Hospital Privileges and the Law

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INTRODUCTION 315

I. HOSPITAL STRUCTURE 315

II. MEDICAL CARE 316

III. HOSPITAL PRIVILEGES 317

IV. IMPACT ON HOSPITALS OF GRANTING PRIVILEGES 317

V. CHANGING ROLE OF PHYSICIANS 318

VI. PEER REVIEW 319

VII. SALARIED PHYSICIANS 320

VIII. OPEN-CLOSED HOSPITALS 320

IX. ETHICS 322

CONCLUSION 324

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The complexity of management of our health facilities has dramatically increased over the past few years. New treatments and technology have increased our ability to extend life and deal with many complex medical problems that were impossible to treat only a short time ago. In addition, extensive research facilities associated with medical institutions are essential to support and develop the medical initiatives that have become possible and expected by a highly discerning public. At the same time, governments are attempting to control health expenditures, which now amount to one-third of the provincial budget in Ontario. Our health system has become increasingly politicized with constant attention by the media and the public. Within this context, I will review the process of granting hospital privileges to physicians and some of the difficulties being encountered in this dynamic environment.

I. HOSPITAL STRUCTURE

Under the Ontario *Public Hospitals Act*[1] every hospital must be governed and managed by a board. The Board of Trustees are volunteers selected to represent the community's interest in the provision and development of medical services by that hospital.

Hospitals have a unique management hierarchy very different from the commercial sector. As C.E.O., I am an employee appointed by the Board of Trustees and report to that Board. The Board also appoints all members of the medical staff and delineates their privileges. In the organizational structure, the members of the medical staff do not report to the C.E.O. and are not employees.

The Board is also responsible for appointing a chief of staff or chair of the *Medical Advisory Committee* (MAC). The MAC has an overall responsibility for the clinical activities, and the physician appointed to lead the MAC as a member of the Board of Trustees, is responsible to advise the Board on the quality of the medical care in the hospital.

The medical staff are formally organized through a medical staff association to represent them with the MAC, administration and the Board. The President and Vice-President of the medical staff association are ex-officio members of the Board of Trustees. This is legislated under the Ontario *Public Hospitals Act.*

Teaching hospitals and hospitals over 100 beds must have three senior members of the medical staff as members of the Board of Trustees. The chair of the MAC, the President and the Vice-President of the medical staff association are hospital Trustees. Physicians therefore have a major input into Board decisions.

1. R.S.O. 1990, c. P.40.

II. MEDICAL CARE

Physicians, in fact, are the gatekeepers of the hospital. The Ontario *Public Hospitals Act* gives physicians a legal monopoly on patient care. Only a physician can admit patients, write medical orders, and discharge patients, although an adult patient does have the right to self discharge even against the physician's order. Physicians therefore have major impact on the resources of the hospital.

Individual members of the medical staff have the ultimate responsibility for patients in the hospital. A section of the Ontario *Public Hospitals Act* states that where a specified officer of the medical staff becomes aware that in his opinion a serious problem exists in the diagnosis, care or treatment of a patient, such officer must discuss the care and treatment with the attending physician and if satisfactory changes are not made, the officer shall assume treatment of that patient.

There is a legislated responsibility on certain members of the medical staff to take action where another physician is identified with not providing adequate medical care to a patient. The Ontario *Public Hospitals Act* was amended to include this requirement to assure that patients were properly treated by the attending physician. It provides authority for another physician to assume responsibility for the patient's care.

Medical residents are qualified physicians taking specialized training at various levels in teaching hospitals. Residents provide medical coverage on the wards under the direction of a designated responsible physician.

In the physician-patient relationship, it is clear that the hospital is not liable for physician actions, but the waters become muddy when the hospital is a complex teaching facility that requires hospital involvement in processes and procedures around patient care. The more hospitals become involved in procedures, the more effort is made to hold the hospital liable for physician actions.

When the hospital appoints its physicians it must take appropriate steps to determine their competence. At a future date the hospital may be responsible for physicians' actions under certain circumstances. For example, if a physician is impaired through alcohol or drug abuse, the hospital could be liable if it was aware that a problem existed and did not take action. The hospital must assure that a responsive system of reporting is in place to deal with these issues. If not, the hospital may be liable for the action of a physician.

There is another issue that is increasing as a cause for concern in this time of restraint. If a patient suffers damage from not having received prompt, accurate diagnosis because the decision was made not to provide medical coverage or services due to limited funds, is the hospital liable? Does restriction of diagnostic tests and professional services shift any responsibility to the institution based on the patient's expectation and right to receive adequate, competent care?

III. HOSPITAL PRIVILEGES

Any physician has the right to request an application form for privileges from the C.E.O. of the hospital. The Ontario *Public Hospitals Act* sets out a procedure for consideration of that application and the action that must be taken in advising the applying physician if his/her application is not accepted.

The administration and Board have a responsibility to take care that only competent physicians are appointed to staff. A credentials committee of the medical staff reviews all documentation relative to a physician's application. The Board listens carefully to its medical staff to assure that recommendations for privileges from the MAC have been thoroughly reviewed by the credentials committee along with recommendations from the Department Chief and the University where the physician will be jointly appointed to the Hospital and University.

IV. IMPACT ON HOSPITALS OF GRANTING PRIVILEGES

The granting of privileges to a physician can have a major impact on the demands put on hospital resources. Many specialties today require elaborate capital investment and major operating costs in terms of physical facilities, specialized staffing, medical and surgical supplies, drugs, and other costs. In this time of constraint, it has become even more important to have a strategic planning process that determines the long range direction that the hospital wishes to pursue and the specialties and staff that will be required to support that strategic plan.

There is a healthy, built-in competitiveness within the hospital environment between and among the various medical specialties as each tries to enhance and improve the services available. There must be a processing place to prioritize these unlimited demands by means of a valid impact analysis for all new programs and physician appointments. For example, the chief of a division at the Hospital for Sick Children moved his practice to the United States. To meet the needs of a patient population and attract a world class division head to replace him, the hospital invested in excess of $5 million to upgrade physical space and equipment for that division.

With over fifty medical divisions at the Hospital for Sick Children, and worldwide competition for medical leaders, the magnitude of the problem becomes apparent. But what if allocation of resources precluded adequate services to permit correct diagnosis and care at a level that the public could expect from that institution? Where does the liability rest?

Physicians are independent contractors with the hospital and although they have appointments granted by the Board, the hospital is not liable for the wrongful act of a non-salaried physician. Although in other jurisdictions, sporadically there have been cases where this premise was successfully challenged; the situation is quite different in Canada and has remained consistent.

Due to the enormous costs of insurance coverage, hospitals in Ontario formed an insurance reciprocal initially known as *Hospital Insurance Reciprocal of Ontario* (HIRO), and currently as *Healthcare Insurance Reciprocal of Canada* (HIROC), due to its expansion to other provinces. The reciprocal provides a form of self-insurance by which claims are shared. Most physicians in Canada belong to the *Canadian Medical Protective Association* (CMPA), which provides protection for physician members. Neither provides insurance in the normal sense. Each member of HIROC is subject to additional assessments if excessive claims are experienced. Under CMPA, physicians do not have insurance but are afforded protection within the assets available under the plan.

Although members of HIROC are now in the commercial market only for excess coverage, large judgments have a major impact on our ability to provide care. The cost of litigation and subsequent judgments become a direct cost that must be absorbed in fixed budgets. Higher costs must be accommodated by reduced services.

Physicians have often interpreted that hospitals abandon them when a malpractice suit arises. In malpractice actions, the facts may give rise to conflict in the position of the hospital and members of the medical staff involved. For this reason, it is important to understand the relationship between the hospitals and their medical staffs.

V. CHANGING ROLE OF PHYSICIANS

Physicians are granted privileges to provide medical care to patients admitted to the hospital. In the past, the majority of physicians saw this as their only role and did not participate in the management of the hospital. The expectation generally was that the hospital management was responsible for providing the resources. The physician had little concern for the cost of resource utilization in the treatment of patients. That role of the physician is changing dramatically as the fiscal pressure and demands for more accountability in the outcomes achieved are creating a new role for physicians and physician managers.

At the Hospital for Sick Children, we expect the senior members of the medical staff to be members of the senior management team of the hospital. Our chief of surgery, chief of paediatrics, chair of the MAC, president of the medical staff association, and the director of our research institute, who is a scientist, are all equal voting members of our senior management team. The senior management group of the hospital is balanced between five vice-presidents, four physicians and a scientist. The physicians in this environment have a major input into the management decisions of the hospital.

The competition that arises relative to new treatment methods, quickly accelerating costs and increasing research activity, must be resolved by managers and physicians. Physicians are now expected to be accountable not only for their clinical activities, but for their use of resources and for participation in the establishment of strategic and operational plans under tight fiscal constraints. This has given physicians new authority ... but at the cost of assuming substantial responsibility. They now must share in management decision-making as well as fulfilling clinical responsibilities for patient care and teaching. An interesting aspect of this new role of the physician will be the degree to which this compromises the physician's previous undivided loyalty to the patient.

It also has broad implications for physicians who have been forced to practice protective medicine for many years. When challenged in inquests or court cases, they must assure they did everything possible within their body of knowledge in dealing with their day-to-day diagnosis and treatments of patients. For many years we have heard the lament from physicians that many tests and x-rays were done unnecessarily, primarily to protect the physician in the event of a poor outcome and challenge in court. Will there be a change in judicial attitude in light of this changing role of the physician?

In the United States, under what is called *Diagnosis Related Groups* (DRG) funding, hospitals are paid a fixed amount for each case regardless of the length of stay of the patient or the resources utilized. A physician who keeps his patients in for a longer period or uses more expensive technology than his peers, is an undesirable physician from the fiscal viewpoint of the hospital.

Under present law in Ontario, it would be impossible to remove physicians' privileges based on their costs of providing care. In the future, this will be an area that will become more in the forefront and difficult to resolve. We have not clarified the expectation of physicians appointed to the medical staff relative to their administrative role and use of resources.

At the present time a hospital can do little, relative to privileges, when a physician does not take part in administrative activities or ignores the cost of the treatment he provides. It is my opinion that changes will occur in this broad area.

However, I am informed that in an American case, the hospital administrator instructed a physician to reduce the length of stay of patients. The physician disagreed but complied. It was held in that case that although the physician is an independent contractor and not an employee, if the administrator overrules the physician, the hospital assumes liability if the patient suffers an adverse outcome such as being sent home prematurely with complications arising.

VI. PEER REVIEW

Quality assurance has been achieved through an extensive system of peer review. Physicians review medical outcomes and challenge, question and debate the best method of treatment, particularly in cases where poor outcomes were experienced. The result has been improved patient care.

In Ontario, quality assurance documentation can be compellable in court. This creates a tremendous reluctance to critically analyze and document situations that might later lead to legal proceedings. The Ontario Hospital Association has made numerous recommendations that documentation related to quality assurance review should be inadmissible in legal proceedings. I strongly agree with this recommendation to strengthen peer review procedures in the hospital. The present situation compromises health care. We must balance the rights of the patient versus better health care standards.

VII. SALARIED PHYSICIANS

The Ontario Government is making a concerted effort to move physicians from a fee for service system to salaried positions. Our paediatric department at the Hospital for Sick Children has recently signed a contract with the Ministry of Health whereby physicians in that department are salaried, funded by the Ministry of Health. This move may precipitate a challenge to the existing status whereby physicians are independent contractors. Does a physician who receives salary and/or sits on senior management blur his or her role as a private contractor? I hope that our attempts to enhance the role of physicians and change their method of payment does not interfere with the way the courts delineate responsibility between hospital and physician and the responsibility of a physician to a patient.

Physicians are also establishing clinical practice groups which operate on separate budgets. The physicians as a group are drawn into a dual responsibility, namely to patients and to the hospital budget and fiscal constraints.

There is also a move towards program management, where a physician is made responsible for the resources and the clinical practice relative to a particular medical program in the hospital. This puts greater fiscal responsibility on the physician managers to live within the resources available while at the same time meeting the clinical demands.

All of these changes have implications in terms of the ultimate responsibility of the physicians and their choice of treatment modes for individual patients.

VIII. OPEN-CLOSED HOSPITALS

Categorization of hospitals into open and closed relative to medical staff privileges has become blurred over the past several years. At one time, there was an expectation that if a physician moved into a locality he or she could expect to be appointed to the local hospital. In many of the teaching hospitals, which were classified as closed, physicians were expected to compete for positions. Due to constraints, community hospitals are now very conscious of their resource limitations and have developed strategic plans that include physician requirements for the future. In many cases, hospitals are still opened relative to appointment of general practitioners to the staff, but closed for specialist staff.

Most hospitals today have implemented an impact analysis, which evaluates the costs that would be incurred by the addition of a new physician to hospital staff. Each analysis is considered in relation to the hospital's resources and budgeting process.

Today it is accepted that the Board has the right to control the number of physicians on staff in line with strategic directions and needs of the hospital and the community it serves. The Hospital Appeal Board has upheld this premise when challenged.

It is obvious that new physicians will find it much harder to obtain appointments, with major consequences to the physician and his or her ability to practice. In the future,

graduating physicians may find it impossible to obtain an appointment in the location of their choice.

Governments have also attempted various methods to restrict numbers of physicians. In British Columbia, the government attempted to restrict billing numbers to physicians. If that action had been upheld, the physician could be in a position of obtaining hospital privileges but precluded from practising medicine. However, the Supreme Court set aside a lower court decision that gave the Medical Services Commission of British Columbia the right to restrict billing numbers. In requiring that a billing number be issued to the petitioner, the Court stated:

> *Section 6 of the Canadian Charter of Rights and Freedoms establishes the right of a Canadian citizen to move to any province for the purpose of gaining a livelihood without being disadvantaged by provincial barriers (other than laws or practices of general application) which establish a preference for provincial residents. The billing number scheme was not a law or practice of general application as it operated variably upon the basic liberty of some licensed members of the medical profession to prevent them from practising. The scheme clearly disadvantaged the petitioner and discriminated primarily on the basis of residence by giving preference to physicians residing in British Columbia. The petitioner's Charter right to pursue a livelihood in the province was not subject to the scheme and was contravened by it.*

In Ontario, over a five year period, the government intends to reduce the number of medical resident training positions by 200 to curtail the number of medical specialists. Paediatrics has taken major cuts with a devastating impact on hospital patient care, because residents provide major patient care in the hospital. During the phase-in period of the resident cutbacks the number of paediatricians in Ontario has actually increased due to free movement from other provinces. As Ontario restricts its training program, physicians are freely moving into Ontario and setting up practice.

Alberta experienced a 20% increase in physician numbers and a 38.4% increase in physician billings during the period 1983-87. With no growth in population, the province has faced staggering increases in utilization.

I suggest that provincial governments will have to proceed to restrict the movement of physicians inter-provincially to curtail the growth of physician numbers. In Ontario, rigid controls on the entry of foreign physicians have been implemented and restrictions on movement across the country will probably be next, particularly for provinces that are still attracting physicians. The court's decision in the British Columbia case will make these efforts extremely difficult. Yet, the courts will no doubt become directly involved in resolving this Canada-wide problem.

In Ontario, although there is no contract between the hospital and the physician, a legitimate expectation of renewal of privileges has been established. It is extremely easy to grant privileges and equally difficult to retract them. Under the *Public Hospitals Act* of Ontario, a physician is appointed by the Board to the medical staff of the hospital, for a period of not more than one year. One might expect that the right therefore exists not to renew at the

end of one year. However, in practice, virtually all appointments are renewed on a yearly basis and it is extremely difficult to refuse the renewal of privileges without clear evidence of lack of professional competence or that continued privileges would jeopardize the delivery of health care in the hospital.

In regard to appointment or changes in privileges in Ontario, a physician has the right of appeal to the Board of the hospital and then to a separate body called "The Hospital Appeal Board". Very few retractions of privileges have been successful, even where there has been substantive evidence and reasons for withdrawal of privileges in the view of the hospital and its senior physician group.

Physician behaviour can only be examined relative to its effect on patient care. In other words, does the behaviour adversely affect the medical care the hospital is able to provide? If the answer is no, it is virtually impossible for the hospital to remove privileges. Thus, a physician's behaviour may be reprehensible with respect to his or her private life, and yet the hospital can do nothing about that physician's privileges if it cannot prove that the physician's conduct affects good patient care. This gives physicians protection that the employees of most businesses do not enjoy.

IX. ETHICS

Although technology has dramatically increased the physician's ability to prolong and maintain life, the decision related to appropriate treatment is becoming more diffuse. The decision to treat or not to treat, the removal of life support and the abortion issue are examples of the complexity physicians face in reaching clinical decisions that may ultimately result in litigation. Many hospitals have developed ethics departments to assist physicians and staff in reaching conclusions. Although the physician must make the final decision, the process for reaching an acceptable outcome involves a multifaceted process.

Physicians expect to take all appropriate measures to treat patients and prolong life. Where does the decision rest to abandon effort on the patient's behalf? What is the limit of this responsibility, particularly when extraordinary efforts on behalf of some patients are seen by the public, relatives, and parents and new expectations created? What is the responsibility of the physician to respond?

Paediatric physicians face enormous problems where treatment is appropriate in the physician's opinion but refused by a parent. Although the physician has recourse to the legal system to obtain permission to continue treatment, cases tend to become public, often with negative consequences for the physician and patient. Two children who received care at the Hospital for Sick Children illustrate the point. The names may be familiar: Andrew Gordon and Elizabeth Lue.

Baby Andrew came to our Hospital just before Christmas 1989. He was seven months old. His mother thought he had the flu. But the doctor hospitalized him for tests, and a day later the parents heard the fearful diagnosis: Andrew had cancer ... a particularly virulent form of cancer that is successfully treated with chemotherapy in just 25 percent of cases. Failure to treat means certain death. The parents, well educated, thoughtful people,

consulted with a number of different physicians, and people knowledgeable about cancer, and decided not to consent to treatment.

Our physicians responded by doing what the law says they must: they notified the Children's Aid Society, which in this case was the Catholic Children's Aid Society of Toronto. A worker from the Society reviewed the situation and "seized" the child. A Court hearing was held almost immediately and the judge ordered treatment to begin, removing custody from the parents for an interim period ... but, happily, not physically separating them from Baby Andrew. The outcome? Baby Andrew tolerated treatment, and remains well four years later.

At the Hospital for Sick Children, however, the outcome might be perceived differently. The media presented the circumstances in a way that outraged the public. June Callwood wrote two columns for the Globe and Mail about the situation, Peter Gzowski devoted an hour of Morningside to it, and the Hospital made page one for several days. Only Christmas took us off the public agenda. There was no lawsuit, but some might say we were "convicted" by the media for interfering in a family's life.

In another highly publicized case, extraordinary measures were taken to assist a patient. Young Elizabeth Lue received wide media coverage related to her need for a life-saving bone marrow transplant. Potential donors in Canada and China responded to constant appeals which ultimately led to 10,000 people providing blood samples for testing at a screening cost of $800,000. In this case, the odds of success were 25-50%, even if a non-related match was found. Elizabeth's mother finally requested the search be abandoned when no suitable match had been found, and the child subsequently died.

CONCLUSION

The decisions regarding hospital privileges are changing as the management of our hospitals adapts to major changing circumstances. We must use discretion and informed judgement to assure fairness in the granting and renewal of privileges. At the same time, patient safety and provision of the best medical care possible are the ultimate objectives.