
CANADA / JUDGMENT

Nagase v. Entwistle

2016 BCCA 257

COURT

British Columbia Court of Appeal

DECIDED

15 June 2016

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2016 BCCA 257 Nagase v. Entwistle

COURT OF APPEAL FOR BRITISH COLUMBIA

Citation:

Nagase v. Entwistle,

2016 BCCA 257

Date: 20160615

Docket: CA43171

Between:

Dr. Daniel Nagase

Appellant

(Plaintiff)

And

Dr. Peter Entwistle, Dr. Jonathan Slater, South Okanagan General Hospital

and the Interior Health Authority

Respondents

(Defendants)

Before:

The Honourable Madam Justice Garson

The Honourable Madam Justice Stromberg-Stein

The Honourable Mr. Justice Fitch

On appeal from: An order of the Supreme Court of British Columbia, dated September 15, 2015 (Nagase v. Entwistle, 2015 BCSC 1654, Vancouver Docket S130086).

Reasons for Judgment

Counsel for the Appellant:

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Place and Date of Hearing:

Vancouver, British Columbia

May 10, 2016

Place and Date of Judgment:

Vancouver, British Columbia

June 15, 2016

Written Reasons by:

The Honourable Madam Justice Garson

Concurred in by:

The Honourable Madam Justice Stromberg-Stein

The Honourable Mr. Justice Fitch

Summary:

The appellant appeals the dismissal of his defamation claim based on allegedly defamatory correspondence written by the respondent physicians. The respondents say that the correspondence cannot form the basis of the claim because it was created in the course of an investigation into the appellant's conduct, pursuant to the standing protocols of a hospital committee, and is therefore protected under s. 51(2) of the Evidence Act. The appellant says that s. 51(2) does not apply, because no committee was involved in the investigation and the records were not forwarded to a committee. Held: The appeal is dismissed. It would be inconsistent with the purpose of the provision and the objects of the legislation to hold that s. 51(2) only protects records created in the course of formal committee proceedings, but not the initial phases of the disciplinary process. The correspondence was created as part of an investigation into the

appellant's conduct, and is therefore protected from production.

Reasons for Judgment of the Honourable Madam Justice Garson:

Introduction

- [1] In the defamation proceeding underlying this appeal, the appellant, Dr. Daniel Nagase, alleges that the respondent physicians defamed him in a series of letters and e-mails. In chambers, he sought various orders concerning the production and use of that correspondence. The respondents relied on s. 51(2) of the Evidence Act, R.S.B.C. 1996, c. 124, as the basis of an absolute immunity from production of the impugned correspondence. The chambers judge agreed that s. 51(2) protected the statements from production and granted an order striking out the action to the extent that Dr. Nagase's claims were founded on them.
- [2] In certain circumstances, s. 51(2) of the Evidence Act exempts from production in legal proceedings a record arising out of the study, investigation, evaluation or program carried on by a committee.
- [3] Dr. Nagase appeals on the basis that s. 51(2) is inapplicable to the correspondence that he relies on as proof of his defamation claim. He says no committee was involved in the communications at issue, and further, that the statements were not made for the purpose of producing and submitting them to a committee, which would ordinarily attract the protection of s. 51(2).
- [4] The respondents say that the correspondence in question was created in the course of an investigation into Dr. Nagase's conduct, undertaken pursuant to the standing protocols of a hospital committee. They therefore submit that it is not subject to production.

Background Facts

- [5] Dr. Nagase was employed at the South Okanagan General Hospital ("SOGH") as a locum emergency room physician beginning in May 2010.
- [6] The respondent, Dr. Peter Entwistle, was Chief of Staff at SOGH. The respondent Dr. Jonathan Slater (now retired) was the senior Medical Director employed by the third respondent, the Interior Health Authority (the "IHA").
- [7] On December 14, 2010, while working as an emergency room physician, Dr. Nagase became concerned about the manner in which a non-acute patient was admitted to emergency. He thought that the admission of this patient, allegedly in a preferential manner, compromised the care of more seriously ill patients. In order to voice his concerns, he interrupted an unrelated meeting that Dr. Entwistle was conducting. Later in the day, he initiated a discussion about his concerns with Dr. Entwistle and the nursing staff.

- [8] Dr. Entwistle was concerned about the tenor of the discussion. He characterized the conversation as disrespectful and unprofessional. Dr. Entwistle asked his chief administrator to collect witness statements from the shift nurses regarding the events that took place on December 14, 2010. In doing so, he wrote the following:

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.

- [9] On December 17, 2010, Dr. Nagase met with Dr. Entwistle and two other hospital staff members to discuss the incident. At that meeting, Dr. Nagase indicated his intention to leave the hospital. He later tendered his resignation, effective February 16, 2011.
- [10] On December 19, 2010, Dr. Entwistle sent an e-mail to Dr. Nagase (with copies to other staff), summarizing his position about the manner in which Dr. Nagase raised his concerns regarding the incident. Dr. Entwistle also forwarded a copy of this e-mail to Dr. Richard Cudmore, the Chief of Staff at Squamish Hospital, where Dr. Nagase also worked.
- [11] Dr. Nagase alleges that this e-mail is defamatory. Dr. Entwistle wrote, in part (irregularities in punctuation appear in the original document):

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 .

However I further have to point out that any further similar incidents may result in the initiation of a formal investigation pursuant to the Interior Health's Medical Staff Policy on Disruptive Behaviour This letter together with any rebuttal letter will be kept in your confidential file and may become part of the record of any subsequent related disciplinary action .

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.

[Emphasis added.]

[12] I note that in the emphasized portions of this correspondence, Dr. Entwistle expressly relates his actions to the IHA protocols for disruptive physician behaviour. I discuss these protocols in further detail below.

[13] On January 5, 2011, Dr. Entwistle sent a formal letter to Dr. Nagase, which included the language of the December 19, 2010 e-mail. Dr. Entwistle also e-mailed a copy of this letter to Dr. Cudmore. Dr. Nagase says that this correspondence was defamatory.

[14] Dr. Nagase provided a response to the letter via e-mail the following day, taking issue with Dr. Entwistle's version of events and reiterating his concerns.

[15] On January 6, 2011, Dr. Entwistle e-mailed Dr. Slater requesting his guidance in relation to the matter. This e-mail also discusses the applicability of the Interior Health's Medical Staff Policy on Disruptive Behaviour, although it is not clear whether Dr. Entwistle was suggesting that procedure be followed. He wrote (irregularities in punctuation in original):

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 .

[Emphasis added.]

[16] On January 13, 2011, Dr. Slater e-mailed Dr. Entwistle and Dr. Nagase, requesting that they meet with him on January 24, 2011 respecting the concerns each had raised. He asked that they provide him with all relevant material, and the names of individuals who would be brought to the meeting. He wrote in part:

I will consider this an appeal by Dr. Nagase of the meeting held between the two of you that resulted in a letter from Dr. Entwistle to Dr. Nagase.

- [17] The following day, Dr. Slater sent a letter to Dr. Entwistle and Dr. Nagase, further to the January 24, 2011 meeting. He noted that Dr. Entwistle raised his concerns about Dr. Nagase's style of communication under the IHA's disruptive physician policy. He indicated that he would hear "statements" from both at the meeting, that he would ask questions, that the meeting was scheduled for 1.5 hours, and that he would make a decision regarding their individual concerns at its conclusion or at a later date.
- [18] Due to delay, the meeting originally scheduled for January 24, 2011, occurred on April 26, 2011. Dr. Nagase attended with his lawyer. Dr. Entwistle attended with a number of physicians and administrative staff. Dr. Nagase and his lawyer met privately with Dr. Slater, at which time certain agreements appear to have been reached. Dr. Nagase was asked to apologize to Dr. Entwistle. Dr. Slater sent a summary letter of the meeting to Dr. Etherington, Vice-President of Medicine and Quality.
- [19] Between April 28 and 30, 2011, Dr. Slater sent a series of e-mails to the medical directors responsible for the sub-regions in the IHA. Those e-mails, which (among other things) question Dr. Nagase's mental health and ability to work in a hospital environment, are alleged to be defamatory. An April 28, 2011 e-mail indicated that Dr. Entwistle's letter to Dr. Nagase regarding the incident was written under the "professional conduct policy".
- [20] Dr. Slater set out his findings in a letter to Dr. Nagase dated May 18, 2011. 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.

- [21] Dr. Nagase obtained copies of the correspondence at issue in this appeal as a result of two separate Freedom of Information requests. As noted, this correspondence forms the basis of the underlying defamation action. If the documents are privileged under s. 51(2) of the Evidence Act, there is no basis for the action.
- [22] There were two applications before the chambers judge at the hearing that led to this appeal.
- [23] Dr. Nagase applied for the following orders:
1. An order that the defendants provide a document list containing all relevant documents.
 2. An order that the defendants provide the factual basis for any claims of privilege made over all listed documents.
 3. An order that the defendants provide the factual basis for any claim of privilege made with respect to a document in this matter, such claim being based on section 51 of the Evidence Act.
 4. A declaration that section 51 of the Evidence Act does not apply to any of the evidence and statements underlying and supporting the plaintiff's claim of defamation and included in the plaintiff's list of documents.
 5. A declaration that the objection made by the defendants to answering questions during the examinations for discovery of the defendants, Entwistle and Slater, that statements made by the defendants were made in circumstances protected by section 51 of the Evidence Act RSBC 1996, c. 124 is invalid.

6. An order requiring the defendants to answer all questions relating to the plaintiff's claim in regard to any defamatory and libelous statements made as described in the plaintiff's notice of claim.
- [24] The respondents applied for an order striking the Plaintiff's Notice of Civil Claim pursuant to Rule 9-5 (1)(a) of the Supreme Court Civil Rules.

Organizational Structures, Bylaws, Rules and Policies

- [25] Before reviewing the chambers judge's reasons on the applications before him, it is useful to review the organizational structures, bylaws, rules and policies relevant to this appeal.

Organizational Structures

- [26] The Hospital Act, R.S.B.C. 1996, c. 200 s. 2(1)(c) stipulates that a hospital has an obligation to constitute a board of management and to enact bylaws and rules necessary for its administration and management. In this instance, the relevant board is the IHA. It is established under the Health Authorities Act, R.S.B.C. 1996, c. 180 and the Regional Health Boards Regulation, B.C. Reg. 293/2001, s. 2. The SOGH is a public hospital as defined in s. 1 of the Hospital Act. It is operated by the IHA.
- [27] The IHA acts through its board of management, which has adopted Medical Staff Bylaws, Medical Staff Rules, and policies and procedures. These collectively govern the conditions under which patient care is given, the conduct of medical staff, and other matters (including matters of complaints and discipline). I discuss these Bylaws, Rules and policies in further detail below.
- [28] Additionally, the IHA has established a number of medical advisory committees.
- [29] The Health Authority Medical Advisory Committee ("HAMAC") is a committee of IHA medical staff, consisting of various individuals who have been appointed to medical leadership positions with the IHA. Its duties include making recommendations to the IHA board respecting cancellation, suspension, restriction and non-renewal or maintenance of the privileges of IHA medical staff. It operates pursuant to the Medical Staff Bylaws.
- [30] Health Service Area Medical Advisory Committees ("HSA MACs") at hospitals within the IHA function under Regional Medical Advisory Committees ("RMACs") for each region, which report in turn to the HAMAC. The parties and the chambers judge have referred to HSA MACs as Local Medical Advisory Committees (or "LMACs"). For ease of reference, I adopt that term.
- [31] As Chief of Staff at SOGH, Dr. Entwistle is responsible for: leading physician credentialing, privileging, appointment and reappointment processes; and, ensuring physician professional conduct meets a high standard, and managing the performance, behaviour and, if necessary, discipline of physicians.

[32] In that role he receives complaints about physicians at SOGH and determines how they will be addressed. Complaints may be addressed in a number of ways. They may be dealt with informally with the physician, or formally with a representative for the physician. Other more formal measures include the provision of a written warning, and referring the physician to a health program. As a final resort, complaints may be referred to the HAMAC. Dr. Entwistle describes his role as essential to HAMAC's ability to fulfill its duties under the Bylaws. He deposed as follows at para. 26 of his affidavit:

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. They are confidential and for the purpose of improving patient care. For example, a physician's written response to a complaint I raise 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.

[33] Dr. Entwistle's formal job description states inter alia that his role is to "ensure physician professional conduct and manages the performance, behaviour and if necessary, discipline of members of the Medical Staff." Dr. Entwistle is a member of, and chairs the SOGH "Local Quality Committee." There is some reference in the evidence to Dr. Entwistle being a member of the SOGH LMAC rather than the Local Quality Committee. This conflict was explained by counsel for the respondents as resulting from the formal Bylaws, Rules and policy manuals being out of date. I do not consider that anything turns on this distinction.

[34] Dr. Slater (now retired) was employed by the IHA as the Acute Services West Medical Director. His duties in that position included addressing performance or behavioural issues of specific physicians throughout the region. Dr. Slater was also a member of the HAMAC. In his affidavit evidence, he deposed that in that capacity, he had an obligation to receive complaints about physicians and to determine how to address those complaints. He stated that his role was an integral part of the HAMAC's professional competence and ethics program at SOGH. Dr. Slater's position respecting the purpose of records made in the course of addressing physician complaints is identical to that of Dr. Entwistle: because any complaint may be referred eventually to the HAMAC, all records concerning such complaints are prepared for submission to the HAMAC.

Bylaws, Rules and Policies

[35] The HAMAC, as noted, is governed by the IHA's Medical Staff Bylaws. Article 11 of the Bylaws sets out a formal procedure for disciplining physicians, which permits HAMAC to suspend, cancel or restrict a physician's privileges.

[36] Section 17 of the IHA's Medical Staff Rules is an adjunct to Article 11 of the Bylaws. Section 17.3 describes a procedure for review of physician complaints:

Procedure for Review of a Complaint Against a Member of the Medical Staff.

Step One

A matter brought to the attention of a Department Head, Chief of Medical Staff or other person in authority from such sources as

- a department QA committee
- colleagues
- other professionals
- Medical Director
- an incident report
- a private informant

provided it is clearly documented will be discussed between the practitioner and the Department Head or Chief of Medical Staff with disclosure of the complaints against the practitioner. If the complaint is without foundation or does not require corrective action, the matter is closed. If corrective action is required and agreed upon with a mechanism for review with clear parameters of expected improvement within a specific timeframe, the course of action will be documented with a copy being forwarded to the HAS Medical Director and the practitioner involved.

Step 2

When corrective action is not agreed upon in the step one, or where attempts at corrective action have failed, a meeting between the practitioner, the Department Head or Chief of Medical Staff, and the HAS Medical Director is held. Should the practitioner so wish, the President of the Medical Staff or other medical staff representative of the practitioner's choice may attend the meeting. The objective of this meeting is to review and, if appropriate, reinforce the directions set by the Department Head or Chief of Medical Staff in step one and to delineate further corrective action in the case of failure to improve. The meeting will be documented with all present receiving copies of all material and with copies lodged with the Senior Medical Director.

[37] The IHA's Medical Staff Policy Manual operates together with the Bylaws and the Rules. It describes the manner in which professional conduct and disruptive behaviour are managed at the institutional level, and the circumstances under which matters are advanced to the HAMAC. Sections 4.0 and 6.0 provide as follows:

4.1 A single confirmed documented incident warrants a discussion with the member of the medical staff. The discussion shall be with the Chief of Medical Staff or may be designated to the department head. The initial approach shall be collegial while pointing out that such behaviour is unacceptable and must cease.

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.

4.3 If it appears to the Chief of Medical Staff that a pattern of repeated disruptive behaviour is developing, the Chief of Medical Staff and Medical Director shall discuss the matter with the medical staff member who may be accompanied by a representative of his choice and shall be given the opportunity to respond.

4.4 If, in the opinion of the Chief of Medical Staff, the behaviour is contrary to this policy, the member shall be given warning that further incidents will result in more formal action pursuant to the Medical Staff Rules - Part I and the Bylaws.

4.5 The Chief of Medical Staff shall send a letter to the member that restates this warning, describes the nature of the disruptive behaviour, outlines the expected behavioural [sic]

4.6 changes and warns the member against any retaliatory action towards the complainant(s).

4.7 The involved physician may submit a written rebuttal to the allegation of disruptive behaviour. Such rebuttal and the follow up letter referred to in 4.5 shall be kept in the member's confidential file and become part of the record of any subsequent related disciplinary action.

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 HSA MAC. The HSA MAC 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 (Step 3) of the Medical Staff Rules, will convene a special meeting within 30 days to consider the recommendation of the HSA MAC. 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.

6.3 If the HAMAC recommends to the Board of Directors a change in, suspension of or termination of privileges, the Board shall provide the member of the medical staff an opportunity to be heard as provided for in Article 11.2.1 of the Medical Staff Bylaws and shall have the right of appeal as provided for in Article [sic] under the provisions Article 11.4 of these Bylaws.

[38] In summary, the Bylaws, Rules and the Policy Manual act in conjunction to create a process for addressing physician complaints. Responses may range from a discussion with the Chief of Medical Staff (in this case Dr. Entwistle) to a formal hearing before HAMAC. There are varying stages of increasing formality between these two extremes.

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[39] I turn next to the chambers judge's reasons.

- [40] The judge began by reviewing the relevant background, the applicable legislation, the organizational structure of the various boards and committees, and the Bylaws, Rules and policies I have outlined above. After examining the parties' arguments, the judge turned to whether the communications in question fell within the ambit of Evidence Act s. 51.
- [41] The judge held that the uncontroverted evidence of Dr. Entwistle was that the receipt of complaints and his actions in addressing them were an integral part of the HAMAC's professional competence and ethics program at SOGH. Similarly, the judge noted that Dr. Slater's uncontroverted evidence was that every complaint about a physician's professional competence and ethics may ultimately be referred to the HAMAC.
- [42] Citing this Court's decision in *Sinclair v. March*, 2000 BCCA 459, the judge held that the purpose of s. 51 is to protect efforts made by hospitals to ensure that high standards of patient care and professional competency are maintained, through ensuring the confidentiality of documents and proceedings by the committees undertaking those tasks (at para. 48). Respecting the scope of s. 51, the judge said the following:

The court [in *Sinclair*] 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 in original.]

- [43] The judge found that the December 14, 2010 incident "plainly pertained to the quality of patient care" (at para. 50). He likewise found that the December 17, 2010 meeting was part of an investigation into the incident and Dr. Nagase's professional conduct and ethics (at para. 52), and that the January 6, 2011 letter to Dr. Slater was part of that investigation, and was written for the purpose of determining if escalating disciplinary measures should be taken (at para. 53).
- [44] The judge therefore determined that all of Dr. Entwistle's actions were taken pursuant to SOGH's professional conduct policy (included in the Medical Staff Policy Manual), and fell squarely within s. 51(2) (at para. 54). Similarly, he found Dr. Slater's actions were taken as a part of the standing duties delegated to him by the IHA and the HAMAC. He held that the purpose of Dr. Slater's correspondence "was to compile a record of his investigation into [Dr. Nagase's] professional conduct and work ethics for the HAMAC" (at para. 56). The judge concluded that the only reason the "record" created by Dr. Slater was not submitted to the HAMAC was because the matter was settled. The judge held that settlement of the matter did not remove the protection of s. 51.

- [45] Finally, the judge found that the same analysis applied to the letter sent to Dr. Cudmore. The judge noted that the communication was created in the course of Dr. Entwistle's investigation, and was forwarded to Dr. Cudmore because Dr. Entwistle wanted to investigate whether similar concerns respecting Dr. Nagase's professional competency and ethics had arisen at Squamish General Hospital (at para. 57).
- [46] Having found that s. 51(2) precluded the production of the correspondence, the judge held that Dr. Nagase's claim was bound to fail to the extent that it relied on such correspondence, and the action was dismissed.

Issues

- [47] I would frame the issue before the Court as follows: did the chambers judge err in concluding that s. 51(2) precluded from production the letters and e-mails underlying the appellant's defamation claim?

Law

- [48] The pertinent portions of the Evidence Act read as follows:

51(1) In this section:

"board of management" means a board of management as defined in the Hospital Act or the board of directors as defined in the Emergency Health Services Act;

"committee" means any of the following:

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

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

- (a) must not be asked nor be permitted to answer, in the course of the legal proceeding, a question concerning a proceeding before a committee, and
- (b) must not be asked to produce nor be permitted to produce, in the course of the legal proceeding, a record that was used in the course of or arose out of the study, investigation, evaluation or program carried on by a committee, if the record
- (i) was compiled or made by the witness for the purpose of producing or submitting it to a committee,
- (ii) was submitted to or compiled or made for the committee at the direction or request of a committee,
- (iii) consists of a transcript of proceedings before a committee, or
- (iv) consists of a report or summary, whether interim or final, of the findings of a committee.

[49] The definition of "medical staff committee", as referred to in s. 51, is set out in s. 41 of the Hospital Act as follows:

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.

Positions of the Parties

- [50] Dr. Nagase contends that because his complaint process was never brought before an actual committee, s. 51 does not apply. He says that s. 51(2)(b) protects only evidence that was compiled or made expressly for the purpose of submission to a committee, at the direction or request of a committee, is a transcript of proceedings at such a committee, or is a report or summary of committee findings. He maintains that because there was no committee involved in a consideration of his conduct, there can be no evidentiary protection under s. 51(2). He says neither Dr. Entwistle nor Dr. Slater followed any of the protocols in the Bylaws, Rules or policies. He says that the complaint against him was dealt with in an ad hoc manner that bypassed the LMAC and the HAMAC. He points out that Dr. Slater forwarded his conclusions directly to Dr. Etherington, and says that there could be no investigatory purpose in forwarding the January 5, 2011 letter to Dr. Cudmore. He says there was no standing committee under which this informal process could operate. He alleges that there is no evidence that Dr. Entwistle is a member of the LMAC.
- [51] The respondents assert that the protection of s. 51(2) extends to records produced by a witness during an investigation that is authorized by a committee through its established standing instructions or protocols. The respondents say that it is not necessary for the committee to have specifically endorsed the investigation, or for the records to be actually submitted to the committee, provided that they were prepared for that purpose. The respondents contend that the professional conduct policy constituted a standing protocol authorizing Dr. Entwistle, Chief of Staff, to investigate and address the appellant's conduct on December 14, 2010 on behalf of the LMAC (or "Local Quality Committee") and the HAMAC. They note that in Dr. Entwistle's affidavit, he deposes that one of his responsibilities as Chief of Staff was to chair the Local Quality Committee. It follows, the respondents say, that the correspondence produced by Dr. Entwistle in investigating and addressing the appellant's conduct is protected from production. They say that Dr. Slater was a member of the HAMAC, and therefore authorized to investigate and address the appellant's conduct on behalf of that committee. The correspondence produced by him in carrying out that investigation is therefore protected from production, regardless of whether the "record" created by him was ultimately submitted to the HAMAC.

Analysis

- [52] This Court considered s. 51 in *Sinclair v. March*, 2000 BCCA 459. While noting that it is not sufficient for a witness to be a member of a "committee" in order to attract the protection of s. 51, and that the witness must be shown to have participated in committee work, Donald J.A. (for the Court) held that the terms of the section should not be narrowly construed (at para. 22).

[53] At para. 22, Donald J.A. adopted the following statement of Baker J. in *Loo (Guardian ad litem) v. Mount St. Joseph Hospital Society* (1995), 46 C.P.C. (3d) 168 at para. 18, respecting the object and purpose of the section:

The objection to production based on s. 57 [now s. 51] should be expressed by specific reference to s. 57(2)(b), and the documents should be described in sufficient detail to permit the court, if required, to determine whether the documents meet the criteria set out in the section. At the same time, the court must not require a degree of particularity that would defeat the purpose of s. 57, which is to protect efforts made by hospitals to ensure that high standards of patient care and professional competency and ethics are maintained, by ensuring confidentiality for documents and proceedings of committees entrusted with this task. [Emphasis added.]

[54] As noted, both Dr. Entwistle and Dr. Slater depose that because all physician complaints may ultimately be referred to the HAMAC, all records prepared in the course of investigating such complaints are prepared for the purpose of submission to the HAMAC.

[55] I have already summarized Dr. Entwistle's role above. In his affidavit, he describes that role in the following terms:

23. In fulfilling my professional role and responsibilities (in my appointed position), I have an obligation to receive complaints about physicians at the Hospital and determine how those complaints will be addressed.
24. Generally, complaints about a physician are addressed by taking one or more of the following actions (depending on the severity of the complaint):
 - (a) informally discussing the complaint with the physician;
 - (b) formally discussing the complaint with the physician and their representative;
 - (c) providing a written warning to the physician;
 - (d) referring the physician to the Physician Health Program of British Columbia (if the complaint arises from a health condition); and
 - (e) as a final resort, referring the complaint to the HAMAC for action and potential discipline.
25. My receipt of complaints about physicians, and the actions I take in addressing them, are an integral part of the HAMAC's professional competence and ethics program at the Hospital. If I did not receive and address complaints about physicians at the Hospital, the HAMAC would not be able to fulfill its duties under the Bylaws to:
 - (a) monitor the quality and effectiveness of medical care provided by physicians at the Hospital and provide advice to the Board about same;
 - (b) 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 Hospital;

- (c) 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
- (d) 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 and Physicians and Surgeons of B.C.

[56] Dr. Slater describes his role in nearly identical terms:

5. In fulfilling my professional role and responsibilities (in my appointed position and as a member of the Health Authority Medical Advisory Committee - the "HAMAC"), I had an obligation to receive complaints about physicians at the Hospital and determine how those complaints will be addressed.
 6. Generally, complaints about a physician are addressed by taking one or more of the following actions (depending on the severity of the complaint):
 - (a) informally discussing the complaint with the physician;
 - (b) formally discussing the complaint with the physician and their representative;
 - (c) providing a written warning to the physician;
 - (d) referring the physician to the Physician Health Program of British Columbia (if the complaint arises from a health condition); and
 - (e) as a final resort, referring the complaint to the HAMAC for action and potential discipline.
 7. My receipt of complaints about physicians, and the actions I took in addressing them, were an integral part of the HAMAC's professional competence and ethics program at the Hospital. If I had not received and addressed complaints about physicians at the Hospital, the HAMAC would not be able to fulfill its duties under the Bylaws to:
 - (a) monitor the quality and effectiveness of medical care provided by physicians at the Hospital and provide advice to the Board about same;
 - (b) 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 Hospital;
 - (c) 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
 - (d) 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 and Physicians and Surgeons of B.C.
- [57] Dr. Nagase says that these are conclusory statements, which are insufficient to establish that the communications were made in the course of or arising out of a study, investigation, evaluation or program carried on by a committee, within the meaning of s. 51(2)(b).

[58] It is true, as Dr. Nagase states, that there was no formal committee meeting or process by which his conduct was reviewed. The communications over which the respondents claim protection from production were all preliminary to, or part of the initial stages of, such an investigation. However, the Bylaws, Rules and the Policy Manual clearly envision a preliminary, informal process to investigate complaints. Does the fact that no committee has yet to consider the complaint mean that records created in the early intervention phase are not protected? In my view, it does not.

[59] In *Rizzo & Rizzo Shoes, Ltd. (Re)*, [1998] 1 S.C.R. 27, the Court adopted the following statement regarding the modern approach to statutory interpretation:

Today there is only one principle or approach, namely, the words of an Act are to be read in their entire context and in their grammatical and ordinary sense harmoniously with the scheme of the Act, the object of the Act, and the intention of Parliament.

[60] Dr. Nagase founds his argument on the literal language of s. 51(2). In my view, this approach ignores the scheme, object, and intention of the Legislature in enacting the section.

[61] In enacting s. 51(2), the Legislature has chosen to absolutely protect communications made concerning the evaluation or investigation of medical staff, or for the purpose of improving medical or hospital practice or care. Dr. Nagase does not argue that the topic of the impugned communications is outside the broad purposes of s. 51(2), but rather that the communications did not originate with, or were not prepared at the behest of, a committee.

[62] The effect of adopting the interpretation proposed by Dr. Nagase would be to permit production of records relating to the initiating phase of the discipline process while protecting only communications created at the more formal and serious stage of discipline. In my view, this interpretation is premised on a literal reading of the words of the statute divorced from the context in which they are used. It would result in a construction of the provision that is not consistent with the objects of the legislation or the stated purpose of the provision. In the debate on the bill at the committee stage, the then Attorney General, the Honourable B.R.D. Smith, stated that the purpose of the provision was to protect the "sanctity" of the peer review process in hospitals (Sinclair at para. 24):

It simply protects the sanctity of a peer review process in the hospitals so that we'll get adequate and proper peer review without people looking over their shoulders.

[63] As Donald J.A. notes in Sinclair, s. 51 represents the Legislature's clear choice in favour of a hospital's interest in confidentiality, rather than a balancing of interests (at para. 26).

[64] When the purpose of the legislation is taken into account, I can find no error in the judge's conclusion that the chain of communications between Dr. Nagase, Dr. Entwistle and Dr. Slater was made for the purposes of an investigation into Dr. Nagase's conduct and is protected from production by s. 51(2). As noted above, the communication is expressly stated to be made pursuant to the various physician discipline processes. Similarly, Dr. Entwistle's communications with Dr. Cudmore occurred in the course of the investigation of

Dr. Nagase's conduct. I do not agree with Dr. Nagase that the absence of a formal committee is fatal to the protection afforded by the section. Interpreting the language of s. 51(2) in such a manner would be contrary to the objectives of the legislation. To find otherwise would result in an anomaly whereby the formal committee proceedings would be exempt from production, but the preliminary and investigatory communications that form the foundation of such a committee proceeding would not be exempt. In my view, it would be an error to interpret the legislation in this manner, thereby ignoring its object and the intention of the Legislature.

Disposition

[65] It follows that I would dismiss the appeal.

"The Honourable Madam Justice Garson"

I AGREE:

"The Honourable Madam Justice Stromberg-Stein"

I AGREE:

"The Honourable Mr. Justice Fitch"

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Prepared on 27 October 2026 · Esheria