CAVALLUZZO HAYES SHILTON
McINTYRE & CORNISH LLP
BARRISTERS SOLICITORS

THE CANADIAN INSTITUTE
IMPLEMENTING *PHIPA* CONFERENCE

May 8-9, 2006

An Overview of the *Quality of Care Information Protection Act (QCIPA)*

Written By:

Elizabeth R. McIntyre & Sharan K. Basran
Cavalluzzo Hayes Shilton McIntyre & Cornish LLP
Barristers and Solicitors
474 Bathurst Street, Suite 300
Toronto, ON M5T 2S5

I. Introduction

Initiatives to improve patient safety and quality of care in the Canadian healthcare system have been the subject of several historic reports. These reports have recognized that most adverse events or near misses to patients, are the result of systemic deficiencies, and improvements are more likely to result, not from modifying individual behaviour, but in systemic improvements through risk management and quality of care programs.[1]

Unfortunately, health care facilities have faced obstacles in implementing effective quality of care programs. This was recognized in the 2001 report, *Patient Safety and Healthcare Error in the Canadian Healthcare System*, by G. Baker and P. Norton. The authors conducted a comprehensive review on patient safety levels and initiatives to improve the quality of care. The review included a survey and interviews of many individuals directly involved in the health care system. Many health care facilities reported challenges in the identification and reporting of adverse incidents and using such information in an effective way to improve the health care system. The barriers identified to achieving these goals included a culture of punishment, the fear of liability, as well as a lack of effective systems with adequate resources:

> There are concerns mentioned by many respondents about how errors are currently being defined, monitored, and acted upon. There is a lack of appropriate tracking systems and protocols to identify adverse events or near misses in many organizations. The punitive culture of many organizations and the lack of resources dedicated to systematic data collection and response to errors hinders the progress of accurately reporting and reducing healthcare errors.[2]

The Baker & Norton Report, along with other studies, have recognized that leading practices in quality of care initiatives include a non-punitive approach to error identification and investigation. This approach focuses on identifying aspects of the system that contribute to errors rather than casting blame on individuals. This data collected is then

---

[1] *Liability and Compensation in Health Care: a Report to the Conference of Deputy Ministers of Health of the Federal/Provincial/Territorial Review on Liability and Compensation Issues in Health Care* (R. Prichard, University of Toronto Press, 1990).

[2] *Patient Safety and Healthcare Error in the Canadian Healthcare System: A Systemic Review and Analysis of Leading Practices in Canada with References to Key Initiatives Elsewhere* (Prepared by G. Ross Baker and P. Norton for Health Canada, 2001, available on Health Canada's website at http://www.hc-sc.gc.ca.

used to identify deficiencies, and to implement systemic changes to reduce the risk of an error or prevent a similar occurrence in the future.[3] In other words, the goal is to prevent the preventable by learning from past incidents, and ultimately to improve patient safety. In addition to a cultural shift, it is necessary that this shift to a non-punitive approach is codified in legislation.

A critical element to quality of care initiatives is full and frank discussion by practitioners and managers, in the health care system. In order to achieve such openness, it has been consistently recognized that the information provided in the course of programs to improve the quality of care must be confidential and protected from disclosure in legal proceedings. More recently, the *National Steering Committee on Patient Safety* confirmed that the then existing legal and regulatory environment in health care perpetuated a fear of blame and litigation. As a result, disclosure discussions and quality improvement processes often did not involve an open dialogue, and sharing of questions or concerns. In that regard, the Committee recommended the following:

> Review and where applicable, revise *The Evidence Act* and related legislation within all Canadian jurisdictions to ensure that data and opinions associated with patient safety and quality improvement discussions, related documentation and reports are protected from disclosure in legal proceedings. The protection would extend to this information when used internally or shared with others for the sole purpose of improving safety and quality. Wording within the applicable Acts should ensure that all facts related to an adverse incident are recorded on a health record that is accessible to the patient or designated next of kin, and are not considered privileged.[4]

For the first time, Ontario has introduced legislation, the *Quality of Care Information Protection Act* (*QCIPA)*, which provides a level of protection to specific quality of care initiatives. *QCIPA* is part of a broader privacy-protecting initiative under which activities to improve the quality of care are facilitated by removing barriers to the gathering and sharing of information. In doing so, Ontario is following the lead of other provinces which already have conferred a statutory privilege on certain quality of care activities. Ontario has also expanded on the protection afforded such information. While the other provinces prohibit disclosure of quality of care information in legal proceedings, *QCIPA* also addresses any form of disclosure.

---

[3] *Ibid. under 4.4. Leading Patient Safety Practices in Canada*

[4] *Building a Safer System: A National Strategy for Improving Patient Safety in Canadian Healthcare*

II. Overview: The Intersection Between *QCIPA* and *PHIPA*

Both the *Personal Health Information Protection Act (PHIPA)*[5] and *the Quality of Care Information Protection Act* (QCIPA)[6] were enacted in Bill 31 (*The Health Information Protection Act).* When the Bill was introduced in the legislature, *PHIPA* was known as Schedule A and *QCIPA* as Schedule B of the Bill. However, this is somewhat misleading, since it implied that *PHIPA* and *QCIPA* were part of one Act. In fact, each operates as a free standing and separate statute.

Moreover, each statutes deals with different types of information for distinct purposes:

PHIPA

- The *PHIPA* relates to personal health information ("PHI"), which is identifying information about an individual patient, living or deceased. PHI includes information related to the health of a specific individual, or health care provided to a specific individual. In addition, PHI must also be identifying in that it is provided in a form that identifies an individual or could reasonably foreseen to identify an individual.[7]

- The purpose of *PHIPA* is to protect the confidentiality of PHI and the privacy of individuals in a manner which is consistent with providing effective health care. It does so by imposing obligations on Health Care Custodians to obtain a patient's consent for the disclosure, use, and collection of PHI, except as permitted under *PHIPA*. At the same time, the Act also grants patient the right to access a record of PHI and the means to exercise this right.[8]

---

[5] *Personal Health Information Protection Act* (PHIPA) S.O. 2004, Chapter 3, Schedule A

[6] *Quality of Care Information Protection Act,* 2004 S.O. 2004, Chapter 3, Schedule B

[7] *supra note 5,* sections 4(1) & 4(2).

[8] *supra note 5,* sections 1, 29, 51.

QCIPA

- The *QCIPA* relates to quality of care information ("QOC information"), which includes but is not limited to Personal Health Information. QOC information may not be health information related to a specific individual, nor identify any one individual. Quality of Care Information is defined in relation to a statutorily recognized "Quality of Care Committee", which meets the requirements set out under *QCIPA*. As explained in more detail below, QOC information is any information, whether PHI or not, which is collected by or prepared for a special committee designated by a health care facility and known as a "Quality of Care" Committee.

- The purpose of *QCIPA* relates to improving quality of care by encouraging frank discussions by overriding patient consent, and allowing health care professionals to disclose information to the Quality of Care Committee. *QCIPA* and *PHIPA* create a protective barrier around QOC information in a number of ways: by prohibiting anyone other than the QOC Committee, including patients, from accessing QOC information[9] ; prohibiting anyone from disclosing QOC information subject to narrow exceptions, and confers a statutory privilege on such information in legal proceedings.[10]

  Therefore the focus is to allow a limited form of disclosure without patient's consent, unlike *PHIPA*, and to limit a patient's right to otherwise access information respecting him/herself such as an incident involving the patient.

In the event of a conflict between *PHIPA* and *QCIPA,* it is clear that *QCIPA* prevails.[11] However, *PHIPA* defines conflict narrowly to cover only those cases, where it is impossible to comply with both *PHIPA* and another Act.[12] Therefore, the statutory intent is clearly to read *PHIPA* and *QHIPA* harmoniously as part of an internally consistent legislative scheme in so far as possible.

---

[9] *Ibid.,* sections 51(1)(a) and 52(1).

[10] *supra note 6*, sections 4(1) and 5(1) & 5(2).

[11] *supra note 5*, section 7(4).

[12] *Ibid.,* section 7(3).

PHIPA also addresses quality of care information in its access provision and provides for different reviews relating to quality of care:

- The right of patients to access information under *PHIPA* applies to a record of PHI about an individual and excludes Quality of Care information.[13] However, it is important to recognize that QOC information does not include information contained in a record maintained for the purpose of providing health care to an individual. This would include a patient's chart and recorded maintained by a health care facility that do not form part of a chart but are needed to provide patient care. QOC Information also does not include facts contained in a record of an incident involving the provision of health to a specific patient, except if those facts are also fully recorded in the health record of the patient.[14]

  Therefore, patients are not restricted from accessing facts of an incident which are recorded (such as in an incident report) and revealed to a Quality of Care Committee under *QCIPA*, when these same facts are not included in the patient's health record. This imposes an important limitation on the protections afforded under *QCIPA.*

- It is also important to note that there are different types of review related to quality of care, which are permitted under *PHIPA* and *QHIPA. PHIPA* allows a health information custodian to use PHI about an individual without a patient's consent, for the purpose of risk management, error management, or for the purposes of activities to improve or maintain the quality of care.[15] Such reviews carried out by committees or other groups which have not been designated as a Quality of Care Committee under *QCIPA* are not shielded from disclosure. Therefore, both managers and professionals working in facilities need to be cognizant of the range of reviews which may be conducted and which ones are subject to protection under *QCIPA.*

---

[13] *Ibid.,* section 51(1)(a).

[14] *supra note 6,* section 1.

[15] *supra note 5, section 37(1)(d)*.

III. Overview of QCIPA

As explained, *QCIPA* does not grant protection to information related to any quality of care review. To the contrary, an individual is only prohibited from disclosing that information which fits within the statutory definition of Quality of Care Information. The definition incorporates a special "Quality of Care Committee" designated under *QCIPA* as such by authorized facilities. QOC information is any information, whether PHI or not, which is collected by or prepared for a Quality of Care committee in relation to its purposes to improve or maintain quality of care.[16] As explained in other literature "...without a quality of care committee there is no quality of care information. If information is discussed without any connection to a quality of care committee, even for the purpose of improving the quality of care, the protection provided in *QCIPA* will not apply."[17]

If information is considered QOC information, then the Act places a complete prohibition on the disclosure of such information, except as permitted under the Act.[18] This includes patients. *QCIPA* also creates a statutory privilege and prohibits disclosure of QOC information in "proceedings" as follows:

- *No person* is allowed to ask a witness and no court or other body holding a proceeding can permit or require a witness in the proceeding to disclose quality of care information.[19] Therefore, the section prohibits asking a witness about QOC information, and the court is directed not to allow the witness to respond to any such questions;

- Quality of care information is not admissible evidence in a proceeding.[20]

---

[16] *supra note 6,* section 1.

[17] *Guide to the Ontario Personal Health Information Protection Act* H. Perun, M. Orr, & F. Dimitriadis (Irwin Law, 2005) at 615.

[18] *Supra note 6,* section 4(1).

[19] *Ibid.,* section 5(1)

[20] *Ibid., section 5(2).*

Proceeding is defined under the Act as follows:

> proceeding includes a proceeding that is within the jurisdiction of the Legislature and that is held in, before, or under the rules of a court, a tribunal, a commission, a justice of the peace, a coroner, a committee of a College within the meaning of the Regulated Health Professions Act, 1991, a committee of the Board of Regents continued under the Drugless Practitioners Act, a committee of the Ontario College of Social Workers and Social Service Workers under the Social Work and Social Services Work Act, 1998, an arbitrator or mediator, but does not include any activities carried on by a quality of care committee.[21]

As can be seen, proceeding has been defined broadly to include a wide range of legal proceedings under provincial jurisdiction. The definition excludes proceedings under Federal Jurisdiction such as those under the *Criminal Code*. Therefore, if a professional discloses potentially criminal activity such as an alleged assault or substandard care which rises to the level of criminal negligence to the QOC Committee, such communications wold not be protected if criminal charges were laid.

Interestingly, unlike other provinces, Ontario did not exclude certain provincial bodies from the definition of proceeding. For example, in British Columbia, the privilege accorded to quality of care initiatives, does not apply to internal Hospital proceedings before a Board of Management, which often holds hearings respecting privileges of a physician or staff appointment. As well, B.C. legislation allows for disclosure to designated regulatory bodies for certain professionals including physicians, nurses, dentists, and others.[22]

Another consideration is whether proceeding includes pre-hearing processes such as an investigation. There are a number of arguments that the privilege applies to investigations. The meaning of proceeding is not restricted under *QCIPA.* Further, the definition of proceedings includes not only matters “before” but “under” the listed bodies. Although this issue has not yet been interpreted, this wording would support that proceedings encompasses both a formal hearing, as well as the investigatory process leading up to a hearing before the designated body. The ordinary meaning of proceeding often includes a step that is part of a larger action before a court or special proceedings before administrative bodies.

---

[21] *Ibid., section 1.*

[22] *Evidence Act* RSBC 1996 Chapter 124, section 51(1).

Further, in order to achieve the objectives of the legislation, full and frank discussion to improve quality of care, the statutory privilege must be meaningful and effective. For instance, it would make no sense to prohibit disclosure of information at a disciplinary hearing for alleged professional misconduct, and permit such information to be disclosed in the course of an investigation conducted by a College. Essentially, investigators would gain knowledge of QOC information when the same information may not be the subject matter of questions or admissible evidence at a hearing.

Another consideration is how *QCIPA* interacts with other provincial legislation mandating reports and investigations, such as the *Coroner's Act*.[23] Proceedings includes a proceeding *before or under* a Coroner. The Coroner's Act imposes an obligation on a person to person to report the "facts and circumstances relating to the death" to the Coroner's office where there is reason to believe a death was caused by specified reasons. As *QCIPA* collected facts of an incident, which are recorded and are not included in the patient's charts is not considered quality of care information, the facts of a death may be disclosed. On the other hand, opinions and evaluations made by a QOC Committee may not be disclosed.

IV. *QCIPA* Designated Quality of Care Committees

To qualify as a "Quality of Care" Committee under *QCIPA* must be specifically designated by an authorized institution and perform quality of care functions. *QCIPA* protects those quality or peer review processes conducted by the QOC Committee for the purpose of evaluating the provision of health care with a view to improving or maintaining the quality of health care **or** the level of skill, knowledge, and competence of the person who provided the health care. Therefore reviews conducted by committees other than a *QCIPA* designated QOC Committee, or by a QOC Committee but for some other purpose unrelated to its function to improve or maintain quality of care would not be protected. However, *QCIPA* does not limit a facility to only one QOC Committee. Rather, it is possible to have more than one Committee so long as they meet all the criteria set out in *QCIPA.*

There are a number of steps in properly setting up a QOC Committee. First, an organization must be authorized under *QCIPA* to establish a QOC Committee:

- public hospitals, private hospitals, and independent health facilities;

---

[23] R.S.O. 1990 c. 37, section 10.

- psychiatric facilities and an institution within the meaning of the *Mental Health Act*;
- long-term care facilities (nursing homes, charitable home for the aged);
- licensed medical laboratories and specimen collection centres;
- the Ontario Medical Association and Canadian Blood Services in respect of its quality assurance activities with licensed medical laboratories and specimen collection centres.[24]

Second, the QOC Committee must possess and perform quality of care functions: one of the functions of the Committee must be to improve and/or maintain the quality of care, or the level of skill, knowledge, and competence of health care professionals.

Practically, these two criteria are implemented pursuant to section 3 of Ontario Regulation 297/04. The Committee must be formally designated in writing by the authorized entity and be conferred with quality of care functions. The designation is typically by way of resolution of the board of directors or senior management, consistent with the hospital's by-laws and internal governing structure. In addition there must be terms of reference, which along with the written designation must be available to the public. The terms of reference would detail such things as its purpose consistent with *QCIPA*, the membership of the Committee, its reporting responsibilities, its authority to collect information from professionals, and set out its mandate or functions broadly. The Ontario Hospital Association has published an excellent resource to guide Hospitals to implement *QCIPA* and guidelines for creating a QOC Committee.[25]

There are several practical considerations which must be considered when applying *QCIPA* to the existing structure of a facility:

- If a Committee is designated as a QOC Committee, it may be a multi-purpose Committee, with quality of care functions being one of several functions. However, it is important to note that protections under *QCIPA* apply only to a QOC Committee's quality of care functions and not for other functions. In other words, the quality of care information may only be protected if it relates primarily or solely to the improvement or maintenance of the quality of health care. If such a structure is adopted, then quality of care information functions must be kept separate from other

---

[24] *Supra note 6,* section 1, *Ontario Regulation 297/04* section 1

[25] *Quality of Care Information Protection Act (QCIPA) Toolkit* (Ontario Hospital Association), available at www.oha.com.

functions. This may involve a designated time period or formal declaration as to when the Committee is engaging in QOC activities, as well as separate minutes or notes for QOC activities.

- Such measures to separate the functions of multi-purpose Committees may be difficult to maintain in practice. In particular, there may be confusion as to whether an issue discussed is considered related to Committee's quality of care functions or not. It has been recommended that a single and QOC Committee dedicated solely to QOC functions is less risky and preferred.[26] In this way, the activities of the QOC Committee clearly relate to a single QOC function, and fit within the four corners of *QCIPA* protected activities.

  This is strengthened by the fact that such a QOC Committee may delegate QOC functions to another Committee not designated as a QOC Committee and retain the protections under *QCIPA*. The information generated by this non-designated Committee is protected because the other Committee is engaged in the review as a delegate of the QOC Committee.[27] This is supported by the regulations, in that QOC Committee includes "..every person who participates or assists with the Committee's function..."[28] Arguably this would include experts, administrative staff, and hospital committees which assist the QOC in achieving its quality of care functions.

- Facilities must also consider whether it is appropriate to designate an existing Committee as a QOC Committee and/or create a new committee under *QCIPA.* As explained earlier, the *PHIPA* allows for quality of review processes outside the scope of *QCIPA*. In particular, the facility must consider whether it wishes to use the information generated for some other purpose beyond improving the quality of care. There may be cases where a facility does not wish to shield information from future uses.

  For example, the facility may wish to make use of a review for recommendations respecting hospital privileges, staff appointments, or discipline. If such a review is

---

[26] *supra note 17* at 619.

[27] *Ibid.,* at 619, and *supra* note 26 at 32.

[28] *supra note 6*

conducted by a QOC Committee under *QCIPA*, the information generated out of the review may not be used. Rather, an entirely separate investigation and analysis must be conducted. Such a review ought to be conducted by another committee outside the scope of *QCIPA.* Further, staff should explicitly advised that such a review is outside the purview of *QCIPA* and not protected from future uses.

- It is essential that there be a structure in place for determining whether a review of care should be conducted under *QCIPA.* There needs to be a central coordinating point to the structure, namely one designated individual who is assigned primary responsibility for quality of care activities throughout a facility. The person ought to be appointed a member of the QOC Committee. This designated individual should also be a member and the main contact for the QOC Committee, and receive notification of adverse incidents, and determine whether a *QCIPA* review is warranted. Such immediate notification should occur before any review by unit managers or department heads is conducted, so that an appropriate determination can be made.

  In this way, the information provided to the primary contact as a member of the QOC Committee may be protected as QOC Information. This is particularly important for incidents which give rise to more serious quality of care concerns and merit reviews that need the protection of *QCIPA*. Otherwise, ad hoc or departmental reviews by a non QOC Committee Member would not be protected under *QCIPA*.[29]

- When determining the composition of the QOC Committee, it is important that Committee Members ensure there is no conflict of interest. For example, if a staff member's actions are under a review, then a manager who exercises control over the terms and conditions of employment should not sit on the Committee for that review. If the manager sits on the Committee, the manager cannot use the information generated out of the QOC Committee Review in investigating the staff member's conduct for disciplinary purposes. Practically, it would be extremely unworkable for a manager to disregard QOC information learned during their work as a QOC Committee member when considering whether to impose discipline.

V. Quality of Care Information

---

[29] *Supra note 26* at 21.

As explained earlier, QOC information is prohibited from disclosure except as permitted under the Act. Quality of Care Information is any information, whether PHI or not, collected by, given, or prepared for a QOC Committee for the sole or primary purpose of assisting the Committee in carrying out its quality of care functions. *QCIPA* also excludes certain types of information as quality of care information, even though such information may come to light for the first time during a QOC Committee review. The following are excluded from the meaning of quality of care information:

- Information contained in a record that is maintained for the purpose of providing health care to an individual. This includes, but is not limited to the patient's chart. Other records are maintained in order to care for patients beyond the chart and may include kardexes, electronic records, nursing reports during shift exchange, nurses' working notes, or prescriptions.

- Information contained in a record that is required by law to be created or maintained; and

- Information which is specifically excluded by the Regulations. To date, there are only two exceptions which have been prescribed: the fact that a quality of care committee met or conducted a review; and when the meeting or review took place.[30] Arguably, this would not include any further details respecting what was discussed, or the subject matter or specific incident under review.

- facts contained in a record of an incident involving the provision of health care to an individual, except if the facts involving the incident are also fully recorded in a health care record.[31]

The following categories of information would fall outside the exclusion:

- facts which do not relate to an incident involving the provision of health care. This would be a narrow exception and immaterial as the most contentious facts in a subsequent legal proceeding would be the provision of health care and the incident arising thereof;

---

[30] Ontario Regulation 330/04, section 2.

[31] *supra note 6*, section 1.

- facts of an incident which are not written down or recorded during the course of a QOC Review. Again, it seems untenable that a QOC Committee would not in practice have some method of recording statements made by professionals involved in the care of a patient, whether by formal (stenographer), or informal means (working notes made by Committee members);

The exclusion respecting "facts of an incident" from quality of care information significantly limits the protections afforded during *QCIPA* reviews and requires careful consideration when advising clients. In particular, *facts of an incident related to the provision of health care to a specific individual*, *which are not recorded in a patient's chart* and revealed in a review conducted by the QOC Committee may be disclosed in a legal proceeding *if they are recorded*. This means that facts not recorded in a patient's chart and then recorded by a QOC Committee, are not protected under *QCIPA*. It is important to note that this exclusion applies to recorded and not oral facts.

There is an argument that this exclusion extends beyond incident reports to include facts of an incident recorded in many different types of documents, so long as the facts are not included in the patient's charts: interview notes or other working notes of the QOC Committee; minutes of a meeting of the QOC Committee; and other documents created by or for the Committee such as a personal account of an incident by a health care professional and given to the QOC Committee.

This exclusion draws a distinction between "fact" and "opinion." It is recognized that opinions and evaluations made by the QOC Committee are protected, including evaluations of the delivery of health care in a particular incident, or recommendations for improving the quality of care. It is unclear however whether all information related to an incident involving a patient would not be protected under *QCIPA.* In particular, the distinction between fact and opinion in the delivery of health care is unclear, as many observations subjective components and there are often competing interpretations of the same event. The fact that a health care professional failed to administer a medication is clearly a fact. However, the views formed by one health care professional that a patient looked pale or faint, or opinions/assessments made from the vital signs of a patient such as the elevated blood pressure of a patient are more problematic. The question arises as to whether such subjective or evaluative aspects of health care constitute facts of an incident.

In addition, facts are also interwoven with subjective opinion or evaluations. This poses the practical problem of how to separate out such information to shield quality of care information.

The policy reasons behind this exclusion attempt to strike a balance between protecting "quality of care" information and ensuring that the patient's right to access facts of an incident is not compromised. In particular, the exclusion qualifies the protection under *QCIPA* and ensures patients have a complete record of his/her health information. This was confirmed by the remarks made by the Minister of Health & Long-Term Care to the General Standing Committee when Bill 31 was introduced:

> This legal protection for quality of care information is available only if the facts of a medical incident are recorded in the patient's file. The information provided to the quality of care committee and the opinions of committee members would be shielded from disclosure in legal proceedings as well as most other disclosures outside the hospital. In this way, we have carefully balanced the need to promote quality care with the need to ensure accountability.[32]

It remains to be seen whether the balance has been appropriately struck or whether health care professionals will be reluctant to engage in discussions respecting an incident considering this exclusion. In particular, professionals must be aware that facts of an incident provided to the QOC Committee may not be protected. In particular, facts not included in a patient's record will not be shielded as quality of care information even if they are recorded in the context of a review by a quality of care committee.

The author views this section as potentially hampering the goal of encouraging full and frank discussions. In the context of litigation, facts are often the most important aspect of a case. It is the facts that determine the outcomes and liability. Furthermore, facts are often disputed and there may be several versions of events as between health care professionals. While it is mandated for professionals to enter complete and accurate entries in the chart, the practical reality in health care institutions across Canada is that all facts or details of an incident may not be fully recorded in the chart. Often the main facts of an incident are charted, and further details are inevitably disclosed in the context of a quality of care review where lengthy interviews are conducted. The question arises as to whether there is any limit as to when facts are "fully recorded", or whether all details which supplement the patient's chart may be disclosed.

---

[32] *Legislative Assembly of Ontario, Minutes of the Standing Committee on General Government,* January 26, 2004, available http://www.ontla.on.ca

Furthermore, the Act imposes no limitations on who records the facts: the interviewer or the interviewee. Therefore, working notes of an interview not verified by a professional as accurate may be disclosed and be an unreliable and prejudicial source of information.

In light of the fact that a review conducted under *QCIPA* is voluntary (a person "...*may* disclose any information to a quality of care committee for the purposes of the committee,"[33]), it is questionable as to whether this exclusion is appropriate. In circumstances involving a serious or critical incident, and where litigation is contemplated, it may be advisable not to participate in a review under *QCIPA*. Otherwise, the process under *QCIPA* may become a discovery process respecting the facts of an incident and impede on traditional privileges such a litigation privilege or solicitor-client privilege, which may have otherwise protected such information.

It is interesting to note that Ontario did not adopt legislation in other provinces and only exclude medical and hospital records from being privileged. For example, both Nova Scotia and Alberta protects all information provided to a statutorily recognized quality of care committee with the exception of "original medical and hospital records pertaining to a patient."[34] The wording in Saskatchewan is broader but distinct from Ontario in that it excludes medical and hospital records that are "prepared as a result of an incident in a hospital, unless the facts relating to that incident are also fully recorded on a record..."[35] prepared for the purpose of providing care and treatment to a patient. In Ontario, disclosure extends beyond patient records to include written facts not in a chart and disclosed to the QOC Committee.

The following are some practical tips in dealing with this exclusion:

- The Ontario Hospital Association has recommended that any factual information is recorded separately from other information generated as part of a *QCIPA* review.[36] Further, health care professionals being interviewed ought to be clearly advised that facts not contained in the patient's chart may be subject to disclosure and are not

---

[33] *Supra note 6*, section 4(1).

[34] *Alberta Evidence Act* R.S.A. 2000, c. A-18, *Evidence Act* R.S.N.S. 1980, c.154.

[35] *Saskatchewan Evidence Act* R.S.S. 1978, c. S-16

[36] *Supra note 26* at 28.

privileged. They should also be advised in advance of what is being recorded. This is necessary so professionals do not misunderstood the process or have a false sense of security. Professionals should also be afforded an opportunity to review what facts have been documented in the patient's chart before being interviewed;

- There ought to be reliable means chosen to document any facts, such as professionals verifying notes made by others in the course of an interview, or the use of a stenographer;

- In most cases, the facts contained in an incident report are not protected from disclosure and professionals ought to limit the information in the incident report to facts as opposed to opinion, subjective views, or any assessment of fault. The Ontario Hospital Association recommends that for serious or critical incidents staff should not complete an incident report, but should notify their manager or the manager responsibility for quality of care activities, who are responsible to coordinate the review and guide staff in the appropriate way to report the incident.[37]

- Professionals should make complete notes of all important facts in the patient's chart at the time of the incident, and use late-entries as necessary. Further, any independent notes for serious or critical incidents should be made in the context of solicitor-client or litigation privilege, in so far as possible.

- In cases involving serious or critical incidents, it is important that facilities and professionals each have counsel to advise whether participation in the quality of review process under *QCIPA* is advisable. This is particularly important where harm has resulted to a patient, the facts are contentious or disputed, and litigation is likely.

The Collection of Information by the QOC Committee

Any person may disclose any information, including Personal Health Information, to a Quality of Care Committee for its quality of care functions without a patient's consent,

---

[37] *Ibid.,* at 23.

despite a provision in any other Act, including *QCIPA* and *PHIPA*.[38] It appear that while a person has the discretion to disclose information, the Quality of Care Committee cannot compel a person to provide information under *QCIPA*.

The disclosure provisions are strengthened by the immunity and non-retaliation parts of *QCIPA.* So long as a person discloses information in good faith to a QOC committee, no action or other proceeding may be initiated against the person making the disclosure. In addition, a person who has disclosed information to a QOC may not be penalized in any way. In particular, a person may not be dismissed, suspended, demoted, disciplined, harassed, or "otherwise disadvantaged" for reasons related to the disclosure.[39]

Disclosure

General Prohibition of Disclosure beyond QOC Committee Members

The general rule is that no person is allowed to disclose quality of care information except as specifically authorized under *QCIPA*.[40] "Disclose" is given a special meaning under *QCIPA* and refers to providing or making information available to a person who is not a member of the quality of care committee with which the information is associated.[41] Therefore, any person is prohibited from sharing that information with any person other than a QOC Committee member. This means that health care professionals who learn quality of care information in the course of a review would be prohibited from disclosing that information to their colleagues and other facility staff.

The Regulations provide that a member of a QOC Committee member includes every person who "participate or assists" with the committee's quality of care functions.[42] Therefore, experts, physicians, nurses, and other staff who provide advice related to quality of care matters, would be included in this expansive definition of the QOC Committee. The QOC Committee may provide QOC information to such individuals in

---

[38] *Supra note* 6, section 3(1).

[39] *Supra note 6*, sections 8(1) & 6(1).

[40] *Ibid.,* section 4(1).

[41] *Ibid.,* section 1.

[42] *Ontario Regulation 330/04,* section 3.

order to fulfill its quality of care mandate, without being considered a disclosure under *QCIPA.*

Further, the Act makes it an offence for a person to disclose QOC information where it is not authorized. Such an offence is punishable by a fine of up to $50 000 for individuals and up to $250 000 for organizations or corporations.[43]

Permissible Disclosures

When considering permissible disclosures, it is important to first consider whether the information prepared for or collected by QOC Committee constitutes QOC information, and is even subject to protection at all. The following chart summarizes information that may be disclosed to a patient and in a legal proceeding: [44]

[43] *Ibid.,* section 7(1).

[44] *Overview of Care Initiatives under the Quality of Care Information Protection Act, 2004: An Overview & FAQs* (2004, Cassels Brock & Blackwell LLP) and available at http://www.casselsbrock.com.

Not Privileged	Privileged
- Recorded Facts of an Incident: Any recorded facts of an incident involving the provision of health care collected by or prepared for the QOC Committee, if these same facts are not in the patient's chart. This may include incident reports, interview notes, or other documentation generated by or for a QOC Committee.	- Quality of care information includes largely opinion including conclusions, evaluations, assessments, expert advice made by the QOC Committee based on the facts. - Such QOC information may be in the form of minutes, reports or discussions/deliberations of the QOC Committee. - This also includes findings or recommendations set out in a report prepared by the QOC Committee.
- Patient health records and documents required by law	- Oral facts: unrecorded facts of an incident involving the provision of health care.
- The fact that a Quality of Care Committee met or conducted a review, and when the meeting or review took place.	
- Any follow-up action taken by management in response to QOC Committee review, so long as it does not include the findings or recommendations of the QOC Committee upon which the actions were based.	

If the information at issue is considered quality of care information, consideration must then be had to whether *QCIPA* authorizes the disclosure of QOC information and by whom. These are set out below, along with how the recipient may use QOC information:

- The Act limits the disclosure of QOC information even within an organization to management of a health facility, which includes both senior management staff and governing bodies such as the board of directors. A Quality of Care Committee has the discretion to disclose quality of care information to management of a facility where the committee considers it appropriate to do so "...for the purpose of improving or maintaining the quality of health care provided in or by the facility."[45]

[45] *supra note 6*, section 4(3).

Typically, management would receive a report with findings as well as recommendations or steps to improve the quality of care.

- Managers who receive QOC information are limited in how they can use and disclose QOC information. Management may only use QOC information for the purpose for which it was disclosed - namely to improve or maintain the quality of health care.[46] Therefore, such information cannot be used to discipline a professional, or to conduct a review respecting his/her practice and hospital privileges. Second, management may also disclose QOC information in its possession to an agent or employee of the same facility, if the disclosure is "...necessary for the purposes of improving or maintaining the quality of health care."[47] One can foresee that Managers may wish to inform medical staff or department heads about finding or recommendations of a QOC Committee so that any changes are effectively implemented. An employee or agent is prohibited from disclosing such information, except if it fits within the harm provision set out below.[48]

- The last exception applies to any person and not only to members of the QOC Committee. A person is permitted to disclose QOC information if the disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm.[49] Similarly, the recipient of such QOC information about harm, can only use the QOC information for the purpose for which the information was disclosed. Presumably, this would mean that a person may take such action to eliminate or reduce the risk such as reporting allegations of incompetence of a health care professional to the board of directors or a regulatory body.

- It appears that any disclosures permitted or required under the *Criminal Code*, as federal legislation, would not be prohibited as *QCIPA* does not prevail over federal legislation.[50]

---

[46] *Ibid.,* section 4(5).

[47] *Ibid.,* section 4(6).

[48] *Ibid.,* section 4(7).

[49] *Ibid.,* section 4(4).

[50] *supra note 26* at 631.