4.5 Hospitals' Decision Making on Patient Care Negatively Impacted by the Physicians Appointment and Appeal Process

4.5.1 Appeal Process for Hospitals and Physicians under *Public Hospitals Act* Needs Review

A hospital's professional staff include the physicians, dentists, midwives and Nurse Practitioners who work in the hospital. Professional staff are appointed directly by the hospital's board—they are typically not salaried employees. Instead, they are reimbursed by the Ontario Health Insurance Plan for services they provide to patients at hospitals and wherever else they practise.

Physicians who work as medical staff are given hospital privileges, meaning they have the right to practise medicine in the hospital and use the hospital's facilities and equipment to treat patients without being employees of the hospital. These hospital privileges were originally intended to allow physicians to base their decisions primarily on what is best for the patient and not what is best for the hospital. The *Public Hospitals Act* (Act) of 1990 governs important elements of the physician-hospital relationship.

We have noted some instances where hospitals were not able to resolve human resources issues with physicians quickly because of the comprehensive legal process that the hospitals are required to follow under the Act. In some cases, longstanding disputes over physicians' hospital privileges have consumed considerable hospital administrative and board time that could be better spent on patient care issues.

Hospital Board Responsibilities Regarding Hospital Privileges

The Act makes the hospital board responsible for the following with respect to hospital privileges:

- establishing a medical advisory committee composed of elected and appointed medical staff members, to consider and make recommendations to the board related to medical staff appointments and their privileges;
- appointing and annually reappointing medical staff and determining their privileges;
- revoking, suspending or refusing reappointment of medical staff where necessary; and
- holding formal legal hearings upon request by medical staff in case of disputes or other issues related to hospital privileges.

In addition, the Act allows physicians to appeal a hospital board decision to the Health Professional Appeal and Review Board. The Board hears appeals from medical staff who consider themselves aggrieved by any decision revoking, suspending, or substantially altering their appointment, among others. Both physicians and hospitals have the right of appeal to a court of law from a Board decision.

Therefore, while hospitals can manage their own employees, such as nurses, pharmacists, dieticians and lab technicians, they do not have the same authority to manage physicians without going through the legal process specified by the Act. This legal process is lengthy, cumbersome and costly, and does not put the patients' interests first, as the following examples indicate.

Hospital Management Unable to Meet Its Service and Staffing Needs

The management of one hospital indicated to us that when its service priorities change or resources are transitioned between programs (for example, to shift operating-room time from one type of surgery to another), and the result will mean changes to its professional staff needs, it has no simple mechanism to give notice to affected professional staff members that their relationship with the hospital will change. If the hospital wishes to recommend that a physician move either within the hospital or to another hospital, or to sever its relationship with a physician, the hospital may not be able to do so without triggering appeal rights. The management explained that this is due to restrictions it faces

under the *Public Hospitals Act*, and that it is more time consuming and costly than proposing changes or moves for non-professional staff members, who are employees of the hospital.

The same hospital management also informed us that, under the *Public Hospitals Act*, the hospital privilege system for physicians leaves it without the flexibility to adjust physician and other staffing resources to meet its changing local needs.

Hospital Board Entangled in Conflict with Its Physician

Management from one hospital board told us that it has had to spend about five years in administrative and legal disputes with one of its physicians:

- The hospital board attempted to not reappoint a physician to hospital privileges in 2009 due to numerous conflicts between the physician and the hospital management on a hospital policy, causing disruptions that put patient care at risk.
- The hospital's internal and external independent reviews found that the physician had hindered the functioning of a department within the hospital. Even though the College of Physicians and Surgeons of Ontario's investigation confirmed that the physician failed to follow hospital policies, the hospital board was not able to refuse the physician's reappointment because the physician appealed the decision to the Health Professions Appeal and Review Board.
- Under the *Public Hospitals Act*, the physician was allowed to continue to work at the hospital between 2009 and 2013 while the case was heard. The Health Professions Appeal and Review Board decided in 2013 that the physician was to be reappointed without any conditions.
- The hospital spent over $800,000 in legal fees on the case, equivalent to the annual funding for two in-patient acute beds. Unable to remove the physician's privileges or require the physician to undertake behavioural assessment, hospital management eventually repaired the hostile work environment with the physician over time.

Recent Increase in Legal Disputes

The Canadian Medical Protection Association provides legal advice and defence to physicians when medical-legal issues arise in their work. The types of medical-legal difficulties the Canadian Medical Protective Association can assist physicians with include, among other things, conflicts with hospitals and human resources issues.

We noted that over the past five years, the Canadian Medical Protection Association reported about 2,250 legal cases involving disputes between hospitals and their physicians. The number of cases per year increased 87% in 10 years, from 285 cases in 2006 to 533 cases in 2015.

4.5.2 Co-ordinating with Physicians Is a Challenge for Hospitals

Some hospital managements believe that under the current structure, it is difficult for hospitals to achieve an integration of patient care. For example, physicians at some hospitals have the professional autonomy to choose different brands of medical devices for the same surgical procedure, such as brackets used in knee joint replacement, resulting in variations in practice and costs.

We also found instances, as in the previous section, where hospital management and individual physicians did not work collaboratively, with the result that they were unable to deliver patient-centred health-care services.

Other examples we found focus on more general scheduling and staffing issues. In some of these cases, patients experienced unnecessary inconvenience and delays in treatment, sometimes with extremely serious outcomes. In particular, as we detail in **Section 4.3.1**, the scheduling of surgeons' hours leaves hospitals at different times of day

without the resources to treat emergency patients in a timely manner. Weekend and holiday scheduling of patient services is also not well co-ordinated, as we detail in **Sections 4.3.2** and **4.4.3**. March break and summertime closures also extend the wait for elective surgery for many patients.

Physicians We Surveyed Are Aware of Scheduling and Co-ordination Issues

Our survey of physicians informed us that physicians are also aware of these problems. Some respondents suggested that more collaboration is needed between hospitals and physicians to decide what is reasonable in terms of work hours and compensation. When we asked the physicians in our survey about the scheduling and use of operating rooms, some suggested two operating-room shifts a day and all-day time slots during the summer to better serve patients and hospital staff. Many physicians saw the need to allow more evening and weekend time for surgery.

When asked whether hospitals should be given the authority to schedule their physicians to work when needed to meet patient demand, including evenings and weekends, 58% of the physicians who responded disagreed and felt that physicians should not be forced to work these times. However, as many as 42% of the physicians who responded to our survey agreed with this suggestion.

RECOMMENDATION 13

To ensure that hospitals, in conjunction with physicians, focus on making the best decisions for the evolving needs of patients, the Ministry of Health and Long-Term Care should review the physician appointment and appeal processes for hospitals and physicians under the *Public Hospitals Act*.

MINISTRY RESPONSE

The Ministry accepts this recommendation and will develop, in consultation with stakeholders, a proposal for a review.

RECOMMENDATION 14

To ensure that hospitals are able to make the best decision in response to the changing needs of patients, the Ministry of Health and Long-Term Care should assess the long-term value of hospitals employing, in some cases, physicians as hospital staff.

MINISTRY RESPONSE

The Ministry accepts this recommendation and will develop, in consultation with stakeholders, a proposal for a review.

4.6 More Effective Scheduling of Nurses Needed

Labour is the biggest single expenditure of hospitals, and the majority of hospital staff are nurses. It therefore follows that nurse staffing is an important area in which hospitals should seek efficiencies while maintaining a safe standard of care for patients.

We found that hospitals could be doing more to deploy nurses more efficiently. First, implementation of centralized scheduling systems would cut down on costly overtime and agency nurses without compromising patient care.

Centralized nurse scheduling could also help hospitals avoid some of the cost-saving measures they currently rely on, including scheduling fewer nurses and employing more Registered Practical Nurses than Registered Nurses, as discussed in the following sections.