CHANGING PHYSICIAN-HOSPITAL RELATIONSHIPS:

Managing the medico-legal implications of change

CMPA | ACPM
THE CANADIAN MEDICAL PROTECTIVE ASSOCIATION
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PURPOSE

With the goal of contributing to effective physician-hospital relationships that support quality care, the purpose of this paper is:

- *to identify the medico-legal implications associated with the changing relationships between physicians and hospitals*
- *to offer recommendations that effectively address these implications, both by mitigating the potential negative consequences and by capitalizing on the advantages that may be available*

Given the diversity of healthcare delivery across the country, local conditions will be important in defining the relationships between healthcare providers and between those providers and the institutions in which they work. Since each situation may be slightly different, the recommendations offered here are meant to provide guideposts to assist in the development of relationships that are appropriate for local conditions and reflective of established accountabilities.

The Canadian Medical Protective Association (CMPA) is cognizant the evolving nature of the physician-hospital relationship is one element of a wider mosaic of change. The role of the medical profession within an increasingly complex and dynamic healthcare system is also undergoing adjustments. However, while these changes are closely linked, putting in place effective steps to address the medico-legal implications of the physician-hospital relationships need not — and should not — wait until the broader issues are resolved. Indeed, the CMPA believes that many of the considerations that should underpin the manner in which physicians and hospitals interact are generally applicable to all aspects of medical practice.

Accordingly, this paper and its recommendations should be of interest to all physicians (not only those whose primary practice is in hospitals), health authorities and hospital leaders, governments, medical regulatory authorities (Colleges), and medical organizations representing physicians.

INTRODUCTION

The Canadian healthcare system is undergoing significant change as it evolves to meet emerging patient and societal needs. At the same time as the Canadian population's healthcare requirements are increasing, resource levels may not be keeping pace with growth in demand. New technologies, higher expectations for healthcare outcomes, an appropriate desire for greater accountability, and focus on assessing and improving system performance all contribute to added complexity.

Physicians' roles in the healthcare system are also changing. The widespread adoption of collaborative care models and greater use of inter-professional teams have improved the access to care for Canadians. While these changes pose challenges, the CMPA is supportive of efforts to expand the delivery of care. The Association has provided constructive and achievable recommendations on how to manage associated medico-legal issues.[1]

One element of this transformation is rapid and significant change in the longstanding relationship between physicians and the hospitals in which they work. There are many factors involved in these changes, some of which are being witnessed across the country while others appear to be the result of local conditions and may not be applicable everywhere. Some of these changes appear to be the product of system-wide decisions aimed at improving accountability, effectiveness, and efficiency across the spectrum of healthcare delivery. Others, however, seem to be aimed at specifically adjusting the responsibilities and the culture within institutions.

The medico-legal implications of some of the changes currently underway may not yet be fully known or appreciated by physicians and the organizations that represent them. If not effectively addressed, these implications could lead to difficulties for physicians and the institutions within which they practise and, if ignored, could disadvantage patients and hinder the delivery of safe and effective care. Effective relationships between physicians and hospitals are vital if the healthcare system is to meet the healthcare needs of Canadians. An important part of the test of such relationships is whether they contribute to quality care.

Within this diverse environment, it is unlikely there is one perfect model or approach that may be universally applicable across thirteen provincial and territorial jurisdictions, let alone to the dozens of local health authorities and regions. However, with its pan-Canadian perspective, the CMPA has identified achievable recommendations that should, if adopted, address the medico-legal implications associated with the changing relationships in a manner that mutually benefits physicians, hospitals, and patients. While it would be counter-productive and inappropriate to place obstacles in the path of positive change, it would be equally unwise to proceed without resolving these implications.

1 The Canadian Medical Protective Association, Collaborative care: A medical liability perspective, 2006. Available online at: https://www.cmpa-acpm.ca/cmpapd04/docs/submissions_papers/pdf/06_collaborative_care-e.pdf

AN EVOLVING LANDSCAPE

One of the strengths of the Canadian healthcare system is its capability to adjust, at least within certain parameters, to local conditions, be they at the provincial or territorial level or, given the increasing decentralization of healthcare decision-making, at the regional level. This local-based reality poses some risks when seeking to identify lessons that may be widely applicable. With this caveat in place, in many parts of the country, the CMPA is witnessing the following trends:

- Provincial and territorial governments are seeking to strengthen and clarify the accountabilities associated with the delivery of care. These can be witnessed in the recent revision of legislation related to the practice of medicine in a number of provinces and territories, including Alberta, the Northwest Territories, Prince Edward Island, Newfoundland and Labrador, and Nova Scotia.
- Accountabilities are also being enhanced at the hospital level. While the recently enacted *Excellent Care for All Act* in Ontario may be the most prominent effort, similar initiatives have been completed or are underway in many jurisdictions. In turn, hospital boards and chief executive officers are, through hospital bylaws and other governing documents, attempting to better define roles and responsibilities within their institutions. These efforts seek to improve the effectiveness and efficiency of care and to align with legislation, regulation, and public expectations.
- Roles and responsibilities within hospitals increasingly reflect the migration towards delivery models based on interprofessional teams that draw on and value the contributions of an array of healthcare providers. This broadening of responsibilities has an impact on the traditional role of physicians.
- A growing reliance on interprofessional teams and collaborative care is occurring at the same time that the scopes of practice of many healthcare providers are being expanded. This expansion frequently results in overlaps between healthcare professions, demanding more effective communication and greater role clarity.
- All elements of the healthcare system are under increasing scrutiny and, while this is generally a welcome trend that reflects the importance of healthcare to Canadians, it can, if not properly managed, have negative consequences on individuals and on institutional culture. Institutions should respond reasonably and positively to such scrutiny, in part by reinforcing their commitment to professional standards.
- While many physicians and hospitals remain comfortable with the traditional privileges model for the provision of medical services within the institution, there is an increasing prevalence of other engagements, including those based on more formal contractual or employment arrangements. The advantages and disadvantages offered by these arrangements vary based on the specifics, but there are significant medico-legal considerations associated with both the privileges and the contract approach. These considerations may not be widely understood by the health authority, hospital or physicians involved.

While it might be attractive to consider "turning back the clock" to a simpler and more straightforward set of conditions, such an approach would be both impossible and misguided. In this regard, the CMPA recognizes that many of the trends identified above have been supported, either actively or implicitly, by physicians and the organizations that represent them. This reflects the fact that, assuming the approaches are effectively managed, the benefits to all parties should outweigh the shortfalls.

CHANGING ROLES AND RESPONSIBILITIES

Longstanding healthcare governance models have recognized the unique perspective and expertise provided by physicians and the importance of engaging that expertise in administrative decision-making. While this system has served Canadians well, the CMPA has recently witnessed efforts to reduce the role of physicians in healthcare administrative decision-making. Within the hospital setting, recognition of physicians' important role in decision-making is perhaps best evidenced by the existence of medical advisory committees and the mandated requirement to include physicians in decision-making roles on the hospital governance body. This requirement is fundamental to the independence and maintenance of the self-regulated nature of the medical profession, including the sole authority for the credentialing and discipline of physicians. However, it appears this too is under threat by those who may not fully understand or recognize the value provided by the current approach. In certain jurisdictions, physicians have expressed concerns that legislative, regulatory, and local bylaw adjustments have served to marginalize their role and contributions in this regard. Such a situation is unfortunate and it may have the longer term result of negatively affecting the quality of care.

Health authorities and hospitals should be encouraging physicians to engage in decision-making and, where obstacles to such engagement exist, should be working actively to remove any barriers. Such obstacles may be tangible (e.g. governance structures) or intangible (e.g. institutional culture). To facilitate the active participation of physicians in organizational decision-making, institutions should review their governing documents (such as bylaws) with a view to facilitating physician engagement, collectively and at the individual level.

Given how some of the trends have unfolded, the changing relationships may be seen as favouring one party over another. The CMPA believes this view is short-sighted and that a reasonable path exists to achieve a mutually beneficial outcome for physicians, health authorities and hospitals and, most importantly, the patients they serve. The focus of attention should not be on protecting the status quo or on change for the sake of change. With a goal of delivering high quality care, relationships and decision-making mechanisms should recognize and capitalize on the expertise of all healthcare providers, including physicians.

It is important for physicians individually, and the medical community collectively, to remain engaged in healthcare decision-making, including at the health authority and hospital level. Disengagement from, or the abrogation of, decision-making is not a viable course of action as it may lead to negative consequences for patients. While physicians face an ever-increasing set of demands on their time, active engagement in the decision-making processes within the institutions in which they practise should be, in the interests of both patients and the medical profession, a priority.

Employment arrangements. Some physicians may be employees of a hospital where they have entered into a relationship with the hospital to provide specified services in return for certain compensation and benefits. The fundamental arrangement is similar to that between the hospital and other employees (e.g. nurses, etc.). Such arrangements are governed by employment law and, unless specified, likely do not include the protections provided by the privileges model.

MEDICO-LEGAL IMPLICATIONS

Six areas of concern

In examining the medico-legal implications of the changing relationships between physicians and the hospitals in which they deliver care, the CMPA has identified six broad areas of concern. While these areas of concern can be viewed separately, they are related and, in some cases, have compounding implications. Although they may not be present in every circumstance, these six inter-related issues warrant serious attention:

- Physicians as advocates for their patients and for safer care
- Appropriate reporting of physicians
- Responding to an adverse event
- Collection, use and safeguarding of physician information
- Practice arrangements
- Provision of liability protection

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Physicians as advocates for their patients and for safer care

Physicians have long viewed themselves as advocates for the most effective care for their patients. The role of health advocate is a key element of the CanMEDS competency framework.[2] While the broad adoption of collaborative or team-based delivery models has expanded the number of healthcare professionals involved in a patient's care, it has not, in the minds of most physicians, reduced this advocacy role. Physicians understand the medical care required in a given situation and they can and should offer a strong voice on behalf of their patients. As the complexities of the healthcare system become even more daunting and wait lists continue to be an obstacle to accessible care, the advocacy role takes on even more importance.

At the system level, physicians are leaders in advocating for safer care through the establishment of appropriate policies, the allocation of adequate resources, and the implementation of changes in institutional and clinical practices that reduce the likelihood of adverse outcomes. However, such advocacy can occasionally bring a physician into conflict with either a colleague or with the health authority or hospital administration.

Conflict, depending on its extent and how it is handled, can be positive both in terms of patient care and in the re-examination of policies that may have become outdated. It is also recognized that these types of conflict can be difficult to manage and, if left unresolved, can have a deleterious impact on organizational performance. Unfortunately, instead of dealing with conflict in a constructive manner that exploits the potential benefits that can be accrued by an organization, the CMPA has observed increasing efforts to stifle appropriate advocacy for system improvements. Such efforts may negatively impact individual physicians, the medical profession, and patient care.

The Association recognizes there can often be a fine line between what constitutes appropriate advocacy, be it for one or more patients or for safer care, and behaviour that can be disruptive to the institution and the clinical environment in which care is provided. The College of Physicians and Surgeons of Ontario (CPSO) states *"Disruptive behaviour is demonstrated when inappropriate conduct, whether in word or actions, interferes with, or has the potential to interfere with, quality health care delivery"*.[3] The challenge for all involved (physicians, other healthcare professionals, institution administration, etc.) is to define appropriateness. The CMPA recognizes this is frequently a difficult task that will be influenced by one's perspective.

The CPSO observes that the extent to which behaviour may disrupt the delivery of care depends not only on its nature, but also on the context in which it arises and the consequences flowing from it. Some examples of behaviour which are not likely to fit within the criterion of disruptive or unprofessional behaviour include:

- healthy criticism offered in good faith with the intention of improving patient care or facilities;
- making a complaint to an outside agency;
- testifying against a colleague;
- good faith patient advocacy.

2 Frank, JR. (ED). 2005. The CanMEDS 2005 physician competency framework. Better standards. Better physicians. Better care. Ottawa: The Royal College of Physicians and Surgeons of Canada. Retrieved online at: http://rcpsc.medical.org/canmeds/CanMEDS2005/CanMEDS2005_e.pdf

3 College of Physicians and Surgeons of Ontario, Guidebook for Managing Disruptive Physician Behaviour, 2008. Available online at: http://cpso.on.ca/uploadedfiles/policies/guidelines/office/Disruptive%20Behaviour%20 Guidebook.pdf?terms=%22disruptive+behaviour+is+demonstrated+when%22

Physicians have a responsibility to their patients, colleagues, other healthcare professionals and the institutions in which they practise to act professionally. Hospitals, regulatory authorities and others have procedures in place to ensure this is the case. Ultimately, the extent to which a physician's behaviour represents a legitimate effort to advocate for a patient or necessary system changes will remain a matter of professional judgment. While decisions requiring such professional judgment are often difficult, they are a necessary element of a system that seeks to deliver quality care.

The CMPA is very concerned by efforts to restrict healthcare providers from responsibly fulfilling the role of advocate. In the case of physicians, these restrictions are increasingly being seen in contractual arrangements, appointments or privileges processes or through the institution of physician "codes of conduct." In addition to posing a significant risk to patient safety, such restrictions are contrary to the lessons learned and the improvements adopted in safety-driven industries (such as the nuclear or airline sectors) where employees are encouraged to speak out to identify and correct unsafe practices.

In the interests of patient care, health authorities and hospitals should be encouraging — not discouraging — reasonably voiced perspectives, even if these views are contrary to their own. For their part, physicians have a responsibility to provide an informed perspective, in a professional and reasonable manner that offers constructive recommendations for improvement. In those instances when health authorities and hospitals believe the advocacy efforts are not appropriate, a process based on procedural fairness and the fundamentals of natural justice should be employed to deal with such concerns. The requirement for such a process is universal and should be equally applicable regardless of a physician's practice relationship with the institution (e.g. privileges, employment, contract, etc.).

Contract arrangements. Many physicians practise in hospitals under contractual arrangements that specify the obligations of the physician (e.g. services to be provided, etc.) and of the hospital (e.g. support to be available, compensation provided, etc.). Such contracts normally contain termination clauses that describe the responsibilities of both parties in the event that one party wishes to end the contract prematurely. The processes associated with the privileges model are not normally included in the contractual arrangement and any issues requiring resolution are likely to be dealt with under contract law.

Appropriate reporting of physicians

All healthcare professionals have a responsibility to report unsafe practices. Health authorities and hospital leaders have a responsibility to investigate and, if necessary, act on such reports. As noted above, efforts that discourage healthcare providers from identifying patient safety concerns threaten the quality and safety of care. However, all involved must also recognize the potential negative impact of reports that allege professional incompetence or negligence on the part of a physician or any other professional. Reconciling these two considerations requires a balanced approach to reporting, one that sets an appropriate threshold for what should be reported and to whom. In this regard, institutions should carefully consider both their internal reporting requirements and those instances in which they would generally report physician performance to medical regulatory authorities.

Internal reporting. The CMPA is observing that many jurisdictions appear to have lowered the thresholds for the internal reporting of physicians by other physicians and healthcare providers. If inappropriately applied, these thresholds can undermine the trust and collegiality that are integral to the successful application of team-based, collaborative care. It is recognized that specific reporting thresholds may vary from one institution to another to reflect local conditions. Communicating the hospitals' reporting expectations can be a challenging task; however, the magnitude of the challenge should not be an excuse for ineffective internal policies and procedures. Hospital leadership has a responsibility to instill a culture that supports appropriate reporting and discourages actions that are vexatious or conducive to an atmosphere of recrimination or, in the worst case, fear.

There will be instances in which physicians practising within a hospital will have acted in a manner not supportive of effective care, be it through inappropriate behaviour, a failure to follow established procedures or incomplete adherence to the standards of practice. Given the consequences for the physician involved, it is important these instances be investigated and handled in a manner characterized by procedural fairness and respect for the interests of all parties. Bylaws and other governance documents generally describe the procedures to be followed and these should be adhered to. Particular attention should be paid to determining when an incident should properly be examined under a quality improvement framework or when an accountability review might be warranted.

External reporting. In most provinces and territories, legislation establishes the responsibilities for health authorities and hospitals to report physicians to the medical regulatory authorities (Colleges), including outlining those circumstances where such reporting is required. While specifics vary by jurisdiction, mandatory reporting circumstances generally involve those in which a physician is suspended or in which a physician's authority to admit, attend, or treat patients has been significantly altered because of incompetence, negligence, or misconduct. Recognizing the potential impact on the quality of care that such decisions entail, the CMPA is of the view that reporting in such circumstances is generally appropriate.

However, the CMPA is alarmed by efforts to increase the scope of this reporting and, in so doing, to elevate issues to the level of the regulatory body when these have been, or could have been, resolved within the health authority or hospital. In certain cases, this trend is being exacerbated by legislation and regulation which, by replacing terms such as "may" by "shall" when describing reporting requirements provides little flexibility in terms of the information provided to Colleges. In some cases, hospital bylaws appear to be mandating reporting that exceeds that specified in the legislation and which includes complaints and incidences that could be dealt with through appropriate health authority or hospital procedures. Additionally, the Association is witnessing examples where hospital authorities appear unwilling to address issues within their purview and

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Accountability review. An accountability review focuses on a specific provider's role in an adverse event or general ability to provide care within the standards expected. Health authorities and hospitals should have established procedures for accountability reviews, including those aimed at ensuring procedural fairness for the healthcare professionals involved.

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feel more comfortable in referring matters to the College that should be addressed at their level. This final circumstance may be the most concerning, given its significant consequences for the physician and its corrosive impact on organizational trust.

The challenge for decision-makers is to identify the appropriate level at which such incidents should be handled and subsequently reported. The CMPA is of the view that, in most provinces and territories, the current legislation identifies those conditions in a suitable manner. Reporting may be warranted when a physician's privileges are terminated or significantly restricted for reasons of clinical competence or a physician's practices have been found to pose an imminent threat to patient safety. Minor or temporary adjustments or remedial actions following a single incident would generally appear to fall below the threshold implied by most legislation. In establishing reporting protocols, health authorities and hospitals could benefit from aligning their practices with both the spirit and the letter of the applicable legislation.

Unnecessary reporting, either within a hospital or health authority or from one of those bodies to a medical regulatory authority, may result in inappropriate outcomes for the physician, the institution, and the public. These could include the loss of the services of qualified physicians or a work environment that becomes so poisoned that healthcare professionals become more focused on self-protection than patient care. This is an undesirable scenario for all involved and, in many cases, is avoidable through early resolution techniques that seek to address the issue at an appropriate level.

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Responding to an adverse event

Notwithstanding the best efforts of healthcare professionals involved in the care of a patient, there will be circumstances in which the outcome is not what was intended. Most adverse clinical outcomes result from the progression of the patient's underlying medical condition. Harm from healthcare delivery is most often the result of inherent risks in investigations or treatments. A small number of adverse outcomes are the result of a series of system failures that, when combined, result in harm. Some adverse outcomes are related to provider performance or a combination of this and other factors. The extent to which a physician's performance may have been a contributing factor to the adverse outcome is often not identifiable without a thorough examination of all factors, including the clinical progression of the underlying condition.

The CMPA has written extensively on the importance of effective reporting of adverse events[4] and on the value to be gained from a "just culture of safety" that supports learning from such events to benefit patient safety.[5] The Association strongly supports and has been very active in encouraging physicians to appropriately disclose adverse events to patients, and it was a key

4 The Canadian Medical Protective Association, Reporting and responding to adverse events: A medical liability perspective, 2009. Available online at: http://www.cmpa-acpm.ca/cmpapd04/docs/submissions_papers/com_reporting_ and_responding_to _adverse_events-e.cfm

5 The Canadian Medical Protective Association, Learning from adverse events: Fostering a just culture of safety in Canadian hospitals and healthcare institutions, 2009. Available online at: http://www.cmpa-acpm.ca/cmpapd04/docs/submissions_ papers/com_learning_from_adverse_events-e.cfm

collaborator in the development of the Canadian Patient Safety Institute's *Canadian Disclosure Guidelines*.[6] The CMPA has also been vocal about the need to reinforce quality improvement processes through which healthcare providers can identify systems-related issues that may have contributed to an adverse event. These processes are aimed at improving the quality and safety of care by learning from adverse outcomes. The Association also recognizes the need for accountability reviews that, in those circumstances where provider performance is seen as being the predominant contributor to the outcome, examine individual performance. While the goals and processes employed in quality improvement and accountability reviews are different, a common characteristic is that both are governed by procedures that generally enable fair and effective examination of the key issues.

Another common characteristic of responses to an adverse event is that they cannot be completed instantaneously and, to be effective, require the collection and analysis of information, usually by individuals with expertise in the issues involved. As a result, these responses do not satisfy the perceived, and often pressing, need for health authorities and hospitals to make immediate statements regarding a particular incident or incidences that garner public or media attention. However, nobody is well served by a rush to judgment that does not appropriately consider all of the facts — not the physician or other healthcare providers, not the institution, not the public, and most importantly, not the patient(s).

Physicians, health authorities and hospitals can all identify instances wherein a rush to judgment has resulted in inappropriate and irreparable harm to the professional reputation of one or more physicians. In such circumstances, it matters little to the physicians and patients involved if the rationale behind early and ill-informed statements was well-intentioned ("to ensure patient safety") or conversely was an effort to deflect attention and accountability away from the institution or from system issues that may be at the root of the problem. Regardless of the intention, the damage to individual reputations is hard, if not impossible, to overcome.

Recognizing there is always room for enhancement in how quality improvement and accountability reviews can be completed, the CMPA urges decision-makers to follow established procedures and to avoid ill or partially informed judgments in the name of timeliness or expediency. The results, unintended or not, can be devastating.

6 Disclosure Working Group. Canadian Disclosure Guidelines. Edmonton, AB: Canadian Patient Safety Institute; 2008. Available online at: http://www.patientsafetyinstitute.ca/English/toolsResources/disclosure/Pages/default.aspx

Collection, use, and safeguarding of physician information

In executing their mandated responsibilities, health authorities and hospitals have both a responsibility and the authority to collect certain types of information about physicians appointed to medical staffs or granted privileges within the institution. In several jurisdictions and for many years, the information collected was generally restricted to previous disciplinary proceedings where there was an adverse finding or to civil litigation where there was a finding of negligence. Both these circumstances (College or hospital disciplinary proceeding and civil litigation) provide for generally fair processes in which the rules seek to protect the interests of all parties, including both the defendant and the complainant or plaintiff. In the past, physicians seeking to practise within a health authority or hospital were not required to disclose their health status. They were also not required to provide information related to pending or ongoing investigations or to completed proceedings that resulted in a favourable outcome for the physician.

In view of the increased accountability being assigned to health authorities and hospitals, and given the need to take all reasonable precautions to enhance the safety of care, it is recognized that this minimalist approach to the collection and use of physician information may not suffice. However, decision-makers should seek a balanced position that recognizes the diverse factors involved.

The CMPA has consistently stated that requiring physicians to release information regarding matters in which there has been no finding adverse to the physician (including those related to pending or ongoing disciplinary matters, hospital disputes, civil actions, or criminal proceedings) could be highly prejudicial to the individual involved. Disclosure of this type of information may lead to the rejection of the physician's application or the restriction of privileges on the basis of speculation and unfounded or frivolous allegations for which the physician is subsequently exonerated. Similarly, and given physicians may choose to settle legal actions for several reasons, no reasonable conclusion can be drawn about whether a physician acted negligently or improperly solely on the basis of an out-of-court settlement in a civil action.

The CMPA is also witnessing a much broader and deeper effort by the regulatory authorities and hospitals to collect a physician's personal health information. The questions posed on licensing requests and privilege and appointment applications and renewals generally relate to an individual's mental state (e.g. depression, etc.), past or current health conditions (including substance use disorders) or to serological status. In view of the highly sensitive and emotional nature of the information involved and the possible patient safety consequences resulting from ill or temporarily incapacitated physicians delivering care outside of a reasonable scope of practice, the CMPA recognizes decisions related to the collection and use of personal health information are difficult. To assist regulatory authorities, health authorities and hospital decision-makers, physicians and others identify the appropriate course of action in such circumstances, the Association recently published a policy paper[7] offering achievable recommendations. These recommendations strike an appropriate balance between the various factors involved in these decisions. They are supported by a more focused examination[8] of the medico-legal risks associated with physicians infected with

7 The Canadian Medical Protective Association, Physician personal health information: Supporting public safety and individual privacy, 2010. Available online at: http://www.cmpa-acpm.ca/cmpapd04/docs/submissions_papers/com_physician_personal_health_information-e.cfm

8 The Canadian Medical Protective Association, Physicians with blood-borne viral infections: Understanding and managing the risks, 2010. Available online at: http://www.cmpa-acpm.ca/cmpapd04/docs/submissions_papers/com_preamble_physicians_with_blood_borne_infections-e.cfm

blood-borne pathogens and by an independent expert panel report[9] examining the risk of transmission between infected physicians and patients.

These reports identify the requirement for clearly articulated and evidence-based procedures regarding the collection, storage, and potential use of physicians' personal health information. Before collecting such information, authorities should have reasonable procedures in place to address privacy concerns and ensure information security. Achieving a balanced approach that protects public safety while respecting the privacy of physicians with medical conditions is a difficult task, one that requires carefully considered decisions and weighs individual and collective consequences.

Notwithstanding the best efforts of all involved, there will inevitably be circumstances when a physician's medical condition requires significant restrictions or limitations to practice, including the worst case scenario, preclusion from practice. Decisions of this magnitude should be made using evidence-based criteria that establish an acceptable level of risk.

Hospitals and institutions have a responsibility to ensure that any restrictions placed on a physician's practice as a result of a medical condition are reasonable and followed. These restrictions will assist in protecting the safety of the public while, at the same time, respect the privacy rights of the individual. However, it is questionable whether this responsibility requires these organizations to collect physicians' personal health information or whether they should be able to rely on the medical regulatory authorities to collect, analyze and assess information that may hinder a physician's ability to safely practise. In view of the sensitivity of the information, the CMPA takes the position that this role is best executed by the regulatory authorities who should have a responsibility to inform health authorities and hospitals of practice restrictions.

Practice arrangements

Historically, physicians delivering care in hospitals have done so under a privileges-based model that recognizes the independent nature of the physician. This model, which has generally worked well, aims to provide the physician with the freedom to reasonably advocate for the interests of the patient. In each province and territory, legislation and regulations require minimum procedures for renewing, restricting, and terminating privileges. The required procedures are typically set out in regional health authority or hospital bylaws and, over the years, have been generally well refined.

Hospital privileges. Medical staff privileges enable physicians to admit patients, direct their care, seek and provide consultations on patient care, and access hospital treatment and diagnostic resources. The processes for obtaining and renewing privileges are found in applicable legislation and regulation and include the right to fair process (including hearings in which the physician and his/her counsel can provide evidence).

9 Shafran, Stephen D., Angel, Jonathan B., Coffin, Carla S., Grant, David R., Jaeschke, Roman, Wong, David K., The Physician with Blood-Borne Viral Infection: What are the Risks to Patients and What is an Appropriate Approach to the Physicians?, 2010. Available online at: http://www.cmpa-acpm.ca/cmpapd04/docs/submissions_papers/pdf/com_physician_with_blood_borne_viral_infection-e.pdf

These procedures identify a vital role for the "medical advisory committee" to review applications and to recommend appointment and reappointment. These responsibilities reinforce that committee's integral role in ensuring the safety of care within the region or hospital.

The privileges-based model is also supported by a wealth of civil case law, built-up over many decades. This case law provides clarity to the processes that should be in place to ensure a physician's entitlement to certain procedural and substantive rights when a hospital seeks to restrict, revoke or fails to renew the physician's privileges. These processes should provide physicians with some comfort they will be provided a fair hearing. Even when not guaranteed by legislation, courts have applied common law (civil code of Québec) principles of natural justice and procedural fairness to privileges decisions based on the unique relationship between hospitals and physicians.

In general terms, procedural fairness requires physicians be aware of the case to be met to either acquire or retain privileges. In addition, in the context of any hearing into those privileges, physicians are generally afforded the following rights:

- notice of the complaint in advance of the hearing
- full disclosure in advance of a hearing, including copies of any documents
- the ability to respond to a complaint
- a hearing on the matter
- representation by legal counsel
- examine and cross-examine witnesses
- present evidence
- an impartial adjudicator
- a decision within a reasonable time period
- written reasons for any decision
- right of appeal

While the privileges-based model has been successful, it is certainly not the only means through which physicians and hospitals can arrange for the delivery of medical services. Increasingly, physicians and hospitals are opting to enter into employment or contractual arrangements. The possible array of such arrangements is quite broad and could range from an employment contract, similar to other professional staff employed by the health authority or hospital (e.g. nurses, etc.), to a services agreement in which the physician agrees to provide medical services to the hospital as an independent contractor.

The potential benefits and shortfalls of adopting either a privileges-based system or one grounded in an employment or contractual arrangement will vary based on the specifics of the arrangement. It is also recognized that the motivations for entering into such arrangements, either on an

individual basis or as negotiated by a provincial or territorial medical association may vary widely and may include access to additional hospital services (including technology and resources), compensation considerations, ability to engage more fully in teaching and research, workplace stability and predictable workloads.

When entering into employment or contractual arrangements, physicians and the organizations that represent them should be aware that the substantive procedural safeguards guaranteed in hospital bylaws regarding privileges do not necessarily extend to other arrangements. In the past, the CMPA has been concerned that many physicians may not understand the implications associated with an employment or contractual approach. Accordingly, the Association has generally advised physicians engaged as employees or under contractual arrangements to ensure a written agreement expressly contains the same procedural protections that are guaranteed under the privileges model. This minimizes the risk the physician may be denied natural justice and procedural fairness, in the event the relationship with the hospital is restricted or curtailed. It is however recognized that, if adopted, this advice may run counter to the rationale that makes the employment or contractual arrangements attractive for health authorities and hospitals.

Contractual arrangements may also pose other medico-legal risks for physicians that should be considered before such agreements are finalized. For example, government agencies, health authorities and hospitals have, on occasion, sought to include unilateral indemnification clauses into their contracts. Such clauses may entail one party being responsible for the legal consequences of certain acts of the other party. Physicians should generally avoid any indemnification clauses that could lead them to be held legally responsible for the actions of others. To assist its members in this area, the CMPA has published a document entitled *General Information on Individual Contracts*[10] which describes the preferred bilateral indemnification clauses as well as a number of other medico-legal issues to be considered in contracts. Physicians should review this advice with their personal counsel before finalizing a contractual agreement.

The CMPA is encouraged by the recent trend towards a model in which physicians are appointed to the medical staff at the health authority or hospital level. This "appointment" approach is prominent in the recently adopted Alberta Health Services Bylaws and the updated *Medical Act* in Prince Edward Island. The concept can also be found in the recently released template hospital bylaws jointly developed by the Ontario Medical Association and the Ontario Hospital Association. While there are implementation risks associated with this approach, it conceptually includes many (but not necessarily all) of the protections found within the privileges model while providing, to both the physician and the health authority or hospital, several of the advantages offered through an employment or contractual arrangement. While the specifics are important, the appointment model has the potential to be a win/win scenario.

Appointment model. The appointment model aims to combine the protections provided by the privileges model with the predictability and specificity of the contract or employment arrangements. While the specifics will vary, this emerging approach applies the processes used to grant or renew privileges to the resolution of physician performance-related issues.

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10 The Canadian Medical Protective Association, General Information on Individual Contracts: Medico-legal Issues to Consider, September 2007. Available online at: http://www.cmpa-acpm.ca/cmpapd04/docs/member_assistance/more/com_general_individual_contract-e.cfm#issue

Provision of liability protection

One of the necessary components of an effective healthcare system is a well-designed, functional medical liability system that assures both healthcare professionals and their patients that their interests and access to due process will be protected. In the event of an adverse outcome proven to have been caused by negligent medical care, it enables the injured patient to receive appropriate compensation. Most Canadian physicians, including those delivering care in hospitals, obtain their liability protection from the CMPA.

The CMPA is a mutual defence organization, operated to provide medical liability protection to its member physicians. As a mutual defence organization, the CMPA exercises discretion in providing assistance to its members. This discretion is guided through extent of assistance principles that recognize the importance of a physician's professional integrity. CMPA members are eligible to receive a broad spectrum of assistance related to medico-legal difficulties arising from their professional work in Canada.

Health authorities and hospitals must also be able to access resources to address legal costs and to pay for damages as a result of litigation stemming from care provided within the institution. While there are various options available (including self-funding), most Canadian hospitals have a form of insurance, either purchased from a commercial provider, obtained through a reciprocal or provided by a quasi-government agency.

Under the current paradigm, a patient who has suffered harm as a result of what they believe to be negligent care can launch a civil action against both the hospital and the individuals involved in their care. The interests of hospital employees (nurses, technicians, etc.) are covered by the hospital's insurance arrangements. If the physician named in the action is a CMPA member, liability protection is provided by the CMPA. This arrangement recognizes that the interests of the physician and of the hospital may not always align and it supports the independence of the medical profession in advancing the interest of patients. In those circumstances where the hospital insurer and the CMPA share the same view on the likely disposition of a legal action, they generally act in concert to ensure timely resolution in an efficient and effective manner.

However, the separation of responsibilities between the hospital insurer and a medical mutual defence organization is not the only approach to ensuring patients have access to compensation. As hospitals and physicians adopt employment and contractual arrangements to govern the delivery of medical services in the institution, there may be a tendency to consider an enterprise liability protection model. However, as noted in a 2005 CMPA comparison of international medical liability systems,[11] in addition to there being no evidence that such an approach would pose any obvious advantages for patients, the implications for hospitals are uncertain, and the risks to physicians are considerable. The current Canadian medical liability system, while always subject to improvement, is effective and physicians should be wary of a proposal that seeks to replace it.

Under an enterprise liability protection model, a health authority or hospital providing healthcare services accepts responsibility for the actions of all staff involved in the provision of clinical services,

11 The Canadian Medical Protective Association, Medical liability practices in Canada: Towards the right balance, August 2005. Available online at: http://www.cmpa-acpm.ca/cmpapd04/docs/submissions_papers/piaa/com_appendix2-e.cfm

including the physicians delivering care in the institution. A patient who believes they have suffered harm and who wishes to seek compensation will have to look to the enterprise, rather than from the individuals, involved in the care. The most prominent example of an enterprise liability protection model may be the National Health Service Litigation Authority (NHSLA) in the United Kingdom.[12] In general terms, the NHSLA is responsible for negligence claims arising from care provided through National Health Services institutions. Physicians operating outside such institutions (e.g. most general practitioners and those specialists with private practices) generally receive their liability protection from one of three medical defence organizations.

The enterprise liability model in the United Kingdom has received mixed reviews. After initially performing satisfactorily, it has recently experienced significant cost increases that have resulted in considerable financial pressures on the healthcare system. The 2005 CMPA study[13] found no evidence that enterprise liability models improve the quality or safety of care. Moreover, it is unlikely the enterprise's liability protection would extend to other forms of accountability reviews of physicians, including complaints to the medical regulatory authorities and hospital matters. In addition, these models are unlikely to provide the unlimited occurrence-based protection offered by the CMPA — areas in which the CMPA is seeing sharply higher requests for assistance. Indeed, in the United Kingdom, in addition to the protection provided by the NHSLA, most physicians delivering care in hospitals also find it necessary to hold membership in one of the mutual defence organizations as a means of defending themselves in regulatory, hospital, human rights, and other non-civil litigation matters.

More fundamentally, enterprise liability protection assumes the interests of the institution and the physician align or, when this is not the case, that those of the institution outweigh those of the physician. The CMPA believes this assumption of aligned interests may be misplaced and that any adoption of enterprise liability protection may place a physician's ability to safeguard his or her professional reputation at risk.

Enterprise liability protection. An enterprise liability protection model involves the hospital, health authority, or other healthcare organization assuming responsibility for providing liability protection for all individuals delivering care within that organization, whether as employees, independent contractors, or through other arrangements.

12 For more information see: www.nhsla.com

13 The Canadian Medical Protective Association, Medical liability practices in Canada: Towards the right balance, August 2005. Available online at: http://www.cmpa-acpm.ca/cmpapd04/docs/submissions_papers/piaa/com_appendix2-e.cfm

RECOMMENDATIONS

As a national association providing medico-legal protection to most physicians across Canada, the CMPA is well positioned to develop recommendations to address the medico-legal implications associated with the changing relationships between physicians and health authorities and hospitals. The CMPA's recommendations are built upon the principles of fairness and balance, recognizing that, while potentially disconcerting for some, these ongoing changes can, if properly managed, further strengthen the healthcare system. However, the CMPA is also very aware that, should the medico-legal implications not be effectively addressed, physicians' professional integrity and the profession's ability to meet the needs of its patients may be compromised. Fortunately, these implications can be addressed through the adoption of a number of achievable recommendations. The most notable are as follows:

Physicians

- Remain engaged in healthcare administrative decision-making, including at the health authority and hospital level, in part by seeking formal and informal leadership roles that advance quality care.
- Understand and adhere to reasonable health authority and hospital procedures for reporting, recognizing that appropriate thresholds are intended to support safer care.
- Actively participate in efforts to resolve conflicts at the local level and, to the extent feasible, avoid unnecessary and inappropriate escalation of these concerns.
- Continue to appropriately advocate for the interests of patients, while being cognizant that inappropriate or overzealous advocacy may be disruptive to the provision of care.
- Avoid forming or communicating hasty or partially informed opinions about the performance of colleagues or other care providers involved in an adverse event.
- Understand the differences between quality improvement (QI) and accountability reviews and actively participate in appropriately constituted QI reviews.
- Disclose personal and personal health information to Colleges in circumstances where it is required by law or when the physician consents to the disclosure because it is necessary to protect patient safety.
- Carefully consider the medico-legal protections specified in any agreement before entering into it, including protections related to procedural fairness and natural justice.
- Understand the different advantages, disadvantages, and protections offered by employment or contractual arrangements and by a privileges-based system. Consider the possible merits and shortfalls of an appointment model similar to that currently being implemented in a number of Canadian jurisdictions.
- Be aware of areas of medico-legal risk in contracts, such as indemnification clauses. Review the CMPA's document entitled *General Information on Individual Contracts* and seek legal advice as required.
- Recognize the limitations of an enterprise liability protection model and its potentially negative consequences on the professional independence and integrity of physicians.

Health authorities and hospitals

- Actively engage physicians and encourage them to be involved in organizational decision-making, including by removing any unintended obstacles to such engagement.
- Establish appropriate thresholds for the reporting of provider performance within the institution, recognizing the need to foster a just culture of safety.
- Avoid a rush to judgment that might irreparably harm the reputations of the professionals involved in the delivery of care. Meet patient needs and learn from the adverse event by devoting appropriate effort to effective disclosure to patients and to properly constituted QI reviews.

- Support a culture in which physicians feel comfortable in advocating for patients in a reasonable manner that reflects the overall context.
- With a view to clarifying what might be perceived as disruptive to the provision of care, determine what constitutes appropriate advocacy.
- Refrain from collecting physicians' personal health information. Instead, rely on Colleges to make evidence-based decisions regarding a physician's practice. If it is deemed necessary to collect personal information, limit it to that which is relevant to a physician's capacity to practise and necessary to ensure the individual meets reasonable credentialing or privileges requirements.
- Institute internal resolution methods, including those related to a physician's ability to deliver services within the hospital, characterized by procedural fairness and adherence to the fundamentals of natural justice.
- Resolve issues regarding an individual's performance (e.g. clinical, behavioural, procedural, etc.) at an appropriate level and avoid unnecessarily escalating such matters to Colleges. Work with the College to identify appropriate reporting thresholds.
- Review contractual arrangements with physicians to ensure the medico-legal concerns identified in the CMPA's document entitled *General Information on Individual Contracts* are addressed.
- Examine the potential applicability and merits of adopting an "appointment" model that effectively combines key elements of privileges and employment or contractual arrangements.

Hospital insurers

- Streamline the resolution of civil litigation actions, where appropriate, in part by working collaboratively with the CMPA and building on protocols already in place.
- Recognize the limitations of an enterprise liability protection model and its potential for unintended consequences.

Medical regulatory authorities (Colleges)

- Encourage health authorities and hospitals to resolve issues regarding an individual's performance at an appropriate level and avoid unnecessarily escalating such matters to the College.
- Collaborate with health authorities and hospitals in identifying appropriate thresholds for reporting physicians to the College.
- Develop clearly written policies for dealing with physician personal health issues that are, to the greatest extent possible, evidence-based and which reflect ongoing advances in the prevention and treatment of such medical conditions.

- Where appropriate and following the exercise of any rights of appeal, communicate to health authorities and hospitals any practice restrictions resulting from a proper evidence-based review by an appropriate committee. Information relating to the physician's health should be disclosed only when necessary and such communication must respect the physician's right to confidentiality.

Medical professional associations

- Continue providing physician input on legislation, regulations, and institutional bylaws.
- Examine the potential applicability and merits of promoting an "appointment" model that effectively combines key elements of privileges and employment or contractual arrangements.
- Communicate to physicians and others the different advantages, disadvantages, and protections offered by employment or contractual arrangements and by a privileges-based system.
- Carefully consider the medico-legal protections specified in any agreement negotiated on physicians' behalf, including protections related to procedural fairness and natural justice.
- Be aware of areas of medico-legal risk in contracts, such as indemnification clauses.
- Recognize the limitations of an enterprise liability protection model and its potentially negative consequences on the professional independence and integrity of physicians.

Governments

- Maintain legislation that protects the independent responsibility of physicians to act in the best interests of their patients while enshrining appropriate protections for physicians delivering services in health authorities and hospitals.
- Examine the potential applicability and merits associated with an "appointment" model that effectively combines key elements of privileges and employment or contractual arrangements.
- Seek improvements in the civil justice system that streamline the fair and equitable resolution of medical liability claims.
- Recognize the limitations of an enterprise liability protection model and its potential for unintended consequences.

CONCLUSIONS

The Canadian healthcare environment can be characterized by an increasingly rapid rate of change as delivery models, technologies and long accepted practices are being replaced by approaches that more effectively respond to the dynamic environment. Within this context, it is not surprising that longstanding relationships between physicians and the hospitals in which they deliver care are also changing. Indeed, it would be both surprising and worrisome if such change was not evident. However, change often brings with it a range of implications and, in the case of physician-hospital relationships, there are medico-legal implications that must be addressed if physicians are to continue to execute their professional obligations to patients and to the healthcare system.

This paper has identified key implications within six inter-related areas of concern:

- physicians as advocates for their patients
- appropriate reporting of physicians
- balanced response to adverse events, including the reporting of those events to the public
- collection, use and safeguarding of physicians' information, including that related to their personal health
- arrangements that govern a physician's ability to deliver care within a healthcare authority or hospital, including both privileges and employment models
- approach through which physicians receive medical liability protection

While some of the medico-legal issues facing physicians and the leadership of health authorities and hospitals may appear daunting, the CMPA believes these can be effectively resolved through the adoption of a number of achievable recommendations. The challenge for decision-makers is to retain those elements of the unique relationship between physicians and hospitals that have served Canadians well, while adapting other elements to respond effectively to new demands on the healthcare system. These challenges are manageable with the focused attention of all involved. In formulating the way ahead, all parties should recognize the primary interests to be served in forging renewed relationships are not those of physicians or institutions but rather those of patients they serve.

Given the dynamic environment facing all healthcare professionals, physicians are left with two primary choices: one is to respond to the changes after they have occurred; the other is to seize opportunities to advance the long-term effectiveness of the healthcare system. In the face of what unfortunately appears to be a diminishing role for physicians in healthcare administrative decision-making, physicians must individually and collectively decide the role the medical profession should and will play in the healthcare system. Canadians have benefited greatly from physicians exercising a responsible, collaborative leadership role, one that respects the expertise of others but brings an important and unique perspective to administrative decision-making.

The CMPA believes it is in the best interests of Canadians that the medical profession be engaged in shaping the future of healthcare. This engagement requires physicians be appropriately empowered to contribute to decisions. Establishing positive, mutually beneficial relationships between physicians and health authorities and hospitals is a vital step if the healthcare system is to provide the services Canadians expect. Physicians, medical organizations, health authorities and hospitals must devote the attention required to resolve the issues that might hinder such relationships. If the issues remain unresolved, the negative impacts will be felt by the healthcare system, the professionals who deliver care and Canadians who depend on that care. However, with the appropriate attention, relationships can evolve to meet the demands of a complex environment and to contribute to the quality care Canadians expect.

Providing a medical liability perspective on issues of importance to the medical profession

In keeping with its 2011–2015 Strategic Plan, the CMPA is committed, in collaboration with others, to encouraging and supporting the development of sound public policies and measures.

As a national association providing medico-legal protection to more than 80,000 physicians across Canada, the CMPA is well positioned to identify medico-legal issues of importance to its members. In recent years, the Association has released several policy papers in support of collaborative care, wait times, electronic health records, reporting and learning from adverse events and on physician individual privacy.

This paper builds on this approach and contributes an important medico-legal perspective on changing physician-hospital relationships.

All CMPA papers are available at cmpa-acpm.ca.

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