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David G. Duff
Allard School of Law at the University of British Columbia, duff@allard.ubc.ca

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Evidentiary Privilege for Hospital Quality Assurance and Risk Management: Assessing Statutory Reform*

Introduction

Quality assurance (QA) and risk management (RM) programs originated relatively recently in Canadian hospitals.[1] Associated with the increasingly institutional framework for the delivery of health care, [2] their development has been stimulated by tougher standards for hospital accreditation,[3] the expanded

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* I am indebted to the Federal/Provincial/Territorial Review on Liability and Compensation Issues in Health Care, by whom I was employed during 1987-88, and for whom this Note was originally written. The views expressed are, however, exclusively my own.

1. G. Richard Batty, "Quality Assurance — What Lies Ahead? A Canadian Legal Respective" (1985) 5 Health Law in Canada 108. The Canadian Council on Hospital Accreditation (C.C.H.A.) traces the appearance of patient care appraisal in Canada to the 1970s: C.C.H.A., "Position on Patient Care Appraisal" (September 1985). These developments appear to have been predated slightly by the emergence of quality assurance and risk management programs in the United States. See, e.g., John Ball, "PSRO — An Alternative to the Medical Malpractice System as a Quality Assurance Mechanism" (1977) 36 Maryland L. Rev. 566.
2. See, e.g., Ellen Picard, "The Liability of Hospitals in Common Law Canada" (1981) 26 McGill L.J. 997 at 998, 1001. According to a 1984 study, roughly 60 percent of the American population had no personal physician and therefore placed primary reliance on hospitals for medical care: Diane Janulis and Alan Hornstein, "Damned If You Do, Damned If You Don't: Hospitals' Liability for Medical Malpractice" (1985) 64 Neb. L. Rev. 689 at 692. Furthermore, the estimate that over 80 percent of all medical malpractice claims closed in 1984 involved an injury arising in a hospital setting confirms the extent to which the hospital is at the centre of the contemporary health care system. See U.S. Congress General Accounting Office, *Medical Malpractice: Characteristics of Claims Closed in 1984* (Washington, D.C.: GAO/HRD-87-55, April 1987) at 24-25.
3. The C.C.H.A. is a voluntary program to which roughly half of Canadian hospitals (representing 80 percent of hospital beds) subscribed in 1979: J.E. Magnet, "Preventing Medical Malpractice in Hospitals: Perspectives from Law and Policy" (1979) 3 Leg. Med. Q. 197. C.C.H.A. Guidelines were amended in January 1983 to require of all hospitals aspiring to a three-year accreditation status that "[a] quality assurance programme that includes effective mechanisms for review and evaluating patient care, as well as responding appropriately to findings, shall be established, supported and maintained." Cited in Batty, *supra*, note 1 at 108. In the United States, the Joint Commission on Accreditation of Hospitals (J.C.A.H.) stipulates that accredited hospitals must "establish, maintain, and support through the hospital's administration and medical staff, an ongoing quality assurance program that includes effective mechanisms for reviewing and evaluating patient care, as well as an appropriate response to such findings." J.C.A.H. Manual, cited in B. Abbott Goldberg, "The Peer Review Privilege: A Law in Search of a Policy" (1984) 10 Am. J. Law & Med. 151. See also the brief history of the J.C.A.H. in Reid F. Holbrook, and Lee J. Dunn, Jr., "Medical Malpractice Litigation: The Discoverability and Use of Hospitals' Quality Assurance Committee Records" (1976) 16 Washburn L.J. 54 at 57-58, and the review of J.C.A.H. standards in Neil L. Chayet and Thomas M. Reardon, "Trouble in the Medical Staff: A Practical Guide to Hospital Initiated Quality Assurance" (1981) 7 Am. J. Law & Med. 301 at 305.

scope of hospital liability for medical malpractice[4] and direct government regulation.[5]

While these measures promise substantial advancement in patient safety and the quality of medical care, considerable concern has been voiced that their full potential is frustrated by the unwillingness of medical personnel to participate wholeheartedly in such programs without clear guarantees of confidentiality for the deliberations and recommendations of QA and RM committees.[6] Consequently, it has been suggested that such communication should be shielded from subsequent public disclosure.[7] Indeed, statutory protection to this effect has existed in Manitoba since 1965 and in Alberta since 1970,[8] and has also been adopted in most American jurisdictions.[9] More recently, evidentiary

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4. While American jurisdictions are considerably more advanced in this respect (accounting, in part, for the earlier appearance of QA and RM in the United States), a noticeable trend toward expanded hospital liability is also apparent in Anglo-Canadian law. See, e.g., Picard, *supra*, note 2; Dr. S.M. Kolber, "Toward the Finding of Greater Hospital Liability (Part 1)" (1984) 4 Health Law in Canada 72; David G. Duff, "The Liability of Doctors and Hospitals: Developments in the Common Law" (July 1987) Research Paper for the Federal/Provincial/Territorial Review on Liability and Compensation Issues in Health Care, at 66-78. As a result, although the Ontario Court of Appeal in *Yepremian* v. *Scarborough General Hospital* (1980), 110 D.L.R. (3d) 513 (Ont. C.A.) disavowed the "corporate liability" doctrine of *Darling* v. *Charleston Community Memorial Hospital*, 33 Ill. 2d 326, 211 N.E. 2d 253, *cert. denied*, 383 U.S. 946 (1966), Canadian hospitals could probably be held liable under existing Anglo-Canadian doctrine for injuries resulting from a failure to establish and maintain an effective QA and RM program. See Magnet, *supra*, note 3 at 201. On U.S. law with respect to hospital liability, see Arthur F. Southwick, "Hospital Liability: Two Theories Have Been Merged" (1983) 4 J. Leg. Med. 1; Janulis and Hornstein, *supra*, note 2.
5. Magnet, *supra*, note 3 at 201. See, e.g., R.R.O. 1980, Reg. 865 (pursuant to the *Public Hospitals Act*, R.S.O. 1980, c. 410), requiring hospital boards to establish credentials, records, tissue and/or medical audit committees [s. 7(1)(e)], as well as a more general "medical advisory committee" [s. 7(1)(b)-(d)] to supervise the practice of medicine in the hospital [s. 7(6)(b)] and to make recommendations regarding the quality of medical care provided in the hospital [s. 7(6)(vii)], particularly with respect to staff appointments and hospital privileges [s. 7(6)(a)(i)-(iii), (vi)]. More specifically, additional regulations adopted in November 1976 [O. Reg. 934/76, s. 1] require each hospital board to "develop an accident prevention policy" [s. 4(a)], to appoint an "accident prevention committee" [s. 4(c)], to meet regularly and make recommendations concerning implementation of the policy [s. 4(d)] and to "ensure the establishment of procedures designed to encourage (i) a safe work environment, (ii) safe work practices and (iii) the prevention of accidents to patients, employees, professional staff and visitors" [s. 4(b)]. Several American states require hospitals to implement risk management programs as a condition of licensure. See U.S. Congress General Accounting Office, *Medical Malpractice: A Framework for Action* (Washington D.C.: GAO/HRD-87-73, May 1987) at 17.
6. See, e.g., Chayet and Reardon, *supra*, note 3 at 306-07; Batty, *supra*, note 1 at 110-11.
7. *Ibid.* See also *infra*, notes 10, 13 and 14.
8. *Evidence Act*, R.S.M. 1970, c. E-150, s. 11; *Evidence Act*, R.S.A. 1980, c. A-21, s. 9.
9. Arthur F. Southwick and Debora A. Slee, "Quality Assurance in Health Care: Confidentiality of Information and Immunity for Participants" (1984) 5 J. Leg. Med. 343 at 359; Goldberg, *supra*, note 3 at 153-54. See, e.g., Colo. Rev. Stat., s. 12-43.5-102(3)(e); Fla. Stat., s. 768.40(4) (1981); Ill. Ann. Stat., ch. 110, ss. 8-2101 to 8-2105 (Smith-Hurd 1984); Ky. Rev. Stat., s. 311.377(2) (1983); Md. Health Code Ann., s. 134(A)(d) (1980); N.Y. Educ. Law, s. 6527(3)

privilege for the quality assurance and risk management process has moved onto the legislative agenda of most Canadian jurisdictions with a Canadian Bar Association resolution in August 1985,[10] amendments to the evidence acts of British Columbia and Nova Scotia in 1986 and 1987,[11] a bill currently before the New Brunswick legislature[12] and recommendations for similar measures in Ontario, Quebec and Saskatchewan.[13]

While widespread support among both medical and non-medical communities suggests the relatively uncontroversial nature of such statutory protection,[14] careful examination reveals several issues demanding cautious legislative treatment. This comment advances specific recommendations for statutory protection of the quality assurance and risk management process by reviewing the current basis for evidentiary disclosure,[15] exploring the reasons for evidentiary privilege generally[16] and in the context of QA and RM,[17] and applying this analysis to the design of a specific statutory rule to protect certain categories of QA and RM information from disclosure during malpractice actions.[18]

Defining Terms

At the outset, it is important to explain the terms "quality assurance" and "risk

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(McKinney 1971, amended 1977); Ohio Rev. Code Ann., s. 2305.25 (page 1981); Or. Rev. Stat., s. 41.675(2) (1981); 63 Pa. C.S.A., ss. 425.2 *et seq.* (1980); Tenn. Code Ann., s. 63-2-219 (1967, amended 1983); Tex. Stat. Ann., art. 4447 (d), s. 3 (Vernon 1976); Vt. Stat. Ann. Tit. 26, ss. 1441-43 (1976); Va. Code Ann., ss. 8.01-581.16, 8.01-581.17 (1977, amended 1981); Wis. Stat. Ann., s. 146.38 (West Supp. 1982).

10. Canadian Bar Association, *Resolution No. 9* (19 August 1985).
11. *Evidence Act*, R.S.B.C. 1979, c. 116, s. 57(4) [as am. 1986]; *Evidence Act*, R.S.N.S. 1967, c. 94, s. 56A(1)(a) [as am. 1987, c. 20].
12. Bill 23, *An Act to Amend the Evidence Act*, New Brunswick, 36 Eliz. II, 1987, s. 43.3(3)(b).
13. See, e.g., Batty, *supra*, note 1 at 111; Ontario Hospital Association (O.H.A.), "Patient Care Review in Hospitals: Hospitals Call for Changes to the Ontario Evidence Act" (May 1986); Association des hopitaux du Quebec (A.H.Q.), *Memoire presente a la Commission de la culture chargee d'etudier le Rapport sur la mise en oeuvre de la Loi sur L'acces* (February 1988); Working Group Respecting the Quality Assurance Process and *The Saskatchewan Evidence Act*, "Memorandum Re: Statutory Protection of the Quality Assurance Process" (9 February 1988), [hereinafter Saskatchewan Working Group, "Memorandum"].
14. Advocates include the Canadian Council on Hospital Accreditation (C.C.H.A.), the Canadian Bar Association (C.B.A.), the Canadian Medical Association (C.M.A.), the Ontario Hospital Association (O.H.A.), the Association des hopitaux du Quebec (A.H.Q.), the Canadian Nurses' Association (C.N.A.), the Saskatchewan Working Group, as well as the Governments of British Columbia, Nova Scotia and New Brunswick. *Supra*, notes 1, 10 and 13; C.M.A. Resolution (20 August 1985); C.N.A. "Brief to the Federal/Provincial/Territorial Review on Liability and Compensation Issues in Health Care" (July 1988) at 28-29, [hereinafter C.N.A. Brief].
15. *Infra*, notes 30-72 and accompanying text.
16. *Infra*, notes 42-51, 85-100 and accompanying text.
17. *Infra*, notes 73-84 and accompanying text.
18. *Infra*, notes 101-40 and accompanying text.

management." Most generally, each involves the organization of institutional mechanisms for assessing and improving the quality of medical care.

For the former, this comprises the development of norms, standards and criteria to monitor the quality of structural *inputs* to the delivery of health care, the *process* of medical care and the final *outcome* of medical treatment,[19] and the establishment of programs and procedures "designed to assist practitioners in modifying practice behavior found to be deficient by quality assessment, to protect the public against incompetent practitioners, as well as to modify structural or resource deficiencies that may exist."[20] Broadly conceived, therefore, quality assurance encompasses the entire spectrum of medical regulatory activities: from standards of professional licensure and hospital accreditation to criteria laid down by hospital credentials committees to systems of peer review, medical audit, utilization review, tissue and death review, and incident reports and finally, to continuing medical education, mandatory relicensure and professional discipline.

Part of the quality assurance process thus defined, risk management is nonetheless distinguishable in its primary emphasis on medical outcomes and the liability implications of adverse results of medical care.[21] Specifically, risk management involves an integrated system for the *identification of unexpected outcomes and risks* causing or having the potential to cause medical (iatrogenic) injury or the impairment of patient safety;[22] the *centralization of data* on all such identified risks; the *communication of this statistical information* to other clinical and administrative departments, and to quality assurance and credentials committees; the *organization of educational programs* to minimize the risk of harm to patients; the *development of specific programs* tailored to the individual institution to address high risk clinical areas such as "operating suite, labor and

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19. See, e.g., Avedis Donabedian, *A Guide to Medical Care Administration, Volume II: Medical Care Appraisal — Quality and Utilization* (1969) at 14-41.

20. American Medical Association (A.M.A.) Council on Medical Service, "Guidelines for Quality Assurance" (1988) 259 J.A.M.A. 2572. See also A.M.A. Council on Medical Service, "Quality of Care" (1986) 256 J.A.M.A. 1032.

21. See generally, American Society of Healthcare Risk Management (A.S.H.R.M.) Legislative Task Force, "Model Language for a Healthcare Risk Management Program" (February 1987). See also Richard Stock, "Risk Management: Minimizing Errors and Liability" (February 1986) Dimensions in Health Service at 22.

22. According to the A.S.H.R.M., this system of identification "can utilize and include", but is not limited to criteria based on outcome studies; monitoring systems based on objective criteria; incident reports; patient grievances (e.g. written complaint letters relating to quality of care issues); committee reports and minutes including quality assurance, credentialing, peer review, morbidity and mortality; legal complaints and suits; "third party" reports by hospital accreditation committees, governmental licensure agencies and professional disciplinary bodies; cases referred to the medical examiner/coroner; outside requests for medical records, x-rays or laboratory reports; security or police reports; and nursing, administrative and/or administrator-on-call reports. A.S.H.R.M., "Model Language," *supra*, note 21 at 2.

delivery, emergency department and anesthesia";[23] and the *review of remedial action* by a "facilities risk manager" charged with the task of implementing, coordinating and effectuating the risk management program.[24]

The obvious advantages of quality assurance and risk management for medical care and patient safety, professional excellence and the public image of the health care facility have encouraged most Canadian hospitals to institute such programs voluntarily.[25] As mentioned earlier, [26] however, this voluntary compliance with C.C.H.A. Guidelines has also been animated by external compulsion posed by the risk of civil liability[27] and by direct government regulation.[28] As a result, as the Ontario Hospital Association observes: "There is a legal responsibility for hospital boards to ensure that policies and procedures are in place to review the quality of patient care and the utilization of hospital resources."[29]

Legal Basis of Compellability

The Ontario *Evidence Act* stipulates that

> [a]ny writing or record made of any act, transaction, occurrence or event is admissible as evidence of such act, transaction, occurrence or event if made in the usual and ordinary course of any business and if it was in the usual and ordinary course of such business to make such writing or record at the time of such act, transaction, occurrence or event or within a reasonable time thereafter.[30]

Similar provisions can be found in the evidence acts of most other Canadian jurisdictions.[31] To the extent that a medical injury is likely to trigger an internal hospital investigation in the form of peer review or medical audit, and since such quality assurance programs are now customary at Canadian hospitals,[32]

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23. *Ibid.* at 3.
24. *Ibid.* at 1.
25. C.C.H.A. "Position on Patient Care Appraisal", *supra*, note 1 at 2.
26. *Supra*, notes 3-5 and accompanying text.
27. *Supra*, note 4.
28. *Supra*, note 5.
29. O.H.A., "Patient Care Review in Hospitals", *supra*, note 13 at 1.
30. *Evidence Act*, R.S.O. 1980, c. 145, s. 35(2).
31. See, e.g., *Evidence Ordinance*, R.O.N.W.T. 1974, c. E-4, s. 38; *Evidence Act*, R.S.P.E.I. 1974, c. E-10, s. 31.1(2) [as am. 1983, c. 13]; *The Saskatchewan Evidence Act*, R.S.S. 1978, c. S-16, s. 31(2); *Evidence Ordinance*, R.O.Y.T. 1971, c. E-6, s. 38(2).
32. *Supra*, note 25 and accompanying text.

the resulting information and evaluation would be admissible in a medical malpractice action.[33]

While these provisions constrain potential plaintiffs to evidence concerning the allegedly negligent event alone, a broader power of compellability is available through provincial court rules regarding documentary and oral examination for discovery. Ontario's *Rules of Civil Procedure*,[34] for example, require disclosure of information "relating to any matter in issue" in the legal action.[35] Of nineteenth century origin, this expression has traditionally been interpreted in very broad terms.[36] In a malpractice action against an individual physician, it could include quality assurance criteria to assess quality of care, factual accounts of adverse outcomes, incident reports, medical audit and peer review to assess the defendant's overall pattern of practice.[37] In a lawsuit alleging the hospital's liability, in addition to the factual details of the patient's injury and incident reports, it could also involve input standards for hospital equipment and personnel, utilization review, and RM for high risk areas and details of risk management efforts to minimize them.

Under Ontario's *Rules*, on the other hand, oral examination for discovery is available as a right only with respect to parties "adverse in interest."[38] Therefore, while an officer of a defendant hospital could be compelled to answer questions concerning the operation of QA and RM programs,[39] a defendant physician could oppose examination of a member of a peer review or medical audit committee on the grounds that the latter is not adverse in interest to the plaintiff. Nevertheless, since the court may grant the plaintiff leave to examine "any person

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33. See, e.g., *Hamulka* v. *Golfman* (1985), 20 D.L.R. (4th) 540 (Man. C.A.); *DeSousa* v. *Kuntz*, 28 September 1987, Vancouver Registry No. C854385 (B.C.S.C.); *Finley* v. *University Hospital Board*, [1987] 2 W.W.R. 40 (Sask. Q.B.) [hereinafter *Finley*]; *Handler* v. *Spetaro* (1988), unreported decision no. 264497/86 (Ont. Dist. Ct.) (Mandel J.). For an American decision to the same effect, see *Kaiser* v. *South Wassau Communities Hosp.*, 58 A.D. 2d 643, 396 N.Y.S. 2d 54 (1977).
34. Pursuant to the *Courts of Justice Act, 1984*, S.O. 1984, c. 11, s. 90.
35. *Rules of Civil Procedure*, O. Reg. 560/84 (Gaz. 22/9/84) [am. O. Reg. 786/84 (Gaz. 29/12/84)]. Rules 30.02(1), 31.06(1). Similar rules in Saskatchewan and Alberta refer to information "touching the matters in question" in the action. See *Czuy* v. *Mitchell* (1976), 72 D.L.R. (3d) 424 (Alta. C.A.). In the United States, Rule 26 of the Federal Rules of Civil Procedure grants a broad right of discovery of all information relevant to the subject matter of the legal action upon a showing of good cause, and provided the information sought is not otherwise privileged.
36. See, e.g., *Compagnie Financiere et Commerciale du Pacifique* v. *Peruvian Guano Co.* (1882), 11 Q.B.D. 55 (C.A.).
37. See, e.g., *Berqwitz* v. *Fast* (1980), 108 D.L.R. (3d) 732 (B.C.C.A.) [hereinafter *Berqwitz*]; *F.* v. *A Psychiatrist* (1984), 53 B.C.L.R. 216, 54 B.C.L.R. 319 (S.C.); *A.G.B.C.* v. *Messier* (1984), 8 D.L.R. (4th) 306 (B.C.S.C.).
38. *Rules of Civil Procedure*, *supra*, note 35, Rule 31.03(1).
39. *Ibid.*, Rule 31.03(2).

who there is reason to believe has information relevant to a material issue in the action,"[40] this obstacle is relatively easy to surmount.

Protection may nonetheless be available under statutory and common law rules of privilege. Thus, for example, Ontario's *Rules* provide that a defendant may resist demands for the production of documents where the stated ground for privilege is upheld by the court.[41] The leading Canadian case setting forth the criteria for the exercise of the court's discretion in this respect is *Slavutych* v. *Baker*.[42] There, citing Wigmore on Evidence,[43] Spence J. listed the four following conditions as essential to the establishment of a privilege on the disclosure of communications:

(1) The communications must originate in a *confidence* that they will not be disclosed.
(2) The element of *confidentiality must be essential* to the full and satisfactory maintenance of the relation between the parties.
(3) The *relation* must be one which in the opinion of the community ought to be sedulously fostered.
(4) The *injury* that would inure to the relation by the disclosure of the communications must be *greater than the benefit* thereby gained for the correct disposal of the litigation.[44]

Three distinct forms of privilege have been held to conform to these criteria. First, protection has traditionally been accorded to communications made by a client to a solicitor to obtain legal advice.[45] Generally accepted as essential to the candour upon which full and frank legal advice depends, the ultimate aim of this "solicitor-client privilege" is the meaningful protection of the legal rights of all — as opposed to the rights only of professional lawyers.[46]

Second, the "lawyer's brief rule" (or attorney's work product privilege) protects information generated by either party in anticipation of contemplated or

40. *Ibid.*, Rule 31.10(1).
41. *Ibid.*, Rules 30.02(2), 30.03(2)(b), 30.06.
42. (1975), 55 D.L.R. (3d) 224 (S.C.C.), [hereinafter *Slavutych*]. For a recent U.S. decision in which the court adopted the identical set of criteria, see *Ott* v. *St. Luke Hosp.*, 522 F. Supp. 706 (E.D. Ky. 1981).
43. John Henry Wigmore, *Evidence in Trials at Common Law*, Vol. 8, 3d ed. (McNaughton Revision) (1961), p. 527, para. 2285.
44. *Slavutych*, *supra*, note 42 at 228 [emphasis in original].
45. See, e.g., *R.* v. *Littlechild* (1980), 108 D.L.R. (3d) 340 (Alta. C.A.).
46. See, e.g., the *dicta* of Jessel M.R. in *Anderson* v. *Bank of British Columbia* (1876), 2 Ch. D. 644 at 649.

impending litigation.[47] The purpose of the rule is twofold: to deter "free-riders" so that appropriate incentives can be maintained for the creation of such information[48] and to guard against the distortion of this information by a party adverse in interest to the client who commissions it.[49] In a broader sense, though, the lawyer's brief rule expresses an underlying framework of property rights in information, providing that the party who takes the initiative to acquire certain information should not be required to share it with an adversary, unless compelling reasons dictate otherwise.[50]

Finally, although less well-established than solicitor-client privilege or the lawyer's brief rule, privilege is occasionally granted where the court concludes that the public interest supporting confidentiality exceeds the competing public interest in the proper administration of justice.[51] On this basis, a recent British Columbia malpractice case[52] extended the law of privilege to the defendant hospital credentials committee's investigation into the suitability of the defendant doctor to become or remain a member of the staff, concluding that "the general public interest" in patient protection against substandard practice required "uninhibited full disclosure without collateral considerations,"[53] whereas impairment to the plaintiff's case was slight given the availability of hospital charts and records, and expert medical testimony to establish the appropriate standard of care.[54] An earlier American case adopted a similar rationale, commenting on the "overwhelming public interest in having . . . staff meetings held on a confidential basis so that the flow of ideas and advice can continue," and concluding that

> [c]onfidentiality is essential to effective functioning of these staff meetings; and these staff meetings are essential to the continued improvement in the care and treatment of patients. Candid and conscientious evaluation of clinical practices

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47. See, e.g., *Rules of Civil Procedure*, *supra*, note 35, Rule 31.10(1). For a concise review of the development of the rule, see *Vernon* v. *North York Board of Education* (1975), 9 O.R. (2d) 613 (H.C.).
48. See, e.g., the *dicta* of Justice Jackson in *Hickman* v. *Taylor*, 329 U.S. 495 (1947) [hereinafter *Hickman*]. See also *Steeves* v. *Rapanos* (1982), 140 D.L.R. (2d) 121 (B.C.S.C.).
49. See, e.g., the *dicta* of Jackett P. in *Susan Hosiery Ltd.* v. *M.N.R.*, [1969] 2 Ex. C.R. 27 at 34.
50. The exception has been articulated by Justice Murphy in *Hickman*, *supra*, note 48, as follows: "Where relevant and nonprivileged facts remain hidden in an attorney's file and where production of those facts is essential to the preparation of one's case discovery may properly be had." Thus, for example, "production might be justified where the witnesses are no longer available or can be reached only with difficulty."
51. See, e.g., the *dicta* of Thurlow J. in *Blais* v. *Andras* (1972), 30 D.L.R. (3d) 287 at 292 (F.C.A.) [hereinafter *Blais*], ruling there that the test for protection had not been met.
52. *Smith* v. *Royal Columbian Hospital* (1981), 123 D.L.R. (3d) 723 (B.C.S.C.) [hereinafter *Smith*].
53. *Ibid.* at 726-27.
54. *Ibid.* at 728.

> is a *sine qua non* of adequate hospital care. To subject these discussions and deliberations to the discovery process, without a showing of exceptional necessity, would result in terminating such deliberations. Constructive professional criticism cannot occur in an atmosphere of apprehension that one doctor's suggestion will be used as a denunciation of a colleague's conduct in a malpractice suit.[55]

While courts have occasionally employed both the lawyer's brief rule and the public interest test to block disclosure of QA and RM information,[56] two developments in the law of privilege have frustrated their general application in Canadian medical malpractice cases. First, most Canadian courts have adopted the "dominant purpose" test articulated by the House of Lords,[57] which applies the lawyer's brief rule only where the dominant purpose of the creation of the information in question is the prospect of impending litigation.[58] This, notes Robertson, has eliminated the privilege once enjoyed by incident reports and hospital accident reports.[59] Since the dominant purposes of peer review and medical audit procedures are the enhancement of medical quality and management of medical risks, information so generated does not fall within the narrow rule of the attorney's work product privilege.[60]

Second, in spite of occasional judicial statements to the contrary,[61] common law courts have resisted the adoption of a general rule that would extend evidentiary privilege to documents and communication on the ground that public safety requires candour and completeness of accident reports, which might be lacking in the absence of such protection. To begin with, the judiciary does

55. *Bredice* v. *Doctors Hosp.*, 50 F.R.D. 249, 250-51 (D.D.C. 1970), *aff'd*, 479 F.2d 920 (D.C. Cir. 1973), [hereinafter *Bredice*].
56. See, e.g. *Smith*, *supra*, note 52; *Bredice*, *supra*, note 55; *Gillman* v. *United States*, 53 F.R.D. 316 (D.C.N.Y. 1971), [hereinafter *Gillman*]; *Oviatt* v. *Archbishop Bergan Mercy Hosp.*, 191 Neb. 224, 214 N.W. 2d 490 (1974), [hereinafter *Oviatt*]. See also the discussion in Gerald Robertson, "Doctrinal Developments in Canadian Health Care Liability, 1975-1988" (July 1988), Research Paper for the Federal/Provincial/Territorial Review on Liability and Compensation Issues in Health Care at 57-59.
57. *Waugh* v. *British Railways Board*, [1980] A.C. 521 (H.L.) [hereinafter *Waugh*].
58. See, e.g., *McCaig* v. *Trentowsky* (1983), 148 D.L.R. (3d) 724 (N.B.C.A.); *Voth Bros.* v. *North Vancouver Board of School Trustees* (1981), 23 C.P.C. 276 (B.C.C.A.).
59. Robertson, *supra*, note 56 at 58.
60. See, e.g., *Dufault* v. *Stevens* (1978), 86 D.L.R. (3d) 671 (B.C.C.A.); *Fiege* v. *Cornwall General Hospital* (1979), 117 D.L.R. (3d) 152 (Ont. H.C.); *Laplante* v. *Matsqui-Sumas-Abottsford General Hospital* (1980), 23 B.C.L.R. 1 (S.C.); *Beans* v. *Shaughnessy Hospital Society* (1983), 49 B.C.L.R. 181 (S.C.). Several American cases have arrived at the same conclusion on the basis of a rule granting privilege only to material prepared "solely" for litigation. See, e.g., *Moon* v. *McKay*, 64 A.D. 2d 1022, 409 N.Y.S. 2d 305 (1978); *Soifer* v. *Mt. Sinai Hosp.*, 63 A.D. 2d 713, 405 N.Y.S. 2d 116 (1978); *Kay Laboratories, Inc.* v. *District Court*, 653 P. 2d 721 (Colo. 1982).
61. See, e.g., *Smith*, *supra*, note 52; *Bredice*, *supra*, note 55; *Gillman*, *supra*, note 56; *Oviatt*, *supra*, note 56.

not appear to view the public interest in such confidentiality as particularly compelling. In *Conway* v. *Rimmer*,[62] for example, Lord Reid dismissed suggestions that "public safety has been endangered by the candour or completeness of such reports having been inhibited by the fact that they may have to be produced if the interests of due administration of justice should ever require production at any time."[63] Similarly, in *Berqwitz*,[64] Craig J.A. ordered the College of Dental surgeons to produce a report investigating the plaintiff's complaint against the defendant, noting that the College was obliged under statute to review the latter's conduct, and concluding that most participants in the peer review process would accept that responsibility regardless of the report's confidentiality.[65] In fact, some commentators reject assertions that disclosure hinders peer review on the ground that this argument "shows little faith or confidence in organized medicine."[66]

More generally, the courts are reluctant to expand the categories of privilege beyond "very special relationships," such as that of solicitor and client,[67] since it is broadly accepted that "[j]ustice is better served by candour than by suppression."[68] As the United States Supreme court remarked in the celebrated case of *United States* v. *Nixon*:

> Whatever their origins, these exceptions to the demand for every man's evidence are not lightly created nor expansively construed for they are in derogation of the search for the truth.[69]

Consequently, even where disclosure involves a recognized a risk of harm to public safety, the courts have generally refused to extend privilege to QA and RM information.[70] Thus, for example, while one American case acknowledged that confidentiality would encourage open communication in the process of peer review, it denied privilege on the basis that "on reflection, one might well debate

62. [1968] A.C. 910 (H.L.).
63. *Ibid.* at 941. The House of Lords has reiterated this position more recently in *Waugh*, *supra*, note 57.
64. *Supra*, note 37.
65. *Ibid.* at 737-38.
66. Holbrook and Dunn, *supra*, note 3 at 76. See also Goldberg, *supra*, note 3 at 154-55.
67. *F.* v. *A Psychiatrist*, *supra*, note 37 at 32, *per* McEachern C.J.S.C.
68. *Waugh*, *supra*, note 57, *per* Lord Edmund-Davies.
69. 418 U.S. 683, 710 (1974).
70. See the cases cited at *supra*, note 37. See also *Kenney* v. *Superior Court*, 255 Cal. App. 2d 106, 63 Cal Rptr. 84 (1967); *Gureghian* v. *Hackensack Hospital*, 109 N.J. Super. 143, 262 A. 2d 440 (1970); *Davison* v. *St. Paul Fire and Marine Insurance Co.*, 75 Wis. 2d 190, 248 N.W. 2d 433 (1977).

wherein the public interest lies."[71] In the final analysis, therefore, most courts concur with the following opinion of the Saskatchewan Court of Queen's Bench:

> [I]n 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 weighs in favour of the latter.[72]

Rationalizing Evidentiary Privilege for QA and RM

The growing demand for legislative action to accord to quality assurance and risk management programs the evidentiary privilege that the courts have denied challenges the more sanguine conclusions of courts and commentators. In contrast, representatives of the medical and legal professions concur in their concern that the delivery of high quality health care is inhibited by the absence of such protection.[73] The possibility that proceedings or communications will be disclosed in civil litigation, it is said, makes medical personnel reluctant to serve on RM and QA committees,[74] to engage in the free and open exchange of information and candid evaluation required to identify individuals or areas of practice that are cause for concern,[75] or to institute remedial programs to improve the quality of health care for all patients.[76]

While there is no empirical data to verify these claims or to evaluate the extent to which this reluctance may have adversely affected the quality of health care exists,[77] it is difficult to dismiss such persistent and widespread concern as completely unfounded. In addition, the inference that a lack of confidentiality has impeded quality assurance and risk management is plausible for three reasons. First, the possible disclosure of a critical evaluation of a fellow professional will likely exacerbate the typical discomfort already accompanying peer review. Second, the risk of disclosure may arouse anxiety among committee participants with respect to their own liability for defamation. Finally, reluctance to participate in a process that might be employed in malpractice actions against

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71. *Nazareth Literary and Benevolent Inst.* v. *Stephenson*, 503 S.W. 2d 177, 179 (Ky. 1973), [hereinafter *Nazareth*].
72. *Finley, supra*, note 33 at 51.
73. See the sources cited at *supra*, notes 6, 13 and 14.
74. National Health Law Committee, "Report to the Annual Meeting of the Canadian Bar Association" (1985) at 3; C.C.H.A., "Position on Patient Care Appraisal," *supra*, note 1 at 2; O.H.A., "Patient Care Review in Hospitals" *supra*, note 13 at 1.
75. National Health Law Committee, *ibid.*; O.H.A., *ibid.*,; Saskatchewan Working Group, "Memorandum", *supra*, note 13 at 6. See also *Smith, supra*, note 52; *Bredice, supra*, note 55.
76. See, e.g., Carol Clemenhagen, "Quality Assurance in Canada — Barriers and Criticisms" (Nov. 1987) *Quality Assurance Quarterly*, cited in C.N.A. Brief, *supra*, note 14 at 28.
77. The conceptual and practical problems in designing and undertaking such a study make it an unlikely prospect.

other medical personnel is consistent with a well-documented physician hostility toward and distrust of the malpractice system generally.[78] This last, in turn, reflects a widespread perception among physicians either that courts persistently misinterpret medical evidence,[79] that judicial determinations of liability are inaccurate and arbitrary,[80] or that the system as a whole unfairly stigmatizes individual physicians for essentially unavoidable accidents that in no respect suggest an overall pattern of poor practice.[81] In this respect, unwillingness to actively participate in the QA and RM process is yet another manifestation of the problem of "defensive medicine" that is widely reported to plague the contemporary medical liability system.[82]

Although one might arguably challenge the factual basis of physician perceptions concerning the risk of liability for defamation or the actual extent to which a malpractice verdict is an arbitrary outcome signifying little or nothing of the overall pattern of the defendant's practice,[83] it is impossible to dismiss these perceptions themselves or their consequences for the effective implementation of risk management and quality assurance. Nor can one ignore the real differences between the standards and sanctions applied by professional self-

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78. See, e.g., Sara Charles, Jeffrey Wilbert and Eugene Kennedy, "Physicians' Self-Reports of Reactions to Malpractice Litigation" (1984) 141 Am. J. Psychiatry 563; Sara Charles, Jeffrey Wilbert and Kevin Franke, "Sued and Nonsued Physicians' Self-Reported Reactions to Malpractice Litigation" (1985) 142 Am. J. Psychiatry 437; Sara Charles, Charlene E. Pyskoty, and Amy Nelson, "Physicians on Trial — Self-Reported Reactions to Malpractice Trials" (1988) West J. Med. 358. See also Peter Bell, "Legislative Intrusions into the Common Law of Medical Malpractice: Thoughts About the Deterrent Effect of Tort Liability" (1984) 35 Syracuse L. Rev. 939.
79. The "most significant" concern identified by the Canadian Council on Hospital Accreditation is that "the work and recommendations of patient care appraisal committees might be used unfairly, inappropriately and out of context in a malpractice action against a physician or hospital." C.C.H.A., "Position on Patient Care Appraisal", *supra*, note 1 at 2.
80. See, e.g., American Medical Society/Specialty Society Medical Liability Project, *A Proposed Alternative to the Civil Justice System for Resolving Medical Liability Disputes: A Fault-Based, Administrative System* (January 1988) at 7-11.
81. See, e.g., Paul Weiler, *Legal Policy for Medical Injuries* (1988), unpublished, at 1-2, 15-17.
82. See, e.g., M.L. Garg, W.A. Gliebe and M.B. Elkhatib, "The Extent of Defensive Medicine: Some Empirical Evidence" (1978) 6 Leg. Aspects of Med. Practice 25; Stephen Zuckerman, "Medical Malpractice: Claims, Legal Costs, and the Practice of Defensive Medicine" (1984) 3 Health Affairs 128; Roger Reynolds, John Rizzo and Martin Gonzalez, "The Cost of Medical Professional Liability" (1987) 257 J.A.M.A. 2776. For more skeptical views of this phenomenon, see Duke Law Journal Project, "The Medical Malpractice Threat: A Study of Defensive Medicine" (1971) Duke L.J. 939; Nathan Hershey, "The Defensive Practice of Medicine: Myth or Reality?" (1972) 50 Milbank Mem. Fund Q. 69.
83. See, e.g., Patricia Danzon, *Medical Malpractice: Theory, Evidence, and Public Policy* (Cambridge, MA: Harvard University Press, 1985) at 39-40. See also John Rolph, "Some Statistical Evidence on Merit Rating in Medical Malpractice Insurance" (1981) 48 J. Risk & Ins. 247; Blaine F. Nye and Alfred E. Hofflander, "Experience Rating in Medical Professional Liability Insurance" (1988) 55 J. Risk & Ins. 150 (arguing that claims experience is sufficiently determinate to permit merit rating of individual physicians' malpractice liability premiums).

regulation and those applicable in a malpractice action — differences that make the physicians justifiably more apprehensive of the latter. Specifically, while quality assurance is conducted by specialized physicians themselves, looks to overall practice patterns and emphasizes education and modification of unacceptable practice patterns rather than sanctions, malpractice actions are directed by an inexpert judiciary, concentrate on a single episode of inferior practice and entail the profoundly public stigma of professional "negligence."[84] Consequently, a clear public interest in the delivery of high quality health care appears to support some form of protection for communications and proceedings of quality assurance and risk management committees.

Public Interests and Private Rights

Public interest in patient safety and quality of care is only one factor to be considered in assessing the case for statutory protection of quality assurance and risk management. According to the courts in *Blais*[85] and *Slavutych*,[86] for example, privilege is justified only where the benefits of confidentiality outweigh the opposing benefit of disclosure to further the proper administration of justice.

Although often characterized as a "public interest,"[87] the litigant's search for information to prove his or her case against an adversary is more appropriately conceptualized as the *individual* interest of the litigant. So conceived, rules of discovery and privilege may be translated into the more determinate language of rights.[88] Thus, the general rule that discovery of an adverse party may be claimed for information "relating to any matter in issue" in the action[89] expresses the right of each litigant to bring to the attention of the court all facts that are pertinent to the outcome of the lawsuit — a right that is limited only where

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84. Thus, as an official of the Canadian Medical Protective Association explains: "negligence, carelessness . . . which courts deal with is not at all the same thing as incompetence or professional misconduct. Negligence may, in a few instances, arise from incompetence. But, most often the doctors who are found negligent in connection with one of their cases are not incompetent." Remarks of Dr. Stuart Lee, cited in Brian Goldman, "Quality assurance will play key role in reducing malpractice suits: CMPA" (1987) 137 C.M.A.J. 447 at 448. See also Council on Medical Service, "Guidelines for Quality Assurance", *supra*, note 20.
85. *Supra*, note 51.
86. *Supra*, note 42.
87. See, e.g., *Blais*, *supra*, note 51; *Nazareth*, *supra*, note 71; Southwick and Slee, *supra*, note 9 at 379.
88. This, of course, assumes that rights discourse can be determinate — a claim that is rejected by the Critical Legal Studies movement. See, e.g., A.C. Hutchinson and P.J. Monahan, "Law, Politics and the Critical Legal Scholars: The Unfolding Drama of American Legal Thought," (1984) 36 Stan. L.R. 199. For a convincing defence of determinacy and an articulation of the sense in which the term is employed here, see Ernest Weinrib, "Legal Formalism" (1988) 97 Yale L.J. 949 at 1008-12.
89. See *supra*, note 35 and accompanying text.

it amounts to harassment of the opponent[90] or draws third parties into the dispute (except when "there is reason to believe" that the third party "has information relevant to a material issue in the action").[91] Conceptually prior to the recognition of any form of privilege, this right can be interpreted broadly as a right of access to justice.

Solicitor-client privilege does not challenge this basic right, but imparts to it a notion of equality by ensuring that those without a professional knowledge of the law will nevertheless retain the right of access to justice.[92] Similarly, while the lawyer's brief rule abandons equality in favour of an alternative notion of property rights recognizing the private efforts of each litigant in the production of information,[93] it nevertheless acknowledges the superiority of each litigant's right of access to justice by admitting an exception to the general rule where production "is essential to the preparation of one's case."[94]

The third branch of the law of privilege, on the other hand, imperils each litigant's basic right of access to justice by ignoring this rights framework altogether. Prohibiting discovery whenever the societal benefits of confidentiality exceed the foregone advantages of a correct disposal of the litigation,[95] the manifestly utilitarian form of this rule contradicts the principles of individual rights upon which the private law is based.[96] By threatening to place a plaintiff's ability to prove a defendant's liability completely beyond reach, this rule may, by procedural fiat, abrogate the substantive rights that the legal system initially purports to recognize.[97] As a result, it is hardly surprising that this branch of the law of privilege remains poorly established[98] and that few courts have found the public interest in patient safety and quality of care to exceed the plaintiff's

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90. See, e.g., *Peter Kiewit Sons* v. *British Columbia Hydro and Power Authority* (1982), 134 D.L.R. (3d) 154 (B.C.S.C.).
91. *Supra*, note 40 and accompanying text.
92. See *supra*, note 46 and accompanying text.
93. See *supra*, note 50 and accompanying text.
94. *Hickman*, *supra*, note 48. See also *supra*, note 50.
95. See *Slavutych*, *supra*, note 44; *Blais*, *supra*, note 51.
96. See, e.g., Weinrib, *supra*, note 88. For an attempt to elaborate these principles in the context of medical liability, see David G. Duff, "The Private Law of Medical Malpractice" (1988) [unpublished].
97. As Goldberg remarks: "It makes little sense to create a cause of action and then, by creating a privilege, destroy the means of establishing it." Goldberg, *supra*, note 3 at 159. See also Southwick and Slee, *supra*, note 9 at 378.
98. *Supra*, notes 62-72 and accompanying text.

interest in the correct disposal of the malpractice action.[99] Courts and legislatures would do well to eschew any acknowledgement of the rule altogether.[100]

Designing a Statutory Rule

The analysis of the previous two sections supports some form of evidentiary privilege for the RM and QA process,[101] but concludes that any legislative reform should observe a framework of individual rights which confers primary status upon the basic right of each litigant to access to justice.[102] This section explores the implications of this conclusion for the design of a specific statutory rule.

PRESERVING ACCESS TO JUSTICE

Effective quality assurance and risk management demand the creation of several types of information of potential interest to the plaintiff in a malpractice action. These include input standards for hospital equipment and personnel, QA criteria to assess quality of care, factual accounts of the adverse outcome, incident or occurrence reports in the form of a medical audit or utilization review investigating and commenting upon the causes of the injury, evaluations of the overall practice patterns of defendant physicians, RM information on high-risk practice areas and details of risk management efforts to minimize these risks. While no plaintiff should require discovery of *all* this material to establish an allegation of medical malpractice, *some* plaintiffs may be unable to prove such a claim without access to *some* QA and RM information.

Specifically, in a malpractice claim against an individual physician, the plaintiff must have access to factual information on the status of his or her physical condition (both pre- and post-injury) and on the procedures employed in

99. See, e.g., the cases cited at *supra*, notes 33, 37, 70 and 71. On the other hand, see the cases cited at *supra*, note 61.
100. This is not to suggest that utilitarian considerations are irrelevant to the formulation of public policy with respect to patient safety and quality of care, nor that the private law should be regarded as the only means of compensating the victims of medical malpractice. On the contrary, I have argued elsewhere that the existing malpractice system functions poorly from the perspectives of both compensation and deterrence, and that these policy goals would be better achieved through the development of alternative legal instruments. See David G. Duff, "Compensation for Medical Injuries: A Legal and Economic Analysis" (January 1989) Research Paper for the Federal/Provincial/Territorial Review on Liability and Compensation Issues in Health Care. See also Weiler, *supra*, note 81 at 113-68, 221-86. Nevertheless, a rule of privilege that disregards private rights to further the public interest in hospital quality assurance and risk management contradicts the norms of the private law of which it is a part and fails to offer a reasonable *quid pro quo* (such as no-fault compensation) to those whose ability to demonstrate malpractice is precluded by confidentiality.
101. *Supra*, notes 73-84 and accompanying text.
102. *Supra*, notes 85-100 and accompanying text.

diagnosis and treatment. Where the fault of a defendant hospital is at issue, the plaintiff's case may depend on factual details concerning the utilization of hospital resources, evidence of the defendant's failure to ensure compliance with established standards for equipment and personnel or proof of an inadequate institutional response to knowledge of risks made available through the risk management process.[103] While the former information on the sequence of diagnosis and treatment is typically available in the patient's medical record[104] access to which the patient is clearly entitled,[105] and which is therefore specifically excluded from protection in most recommendations[106] and in all Canadian jurisdictions recognizing a statutory rule of privilege[107] — documentation of the latter is impossible without some access to material associated with quality assurance and risk management activities.[108] The basic right of access to justice thus argues for a significant range of discoverability.

On the other hand, although undoubtedly of considerable utility to a malpractice plaintiff, other categories of QA and RM information are not necessary to the preparation of his or her case. In particular, this is true of detailed criteria for the process of QA assessment, incident reports determining the cause of iatrogenic injury and peer review evaluating a defendant physician's overall practice pattern. While quality assurance criteria might serve as a convenient reference for evidence of customary practice, absent a "conspiracy of silence" among medical practitioners, this information can be obtained from the testimony of expert witnesses called on the plaintiff's behalf.[109] Consequently, discovery represents a form of "free-riding" by plaintiffs and their attorneys. Similarly,

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103. For an explanation of the various grounds of hospital liability, see the sources cited at *supra*, note 4. See also the discussion of the impact of evidentiary privilege on hospital liability in Goldberg, *supra*, note 3 at 161-66.

104. In fact, Ontario regulations mandate the compilation of this information in the patient's medical record. R.R.O. 1980, Reg. 865, s. 38(1).

105. See, e.g., Harold L. Hirsh, "Medical Records: Medicolegal Balm or Bomb?" (1987) 6 Med Law 525 at 526-28; Maureen Fiorini, Gary Trotter and Anthony Galea, "Production of clinical notes in personal injury litigation in Ontario" (1988) 138 C.M.A.J. 513.

106. The C.B.A. resolution stipulates that "no document forming part of an individual's hospital medical record is intended nor can be sheltered under this exemption." C.B.A. Resolution, *supra*, note 10. See also O.H.A., "Patient Care Review in Hospitals", *supra*, note 13 at 2.

107. See *Evidence Act*, R.S.M. 1970, c. E-150, s. 11(4); *Evidence Act*, R.S.A. 1980, c. A-21, s. 9(4); *Evidence Act*, R.S.B.C. 1979, c. 116, s. 57(3); *Evidence Act*, R.S.N.S. 1967, c. 94, s. 56A(3) [as am. 1987]. See also Bill 23, *An Act to Amend the Evidence Act*, New Brunswick, 36 Eliz. II, 1987, s. 43.3(3)(b).

108. Goldberg, *supra*, note 3 at 167; Southwick and Slee, *supra*, note 9 at 378.

109. Southwick and Slee, *supra*, note 9 at 380. While the possibility of an effective conspiracy of silence was considerable when medical malpractice was evaluated according to the standards of customary practice in the locality of the defendant (liability could not be established unless an expert witness from the same community testified against the defendant), judicial abandonment of this "locality rule" makes such a result far less likely. Indeed, despite occasional references to such a "conspiracy", there is little evidence that the problem remains. For a brief review of the rise and fall of the locality rule, see Duff, *supra*, note 4 at 22-26.

as the Saskatchewan Working Group observes, as long as patients are entitled to their medical records — and provided these are legislatively required to contain factual documentation of all adverse incidents[110] — production of occurrence reports allows the plaintiff to "'freeload' upon the work of a quality assurance committee."[111] Finally, although the conclusions of a peer review committee might be used to damage a defendant physician's credibility and to suggest a consistent pattern of poor medical practice, these matters are peripheral to the central issue of whether the defendant was at fault in the particular actions that are the subject of the lawsuit.[112] In this respect, moreover, their admissibility threatens to divert the court's attention from its proper task, thereby substantiating physician apprehension of misinterpretation and judicial arbitrariness.[113]

Despite the absence of a basic evidentiary right of plaintiffs to QA criteria, occurrence reports and peer review, the very principle of a basic right of access to justice argues for strict limits on the scope of evidentiary privilege for the quality assurance and risk management process. Consequently, any statutory reform should recognize only clearly defined exceptions to a general rule of disclosure, instead of a general scheme of protection qualified by narrow instances of discoverability.[114] In this respect, contemporary Canadian legislation appears to be inexcusably overbroad. In each province where a statutory rule of privilege is in force or before the legislature, protection is extended to broadly defined "committees . . . for the purpose of studying or evaluating medical practice in a hospital,"[115] while narrow exceptions are provided for medical records alone.[116] As a result, evidence that is essential to a malpractice claim against

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110. See, e.g., College of Physicians & Surgeons of Saskatchewan, "Response to the Discussion Paper Prepared by the Working Group Respecting Quality Assurance Processes and the Saskatchewan Evidence Act" (1985) at 4.
111. Saskatchewan Working Group, "Memorandum", *supra*, note 13 at 3. As Craig J.A. observed in *Berqwitz*, *supra*, note 37 at 737-38, this evidence would be useful to plaintiffs both in proving fault and in assessing their prospects for success prior to the initiation of litigation.
112. See, e.g., *Smith*, *supra*, note 52 at 728.
113. See *supra*, notes 79-80, and accompanying text.
114. In addition to the fairness of such a rule in preserving plaintiffs' basic rights of access to justice, this approach affords greater certainty of confidentiality for information falling within the protected categories than does a general rule of privilege allowing discovery on a case-by-case basis where the information is "*essential to prove the plaintiff's case* (*or defendant's defense*) or to prove a necessary element of the plaintiff's case or the defendant's defense." Southwick and Slee, *supra*, note 9 at 379-380 [emphasis in original]. By withholding an absolute guarantee of confidentiality for any category of QA or RM information, the latter approach may do little to assuage the current reluctance of medical personnel to actively participate in quality assurance and risk management programs.
115. See *Evidence Act*, R.S.M. 1970, c. E-150, s. 11(2); *Evidence Act*, R.S.A. 1980, c. A-21, s. 9(2); *Evidence Act*, R.S.N.S. 1967, c. 94, s. 56A(2) [as am. 1987]. Similar language appears in *Evidence Act*, R.S.B.C. 1979, c. 116, s. 57(1); Bill 23, *An Act to Amend the Evidence Act*, New Brunswick, 36 Eliz. II, 1987, s. 43.3(2).
116. *Supra*, note 107.

a hospital may remain privileged by the operation of the statute. A distinct class of plaintiff, therefore, is effectively stripped of its substantive legal rights.[117]

PUBLIC INFORMATION AND THE LAW OF PRIVILEGE

While an earlier section identified a public interest in evidentiary privilege for the quality assurance and risk management process,[118] and the previous subsection found no basic plaintiff right to QA criteria, occurrence reports and peer review,[119] active protection of this information has yet to be justified in terms of the rights framework delineated above.[120] In fact, an alternative argument favouring disclosure asserts that since the hospital is a *public* institution, and since quality assurance and risk management are *public* duties, malpractice plaintiffs should have an unrestricted right of discovery over the resulting *public* information.[121]

Initially, this conclusion seems compelling. The contrast between the public purpose of quality assurance and risk management programs and the private objectives of litigation makes any facile analogy to the lawyer's brief rule inappropriate. Nevertheless, a more developed notion of rights to information may support a rule of confidentiality where basic rights of access to justice remain undisturbed.

The definition of QA and RM as "public" duties obscures as much as it illuminates. In evaluating the claim for privilege, the essential question concerns the *purpose* of the public duty. Clearly, this is not primarily to furnish plaintiffs with expert testimony with which they may readily demonstrate the defendant's fault, impeach the credibility of opposing arguments or assess the prospects of contemplated litigation. On the contrary, the primary objectives of quality assurance and risk management are to improve the quality of medical care and to enhance patient safety. Where confidentiality can be demonstrated to serve these goals without violating basic rights of access to justice, therefore, the public interest may legitimately sustain a statutory rule of privilege.

The implications of this conclusion for statutory design are threefold. First, the legislation should stipulate that it applies only to communications of and proceedings before committees charged with the task of risk management or

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117. This result has obvious constitutional implications with respect to the equality provisions of the Charter. I leave to constitutional lawyers the task of marshalling these arguments in conformity with the applicable legal doctrine. For a brief survey of American cases challenging legislated privilege as violating principles of equal protection and due process, see Southwick and Slee, *supra*, note 9 at 359-60.
118. *Supra*, notes 73-84 and accompanying text.
119. *Supra*, notes 109-13 and accompanying text.
120. *Supra*, notes 88-100 and accompanying text.
121. See, e.g., Craig J.A.'s decision in *Berqwitz*, *supra*, notes 64-65 and accompanying text.

quality assurance.[122] Such committee participants should not be accorded a general protection against appearing as witnesses and answering questions based on their professional opinions or concerning their knowledge of facts at issue in a legal proceeding.

Second, statutory protection should not extend to proceedings before a professional disciplinary body, hospital credentials committee or hospital accreditation authority.[123] While strict confidentiality here might be expected to encourage physician participation on QA and RM committees, as well as candour and self-criticism in their analyses,[124] an extensive rule of this sort would undermine its initial purpose which is to enhance patient safeguards and quality of care.[125] The ultimate sanction of professional discipline or the loss of hospital privileges is an essential part of the process of quality assurance and cannot be excised without causing injury to the entire project.[126] In any event, since resistance to the effective implementation of quality assurance and risk management programs appears to originate primarily in physician anxiety about its implications for the medical malpractice environment,[127] the marginal impact of such sweeping protection is probably slight.

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122. See, e.g., *Evidence Act*, R.S.M. 1970, c. E-150, s. 11(5); *Evidence Act*, R.S.A. 1980, c. A-21, s. 9(5); *Evidence Act*, R.S.B.C. 1979, c. 116, s. 57(2); *Evidence Act*, R.S.N.S. 1967, c. 94, s. 56A(4) [as am. 1987]. See also Bill 23, *An Act to Amend the Evidence Act*, New Brunswick, 36 Eliz. II, 1987, s. 43.3(5).
123. See, e.g., Saskatchewan Working Group, "Memorandum", *supra*, note 13 at 5; *Evidence Act*, R.S.B.C. 1979, c. 116, s. 57(1), which expressly rules out evidentiary privilege in "a proceeding before a board or body connected with an organization of health care professionals, by way of a hearing or appeal respecting the conduct or competence of a member of the profession represented by the organization of health care professionals." Of those Canadian jurisdictions which have adopted a statutory rule of privilege, British Columbia is alone in restricting its application before professional disciplinary bodies. See, e.g., *Evidence Act*, R.S.M. 1970, c. E-150, s. 11(6)(a); *Evidence Act*, R.S.A. 1980, c. A-21, s. 9(1); *Evidence Act*, R.S.N.S. 1967, c. 94, s. 56A(1)(a) [as am. 1987].
124. See, e.g., Saskatchewan Medical Association, "Brief to The Federal/Provincial/Territorial Review of Liability and Compensation Issue in Health Care" (June 1988) at 2.
125. It must be remembered that candour alone is not the objective of peer review, but instead serves as a means to the ultimate end of quality assurance.
126. See, e.g., Southwick and Slee, *supra*, note 9 at 348, commenting that "disclosure of quality assurance records and reports to in-house personnel is a necessary part of the quality assurance function." The same may be said of the process of professional self-discipline. Indeed, Ontario's *Public Hospitals Act*, R.S.O. 1980. c. 410, s. 30, imposes affirmative obligations on hospital administrators to "prepare and forward a detailed report to the College of Physicians and Surgeons" where "(a) the application of a physician for appointment or reappointment to a medical staff of a hospital is rejected by reason of his incompetence, negligence or misconduct; (b) the privileges of a member of the medical staff of a hospital are restricted or cancelled by reason of incompetence, negligence or misconduct; or (c) a physician voluntarily or involuntarily resigns from a medical staff of a hospital during the course of an investigation into his competence, negligence or conduct."
127. See *supra*, notes 78-82.

Finally, protection need apply only to QA criteria, incident reports and peer review as opposed to the entire quality assurance and risk management process.[128] Advocates of legislative reform typically emphasize the reluctant participation of individual physicians on RM and QA committees and the widespread concern among physicians that review procedures not be employed to impugn individual colleagues in malpractice actions. But, as the Saskatchewan Union of Nurses points out, quality assurance programs "are not limited to 'peer' reviews of individual performance."[129] Rather,

> Audits and problem identification studies, if performed professionally, follow defined guidelines and are general in nature such that they point more to 'systems' problems, as opposed to individual performance problems.[130]

While information on such systemic performance problems could be central to a malpractice claim directed at an allegedly negligent hospital, it is largely irrelevant to a lawsuit against an individual physician. Since it is unlikely to contain critical evaluations of individual colleagues or to contribute to their stigmatization in medical malpractice actions, the possibility of its subsequent disclosure is unlikely to dissuade individual physicians from active participation on the RM and QA committees. On the other hand, given the implications of disclosure for the *organizational* liability of health care providers, it is possible that such a prospect might dissuade hospital boards from instituting strong quality assurance and risk management programs. Nevertheless, since this reaction is both easier to identify and less destructive than the diffuse opposition of individual medical personnel, compliance can probably be induced through the combined effect of public regulation and the threat of civil liability itself.[131]

COLLATERAL ISSUES

Two final issues merit some brief discussion. First, two factors support a provision restricting any privilege to malpractice actions alone:[132] 1) identification of

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128. This argument merely presents further justification for the conclusion arrived at in the previous section on the basis of the more fundamental right of access to justice. See *supra*, notes 103-17 and accompanying text.
129. Saskatchewan Nurses Association, "Brief in Response to the Working Group Respecting the Quality Assurance Process and the Saskatchewan Evidence Act" (9 February 1988) at 2.
130. *Ibid.* at 6. In a similar vein, Southwick and Slee distinguish between the "procedural" and the "substantive" aspects of quality assurance programs, noting that information of the former variety must be disclosed to maintain accreditation status, to resolve litigation alleging institutional liability, antitrust activities or wrongful denial of hospital privileges, and to demonstrate compliance with government regulations. Southwick and Slee, *supra*, note 9 at 347.
131. See sources cited at *supra*, note 4.
132. See, e.g., Saskatchewan Working Group, "Memorandum", *supra*, note 13 at 5.

medical malpractice as the source of most physician anxiety responsible for impeding QA and RM,[133] and 2) recognition of additional rights of access to information to permit either informed public debate about questions of cost and quality in the delivery of health care,[134] a physician to appeal a denial of hospital privileges[135] or a union member to grieve a disciplinary action in a labour arbitration proceeding.[136] While most American states provide for an exception to the general rule of privilege by allowing physicians access to peer review records to challenge staff denials,[137] little regard is devoted to the equally compelling interests of the general public and non-medical personnel in access to privileged information.

Second, participants in the quality assurance and risk management process — whether witnesses or committee members — should be granted statutory immunity against libel or slander actions initiated by those who are criticized through the process of peer review.[138] Nevertheless, this immunity should be restricted to those acting in good faith,[139] with the obligation on the complainant to demonstrate the absence of such good faith.[140]

Conclusions

Patient safety and high quality medical care are important policy objectives that deserve legal encouragement. In the current context, this entails some measure of statutory protection for information generated in the course of hospital quality assurance and risk management programs.[141] Nevertheless, a balanced approach requires that this objective not overwhelm the competing rights of injured patients, hospital personnel (medical and non-medical) and the general

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133. *Supra*, notes 78-82 and accompanying text.
134. Saskatchewan Nurses Association, *supra*, note 129 at 5.
135. Goldberg, *supra*, note 3 at 155.
136. *Ibid.* at 7.
137. See, e.g., Alaska Stat., s. 18.23.030 (1981); Ariz. Rev. Stat. Ann., s. 36-445.01A (Supp. 1983); Cal. Evid. Code, s. 1157 (West Supp. 1984); Colo. Rev. Stat., s. 12-43.5-102(3)(e) (1978); Hawaii Rev. Stat., s. 624-25.5 (Supp. 1983); Indiana Code Ann., s. 34-4-12.6-2(b) (Supp. 1983); Ky. Rev. Stat. Ann., 311.377(6) (1983); Or. Rev. Stat., s. 41.675(5) (1984); Wash. Rev. Code Ann., s. 4.24.250 (West Supp. 1983).
138. See, e.g., *Evidence Act*, R.S.A. 1980, c. A-21, s. 9(6); *Evidence Act*, R.S.M. 1970, c. E-150, s. 12; *Public Hospitals Act*, R.S.O. 1980, c. 410, s. 10: "No member of a committee of a hospital or of the board or Appeal Board of the staff thereof and no witness in a proceeding or investigation before such committee or board is liable for anything done or said in good faith in the course of a meeting, proceeding, investigation or other business of the committee or board."
139. Neither Alberta nor Manitoba have adopted such a provision. *Ibid.*
140. See, e.g., *Evidence Act*, R.S.B.C. 1979, c. 116, s. 57(4) [as am. 1986]; *Evidence Act*, R.S.N.S. 1967, c. 94, s. 56B [as am. 1987, c. 20]; *The Medical Profession Act, 1981*, S.S. 1980-81, c. M-10.1, s. 60(1).
141. *Supra*, notes 73-84 and accompanying text.

public to broad categories of QA and RM information.[142] As a result, several conclusions for the design of a statutory rule of privilege for the quality assurance and risk management process necessarily follow.

First, privilege should be acknowledged only in the limited areas of QA criteria, occurrence reports and peer review.[143] Otherwise, legislation should provide for a general rule of discoverability. Second, patients should retain the right to their medical records, which should be required to contain a factual account of any adverse incident.[144] Similarly, plaintiffs and the public should retain a right of access to general systemic or procedural information so that institutional measures to improve quality and enhance patient safety can be externally evaluated.[145] Third, evidentiary privilege should be recognized only in the context of malpractice actions.[146] In particular, no protection should apply before professional disciplinary bodies, hospital credentials committees or hospital accreditation authorities.[147] Finally, participants in the QA and RM process should be accorded full immunity from libel or slander liability, provided that they have acted in good faith, with the onus of proving bad faith resting upon the party alleging defamation.[148]

While legislation along these lines might still fail to secure enthusiastic participation in quality assurance and risk management programs, it is likely to have some positive effect since it specifies the most sensitive categories of information as privileged. Regardless, such a rule provides the greatest sphere of confidentiality that is consistent with the competing rights of patients who are the unfortunate victims of malpractice that quality assurance and risk management fail to prevent. In this respect, any continued professional reluctance to take part in QA and RM programs would be attributable not to a lack of further evidentiary privilege, but to the inherent limitations of professional self-

142. *Supra*, notes 85-100, 132-37 and accompanying text.
143. *Supra*, notes 109-13, 128-31 and accompanying text.
144. *Supra*, notes 104-07 and accompanying text.
145. *Supra*, note 133 and accompanying text. Although lacking in existing Canadian legislation, such a provision could be patterned on a section in the British Columbia statute permitting disclosure of information to advance medical research or medical education "in a manner that the disclosure or publication precludes the identification in any manner of the persons whose condition or treatment has been studied, evaluated or investigated." *Evidence Act*, R.S.B.C. 1979, c. 116, s. 57(5)(c) [as am. 1986].
146. *Supra*, notes 123-27, 132-36 and accompanying text.
147. *Supra*, notes 123-27 and accompanying text.
148. *Supra*, notes 138-40 and accompanying text.

regulation,[149] or to the civil liability regime itself and the defensive medical practices that it engenders.[150] The resolution of these problems, of course, involves much more than the law of evidence.

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149. See, e.g., Michael J. Trebilcock, "Regulating Service Quality in Professional Markets" in Donald N. Dewees, ed., *The Regulation of Quality* (1983) 84; Robert C. Derbeyshire, "How Effective is Medical Self-Regulation?" (1983) 7 Law & Hum. Behav. 193; Andrew K. Dolan, and Nicole D. Urban, "The Determinants of the Effectiveness of Medical Disciplinary Boards: 1960-1977" (1983) 7 Law & Hum. Behav. 203; Gary L. Gaumer, "Regulating Health Professionals: A Review of the Empirical Literature" (1984) 62 Mil. Mem. Fund Q. 380.
150. *Supra*, notes 78-82 and accompanying text.