INTRODUCTION

1. The Healthcare Insurance Reciprocal of Canada (HIROC) appreciates the opportunity to make this submission to the ATIPPA Review Committee. Our submission focuses on the interplay between the *Access to Information and Protection of Privacy Act*, S.N.L. 2002. c. A-1.1 (ATIPPA) and the prohibition of disclosure of opinions and conclusions expressed during a quality or peer review pursuant to the *Evidence Act*, R.S.N.L. 1990, c. E-16 (*Evidence Act*).

HIROC

2. HIROC is an insurance reciprocal exchange which operates on a subscription and not-for-profit basis. It is the leading and largest healthcare liability insurer in Canada with approximately 600 health care facilities such as hospitals, nursing homes and community health centres, as members and subscribers in provinces across Canada. HIROC provides liability insurance to the four regional health authorities in Newfoundland and Labrador.

3. In addition to providing liability insurance to its members and subscribers, HIROC is a well-known advocate and promoter of health care interests within Canada. In accordance with its philosophy and vision statements, it promotes efficiency and innovation in healthcare insurance related areas through the delivery of comprehensive risk management and patient safety programs, as well as, critical resources and research information.

4. HIROC has provided educational programs to its subscribers and others within the healthcare sector since the time of its inception. HIROC participates regularly on various government committees and task forces aimed at addressing systemic issues as diverse

as disclosure, liability, risk management, interprofessional collaboration and healthcare safety.

5. HIROC's Communications Department works collaboratively with subscribers to ensure they are kept up-to-date regarding industry specific news, organizational program and service developments, marketing and special events. HIROC's Healthcare Risk Management staff provide advisory services to subscribers on a wide range of clinical and operational issues. HIROC also offers additional risk management services, such as risk assessment checklists, case studies and resource guides, at no additional charge to its subscribers.

6. Since 2009, HIROC's risk management self appraisal tools have been included in Accreditation Canada's standards.

7. HIROC is one of the earliest members of the Canadian Patient Safety Institute (CPSI). In 2001 the need for a coordinated strategy to improve patient safety was recognized. That year, the annual conference of the Royal College of Physicians and Surgeons included a one-day forum on patient safety. Following the one-day forum, the National Steering Committee on Patient Safety (NSCPS) was developed. The NSCPS then consulted with Canadian healthcare organizations, provincial and territorial Ministries of Health, Health Canada and other experts. The NSCPS's report, *Building a Safer System*, was released in 2002 and proposed a national integrated strategy for improving patient safety. A key recommendation of the report was the creation of the CPSI.

8. The 2003 First Ministers' Accord on Health Care Renewal recognized the need for a national strategy for improving patient safety. Further, it stated that the Health Ministers would take leadership in implementing the recommendations of the NSCPS. The 2003

federal budget included $10 million annually for patient safety initiatives, including the creation of the CPSI. In December of 2003, Health Canada officially created the CPSI. Since then, HIROC has been active within the CPSI and has representatives sitting on a number of CPSI committees.

9. HIROC is one of several founding members of the Ontario Healthcare Risk Management Network (OHRMN – now called the Canadian Healthcare Risk Management Network or CHRMN). The network encourages closer cooperation amongst healthcare risk management and patient safety personnel by encouraging the exchange of ideas and information relative to risk management and patient safety, promoting professional development and acting as a resource for healthcare organizations interested in initiating or improving their risk management capability.

10. HIROC has a number of partnerships through which it supports and encourages patient safety and healthcare provider education. Examples of those partnerships include:

- HIROC and the Canadian Medical Protective Association (CMPA) have developed a joint statement regarding Liability Protection for Midwives and Physicians to assist in responding to questions from both groups regarding their respective responsibilities when involved in the care and treatment of the same patient during the course of pregnancy, birth and the post-partum period.

- HIROC is a key sponsor of CPSI's Safer Healthcare Now! initiatives in Ontario and Atlantic Canada.

- HIROC and the Society of Obstetricians of Canada formed Salus Global Corporation which focuses on the development, marketing and operational support of programs and tools to improve healthcare performance and safety.

- HIROC and the Institute for Safe Medication Practices Canada recently signed a partnership agreement. The agreement recognizes several areas of mutual benefit including joint marketing initiatives, the sharing of selected anonymous aggregate data and potential refinements to the type of data collected to ensure consistency.

- HIROC staff sit on a number of committees of the Ontario Hospital Association (OHA). HIROC is also a regular sponsor of OHA events and seminars. Both organizations joined the CMPA and the College of Physicians and Surgeons of Ontario in developing and co-sponsoring a video conference series aimed at physicians wishing to learn more about upcoming regulatory and legal guidelines related to disclosure.

- HIROC sits on the Federation of Medical Regulatory Authorities of Canada (FMRAC)'s National Risk Management Committee. Arising from ongoing collaboration with HIROC to develop Self-Assessment Modules for medical regulatory bodies, the Committee is accountable for facilitating the development, dissemination, adoption and evaluation of best medical regulatory practices, including the development of the first every accreditation program for medical regulatory bodies.

- HIROC has acted as a sponsor and participant in conferences organized by the Newfoundland and Labrador Association of Health Care Risk Managers.

QUALITY AND PEER REVIEWS IN THE HEALTH CARE SETTING

11. In recent years, considerable attention has been paid by researchers and accreditation agencies to practices for ensuring patient safety. It is now beyond question that a

hospital or health care organization must take considerable and considered steps in implementing practices designed to achieve maximal levels of patient safety.

12. Quality and peer reviews play a significant role in patient safety. These reviews examine the provision of health care to an individual patient or group of patients while aiming to maintain or improve the quality of care provided and/or the level of skill and knowledge of those involved in providing the care. The benefits of peer review and quality review have long been recognized and applied in processes such as mortality and morbidity rounds or grand rounds.

13. During such reviews, participants are encouraged to speak frankly. In the process of providing their own thoughts and opinions, participants may make subjective remarks. They are not required to provide any particular research or analysis to support their thoughts and opinions. That said, in some cases, a participant may chose to refer to a journal article or ongoing research. Essentially, the process envisioned for a quality or peer review is a “no holds barred” approach in which individuals can speak freely and without fear of critique or reprisal.

14. The focus of the review is on patient safety and quality of care; it is not to lay blame or assign liability. Further, the approach to a review may not be in line with that which is required in a legal proceeding. As such, quality and peer reviewers do not always proceed on the same basis as expert witnesses commissioned to provide a report in a civil suit; nor do they necessarily answer the same questions. A finding that an event was preventable does not necessarily mean that the event occurred due to negligence or care at a level less than a professional standard.

15. Research and policy papers respecting quality and peer review document the reluctance of healthcare professionals to participate in such processes without assurances that the opinions that they and others provide in the process will not be used against them in later legal proceedings, such as civil suits or disciplinary proceedings, arising out of the same facts. In an effort to promote and encourage participation in quality processes, governments in Canada, the United States and certain Commonwealth countries have legislated evidentiary protections or privileges for the opinions provided during, and the conclusions of, such processes. The legislation in these jurisdictions has taken different forms, but all have in common a prohibition against the later use of conclusions and opinions in defined legal proceedings.

16. While this prohibition exists in the legislation, it does not prevent cases from being assessed and litigated. The only thing that the legislation does is prohibit the opinions and conclusions from being referenced. The key pieces of information required to examine a case remain available to all parties: the medical record and any relevant policies. Further, those individuals who provided care or who may have information relevant to the matter at issue remain compellable as witnesses with respect to factual inquiries.

EVIDENCE ACT

17. In Newfoundland and Labrador, the *Evidence Act* provides the statutory prohibition against the use of conclusions and opinions from quality and peer reviews in defined legal proceedings. Specifically, section 8.1 states:

> *(1) In this section*
>
> *(a) "legal proceeding" includes an action, inquiry, arbitration, judicial inquiry or civil proceeding in*

which evidence may be given and also includes a proceeding before a board, commission or tribunal; and

(b) "witness" includes a person who, in a legal proceeding

(i) is examined orally for discovery,

(ii) is cross examined on an affidavit made by that person,

(iii) answers interrogatories,

(iv) makes an affidavit as to documents, or

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

(2) This section applies to the following committees:

(a) the Provincial Perinatal Committee,

(a.1) the Child Death Review Committee under the Fatalities Investigations Act ;

(b) a quality assurance committee of a member, as defined under the Hospital and Nursing Home Association Act , and

(c) a peer review committee of a member, as defined under the Hospital and Nursing Home Association Act.

(3) No report, statement, evaluation, recommendation, memorandum, document or information, of, or made by, for or to, a committee to which this section applies shall be disclosed in or in connection with a legal proceeding.

(4) Where a person appears as a witness in a legal proceeding, that person shall not be asked and shall not

(a) answer a question in connection with proceedings of a committee set out in subsection (2); or

(b) produce a report, evaluation, statement, memorandum, recommendation, document or information of, or made by, for or to, a committee to which this section applies.

(5) Subsections (3) and (4) do not apply to original medical or hospital records pertaining to a person.

> *(6) Where a person is a witness in a legal proceeding notwithstanding that he or she*
>
> *(a) is or has been a member of;*
>
> *(b) has participated in the activities of;*
>
> *(c) has made a report, evaluation, statement, memorandum or recommendation to; or*
>
> *(d) has provided information or a document to a committee set out in subsection (2) that person is not, subject to subsection (4), excused from answering a question or producing a document that he or she is otherwise bound to answer or produce.*

EVIDENCE ACT AND ATIPPA

18. An issue arises in the context of the interaction of the *Evidence Act* and the ATIPPA.

19. Section 6 of the ATIPPA provides direction in terms of conflicts with other legislation and how such conflicts ought to be resolved. Specifically section 6 states:

> *6.(1) Where there is a conflict between this Act or a regulation made under this Act and another Act or regulation enacted before or after the coming into force of this Act, this Act or the regulation made under it shall prevail.*
>
> *(2)* ***Notwithstanding subsection (1), where access to a record is prohibited or restricted by, or the right to access a record is provided in a provision designated in the regulations made under section 73, that provision shall prevail over this Act or a regulation made under it****.*
>
> *(3) Subsections (1) and (2) shall come into force and subsection (4) shall be repealed 2 years after this Act comes into force.*
>
> *(4) The head of a public body shall*
>
> *(a) refuse to give access to or disclose information under this Act if the disclosure is prohibited or restricted by another Act or regulation; and*

> *(b) give access and disclose information to a person, notwithstanding a provision of this Act, where another Act or regulation provides that person with a right to access or disclosure of the information. [Emphasis added]*

20. The regulations made pursuant to section 73 of the ATIPPA provide a list of Acts which have been designated to override the provisions of the ATIPPA. Section 8.1 of the *Evidence Act* is included in this list:

> *5. For the purpose of subsection 6(2) of the Act, the following provisions shall prevail notwithstanding another provision of the Act or a regulation made under the Act:*
>
> *…*
>
> *(f) section 8.1 of the Evidence Act*

21. However, due to the wording of section 8.1 of the *Evidence Act*, there is a limitation to the override. The *Evidence Act* prohibition arises in the context of a "legal proceeding." Thus, in the event that there is no legal proceeding, the *Evidence Act* prohibition against disclosure would not apply.[1]

22. This is a different scenario than that of the other legislation referenced in section 5 of the ATIPPA Regulations.[2] In those cases, the referenced legislation prohibits, restricts or limits access to records without regard to a particular triggering event. Those limitations exist at all times.

23. The *Personal Health Information Act*, S.N.L. 2008, c. P-7-01 (PHIA) came into force after the ATIPPA and appears to have addressed the issue noted with the ATIPPA vis à vis the *Evidence Act*. In that respect, section 58 of PHIA states:

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[1] *Eastern Regional Integrated Health Authority*, 2007 CanLII 28206 (NL IPC).

[2] *Eastern Regional Integrated Health Authority*, 2009 CanLII 60044 (NL IPC).

> ***58. (1) A custodian shall refuse to permit an individual to examine or receive a copy of a record of his or her personal health information where***
>
> *(a) another Act, an Act of Canada or a court order prohibits disclosure to the individual of the record or the information contained in the record in the circumstances;*
>
> *(b) granting access would reveal personal health information about an individual who has not consented to disclosure; or*
>
> ***(c) the information was created or compiled for the purpose of***
>
> *(i) a committee referred to in subsection 8.1(2) of the Evidence Act ,*
>
> *(ii) review by a standards or quality assurance committee established to study or evaluate health care practice, or*
>
> *(iii) a body with statutory responsibility for the discipline of health care professionals or for the quality or standards of professional services provided by health care professionals. [Emphasis added]*

24. The PHIA provision has no “triggering” event. The prohibition against disclosure exists at all times and is in line with the provisions for the other legislation referenced in section 5 of the ATIPPA Regulations.

25. In general, an access to information request regarding quality or peer review would be appropriately dealt with under PHIA. As such, the protections for quality and peer review under the *Evidence Act* are maintained and there is no issue of concern. However, it is conceivable that there may be a quality or peer review that would fall under the domain of the ATIPPA as opposed to the PHIA. In such a case an access request for a quality or peer review would be treated differently as compared to a similar request under PHIA.

For consistency, an access request for the same type of information should be treated in the same manner.

RECOMMENDATION

26. Given the above issue with inconsistent treatment of quality and peer reviews, HIROC recommends that the ATIPPA be amended to be in line with section 58 of the PHIA.