Order F06-15

PROVINCIAL HEALTH SERVICES AUTHORITY

Celia Francis, Adjudicator
July 14, 2006

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Summary: Applicant requested access under the Act to a tape recording and a transcript of a meeting of a hospital committee that he had attended as a committee member. Section 51(5) of the *Evidence Act* prohibited disclosure. Because of s. 51(7) of the *Evidence Act* and s. 79 of the Act, the prohibition on disclosure applied despite the applicant's right of access to records under the Act. The correctness or propriety of the disclosure and use in the other proceedings was not in the circumstances a matter for this inquiry under the Act.

Key Words: privilege—prohibition—proceeding—quality of care.

Statutes Considered: *Freedom of Information and Protection of Privacy Act*, s. 79; *Evidence Act*, s. 51.

Authorities Considered: B.C.: Order 04-25, [2004] B.C.I.P.C.D. No. 25.

Cases Considered: *Lew (Guardian ad Litem) v. Mount Saint Joseph Hospital Society*, [1995] B.C.J. No. 2755 (S.C.); *Cole v. St. Paul's Hospital* (August 21, 1998), Vancouver C963888 (B.C.S.C.); *Sinclair v. March*, [2000] B.C.J. No. 397 (S.C), reversed in part [2000] B.C.J. No. 1676 (C.A.); *K.D. v. British Columbia Women's Hospital*, [2003] B.C.J. No. 3179 (S.C.); *Cimolai v. Hall*, [2005] B.C.J. No. 81 (S.C.).

1.0 INTRODUCTION

[1] In two closely-timed requests under the *Freedom of Information and Protection of Privacy Act* ("Act"), the applicant asked the Provincial Health Services Authority ("PHSA") for access to minutes, transcripts and the "original tape set, or a veritable copy" of a September 15, 1999 meeting of the Infection

Control Committee ("ICC") at the Children's and Women's Health Centre ("CWHC") in Vancouver. CWHC was, at the time of the access requests, a public body in its own right under the Act, and part of the PHSA, also a public body under the Act.

[2] The applicant was a member of the ICC and, on September 15, 1999, attended its meeting respecting an infectious disease outbreak at the hospital. He was later dismissed from his position at CWHC. This coincided with or spawned various complaints, investigations and litigation, including a defamation suit by the applicant against physicians and officials at the hospital, some of whom were also ICC members who had attended its September 15, 1999 meeting. The applicant's defamation suit was dismissed at trial and he has appealed it.

[3] The PHSA had earlier told the applicant that no tape of the ICC meeting could be found. This led to the question being raised in the inquiry that resulted in Order 04-25[1] of whether there had been an adequate search for the tape. Because the tape turned up during the course of that inquiry, I decided that the adequate search issue did not need to be dealt with in Order 04-25 and that it would be open to the applicant to request a review of the PHSA's response under the Act once he received it.

[4] On November 15, 2004, the PHSA responded to the applicant's access request by denying access to the requested records, on the basis that the ICC was a committee within the meaning of s. 51 of the *Evidence Act* and that s. 51(5) prohibits disclosure of information or records provided to the ICC or of any of the ICC's findings or conclusions. For the transcript only, the PHSA also relied on s. 14 of the Act, on the basis that the transcript had been prepared by counsel to the PHSA and the CWHC for the purpose of providing legal advice to those bodies.

[5] The applicant asked for a review under the Act of the PHSA's refusal to give access to the tape and the transcript. The applicant did not request a review with respect to the meeting minutes. In the request for review, the applicant claimed the PHSA had given a version of the tape to individual defendants in the defamation litigation and to an investigator who had looked into certain harassment complaints made against the applicant. The applicant also claimed that the PHSA knew that it had "floated" a transcript of the meeting and that PHSA counsel had tried to disseminate "bogus" transcripts.

[6] Because the matter did not settle in mediation, a written inquiry took place under Part 5 of the Act.

[1] [2004] B.C.I.P.C.D. No. 25.

2.0 ISSUE

[7] In its initial submission in the inquiry, the PHSA dropped its reliance on s. 14 of the Act. This left only s. 51 of the *Evidence Act* for consideration and the notice of inquiry described that issue as whether, "in light of s. 51(7) of the *Evidence Act*, [the Information and Privacy Commissioner] has the jurisdiction to proceed with the inquiry respecting records to which the public body decided to apply s. 51(6) of the *Evidence Act*."

[8] The PHSA objected to this wording in its initial submission, saying that

> … whether or not section 51 of the *Evidence Act* applies to the records is not the result of a decision by the PHSA. The question of whether section 51 applies to the Records is a matter of law. If section 51 applies, the PHSA is prohibited from disclosing the Records and the Commissioner does not have jurisdiction to order their disclosure under the Act.[2]

[9] This is the first order on the application of s. 51 of the *Evidence Act* to records requested under the Act. I do not agree with the PHSA that whether a record falls under s. 51 is exclusively "a matter of law" in the sense the PHSA intends. Section 51 operates as a matter of law, of course, but determining whether a particular record falls within the requirements of s. 51 may involve questions of fact or mixed fact and law. I would describe the issue in this inquiry as simply whether s. 51 of the *Evidence Act* prohibited the PHSA from giving the applicant access to some or all of the tape and the transcript.

3.0 DISCUSSION

[10] **3.1 Relevant Statutory Provisions**—Section 51 of the *Evidence Act* is a somewhat complex provision that prohibits disclosure of certain information or records regardless of most of the provisions of the Act. Sections 51(1) and (2) define the information and records to which the section applies, in part by reference to several provisions in the *Hospital Act*. Sections 51(5), (6), (7) and (8), in combination with s. 79 of the Act, establish how s. 51 and the Act interact.

[11] Section 79 of the Act provides as follows:

> **Relationship of Act to other Acts**
>
> 79 If a provision of this Act is inconsistent or in conflict with a provision of another Act, the provision of this Act prevails unless the other Act expressly provides that it, or a provision of it, applies despite this Act.

[2] Para. 6, initial submission.

[12] Section 51 of the *Evidence Act* reads, in full, as follows:

Health care evidence

51(1) In this section:

"board of management" means a board of management as defined in the *Hospital Act;*

"committee" means any of the following:

(a) a medical staff committee within the meaning of section 41 of the *Hospital Act;*

(b) a committee established or approved by the board of management of a hospital, that includes health care professionals employed by or practising in that hospital, and that for the purpose of improving medical or hospital care or practice in the hospital

(i) carries out or is charged with the function of studying, investigating or evaluating the hospital practice of or hospital care provided by health care professionals in the hospital, or

(ii) studies, investigates or carries on medical research or a program;

(c) a group of persons who carry out medical research and are designated by the minister by regulation;

(d) a group of persons who carry out investigations of medical practice in hospitals and who are designated by the minister by regulation;

"health care professional" means

(a) a medical practitioner,

(b) a person qualified and permitted under the *Dentists Act* to practise dentistry or dental surgery,

(c) a registered nurse as defined in the *Nurses (Registered) Act,*

(d) [Repealed 1998-42-7.]

(e) a person registered as a member of a college established under the *Health Professions Act,*

(f) a pharmacist as defined in the *Pharmacists Act, or*

(g) a member of another organization that is designated by regulation of the Lieutenant Governor in Council;

"hospital" means a hospital as defined in the *Hospital Insurance Act* and includes

(a) a hospital as defined in the *Hospital Act,* and

(b) a Provincial mental health facility as defined in the *Mental Health Act;*

"legal proceedings" means an inquiry, arbitration, inquest or civil proceeding in which evidence is or may be given, and includes a proceeding before a tribunal, board or commission, but does not include any of the following proceedings:

(a) a proceeding before a board of management;

(b) a proceeding before a board or body connected with an organization of health care professionals, that is a hearing or appeal concerning the conduct or competence of a member of the profession represented by that organization;

(c) a proceeding in a court that is an appeal, review or new hearing of any matter referred to in paragraph (a) or (b);

"organization of health care professionals" means an organization of health care professionals that is designated by regulation of the Lieutenant Governor in Council for the purposes of this section;

"witness" includes any person who, in the course of legal proceedings,

(a) is examined for discovery,

(b) is cross examined on an affidavit made by him or her,

(c) answers any interrogatories,

(d) makes an affidavit as to documents, or

(e) is called on to answer any question or produce any document, whether under oath or not.

(2) A witness in a legal proceeding, whether a party to it or not,

(a) must not be asked nor be permitted to answer, in the course of the legal proceeding, a question concerning a proceeding before a committee, and

(b) must not be asked to produce nor be permitted to produce, in the course of the legal proceeding, a record that was used in the course of or arose out of the study, investigation, evaluation or program carried on by a committee, if the record

(i) was compiled or made by the witness for the purpose of producing or submitting it to a committee,

(ii) was submitted to or compiled or made for the committee at the direction or request of a committee,

(iii) consists of a transcript of proceedings before a committee, or

(iv) consists of a report or summary, whether interim or final, of the findings of a committee.

(3) Subsection (2) does not apply to original or copies of original medical or hospital records concerning a patient.

(4) A person who discloses information or submits a record to a committee for the purpose of the information or record being used in a course of study, an investigation, evaluation or program of that committee is not liable for the disclosure or submission if the disclosure or submission is made in good faith.

(5) A committee or any person on a committee must not disclose or publish information or a record provided to the committee within the scope of this section or any resulting findings or conclusion of the committee except

(a) to a board of management,

(b) in circumstances the committee considers appropriate, to an organization of health care professionals, or

(c) by making a disclosure or publication

(i) for the purpose of advancing medical research or medical education, and

(ii) in a manner that precludes the identification in any manner of the persons whose condition or treatment has been studied, evaluated or investigated.

(6) A board of management or any member of a board of management must not disclose or publish information or a record submitted to it by a committee except in accordance with subsection (5) (c).

(7) Subsections (5) and (6) apply despite any provision of the *Freedom of Information and Protection of Privacy Act* other than section 44 (2) and (3) of that Act.

(8) Subsection (7) does not apply to personal information, as defined in the *Freedom of Information and Protection of Privacy Act,* that has been in existence for at least 100 years or to other information that has been in existence for at least 50 years.

[13] The provisions of the *Hospital Act* that s. 51 of the *Evidence Act* refers to are:

"board of management" means the directors, managers, trustees or other body of persons having the control and management of a hospital;

> 41(1) In this section, **"medical staff committee"** means a committee established or approved by a board of management of a hospital for
>
> (a) evaluating, controlling and reporting on clinical practice in a hospital in order to continually maintain and improve the safety and quality of patient care in the hospital, or
>
> (b) performing a function for the appraisal and control of the quality of patient care in the hospital.

[14] **3.2 Judicial Consideration of Section 51**—The courts have considered what is now s. 51(2), which contains a prohibition against a witness in a legal proceeding testifying or providing records relating to the proceedings of a s. 51 committee. The leading case is the Court of Appeal's decision in *Sinclair v. March*.[3] The parties did not refer me to, nor did I find, any judicial consideration of s. 51 that is specific to ss. 51(5) to (8).

[15] *Lew (Guardian ad Litem) v. Mount Saint Joseph Hospital Society*,[4] a medical malpractice case, considered what was then s. 57 of the *Evidence Act*. In a ruling on document listing and production, Baker J. concluded that what is now s. 51(2)(b) did not create a privilege that can be waived:

> ¶14 In its list of documents, the defendant hospital has made a general reference to s. 57 as a basis for a claim for privilege. Although in that list, and in the submissions of counsel, reference has been made to a "privilege" created by s. 57, the section does not merely create or recognize a privilege which may be waived by the beneficiary. Where a record satisfies the requirements of s. 57(2)(b) [now s. 51(2)(b)], disclosure is prohibited, and a witness may not choose to produce the document, as a witness may choose to waive the privilege accorded to solicitor-client communications.

[16] Baker J. also described the requirements, having regard to the purpose of the section, for demonstrating that what is now s. 51(2)(b) applied to a record:

> ¶18 The objection to production based on s. 57 should be expressed by specific reference to s. 57(2)(b), and the documents should be described in sufficient detail to permit the court, if required, to determine whether the documents meet the criteria set out in the section. At the same time, the court must not require a degree of particularity that would defeat the purpose of s. 57, which is to protect efforts made by hospitals to ensure that high standards of patient care and professional competency and ethics are maintained, by ensuring confidentiality for documents and proceedings of committees entrusted with this task.

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[3] [2000] B.C.J. No. 397 (S.C.), reversed in part [2000] B.C.J. No. 1676 (C.A.).
[4] [1995] B.C.J. No. 2755 (S.C.).

> ¶19 In my view, both these objectives can be met by requiring a party relying on s. 57 to make sufficient disclosure in a list of documents to allow a court to determine:
>
> (a) that the document or "record" was used in the course of or arose out of the study, investigation, evaluation or program carried on by a committee; and
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> (b) that the "committee" in question meets the definition of committee in section 57(1); and
>
> (c) that the record in question falls within one or more of the four categories set out in section 57(2)(b).

[17] In *Cole v. St. Paul's Hospital*,[5] the plaintiff was a physician who had been dismissed from his position at a hospital. In a suit for breach of his employment contract, he sought to compel the defendant hospital to produce reports and correspondence relating to hospital committees struck to inquire into procedures within the surgery department and, eventually, the plaintiff's management of that department. As in *Lew*, Low J. (as he then was) found that s. 51 did not create a privilege that can be waived. Even though it was apparent that the committee records were relevant to the plaintiff's wrongful dismissal suit, s. 51(2)(b) prohibited their production:

> [7] …. s. 51(2)(b) does not set up a privilege. Rather, it sets up a prohibition against production. It is a statutory directive that is not attacked on constitutional or other grounds. The plaintiff argues that the subsection should be interpreted strictly, but I am unable to see any basis upon which its application could be narrowed to accommodate the plaintiff's wishes in this case. The language of the statute is clear and unequivocal, and its meaning and application here unarguable. No exceptions or judicial discretion are allowed for in the statute. The plaintiff will have to acquire the information in the documents, such as names of potential witnesses, by other means of discovery available to him.

[18] In *Sinclair v. March*, another medical malpractice case, Dillon J. considered the purpose and limited scope of s. 51, suggesting that it would not necessarily protect all activities or records of a s. 51 committee:

> ¶12 … the purpose of the protection in s. 51 is to give hospitals latitude to improve the quality of medical care and practice in hospitals. … The scope of the section is limited. It does not protect every activity of a hospital committee when those committees are broadly structured to undertake duties beyond those envisioned within the scope of s. 51. The most reasonable meaning extracted from the purpose and scope of the section relates to the key functional concept of improvement of medical care and practice. To 'improve' is to advance or raise to better quality or condition. Hospital committees are not to be fearful that their work to advance and enhance the quality of hospital care and practice will be

[5] (August 21, 1998) Vancouver C963888 (B.C.S.C.).

> exposed to scrutiny in the event of civil proceedings. 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.
>
> ¶13 It also does not protect the actions of individuals as a matter of course, regardless of incidental membership on a committee. There must be a "proceeding" before a committee in which the individual participates or the individual must have made a record that was used by a committee and prepared for the committee or at the request of the committee.
>
> ¶14 Records are protected from disclosure only to the extent that the public interest as expressed in s. 51 requires. For example, a review conducted for assessment of management skills was distinguished from an evaluation of hospital practice or patient care (*Cole v. St. Paul's Hospital* (21 August 1998) Vancouver C963888 (B.C.S.C.) at para. 8).
>
> ¶15 Documents related to practice and procedures in place at a hospital governing the care and treatment of patients at the time of an incident are subject to production (*Morrison v. Hicks*, [1988] B.C.J. No. 1758; (16 September 1988) Vancouver C863899, (B.C.S.C.)). Documents related to applications for hospital privileges and the hospital's replies to such applications have been ordered to be produced as relevant to the issue of whether privileges were withdrawn because of the incident giving rise to the litigation (*Lew (Guardian ad litem) v. Mount St. Joseph Hospital Society*, supra at para. 5). Documents related to a doctor's standard of practice at a hospital are not automatically protected unless they fall within s. 51(2)(b) (*Lew (Guardian ad litem) v. Mount St. Joseph Hospital Society*, supra at para. 24). Thus, notes to superiors or to colleagues complaining of a physician's conduct may not necessarily meet the criteria of s. 51. On the other hand, some documents, such as minutes of committee meetings, are obviously protected provided that the committee does not have functions broader than the scope of section 51. Key here is the appreciation that a document may be prepared for a variety of uses, not all of which will meet the purpose and criteria of the section.

[19] Dillon J. took the approach in *Lew* that documents had to be described in sufficient detail for the court to be able determine whether they met the criteria of s. 51. A hearsay assertion that hospital administration had advised that a document was prepared for the purpose of being reviewed by a s. 51 committee was not sufficient to establish the applicability of the section.[6]

[6] *Sinclair v. March* (SC), paras. 16 and 17.

[20] Dillon J. also concluded that one committee investigation was not protected because it did not concern quality of care:

> ¶19 From these cases, it is apparent that records prepared by Dr. MacPherson when he conducts an investigation into hospital practice or medical care are not automatically protected within the section just because he is also a member of the Medical Advisory Committee. The record must meet the criteria in s. 51(2)(b). Particularly, it must have been used by a committee within the meaning of the section. Further, Dr. MacPherson or the hospital must be able to indicate into which category of s. 51(2)(b) the record falls. Not all investigations into practice go to a committee within the meaning of s. 51. There must be particulars so that the court can scrutinize and be satisfied that the document falls within the section.
>
> …
>
> ¶21 The Medical Advisory Committee was not acting within the scope of s. 51 in making decisions regarding funding allocation and the hospital budget. This is not related to the purpose of the section. It cannot be that all committee activities within a hospital fall within the section just because a committee performs broad functions, one of which may fall within the section. A distinction is noted with respect to the Medical Audit Committee which Dr. MacPherson said was established for the purpose of coordinating the investigation and improvement of medical care and practice in the hospital. …
>
> ¶22 From these paragraphs, it is apparent that the hospital distinguishes different functions of different committees, not all of which are related to improving medical or hospital care or practice. It is not known why the report was not prepared for the Medical Audit Committee which appears to have this function as its sole purpose, but the credentials committee determines continuation of medical privileges at the hospital. It is not known whether the credentials committee actually used the report but Dr. MacPherson testified on discovery that disciplinary action taken against the defendant doctor in 1994 related to quality assurance issues.

[21] The Court of Appeal agreed: with the purpose of s. 51 as described in *Lew*; with the need for the hospital to set out a sufficient description of the material for which protection is claimed so that it can be determined whether or not s. 51 applies; that the court must be informed of how a hospital committee is involved with a document and for what purpose; and with Dillon J.'s observations about the scope of s. 51.[7]

[7] *Sinclair v. March* (C.A.), paras. 20, 23 and 24.

[22] The Court of Appeal did not agree that s. 51 was designed to balance the interests of litigants and a hospital's efforts to improve care:

> ¶22 I agree with the chambers judge that it is not enough for the witness to be a member of a committee envisioned by s. 51 for the protection to attach. The witness may be pursuing the matter in question as a part of hospital administration and not within the committee structure. While 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.

[23] After quoting from the Hansard debate in 1985 when substantially the current wording of s. 51 was enacted, it said the following:

> ¶26 … the 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 a court should give the language of the enactment its full force and effect with the object in mind: s. 8, *Interpretation Act*, R.S.B.C. 1996, c. 238. This was the approach taken by Mr. Justice Low in *Cole v. St. Paul's Hospital* (21 August 1998), Vancouver Registry No. C963888 (B.C.S.C.), at para. 7….

[24] The Court of Appeal also reversed Dillon J.'s conclusion that one committee investigation did not relate to quality of care:

> ¶20 …. I respectfully disagree, however, with her characterization of the subject-matter of the first investigation. In my opinion, when a hospital committee investigates whether a surgical procedure is "frivolous" the information it generates falls squarely under s. 51.…

[25] In *K.D. v. British Columbia's Women's Hospital,*[8] also a medical malpractice case, the plaintiff sought to testify about the contents of a letter from her physician to a hospital committee. The court found that the plaintiff was a witness in a legal proceeding within the meaning of s. 51 and, because her physician's letter to the hospital committee was inadmissible under s. 51(2)(b), her oral evidence about the contents of the letter, which the physician had shown her, was equally inadmissible.

[26] **3.3 The Parties' Positions––**The PHSA's submissions as to how s. 51(5) and s. 51(6) of the *Evidence Act* prohibit the PHSA from giving the applicant access to the tape and the transcript may be summarized as follows:

[8] [2003] B.C.J. No. 3179 (S.C.)

1. The ICC is a subcommittee of the Quality of Care Committee ("QCC"), which is in turn a subcommittee of the Medical Advisory Committee ("MAC"), and:

   a) these are all committees under s. 51(1) of the *Evidence Act* because the committee structure was approved by CWHC's board of directors;

   b) the purpose of these committees is to improve medical and hospital care and practices at CWHC;

   c) their membership within the MAC structure includes medical professionals.

2. The tape and the transcript contain information provided to the ICC that is within the scope of s. 51 and also contain findings and conclusions of the ICC which, under s. 51(5)(a), cannot be disclosed except to CWHC's board of directors.

3. Section 51(6) therefore prohibits the CWHC board of directors from disclosing the tape and the transcript in response to the applicant's access request.

4. Sections 51(7) and (8) provide that ss. (5) and (6) apply despite the Act, which constitutes a statutory override under s. 79 of the Act.[9]

[27] The applicant submitted that s. 51 of the *Evidence Act* does not prohibit disclosure of the tape and the transcript to him because:

1. The tape has been used against him at a number of levels within the PHSA, including harassment investigations in which he was the respondent, and this waived any privilege the PHSA may have had over the tape.

2. The PHSA introduced a "bogus" version of the tape in a discovery in connection with the applicant's defamation suit. A true version of the tape must be provided under the Act, as perjury and fraud are matters for the criminal courts but also for the Commissioner.

3. Several versions of the transcript were prepared through and introduced by defence counsel at the trial of the defamation suit, with one version being entered as an exhibit.

4. During the trial of the defamation suit, the PHSA at first attempted to suppress the tape under s. 51, but eventually withdrew that motion because "they would have been caught in court with a perjury".[10]

[9] Paras. 12-30, 37-42, PHSA's initial submission.
[10] Applicant's initial submission, para. 12.

[28] According to the applicant, access to the tape and the transcript is critical to his employment and to his life. He summarized his interest in gaining access in the following way:

> … the fact that the Centre [CWHC] and others attempted to use that material against me on several occasions. When it was apparent that the Centre and these others had lied, the Centre and PHSA thereafter attempted to prevent the tape from surfacing. Had the tape related to a meeting that was unrelated to myself, one could see when the Section 51 application might be upheld. In this case, however, I was in attendance at the meeting, and the contents of the tape in the conduct of the meeting were used against me. One may have members of the Bar attest in court as so-called agents of the court and you may have sworn affidavits from stuffy-shirted and abusive administrators. Whereas these words may seem real to the Court, they may simply be based on a lie. Documents provided by hospital and PHSA lawyers may be purposely altered as a basis for "litigation strategy". If never caught, the lies become truth and history is re-written. I do believe that the Commissioner can see through their behaviour and act according to the heart of freedom of information.
>
> It is obvious why the Centre and the PHSA are trying so hard to abuse the *Evidence Act*. They desperately need to remove evidence which is so damaging to them.[11]

[29] **3.4 Discussion of Section 51's Application**—Affidavits of Dr. Douglas Cochrane and Dr. Deborah Money explained the CWHC's committee structure at the relevant time and the lead-up to the ICC meeting on September 15, 1999.

[30] As a result of the 1998 amalgamation of three hospitals into the CWHC, the quality of care committees for those hospitals were also amalgamated into a single committee structure. In October 1998, CWHC's board of directors approved the quality of care committee structure set out in CWHC's medical staff bylaws and draft medical staff rules. Two advisory committees reported to the CWHC executive and board of directors: the Medical Advisory Committee ("MAC") and the Professional Advisory Committee ("PAC"). The Quality of Care Committee ("QCC") was a subcommittee of the MAC that reported to both the MAC and the PAC, and the ICC was one of a number of joint MAC/PAC appointed subcommittees of the QCC.

[31] The CWHC medical staff rules included terms of reference under which the MAC and the QCC operated in September 1999. At that time, Dr. Cochrane was a member of the MAC and Dr. Money was both a member of the QCC and the chair of the ICC.

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[11] Paras. 10 & 11, applicant's initial submission.

[32] The MAC's membership included health care professionals employed such as heads of various hospital departments and its mandate included:

> 8.1.1 To report to and advise on policy to the Board and the Chief Executive Officer on all matters of a medical nature including the organizational, clinical, educational and research activities.
> 8.1.2 To specifically provide advice to the Board and the CEO and to report back to the medical staff on the monitoring of the quality, quantity, effectiveness, and sufficiency of health care provided and the reporting on the quality of that care to the Board, subject to section 51 of the *Evidence Act.*
> 8.1.3 To provide advice to the Board and CEO and to report back to the medical staff on the quality of care delivered to patients.[12]

[33] The MAC's duties included:

> 2.2.1 To receive, study and act upon reports from Heads, Departments, Programs and Committees concerning the review, analysis and evaluation of clinical practices with the medical staff to determine the quality of care delivered to patients rendered in the Health Centre;
> 2.2.2 To ensure medical practice standards are developed and adhered to by all medical departments and programs, and that the outcomes of surveillance systems regarding the quality of medical care are directed towards the continuing improvement of the quality of patient care;
> 2.2.3 To liaise with other Health Care providers as required to ensure quality care is delivered to patients.[13]

[34] The mandate of the QCC, whose membership was primarily medical professionals, included:

> 1.1 The Quality of Care Committee is a committee responsible to the MAC, PAC, and Health Centre Executive for the planning, development, implementation and monitoring of quality, utilization and risk issues related to the care provided in the Health Centre. The Quality of Care Committee has subcommittees which will be responsible for the aforementioned tasks within specific areas and the Quality of Care Committee will coordinate and provide overall focus for the subcommittees. The quality, utilization and risk system will relate directly to achieving the goals and strategies of C&W. The committee works within the framework of program management, departments and integrated services.[14]

[12] Cochrane affidavit, Exhibit "C".
[13] Cochrane affidavit, Exhibit "F".
[14] Cochrane affidavit, Exhibit "G".

[35] The QCC's duties were:

> 2.1 To oversee the development and support the implementation of the quality and utilization improvement system in the programs, departments, and integrated services of C & W.
> 2.2 To establish priorities related to quality and utilization improvement and risk related initiatives.
> 2.3 To sponsor ongoing projects dedicated to improving identified processes and outcomes at C & W.
> 2.4 To oversee the development and support the implementation of the quality, utilization improvement and risk assessment system in the programs and integrated services of C & W.
> 2.5 To regularly receive and review information, including a corporation quality and utilization report, regarding the Health Centre's performance based upon established indicators of performance.
> 2.6 To report regularly and make recommendations to the Medical Advisory Committee, Professional Advisory Committee and to the appropriate Vice-Presidents regarding the operation of the Health Centre's quality and utilization improvement system and the activities of the Committee.
> 2.7 To establish effective reporting relationships between the Quality of Care Committee and Sub-committees, the PBCUs, Programs[,] departments and integrated services of C & W.
> 2.8 To receive reports from and support the Quality of Care Subcommittees' activities and to ensure that quality improvement issues at the program level are reviewed, monitored and resolved.[15]

[36] The ICC operated under terms of reference it approved in August 1999, according to which the ICC was composed primarily of medical professionals, including physicians and nurses, and had the following mandate:

> 1.0 To ensure the safest environment that is practical for the patients, family, visitors and staff of the hospital in all situations involving the transfer of infectious agents.[16]

[37] The duties of the ICC were:

> 2.1 To formulate policies for the maintenance of the safest environment that is practical for the patients, family, visitors and staff of the hospital in all situations involving the possible transfer of infectious agents;
> 2.2 To ensure a process is in place to review the effectiveness of the aforementioned policy.[17]

[15] Cochrane affidavit, Exhibit "G".
[16] Cochrane affidavit, Exhibit "H".
[17] Cochrane affidavit, Exhibit "H".

[38] Dr. Money deposed as follows about the ICC meeting involved here:

> 3. In the summer of 1999, there had been a number of serious Methacillin Resistant Staphylococcus Aureus ("MRSA") infections in the special care nursery at the Health Centre. As Chair of the Infection Control Committee, I called an extraordinary meeting of the Committee for September 15, 1999. The purpose of the meeting was to review the current management of the MRSA outbreaks in the special care nursery and to discuss the issues that the Committee needed to consider in order to develop a medical MRSA policy of the Health Centre that was consistent with current provincial, federal and international policies and procedures in infection control, in particular, in the control of the MRSA.
>
> 4. The meeting was held as scheduled on September 15, 1999. The proceedings at the meeting were tape recorded.
>
> 5. On September 21, 1999 I attended the Quality of Care Committee meeting at the Health Centre and reported to the Committee on the results of the meeting of the Infection Control Committee of September 15, 1999.

[39] Dr. Cochrane added the following in his affidavit:

> 13. On September 13, 1999, the Medical Advisory Committee received a report from the Chair of the Infection Control Committee, Dr. Money, regarding a number of serious Methacillin Resistant Staphylococcus Aureus ("MRSA") infections in the Special Care Nursery at the Health Centre. In order to fulfill its duty to provide medical advice to the Executive and Board of Directors of the Health Centre, the Medical Advisory Committee decided to identify and assess the key issues related to the MRSA outbreak and formulate policies with respect to MRSA infections. Dr. Money reported that the Infection Control Committee was focused on reviewing the current management of outbreaks of MRSA and developing a medical MRSA policy for the Health Centre consistent with provincial, federal and international policies. She advised the Medical Advisory Committee that an extraordinary meeting of the Infection Control Committee would be held on September 15, 1999, with a goal of developing an evidence-based medical policy on MRSA.
>
> 14. On receiving the report from the Chair of the Infection Control Committee, the Medical Advisory Committee asked the Infection Control Committee to establish clear guidelines with respect to how to deal with MRSA infections in the Health Centre.
>
> 15. Dr. Money reported on the results of the Infection Control Committee meeting of September 15, 1999 to the Quality of Care Committee on September 21, 1999.

[40] In my view, for this inquiry, the analysis of the application of s. 51 breaks down as follows:

1. The ICC must be a "committee" within the meaning of s. 51(1).

2. Section 51(7) gives precedence to s. 51(5) and s. 51(6) in the event that they conflict with a provision of the Act, such as the right of access to information in s. 4 of the Act.

3. The fact that Dr. Money, the chair of the ICC, reported to the QCC, of which she was a member, about the ICC meeting does not necessarily signify that the tape or the transcript of the ICC meeting were information or records that it submitted to the hospital board of management under s. 51(6).

4. The more material prohibition on disclosure to consider is s. 51(5), which forbids a committee or person on a committee from disclosing or publishing information or a record provided to the committee within the scope of s. 51 or any resulting findings or conclusion of the committee.

5. The prohibition on disclosure in s. 51(5), by implication having regard to s. 51(7) and s. 51(8), includes the PHSA, a public body with custody and control under the Act of committee records.

[41] The fact that Article 5.1 of the ICC terms of reference said that documents prepared for and at its request were protected under s. 51 of the *Evidence Act* does not make them so. Nor, as recognized in *Sinclair v. March*, does s. 51 cloak all activities or records of a hospital committee structured to undertake duties which extend beyond s. 51.

[42] What is pertinent is that the ICC was part of a committee structure approved by the CWHC board of directors, under which the ICC was responsible for improving hospital practice and quality of care of patients by formulating and reviewing the effectiveness of policies to ensure a safe environment regarding the transfer of infectious agents. I find this a sufficient basis to conclude that the ICC was a committee within the meaning of s. 51 of the *Evidence Act*. The next question is whether, under s. 51(5), the tape or the transcript was either information or a record provided to the ICC within the scope of s. 51 (that is, for the purpose of improving medical or hospital care or practice) or any resulting findings or conclusion of the ICC.

[43] The applicant is of course aware of what happened at the ICC meeting because he attended as an ICC member. I have had the benefit of the affidavits of Dr. Cochrane and Dr. Money. I have also reviewed the tape and the transcript. The ICC meeting was an extraordinary meeting called to review the current management of MRSA outbreaks in the hospital and to develop an evidence-based medical infection control policy particular to MRSA. As it turned out, the meeting was a fractious one from which few or no productive committee findings or conclusions emerged on the MRSA issues.

[44] Despite the futility with which the ICC extraordinary meeting unfolded on September 15, 1999, the purpose of the meeting fell within the committee's responsibilities for improving hospital practice and quality of care by formulating and reviewing the effectiveness of policies to ensure a safe environment regarding the transfer of infectious agents and, from my review of the records, this remained the committee's purpose throughout the meeting. Having regard to the overall purpose of s. 51, I conclude that the tape and the transcript consist of information, useful or not, that was provided to the ICC within the scope of s. 51 and, because of s. 51(5) and s. 51(7) of the *Evidence Act* and s. 79 of the Act, the records in question cannot be disclosed to the applicant, despite his right of access to records in s. 4 of the Act.

[45] **3.5 Implications of Disclosure for Other Proceedings––** The applicant submitted that s. 51 of the *Evidence Act* does not prohibit the tape and the transcript of the ICC meeting from being disclosed to him under the Act because they were disclosed to him—in altered form, according to him—for other proceedings. By contrast, the PHSA submitted that, other than the exceptions set out in the section, s. 51 creates an absolute prohibition on disclosure. Words or conduct of the PHSA could not waive the prohibition and the disclosure of the tape or the transcript for other proceedings—whether that disclosure was right or wrong under s. 51—is irrelevant to the applicability of the s. 51 prohibition when the same records are requested under the Act.

[46] I directed supplementary questions to the parties in this area. I also said this to the applicant:

> I must impress upon the applicant that is not sufficient to simply make bald assertions to this inquiry that counsel, or anyone, was untruthful in their correspondence relating to the applicant or improper in their conduct before the court. If it is relevant to the applicant's position in this inquiry to assert that counsel for the public body or for the defendants in the defamation suit have not accurately represented what transpired before the court or in their dealings with the applicant's counsel in that proceeding with respect to the tape or the transcript, then it is incumbent upon the applicant to provide concrete evidence of these matters.
>
> By this I mean documents (correspondence that compromises what the public body has submitted), sworn statements (such as from the applicant's counsel at trial), complete excerpts from the transcripts of the trial insofar as s. 51 of the *Evidence Act* is concerned (including, but not limited to, the untranscribed submissions and discussion that are referred to on p. 2233 of the transcript) and judicial rulings (if they exist).

[47] Taking into account both parties' responses to my supplementary questions, I summarize the evidence in this inquiry on disclosure of the tape and the transcript for other proceedings as follows:

1. Neither the PHSA nor the CWHC was a party to the applicant's defamation suit against various hospital physicians and officials, some of whom were ICC members who attended its September 15, 1999 meeting with the applicant.

2. A June 16, 2004 email from counsel for the defendants in the defamation suit to counsel for the plaintiff (the applicant in this inquiry) stated as follows:

> It has come to our attention in the last week that the infection control committee of Children's and Women's Hospital is a section 51 committee under the *Evidence Act*. As such, the tape of the September meeting and minutes of other meetings of the committee should not have been disclosed in the litigation and no evidence about the proceedings at any meetings of the committee should have been placed before the Court. As the Act contains a prohibition rather than creating a privilege it is not open to any party to waive the provisions of the Act. Even if a waiver were possible, it would be the Hospital that would have the right and they have advised that they consider that the Act should have been followed and the material not introduced.
>
> Under the circumstances, even though the proceedings before the committee are helpful to our case, we must advise the Judge that she is obliged to disregard all evidence that she has heard regarding what took place at the meetings of the infection control committee.
>
> Please advise as to your position at your earliest opportunity.

3. A June 30, 2004 letter from the applicant's counsel in respect of the harassment allegations against him to counsel for the CWHC and counsel for the defendants in the defamation suit included the following:

> We have been advised that CWHC intends to apply in the defamation proceedings to suppress committee material, including the tape of the September 15, 1999 ICC meeting. The hospital relies on Section 51 of the *Evidence Act*.
>
> In the harassment proceedings, we asked the investigator to ask the hospital for production of the tape. The hospital has resisted that request. Recently Mr. Dives [counsel for defendant physicians] advised the investigator of the hospital's intention to apply in the defamation proceedings to have committee materials, including the tape, excluded pursuant to Section 51 of the *Evidence Act*.
>
> With regard to the harassment proceedings, our position is that Section 51 of the *Evidence Act* does not apply to those proceedings.

4. Around this time in 2004, the inquiry that led to Order 04-25 was underway and it put in issue the adequacy of the PHSA's search for a tape of the September 15, 1999, ICC meeting. A July 7, 2004, letter from PHSA counsel informed that inquiry about the PHSA's recent discovery of the tape:

> It is come to the writer's attention that a copy of the tape recording is in the possession of counsel representing various doctors in a defamation action commenced by the Applicant in this inquiry, and that the tape has recently been introduced into evidence during the trial of that defamation action. Further, it has also come to the writer's attention that the original of the tape recording is in the custody of the Medical Affairs Office at the Health Centre.
>
> The Health Centre has taken the position in the trial that the introduction into evidence of the tape recording of the Infection Control Committee meeting was prohibited by section 51 of the *Evidence Act*, in that the Infection Control Committee is a Quality Assurance Committee and the subject of the discussion at the meeting was a quality assurance discussion. Independent counsel for the Health Centre will be making an application to the trial judge in the defamation action to have the tape recording withdrawn from evidence based on section 51 of the *Evidence Act*. That application is currently tentatively planned for July 28 or 29, 2004 during a resumption of the ongoing trial in that action.

5. A July 29, 2004 letter from CWHC counsel to counsel in the defamation suit stated as follows:

> As you are aware, Bull, Housser has been retained to provide advice to the Children's and Women's Health Centre (the "Hospital") with respect to an evidentiary issue that arose in the course of this trial. Having considered the matter, the Hospital has decided it will not argue the section 51 issue in these circumstances. I write to confirm the basis upon which this matter has been resolved following our discussions this past week.
>
> I understand that counsel are agreed that as a result of the Hospital's decision, they will not argue the s. 51 issue either. They further agree that there is presently an insufficient evidentiary basis before the Court in this matter for the Judge to make a determination as to the applicability of s. 51 to the proceedings of the Infection Control Committee at its meeting of September 15, 1999 (the "Meeting"), and will so advise the Court.
>
> Counsel and their clients also agree that the Meeting was a confidential proceeding and they will not publish the proceedings or seek to publicize the Meeting beyond this trial. Finally, counsel

> and their clients have agreed that the Hospital is not estopped from raising the applicability of s. 51 to the meeting in any other forum or subsequent proceedings to which s. 51 applies.

6. A July 13, 2004 letter from the applicant's counsel to the investigator of the harassment allegations against the applicant stated:

> We confirm your advice that the hospital will provide the September 15, 1999 tape to you. We enclose copies of correspondence with regard to the tape including July 7, 2004, disclosing the hospital's possession of the original tape.

7. There is no reference to s. 51 of the *Evidence Act* in the reasons for judgement dismissing the applicant's defamation suit.[18] The reasons for judgement, in combination with transcript excerpts that the applicant provided, do indicate, however, that physicians who were at the ICC meeting testified about the meeting at the trial and the presiding justice listened "more than once to a tape recording of portions of the September 15, 1999, meeting".[19]

8. Transcript excerpts from the trial of the defamation action also indicate that a tape (two versions) and a transcript of the ICC meeting were entered as exhibits and that the following interaction with respect to s. 51 of the *Evidence Act* happened at the close of evidence on August 3, 2004:

> Counsel for the defendants: Yes, my lady, on the Section 51 issue, just to remind you of how it came up, I'd been advised by someone at the hospital that they took the position that it was a Section 51 committee, and I felt under the circumstances I had to bring it to the court's attention and give the opportunity to the hospital, or for your ladyship to give the hospital an opportunity, and when we were last together, I advised you that they were in the process or had just retained Penny Washington to advise them on this point. Matters have transpired between counsel since then, and where we are at this point, and always, of course, subject to your ladyship's direction, is that the hospital has made a decision not to attend to assert that the proceedings before the Infection Control Committee are covered by Section 51.
>
> …
>
> Counsel for the plaintiff: My friend and I are in agreement that in the record before you we don't know what other evidence may or may not have been called if the hospital had chosen to come forward but certainly the record before you is insufficient for you to form a conclusion that this is a Section 51 Committee and that the

[18] *Cimolai v. Hall*, [2005] B.C.J. No. 81 (S.C.).
[19] Paras. 301 and 302, *Cimolai*.

> proceedings that are in evidence before you would constitute communications that are prohibited under Section 51.
>
> And so my friend and I are in agreement that it is in effect a dead issue in view of the hospital's decision not to participate to assert that the privilege does exist.
>
> Counsel for the defendants: I agree with that approach, My Lady.
>
> The Court: So, where does that leave us now?
>
> (Discussion followed about the quality of the two tapes and the transcript, after which the tapes were marked as exhibits (37A and 37B) and a copy of the transcript was to follow for entry into evidence.)

9. The investigator who looked into harassment allegations against the applicant apparently also listened, at the applicant's insistence, to a tape recording of the ICC meeting.[20]

[48] I will not attempt to resolve the applicant's allegation that the PHSA and the defendants in the defamation suit misled the court with an altered version of the tape. This inquiry is not a forum for investigating claims of fraud on a court. I also do not think I could resolve the applicant's allegations on the evidence that is before me.

[49] According to the PHSA, previous use or disclosure of the tape or the transcript is not relevant anyway. Further, the agreement of counsel confirmed in the July 29, 2004 letter was that the PHSA was not estopped from raising s. 51 in other proceedings, and that the use of the tape in the investigation into the harassment allegations was permitted under s. 51(5)(a) because the investigation and related proceedings were proceedings before a hospital board of management related to the applicant's hospital privileges.

[50] According to the applicant, neither he nor his counsel in his defamation suit agreed to what is described in the July 29, 2004 letter, but the applicant did not provide me with anything, including from his counsel in the defamation suit, to support this contention.

[51] I doubt the importance of an agreement between the parties to the defamation suit that the PHSA would not be estopped from asserting s. 51 in other proceedings. The language of and case law around s. 51 indicate that the prohibitions on disclosure do not allow for discretion or waiver by the PHSA or by anyone else. I therefore seriously question whether, in terms of the applicability of s. 51 in this inquiry, there is any legal significance or effect in the hospital's decision not to take a position in the defamation suit on the applicability of s. 51

[20] See p. 3, applicant's letter of February 27, 2006 and p. 3, PHSA's letter of February 27, 2006.

to the tape and the transcript or in whether or not the parties to the defamation suit (including the applicant) agreed that the PHSA would not be estopped from raising or relying on s. 51 in other proceedings.

[52] It remains far from clear to me how disclosure of the tape and the transcript to parties to the defamation suit (the applicant as the plaintiff and the defendant physicians) for use in that suit—which obviously happened—reconciles with s. 51 of the *Evidence Act* and the jurisprudence around it (such as *Cole v. St. Paul's Hospital*, where the plaintiff was a physician who was a member of the hospital committee and attended its meeting, but was still prohibited by s. 51 from gaining disclosure or use of records about the committee meeting for his litigation against the hospital). It is reasonably clear, though, that the trial judge in the defamation suit made no decision with respect to s. 51.[21] There is certainly no evidence of such a ruling.

[53] I am left to apply s. 51 of the *Evidence Act*, in conjunction with s. 79 of the Act, on the evidence that is before me in this inquiry. I find that disclosure of the tape and the transcript of the ICC meeting on September 15, 1999 is prohibited by s. 51(5) and, because of s. 51(7) of the *Evidence Act* and s. 79 of the Act, that this prohibition prevails despite the applicant's right of access in s. 4 of the Act to records in the custody or under the control of the PHSA.

4.0 CONCLUSION

[54] For the reasons given above, I find that s. 51(5) of the *Evidence Act* prohibits disclosure of the disputed records and this prohibition applies despite the applicant's right of access to records under the Act. Under s. 58(1) of the Act, I confirm the PHSA's decision to refuse to give the applicant access to the disputed records.

July 14, 2006

ORIGINAL SIGNED BY

Celia Francis
Adjudicator

OIPC Files: F04-23826 and F04-23828

[21] See PHSA's letter of May 8, 2006.