LEGAL MECHANISMS TO IMPROVE QUALITY OF CARE IN CANADIAN HOSPITALS

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Tens of thousands of Canadians die each year as a result of preventable injuries sustained in hospitals. The patient safety literature suggests that we must implement systems and processes designed to prevent errors, rather than focusing on the mistakes of individual health professionals. Although the law tends to reinforce the provider-centric approach to errors, several law reforms have the potential to catalyze a systems-centric approach that finds support in the patient safety literature: shifting some liability from physicians to hospitals, reforming hospital governance practices, and reconsidering the legal relationship between physicians and hospitals.

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I. INTRODUCTION

Tens of thousands of Canadian patients die each year as a result of preventable injuries incurred in hospitals, and many more are seriously injured or provided with unnecessary or inappropriate care. Evidence from the patient safety literature indicates that the most effective approach to preventing these injuries is one that focuses on modifying high-level systems and processes, rather than scrutinizing the behaviour of individual health professionals. Specifically, a hospital's culture, as embodied by its board's approach to safety and quality, affects the outcomes of its patients. Although there is a sizeable body of health policy scholarship addressing the link between hospital governance and patient safety, there are few scholars exploring the legal mechanisms for facilitating the uptake of these good governance practices.

In this article, I explore three such legal mechanisms. First, I argue that the reluctance of Canadian courts to hold hospitals liable fails to align legal responsibility with the ability to effectively prevent patient injuries and fails to incentivize hospitals to assume responsibility for their role in ensuring patient safety. Second, I explore the ways in which provincial governments can reform the legislation regulating hospitals and health regions with a view to catalyzing the adoption of practices that will improve governance over patient safety (and thus reduce the rates of patient injuries). In a related vein, I argue that provincial governments must re-evaluate the legal relationship between physicians and hospitals and,

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in particular, the model by which physicians are appointed to the medical staff of a hospital, which may negatively impact patient safety.

II. SCOPE OF THE PATIENT SAFETY PROBLEM

A sizeable body of literature dating back to the 1990s reveals widespread concerns over the quality of health care services. For example, numerous studies show considerable variation in the rates at which different doctors or hospitals perform particular medical procedures, even when controlling for variables such as demographics and patient preferences.[1] Clinical practice variation is a matter of concern from a medical perspective, due to the avoidable risks and complications associated with unnecessary procedures or tests, and from a financial perspective, due to the costs associated with unnecessary services and the treatment of avoidable complications. Several major studies from the 1990s also showed alarmingly high rates of patient deaths due to avoidable medical errors. For example, in 1999, the Institute of Medicine released its landmark publication, *To Err Is Human*, which reported up to 98,000 annual deaths in the United States due to medical error.[2] Using a methodology that yielded conservative estimates, a 2004 Canadian study by G Ross Baker et al. found that 70,000 preventable adverse events occurred in Canadian hospitals each year. Of these incidents, 23,750 resulted in avoidable fatalities.[3] These studies on clinical practice variation and avoidable medical errors captured the attention of health professionals, policy-makers, the public, and the media, and helped to catalyze the patient safety movement.

Despite the investment of tens of millions of dollars in studying and improving patient safety since the 1990s, progress has been modest. Reflecting on his 2004 study, Baker argued that "[t]he harsh reality is that even after 10 years of intense efforts and large expenditures, Canadian health care is still not reliably safe, a prospect that few anticipated in 2004."[4] Evaluating five years of patient safety efforts following the Institute of Medicine Report, Longo et al. similarly concluded that, "[t]he current status of hospital patient safety systems is not close to meeting [the Institute of Medicine] recommendations … patient safety system progress is slow and is a cause for great concern."[5] Six years later, Robert M. Wachter noted only a "modest improvement."[6] Perhaps more concerning than this lack of progress are

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1 See e.g. Yunjie Song et al, "Regional Variations in Diagnostic Practices" (2010) 363:1 New Eng J Med 45; HG Welch et al, "Geographic Variation in Diagnosis Frequency and Risk of Death Among Medicare Beneficiaries" (2011) 305:11 J American Medical Assoc 1113; John E Wennberg, "Perspective: Practice Variations and Health Care Reform: Connecting the Dots" (2004) Health Affairs 140; John E Wennberg, "Unwarranted Variations in Healthcare Delivery: Implications for Academic Medical Centres" (2002) 325:7370 British Medical J 961.

2 Institute of Medicine, *To Err is Human: Building a Safer Health System*, ed by Linda T Kohn, Jonet M Corrigan & Molla S Donaldson (Washington, DC: National Academy Press, 2000) at 1 [*To Err is Human*].

3 G Ross Baker et al, "The Canadian Adverse Events Study: The Incidence of Adverse Events Among Hospital Patients in Canada" (2004) 170:11 CMAJ 1678 at 1678, 1684.

4 G Ross Baker, "An Opportunity for Reflection" (2014) 17 Healthcare Q 1 at 1.

5 Daniel R Longo et al, "The Long Road to Patient Safety: A Status Report on Patient Safety Systems" (2005) 294:22 J American Medical Assoc 2858 at 2858. The authors examined the uptake of several patient safety systems: computerized physician order entry systems, computerized test results, assessments of adverse events, specific patient safety policies, use of data in patient safety programs, drug storage, administration and safety procedures, manner of handling adverse events and error reporting, prevention policies, and root cause analysis.

6 Robert M Wachter, "Patient Safety at Ten: Unmistakable Progress, Troubling Gaps" (2010) 29:1 Health Affairs 165 at 165. His study reviewed patient safety progress in several areas: creating and enforcing safety standards through regulation and accreditation, tracking and reporting errors, the uptake of information technology tools, medical malpractice and accountability reforms, using the payment system

recent studies suggesting that the initial estimates grossly underestimated the scope of the patient safety problem. While the Institute of Medicine estimated 98,000 premature deaths per year due to medical error, subsequent studies suggest that more accurate figures range from 210,000 to 400,000 deaths per year.[7]

III. CAUSES OF PATIENT INJURIES

Historically, hospitals acted merely as doctors' workshops by providing equipment and personnel to assist in the practice of medicine.[8] Hospitals were governed by boards of directors, which were largely concerned with raising sufficient capital to build and maintain hospital facilities, rather than overseeing the quality of health care services. Instead, professional self-regulatory bodies and the medical staff structure within hospitals asserted primary jurisdiction over regulating the quality of health services through licensure, professional discipline, and hospital privilege regimes. In other words, doctors had almost complete autonomy over patient care within hospitals, and hospital governance structures and practices reinforced the bifurcation between clinical responsibilities and hospital administrative functions. As such, when a patient injury occurred, the tendency was to scrutinize the actions of health professionals most closely involved in the patient's care in order to ascertain what caused the injury and who, if anyone, to hold accountable. Rather than assuming responsibility for the quality of care provided to patients within their facilities, hospital boards treated these patient injuries as a matter for the medical staff to address.

This tendency to scrutinize the actions of health professionals was called into question by a growing body of patient safety scholarship flowing from the Institute of Medicine's 1999 report and other similar studies. Specifically, this literature suggests that many, if not most, patient injuries are caused or exacerbated by the systems within which health professionals work — systems that are organized, managed, coordinated, overseen, and funded by a complex mix of self-regulation, hospital policies and bylaws, and governmental policies and laws.[9] For instance, evidence indicates that the relationship between surgical volume and patient outcomes more closely correlates with the number of procedures performed in a particular hospital per year than the number of procedures performed by a particular doctor, despite the fact that surgery seems individualistic, with "the surgeon as the megastar with a large but unknown supporting cast."[10]

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to drive patient safety, research into patient safety, and the involvement of providers, patients, and provider organizations in patient safety.

7 See e.g. John T James, "A New, Evidence-Based Estimate of Patient Harms Associated with Hospital Care" (2013) 9:3 J Patient Safety 122; Martin A Makary & Michael Daniel, "Medical Error: The Third Leading Cause of Death in the US" (2016) 353 British Medical J 2139.

8 See generally Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry* (New York: Basic Books, 1982); David Gagan & Rosemary Gagan, *For Patients of Moderate Means: A Social History of the Voluntary Public General Hospital in Canada, 1890–1950* (Montreal: McGill-Queen's University Press, 2002).

9 In a review of 1452 patient charts revealing 889 medical errors, Mello and Studdert found that only 30 percent of the errors were attributable solely to individual health professionals, while 66 percent involved both individual and systemic factors: Michelle M Mello & David M Studdert, "Deconstructing Negligence: The Role of Individual and System Factors in Causing Medical Injuries" (2008) 96:2 Geo LJ 599 at 610. Leape et al estimated that 78 percent of adverse drug events in hospitals were caused by systemic factors: Lucian L Leape et al, "Systems Analysis of Adverse Drug Events" (1995) 274:1 J American Medical Assoc 35.

10 Robert M Wachter & Kaveh G Shojania, *Internal Bleeding: The Truth Behind America's Terrifying Epidemic of Medical Mistakes* (New York: Rugged Land, 2004) at 143.

The patient safety literature also indicates that the most effective injury recognition and prevention strategies are those implemented at the systems level. Human beings are inherently fallible, it is difficult to modify individual behaviour, and conditions intrinsic to the provision of health care services exacerbate the tendency of humans to make mistakes. Health professionals are often busy, stressed, and tired, must complete complex, simultaneous processes and are required to make quick decisions based on limited information under the constraint of scientific uncertainty. If errors are the product of a chain of causes, human factors such as temporary inattention, misjudgment, and forgetfulness are the final, and least manageable, links in the chain.[11] While the traditional approach to quality improvement focused on modifying the behaviour of health professionals, the patient safety literature suggests that systems and processes designed to anticipate and prevent errors are a significantly more effective means of injury prevention.[12]

In contrast to individual health professionals, actors such as hospitals are well-situated, both logistically and financially, to identify problematic patterns of care and to implement processes and systems that anticipate and guard against human errors. Furthermore, error prevention systems implemented at the systems level protect more patients than strategies aimed at modifying the clinical decisions of individual health professionals, as the latter may leave potentially dangerous conditions in place, which may lead other practitioners to make the same errors in the future. In this regard, White argues that "there are many unseen or invisible systems and processes that contribute to an error, and blaming a person does little to resolve the latent errors, which will persist until the next person makes the same error."[13]

Given significant advances in our understanding of the prevalence and causes of patient injuries and strategies for their prevention, along with sizable investments in both time and money in an effort to make health care safer, why has progress been so modest? In the remainder of this article, I explore the role that law may play in catalyzing improvements to the quality of care delivered in hospitals.

IV. TORT LIABILITY OF HOSPITALS

Until relatively recently, the primary mechanism by which the law responded to patient injuries was through medical malpractice claims against health professionals. Tort law has and continues to reinforce the provider-centric view of patient injuries, rather than embracing the systems-centric focus of the patient safety movement. More specifically, the legal responsibility for an adverse event generally rests with the individual physicians who are most directly involved in treating injured patients. The actions of health professionals are most closely connected to adverse events, both temporally and spatially, while the systemic contributors that lay within the control of the hospital itself are further removed from patients

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11 James Reason, "Human Error: Models and Management" (2000) 320:7237 British Medical J 768.

12 See e.g. Thomas W Nolan, "System Changes to Improve Patient Safety" (2000) 320:7237 British Medical J 771.

13 Susan V White, "Patient Safety Issues" in Jacqueline Fowler Byers & Susan V White, eds, *Patient Safety: Principles and Practice* (New York: Springer, 2004) 3 at 18. Barry Turner notes that "higher-level errors are more likely to pick up and combine with smaller, lower-level errors that, by themselves, would not have produced anything untoward": Karl E Weick, "The Reduction of Medical Errors Through Mindful Interdependence" in Marilynn M Rosenthal & Kathleen M Sutclife, eds, *Medical Error: What Do we Know? What Do we Do?* (San Francisco: Jossey-Bass, 2002) 177 at 185, citing Barry Turner, *Man-Made Disasters* (London: Wykeham, 1976) at 187.

and are often not readily apparent. As White argues, although "[t]here are multiple factors involved in a single error … only the action of the practitioner is really visible."[14]

Although the patient safety literature has prompted a shift from a provider-centric view of quality improvement to one that is systems focused, this shift has not been reflected in tort law. Canadian courts are not generally receptive to hospital liability.[15] Historically, patients retained their own physicians and, as such, had limited relations with the hospital itself. Consequently, the hospital owed limited legal duties to patients: the provision of competent staff and the maintenance of an adequate facility.[16] Furthermore, due to the limited control that hospitals exerted over physicians and the fact that they were paid directly by patients, and then, with the inception of Medicare, by provincial governments, Canadian courts generally deem physicians to be independent contractors rather than hospital employees. As such, hospitals are not vicariously liable for physician negligence in the way that they are liable for the actions of other health professionals, such as nurses.

The seminal Canadian case on hospital liability is *Yepremian v. Scarborough General Hospital*.[17] In that 1980 case, the plaintiff attended at an emergency department where the internist failed to diagnose and treat his diabetes, culminating in cardiac arrest and brain damage. Although a majority of the Ontario Court of Appeal refused to hold the hospital liable, Justice Blair would have found for the plaintiff on the basis that he looked to the hospital rather than individual physicians to provide him with competent care:

> [T]he responsibilities of the hospital to the patient have expanded greatly in breadth and depth in this century.… Public expectations that hospitals will provide total care and make all arrangements are influencing courts in determining the responsibilities of hospitals. If the hospital is to bear more responsibility for the doctor, present systems and organization may have to be reviewed.[18]

For the past 37 years, Canadian courts have applied this case almost without exception and without considering its ongoing applicability in light of the kinds of health system changes highlighted by Justice Blair.

In addition to the well-established hospital duties to provide adequate personnel and facilities, a handful of cases have found that hospitals have the responsibility to establish "such systems as are required for the co-ordination of personnel, facilities, equipment and records so that the patient receives reasonable care."[19] For example, in *Braun Estate v. Vaughan*, a patient died from cervical cancer after she failed to receive the results of a test

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14 *Ibid*.

15 This lack of receptiveness to hospital liability stands in contrast to other jurisdictions, such as the US and Britain, in which courts impose liability on the basis that physicians are hospital employees or agents or that hospitals owe a non-delegable duty to provide non-negligent medical care. See e.g. Patrick C Osode, "Canadian Law and the Liability of the Modern Hospital for Negligence (Part 1)" (1993) 12:3 Med & Law 593; Clark C Havighurst, "Vicarious Liability: Relocating Responsibility for the Quality of Medical Care" (2000) 26:1 Am J L & Med 7; Martin C McWilliams & Hamilton E Russell, "Hospital Liability for Torts of Independent Contractor Physicians" (1996) 47:3 SCL Rev 431.

16 Ellen Picard, "The Liability of Hospitals in Common Law Canada" (1981) 26:4 McGill LJ 997 at 997.

17 (1980), 28 OR (2d) 494 (CA).

18 *Ibid* at 560.

19 Ellen I Picard & Gerald B Robertson, *Legal Liability of Doctors and Hospitals in Canada*, 3rd ed (Toronto: Carswell, 1996) at 369–70 [footnotes omitted], cited for example in *Wild v Salvation Army Maternity Hospital et al* (1998), 171 NSR (2d) 201 (SC) at para 44.

that had been conducted following a surgical procedure in the defendant hospital.[20] The hospital and doctor shared liability for failing to have a system in place to track test results and to ensure that patients received these results. In that case, the Manitoba Court of Appeal found that the hospital had a duty to "provide a reasonable and practical 'safe system' including the coordination of services between physician, patient and the institution."[21] However, because such a duty has been found in so few cases and only those with the most egregious hospital failures, the legal responsibility to establish safe systems has not served as an incentive for hospitals to take significant initiative over quality of care.[22]

Although Canadian courts are not receptive to hospital liability, there is considerable support in the legal literature for moving away from a focus on physician liability and towards expanded hospital liability, on the basis that it better aligns legal responsibility with the ability to prevent injuries.[23] According to the patient safety literature, human beings are naturally fallible and it is difficult to modify the behaviour of individuals, especially given the nature of the health care environment. In other words, physicians are likely to be poorly deterred by tort liability. Tort law also provides a limited deterrent due to the significant length of time that generally elapses between injury and judgement, the fact that physicians are insured and thus do not pay out of pocket for tort judgments, and there are very few negligently injured patients who ultimately file lawsuits (and even fewer plaintiffs who are successful with those claims).[24] In contrast to physicians, hospitals are arguably in a better position to more deliberately weigh whether or not to adopt a particular process or system designed to ensure patient safety, including the potential tort liability associated with that decision, and then to logistically and financially implement and monitor those processes or systems.

Although there is arguably some unrealized potential for hospital liability to catalyze the implementation of policies designed to improve quality of care by hospitals, relying solely on liability as a means of encouraging the uptake of safe systems would be problematic for several reasons. First, there is evidence from the physician liability context that very few injured patients bring legal claims.[25] Although this problem may not be as acute with hospital defendants, injured patients may still be unaware that they have viable legal claims, may have trouble meeting the requirements for a negligence claim (namely, proving that an injury

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20 [2000] 3 WWR 465 (Man CA).

21 *Ibid* at para 49.

22 Other cases in which the courts have found such a duty are *MacPhail v Desrosiers et al*, 1998 NSCA 159, 170 NSR (2d) 145 at para 16, in which liability was imposed for failure to follow a policy prohibiting women from driving after receiving an abortion, and *Martin v Listowel Memorial Hospital*, 1998 CarswellOnt 3080 at para 60 (Ct J (Gen Div)), rev'd on other grounds (2000) 51 OR (3d) 384 (CA), in which the Court deemed a hospital liable for a failure to have policies or procedures for nurses to follow when admitting premature mothers.

23 See e.g. Bruce Chapman, "Controlling the Cost of Medical Malpractice: An Argument for Strict Hospital Liability" (1990) 28:3 Osgoode Hall LJ 523 at 536; Richard J Pierce, Jr, "Encouraging Safety: The Limits of Tort Law and Government Regulation" (1980) 33:6 Vand L Rev 1281 (forcing those with more control over accidents to absorb their cost "provides an incentive to reduce the accident rate, the consequences of accidents, or both" at 1289). See also Philip G Peters, "Resuscitating Hospital Enterprise Liability" (2008) 73 Miss L Rev 370 at 376; Kenneth S Abraham & Paul C Weiler, "Enterprise Medical Liability and the Choice of the Responsible Enterprise" (1994) 20 Am J L & Med 29.

24 See e.g. Michelle M Mello & Troyen A Brennan, "Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform" (2002) 80:7 Tex L Rev 1595.

25 David M Studdert et al, "Claims, Errors, and Compensation Payments in Medical Malpractice Litigation" (2006) 354:19 New Eng J Med 2024.

would not have occurred but for the hospital), and patients with low-value injuries may have trouble retaining legal counsel. Furthermore, tort liability may skew hospital quality of care priorities away from reforms that are likely to protect the most patients and towards those for which there have been successful tort claims. Finally, tort law is largely reactive (for example, it addresses problems after they have arisen), rather than encouraging the uptake of quality improvements designed to proactively prevent injuries.

In sum, while there are certainly arguments for expanding hospital liability for patient injuries this, in and of itself, is not sufficient. Given the lack of traction that arguments for greater hospital liability are likely to receive before Canadian courts, and limits on the ability of tort liability to drive improvements in patient safety, it is also necessary to explore other legal mechanisms for encouraging hospitals to improve patient safety.

V. BOARD OVERSIGHT OVER QUALITY OF CARE

There is a seemingly endless number of studies outlining particular problems with patient safety, such as health care associated infections, pressure ulcers, ventilator-induced pneumonia, adverse drug events, or avoidable readmissions. In addition, many studies recommend strategies to combat these issues, such as surgical checklists, handwashing compliance policies, or medication reconciliation processes. It is difficult for the law to play a role in directly reinforcing the adoption of these strategies.[26] For example, it is not practical for governments to pass laws that mandate the uptake of a particular pre-operative checklist or diagnostic guideline, as these sorts of processes and tools are constantly evolving and must be adopted to institutional context. However, where the law has an important contribution to make is in setting out broad governance structures creating an environment that is conducive to effectively addressing these more granular patient safety issues. As Baker argues, "[i]mproved patient safety relies not just on knowledge of safe practices but also on creating care environments that support individuals and teams to identify, adapt and spread these practices."[27]

Soon after the inception of the patient safety movement and the shift towards a systems-centric approach to quality improvement, researchers identified institutional culture as an important contributor to hospital safety. Although it is difficult to define or measure "culture," it is frequently argued that the safest health facilities are those in which quality of care is treated as a priority at the highest levels of the organization — the benefits of which trickle down through the entire hierarchy of the organization. For example, W. Richard Scott et al. argue that the institutionalization of quality must occur through belief systems and associated practices that predominate and provide organizing principles that supply guidelines for all actors within the organization.[28] Similarly, Turner argues that the higher in an organization that a patient safety problem persists, "the more likely it is to be

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[26] Although law may be ill-suited to improve the uptake of specific patient safety practices, policy-makers can certainly play a role in supporting the development and dissemination of evidence-based guidelines on these practices and assisting in their implementation, for example, through provincial health quality councils.

[27] G Ross Baker, "The Challenges of Making Care Safer: Leadership and System Transformation" (2012) 15 Healthcare Q (Special Issue) 8 at 9.

[28] W Richard Scott et al, *Institutional Change and Healthcare Organizations: From Professional Dominance to Managed Care* (Chicago: University of Chicago Press, 2000) at 170–71.

disseminated through the amplifying power of the organization … [and] higher-level errors are more likely to pick up and combine with smaller, lower-level errors that, by themselves, would not have produced anything untoward."[29]

Various major inquiries into adverse events identify the culture of the institution and the behaviour of those at the top of the governance structure as contributing factors to unsafe conditions. For example, an inquiry into pediatric cardiac deaths at the Bristol Royal Infirmary in the United Kingdom concluded that "to a very great extent, the flaws and failures … were within the hospital, its organisation and culture, and within the wider [National Health Service] as it was at the time."[30] More specifically, the Chief Executive of the institution believed that health care was led by specialists, who were self-teaching and self-correcting, and only they could identify defects in clinical performance. In contrast, the role of management was merely to provide the facilities to allow for the exercise of clinical freedom, an attitude that the report linked to poor quality of care.[31]

There is considerable variation in the hospital governance structures employed across Canada. Historically, hospitals were governed by a board of directors that was largely concerned with fundraising and other financial issues. These boards tended to be comprised of prominent local businesspeople and professionals such as lawyers and accountants. Hospital boards deferred almost entirely to their medical staffs on matters relating to the quality and safety of health care services and on care delivery more broadly. Beginning in the 1990s, governments across Canada restructured their health care systems through regionalization. In all provinces other than Ontario, this involved the devolution of some authority for strategic planning and policy-making downwards from provincial ministries of health to regional health authorities, and the devolution of authority for health facility governance and health service delivery upwards from hospital boards to these newly-created entities. In all provinces other than Ontario, individual hospital boards were replaced by regional health authorities who were given responsibility for the delivery of hospital and various other health services within their geographic boundaries. While Ontario did move towards regionalization with the creation of Local Health Integration Networks, individual hospitals continue to be governed by their own boards.

During this period of health system reorganization, there was a growing recognition in the patient safety literature that boards ought to bear the ultimate responsibility for the quality of care delivered within their facilities. In other words, boards should not defer entirely to hospital management or the clinical staff in matters relating to quality of care. Provincial legislation reflects this by delegating specific responsibilities for quality of care to the medical staff, and more general oversight responsibilities to boards. For example, in Alberta, medical staff of a hospital is

> responsible to the board,

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29 Turner, *supra* note 13.

30 UK, Bristol Royal Infirmary Inquiry, *Learning from Bristol: The Department of Health's Response to the Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary, 1984–1995*, cm 5207(I) (London: The Stationery Office, 2001) at 9.

31 *Ibid* at 68.

(a) for the quality of the professional services provided by the medical staff,

(b) for reviewing professional practices of the medical staff,

(c) for the improvement of the care of patients under the care of the medical staff, and

(d) for the clinical and scientific work of the medical staff.[32]

In contrast, a regional health authority has several duties, one of which is to "ensure that reasonable access to quality health services is provided in and through the health region."[33]

Although legislation may, on its face, vest responsibility for quality of care in hospital leadership, there are concerns that boards sometimes abdicate this responsibility in favour of being unduly deferential to the hospital medical staff. As Baker argues, although "the responsibility for clinical care is delegated to program … directors and clinical leads"[34] in many Canadian hospitals, the goals of improved quality and safety must be "embraced by senior leaders, with clear accountability from the board to the ward."[35] Many hospitals have retained the bifurcation between clinical and administrative responsibilities that dates back to the inception of the modern hospital. This approach is inconsistent with evidence from the patient safety literature supporting a systems-centric rather than a provider-centric approach as well as the importance of hospital culture and board involvement in patient safety. In addition, there are potential conflicts of interest between hospital duties to ensure quality and efficiency and the interests of the medical staff. As Robert Bear argues, "[h]ospital interests rub against those of their doctors"[36] in various important areas.

Most provinces have retained bits and pieces of their public hospitals legislation, which predates regionalization legislation by many decades. Furthermore, aside from piecemeal legislative reforms, most provinces have also not substantively revisited their laws governing health regions in light of emerging evidence on patient safety and good governance practices. In the remainder of this Part, I explore examples from various provinces and the health policy literature to illustrate how the law might be deployed in support of good governance with a view to improving the quality and safety of hospitals.[37] In other words, how can the law be used as a mechanism to translate health policy evidence into practice?

Several provinces have enacted reforms that restrike a balance between the necessity of a board having advice on clinical matters from the hospital's medical staff, while still retaining overall stewardship over clinical matters. One such reform is a requirement that boards receive quality of care information from more diverse sources. For example, health

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32 *Hospitals Act*, RSA 2000, c H-12, s 14. Similarly, in New Brunswick, the Medical Advisory Committee has the explicit responsibility of making "adequate [provisions] for the supervision of all medical services": *Regional Health Authorities Act*, RSNB 2011, c 217, s 28(3).

33 *Regional Health Authorities Act*, RSA 2000, c R-10, s 5(iv).

34 Baker, *supra* note 27 at 10.

35 *Ibid*.

36 Robert Bear, "Hiring Doctors: Whose Interests Should Come First?" (15 November 2012) *Healthy Debate* (blog), online: <healthydebate.ca/opinions/doctors_and_hospitals_relationship>.

37 The scope of this article is not to exhaustively canvass hospital governance structures in Canada, but rather to provide examples of the kinds of laws that might be implemented to support good governance over safety and quality.

regions in New Brunswick not only have medical advisory committees, but also professional advisory committees, which legislation tasks with advising the board with respect to clinical care and health issues, criteria for admitting and discharging patients, quality assurance and risk management, and other issues referred by the board.[38] These committees, which are appointed by boards, must have no more than 15 members, at least five of whom must be members of different health professions.[39] Ontario has arguably gone the furthest in this regard, by mandating that all hospital boards appoint a quality committee to monitor and report to the board on quality of care, make recommendations regarding quality improvement, disseminate and monitor the use of best practices information, and oversee the preparation of an annual quality improvement plan.[40] These committees are composed of one member of the Medical Advisory Committee, the Chief Nursing Executive, one person who works in the hospital but is neither a nurse nor a physician, the hospital's administrator, and at least the number of voting members of the hospital's board such that one-third of the members of the quality committee are voting board members.

Various provinces have attempted to mitigate conflicts of interest between the hospital's goals and the interests of the medical staff by regulating the composition of the board itself or the ability of certain board members to vote. For example, in Ontario, the *Public Hospitals Act* requires that the Chief of Staff or Chair of the Medical Advisory Committee, the President of the Medical Staff and, in certain hospitals, the Vice-President of the Medical Staff, all sit on a hospital board. Various individual hospital bylaws mandate other ex officio board members (that is, those who are appointed by virtue of their position), such as municipal councillors or representatives of educational institutions, foundations, or volunteer organizations.[41] This is concerning, as a survey of hospital board members completed by the Ontario Auditor General found that 10 percent of respondents "indicated that one of their top three roles as a board member was to represent specific interests, including medical and community groups, municipalities, volunteers, and the hospital's foundation."[42] These interests may conflict with the duty to ensure that patients receive high-quality care or with other board duties, such as good financial stewardship. In 2010, Ontario passed legislative amendments to specify that if members of a hospital medical staff sit on the board, they cannot be voting members.[43] Although this represented a step in the right direction, it is still concerning that hospital boards have ex officio members.

Although some other provinces abandoned certain ex officio board members when they replaced hospital boards with regional health authorities, it is still common for various individuals from the medical staff to sit on the board by virtue of their positions. As with Ontario, some provinces do not give these individuals voting status, but policy-makers have tended not to consider whether to remove these individuals from boards entirely and to

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38 *Regional Health Authorities Act*, *supra* note 32, s 27(1).
39 *Ibid*, s 27(2).
40 *Excellent Care for All Act, 2010*, SO 2010, c 14, s 4.
41 A survey of hospital boards in the Greater Toronto Area found that boards had an average of six ex-officio members out of an average 22 member board. One board had 12 ex-officio members out of a total of 25: Office of the Auditor General of Ontario, *2008 Annual Report* (Toronto: Queen's Printer of Ontario, 2008) at 310 [Ont Auditor General, *2008 Report*].
42 *Ibid* at 309.
43 *Hospital Management*, RRO 1990, Reg 965, s 2(2).

relegate them to an advisory role.[44] For example, in New Brunswick, the board of a regional health authority includes the Chief Executive Officer, the Chairperson of the Professional Advisory Committee, and the Chairperson of the Medical Advisory Committee, all of whom are non-voting members.[45] Nova Scotia provides a counter-example to this trend, with the legislation limiting various ex officio board members and providing that no more than three of the maximum permitted number of voting members of a board may be individuals employed by the health authority or hospital, or hold privileges at a hospital in the district, unless otherwise specified by the Minister in the regulations.[46]

Although reforms designed to minimize conflicts of interest are consistent with good governance practices, merely taking steps to minimize undue influence of board members whose interests may skew away from quality of care is insufficient. In order for the board to truly act as a steward of safety and quality, they must themselves devote adequate time and attention and have sufficient expertise in these matters to understand the information provided by clinicians and to ask the right questions.[47] Several empirical studies from the American context provide the basis for the kinds of governance activities that trickle down and impact patient care. These studies show a correlation between board involvement in quality of care and patient outcomes. Organizations categorized as high-performing in relation to patient outcomes are more likely to have a board committee devoted to quality of care, devote specific time at each meeting to quality of care issues, train board members in quality of care, and familiarize themselves with quality indicators and to review those indicators.[48] Unfortunately, there are no such studies from the Canadian context, which would be useful in determining the kinds of board practices that are most effective in improving patient outcomes.[49]

Although Canadian hospitals and health regions engage in many of the quality and safety practices that find support in the American literature, the adoption of these practices is far from universal. Given that they are not generally mandated by legislation, these priorities may fall to the wayside of other board activities. For example, one survey study of Canadian hospital boards found that only one-third of boards spend 25 percent of their time or more

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44 The experiences of other jurisdictions are instructive on how to engage physicians in leadership decisions, without undue deference to professional autonomy. See e.g. G Ross Baker & Jean-Louis Denis, "Medical Leadership in Health Care Systems: From Professional Authority to Organizational Leadership" (2011) 31:5 Public Money & Management 355; Paul Anand et al, "Autonomy and Improved Performance: Lessons From an NHS Policy Reform" (2012) 32:3 Public Money & Managment 209.

45 *Regional Health Authorities Act*, *supra* note 32, s 20(1)(b).

46 *Health Authorities Act*, SNS 2000, c 6, s 13.

47 In this regard, a survey study by Baker et al found that while most board chairs reported that their boards received numerical reports on quality and safety indicators, that only half rated this information as excellent or good in assessing performance: G Ross Baker et al, *Effective Governance for Quality and Patient Safety in Canadian Healthcare Organizations: A Report to the Canadian Health Services Research Foundation and the Canadian Patient Safety Institute* (Ottawa: Canadian Health Services Research Foundation, 2010) at 3 [Baker et al, *Effective Governance*].

48 Ashish Jha & Arnold Epstein, "Hospital Governance and the Quality of Care" (2010) 29:1 Health Affairs 182. See also Joanna Jiang et al, "Board Engagement in Quality: Findings of a Survey of Hospital and System Leaders" (2008) 53:2 J Healthcare Management 121; Joanna Jiang et al, "Board Oversight of Quality: Any Differences in Process of Care and Mortality?" (2009) 54:1 J Healthcare Management 15; T Vaughn et al, "Engagement of Leadership in Quality Improvement Initiatives: Executive Quality Improvement Survey Results" (2006) 2:1 J Patient Safety 2.

49 Baker et al, *Effective Governance*, *supra* note 47, note that "[f]ew articles in the healthcare governance literature offer data on the board role in improving quality of care, and only a handful of publications in the quality improvement literature address governance" (*ibid* at 5). Instead, the literature on board governance "has been largely dominated by … normative discussions" (*ibid*).

on quality and safety issues. Only 43% of board chairs reported that all meetings have a specific item on the agenda relating to quality and safety, while 13% percent reported that none or few board meetings included" such an item.[50]

The process for appointing boards in most provinces is not transparent or adequate to ensure that boards have the adequate competencies to fulfill their functions, including those relating to quality or safety, or that board members receive sufficient training in these competencies. In this regard, Baker et al. argue that boards should include at least one member "who has expertise in healthcare quality or similar expertise in other industries"[51] and that boards should develop a plan for their members "to broaden their knowledge and skills in quality and patient safety."[52] The Ontario Auditor General similarly identified this as an area of concern for hospital boards.[53] In addition to more traditional expertise in finance and accounting, management, and legal and risk management, several competencies may more directly benefit patient care, such as expertise in patient relations, governance and accountability, the measurement of quality indicators, and reliable system design.

Although there have been legislative amendments targeted at improving hospital governance over patient safety, these have largely come in a piecemeal fashion and some provinces lag behind others in their adoption. Furthermore, any discussion of such reforms must be accompanied by better data from the Canadian context on the link between specific governance reforms and patient outcomes. The existing hospital governance structures are largely a relic of history, rather than a reflection of evidence-based decisions on how best to measure, monitor, and oversee quality and safety within hospitals. Significant changes in the delivery of health care services and in the relationships between physicians, hospitals, and patients demand that policy-makers revisit their laws to ensure that they are supportive of good governance.

VI. PATIENT SAFETY AND THE HOSPITAL-PHYSICIAN RELATIONSHIP

The majority of Canadian physicians do not have a contract of employment with the hospital or health region within which they work, but rather are granted privileges to admit and treat patients by the applicable hospital board or health region. In theory, the process of granting privileges has a close nexus with quality of care. First, the appointment of a physician to a hospital medical staff involves an examination of his or her credentials, thereby theoretically protecting patients from the risks associated with unqualified or underqualified practitioners. However, a recent report to the British Columbia government highlighted lax approaches to credentialing, which failed to "protect the organization and the

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50 *Ibid* at 20.

51 *Ibid* at 1.

52 *Ibid*. A recent report published by the Government of Alberta similarly recommended that the Minister and the Alberta Health Services Board adopt a procedure for the recruitment and selection of board members that is competency-based, non-partisan, and transparent: Government of Alberta, *Working Together to Build a High Performance Health System: Report of the Health Governance Review Task Force* (Edmonton: Alberta Health, 2013) at 3.

53 Ont Auditor General, *2008 Report*, *supra* note 41.

public."[54] Second, as hospital privileges expire after a set term (usually one year), the renewal process could act as a quality assurance mechanism if it incorporated a detailed review of a physician's performance. However, renewals tend to involve little scrutiny, and are granted as a matter of course. Third, hospitals have processes in place to suspend or revoke a physician's privileges, which could act as a mechanism to prevent patient injuries when there are concerns with quality of care. However, as I discuss in greater detail below, several factors serve to discourage hospitals from suspending or revoking a physician's privileges.

Although provincial laws clearly grant hospitals or health regions the ultimate power to grant or revoke physician privileges,[55] their boards are roundly criticized for their extreme deference to privileging recommendations emanating from their medical staffs. In most provinces, hospital or regional boards are required to seek the input of the Medical Advisory Committee in making these decisions.[56] However, anecdotal evidence suggests that boards do not merely seek advice in privileging decisions, but often abdicate their responsibility to independently consider such matters. For example, a recent report published by Alberta Health notes that the typical approach of boards has been to "simply 'rubber [stamp]' the recommendations brought to them by the Medical Advisory Committee."[57] A report for the Ontario Hospital Association similarly argued that although physician credentialing is a primary responsibility of hospital boards, "it receives, at best superficial attention in many hospitals,"[58] which employ a "rather perfunctory process"[59] that consists largely of approving Medical Advisory Committee recommendations.

Because hospital or regional Medical Advisory Committees are comprised of other physicians,[60] there is a serious concern that their privileging recommendations will be unduly influenced by concerns other than quality of patient care, such as personal loyalties or rivalries. For example, it may be difficult for a physician to recommend the revocation of a well-liked colleague or professional mentor's privileges, even in the face of serious concerns with patient safety. In a report to the British Columbia government on physician privileges, Cochrane argued that "the Department Head, who may be a member of the practice group,

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54 DD Cochrane, *Investigation into Medical Imaging, Credentialing and Quality Assurance: Phase 2 Report* (BC Patient Safety and Quality Council, 2011) at 35. In his report examining the privileges of radiologists in British Columbia, Cochrane argued that reliance by the Medical Advisory Committee on the recommendations of department heads resulted in a credentialing process that was "functionary" and added "no critical review" (*ibid).* This report recommended that credentialing should be a hospital responsibility, rather than a departmental responsibility, as the latter do not have the necessary tools to properly evaluate credentials.

55 See e.g. *Operation of Approved Hospitals Regulation*, Alta Reg 247/1990: "The board shall establish a hospital medical staff by appointing qualified physicians to the medical staff" (*ibid*, s 32(1)) and "may review, suspend or terminate the appointment of any member of the medical staff" (*ibid*, s 32(3)).

56 For example, New Brunswick's *Regional Health Authorities Act*, *supra* note 32, specifies that "[b]efore making appointments to the medical staff of a regional health authority or granting privileges, a board shall request advice from the medical advisory committee as to the appointments to be made the privileges to be granted" (*ibid*, s 28(2)).

57 Dennis Kendel, *A Review of Alberta Health Services:Physician Credentialing & Practice Privileging for Pathology & Radiology* (Edmonton: Government of Alberta, 2012) at 4.

58 Maureen A Quigley & Graham WS Scott, *Hospital Governance and Accountability in Ontario* (Toronto: Ontario Hospital Association, 2004) at 41.

59 *Ibid*.

60 For example, in Ontario hospitals, the Medical Advisory Committee is comprised of the president, vice-president, and secretary of the medical staff, the chief of staff, the chief of the dental staff (if applicable), and other members of the medical staff that are appointed or elected in accordance with the hospital's bylaws: *Hospital Management*, *supra* note 43, s 7.

may find him or herself in conflict when exercising the Department Head responsibilities."[61] In particular, there is a conflict of interest in being called upon to "evaluate his/her department members, who are also on-call or business partners."[62]

Privileging decisions remain delegated to the facility level in some provinces, while others administer privileges on a region-wide basis. Provinces should consider moving to the latter model, as it would help to eliminate a physician's close colleagues from making privileging recommendations. Provinces may also minimize conflicts of interest by mandating a strict separation between the Medical Advisory Committee and the President of the Medical Staff. For example, in British Columbia, the President of the Medical Staff is the Chair of the Medical Advisory Committee, and the Vice-Chair of the Medical Staff is the Chair of the Credentials Committee of the Medical Advisory Committee.[63] This creates a conflict of interest, as the Medical Advisory Committee is tasked with ensuring quality of care, while the President and Vice-President of the Medical Staff serve as advocates for the hospital's physicians.

Another concern with the privileging model and its implications for patient safety is that provincial laws create an onerous process for suspending or revoking a member of the medical staff, even when there are concerns with quality of care. For example, in Ontario, a doctor who is aggrieved by a privileging decision is entitled to a hearing before a hospital board, followed by a right of appeal to the Health Professions Appeal and Review Board and then the Divisional Court. Physicians are also afforded various procedural rights that are prescribed by statute, such as the right to written reasons for the privileging decision.[64] Such a process is time consuming and costly, with hospitals incurring considerable legal fees to remove a physician from the medical staff. As such, hospitals are arguably discouraged from pursuing suspension or revocation, thereby putting patients at risk. According to the former President and CEO of the Ontario Hospitals Association, "[i]n rare instances where the quality of a physician's care is in serious question, the system is weighted toward protecting a physician's 'right' to practice."[65] If a hospital decides to proceed with revoking privileges, the hospital faces what he characterizes as "a multi-year legal process that is adversarial, complicated and very expensive."[66] Conversely, doctors have an incentive to engage in this process, as their legal costs are covered by their mutual defence organization, the Canadian Medical Protective Association. A 2010 decision of the Ontario Court of Appeal may further discourage hospitals from suspending or revoking privileges. In *Rosenhek v. Windsor Regional Hospital*, the Court awarded $3 million to a doctor whose privileges were revoked in bad faith.[67]

Given these disincentives to suspend or revoke privileges and the conflicts of interest built into the credentialing and privileging process, the privileges model seems difficult to justify on the basis of improved quality of care, cost savings, reduced wait times, or any other

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61 Cochrane, *supra* note 54 at 34.
62 *Ibid*.
63 *Ibid* at 35.
64 *Public Hospitals Act*, RSO 1990, c P.40, ss 37–43.
65 Laura Vogel, "Ontario Hospital Association Proposes to Scuttle Privileges Model for Doctors" (2010) 182:10 CMAJ E441 at E441.
66 *Ibid.*
67 2010 ONCA 13, 257 OAC 283.

variable. Instead, it is largely a relic of history with procedural protections that are valued by physicians. Accordingly, one potential reform that provincial governments ought to consider is abolishing this model in favour of the type of contracts that characterize most forms of employment. This reform would dovetail with the gradual shift away from reimbursing physicians on a fee-for-service basis and towards salaries, which is already occurring across Canada. Movement towards an employment model may also prompt courts to reconsider their characterization of physicians as independent contractors, thereby prompting greater board involvement in quality of care.

An alternative to adopting employment relationships with physicians would be to reform the privileges model. As described above, one possible set of reforms would be to amend hospital laws to treat privileges as a regional matter or to mandate greater separation of the President of the Medical Staff from credentialing and privileging decisions. In 2007, a physician murdered a nurse, with whom he had a romantic relationship, in an Ontario hospital in which they both worked. This doctor was known to engage in "disruptive behaviour" with other health professionals in the hospital, which put both colleagues and patients at risk. A Coroner's Inquest into this incident produced various recommendations for reforming the *Public Hospitals Act* with a view to ensuring "that patient and staff safety, as well as patient care, must … not be superceded by a physician's right to practice."[68] More specific recommendations included simplifying the process for immediate suspension or revocation of privileges. Other suggestions included replacing the current system of repetitive hearings with a streamlined system whereby physicians have an opportunity for an immediate hearing before an external tribunal following a decision by the hospital board. Although this Inquest led some Ontario hospitals to examine their internal policies or bylaws, it did not lead to substantive changes either in Ontario or elsewhere in terms of streamlining the appeals process. Furthermore, although this Inquiry prompted much discussion around suspending or dismissing "disruptive physicians," who did not pose a clear and immediate threat to patient safety but whose conduct contributed to an unsafe environment, there has been little perceptible difference in the ease or frequency of privilege suspensions or revocations.

Given changes in hospital governance and health service delivery, considerable evidence in support of treating quality of care as a systems issue, and recent examples of failures in the credentialing and privileging processes, it is clear that provinces must at least consider whether to retain or reform the privileges model, which has persisted since the inception of the modern hospital. Provinces cannot allow inertia, and perhaps a reluctance to take on provincial medical associations, to act as barriers to reforms that could improve patient safety. In addition, given that the health policy literature is almost devoid of analyses or empirical studies exploring the relative merits of the privileges model and its alternatives, policymakers must devote further resources to examining this issue.

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[68] Coronor's Jury, "Dupont Inquest: Coroner's Jury Recommendations" (11 December 2007) at 1, online: <https://oaith.ca/ assets/files/Publications/Coroners-Jury-Recommendations-Dupont.pdf>.

VII. CONCLUSION

Despite considerable investment in studying and improving the quality and safety of health care services over the past fifteen or more years, tens of thousands of Canadians die each year from preventable injuries sustained in hospitals. There is a significant body of literature showing that these injuries must be looked at through a systems lens, rather than focusing on the actions of individual health professionals. In this article, I explored the ways in which the law can support such a shift towards a systems focus. In particular, Canadian courts have maintained the status quo with regard to hospital liability for 37 years, even in the face of significant changes to the delivery of health care services and the relationship between doctors, hospitals, and patients. Tort law is limited by the few patients who bring claims and its reactive nature. In addition, it will arguably not motivate a hospital to revolutionize its overall approach to patient safety. However, it can be effective at prompting a response to a particularly dangerous gap in safety.

Just as Canadian courts must reconsider their application of the law in light of health system changes, provincial governments are also overdue in revamping legislation to support hospital boards in acting as stewards of quality and safety. The patient safety literature identifies institutional culture and board involvement in patient safety as major contributors to patient outcomes. Although further study in the Canadian context is necessary, provincial governments should explore such legislative reforms as minimizing conflicts of interest between the medical staff and governance matters, and ensuring sufficient board competence and attention to matters of quality and safety. Governments should also consider whether to more substantially restructure their legal relationship with physicians, either by reforming or abandoning the privileges model. As it is currently structured, this model makes it difficult for hospitals to remove physicians from the medical staff, even when there are concerns with quality and safety. Hospitals were largely structured around accommodating the interests of physicians and protecting their autonomy, which should no longer be permitted to dominate over more pressing concerns with quality and safety.