Transcript

Video: Creating a Safe Space Confidentiality & Legal Privilege for Peer to Peer Support Programs

Minutes: 1:00:21

MR. CHRISTOPHER THRALL: [0:00:02] Psychological Health and Safety of Healthcare Workers, this, our first episode, focuses on confidentiality and legal privilege for peer-to-peer support programs. [0:00:12] Our guest speakers will review the guidelines and clarify the legal privilege and professional confidentiality considerations of implementing peer-to-peer support programs for health professionals who are emotionally affected by a patient safety incident. [0:00:26] My name is Christopher Thrall. [0:00:28] I'm the Communications Officer with CPSI. [0:00:31] I would like to welcome you on behalf of our partners, Patients for Patient Safety Canada, the Mental Health Commission of Canada, the Canadian Medical Protective Association, Sinai Health System, HIROC, and the Canadian Nurses Protective Society. [0:00:45] Welcome as well on behalf of our technical host, Gina Peck from CPSI.

[0:00:50] Before we begin, I'd like to introduce our speakers today. [0:00:53] We will begin with Markirit Armutlu, who joined the Canadian Patient Safety Institute in 2017 as a senior program manager and is the lead for the Psychological Health and Safety of Healthcare Workers program. [0:01:05] Welcome, Markirit to the webinar.

[0:01:08] Markirit will be followed by Diane Aubin, a healthcare culture and patient safety specialist, with Diane Aubin Consulting. [0:01:16] After working in patient safety for over ten years at the Canadian Medical Protective Association and then the Canadian Patient Safety Institute, Diane was compelled to study the psychology of errors in healthcare. [0:01:28] Her doctoral thesis explored the impact of shame on health professionals after an adverse event. [0:01:34] Thank you for joining us, Diane.

[0:01:37] Brent Windwick is not only a health lawyer but also Assistant Adjunct Professor of Medicine and Dentistry and former Executive Director of the Health Law Institute at the University of Alberta. [0:01:49] Thank you so much for joining us today, Brent.

[0:01:52] Representing HIROC subscribers and their employees in medical malpractice and other civil lawsuits, Jonathan Gutman is legal counsel at the Healthcare Insurance Reciprocal of Canada. [0:02:04] Jonathan is a member of the Canadian Bar Association, the Ontario Bar Association, and the Medical Legal Society of Toronto. [0:02:11] Welcome, Jonathan.

[0:02:14] And finally, we will hear from Melanie de Wit, Vice President of Legal Affairs, Risk Management, Privacy, Ethics, and Operational Readiness at Sinai Health. [0:02:25] Melanie also teaches health law and risk management in the Master of Science Quality Improvement Program at the University of Toronto's Institute for Health Policy Management and Evaluation. [0:02:36] Welcome, Melanie, to the webinar.

[0:02:39] If you miss part of this webinar or want to share your learnings with others in your team or organization, please know that it is being recorded and will be available on our website within the next week. [0:02:49] I will also list the upcoming webinars in this series at the end of our hour together. [0:02:53] Please write your questions in the Q&A box on your screen or chat them directly to me, Chris Thrall. [0:02:59] They will be compiled and provided to our speakers at the end of the call.

[0:03:02] If you run into IT difficulties, please connect with us in the chat box and we would be happy to assist. [0:03:07] And now with our introductions and orientation out of the way, I would like to invite Markirit to open up the discussion on creating a safe space.

MS. MARKIRIT ARMUTLU: [0:03:18] Thank you so much, Chris. [0:03:21] Thank you everyone, and thank you to Diane, Brent, Jonathan, and Melanie for being with us today. [0:03:27] I'd like to take a moment to just reflect on the Canadian Patient Safety Institute and some of the work that we're doing around this program. [0:03:38] The CPSI works with governments, health organizations, leaders, and healthcare providers to inspire extraordinary improvement in patient safety and quality. [0:03:48] In line with its 2018 and 2023 strategic direction, CPSI works to contribute evidence to inform policies and standards that best support patient safety at organizational and health system levels and works to embed patient safety requirements in regulations, standards, and accreditation.

[0:04:08] In developing the national program for the psychological health and safety of healthcare workers, CPSI

has partnered with the Mental Health Commission of Canada and has brought together experts from across the country to address the needs of healthcare workers who are traumatized by events during the provision of care known as the second victim of phenomenon. [0:04:31] In 2000, Dr. Albert Wu first coined this term in his opinion piece titled Medical Error: The Second Victim, The Doctor Who Makes a Mistake Needs Help Too, thereby recognizing the need for organizational support for the healthcare provider who's on the sharp end of patient safety incidents.

[0:04:53] Now healthcare workers are normally able to handle the day-to-day stresses of patient care and healthcare management. [0:05:01] These stress levels can however escalate significantly when a healthcare worker experiences the unexpected loss of a patient, a very difficult outcome, difficult encounters with a patient's family member, or disagreement with a colleague over care management, potentially resulting in the healthcare worker or provider feeling psychologically or emotionally distressed.

[0:05:29] Healthcare is indeed a high-stress environment, and healthcare workers and providers are expected to work efficiently and safely in often difficult and pressured settings. [0:05:42] A 2016 Stats Canada report indicated a high turnover rate amongst healthcare providers, resulting in job vacancies in healthcare across the country. [0:05:53] Now higher turnover rates are associated with deteriorated mental health and with an increased likelihood of patient safety incidents, thus the link to patient safety. [0:06:04] The probability of contributing to a patient safety incident increased exponentially when healthcare providers are suffering from psychological stress.

[0:06:15] CPSI is therefore working with its partners to identify enabling and supportive organizational practices and policies for psychological health and safety of healthcare workers through peer support programs and resources to promote healthcare worker wellbeing and safety, and thereby also patient safety. [0:06:38] This program is intended to influence policymakers, organizations, regulators, and accreditation standards. [0:06:47] In addition, it will provide best practice guidelines, tools, and resources to support healthcare leaders and frontline healthcare providers.

[0:06:58] The program aims to develop recommendations for Canadian best practices and to produce a comprehensive

toolkit to help implement peer support programs across the country. [0:07:12] So I'm very pleased that we're able to share this series of four webinars with you and that you're able to join us for our first webinar that's specifically on the topic of confidentiality and legal privilege for peer support programs. [0:07:27] I welcome you to register for the next three, and as we progress to the following next three presentations, you will see that we will move from the term second victim and really look specifically at the psychological health and safety of healthcare workers. [0:07:48] We're trying to remove that term of second victim and replace it, and we will evolve that term as we progress with our webinars. [0:07:59] And you'll see evidence of that in the following webinars.

[0:08:03] For today's work and today's presentation, I want to just take a very quick moment to acknowledge the contributors to the documents that you have freely accessible on the CPSI web page, Creating a Safe Space, Addressing Confidentiality, and Peer-to-Peer Support Programs for Healthcare Professionals. [0:08:28] And our contributing authors being Angela Price-Stephens from the Canadian Nurses Protective Society, Brent Windwick, who is one of our guest speakers today, who at the time was with Field Law, Deborah Prowse from Patients for Patient Safety Canada, representing patients, Dr. Meri Bukowskyj from the Canadian Medical Protective Society, Jonathan Gutman from HIROC, Melanie de Wit from Sinai Health Systems, and our CPSI consultant, Diane Aubin. [0:09:05] So with that, I'm going to go to our next slide very quickly, and I'd like to invite Diane to please start with the presentation. [0:09:17] Thank you, Diane.

MS. DIANE AUBIN: [0:09:21] Thank you very much. [0:09:24] Yes, learning objectives for today, I'm going to explain the reasons why health professionals often feel emotional stress and distress and identify some of the fears and concerns that prevent health professionals from seeking support. [0:09:40] And basically I'm going to provide a bit of context, just a brief context for why confidentiality is an important consideration for peer support programs. [0:09:50] I'm hoping this will set us up nicely for my colleagues and their presentations.

[0:09:57] I'm going to start with a very short little story. [0:10:00] I was at a restaurant a couple weeks ago, and my bill came. [0:10:04] And as always, I looked at it to make sure it was right, and I noticed that there were four drinks on it that we hadn't ordered at our table. [0:10:13] So I

called the waiter over and I said excuse me, but I don't think this is right. [0:10:18] And he said oh, I'm so sorry, you're right, I confused the two tables, I'll fix that right away. [0:10:24] And I said well, we all make mistakes, so no worries. [0:10:27] And we went on our way and I'm sure he wasn't bothered by it.

[0:10:31] But I want you to imagine a different scenario. [0:10:35] I'm allergic to shellfish, so what if instead I had said I have a shellfish allergy, which I usually say when I go to restaurants just in case, and I told the waiter about it and he said yeah, sure I'll let the chef know, I'll let the cooks know. [0:10:50] But he was busy; he was overworked. [0:10:52] There were a couple of people who had called in sick that day, and he had 12 tables instead of eight, so he was running around. [0:11:00] And he forgot to tell the chef. [0:11:03] So my order happened to be deep-fried in the same oil as shellfish. [0:11:09] So I start eating my food and I get an allergic reaction. [0:11:14] I go into anaphylactic shock. [0:11:17] Let's say I didn't die, but I got really sick. [0:11:21] You could imagine that the waiter would be devastated. [0:11:24] That would probably traumatize him and affect him for the rest of his life.

[0:11:31] So you are all probably guessing by this point that I'm telling this for a very good reason and how it's related with health professionals. [0:11:43] Because health professionals, every single time they walk through that door to the hospital or clinic, there's a possibility that they will be faced with this kind of scenario. [0:12:00] Every time they see a new patient, there's a life and death possibility.

[0:12:06] So they have a lot of emotional stress at work. [0:12:09] And on top of that, there's an expectation that they're going to be perfect, that they're not going to make mistakes. [0:12:15] And that expectation is from themselves as well. [0:12:18] They're under terrible time and resource pressures with having to do more and more with less and less time, fewer and fewer resources. [0:12:27] They work in a highly complex system where several people are looking after the same patient. [0:12:33] And there's a lot of communications, a lot of opportunities for things to go wrong. [0:12:37] And they're also often making complex decisions, so no wonder they're under stress. [0:12:41] And then add onto that the risk of something going wrong. [0:12:46] So there's not only the emotional stress in a

regular workday; there's an added emotional burden associated with a patient safety incident.

[0:12:57] So when a patient safety incident happens and there's the shame, I'm sure many of you are familiar with the emotional reactions to a medical error, an adverse event, patient safety incident. [0:13:08] There's shame, humiliation, guilt, and remorse. [0:13:13] Their self-esteem is eroded. [0:13:14] Suddenly they don't feel that they should be a nurse or a doctor or a pharmacist. [0:13:22] They can go through panic, anxiety, grief, and depression. [0:13:25] And some of you probably also heard there's the possibility of PTSD after a patient safety incident.

[0:13:33] So in a just culture, the ideal, we would have these open and transparent disclosures and discussions. [0:13:41] Everybody would recognize that errors are most often system errors where a number of things go wrong before that that error reaches the patient. [0:13:52] There'd be incident analysis or debriefings or M&M rounds where it was blame-free. [0:13:58] So that's the ideal culture.

[0:14:00] The reality, however, but let's say it's getting better, I think because of a lot of the work CPSI does, but I'm biased, there's still that culture of silence. [0:14:11] There's still that fear of talking about mistakes. [0:14:16] And there's that shame and blame judgment, bullying, gossip when a mistake happens, unfortunately.

[0:14:24] So this, on top of this we have a number of hurdles for health professionals have to go through if they want to seek help. [0:14:35] First of all, they fear judgment. [0:14:37] They fear somehow this is going to get out that they needed help, that maybe they're not mentally healthy, and they're not fit for the job. [0:14:45] Somebody somewhere is going to find out and think well, maybe they're going to see this person, the peer support program, because they feel guilty. [0:14:55] Maybe it is their fault. [0:14:57] So they fear that. [0:14:59] And of course there's the stigma of mental health issues. [0:15:02] They don't want to be seen, mental health in greater society and among health professionals, they feel that mental health issues means a sign of weakness.

[0:15:14] And then, and we're getting to this, is the legal risk. [0:15:17] So they fear that the fact that they went to talk to someone about this patient safety incident means that somehow, somewhere, somebody's going to want to know what was

said during that conversation and it'll come back to haunt them.

[0:15:33] So no wonder confidentiality is a big issue for peer support programs. [0:15:39] And we have worked with a number of organizations to set up peer support programs across the country. [0:15:46] And they have all said that confidentiality is the number one issue when it comes to setting up peer support programs, that it is also the key to success.

[0:15:58] So it is very important, and my colleagues will now talk to you about what our working group discovered about confidentiality and legal privilege and what we recommend to organizations when they're setting up a peer support program. [0:16:10] Thank you.

MR. THRALL: [0:16:13] Excellent. [0:16:13] Thank you so much for that, Diane. [0:16:15] That was wonderful, and it really did bring us through the hurdles that we're going to face in this peer-to-peer program development and bring us to the legality and confidentiality. [0:16:23] And in that regard, I'd like to invite Brent Windwick to offer his comments.

MR. BRENT WINDWICK: [0:16:29] Thank you, Christopher. [0:16:31] I'll just get my slides started here. [0:16:36] So I think that a couple of points are important to reinforce from what Diane has just said. [0:16:43] One is that I think that we all get that voluntary, engaged participation in peer-to-peer support programs does depend on participants feeling safe to share information. [0:16:58] And we also get that concerns about how this information might be used outside of the safe space of a PPS program can discourage voluntary, engaged participation.

[0:17:14] Go the next slide. [0:17:17] I think that what I and Jonathan and Melanie are going to talk to you about is how to operate with those principles, those objectives in mind in an environment that is somewhat uncertain legally to get the most out of the legal protections and frameworks that are available. [0:17:42] But to be realistic and also to understand how to actually improve the system so that so that these programs can be optimally effective.

[0:17:58] So what I'm going to do in the ten minutes that I have is I want to talk about a couple of key legal distinctions here, just to set the table for you. [0:18:07] And then I'm going to talk about how legal protection or legal vulnerability comes through legislation. [0:18:17] And

then Jonathan is going to talk about the same sort of subjects, but in relation to the common law. [0:18:24] And that distinction I'm going to explain to you now.

[0:18:27] So the first thing that I want to talk about is the difference between confidentiality and privilege. [0:18:35] Lots of people, I think, have a basic understanding that there is, that there is a difference. [0:18:41] But I just want to be clear about this to get us started. [0:18:46] So confidentiality is at its root an ethical duty not to share information without the consent of its source. [0:18:55] And you can imagine many scenarios in which confidentiality is expected or it is offered or promised and you rely on that promise.

[0:19:19] The legal status of confidential information, however, does depend on the context, and I think Jonathan will talk more about this. [0:19:19] And there's always an element of public interest there, which means a balancing of different interests, often the interests of individuals versus more collective interests. [0:19:30] And often it cannot be predicted with certainty until it's actually adjudicated.

[0:19:36] Secondly, or by contrast, privilege is a legal concept, a legal concept that is centuries old and is either a legal discretion or a legal prohibition that either allows someone not to disclose information or prevents them from sharing information. [0:19:58] And because it's a sort of a legal concept and there are some formal rules around it, the legal status of privileged information can be predicted with more certainty, but it's subject to legal exceptions and sometimes also has to be adjudicated.

[0:20:14] And lastly, confidentiality can coincide with privilege, but not necessarily. [0:20:19] That is to say confidentiality or an expectation of confidentiality is often a necessary precondition to legal privilege but may not be the whole story.

[0:20:31] So I'm going to just very briefly use the example of protection of apologies to illustrate the difference between statute or legislation and common law rule. [0:20:44] Apology is not our subject today, but it provides a nice example. [0:20:48] And in the last bullet point on this slide, I've given you references to three cases that you could easily Google, and they're all very short. [0:20:58] And they tell you an interesting story about how legislated protection can actually be interpreted by the courts in a way

that might not be expected if you just read the legislation itself.

[0:21:14] So very briefly, the statutory or legislative language is very similar in all provinces and territories about protection of apologies from being used as admissions of liability in legal proceedings. [0:21:27] It does not void insurance, and cannot be used as evidence in legal proceedings. [0:21:36] And if you looked at something like the Alberta Evidence Act, also something you could easily Google, in that particular section, you would see that standard language and I won't take up the time to repeat it here.

[0:21:48] But if you look at these three cases in the last bullet point, you can see that, so for example, in the Robinson case, the question was a lawyer failed to register a mortgage renewal. [0:22:00] In the Cormack case, someone dove off of a pier into a lake and was badly injured, and the owners of the property had a conversation afterwards. [0:22:10] In the Cole case, that was the Toyota airbag case, where the Toyota Company or Takata came out and gave public apologies.

[0:22:20] And in each of those cases, when the protection of the apology was challenged, the court said certain types of language, the language that is pure apology, is protected by the legislation. [0:22:34] But the facts around that apology, like I shouldn't have, I should have warned you not to dive off the deck or, you know, I made a mistake in not registering that mortgage renewal, that information was not protected. [0:22:51] So contextual facts were not. [0:22:54] So you can see how legislation by itself versus the common law actually has a different complexion. [0:23:03] Next slide.

[0:23:04] So now just to talk very briefly about statutory or legislative protection. [0:23:09] And this slide tells you a story of 50 years of attempts by legislators to try to meet the needs of healthcare providers to create safe spaces to talk about events that harmed patients. [0:23:29] And as you can see, there has been an evolution over that period of time. [0:23:24] And where we stand right now, interestingly, is in quite a patchwork situation where each province of course has its own legislative regime and provides different types of protection for different types of proceedings.

[0:23:54] The bottom line with peer-to-peer support programs is that they're new to this game. [0:24:02] And so in all

likelihood, it would be necessary to try to use the analogy of some of these other more traditional protections in order to provide legal protection or legal privilege that is, for peer-to-peer support programs. [0:24:19] And we're going to talk about that a bit more later in the presentation.

[0:24:25] The other point that I want to make about this slide is that this slide really talks about what we're really, we're sort of primarily focusing on this morning, which is patient safety incidents, primarily within hospitals and healthcare facilities. [0:24:41] In addition, of course, there are legal frameworks and proceedings around the regulation of professionals that also can have its own sort of legislative protection.

[0:24:55] So for example, if a College of Nurses has a disciplinary proceeding or investigation ongoing, they will undoubtedly have legislated confidentiality around that proceeding in terms of being able to use that information in civil lawsuits, for example. [0:25:16] But that doesn't mean that within the College of Nurses proceeding, there may not be compelled disclosure of a lot of information which may actually challenge the confidentiality of peer-to-peer support information. [0:25:32] Next slide.

[0:25:34] So this is a very quick overview, and hopefully we'll have some questions to flesh this out a bit. [0:25:42] But I want to just conclude by giving you an idea of some of the statutory or legislative obligations and rights that can impact protection and sharing of PPS information. [0:25:55] And as I said earlier, the kind of concurrent proceedings regulated by statute.

[0:26:02] And I'll just take you finally to the last bullet point to say that the place where you normally see the court step in and kind of draw fine distinctions is where there are legal disputes about things like the facts around the situation as opposed to say, the impact of the situation, which very, very possibly could be considered confidential and protected. [0:26:29] Opinions about contributing factors, recommendations, these are the kinds of things that are actually the battleground for disclosure in legal proceedings of the kinds of information that come out of patient safety incidents. [0:26:44] So I'll stop there because my time is up. [0:26:46] I'll turn the mic over to Jonathan to talk about common law obligation and rights, and hopefully we can work our way back around to some of these issues in the questions. [0:26:54] Thank you.

MR. THRALL: [0:26:58] Thank you very much. [0:27:00] Go ahead, Jonathan.

MR. JONATHAN GUTMAN: [0:27:01] Sorry, I didn't mean to interrupt you there, Chris. [0:27:03] I was just going to say thanks to Brent. [0:27:06] So as Brent indicated, I'm going to discuss some of the common law protections that exist that aren't found within statute. [0:27:14] As Brent indicated, common law will regulate proceedings in situations where statute law doesn't expressly apply. [0:27:22] And at common law, there are generally two kinds of privilege that can be established. [0:27:27] One is a class privilege, which protects communications within a defined relationship. [0:27:33] And the second is case-by-case privilege, which as the name suggests, is a privilege that's evaluated each time it's raised.

[0:27:41] Some class privileges are well known. [0:27:44] Probably the most obvious is lawyer-client privilege. [0:27:46] Just about everyone's heard of that one. [0:27:49] And with a class privilege, once a party asserting it establishes that the communications at issue fall within the class, the privilege exists, subject to any arguments about exceptions.

[0:28:00] So to stick with our lawyer-client privilege example, the party claiming the privilege has to establish that communications in question were between a lawyer and a client, they were made in confidence, and for the purpose of obtaining legal advice. [0:28:13] If they can do that, then the privilege is established, subject to any fights about exceptions.

[0:28:21] When our group looked at peer-to-peer support programs, we concluded that peer-to-peer support doesn't fit within any of the established classes of privilege. [0:28:30] And it's worth noting that in common law, there's no class privilege for doctor-patient communications. [0:28:38] Now I will note a slightly different situation in Quebec. [0:28:41] The Quebec Charter of Human Rights and Freedoms does have some legislative restrictions on disclosure that may affect a request to produce doctor-patient communications. [0:28:52] I'm not an expert on Quebec procedures, so I won't go into detail on that. [0:28:55] But I wanted to highlight that potential difference.

[0:28:58] Most relationships are addressed on a case-by-case basis when privilege is asserted, such as for doctor-patient communications, at least outside of Quebec, or journalist

informant communications. [0:29:10] And part of the reason for this is that there's a fundamental proposition that courts operate with, which is that everyone owes a general duty to give evidence relevant to a matter before the court. [0:29:23] And the reason for this is that the court process is a truth-seeking exercise. [0:29:28] And courts are not eager to, and courts are not eager to do anything that would detract from that search for the truth. [0:29:37] And the corollary to that is they're not eager to recognize new class privileges.

[0:29:42] So claims for case-by-case privilege are assessed using the Wigmore criteria. [0:29:48] And here they are; there are four of them. [0:29:51] And any party claiming privilege must establish that all four criteria are met. [0:29:56] So the first one is that the communications at issue must originate in a confidence that they will not be disclosed. [0:30:03] As Brent indicated, confidentiality is a necessary condition, but not a sufficient one for privilege. [0:30:10] Second, the element of confidentiality must be essential to the maintenance of the relationship in which the communications arose. [0:30:17] Third, the relation must be one which in the opinion of the community ought to be sedulously fostered or diligently fostered. [0:30:26] And fourth, the injury that would inure to the relation by the disclosure of the communications must be greater than the benefit gained for the correct disposal of the litigation.

[0:30:35] So probably the most notable criteria is the fourth one, because it contains a balancing exercise. [0:30:41] Even if the first three criteria are met, a court or tribunal must still weigh the cost of disclosure against the benefits to the litigation process. [0:30:50] And the outcome of this exercise will depend on the specific issues in the litigation and what evidence is in the records that are being sought. [0:30:59] The outcome may not be the same for every case involving the same kind of records.

[0:31:04] And so one of the recommendations we made in our paper was to have communications in a peer-to-peer support program focus on the emotional responses of the healthcare provider and not the facts of what happened. [0:31:18] This should help protect those communications because information about the emotional reactions of a healthcare provider is unlikely to be of much benefit to the litigation process in that search for truth.

[0:31:29] I will note that in the context of an application for production of peer-to-peer support communications, it's likely that the Wigmore criteria would also be used in Quebec, notwithstanding its slightly different legal traditions. [0:31:44] The Wigmore criteria have been applied in other cases in Quebec where there have been claims for case-by-case privilege and no statute determines the issue. [0:31:53] So for example, in cases where privilege is claimed over journalist informant communications or researcher participant communications.

[0:32:04] So there are a number of legal processes where the sharing of peer-to-peer support information could be contested. [0:32:11] It could be in workplace investigations and grievances, college complaints and disciplinary processes, civil litigation, or criminal prosecutions. [0:32:21] And it's worth noting that the Supreme Court of Canada has commented that the balancing exercise that occurs at the fourth step of the Wigmore criteria evaluation may be different in criminal versus civil context, even where the same records are at issue. [0:32:36] And the reason for that is simply that there are different things at stake in different proceedings. [0:32:40] So down the road, if this is ultimately one day litigated, it will be important not to draw lessons from one context too freely into another context. [0:32:51] The outcomes may be different depending on which legal process is engaged.

[0:33:00] So as you will have gathered, there's a potential legal dispute about whether the Wigmore criteria would be satisfied and common law privilege applies. [0:33:08] There's also a potential dispute about the scope of protection. [0:33:12] In the MA Erine [phonetic] case, the Supreme Court of Canada identified a few ways that partial privilege might be recognized. [0:33:19] So in other words, some of the information that's requested to be disclosed might be released, but not all of it.

[0:33:28] And this could be done in a few different ways. [0:33:31] Disclosure could be made of a limited number of documents. [0:33:34] A court could edit those documents to remove non-essential material, and/or conditions could be imposed on who may see and copy the documents. [0:33:43] So it's not necessarily an all-or-nothing question. [0:33:48] All of this doesn't mean that peer-to-peer support programs shouldn't be instituted or aren't valuable. [0:33:53] These are just some conditions, sorry, considerations to bear in mind.

[0:34:02] So just to quickly summarize the last couple of sections on how peer-to-peer support programs fit, they're not explicitly addressed in current statutory protection regimes. [0:34:14] Arguably there is a public interest analogous to critical incident and quality assurance reviews. [0:34:20] And perhaps most importantly, claims of entitlement to legal protection haven't been tested to date in any legal proceedings that we're aware of. [0:34:29] Certainly there is an argument for privilege, but we wouldn't want participants in any peer-to-peer support programs to be thinking that privilege is assured just because the program will do its best to maintain confidentiality. [0:34:44] Unfortunately, there is a bit of uncertainty here, and that's likely to stay for a little while. [0:34:50] And with that, I will turn things over to Melanie.

MR. THRALL: [0:34:55] Excellent, thank you so much there. [0:34:57] Really appreciate the insights and the legal explorations we were doing with both Jonathan and Brent. [0:35:03] And now of course, I would like to invite Melanie de Wit from Sinai Health to offer her comments. [0:35:18] Melanie, you may still be muted right now. [0:35:20] If you could unmute your microphone and join us, that'd be wonderful.

MS. MELANIE DE WIT: [0:35:25] Sorry about that, I was just thinking to myself. [0:35:28] Thanks for…

MR. THRALL: [0:35:28] No problem.

MS. DE WIT: [0:35:29] Having me join you today. [0:35:31] What I propose to do is, with the benefit of the last two presentations, [0:35:38] I wanted to take the audience through our implementation of a peer-to-peer support program at the Sinai Health system in Toronto, which is, so in the context of the Ontario statutory income and law landscape.

[0:35:57] So the Sinai Health System includes both Mount Sinai Hospital and Bridgepoint Hospital. [0:36:03] So we've got about 800 acute rehab and chronic care beds. [0:36:09] And when I joined Sinai a few years ago, one of my tasks was to refresh our safety reporting system to make it easier for people to report safety events and then to respond to safety events in a way that both produced quality improvement on the front lines, and that started to shift the culture and the discussion on the front lines around safety reporting.

[0:36:42] So we invested in some technology that made it easier to report. [0:36:48] We set up clearer processes on

what happens when you do report a safety event. [0:36:54] What do we do with them? [0:36:55] How do we review? [0:36:56] Who reviews, making sure that we had a privileged forum where we were conducting these reviews? [0:37:04] And we spent quite a bit of time educating nurses, managers, allied health providers, physician groups on disclosure of harm, on how to conduct a robust quality review and how robust participation, because we were in a privileged forum, was really necessary to impact safety at the front lines.

[0:37:31] So through that work, our reporting of safety events more than doubled, which I think speaks to the shift that we've seen in our safety culture at Sinai. [0:37:44] And as that was occurring, our providers were clearly signaling to us that the more comfortable we feel reporting, the more comfortable we feel having discussions in a multidisciplinary protected forum about what went wrong, the more support we actually find ourselves needing to navigate safety events.

[0:38:11] So we committed to implementing a support program for staff who were involved in safety events. [0:38:22] And the literature was already telling us even a couple of years ago that the way to do this effectively was to use a peer support model. [0:38:32] So we surveyed our staff on various things that they wanted to see implemented in a peer support program. [0:38:38] And we learned that, consistent with what's reported in the literature, more than half of our staff have experienced a serious safety event. [0:38:48] And of those people, more than half had adverse emotional impacts as a result of that experience. [0:38:56] And we also learned that people were reaching out to someone to talk to. [0:39:02] And most people were reaching out to a colleague to debrief or obtain emotional support following a safety event.

[0:39:11] And the other thing we learned was of all the factors that staff thought would influence whether they would access a peer-to-peer support program, confidentiality was cited as the most, the biggest factor. [0:39:26] And so we really came to the table to design the peer support program with that in mind.

[0:39:35] So some of the things that we have done, and I say this as a trained lawyer and I agree with everything that's been said about how there is a lack of clarity around whether information that's documented or communicated in a peer support context would be privileged, I also want to highlight that our survey results showed that these discussions are happening. [0:40:03] But they're happening informally, and

they're happening with people who aren't trained to provide peer support following serious safety events. [0:40:14] And those discussions that are already happening, they are not privileged either, right. [0:40:19] So when a nurse speaks to a colleague or when a physician talks to their chief after a serious safety event, there's no legal protection for those discussions.

[0:40:31] So what we wanted to do is, although sometimes formalizing a place for this support to occur can increase the risk, we also wanted to make sure that there were, safeguards exist that don't exist in the kind of informal current state of affairs to mitigate some of those legal risks.

[0:40:52] And then I think it's also important just to note at a high level that today we're focused on highlighting the legal risks of a peer support program. [0:41:02] But we have to balance those risks against the risks that we're aware of by virtue of working in healthcare around the safety risks associated with not having this peer support available or not encouraging full and frank discussion about safety events and also the risks to our human capacity in healthcare.

[0:41:26] So we know from the literature that when people don't have effective supports following serious safety events, that there can be long-term consequences associated with that. [0:41:43] And some people will even opt out of an area of healthcare or opt out of healthcare altogether. [0:41:48] So I think today we just want to bring the legal risks to your attention. [0:41:53] But also we're cognizant of the fact that we want to balance those with the other risks at play.

[0:41:59] So when we implemented our program, which we're still in the process of doing, we're launching our pilot this summer, in the terms of reference and in the policy that we've created, we highlight the importance of confidentiality. [0:42:17] We make the link to the broader public interests that are served in offering peer-to-peer support. [0:42:24] And really we're tracking the language of the Wigmore criteria that Jonathan went through with you, so that we're ensuring that if we're ever asked to produce records, that we can go to court with a policy that kind of tracks the language in Wigmore to make the case that these communications are privileged.

[0:42:48] We've also situated the program within the risk portfolio and our existing Critical Incident Framework, which

we are confident is protected by privilege and which has been tested in court before. [0:43:05] And so by linking the two, we just want to make clear to whoever adjudicates a potential dispute down the road that this really was created with the intention of being confidential and is really tightly associated with quality improvement work in healthcare.

[0:43:24] We also emphasize trained emotional support and not a review of facts. [0:43:34] And so that is emphasized in the policy, in the training that we're doing with our peer-to-peer supporters, in our staff communications, and also in a preamble to the meeting with the individual who accesses the program. [0:43:51] So really trying to elicit and provide emotional support and not review the facts. [0:43:57] And the review of the facts, there is a protected forum to do that, and that's the quality review process. [0:44:05] So really distinguishing the two, and I think a lot of the groundwork that we did around educating people about what is a quality review, what are we trying to achieve, how is it protected will serve us well, because people will be prepared to make that distinction.

[0:44:22] We also limit and de-identify the documentation within the program. [0:44:29] So at the end of a meeting between the peer supporter and the person who's accessed the program, there is a one-pager that the peer supporter completes. [0:44:42] But it doesn't include identifying information. [0:44:47] And it's really quite limited to allowing us to do any follow-up that's required in terms of providing additional support and gathering data so that we can assess our program and make sure that we iterate in a way that is meaningful and impactful to our frontline providers.

[0:45:09] And then we do have a group debrief that occurs on a monthly basis with our peer supporters. [0:45:17] But again, there's no identifiable information shared within that forum. [0:45:24] And any documentation that we're making at a meeting like that is really just to improve the program. [0:45:32] It's de-identified or it's for the purposes of data collection.

[0:45:37] So this is what we've done so far. [0:45:41] We're launching the program in our Women and Infants program this summer, and these are the steps that we've taken to try to maximize our chances of both confidentiality and privilege. [0:45:56] And I think I'll leave it at that, but happy to take any questions that come up.

MR. THRALL: [0:46:03] Fantastic, thank you so much, Melanie. [0:46:04] And of course thank you, Diane, Jonathan, and Brent, for those delightful presentations. [0:46:09] And of course thank you, Markirit, for inviting such terrific spokespeople to lend their insights. [0:46:14] We have actually received a few questions from the chat box. [0:46:17] I invite anybody to enter their questions directly to me or to all participants in the chat box or through the Q&A box. [0:46:25] The first one that came in from Nicola [phonetic], just at the end of Jonathan's presentation, so I'll present it to Jonathan first, what if the peer support programs do not document their interactions and the information shared? [0:46:39] Could the peer support person be requested to testify on their memory of the information shared?

MR. GUTMAN: [0:46:50] I think that that would be possible. [0:46:54] Again, there would be an issue, certainly there would be the same issues of privilege that could be raised and whether or not that would be appropriate. [0:47:01] There's also the question of how much memory that peer support person would have by the time there was a request for them to testify. [0:47:09] It's not uncommon for memories to fade. [0:47:13] And so I think it would be an open question as to whether the peer support person would have any recollection that would contain any relevant information. [0:47:22] We haven't really talked about it here, but the evidence that's being presented also has to be relevant to the issues of - -. [0:47:29] I think there would be a - - question as to whether they would have any relevant information that they recalled.

MR. THRALL: [0:47:35] Got you. [0:47:36] All right, thank you. [0:47:37] Brent or Melanie, do you have anything to add to that?

MR. WINDWICK: [0:47:42] I would simply add that the question of whether by not documenting discussions you can avoid or get around the sort of disclosure issue, I would look at the question a little bit differently. [0:48:02] I think I would examine whether the program operates most effectively with documentation. [0:48:10] And rather than simply trying to leave it undocumented to provide that protection, think more about the kind of recommendations that Melanie's program is making about de-identifying and limiting the type of information that is part of the conversations. [0:48:29] To my mind, that's a better way of balancing the effectiveness

of the program, the engagement of participants, and the risks of disclosure.

MR. THRALL: [0:48:39] Great, thank you. [0:48:41] Melanie, Diane, - -.

MS. DE WIT: [0:48:44] I guess I would add that my experience as a litigator has shown that in order to get to the point where someone is in front of you under oath and you can ask them questions, there are quite a few steps to move through. [0:48:59] And so I think it's really helpful to be able, as soon as this is raised, to produce documentation that creates a disincentive to pursue the kind of expensive motion that you would require to get someone under oath in front of you. [0:49:15] So we would be producing a policy that says look, we're not talking about the facts during these exchanges. [0:49:21] This was meant to be confidential, tracking the Wigmore language so that there's kind of at the front end a disincentive to spend the time and money to get this person in front of you. [0:49:34] I can imagine in the kind of 0.5% of cases that the kind of case might make it worth the plaintiff's lawyers kind of while to do this. [0:49:47] But I think those cases are really few and far between.

[0:49:51] And then I agree with what Jonathan said. [0:49:53] Typically by the time you're in this position, years have gone by. [0:49:58] And hopefully we'll have trained our providers to say you know, our standard practice is that we're only eliciting, we're only there to provide emotional support. [0:50:12] We're really not engaging in facts, and I don't really have a memory of exactly what was discussed.

MR. THRALL: [0:50:18] Got you, excellent add-on. [0:50:20] Thank you so much for that. [0:50:22] I do have a follow-up actually directly to Melanie from Renee [phonetic]. [0:50:26] Renee is currently finalizing their policy for peer support programs and would really like to include some of the information that you shared. [0:50:32] Would you be willing to share either your peer support program or supporting documentation to the participants of this webinar?

MS. DE WIT: [0:50:41] Yeah, absolutely. [0:50:42] So anyone can reach out to me directly, and we're happy to share. [0:50:46] And I think really as a system, we should be collaborating wherever possible. [0:50:50] There's no need for us to be developing these things in isolation, so I'm sure that we can all learn lessons from one another's efforts on this.

MR. THRALL: [0:50:59] Fantastic. [0:50:59] Yes, we've been having actually quite a few questions in the chat box coming up asking for your peer-to-peer support program. [0:51:06] It'd be fantastic. [0:51:07] So we'll get a little information from you to share to all the participants through an email out to them. [0:51:13] But by all means we'll share your contact information, of course, in the slides there. [0:51:18] So thank you very much. [0:51:19] I do actually have a question for Brent here that came up as well. [0:51:24] What is the likelihood of statutory protection specifically directed at peer-to-peer support information?

MR. WINDWICK: [0:51:32] I think that the likelihood of that right now is small, but that's not to say that legislation cannot change over time. [0:51:44] I think a really great example of this is how Ontario evolved its QCIPA legislation dealing with quality improvement activity and led the legislative framework around it. [0:52:00] QCIPA came in, I think, in 2004. [0:52:03] And in 2015 or 2016, there was a review. [0:52:06] And in 2017, there was a new version of QCIPA which was I think much more, much more nuanced and much more sort of practical in terms of setting out the balancing interests between public transparency and accountability and psychological safety for providers. [0:52:29] As I said earlier, I think that that legislative protection has to be either invoked in the case of peer-to-peer review by analogy to legislation that deals with quality improvement. [0:52:45] Or as Melanie described very nicely, actually kind of locked in through a policy, a directed policy approach. [0:52:56] And so I think that's the landscape that we're dealing with right now.

MR. THRALL: [0:53:00] Great, thank you. [0:53:01] Jonathan, do you have anything to add to that?

MR. GUTMAN: [0:53:05] No, I agree with what's been said.

MR. THRALL: [0:53:08] Perfect. [0:53:10] Just a quick up, Melanie, perhaps you can answer. [0:53:14] Martin [phonetic] was wondering what you mean by de-identified data or information.

MS. DE WIT: [0:53:21] So I mean that the staff's name is not recorded, that if we were to look back two years from now, it would be hard, not impossible. [0:53:32] Truly de-identifying information means that ideally you can't relink it. [0:53:38] But there wouldn't be enough information on the face of the document to indicate what staff member accessed the program on that day.

MR. THRALL: [0:53:51] Perfect, thank you so much. [0:53:54] All right, I do have a follow-up question from Nicola that I'll ask Jonathan first. [0:53:59] What would be the legal considerations or obligations for a peer support person that became aware of an adverse event through a peer support discussion? [0:54:08] Would they be legally obliged report that event?

MR. GUTMAN: [0:54:15] Well, I think the precise obligations would probably depend on the situation. [0:54:22] And I think it would matter whether there was some ongoing risk to a patient. [0:54:30] My guess is that if they became aware of an adverse event, there might be some recommendations that they could give to the person communicating it, about reporting it. [0:54:42] I think typically it's the people involved who are supposed to report adverse events or incidents when they happen. [0:54:50] And ideally it's the person who is involved that should be, or someone who was involved that should be reporting it. [0:54:56] It may not necessarily be the person seeking peer support, but I think that's the first step, is to see if it has been reported by someone who was involved.

MR. THRALL: [0:55:07] Got you, so really case by case. [0:55:10] Please, go ahead, Melanie.

MS. DE WIT: [0:55:11] I can say at Sinai through our Critical Incident and Disclosure of Harm Policy, anyone who becomes aware of a safety event is required to enter it into our safety reporting system. [0:55:23] That's an expectation that we've set by policy that binds everyone in the organization. [0:55:31] So at Sinai as a matter of policy, yes, someone would need to report to the safety event. [0:55:37] We anonymized fairly quickly in our reporting process who actually brought forward the concern. [0:55:45] And it's not information that we share. [0:55:48] Because once we have details about what happened to who, then we're able to go into the chart and gather the people who were involved and convene a protected setting in which we can look at what were the system-level factors that might have contributed to this. [0:56:04] And what can we do, what are one or two high-impact things that we can do to reduce the chance of this happening again.

MR. THRALL: [0:56:12] Perfect, thank you, Melanie. [0:56:13] Brent, did you have something to add?

MR. WINDWICK: [0:56:15] Only to just suggest that there are a variety of reporting obligations across the country, but they

are actually not uniform. [0:56:29] And so I think in addition to it being situation-dependent and organizational policy-dependent, it also actually does depend upon the province. [0:56:41] And if you look at the landscape of legislation that exists right now that mandates reporting in my prehistoric province of Alberta, there is no legislation. [0:56:53] But in Newfoundland, for example, there is year-old legislation, and there's sort of a spectrum in between or amongst these. [0:57:04] And they contain different provisions that tell you the threshold at which reporting is required, whether reporters are legally protected, whether their identities are legally protected, and so forth.

MR. THRALL: [0:57:16] Great, thank you so much, Brent. [0:57:19] I do have one last question that I'm going to open up for Melanie, coming from Marsha [phonetic]. [0:57:23] It was really along the lines of this not sort of discussing the facts in a peer-to-peer support environment. [0:57:31] But Marsha says the critical incident stress model, for example, the Mitchell model, debriefing has a step that involves the event review. [0:57:39] Do you recommend that that specific step not be used with these events that involve patient safety?

MS. DE WIT: [0:57:45] I definitely recommend that that not be part of the information that gets captured. [0:57:51] I think obviously you can't provide support in the absence of any facts. [0:57:56] And I don't mean to suggest that we should be providing support in the absence of any factual context. [0:58:05] But there's a way of providing really, at a high level, what happened to trigger the types of feelings that are being experienced. [0:58:14] And then to fairly quickly focus on that emotional consequence of the events, and certainly steering clear of any individual's contribution to how the events unfolded. [0:58:30] But really sticking to the what happened, not the how, so the how gets answered and the how and the why get answered in the review. [0:58:39] The what, at a high level, I think to your point, is essential to capture at the beginning of the session.

MR. THRALL: [0:58:48] Perfect, thank you so much for that, Melanie. [0:58:50] I do see that we're at time. [0:58:52] We do want to respectfully thank Diane Aubin, Jonathan Gutman, Brent Windwick, and Melanie de Wit for sharing your time and your expertise for this. [0:59:00] Thanks of course to all of you for taking the time to attend on behalf of me, Christopher Thrall, Program Lead Markirit Armutlu, technical host Gina Peck, and the rest of the team at the Canadian

Patient Safety Institute. [0:59:12] Thanks again to our partners, Patients for Patient Safety Canada, the Mental Health Commission of Canada, the Canadian Medical Protective Association, Sinai Health System, HIROC, and the Canadian Nurses Protective Society.

[0:59:24] If you want to continue this conversation started in this discussion, please feel free to send us an email. [0:59:29] We will forward your comments and any questions you may have had that were unaddressed onto our speakers. [0:59:34] You should all receive Gina Peck's follow-up thank you email in your inbox shortly, and you can respond to that. [0:59:40] We will also post a recorded copy of this webinar on the CPSI website in the next week or so. [0:59:45] We invite you to join us for the next three webinars in this series, which continues on June 12th with the Results of the Pan Canadian Survey of Healthcare Workers' Views on the Second Victim Phenomenon. [0:59:56] Following that, on June 20th, join us for a Global Environmental Scan of Peer-to-Peer Support Programs. [1:00:03] The series ends on September 20th with Canadian Best Practices for Peer-to-Peer Support Programs and the launch of the Peer-to-Peer Support Toolkit. [1:00:12] Have a wonderful day, everyone, and we will hope to see you again soon.

[END of transcript]