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QUALITY ASSURANCE IN SASKATCHEWAN

I. INTRODUCTION

Quality assurance and risk management programs are relatively recent additions to the administrative operations of Canadian hospitals and health care facilities. The development of these programs may be viewed as an institutional reaction to more arduous standards for hospital accreditation, the expanded scope of hospital liability for medical malpractice, and discontentment with the minimal standard of care enforced through lawsuits and increased government regulation of health care facilities.

Although quality assurance and risk management programs have been praised for their laudable goals of improved patient safety and quality of medical care, great concern has been raised that the full potential of these programs will not be realized due to the unwillingness of medical personnel to participate in the programs without clear guarantees of confidentiality. Fear of reprisal has been the greatest hindrance to the quality management activities of Saskatchewan health care facilities.

The implementation of quality assurance and risk management programs in Canadian hospitals has given rise to two legal issues:

1. The peer review process, which is so vital to the effective program of quality assurance, must be granted privilege from production of relevant documentation in court and committee members must be assured of immunity from being called to testify.


2 David G. Duff, "Evidentiary Privilege for Hospital Quality Assurance and Risk Management: Assessing Statutory Reform" (1989) 47 University of Toronto Faculty of Law Review 526.
(2) As a possible consequence of the introduction of quality review and risk management programs, does a health care facility impose a higher duty of care upon itself, thereby inadvertently risking an increased exposure in a negligence action?

The scope of this paper is limited to a discussion of the first issue posed above. Despite the recent amendments to The Saskatchewan Evidence Act, the question of whether or not the proceedings of a quality review committee are confidential and therefore exempt from discovery and disclosure remains a pressing legal issue for most Saskatchewan health care facilities.

II. DEFINITIONS OF RISK MANAGEMENT AND QUALITY ASSURANCE

Explanation of the terms "risk management" and "quality assurance" is in order as each program has different objectives in regard of the organization and administration of improved medical care in a health care facility. Quality Assurance focuses on the quality of care delivered to the patients of the health care institution. Its two specific functions are (1) continuous review of patient care, and (2) appropriate follow-up mechanisms to maintain the quality of care. Potential problems are reviewed in detail and this review often leads to the further review of the practice of individual physicians. These practices are then analyzed by the physician's peers and corrective measures may be recommended. The entire process is documented.

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3 Batty, supra, at 110.

4 For readers interested in discussion of the issue of increased liability for hospitals as a result of the introduction of quality assurance, see G. Batty, "Quality Assurance - What Lies Ahead? A Canadian Legal Respective" (1985) 5 Health Law in Canada 108.

5 Robin Williams, "Confidentiality and Quality Assurance" (1990) 10 Health Law in Canada 215.
Risk management focuses on the analysis of risk and protecting the institution against liability claims and losses. As such, risk management is a vehicle for total quality management.

For this reason, risk management has been defined as "the science for identification, evaluation and treatment of the risk of financial losses."6

A. QUALITY ASSURANCE PROGRAMS

1. Purpose of Quality Assurance

As previously mentioned, quality care review or quality assurance is intended to function as a form of meaningful, open and candid peer review through which the quality of patient care delivered at a health care institution may be evaluated and thus continuously improved for the benefit of all health care recipients. More specifically, quality assurance entails:

- 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, and the establishment of programs and procedures "designed to assist practitioners in modifying practice behaviour 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."7

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6 T. Dankmyer and J. Groves, "Taking Steps for Safety's Sake" (1977) 51 Hospitals, 51 at 60.

The Canadian Council of Hospital Accreditation explained the standard for quality assurance programs as follows:

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. Examples of mechanisms of review include medical, nursing and other professional audits, clinical rounds and other chart reviews.  

It must be stressed that quality assurance information is provided for the purpose of improving care and not to ascertain blame or fault, although this often occurs where poor care is attributed to an individual.

2. Quality Assurance Techniques and Documentation

Quality assurance programs principally depend on the duty of physicians to supervise one another and on department heads to monitor their staff. The most effective techniques utilized in any quality assurance program is open and candid peer review, performance appraisals and chart audits.

Quality review data is highly sensitive for several reasons. First, the process of gathering information for quality assurance committees is often informal and, at best, semi-formal. Traditional legal rules of gathering evidence are not followed. Thus most documentation is based on the opinions of other professionals.

Second, the documentation of opinion is generally retrospective and based on second or even third-hand information by persons not present at the event that is the focus of the committee's

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8 Canadian Council on Hospital Accreditation, Standards for Accreditation of Canadian Health Care Facilities (Ottawa, 1983).
deliberations. Thus, the documents produced by a quality review committee will usually provide only hearsay evidence. Similarly, reports are seldom made contemporaneously with the event and many activities such as chart audits are frequently conducted months after the event.\(^9\)

Third, the standard of criticism in peer review is based on optimal standards and must be contrasted with the legal standard of care.\(^10\) In the observation of Dr. Williams, Chief of Staff for St. Mary's General Hospital in Timmins, Ontario, "discussions at physician QA [quality assurance] meetings often becomes pointed, brutal and sometimes perjurative."\(^11\) The peer review process during which these heated debates arise is intended to function much like the Socratic method used in Platonic discourse, i.e. the exchange of ideas, questions, argument and debate, is intended to reveal the perfect "form" of quality health care to hospital administrators and physicians. The method is not concerned with merely attaining or maintaining standards that are simply "reasonable" or "prudent". Its focus in on excellence.

B. RISK MANAGEMENT PROGRAMS

1. Purpose of Risk Management

Risk Management is concerned with actual and potentially compensable events, and in particular, the adverse outcomes of such events. As such, risk management programs generally involve a system for detection, evaluation and resolution of risks involving losses from injury to persons and property.


\(^11\) Williams, at 216.
2. **Risk Management Techniques and Documentation**

There are generally five components identifiable in any risk management program:

1. Identification of actual potential sources of loss;

2. An evaluation of potential or actual sources of risk, both in terms of frequency and severity;

3. Reduction of risks;

4. Elimination of risks;

5. Prevention of risks, especially those which largely involve human error, that is, wrong drug, failure to follow established hospital procedure, failure to communicate, etc.  

In some health care facilities other techniques may be incorporated to a risk management program. However, the basic ingredients remain alike: identification, evaluation, elimination, reduction, prevention and minimization of risks. A variety of information sources are utilized to identify both actual and potential sources of risk and include the following:

- incident reports
- utilization management reports
- environmental rounds
- unanticipated returns to the O.R.
- incomplete consents reports
- worker's compensation reports
- medical credentialling reports
- word of mouth reports
- unanticipated returns to the hospital
- labour-management

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12 Kevin P. Feehan, "Legal Access to Health Records/Protection of Quality Assurance Activities" (1991) 12 *Health Law in Canada* 3 at 5-6

III. EVOLUTION OF QUALITY ASSURANCE PROGRAMS

In the United States, the implementation of quality assurance programs was a direct consequence of corporate liability imposed on American health care facilities by the courts. In the case of Darling v. Charleston Community Memorial Hospital, 211 N.E. 2d 253, the hospital was found liable for exacerbation of a patient's injuries when an incompetent physician and nursing staff failed to call for a consultation. The finding increased the corporate liability of hospitals in regard of physician malpractice by indicating that the hospital had a duty to supervise treatment given to a patient by a physician practising within the health care institution. As a result of the decision in Darling, supra, a number of states imposed a statutory duty on hospitals to review the quality of services and treatment provided. 14

This responsibility now exists in Canadian health care facilities. Hospital boards and administrators have a duty to ensure that medical staff privileges are bestowed only to competent and qualified physicians. As a result, much time is devoted to the credentialling system, revision of medical staff bylaws and enforcement of hospital policies and regulations. 15


15 Ibid., at 80.
Liability in health care institutions may be direct or indirect. Direct or corporate liability results from an institutional failure to act according to acceptable standards of conduct. Indirect or vicarious liability stems from the health care institution's responsibility for the negligence of an employee.\textsuperscript{16}

IV. LEGAL IMPLICATIONS FOR QUALITY ASSURANCE PROGRAMS IN SASKATCHEWAN

A. PROTECTION OF QUALITY ASSURANCE ACTIVITIES

1. Rationalizing Evidentiary Privilege for Quality Assurance

(a) Patient Access to Health Records

The importance of keeping medical records was emphasized by the Canadian Council of Hospital Accreditation and is quoted by the ontario High Court in \textit{Kolesar v. Jefferies} (1976), 59 D.L.R. (3d) 367 at 373; affd, (1977) 77 D.L.R. (3d) 161 (S.C.C.) as follows:

\begin{quote}
importance of medical records
\end{quote}

Medical records are an important tool in the practice of medicine. They serve as a basis for planning patient care; they provide a means of communication between the attending physician and other physicians and with nurses and other professional groups contributing to the patient's care; they furnish documentary evidence of the course of the patient's illness, treatment and response to treatment. Very importantly, in the accredited hospital, they serve as the basic document for the medical staff's review, study and evaluation of the medical care rendered to the patient. For these reasons the C.C.H.A. considers the quality of medical records not only an important indication of the quality of patient care given in a hospital, but a valuable tool to maintain quality care and promote staff education.

\textsuperscript{16} Ibid., at 80.
The legislative requirements in regard of the content of hospital or medical records are set out in subsections 12(1)-(3) of Sask. Reg. 285/74 made under *The Hospital standards Act*, R.S.S. 1978, c.H-10. These regulations generally instruct that in addition to the personal details of a patient, the hospital records will usually consist of the following:

1. Family History
2. Patient's Personal History
3. Previous Diseases
4. History of Present Complaint
5. Body Function
6. Physical Examination
7. Investigations, Diagnosis and Treatment
8. Progress Reports
9. Consultative Reports
10. Emergency Reports, and
11. Consent Forms, Diagnostic and Therapeutic Orders, and Progress Reports

The optimal hospital record should present a clear portrait of the patient's condition on admission, the history, the physical findings, the investigations undertaken and the results obtained, the conclusions reached, the treatment provided, the progress made during the period of hospitalization and the condition on discharge.

It is trite law that the hospital record must be disclosed to the patient upon request. The rationale behind this policy is clear - the hospital record contains the facts surrounding the patient's sojourn in the hospital, without which it would be impossible to establish a negligence claim - and reflect the trend toward full disclosure.


(b) Access to Risk Management Reports

The most common risk management document is the incident report. An incident report is usually compiled by a nurse or other hospital employees and is a report to management on occurrences or mishaps outside the ordinary. Such reports usually directly involve patients, but may also involve any aspect of hospital operations.

The purpose of this genre of report is to bring to the attention of the hospital administrators any occurrence that could cause patient injury or the deterioration of a hospital service. The report is made almost contemporaneously with the occurrence of an "incident" by the parties involved and is therefore akin to police officers' notes or witness statements. An incident report should include an explanation of how and why the event took place.

It is imperative to observe that incident reports are management and not health treatment documents. The basic form of incident report contains:

(1) Name and address of the injured party or owner of damaged, lost of missing personal property.
(2) Time and date of the incident.
(3) The name, position, and signature of the person completing the report. If the individual who is writing the report is someone other than the person who observed the incident, then the name of the witness(es) should be obtained. If employed by the health facility, the position of the witness(es) should also be included.
(4) Adequate space should be included for a concise description of what transpired. The details should include an account of the location of the incident and a description of the surroundings. For example, if the floor upon which a patient fell was newly waxed and slippery that fact should be noted. Similarly, if a patient was injured when he fell against equipment left in a corridor that too should be noted.
(5) Any special care instructions in the patient's health record that may be pertinent to the incident should also be included in the report. For example, if an entry read "DO NOT LEAVE THE PATIENT UNATTENDED - suffering hallucinations" and the patient is found alone and injured in a washroom tub, both facts should be noted in the incident report. Similarly, if the health record included a notation "ALLERGY - PENICILLIN" and the patient suffered a severe reaction to an injection of penicillin, this should be disclosed in the incident report.

(6) If the patient had been given any relevant instructions regarding his condition these should be noted in the document. For example, if the patient had been told not to walk without the assistance of a nurse and this was noted on the health record, it would be important to include this information in the incident report. If the patient was found with a broken leg in the hallway after attempting to walk without assistance, the background information could help avert litigation or lessen the health facility's liability.

Although many health law specialists argue against disclosure of incident reports, the general policy in Saskatchewan is that incident reports will be disclosed where they contain factual information that supplements the medical and hospital record.

(c) Access to Quality Assurance Reports

The issue of whether quality assurance information is privileged arises primarily in the context of whether such information is discoverable or admissible in legal proceedings.

Because meaningful, open and candid peer review is the cornerstone of any quality assurance program, proponents of the quality assurance method stress that physicians and medical staff

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19 Rozovsky, at 110-111.
must be assured of confidentiality. The basic premise of the argument for confidentiality is:

if privilege is granted to quality assurance information, the result will be to encourage far more widespread and active participation in the review process by doctors and other health care professionals and to strengthen hospital-wide quality assurance programs, which ultimately in is the best interest of all patients. 20

Conversely, from a plaintiff's vantage point, access to quality assurance reports may ultimately be in the best interests of the public as disclosure of such records may open the door of what has traditionally been referred to as a "closed shop conspiracy of silence... 21

In response to this assertion, Marion Stevens, Director of Quality Assurance and Risk Management at the Hospital for Sick Children in Toronto, suggests access to quality review records is unnecessary. In her opinion, any competent expert witness should be able to identify information that would be captured by quality assurance reporting since such information is available in the patient's chart and treatment documents. 22

20 Feehan, at 7.
21 Ibid., at 7.
22 Marion Stevens" "Protection of Quality Assurance and Peer Review Data" (1989) 9 Health Law in Canada 79.
B. STATUTORY PROTECTION GIVEN TO QUALITY ASSURANCE DOCUMENTS

1. section 35.1 of The Saskatchewan Evidence Act

(a) The Law Before section 35.1: Finley v. university Hospital Board

In Finley v. University Hospital Board, [1987] 2 W.W.R. 40 (Sask. Q.B.), the infant plaintiff, via his guardian ad litem and his parents, commenced an action against the defendant hospital board and physicians for injuries the infant allegedly suffered at the time of birth. Following the birth of the infant plaintiff, the hospital board, as well as the College of Physicians and Surgeons, conducted an investigation in regard of the involvement of the co-defendant, Dr. Sugarman, in the delivery of the infant. Several documents and other communications resulted from the investigation and the plaintiffs sought an order for production of a "confidential" letter addressed to Dr. Sugarman by the College of Physicians and his reply to the letter. Both Dr. Sugarman and the board refused to produce the letters to the plaintiffs on the grounds that (i) they were protected by subsections 60(1)-(2) of The Medical Professions Act, S.S. 1980-81, c. M-10-1 and (ii) such documentation was privileged according to the four-part wigmore test23 approved by the Supreme Court of Canada in Slavutych v. Baker, [1976] 1 S.C.R. 254.

23 According to the Wigmore test, the four requirements for privilege are: (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; and (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 litigation. If all four questions are answered in the affirmative, the communications ought to be protected from disclosure and discovery.
The Court ultimately rejected both arguments. In regard of the first argument posed by the defendants, Mr. Justice Maher instructs at 44-45:

Section 60(1) of the Act prohibits action being taken against any committee or its members, the registrar of the college for any acts done in good faith pursuant to the provisions of the Act. Section 60(2) follows and reads:

(2) No witness in a legal proceeding shall be asked any questions about proceedings before or by, or information or evidence given to, a committee appointed by the council for the purpose of investigating and studying matters relating to morbidity, mortality or the cause, prevention, treatment or incidence of disease, but the witness is not excused from answering question or producing documents that he is otherwise bound to answer or produce.

I am not persuaded that the correspondence in question falls within the ambit of s. 60(2) of the Act. The section appears to be designed to protect from disclosure in legal proceedings evidence given to the various committees of council and there is nothing before me to indicate that the letters for which production is sought were ever before or considered by a committee of council. While Dr. Sugarman may have assumed he was required to respond to the letter of the inquiry from the college and that his reply would be confidential, these assumptions alone do not bring him within the protection from disclosure of the section. Moreover, the production of documents that a witness is otherwise bound to produce is specifically excluded and, unless the correspondence is otherwise privileged, I failed to see how s. 60(2) would entitle either Dr. Sugarman or the college to refuse production.

In regard of the second argument, the learned justice determined that where production is sought of a communication resulting from an investigation by a hospital, prompted by circumstances which give rise to litigation, the interests of the litigant outweigh those of the community, and unless special circumstances exist that suggest the maintenance of confidentiality for reasons of public policy, disclosure ought to be ordered.
(b) The Reaction of the Legislative Assembly of Saskatchewan

After the Court of Queen's Bench decision in Finley, supra, Canadian health care facilities were faced with a dilemma: How to maintain an effective quality assurance reporting mechanism while preventing the information discussed therein from being obtained in discovery proceedings or used as evidence against the health care institution? Clearly, the privilege provided by sections 60(1)-(2) of The Medical Professions Act, supra, was not adequate to protect the proceedings of quality assurance committees, nor was the common law test for privilege adequate protection for quality assurance materials unless special circumstances were in existence.

The Legislative Assembly of Saskatchewan attempted to solve this conundrum by amending the provincial evidence act. Section 35.1 of The Saskatchewan Evidence Act, R.S.S. 1978, c. S-16 provides in part:

(1) In this section:

(a) "board of governors" means the:

(i) board of directors;
(ii) board of management; or
(iii) other head;

of a hospital that is legally authorized to operate the hospital;

(b) "committee" means a committee designated as a quality assurance committee by the board of governors or the bylaws of a hospital to examine and evaluate on an on-going basis the provision of care and services to patients in the hospital for the purpose of:

(i) educating persons who provide health care; or
(ii) improving the care, practice or services provided to patients by the hospital;

(d) "legal proceeding" means any civil proceeding or inquiry in which evidence is or may be given and includes a proceeding for the imposition of punishment by way of fine,
penalty or imprisonment to enforce an Act or regulation made pursuant to an Act.

(2) Subject to subsection (4), a witness in any legal proceeding, whether a party to it or not:

(a) is not liable to be asked and is not permitted to answer any question or make any statement with respect to any proceeding before a committee; and

(b) is not liable to be asked to produce and is not permitted to produce any report, statement, memorandum, recommendation, document, information, data or record that is:

(i) prepared exclusively for the use of or made by;

or

(ii) used exclusively in the course of, or arising out of, any investigation, study or program carried on by;

a committee.

(3) Subject to subsection (4), no report, statement, memorandum, recommendation, document, information, data, or record mentioned in clause 2(b) is admissible as evidence in any legal proceeding.

(4) The privileges in subsections (2) and (3) do not apply:

(a) with respect to medical and hospital records that are:

(i) prepared for the purpose of providing care and treatment to a patient in a hospital;

(ii) prepared as a result of an incident in a hospital, unless the facts relating to that incident are also fully recorded on a record described in subclause (i); or

(iii) required by law to be kept by the board of governors;

(b) to legal proceedings founded on:

(i) defamation;

(ii) inducing breach of contract; or

(iii) civil conspiracy;

based directly on any proceeding before a committee or any report, statement, memorandum, recommendation, document, information, data or record, mentioned in clause (2)(b) or;

(c) to disciplinary proceedings where the impugned conduce is a disclosure or submission to a committee
One observes that subsections 35.1(2)(b) and (3) create a statutory privilege in regard of the production and admissibility of quality assurance documents prepared by a quality assurance committee. Only three exceptions to the general prohibition of disclosure and discovery exist. First, according to subsection 35.1(4)(a)(i) all hospital treatment records made for the purpose of providing care to a patient must be disclosed. Second, subsection 35.1(4)(a)(ii) requires that reports made in regard of an "incident" in a hospital must also be disclosed unless the facts relating to that incident are fully recorded on the hospital record. Third, according to subsection 35.1(4)(a)(iii) all records that a board of governors is required by law to keep must be disclosed.

This amendment sparked great debate. It is of interest to note that while the CBA supported the proposed amendment and indeed pressed the government to affect changes similar to the Alberta, Manitoba and B.C. Acts, the Saskatchewan Trial Lawyers Association actively opposed the amendments.24

2. Judicial Interpretation of section 35.1

(a) Kerr v. Saskatchewan (Minister of Health)

In Kerr v. Saskatchewan (Minister of Health), [1992] 6 W.W.R. 684 (Sask. Q.B.), the plaintiff's husband had committed suicide while a patient in the psychiatric wing of the Regina General Hospital. A mortality review committee was formed pursuant to hospital policy to investigate the death. Certain minutes and records were produced as a result of the investigation. The plaintiff

24 Third Session-Twenty-First Legislature of the Legislative Assembly of Saskatchewan, Debates and Proceedings, N.S. Vol. XXXII, No. 10SS Thursday, August 24, 1989, 1 p.m.
brought an action against the hospital under *The Fatal Accidents Act* and sought production of the records produced by the mortality review committee. The hospital claimed that the minutes were privileged under s. 35.1 of *The Saskatchewan Evidence Act* and therefore refused the plaintiff's request for production. The plaintiff then successfully applied to the courts to have the records produced.

Mr. Justice Halvorson noted that section 35.1 of the Act was created in 1989 in order to override the common law rule in *Finley*, supra. The learned Justice characterized section 35.1 as a compromise between suppression of confidential information and disclosure of relevant facts to a litigant. At 687, he instructs:

[B]Y the combination of subs. (2), (3) and (4), records prepared as a result of an incident in a hospital are privileged but only if the facts are fully reached in the patient care and treatment records of the hospital. Therein lies the compromise. The facts cannot be concealed by the hospital. However, the litigant must seek the facts from other discloseable hospital records and look to the record of the investigating committee as a last resort. As it is only the hospital which can ascertain whether the facts in the investigatory report are disclosed elsewhere, it will therefore, be incumbent on the hospital to convince the court on this point before the s. 35.1 privilege can attach to the report.

(b) *Soerensen (Guardian ad litem of) v. Sood*

Section 35.1 of *The Saskatchewan Evidence Act* was most recently discussed in *Soerensen (Guardian ad litem of) v. Sood*, [1993] 8 W.W.R. 709 (Sask. Q.B.). In this case a mother had commenced malpractice proceedings against her doctor alleging negligent prenatal care and that this substandard prenatal care resulted in damages to her son. She further alleged that the hospital did not have adequate medical staff or equipment to care for the infant born with a diaphragmatic hernia. However, no negligence was claimed against the hospital.
The hospital's quality review committee conducted a review of the care provided to the mother and son during the four hour period they had attended the hospital before being transported to another health care facility. Minutes were taken during the peer review process and the solicitor for the plaintiffs requested disclosure of this information. When the hospital refused, the mother applied under Queen's Bench rule 236 for an order directing the hospital to produce the committee's records.

Madame Justice Gunn allowed the plaintiffs' application on the basis that all three requirements under Rule 236 had been met and by application of Kerr, supra. There was no dispute that the documents were in the possession of the hospital and that it was not a party to the action. Similarly, there was no dispute that the documents related to the matters in issue. In regard of the dispute as to whether the documents could be produced at trial, the learned Justice found that the documents were prepared by a committee contemplated by s. 35.1(1)(b) of the Act, and that the committee's documents were "prepared as result of an incident in a hospital" as envisaged by s. 25.1(4)(a)(ii). As such, the records would only be privileged if the facts relating to the birth were fully recorded in the hospital records. She further found that the hospital did not meet the onus of establishing that the facts were fully disclosed elsewhere and therefore the assertion of privilege under s. 35.1 failed.

Both Kerr and Soerensen have been argued at the Court of Appeal. To date, no decision has been rendered in regard of either case.

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25 The three requirements under Rule 236 are: (1) the documents sought must be in the possession of a third party not a party to the action; (2) there must be reason to believe the documents relate to the matter in issue; and (3) the party, in whose possession the documents lie, might be compelled to produce them at trial.
Obvious problems flow from the interpretation of s. 35.1 given by Mr. Justice Halvorson and Madame Justice Gunn. In essence, these decisions have had the effect of emasculating the protection provided by the provision. As the law now stands, it appears that all a plaintiff must do to attain disclosure is:

1. show that the hospital has a quality review committee program;
2. show that the program reviewed the medical attention given to the plaintiff; and
3. assert that some "fact" is not contained in the hospital patient records.

There does not appear to be any onus on a plaintiff to examine the nurses, physicians or any other attending hospital staff in order to determine the "facts" of a proposed case. Without such a requirement, the words of Mr. Justice Halvorson, to the effect that disclosure of a quality assurance committee's records should be a "last resort", ring hollow. A further consequence seems to be that the court will be called upon to examine all quality review documents on a case by case basis.

v. CONCLUSION

without meaningful protection, quality assurance programs in Saskatchewan run the risk of becoming little more than a formality, supported only to fulfill hospital accreditation requirements. Perhaps the approach taken by David Duff provides the most balanced answer to the question of privilege and quality assurance programs:

First, privilege should be acknowledged only in the limited areas of QA [quality assurance] criteria, occurrence reports and peer review. 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. 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. Third, evidentiary privilege should be recognized only in the context of malpractice actions. In particular, no protection should apply before professional disciplinary bodies, hospital credentials committees or hospital accreditation authorities. Finally, participants in the QA and RM [risk management] 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.26

Pending the Court of Appeal's decisions in Kerr and Soerensen, section 35.1 may provide little comfort to quality assurance committee participants. Further statutory amendments may be in order lest physicians and other health care workers decline to participate in the process entirely.

_luff, at 548._
Please gather into groups of seven to eight. Identify a group reporter at the beginning.

Attached are the scenarios for your group discussion. Please:

- Identify the issues;
- Record your questions; and
- Record your responses.

Each group will report at the beginning of the panel session.

**SCENARIO ONE**

Your practice is located in a mid-sized community in Saskatchewan. One of your clients, Mr. Jennings, is well-known to you and you are aware that he has suffered various bouts of depression over the years. This is also known to his physician, Dr. Heathrow, who has prescribed Nardil, an anti-depressant, for Mr. Jennings.

This past Christmas, Mr. Jennings traveled to Saskatoon to visit with relatives. While here, he suffered from what appeared to be a bad cold and, just prior to leaving for home, attended at a Minor Emergency Clinic. There, it was suggested that he simply purchase some Ornade that would help address the symptoms. Mr. Jennings stopped at a nearby pharmacy, purchased the Ornade, took some and proceeded to travel home.

He, however, suffered a severe hypertensive crisis and wound up in your local hospital. He has later learned that he apparently suffered from a drug reaction. He is upset about it and has sought advice from you as to what action he may take.

**SCENARIO TWO**

You are consulted by a Ms. SeYmour who believes that a physician who previously treated her was negligent and she desires to commence an action against him. From discussions with her, you learn that in the summer of 1992, Ms. SeYmour was troubled by a sore on her foot. She periodically attended on Dr. Radcliffe who prescribed various topical ointments.

The condition of the foot did not improve, however, and the sore appeared more like a growth. Accordingly, in the fall of 1992, Ms. SeYmour consulted Dr. Anne Toews who treated the foot for a while and then suggested that a biopsy be undertaken. This biopsy was delayed, however, as Ms. SeYmour's job required that she be out of town frequently and her travel schedule did not permit the biopsy to be done until late that fall.
**SCENARIO TWO CONT'D**

The biopsy indicated a cancerous growth and Ms. Seymour was referred to the Cancer Clinic. Despite aggressive treatment, the foot had to be removed in the spring of 1993. Recovery seemed to be going quite well, however, the cancer re-occurred in the fall of 1993 and Ms. Seymour had to have her leg amputated below the knee. At that time, a resident made a comment to Ms. Seymour that the type of cancer she has is usually diagnosed rather easily early on, such that complications to the extent she experienced do not easily occur. This comment bothered Ms. Seymour, however, much of her time was involved in fittings for her prosthesis and adjusting to her changed physical condition. However, today, April 22, 1994, she has come to consult you.

**SCENARIO THREE**

Your client, Emily Waters, has been an occupational therapist for a number of years at Smalltown Union Hospital. Indeed, she established the therapy program at this hospital and took special training to promote therapy for seniors that was of great assistance in the Seniors Rehabilitation Program which she and Dr. Claudia Livingstone established at the hospital.

In addition, Ms. Waters and her husband have undertaken numerous fundraising projects over the years in promotion and support of Smalltown Union Hospital. The success of these fundraising campaigns was, in large part, due to the fact that the Waters are well-known in the community, having a large dairy operation and having invested heavily in the new particleboard manufacturing plant being developed in Smalltown.

However, with the advent of District Health Boards, Smalltown Union Hospital became a part of a large district. The District Health Board determined that Smalltown Union Hospital should be converted into a small community health centre. The District Health Board felt that the Rehabilitation for Seniors Program was no longer necessary as seniors within the district could be served adequately by therapists in the large urban centres. Nonetheless, given Ms. Waters' clear abilities in the area, the Board wished to retain her as an occupational therapist. The one available position was in Midsize, Saskatchewan, which was located in the extreme far end of the district.

Ms. Waters has come to consult you with respect to her options.