs. Those that do not nevertheless provide valuable insight into the way courts interpret qualified privilege laws. The search was conducted by mapping decisions related to the laws in each province and territory. Judicial activity has been more intense in some areas of the country than in others; for instance, courts have yet to consider Ontario's *Quality of Care Information Protection Act*, *2004* in any reported decision.

tive landscape, but also to contextualize the various fact situations where health professionals and institutions may have to rely on qualified privilege laws. In Part II, the article assesses and analyzes legislative and judicial responses to the quality of care information protection schemes in light of the policy objectives outlined above. The article argues that the "balancing of interests" approach adopted by legislators and courts is appropriate and should be encouraged as it is the best way, at least at this time, to support efforts to improve patient safety while recognizing patients' informational needs following a PSI.

I. Qualified Privilege in Canadian Provinces and Territories

All Canadian provinces and territories have comparable qualified privilege laws. In most instances, the relevant legislative provisions can be found in the laws on evidence.[20] So far, Ontario and Nova Scotia are the only provinces that have enacted stand-alone legislation dealing with the protection of quality of care information.[21]

In general terms, the legislative schemes provide that witnesses involved in legal proceedings are protected from the obligation to answer questions or disclose information related to the work of quality of care committees.[22]

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[20] *Alberta Evidence Act*, RSA 2000, c A-18 [*Evidence Act – AB*]; *Evidence Act*, RSBC 1996, c 124 [*Evidence Act – BC*]; *Manitoba Evidence Act*, CCSM c E150 [*Evidence Act – MB*]; *Evidence Act*, RSNB 1973, c E-11 [*Evidence Act – NB*]; *Evidence Act*, RSNL 1990, c E-16 [*Evidence Act* – NL]; *Evidence Act*, RSNWT 1988, c E-8 [*Evidence Act – NWT*]; *Evidence Act*, RSNWT (Nu) 1988, c E-8 as duplicated for Nunavut by s 29 of the *Nunavut Act*, SC 1993, c 128 [*Evidence Act – NU*]; *Evidence Act*, SS 2006, c E-11.2 [*Evidence Act – SK*]; *Evidence Act*, RSY 2002, c 78 [*Evidence Act – YK*]. Prince Edward Island and Québec deal with the qualified privilege in other legislation: *Health Services Act*, RSPEI 1988, c H-1.6 [*HSA – PEI*]; *An Act respecting health services and social services*, CQLR c S-4.2, ss 183.3–183.4 [*HSSS – QC*].

[21] See *QCIPA 2004 – ON*, *supra* note 14; *QIPA – NS*, *supra* note 14. Ontario's context is particularly interesting because the *Quality of Care Information Protection Act*, *2004* was enacted along with the *Personal Health Information Protection Act*, SO 2004, c 3, Schedule A, as part of the same bill – Bill 31, *An Act to enact and amend various Acts with respect to the protection of health information*, 1st Sess, 38th Parl, Ontario, 2004 – but as separate legislation.

[22] For typical wording of the privilege, see *Evidence Act – NL*, *supra* note 20, s 8.1(4):

The privilege applies in a variety of settings depending on the jurisdiction. For instance, in the Newfoundland & Labrador *Evidence Act*, the privilege can be relied on in a "legal proceeding," which is very broadly defined as an "action, inquiry, arbitration, judicial inquiry or civil proceeding in which evidence may be given and also includes a proceeding before a board, commission or tribunal."[23] Similarly broad wording is found in the legislation of most other Canadian provinces and territories.[24] However, in New Brunswick, the qualified privilege is limited to legal proceedings "in any court," which means that administrative tribunals, inquiries, and professional colleges probably do not fall under the protection of the legislation.[25] Moreover, a significant number of jurisdictions specify that the privilege cannot be relied on in disciplinary matters.[26] Nevertheless, generally speaking, in Canada, health professionals and staff can rely on qualified privilege laws to

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> Where a person appears as a witness in a legal proceeding, that person shall not be asked and shall not (a) answer a question in connection with proceedings of a committee set out in subsection (2); or (b) produce a report, evaluation, statement, memorandum, recommendation, document of information of, or made by, for or to, a committee to which this section applies.

The *Evidence Act – AB*, *supra* note 20, s 1(a)(i) does not refer to proceedings but to an "action," which is defined as including "an issue, matter, arbitration, reference, investigation or inquiry."

23 *Evidence Act – NL*, *supra* note 20, s 8.1(1)(a).

24 *Evidence Act – AB*, *supra* note 20, s 1(a); *Evidence Act – BC*, *supra* note 20, s 51(1); *Evidence Act – MB*, *supra* note 20, s 1; *QIPA – NS*, *supra* note 14, s 2(d); *Evidence Act – NU*, *supra* note 20, s 13; *Evidence Act – NWT*, *supra* note 20, s 13; *QCIPA 2004 – ON*, *supra* note 14, s 1; *HSA – PEI*, *supra* note 20, s 26(c). In Saskatchewan, the qualified privilege arises in civil proceedings or inquiries but not in "legal proceedings founded on defamation, breach of contract or civil conspiracy": *Evidence Act – SK*, *supra* note 20, s 10(4)(b). Yukon has a similar provision: *Evidence Act – YK*, *supra* note 20, s 13(3)(c).

25 *Evidence Act – NB*, *supra* note 20, s 43.3(1) (definition of "legal proceeding").

26 British Columbia, the Northwest Territories, and Nunavut specifically exclude such bodies: *Evidence Act – BC*, *supra* note 20, s 51(1) (definition of "legal proceedings", subsection (b)); *Evidence Act – NWT*, *supra* note 20, s 13 (definition of "legal proceedings", subsection (b)); *Evidence Act – NU*, *supra* note 20, s 13 (definition of "legal proceedings", subsection (b)). Saskatchewan provides that the privilege does not apply in "disciplinary proceedings where the impugned conduct is a disclosure or submission to a committee": *Evidence Act – SK*, *supra* note 20, s 10(4)(c). In Ontario, the legislation specifically *includes*

protect them in a fairly wide number of settings in which they may be called upon to testify or to produce records and other information.[27]

In most Canadian provinces, the privilege cannot be waived. This was stated quite clearly by the Alberta Court of Queen's Bench in *Bruce Estate v Toderovich*: "As a statutory rule of evidence, the prohibition on production is absolute. It is not a privilege or a confidence that a party or witness can elect to waive or that can be waived impliedly by public disclosure."[28] However, in New Brunswick, because witnesses are "excused" from answering questions, producing documents, and disclosing opinions, it appears that a waiver may be possible in that jurisdiction.[29]

The best way to examine the legislative schemes and their judicial interpretation is to focus on two key elements, namely the constitution of quality of care committees and the scope of the qualified privilege. These are addressed in the next two sections, respectively.

A. Constitution of quality of care committees

A key element of all qualified privilege legislative schemes is the quality of care committee (the name of which varies),[30] a pre-established ad-

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the "committee of a College" within the purview of the privilege: *QCIPA 2004 – ON*, *supra* note 14, s 1 (definition of "proceeding").

27 The question of the forum to which the qualified privilege applies has not been the subject of many court decisions. But see *Freedom of Information and Protection of Privacy Act (NS) (Re)* (1996), 137 DLR (4th) 410, 64 ACWS (3d) 1255 (NSSC).

28 2010 ABQB 21 at para 43, 483 AR 322 [*Bruce Estate*]. See also *Dawe v Evans*, 2009 ABQB 724 at paras 27–28, 483 AR 72 [*Dawe*]; in British Columbia, see *Sinclair v March*, 2000 BCCA 459 at para 26, 78 BCLR (3d) 218 [*Sinclair*].

29 See *Evidence Act – NB*, *supra* note 20, s 43.3(2). This was the court's interpretation in *McCormack v Nova Scotia (AG)* (1993), 123 NSR (2d) 271 at 282, 41 ACWS (3d) 1088 (SC), and *MacKenzie v Kutcher*, 2004 NSCA 4 at para 43, 220 NSR (2d) 285 [*MacKenzie*], two Nova Scotia cases dealing with section 60 of the province's *Evidence Act* (*supra* note 14), which has now been repealed. The wording in Nova Scotia's new *Quality-improvement Information Protection Act* (*supra* note 14) has eliminated the problem in that province, but it appears the matter warrants further clarification in New Brunswick.

30 Four provinces and territories use the term "quality assurance committee" (see *Evidence Act – AB*, *supra* note 20, s 9(1)(b); *Evidence Act – NL*, *supra* note 20,

ministrative committee within which privileged discussions can be held and documents exchanged without concern for subsequent disclosure in a legal proceeding. It is crucial to note that these committees are at the heart of the legislative schemes[31] and that information flowing from other bodies will not benefit from the qualified privilege.[32] This being said, the description of the committees whose information is protected varies throughout the coun-

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s 8.1(b); *Evidence Act – NWT*, *supra* note 20, s 13; *Evidence Act – YK*, *supra* note 20, s 13(1)); three refer to "committees" established for the purpose of evaluating and improving hospital care (see *Evidence Act – NU supra* note 20, s 13; *Evidence Act – BC*, *supra* note 20, s 51(1); *Evidence Act – NB*, *supra* note 20, s 43.3(2)); three use "quality improvement committee" (*QIPA – NS*, *supra* note 14, s 2(h); *HSA – PEI*, *supra* note 20, s 26(f); *Evidence Act – SK*, *supra* note 20, s 10(1)); and the remaining provinces use "critical incident review committee" (*Evidence Act – MB*, *supra* note 20, s 9(1)), "quality of care committee" (*QCIPA 2004 – ON*, *supra* note 14), or "risk management committee" (*HSSS – QC*, *supra* note 20, ss 183.1–183.2). However, this diverse nomenclature invariably refers to committees created to assure or improve the quality of health care. The authors will be faithful to the terminology chosen by a given province when discussing specific examples. Otherwise, the term "quality of care committee" will be used.

31 As explained by Ms. Carol Appathurai, Acting Director, Health Information Privacy and Sciences Branch, to the Ontario legislature's Standing Committee on General Government during its deliberations on the then-proposed *Quality of Care Information Protection Act, 2004*, "[t]he 'quality of care committee' is a body that's established, and we wanted to be sure that quality-of-care committees wouldn't just spring up self-appointed, so there had to be some conditions around them. … It has to be 'established, appointed or approved by a health facility' or 'by an entity that is prescribed by the regulations,' and it has to carry on activities for the purpose of quality care improvement" (Ontario Bill 31 Standing Committee Deliberations, *supra* note 15 at G-21).

32 For information about the type of health care body that is entitled to establish a quality of care committee, see *Canadian Incident Analysis Framework*, *supra* note 4 at 121–22. There are important variations. For example, under Ontario's *Quality of Care Information Protection Act*, *2004*, hospitals and other health facilities have the authority to create such committees (see *QCIPA 2004 – ON*, *supra* note 14, s 1 (definition of "quality of care committee", subsection (a)); Bill 119, *supra* note 14, Schedule 2, s 2(1) (definition of "quality of care committee", subsection (a)) (adding "quality oversight entity" to the list of bodies entitled to create committees). Conversely, in Alberta and British Columbia, the provincial health minister may also create such committees by order or regulation (*Evidence Act – AB*, *supra* note 20, s 9(1)(b)(iii)); *Evidence Act – BC*, *supra* note 20, s 51(1) (definition of "committee", subsection (d)).

try. For instance, in New Brunswick, the privilege attaches to information flowing from "a committee established … to conduct any study, research or program for the purpose of medical education or improvement in medical or hospital care or practice."[33] Some provinces and territories extend the protection beyond the hospital setting but rely on a dominant purpose test. For example, Alberta's *Evidence Act* defines a "quality assurance committee" as a "committee, commission, council or other body that has as its *primary* purpose the carrying out of quality assurance activities."[34] The latter expression is defined as "planned or systematic activity the purpose of which is to study, assess or evaluate the provision of health services with a view to the continual improvement of (i) the quality of health care or health services, or (ii) the level of skill, knowledge and competence of health service providers."[35]

In the past several years, courts have examined the issue of committee constitution. For instance, in *Forsberg v Naidoo*, the Alberta Court of Queen's Bench concluded that a committee set up immediately following a patient safety incident and comprised of only one member was properly constituted.[36] The court held that "[i]t would seem at odds with the legislative purpose of improving health care that the statutory privilege could be overcome on the basis that it was triggered by a particular incident."[37]

Another flexible interpretation of the legislative requirements related to committee constitution is found in *Sinclair v March*,[38] the leading case on section 51 of British Columbia's *Evidence Act*. The Court of Appeal noted

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33 See *Evidence Act – NB*, *supra* note 20, s 43.3(2)(a).

34 *Evidence Act – AB*, *supra* note 20, s 9(1)(b) [emphasis added].

35 *Ibid*, s 9(1)(a).

36 2009 ABQB 369 at para 15, 484 AR 234. The plaintiff, who had undergone several amputations because of a meningococcal disease contracted while at the defendant Leduc Community Hospital, sought the production of letters and memos listed as privileged in the Affidavit of Records of the defendant.

37 *Ibid* at para 16.

38 *Sinclair*, *supra* note 28. The plaintiff, who had suffered complications following bariatric surgery, sued her doctor and the hospital where the procedure took place. She sought the production of various correspondence, memoranda, minutes of meetings, and reports dating from 1962 to 1994. The hospital argued that the materials were protected by the qualified privilege. The chambers judge had ordered the production of some of the documents and greater description of

that "[w]hile it must be shown that the witness participated in committee work as described in s. 51, I do not think that the terms of s. 51 should be narrowly construed to balance the loss of access by the litigant."[39] The court added that section 51 "must be given its full effect even in circumstances where there is more than one aspect to the committee's function."[40]

The Nova Scotia Court of Appeal adopted a similar approach in *MacKenzie v Kutcher*.[41] The plaintiff had argued that the hospital committee was not properly constituted as it included "external" experts who did not prac-

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others. The Court of Appeal affirmed the order for the hospital to provide fuller descriptions but set aside the order to produce the documents at issue.

39 *Ibid* at para 22.

40 *Ibid* at para 30. Another interesting case is *Parmar (Litigation guardian of) v Fraser Health Authority*, 2012 BCSC 1596, 225 ACWS (3d) 448, where an infant plaintiff argued that there was no evidence that the committee tasked with reviewing a PSI connected with the plaintiff's birth had been approved by the hospital's board of management. The British Columbia Supreme Court disagreed. It appeared that when the infant plaintiff was born, a Local Quality Review Committee (LQRC) already in existence was seized of the matter. The committee was accountable to the defendant health authority, which also approved the committee's membership. The court was satisfied on the basis of the evidence before it that the defendant hospital had taken the necessary steps to set up the LQRC in accordance with the requirements of the province's *Evidence Act*.

41 *MacKenzie*, *supra* note 29. This case did not involve a PSI but is of interest nevertheless. Mr. MacKenzie, an administrative director for a mental health unit in a Yarmouth hospital, was dismissed from his job following a review by the defendants, two doctors (experts from another region) who were retained to conduct an operational review of all programs delivered by the mental health unit. The review was prompted by concerns related not only to management but also to patient safety. The plaintiff subsequently sued the two doctors on the basis of various torts including negligence and defamation. For a recent case involving another non-PSI setting, see *Hamburger v Fung*, 2014 BCSC 1625 at para 31, 244 ACWS (3d) 54 [*Hamburger*], where, in dismissing an application to strike out civil claims related to a dispute about access privileges to a lab by cardiologists, the court expressed sympathy for the defendants' submissions that section 51 of British Columbia's *Evidence Act*, *supra* note 20, provided a complete defence to the claims. The plaintiff had submitted, *inter alia*, that before a court could determine the scope of section 51's protection, evidence had to "be adduced to determine whether a 'committee' as defined exist[ed] and whether the required activities were been carried on by that committee" (*ibid* at para 23). The matter was left for the trial judge to resolve.

tice within the region. However, the court adopted a broad interpretation of the phrase "hospital committee"[42] and noted that the restriction to internal staff could not be read into the legislative provision given its purpose "to support the activities of hospitals improving medical or hospital care or practice by ensuring confidentiality for the documents and proceedings of committees that are given the task of studying or evaluating medical or hospital care or practice."[43]

The cases discussed so far reveal the courts' inclination to reinforce legislated initiatives to protect quality of care information from disclosure, at least in relation to committee constitution or structure. Caution should be exercised, however, because courts can insist on strict adherence to the legislative dispositions. The decision in *Eastern Regional Integrated Health Authority v Newfoundland and Labrador (Commission of Inquiry on Hormone Receptor Testing)*[44] is instructive in this regard. The defendant Commission conducted a public inquiry following serious problems with laboratory tests conducted at the Health Sciences Centre in St. John's. The plaintiff relied on section 8.1 of Newfoundland and Labrador's *Evidence Act*, arguing that reports from outside experts should not be made public as they were "made by, for or to" a "quality assurance committee" or a "peer review committee," as specified in sections 8.1(4)(b) and 8.1(2)(b)–(c) of the *Act*, respectively, and were thus protected.[45] The application was denied. Discussing the "peer review committee" issue first, the court noted that the process of retaining the two experts did not comply with the hospital's own

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42 *MacKenzie*, *supra* note 29 at paras 20, 25. The case dealt with the now repealed section 60 of Nova Scotia's *Evidence Act* (*supra* note 14), but is nevertheless instructive as it illustrates the court's willingness to adopt a broad view of committee constitution. That provision's replacement, the *Quality-improvement Information Protection Act* (*supra* note 14), brings about significant changes. Indeed, section 3(1) provides that "[a] quality-improvement committee may be established or designated by (a) a health authority; (b) the Minister; or (c) an entity prescribed by regulations, with terms of reference and membership … to carry out quality-improvement activities." Section 2(h) defines "quality-improvement activity" as "an activity of a quality-improvement committee … implemented for the purpose of assessing, investigating, evaluating or making recommendations respecting the provision of health services."

43 *MacKenzie*, *supra* note 29 at para 24.

44 2008 NLTD 27, 274 Nfld & PEIR 172 [*Eastern Regional Integrated Health Authority*].

45 *Ibid* at paras 30–33.

peer review policies.[46] There was no "sentinel event" (i.e., PSI) report given to the experts or to the physicians under review to comment upon as required by the policy.[47]

The plaintiff's submission that the external reports were prepared for a quality assurance committee did not fare better. The evidence before the court revealed that the hospital did not have a quality assurance committee in place at the time, nor were there policies in place relating to such a committee.[48] The selection of the two experts had occurred quite informally[49] and no terms of reference had been provided to them until well after they had agreed to provide their expertise.[50] In addition, as the term "quality assurance committee" is not defined by the legislation, the court considered similar legislative dispositions in Alberta and Saskatchewan,[51] among other definitions, and concluded that the external reports were "not part of a continuous Quality Review process involving research on long-standing Policies set out in a particular department."[52]

The conclusion to be drawn from *Eastern Regional Integrated Health Authority* is that a properly constituted quality of care committee is the first step to ensuring the protection of the law for all those involved in quality of care investigations. The scope of the qualified privilege – to whom and to what it applies – is also an important element of the protection envisaged by legislation, and it will now be examined.

B. The scope of the qualified privilege

1. Witnesses

Who can claim the qualified privilege? In the majority of provinces and territories, the qualified privilege can be invoked only by a "witness" in

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46 *Ibid* at para 44.

47 *Ibid* at para 41.

48 *Ibid* at para 82.

49 *Ibid* at para 99.

50 *Ibid* at para 75.

51 *Ibid* at paras 82–83.

52 *Ibid* at para 99.

a proceeding.[53] As already noted, New Brunswick is the only province to "excuse" the witness from answering questions and producing documents.[54] All other provinces and territories have formulated a prohibitive provision.[55]

The term "witness" is usually defined broadly and has not been the subject of legal debate very often. An example of a case where the issue was considered is *KD v British Columbia's Women's Hospital*.[56] The court had to determine whether information seen by the plaintiff herself was subject to the qualified privilege. Counsel tried to lead evidence from the plaintiff

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53 A typical example is found in section 9(1) of the *Manitoba Evidence Act* (*supra* note 20), where the term "witness" is defined as follows:

> [I]n addition to its ordinary meaning, [it] includes a person who, in the course of a legal proceeding,
>
> (a) is examined for discovery;
>
> (b) is cross-examined on an affidavit made by him or her;
>
> (c) answers interrogatories;
>
> (d) makes an affidavit as to documents; or
>
> (e) is called upon to answer any question or produce any record, whether under oath or not.

Some provinces and territories, such as Alberta, Nunavut, and Ontario, specify that the term "witness" includes persons who are not parties to the proceedings: *Evidence Act – AB*, *supra* note 20, s 9(2); *Evidence Act – NU*, *supra* note 20, s 14(1); *QCIPA 2004 – ON*, *supra* note 14, s 1. Prince Edward Island's and Québec's statutes employ the more general term "person" instead of "witness": *HSA – PEI*, *supra* note 20, s 29(1); *HSSS – QC*, *supra* note 20, ss 183.3–183.4. Yukon is the only jurisdiction where the privilege is not clearly attached to an individual. Rather, section 13(2) of its *Evidence Act*, *supra* note 20, states that "*evidence* is not admissible in a legal proceeding" [emphasis added].

54 *Evidence Act – NB*, *supra* note 20, s 43.3(2).

55 See e.g. *Evidence Act – AB*, *supra* note 20, s 9(2)(a) ("[a] witness in an action, whether a party to it or not, is not liable to be asked, and shall not be permitted to answer, any question"); *Evidence Act – NL*, *supra* note 20, s 8.1(4) ("[w]here a person appears as a witness in a legal proceeding, that person shall not be asked and shall not (a) answer a question in connection with proceedings of a committee").

56 2003 BCSC 2016, [2005] BCWLD 2023. This is a ruling on an objection made during evidence in connection with an action related to the death of one of the plaintiff's twins following an emergency caesarean section.

about a letter she had been shown during a post-incident meeting with one of the defendants who had prepared a written response to the allegations of negligence for the hospital. The court concluded it had no discretion to admit this evidence, as the plaintiff was a witness within the meaning of section 51 of British Columbia's *Evidence Act*.[57] The court noted that to admit the evidence "would likely defeat or impair the purpose of the legislation."[58] The court upheld the privilege but stated that the plaintiff was "entitled to give evidence about her state of mind following her review of the letter."[59]

2. Records

The qualified privilege extends not only to witness testimony but also to the production of records and other documents. Four provinces simply state that reports and other types of information are not admissible as evidence in legal proceedings,[60] while others, such as Alberta, provide that a witness "is not liable to be asked to produce and shall not be permitted to produce any quality assurance record."[61]

A crucial point must be noted: the privilege does not apply to information contained in medical, patient, or hospital records concerning a patient.[62]

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57 *Ibid* at para 29.

58 *Ibid*.

59 *Ibid* at para 30. Another example of a decision on the issue of witnesses is *Boissonnault c Fortin*, 2010 QCCA 1620, EYB 2010-179103, where, in a terse judgment, the Québec Court of Appeal confirmed that the risk manager of Ste Justine Hospital in Montréal was protected by sections 183.3 and 183.4 of Québec's *Act respecting health services and social services* (*HSSS – QC*, *supra* note 20), and thus did not have to provide information to the court.

60 See *QCIPA 2004 – ON*, *supra* note 14, s 5(2) (providing that "quality of care information is not admissible in evidence in a proceeding"); see also *Evidence Act – MB*, *supra* note 20, s 9(3); *HSA – PEI*, *supra* note 20, s 29(2); *Evidence Act – SK*, *supra* note 20, s 10(3).

61 *Evidence Act – AB*, *supra* note 20, s 9(2)(b).

62 For instance, information in a hospital chart or record of care. See e.g. *Evidence Act – BC*, *supra* note 20, s 51(3); *Evidence Act – NL*, *supra* note 20, s 8.1(5). There is a similar provision in almost all provinces and territories: *Evidence Act – AB*, *supra* note 20, s 9(3); *Evidence Act – MB*, *supra* note 20, s 9(4)(a); *Evidence Act – NB*, *supra* note 20, s 43.3(3)(b); *QIPA – NS*, *supra* note 14,

This is so because this information relates to patient care rather than to quality of care activities. Some jurisdictions specify that the facts which are contained in a record or incident report are not privileged either,[63] unless such facts are also included in a patient or medical record and accessible to the patient.[64] As noted by Perun, Orr, and Dimitriadis, "[t]he underlying

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s 2(j)(i); *Evidence Act – NU supra* note 20, s 14(2); *Evidence Act – NWT*, *supra* note 20, s 14(2); *Evidence Act – SK*, *supra* note 20, s 10(4)(a)(i); *Evidence Act – YK*, *supra* note 20, s 13(3)(b); *HSA – PEI*, *supra* note 20, ss 26(g)–(i), 29(2); *QCIPA 2004 – ON*, *supra* note 14, s 1 (definition of "quality of care information", subsection (c)). Exceptionally, in Québec, the legislative scheme adopts a broader focus based on confidentiality of the records and minutes of risk management committees, while recognizing the right of patients to access their medical records: *HSSS – QC*, *supra* note 20, ss 17, 183.4.

63 This is mentioned in the laws of Manitoba, Ontario, PEI, and Saskatchewan with variations in wording. See respectively *Evidence Act – MB*, *supra* note 20, s 9(4)(b); *QCIPA 2004 – ON*, *supra* note 14, s 1 (definition of "quality of care information", subsection (e)); HSA – PEI, *supra* note 20, ss 26(g)(ii), 29(2); *The Regional Health Services Act*, SS 2002, c R-8.2, s 58(7) [*RHSA – SK*].

64 This exception is found in the laws of Manitoba, Saskatchewan, and Ontario. The manner in which the exception is worded varies somewhat from one province to another, and a careful reading of these provisions is essential. See respectively *Evidence Act – MB*, *supra* note 20, s 9(4)(b); *RHSA – SK*, *supra* note 63, s 58(7)(a); *QCIPA 2004 – ON*, *supra* note 14, s 1 (definition of "quality of care information", subsection (e)). In Bill 119, *supra* note 14, the Ontario government has attempted to clarify the exemption for facts, and has significantly expanded the type of information that will not be protected by the statutory privilege. Section 2(3) of the proposed legislation provides:

> "Quality of care information" does not include any of the following:
>
> …
>
> 3. Information relating to a patient in respect of a critical incident that describes,
>
> i. facts of what occurred with respect to the incident,
>
> ii. what the quality of care committee or health facility has identified, if anything, as the cause or causes of the incident,
>
> iii. the consequences of the critical incident for the patient, as they become known,
>
> iv. the actions taken and recommended to be taken to address the consequences of the critical incident for the patient, including any health care or treatment advisable, or

principle appears to be that facts relating to health care incidents should not be shielded from the patient involved."[65] They suggest, based on the language in Ontario's *Quality of Care Information Protection Act, 2004*, that "where the facts are not included in a record that will be accessible to the patient, they will not be able to be shielded as quality of care information, even if they are recorded in the context of a review by a quality of care committee."[66] According to their interpretation, "unrecorded facts; any information that does not relate to 'an incident involving the provision of health care;' and information that does not consist of 'facts'" (for example, an opinion or evaluation of a PSI) are protected as quality of care information.[67] The issue of the exclusion of facts from the privilege was addressed in *Lancaster v Minnaar*,[68] where the court noted that the onus was on the defendant Health District Board to show that the facts recorded in the minutes of a quality assurance committee and unedited notes related to them "were also contained in medical and hospital records prepared for the care and treatment of the plaintiff."[69]

> v. the systemic steps, if any, that a health facility is taking or has taken in order to avoid or reduce the risk of further similar incidents.

65 Perun, Orr & Dimitriadis, *supra* note 13 at 623–24.

66 *Ibid* at 623.

67 *Ibid* at 623–24. This interpretation may change if the new legislation is adopted. See *supra* note 64.

68 2006 SKQB 380, 288 Sask R 31. The case dealt with an earlier version of the Saskatchewan legislation, but is nevertheless instructive since the requirement therein, whereby facts related to an incident had to be fully recorded in a medical record in order to be protected, was similar to the current provision.

69 *Ibid* at para 21. There are interesting comments on the issue by Saskatchewan's Court of Appeal in two older decisions. In *Soerensen (Litigation guardian of) v Sood* (1994), 115 DLR (4th) 598 at 505–06, 123 Sask R 72 (CA), the court wrote:

> Second, the term "facts related to the incident" in ss. (4)(a)(ii) must be read as referring only to the facts related to the incident which are recorded in the document under consideration, rather than all the facts of the incident. This is the only interpretation which does not make the exception in ss. (4)(a)(ii) so broad as to nullify entirely the privilege which the legislature so painstakingly created in ss. (2) and (3). If the words in the subsection were taken to mean all the facts of the incident in their broadest

To assess the scope of the qualified privilege, it is essential to consider the description of the protected documents. This varies in specificity from one province or territory to the next. Manitoba, for instance, refers to "any information that is written, photographed, recorded or stored in any manner, on any storage medium or by any means, including by graphic, electronic or mechanical means,"[70] while Alberta refers to a "quality assurance record," which includes, among other things, "books, documents, maps, drawings, photographs, letters, vouchers and papers."[71]

There have been a number of judicial decisions on issues related to the protection of documents. In *Bruce Estate*,[72] the plaintiff and others alleged inadequate sterilization and procedures for dealing with a nosocomial infection at the defendant hospital. In her application to certify an action as a class proceeding, the plaintiff swore an affidavit containing a report (in the form of a root cause analysis) and a news release summarizing it. Both the report and the news release were publicly available on the website of the Health Quality Council of Alberta (HQCA). The Council sought intervener status to argue that neither the report nor the news release were admissible in evidence because of section 9 of the *Alberta Evidence Act*.[73] The Alberta Court of Queen's Bench concluded that the report was protected by section

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> sense, a hospital could never prove that such facts were fully recorded in the ss. (4)(a)(i) records; there would always be small details overlooked, or deemed irrelevant, or too insignificant to be recorded by the person making the record.

See also *Kerr v Saskatchewan (Minister of Health)* (1994), 115 DLR (4th) 588, 123 Sask R 63 (CA), aff'g (1992), 98 DLR (4th) 66, 106 Sask R 77 (QB).

70 *Evidence Act – MB*, *supra* note 20, s 9(1) (definition of "record").

71 *Evidence Act – AB*, *supra* note 20, s 9(1)(c).

72 *Supra* note 28.

73 See *ibid* at para 28, where an affidavit in support of the HCQA's position is reproduced in part and reads:

> Participants in any quality assurance activity must feel comfortable and confident that their disclosures to a quality assurance committee will not form the foundation for evidence in a court or other legal proceeding. The HQCA is concerned if a report from a quality assurance activity can become evidence in a proceeding, there will be a chill on the willingness of individuals and organizations to participate in and be candid in dealing with the quality assurance committee or its subcommittees.

9(1) of the *Act* as it was created for and received by the quality assurance committee for quality assurance purposes.[74] The plaintiff tried to convince the court to read section 9(2)(b) narrowly, because she was not "asked" to produce the evidence but produced it of her own free will in her affidavit. The court refused to interpret section 9(2)(b) in this way, reading the phrase "is not liable to be asked to be produced and shall not be permitted to produce" as being disjunctive and thus as prohibiting two acts, i.e., both asking to produce and producing voluntarily.[75] The fact that the plaintiff was not "asked" to produce the evidence was therefore irrelevant because she still sought to "produce" it. The plaintiff also argued that because the report had been made public and was available from another source, section 9 should no longer apply. The court rejected this interpretation[76] and stated:

> The Legislature has chosen to place the goal of improving the quality of health care and health services ahead of any litigation advantage that may accrue to a party by the use of such a report. The prohibition is intended to ensure that an investigation can be completed and a report prepared in a comprehensive, efficient, effective and expeditious manner so as to identify and hopefully rectify any problems or potential problems in the delivery of health care services as soon as possible.[77]

The report and news release were therefore expunged from the plaintiff's affidavit.

In *Dawe v Evans*, a letter summarizing the circumstances of a newborn's death and the discussions held by the Neonatal Mortality Review Committee was considered privileged under section 9 of the Alberta *Evidence Act*.[78] The court found that because the opinion expressed in the letter was likely a result of the quality assurance process, the doctor who had written the letter was not allowed to answer questions pertaining to it. He was, however, required to answer questions with regard to any opinion he may have formed before participating in quality assurance activities. The

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74 *Ibid* at para 23.

75 *Ibid* at para 37.

76 *Ibid* at para 41.

77 *Ibid* at para 42.

78 Dawe, *supra* note 28 at para 35; *Evidence Act – AB*, *supra* note 20.

court also held that the prohibition persisted even after the quality assurance activities had ended.[79]

Finally, in *Mackenzie v Kutcher*,[80] the debate was whether certain documents related to an operational review by the defendant doctors were privileged. The documents included data and findings obtained from focus groups, handwritten notes about the operational review, completed ques-

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[79] Other cases confirm that courts tend to uphold the privilege. See e.g. *MM c Centre hospitalier régional de Trois-Rivières (CHRTR)*, 2012 QCCAI 48 at para 45 (available on CanLII), a decision by the Commission d'accès à l'information du Québec, in which a patient who had sustained injury following a fall in a hospital sought production of various documents including nurses' notes, the disclosure report, and an investigation report from the hospital's risk management officer. The hospital agreed to provide the patient with the first two documents but sought the protection of qualified privilege legislation regarding the investigation report. The Commission agreed with this position, noting the "watertight protection" offered by sections 183.3–183.4 of *An Act respecting health services and social services* (*HSSS – QC*, *supra* note 20), which require the absolute confidentiality of the documents and minutes of the hospital's quality of care committee. See also *Descamps c Hébert*, 2011 QCCS 7490 at para 33, EYB 2011-204867, where the Québec Superior Court, ruling on 37 objections to questions posed to two doctors and a nurse being sued for the misdiagnosis of a myocardial infarction, held that questions pertaining to risk management protocol, hospital rules and procedures, and the facts themselves were allowed. However, questions pertaining to the content of risk management records and other confidential information obtained by the risk manager or risk management committee were not allowed, and the objections in respect of these documents were sustained. Finally, see *Hamburger*, *supra* note 41 at para 18, where the court discussed the unreported *voir dire* procedure in *Fouad v Longman*, 2014 BCSC 327 [unpublished]. Following the *voir dire*, the court in *Fouad* upheld the qualified privilege regarding letters and other communications, noting, "I do not agree that the defendant's motives or additional agenda in requesting the review, even if proven to be malicious, is sufficient to prevent the operation of s. 51 of the *Evidence Act*. The policy behind s. 51 is to encourage absolute candour in matters of patient care and professional competency" (*Fouad*, *ibid*, at para 13, cited in *Hamburger*, *supra* note 41 at para 18).

[80] *Mackenzie*, *supra* note 29; see *supra* note 41 for the facts of the case. While, as noted above, section 60 has been repealed by Nova Scotia's *Quality-improvement Information Protection Act*, the analysis in *Mackenzie* is useful in understanding courts' interpretation of legislative requirements. The new legislation relies on the term "quality-improvement information," which is defined very broadly to include "information in any form"; this presumably covers a wide array of documents and records. See *QIPA – NS*, *supra* note 14, s 2(j).

tionnaires by staff, and confidential notes taken during meetings by staff, including peer reviews. Generally, the data and information gathered during the review were seen as confidential in nature by the reviewers and the individuals who provided information to them. Interestingly, Hamilton JA paraphrased one of the defendants' affidavits as stating that "many of the staff members interviewed expressed concern that there would be reprisals if they met the respondents and that some of them would not have participated in the review if the information given by them could be divulged at a later date."[81] The Superior Court judge who first heard the application had determined that the documents were protected by what was then section 60 of Nova Scotia's *Evidence Act*.[82] The Court of Appeal agreed and gave a broad interpretation of the phrase "document … of, or made by … a committee" in the statute,[83] finding that it included documents that were not authored by the committee, such as questionnaires filled out by staff, if these documents were authored at the committee's request and for its purposes only. This conclusion leads to a consideration of the issue of "dominant purpose" found in some of the Canadian qualified privilege laws.

3. Dominant purpose

In some provinces, the privilege is linked to a dominant purpose test. This notion was mentioned briefly above in discussing properly constituted quality of care committees and the requirement, in Alberta for example, that their primary purpose be the carrying out of quality of assurance activities. More commonly, however, the dominant purpose requirement is that the *information* prepared by a committee be primarily for quality of care purposes. The legislative objective is the same: to ensure that the qualified privilege does not extend to information or committees that are vaguely or peripherally linked to quality of care issues. For example, in the Saskatchewan legislation, the protection extends to documents, reports, and information "prepared exclusively for the use of or made by a committee" or to information "used exclusively in the course of, or aris[ing] out of, any investigation, study or program carried on

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81 *Mackenzie*, *supra* note 29 at para 7.

82 See *MacKenzie v Kutcher*, 2003 NSSC 76 at paras 23–24, 213 NSR (2d) 288; *Evidence Act – NS*, *supra* note 14, s 60.

83 *Evidence Act – NS*, *supra* note 14, s 60(2).

by a committee."[84] In Ontario, the privilege is linked to the protection from disclosure of "quality of care information," which is defined as "information that is collected by or prepared for a quality of care committee for the *sole* or *primary* purpose of assisting the committee in carrying out its functions."[85]

Courts have occasionally grappled with the issue. The case of New Brunswick is particularly interesting in this regard, as court decisions eventually prompted the province to modify section 43 of its *Evidence Act* to make it somewhat less restrictive. Indeed, in the 1996 case of *Doyle v Green*,[86] the province's Court of Appeal had to consider an earlier version of section 43.3(2)(b), which stated that a witness was excused from producing a document "prepared exclusively for the purpose of being used in the course of, or arising out of, any study, research or program, the dominant purpose of which is medical education or improvement in medical or hospital care or practice."[87] Noting the importance of the qualifiers "exclusively" and "dominant purpose," the court wrote:

> These words are intended to limit the exclusionary privilege to documents generated by a hospital or committee. A hospital or hospital committee cannot be required to produce a document prepared exclusively for the purpose of being used in the course of, or arising out of, any study, research or program, the dominant purpose of which is medical education or improvement in medical or hospital care or practice.[88]

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84 *Evidence Act – SK*, *supra* note 20, s 10(2)(b).

85 *QCIPA 2004 – ON*, *supra* note 14, s 1 (definition of "quality of care information", subsection (a)) [emphasis added]. No significant changes are envisaged in the proposed *Quality of Care Information Protection Act, 2015* (Schedule 2 of Bill 119, *supra* note 14) on this part of the definition. See also *Evidence Act – MB*, *supra* note 20, s 9(2)(b)(i)–(ii); *Evidence Act – NB*, *supra* note 20, s 43.3(2)(b); *Evidence Act – NU*, *supra* note 20, s 14(1)(b); *Evidence Act – YK*, *supra* note 20, s 13(2)(b).

86 (1996), 182 NBR (2d) 341, 463 APR 341 (CA) [*Doyle*]. The case involved an application to produce 127 documents related to a hospital investigation following the unexpected paraplegia of a patient who had undergone a hernia operation.

87 *Ibid* at 353.

88 *Ibid* at 356. The reasoning in *Doyle* was followed in *Comeau v Saint John Regional Hospital* (1997), 192 NBR (2d) 161 at 176, 74 ACWS (3d) 845 (QB).

In 1999, the wording of the legislative provision was modified to remove the word "exclusively" so that section 43.3(2)(b) now retains only the requirement that the document must apply to activities "the *dominant purpose* of which is medical education or improvement in medical or hospital care or practice."[89]

The New Brunswick legislator's decision to relax the wording of section 43.3 somewhat, and consequently to increase the breadth of the privilege, highlights the inherent dilemma in enacting qualified privilege legislation, namely the need to counterbalance the protection of quality of care information with access to information and transparency. Understanding how to minimize this tension requires a more in-depth examination of the policy choices that must be made and their consequences for health institutions and practitioners on the one hand and for patients and their families on the other.

II. Protecting Quality of Care Assurance Activities: An Assessment

As noted at the beginning of this article, qualified privilege laws are seen as one component of a culture shift aiming to recognize the importance of system-based institutional responses to adverse events in health institutions and the need to encourage health care providers to participate in quality of care assessments. However, relying on qualified privilege laws raises questions of fairness for patients who seek access to as much information as possible about PSIs having a bearing on their health, especially when outcomes are serious.[90] In this part, the article considers the challenges involved in striking the right balance between these two competing interests.

A. Legislative and judicial perspectives

The discussion of Canadian qualified privilege laws in Part I above shows that legislators have attempted to strike a fair balance between the interests of patients/litigants and those of health providers, while ensuring that the public interest is met. For example, in Ontario's *Quality of Care Information Protection Act, 2004*, the legal protection of quality of care

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89 *Evidence Act – NB*, *supra* note 20, s 43.3(2)(b) [emphasis added].

90 For a report outlining patients' expectations, see Ontario, Ministry of Health and Long-Term Care, *QCIPA Review Committee Recommendations* (23 December 2014) at 22, online: <www.health.gov.on.ca/en/common/legislation/qcipa/docs/qcipa_rcr.pdf>.

information is achieved through (a) a general prohibition against disclosing quality of care information;[91] (b) a qualified privilege prohibiting persons, courts, and other bodies from disclosing quality of care information in proceedings;[92] and (c) a wide definition of the proceedings to which the privilege applies.[93] At the same time, the legislation tries to limit the privilege so that patients have access to some information; this is made possible through (a) a fairly narrow definition of quality of care information with a built-in dominant purpose test,[94] (b) the exclusion of health records and of facts contained in a record of an incident from the application of the non-disclosure privilege,[95] and (c) the definition of what constitutes a quality of care committee.[96]

These features help circumscribe, at least to some extent, the ambit of the quality of care information that is protected from disclosure in legal proceedings, and they confirm that the competing policies at play are recognized by legislators.[97] However, it remains the case that the enactment

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91 See *QCIPA 2004 – ON*, *supra* note 14, s 4(1). The *Act* provides exceptions where disclosure is permitted, namely: if it is made to a quality of care committee (s 3), if it is made to the management that established a quality of care committee (s 4(3)), or if it has the purpose of preventing or reducing bodily harm (s 4(4)).

92 See *ibid*, s 5.

93 See *ibid*, s 1 (definition of "proceeding").

94 See *ibid*, s 1 (definition of "quality of care information", subsections (a)–(b)).

95 *Ibid*, s 1 (definition of "quality of care information", subsections (c)–(f)). This will be expanded if Bill 119, *supra* note 14, is adopted.

96 *QCIPA – ON*, s 1 (definition of "quality of care committee").

97 See, for instance, the comments made by Ms. Carol Appathurai, Acting Director, Health Information Privacy and Sciences Branch, to the Ontario legislature's Standing Committee on General Government during its deliberations on the then-proposed *Quality of Care Information Protection Act, 2004*: "In this act, we've attempted to bring a balance between protecting quality-of-care information but ensuring that information that needs to be public for the sake of the patient is not shielded" (Ontario Bill 31 Standing Committee Deliberations, *supra* note 15 at G-21). The balance is also reflected in the "Purposes" of the *Personal Health Information Protection Act*, SO 2004, c 3, Schedule A, s 1(b), which include "to provide individuals with a right of access to personal health information about themselves, subject to limited and specific exceptions set out in this Act"; one of those exceptions is quality of care information, as set

of a qualified privilege law is, in itself, an indication that protecting quality of care activities is prioritized over full access to health information by patients.

As can be gleaned from the survey in Part I, when Canadian courts have been called upon to assess and apply qualified privilege laws, they have been generally supportive of the need to protect quality of care information. This has not always been the case. Indeed, decisions predating the 1999 *To Err Is Human* report showed a fairly clear reluctance to limit litigants' access to information.[98]

However, the more recent trend reveals a different approach, as noted in *Sinclair*:

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out in section 51(1)(a). The same point of view was present in the legislative debate in Manitoba: see Manitoba, Legislative Assembly, *Hansard*, 38th Leg, 3rd Sess, Vol 56, No 33 (20 April 2005) at 1645 (Hon Tim Sale). Interestingly, the preamble of the proposed *Quality of Care Information Protection Act, 2015* (Schedule 2 of Bill 119, *supra* note 14) explicitly recognizes the competing policy choices and the need to attempt to reconcile them:

> The people of Ontario and their Government:
>
> …
>
> Are committed to ensuring that measures to facilitate the sharing of information for quality improvement purposes do not interfere with the right of patients and their authorized representatives to access information about their health care or with the obligations of health facilities to disclose such information to patients and their authorized representatives ….

98 See David G Duff, "Evidentiary Privilege for Hospital Quality Assurance and Risk Management: Assessing Statutory Reform" (1989) 47:2 UT Fac L Rev 526 at 535–36. See e.g. *Finley v University Hospital Board* (1986), 33 DLR (4th) 200 at 211, 53 Sask R 124 (QB), where the court stated:

> I conclude that in cases where an investigation is prompted by circumstances which are or become the subject matter of litigation, the question of balancing the respective interests of the community against those of the litigant weigh[s] in favour of the latter. Unless special circumstances exist that suggest the maintenance of confidentiality is deemed desirable for the purpose of public policy, the weight of authority appears to hold that disclosure should be ordered in cases where the matter of the complaint under review is the subject matter of the litigation for which disclosure is sought.

> [T]he Legislature intended to protect this area of hospital activity by preventing access by litigants. Rather than striking a balance of interests, the Legislature made a clear choice in favour of one interest, hospital confidentiality. In the course of deciding an issue under s. 51 [of British Columbia's *Evidence Act*] a court should give the language of the enactment its full force and effect with the object in mind.[99]

This approach has been maintained even in the face of perceived injustice by patient-plaintiffs. For instance, in *Parragh v Eagle Ridge Hospital and Health Care Centre*,[100] the two plaintiffs sought compensation for the harm they suffered after having contracted a serious bacterial infection shortly after undergoing day surgery at the defendant hospital. The plaintiffs argued, *inter alia*, that it was fundamentally unjust to be denied access to the results of an internal inquiry carried out by the hospital as a result of the infectious outbreak. The court answered in stating: "[I]t is not unjust in the sense the notion is understood in this context. The legislature has made a determination as to how the competing interests at play when a hospital, with a view to improving medical or hospital care, undertakes an investigation into that care, are to be treated."[101]

As matters currently stand, as surveyed in Part I of this study, judicial denial of legislative protection has occurred only in cases of failure by health providers and institutions to abide by the specific requirements of the legislation.[102] Indeed, decisions such as *Eastern Regional Integrated Health Authority* show that some courts will refuse to apply the statutory protection if the details of the legislative scheme are not strictly adhered to.[103] However, none of the decisions take a stance against the fundamental policy position stipulating a need for at least some protection of quality of care information.

This is not to say that courts have been oblivious to the impact of a restrictive interpretation on claimants. Some judges have remarked on the

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99 *Sinclair*, *supra* note 28 at para 26.

100 2008 BCSC 1299, 170 ACWS (3d) 729.

101 *Ibid* at para 34.

102 See e.g. *Eastern Regional Integrated Health Authority*, *supra* note 44.

103 *Ibid*; Davinder Sidhu & Máire A Duggan, "Statutory and Common Law Protection of Laboratory Quality Assurance Data in Canada" (2012) 4:2 Can J Pathology 54 at 57–58.

importance of disclosure and access to information. This is clear from the words of the chambers judge in *Sinclair* while discussing section 51 of British Columbia's *Evidence Act*:

> But the section does not give blanket protection to all of a hospital's documentary workings under the rubric of improving patient care and practice. Such a broad interpretation would not achieve the balance intended by the legislature between the public interest in the search for truth in litigation and freedom to improve patient care. The duty not to disclose should not be lightly extended to other classes of documentation just because they involve personnel who provide or administer patient care in a hospital. The scope of public interest identified in the section does not go so far. At the same time, the section should not be given so restrictive a meaning as to defeat the intention of the statutory provision.[104]

Overall, then, whether one considers the choices made by legislators in the drafting of qualified privilege statutory schemes or those that arise in judicial interpretation, there is a clear endorsement of the basic principle whereby quality of care information – as defined in qualified privilege laws – should be protected. But there is also a recognition that patients' access to information cannot be completely limited. Access is essential not only in the context of a specific PSI, when answers are sought about the event and its aftermath, but also in relation to the public interest in the safety of health institutions and health care generally.

B. Balancing protection of information and disclosure to patients

In order to assess whether the "balancing of interests" approach upon which legislators and courts have relied should be endorsed, it is useful to consider a scenario in which patients would be given full access not only to the information contained in their own medical records but also to reports, discussions, assessments, and other quality of care initiatives flowing from an institutional investigation of an adverse event – in other words, a scenario in which the qualified privilege would be abandoned.[105]

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[104] *Sinclair v March*, 2000 BCSC 349 at para 12, 73 BCLR (3d) 86 (Dillon J), cited in *Sinclair*, *supra* note 28 at para 21.

[105] For an interesting case study, see Kelly G Dunberg, "Just What the Doctor Ordered? How the Patient Safety and Quality Improvement Act May Cure

Presumably, such a measure would increase access to information about adverse events at least within the context of "legal proceedings" as defined in qualified privilege laws.[106] This could be useful during litigation, complaints, or other proceedings against health care providers and institutions, especially if post-PSI reports and statements disclose admissions of fault. Access to this type of information could perhaps enhance the chances of finding civil liability and increase the possibility of compensation.[107]

The consequences for health providers' behaviour if the privilege were removed are not as clear and need more assessment.[108] However, there is research supporting the notion that in the absence of qualified privilege protection, health care practitioners would be more reluctant to disclose PSIs and to participate in the information gathering processes following their occurrence.[109] This would mean that less quality of care information would

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Florida's Patients' Right to Know about Adverse Medical Incidents (Amendment 7)" (2012) 64:2 Fla L Rev 513. The author discusses a 2004 amendment to the Florida Constitution that effectively eliminated privilege protections in that state and allowed access to records and reports of past PSIs involving health practitioners and institutions.

106 See Part I, above, for a discussion of "proceedings" in Canadian legislation.

107 As found in the literature on disclosure of adverse events, access to more complete information may lead to other benefits as well, in terms of patient trust in the health care system and health care providers. See e.g. Fred Rosner et al, "Disclosure and Prevention of Medical Errors" (2000) 160:14 Arch Intern Med 2089 at 2090.

108 Generally speaking, since patient-safety legal initiatives (including qualified privilege laws) are relatively new, there is very little data as to their effectiveness and efficiency; see Downie et al, *supra* note 12 at 5; Gilmour, *supra* note 12 at 65–66.

109 See *To Err Is Human*, *supra* note 1 at 109–12; Bianca Perez et al, "Understanding the Barriers to Physician Error Reporting and Disclosure: A Systemic Approach to a Systemic Problem" (2014) 10:1 J Patient Saf 45 (discussing a number of barriers to transparency about errors); Norna F Waters et al, "Perceptions of Canadian Labour and Delivery Nurses about Incident Reporting: A Qualitative Descriptive Focus Study" (2012) 49:7 Intl J Nurs Stud 811 at 814–15 (addressing specifically the fear-of-litigation issue); Nick O'Connor, Beth Kotze & Murray Wright, "Blame and Accountability 2: On Being Accountable" (2011) 19:2 Australas Psychiatry 119 at 119 (arguing that a "no blame culture" is essential to voluntary reporting); Lauris C Kaldjian et al, "Reporting Medical Errors to Improve Patient Safety: A Survey of Physicians

be generated. Such a consequence would not necessarily benefit injured patients, as the information about the adverse event that produced the injury would not be as complete and explicit.

Given this, and despite the lack of empirical evidence within the health context, it intuitively seems that abandoning the privilege would not necessarily be advantageous in terms of patients' access to information. The experience of other industries – aviation in particular – provides valuable insights into the need for incentives to encourage reporting of adverse events without fear of reprisal.[110]

Moreover, as discussed above, qualified privilege laws protect only some information from access by patients/litigants, namely the work of quality of care committees. Patients remain free to pursue legal action or rely on the complaint process if they so wish and, in that context, substantial information may be gleaned from medical records, professional colleges' records of investigation, and the testimony of expert witnesses appearing on a patient's behalf.[111]

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in Teaching Hospitals" (2008) 168:1 Arch Intern Med 40 at 44 (considering factors affecting error reporting by physicians).

[110] See Paul Barach & Stephen D Small, "Reporting and Preventing Medical Mishaps: Lessons from Non-Medical Near Miss Reporting Systems" (2000) 320:7237 Brit Med J 759. For other articles comparing the health sector to other industries, see e.g. Lucian L Leape, "Reporting of Adverse Events" (2002) 347:20 New Eng J Med 1633 at 1635 (discussing the experience in aviation); René Amalberti et al, "Five System Barriers to Achieving Ultrasafe Health Care" (2005) 142:9 Ann Intern Med 756 (looking at industries viewed as "ultrasafe" and the barriers encountered by the health sector to achieve this status); Linda SGL Wauben, Johan F Lange & Richard HM Goossens, "Learning from Aviation to Improve Safety in the Operating Room – A Systematic Literature Review" (2012) 3:3 J Healthc Eng 373 (making very interesting comparisons between the aviation and health care sectors – in particular the operating room setting – and arguing for "strong (horizontal) leadership communicating urgency for change and creating a safe culture to speak up and report error" at 386); Sidney Dekker, "The Criminalization of Human Error in Aviation and Healthcare: A Review" (2011) 49:2 Saf Sci 121 (discussing why criminal prosecution is a threat to safety and has an effect on willingness to report and disclose safety-related information).

[111] Duff, *supra* note 98 at 541.

When discussing whether a "balancing of interests" approach in the enactment and application of qualified privilege laws is defensible in the context of PSI reduction strategies, it is important to recognize the complexity of the landscape in which these laws operate. As noted by Flood and Thomas, the Canadian focus so far has been on "improved information gathering and dissemination of best practice standards,"[112] and indeed, qualified privilege laws are linked to these efforts as they aim to encourage active participation of health care providers in collecting information. However, other types of legal interventions may also contribute to the goal of adverse event reduction. Proposed measures include expanding disclosure obligations to patients,[113] enacting "apology legislation,"[114] mandating compensation through no-fault rules,[115] adopting organizational liability rules,[116] and others. Some studies have even suggested that civil litigation can have a positive effect on PSI reduction.[117]

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[112] Colleen M Flood & Bryan Thomas, "Canadian Medical Malpractice Law in 2011: Missing the Mark on Patient Safety" (2011) 86:3 Chicago-Kent L Rev 1053 at 1092.

[113] Richard C Boothman, Sarah J Imhoff & Darrell A Campbell Jr, "Nurturing a Culture of Patient Safety and Achieving Lower Malpractice Risk through Disclosure: Lessons Learned and Future Directions" (2012) 28:3 Front Health Serv Manage 13. For an assessment of the efforts in the United Kingdom in this regard, see Yvonne Birks et al, "An Exploration of the Implementation of Open Disclosure of Adverse Events in the UK: A Scoping Review and Qualitative Exploration", online: (2014) 2 Health Services and Delivery Research 20 <eprints.whiterose.ac.uk/79933/1/openDis.pdf>. See also *supra* note 17.

[114] Roy Ilan & Yoel Donchin, "Creating Patient Safety Capacity in a Nation's Health System: A Comparison between Israel and Canada" (2012) 1:19 Isr J Health Policy Res 1 at 2; Stuart McLennan, Leigh E Rich & Robert D Truog, "Apologies in Medicine: Legal Protection Is Not Enough" (2015) 187:5 CMAJ E156 (raising doubts about the effectiveness of these laws).

[115] Barry R Furrow, "Adverse Events and Patient Injury: Coupling Detection, Disclosure, and Compensation" (2012) 46:3 New Eng L Rev 437 at 467–70. For interesting studies on patient safety in the context of a no-fault regime, see Katharine Wallis & Susan Dovey, "No-Fault Compensation for Treatment Injury in New Zealand: Identifying Threats to Patient Safety in Primary Care" (2011) 20:7 BMJ Qual Saf 587; Joanna Manning, "New Zealand's Remedial Response to Adverse Events in Healthcare" (2008) 16:2 Torts LJ 120.

[116] See e.g. Tracey Evans Chan, "Organizational Liability in a Health Care System" (2010) 18:3 Torts LJ 228.

[117] There is an interesting debate on this issue. See Joanna C Schwartz, "A Dose

Debating the merits of these options is beyond the scope of this article, and the point being made here is simply that qualified privilege laws are but one element of the "patient safety culture" that all health institutions are encouraged to develop.[118]

Therefore, keeping in mind the complexity of multifaceted interventions to reduce PSIs in institutional settings and the fact that more empirical research is needed to assess how they contribute to safer health care, a "balancing of interests" approach regarding qualified privilege laws seems very reasonable and should be encouraged. This approach is especially important from the patient perspective as the ambit of privilege appears to be expanding, at least in some jurisdictions. This tendency is linked to some provinces' new reporting requirements to ministries of health or regional health authorities and the fact that these requirements are coupled with protection from disclosure through statutory privilege.[119] The perception that adverse

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of Reality for Medical Malpractice Reform" (2013) 88:4 NYUL Rev 1224. The author conducted a national survey of American health care professionals and risk managers in the United States, and came to conclude that "the openness and transparency promoted by the patient safety movement has pried open the historically secretive world of malpractice litigation," as lawsuits are seen as a valuable source of information about safety issues (*ibid* at 1299). See also George J Annas, "The Patient's Right to Safety: Improving the Quality of Care through Litigation against Hospitals" (2006) 354:19 New Eng J Med 2063; Barry R Furrow, "The Patient Injury Epidemic: Medical Malpractice Litigation as a Curative Tool" (2011) 4:1 Drexel L Rev 41. For the opposite point of view, see Bryan A Liang, "A Policy of System Safety: Shifting the Medical and Legal Paradigms to Effectively Address Error in Medicine" (2004) 5:1 Harvard Health Policy Rev 6 at 9.

[118] For an interesting assessment by patient safety leaders in the United States regarding efforts since the *To Err Is Human* report and next steps for the future, see Robert M Crane & Brian Raymond, "Roundtable on Public Policy Affecting Patient Safety" (2011) 7:1 J Patient Saf 5.

[119] See Gilmour, *supra* note 12 at 63–64. The author gives Saskatchewan as an example; see *RHSA – SK*, *supra* note 63, c R-8.2, s 58(5). See also, in Manitoba, the *Regional Health Authorities Act*, SM 2005, c 24, CCSM c R34, s 53.10. See Downie et al, *supra* note 12 at 15–16 (where the authors note a general trend towards expansion of the "legal frameworks," including qualified privilege, that regulate quality of care and patient safety). For a concrete suggestion to expand the qualified privilege, see Carol Brass, "A Proposed Evidentiary Privilege for Medical Checklists" (2010) 2010:3 Colum Bus L Rev 835 at 842 (proposing an evidentiary privilege to bar admissibility of medical checklists in court). As the author notes, "[c]hecklists are the ideal way to look at medical

events are under-reported could also lead to a possible expansion of qualified privilege laws to encourage health professionals to participate fully in reporting initiatives.[120]

In light of this, giving patients access to some information while protecting quality of care information from disclosure in certain contexts is defensible. If the objective of improving quality of care through quality assurance activities and risk management can be achieved without diminishing disclosure rights and thereby limiting patients' access to justice (or to a fair trial, or to compensation), then, as stated by Duff, "the public interest may legitimately sustain a statutory rule of privilege."[121] Hopefully, the approach will assist in the ultimate quest to improve patient safety.

Conclusion

The objective of this article was to examine qualified privilege laws protecting quality of care information in Canada and the treatment of these laws by Canadian courts, in order to better understand how they fit within current strategies to reduce PSIs and thus improve patient safety. The analysis of the relevant laws and their judicial treatment revealed that Canadian courts have generally recognized and endorsed the legislative goal of improving the quality of health care and health services by encouraging health practitioners and administrators to fully discuss undesirable outcomes in patient care, secure in the knowledge that they are protected, at least to some degree, from negative personal and professional repercussions. The courts' insistence on strict adherence to legislative criteria ensures that this statutory privilege is balanced with patients' need to access information about their care.

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error on a broad-based, institutional level, to diagnose systematic problems, and to ensure that individual actors are incorporating the solutions into their everyday actions." For a general encouragement to extend the privilege to "all documentation resulting from the quality assurance process including RCA, recommendations, reports and notices," see Baker et al, Canadian Patient Safety Institute, "Review", *supra* note 13 at B17.

120 Under-reporting is identified as an issue in a number of studies. See e.g. Tim Outerbridge, "Building Systemic Models for Medical Error Reporting" (2004) 12 Health LJ 275 at 276–77; Sarah Burningham, Wayne Renke & Timothy Caulfield, "Is Patient Safety Research Protected from Disclosure?" (2013) 20 Health LJ 47 at 48; Waite, *supra* note 17 at 25.

121 Duff, *supra* note 98 at 543.

As can be seen from the present study, both legislators and judicial actors have a role to play in coming to a fair compromise between the necessity of protecting quality of care information and ensuring access to health information by patients. Adopting a "balancing of interests" approach in this context is sensible. However, even if legislators tweak existing laws and judges are mindful of the interests at play, the optimal formula to reduce PSIs remains elusive for now. There is therefore a pressing need for more research to assess the possible links not only between qualified privilege laws and incentives to report PSIs, but also between other legal interventions – including civil litigation[122] – and improved quality of care.

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[122] See studies cited *supra* note 117.