
CANADA / JUDGMENT

Nagase v. Entwistle

2015 BCSC 1654

COURT

Supreme Court of British Columbia

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2015 BCSC 1654 Nagase v. Entwistle

IN THE SUPREME COURT OF BRITISH COLUMBIA

Citation:

Nagase v. Entwistle,

2015 BCSC 1654

Date: 20150915

Docket: S130086

Registry: Vancouver

Between:

Dr. Daniel Nagase

Plaintiff

And

Dr. Peter Entwistle, Dr. Jonathan Slater, South Okanagan General Hospital, and The Interior Health Authority

Defendants

Before: The Honourable Mr. Justice G.C. Weatherill

Reasons for Judgment

Counsel for the Plaintiff:

J.H. Schenk

Counsel for the Defendants:

P.A. Washington

Place and Date of Hearing:

Vancouver, B.C.

August 31, 2015

Place and Date of Judgment:

Vancouver, B.C.

September 15, 2015

I. Introduction

- [1] The plaintiff claims against the defendants for defamation, interference with contractual relations and breach of his privacy. The trial of the action is scheduled to commence on November 2, 2015.
- [2] There are two applications before me.
- [3] The plaintiff applies for various orders relating to the production and use in this proceeding of documents he alleges were defamatory of him as well as documents related thereto ("Correspondence").
- [4] The defendants apply for an order striking the plaintiff's notice of civil claim pursuant to Rule 9-5(1)(a) of the Supreme Court Civil Rules on the basis that the plaintiff is precluded by s. 51(2)(b)(i) of the Evidence Act, R.S.B.C. 1996, c. 124 [Evidence Act] from producing or utilizing the Correspondence in the Action.

II. Background

- [5] The plaintiff is a physician. He had locum privileges at Squamish General Hospital in Squamish, British Columbia. In May 2010, he also began working as a locum emergency room physician at the South Okanagan General Hospital in Oliver, British Columbia ("SOGH").
- [6] The defendant, Dr. Entwistle is, and was at all material times, the Chief of Staff at SOGH. His duties included ensuring appropriate physician professional conduct and managing the performance, behaviour and, if necessary, discipline of physicians at the hospital.
- [7] On December 14, 2010, the plaintiff was working in the SOGH emergency ward attending to patients needing acute care. An incident occurred which involved one of the emergency ward nurses dealing with a non-acute care patient of Dr. Entwistle's. The plaintiff was concerned that the non-acute care patient should not have been admitted using the emergency ward resources and that, as a result, general patient safety had been compromised. The plaintiff spoke to the head nurse but formed the view that she summarily dismissed his concerns. There was a somewhat heated exchange within the emergency ward between the plaintiff and the head nurse, all within the earshot of patients.

[8] Later that day, the plaintiff apprised Dr. Entwistle of his concerns and his views about what had happened. A discussion was then initiated by the plaintiff with Dr. Entwistle and the ER staff. Dr. Entwistle's evidence on examination for discovery is that the purpose of the discussion was to congratulate one of the ER nurses for her work during the disruption and to discuss the plaintiff's view that he had been overruled by the head nurse. According to the plaintiff, during the course of the discussion, Dr. Entwistle took great offence to the plaintiff's suggestion that there had been a delay in the provision of acute care as a result of the alleged "mis-management of resources" by the nurses involved. The plaintiff deposes that he "held firm" in his assertions that the incident had been dangerous and had presented a serious and unnecessary risk to the patients. He suggested that Dr. Entwistle had been in a conflict of interest because the non-acute patient involved was Dr. Entwistle's patient. He also suggested that a policy be implemented to admit patients in a safer and more communicative fashion by involving the ER physician.

[9] Dr. Entwistle immediately requested that his chief administrator obtain reports from the nurses and staff who had been involved in the incident. He wrote:

I would be most grateful if you could obtain reports of the events from the nurses working this morning relating to my patient [] and to the events that transpired around him. Dr. Nagase has made some potentially very serious allegations alleging abuse of my power as chief of staff .

It is my belief that there is no fault lying with any SOGH nurses nor that any patient has suffered any adverse outcome.

[10] The following day, the plaintiff sent a note to Dr. Entwistle setting out his views of how non-acute care admitting should take place in the emergency ward.

[11] On December 17, 2010, a meeting took place among the plaintiff, Dr. Entwistle, the head of the ER, Dr. DeVries, and the acting SOGH administrator, Sherri Uribe. It appears that reference was made at the meeting to the SOGH's Professional Conduct & Disruptive Behaviour Policy which is included in its Medical Staff Policy Manual. During the meeting, the plaintiff formed the view that his concerns would not be addressed. The parties agreed that the plaintiff would resign from his position at SOGH effective February 16, 2011.

[12] On December 19, 2010, Dr. Entwistle sent an email to the plaintiff, with copies to other staff, which the plaintiff alleges was defamatory of him. Dr. Entwistle wrote, in salient part:

The second issue discussed was directly consequent to the incident we described and that you acknowledged when I, nursing colleagues and a patient felt that your behaviour on the evening of Tuesday 14th December 2010, between the hours of approximately 5 pm and 6 pm that was felt to be disruptive to the ER department as a whole, resulting in patient care delay, (though I believe that this was not clinically significant), and verbal communication that was intimidating and incessant.

As I described to you one of the purposes of our meeting was also as the first step in the [Interior Health Authority] guidance policy protocol for managing Physician Disruptive behaviour. It is the policy of the Medical Staff of Interior Health that patients, medical staff members, other health care providers, volunteers and visitors will be treated respectfully and with dignity. It is my contention that your behaviour on the evening of Tuesday 14th December 2010 fell short of this. I don't believe that you contested the facts at our meeting that your behaviour was perceived to be inappropriate, [disrespectful] and unprofessional. I also believe that you acknowledged that you continued in your behaviour despite being asked repeatedly to move out of the department and also to end the discussion. You also acknowledged that this had been witnessed by both nursing staff and patients. I believe that [your] concerns were a genuine attempt to offer constructive criticism and with the apparent aim to improve the outcome of patients, however the manner in which you did this was unacceptable. I would however wish to make the point very clearly that [our] concern and complaint is directed to the single identified episode of unacceptable behaviour and is not directed to you as a person

We discussed concerns that had been expressed at your other site of work at Squamish, and whilst not describing specifics you confirmed that you had undergone a similar disciplinary meeting there as well. I will forward a copy of this letter together with any rebuttal letter I receive subsequently to Dr. Richard Cudmore, Chief of Staff at Squamish Hospital.

- [13] Shortly thereafter, a copy of this email was forwarded to Dr. Cudmore, Chief of Staff at the Squamish General Hospital, where the plaintiff also had privileges. He did so to apprise Dr. Cudmore of the incident, to assist him in ensuring that high standards of professional competence and ethics were maintained at Squamish General Hospital and to determine whether there had been similar incidents at the Squamish hospital involving the plaintiff.
- [14] On January 5, 2011, Dr. Entwistle sent a formal letter to the plaintiff which included the language in the December 19, 2010 email. He also sent, via email, a copy of the letter to Dr. Cudmore.
- [15] The following day, Dr. Entwistle received a lengthy and detailed email from the plaintiff setting out his response to the January 5, 2011 letter. The response was forceful, disagreed with Dr. Entwistle's version of what had occurred at the December 17, 2010 meeting and reiterated the plaintiff's concerns. Dr. Entwistle considered the response to have been disrespectful. The response was not sent to Dr. Cudmore.
- [16] Later on January 6, 2011, Dr. Entwistle sent an email enclosing the January 5, 2011 letter and the plaintiff's response to the defendant, Dr. Slater. Dr. Slater, now retired, was at all material times employed by the defendant, Interior Health Authority ("IHA"), as the Senior Medical Director. His duties included addressing performance or behavioural issues of specific physicians, where necessary, or when such an issue was referred to him for review and action by a medical director, program head or department head at a hospital. Dr. Entwistle's email included the following request:

I would be grateful for your guidance on how to proceed with this. A large part of me wishes simply to acknowledge receipt of his letter and move on which I understand the Interior Health's Medical Staff Policy on Disruptive behaviour.

However I wonder if from IH's perspective then this shouldn't be escalated, if only because the tone and tenor of Dr. Nagases responses have been accusatory and essentially an example of further intimidating behaviour

I have spoken with Dr. Cudmore, COS at Squamish, this morning who again confirmed disciplinary meeting between Dr. Nagase and Dr. John Maynard, their senior medical director.

I feel sorry for Daniel in many ways but I am not sorry that he will be leaving our facility and I have yet to meet anyone who feels differently.

[17] On January 14, 2011, Dr. Slater sent a letter to the plaintiff and Dr. Entwistle indicating that he had scheduled a meeting with them for January 24, 2011 to discuss the concerns that had been raised, including Dr. Entwistle's concerns about the plaintiff's style of communication under the Disruptive Physician Policy. He stated, in part:

I will hear statements on each of these concerns. I will ask questions. As previously stated, you may ask for individuals to present corroborating information. I would like the names of those persons in writing before next Wednesday. When I close the discussion, there will be no further conversation on that topic.

The meeting is scheduled for 1.5 hours. At the end of that time I will either make a decision on the individual concerns or give you a time frame for a decision.

[Emphasis added]

[18] For various reasons relating to the parties' schedules, the January 24, 2011 meeting was delayed.

[19] By email to the plaintiff, Dr. Entwistle and others, dated February 24, 2011, Dr. Slater wrote:

My feeling is that this is taking way too long to resolve. My schedule and those of the Chief of Staff and the nursing administrator also have to be accommodated. We've already canceled one meeting at your request. As well, we have to consider the impact of these delays on the other people involved. April will take us to well beyond four months from the original incidents.

If you have no interest in working in IHA in the future we can cancel this meeting and not worry about scheduling another. I'll then take the position that your behaviour was disruptive and that your concern about the Chief is without merit. I will further recommend to our executive medical group that you should not work in IHA until such time as you've developed a good track record elsewhere.

If this isn't acceptable, we should meet on the 22nd of March as previously suggested.

- [20] The meeting ultimately took place on April 26, 2011 when the plaintiff and his then counsel met with Drs. Slater and Entwistle as well as SOGH's management. The purpose of the meeting was to discuss the plaintiff's conduct on December 14, 2010.
- [21] Between April 28 and 30, 2011, Dr. Slater exchanged several emails with various medical directors responsible for the sub-regions within the IHA which, among other things, questioned the plaintiff's mental health status. The plaintiff alleges that these emails were also defamatory of him.
- [22] By letter to the plaintiff dated May 18, 2011, Dr. Slater set out his findings. Copies of the letter were sent to Dr. Entwistle and several IHA senior medical directors and officers. Dr. Slater stated, in part:

I began the meeting by stating that while I realized there was a lot of history to cover, this meeting was to focus on events occurring on December 14th, 2010. After I read a description of the morning's events, [your lawyer] asked if you, me and him could meet to discuss a way forward.

We met in the hallway while the others remained in the conference room. My understanding of our way forward was that you would apologize to Dr. Entwistle and the nursing representatives present about your style of communication and the steps you were taking to improve it. They would have a chance to respond and we would then discuss what the future could look like.

Unfortunately your apology included suggestions that Dr. Entwistle had "cornered" you in a discussion that you had yourself initiated. You also expressed concern that he had communicated with your previous hospital in Squamish. You went on to suggest that the Oliver hospital community at large had significant problems with patient safety.

While you asked for feedback, you chose to frame your response in a way that suggested your style of communication was prompted by a concern for patient safety. You chose to argue, rather than accept feedback you could have used to move forward. By the end of the evening, the unanimous opinion of those in the room was that you could not come back to South Okanagan General Hospital as the conditions for success weren't there. A major factor in reaching that conclusion was your difficulty in accepting that others found your style of communication to be disrespectful and intimidating. You need to know that concerns about patient safety don't excuse disrespectful behaviour.

I don't propose to get into a protracted argument about whether this is right or wrong. From where I sit, the balance of probabilities suggests that a problem exists. You have made some first steps in dealing with such a problem by making contact with the physician health program and taking the effective communication course. I congratulate you on taking those steps. I am going to suggest some others and hope you accept them in the helpful spirit in which they are intended.

As I told you when we first stepped out of the room to discuss a way forward, you can't talk yourself out of a situation you've behaved yourself into. You have to behave your way out. All of us this evening were very concerned about your behaviour. None of us are happy about that.

I will need to see solid evidence of change before I can recommend you for membership on the medical staff of hospitals in my portfolio. I would also want to interview you before making such a recommendation. I hope that this meeting will help you address the concerns others have.

[23] The plaintiff alleges this letter was defamatory of him. He also alleges that Drs. Slater and Entwistle repeated the defamatory words in various emails and verbal statements to others.

III. The Evidence Act s. 51

[24] Section 51(2)(b)(i) of the Evidence Act provides as follows:

51(2) A witness in a legal proceeding, whether a party to it or not,

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

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

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

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

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

[25] "Committee" is defined in s. 51(1) of the Evidence Act as follows:

51 (1) In this section:

"committee" means any of the following:

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

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

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

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

(b.1) a committee that is established or approved by the boards of management of 2 or more hospitals, that includes health care professionals employed by or practising in any of those hospitals and that, for the purposes of improving medical or hospital practice or care in those hospitals, or during transportation to or from those hospitals,

(i) carries out or is charged with the function of studying, investigating or evaluating the medical or hospital practice of, or care provided by, health care professionals in those hospitals or during transportation to or from those hospitals, in relation to a matter of common interest among those hospitals, or

(ii) studies, investigates or carries on medical research or a program in relation to a matter of common interest among those hospitals;

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

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

[26] "Committee" is defined in s. 41(1) of the Hospital Act, R.S.B.C 1996, c. 200 [Hospital Act] as follows:

41(1) In this section, "medical staff committee" means a committee established or approved by a board of management of a hospital for

(a) evaluating, controlling and reporting on clinical practice in a hospital in order to continually maintain and improve the safety and quality of patient care in the hospital, or

(b) performing a function for the appraisal and control of the quality of patient care in the hospital.

IV. Medical Advisory Committees

[27] In the case of the SOGH and the IHA, several committees had been established and were in place at all material times.

[28] The Health Authority Medical Advisory Committee ("HAMAC") is a committee of the medical staff of the IHA. It comprised of members of the medical staff who have been appointed to medical leadership positions within the IHA, members of the medical staff who have been elected by the medical staff of the IHA, the Medical Health Officer of the IHA, the Senior Medical Administrator of the IHA, the Chief Executive Officer and other senior administrative or medical staff of the IHA as appropriate.

[29] At all material times, Dr. Slater was a medical director of the IHA and an appointed member of the HAMAC. As such, he had an obligation to receive complaints about physicians at the SOGH and determine how those complaints would be addressed. This was an integral part of HAMAC's professional competence and ethics program at SOGH. Dr. Slater was also responsible for:

- a) organizing and providing leadership and direction to the physicians at the SOGH in relation to professional activities in all of the departments at that hospital;
- b) reviewing the permits to practise or privileges issued to physicians at the SOGH; and
- c) addressing performance or behavioral issues of specific physicians, where necessary, or when such an issue is referred by a medical director, program head or department head at the SOGH.

[30] Each of the hospitals within the IHA has its own Local Medical Advisory Committee ("LMAC"). Each region within the IHA has a Regional Medical Advisory Committee ("RMAC"). Each RMAC reports to HAMAC.

[31] At all material times, Dr. Entwistle was a member of the SOGH LMAC. As Chief of Staff of SOGH, his responsibilities included:

- a) leading physician credentialing, privileging, appointment and reappointment processes;
- b) ensuring physician professional conduct meets a high standard; and
- c) managing the performance, behaviour and, if necessary, discipline of physicians.

V. Bylaws, Rules and Professional Conduct Policies

[32] Section 2(1)(c) of the Hospital Act provides that hospitals have an obligation to:

- (c) have a properly constituted board of management and bylaws or rules thought necessary by the minister for the administration and management of the hospital's affairs and the provision of a high standard of care and treatment for patients.

[33] HAMAC enacted Medical Staff Bylaws for the IHA. ("MS Bylaws"). Pursuant to s. 8.1.3.2 of the MS Bylaws, the HAMAC has an ongoing obligation to monitor the quality and effectiveness of medical care provided by the physicians at SOGH and to provide advice to the IHA Board. Moreover, pursuant to ss. 8.1.2, 8.3.2.3 and 8.3.5.1 of the MS Bylaw, it has an ongoing obligation to:

- a) make recommendations to the Board with respect to the cancellation, suspension, restriction, or non-renewal of the permits to practise of all physicians at the SOGH;
- b) make recommendations to the Board concerning the review of physicians, and regarding disciplinary measures for violations of the Bylaws, Rules or Policies by physicians; and

- c) review and report any concerns related to the professional and ethical conduct of physicians to the Board and, where appropriate, report those concerns to the College of Physicians and Surgeons of B.C.

[34] The Board of Directors of the IHA also enacted a Professional Conduct & Disruptive Behaviour Policy ("PC Policy") setting out the broad standards of organizational behaviour and practice expected of all persons associated with the IHA, including medical staff. Each physician is required to agree to abide by the PC Policy before receiving a permit to work at the SOGH.

[35] The PC Policy set out the procedure to be followed in the event of disruptive behaviour on the part of a physician. Any member of the medical staff may report incidents of disruptive behaviour. Section 4.2 of the PC Policy provides that:

4.2 The report and the member's response shall be kept in the member's confidential file and become part of the record of any subsequent related disciplinary action unless the allegation is deemed unfounded when it shall be destroyed.

[36] Sections 6.1 and 6.2 of the PC Policy provides that:

6.1 If, despite the follow-up procedure outlined in 4.0, the disruptive behaviour continues, the Chief of Medical Staff may refer the matter to the [LMAC]. The [LMAC] shall hear the matter and decide the next steps that may include referral of the matter to the HAMAC. The member may attend the meeting with a representative of his/her choice.

6.2 If the matter is advanced to the HAMAC, the HAMAC, as provided for in 17.3 of the Medical Staff Rules, will convene a special meeting within 30 days to consider the recommendation of the [LMAC]. The physician will be notified in writing of the recommendations, the date and time of the HAMAC meeting, and be reminded of his/her right to be heard.

[37] If a physician engages in unprofessional or unethical conduct, breaches professional ethical codes, or violates applicable legislation, the Bylaws, the Rules or the Policies, the Board may, upon advice received from the HAMAC, cancel, suspend, restrict or refuse to renew the permit to practise of a physician at the hospital.

VI. Issue

[38] The issue for determination is whether the defendants have demonstrated on the balance of probabilities that the Correspondence meets the criteria set out in s. 51(2)(b) of the Evidence Act such that the plaintiff is precluded from producing it in this litigation.

VII. Analysis

- [39] The plaintiff takes the position that s. 51(2) of the Evidence Act is not applicable because the Correspondence was not used and did not arise out of a "study, investigation, evaluation or program carried on by a committee", nor was it compiled or made for the purpose of producing or submitting it to a committee.
- [40] Counsel for the plaintiff submits that there is no evidence that any of the impugned Correspondence was created for the purpose of going to a committee. Rather, he submits that Drs. Entwistle and Slater completely skipped any process by a committee as that word is defined by s. 51 and proceeded on an ad hoc basis to deal with the plaintiff's conduct.
- [41] He submits that Dr. Entwistle's general statement in his affidavit sworn on August 19, 2015 that:
26. As every complaint about a physician's professional competence and ethics may ultimately be referred to the HAMAC, every record I make in the course of addressing a complaint about a physician's professional competence and ethics is made for the purpose of producing them to the HAMAC.

and Dr. Slater's general statement in his affidavit sworn August 24, 2015 that:

9. As every complaint about a physician's professional competence and ethics may ultimately be referred to the HAMAC, every record I make in the course of addressing a complaint about a physician's professional competence and ethics is made for the purpose of producing them to the HAMAC. For example, a physician's written response to a complaint is kept in the physician's confidential file for the purpose of producing it to the HAMAC should disciplinary action against the physician be contemplated.

are woefully inadequate to support a finding that the defendants are entitled to the protection of s. 51(2) of the Evidence Act.

- [42] He submits there is no evidence that the PC Policy was promulgated by any committee. Rather, it was merely an administrative policy in place at the hospital. He submits that, hence, the December 17, 2010 meeting was not part of any committee process.
- [43] He submits further that there is no policy, process or procedure that entitled Dr. Entwistle to forward the December 19, 2010 and January 5, 2011 correspondence to Dr. Cudmore at the Squamish General Hospital. Finally, he submits that the Correspondence prepared and sent by Dr. Slater was not pursuant to any committee role but rather was nothing more than ad hoc decision-making by him alone, as evidenced by the statements Dr. Slater made in his January 14, 2011 letter that: "I will either make a decision on the individual concerns or give you a time frame for a decision." and further evidenced by statements in his February 24, 2011 email, to the effect that he would take the position that the plaintiff's behaviour was disruptive and without merit and he would make recommendations to the executive medical group.

- [44] The plaintiff submits that Dr. Slater's correspondence of January 14 and February 24, 2011 make it clear that the investigation and decision was his alone and not something that would be part of any committee process. The plaintiff submits that no committee process was ever followed.
- [45] The defendants submit that, by the very nature of their positions, Drs. Entwistle and Slater had the obligations and duties, set out by the IHA Board in the form of the Bylaw to investigate and deal with the complaint against the plaintiff. They submit that the Correspondence constitutes a record that arose out of and was used in the course of an investigation into the plaintiff's conduct in respect of the December 14, 2010 incident as part of their respective committee involvement.
- [46] The uncontroverted evidence of Dr. Entwistle is that the receipt of complaints about physicians, and the actions he takes in addressing them is an integral part of the HAMAC's professional competence and ethics program at SOGH. He deposed further that, because every complaint about a physician's professional competence and ethics may ultimately be referred to the HAMAC, every record he makes in the course of addressing a complaint about a physician's professional competence and ethics is made for the purpose of producing them to the HAMAC.
- [47] The uncontroverted evidence of Dr. Slater is that every complaint about a physician's professional competence and ethics may ultimately be referred to the HAMAC and that every record he makes in the course of addressing such a complaint is made for the purpose of producing them to the HAMAC. A physician's written response to a complaint is kept in the physician's confidential file for the purpose of producing it to the HAMAC in the event that disciplinary action against the physician is contemplated, or in the event that it is required for future reference.
- [48] The leading authority on the applicability of s. 51 of the Evidence Act is *Sinclair v. March*, 2000 BCCA 459. At para. 23 of the decision, the Court of Appeal agreed that the purpose of s. 51 is to protect efforts made by hospitals to ensure that high standards of patient care and professional competency and ethics are maintained, by ensuring confidentiality for documents and proceedings of committees entrusted with such tasks. The court made it clear that s. 51 of the Evidence Act was enacted not only to protect hospital committee deliberations but also the work of those authorized by the committee pursuant to standing instructions and protocols:
- [30] . As I have said in various ways, s. 51 must be given its full effect even in circumstances where there is more than one aspect to the committee's function. Nor do I consider it necessary for the committee to have "endorsed" a request for investigation if it can be shown in some other way, either by standing instructions or protocols established by the committee, that the committee has authorized the activity on its behalf.

[Emphasis added]

- [49] Section 51 of the Evidence Act requires that a hospital undertake certain steps to establish the committee or committees whose work product is then prohibited from production: *Parmar (Litigation guardian of) v. Fraser Health Authority*, 2012 BCSC 1596 at para. 14.
- [50] The December 14, 2010 incident that led to the Correspondence occurred in the Emergency Room Department of the SOGH. The incident plainly pertained to the quality of patient care that was being provided in the emergency ward as well as the interactions among the plaintiff, Dr. Entwistle and other medical staff regarding patient care.
- [51] Dr. Entwistle had concerns about the plaintiff's behaviour and its effect on the department and the care of patients. In particular, Dr. Entwistle considered that the plaintiff had not conducted himself in a courteous, respectful or dignified manner towards medical staff and nursing colleagues and was concerned that the quality of patient care in the SOGH had been or could in the future be compromised. He asked the Manager of Acute Services, to obtain a report from the nurses who were involved in the incident for an objective assessment of his own impression, having witnessed the incident himself.
- [52] The December 17, 2010 meeting among the plaintiff, Dr. Entwistle, Dr. DeVries and the acting hospital administrator, during which the plaintiff advised that he would be resigning effective February 16, 2011, was clearly part of an investigation into the incident and the plaintiff's professional conduct and ethics.
- [53] Dr. Entwistle's January 6, 2011 correspondence to Dr. Slater was a request for guidance on how to address the plaintiff's response to the December 19, 2010 email and January 5, 2011 letter and determine whether escalating disciplinary measures should be taken against the plaintiff. Again, this correspondence was part of his ongoing investigation into the plaintiff's professional conduct and ethics, and a determination of additional steps that should be taken.
- [54] The foregoing actions of Dr. Entwistle were clearly undertaken pursuant to the PC Policy. The PC Policy constituted a standing protocol, established by the Board of the IHA, authorizing the Chiefs of Staff of the hospitals in its region to carry out, on behalf of the HAMAC, precisely the kind of actions taken by Dr. Entwistle, including the disciplinary investigation and the preparation of precisely the kind of record regarding that investigation that Dr. Entwistle prepared.
- [55] The records created by Dr. Entwistle came into existence as a direct result of him carrying out his duties as a member of the SOGH LMAC to investigate the December 14, 2010 incident. Through this investigation, the plaintiff demonstrated behaviour that gave rise to concern, which resulted in Dr. Entwistle pursuing further investigations into the plaintiff's conduct. In my view, those records fall squarely into the categories of records contemplated by s. 51(2) of the Evidence Act.

- [56] Similarly, the actions taken by Dr. Slater were undertaken as part of the standing duties and obligations delegated to him by the IHA and the HAMAC. In my view it is clear that the purpose of the Correspondence created by Dr. Slater was to compile a record of his investigation into the plaintiff's professional conduct and work ethics for the HAMAC. This was not a situation where the record is merely related to a matter of management or administration of hospital staff. The only reason the Correspondence was created was as a direct result of an investigation into the professional conduct and disruptive behaviour of the plaintiff under the Bylaw. The reason the "record" created by him was not ultimately submitted to the HAMAC was that, during the meeting on April 26, 2011, the plaintiff and his counsel agreed that the matter would not go any further. Such an agreement does not remove the protection afforded by s. 51 of the Evidence Act.
- [57] The foregoing analysis applies equally to the January 5, 2011 email sent by Dr. Entwistle to Dr. Cudmore. Although Dr. Cudmore was not part of the SOGH LMAC, the evidence is that Dr. Entwistle's communication with him was in the course of his investigation of the plaintiff's professional competency and ethics. Dr. Entwistle's uncontroverted evidence is that he forwarded the email to Dr. Cudmore because the plaintiff held a permit to practice at the Squamish General Hospital, and because the IHA and Vancouver Coastal Health (which operates the Squamish General Hospital) work closely together and the Chiefs of Staff at hospitals collaborate on physician credentialing and patient care in order to ensure a high standard of patient care is maintained. He wanted to investigate whether similar concerns had been experienced at Dr. Cudmore's hospital.
- [58] The purpose of s.51 of the Evidence Act is to protect efforts made by hospitals to ensure that high standards of patient care and professional competency and ethics are maintained, by ensuring confidentiality for documents created by those involved in the committees entrusted with this task. Such confidentiality protects the sanctity of the peer review process within hospitals: Sinclair at paras. 23 - 24. In this case, the Correspondence are clothed with such protection.

VIII. Conclusion

- [59] I find that s. 51(2) of the Evidence Act precludes the plaintiff from producing the Correspondence in this proceeding.
- [60] The law is clear that, to the extent a plaintiff's inability to rely on the documentation results in it being plain and obvious that his claim is bound to fail, the claim should be struck out: R. v. Imperial Tobacco Canada Ltd., 2011 SCC 42 at para. 17; Henry v. British Columbia (Attorney General), 2012 BCSC 1401 at para. 38; Extra Gift Exchange Inc. v. Ernest & Twins Ventures (PP) Ltd., 2007 BCSC 426 at paras. 17 - 22.
- [61] Counsel are in agreement that, to the extent the court finds that the Correspondence is protected by the s. 51 of the Evidence Act production prohibition, the plaintiff's action in respect of that correspondence must be dismissed.

[62] Accordingly, the plaintiff's claims against the defendants in defamation, breach of privacy and interference with contractual relations are struck to the extent that those claims are founded on the Correspondence.

[63] The defendants are entitled to their costs of the application at Scale B.

"G.C. Weatherill J."

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