Professional Staff Credentialing Toolkit

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Ontario Hospital Association

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This edition is an updated version of a Toolkit originally published in 2012. We wish to recognize the significant contributions of OHA member hospitals, OHA staff, health system stakeholders, and lawyers at DDO Health Law in developing the original content.

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Disclaimer

This resource document was prepared as a general guide to assist hospitals in understanding the legislation and processes around credentialing professional staff members. The material in this resource document is for general information only and may need to be adapted by hospitals and health care providers to accommodate their unique circumstances. This document reflects the interpretations and recommendations regarded as valid at the time of publication based on available information. It is not intended as, nor should it be construed as, legal or professional advice or opinion. Hospitals concerned about the applicability of specific credentialing practices and issues relating to privileges within their organization are advised to seek legal and/or professional advice based on their particular circumstances. Neither the OHA nor the Toolkit author, jointly or severally, will be held responsible or liable for any harm, damage, or other losses resulting from reliance on, or the use or misuse of the general information contained in this resource guide.

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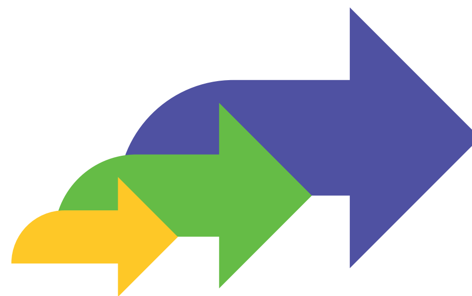


Introduction to the Toolkit

The Ontario Hospital Association (OHA) has a mandate to promote and foster excellence in health care governance, promote a culture of shared accountability, and assist hospitals in their efforts to enhance the governance of their organizations. In support of this mandate, the OHA is pleased to provide this updated edition of the Professional Staff Credentialing Toolkit to Ontario hospitals.

The Toolkit provides practical guidance to assist hospitals in managing one of their most critical resources: Board-Appointed Professional Staff (physicians, dentists, midwives, and extended class nurses). It explores the relationship between hospitals and the Board-Appointed Professional Staff who are granted "privileges" to practice at a specific hospital.

Although the Toolkit contains a list of Resources and References, it does not provide a synthesis of credentialing literature. For those interested in a review of the literature, a list of references is provided in Appendix III.

Guide to the Toolkit

What is the *Professional Staff Credentialing Toolkit*?

The Toolkit is a resource for Ontario hospitals. It is specifically designed for hospital board members, CEOs, Chiefs of Staff/Chairs of the Medical Advisory Committee (MAC), Chiefs of Departments (and other clinical leaders), and Heads of Divisions, as well as the many administrative personnel who manage the hospital's credentialing process. The Toolkit begins with background information, then guides readers through the credentialing process chronologically (i.e., from recruitment through retirement). It provides several resources including, frequently asked questions (FAQs), templates, checklists and sample documents.

Why is the *Professional Staff Credentialing Toolkit* needed?

The relationship between Ontario hospitals and their Professional Staff is tremendously important to the patient care experience. The relationship is also complicated and can be difficult to explain to patients, board members, Professional Staff members and hospital leaders. This Toolkit was drafted to provide a comprehensive education on the roles and responsibilities, history and current issues that arise between hospitals and their Professional Staff.

The credentialing process involves many stakeholders within the hospital playing different and crucial roles. Mistakes can be costly: gaps have the potential to compromise quality of care, disrupt staff and lead to legal proceedings. The legal context of credentialing is unique to hospitals and has a rich history. The Toolkit is intended to provide concrete, practical information that demystifies the process and reflects both legal requirements and best practice.

What's New in the Update

This second edition updates the 2012 Professional Staff Credentialing Toolkit to:

1. Reflect updates made to the OHA/OMA Prototype By-law;

2. Reflect changes made to the *Public Hospitals Act*, section 33 mandatory reporting of physicians to the College of Physicians and Surgeons of Ontario (see pages 43, 84, 95) and section 44 ceasing to operate or provide services (with amendments relating to the *Connecting Care Act*, 2019) (see page 109);

3. Acknowledge the Auditor General of Ontario's comments in 2016 and 2018 recognizing the financial implications of the *Public Hospitals Act* scheme on a publicly funded health care system (see pages 17-18);

4. Acknowledge the introduction of the *Connecting Care Act*, 2019 and the new Ontario Health Teams (see pages 9, 11);

5. Include the Health Insurance Reciprocal of Canada's recommendations for credentialing (see pages 15-17);

6. Address the impact of new technology on credentialing including for remote consultations such as telehealth and medical assistance in dying (see pages 11-12);

7. Include updates in case law (that is, decisions that have gone before the Ontario Health Professions Appeal and Review Board and courts across Canada) (see pages 18, 22, 23, 28-29, 46, 49, 60-61, 98, 114, 119, 142-145); and

8. Reference advances made in joint credentialing efforts (see pages 65-67, 71-72)

Mandatory Requirements versus Best Practice and Innovative Ideas

In **Chapter 2, Legal Context,** readers will learn that the *Public Hospitals Act* and its regulations set out a comprehensive code for managing the privileges hospitals grant to physicians. The process mandated by the *Public Hospitals Act* is a legal requirement. When an obligation flows from the *Public Hospitals Act*, its regulations, other legislation, or case law that has developed over years, the Toolkit identifies the source of the requirement.

In other instances, the Toolkit identifies best practice or makes recommendations about practical ways to address privileges issues. For example, dentists, midwives and extended class nurses are not subject to the detailed processes set out in the *Public Hospitals Act*; therefore, there is significant flexibility for hospitals to design their own processes for credentialing Professional Staff other than physicians and dealing with their privileges issues. Often, hospital by-laws treat all Professional Staff the same, but the Toolkit identifies when this need not be the case.

It is important to note that this Toolkit builds upon the *OHA/OMA Prototype Board-Appointed Professional Staff By-law, 2021* (OHA/OMA Prototype By-law) , which we recommend for our hospital members. If a hospital has not adopted the by-law or has customized it to suit their unique situation, the hospital's own by-laws need to be considered in the context of all privileging matters. It is important to adapt any of the sample documents offered in this Toolkit to your own context.

Chapter Summaries

Chapter 1, Overview, provides answers to two fundamental questions: (1) What are privileges? and (2) Who needs them? This Chapter provides a basic overview of credentialing.

Chapter 2 sets out the **Legal Context** associated with the credentialing process. Hospitals will become familiar with key Ontario statutes such as the *Public Hospitals Act*. In addition, readers will learn about the significant consequences faced by hospitals when credentialing requirements are not carried out properly.

Chapter 3, Roles and Responsibilities, describes key players in the credentialing process and the responsibilities of various stakeholders, including members of the hospital board, MAC, Professional Staff, health regulatory colleges and others. The chapter contains itemized lists detailing responsibilities for various hospital staff, to help them better understand their role in the credentialing process.

Chapter 4, Planning and Recruitment, guides readers through the steps for recruiting Professional Staff. Readers will learn about Professional Staff Human Resources Plans and impact analyses.

Chapter 5 addresses **Initial Appointments**, including receipt of applications, credentialing and checking references, consideration by the Credentials Committee and MAC, and appointment decisions made by the board. Readers will learn about an individual's right to apply for privileges, what a hospital privileges application should include, and how to manage common issues associated with initial applications.

Chapter 6 deals with **Professional Staff Re-appointment**. This chapter explores changes to privileges, re-application rights, re-application content and criteria, and how to manage Professional Staff members who fail to re-apply for privileges.

Chapter 7 addresses **Everyday Management** issues once privileges are in place, including orientation and training of Professional Staff, key policies, leaves of absence, and occupational health and safety.

Chapter 8 examines **Performance Evaluations and "Progressive Management"** issues. This chapter explains how to establish good communication with Professional Staff, complete performance evaluations, implement a system of progressive management, and discipline Professional Staff as necessary.

Chapter 9 – in rare circumstances, hospitals must consider **Refusing Appointments and Re-appointments and Suspending, Restricting or Revoking Privileges**. This chapter looks at how these situations arise, as well as various types of suspensions and the notification process. It provides practical information to assist the board and MAC in discharging their duties when these difficult situations occur.

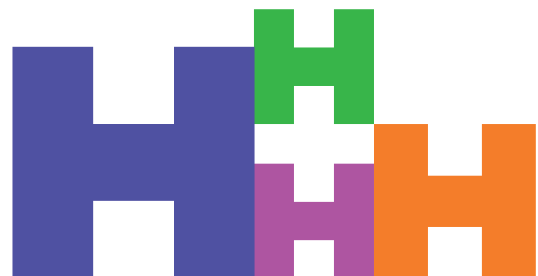
Chapter 10, Resignation and Retirement, can present challenges to hospitals in terms of transfer of care, succession planning and notifying the proper parties. This chapter highlights a number of important considerations, including the creation of resignation/retirement policies and ensuring that Professional Staff take certain steps prior to departing.

Chapter 11, Maintaining Credentialing Files, highlights key documentation issues and the content of the hospital credentialing file. This chapter discusses the need for confidentiality, issues that may arise with freedom of information requests and recommendations relating to retention periods.

Chapter 12, Academic Issues, identifies credentialing issues specific to academic health centres. This chapter defines key players in teaching hospitals; explores the relationships between the Professional Staff, the university and the hospital; and describes different academic disputes that may affect privileges.

At the end of this Toolkit, there are various appendices that provide helpful reference materials:

Appendix I: Glossary
Appendix II: Excerpts from *Public Hospitals Act* (and Regulation 965), *Regulated Health Professions Act, 1991*, and the OHA/OMA Prototype By-law
Appendix III: Resources and References



Chapter 1: Overview

Chapter Summary

- One of the most important governance roles undertaken by hospital boards is credentialing of Professional Staff (including physicians, dentists, midwives and extended class nurses).
- "Credentialing" is an umbrella term used by many hospitals, which includes a range of activities and processes, such as: applications for initial appointments, verification of qualifications, identification of the scope and nature of privileges, granting of privileges, periodic review and annual re-appointment.
- Hospital "privileges" create unique relationships between hospitals and their Professional Staff and those relationships exist in a complicated legal context. Rights are triggered when someone applies for and receives privileges at a hospital.
- Professional Staff are key members of every hospital's clinical team, without whom, hospitals cannot provide clinical services.
- Privileges are important to practitioners and have a professional, financial, and reputational impact on Professional Staff.
- Hospital by-laws set out categories of Professional Staff (such as Active Staff and Courtesy Staff) and the rights attached to each category.
- Not everyone who provides clinical care at a hospital requires privileges.

Board-Appointed Professional Staff

This Toolkit covers the relationship between hospitals and their Board-Appointed Professional Staff (physicians, dentists, midwives and extended class nurses). "Medical Staff", "Dental Staff", "Midwifery Staff", and "Extended Class Nursing Staff" are all defined terms under the *Public Hospitals Act*, Regulation 965. By definition, membership in those groups requires privileges granted by the hospital board.[1]

PROFESSIONAL STAFF CATEGORY	GRANTED PRIVILEGES TO:
Medical Staff	Diagnose, prescribe for, and treat patients
Dental Staff	**Oral and Maxillofacial Surgeons:** diagnose, prescribe for and treat patients **Dentists:** attend to patients in cooperation with a member of the Medical Staff
Midwifery Staff	Assess, monitor, prescribe for and treat patients
Extended Class Nursing Staff	Diagnose, prescribe for and treat patients

1 See, R.R.O. 1990, Reg. 965, s. 1(1). Please note that, under Regulation 965, the definition of Extended Class Nursing Staff also includes extended class nurses who are employed by the hospital. However, the Regulation states in section 7(2.1), that the sections on appointments and re-appointments and dismissal, suspension or restrictions of privileges apply only to extended class nurses to whom the board has granted privileges. Hospitals may employ nurse practitioners and if they are employed, those nurse practitioners are not permitted to be members of the Board-Appointed Professional Staff according to the *Public Hospitals Act*.

This Toolkit characterizes these four groups collectively as "Professional Staff. For the most part,[2] Professional Staff are independent contractors and not hospital employees.[3] Regardless of the relationship (whether employee or independent contractor), membership in the Professional Staff always requires privileges.

The Toolkit does not apply to other types of hospital employees who also provide clinical services (e.g., nurses, pharmacists, laboratory technicians, dieticians, psychologists, social workers, occupational therapists, physiotherapists, medical radiation technologists and others). It specifically does not apply to extended class nurses who are hospital employees because the *Public Hospitals Act* regime does not apply to employed nurses in the extended class.

What are Privileges?

The term "privileges" is used because Professional Staff are given the privilege of using hospital resources in return for providing care to hospital patients. There is no definition of "privileges" in the *Public Hospitals Act* or its regulations. As stated in the case of *Kadiri,* "[p]rivileges define the scope of a physician's ability to use the hospital's resources to care for his or her patients."[4]

Generally speaking, the concept of privileges is understood to include:

- Membership in a category of Professional Staff (such as Active, Associate, Courtesy, *Locum Tenens*).
- Types of clinical procedures or services the member is entitled to perform for hospital patients (such as the right to admit in-patients, register out-patients and perform certain kinds of clinical procedures).
- Access to certain hospital staff, facilities, equipment, systems and supports (such as working with other health care professionals, use of the Operating Room, certain machinery and tools, or information systems).
- Affiliation with a particular Department or Division, in larger organizations.

Hospitals can choose to define "privileges" in their Professional Staff by-laws. Having a definition of privileges is not legally required, but it is a good practice as it explains when changes to a Professional Staff member's title, environment, relationships, compensation, resources or duties may give rise to a *Public Hospitals Act* dispute process and when such changes may not. Hospitals without a clear definition of privileges may find themselves in a formal dispute process before the Medical Advisory Committee, Board and beyond under the *Public Hospitals Act*, for changes made to a Professional Staff member's resources and supports at the hospital that the hospital thought it had the unilateral discretion to amend at any time. Such changes might include changes to office space, access to specific levels of nursing or other clinical staff, scheduling, or upgrades to hospital equipment. Formal dispute resolution processes under the *Public Hospitals Act* can be extremely costly and time consuming, as discussed further in this Toolkit.

The concept of physician privileges was examined in detail in the Ontario Hospital Appeal Board case of Dr. Dittmer and Parkwood Hospital.[5] In this case, a physiatrist's access to an electromyography laboratory was terminated. Conducting EMGs comprised approximately 95% of his practice at Parkwood and his Parkwood practice provided approximately 20% of his income. Parkwood Hospital asserted that laboratory access was a courtesy, and therefore terminating such access did not substantially alter Dr. Dittmer's privileges. The Appeal Board, however, interpreted privileges broadly and found that termination of Dr. Dittmer's laboratory access constituted

2 There are notable exceptions, for example, radiologists and pathologists may be employees of hospitals. Some hospitals choose to employ some or all of their Professional Staff.

3 There has been some discussion around the changing status of physician employment. See the 2016 Annual Report of the Office of the Auditor General of Ontario, Large Community Hospital Operations, the Auditor General's 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." and the Ministry response "The Ministry accepts this recommendation and will develop, in consultation with stakeholders, a proposal for a review" at p. 467.

4 Kadiri v. Southlake Regional Health Centre, 2015 ONCA 847 at para 11.

5 *Dittmer v. The Board of Directors of Parkwood Hospital* (1998), unreported file No. H 99/97 (Ontario Hospital Appeal Board). This case is also reviewed in detail in Chapter 12, Academic Issues.

a "substantial alteration" of his privileges within the meaning of section 41(1)(b) of the *Public Hospitals Act*.[6] The Appeal Board also stated the following with respect to privileges:

> "Privileges" is not a defined term in the Act. In broad terms, hospital privileges comprise a bundle of rights of a physician to carry out professional practice in the hospital. Those rights include some degree of access to the material and human resources of the hospital including hospital beds for the physician's patients (if the privileges include the right to admit patients), operating rooms (if the physician is a surgeon), diagnostic equipment, examining rooms, interns, residents, lab technicians and nursing staff. To the extent that the hospital's by-laws or the document setting out a physician's privileges do not specify the resources attaching to the grant of privileges, a particular physician's privileges must be taken to include access to those resources which are typically employed in the type of practice in which that physician is engaged. Further, and again to the extent to which access to resources is not, and has not previously been specified in the by-laws or the documents setting out the particular physician's privileges, the resources to which the physician has historically had access in his or her practice in the hospital must be considered in determining what access to resources attached to the privileges in question.[7]

The case of Drs. Kutzner and Blackwell in Saskatchewan also examined the issue of hospitals making changes to physician privileges and concluded that not every change to a physician's access to facilities and services constitutes a change in privileges giving rise to a right to a hearing.[8]

6 *Dittmer* at 10 , the Appeal Board states "[s]ubstantial" is to be measured against the physician's practice in that hospital, not against his overall practice." The EMG laboratory services constituted only 20% of his overall medical practice, but 95% of his practice at Parkwood Hospital.

7 *Dittmer* at 8. See also *Abramson v Medical Advisory Committee (North York General Hospital)*, 2011 CanLII 93929 (ON HPARB).

8 *Prairie North Regional Health Authority v. Kutzner*, 325 D.L.R. (4th) 401, 2010 SKCA 132. See also *Bhargava v. Lakeridge Health Corporation*, 2011 CanLII 22743 (ON HPARB), *Davidson v Sunnybrook Health Sciences Centre*, 2012 CanLII 35969 (ON HPARB) and *Dr. Steven Bryniak v. Regional Health Authority B*, 2013 NBQB 395 (CanLII).

That said, extra caution should be exercised where a hospital proposes to temporarily or permanently restrict or change a member's resources or supports so as not to substantially alter privileges or otherwise inadvertently suspend, restrict or revoke a member's privileges – thereby triggering a right to a *Public Hospitals Act* hearing. *See Chapters 9, Refusing Appointments and Re-appointments and Suspending, Restricting or Revoking Privileges and 10, Resignation and Retirement.*

Hospital privileges are valuable to those who hold them; to be appointed to a hospital can have significant professional, financial and reputational benefits. Some health care practitioners aspire to belong to a particular hospital's Professional Staff in order to have access to certain kinds of patients or equipment, for the research or educational opportunities, or for the collegial environment.

Privileges cannot be delegated or shared. Privileges are granted to an individual after they apply to the hospital and are credentialed and approved by the board. An individual with privileges cannot delegate or assign their hospital privileges to any other person.

Categories of Professional Staff

Hospitals establish their own categories of Professional Staff as these are not prescribed by the *Public Hospitals Act.*

As an example, the OHA/OMA Prototype By-law identifies six standard categories of Professional Staff with the following details respecting the rights and responsibilities attached to each category (among others[9]). *See table on next page.*

To change a member's category of Professional Staff membership constitutes a change in privileges, giving rise to the application of the *Public Hospitals Act.* If the recommended change of Professional Staff category is not made at the request of the member, the member may request a hearing before the hospital board.

9 Not every hospital has adopted the OHA/OMA Prototype By-law and may have different categories of Professional Staff or may define the scope of privileges differently.

CATEGORY OF PROFESSIONAL STAFF	PURPOSE	ADMITTING PRIVILEGES	INDEPENDENT PRACTICE	VOTE AT PROFESSIONAL STAFF MEETING	OTHER
Active	The main group of members of the Professional Staff Must have at least one year of completed satisfactory service	Yes	Yes	Yes*	If an academic institution, active staff members are usually required to hold and maintain a university appointment
Associate	Mandatory transitional (or probationary) category for all new appointments to the hospital seeking active staff privileges (for at least one year but not longer than two years)	Yes**	Depends – some hospitals require associate staff to work under the supervision of an Active Staff member ***	Maybe*	At six-month intervals, supervisor to complete a performance evaluation
Courtesy	To meet a specific need of the hospital or where the board deems it advisable	Not usually	Depends – some hospitals allow independent practice while some require certain courtesy staff to work under the supervision of Active Staff members	No	As an extension of courtesy privileges or as another category called “Regional Ordering”, some hospitals give authority for remote specialists to order laboratory tests and treatments without being part of the Active Staff.
Locum Tenens	Planned replacements for a physician, dentist or midwife or to provide episodic or limited surgical or consulting services	Yes**	Depends – some hospitals require *Locum Tenens* staff to work under the supervision of an Active Staff	Not usually	
Extended Class Nursing	Extended class nurses who are not employees	Yes ****	Not during initial probationary period	No*	New applicants have a probationary period of six months to include a performance evaluation

CATEGORY OF PROFESSIONAL STAFF	PURPOSE	ADMITTING PRIVILEGES	INDEPENDENT PRACTICE	VOTE AT PROFESSIONAL STAFF MEETING	OTHER
Honorary	To honour a former member who has retired and/or contributed to the hospital and has an outstanding reputation or made an extraordinary accomplishment	No	No – no regular clinical, academic or other duties	No	Note – this is not a "category" of professional staff but rather a policy or practice that hospitals may choose to maintain. The OHA/OMA Prototype By-law does not include this category
Temporary					The OHA/OMA Prototype describes temporary appointment as a process (see section 3.6 of the Prototype Bylaw). For further information, see the discussion in Chapter 5: Initial Appointment

* Only physicians are entitled under the *Public Hospitals Act* to vote at meetings of the Medical Staff and to be eligible to be elected or appointed an Officer of the Professional Staff. The OHA/OMA Prototype By-law extend the name of The Medical Staff to the "Professional Staff" and allows dentists, midwives and extended class nurses to attend meetings of the Professional Staff. However, only Active Staff and Associate Staff physicians may vote under the OHA/OMA Prototype By-law at meetings of the Professional Staff.

** There can be some exceptions within the categories (for example, some Associate Staff members may not have admitting privileges).

*** The *Public Hospitals Act* does not require specific Professional Staff categories and does not require that certain categories of Professional Staff be supervised. The OHA/OMA Prototype By-law recommends that Associate and *Locum Tenens* categories "work under the supervision of a member of the Active Staff." This may be achieved in a variety of ways in practice (on a continuum of conducting periodic reviews and mentoring, to direct oversight of all clinical work). Hospitals should be able to explain the supervising expectations to those involved. Guidance may come from regulatory colleges on the role of supervisors. In any case, the scope of the supervision should be clear to both the supervisor and supervisee at the outset of the relationship.

**** Since 2012, registered nurses in the extended class have had the authority to admit patients to hospitals under Regulation 965 of the *Public Hospitals Act.*

Upon initial appointment and with any subsequent change to a member's category of privileges, a hospital should communicate in writing to which category the Professional Staff member belongs. This is most important if there will be an initial appointment to one category of privileges with the intention for the individual to transition to a different category after a set period of time, after achieving further training or experience, when someone else retires, or another triggering future event.

Note - there are also specific categories of professional staff that may be particular to academic hospitals. Please review Chapter 12: Academic Issues for further information.

Core Privileges – Types of Procedures

Upon appointment to the Professional Staff, the hospital should advise the member of the types of procedures that they are permitted to perform.[10] Few hospitals have gone so far as to produce lists of core privileges that attach based on a Department or Division. However, doing so can greatly clarify the scope and range of the privileges assigned to a member on appointment or re-appointment. Providing a list of core privileges may also avoid unnecessary hospital limitations to a professional's scope of practice. Having a list of the types of procedures that attach to the appointment or re-appointment serves as a role description and assists the hospital when determining whether the applicant is qualified. It also tells the applicant what to expect. The kinds of elements that may be set out in the role description include:

- List of procedures to be performed (noting any exclusions);
- Departments to be served;
- Description of types of patients to be seen (such as: diseases, risk categories, body parts, or anatomical regions);
- Technology or equipment to be used;
- In-patient/out-patient services; and
- Knowledge or training expectations.

It is important to clarify whether an appointment in a particular Department or service requires or entitles all Professional Staff in that Department or service to perform all clinical procedures or whether certain procedures are restricted based on training, experience, or seniority.

10 Note that the midwifery scope of practice is the same for each midwife across the province regardless of hospital.

Who Needs Privileges?

A physician, dentist,[11] midwife, or extended class nurse[12] who wants to provide services at a hospital requires privileges. Without privileges, physicians, dentists, midwives or extended class nurses from the community are treated as external practitioners who cannot admit, diagnose, prescribe for, treat, or order tests for patients of the hospital. They cannot use hospital equipment or other hospital resources. They are not allowed to participate in rounds (on-site clinical consultations and discussions about patients) nor view patients' health records.[13] They are generally not permitted in areas of the hospital restricted to staff and would be subject to visiting hour restrictions. They would be allowed to attend continuing education rounds or other sessions where professionals or the general public are invited.

Midwives practicing in Ontario require privileges at a hospital as part of their registration requirements, although midwives can be registered with the College of Midwives of Ontario without privileges. Since midwives offer choice of birthplace to their clients, midwives are required by the College of Midwives of Ontario to meet competency requirements for both hospital and home births. Obtaining hospital privileges is therefore critical to the practice of midwifery in the province.

Sometimes, the lines are blurry as to whether activity at or for the hospital requires privileges. Hospitals may need to develop policies for managing relationships with practitioners who do not require privileges, to establish the boundaries. Hospitals may require legal advice to set up policies to clarify the relationships for the following kinds of situations:

11 For purposes of this Toolkit, we include oral and maxillofacial surgeons in the meaning of dentists.

12 However, as mentioned above, there is another category of extended class nurse who is employed by the hospital and does not hold privileges.

13 Of course, under the *Personal Health Information Protection Act*, 2004, personal health information can be disclosed to external practitioners with the consent of the patient, as required by law, or by relying on implied consent if the external practitioner is a member of what is commonly known as the patient's "circle of care". As Ontario Health Teams are implemented, external health care providers will not necessarily need hospital privileges to view hospital records using shared electronic health information systems.

	GENERALLY DO NOT NEED PRIVILEGES IF...	WILL USUALLY NEED PRIVILEGES IF...
Clinical observers	They are truly only observing (in accordance with the hospital's clinical observer policy, having signed a confidentiality agreement and having been registered with someone at the hospital to attend with them). These arrangements should be short-term in nature (i.e., measured in weeks or a few months, and not years).	Asked for clinical consult on a case or assist in the provision of treatment, e.g., "hands in the surgical field". Writing in or reviewing the clinical chart. A long-term relationship is contemplated.
Researchers	They are strictly doing research with no clinical interaction with patients.	Providing clinical care. Engaged in a clinical trial as the treating physician/researcher. Writing in the clinical chart. Some hospitals have created a special category of privileges for researchers; where such a category exists, the researcher should seek privileges.
Complementary and alternative therapy practitioners	Therapies are performed by practitioners (who are not regulated health professionals) who have been retained by patients directly. Some hospitals have introduced complementary and alternative therapy policies to address patient requests to have their personal non-regulated providers visit them in hospital. The policies can include disclaimers and releases to be signed by the patient; the hospital does not take responsibility for the care provided. The practitioner does not have access to the patient's hospital chart without patient consent; the practitioner may not document on the patient hospital chart.	Physicians, dentists, midwives or extended class nurses who are performing complementary and alternative therapies – will still need privileges in order to be part of the Professional Staff. The board must have approved their provision of alternative and complementary therapies as within their scope of privileges.
Students (not yet licensed physicians, dentists, midwives or extended class nurses) *See Chapter 12, Academic Issues.*	Generally do not need privileges but are subject to the terms of an affiliation agreement between the hospital and a university or college (which includes terms such as professional liability protection coverage (insurance), indemnity and accountability	n/a
Residents *See Chapter 12, Academic Issues.*	It depends. Some hospitals rely on the robust application process at a university and do not require residents to hold hospital privileges.	It depends. Some hospitals have a category of privileges for Residents (or House Staff) requiring them to hold privileges if they are providing patient care within the hospital.

	GENERALLY DO NOT NEED PRIVILEGES IF...	WILL USUALLY NEED PRIVILEGES IF...
Fellows *See Chapter 12, Academic Issues.*	It depends. Some hospitals rely on the robust application process at a university and do not require Fellows to hold hospital privileges. Some hospitals have Research Fellows or other types of Fellows who do not have patient care duties and do not require those groups to hold privileges.	It depends. Some hospitals have a category of privileges for Fellows (or House Staff) requiring them to hold privileges.
Retired Senior Staff Members	Mentoring and acting as a general source of information and knowledge exchange to Professional Staff members. Attending and speaking at educational events. This arrangement usually requires a contract or written terms to explain that the individual is no longer a member of the Professional Staff and expectations around privacy. Some hospitals use different coloured name badges for retired staff.	Providing clinical care. Consulting on specific cases. Writing in the clinical chart. Meeting patients.
Medical Assistance in Dying (MAiD)	It depends. Some hospitals may permit external clinicians to do remote (telehealth or through other technology) consultations at the initiation of an inpatient without privileges. The practitioner does not have access to the patient hospital chart without patient consent; the practitioner may not document directly on the patient hospital chart.	Performing or assisting with a medically assisted death within a hospital. It depends. Some hospitals require external clinicians who do remote (telehealth or through other technology) consultations at the initiation of an inpatient to have privileges before consulting or reviewing the health record to evaluate an inpatient's eligibility for MAiD. Writing in the clinical chart.
Ontario Health Team or collaborative shared care arrangements	Not providing services on behalf of a hospital Only providing services at other service sites such as long-term care home, community health centre, primary care team, home care agency etc. and not at the hospital. Seeing patients onsite at a hospital where there is an obvious and official notice that the service is being provided by a separate individual or organization that is not the hospital (such as: a pharmacy, a co-located primary care clinic, or a supportive housing service etc.) Given read-only access to a shared electronic record for the region or shared patient group.	Providing services on behalf of a hospital Seeing patients onsite at a hospital where it is the hospital's program or service Seeing patients offsite or in any other environment where the service is being provided by the hospital (such as: mobile teams, assessment clinics, telehealth services etc.) Wanting to integrate services so that external clinicians have authority to admit, discharge or treat individuals in hospital or related to hospital programs Writing in the hospital's clinical chart as part of the hospital.
Telehealth/telemedicine	It depends. Usually where patient is at your hospital, but practitioner is somewhere else (Host Hospital)	It depends. Usually where practitioner is at your hospital, but patient is somewhere else (Home Hospital)

Medical Assistance in Dying (MAiD)

With the introduction of medical assistance in dying (MAiD), hospitals have faced a new challenge of dealing with external physicians and nurse practitioners attending at hospitals to complete eligibility evaluations or perform an assisted death for an inpatient. Some hospitals have discovered that patients have engaged their own first or second consultations to determine eligibility for MAiD with external clinicians without the prior knowledge of the hospital. This may be more common in hospitals that do not provide MAiD. Some of those consultations are taking place via telephone calls and remote video meetings while others happen where the external clinician attends onsite at the hospital without notifying the hospital of their presence. Hospitals are advised to have policies to address when external physicians or nurse practitioners are required to hold hospital privileges before being permitted to perform assessments or examinations on hospital premises. Hospitals should also have educational materials to explain the process to patients and their families inquiring about MAiD. Hospitals should ensure anyone who is performing a clinical intervention or delivering MAiD on their premises has the appropriate privileges to do so.

Telemedicine/telehealth Consultants

The College of Physicians and Surgeons of Ontario defines "telemedicine" as:

> [b]oth the practice of medicine and a way to provide or assist in the provision of patient care (which includes consulting with and referring patients to other health-care providers, and practising telemedicine across borders) at a distance using information and communication technologies such as telephone, email, audio and video conferencing, remote monitoring, and telerobotics," noting that "[p]atients, patient information and/or physicians may be separated by space (e.g. not in same physical location) and/or time (e.g. not in real time).[14]

The Canadian Nurses Association uses the World Health Organization's definition of "telehealth" as:

> the delivery of health care services, where patients and providers are separated by distance. Telehealth uses ICT [information and communications technology] for the exchange of information for the diagnosis and treatment of diseases and injuries, research and evaluation, and for the continuing education of health professionals.[15]

For purposes of this Toolkit, a "telemedicine/telehealth appointment" is a clinical consultation provided by a clinician at one location (the "Home Hospital") to a patient at another location (the "Host Hospital") through the use of video and telecommunications technology.

Although telemedicine/telehealth have been utilized for decades, the law with respect to credentialing telemedicine/telehealth consultants remains unclear. Hospitals have adopted a number of differing practices regarding telemedicine/telehealth appointments. Hospitals should seek legal advice to determine how best to manage Professional Staff who are engaged in telemedicine/ telehealth appointments (as a Home Hospital) and the best arrangements to make with external consultants performing telemedicine/telehealth appointments with patients at their hospitals (as a Host Hospital).

In our view, a Home Hospital is best situated to evaluate the credentials of telemedicine/telehealth consultants in the manner set out in the *Public Hospitals Act* and in the OHA/OMA Prototype By-law, and to continually monitor the care provided by the telemedicine/telehealth consultant. It would be extremely difficult for a Host Hospital to adequately discharge any duty to credential telemedicine consultants since it has no way to observe the consultant first-hand, or conduct monitoring as necessary on an ongoing basis. However, both Home and Host Hospitals require legal and insurance advice to explain the risks and risk management strategies they should employ in order to facilitate these appointments and meet their obligations under the *Public Hospitals Act* and their Professional Staff by-law.

14 College of Physicians and Surgeons of Ontario, "Telemedicine" (April 2007, reviewed and updated December 2014), online: CPSO, <https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Telemedicine>.

15 Canadian Nurses Association, "Fact Sheet: Telehealth", (March 2018), online: CNA, <https://www.cna-aiic.ca/-/media/cna/page-content/pdf-en/telehealth-fact-sheet.pdf>.

How are Physicians Treated Differently than Dentists, Midwives and Nurse Practitioners with Respect to Hospital Privileges?

As you will read in Chapter 2, Legal Context, the *Public Hospitals Act* applies to physicians only, and not to dentists, midwives or extended class nurses. However, the regulations under the *Public Hospitals Act* allow hospital boards to pass by-laws for other Professional Staff members and, to the extent that hospitals exercise that discretion, the Professional Staff by-law typically applies the same procedural rights to all groups.[16] All hospitals that engage the services of dentists, midwives and extended class nurses should have clear credentialing rules that apply to those groups. However, it should be noted that only physicians have the right to appeal a decision of a hospital board that affects their privileges to the Health Professions Appeal and Review Board (HPARB) and then on to the Divisional Court. The *Public Hospitals Act* does not extend this right of appeal to any other members of the Professional Staff. Where there is a question about the particular procedural protections to be afforded to an individual in a specific case, the board should consult its legal counsel.

16 For example, the OHA/OMA Prototype By-law extends the procedural rights afforded to physicians under the *Public Hospitals Act* to all categories of the Professional Staff.

Overview of the Credentialing Process

"Credentialing" is commonly used as an umbrella term to capture a full range of activities and processes including: applications for initial appointments, verification of qualifications, identification of the scope and nature of privileges, granting of privileges, periodic review and annual re-appointment.

However, there are actually four aspects included under the umbrella term of credentialing:

1. **Planning:** The process of strategic planning regarding necessary Professional Staff resources.
2. **Recruitment:** The process of identifying and interviewing candidates for available positions.
3. **Credentialing:** The process of obtaining, verifying and assessing the qualifications of practitioner to provide care or services in or for a health care organization.[17]
4. **Privileging:** The process whereby a specific scope and content of patient care services (that is, clinical privileges) are authorized for a health care practitioner by a health care organization, based on evaluation of the individual's credentials and performance.[18]

To become a member of the Professional Staff, an individual must apply to the board for an appointment. If, and when an individual is appointed to the Professional Staff, the board grants a category of privileges (see above). These privileges must be renewed annually through the hospital's re-appointment process should the professional choose to re-apply for privileges.

17 This definition comes from an American source, but conveys the Canadian use of the term. See the Medical Staff Essentials: Your Go To Guide, The Joint Commission, 2017, p. 255.

18 See the Hospital Accreditation Standards (HAS), Joint Commission 2010, Joint Commission Resources, Inc. Oakbrook Terrace, IL, at GL-26.

Credentialing Process

PROFESSIONAL STAFF HUMAN RESOURCES PLANNING PROCESS

- Chiefs of Department develops annual Professional Staff Human Resources Plans with input from members of the Professional Staff
- MAC reviews the Departmental plans (and considers creating a corporate Professional Staff Human Resources Plan which includes all Departmental plans)
- Senior Management reviews the plan(s)
- MAC reviews the plan(s)
- Board approves the plan(s)

RECRUITMENT PROCESS

- Recruitment proceeds
- Interview Panel is formed
- Interview Candidate: Chief of Department, Chair of MAC and CEO or delegate completes Impact Analysis with candidate

CREDENTIALING PROCESS

- An application package is sent to the applicant
- An application is submitted to the CEO (or delegate)
- Chief of Department reviews and recommends appointment
- Credentials Committee reviews appointment

PRIVILEGING PROCESS

- Credentials Committee recommends appointment
- MAC recommends appointment → Notifies applicant
- Board approves appointment and grants privileges
- Physician/dentist/midwife/extended class nurse begins practice

Process time 60 days (or extended as necessary with reasons)

Reasons to Credential

The hospital, through its board, must exercise due diligence in all aspects of the credentialing process (from recruitment through application, appointment and re-appointment, performance evaluation, and as necessary, suspension, restriction and revocation).

Hospital Professional Staff have a direct impact on the quality of care provided in a hospital, and for that reason, there must be an effective method to ensure the hospital recruits and maintains an appropriate complement of skilled health practitioners.

A hospital's failure to properly evaluate applicants at the outset – and, once granted privileges, assess current members of the Professional Staff with some regularity – could result in harm to patients and potentially expose the hospital to liability.

Patients and their families assume that Professional Staff have been appropriately vetted by the hospitals in which they practice, and put their trust in such a process even where they are not intimately familiar with the specifics of the process. A robust credentialing program also:

- Ensures every candidate has the knowledge, skill and judgment to deliver care.
- Screens for issues that could compromise quality of care and safety.
- Ensures accuracy of documentation.
- Finds candidates who meet strategic directions and needs of the hospital.
- Ensures a general willingness to be part of a team environment and be governed by the Rules and Regulations of the hospital.
- Contributes to a positive working environment.

A sound credentialing program makes good sense for hospitals. It clarifies the hospital's expectations and processes, and creates transparency. It is also required by law. In the case of *Thannikkotu*, the Ontario Health Professions Appeal and Review Board stated:

> …the [*Public Hospitals Act*] requires the Board of the Hospital to fulfill a fiduciary duty to ensure it effectively credentials physicians in accordance with the terms of the Act, any hospital governing by-laws and patient safety. Underlying this duty is the notion that patient safety must be of paramount concern to the Board of the Hospital when making a decision regarding physician applications for appointment.[19]

As evidenced in case law (see *Chapter 2, Legal Context*), a court may find a hospital negligent for failing to appropriately credential its Professional Staff. The Health Insurance Reciprocal of Canada (HIROC) issued a Risk Reference Sheet acknowledging there has been increased litigation resulting from lapses in credentialing processes:

> As evidenced by HIROC claims and related Canadian inquests, credentialing, privileging and performance management processes are closely linked to the provision of safe and high quality patient care and more than an administrative duty of healthcare organizations. Decisions made should be based on standardized criteria and processes that are transparent, freely available, fair, balanced and equally applied to all. Consequently, inconsistent and questionable credentialing and privileging practices directly impact patient safety and the culture of an organization.[20]

In that Risk Reference Sheet, HIROC explains the following themes in litigation claims by patients against hospitals for:

- Perceived/actual 'rubber stamping' of recommendations for appointment/ reappointment by healthcare organizations

19 Thannikkotu v. Trillium Health Centre, 2011 HPARB at p. 19.

20 Health Insurance Reciprocal of Canada, Risk Reference Sheet: Inappropriate Credentialing, Re-Appointment and Performance Management, 2020 at p. 1 https://www.hiroc.com/system/files/resource/files/2020-11/Inappropriate_Credentialing.pdf

- Perceived over reliance on information from provincial/ territorial professional regulatory authorities to inform appointment and privileging decisions
- Alleged multi-patient harm incidents involving the same practitioner resulting in class actions
- Allegations that re-appointment processes did not include quality and utilization data and performance reviews
- Lack of performance evaluation processes for Professional Staff and chiefs/heads
- Alleged failure to have a robust process that asks for all pertinent malpractice claim settlements (versus those with a legal judgment) and complaints resulting in a regulatory body hearing (versus those with negative finding/undertaking)
- Perceived lack of independent verification of information provided by applicants

HIROC also noted the following themes in litigation against hospitals by their Professional Staff members for:

- Allegations that appointment, re-appointment, privileging and disciplinary decisions were unreasonable, arbitrary and/or made in bad faith
- Out-of-date professional staff by-laws
- Allegations that there was a breakdown in process for revoking privileges:
  - Not previously defined and/ or not related to quality of care issues (e.g. to resolve interdisciplinary/ conflicts among practitioners)
  - Without following due process (e.g. progressive disciplinary and natural justice)
- Perceived/actual systemic tolerance of unprofessional/ disruptive behaviour, in particular in surgical and obstetrical settings
- Lack of documentation of:
  - Discussions with credentialed staff regarding their unprofessional/disruptive behavior resulting in ongoing conflicts and denial of the conversations and the behaviour
  - The rationale to support appointment, reappointment, privileging and disciplinary decisions
- Perceived lack of independent verification of information provided by applicants

THE CASE OF DR. MICHAEL SWANGO

Dr. Michael Swango is a physician convicted in the United States of murdering four patients and is suspected of involvement in dozens of fatal poisonings of patients and colleagues over a 15-year period in the 1980s and 90s. He moved frequently and held a number of positions in different professions within health care (including as a paramedic). At a few workplaces, his colleagues raised suspicions, but there were no in-depth investigations; his colleagues either were unable to prove their concerns or he would disappear before suspicions were confirmed. He is alleged to have used an alias, forged documents, and falsified his criminal record to secure positions in a number of hospitals in different American states. Unfortunately, it is said these facilities did not rigorously review or confirm the documents he presented on initial appointment and therefore did not uncover his criminal record for poisoning or his trail of poor evaluations and disappearances under suspicious circumstances. While an extreme case, it does underscore the need for a rigorous credentialing process with checks and balances to uncover fraudulent applications.[21]

21 See J. Stewart, *Blind Eye: How the medical establishment let a doctor get away with murder*. New York: Simon & Schuster, 1999.

THE CASE OF DR. DENNIS ROARK

Dr. Dennis Roark was able to work as a physician for more than a decade in the United States and London, Ontario without having completed medical school.[22] He plead guilty in the United States to using false documents to obtain a medical license. Although he had not completed medical school, he held medical residency positions and was hired at different hospitals. His case was uncovered when he applied for a cardiac surgery position in the United States and the hospital contacted the American Medical Association for independent verification of the information in his application form about his medical school. He was not on the list. With further probing, it was discovered that he falsified his records. In response to this case, the College of Physicians and Surgeons of Ontario contacted hundreds of medical schools throughout the world to verify the educational background of all the doctors practising in Ontario. The search uncovered another person operating as a physician without proper training, Stephen Chung, who had been working as a physician in Hamilton from 1983 to 1998 without graduating from medical school. In 2002, he was given an 18-month conditional sentence after defrauding the Ontario health care system of $4.5 million.

Tips for Appropriate Credentialing

Boards and hospital management should consider the following credentialing practices:

- Boards should become familiar with their roles in credentialing and rigorously review recommendations from the MAC for appointment and re-appointment.
- Hospitals should integrate quality and utilization data with appointments and re-appointments.
- Hospitals should develop performance evaluation processes for their Professional Staff.
- Hospitals should make transparent their credentialing processes for all members of the Professional Staff and apply the same rules regardless of the Professional Staff group.
- Chiefs, Heads, or other management should allocate beds and resources exclusively based on clinical priorities.
- Hospitals should ensure new Professional Staff members do not commence provision of services until they are granted hospital privileges.
- Hospitals should streamline the credentialing process to avoid delays, minimize administrative burdens (especially for important recruits) and improve patient access to care.
- Chiefs should become familiar with progressive management and always afford members of the Professional Staff with the basic elements of natural justice to which they are entitled. *See Chapter 2, Legal Context.*
- Hospitals should ensure all applications for privileges are processed in a timely way for all Professional Staff.

Is this the Right Model?

Our current model of the relationship between Professional Staff and hospitals has come under fire recently for the costs associated with disputes. The Auditor General of Ontario commented on the complexity of the appeal process for hospitals and physicians under the *Public Hospitals Act* and has even called for a review of the physician appointment and appeal processes for hospitals and physicians under the *Public Hospitals Act.*[23] In the 2016 report, the Auditor General stated:

22 B. Sibbald, "Phoney-physician furore leads to massive credentials check" CMAJ 1998; 159 (5):557.

23 Recommendation 13 2016 Annual Report of the Office of the Auditor General of Ontario, Large Community Hospital Operations, at p. 467: "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*.

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 practice.

Physicians who work as medical staff are given hospital privileges, meaning they have the right to practice 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. …

…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 …[24]

The Auditor General provided two case examples:

Case 1: One hospital told the Auditor General that it feels stuck when it needs to make service changes or wants to transition resources between programs (for example, to shift operating room time from one type of surgery to another). If Professional Staff are affected, there is no simple mechanism to give notice to those Professional Staff and move on. 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 under the *Public Hospitals Act*. The hospital explained its relationships with physicians is more time consuming and costly than its relationships with its employees. The hospital said the *Public Hospitals Act* leaves the hospital without the flexibility to adjust physician and other staffing resources to meet changing local needs.

Case 2: A hospital reported it spent five years in administrative and legal disputes with one physician. The hospital's internal and external independent reviews found the physician hindered the functioning of the department in which he worked. The College of Physicians and Surgeons of Ontario's investigation confirmed that the physician failed to follow hospital policies. However, the hospital board was not able to refuse the physician's reappointment because the physician appealed the board's decision to the Health Professions Appeal and Review Board. The physician continued to work at the hospital for four years while the case was heard. HPARB reinstated the physician without any conditions at the conclusion of the hearing. The hospital spent $800,000 in legal fees. The hospital was eventually able to repair the hostile work environment with the physician over time.[25]

Also in the 2016 report, the Auditor General stated that the Canadian Medical Protective Association, who provides legal advice and defence to physicians, reported a 87% over 10 years of legal cases involving disputes between hospitals and their physicians from 285 such cases in 2006 to 533 cases in 2015.

24 2016 Annual Report of the Office of the Auditor General of Ontario, Large Community Hospital Operations, at pp. 465-466.

25 2016 Annual Report of the Office of the Auditor General of Ontario, Large Community Hospital Operations, at p. 466.

FAQs

1. If a physician does not have privileges, what can that physician do in the hospital?

Similar to any member of the public, the physician can visit the hospital (i.e., visit patients who are receiving visitors, and attend public lectures or other hospital events). The physician cannot access the patient's health record, sit in on clinical rounds, admit, treat, diagnose, consult or order tests, or use hospital equipment. The physician would not be permitted in areas restricted to hospital staff, and would be subject to visiting hour restrictions.

2. Can privileges be delegated or assigned?

No. Privileges attach to an individual and cannot be delegated or assigned to another person.

3. Does a physician who is employed by the hospital require privileges?

Yes. Regardless of the relationship (whether employee or independent contractor), membership in the Professional Staff always requires privileges.

Chapter 2: Legal Context

Chapter Summary

- The *Public Hospitals Act*, and Regulation 965 made under that Act, create a comprehensive framework that governs the relationship between hospitals and Medical Staff.
- In order to be a member of a hospital's Medical Staff, physicians must be given privileges by the hospital board, regardless of whether they are independent contractors or employees.
- A robust body of case law (judge-made law, also known as common law) exists in Ontario and throughout Canada that clarifies the duties owed by hospitals to their community and to their physicians.
- Regulation 965 requires hospitals with Dental Staff, Midwifery Staff or Extended Class Nursing Staff, to articulate in their by-laws the duties of these Professional Staff and the criteria with respect to their appointment and re-appointment. Hospitals may choose to extend the same credentialing and privileging rules applied to the Medical Staff to all Professional Staff and can do so through their by-laws. However, since the *Public Hospitals Act* scheme does not apply to them, Dental Staff, Midwifery Staff and Extended Class Nursing Staff do not have the same rights of appeal to the Health Professions Appeal and Review Board (HPARB) and Divisional Court accorded to physicians.
- The key legal principles that must inform all encounters with physicians – and other Professional Staff members by extension – relate to "procedural fairness" and "natural justice":
    - The member is entitled to adequate notice about the proceedings and any allegations and evidence against them.
    - The member must be given a reasonable opportunity to defend themselves and to provide their own version of events, to bring evidence, to make arguments and to cross-examine witnesses.
    - The decision-making body has a duty to act fairly and in an unbiased manner.
- Hospitals should seek legal advice when privilege disputes arise with Professional Staff to ensure that all legal processes set out in the *Public Hospitals Act* and the hospital by-laws are followed, and that procedural fairness is extended to the Professional Staff member at all stages.
- Credentialing in the context of academic health centres attracts additional legal rules. *See Chapter 12, Academic Issues.*

Understanding the Legal Context

All hospital management and board members need to be familiar with the legal context of hospital privileges.

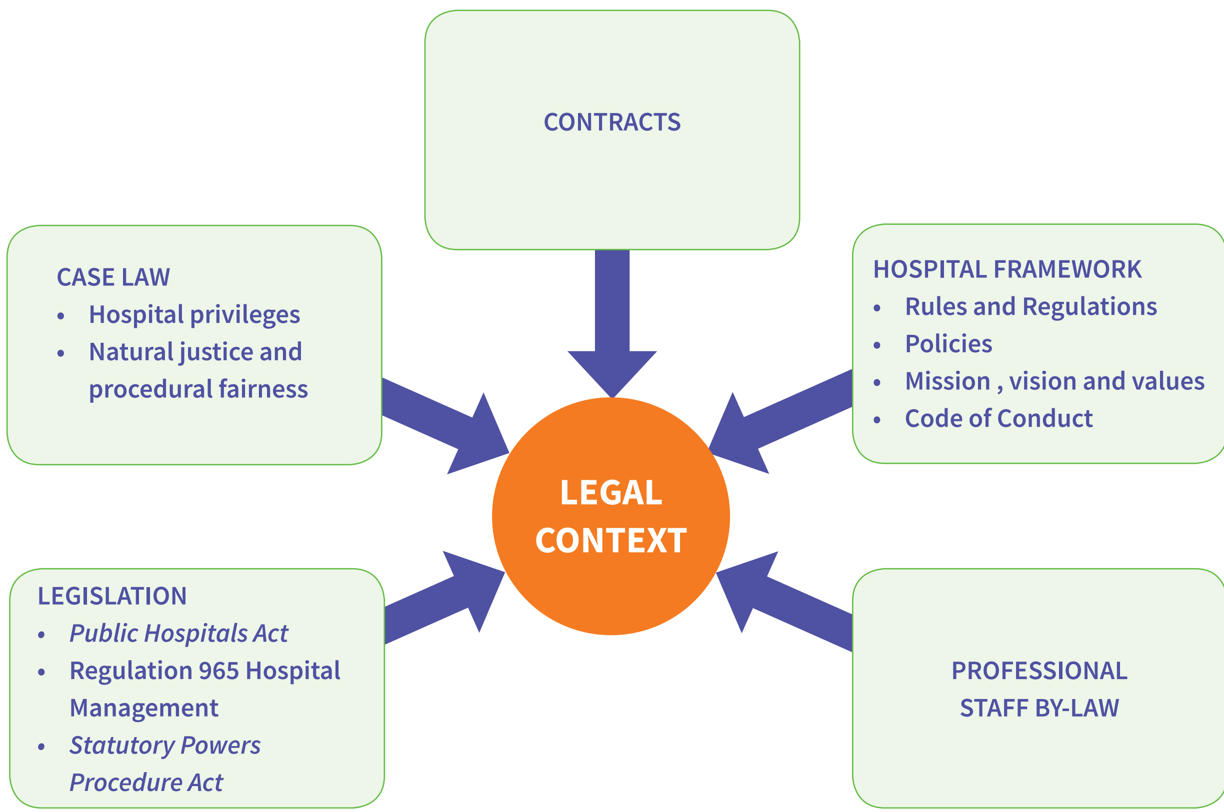
There can be serious costs and consequences for hospitals involved in privileges disputes. There are a variety of ways to manage these relationships and avoid most privileges disputes. A basic understanding of the legal context will assist hospitals in avoiding common mistakes.

Hospitals are primarily governed by provincial (and not municipal or federal) law. When addressing hospital privileges issues, a hospital in Ontario is bound by:

- *Public Hospitals Act* (see specifically the Definitions and sections 33-44) https://www.ontario.ca/laws/statute/90p40
- Regulation 965 under the *Public Hospitals Act* (see specifically the definitions and sections 2-4, 6-7.1, 18) https://www.ontario.ca/laws/regulation/900965
- *Statutory Powers Procedure Act* https://www.ontario.ca/laws/statute/90s22

- The hospital's Professional Staff by-law (so-called, if extended to Dental Staff, Midwifery Staff and/or Extended Class Nursing Staff) or Medical Staff by-law (if only relating to physicians). See the *OHA/OMA Prototype Board-Appointed Professional Staff By-law, 2011* (OHA/OMA Prototype By-law).
- Canadian case law on hospital privileges and administrative law principles of procedural fairness and natural justice.
- Contracts between the hospital and the Professional Staff member setting out respective obligations.
- The hospital's mission, vision and values, Rules and Regulations, policies, and Codes of Conduct.

See Chapter 12, Academic Issues, for additional legal considerations for credentialing in the context of academic health centres.



Public Hospitals Act

From a legal perspective, the relationship between hospitals and members of their Medical Staff[1] is a statutory relationship of privileges. There is a comprehensive scheme in the *Public Hospitals Act* explaining that a hospital board may appoint physicians to the Medical Staff, how members of the Medical Staff are to be appointed and re-appointed, and how to resolve disputes between hospitals and members of the Medical Staff about restrictions, suspensions and revocations of privileges through board hearings.

The case of Beiko[2] dealt with a group of ophthalmologists who went to court to sue for breach of contract and negligent misrepresentation when the hospital reduced their operating room time. The physicians initiated a court process for damages prior to having their appeal before HPARB finalized. The court held it did not have jurisdiction to hear a dispute about privileges without the parties having followed the statutory route in the *Public Hospitals Act* first. The court's decision nicely summarizes the *Public Hospitals Act* scheme, as articulated by Mr. Justice Morawetz:[3]

> "In my view, the Act establishes a comprehensive code under which the hospital determines privileges for a member of staff.
>
> Section 36 establishes the basis upon which the board (defined in the Act) may determine hospital privileges. Having undertaken that responsibility, it follows that issues relating to privilege are determined in accordance with the provisions of ss. 36-43. Although the board has not specifically been granted the power to award monetary damages, it does have the power to establish a MAC, which has the authority to consider and make recommendations to the board respecting any matter referred to it under s. 37 and perform such other duties as assigned to it by or under this or any other Act or by the board.
>
> Every application in respect of privileges is to be submitted to the administrator who immediately refers such application to the MAC.
>
> The MAC in turn makes recommendations in respect of each application in writing to the board. The MAC also gives written notice to the applicant and to the board of its recommendation. Thus, an applicant can then require a hearing by the board in accordance with subsection 37(7). At a hearing by the board, the person requiring the hearing is afforded an opportunity to examine before the hearing any written or documentary evidence that will be produced at the hearing.
>
> Any member of the medical staff of a hospital who considers himself or herself aggrieved by any decision which substantially alters his/her privileges is entitled to written [reasons] of the decision and a hearing before the Appeal Board [HPARB].
>
> The procedures in respect of a hearing before the board also apply to a hearing before the Appeal Board. The Appeal Board has the authority to substitute its own opinion for that of the board, person or body making the decision appealed from.
>
> There is a further procedure available to any party to appeal from the decision of the Appeal Board to the Divisional Court, which appeal may be made on a question of law or fact or both and the Court may substitute its opinion for that of the Appeal Board."

The *Public Hospitals Act* scheme has a provision that addresses scenarios where a Medical Staff member disagrees with a privileges decision taken by the hospital or hospital board. Physicians must first seek recourse using their rights and remedies under the *Public Hospitals Act*. They will usually be turned away by courts if they try instead to circumvent the *Public Hospitals Act* process and go directly to the civil legal system to seek redress (such

1 The *Public Hospitals Act* does not refer to other members of the Professional Staff such as Dental Staff, Midwifery Staff or Extended Class Nursing Staff. However, the *Public Hospitals Act* Regulation 965 acknowledges these clinicians and requires that hospitals with these Professional Staff groups outline their relationship with their hospital through their by-laws.

2 *Beiko* v. Hotel Dieu Hospital St. Catharines, [2007] O.J. No. 331 (Sup. Ct. Jus.).

3 *Beiko* at paras. 45-52, pp. 9-10.

as breach of contract legal claims, as in Beiko).[4] Both the physician and the hospital may appeal board decisions to HPARB,[5] and further, to the Divisional Court.[6] Aggrieved members of the Medical Staff can also take HPARB decisions in their favour to court, to seek damages from a hospital.

The key provisions of the *Public Hospitals Act* relating to the credentialing process are identified below:

- The hospital board must establish the Medical Advisory Committee (MAC) with members of the Medical Staff.[7]
- Only the hospital board may appoint physicians to the Medical Staff, determine the scope and type of privileges granted, and revoke, suspend or refuse to appoint a physician.[8]
- Every physician is entitled to apply for appointment or re-appointment to the hospital's Medical Staff, and the CEO must supply an application form to a physician on written request.[9]
- Every appointment to the Medical Staff is limited to not more than one year. [10]
- Every application for appointment to the Medical Staff must be immediately referred to the MAC and considered within 60 days (the 60-day period can be extended by the MAC on written notice to the applicant and the board, with reasons).[11]
- The MAC must give written notice of its recommendation to the applicant and the board.[12]
- The applicant is entitled to a hearing before the board. [13] However, if an applicant does not request a hearing, no hearing is held and the recommendation of the MAC may be accepted by the board. *See Chapter 9, Refusing Appointments and Re-appointments and Suspending, Restricting or Revoking Privileges.*
- Section 39 sets out the rules that apply to a board hearing.
- When a physician has applied for re-appointment within the prescribed time, their appointment continues until re-appointment is granted or, if the board refuses to grant the re-appointment, until the HPARB appeal process is completed if it proceeds to HPARB.[14]
- The board has the power to close the hospital or close a service with no right of an affected physician to a board hearing.[15]

The *Public Hospitals Act* scheme is explained throughout this Toolkit. *See also Chapter 3, Roles and Responsibilities, for a detailed listing of the role of each stakeholder in the privileges process.*

4 Note though the decision of the Ontario Court of Appeal in *Kadiri v. Southlake Regional Health Centre, 2015* ONCA 847 (CanLII) where the Court said whether a physician has followed through with the statutory privileges dispute-resolution process under a hospital's bylaws and the *Public Hospitals Act* will turn on the specific facts of each case. Depending on the specific circumstances of a case, proceeding to a hearing before the HPARB may or may not be required of the physician. In the *Kadiri* case, the physician was not required to go to HPARB before bringing his action in court because (i) Dr. Kadiri and the Hospital had worked out an arrangement to deal with their dispute and (ii) at the time Dr. Kadiri commenced his lawsuit, he had returned to a full practice at the Hospital with full privileges.

5 Section 41.

6 Section 43.

7 Section 35.

8 Section 36.

9 Section 37(1).

10 Section 37(2).

11 Section 37(3) - (5). See Waddell v. Weeneebayko, 2018 CanLII 39843 (ON HPARB) at para 86 where HPARB reviewed a situation where a hospital did not consider a physician's application within 60 days from the date of the application but concluded that was primarily due to the physician's actions and confusion over whether the physician was re-applying for privileges or not.

12 Section 37(6).

13 Section 39(1).

14 Section 39(3). Note that this right to maintain an appointment does not apply where privileges are revoked or suspended.

15 Section 44. This section removes the usual *Public Hospitals Act* procedural entitlements with respect to privileges decisions where a board (or the Minister of Health) determines the hospital will cease to operate as a public hospital or cease to provide a service.

It is important to remember that the *Public Hospitals Act* privileges scheme applies even when physicians are employees of the hospital. Some hospitals for historical or strategic reasons, employ all their Medical Staff or specific types of physicians (e.g., pathologists). When a physician has privileges and is an employee, the employment relationship can be terminated for just cause or with appropriate notice, per employment law.[16] But the physician retains their privileges, and those privileges can only be terminated through the process set out in the *Public Hospitals Act.*

Where an employment relationship has been terminated, it may be contemplated that the individual continue as an independent contractor and maintain their privileges.

The relevant excerpts from the *Public Hospitals Act* are included in AppendixII.

Hospital Management Regulation 965

Regulation 965 under the *Public Hospitals Act* provides further details about the roles and responsibilities of the MAC and references that a hospital may have privileged Dental Staff, Midwifery Staff, and Extended Class Nursing Staff.

Regulation 965 sets out that the board must establish the criteria for appointment and re-appointment of Medical Staff in the by-laws; and when the hospital has Dental Staff, Midwifery Staff or Extended Class Nursing Staff, their criteria for appointment and re-appointment must be identified.[17]

The Regulation also identifies which physicians must be on the MAC (only physicians may vote at the MAC):

- President of the Medical Staff;
- Vice-President of the Medical Staff;
- Secretary of the Medical Staff;
- Chief of Staff (or a physician on the MAC who is appointed as Chair of the MAC);
- If the hospital is a Group A hospital,[18] the Chief of Dental Staff, if any; and
- Other physicians appointed in accordance with the by-laws.[19]

The MAC has an obligation to make recommendations to the board on various privileges matters, including:

- Every application for appointment or re-appointment of Dental Staff, Midwifery Staff or Extended Class Nursing Staff;
- What privileges to grant to Dental Staff, Midwifery Staff or Extended Class Nursing Staff; and
- Dismissal, suspension or restriction of privileges of all Professional Staff members.[20]

The MAC is also responsible under Regulation 965 for making the following recommendations to the board:

- By-laws respecting all Professional Staff;
- Clinical and general rules relating to all Professional Staff;
- Quality of care provided by all Professional Staff;
- The supervision of the practice of medicine, dentistry, midwifery and extended class nursing by the Professional Staff members;[21] and
- Where the MAC identifies systemic or recurring quality of care issues in making its recommendations to the board under sub-clause (2)(a)(v), it shall also make recommendations about those issues to the board's Quality Committee.[22]

16 *Ready v Saskatoon Regional Health Authority*, 2017 SKCA 20.

17 Section 4(1)(b).

18 Public hospitals are classified into different groups according to size and function; see *Public Hospitals Act*, R.R.O. 1990, Reg. 964, "Classification of Hospitals".

19 Section 7(1).

20 Section 7(2) - Note that these MAC obligations apply only with respect to Extended Class Nursing Staff who are not employees.

21 Section 7(2) - Note that these MAC obligations apply with respect to Extended Class Nursing Staff, both employees and independent contractors.

22 *Public Hospitals Act*, R.R.O. 1990, Reg. 965, s. 7(7).

Regulation 965 also creates a process for transferring patient care when a member of the Professional Staff is unable to perform their professional duties. In such a case, the Professional Staff member must arrange for another member of the Professional Staff to take over care of the patient, and that transfer of care must be duly noted in the patient's health record.[23] If the hospital's administrator (CEO) believes that a member of the Professional Staff is unable to perform their duties with respect to a patient, the CEO has a duty to notify:

- The Chief of Staff/Chair of the MAC
- In the case of a physician, the President or Secretary of the Medical Staff
- In the case of a member of the Extended Class Nursing Staff, the Chief Nursing Executive[24]

Board Membership

Regulation 965 prohibits any employees or members of the Medical Staff, Dental Staff, Extended Class Nursing Staff or Midwifery Staff from being voting directors on the board; as such, these individuals can only be non-voting members. This regulation requires the CEO, Chief of Staff, Chief Nursing Executive and the President of the hospital's Medical Staff to sit as members of the board.

The relevant excerpts from Regulation 965 are included in Appendix II.

Statutory Powers Procedure Act

The *Statutory Powers Procedure Act* [25] is an Ontario statute that prescribes procedural rules for tribunal proceedings; this includes hospital board hearings where privileges decisions are under review.

Some procedural rules under the Act are mandatory. For example, the Act requires that a Professional Staff member be provided with reasonable information of any allegations, prior to a hearing, where their good character, propriety of conduct or competence is an issue in the proceeding.[26]

The Act also creates discretionary powers that the hospital board may choose to utilize. For example, a hospital board may admit oral testimony and "any document or other thing, relevant to the subject-matter of the proceeding."[27] A hospital board may also "take notice" of certain facts, meaning it can consider facts that have not been proven by the parties through evidence. Examples of such facts include generally recognized scientific or technical facts.[28]

Procedural requirements under the Act may be waived with the consent of the parties and the board;[29] this includes foregoing a hearing altogether.[30] Further flexibility can also be attained if the board creates its own rules. Such rules may address procedures such as pre-hearing conferences, electronic hearings and alternative dispute resolution. [31]

Hospitals should seek legal advice to establish the procedural rights for their privileges hearings.

By-laws

This Toolkit references and relies on the OHA/OMA Prototype By-law. If a hospital has not adopted the by-law or has customized it to suit their unique situation, the hospital's own by-laws need to be considered in the context of all privileges matters. It is important to adapt any of the sample documents offered in this Toolkit to individual organizational contexts.

The *Public Hospitals Act* requires that hospital by-laws include provisions for the organization of the Medical Staff in the hospital. Regulation 965 under the *Public Hospitals Act* also requires that, if a hospital has a Dental Staff,

23 Section 18(1) and (2).

24 Section 18(3). Although not mentioned in the *Public Hospitals Act*, for dentists, the CEO might contact the Head of the Dentistry Division/Department, and for midwives, the CEO might contact the Head of the Midwifery Division/Department.

25 *Statutory Powers Procedure Act,* R.S.O. 1990, c. S.22

26 Section 8.

27 Section 15(1).

28 Section 16(b).

29 Section. 4(1).

30 Section 4.1.

31 Sections 4.7 and 5.2.

Midwifery Staff or Extended Class Nursing Staff, the by-laws must set out the duties of the staff and the criteria with respect to their appointment and re-appointment.

Hospitals must keep in mind that the rights to a board hearing[32] and to appeal board decisions to HPARB and Divisional Court apply only to members of the Medical Staff. Those rights do not extend to the other Professional Staff members. The OHA/OMA Prototype By-law applies much of the *Public Hospitals Act* scheme for Medical Staff to other Professional Staff members, e.g., one-year appointments to the Professional Staff and the right to a hearing before the board if the applicant requests, after receiving the MAC's recommendation with respect to privileges. This is a decision each hospital must make. Of course, a hospital cannot extend to the other Professional Staff members the right to appeal board decisions to HPARB and then to Divisional Court – only legislation can do that.

This Toolkit generally assumes that the right to a board hearing has been extended to Dental Staff, Midwifery Staff, and Extended Class Nursing Staff, as we would consider that best practice.

While each hospital's Professional Staff by-law will be different, in general terms, the by-law will cover such things as:

- The hospital's criteria for appointment and re-appointment to the Professional Staff. For example, licence to practice, professional liability protection (insurance), appropriate references, and appropriate specialist qualifications where applicable.
- The different categories of Professional Staff (e.g., active staff, associate, courtesy staff, etc.) and the rights and responsibilities that attach to those categories (e.g., right to admit patients, responsibility to attend Departmental meetings).
- Where the hospital is organized into Departments, the different Departments (e.g., surgery, emergency, pediatrics, etc.) and the clinical leaders within those Departments.
- The process to be followed to fulfill each of the requirements of the *Public Hospitals Act*:
  - Handling of initial applications
  - Process for granting initial appointments
  - Process for granting annual re-appointments
  - Process for approving changes in privileges
  - Steps to be taken when it is considered necessary to restrict, suspend or revoke an appointment (including urgent mid-term action)
- Administrative matters, such as granting leaves of absence, monitoring practice and transferring care from one Professional Staff member to another.

Hospital Rules and Regulations

Hospital Rules and Regulations, policies, mission, vision and values, Codes of Conduct and medical directives also contribute to the legal context within which Professional Staff members work.

While not every hospital has written Professional Staff Rules and Regulations, hospitals should consider addressing the following topics in written form:

- Board privileges hearings
- Chief of Staff/Chair of the MAC selection process
- Code of Conduct
- College reporting obligations
- Continuing professional education expectations
- Delegation of controlled acts
- Dispute resolution
- Effective referrals
- Health records content and completion
- Job descriptions for clinical leaders (Chiefs of Department, Chief Nursing Executive)

32 For clarity, "board" refers to the hospital board, and "HPARB" refers to the Health Professions Appeal and Review Board, a provincial tribunal that hears appeals concerning physicians' hospital privileges under the *Public Hospitals Act*.

- Leave of absence
- *Locum Tenens* appointments
- Maintaining Professional Staff files
- Medical directives
- Most Responsible Clinician/Transfer of Care
- Occupational health and safety policies regarding immunizations, screenings and tests
- On-call guidelines
- Participation on committees
- Requests to reduce on-call coverage
- Supervision of students and trainees
- Suspension/restrictions/revocation of privileges policy
- Telehealth and remote consultations and procedures
- Utilization expectations
- Vacations/sick days
- Whistleblower protection

As with by-laws, Rules and Regulations should be reviewed on a routine basis (e.g., every three years) to ensure they reflect or are consistent with:

- Any updates to the hospital's by-laws
- Any changes to the *Public Hospitals Act* that could impact operationally on the Professional Staff
- Actual practice within the hospital
- Restructuring within the hospital and its clinical leadership
- New legislative requirements, such as critical incident reporting under Regulation 965
- Best practices within the industry

To be effective, these Rules and Regulations, policies, Codes of Conduct and medical directives must be easily accessible to members of the Professional Staff. They should be mentioned during any orientation for new Professional Staff Members and available online, if possible, through a hospital intranet or portal.

If problems arise with a member of the Professional Staff, they should be directed to the relevant Rules and Regulations to assist them in understanding the expectations of the hospital.

Contracts

As stated above, most Professional Staff members are independent contractors, not hospital employees. While not mandatory, the parties may choose to document their understanding of their relationship in a formal written contract.

In some cases, hospitals and Professional Staff recruits will enter into formal written contracts that document each party's roles and responsibilities and reflect any promises or negotiations made as part of the recruitment process. This contract supplements the contract created by the privileges process.

Many contracts are in writing, but it is important to realize that verbal contracts can also be legally binding. Written contracts are preferred as they stand as concrete evidence, clearly detailing terms and conditions that will be enforceable should disputes arise, and often setting out consequences and damages to be assessed if the contract is broken.

No contract should be signed until the board has granted privileges.

Written contracts with recruits may address the following matters:

- Nature and scope of privileges granted
- Category of staff (associate staff, active staff, courtesy, *Locum Tenens*)
- Probationary periods (if any)
- Accountability (e.g., to Chief of Department)
- Whether the Professional Staff member will be supervised
- Whether the Professional Staff member will have leadership responsibilities
- On-call commitments
- Participation in existing alternate payment plans
- Recruitment incentives, such as office space, administrative support, moving expenses, and signing bonuses (*see Chapter 4, Planning and Recruitment*)
- Termination clause

See also Chapter 5, Initial Appointment, for letters of offer for initial appointments.

Contracts may also be entered into under the following circumstances:

- Many hospitals enter into agreements with those holding Professional Staff leadership positions (e.g., Chief of Staff/Chair of the MAC or Chief of Department). Such agreements should document certain elements of the arrangement, such as the compensation/stipend paid by the hospital for the position, term and termination provisions, and the scope of duties. In particular, any additional duties and the reporting relationship for those duties should be included as part of such an agreement.
- Where a physician, dentist, or midwife is an employee of the hospital, a written employment agreement is recommended. A common provision in these agreements is that if the individual's privileges are revoked, the employment relationship ends (unless the employee has other non-clinical duties that could continue). However, hospitals should remember that privileges cannot be terminated using notice provisions in an employment contract. The only way privileges can be revoked is using the legal process under the *Public Hospitals Act*. As a reminder, Regulation 965 under the *Public Hospitals Act* differentiates between extended class nurses who are employees and extended class nurses who have privileges and are not employees.

Affiliation Agreements

Academic health sciences centres are formally affiliated with universities that have medical schools, through a written affiliation agreement. Affiliation agreements typically include elements that require:

- Certain members of Professional Staff to hold an appointment at the university, and if they lose that appointment they cannot be on the hospital's Professional Staff (or if they lose their hospital appointment they cannot be on the university faculty).
- Hospitals and Professional Staff must abide by certain university policies when issues arise within the hospital environment that involve cross-appointed faculty and/or students (such as harassment policies).
- Disclosure of information about any actions taken by either the hospital or the university that may affect the appointment of the Professional Staff member.
- Other affiliation agreements may be entered into with universities or colleges that do not have a medical school (e.g., where the agreement is between the college and the hospital to place the college's students in a clinical setting).

See Chapter 12, Academic Issues, for more information about the academic context.

Case Law

While the *Public Hospitals Act*, Regulation 965, and the hospital by-laws set out the comprehensive code to follow with respect to hospital privileges, case law from HPARB, Ontario courts and other Canadian courts interpret the rules through actual events. There are hundreds of cases that interpret rules about hospital privileges and that clarify the rights and responsibilities of the Professional Staff members, hospitals, administrators and boards.

The case law focuses on physicians, as opposed to other members of the Professional Staff. As previously mentioned, Dental Staff, Midwifery Staff and Extended Class Nursing Staff have no statutory right to appeal hospital board decisions; as such, they are not the focus of case law (but the principles of the case law would nonetheless apply).

There are a wide range of procedural rights and issues that can arise in the context of hospital privileges disputes. It is not possible to canvass all those issues here.

The main themes that emerge from privileges case law are:

1. Hospitals owe a duty of care to their patients (and staff).

Hospitals have an obligation to under the *Public Hospitals Act* and its regulations to provide competent medical personnel and appropriate facilities to their patients.[33] A hospital is not responsible for negligence of the physicians

33 *Yepremian et al v. Scarborough General Hospital*, (1980) 110 D.L.R. (3d) 513 (Ont. C.A.).

who practice in the hospital, but it is responsible to ensure that physicians or staff are reasonably qualified to do the work they might be expected to perform.[34]

CASE OF YEPREMIAN V. SCARBOROUGH GENERAL HOSPITAL (Ontario Court of Appeal, 1980)

In *Yepremian*, the plaintiff had a cardiac arrest and suffered brain damage. The plaintiff claimed damages against a doctor and the hospital where he had received care. The plaintiff claimed that the hospital should be liable for the negligent medical care of its physician. The Court of Appeal held that the hospital was not vicariously liable for the actions of its physician, but that a hospital would be responsible if it does not appropriately select its medical staff. The Court of Appeal wrote:

> "I think,a member of the public who knows the facts is entitled to expect that the hospital has picked its medical staff with great care, has checked out the credentials of every applicant, has caused the existing staff to make a recommendation in every individual case, makes no appointment for longer than one year at a time, and reviews the performance of its staff at regular intervals. Putting it in layman's language, a prospective patient or his family who knew none of the facts, would think: 'If I go to Scarborough General, I'll get a good doctor.'"

Hospitals also have an obligation to provide safe and effective care to their patients and create safe working environments for their staff – these are the primary obligations of hospitals and supersede any professional's right to practice.

Not all hospitals are held to the same standard of care. There is case law recognizing that some smaller community hospitals and their physicians are not held to the same standard of care as larger teaching centres:

34 Ibid.

> The evidence is that these criteria and the professional staff to meet them were at a higher level in large teaching hospitals in other parts of Canada, but in my view the Defendant Moncton hospital must be judged by the standards reasonably expected by the community it serves, not communities served by large teaching facilities.[35]

It is best to err on the side of caution and make credentialing decisions with the utmost care, fairness and thoughtfulness, not only for the protection of the patients, but also to protect the hospital and its board from liability.

2. Hospitals owe procedural fairness and natural justice to members of their Professional Staff (and individuals applying for membership).

While no one has a right to be granted hospital privileges,[36] hospitals are responsible for following the *Public Hospitals Act*, Regulation 965, and their own by-laws when dealing with issues of appointment, re-appointment, and changes to privileges and when managing suspensions, restrictions or revocation of privileges.

Administrative law governs agencies that have the legal authority to make decisions that can affect others – such as hospital boards. Directors who sit on hospital boards have been vested with important power and must uphold certain principles in order to use this power responsibly. Two of these principles are **natural justice** and **procedural fairness**.

Natural justice means justice that is defined in a moral sense – what is fair – as opposed to legal justice grounded in the law. Natural justice encompasses the ideas that an individual has the right to adequate notice about proceedings and to be heard by an impartial decision-maker.

35 *Bateman v. Doiron* [1991] N.B.J. No. 714, aff'd (1993), 141 N.B.R. (2d) 321 (N.B.C.A.).

36 In the 2010 Rosenhek decision, Justice Greer stated, "No physician has a right to hospital privileges. Patient safety and quality of care are the paramount concerns when making a decision with respect to physician privileges." *Rosenhek v. Windsor Regional Hospital* [2010] O.J. No. 2893 (Sup. Ct. Jus.) at 33.

Procedural fairness, or due process, is a twin concept to natural justice. It is a duty of decision-makers to ensure procedural fairness in the circumstances, including:

- The nature of the decision being made and process followed in making it.
- The nature of the statutory scheme and the terms of the statute pursuant to which the body operates.
- The importance of the decision to the individual or individuals affected.
- The legitimate expectations of the person challenging the decision.
- The choices of procedure made by the agency itself.[37]

Specifically, within the credentialing process, procedural fairness is owed by the hospital to the Professional Staff member:

- The Professional Staff member has a right to receive notice of the allegations against them.
- The Professional Staff member has a right to present their case before the board, to present witnesses, to review documentation in advance, and to cross-examine witnesses.
- The Professional Staff member has a right to have a fair, impartial, open decision-making process.

Procedural fairness is a major reason why a board cannot act as a "rubber stamp" of the MAC's recommendation. It must instead "bring an independent responsible and committed approach to the review process."[38] Members of the MAC and the Credentialing Committees must bring this same commitment to the process.

Through the *Public Hospitals Act*, physicians who feel aggrieved by an appointment or re-appointment decision or with respect to the suspension, restriction or revocation of their privileges are given the right to a hearing before the hospital board. They can raise procedural fairness and natural justice issues at that time. They may also raise fairness issues before HPARB and after that to the courts, if necessary.

To illustrate the importance of natural justice and procedural fairness, consider the case of *Rosenhek v. Windsor Regional Hospital*.[39] In 1989, the hospital board revoked Dr. Rosenhek's privileges without providing him with an opportunity to respond. In 2007, the Ontario Superior Court of Justice found that there was bad faith and a denial of natural justice on the part of the hospital board. The court also found that Dr. Rosenhek experienced economic loss as a result of the manner in which his privileges were revoked. The Court awarded the physician three million dollars in damages.

Natural justice and procedural fairness simply reflect common sense. As the Ontario court has described:

"The requirements of natural justice could be easily satisfied. The doctor could be provided with the nature of the complaint, in advance. The doctor could then have the report and opportunity to question the complainant regarding the allegations. The doctor could appear before the Medical Advisory Committee and state his or her position. The Medical Advisory Committee could make their recommendation based upon the evidence before them. As long as the committee members are not biased or have a conflict then they should be able to make reasoned recommendations to the Hospital board. Due to the nature of the composition of hospital boards they would probably follow the recommendations of their Medical Advisory Committee, unless there is good reason not to follow the recommendation."[40]

37 *Baker v. Canada (Minister of Citizenship and Immigration)*, [1999] 2 S.C.R. 817.

38 *Cimolai v. Children's and Women's Health Centre of British Columbia*, [2006] B.C.J. No. 2199 (S.C.), at 60.

39 *Rosenhek v. Windsor Regional Hospital* [2007] O.J. No. 4486 (Sup. Ct. Jus.).

40 *Zahab v. Salvation Army Grace General Hospital – Ottawa* [1991] O.J. No. 763 (Ct. J. (Gen. Div.)).

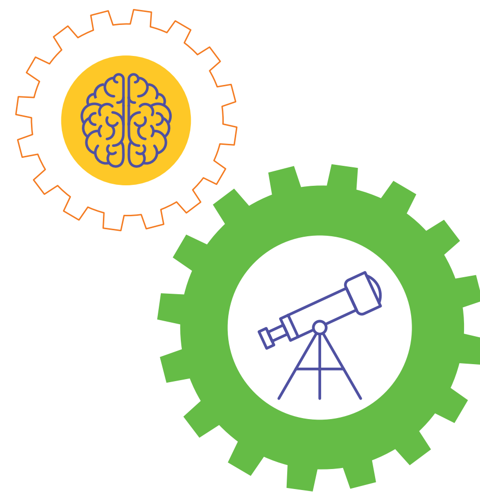
3. The *Public Hospitals Act* sets out a comprehensive code for addressing privileges issues.

Occasionally, physician plaintiffs will initiate legal actions outside the *Public Hospitals Act* scheme, such as wrongful dismissal, constructive dismissal or breach of contract lawsuits against hospitals. Unless there is a clear and entirely separate matter to be resolved, the courts generally discourage physician plaintiffs from initiating legal actions outside the *Public Hospitals Act* scheme.

In the cases of Drs. Fornazzari and Bagheri in Ontario,[41] two physicians claimed damages for breach of contract against the same hospital, alleging constructive dismissal because the hospital introduced a new physician compensation model. In almost identical decisions, the Superior Court of Justice held:

> "Section 41 of the [*Public Hospitals Act*] sets out a comprehensive code to deal with disputes arising from decisions not to appoint or re-appoint or decisions which change or substantially alter an individual's hospital privileges. It states that the person is entitled to written reasons from the board, a hearing before the Appeal Board and ultimately, the [*Public Hospitals Act]* provides a right to appeal the [Health Professions Appeal and Review Board] decision to the Divisional Court. In my view, given that the Plaintiff's argument with CAMH concerns the alteration of her compensation, which arises from her application for re-appointment, the proper process for her to follow is that set out in the legislation, specifically s. 41 of the [*Public Hospitals Act*]. It seems to me that whether the proposed change to the compensation model constitutes a substantial alteration to the privileges of the doctors would be exactly the sort of question the specialized board ought to be determining."[42]

Justice Morawetz (who also presided in the *Beiko* case that introduced this Chapter) concluded that the court did not have jurisdiction to usurp the statutory regime of the *Public Hospitals Act* on issues relating to privileges. He concluded that, following the statutory process, it is open to applicants to bring an action for damages. He also stated that strictly employment or contractual issues between hospitals and physicians could be dealt with by the courts.



41 *Bagheri v. Centre for Addiction and Mental Health*, 2010 ONSC 2886, [2010] O.J. No. 2050, (Sup. Ct. Jus.) and *Fornazzari v. Centre for Addiction and Mental Health*, 2010 ONSC 2884, [2010] O.J. No. 2056 (Sup. Ct. Jus.).

42 *Fornazzari v. Centre for Addiction and Mental Health*, 2010 ONSC 2884, [2010] O.J. No. 2056 (Sup. Ct. Jus.) at 7; *Bagheri v. Centre for Addiction and Mental Health*, 2010 ONSC 2886, [2010] O.J. No. 2050, (Sup. Ct. Jus.) at 7.

Chapter 3: Roles and Responsibilities

Chapter Summary

- While other chapters in this Toolkit organize credentialing responsibilities by task, this chapter summarizes those responsibilities by role (for example, a board member or Chief of Department can turn to their "role" in this chapter and see a summary of all the responsibilities commonly assigned to that role).
- This chapter identifies common roles and key players. It is acknowledged that each hospital may identify different positions to fulfill the listed responsibilities and will adapt the roles and listed responsibilities to its specific situation.
- Under each of the "roles", we have summarized the possible "responsibilities" that can be assigned to that role. Only where we have indicated by the acronym PHA for *Public Hospitals Act* or its Regulation 965, or RHPA for *Regulated Health Professions Act,* 1991, is the responsibility mandatory. Otherwise, hospitals may wish to assign the list of responsibilities to reflect their own by-laws and practices.
- The lists of responsibilities align with the *OHA/OMA Prototype Board-Appointed Professional Staff By-law, 2011* (OHA/OMA Prototype By-law) and common practices of hospitals.
- Hospital by-laws may assign additional responsibilities that go beyond the legislation.
- Hospitals can exercise discretion in assigning many of the tasks in the credentialing process so long as the board makes the final decisions.

Overall Responsibility

The following Table lists credentialing tasks covered in this Toolkit and provides examples of the role(s) commonly assigned to complete each task.

TASK	COMMONLY ASSIGNED TO:
Recruitment (Chapter 4)	Chiefs/Heads
Impact Analysis (Chapter 4)	Chiefs/Heads
Applications (Chapter 5 & 6)	CEO receives application
Credentialing (Chapters 5 & 6)	Credentials Committee
Initial appointment (Chapter 5)	• Chiefs/Heads recommend appointments • Medical Advisory Committee (MAC) recommends appoint-ments • Board decides appointments
Re-appointment (Chapter 6)	• CEO receives re-appointment applications • Chiefs/Heads recommend re-appointments • MAC recommends re-appointments • Board decides re-appointments
Performance Reviews (Chapter 8)	Chiefs/Heads

TASK	COMMONLY ASSIGNED TO:
Progressive Management/Discipline (Chapter 8) - Warning - Reprimand - Supervision - Required additional training	Chiefs/Heads (in consultation with Chief of Staff/Chair of MAC)
Administrative Suspensions (Chapter 9)[1]	• Chief of Staff/Chair of the MAC recommends suspensions • MAC reviews suspensions • Board decides suspensions
Immediate Mid-Term Suspensions (Chapter 9)	• Chief of Department or CEO or Chief of Staff/Chair of the MAC • MAC reviews mid-term suspensions on an urgent basis • Board decides on mid-term suspensions on an urgent basis
Non-Immediate Mid-Term Suspensions (Chapter 9)	• CEO or Chief of Staff/Chair of the MAC or Chief of Department (or their delegates) recommends non-immediate mid-term suspensions • MAC reviews non-immediate mid-term suspensions • Board decides non-immediate mid-term suspensions
Decision to Restrict, Suspend or Revoke Privileges (Chapter 9)	• Chiefs/Heads recommend decisions (internal or external investigation) • MAC reviews and recommends decisions • Board makes final decision
Resignation and Retirement (Chapter 10)	Chiefs/Heads

Chapters 4 to 10 of this Toolkit explore these tasks in more detail. They identify the source of the legal requirements and offer recommendations for best and innovative practices in these areas.

1 Some hospitals have policies that contemplate "administrative suspensions", which are suspensions for acts such as failing to pay regulatory College dues and having a lapse in licensure, failing to maintain professional insurance, failing to meet occupational health and safety obligations (e.g., mask fit testing, cardio-pulmonary resuscitation, tuberculosis testing), or failing to rectify health records deficiencies after being notified. There is no legal requirement to include administrative suspensions.

Board

The **board** is commonly responsible for:

1) Appointing and re-appointing the Medical Staff, as well as revoking or suspending appointments and cancelling or suspending any member of the Medical Staff who no longer meets the hospital's qualifications or who contravenes any applicable by-laws, rules, regulations or statutes (PHA).

2) Appointing and re-appointing other members of the Professional Staff (i.e., dentists, midwives and extended class nurses), where the by-laws provide for these types of Board-Appointed Professional Staff members.

3) Determining the scope of any privileges granted to a member of the Professional Staff (PHA).

4) Reviewing temporary appointments made by the CEO and recommended by the MAC to continue (PHA).

5) Holding hearings on Medical Staff privileges issues (and on privileges issues relating to other members of the Professional Staff, where the by-laws provide for these types of Board-Appointed Professional Staff members) (PHA).

6) Complying with the rules for privileges hearings established by the *Public Hospitals Act* (PHA).

7) Representing the hospital at appeals to the Health Professions Appeal and Review Board (HPARB) in Medical Staff privileges matters (PHA).

8) Approving Rules and Regulations for the Professional Staff.

9) Approving policies and procedures that are applicable to the Professional Staff.

10) Making decisions about the granting of a leave of absence for Professional Staff where there will be a suspension or restriction of privileges (or, alternatively, approving a leave of absence policy to be administered by the Chief of Staff/Chair of the MAC).

11) Monitoring activities in the hospital and taking such measures as it considers necessary to ensure compliance with the *Public Hospitals Act*, its regulations and the hospital by-laws (PHA).

12) Passing by-laws to set standards for appointing and re-appointing members of the Professional Staff (PHA).

13) Appointing the Chief of Staff (if there is one) who chairs the MAC (or appointing a member of the MAC to act as Chair of the MAC) (PHA).

14) Establishing the MAC to assess credentials, health records, patient care, infection control, the utilization of hospital facilities and all other aspects of health care and treatment at the hospital (PHA).

15) Determining through the by-laws whether the MAC will include non-Medical Staff members (without a vote), in addition to the voting Medical Staff members on the MAC.

16) Establishing sub-committees of the MAC, and appointing non-Medical Staff members of those sub-committees as appropriate (PHA).

17) Receiving reports from the MAC through its Chair respecting the work of the MAC.

18) Determining departmental and divisional structures, if any (PHA).

19) Appointing the Chiefs of Department, if any (PHA).

Key messages for **boards:**

- Professional Staff credentialing is one of the most important duties the board fulfills in a hospital.
- The board ultimately makes any decisions about Professional Staff privileges: categories and scope of privileges; appointment; re-appointment; changes to privileges; and suspension, restriction or revocation of privileges.
- While the preparation and coordination of materials may be done by hospital staff or board sub-committees, the final decisions must be made by the board alone, and cannot be delegated.
- All privileges decisions must be made on a case-by-case basis after a thorough, careful and independent review by the board.
- The board is responsible for ensuring an effective and fair credentialing process. While it does not need to receive all the details for every applicant or each member of the Professional Staff – it must be assured that the processes meet legal requirements. This responsibility can be discharged by:
    - Ensuring the Professional Staff By-law is reviewed by legal counsel (usually every three years or more frequently if there is new legislation or new guidelines such as the OHA/OMA Prototype By-law).
    - Asking the Chief of Staff/Chair of the MAC to summarize the hospital's credentialing process and confirm it has been followed.
    - Asking whether there are any differences in how dental, midwifery and extended class nursing applications are processed as compared with physician applications.
    - Ensuring the MAC recommendations are consistent with the hospital by-laws, Rules and Regulations, hospital policies and Professional Staff Human Resources Plans.
    - Asking a board sub-committee, such as an Audit Committee, to do an annual audit of the hospital's credentialing process by reviewing a random sample of applications for appointment, re-appointment and changes to privileges.
- While the board should give significant weight to the MAC's clinical expertise when reviewing its recommendations on appointment and re-appointment, there are additional issues that the board must consider when making privileging decisions such as: quality of patient care; patient, staff and public safety; the hospital's legal obligations; fairness to the Professional Staff member; the role of the hospital in the community; and the effective and efficient operation of the hospital.
- Hospital privileges disputes can be extremely expensive and can have negative consequences for the reputation of the hospital – board members must take this role seriously.
- Privileges hearings are unique to hospitals and the board members should understand their role in a quasi-judicial process.
- HPARB can overturn a hospital's decision. If it does so, a member of the Professional Staff may have the right to return to the hospital or have access to resources that were previously restricted.

FAQs

1. How often should the board receive credentialing training?

The *Public Hospitals Act* does not require board training, but governance best practice generally recommends that board members receive credentialing training during their orientation and at least every three years thereafter (and more frequently if there are new developments, such as new legislation, new guidelines, or significant new case law).

2. When do Professional Staff appointments and re-appointments come to the board's attention?

Appointments may come to the board's attention throughout the year, as new Professional Staff members apply for privileges or are actively recruited to become part of the hospital's Professional Staff.

All appointments are for a maximum term of one year under the *Public Hospitals Act*. Re-appointments to the Professional Staff tend to come to the board's attention all at once, as most hospitals define a "credentialing year" for all Professional Staff members, with applications for re-appointment due at the same time each year (e.g., a credentialing year may be July 1st – June 30th, with re-application forms due by April 30th). Note that there is no requirement for all Professional Staff members to follow the same credentialing year, and there may be benefits to staggering the timing of re-appointment applications (such as by Department so that different Departments submit applications at different times throughout the year) to make the workload more evenly distributed throughout the year for administrative staff, the MAC and board.

There may also be temporary, mid-term, or consultant staff appointments that come before the board for approval throughout the course of the year.

If there is an urgent need to suspend, restrict or revoke a member's privileges, the board should be alerted as soon as possible.

If for any reason the MAC is not recommending someone for appointment or re-appointment, the MAC must notify the board, along with the applicant, as required by the *Public Hospitals Act* (this applies to a physician in all cases, and also to other Professional Staff where the by-laws specifically require this). The applicant may choose to request a hearing before the board concerning their privileges.

Medical Advisory Committee

The **MAC** is commonly responsible for:

1) Making recommendations to the board, including recommendations concerning the:

   a. Applications for appointment or re-appointment to the Professional Staff and any requests for changes in privileges. This applies to every application from every member of the Professional Staff (PHA).

   b. Privileges to be granted to each member of the Professional Staff (PHA).

   c. Revocation, suspension or restrictions of privileges of any member of the Professional Staff (PHA).

   d. Quality of care provided in the hospital by the Professional Staff (PHA and the *Excellent Care for All Act*).

   e. Professional Staff by-laws (PHA).

   f. Rules and Regulations respecting the Professional Staff (PHA).

   g. Policies and practices that affect the Professional Staff (PHA).

   h. Creation of MAC sub-committees (PHA).

2) Making recommendations to the Quality Committee of the board where the MAC identifies systemic or recurring quality of care issues.[2]

2 *Public Hospitals Act,* R.R.O. 1990, Reg.965, s.7(7).

3) Reviewing applications for appointment or re-appointment to the Medical Staff within the 60-day window set out by the *Public Hospitals Act* (or extending the 60-day period on written notice to the applicant and the board, with reasons)[3] (PHA).

4) Notifying the board and the applicant of its decision, in writing, of its recommendation regarding any application for appointment or re-appointment (PHA).

5) Supervising the clinical practice of medicine, dentistry, midwifery and extended class nursing at the hospital (PHA).

6) Appointing Medical Staff members to certain committees (PHA).

7) Receiving reports of MAC sub-committees (PHA).

8) Advising the board on any matter referred to the MAC by the board (PHA).

9) Receiving recommendations for appointment and re-appointments from the Credentials Committee (where one exists).

10) Reviewing applications with reference to Professional Staff Human Resources Plans and impact analyses.

11) Reviewing temporary appointments made by the CEO that are proposed to be continued.

12) Investigating quality of care issues with respect to specific members of the Professional Staff as requested.

Key messages for **MAC**s:

- The MAC is the primary committee responsible for supervising the Professional Staff in the hospital.
- The MAC is accountable to the board in accordance with the *Public Hospitals Act* and its regulations.
- The *Public Hospitals Act* and its regulations, as well as the hospital by-laws, set out the duties of the MAC.
- The MAC is responsible for making recommendations to the board concerning the appointment, re-appointment, revocation, suspension or restriction of – or any changes to – the hospital privileges of all Professional Staff members. The MAC does not make final decisions with respect to hospital privileges – the board does.
- The board relies on the MAC's recommendations due to the MAC's clinical expertise – however, the board is not bound to follow their recommendations. It is possible that a hospital board will not agree with the MAC or will challenge the process the MAC followed to come to its recommendation.

"The most cogent source of medical expertise relevant to the practice of medicine within a hospital is to be found in its Medical Advisory Committee and Chief of Staff. A board has every justification to give great weight to their advice. **However, a Board of Governors must not permit itself to become the rubber stamp of approval for proposals made by its Medical Advisory Committee**. No member of a Board of Governors ought to feel uneasy or embarrassed to question the basis of a proposal of the medical staff. Every Board member owes a duty to his community to require that the advisors of his board demonstrate that they have given full and fair consideration to the issues, and that their recommendations support the established policies and objectives of that hospital. A board is in breach of its trust to the public if, for selfish motives, it permits any individual or group involved with the operation of its hospital to deviate from those objectives or distort those policies."

***Re Sheriton and North York General Hospital* (Hospital Appeal Board, 1973) referred to in *Pratt v. Fraser Health Authority* (BCSC, 2007)**

3 It would be considered best practice to review all Professional Staff applications for appointment or re-appointment within 60 days (or extended as necessary with reasons).

- The MAC should ensure the information provided to the board is accurate and complete. Taking into account the *Public Hospitals Act* and the privileges case law, the MAC should endeavour to demonstrate to the board that its recommendation is:
  - Consistent with the *Public Hospitals Act* and its regulations and the hospital by-laws.
  - Objective (i.e., any conflicts of interest have been identified and managed).
  - Fair to the Professional Staff member.
  - Aligned with the hospital's mission, vision and values.
  - Balanced and complete – The MAC has considered the issues of quality of care; patient, staff and public safety; the community's needs; and the effective and efficient operation of the hospital.
- In most hospitals, the MAC does not get involved in the detailed review of every candidate for appointment or re-appointment. It faces the same challenges as the board; it must exercise thoughtful, independent judgment and not act as a mere rubber stamp for the work of the Credentials Committee (or person assigned to perform the credentialing function).
- In order to be assured it has the right information upon which to base its decisions, the MAC should:
  - Support the development of departmental Professional Staff Human Resources Plans (and as appropriate, a corporate plan) so that there is an objective assessment of the hospital's needs and interests.
  - Understand the hospital's mission, vision and values.
  - Review the terms of reference for the Credentials Committee (or person assigned to perform the credentialing function) and its procedures every three years (or more frequently if there have been significant changes in the legal landscape).
  - Ask the Credentials Committee for an annual report identifying challenges and emerging issues.
  - Provide training to or written policies for Chiefs/ Heads responsible for making recommendations to the MAC so that there is a consistent approach with respect to appointment, re-appointment and disciplinary decisions and so that they understand the scope of their authority for changing activities, resources and duties of members of the Professional Staff.
  - Where the MAC anticipates it will not recommend an appointment or re-appointment, offer to meet with the member of the Professional Staff in order to hear their side and to ensure it has complete information from both sides (i.e., the Chief of Department/Head and the Professional Staff member) before making a recommendation to the board. Note that there is no statutory obligation for the MAC to offer a member of the Professional Staff a meeting or a hearing before the MAC in these circumstances.
- The MAC should ensure:
  - Consistency across Departments and Divisions.
  - Alignment with the hospital's mission, vision and values.
  - Removal of subjectivity and personality-based decision-making and recommendations.
- The MAC structure offers an opportunity for the dissemination of information throughout the hospital. The MAC typically consists of the Chief of each Department; as such, it is a vehicle to convey updates on key hospital initiatives to the Chiefs, who can then pass information to the Professional Staff members at departmental meetings.

FAQs

1. Given that the MAC is made up of clinical experts, why doesn't the board delegate privileges decisions to the MAC?

The *Public Hospitals Act* does not allow the board to delegate its decision-making authority to the MAC. While the MAC must make recommendations to the board, the board retains the ultimate accountability for privileges decisions.

2. If there are non-physician members on the MAC, can those members vote on Professional Staff appointments or re-appointments?

No. The *Public Hospitals Act*, Regulation 965 permits only physicians (and the Chief of the Dental Staff if there is one in certain hospitals) to sit as members on the MAC. Some hospitals have broadened their MAC membership to include other disciplines, but those other disciplines may not vote on official MAC business such as privileges matters. For example, the OHA/OMA Prototype By-law allows for the CEO, Head of the Midwifery Division/Department, Head of the Dental Division/Department, Chief Nursing Executive and any Vice President of the hospital to attend MAC meetings, but without a vote. Even if hospital by-laws extend privileges to dentists, midwives and extended class nurses, only physician members (and Chief of the Dental Staff if there is one) of the MAC can vote on their appointment, re-appointment, and mid-term action affecting Professional Staff member privileges. However, the MAC may wish to solicit input from practice leaders for midwives, dentists and Nurse Practitioners.

3. Is the MAC required to hold a meeting or hearing if there is a privileges dispute?

No. The *Public Hospitals Act* requires that there be a board hearing, if the applicant so requests, but does not require a hearing or meeting at the MAC before that board hearing. The OHA/OMA Prototype By-law also does not contemplate a MAC meeting or hearing. Although there is no statutory obligation to offer a member of the Professional Staff a meeting or a hearing before the MAC, if a dispute arises, the MAC may choose to offer to meet with the member of the Professional Staff in order to hear their side and to ensure it has complete information – from both the Chief of Department/Head and the Professional Staff member – before making a recommendation to the board.

See Chapter 9, Refusing Appointments and Re-appointments and Suspending, Restricting or Revoking Privileges, for more information on how to run these hearings.

Chief of Staff/Chair of the MAC

Hospitals are required under the *Public Hospitals Act* to have either a Chief of Staff or a Chair of the MAC. Where the hospital does not have a Chief of Staff, the board must appoint a Chair of the MAC from among the members of the MAC. Where a hospital decides to have a Chief of Staff, the Chief of Staff is appointed by the board and must fulfill the function of the Chair of the MAC. Sometimes this position is called the Physician-in-Chief (or Psychiatrist-in-Chief, at mental health facilities).

The Chief of Staff/Chair of the MAC has specific roles set out in the *Public Hospitals Act* and its regulations, as well as in section 9.3 of the OHA/OMA Prototype By-law. Some of the duties set out below may be performed by a Vice-President Medical or Medical Director.

The **Chief of Staff/Chair of the MAC** may be responsible for:

1) Acting as the Chair of the MAC (PHA).

2) Acting as an *ex-officio* member of the board.

3) Acting as an *ex-officio* member of all MAC sub-committees.

4) Reporting regularly to the board on the work and recommendations of the MAC:

   a. Supervising the clinical, academic and administrative activities of the Professional Staff.

   b. Considering applications for Professional Staff privileges.

   c. Consulting with Chiefs of Department and Heads regarding proposals to change Professional Staff members' privileges.

   d. Making recommendations to the board (and in some hospitals, making decisions) with respect to leaves of absence, and if appropriate, imposing conditions on privileges for members returning from a leave of absence.

5) Participating in all MAC discussions, including recommendations made by the MAC regarding the granting, renewal, suspension, restriction or revocation of privileges.

6) Apprising members of the Professional Staff of their rights to a hearing or appeal in privileges matters.

7) Representing the MAC at board hearings on privileges matters.

8) Ensuring the credentialing process complies with the *Public Hospitals Act* and its regulations, the hospital by-laws, Rules and Regulations and hospital policies and practices.

9) Receiving application forms from the CEO (keeping a copy) and sending them to the Credentials Committee and applicable Chief of Department.

10) Meeting with potential applicants to the Professional Staff.

11) Reviewing patient care with respect to specific Professional Staff members as necessary (PHA).

12) Filing reports with the MAC if it becomes necessary to take over the care of a patient, as required by the *Public Hospitals Act* (PHA).

13) Temporarily restricting or suspending the privileges of any member of the Professional Staff and reporting to the MAC.

14) Ensuring the development of:

    a. Departmental Professional Staff Human Resources Plans and a corporate plan, as appropriate

    b. Recruitment strategies

    c. Orientation program

    d. Quality improvement programs

    e. Continuing education and professional development for the Professional Staff

    f. Resource utilization reviews

    g. Rules and Regulations

    h. Policies and practices

    i. Performance evaluation process tied to re-appointment

15) Participating as a member of the hospital's Senior Management Team in decisions with respect to strategic planning and resource allocation.

16) Receiving and considering complaints about behaviour, impairment/incapacity or competence involving Professional Staff members and ensuring the complaints are acted upon by the MAC where appropriate.

17) Notifying the Professional Staff member's regulatory college if there are reasonable grounds to believe a member has sexually abused a patient.

Key messages for **Chief of Staff/Chair of the MAC**:

The Chief of Staff/Chair of the MAC oversees all the responsibilities of the MAC with respect to hospital privileges.

- As a non-voting member of the board, the Chief of Staff/Chair of the MAC serves as a liaison between the MAC and the board, reporting to the board on quality of care issues and recommendations on privileges appointments. The Chief of Staff/Chair of the MAC acts as the voice of the clinical leadership and answers the board's questions with respect to vision, direction and process issues of Professional Staff credentialing.

- The Chief of Staff/Chair of the MAC should be prepared to assure the board that: the credentialing process is reasonable, prudent and meets public hospital standards; and the credentialing process contemplated in the by-laws is consistently followed. Some boards may require an annual certification to this effect, signed by the Chief of Staff/Chair of the MAC.

- The Chief of Staff/Chair of the MAC has the responsibility to introduce members of the Professional Staff to the board through the appointment process.

- A major challenge faced by the Chief of Staff/Chair of the MAC is managing conflicts of interest. The Chief of Staff/Chair of the MAC receives complaints about members of the Professional Staff and participates in or is accountable for investigations into allegations about impairment/incapacity, behaviour or incompetence. As a result, the Chief of Staff/Chair of the MAC should not participate in decision-making at the MAC if they have participated in any way in an investigation.
- The Chief of Staff/Chair of the MAC is responsible for ensuring that concerns about Professional Staff members are appropriately managed and escalated.
- The Chief of Staff/Chair of the MAC may be privy to highly confidential information (especially with respect to health, personal, legal or professional issues) relating to members of the Professional Staff. It is critical that the Chief of Staff/Chair of the MAC maintain strict confidentiality and not share more information than is necessary for any particular purpose.
- The Chief of Staff/Chair of the MAC is often tasked with managing informal disputes between Professional Staff members and between Professional Staff members and their Chiefs/Heads.

Credentials Committee

A Credentials Committee is typically a sub-committee of the MAC. However, hospitals are not required to have a Credentials Committee. If the hospital does not have a Credentials Committee, the functions of the Credentials Committee may be performed by the MAC itself.

In some hospitals, these functions may be performed by the administrative assistant to the CEO or a Manager/Director of Medical/Professional Affairs. For purposes of the Toolkit, we refer to the one or more individuals as the "Credentials Committee", acknowledging that there may be an administrator who completes the steps prior to the Credentials Committee or MAC reviewing the packages.

The **Credentials Committee** may be responsible for:

1) Reviewing the materials submitted in applications for appointment, re-appointment and changes to privileges.
2) Receiving recommendations of Department Chiefs for re-appointment applications.
3) Ensuring the hospital has received all necessary information from applicants to make a decision.
4) Ensuring an impact analysis has been performed for new applicants.
5) Investigating each applicant's professional competence.
6) Obtaining proof of license and professional liability protection coverage (insurance).
7) Reviewing letters of reference or otherwise contacting referees.
8) Verifying each applicant's qualifications.
9) Reviewing regulatory college public register information for applicants.
10) Confirming occupational health and safety and administrative requirements have been met (such as mask fit testing, CPR, immunization, and infection control requirements).
11) Considering whether an application meets the qualifications and criteria of the hospital by-laws.
12) Ensuring all paperwork is organized and signed.
13) Identifying problems or defects with an application.
14) Reminding applicants of pending deadlines.
15) Submitting a report and recommendations to the MAC.

Key messages for **Credentials Committees**:

- The Credentials Committee may be charged with the data collection and quality control functions of the credentialing process. If the Credentials Committee does not perform its function (and the responsibilities are not performed by another person or group), the MAC and board will not have reliable data upon which to base their decisions.
- The principles of "natural justice" and "procedural fairness" apply to the application process for appointments and re-appointments to the Professional Staff. This means:
  - The criteria for appointment and re-appointment must be transparent:
    a. All qualifications and criteria must be set out in the by-laws.
    b. No other criteria may be used.
  - Applicants must be alerted to and given an opportunity to correct mistakes or omissions in their forms.
  - All applicants must be judged fairly and objectively according to the transparent criteria (for an example of the types of criteria used to qualify Professional Staff members for appointment and re-appointment – see the *OHA/OMA Prototype By-law*).
- The application forms for appointment and re-appointment must be aligned with the by-laws. Every time the by-laws are amended, the application forms need to be reviewed and updated as necessary. This includes in joint credentialing relationships with other hospitals.
- The applicant, Chief of Staff/Chair of the MAC and Chiefs of Department should be alerted to problems with applications as soon as possible so that issues may be resolved well in advance of appointment and re-appointment deadlines.
- The Credentials Committee should inform the MAC on an annual basis of any themes, emerging issues or challenges it identifies with respect to the appointment and re-appointment process.

While the credentialing function is usually tied to applications, there is an ongoing role for an administrative person to monitor the licensure and professional liability protection coverage (insurance) of all Professional Staff members. Hospitals must ensure that someone in the organization reviews reports from the regulatory colleges (i.e., the College of Physicians and Surgeons of Ontario, the Royal College of Dental Surgeons of Ontario, the College of Midwives of Ontario and the College of Nurses of Ontario) for reports of suspended, restricted or revoked licenses.

CEO

There are a number of credentialing responsibilities assigned to the CEO under the *Public Hospitals Act*. The OHA/OMA Prototype By-law identifies additional opportunities for the CEO to be involved in the credentialing process.

The **CEO** may be responsible for:

1) Supplying application forms to any physician, upon written request, as mandated by the *Public Hospitals Act* (PHA).[4]
2) Supplying application forms to dentists, midwives and extended class nurses upon request.
3) Making available to new applicants, along with the application forms, important information about the hospital, including the mission, vision, values and strategic plan; the Health Ethics Guide (as applicable in certain faith-based organizations); by-laws, Rules and Regulations and appropriate policies to applicants for appointment to the Professional Staff.
4) Receiving applications for appointment and re-appointment and applications for changes to privileges, and referring these immediately to the MAC (PHA).
5) Meeting with potential applicants to the Professional Staff.

4 It would be considered best practice to do the same for other professions who ask for an application.

6) Granting temporary privileges to physicians, dentists, midwives and extended class nurses, and continuing those privileges on the recommendation of the MAC until the next board meeting.

7) Temporarily restricting or suspending the privileges of any member of the Professional Staff where appropriate under the by-laws and then reporting the details of the action taken to the MAC.

8) Notifying a Professional Staff member's regulatory body if there are reasonable grounds to believe that the member is incompetent, incapacitated or has sexually abused a patient, as required by the *Regulated Health Professions Act* (RHPA).

9) Notifying the College of Physicians and Surgeons of Ontario if:

   a. A physician has been denied appointment or re-appointment by reason of incompetence, negligence or misconduct;

   b. A physician has had their privileges restricted or cancelled by reason of incompetence, negligence or misconduct;

   c. A physician voluntarily or involuntarily resigns from the Medical Staff or restricts their practice by reason of incompetence, negligence or misconduct; or

   d. A physician voluntarily or involuntarily resigns from the Medical Staff or restricts their practice as a result of or during the course of an investigation into their competence, negligence or conduct (PHA).[5]

10) Notifying the Chief of Staff/Chair of the MAC if they believe that a physician is unable to perform the person's professional duties with respect to a patient in the hospital (PHA).

5 See also the *Regulated Health Professions Act, 1991*, Schedule 2 the Health Professions Procedural Code, s. 85 for mandatory duties of reporting any regulated health professional including physicians, midwives, dentists, and nurse practitioners to their regulatory colleges in the cases of incompetence, incapacity or sexual abuse of patients.

Key messages for **CEO**s:

- Busy CEOs may need to delegate some of the responsibilities assigned to them in the by-laws. CEOs should review their obligations as set out in the by-laws and determine which of their responsibilities they will delegate and to whom. It is important to note that the CEO remains responsible for those functions they delegate to others.
- One of the recommendations of the Dupont/Daniel inquest[6] in Windsor, Ontario was for CEOs to have more responsibility to temporarily suspend a member of the Professional Staff if there are concerns about the member's practice. This reflects a long-standing concern that, unless there is a legal obligation to report, clinicians may not be willing to report their fellow clinicians to authorities. The OHA/OMA Prototype By-law empowers CEOs to temporarily restrict or suspend privileges in specific circumstances, such as where the Professional Staff member's conduct is reasonably likely to expose a patient or co-worker to harm or injury.
- The mandatory reporting requirements under the *Public Hospitals Act* and the *Regulated Health Professions Act* with respect to incompetence, negligence, misconduct and sexual abuse usually fall to the CEO.
- Hospital privileges disputes can be extremely expensive and have negative consequences for the reputation of the hospital. The CEO should never be taken by surprise when a privileges issue is being brought before the board for consideration. The CEO should be informed of all Professional Staff disputes.
- CEOs should not participate in internal investigations with respect to Professional Staff privileges in order to avoid conflicts of interest. However, CEOs do not have voting rights as board members under the *Public Hospitals Act* regulations, and as such, are unable to participate in decisions made at board hearings.

6 Verdict and Recommendations of the Coroner's Jury in the Daniel/Dupont Inquest (2007) https://www.oha.com/Documents/Dupont-Daniel%20Inquest%20-%20Jury%20Recommendations%20-%20Dupont-Daniel%20Inquest%20December%202007%20--Homicide.pdf

- CEOs should be aware that the *Public Hospitals Act* requires the CEO to provide an application form to any physician who requests one; this is not discretionary. Some hospital by-laws have been amended to extend this right to any Professional Staff.

Chiefs of Department/Heads of Division

Academic health sciences centres and larger tertiary centres are complex organizations often divided into Departments and Divisions, to organize the delivery of care and the Professional Staff members. In this type of organization, Chiefs of Department and Heads of Division often take over a sizeable portion of the duties assigned to the Chief of Staff/Chair of the MAC.

Not all hospitals have Departments or Divisions; in smaller hospitals, the duties of Chiefs of Department may be undertaken by other supervisory leadership positions such as clinical directors and senior physicians/clinicians or may remain under the jurisdiction of the Chief of Staff/Chair of the MAC. Throughout the Toolkit, we often refer to the "most appropriate clinical leader" in order to acknowledge the different roles in hospitals.

Descriptions of the duties of Chiefs, Deputy Chiefs and Heads have been significantly streamlined in the OHA/OMA Prototype By-law. This means that hospitals should develop position descriptions for Chiefs of Department and Heads of Division (either as stand-alone policies or part of the Rules and Regulations), to be approved by the board.

Chiefs of Department may be responsible within their own Department for:

1) Preparing and implementing a Department-specific Professional Staff Human Resources Plan in accordance with the hospital's strategic plan after receiving and considering input from the members of the Professional Staff. Participating in the development and implementation of the hospital's overall Professional Staff Human Resources Plan, where applicable.
2) Ensuring that new Professional Staff members participate in Departmental orientation programs.
3) Making recommendations to the MAC regarding appointment, re-appointment, change in privileges and any disciplinary action to which Professional Staff members of the Department would be subject.
4) Advising the MAC with respect to the quality of care provided by the Professional Staff members of the Department.
5) Developing, in consultation with members of the Department and the MAC, standards for quality, patient safety and patient care for the Department that are consistent with hospital quality standards that shall serve as the basis for individual Professional Staff members' annual evaluations.
6) Speaking to Professional Staff members about their behaviour, interpersonal skills or competency, if required, and documenting more formal disciplinary type conversations.
7) Conducting a written performance evaluation of all Professional Staff members of the Department on an annual basis as part of the re-appointment process and conduct an enhanced performance evaluation on a periodic basis.
8) Supervising the professional care provided by all members of the Professional Staff in the Department.
9) Disciplining Department members in regard to matters of patient care, cooperation with hospital employees, compliance with hospital by-laws, Rules and Regulations, and policies, including on-call requirements and documentation of care.
10) Examining the condition and scrutinizing the treatment of any patient within the Department if concerns about quality of patient care arise; notifying the attending Professional Staff member and speaking to the Professional Staff member if concerned about a serious problem in the diagnosis, care or treatment of a patient. This includes assuming the duty of investigating, diagnosing, prescribing for and treating the patient if the Professional Staff member is not able to do so (PHA).

11) Notifying a Professional Staff member's regulatory college if there are reasonable grounds to believe that a member has sexually abused a patient (PHA).

12) If the hospital by-laws allow, temporarily restricting or suspending privileges of a member of the Professional Staff in consultation with other members of the senior team.

Heads of Division may have similar responsibilities within their Division.

Key messages for **Chiefs/Heads**:

- The clinical leaders, such as Chiefs of Department, who directly supervise members of the Professional Staff have the biggest impact on the credentialing process, they:
  - Recruit.
  - Determine the needs of the hospital.
  - Determine whom to recommend for appointment, re-appointment, and changes to scope and categories of privileges.
  - Perform performance reviews.
  - Identify problems.
  - Manage team dynamics.
  - Manage problems with competence, behaviour, capacity/impairment.
  - conduct internal investigations.
  - Take disciplinary action, in consultation with the Chief of Staff/Chair of the MAC as appropriate.
  - Recommend taking action to restrict, suspend or revoke privileges.
  - Under some hospitals' by-laws, have the power to temporarily suspend privileges (after consulting with other senior members).
  - Assume responsibility for care if urgent needs arise.
- It is therefore critical for the Chiefs to clearly understand:
  - Their role in the credentialing process (and the scope and limits of their authority to make oversee their Professional Staff members).
  - The hospital's mission, vision and values (and the strategic directions of the hospital).
  - How to set clear goals and standards of practice for their Professional Staff.
  - How to performance manage their Professional Staff and in particular, how to address competence or capacity/impairment issues and behavioural issues and how to have difficult conversations about complaints and performance expectations.
  - The fundamentals of managing and leading a team.
- Chiefs will also want to ensure that they follow the rules and processes set out in the by-laws and that they:
  - Avoid recruiting new members of the Professional Staff without informing anyone.
  - Take disciplinary action where required, consistent with the processes contemplated in the by-laws and in consultation with the necessary people to avoid overstepping into a unilateral change in privileges.
  - Consult with the Chief of Staff/Chair of the MAC or CEO on serious cases.
  - Develop clinical programs that are aligned with the hospital's strategic plan.
  - Understand that Professional Staff members have additional rights under the *Public Hospitals Act* and by-laws beyond what other independent contractors or employees would have and that there is a legal process that must be followed in order to change, restrict or revoke a Professional Staff member's privileges.

- Unfortunately, some of the highest profile and most costly decisions involving privileges disputes with Professional Staff members relate to disputes between Chiefs/Heads and the Professional Staff in their Departments or teams.[7] It is essential that before a Chief/Head makes any change to a Professional Staff member's duties, activities, compensation, or resources, they consult with the Chief of Staff/Chair of the MAC or the CEO. *See Chapters 8, Performance Evaluations and Progressive Management and Chapter 9, Refusing Appointments and Re-appointments and Suspending, Restricting or Revoking Privileges.*
- The annual performance review and evaluation process is also critical. It is an opportunity to recognize positive performance, to point out problematic performance, and to identify ways to improve or remedy performance issues.

FAQs

1. What types of matters should be reviewed as part of the annual performance review of a Professional Staff member?

- Skills, attitude and judgment of the applicant.
- Participation in continuing education.
- Ability of the applicant to communicate with patients, families, and staff.
- Ability of the applicant to cooperate with the board, CEO, Chief of Staff/Chair of the MAC and Chief of Department.
- Ability to supervise staff.
- Appropriate and efficient use of hospital resources.

The jury recommendations from the Dupont/Daniel inquest[8] also commented on what should be included in an annual evaluation of physicians:

> "Professional Staff by-laws should ensure annual evaluation of physicians' quality of medical care, utilization of resources, completion of required programmes, and professional behaviours including interactions with patients and staff. Such evaluations should include feedback/assessments from multiple members of the healthcare team (i.e., 360 degrees evaluation)."
>
> ***Jury recommendation from the Dupont/Daniel Coroner's Inquest***

2. What if concerns are raised about performance during a *Quality of Care Information Protection Act, 2016* review?

If concerns are raised during a *Quality of Care Information Protection Act, 2016* review regarding the skill or competence of a Professional Staff member that do not require immediate action or discipline, the Quality of Care Committee (as it is known under that Act) should conclude the review process and include a recommendation to review the individual's actions. However, any follow-up disciplinary review is likely to be linked, at least in perception, to the process and the hospital will have to consider how to manage or alleviate staff concerns in this regard.

7 See for example, *Saskatoon Regional Health Authority and Johnson, 2014 SKQB 266 (CanLII)*, <http://canlii.ca/t/gdr5n>, *Horne v Queen Elizabeth II Health Sciences Centre*, 2018 NSCA 20 (CanLII) and *Tenn-Lyn v Medical Advisory Committee*, 2016 CanLII 80391 (ON HPARB).

8 Verdict and Recommendations of the Coroner's Jury in the Daniel/Dupont Inquest (2007) https://www.oha.com/Documents/Dupont-Daniel%20Inquest%20-%20Jury%20Recommendations%20-%20Dupont-Daniel%20Inquest%20December%202007%20--Homicide.pdf

Professional Staff

Examples of duties of Professional Staff are set out in the OHA/OMA Prototype By-law in section 6.7.

Members of the **Professional Staff** may be responsible for:

1) Attending and treating patients within the limits of the privileges granted unless the privileges are otherwise restricted.

2) Recognizing the authority of and being accountable to the Chief of Staff/Chair of the MAC, Chief of the Department, Head of Division, the MAC, CEO and the board.

3) Participating in annual and any enhanced periodic performance evaluations, and providing such releases and consents as will enable such evaluations to be conducted.

4) Being candid, honest, thorough and accurate in their applications for appointment, re-appointment and changes to privileges.

5) Completing and submitting re-application or change of privileges forms on a timely basis, with complete and accurate information.

6) Complying with applicable legislation and the hospital's by-laws, Rules and Regulations and policies.

7) Ensuring they meet the criteria for re-appointment to the Professional Staff set out in the by-laws, including meeting the occupational health and safety requirements of the hospital and maintaining professional practice liability coverage (insurance).

8) Taking recommended steps to improve or remedy performance issues.

9) Advising the Chief of Staff/Chair of the MAC about the commencement of any regulatory disciplinary proceeding, proceeding to restrict or suspend privileges at other hospitals, or malpractice action.

10) Ensuring they are skilled and able to perform all procedures assigned to them.

11) Ensuring that any concerns relating to the operations of the hospital are raised and considered through the proper channels of communication within the hospital such as the Chief of Staff/Chair of the MAC, Chiefs of Department, MAC, CEO and/or the board.

10) Providing the Chief of Staff/Chair of the MAC (or the member's Chief of Department) with at least two-three months' notice of the members' intention to resign.

11) Providing input, if interested, to the development of departmental Professional Staff Human Resources Plans.

Other Key Roles

President of the Medical Staff

The **President of the Medical** Staff has a limited role in the credentialing process. As a member of the MAC, the President of the Medical Staff will be involved in reviewing applications and re-appointment applications and making recommendations to the board. The President of the Medical Staff is not a voting member of the board and hence is not able to participate in board privileges hearings.

The *Public Hospitals Act* includes a process for addressing serious problems in the diagnosis, care or treatment of a patient by the attending physician. The Chief of Staff/ Chair of the MAC and Chief of Department are primarily responsible for discussing serious problems with the attending physician and relieving the physician of responsibility for that patient if the serious problems are not addressed to their satisfaction. In this case, the Chief of Staff/Chair of the MAC or Chief of Department, as applicable:

- Assumes care of the patient;
- Notifies the attending physician, CEO and patient that the physician has been relieved of their responsibility for the patient;
- Advises two members of the MAC of actions taken within 24 hours; and,

- Provides a written report to the Secretary of the MAC within 48 hours.

The *Public Hospitals Act* states that, where a hospital does not have a Chief of Staff, the responsibilities above apply to the President of the Medical Staff.

Secretary of the Medical Staff

Similar to the President of the Medical Staff, the **Secretary of the Medical Staff** is a member of the MAC and as such, will be involved in reviewing applications and re-appointment applications for privileges and making recommendations to the board.

The *Public Hospitals Act* also gives the Secretary of the Medical Staff a specific duty relating to action taken by the Chief of Staff/Chair of the MAC, Chief of Department or President of the Medical Staff where one of them relieves an attending physician of responsibility with respect to a particular patient because of a serious problem in diagnosis, care or treatment. If the MAC concurs with the action taken, the Secretary of the Medical Staff must make a detailed report of the problem and the action taken to both the CEO and the board.

Students, Residents and Fellows

It is very common for **students** to be working in a hospital as part of their formal education. Much like Professional Staff members with privileges, students will often be provided with an identification badge, e-mail address, locker, and other amenities. However, these amenities do not amount to "privileges".

The relationship between hospitals and medical students (or dental, midwifery, extended class nursing students) is usually set out in academic affiliation agreements, which are written agreements between a hospital and the university or college with which it is affiliated.

Residents and fellows are treated differently from medical and/or dental students. They sometimes receive privileges because they have a degree. A separate category of privileges often exists for residents and fellows, setting limits on their privileges and any required supervision.

Observers

Many hospitals have in place policies with respect to observers. **Observers** may not diagnose, care for or treat patients, and as such, they do not need to apply for or receive privileges. In the event that an observer is called on to provide clinical care, privileges must first be obtained.

Regulatory Colleges

Health regulatory colleges are bodies that regulate the practice of a particular health profession to protect and serve the public interest.

The duties of the health regulatory colleges may be found in the *Regulated Health Professions Act,* the Health Professions Procedural Code (Schedule 2 to the *Regulated Health Professions Act*), and the legislation governing the specific profession (i.e., the *Medicine Act*, the *Dentistry Act,* the *Midwifery Act* and the *Nursing Act*).

Colleges are responsible for:

1) Serving and protecting the public interest.
2) Regulating the practice of the profession.
3) Governing college members in accordance with the relevant legislation and by-laws.
4) Giving out certificates of registration to those entitled to practice.
5) Developing standards of qualification for persons to be issued certificates of registration.
6) Developing and enforcing standards of practice.
7) Developing and enforcing professional ethics standards.
8) Developing and maintaining programs that assist members with exercising their rights under the Regulated Health Professions Act, and the Health Professions Procedural Code.
9) Responding to patients' concerns and investigating complaints from members of the public, hospitals and other colleges.

10) Disciplining members, including conducting discipline hearings, where appropriate.

11) Working in consultation with the Minister of Health and Long-Term Care to ensure that the people of Ontario have access to adequate numbers of qualified, skilled and competent regulated health professionals.

12) Fostering positive relationships between the college and its members, other health profession colleges, key stakeholders, and the public.

13) Promoting inter-professional collaboration with other health regulatory colleges.

14) Having a website with a public register of its members and their standing.

Colleges also require their members to undergo quality reviews (such as peer assessments or other reviews) and may restrict a member's practice by imposing terms and conditions on the member's licence. In the case of the College of Physicians and Surgeons of Ontario, college inspectors may inspect or observe a physician's private practice.

FAQs

1. Why does a hospital have to get involved in credentialing at all? Isn't credentialing the responsibility of a regulatory College?

A health regulatory College screens its members to ensure they have the requisite training and experience to hold licensure or registration in the College and grants permission for its members to use restricted titles such as "physician", "surgeon", "dentist", "dental surgeon", "nurse practitioner" or "midwife". A hospital is entitled to and expected to rely in part on documentation from a regulatory College of a candidate's licensure status (such as through a Certificate of Professional Conduct and information included on the public register). However, a hospital's process of credentialing goes well beyond what a regulatory College completes and takes into account screening criteria set out in the hospital's by-laws. The functions are complementary but are not a substitution for each other.

Health Professions Appeal and Review Board (HPARB)

HPARB hears all privileges appeals under the *Public Hospitals Act*. Under the *Public Hospitals Act*, only members of the Medical Staff are entitled to appeal a decision of the hospital board with respect to their privileges to HPARB.[9] (HPARB was previously known as the Hospital Appeal Board.)

Any applicant for appointment or re-appointment to the Medical Staff of a hospital who was a party to a proceeding before the hospital board, and who considers themselves aggrieved by that board's decision not to appoint or re-appoint them to the Medical Staff, is entitled to a hearing before HPARB. Any member of a hospital's Medical Staff who considers themselves aggrieved by any decision revoking, suspending, or substantially altering their privileges is also entitled to an HPARB hearing.

HPARB grants a hearing "*de novo*", which means HPARB hears and decides upon all the evidence and does not simply review the decision of the hospital board. The parties may call new witnesses and supply new documentation and evidence that had not been considered at MAC meetings or hospital board hearings. Even if there had been procedural missteps by a hospital in following the *Public Hospitals Act* requirements in credentialing or privileging, the HPARB process starts a new process.[10]

At the conclusion of a hearing, HPARB may confirm the decision of the hospital board, substitute its decision for that of the hospital board, or direct the board or any other person to take such action as it considers appropriate, in accordance with the *Public Hospitals Act*. Any party (the physician or the hospital) can appeal the decision of HPARB to Ontario's Divisional Court.

9 The *Public Hospitals Act* is silent on the availability of an appeal to HPARB for dentists, midwives or extended class nurses. HPARB has not yet published a case from those professional groups under the *Public Hospitals Act* privileges regime.

10 See Waddell v. Weeneebayko, 2018 CanLII 39843 (ON HPARB) at para 86 where HPARB reviewed a situation where a hospital did not consider a physician's application within 60 days from the date of the application but concluded that was primarily due to the physician's actions and confusion over whether the physician was re-applying for privileges or not. However, even if there had been procedural issues by the hospital board, the HPARB hearing was a hearing de novo and the merits of the application were to be considered.

Chapter 4: Planning and Recruitment

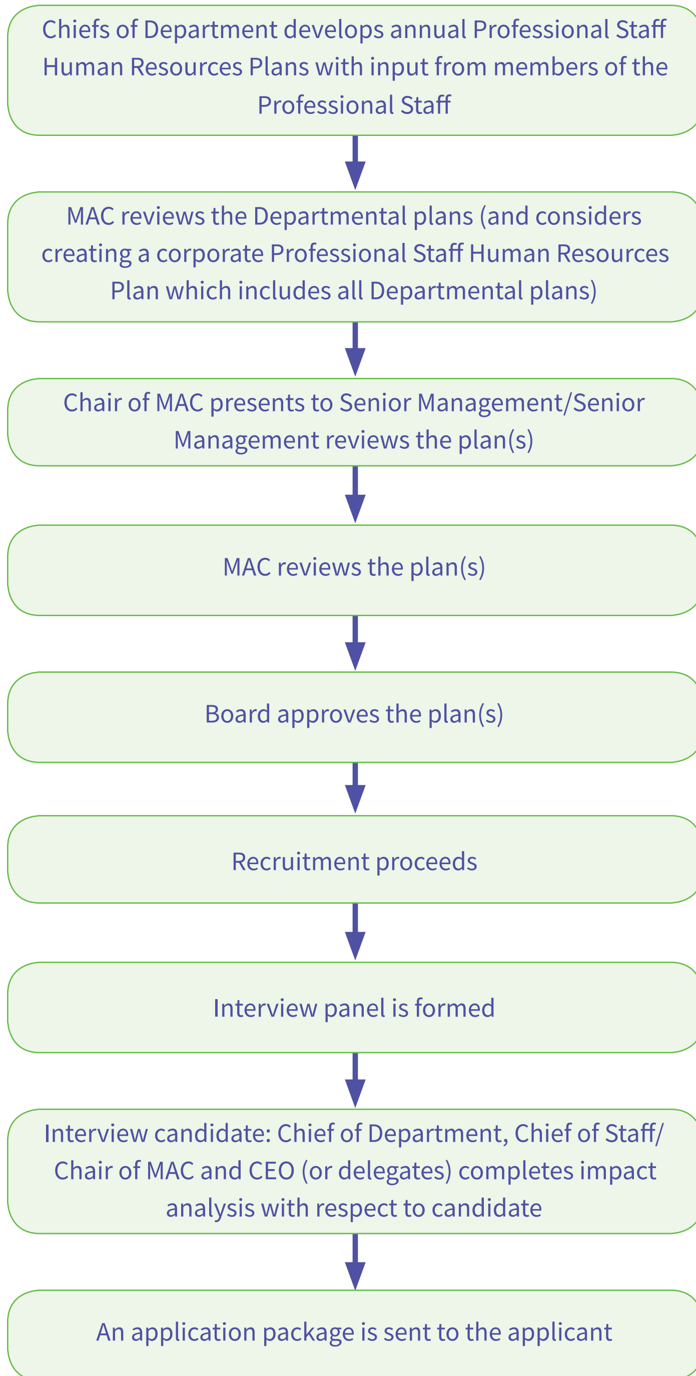
Reference Key:

Public Hospitals Act:	None
OHA/OMA Prototype By-law:	Sections 3.3, 3.4, 3.5

Chapter Summary

- A formal Professional Staff Human Resources Plan helps hospitals determine the appropriate number and type of Professional Staff members they require in both its current state and future state, in order to meet strategic goals for clinical care – these may be done on corporate and Departmental levels.
- A Professional Staff Human Resources Plan is also an excellent succession planning tool.
- While the *Public Hospitals Act* does not mandate planning initiatives, the OHA/OMA Prototype By-law references both Professional Staff Human Resources Plans and impact analyses as required tools which need to be completed before initial appointments are granted.
- Professional Staff Human Resources Plans that involve broad consultation throughout the hospital can assist with providing an objective analysis for the recruitment needs of a hospital and its community.
- Performing an impact analysis for each new applicant helps hospitals operate within their financial restrictions and ensure efficient utilization within their organizations.
- From time to time, hospitals may refuse initial appointments to the Professional Staff based on insufficient resources or misalignment with the strategic directions of the hospital. To successfully defend that position, hospital boards can rely on objective data included in the Professional Staff Human Resources Plans and individual impact analyses.
- Recruitment efforts need to be consistent with the Professional Staff Human Resources Plans.
- Systemic recruitment issues have made recruitment of physicians, in particular, challenging. Government programs (such as *Locum Tenens* programs) have been created to assist smaller, rural or northern hospitals with their recruitment efforts.
- Recruitment initiatives should be well-communicated internally to avoid disputes with existing Department staff who may be adversely impacted (e.g., less operating room (OR) time).

Planning and Recruitment Process



Professional Staff Human Resources Plans

Hospitals are becoming even more strategic about their planning, recruitment and succession planning efforts for Professional Staff.

Professional Staff Human Resources Plans and individual impact analyses (for initial appointment) are tools that can assist hospitals to collect the information they need to operate efficiently and effectively.

There are no legislative requirements that prescribe how a hospital should carry out its planning efforts.

The OHA/OMA Prototype By-law references both Professional Staff Human Resources Plans and impact analyses as required tools which should be completed before initial appointments are granted.

A Professional Staff Human Resources Plan provides information and future projections with respect to the management and appointment of the Professional Staff based on the mission, vision and strategic plan of the hospital.

The Chief of Staff/Chair of the Medical Advisory Committee (MAC) (or most appropriate clinical leader) should be tasked with the responsibility to ensure that the hospital has a Professional Staff Human Resources Plan(s). The Plan(s) should be informed by the Chiefs of Department after receiving and considering the input of members of the Professional Staff in the Department.

Each Department's input could consider:

- The required number and expertise of Professional Staff.
- Reasonable on-call requirements for members of the Professional Staff of the Department.
- A process for equitably distributing resource changes to members of the Professional Staff within the Department.

- A process for making decisions with respect to changes in Department resources and a related dispute resolution process.[1]
- Chiefs of Department (or most appropriate clinical leaders) should also consider identifying:
  - Current number and type of Professional Staff members (part-time and full-time) within Department.
  - Professional Staff members who are expected to resign or retire within next two years.
  - Number and type of Professional Staff members needed to provide the current level of services.
  - Anticipated change in service levels over the next two years (due to change in population, hospital's strategic plan, etc.).
  - Anticipated increase or decrease in number and type of Professional Staff members needed to provide services over next two years.
  - Number and type of Professional Staff members to be recruited.

The Plans may also identify any changes in resources (space, equipment, budget, and support staff) that may be required to accommodate additional Professional Staff members within the Department. These Plans also create an opportunity to approach and engage senior Professional Staff members in a strategic constructive discussion about the hospital's needs and their anticipated retirement plans.

Professional Staff Human Resources Plans may be reviewed by the Chief of Staff/Chair of the MAC (or most appropriate clinical leader), the CEO (or delegate), and the MAC before they are sent to the board for approval. The Plans should be updated on a regular basis, as the hospital updates and fine-tunes its own strategic plan. Hospitals should consider distributing the Plan(s) to Professional Staff members and applicants for appointment as appropriate.

Board Reliance on the Plans

Professional Staff Human Resources Plans are important resources for the board. The OHA/OMA Prototype By-law expressly contemplates that a board may refuse to appoint an applicant to the Professional Staff when:

> "…the Professional Staff Human Resources Plan and/or Impact Analysis of the Corporation and/or Department does not demonstrate sufficient resources to accommodate the applicant."[2]

Case law supports the board's right to refuse appointment in such cases. The British Columbia Medical Appeal Board (now the Hospital Appeal Board) confirmed that a hospital is entitled to determine the services it will plan and provide, and it can refuse to appoint physicians who seek privileges that are inconsistent with the services it provides:

> "There is no hospital in this province which can serve all the needs of the population which it serves. It is the responsibility of its Board of Management to determine which services are to be delivered to best answer the needs of the community and can be supplied by the hospital. The demands for any new service come from two sources: the community and the physicians practising in that community.
>
> In this case, no evidence has been submitted to suggest that the community itself felt the need for a plastic surgery service at the Hospital. Patients requiring this service have been looked after in nearby hospitals and in the referral centres in Vancouver. As well, the physicians practising in the Hospital gave no evidence that they felt that their patients were suffering from a lack of this service being immediately available in Langley. Although evidence was presented by the Hospital which revealed that the community was reaching a size where a plastic surgeon could be supported, the Manpower Committee of the Hospital has not yet recommended that the service be developed further than that which is currently available. Long range plans obviously include this as an expansion

1 Section 8.4.

2 Section 3.3(5)(b)

service along with others, but no evidence was presented to suggest that plans have been developed to allow such an expansion in the near future."[3]

In considering a new application, the board of a hospital may take into account the ratio of physicians to available beds and whether a particular Department is adequately staffed or a specialty is filled.[4] A board of a hospital is entitled to determine the appropriate complement of doctors for its Medical Staff.[5]

An applicant may try to prove that a hospital requires another physician or other type of Professional Staff member in order to provide sufficient and safe care to a community.[6] Hospitals do not have to grant privileges to every individual who applies. However, if a hospital proposes to refuse an initial appointment to the Professional Staff based on insufficient resources or misalignment with the needs or strategic directions of the hospital, the hospital will need to provide evidence or statistics to support that position in a timely manner (such as through a Professional Staff Human Resource Plan or impact analysis).

Systemic Recruitment Challenges

Physician shortages are uniquely felt in smaller rural and northern communities. Hospitals may wish to avail themselves of the following services that address the impact of physician shortages:

- The *Underserviced Area Program* of the Ministry of Health, which addresses some of these issues by offering health care professionals both practice and financial incentives, and supports for health service providers.
- HealthForceOntario,[7] a Government of Ontario initiative that assists communities and hospitals to address recruitment challenges, including immigration and supervision issues:
  - Provides information about licensure, certification requirements[8] and career counseling and support for internationally educated health professionals.
  - Administers the Locum Credentialing Application Program, whereby family physicians interested in doing *Locum Tenens* to work in small and rural hospitals can complete an application form which is provided to interested hospitals.[9]
  - Provides urgent emergency department locum coverage as an interim measure of last resort to designated hospitals that are facing significant challenges covering emergency department shifts, by making physicians from other emergency departments in Ontario available for shifts (known as the Emergency Department Coverage Demonstration Project).[10]
- Touchstone Institute[11] (formerly the Centre for the Evaluation of Health Professionals Educated Abroad) provides professional competency assessment, ongoing evaluation and orientation programs for internationally educated health professionals.

The Agreement on Internal Trade (AIT) is another factor that may impact recruitment. The AIT is a signed treaty amongst Canada's provinces and territories that entitles physicians and other health care professionals

3 Varkony v. Langley Memorial Hospital (1992), (BC Medical Appeal Board) at 18-19.

4 *Re Macdonald and North York General Hospital*, [1975] O.J. No. 2372 (Ont. Div. Ct.).

5 *Chin v. Salvation Army Scarborough Grace General Hospital*, [1988] O.J. No. 517 (Ont. Div. Ct.).

6 *Dr. Borenstein and Humber River Regional Hospital* (2003), (ON Health Professions Appeal and Review Board).

7 See HealthForceOntario <http://www.healthforceontario.ca/> for all programs, including HealthForceOntario Northern Specialist Locum Programs (NSLP), Rural Family Medicine Locum Program (RFMLP), Emergency Department Locum Program (EDLP) and HealthForceOntario Postgraduate Return of Service (ROS) Program.

8 HealthForceOntario, Licensing and Certification (2019), http://www.healthforceontario.ca/UserFiles/file/PRG/Module01-PRG-Licensing-EN.pdf

9 http://www.healthforceontario.ca/UserFiles/file/PRC/recruitment-essentials-locum-en.pdf

10 http://www.healthforceontario.ca/UserFiles/file/EDLP/ed-toolkit-2013-en.pdf

11 https://touchstoneinstitute.ca/

with a practice licence in any Canadian province to an equivalent licence in any other province. The College of Physicians and Surgeons of Ontario (CPSO) has expressed concerns that some provinces may have lowered their entry standards in order to recruit physicians.[12] With the Ontario *Labour Mobility Act,* 2009, physicians from another province who may not meet CPSO standards are entitled to a CPSO licence. This increases the need for a thorough credentialing process on the part of Ontario's hospitals. *See Chapter 5, Initial Appointment.*

Recruitment Process

Most applications for initial appointment to a hospital will be received because of planning and recruitment efforts. Hospitals tend to identify needs through the preparation and updating of a Professional Staff Human Resources Plan. They then undertake a search (post a job description and seek applicants) either directly or through a search firm. Some recruit through the academic and clinical placements of learners and fellows.

In order to avoid a deluge of applications, postings for Professional Staff positions should invite expressions of interest (not applications). These applicants can then be pre-screened before they receive applications. *See discussion of receiving unsolicited applications for appointment in Chapter 5, Initial Appointment.*

The recruitment process will involve a face-to-face interview, typically involving the CEO (or delegate), Chief of Staff/Chair of the MAC and applicable Chief of Department (or most appropriate clinical leaders). This interview allows the hospital to canvass any questions or issues raised by the application form or supplemental materials submitted by the applicant. The applicant can also familiarize themselves with the hospital premises and resources.

It is also a useful practice to debrief any applicant who chooses not to accept privileges at the hospital after showing an initial expression of interest. This can help the hospital identify areas where it needs to improve its recruitment efforts.

12 J. Hefley, J. Mandel and R. Gerace, Internationally Educated Healthcare Workers: Focus on Physicians in Ontario (HealthcarePapers 10(2) 2010:41-45.

Recruitment Incentives

Rural and northern hospitals have also been proactive in coming up with their own creative strategies to address shortages. For one, common credentialing policies and processes allow hospitals to pool their Professional Staff resources more easily. *See Chapter 5, Initial Appointment, for a discussion of Joint Credentialing Initiatives.*

Foundations have raised funds to support hospitals in their Professional Staff recruitment efforts.

Return of service arrangements are another form of recruitment incentive, whereby a hospital or the Ministry of Health pays for postgraduate education of physicians. This payment is made in the form of a loan, which is forgiven over time when the physician returns to the community to work at the hospital. Hospitals should seek legal advice on how best to protect themselves when structuring such arrangements.

Impact Analysis

The OHA/OMA Prototype By-law defines an impact analysis as:

> a study conducted by the Chief Executive Officer in consultation with the Chief of Staff and the affected Chief(s) of Department to determine the impact upon the resources of the Corporation, including the impact upon the resources of a Department, of a proposed appointment of an applicant to the Professional Staff or an application by a Professional Staff member for additional privileges or a change in membership category.[13]

The impact analysis should be a standard form that can be easily completed for each applicant for appointment, and should canvas the following areas:

- Will the Professional Staff member be using inpatient resources?
- Will the Professional Staff member be paid a stipend, recruitment bonus, etc.?

13 Section 1.1(v)

- Will the Professional Staff member require an in-hospital office or other clerical support or office equipment?
- Will the Professional Staff member require OR time?
- Will the Professional Staff member require clinic time? specialized unit time? laboratory support? diagnostic imaging support?

For the planning and recruitment of midwives, the Ministry of Health's needs assessment process should be consulted as it is an independent process to the one hospitals perform.[14] *See the OHA Resource Manual for Sustaining Quality Midwifery Services in Hospitals for more information.*

The impact analysis should be reviewed by the Chief of Department, Chief of Staff/Chair of the MAC (or most appropriate clinical leaders) and CEO (or delegate).

It is also critical that the impact analysis focus on the impact of a new recruit on the existing Professional Staff. In the case of *Beiko*, four ophthalmologists practising at Hotel Dieu Hospital in St. Catharines brought a breach of contract lawsuit against the hospital and its CEO.[15] The hospital recruited a new ophthalmologist with the objective of increasing the number of ophthalmologic cases performed at the hospital. However, the new recruit would impact the OR time available to the existing four. The four attempted to claim $500,000 in damages from the hospital through a breach of contract lawsuit, alleging that their OR block was effectively a contract between them and the hospital. The ophthalmologists complained about their reduced OR time as a change in privileges, which reduction was supported by the MAC and ultimately the hospital board at a privileges hearing. The court found that the physicians could not sue the hospital for breach of contract until they pursued their appeal rights to the Health Professions Appeal and Review Board (HPARB) under the *Public Hospitals Act*. Nevertheless, the case underscores the importance of communicating clearly and transparently with existing Professional Staff about recruitment plans and inviting them to make proposals as to how to achieve the hospital's objectives.

For example, when a hospital wishes to recruit a full-time physician to take the place of several part-time physicians, it would be prudent for the hospital to meet with the existing physicians to identify the hospital's concerns about the part-time service, any gaps in hospital needs, and how a full-time physician would better serve the hospital and community. The Chief of Department (or most appropriate clinical leader) may also invite the existing part-time physicians to make proposals to the hospital about how they can better service the Department's needs, in order to have a clear and open process prior to recruiting.[16]

Best Practices in Recruitment

- Recruiting Professional Staff in accordance with the Professional Staff Human Resources Plans.
- Completing essential steps in the recruitment process.
- Communicating clearly the category/status of appointment for which you are recruiting.
- Approving an application from a candidate only with objective data to support recruitment in the form of a Professional Staff Human Resources Plan and individual impact analysis for the applicant.

FAQs

1. If a dentist, midwife or extended class nurse makes an application for appointment, does the hospital have to process the application?

Under the *Public Hospitals Act*, a bundle of rights attaches to a physician candidate as soon as they request and submit an application to the hospital. While no one is entitled to an appointment to the Medical Staff at a hospital, an applicant is entitled to have their application reviewed by the MAC and board and to receive a decision

14 See the OHA "Resource Manual for Sustaining Quality Midwifery Services in Hospitals", p. 35.

15 *Beiko v. Hotel Dieu Hospital St. Catherines,* 2007 CanLII 1912 (Ont. S.C.).

16 If the existing part-time Professional Staff members disagree with the recruitment strategy a privileges dispute may arise. Such situations can be difficult for all parties involved. Legal advice should be sought.

about appointment in a timely manner. These rights under the *Public Hospitals Act* apply only to physicians, but it would be considered best practice to extend these rights to dentists, midwives and extended class nurses through the hospital's by-laws. If these rights are not extended, it is important for the hospital to have written by-laws or processes that explain the hospital's approach to initial applications from dental, midwifery, and extended class nursing applicants. There should be a fair and transparent process for all applicants to the Professional Staff.

2. How do we avoid having candidates recruited outside the formal credentialing and appointment process?

Hospitals can implement office opening protocols so that someone (such as the Chair of MAC, Manager of the Medical Affairs Office, or assistant to the CEO) performs a check and balance to ensure that no member of the Professional Staff starts working within the hospital without having privileges. This is usually achieved by ensuring that physicians, dentists, midwives and extended class nurses cannot obtain the following until they have been approved by a central office:

Email address
Phone number
Keys
Access to health records

Hospitals should also ensure their Chiefs/Heads understand and adhere to a formal recruitment process.

3. How should conflicts of interest be managed when dealing with recruitment efforts? Don't existing Professional Staff members have an inherent conflict of interest in determining whether there is enough work for a new or different kind of health practitioner to join a Department or hospital?

Conflicts of interest can and do arise with recruitment efforts. The introduction of new members and disciplines to a Professional Staff team can have potentially negative implications for the financial opportunities and access to hospital resources available to existing members of the team. It is important to acknowledge and declare these conflicts. Professional Staff Human Resources Plans that involve broad consultation throughout the hospital can assist with providing an objective analysis of the recruitment needs of a hospital and its community. Boards should ask if there are any conflicts of interest with respect to the recommendations to grant (or refuse to grant) privileges.

Chapter 5: Initial Appointment

Reference Key:

Public Hospitals Act:	Sections 36-38
OHA/OMA Prototype By-law:	Sections 3.1 – 3.6

Chapter Summary

- As a result of planning and recruitment efforts, hospitals will receive applications for initial appointment to the Professional Staff.
- A hospital may also receive uninvited applications for appointment.

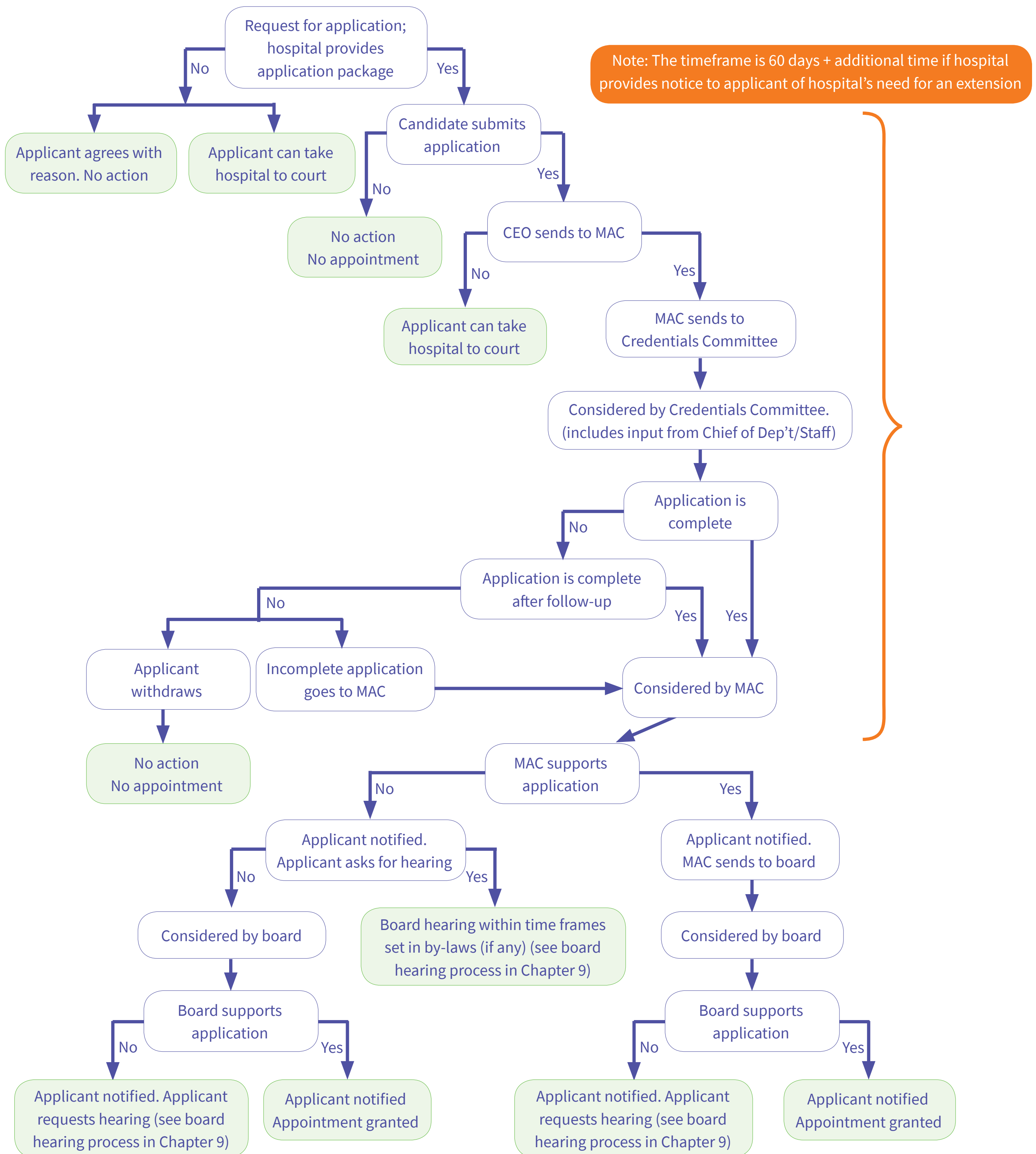
There are six steps to the initial appointment process:

1. Receipt of application form
2. Collection of supplemental information
3. Verification of credentials (including independent confirmation of information)
4. Assessment of credentials (including alignment with hospital goals and resources)
5. Recommendation of the Medical Advisory Committee (MAC)
6. Decision by the board

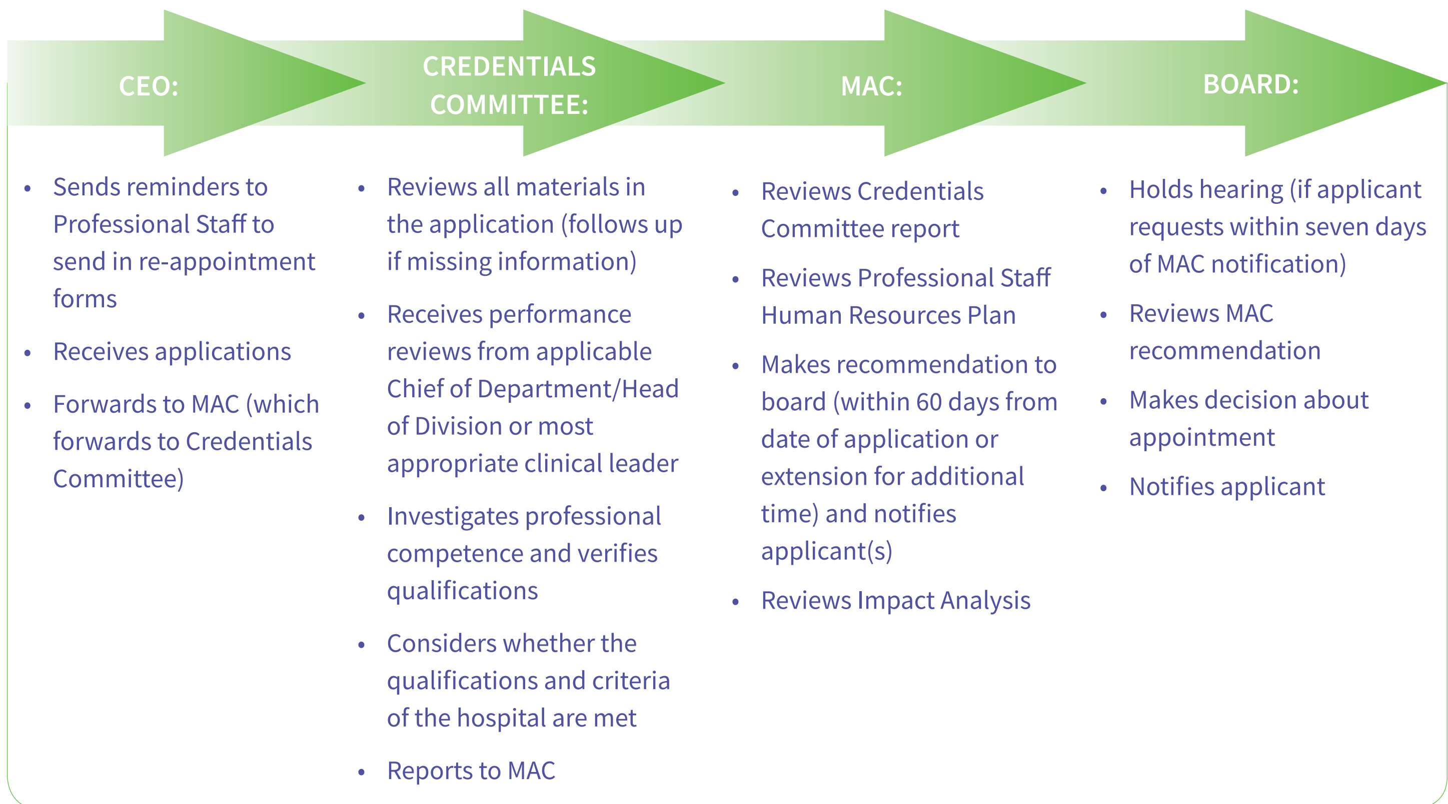
- Any physician who applies for privileges at a hospital is entitled to have their application considered by the board (this right is found in the *Public Hospitals Act* and can also be extended to apply to dentists, midwives or extended class nurses if included in the hospital's by-laws). A hospital cannot merely refuse to review a physician's application.
- Extra care should be taken with initial appointments to the Professional Staff, because these applicants may be unknown to the hospital. This requires greater reliance on third-party information (including from academic institutions, regulatory bodies and references).
- An initial probationary period may be appropriate to allow hospital leadership to assess a new Professional Staff member's skills. However, it is inappropriate to leave individuals in a permanent state of "probation".
- Credentialing is the process by which a hospital reassures itself that applicants for initial appointment to the Professional Staff have all the necessary qualifications in order to be granted privileges.
- While there is a significant role for Chiefs of Department (or most appropriate clinical leader), administrative staff, the Credentials Committee and the MAC, it is the board which makes the ultimate decision whether or not to grant privileges.
- The concept of temporary appointments can be included in the hospital by-laws to allow a CEO or Chief of Staff/Chair of the MAC the authority to grant time-limited appointments in urgent situations (e.g., in a pandemic or otherwise as part of emergency preparedness). [1]
- Chiefs and Heads must realize that a formal credentialing process is required for each new applicant to the Professional Staff (regardless of the applicant's seniority). Hospitals should have processes to ensure privileges are in place before work commences.

1 See section 3.6 of the OHA/OMA Prototype Bylaws

Appointment Process



Initial Appointment Process by Role



Right to Apply for Privileges

Most applications for initial appointment to a hospital will be received because of planning and recruitment efforts (*see Chapter 4, Planning and Recruitment*). Interested candidates will be considered in the context of a position opening, and the successful candidate will submit an application.

However, section 37(1) of the *Public Hospitals Act* provides that any physician is entitled to apply to be appointed at any hospital. The CEO must give an application form to any physician who asks for one. Once submitted, the CEO (as the administrator under the *Public Hospitals Act*) is required to forward the application to the MAC immediately. The physician is entitled to have their application ultimately considered by the board in a timely manner. A hospital cannot refuse to review an application. If a hospital refuses the initial appointment, for whatever reason, the candidate is entitled to request a hearing before the board. *See Chapter 9, Refusing Appointments and Re-appointments and Suspending, Restricting or Revoking Privileges.*

On a practical note, although not required, some hospitals will ask physicians to meet with the hospital before providing an application form. This allows the hospital to explain its Professional Staff needs to the physician, so that the physician can better understand whether there is a need for their services and whether the application for appointment will be favourably received.

In summary, a bundle of rights attaches to a physician candidate as soon as they request and submit an application to the hospital. While no one is guaranteed an appointment to the Medical Staff at a hospital, an applicant is entitled to have their application reviewed by the MAC and board and to receive a decision about appointment in a timely manner.

These rights under the *Public Hospitals Act* apply only to physicians, but they can be, and are usually extended to dentists, midwives and extended class nurses through the hospital's by-laws. If these rights are not extended, it is important for the hospital to have written by-laws or processes that explain the hospital's approach to initial applications from dental, midwifery, and extended class nursing applicants. There should be a fair and transparent process for all applicants to the Professional Staff.

Content of an Application Package

The hospital by-laws should set out the content of the application package to be sent to candidates interested in an appointment to the hospital's Medical Staff (or Professional Staff, as applicable). The application package typically includes (or provides a link to online resources):

- Application form for initial appointment
- Mission, vision, values and overview of the hospital's strategic plan
- *Public Hospitals Act* and Regulation 965
- By-laws
- Professional Staff Rules and Regulations
- Listing of policies applicable to the Professional Staff
- Applicable codes of ethics, such as the Health Ethics Guide of the Catholic Health Association of Canada

The *Public Hospitals Act* does not prescribe what must be included in an application form or package; this is reserved for the hospital's by-laws. Section 3.4 of the OHA/OMA Prototype By-law sets out recommended content for Professional Staff applications for initial appointment, including "signed consents to enable the hospital to inquire with the applicable regulatory college and other hospitals, institutions and facilities where the applicant has previously provided professional services or received professional training to allow the hospital to fully investigate the qualifications and suitability of the applicant." This Toolkit includes sample content for an application for appointment and a sample application form.

There is more publicly available information about candidates for privileges than ever before. Regulatory Colleges now post additional information on their public registers about licensed members' criminal charges, cautions-in-person, mandatory continuing education, and disciplinary findings from other jurisdictions. This information is vital to review at the initial appointment phase. However, if a hospital's by-laws do not contemplate such information as relevant to the initial application, the hospital could be criticized for collecting and considering irrelevant content.

Receipt of an Application and Timelines for Processing

Under section 37(3) of the *Public Hospitals Act*, applications are to be submitted to the CEO (as the administrator under the Act) who shall immediately refer the application to the MAC. In many hospitals, applications are sent directly to the Professional Staff Office or credentialing office. It should be clear on the application form to which position or office within the hospital the application is to be submitted. In some hospitals, application forms are completed online. *See Chapter 11, Maintaining Professional Staff Files.*

The *Public Hospitals Act* sets timelines for the processing of applications. It requires that the MAC render its recommendation to the board in writing within 60 days of the date of the application.[2] An extension beyond the 60 days is permitted on notice to both the board and the applicant (but the notice must include reasons for the delay).[3] The Credentials Committee and the MAC must be mindful of the timelines and seek to process applications in a timely manner.

There have been a few physician privileges cases that address the issue of the timing of the processing of an application. For example, in the case of Waddell v. Weeneebayko, 2018 CanLII 39843 (ON HPARB), the Health Professions Appeal and Review Board reviewed a situation where a hospital did not consider a physician's application within 60 days from the date of the application. HPARB

2 *Public Hospitals Act* s. 37(4).

3 *Public Hospitals Act* s. 37(5).

concluded that delay was primarily due to the physician's actions and confusion over whether the physician was re-applying for privileges or not.

While the *Public Hospitals Act* only strictly applies to physician applications, the hospital by-laws should consider extending the same timelines to the processing of applications of other members of the Professional Staff, or clearly identify alternate timelines. Whatever the decision, hospitals should ensure their practice is fair and transparent and that applications are processed in a timely manner.

No Professional Staff member should have to experience unreasonable waits in processing their applications. Delays in processing hospital applications for all Professional Staff can have a serious negative impact on clinical care.

Chief of Department's (or Most Appropriate Clinical Leader) Recommendation of an Applicant

If the hospital has Departments and/or Divisions, the Chief of Department and/or Head of Division should be asked to comment on any application for initial appointment to their staff.

If the hospital does not have Departments or Divisions, the by-laws should set out an explanation of who will be asked to comment on the application (i.e., the most appropriate clinical leader).

The Credentials Committee will need to know the background for recruiting the applicant (if any) and whether there were any negotiations relating to the type or scope of privileges. The Chief of Department and/or Head of Division should be clear about whether they support the application and the reasons why or why not.

Credentials Committee's Collection, Verification and Assessment of Qualifications

Credentialing is the process by which a hospital collects, verifies and assesses the information included in the application and reassures itself (often through independent third-party confirmation) that applicants for initial appointment have all the necessary qualifications for the position. This is the stage where hospitals demonstrate their due diligence in the appropriate vetting of prospective Professional Staff members. Extra care and review should be taken for initial appointments to the Professional Staff because in general, these applicants are not known to the hospital.

In the United States, credentialing is a highly regulated activity.[4] In Ontario (and Canada generally), the act of credentialing is not prescribed in the *Public Hospitals Act* or its regulations, and there are no accreditation standards specifically related to hospital credentialing. As a result, credentialing practices differ from hospital to hospital and should be set out explicitly in the hospital by-laws and hospital policy. The hospital by-laws ought to describe the tasks to be completed before an application is brought to the hospital board for consideration for appointment. These tasks are usually completed in sequence by an administrative person, the Credentials Committee and the MAC.

The *Public Hospitals Act* requires that the MAC review all applications before the hospital board makes a decision about appointment. In practice, most hospitals include one or more steps prior to the MAC review. Specifically, by-laws typically require an administrative person and then the Credentials Committee to do the first review of all applications.

4 *See Verify and Comply, A Quick Reference Guide To Credentialing Standards, Seventh Edition* Stephanie Russell, Kathy Matzka, and Carol S. Cairns 2017, *The Handbook for Credentialing Healthcare Providers*, Ellis Knight, 2016, and *Health Care Credentialing, A Guide to Innovative Practices*, Fay A. Rozovksy et al, Walters Kluwer, Aspen Publishers, 2010.

Since there is no legal requirement to have a Credentials Committee, committee tasks may be performed by an individual or another group or committee. In some hospitals, these tasks are completed by the assistant to the CEO or a Manager/Director of Medical Affairs. For purposes of the Toolkit, we'll refer to the one or more individuals as the "Credentials Committee", acknowledging that there may be an administrative person who completes the steps prior to the Credentials Committee reviewing the packages.

For a summary of the roles and responsibilities of the Credentials Committee, see Chapter 3, Roles and Responsibilities.

In summary, the Credentials Committee performs the following tasks with respect to applications for initial appointment:

- Reviews each application and any supplemental material (e.g., written letters of reference, certificate of professional liability protection coverage or insurance, copy of certificate of registration, curriculum vitae, Certificate of Professional Conduct (CPC), and content posted on the public register available through the applicant's regulatory college).
- Reviews the recommendation of the Chief of Department/Head of Division specific to each application.
- Contacts primary sources of information, as well as independently verifies the information provided by the applicants.
- Ensures all required information has been provided and follows up with candidates if their applications are incomplete.
- Investigates each applicant's professional competence.
- Verifies the applicant's qualifications.

The hospital by-laws set out the criteria against which every applicant for appointment is to be evaluated. Hospitals may only consider the criteria listed in the by-laws when determining an applicant's qualifications. In order to be fair, the evaluation and appointment process criteria must be transparent to the applicant.

In making a determination to support an application for appointment, a Credentials Committee should be able to answer "yes" to all the following statements:

- ☑ The application is complete.
- ☑ The application meets the criteria in the by-laws.
- ☑ The application is appropriate for the privileges requested (that is, contains the relevant information and qualifications for the category and types of privileges requested).
- ☑ The Chief of Department/Head of Division supports the application.
- ☑ All three letters of reference support the application.
- ☑ The applicant is in good standing with their regulatory body.
- ☑ The applicant has appropriate professional liability protection coverage or insurance in place.

Reminder: Information collected by the hospital is confidential and should be protected. *See section on Confidentiality, Access and Disclosure in Chapter 11, Maintaining Credentialing Files.*

Letters of Reference

Most hospitals require candidates for initial appointment to provide letters of reference. These letters of reference come from individuals with whom the candidate has worked in the past. Given that the hospital is unlikely to have first-hand experience with most candidates, letters of reference are an important part of the credentialing process for initial applications.

As a practice tip, it is a good idea to:

- Construct a questionnaire that sets out specific questions for the referee to answer.
- Scan a picture of the applicant and send it to the professional references with the questionnaire to confirm the identity of the individual.

Hospitals rely on referees to provide an objective and honest description of the candidate and their conduct, experience and competence. Hospitals should require that the letters of reference be sent directly to the hospital and that the letters be kept confidential (i.e., not shared with the candidates). Practically speaking, the letters should be kept confidential and should not be subject to access or review if a candidate or Professional Staff member asks for access to their file. *See Chapter 11, Maintaining Professional Staff Files.*

In *Straka v. Humber River Regional Hospital et al.*,[5] a physician was offered a position at the Humber River Regional Hospital contingent upon Humber's receiving letters of reference from his colleagues at St. Michael's Hospital. The letters were provided to Humber in strict confidence. Dr. Straka did not receive an appointment, but was permitted to practice on a Locum Tenens basis. Dr. Straka brought a court application to compel the hospital to give him a copy of the letters of reference. His application was defeated because the court found the letters to be "privileged". The court held that the shield of confidentiality was essential to the effective maintenance of the relationship between referees and hospital boards. Giving references is effectively a peer review process, and a critical element to the credentialing process. As such, the court found that it was important to keep the reference letters confidential from the applicant. The court also concluded that Dr. Straka should have pursued a review of his case under the *Public Hospitals Act* (i.e., his appropriate remedy for the refusal of his application was to appeal to HPARB, not apply to the court).

Given the importance of reference letters to the peer review process and credentialing, it is recommended that the hospital receiving the letters take measures to ensure their source is legitimate. Hospitals may choose to contact referees by phone, confirm the name of the referee with the Canadian Medical Directory or other similar listing, or use the Internet to cross-reference referees and their professional backgrounds.

5 51 O.R. (3d) 1, [2000] O.J. No. 4212 (C.A.).

Certificate of Professional Conduct

In the OHA/OMA Prototype By-law, applicants for appointment to the Medical Staff, Dental Staff, and Midwifery Staff must have a current Certificate of Professional Conduct (CPC)[6] from their most recent licensing bodies. Extended Class Nursing Staff must have a letter of good standing.

A CPC verifies that a Professional Staff member is registered, and confirms membership in good standing with their respective college. Hospital personnel involved in credentialing can request CPCs to assist them in reviewing applications for hospital privileges.

A CPC will likely contain the applicant's qualifications (including date, place and specialties), history of previous disciplinary findings, and other information that the Registrar believes is relevant to an application for hospital privileges. It may not be up-to-date on current matters before the College.

To obtain a CPC, a member must request it from their regulatory college, along with a fee and consent to the release of information.

MAC's Recommendation for Appointment

If the hospital does not have a Credentials Committee, the MAC is responsible for all the elements listed above as tasks assigned to the Credentials Committee. The MAC should have a thorough review of any applications that are identified as problematic.

The additional tasks that the MAC will perform are:

- Reviewing the Credentials Committee's report.
- Considering the Departmental Professional Staff Human Resources Plans.
- Considering the impact analysis data.

6 The name of the CPC varies according to the regulatory body and may be called a letter of professional conduct, a letter of standing, or another name similar in nature.

- Making a recommendation to the board as to whether to grant privileges to the applicant.
- If the recommendation is positive, considering and determining the list of procedures and privileges to give the applicant.

Regulation 965 of the *Public Hospitals Act* allows only physicians to be voting members of the MAC. While many hospitals have created a more multi-disciplinary MAC to reflect the reality of the Professional Staff mix within the hospital, any Professional Staff member on the MAC who is not a physician cannot have voting rights with respect to decisions about initial appointments (or any other privileges matters).

When the MAC makes its decision (to either recommend or not recommend the applicant), it must notify both the applicant and the hospital board in writing.

Sections 37(6) and (7) of the *Public Hospitals Act* require that a physician applicant be notified that they are entitled to:

- Written reasons for the recommendation if a request is received by the MAC within seven days of the receipt by the applicant of notice of the recommendation.
- A hearing before the hospital board if a written request is received by the board and the MAC within seven days of the receipt by the applicant of the written reasons. If a hearing is requested, see Chapter 9, Refusing Appointments and Re-appointments and Suspending, Restricting or Revoking Privileges, for a discussion about board hearings.

This notification can also apply to other members of the Professional Staff if the same process is extended to them in the hospital by-laws.

For the vast majority of applicants, there will be no need for a hearing because the MAC will recommend the applicant for appointment and the MAC will prepare a list of initial appointments for the board to consider. However, when there are problems with the application, the MAC should seek legal advice. *See Chapter 9, Refusing Appointments and Re-appointments and Suspending, Restricting or Revoking Privileges.*

Board's Role: Deciding to Appoint to the Professional Staff

Once the administrative staff person has collected the information, the Credentials Committee has reviewed the applications and made recommendations to the MAC, and the MAC has reviewed the applications and made recommendations to the board, the next step is appointment, which is the responsibility of the board.

Section 38 of the *Public Hospitals Act* states that if an applicant does not require a hearing after receiving the MAC's written recommendation with respect to appointment, the board may implement the recommendation of the MAC.

Section 39 of the *Public Hospitals Act* states that where an applicant requires a hearing, the board shall appoint a time for the hearing and at that point will decide on the appointment. *See Chapter 9, Refusing Appointments and Re-appointments and Suspending, Restricting or Revoking Privileges.*

To make its decisions about appointments and the privileges to be assigned, the board primarily relies on the recommendations of the Credentials Committee and the MAC. The board is entitled to give "great weight" to the recommendations of the MAC, due to its medical expertise.[7] However, the board must make its own independent decision. The board is responsible for ensuring an effective and fair credentialing process.

While it does not need to receive all the details for every candidate, it must be reassured that the processes meet legal requirements. This responsibility can be discharged by:

- Ensuring the Board-Appointed Professional Staff By-law is reviewed by legal counsel (usually every three years or more frequently if there is new legislation or new guidelines such as the OHA/OMA Prototype By-law).

7 *Re Sheriton and North York General Hospital* (ON Hospital Appeal Board, 1973), referred to in Pratt v. Fraser Health Authority (BCSC, 2007)

- Asking the Chief of Staff/Chair of the MAC (or most appropriate clinical leader) questions about:
  - The length of time it takes to process applications.
  - The trends in applications.
  - Whether the hospital is successful or faces challenges with respect to recruitment.
  - The steps the Credentials Committee takes to:
    a. Protect against fraudulent applications.
    b. Verify information in applications from primary sources and independent third parties.
    c. Review letters of reference and whether and how they follow up on issues of concern.
    d. Follow up on applications that raise concerns.
    e. Review trends in credentialing best practices.
  - How the applications relate to the Professional Staff Human Resources Plans and the hospital's strategic plan.
  - Whether the candidates are qualified, and not just the only applicants who applied.
- Considering whether the MAC's recommendations are consistent with the hospital by-laws, Rules and Regulations, hospital policies and the Professional Staff Human Resources Plans.
- Asking a board sub-committee (like the Audit Committee) to complete an annual audit of the hospital's credentialing process by reviewing a random sample of applications for appointment, re-appointment and changes to privileges.

Further, if any board member has independent knowledge of a candidate, that knowledge should be disclosed. It would be prudent to seek legal advice if the board independently raises concerns about a candidate who has been recommended for appointment by the MAC.

Regional/Joint Credentialing Initiatives

A variety of circumstances arise when regional or "joint" credentialing between hospitals makes sense, including:

- When two or more hospitals share Professional Staff.
- When Hospital A needs Professional Staff to perform a service and Hospital B provides the Professional Staff to perform that service (e.g., Hospital B provides anesthesiologists to Hospital A).
- When the hospitals intend to share Professional Staff in an under-resourced area and want to allow for streamlined credentialing.
- To reduce the burden on Professional Staff who work in multiple locations.

A hospital board cannot delegate its responsibility for decisions about appointment or re-appointment to the Professional Staff. Each hospital board retains ultimate responsibility for the credentialing process and cannot fetter (meaning confine or restrain) its decision-making power by virtue of being part of a joint credentialing initiative. Any joint credentialing initiatives must be satisfactory to each hospital's board.

There may be many ways to conduct joint credentialing. It is important for participating hospitals to seek legal advice early in the process to ensure the proposal for joint credentialing meets legal requirements.

To initiate a joint credentialing initiative, all participating hospitals should consider:

- Recording how the joint credentialing initiative will be conducted (such as through a Joint Credentialing Policy that is approved by each hospital board) to:
  - Identify the purposes for the initiative.
  - Determine the scope of the initiative:
    a. Will it only apply to certain categories of Professional Staff?
    b. Will all participating hospitals share a Professional Staff?

- Clarify how accountability for each hospital in the partnership is retained under the *Public Hospitals Act* and Professional Staff by-law.
- Address all aspects of the joint credentialing initiative including processes of appointment, re-appointment, change in privileges and suspension, revocation or restriction of privileges.
- Identify the common criteria for appointment and re-appointment in the joint process.
- Determine how information (and how much information) will be exchanged among the participating hospitals with the consent of the individual and for what purposes (and what happens if an individual withdraws consent for the sharing of information).
- Determine how complaints, problems and disciplinary matters will be managed and communicated between the participating hospitals.
- Identify which hospital(s) will conduct performance reviews.
- Determine how liability, indemnities and insurance will be affected (this may be easier where there is a joint insurer for all participating hospitals).

- Amending their Professional Staff by-law to contemplate the joint credentialing process and making any necessary changes to hospital by-laws in order to harmonize with the common criteria for appointment and re-appointment.
- Creating a new Joint Credentialing Application Form that addresses the new process and its terms and conditions.
- Discussing the initiative with their Professional Staff to explain how the process will work and who is entitled to participate.

As one example of joint credentialing initiatives, some hospitals have streamlined application processes for candidates who have gone through the usual credentialing process at another participating hospital. Applicants may qualify for a streamlined application process provided they hold and agree to maintain a primary appointment at another participating hospital. Streamlined applications may include content such as:

- A Joint Credentialing Application Form requesting privileges (that is, the category, type and scope of privileges requested);
- A shared CPC;
- A consent permitting all participating hospitals where the applicant has applied to review all credentialing information held by other hospitals for purposes of joint credentialing;
- Relevant undertakings that would be required on appointment or re-appointment; and
- Consents and releases that would be required on appointment or re-appointment.

The hospital where the applicant holds the primary appointment typically shares the applicant's privileges file with the other hospitals to allow their Credentials Committee (or equivalent) to carry out their investigations and due diligence, and the primary hospital typically provides written assurance that it has complied with the agreed-upon credentialing processes in its by-laws. This cuts down on the need to collect the original documentation and independently verify references, saving significant time.

No applicant information should be shared amongst hospitals participating in a joint credentialing scheme without the prior written consent of that applicant. This consent should form part of the application process.

Hospitals should highlight that the following information could be exchanged among participating hospitals:

- Information relating to the application for appointment or re-appointment and any supporting documentation.
- Information from the applicant's regulatory college.
- Information from the applicant's professional liability protection provider (insurer).

- Any changes to privileges including actions or proposals to restrict, suspend or revoke privileges for any reason.
- Performance reviews.
- Requests and grants of leave of absence.
- Complaints or compliments with respect to the applicant's practice.
- Information relating to internal investigations involving the applicant.
- Information with respect to external investigations involving the applicant such as by OHIP, a coroner, or the police.

All information exchanged should be treated as confidential by the receiving hospital.

Examples of joint credentialing systems in Ontario include: the cMARS reappointment system

Probationary Period

The OHA/OMA Prototype By-law includes the concept of a probationary period for new recruits to the Associate category of Professional Staff (before becoming Active Staff) and for Extended Class Nursing. While not required by law, probationary periods have been recognized in case law as providing hospital leaders "the opportunity to assess, in a supervised setting, an associate's abilities"[8] in the case of new recruits and existing Professional Staff who wish to change categories of privileges. This assessment may be foundational to the hospital establishing a safe environment for its patients.

However, there has also been a misuse of probationary periods. In the case of *Saskatoon Regional Health Authority and Johnson*, *2014 SKQB 266* (CanLII), <*http://canlii.ca/t/gdr5n*>, a department head was described as a"rogue elephant stampeding through the Bylaws" (para. 119) who used temporary appointments to create a longer probationary period for his department and did not explain to candidates that appointments were temporary only.

Temporary Appointments

A temporary appointment refers to limited clinical privileges that have been granted for a specific period of time. Details of such appointments may be outlined in a hospital's by-laws or policies.

It may be necessary at times for the hospital to accommodate temporary appointments to the Professional Staff to deal with time-sensitive issues or to meet specific hospital needs. For example, in the case of a telehealth consultation or appointment for the purposes of assisting with a medically-assisted death. *See Chapter 1.*

Although not contemplated in the *Public Hospitals Act*, hospital by-laws typically include a provision to allow for temporary appointments. In the OHA/OMA Prototype By-law, the authority is granted to the CEO (or delegate), after consultation with the Chief of Staff/Chair of the MAC (or most appropriate clinical leader) to:

- Grant a temporary appointment and temporary privileges to a physician, dentist, midwife or registered nurse in the extended class; and
- Continue a temporary appointment and temporary privileges on the recommendation of the MAC, only until the next board meeting.[9]

However, temporary appointments are always subject to MAC and board approval and must be brought forward for such approval at the earliest opportunity.

From time to time (for example, in the summer months when hospital boards may not meet), it may happen that a temporary appointment starts and finishes before board approval can be sought. In such cases, the board should be notified of the appointment.

8 Thannikkotu v. Trillium Health Centre, 2011 HPARB at p. 20.

9 See OHA/OMA Prototype By-law, s. 3.6.

Situations that give rise to the need for temporary privileges require increased due diligence. Often, these appointments are to accommodate visiting professionals or involve urgent care situations. It is always available for the hospital to grant modified or restricted temporary privileges (for example, a hospital might grant a new Professional Staff member temporary privileges and require an existing Active Staff member to co-sign health records entries). An urgent situation does not relieve the hospital from exercising due diligence. Temporary appointments should not be granted until the applicant's licensure and professional liability protection coverage (insurance), at a minimum, have been confirmed. If time permits, hospitals should collect as much information as possible as would have been collected in the usual course for an initial application, including a CPC.

It is strongly advised that each hospital have clear policies in place to ensure all temporary appointments are granted to competent and qualified persons only.

Temporary appointments are not recommended on a regular basis and should be reserved for exceptional circumstances. For example, as a measure of emergency preparedness:

- Emergency preparedness documentation must include how appointments will be determined in case of a disaster or pandemic.
- Look first to existing members of Professional Staff (who have already gone through the credentialing process) and broaden their appointments to a wider range of privileges as appropriate.
- If hospitals in a region intend to share their Professional Staff members for a short duration of time in an emergency, participating hospitals could send each other a list of their approved Professional Staff members (with their approved privileges) so that temporary privileges can be granted.

Hospitals should avoid leaving Professional Staff members in a temporary appointment category. It is important to communicate with an appointed staff member the nature of their status (i.e. clear communication to avoid future potential conflicts over the nature of their appointment). Hospitals should have a mechanism for following up at the end of a period of appointment so that there is no confusion over whether temporary becomes something more because the staff member continues to provide services after a fixed term.

Lessons Learned in New Brunswick

As a backdrop to why a robust credentialing process is so critical, hospitals are encouraged to read the New Brunswick Commission of Inquiry into Pathology Services at Miramichi Regional Health Authority, a report of Mr. Justice Paul S. Creaghan.[10]

The report deals with the activities of one pathologist and the system that failed to properly credential him. Dr. Menon came to the Miramichi Regional Health Authority in 1993 as the sole applicant for a staff position in surgical pathology at the Miramichi Regional Hospital. When his application was referred to the Credentials Committee, no one was available to act as a pathology peer to assist in the evaluation of Dr. Menon's competency.

The Credentials Committee approved probationary privileges for one year, characterized as the usual practice for any new member of the medical staff. In spite of this fact, the hospital CEO offered Dr. Menon a position without any restriction as to term. The application for initial privileges did not go to either the MAC or the board for approval.

Over many years, there were problems with Dr. Menon's turnaround times and his absenteeism. He was resistant to quality improvement initiatives, and there were minor and major errors in his diagnoses and his reports. During his time on staff he was not peer reviewed. Attempts to discipline and terminate him were never followed through. Finally, a complaint to the College of Physicians and Surgeons of New Brunswick resulted in an executive suspension of Dr. Menon's license to practice in 2007.

10 Commissioner's Report, Vol. 1: Commission of Inquiry into Pathology Services at the Miramichi Regional Health Authority (December 8, 2008), available online at: http://leg-horizon.gnb.ca/e-repository/monographs/30000000048259/30000000048259.pdf . Or to obtain a copy of this report please contact the New Brunswick Department of Health.

The College action terminated Dr. Menon's conduct of surgical pathology at Miramichi Regional Health Authority after he had been on staff for 12 years.

In his report, Mr. Justice Paul S. Creaghan wrote:

> "I am satisfied that Mr. Tucker and the hospital's Credentials Committee did not get adequate information or satisfactory reference on Dr. Menon's qualifications and capabilities before hiring him. It is self-evident that the first rule in providing quality assurance in any hospital department is to take reasonable steps to ensure that the health professionals who are employed are fully capable of doing the job required of them. Why was Dr. Menon terminated in Fredericton? What was his employment record in Holland? Why was the Chief of Anatomical Pathology in Saint John unwilling to hire him?
>
> These were all red flags that did not get waved very vigorously or were not looked for hard enough. The fact that a pathologist was much needed in Miramichi was no excuse. The chance for a poor doctor rather than risk having no doctor simply is an unacceptable principle to apply in our health delivery system."[11]

And at Recommendation No. 6, he further stated:

> "The requirements for granting hospital privileges at the Miramichi Regional Hospital were perfunctory. If a physician had a license to practice medicine in New Brunswick and passed a collegiality test administered by the physicians' Credentials Committee, they would be a suitable candidate for hospital privileges. Initially the Committee would recommend a one-year probationary period. Subsequently, the normal course would see an annual renewal of those privileges by the board of directors on the recommendation of the Committee as a matter of routine. The Commission found that the process of granting hospital privileges was very informal and lacked serious assessment of competency. However, from a realistic and practical standpoint, the process is what can be expected in a small regional hospital facility."[12]

11 Creaghan Report, p. 23.

12 Creaghan Report, p. 108.

FAQs

1. Must we process unsolicited applications?

In the case of physicians — yes. Any physician is entitled by law to apply for privileges at a hospital. The by-laws may or may not extend this right to dentists, midwives and extended class nurses (and if not, there should be written rules to communicate to dental, midwifery and extended class nursing applicants that their unsolicited applications will not be processed).

Once received, the hospital must ensure the MAC reviews an application and makes a recommendation to the board, and that the board considers it.

A hospital does not have to grant privileges to everyone who applies. Practically speaking, it is reasonable for hospitals to have clear recruitment processes so that interested parties have an opportunity to access application forms and be apprised of any available positions. Interested applicants may also be redirected to Chiefs of Department and/or Chiefs of Staff for further information.

2. Can we refuse to process an application that is incomplete?

No. It must be processed and considered by the board, but appointment may be refused because the candidate does not meet the required qualifications set out in the by-laws. In the case of *Re Watts and Clinton Public Hospital*,[13] the hospital refused to process an application (for re-appointment) because the Credentials Committee identified that it was incomplete. The court found that whether an application is complete is "immaterial". The *Public Hospitals Act* sets up a scheme by which the MAC reviews the application, makes its recommendation, and presents that recommendation to the board. There is no scope to refuse to process the application.

13 Ontario Superior Court of Justice, 2005.

The Credentials Committee (or other hospital representative) should advise the applicant in writing that the application is not complete and ask for the missing information. If the applicant refuses to provide the information, the applicant should be given the options of (a) submitting the remaining information by a set date; (b) requesting the application be put on hold; or (c) withdrawing the application. Applicants should also be reminded that if their applications are refused because they are incomplete (which will happen if the missing information is material), they may have to report the refusal in future applications for privileges (although not included in the OHA/OMA Prototype By-law, some hospital by-laws include such reporting obligations).

3. Can we ask for information not listed in our by-laws?

No. If a hospital wishes to amend the qualifications for appointment, the hospital must amend its by-laws.

4. Should hospitals conduct criminal record checks on Professional Staff applying for appointment?

The OHA/OMA Prototype By-law does not explicitly refer to criminal record checks as a required part of the appointment process. However, some hospitals have introduced criminal record checks for all clinical staff (including board-appointed Professional Staff) given their access to potentially vulnerable patients.

The OHA generally recommends that hospitals conduct criminal record checks at the time of an applicant's initial appointment to the Professional Staff. Hospitals are further encouraged to align their criminal record check policies for Professional Staff with those for employees, board members, volunteers, etc.

A criminal record check lists unpardoned offences, convictions and criminal activity under the Criminal Code (Canada). A vulnerable sector check lists pardoned offences and dropped charges, and can be conducted in addition to a criminal record check where the hospital deems it appropriate. Criminal record checks and vulnerable sector checks may only be initiated with the consent of the individual.

5. What should hospitals do if an applicant has a criminal record?

Hospitals may wish to seek legal advice. Hospitals should consider the following factors when determining whether an individual's criminal record makes the individual unsuitable as a candidate to join the Professional Staff:

- The nature of the criminal activity.
- When it happened.
- The patient population the hospital serves.
- The proposed scope of privileges and activities the individual would perform.

Criminal record history should be treated as confidential.

6. What should we do if we discover someone has been providing clinical care at our hospital without being credentialed/appointed?

Seek legal advice immediately. The individual should be notified immediately and be told to cease all clinical work. The Chief of Staff/Chair of the MAC, Chief of Department (or most appropriate clinical leader), CEO and hospital insurers should be notified. The MAC and board will also need to be notified.

If someone does not hold privileges at the hospital, they cannot see the chart, sit in on rounds, admit, treat, diagnose, consult or order tests, or use hospital equipment. While a full review will need to be done, someone should immediately confirm the nature of the individual's license and determine whether they hold professional liability protection coverage (insurance). It will also be important to collect information with respect to any complaints or concerns raised about the person's practice within the relevant timeframe. The person may be given temporary privileges through the normal course, if they meet the qualifications.

It will be important to review how it came to be that the person started working without being properly appointed.

7. How much information does the board usually receive about the Professional Staff it appoints?

The board will usually receive a written report from the MAC supplemented by a verbal report from the Chief of Staff/Chair of the MAC (or most appropriate clinical leader) on behalf of the MAC. The board will usually receive a list of names of candidates for appointment and each candidate will have a category of privileges requested. These reports are typically brief. For initial appointments, the Chief of Staff/ Chair of the MAC (or most appropriate clinical leader) may provide some background about recruitment efforts and how candidates for appointment will fulfill elements of the Professional Staff Human Resources Plans. The board needs sufficient information to be satisfied with the process followed by the Credentials Committee and the MAC in arriving at the recommendation. If it is not satisfied, it should seek more information. A board could have a sub-committee (such as the Audit Committee) complete an annual audit of the hospital's credentialing process by reviewing a random sample of applications for appointment, re-appointment and changes to privileges. However, a board will need much more information (and possibly, independent legal advice) than a mere list of candidates and list of privileges if the MAC is recommending the board:

- NOT appoint a candidate to the Professional Staff
- NOT re-appoint a member of the Professional Staff
- Suspend a Professional Staff member's privileges
- Restrict a Professional Staff member's privileges
- Revoke a Professional Staff member's privileges

See Chapter 9, Refusing Appointments and Re-appointments and Suspending, Restricting or Revoking Privileges.

8. Can the board disagree with the MAC? What happens if the board is considering not implementing a recommendation of the MAC?

Yes. Although the board receives recommendations from the MAC (as required by the *Public Hospitals Act*), the board must ultimately make its own decision with respect to initial appointment (and re-appointment). In fact, it is a duty of the board to question the information and to satisfy itself, independently from the MAC, that a particular individual should be granted privileges.

However, if the board receives a recommendation from the MAC that, for some reason, it is considering not implementing, it is recommended that the board receive independent legal advice before making its decision. The issue should be deferred to the next board meeting and legal counsel consulted by the Board Chair in the interim.

9. Should the appointment of physicians and other Professional Staff members be dealt with in an in camera session of the board?

Yes. These decisions deal with personal matters relating to Professional Staff members. For that reason, it is appropriate to hold the meeting in camera and report the outcome of the debate/discussions to the open session, as determined by the board.

10. Can the board appoint physicians for more than one year?

No. The *Public Hospitals Act* specifically states that appointments can be "for a period of not more than one year".

Often, new appointments come to the attention of the board at a time different from an annual re-appointment date. If the hospital has adopted a set date for all re-appointments, the board can decide how it wishes to manage the appointment term (as long as it is not for more than one year to align the new member to the annual re-appointment calendar).

11. Must a hospital have a Credentials Committee?

No. The *Public Hospitals Act* does not require that there be a Credentials Committee. In such a case, the MAC would ultimately be responsible for the duties of the Credentials Committee set out in this chapter.

12. We are a small hospital. Can we grant privileges to a physician on the basis that the closest tertiary centre has already done its investigations and granted the physician privileges?

You may want to consider initiating a joint credentialing process, including a joint Credentials Committee. As a reminder, regardless of the credentialing process, each hospital's MAC must review every application for

privileges, and the board must make final decisions about appointment. However, there may be streamlined or expedited processes as discussed in this Chapter.

13. Why do we need to ask members of our Professional Staff for evidence of insurance? Doesn't their college already do this?

Every hospital has a duty to satisfy itself that every member of its Professional Staff has appropriate professional liability protection coverage or insurance (e.g., most physicians are members of the Canadian Medical Protective Association). Even where a joint credentialing process has been established, each hospital should have a process in place to check that the applicant has appropriate professional liability protection coverage or insurance.

14. Are dentists, midwives and extended class nurses entitled to the same procedural protection as physicians under the *Public Hospitals Act*?

The provisions of the *Public Hospitals Act* apply to members of the Medical Staff only. The *Public Hospitals Act* itself does not refer to other Professional Staff members. However, the regulations under the *Public Hospitals Act* allow hospital boards to pass by-laws for other Professional Staff groups (dentists, midwives, and extended class nurses). And when hospital boards do so, the by-laws typically apply the same processes to all groups. For the purposes of consistency, the OHA recommends that the same or similar processes are used for the appointment of Professional Staff.

In any particular case, where there is a question about what particular procedural protection should be afforded to an individual applicant or group of applicants, the board should consult its own legal counsel.

15. Are courtesy medical staff, locum tenens, and temporary medical staff entitled to the same procedural protection as active and associate medical staff under the *Public Hospitals Act*?

The general rights to procedural fairness and natural justice established by the *Public Hospitals Act* apply to all medical staff, regardless of the category of appointment. However, members of the Active Staff usually have entitlements to longer notice, more consultation and involvement in decision-making given their highly integrated role within hospitals. A hospital's by-laws set out categories of Professional Staff (such as Active Staff and Courtesy Staff) and the rights attached to each category. Those rights might be slightly different.

16. Should we send a letter of offer before the application has been approved by the board?

It is important for hospitals to be clear with applicants about the stage of their application and the contingencies for full appointment. Hospitals should avoid enticing applicants to make significant changes in their professional, personal and family lives (such as resigning from a current post and/or planning a major geographical move) until, and unless it is clear that the application will be approved. Clear and transparent communication is essential.

Chapter 6: Re-appointments and Changes to Privileges

Reference Key:

Public Hospitals Act:	Sections 36-38
OHA/OMA Prototype By-law:	Sections 3.7, 3.8

Chapter Summary

- Any Medical Staff member who applies to a hospital for re-appointment or a change of privileges is entitled to have their application considered by the board. A hospital cannot merely refuse to review a Medical Staff member application (this right can be extended to also apply to other members of the Professional Staff through the hospital by-laws).

There are six steps to the re-appointment process:

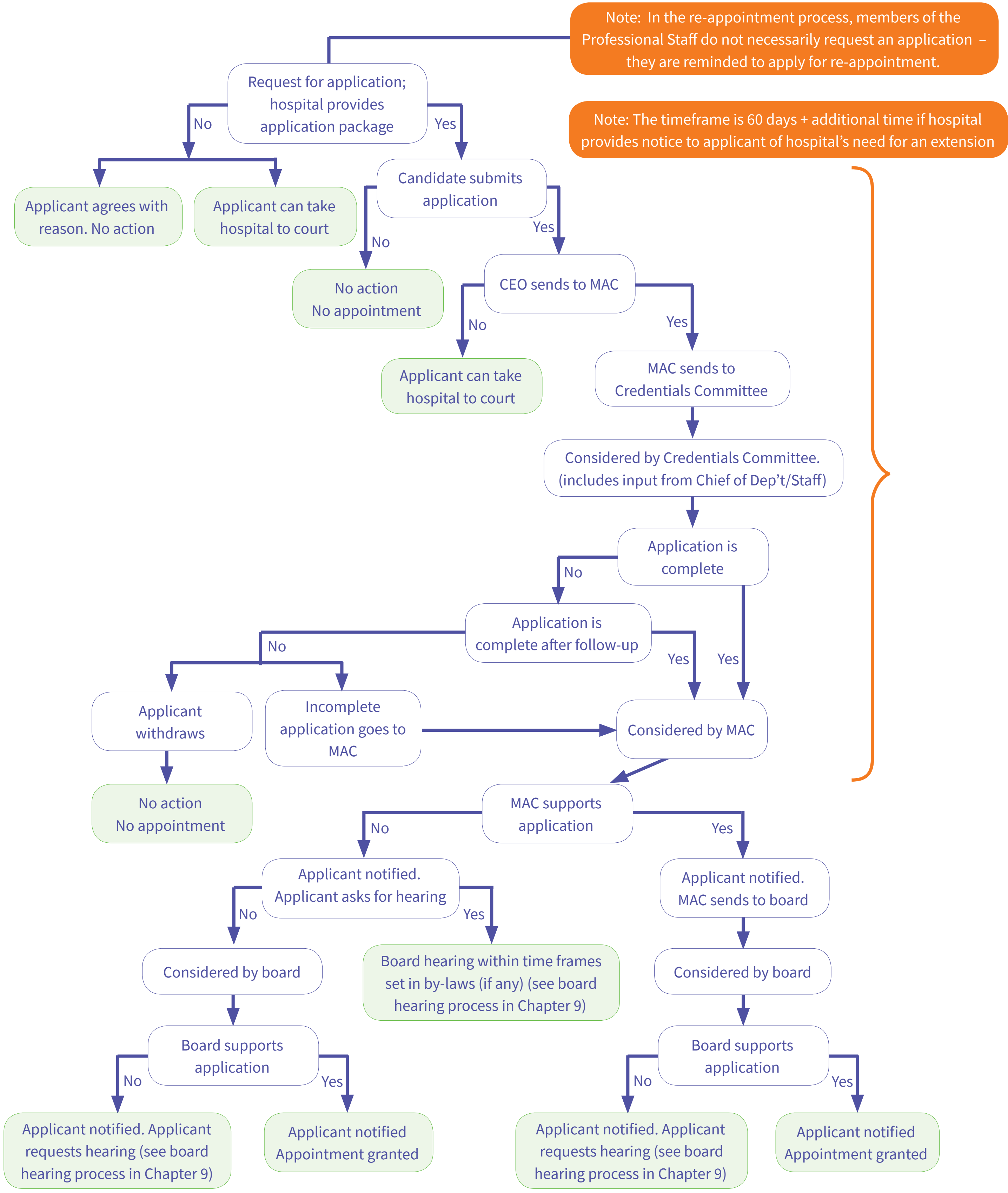
1. Planning for re-appointments.
2. Collection of information through an application form and supplemental information.
3. Verification of credentials (including independent confirmation of information).
4. Assessment of credentials.
5. Recommendation of the Medical Advisory Committee (MAC).
6. Decision by the board.

- While the initial appointment application may be more detailed, hospitals have an ongoing responsibility to collect information, and verify and assess the credentials of members of the Professional Staff for re-appointment. It is insufficient to rely on the absence of negative information (i.e., no complaints) as the sole basis for re-appointment.

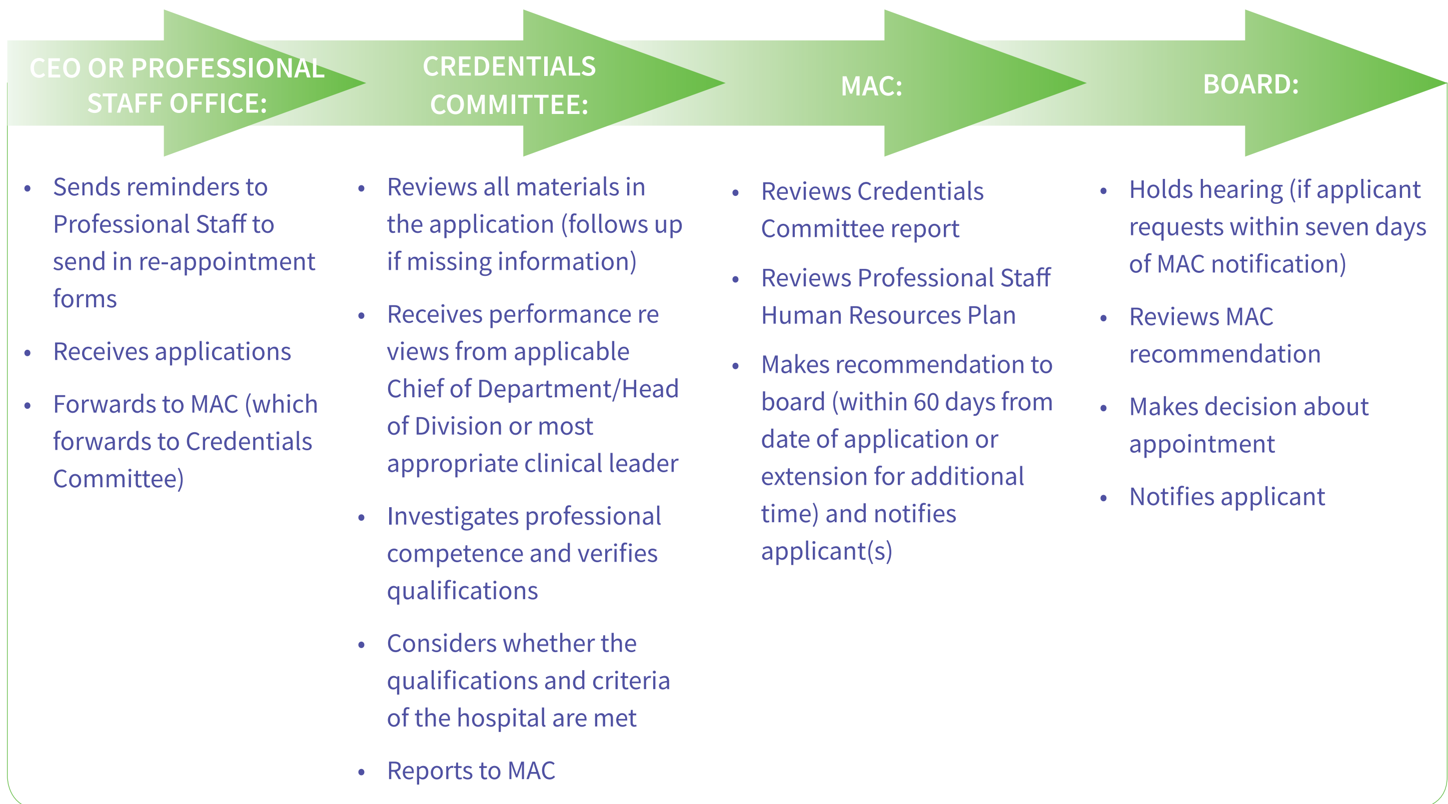
- Professional Staff members can also request to have their category of privileges or range of privileges changed, and this change of privileges request may trigger the need for the Professional Staff member to submit additional information.

- It is still the board that makes re-appointment and change of privileges decisions. This responsibility cannot be delegated to the MAC.

Re-appointment Process



Re-appointment Process by Role



Differences from the Initial Appointment Process

Much of Chapter 5, Initial Appointment, will be relevant to this Chapter on re-appointments. However, the re-appointment process is generally not as cumbersome as the initial appointment process, because the hospital is familiar with the applicant and the historical and static information would have been gathered during the initial appointment process.

Right to Apply for Re-appointment or Change of Privileges

Section 37 of the *Public Hospitals Act* provides that any physician is entitled to apply to be re-appointed at any hospital or to apply for a change in hospital privileges.

A re-appointment application must be provided to a physician on written request. Once submitted, the physician is entitled to have that application forwarded to the MAC and ultimately considered by the board. If a hospital refuses an application for re-appointment or change of privileges for whatever reason, the candidate is entitled to request a hearing before the board. *See Chapter 9, Refusing Appointments and Re-appointments and Suspending, Restricting or Revoking Privileges.*

In summary, a bundle of rights attaches to a candidate as soon as they request and submit an application for re-appointment to the hospital. While no one is guaranteed to be re-appointed or to have their privileges changed, an applicant is entitled to have their application reviewed by the MAC and board and receive a decision about re-appointment or change of privileges.

These rights under the *Public Hospitals Act* apply only to physicians, but can be and usually are extended to dentists, midwives and extended class nurses through the hospital's by-laws. If these rights are not extended, it is important for the hospital to have written by-laws or processes that explain the hospital's approach to re-appointment for

Dental Staff, Midwifery Staff and Extended Class Nursing Staff. There should be a fair and transparent process for re-appointment to the Professional Staff.

Timing

The hospital by-laws should include a placeholder that allows the MAC to annually set a date(s) for re-appointment applications to be submitted. While many hospitals schedule all re-appointments to the Professional Staff at the same time every year, hospitals can stagger their re-appointments. Large hospitals may choose to stagger their re-appointment process (for example, by Department or Division) so as not to overwhelm the board with hundreds of re-appointment applications at the same time. The board may also be asked to consider re-appointments at other times, (e.g., as initial appointments expire).

Content of an Application

The hospital by-laws should set out the content to be included in an application for re-appointment. The application package usually includes (or provides a link to online resources):

- Application form for re-appointment.
- *Public Hospitals Act* and Regulation 965.
- By-laws (if they changed within the last year, or confirmation that they have not changed).
- Rules and Regulations (if they changed within the last year, or confirmation that they have not changed).
- Listing of new policies applicable to the Professional Staff.
- Listing of new initiatives pursued by the hospital.

The *Public Hospitals Act* does not prescribe what must be included in an application form for re-appointment. This is reserved for the hospital's by-laws. Section 3.7 of the OHA/OMA OHA/OMA Prototype By-law includes recommendations for what should be included in an application for re-appointment.

As explained in Chapter 5: Initial Appointment, hospitals should make sure to include in the criteria for re-appointment all information necessary to identify strengths and problems with candidates. There is more publicly available information about candidates for privileges than ever before. Regulatory Colleges now post additional information on their public registers about licensed members' criminal charges, cautions-in-person, mandatory continuing education, and disciplinary findings from other jurisdictions. This information continues to be relevant at the re-appointment stage. However, if a hospital's by-laws do not contemplate such information as relevant to the application for re-appointment, the hospital could be criticized for collecting and considering irrelevant content.

Receipt of an Application and Timelines for Processing

Under section 37(3) of the *Public Hospitals Act*, applications for re-appointment are to be submitted to the CEO (as the administrator under the Act) who shall immediately refer the application to the MAC. In many hospitals, re-appointment applications are sent directly to the Professional Staff Office or credentialing office. It should be clear on the application form to which position/office within the hospital the application must be submitted. In some hospitals, the application forms are completed online. *See Chapter 11, Maintaining Professional Staff Files.*

For timelines that apply to processing applications for initial appointment, see Chapter 5, Initial Appointment. These same timelines apply to processing of re-appointment applications.

Chief of Department's (or Most Appropriate Clinical Leader) Recommendation of an Applicant

In an initial appointment, the hospital relies on letters of reference to confirm an applicant's qualifications. For re-appointments requests to changes to privilege, hospitals rely on the Chief of Department's recommendation. In smaller hospitals not divided into Departments/Divisions, the Chief of Staff/Chair of the MAC (or most appropriate clinical leader) may fulfill the role of reviewer.

The Chief of Department or Head of Division (or whoever is commenting on the application) should be clear whether they support the application and the reasons why or why not. Merely stating that there have not been any problems with a member of the Professional Staff is insufficient. Each member of the Professional Staff should have some kind of annual performance review. *See Chapter 8, Performance Evaluations, Monitoring, Progressive Management and Discipline, for a sample list of matters to be included in a re-appointment performance review.* For efficiency, Active Staff member performance reviews may be more in-depth than reviews of other categories of Professional Staff.

Factoring the results of the annual performance review into the credentialing process is one of the key ways that re-appointment differs from the initial appointment process.

Credentials Committee's Collection, Verification and Assessment of Qualifications

In addition to the initial appointment duties it performs, the Credentials Committee plays an ongoing role in collecting, verifying and assessing information for applications for re-appointment and for changes to privileges.

In summary, the Credentials Committee performs the following tasks with respect to applications for re-appointment:

- Reviews each application and supplemental material (e.g., evidence of professional liability protection coverage or insurance and may also include information from the regulatory college public register).
- Reviews the recommendation of the Chief of Department specific to each application (or Chief of Staff/Chair of the MAC in hospitals without Departments).
- Contacts primary sources of information and collects information to independently verify the information provided by the applicants (for example, the public register of the regulatory college).
- Ensures all the required information has been provided and follows up with candidates if their applications are incomplete.
- Investigates each applicant's professional competence.
- Verifies the applicant's qualifications.

The hospital by-laws set out the criteria by which every applicant for re-appointment is to be evaluated. Hospitals may only consider the criteria listed in the by-laws when determining an applicant's qualifications. These ideas are also useful for any independent confirmation required for re-appointment.

In making a determination to support an application for re-appointment, the Credentials Committee should be able to answer "yes" to all the following statements:

- ☑ The application is complete.
- ☑ The application meets the criteria in the by-laws.
- ☑ The application is appropriate for the privileges requested (that is, contains the relevant information and qualifications for the category and types of privileges requested).
- ☑ The Chief of Department (or most appropriate clinical leader) supports the application.
- ☑ The applicant is in good standing with their regulatory body.
- ☑ The applicant has appropriate professional liability protection coverage (insurance) in place.

Reminder: Information collected by the hospital is confidential and should be protected. *See section Confidentiality, Access and Disclosure in Chapter 11, Maintaining Credentialing Files.*

MAC's Recommendation for Re-appointment

The MAC performs the same analysis for re-appointment as it does for initial appointment, but based on the information provided on re-appointment.

As a reminder, the *Public Hospitals Act*, Regulation 965, allows only physicians to be voting members of the MAC. While many hospitals have created a more multi-disciplinary MAC to reflect the reality of the Professional Staff mix within the hospital, any Professional Staff member on the MAC who is not a physician cannot have voting rights with respect to decisions about re-appointments.

Sections 37(6) and (7) of the *Public Hospitals Act* require that a physician applicant be notified that they are entitled to:

- Written reasons for the recommendation, if a request is received by the MAC within seven days of the receipt by the applicant of a notice of the recommendation.
- A hearing before the board if a written request is received by the board and the MAC within seven days of the receipt by the applicant of the written reasons. *If a hearing is requested, see Chapter 9, Refusing Appointments and Re-appointments and Suspending, Restricting or Revoking Privileges.*

This notification can also apply to other members of the Professional Staff if the same process is extended to them in the hospital by-laws.

Just as with initial appointments, for the vast majority of applicants for re-appointment, there will be no need for a hearing because the MAC will recommend the applicant for re-appointment and the MAC will prepare a list of re-appointments for the board to consider. However, when there are problems with the application, the MAC should seek legal advice.

Board's Re-appointment to the Professional Staff

The board's role in re-appointment is exactly the same as with initial appointment. The board needs sufficient information to be satisfied with the process followed by the Credentials Committee and the MAC in arriving at the recommendation. The board has a duty to question the information received and satisfy itself that the recommendation is appropriate. *See Chapter 5, Initial Appointment.*

Changes to Privileges

Professional Staff members are also permitted to request changes to their Professional Staff category or type of privileges. Requests for changes may arise in situations such as where a Professional Staff member:

- has undertaken new training and would like to expand services and procedures offered to the hospital
- was told they would be considered for a change of category of privileges after a probationary period
- has been in a particular role and wants to change roles for which they are qualified (such as a surgical assistant who wishes to provide full surgical services)[1]
- wishes to reduce services, such as on-call coverage or no longer provide a particular type of procedure
- wishes to become more involved with the hospital (such as moving from courtesy staff to associate or active staff)

Professional Staff who wish to change their privileges must do so by making similar applications (just like a re-appointment application). Such applications are

1 See for example, *Thannikkotu v Trillium Health Centre*, 2012 CanLII 16327 (ON HPARB), <http://canlii.ca/t/fqrwf>. In that case, Dr. Thannikkotu appealed to HPARB when his application for a change of privileges from courtesy staff to active staff was rejected by the hospital. While HPARB concluded the hospital was not fully fair or transparent in handling the application, it was not persuaded that Dr. Thannikkotu's scope of practice fits the criteria of active staff category under the hospital's by-law. He had never acted as most responsible physician and had not completed a two year period as an associate staff member.

considered in the same way as applications for re-appointment unless additional information is required to expand the scope of practice for an applicant at the hospital. If a broader range of privileges will be extended, it may be necessary to collect information in the same manner as through initial appointments. It is also appropriate in requests for changes to privileges to conduct an impact analysis and consider the impact of the request on other members of the Professional Staff.

Chiefs/Heads or other leaders must explain the process for applying for a change of privileges to Professional Staff members who raise issues of concern about their current status. This is especially important where a Professional Staff member has been in a temporary role and has a reasonable expectation of an eventual category change or if a Professional Staff member decides they want to increase or decrease their services. While such conversations may start out as informal discussions, Professional Staff members should be told there is a formal process they are entitled to engage if they wish to be considered for changes to the category of their privileges or types of procedures they provide at the hospital.

Chiefs/Heads cannot unilaterally decide to change the category of privileges held by members of their Department or Division or at the hospital in general.[2]

FAQs

1. Do all re-appointments need to take place at the same time?

No. In most hospitals, for administrative convenience, all appointments or re-appointments for particular Departments/Divisions are considered together, but they do not have to be. Each hospital can decide on the process that works best for its circumstances.

2. What happens if someone fails/refuses to re-apply?

It is usual practice to send a general reminder of deadlines for applications for re-appointment to all members of the Professional Staff. If this general reminder fails to elicit an application form, it is also common practice to send at least one specific reminder directed to the individual (and to investigate whether the contact information for the member has changed).

The *Public Hospitals Act* provides that, when a physician has applied for re-appointment *within the time prescribed*,[3] their appointment continues until re-appointment is granted or, if the board refuses to grant the re-appointment, until the Health Professions Appeal and Review Board (HPARB) appeal process is completed (if any). Hospitals can, therefore, prescribe a window of time during which re-appointment applications will be accepted. If someone fails or refuses to re-apply within that window, they are not considered to have submitted an application. Generally speaking, they have no right to a board hearing and no right to appeal the decision to HPARB. They would be considered to be resigning their appointment and privileges. *See Chapter 10, Resignation and Retirement*, *for how to follow up to ensure appropriate transfer of care at resignation.*

If the window is missed through Professional Staff member error or inadvertence, or failure of the hospital to send out reminders about the application deadlines, leniency on late submissions may be appropriate.

3. What steps should be taken when a member of the Professional Staff refuses, on principle, to provide certain information on their re-application form?

Legal advice should be sought. Generally speaking, the Credentials Committee and MAC may treat this as an incomplete application. As discussed in Chapter 5, Initial Appointment, an incomplete application must be processed and considered by the board, but re-appointment may be refused if the candidate does not meet the required qualifications set out in the by-laws. As a courtesy to the Professional Staff member, the Credentials Committee should advise the applicant in writing that the application is not complete and ask for the missing information. If the applicant refuses to provide the information, the applicant should be given the options of (a) submitting the remaining information by a set date; (b) requesting the application be put on hold; or (c) withdrawing the application. Applicants should also be reminded that if their applications are refused because

2 See for example, Tenn-Lyn v Medical Advisory Committee, 2016 CanLII 80391 (ON HPARB), <http://canlii.ca/t/gvrcr>

3 Section 39(3).

they are incomplete (which will happen if the missing information is material), they may have to report the refusal in any future applications for privileges, as some hospital by-laws require such reporting.

When the MAC recommends that the board refuse to re-appoint due to a materially incomplete application form, the Professional Staff member is entitled to ask – and will most likely ask – for a hearing before the board. The board will then hear why the individual refuses and will determine whether to allow the application or not.

4. If a Professional Staff member wishes to expand or contract/reduce their services, how is that negotiated?

It depends on what the individual wishes to do and whether that vision aligns with what the hospital needs. Requests for changes to privileges require active communication. Where a Professional Staff member desires a change (whether it is to take on new procedures, use different equipment, change categories of membership, take fewer consultations, or reduce on-call services), such changes may be agreeable to the hospital. Where there is an alignment of interests, a Professional Staff member would make an application for a change of privileges and that application would follow the same process for re-appointment. However, there will be situations where a Professional Staff member's requests are not acceptable to the hospital. In those cases, it is important for the most appropriate hospital leader to listen to the request, explain why the request is not aligned with the hospital's interests (including for example the impact on patient care, other Professional Staff members and other hospital staff), and discuss possible alternative options or timing. If after receiving the hospital's concerns a Professional Staff member still chooses to make the application for a change in privileges, that application must be considered by the hospital. Unsupported applications for changes to privileges are usually denied. *See Chapter 9 Refusing Appointments and Re-appointments and Suspending, Restricting or Revoking Privileges.*

Chapter 7: Everyday Management

Reference Key:

Public Hospitals Act:	Section 33
OHA/OMA Prototype By-law:	Section 3.10

Chapter Summary

- Although Professional Staff members are generally not hospital employees, issues arise in their everyday management that are similar to those occurring with employees, such as: orientation, training, occupational health and safety and leaves of absence.
- Open communication is critical, as it helps to maintain healthy relationships and enhances early identification of any issues related to members of the Professional Staff.
- Hospital Professional Staff "compacts" or statements of mutual expectations may be useful to capture common commitments to patient care.
- Hospitals should consider developing leave of absence policies to manage Professional Staff member absences that fall outside normal vacation and sick days.
- Policies, medical directives and other general information relating to the Professional Staff should be maintained.

Orientation

Similar to employees, Professional Staff require orientation to the hospital upon their initial appointment (or when they return from an extended leave). While they may not receive as comprehensive an orientation program as hospital employees, a basic orientation is important.

As part of the application process, members of the Professional Staff should receive copies of:

- Mission, vision, values and strategic plan of the hospital;
- By-laws;
- Rules and Regulations;
- Listing of policies applicable to the Professional Staff; and
- Health Ethics Guide (where applicable).

New members to the Professional Staff should also receive a copy of (or be provided with instructions for electronic access to) the following (not an exhaustive list):

- Codes of Conduct;
- Computer access, software policies and telecommunications policies;
- Departmental rules and policies;
- Effective referrals;
- Emergency code policies;
- Health records policy;
- Infection control procedures;
- Leave of absence policy;
- Medical directives;
- Occupational health and safety policies;
- Organizational charts;
- Patient rights policies;
- Privacy policy;
- Reductions in on-call coverage
- Resignation and retirement policy;
- Smoke-free policy;
- Workplace harassment and discrimination policy;
- Workplace violence prevention policy; and
- Accessibility policies.[1]

1 The *Accessibility for Ontarians with Disabilities Act* requires public and private sectors to develop standards in the areas of customer service, built environment (buildings and other structures), employment, information and communications, and transportation. Each hospital as a "designated public sector organization" is required to comply with the requirements of the ***Integrated Accessibility Standards Regulation*** which establishes the accessibility standards for information and communications, employment, transportation, the design of public spaces and customer service.

Hospital-Professional Staff Compacts

Hospital-Professional Staff "compacts" (or statements of mutual expectations) are becoming more popular as vehicles to engage Professional Staff members in strategic planning and facilitate on-going communication between hospital management and Professional Staff.[2] These compacts generally communicate mutually agreed upon values, commitments, responsibilities and shared goals between hospitals and their Professional Staff. They may exist outside the hospital's by-laws, Rules and Regulations, Codes of Conduct and policies and procedures, but should be consistent with those documents. Compacts are not intended to be formal legal agreements and so they may or may not be communicated in writing. They are intended to be "living" documents or commitments that develop over time to reflect the changing dynamic of providing care.

Mandatory Training

Each hospital will determine any mandatory training expectations for its Professional Staff. The list of training requirements may or may not mirror the requirements for other clinical staff. The following kinds of training may be appropriate for members of the Professional Staff:

- Privacy
- Computer training
- Charting expectations
- Emergency codes
- Fire training
- Occupational health and safety (including workplace violence and harassment prevention)
- Any policies that relate to training or requirements that will be placed on Professional Staff as a condition of being granted privileges

2 S. Shukla et al. "Physician compact: a tool for enhancing physician satisfaction and improving communication" *Physician Executive Journal of Medical Management*. 2009, 35(1): 46-49.

Infection Control and Screening

Every hospital should clearly state its expectations relating to site-specific infection control, testing and screening requirements for all personnel (regardless of whether they are employees or independent contractors). Such requirements shall include compliance with provincial communicable disease surveillance protocols as mandated through Regulation 965 of the *Public Hospitals Act*.[3]

Regulation 965, section 4(e) of the *Public Hospitals Act* requires that hospitals pass by-laws that "establish and provide for the operation of a health surveillance program including a communicable disease surveillance program in respect of all persons carrying on activities in the hospital."

The Regulation further notes that, "[these by-laws] shall, with respect to a particular communicable disease, include the tests and examinations set out in any applicable communicable disease surveillance protocol published jointly by the Ontario Hospital Association and the Ontario Medical Association for that disease and approved by the Minister.[4] Further information on the Communicable Diseases Surveillance Protocol is available online.[5]

Hospital personnel will also be expected to use Routine Practices[6] at all times, and Personal Protective Equipment when required.

Occupational Health and Safety

Members of the Professional Staff have responsibilities to assist hospitals in meeting their occupational health and safety obligations. These responsibilities should be reinforced in the by-laws, letters of offer and re-appointment, and hospital policies.

3 *Public Hospitals Act,* R.R.O. 1990, Reg. 965, s. 4(e) https://www.ontario.ca/laws/regulation/900965#BK4

4 *Public Hospitals Act,* R.R.O. 1990, Reg. 965, s. 4(2)

5 https://www.oha.com/labour-relations-and-human-resources/health-and-safety/communicable-diseases-surveillance-protocols

6 For further information on Routine Practices, please refer to "Routine Practice and Additional Precautions in Health Care Settings", Provincial Infectious Disease Advisory Committee, Public Health Ontario (Third Revision, 2012): https://www.publichealthontario.ca/-/media/documents/bp-rpap-healthcare-settings.pdf?la=en

Workplace violence and harassment laws apply to all employers in Ontario, including hospitals. Violence and harassment are issues that must be addressed as part of every hospital's overall occupational health and safety program. Hospitals must:

- Have written policies about workplace violence and harassment prevention.
- Have violence and harassment programs that deal with reporting, investigating and dealing with incidents of violence and harassment.
- Conduct risk assessments about workplace violence prevention.
- Inform their Joint Health and Safety Committee or Health and Safety Representative (or where neither exists, the workers) of the results of risk assessments.
- Implement control measures to address the risks identified in risk assessments. The control measures must cover summoning immediate assistance in the event of a violent episode.
- Inform and instruct workers on the violence and harassment policy and program (including the control measures).

Changes to the *Occupational Health and Safety Act* were introduced in part in response to the tragic death in 2005 of an Ontario nurse, Lori Dupont, at the hands of Dr. Marc Daniel, a member of the hospital's Professional Staff. Ms. Dupont had ended a romantic relationship with Dr. Daniel months earlier, but they continued to work in the same hospital. Dr. Daniel had a history of abusive and harassing behaviour, in both his professional and personal life. He received psychiatric and psychological treatment at the hospital during a medical leave. He murdered Ms. Dupont in the operating theatre recovery room of the hospital on a day they were scheduled to work together.

The jury commented that, despite significant documented complaints of serious disruptive behaviour, the hospital was indecisive about how to manage the physician. The inquest jury recommended amendments to the *Public Hospitals Act* and called on hospitals to develop processes to allow for the early identification of and response to disruptive physician behaviour. The jury also underscored that a clinician's right to practice must never be interpreted to supersede patient or staff safety, nor quality of care.[7]

Incapacitated and Incompetent Professional Staff

Under the *Regulated Health Professions Act*, "incapacity" occurs when a regulated health professional "is suffering from a physical or mental condition or disorder that makes it desirable in the interest of the public that the member's certificate of registration be subject to terms, conditions or limitations, or that the member no longer be permitted to practice". "Incompetence" occurs when a regulated health professional's care of a patient displays "a lack of knowledge, skill or judgment of a nature or to an extent that demonstrates that the member is unfit to continue to practise or that the member's practice should be restricted."

Managing incapacitated and incompetent Professional Staff raises a host of challenges. Clinical leaders should be familiar with their obligations under the *Regulated Health Professions Act* and *Occupational Health and Safety Act* with respect to managing these issues.

There are important discussions to facilitate among the staff in order to foster a culture that balances patient safety and support for the Professional Staff member.

Hospitals must file a report with the applicable regulatory college if there are reasonable grounds to believe that a Professional Staff member is incompetent or incapacitated. [8]A person who terminates the employment or revokes, suspends or imposes restrictions on the privileges of a Professional Staff member for reasons of professional misconduct, incompetence or incapacity must file a report

7 See Verdict of Coroner's Jury, Lori Dupont Inquest: https://www.oha.com/Documents/Dupont-Daniel%20Inquest%20-%20Jury%20Recommendations%20-%20Dupont-Daniel%20Inquest%20December%202007%20--Homicide.pdf

8 *Regulated Health Professions Act,* 1991, S.O. 1991, c.18, Schedule 2 Health Professions Procedural Code s. 85.2.

with the Registrar of the individual's college.[9] A report is required even where the Professional Staff offers to resign.

There are additional but similar rules under section 33 of the *Public Hospitals Act* for reporting physicians:

Where,

(a) the application of a physician for appointment or reappointment to a medical staff of a hospital is rejected by reason of his or her incompetence, negligence or misconduct;

(b) the privileges of a member of a medical staff of a hospital are restricted or cancelled by reason of his or her incompetence, negligence or misconduct;

(c) a physician resigns from a medical staff of a hospital or restricts his or her practice within a hospital and the administrator of the hospital has reasonable grounds to believe that the resignation or restriction, as the case may be, is related to the competence, negligence or conduct of the physician; or

(d) a physician resigns from a medical staff of a hospital or restricts his or her practice within a hospital during the course of, or as a result of, an investigation into his or her competence, negligence or conduct,

the administrator of such hospital shall prepare and forward a detailed report to The College of Physicians and Surgeons of Ontario.

When making a report to a regulatory college, a hospital may balance a number of factors in addressing such issues, including:

- Statutory obligations;
- The desire to have a productive and efficient workforce;
- The desire to have positive work environment;
- Privacy rights Professional Staff members might have;
- Establishing "reasonable grounds" to believe the member is incapacitated or incompetent;
- The member's explanation for their conduct; and
- Addressing any medical problems of the Professional Staff member.

Hospital leadership should be familiar with resources for Professional Staff who have impairment or capacity issues, including the Ontario Medical Association Physician Health Program.[10] Hospitals should also consider the CPSO/OHA Guide to the Management of Disruptive Physician Behaviour (2008), the Health Quality Council of Alberta "Resource Toolkit: Managing Disruptive Behaviour in the Workplace" (2013) and the Canadian Medical Protective Association Discussion Paper, "The role of physician leaders in addressing physician disruptive behaviour in healthcare institutions" (2013) .

Leaves

Since members of the Professional Staff are often independent contractors and not employees, Professional Staff members independently arrange for their colleagues to cover routine absences such as vacation and sick days. However, every hospital should have a policy or protocol to provide guidance for situations beyond those routine absences, including where:

- A member of the Professional Staff desires or requires a leave of absence from duties at the hospital; and
- The hospital will be affected by the leave and is therefore involved in the plans to arrange for suitable clinical and administrative coverage for the member's services.

9 *Regulated Health Professions Act* Code, s. 85.5 and additional obligations to report in such cases to the College of Physicians and Surgeons of Ontario for physicians exist under the *Public Hospitals Act*, s. 33.

10 For the Physician Health Program, call 1-800-851-6606 or visit http://php.oma.org/. For nursing practice support, visit http://www.cno.org/en/learn-about-standards-guidelines/Practice-Support/practice-support-faqs/. For LifeWorks, the midwifery support program, call 1-877-207-8833 or visit www.lifeworks.com. For the Members' Assistance Program for dentists, call 1-800-268-5211 or visit or www.workhealthlife.com.

As a note, in some hospitals, *Locum Tenens* arrangements are used to cover planned vacations so that a leave of absence is not required.

The OHA/OMA Prototype By-law includes a provision for leaves of absence:

3.10 Leave of Absence

(1) Upon request of a Professional Staff member to the relevant Chief of Department, the Chief of Staff may grant a leave of absence of up to 12 months, after receiving the recommendation of the Medical Advisory Committee:

(a) in the event of extended illness or disability of the member, or

(b) in other circumstances acceptable to the Board, upon recommendation of the Chief of Staff.

(2) After returning from a leave of absence granted in accordance with section 3.10(1), the Professional Staff member may be required to produce a medical certificate of fitness from a physician acceptable to the Chief of Staff. The Chief of Staff may impose such conditions on the privileges granted to the member as appropriate.

(3) Following a leave of absence of longer than 12 months, a Professional Staff member shall be required to make a new application for appointment to the Professional Staff in the manner and subject to the criteria set out in this By-law.

It will also be necessary to involve the board if the leave of absence will be accompanied by a restriction or suspension of privileges.

Each hospital may consider having a leave of absence policy for Professional Staff, to include:

- How the member should make a request for leave of absence;
- Who makes decisions about leaves of absence and under what circumstances;
- The criteria to be considered for approving a leave of absence;
- How the decision about the leave of absence will be made and communicated;
- Duties of the Chief of Staff/Chair of the MAC (or most appropriate clinical leader) during a member's leave;
- What will happen if there needs to be an extension or termination of leave;
- How the member can request an extension;
- How the member requests reinstatement;
- The criteria to be considered for reinstatement;
- Who makes decisions about reinstatement;
- How the decision about reinstatement will be made and communicated; and
- What happens if the member does not request reinstatement or an extension of leave, and the leave lapses.

Factors to consider when granting a leave of absence:

- The reason for the request;
- The length of leave requested;
- Whether leaves of absence have been granted in the past to other members in similar circumstances;
- Whether granting the current request for leave will set a precedent, and what this implies;
- Whether the hospital will reasonably be able to arrange for coverage during the leave and whether patient care will be compromised;
- Other information provided by the member and the Chief of Staff/Chair of the MAC (or most appropriate clinical leader); and
- Any other factors deemed appropriate.

Factors to consider at the time of reinstatement after a leave of absence:

- Whether the timing of the reinstatement coincides with what had been planned (e.g., early return may not be possible if contracts have been secured with other clinicians to provide coverage).
- Whether it is safe for the member to return and whether patient care could be compromised.
- Whether the member meets all criteria for re-appointment to the Professional Staff.
- Whether the hospital is able to accommodate any supports, restrictions, or requirements for supervision or monitoring of the member.
- Other information provided by the member and the Chief of Staff/Chair of the MAC (or most appropriate clinical leader).
- Any other factors deemed appropriate.

Documentation

Someone, such as an administrative person who supports the Credentials Committee (administrative assistant to the CEO or a Manager/Director of Professional Affairs, for example), should keep track of certain documentation relating to the Professional Staff in order to be able to chronicle changes over the years. Such information can be important for defending litigation and to demonstrate communication with members of the Professional Staff if they claim they were not advised about new initiatives or policies. Examples include:

- Medical directives (date stamped, indicating when replaced, and by what, and when revoked).
- Announcements of new initiatives, hospital plans, etc.
- Policies relating to the Professional Staff (date stamped, indicating when replaced, and by what, or when revoked).
- Professional Staff By-law.
- Mandatory training lists to confirm who completed training.
- Annual lists of appointments to the Professional Staff.
- Annual Chief of Staff/Chair of the MAC certification of the credentialing process.

For further detail about what should be kept in individual Professional Staff member files, see Chapter 11, Maintaining Credentialing Files.

FAQs

1. What key policies do we need to manage successfully our Professional Staff?

It is up to each hospital to determine its list of priority policies for Professional Staff. Hospitals can look to the following list for guidance:

- Codes of Conduct
- Computer access, software policies and telecommunications policies
- Departmental rules and policies
- Effective referral
- Emergency code policies
- Health records policies
- Infection control procedures
- Leave of absence policies
- Medical directives
- Occupational health and safety policies
- Organizational charts
- Patient rights policies
- Privacy policies
- Reduction in on-call coverage
- Resignation and retirement
- Smoke-free policies
- Workplace harassment and discrimination policies
- Workplace violence prevention policies
- Accessibility policies

2. Must Professional Staff complete mandatory training exercises employees take part in?

A hospital should determine which of its mandatory training requirements apply to its Professional Staff. Anything directly relating to the Professional Staff member's primary obligations (such as with respect to personal devices) or impacting the provision of services on-site, and safety or quality of care issues, should involve the Professional Staff.

3. How do we manage Professional Staff who refuse to comply with provisions under the *Occupational Health and Safety Act* on the basis that they are not employees? (e.g., refusal to wear proper footwear in the operating room)

Hospital occupational health and safety policies should be mandatory for all members of the Professional Staff. Members of the Professional Staff are obliged to comply with the hospital's legal duty to maintain safe premises. Failure to abide by such provisions can result in disciplinary action. *See Chapter 8, Performance Evaluations and Progressive Management.*

4. Do all leaves of absence require a process of approval by the hospital board?

No. Many leaves are managed through *locum* coverage, vacation or other informal arrangements that are not brought to the attention of the board. However, if a hospital proposes to suspend or restrict a Professional Staff member's privileges during the leave of absence, the board must be involved in those decisions.

4. How long can we grant Professional Staff members a leave of absence?

For members of the Medical Staff, because an appointment cannot exceed 12 months, it is generally understood that a leave of absence cannot extend beyond the privileging year (i.e., up to 12 months). Hospitals typically have annual appointment processes for dentists, midwives and extended class nurses also. If this is the case, the same time limitation applies to their leaves of absence where there will be a restriction or suspension of practice.

5. How do we align requests for parental leave for 18 months with a 12-month privileging year?

In late 2017, the provincial and federal governments introduced changes to parental leave entitlements for employees to extend job protection and employment insurance benefits. If a Professional Staff member is an employee, those employment entitlements are automatically available. If a Professional Staff member is an independent contractor, the issue of position protection should be considered as part of practice plans and hospital policies. Hospitals should seek legal advice.

6. Do we have to take a Professional Staff member back after a leave of absence?

Upon return from a leave of absence, the Professional Staff member may be required to produce a certificate of fitness. Legal advice should be sought if the hospital is considering not permitting a Professional Staff member to return from a leave of absence.

In the case of *Re Powell River General Hospital and Dr. Hobson*,[11] a physician took a leave of absence from the staff of the hospital for several months. Upon application for re-appointment, he was refused by the hospital. On appeal to the B.C. Medical Appeal Board, Dr. Hobson was ordered re-appointed with limited privileges (including treating patients for conditions resulting from diseases for which he previously treated them). While it was clear in that case that the community could not support three general surgeons, and there was no demonstrated need or benefit to the hospital in a grant of full privileges, the Medical Appeal Board determined that the community would benefit to the extent he was able to treat his prior patients who required his further services.

11 December 9, 1990, at pp. 4-5.

Chapter 8: Performance Evaluations and Progressive Management

Reference Key:

Public Hospitals Act:	Sections 33-34
OHA/OMA Prototype By-law:	Section 3.7(2)(c), 4.1, 4.2

Chapter Summary

In order to satisfy the hospital's obligations to its patients, the public, and its employees, hospitals have an ongoing responsibility to oversee the work performed by Professional Staff and manage any issues that arise.

- The management of Professional Staff performance includes effective communication, performance evaluations and progressive management. These tasks generally fall to the Chief of Staff/Chair of the Medical Advisory Committee (MAC) or the most appropriate clinical leader, such as the Chief of Department or Head of Division.
- Successful management of the Professional Staff starts with setting clear goals and expectations and is realized through consistent follow-up. Hospital leaders cannot over-communicate with the Professional Staff about the duties, obligations and standard of performance expected of them.
- Performance evaluation is an opportunity to recognize successful practice and to be proactive and to avoid or moderate certain performance issues.
- Progressive management is the process that should evolve from the performance evaluation. It is a systematic process designed to achieve optimal performance in a respectful and professional manner.
- Hospitals can and should take a progressive management approach when responding to issues of a Professional Staff member's competency, conduct or capacity. All management action including disciplinary action should be fair, clear, consistent and progressive (when reasonable).
- Disciplinary action can include verbal and written warnings, apologies, reprimands, suspensions, and restriction or revocation of privileges (or can lead to a decision not to re-appoint a member) as long as appropriate processes are followed. If there have been long-standing legacy issues with a member of the Professional Staff that have not been addressed or managed, it may take longer to realign the member with the hospital's culture and requirements or to sever the relationship.
- With the exception of temporary suspensions in urgent situations, only the board can suspend, restrict or revoke hospital privileges. Chiefs of Department and Heads of Division (or most appropriate clinical leaders) should be careful not to overstep their jurisdiction when disciplining members of the Professional Staff. Depending on the severity and impact of the decision, it could constitute a "change in privileges" giving rise to the member's having a right to a hearing before the board.

Communication

All good management starts with setting and communicating clear goals and expectations.

It is essential that hospitals communicate with their Professional Staff on an ongoing basis about the expected duties, obligations and standards of performance. While initial communication is important, follow-up communication is often what makes the difference in managing difficult situations. Consistency and clarity are essential for effective communication.

Communications to, and expectations from, Professional Staff should be reasonable, as well as equally and consistently applied to all members of the Professional Staff (and as necessary, to members of smaller groups similar to departments and divisions).

Goals and expectations that are specific to a member of the Professional Staff should be documented in the member's first letter of offer, annual performance evaluation, or letter of re-appointment. It helps if there are written role descriptions, lists of core privileges and Codes of Conduct that can be referenced to set and manage expectations.

If there are general rules and expectations for the entire Professional Staff of the hospital/department/division (such as policies, Rules and Regulations, mission, vision and value statements or clinical guidelines), it is helpful for those to be set out in writing and distributed (or made available through a hospital intranet) to all Professional Staff (and shared with all new Professional Staff in orientation packages).

Performance Evaluation

A performance evaluation is an effective, systematic method of communication between a hospital and its Professional Staff. The OHA/OMA Prototype By-law contemplates an annual performance evaluation process for members of the Professional Staff that is tied to the re-appointment process.[1]

In addition to its recommended use in the re-appointment process, the performance evaluation should be used by hospitals for the following purposes:

- Clarifying role requirements and standards.
- Providing feedback to the Professional Staff member regarding their progress toward meeting these standards (including both positive and constructive feedback).
- Guiding future performance by formulating an action-plan.

Those charged with responsibility for conducting the performance evaluation process should be provided with formal training on the proper methods for conducting such evaluations.

In addition to formal performance evaluation processes, members of the Professional Staff need regular and timely feedback about their performance, including reinforcement for positive actions and redirection for negative actions. Much of this feedback will be provided verbally, and should be provided on an ongoing basis, not just annually once the re-appointment processes have been invoked.

As a cautionary note, *pro forma* performance evaluation template letters should not be utilized if there have been problems with a member's conduct, competency or capacity. Such template letters could be used against a hospital in privileges disputes and civil litigation to demonstrate the Professional Staff member's behaviour could not have been problematic because their annual performance evaluations were positive. Annual performance evaluation letters should be customized to address any problematic issues.

Identifying Performance Issues

In addition to the issues identified in the performance appraisal, everyday management of Professional Staff may lead to the identification of matters that require attention on a timely basis, that is, they cannot wait until the annual performance evaluation or re-appointment process.

Every hospital should have a policy about processing complaints and concerns about members of staff (including members of the Professional Staff). There should be a variety of ways in which issues can be detected early and reported to hospital authorities.

Generally speaking, Chiefs of Department (or the most appropriate clinical leaders) (and ultimately the Chief of Staff/Chair of the MAC) have the responsibility to investigate and respond to concerns.

1 See OHA/OMA Prototype By-law s. 3.7. Some hospitals engage in detailed performance evaluations every three years and simple evaluations annually.

Performance issues may come to the hospital's attention through:

- Administrative alerts (such as Health Records alerts when Professional Staff members have not completed their charts)
- Complaints from patients or families or the public
- Complaints from staff, volunteers, or other health care institutions
- Complaints from students or affiliated academic institutions
- Criminal charges or convictions
- Incident reports (including death and critical incidents)
- Internal investigations
- Media/social reports or online reviews
- Peer reports
- Performance measures
- Performance reviews/observations by supervisor
- Reports from regulatory colleges
- Self-reports
- Utilization reports

Examples of some categories and situations giving rise to the need for progressive management include (this is not an exhaustive list):

- **Assault/Harassment/Sexual Harassment:** abusing patients, staff or others verbally, physically or sexually; harassment; engaging in inappropriate relationships.
- **Attendance** – failing to:
  - attend to patient care needs because of absence;
  - provide on-call coverage;
  - attend mandatory meetings;
  - secure coverage for absences;
  - meet with the Chief of Department or Head or other clinical leaders on reasonable request; or,
  - arrive on time for patient care appointments or administrative meetings.
- **Behaviour:** engaging in rude, disruptive or insubordinate behaviour.
- **Fitness to Practice:** practicing while impaired.
- **Health Records:** failing to keep appropriate records, offensive content, insufficient documentation, incorrect content, making illegible records, falsifying records, and/or failing to sign off on charts.
- **Misrepresentations:** misrepresenting information in the course of patient care or administrative or other duties, including on applications for appointment or re-appointment.
- **Patient Safety and Patient Rights:** action or inaction giving rise to concern for the safety or well-being of a patient; failing to respect patient rights.
- **Privacy:** breach of privacy including, for example, inappropriate collection, use or disclosure of information or loss or destruction of records, failing to assist the hospital with privacy complaints, inappropriate storage of records, use of unauthorized technology, inappropriate activity in shared electronic information systems with other health care organizations or national/provincial/regional databases.
- **Professional Practice:** providing sub-standard practice, refusing to perform necessary services, providing inappropriate care or advice, failing to register patients, influencing patients to take certain action or inaction for personal gain.
- **Public Safety:** action or inaction giving rise to concerns for the safety of the public or specific persons.
- **Research, Academic or Teaching Misconduct:** failing to abide by accepted research and academic practices, or to provide appropriate teaching or support to medical residents and students.
- **Rules:** failing to abide by the policies and procedures of the hospital or department or division specific rules.

Investigations

Regardless of how an issue of concern comes to the hospital's attention, it may be necessary to conduct an investigation in order to verify the allegations. There may be statutory obligations to investigate (for example, in the case of allegations of violence, harassment or safety). The exact nature and scope of the investigation will depend on the type or character of the alleged concerns. An investigation might take minutes to complete and involve asking a few questions and identifying solutions. However, there may be complicated situations that take weeks to complete and require external investigators, interviews, document review, research and formal reports.

A meeting or interview with the Professional Staff member is almost always warranted in an investigation. Even when there is overwhelming evidence against someone, it is still essential to interview them so they have an opportunity to provide an explanation.

When conducting an investigation into a member's conduct, competency or capacity, a hospital should:

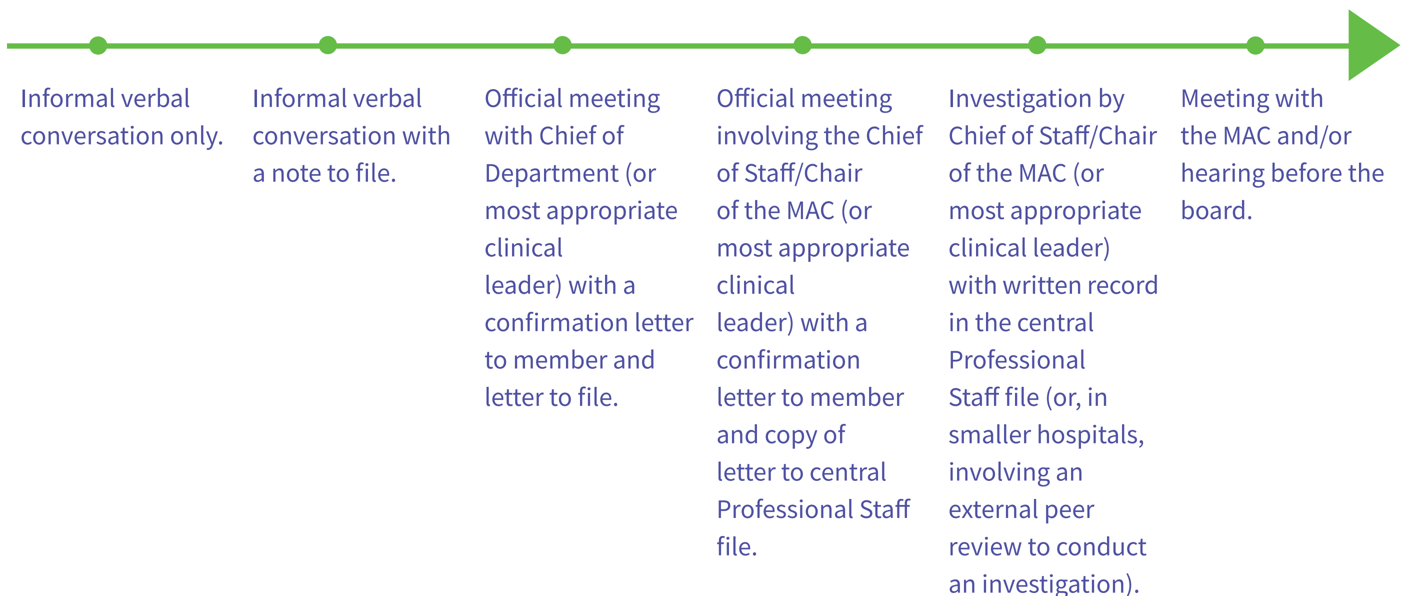
- Decide the purpose for and goals of the investigation.
- Scale the investigation to the nature and severity of the situation.
- Determine who will receive the report and whether it will be confidential.
- Determine whether the report will be directed to legal counsel to establish privilege.
- Select the investigator(s) (who should be impartial).
- Determine the scope of the investigation including timelines, methodology, and clear and specific terms of reference for the investigator(s), with input from the Professional Staff member.
- Ensure the Professional Staff member has an opportunity to respond to the allegations or concerns raised.

A Progressive Management Approach

With the exception of egregious situations, incidents, or behaviour, problems involving Professional Staff should be dealt with using a "progressive management" approach. The essential elements of that approach are:

1. **Clear Goals and Expectations:** Professional Staff should be given a clear set of goals and expectations.
2. **Regular and Timely Feedback:** Professional Staff need regular and timely feedback about their performance. If an incident occurs, feedback should be provided to the member of the Professional Staff as soon as possible after the incident.
3. **Formal Feedback and Documentation:** While it may be appropriate in the initial stage of dealing with a minor issue to have an informal discussion, "chat over coffee" or "hallway conversation" with the member of the Professional Staff to clarify the expectations, the formality of the feedback and documentation should increase depending on the severity of the situation and over time. Consider the following continuum of progressive formality:

Continuum of Progressive Disciplinary Actions



Hospitals are reminded that all notes, emails, texts, letters and other documents can become a matter of public record in Professional Staff privileging cases, coroners' investigations, privacy investigations and other legal proceedings.

If the hospital leadership does not document its concerns, as well as document that the Professional Staff member was informed of the issues and given an opportunity and the means to improve, many internal and external adjudicators will consider that the incident or issues did not happen or that there was a procedural defect in the management of the situation. This can often lead to the dismissal of the allegations. It is very difficult to respond to allegations that a member of the Professional Staff "has had issues for years", if there is no written evidence to support such allegations. If there is no documentation, hospital leadership may have to start afresh and respond to the allegations occurring within the last year of appointment. Any form of documentation can be helpful, including email messages and hand-written notes to file. It is good practice to date notes to file and confirmation letters to the member, and to record the dates of conversations.

4. **Opportunities to Succeed (not set up to fail):** If there is an issue with a member of the Professional Staff, the member should be given the opportunity and means to improve. That might include clarifying short- and long-term goals and expectations in writing, coaching or mentoring the member, providing an encouraging work environment, assisting the member to re-integrate into a team environment, or suggesting extra training, remedial training or supervision. Rules should be applied equally throughout a Department; leaders should avoid targeting only certain Professional Staff for compliance. Chiefs of Department (or most appropriate clinical leaders) may themselves become the subject of scrutiny if it can be shown that they did nothing to assist a struggling member of the Professional Staff to improve, or if they in fact set up an environment where the member would certainly fail. Similarly, not sufficiently supporting a struggling member may also jeopardize the acceptability of the progressive management action.

5. **Progressive and Proportional Response:** Depending on the situation, Chiefs of Department (or most appropriate clinical leaders) may eventually, or urgently, need to take disciplinary action. The response should be proportional to the issues and the history with the Professional Staff member. Consider the following continuum of progressive disciplinary action options (not an exhaustive list – and these options may be considered alone or in combination):

   - Verbal recommendation
   - Verbal warning (with deadlines for improvement with note to Department file
   - Written warning (with deadlines for improvement)
   - Written warning (with deadlines for improvement) with copy to Chief of Staff/Chair of the MAC (or most appropriate clinical leader) and copy to central Professional Staff file
   - Verbal apology
   - Written apology
   - Reprimand
   - External peer review
   - Mandatory training/education
   - Increased supervision
   - Recommendation to the Chief of Staff/Chair of the MAC (or most appropriate clinical leader)/CEO for temporary suspension*
   - Recommendation to the Chief of Staff/Chair of the MAC (or most appropriate clinical leader)/MAC for permanent or temporary reduction or change in duties or assignments*
   - Recommendation to the Chief of Staff/Chair of the MAC (or most appropriate clinical leader)/MAC for revocation of privileges or change in category of privileges*

**Note: A Chief of a Department (or other clinical leader) may not unilaterally exercise these options as they give rise to the member of the Professional Staff's right to a hearing before the board.*

6. **Professional Staff Member Given Due Process:** Demonstrating that the process by which a member of the Professional Staff is disciplined may be just as important as being able to demonstrate that an issue occurred. As a general rule the more serious the issue or the more serious the proposed disciplinary action, the more procedural rights should be given to the member of the Professional Staff. Chiefs of Department (or most appropriate clinical leaders) should seek advice from the Chief of Staff/Chair of the MAC (or other senior clinical leader) or legal counsel if unsure as to the process that must be followed in a particular disciplinary case. The following is a short list of the progressive bundle of rights that Professional Staff may be entitled to exercise depending on the severity of the situation and the proposed disciplinary response:[2]

    - Right to know what rules apply to them.
    - Right to know the case and allegations against them.
    - Right to know the identity of the person making allegations, and the content of those allegations.
    - Right to try to remediate or improve their actions.
    - Right to know (and sometimes choose, or at least comment on) the process by which they will be judged (or the rules that apply to the review of the situation before a decision is made).
    - Right to make a response (verbally or in writing).
    - Right to have a lawyer represent them.
    - Right to a hearing before an "impartial" decision-maker.
    - Right to have input in the selection of investigator or decision-maker.
    - Right to a decision.
    - Right to have written reasons for the decision.

2 As a reminder, the Public Hospitals Act sets out specific rights of members of the Medical Staff in the context of a refusal to re-appoint or a suspension, restriction or revocation of privileges. The hospital by-laws and the Professional Staff Rules and Regulations may also set out specific rights.

A similar model that has received a great deal of attention in the medical community is the "Disruptive Behaviour Pyramid" by Gerald Hickson and his colleagues.[3] Their "staged approach" to managing behaviour begins with informal feedback and providing various opportunities for improvement prior to disciplinary action. The "cup of coffee" approach (advising the individual about issues in a casual setting, such as over a cup of coffee) is intended to manage behavioural issues before they become risk management and legal issues. The model focuses on creating awareness, as some individuals are simply unaware that their behaviour is not the norm, or that certain behaviours detract from a culture of safety. The approach also allows for human error, as it is only when a pattern persists that authoritative intervention is required. The model serves as a reminder that the majority of Professional Staff do not pose any behavioural issues.

Helpful guidance material has been developed in response to the growing body of literature that raised concerns about the behaviour of health care professionals and the impact of behaviour on patient outcomes. For example, recent guidance material has been released from the Health Quality Council of Alberta, "Resource Toolkit: Managing Disruptive Behaviour in the Workplace" (2013)[4] and the Canadian Medical Protective Association Discussion Paper, "The role of physician leaders in addressing the physician disruptive behaviour in healthcare institutions" (2013)[5]

Immediate, Mid-Term Action

If there is an egregious incident (usually having to do with safety or significant risk management issues), immediate disciplinary action may be warranted.

Section 34 of the *Public Hospitals Act* sets out requirements for a Chief of Department, or Chief of Staff/Chair of the MAC or President of the Medical Staff (depending on the structure of the hospital) to intervene in situations where

3 G. Hickson et al, "Disruptive Behaviour Pyramid" Acad Med, Nov. 2007

4 March 2013 https://hqca.ca/health-care-provider-resources/frameworks/managing-disruptive-behavior-in-the-healthcare-workplace-provincial-framework/

5 2013 https://www.cmpa-acpm.ca/static-assets/pdf/about/annual-meeting/13_Disruptive_Behaviour_booklet-e.pdf

there are serious concerns about the diagnosis, care or treatment of a patient. That officer of the Medical Staff (or delegate) is required to:

- Discuss the issue with the attending physician.
- If changes in diagnosis, care or treatment satisfactory to the officer are not made, they are required to:
  - Assume the patient care responsibilities for that patient (investigating, diagnosing, prescribing for and treating the patient).
  - Notify the attending physician and the patient (if possible) that the attending physician is no longer providing care.
  - Inform two members of the MAC within 24 hours of the assumption of patient care and file a written report to the MAC within 48 hours.
  - If the MAC agrees with the opinion of the officer that the action was necessary, the MAC is required to file a detailed written report to the CEO and the board.

Sections 4.1 to 4.5 of the OHA/OMA Prototype By-law provides an example of how hospitals can implement the section 34 requirements (and extend the requirements to apply to the members of the Dental, Midwifery and Extended Class Nursing Staff). Those sections of the OHA/OMA Prototype By-law also provide an example of how a hospital can require all members of the Professional Staff to be on alert for and report situations of serious patient safety issues (for example, belief that another member is incompetent or attempting to exceed their privileges, or acting in a manner that could cause harm or injury).

All serious concerns about incompetence, misconduct, or negligence should be reported to the CEO and the Chief of Staff/Chair of the MAC (or most appropriate clinical leader as indicated in the by-laws) immediately with any evidence to support such claims as such concerns may require a report to a regulatory college and may warrant temporary suspension or restriction of the member's privileges.

See Chapter 9, Refusing Appointments and Re-appointments and Suspending, Restricting or Revoking Privileges.

FAQs

1. Can we selectively enforce a policy against only certain Professional Staff members?

No. One of the key principles in managing Professional Staff in hospitals is the consistent application of rules and policies. Hospital MACs and boards may be criticized (and actions taken against the Professional Staff member overturned) if it becomes clear that certain members of the Professional Staff were singled out.

2. At what stage of disciplinary action do we have to report a member of our Professional Staff to their regulatory college?

Legal advice should be sought when considering making a mandatory report to a regulatory college. However, the following is clear, the administrator of the hospital should create a report as soon as possible:

- where an application for appointment or reappointment is rejected by reason of incompetence, negligence or misconduct;
- after a board has suspended, restricted or revoked a member's privileges;
- after a CEO, Chief of Staff/Chair of the MAC or Chief of Department has temporarily suspended a member's privileges;
- if the MAC has issued a finding against the member of incompetence, negligence, incapacity or misconduct;
- if the member resigns or retires related to their competence, negligence or conduct;
- if the member voluntarily resigns or restricts their practice during an investigation into their practice or behaviour;
- if there are allegations of sexual abuse (unless there is reason to believe the allegations are frivolous or vexatious).

For a description of reports to regulatory colleges, see Chapter 9, Refusing Appointments and Re-appointments and Suspending, Restricting or Revoking Privileges.

3. How should the hospital respond if a complaint is about the CEO, or Chief of Staff/Chair of the MAC in their capacity as a member or Professional Staff?

Such reports should be directed to the CEO or Chair of the board, as appropriate, who will determine the course of action. Legal advice should be sought when considering what steps to take. Hospitals should consider engaging an external consultant to conduct an investigation to ensure objectivity.

4. This chapter and Chapter 9 explain that privileges can be restricted, suspended and revoked. What is the difference?

"Restriction" means any negative modification, reduction, reassignment, or change to a Professional Staff member's privileges.

"Suspension" means the temporary revocation of some or all of one's privileges. A suspension may be immediate or non-immediate.

"Revocation" means the withdrawal or cancellation of some or all of one's privileges after they have been granted. A revocation of privileges is the most serious of these actions.

Chapter 9: Refusing Appointments and Re-appointments and Suspending, Restricting or Revoking Privileges

Reference Key:

Public Hospitals Act:	Sections 33, 36, 39, 41-44; Regulation 965 Section 18(3)
OHA/OMA Prototype By-law:	Sections 3.1(3), 4.1, 4.2

Chapter Summary

- Hospitals have an obligation to provide safe and effective care to their patients and create safe working environments for their staff. These are the primary obligations of hospitals and supersede any Professional Staff member's right to practice. A hospital's failure to take action to suspend, restrict or revoke privileges in cases of incompetence, incapacity or misconduct can leave hospitals exposed to civil litigation.
- When the Medical Advisory Committee (MAC) recommends that a physician not be appointed or re-appointed to the Medical Staff, or that a physician's privileges be suspended, restricted, revoked or otherwise changed, the *Public Hospitals Act* and the hospital by-laws set out a process whereby the physician is entitled to a formal hearing at their request before the hospital board (it would be considered best practice to extend these rights to apply to Dentists, Midwives or Extended Class Nursing Staff through inclusion in the hospital's by-laws).
- Only the board can decide not to appoint, re-appoint, suspend, restrict or revoke the privileges (except when the hospital by-laws allow the CEO or Chief of Staff/ Chair of the MAC to instigate initially urgent, time-limited suspensions).
- Chiefs of Department (or most appropriate clinical leaders) cannot simply "terminate" a member from the Professional Staff with notice or pay in lieu of notice. A much more complex process must be followed.
- These decisions have significant financial, reputational and emotional impact on Professional Staff members. If clinicians are refused appointment or re-appointment or have their privileges suspended, restricted or revoked, there is an immediate impact on their practice. They may also be obliged to alert all future hospitals, because some hospital by-laws require disclosure in the application form of any loss of privileges or failure to obtain privileges at other hospitals.
- In most situations, there will be a duty for a hospital to report to a regulatory college if the hospital refuses, suspends, restricts or revokes privileges (under either the *Public Hospitals Act* or the *Regulated Health Professions Act*).

Legal Context

As described in Chapter 2, Legal Context, the *Public Hospitals Act* sets out a comprehensive scheme to allow physicians to challenge hospital decisions that negatively impact their practices. However, it is best practice to extend these procedural rights to dentists, midwives and extended class nurses through the hospital by-laws.

While no one has a right to be granted or keep hospital privileges[1], hospitals are responsible for following the *Public Hospitals Act*, Regulation 965, and their own by-laws when processing applications for appointment, re-appointment and changes to privileges or when considering suspensions, restrictions or revocation of privileges.

These decisions can be organized into two categories:

- **Applications for Appointment/Re-appointment:** Refusals of initial appointments, re-appointments or changes to privileges (a board decision is made after the appropriate application is received).
- **Mid-term Action:** Suspensions, restrictions or revocations of privileges between annual re-appointments (this typically occurs when an urgent response is necessary such as for reasons of safety).

1 In the 2010 Rosenhek decision, Justice Greer stated, "No physician has a right to hospital privileges. Patient safety and quality of care are the paramount concerns when making a decision with respect to physician privileges." *Rosenhek v. Windsor Regional Hospital*, 2010 ONSC 3583, [2010], O.J. 2893 (Sup. Ct) at 33.

These decisions have a direct impact on a clinician's current and future livelihood. Therefore, they are sensitive to manage and require hospital management to have at least a basic understanding of the legal context and rights afforded to the clinician. Hospitals require legal advice in these circumstances.

For additional information, see Chapter 2, Legal Context.

Impact on the Individual

Decisions impacting privileges have significant financial, reputational and emotional impact on clinicians. Refusal of an appointment or re-appointment or the suspension, restriction or revocation of privileges would have an immediate, personal impact on a clinician. They may also be required to notify the regulatory college under the *Public Hospitals Act* or *Regulated Health Professions Act*. And, as some hospital by-laws require any loss of privileges or failure to obtain privileges at other hospitals to be disclosed on application or re-application, the clinician may also have to alert future hospitals about the privileges decision.[2]

The timing of board decisions can also have a significant impact on the clinician. When a Professional Staff member has applied for re-appointment, the *Public Hospitals Act* requires that the Professional Staff member's privileges continue intact:

a. Until the re-appointment is granted, or

b. Where they are served with notice that the board refuses to grant the re-appointment, until the time for giving notice requiring a hearing before Health Professions Appeals and Review Board (HPARB) has expired; and, where a hearing is required, until the decision of HPARB has become final.[3]

However, a physician who appeals a mid-term suspension or revocation to HPARB may not be permitted to practice while awaiting the outcome of the HPARB hearing or of any subsequent appeals. Mid-term suspensions should not be entered into lightly given the significant impact on the Professional Staff member. For example, midwives are required to provide continuity of care for their patients (that is, prenatal, intrapartum and postpartum care) over several months and a mid-term suspension may significantly interrupt that care model.

ROSENHEK DAMAGES AWARD

Hospitals must understand that there can be serious consequences to bad faith action by hospital leadership and boards. The leading case is *Rosenhek v. Windsor Regional Hospital*[4], where Mr. Justice Joseph G. Quinn stated the following:

> "I find there was bad faith on the part of the Board of Governors in terminating the privileges of Dr. Rosenhek for a very minor problem and for which Dr. Rosenhek may have been only partially responsible … The lack of good faith is based on the manner in which [the board] hearing was conducted and the reason for revocation of privileges.
>
> "I find [the hospital's] predominant purpose in revoking [Dr. Rosenhek] privileges was to resolve a perceived problem among the specialists … It is also clear that [the hospital's] decision to revoke [Dr. Rosenhek's] privileges was not in accordance with the *Public Hospitals Act*. The recommendations of the Medical Advisory Board were never given to [Dr. Rosenhek] as required by s. 37(6). [Dr. Rosenhek] was never given notice of the hearing as required by s. 37(7). I find that [the hospital's] act, in revoking [Dr. Rosenhek's] privileges, was unlawful … [Dr. Rosenhek], I find, has suffered an economic loss as a result of the revocation … I find that [Dr. Rosenhek's] is entitled to damages from [the hospital] on the basis of the tort of intentional interference with economic relations …
>
> "In conclusion, I would allow [Dr. Rosenhek's] claim in the amount of $3,000,000 plus prejudgment interest."

2 Please note, such a report about being refused privileges is not a requirement under the *OHA/OMA Prototype Board-Appointed Professional Staff By-law, 2011* (OHA/OMA Prototype By-law).

3 *Public Hospitals Act*, s. 39(3) as it applies to physician privileges.

4 Ibid. (Note that this hospital board's subsequent decision in 2009 to revoke Dr. Rosenhek's privileges was upheld by HPARB (HPARB October 2009).)

Does a Hospital Have the Authority to Make Changes to Privileges without Giving Rise to a Suspension, Restriction or Revocation of Privileges?

To ensure effective management and operations, a hospital – through its Chief of Staff/Chair of the MAC, Chiefs of Department, Heads of Division and other clinical leadership – has reasonable latitude to assign or re-assign Professional Staff duties, resources, and supports without triggering a change in privileges and the legal rights to a board hearing.[5] However, a hospital must be mindful that at some point – depending on the nature and magnitude – changes made by the hospital could be seen by the member (and just as importantly by HPARB or a court) to result in a substantial alteration of privileges (or suspension, restriction or revocation of the Professional Staff member's privileges), even if there is no change in the category of privileges the member enjoys.

Hospitals should exercise extra caution, if they propose to temporarily or permanently restrict or change a member's duties, resources or supports substantially, thereby negatively altering the member's:

- Income;
- Ability to engage in the type of practice they have enjoyed at the hospital (for example, a surgeon may require access to the operating room (OR) to conduct surgery);
- Access to the use of residents or students;
- Access to research subjects;
- Opportunities for referrals; or
- Reputation.

This is an especially important message to convey to Chiefs of Department and Heads of Division and other clinical leadership so that they do not unilaterally change or revoke a member's duties, resources and supports in ways that substantially alter their privileges and inadvertently trigger the *Public Hospitals Act* legal process.

Chiefs of Department should also remember that any comprehensive changes within a Department need to be fair and reasonably allocated amongst the Professional Staff members (e.g., if a new surgeon requires a block of OR time, the OR time of the other Department members should be impacted proportionately).

Reasons to Refuse an Application or to Suspend, Restrict or Revoke Privileges

The following are examples of situations that could result in refusals of applications for appointment or re-appointment, or mid-term suspensions, restrictions or revocations of privileges:

- The individual does not have or fails to maintain the qualifications for appointment, re-appointment or change in privileges as set out in the hospital's by-laws.[6]
- The appointment is not (or re-appointment is no longer) consistent with the need for service.
- The Professional Staff Human Resources Plans or impact analyses do not demonstrate sufficient resources to accommodate the applicant.
- The appointment is not consistent with the strategic plan and mission of the hospital.
- There are concerns about the individual's competence, capacity or conduct.
- Issues have been identified relating to safety, quality of care, legal compliance or effective operations of the hospital, as evidenced by letters of reference,

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5 See for example, *Prairie North Regional Health Authority v. Kutzner*, 325 D.L.R. (4th) 401, 2010 SKCA 132 where the Saskatchewan Court of Appeal concluded that the hospital had the authority to change operating room schedules without giving an affected physician a right to appeal. See also *Davidson v Sunnybrook Health Sciences Centre*, 2012 CanLII 35969 (ON HPARB) and *Abramson v Medical Advisory Committee (North York General Hospital)*, 2011 CanLII 93929 (ON HPARB).

6 See OHA/OMA Prototype By-law, ss. 4.3(8) and 4.8(1). See *Waddell v Weeneebayko Area Health Authority*, 2018 CanLII 39843 (ON HPARB), aff'd 2019 ONSC 7375 (Div Ct).

performance reviews, complaints, incident reports, self-reports, administrative alerts, regulatory college reports, etc.

- There are concerns about the individual's malpractice history or civil/criminal/regulatory claims history.

The reason for refusing appointments and reappointments may differ from the reasons to suspend, restrict or revoke privileges. These reasons are often set out in the hospital by-laws,[7] Rules and Regulations, Code of Conduct policies, or perhaps in written contracts with the Professional Staff.

A hospital should always maintain a transparent process for reaching its decisions, clearly outlining the reasons for its decisions (e.g., changes in privileges), whether these are budgetary, changes in clinical service direction, or issues with individual Professional Staff members.

REASONS TO REFUSE APPOINTMENT OR RE-APPOINTMENT OR TO SUSPEND, RESTRICT OR REVOKE PRIVILEGES

- No position available
- Not qualified
- Concerns raised in letters of reference (for initial appointment)
- Concerns about malpractice history or civil actions/criminal record/regulatory claims
- Concerns about competence, capacity or conduct
- Incomplete application
- Lack of resources
- Performance review concerns
- Suspended/revoked license to practice
- Suspended or terminated professional liability protection coverage (insurance)
- Change in strategic direction
- Closing service or hospital[8]
- Failure to follow hospital policy
- Failure to complete occupational health and safety requirements or mandatory training

7 See OHA/OMA Prototype By-law ss. 4.3(8) for refusing privileges, and s. 5.2, for suspending, restricting or revoking privileges.

8 *Public Hospitals Act*, s. 44.

Teamwork, Culture and Dissenting Voices

A culture of patient safety requires that everyone who works in a hospital be free and willing to raise their issues of concern. Professional Staff members should be encouraged to advocate for patients and to speak up about quality, collegiality, safety, excessive workloads, and poor equipment. The Canadian Medical Protective Association has stated its concerns about efforts by hospitals to restrict healthcare providers from responsibly fulfilling the role of advocate:

> 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, … 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 … 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.).[9]

These conversations can be uncomfortable but are vital to safety.

There are limits to appropriate advocacy specifically where a Professional Staff member crosses over the line of responsible or respectful engagement. Privileges disputes case law is clear that where a Professional Staff member contributes to a toxic work environment, that activity negatively impacts on patient safety and care

9 CMPA, Changing Physician-Hospital Relationships, p. 6 https://www.cmpa-acpm.ca/static-assets/pdf/research-and-policy/public-policy/com_2011_changing_physician-e.pdf

and may justify denial of re-appointment or suspensions, restrictions or revocation of privileges. For example, in the *Pierro v. The Hospital for Sick Children*[10] , where the Court stated that disruption and conflict amongst a hospital's employees can only adversely affect the care of patients, and that a hospital is "obliged to ensure that its employees can work together in the most harmonious environment possible."

Where there are serious disruptions to a team environment, such behaviour may justify serious action. In *Gupta v. William Osler Health System*[11], the court stated that a hospital board has a variety of factors to consider when revoking hospital privileges:

> It is clear that the Court in Rosenhek was not suggesting that the only public-interest factor to be considered related to the quality of care provided by the hospital. I appreciate, as stated by this Court in Soremekun at para. 16, that ensuring patient safety in the provision of hospital services is a main purpose of the Act and it was the one factor singled out in the Rosenhek case. However, the Court there referred to "various public-interest factors" (emphasis added). As the Appeal Board held, there must be a balance of several disparate interests, including the Respondent's right to expect that its professional staff will follow its policies and their responsibilities. As the Respondent argues, public interest must include maintaining public confidence in public institutions, and egregious misconduct by people working in those institutions, particularly physicians, attacks this public confidence. Furthermore, as the Appeal Board noted, [the nurse] has a right to a safe working environment, free from harassment and threats of violence. This is not a matter of punishing the Appellant, or applying private law concepts, as the Appellant suggests, but rather furthering the various public objectives of the Act.

10 *Pierro v. The Hospital for Sick Children*, [2016] ONSC 2987

11 *Gupta v William Osler Health System*, 2017 ONSC 1294 (Div Ct).

Chief of Department Makes Initial Recommendations

As a reminder, except if the hospital by-laws permit, when there is a need for immediate action, a Chief of Department cannot unilaterally suspend or revoke someone's privileges. The term Chief of Department will be used in this section, but it is acknowledged this role may be played by another clinical leader.

If there are issues with a candidate for initial appointment or with a member of the Professional Staff, the Chief of Department will likely be the first person to address those issues. *See Chapter 5, Initial Appointment; Chapter 6, Re-appointments and Changes to Privileges; and Chapter 8, Performance Evaluations and Progressive Management.*

If the Chief of Department wishes to initiate proceedings to refuse, suspend, restrict, or revoke privileges for any reason, **prior** to taking any steps to reduce or limit the clinician's practice, they should:

1. Advise the Chief of Staff/Chair of the MAC of all the relevant information as soon as possible, including:
   - A summary of the actual or potential issues.
   - A copy of any documentation of how the issues have been raised and addressed with the Professional Staff member (including copies of any annual performance reviews or letters of reference, if applicable).
   - A summary of the action the Chief proposes the hospital take (whether the Chief recommends refusal, suspension, restriction or revocation of privileges).
2. Notify the Chief of Staff/Chair of the MAC if there are extenuating circumstances that must be considered or addressed (such as health issues affecting the Professional Staff member's performance, keeping in mind that such information must be carefully protected).
3. Consider and advise the Chief of Staff/Chair of the MAC whether the concerns are serious enough to propose immediate suspension (if so, see Mid-Term Action Process below).

Informal Resolutions and Collection of Information

Informal resolutions can often be achieved before initiating formal proceedings. Often, the Chief of Staff/ Chair of the MAC (or the CEO, VP Medical or some other senior leader) can become involved as an objective third-party before the matter goes to the Credentials Committee (for applications for appointment, re-appointment or changes to privileges) or to the MAC (for possible mid-term suspensions, restrictions or revocations of privileges). The Chief of Staff/Chair of the MAC may assist in discussing options and resolutions and potentially mediate between the Chief of Department and the applicant/ member of the Professional Staff. There may be external resources that can be utilized to find solutions (such as the Ontario Medical Association's Physician Health Program). The Chief of Staff/Chair of the MAC may decide to initiate an investigation or gather further information. *See Chapter 8, Performance Evaluations, and Progressive Management.* The Chief of Staff/Chair of the MAC should also consult with legal counsel.

Formal MAC Process

If informal efforts do not resolve the issues, then the formal MAC and board processes must be engaged if the hospital proposes to refuse an application for appointment, re-appointment or changes to privileges or proposes to suspend, restrict or revoke privileges. There are slightly different processes depending on whether the issue relates to the processing of an application for initial appointment, re-appointment, or changes to privileges, or involves mid-term action for suspension, restriction or revocation of privileges.

Initial Appointment, Re-appointment and Changes of Privileges

Chapters 5 and 6 dealt with initial appointments and re-appointments to the Professional Staff. In those chapters, it was explained how applications are reviewed by the Credentials Committee and then forwarded to the MAC.

If there are problems with one or more applications, the MAC may choose to have a separate meeting to investigate thoroughly the concerns. In some cases, it may be appropriate for the MAC to invite the applicant to the MAC meeting to provide their side of the story. While a meeting before the MAC is not required by the *Public Hospitals Act*, some by-laws contemplate giving the member an opportunity to respond to the issues or allegations against their application.[12] This can be a useful part of this process that can lead to early resolution of issues and avoid the time, cost and emotional upheaval resulting from a privileges hearing before the board. Depending on the circumstances, a separate MAC meeting can be very informal (with short questions and answers) or more like a legal proceeding.

When the MAC makes its decision (to either recommend or not recommend the applicant to the board for appointment or re-appointment or a change to privileges), it must notify both the applicant and the hospital board in writing of its decision. Sections 37(6) and (7) of the *Public Hospitals Act* require that a physician applicant be notified that they are entitled to:

- Written reasons for the recommendation if a request is received by the MAC within seven days of the receipt by the applicant of a notice of the recommendation.
- A hearing before the board if a written request is received by the board and the MAC within seven days of the applicant receiving the written reasons.

This notification can also apply to other members of the Professional Staff if the same process is extended to them in the hospital by-laws.

When informal processes have not resolved outstanding issues with an application, especially when the MAC does not support the application, applicants are likely to request a board hearing.

12 The OHA/OMA Prototype By-law does not contemplate a MAC meeting where an application for appointment, re-appointment or change to privileges is not being recommended for the MAC's approval, given that such a meeting is not a legal requirement. Such processes can also be set out in hospital policy.

Mid-Term Action

In Chapter 8, performance reviews and progressive management were discussed. If the informal resolutions above are exhausted, and the hospital wishes to pursue a suspension, restriction or revocation, someone who has been involved in the matter (either the Chief of Department, Chief of Staff/Chair of the MAC, CEO or VP Medical) should formally notify the MAC in writing of their concerns and supply the MAC with all relevant documentation.

The grounds for immediate mid-term action and non-immediate mid-term action are different. In an instance of immediate mid-term action, the member of the Professional Staff ceases to practice at the hospital *immediately* (cannot treat patients or earn an income). The grounds for immediate action are often limited to the most emergent situations, where the conduct, performance or competence of a member "exposes or is reasonably likely to expose any patient, health care provider, employee or any other person at the Hospital to harm or injury," or "is or is reasonably likely to be detrimental to patient safety or to the delivery of quality patient care within the hospital."[13] Whereas in an instance of non-immediate action, the member of the Professional Staff continues to practice in the hospital while the matter is referred to the MAC for recommendations. *Also, see the section on Temporary Suspension later in this chapter.*

For any serious allegations against a member of the Professional Staff, the MAC may choose to have a separate meeting to investigate thoroughly the concerns. In those cases, it is likely appropriate for the MAC to invite the member of the Professional Staff to the MAC meeting. While a meeting before the MAC is not required by the *Public Hospitals Act*, some by-laws[14] contemplate giving the member an opportunity to respond to the allegations (especially if there are allegations of professional misconduct, negligence or incompetence that can give rise to a duty to report to the member's regulatory college). Again, this can be a useful part of the process that can lead to early resolution of issues and avoid the time, cost and emotional upheaval resulting from a privileges hearing before the board. Depending on the circumstances, a separate MAC meeting can be very informal (with short questions and answers) or more like a legal proceeding.

MAC Privileges Meetings

In either case (whether for refusal of an application or for mid-term action), if a separate MAC meeting is held, the MAC may meet as a whole committee or strike a panel of the Executive Committee of the MAC (if one exists) to preside over the meeting.[15] Only MAC members with the right to vote on issues related to appointments, credentialing, re-appointments and disciplining shall preside at such a meeting of the MAC. Specifically, the *Public Hospitals Act*, Regulation 965, allows only physicians to be voting members of the MAC. While many hospitals have created a more multi-disciplinary MAC to reflect the reality of the Professional Staff mix within the hospital, any Professional Staff member on the MAC who is not a physician cannot have voting rights. This is particularly critical during privileges disputes, where every decision and action taken throughout the process may be subject to the later scrutiny of HPARB or the courts. If there is a MAC panel, the membership must be acceptable to the applicant/Professional Staff member, although the applicant/Professional Staff member must have valid reasons for objecting to any particular member (i.e., an actual or perceived conflict of interest).

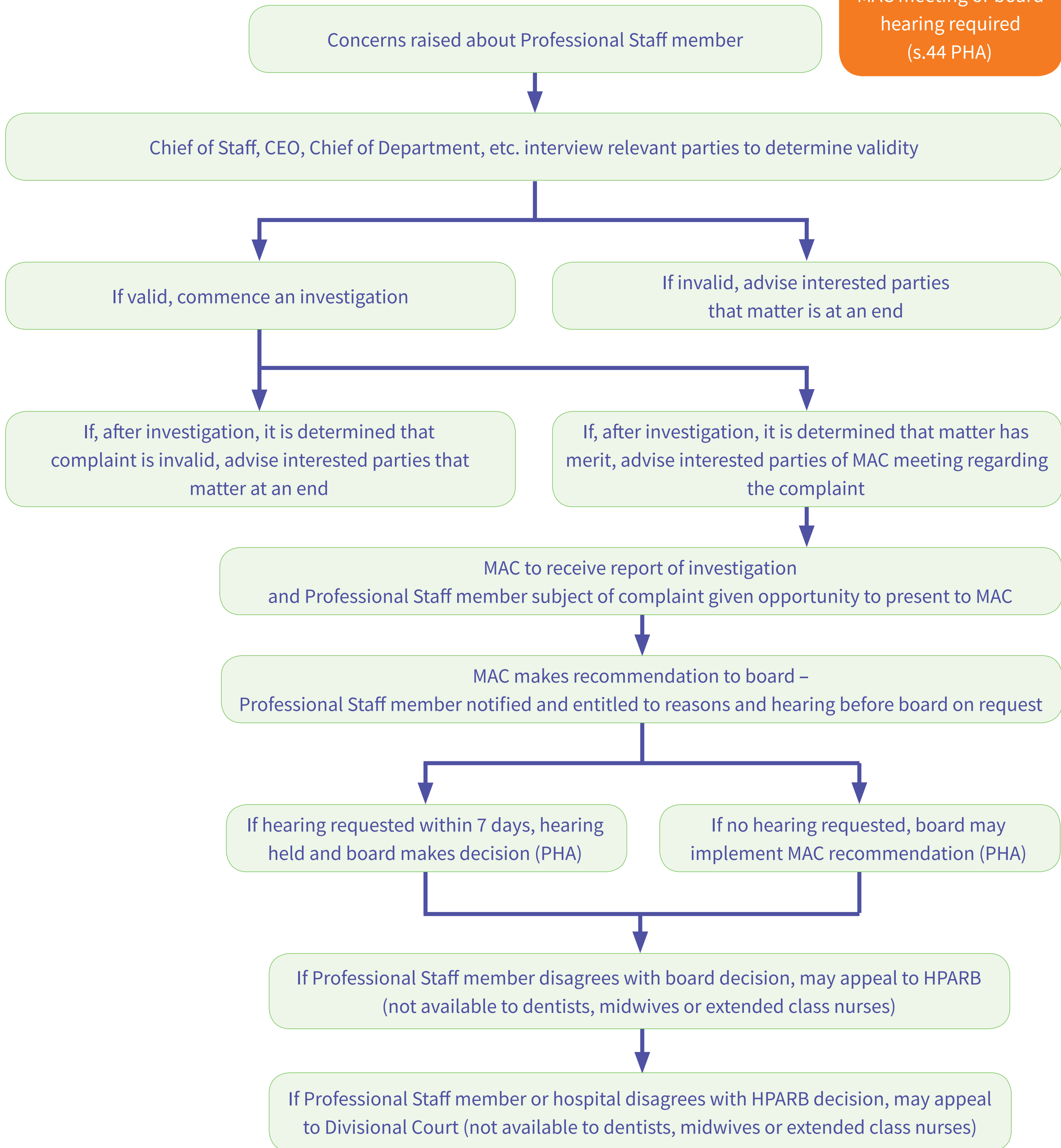
13 OHA/OMA Prototype By-law, s.5. See also *Abouhamra v Prairie North Regional Health Authority*, 2016 SKQB 293 (CanLII) at para. 131: "the immediate suspension of a professional person (or even of other privileges) is a drastic step that should be taken only as a last resort and even then only after careful consideration of whether other measures might suffice," and at para. 132: 'the weight of judicial authority is that the harsh remedy of interim suspension is to be used sparingly and carefully, and must rest upon a proper factual foundation."

14 For example, the OHA/OMA Prototype By-law contemplates a meeting before the MAC in situations where a temporary restriction or suspension of privileges was applied or where there is a recommendation to the MAC for the restriction or suspension, or revocation of privileges. See section 5.5.

15 While neither the *Public Hospitals Act* nor the OHA/OMA Prototype By-law contemplate an Executive Committee of the MAC, there may be benefits – depending on the size of the MAC – of including a MAC Executive Committee in the by-laws in order to handle issues like this and help avoid scheduling problems.

Mid-Term Suspension, Restriction, Revocation

* Some parts of this process will be determined by the hospital by-laws.



The hospital can establish the rules and format for a MAC privileges meeting. The MAC and the applicant/Professional Staff member should agree on a date and time for the meeting. The by-laws or policy typically provide a timeframe within which the meeting must happen, in order to ensure that the process moves along without undue delay. Caution should be exercised in creating timelines that are too rigid in the by-laws or policy, as the parties to the meeting may not be able to schedule and prepare within a few days or weeks, particularly when the facts and legal issues are complicated.

If the MAC and the Professional Staff member can negotiate a satisfactory resolution to the matter at the MAC level (e.g., remedial training, attendance at the Ontario Medical Association's Physician Health Program, etc.), this resolution must be sanctioned by the board if it involves any restriction on the Professional Staff member's privileges. Otherwise, if the clinician is dissatisfied with the MAC's proposed recommendation to the board and asks for a board hearing, they are entitled to one.[16]

Ultimately, the board decides about all privileges decisions. Accordingly, other than immediate interim suspensions by the CEO or Chief of Staff/Chair of the MAC or Chief of Department, which are discussed later in this Chapter, no substantial alteration in privileges can be implemented until a decision is made by the board.

Board Hearings

When the MAC recommends that a physician not be appointed or re-appointed to the Medical Staff or that a physician's privileges be suspended, restricted, revoked or otherwise changed, the *Public Hospitals Act* and the hospital by-laws set out a process whereby the physician is entitled to a formal hearing before the hospital board. It is best practice to extend these rights to dentists, midwives or extended class nurses through inclusion in the hospital's by-laws.

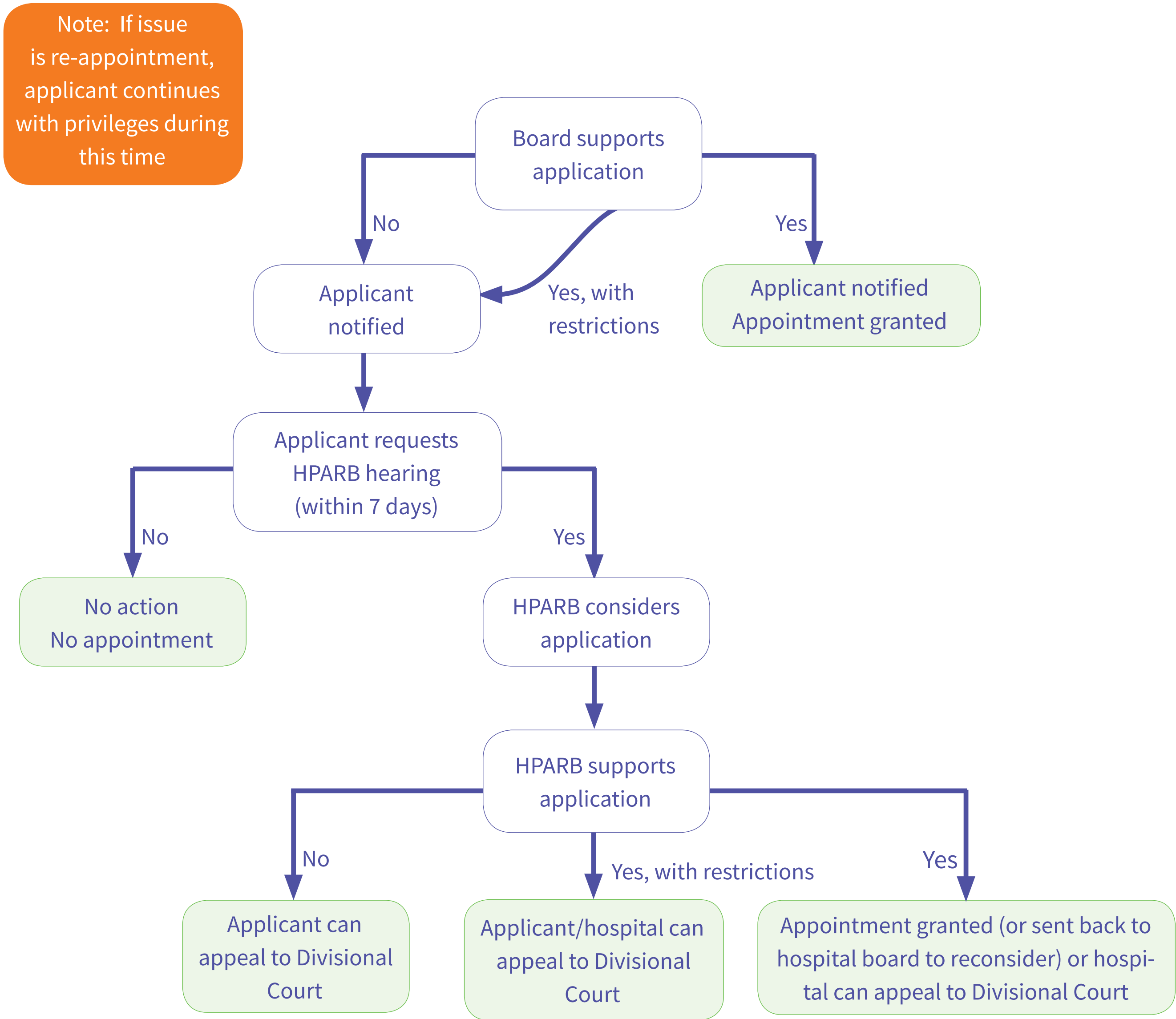
MAC RECOMMENDATION	IMPACT ON MEMBER	RIGHT TO A BOARD HEARING?	SOURCE
Refusing a request for initial application for any reason (other than due to closure of hospital or service). This includes: no position is available, not qualified, concerns about references, incomplete application, or concerns about competence, capacity or conduct	Clinician is not invited to join the Professional Staff	Yes	PHA, ss. 36, 37
Refusing a request for re-appointment for any reason (other than due to closure of hospital or service) including: no longer meets qualifications; concerns of competence, capacity or conduct	Member of the Professional Staff is not renewed and is no longer able to practice at the hospital	Yes	PHA, s. 36
Refusing a request for a change in privileges	Member's privileges and appointment level do not change	Yes	PHA, s. 37

16 This is a right of physicians under the *Public Hospitals Act*, and may be a right extended to other members of the Professional Staff through the hospital by-laws.

MAC RECOMMENDATION	IMPACT ON MEMBER	RIGHT TO A BOARD HEARING?	SOURCE
Suspending privileges because of administrative issue (e.g., incomplete health records)	Temporary suspension of privileges; member cannot provide all or portion of services	Yes	PHA, ss. 36, 37
Suspending privileges because no longer holds qualifications	Member cannot provide all or portion of services	Yes	PHA, ss. 36, 37
Restricting privileges because of concerns of competence, capacity or conduct	Member cannot provide a portion of services	Yes	PHA, ss. 33, 36, 37
Revoking privileges because of concerns of competence, capacity or conduct	Member's appointment is terminated and cannot provide any services	Yes	PHA, ss. 33, 36, 37
Refusing a request for appointment or re-appointment because closing a service or hospital	Applicant or member of the Professional Staff is not appointed or renewed and is not able to practice at the hospital	No	PHA, s. 44
Refusing a request for a change in privileges because closing a service	Member's privileges and appointment level do not change	No	PHA, s. 44
Restricting privileges because closing a service or hospital	Member cannot provide a portion of services	No	PHA, s. 44
Revoking privileges because of closing a service or hospital	Member's appointment is terminated and cannot provide any services	No	PHA, s. 44
Changing duties, resources or supports	Member's duties, resources or supports within the hospital are increased or decreased or otherwise changed in some way	It depends. If substantial alteration of privileges, yes. If not substantial alteration of privileges, no (case law).*(See analysis under section "Does a Hospital Have the Authority to Make Changes without Giving Rise to a Suspension, Restriction or Revocation of Privileges?" in this Chapter)*	

Board Hearing Process

* Continued from Appointment Process (Chapter 5) and Re-appointment Process (Chapter 6).



When a hospital board makes a decision about privileges, it is considered to be a "quasi-judicial decision-maker"; therefore, it must act fairly and in accordance with the principles of natural justice. *See Chapter 2, Legal Context.*

If an initial applicant/Professional Staff member desires a hearing before the board, they must make a request in writing to the Board Chair within seven days of receiving reasons for the MAC's recommendation.[17] Practically speaking, the notice is often delivered to the Board Chair through either the CEO, the Chief of Staff/Chair of the MAC or the most appropriate clinical leader, as the applicant/Professional Staff member will have had no contact with the Board Chair up to this point.

The Professional Staff member (or the initial applicant) and the MAC (and any others specified by the board) are parties at a board hearing.[18] The Chief of Staff/Chair of the MAC or a designate represents the MAC at the hearing. There are generally three lawyers involved:

- legal counsel to the MAC;
- legal counsel to the Professional Staff member; and
- legal counsel to the board (as decision-maker).[19]

The board has two choices:

- For the hearing to be before the full board, which can often lead to scheduling challenges;[20] or,
- The board can delegate to the Executive Committee the authority to hear the privileges dispute on behalf of the full board.[21]

If the board wishes to explore other options, it should consult legal counsel.

Only board members with the right to vote shall preside at board hearings. The board may not include anyone who has taken part in any investigation or consideration of the subject matter of the hearing.[22]

This rule most often impacts the CEO and Chief of Staff/ Chair of the MAC, or other members of the MAC who sit on the board and who may have been involved in earlier efforts to investigate or resolve the privileges dispute. Any member of the MAC who participated in the MAC meeting is also precluded from participating in the board hearing. (Note, however that employees of the hospital and members of the Professional Staff do not have voting rights as board members under the *Public Hospitals Act* regulations, and are therefore unable to vote at board hearings in any event.) Further, the Professional Staff member may object to the presence of a particular board member on the board hearing panel, but must have valid reasons for the objection (i.e., a perceived or actual conflict of interest).

While the board is entitled to unilaterally set a date and time for the hearing,[23] practically speaking, the scheduling is often a matter of some negotiation. The board, MAC and the applicant/Professional Staff member should agree on a date and time for the hearing. The by-laws or policy typically provide a timeframe within which the hearing must happen in order to ensure that the process moves along without undue delay. Caution should be exercised in creating timelines in the by-laws or policy that are too rigid, as the parties to the meeting may not be able to schedule and prepare within a few days or weeks, particularly when the facts and legal issues are complicated. The applicant/Professional Staff member should be advised in writing of the context for the board hearing and the procedural rights that are applicable. After the hearing, the board notifies the parties of its decision. The applicant/Professional Staff member is entitled to receive written reasons for the decision.[24]

It is important to note that within the legal context, rights of appeal from a decision of the board only apply

17 *Public Hospitals Act*, s. 37(7) applies to physicians only. These procedural rules may be extended to other members of the Professional Staff through the hospital by-laws.

18 *Public Hospitals Act*, s. 39(2).

19 *Dignan v. Board of Directors of South Muskoka Memorial Hospital* (1998), (ON Health Professions Appeal and Review Board).

20 Board hearings can last from hours to days.

21 As long as the hospital's administrative by-laws contemplate a Board Executive Committee to which the board may delegate decision-making on matters such as privileges hearings, and the Executive Committee reports back its findings to the full board at its next meeting.

22 *Public Hospitals Act*, s. 39(4).

23 *Public Hospitals Act*, s. 39(1).

24 For physicians, this right is set out in the *Public Hospitals Act*, s. 41(1).

to physicians. That is, if a member of the Medical Staff (or physician applicant for initial appointment) feels aggrieved by the board's decision, they have the right to request a hearing before HPARB.[25] This right is not available to members of the Dental, Midwifery or Extended Class Nursing Staff because the right comes from the *Public Hospitals Act* and cannot be extended to apply to other disciplines in the by-laws. A request for an HPARB hearing must be made within seven days of receiving the board's written reasons for its decision. Decisions of HPARB may be appealed to Divisional Court.[26]

No Hearing if Closing the Hospital or Closing a Service

While most situations in which a clinician's privileges are negatively affected give rise to the right for a hearing before the hospital board, there are two notable exceptions. When a hospital is closing and will cease to operate as a hospital, all members of the Professional Staff will be negatively affected. Sections 44(1) and (1.1) of the *Public Hospitals Act* state that in these circumstances a board may:

- Refuse the application of any physician for appointment or re-appointment to the Medical Staff or for a change in hospital privileges;
- Revoke the appointment of any physician; and
- Cancel or substantially alter the privileges of any physician.

Similarly, under sections 44(1.2) and (2), if a hospital will no longer be providing a particular service, a board may:

- Refuse the application of any physician for appointment or re-appointment to the Medical Staff of the hospital if the only hospital privileges to be attached to the appointment or re-appointment relate to the provision of that service.
- Refuse the application of any physician for a change in hospital privileges if the only privileges to be changed relate to the provision of that service.
- Revoke the appointment of any physician if the only hospital privileges attached to the physician's appointment relate to the provision of that service.
- Cancel or substantially alter the hospital privileges of any physician which relate to the provision of that service.

Section 44(3) states that the board may make a decision without holding a hearing. Section 44(4) revokes the normal procedural rights of physicians to have their applications considered by the MAC, to receive the MAC's recommendation, to require a hearing before the board and to appeal to HPARB.

Since section 44 applies only to physicians, it is important to remember to include these exceptions in the by-laws so they apply to dentists, midwives and extended class nurses within the hospital.

Section 44(5) protects corporations which own or operate hospitals from liability "for any act done in good faith in the execution or intended execution by a board of its authority under subsection (1) or (2) or for any alleged neglect or default in the execution in good faith by a board of such authority." In *Beattie v. Women's College Hospital*,[27] two physicians who practiced for many years in the hospital's urgent care centre brought an action for wrongful dismissal after the hospital closed its urgent care centre and, as a consequence, terminated their privileges. The Ontario Court of Appeal upheld the trial judge's dismissal of the action on the ground that it was barred by s. 44(5).

Temporary Suspensions

In order to manage urgent situations, by-laws should contemplate a procedure for temporary suspensions of privileges.

For example, the OHA/OMA Prototype By-law includes authority for the CEO, the Chief of Staff/Chair of the MAC, Chief of a Department, or their delegates, to temporarily restrict or suspend hospital privileges. In the case of immediate action, section 4.3 reads as follows:

25 *Public Hospitals Act*, s. 41.

26 *Public Hospitals Act*, s. 43(1).

27 2018 ONCA 872.

(1) The Chief Executive Officer, Chief of Staff, or Chief of Department may temporarily restrict or suspend the privileges of any Professional Staff member, in circumstances where in their opinion the member's conduct, performance, or competence:

(a) exposes or is reasonably likely to expose any Patient, healthcare provider, employee, or any other individual at the Corporation to harm or injury; or

(b) is or is reasonably likely to be detrimental to Patient safety or to the delivery of quality Patient care within the Corporation,

and immediate action must be taken to protect Patients, healthcare providers, employees, and any other individuals at the Corporation from harm or injury.

(2) Before the Chief Executive Officer, Chief of Staff, or Chief of Department takes action authorized in section 4.3(1), they shall first consult with one of the other of them. If prior consultation is not possible or practicable under the circumstances, the individual who takes the action shall immediately provide notice to the others. The individual who takes the action shall forthwith submit a written report on the action taken with all relevant materials and information to the Medical Advisory Committee.

In the case of non-immediate action, section 4.4 of the OHA/OMA Prototype By-law states that:

(1) The Chief Executive Officer, Chief of Staff, or Chief of Department may recommend to the Medical Advisory Committee that the appointment of any Professional Staff member be revoked or that their privileges be restricted or suspended in any circumstances where in their opinion the Professional Staff member's conduct, performance, or competence:

(a) fails to meet or comply with the criteria for annual reappointment;

(b) exposes or is reasonably likely to expose any Patient, healthcare provider, employee, or any other individual at the Corporation to harm or injury;

(c) is or is reasonably likely to be detrimental to Patient safety or to the delivery of quality Patient care within the Corporation or impact negatively on the operations of the Corporation; or

(d) fails to comply with the Corporation's by-laws, Rules, or Policies, the *Public Hospitals Act*, or any other relevant law.

(2) Before making a recommendation under section 4.4(1), an investigation may be conducted. Where an investigation is conducted, it may be assigned to an individual or committee within the Corporation other than the Medical Advisory Committee or an external consultant.

While the *Public Hospitals Act* provides that only the board may revoke or suspend Medical Staff privileges, HPARB has recognized that there needs to be a process in the by-laws, such as that in the OHA/OMA Prototype By-law, "which permits [the hospital] to immediately suspend privileges pending a formal hearing in which the elements of natural justice are preserved, while at the same time protecting the public interest."[28]

Even in an emergency, there is a duty of fairness owed to the Professional Staff member involved. If a situation involving a Professional Staff member of the hospital gives rise to the need immediately to suspend the member's privileges, the Chief of Staff/Chair of the MAC (or most appropriate clinical leader) must immediately notify the Professional Staff member in writing. The notice should specify the incident or incidents that gave rise to the suspension of privileges (on an interim basis) and explain the member's procedural rights to a board hearing (and to appear before the MAC if that process is available under

28 *Nikore v. Brantford General Hospital* (ON Hospital Appeal Board, 1990). See *Kaila v Bluewater Health*, 2014 CanLII 19532 (ON HPARB) for an example of a case involving an immediate, temporary suspension of privileges without a hearing. Following the suspension, the Hospital Board re-instated privileges with conditions and restrictions, which the physician then appealed to HPARB. HPARB's decision was to reinstate with conditions (such as advising security when he entered or exited the hospital), which it found did not substantially alter the physician's privileges. The facts in *Gupta v William Osler Health System*, 2017 ONSC 1294 (Div Ct) also involve an immediate temporary suspension that was confirmed by the MAC and the hospital board, followed by a meeting of the MAC to consider whether the physician could return to work or would have his privileges revoked.

the by-laws). In these emergency situations, timing can be extremely sensitive: the Professional Staff member has been stripped of their livelihood and their professional reputation is at risk. All parties should make efforts to coordinate schedules to deal with matters expeditiously, without compromising the quality of the investigation.

Administrative Suspensions

Some hospitals have policies that contemplate "administrative suspensions", which are suspensions for acts such as failing to pay regulatory college dues and having a lapse in licensure; failing to maintain professional liability protection (insurance); failing to meet occupational health and safety obligations (e.g., mask fit testing, cardio-pulmonary resuscitation, tuberculosis testing); or failing to rectify health records deficiencies after being notified. These suspensions may be recommended by the Chief of Department, Chief of Staff/Chair of the MAC or most appropriate clinical leader, but are implemented only upon a board decision. They are intended to be time-limited, as they suspend privileges only as long as the issue remains unremedied. Once remedied to the satisfaction of the Chief of Staff/Chair of the MAC, Chief of Department (or most appropriate clinical leader) (e.g., the mask fit testing has been completed or the health records have been brought up-to-date), the suspension is over and the Professional Staff member may return to full service at the hospital.

Such suspensions still trigger the rights and procedural fairness requirements of the *Public Hospitals Act* and the by-laws. Someone whose privileges have been suspended would be entitled to a board hearing, if requested.

Communication is the key to the successful management of these issues. It is important for hospitals to consider:

- Dissemination of policies and standards that highlight the administrative suspension consequences.
- Sending reminders to all Professional Staff well in advance of deadlines to comply.
- Providing warning notice(s) in advance of deadlines to members who have not complied (with documentation of the efforts made by the hospital to contact the member).

If a member of the Professional Staff receives a suspension, they may have to alert future hospitals of the suspension (because some hospital by-laws require such disclosure in their applications). Some hospitals provide a document that accompanies the suspension that explains the reason for the suspension, so that the member can include the document in future application packages.

Tips

Boards should consider the following:

- It may not be acceptable for a board to revoke or not renew a Professional Staff member's privileges where there has been no previous history of documented complaints or attempts at effecting remediation or other more moderate forms of disciplinary action.
- To the extent that a hospital has policies and Rules and Regulations, they must be consistently enforced or it may be difficult to rely on a breach of them as grounds for taking disciplinary action.
- It is crucial to keep the MAC and board members separate during privileges disputes so that board members will be free to participate in the board hearing.
- Before revoking a Professional Staff member's privileges, the MAC (and the board) should consider what steps, if any, have been taken or could be taken to remediate the hospital's concerns with the Professional Staff member's practice.
- Revoking a Professional Staff member's privileges due to a lack of collegiality is possible; however:
  - The Professional Staff member's behaviour must be significant enough that it may impact on quality of care.
  - The Professional Staff member must have been given an opportunity to correct their behaviour and failed to do so (unless the behaviour was egregious).[29]

29 See CPSO/OHA Guidebook for Managing Disruptive Physician Behaviour, online: OHA <http://www.oha.com/CurrentIssues/Issues/eHealth/Documents/Guidebook%20For%20Managing%20Disruptive%20Physician%20Behaviour.pdf>.

- The process contemplated by the *Public Hospitals Act* treats all Medical Staff members equally and does not distinguish between active staff and other categories of staff such as (probationary, associate, courtesy or temporary staff). It can be just as difficult to revoke the privileges of an associate Professional Staff member as a long-standing member of the Professional Staff. However, active staff and Professional Staff members who provide full-time equivalent services at a hospital may deserve longer notice periods for change and greater involvement in discussions and input into change initiatives than do other categories of Professional Staff.
- HPARB or a court can overturn a hospital board's privileges decision and can order that an individual be reinstated to the Professional Staff.
- When HPARB or a court finds that a hospital board's decision is unwarranted or is deficient with respect to procedural fairness, a member of the Professional Staff may have legal remedies to compensate for any financial loss they experienced.[30] Even if a Professional Staff member is eventually reinstated, there may still be a claim for lost income and legal costs incurred during the period in which their privileges were restricted or suspended.[31]

Reporting Obligations

When a hospital has taken action against any Professional Staff member (that is to suspend, restrict, or revoke privileges) for reasons of professional misconduct, incompetence or incapacity, there are reporting obligations to a regulatory college and perhaps within the hospital organization itself. There are two sources for these obligations: the *Public Hospitals Act* and Health Professions Procedural Code under the *Regulated Health Professions Act.*

Public Hospitals Act

The reporting obligations that arise under the *Public Hospitals Act* relate only to physicians (not dentists, midwives, extended class nurses) in the following circumstances:

- The CEO of a hospital (the administrator of the hospital) must notify the College of Physicians and Surgeons of Ontario (CPSO) if:
  - A physician has been denied appointment or re-appointment by reason of incompetence, negligence or misconduct.
  - A physician has had their privileges restricted or cancelled by reason of incompetence, negligence or misconduct.
  - A physician resigns from the Medical Staff or restricts their practice within a hospital and the CEO has reasonable grounds to believe that the resignation or restriction is related to the competence, negligence or conduct of the physician.
  - A physician voluntarily or involuntarily resigns or restricts their practice from the Medical Staff during the course of, or as a result of, an investigation into their competence, negligence or conduct.[32]
- The CEO of a hospital (the administrator of the hospital) must notify the Chief of Staff /Chair of the MAC (and Chief Nursing Executive if it involves an extended class nurse and the President or Secretary of the Medical Staff if it involves a physician) if they believe that a member of the Professional Staff is unable to perform the person's professional duties with respect to a patient in the hospital.[33]

30 *Horne v Queen Elizabeth II Health Sciences Centre*, 2018 NSCA 20 (CanLII).

31 *Rosenhek v. Windsor Regional Hospital*, [2007] O.J. No. 4486 (Sup. Ct.). See also *Kadiri v. Southlake Regional Health Centre*, 2015 ONCA 847, which confirms that in cases of reinstatement, depending on the circumstances, a physician may be able to bring a claim in court without first seeking relief from the HPARB.

32 *Public Hospitals Act,* s. 33.

33 *Public Hospitals Act,* R.R.O. 1990, Reg. 965, s. 18(3). Note that midwives and dentists are now mentioned in this section (since a 2017 regulatory amendment).

- An officer of the hospital's Medical Staff must notify the attending physician if they are aware that a serious problem exists in the diagnosis, care or treatment of a patient.[34]

Regulated Health Professions Act, Schedule 2: Health Professions Procedural Code

Reporting obligations arise under the *Regulated Health Professions Act* in the following circumstances:

- Where a CEO of a hospital (person responsible for the operation of the hospital) has reasonable grounds to believe that a member (including dentists, midwives, extended class nurses) and who practices at the facility is incompetent or incapacitated.[35]
- Where a board of a hospital revokes, suspends or imposes conditions on a member's privileges for reasons of professional misconduct, incompetence or incapacity, or where a member resigns or relinquishes their privileges before the hospital had the opportunity to take such actions.[36]
- Where a hospital or another member of the Professional Staff comes into possession of information that would alert them to concerns regarding sexual abuse of a patient.[37]

Legal advice should be sought when considering making a report to a regulatory college. Following legal advice, it is advisable to report as soon as possible in the following circumstances: (1) privileges have been suspended, restricted or revoked; (2) the MAC has issued a finding against the member of incompetence, negligence, incapacity or misconduct; (3) the member resigns or retires or voluntarily restricts their practice during an investigation into their practice or, behaviour; or, (4) there are allegations of sexual abuse.

34 *Public Hospitals Act*, s. 34(3). Note, dentists, midwives and extended class nurses are not mentioned in this section.

35 *Regulated Health Professions Act*, Health Professions Procedural Code, s. 85.2.

36 Ibid. S.85.5.

37 Ibid. S.85.1 and 85.2.

FAQs

1. Are dentists, midwives, extended class nurses entitled to the same procedural protection as physicians under the *Public Hospitals Act*?

Strictly speaking, no. The provisions of the *Public Hospitals Act* apply to members of the Medical Staff only. The *Public Hospitals Act* itself does not refer to other Professional Staff members. However, the regulations under the *Public Hospitals Act* do allow hospital boards to pass by-laws for other Professional Staff groups (dentists, midwives, extended class nurses). And when hospital boards do so, the by-laws typically apply the same processes to all groups. For purposes of consistency and fairness, the OHA recommends as best practice that the same or similar processes are used for the appointment of Professional Staff.

In any particular case, where there is a question about what particular procedural protection should be afforded to an individual applicant or group of applicants, the board should consult its own legal counsel.

2. Why can we not just dismiss a member of the Professional Staff? Can't we just give the person "notice"?

As discussed above and in Chapter 2, Legal Context, the *Public Hospitals Act* sets out a comprehensive code for managing the relationship between a hospital and a physician. This entitles any physician on the Medical Staff the right to a hearing before the board before their privileges are impacted. Even in the rare circumstance where a physician has privileges and is also an employee at a hospital, the physician's privileges cannot be terminated without making available the legal process under the *Public Hospitals Act*. The cornerstone of the privileges framework is procedural fairness, which must be provided at every step.

It is possible that the hospital's by-laws may not extend the same concepts of natural justice and procedural fairness to other members of the Professional Staff (dentists, midwives, extended class nurses). This would be unusual.

3. Are there any circumstances in which we can suspend Professional Staff privileges immediately? Who has the right to do this?

A hospital's by-laws should provide a mechanism that allows specific hospital leaders (e.g., the CEO and Chief of Staff/Chair of the MAC or the Chief of Department) to suspend a Professional Staff member's privileges pending a formal hearing in cases where public protection demands immediate action. Even in this circumstance, the hospital owes a duty of natural justice and procedural fairness to the Professional Staff member. Timelines for board hearings in these circumstances are typically expedited, taking into account that the Professional Staff member's livelihood and reputation are at risk.

4. Must the hospital first try to help a member of the Professional Staff remediate their behaviour before revoking privileges?

Where the behaviour or performance issues can be remediated, this is typically a prudent course of action. The concept of procedural fairness includes ensuring that the discipline matches the problem. If the discipline is too severe too early in the process, the hospital board risks being overturned at HPARB.

There may also be lessons the hospital and its leadership can learn to improve the relationship, behaviour or performance of the Professional Staff member.

5. Can we suspend a Professional Staff member who doesn't do their share of on-call?

Yes. If it is part of their responsibilities and the Professional Staff member refuses to participate (and does not have a legitimate reason why they cannot participate), this may be cause to suspend privileges. This may warrant a temporary suspension (i.e., effective until the problem is remedied) or may lead to the revocation of privileges or recommendation not to re-appoint.

The issue of reducing on-call obligations may also arise in the context of an individual's intention to retire. Some hospitals have an agreed upon staged reduction in privileges including on-call obligations for senior Professional Staff who intend to retire. *See Chapter 10, Resignation and Retirement.*

In the case of *Bhargava v Lakeridge Health Corporation* [38] the Health Professions Appeal and Review Board considered whether a hospital's "Physician On-Call Policy" to tie a reduction in on-call coverage to a proportionate reduction in elective resources amounted to a substantial alteration of the Appellant's privileges. HPARB concluded that Dr. Bhargava's privileges were substantially altered when the hospital reduced his cardiology services commensurate with his choice to reduce his on-call coverage. However, HPARB also concluded that the hospital had the authority to implement the policy and apply it to Dr. Bhargava in accordance with the *Public Hospitals Act*.

6. Can we suspend a Professional Staff who doesn't complete their charts on a timely basis?

Yes. However, the hospital must have a policy that sets out its expectations regarding chart completion.

7. Can we ask a member of the Professional Staff to undertake not to exercise their privileges during an investigation? And if so, must we report that to the regulatory college?

It is possible to negotiate with a Professional Staff member that they will not exercise their privileges during an investigation into their competence, capacity or conduct. Under the *Public Hospitals Act*, an administrator must report a physician to the CPSO if the physician restricts their practice within the hospital during the course of or as a result of an investigation in their competence, negligence or conduct. For other disciplines, the hospital should seek legal advice as to whether a report to the regulatory college is required.

8. Why does the board need to revoke privileges? Isn't this the role of the college?

No. Health regulatory colleges have the jurisdiction to suspend or revoke, or add restrictions to, a licence to practice. The decision to revoke Professional Staff privileges is solely the jurisdiction of the hospital board.

38 2011 CanLII 33743 (ON HPARB), <http://canlii.ca/t/flskv>.

9. Once we revoke privileges, can HPARB reinstate those privileges?

Yes. A decision of a hospital board can be appealed to HPARB, and HPARB may reinstate those privileges.

10. Can a Professional Staff member initiate a wrongful dismissal/constructive dismissal case against the hospital?

The concepts of wrongful dismissal/constructive dismissal only apply to Professional Staff members when they are employees of the hospital. Courts have held that when Professional Staff members are individual contractors rather than employees, the *Public Hospitals Act* scheme must be utilized; however, when Professional Staff members are employees, they may also have the right to wrongful dismissal claims in addition to their rights under the *Public Hospitals Act*.

11. Who can/should we tell when we revoke, suspend or restrict privileges?

The hospital should seek legal advice as to what mandatory reports are required to the regulatory college. Generally, if the revocation, suspension or restriction results from a determination of incompetence or incapacity, a report will be required.

Legal advice may be required to determine how to announce appropriately internally and externally revocations, suspensions and restrictions of privileges. If related to incapacity or issues about the member's health, extra care should be taken to protect the person's personal health information. A hospital should keep a list of internal people to notify when a Professional Staff member has privileges revoked, suspended or restricted. The list could include:

- CEO
- Chief of Department, Head of Division (or other clinical leaders)
- Chief of Staff/Chair of the MAC
- Health records
- Hospital committees (if the Professional Staff member sat on internal committees)
- Paging/information/front desk (so that they can remove or suspend the member from their lists)
- Pharmacy
- Security
- Senior management team

Subject to terms of common credentialing processes that contemplate such reports, hospitals should not advise other hospitals where the Professional Staff member has privileges without seeking legal advice.

Additional legal advice should be sought with respect to communicating with the member's patients.

12. Do we need a Professional Staff member on the board panel that hears a privileges dispute under the *Public Hospitals Act*?

No. Any Professional Staff who sit on the board cannot vote. The board can, however, engage clinical experts to provide objective advice to the board if complicated competency issues arise. This process may provide even better, objective advice to the board.

13. Does the board have the authority to settle a privileges matter?

Yes. If the MAC and Professional Staff member reach a settlement (such as an agreed-upon plan of remedial training) that is acceptable to the board, the parties can agree not to proceed with the formal board hearing.

14. Can the board disagree with the MAC's recommendation?

Yes. The board should give great weight to the MAC's recommendations, but it cannot rubber stamp those recommendations. It is possible for the board to accept the MAC's recommendations about appointments, re-appointments, changes in privileges, revocation/suspension/restriction of privileges, to reject the MAC's recommendations, or to substitute its own opinion.

Chapter 10: Resignation and Retirement

Reference Key:

Public Hospitals Act:	Section 33
OHA/OMA Prototype By-law:	Section 3.11

Chapter Summary

- Hospitals and members of the Professional Staff have joint responsibility for managing the transfer of care issues that arise when a member of the Professional Staff resigns or retires.
- The standard period of notice for a resignation/retirement is two to three months. Hospitals should use discretion during unique circumstances.
- Hospitals should clarify in writing their transfer of care standards and applicable policies and follow up with Professional Staff individually, as warranted.
- Notices of resignations/retirements must be in writing (if not, the hospital should provide written follow-up).
- Professional Staff Human Resources Plans should include succession planning.
- Some resignations/retirements require reporting to regulatory Colleges.

Obligations and Timing

The transfer of patient care following notice of impending resignation or retirement is a mutual obligation of the hospital and the member of the Professional Staff.

In many hospitals, two to three months' notice is required to ensure the safe and organized transfer of care. Hospitals are advised to use discretion during unique circumstances of resignation or retirement.

Hospitals should specifically prepare for circumstances under which an urgent transition of care and duties must occur (such as in the case of an unanticipated illness or early maternity/parental leave). Under these circumstances, the hospital will inevitably assume a greater degree of responsibility for managing the transition. In such cases, it will be important for the affected Department's other clinical staff to work closely with the most appropriate clinical leader.

The College of Physicians and Surgeons of Ontario (CPSO) has written guidelines for termination of the relationship between physicians and their patients, with which physicians are expected to comply.[1] These guidelines pertain most directly to private practice settings. Nevertheless, most of the principles in the CPSO statement translate readily to a hospital setting. A hospital could choose to adopt the CPSO's guidelines and extend them to apply to all Professional Staff members (physicians, dentists, midwives and extended class nurses).

Succession Planning

To the extent that such departures can be anticipated, hospitals should include retirement and resignation planning in their Professional Staff Human Resources Plans. *See Chapter 4, Planning and Recruitment.*

Documentation

Hospitals should consider implementing a Professional Staff Resignation/Retirement Policy so that their expectations for transfer of care are clearly outlined prior to a member's decision to resign or retire.

1 College of Physicians and Surgeons of Ontario, "Ending the Physician-Patient Relationship" (May 2017), online: CPSO < https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Ending-the-Physician-Patient-Relationship >; College of Physicians and Surgeons of Ontario, "Closing a Medical Practice" (September 2019), online: CPSO < https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Closing-a-Medical-Practice >.

All resignations and retirements should be provided by the Professional Staff member in writing. Hospitals should ensure the Professional Staff member clarifies:

- Their proposed last date of service.
- Whether the resignation/retirement relates to all services they provide at the hospital (or only a subset).
- Whether the member wishes to maintain any relationship with the hospital (such as courtesy staff or *locum tenens* appointment, which would constitute a request for a change in privileges). *See Chapter 6, Re-appointments and Changes to Privileges.*
- Their plan for transfer of care.

It may also be necessary for the hospital to clarify with the Professional Staff member:

- The hospital's expectations for transfer of care and transfer of administrative responsibilities.
- Whether the resignation triggers a resignation of other affiliations (such as university appointments or joint appointments with community agencies).
- The hospital's administrative requirements arising out of the resignation/retirement and key contact individuals on specific issues (e.g., leaving office space, return of hospital badge, security passes and keys).
- The restrictions on holding hospital email addresses after resignation.
- How the Professional Staff member should identify themselves post-resignation (i.e., is there an "honorary" staff category of privileges that recognizes the former affiliation?).

FAQs

1. When a member of the Professional Staff resigns during an investigation into competency or behaviour, is the hospital required to advise the College? Is the hospital required to advise other hospitals where it knows the member has privileges?

The hospital must notify the CPSO if a physician voluntarily or involuntarily resigns (including retires) from the Medical Staff or restricts their practice within a hospital during the course of, or as a result of, an investigation into their competence, negligence or conduct.[2]

Further, if a hospital intended to revoke the privileges of any Professional Staff member for reasons of professional misconduct, incompetence or incapacity, but did not revoke the privileges because the Professional Staff member resigned, retired or relinquished their privileges, the hospital must notify the health regulatory college.[3] This obligation typically falls to the CEO (but may be delegated).

Unless previously agreed upon with the member (such as in joint credentialing arrangements), there is no obligation to inform other hospitals of the resignation, and hospitals should seek legal advice before doing so. Significant negative consequences can occur when a hospital engages in discussions with third parties regarding a physician's competence, capacity or conduct.

2. How should we confirm a resignation?

To avoid confusion, a notice of resignation/retirement should always be submitted in writing. If it is tendered verbally, the hospital should ask for it in writing. If the member refuses to put it in writing, the Chief of Staff/ Chair of the Medical Advisory Committee (MAC) or delegate should confirm it in writing.[4]

2 *Public Hospitals Act*, s. 33.

3 *Regulated Health Professions Act*, 1991 Health Professions Procedural Code, s. 85.5.

4 See *Waddell v Weeneebayko Area Health Authority*, 2018 CanLII 39843 (ON HPARB), aff'd 2019 ONSC 7375 (Div Ct) where significant confusion arose after a physician resigned in writing but intended to continue an affiliation on his own terms with the hospital.

3. What should we do if someone resigns or retires unexpectedly, with little or no notice?

You may wish to impress upon the Professional Staff member that they have professional obligations to their patients. It may be necessary to send a letter to remind them of the hospital's expectations with respect to transfer of care.

You may also wish to seek legal advice.

4. Can we include a "resignation" or "retirement" notice period in our letters of offer/letters of re-appointment and in the by-laws?

Yes. You can disseminate a Professional Staff Resignation/ Retirement Policy, but you can also notify the members of the expectation of "notice" in the hospital's by-laws and in letters of initial appointment and re-appointment such as the following:

> *If you wish to terminate your privileges with this hospital, you will provide the hospital with at least three months' notice in writing. This period of notice may be waived in whole or in part by the Hospital, at its discretion.*

5. Who can we (and should we) notify if a Professional Staff member resigns or leaves?

The hospitals should keep a list of internal people to notify when a Professional Staff member gives notice of their resignation or retirement. The list could include:

- Board
- CEO
- Chief of Department, Head of Division (or other clinical leaders)
- Chief of Staff/Chair of the MAC
- Hospital committees (if the Professional Staff member sat on internal committees)
- Secretary of the MAC
- Paging/information/front desk (so that they can remove the member from their lists
- Pharmacy
- Security
- Senior management team

Depending on the circumstances, it may be appropriate for the hospital and the Professional Staff member to issue a joint communiqué to notify patients and referring community agencies. The hospital should work with the resigning/retiring member to notify community partners served by the Professional Staff member. Under an academic affiliation agreement, there may also be obligations to inform a university of the member's departure. *For additional information, see Chapter 12, Academic Issues.*

If the member resigns or retires in the context of a dispute with the hospital, a hospital concerned about facing a claim for defamation should seek legal advice about disclosure of the pending resignation/retirement.

6. We think that a Professional Staff member who joined us just a few years ago should no longer be practising. Can we suggest they retire? Should we not have given them privileges in the first place?

The initial appointment to the Professional Staff must be done in the same way for all applicants through a robust credentialing process. Once appointed, the provision of care by Professional Staff should be guided by the rigour of the annual re-appointment process, and in response to any concerns about patient care as they are raised. Issues of age and ability to safely practice are sensitive matters, and you may wish to seek legal advice. *See Chapter 5, Initial Appointment; Chapter 6, Re-appointment and Changes to Privileges; and Chapter 8, Performance Evaluations and Progressive Management.*

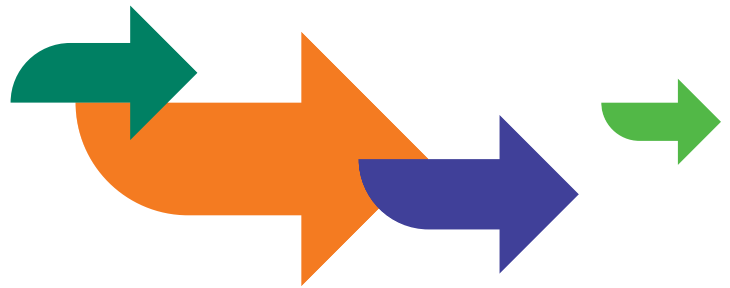
Note that hospitals may not have mandatory retirement policies for Professional Staff members who are age 65 or older, given changes in 2006 to the Human Rights Code. In the case of *Shaver v. Queensway Carleton Hospital*[5] a physician alleged discrimination when he was required

5 2017 HRTO 685 (CanLII), <http://canlii.ca/t/h4df8>

to resign his privileges in accordance with the hospital's on-call "sunset" policy, which he argued was tantamount to mandatory retirement. The human rights tribunal concluded there was no discrimination because the decision was not related to Dr. Shaver's age or disability, but instead related to his decision to cease his on-call duties.

7. How should we manage on-call requirements for Professional Staff who may be approaching retirement?

The issue of reducing on-call obligations often arises in hospitals in the context of a Professional Staff member's intention to retire. Some hospitals have an agreed upon staged reduction in privileges including on-call obligations for senior Professional Staff who intend to retire. If hospitals offer these arrangements, they should have a written policy to clarify the terms and process for consideration. Prior to implementation, such policies should be distributed to the Professional Staff for consultation.



In the case of *Bhargava v Lakeridge Health Corporation*[6] the Health Professions Appeal and Review Board considered whether a hospital's "Physician On-Call Policy" to tie a reduction in on-call coverage to a proportionate reduction in elective resources amounted to a substantial alteration of the Appellant's privileges. HPARB concluded that Dr. Bhargava's privileges were substantially altered when the hospital reduced his cardiology services commensurate with his choice to reduce his on-call coverage. However, HPARB also concluded that the hospital had the authority to implement the policy and apply it to Dr. Bhargava in accordance with the *Public Hospitals Act*.

6 2011 CanLII 33743 (ON HPARB), <http://canlii.ca/t/flskv>.

Chapter 11: Maintaining Credentialing Files

Reference Key:

Public Hospitals Act:	None
OHA/OMA Prototype By-law:	None

Chapter Summary

- Maintaining a centralized documentation system for Professional Staff credentialing files helps to identify, in a timely way, issues relating to Professional Staff performance.
- Some hospitals have adopted an online system to assist in the process, including reminders of key deadlines.
- Hospitals must take measures to protect the confidentiality of the credentialing file.
- Freedom of information legislation applies to hospitals, although there are specific exclusions that relate to credentialing files.
- Hospitals should have a formal policy with respect to how long they retain the documentation within a credentialing file.

Content of Credentialing Files

Although not a legal requirement, it is recommended that hospitals maintain a central credentialing file for every member of the Professional Staff. Professional Staff members' files should be centrally stored so that all relevant information is available for credentialing, performance reviews, privileges hearings and providing references. Centralizing Professional Staff files in a single location within the hospital leads to easier identification of emerging patterns regarding a member's professional development or performance issues, especially as positive or negative feedback is received.

The credentialing process has become more involved and rigorous over the years. As a result, more documentation is required to chronicle the relationship between hospitals and their Professional Staff members. While a credentialing file may once have been made up of a single letter from the applicant requesting privileges to provide services at the hospital, today's credentialing file is likely to include:

- Photograph (confirmation of identification);
- Contact information (work information/home information/emergency contact information);
- Initial application form and supporting documentation (including notes from third-party confirmation of credentials. *See Chapter 5, Initial Appointment)*
  - Evidence of schooling (certificate or diploma)
  - Evidence of post-graduate training (internships, residencies, fellowships)
  - Evidence of training and experience
  - Confirmation of license to practice
  - Confirmation of professional liability protection (insurance) coverage
  - Chronological work history in health care
  - Curriculum vitae
  - Criminal record check results
  - Release and authorization forms
  - Certificate of professional conduct from regulatory college
  - Letters of reference (these should be kept separately, marked "Strictly Confidential", and the member should not have access to this information if the letters were provided in confidence). *See Chapter 5, Initial Appointment.*
  - Copies of infection control test results and screenings, and certificates of completion for mandatory occupational health and safety training and screening
  - Follow-up correspondence asking for further information or confirmation of completion;

- Application forms for annual re-appointment and changes to privileges (including notes from third-party confirmation of credentials) *See Chapter 6, Re-appointment and Changes in Privileges.*
  - Updates to initial application
  - Updated curriculum vitae
  - Letters of recommendation from Department Chiefs and others
  - Certificates of professional conduct from college
  - Copies of infection control test results and screenings and certificates of completion for mandatory occupational health and safety training and screening
  - Release and authorization forms
  - Follow-up correspondence asking for further information or confirmation of completion;
- Correspondence between the hospital and the Professional Staff member
  - Letters of offer (or employment contracts if employees)
  - Notification of recommendations made by the Chief of Department (or most appropriate clinical leader) and the Medical Advisory Committee (MAC) and decisions made by the board with respect to appointment, re-appointment, change of privileges or suspension, restriction or revocation of privileges;
- List of privileges held (as amended from time to time);
- List of administrative duties;
- Correspondence relating to physical or mental impairments (this information should be marked "strictly confidential protected from unauthorized access");
- Correspondence relating to leaves of absence;
- Performance reviews and peer reviews;
- Written compliments from patients, colleagues, staff, the public;
- Written complaints from patients, colleagues, staff, the public;
- Investigation reports involving the Professional Staff member's practice or conduct;
- Disciplinary correspondence, letters of warning, reprimands, notices of suspension;
- Reasons from board hearings;
- University appointments and related correspondence;
- Cross-appointment information and related correspondence;
- Legal advice received by the hospital with respect to the member (this should be kept separately, marked "Strictly Confidential", and the member should not have access to the information); and
- Consents by the member for release of information from the file.

These documents are usually stored in reverse chronological order (most recent documentation at the top of the file).

Some hospitals require that documents from third-parties (such as graduate school diplomas) be notarized so that the receiving hospital has greater assurance (or has reassurance) that they are "true copies" of the originals and have not been altered.

Online Tracking Systems

A few hospitals have initiated electronic, online applications for initial appointment and re-appointment to assist in expediting the collection and storage of Professional Staff member information. Some of these programs are sophisticated and include a variety of features that help streamline the application process, reduce duplication, and organize information quickly and logically. By using an online application tool, some or all of the information can be produced by Professional Staff members (or administrative staff) using simple forms and drop-down menus. For example, a member may be able to answer whether mask fit testing has been completed, whether a change in privilege status is requested, and whether privileges have been obtained at another hospital.

Once an application form is complete, it can be accessed online by the Chief of Department (or most appropriate clinical leader), Credentials Committee, and MAC for review. As well, some of these programs can track statistics, which provide MACs with a much more detailed picture of current privileges and any changes throughout the hospital.

Online tools can also be excellent methods for facilitating communication. For example, some hospitals use online tools to notify Chiefs of Departments (or most appropriate clinical leaders) about such matters as when there are new applications or when they need to approve applications. This can save a great deal of time for those who would otherwise have to send out this information manually.

As well, select departmental access to limited information allows a timely determination of whether someone who presents on a unit or in the operating room (OR) actually has privileges. Some hospitals find that their online databases are used by OR staff to verify newly appointed members of the Professional Staff or physicians who have been granted temporary privileges. It would also allow new staff on a unit to verify the privileges of a long-standing Professional Staff member.

There are many benefits to the electronic programs, and the uses are limited only by a hospital's creativity (and budget).

Retention Periods

The OHA Record Retention Guidelines (2018)[1] recommend the following retention periods:

RECORD	PHYSICIAN APPLICATIONS
Legal retention period:	n/a
Recommended retention period:	Two years
Rationale:	*Limitations Act*, s.4
Comments:	If the application results in an appointment, the application constitutes part of the appointment record.
RECORD	**PHYSICIAN APPOINTMENT RECORDS**
Legal retention period:	n/a
Recommended retention period:	End of appointment year plus six years
Rationale:	Reasonable practice/*Limitations Act*, s.4 and s.15
Comments:	Physicians' appointments are generally made from year to year. Except for incidents involving patient care or disciplinary consideration or action, the issues most likely to arise with respect to an appointment are the terms of the appointment, which involve primarily contractual issues, for which two years would be an appropriate retention period. Incidents or disciplinary considerations that could have some relevance to a legal proceeding, inquiry or investigation (especially relating to patient care) should be retained longer, given the ultimate limitation period of 15 years under the *Limitations Act*. The seven-year recommendation is a balance between these considerations. Hospitals may wish to use it as the basis for a single retention period for appointment records.

Note: Hospitals should apply the same rules to all Professional Staff credentialing files.

1 Page 21.

Confidentiality, Access and Disclosure

The Professional Staff member's credentialing file should be considered confidential and stored in a secure location (whether in hard paper copy or electronically). Generally speaking, access to the information should be restricted to hospital staff members who have a need to know and use the information (such as the Chief of Department (or other clinical leader), Chief of Staff/Chair of the MAC, CEO, Credentials Committee, and administrative staff performing credentialing-related functions).

Hospitals should develop policies or practices to anticipate requests for access to Professional Staff credentialing files and should identify on what authority information will be shared under the following kinds of circumstances (e.g., with written consent from the member, or as permitted or required by law):

- Professional Staff members access to their own files (need to keep third-party information that was provided to the hospital in confidence, such as letters of reference);
- Legal requests (for example, relating to regulatory college proceedings, litigation, and criminal investigations);
- Requests from a university if the member is cross-appointed;
- Requests from other hospitals if the member is cross-appointed or for their own credentialing processes;
- Requests from patients and their families;
- Requests from the public;
- Requests from the Ministry of Health;
- Requests from Occupational Health and Safety;
- Requests for letters of reference;
- Media requests; and
- Disaster or emergency management – sharing information with other hospitals, or the province or region to establish options for emergency staffing of the health care system.

Hospitals may need to seek legal advice when responding to requests for access to these files.

Freedom of Information Requests

Hospitals are subject to the *Freedom of Information and Protection of Privacy Act*.[2]

The Act has two purposes:

(a) To **provide a right of access to information** under the control of institutions in accordance with the principles that,

i. Information should be available to the public,

ii. Necessary exemptions from the right of access should be limited and specific, and

iii. Decisions on the disclosure of information should be reviewed independently of the hospital controlling the information; and

(b) To **protect the privacy of individuals** with respect to personal information about themselves held by institutions and to provide individuals with a right of access to that information.

The Act establishes that every person potentially has the right of access to **any record or part of a record** in the custody or under the control of the hospital. While the right of access is quite broad, the hospital's obligation to provide access to records is affected by the following limitations:

- Only records that came into the custody or under the control of the hospital on or after January 1, 2007 are subject to the Act;
- The hospital may refuse access to records if the request is deemed to be frivolous or vexatious;

2 R.S.O. 1990, c. F-31.

- Certain records are excluded from the Act, meaning that the Act does not apply to them; and
- The Head of an institution (the Board Chair or their delegate) must not (in the case of mandatory exemptions) or may not (in the case of discretionary exemptions) disclose certain records.

Section 65 of the Act excludes credentialing files from the requirements of the Act. Clause 65(6)5 provides that the Act does not apply to records collected, prepared, maintained or used by (or on behalf) of the hospital that relates to meetings, consultations, discussions or communications about applications for hospital appointments, appointment of hospital privileges and anything that forms part of the personnel file. Generally speaking, records in a credentialing file will not be subject to a right of access under the Act and are excluded from the privacy provisions of the Act.

However, the credentialing file exclusion is not absolute, and section 65(7) outlines its exceptions. These exceptions refer to the types of records subject to the Act, which, if a hospital received a request for access, would require the hospital to process the record and determine if any other exclusions or exemptions apply. These exceptions are:

- An **agreement** between a hospital and a union;
- An **agreement** between a hospital and one or more hospital employees which ends in a proceeding before a court, tribunal, or other entity relating to labour relations or to employment-related matters;
- An **agreement** between a hospital and one or more employees resulting from negotiations about employment-related matters; or
- An **expense account** submitted by an **employee** of a hospital for the purpose of seeking reimbursement for expenses incurred by the employee in their employment.

There are other exclusions and exemptions under the Act and exclusions in other legislation (such as the *Quality of Care Information Protection Act*) that would restrict the release of credentialing file records to the public (such as labour and employment, quality of care information, research, teaching, personal practice, third-party and personal information records). Hospitals should review the *OHA Guidance Document # 11: FIPPA and Implications for Credentialing and Personal Practice Records* for further recommendations for how to deal with Freedom of Information requests for credentialing file records under the Act.

The Information and Privacy Commissioner of Ontario (IPC) has considered section 65(6)5 in three cases involving access requests for documents relating to complaints made about physicians with hospital privileges. The IPC determined that in order for section 65(6)5 to apply, the hospital seeking to rely on the exemption must establish that:

1. the records were collected, prepared, maintained or used by an institution or on its behalf;
2. this collection, preparation, maintenance or usage was in relation to meetings, consultations, discussions or communications; and
3. these meetings, consultations, discussions or communications are about applications for hospital privileges, the appointments or privileges of persons who have hospital privileges or anything that forms part of the personnel file of those persons.

In two cases where physicians with hospital privileges were seeking access to documents relating to complaints made about themselves, the IPC upheld the hospitals' exclusion of the documents from the purview of the Act (Order PO-3526 (2015) and Order PO-3336 (2014)).

In Order PO-3526[3], the document sought was an investigation report prepared by an investigator retained by the hospital to investigate complaints made by a number of hospital staff against the physician who sought the report. The IPC found that "the subject matter of the investigation report – complaints made about the appellant and investigated for the benefit of [the hospital's] consideration of them in the context of its relationship with the appellant – has some connection to the appellant's hospital appointment and privileges." In reaching its conclusion to uphold the exclusion of the report, the IPC confirmed that:

3 https://decisions.ipc.on.ca/ipc-cipvp/orders/en/item/134779/index.do

- There is no requirement that some action be taken in respect of the physician's appointment or privileges in order for the exclusion to apply.

- An outstanding application for privileges or an amendment, alteration or revocation of privileges is not necessary to engage the exclusion.

- Such action (i.e. an outstanding application or amendment, alteration or revocation of privileges) is not a prerequisite for establishing that a record prepared for a hospital was used by it in communications about the appointment or privileges of a physician.

- There is no requirement that the individual with privileges is a hospital employee in order for the exclusion to apply.

In Order PO-3336[4], the documents at issue were 36 emails sent to and from hospital employees and privileged staff on hospital-issued email accounts over the course of resolving six complaints brought against the physician. Some of the records summarized meetings, which were shared with staff who were unable to attend, as well as the actual communications between those who initiated the complaints and the hospital. With respect to the third branch of the test, the IPC held that "the examination of the complaints that are reflected in the records, including a determination respecting his privileges at the hospital, demonstrates a sufficiently strong and significant connection between the contents of the records and the continuation of the appellant's hospital privileges." The IPC found that all three branches of the test were met and that section 65(6)5 operated to exclude the records from the operation of the Act.

In contrast to these two decisions, in Order PO-3861 (2018)[5], the IPC found that section 65(6)5 did not apply to exclude the records sought from the application of the Act. In this case, the documents sought related to complaints that the requester had made to the hospital, the University of Ottawa, the College of Physicians and Surgeons of Ontario and the hospital's Board of Governors regarding a number of physicians with privileges at the hospital. The records consisted of emails discussing the complaints, consulting about the complaints, discussing what materials to review in order to respond to the complaints, and providing responses to the complaints, both in draft and final form. The IPC held that the third branch of the test was not met, and distinguished Orders PO-2526 and PO-3336, finding that the records for which the exclusion was claimed did not have "some connection" to applications for hospital appointments, the appointments or privileges of persons who have hospital privileges or anything that forms part of the personnel file. Instead, the IPC found that the discussions related to how to respond to the appellant's complaints.

Other Documents

For use in litigation or privileges hearings, hospitals should also keep corporate records that relate to Professional Staff rules and decisions such as historic versions of:

- Professional Staff by-laws (and explanations for changes)

- Rules and Regulations

- Professional Staff policies (or other policies passed by the MAC)

4 https://decisions.ipc.on.ca/ipc-cipvp/orders/en/item/134339/index.do

5 https://decisions.ipc.on.ca/ipc-cipvp/orders/en/item/315903/index.do

Chapter 12: Academic Issues

Reference Key:

Public Hospitals Act: Regulation 964
OHA/OMA Prototype By-law: None

Chapter Summary

- Credentialing in the context of academic health centres is subject to additional legal rules and management considerations.
- In an academic hospital, a triangular relationship exists among Professional Staff, the university and the hospital. Many clinicians are both “faculty” at the university and “Professional Staff” at the hospital.
- Managing the relationship with residents, fellows and post-doctoral fellows raises slightly different issues than credentialing Professional Staff. Recruitment and verification of credentials may be predominantly dealt with through a Post-graduate Medical Education Office at a university (although some hospitals retain a credentialing role).
- A number of additional academic disputes may affect privileges, including academic freedom and intellectual property issues, which may be managed by utilizing dispute resolution processes determined by the university (and not the hospital exclusively depending on the affiliation agreement and applicable policies).
- Affiliation agreements, Professional Staff by-laws, and contracts between hospitals and Professional Staff may be examined by the Health Professions Appeal and Review Board (HPARB) and courts in privileges disputes to determine whether there is sufficient evidence of an academic commitment on the part of the hospital, and to determine the scope of decision-making between the hospital and university. These documents have a dramatic impact on whether an individual has a right to a hospital board hearing and whether a hospital is justified to alter duties or resources, terminate a contract, revoke privileges, or revoke access to services. Great care must be taken to appropriately detail the academic mission and expectations in these documents.

Academic Hospitals

An academic or teaching hospital is one affiliated with a university that provides formal clinical training placements for health professionals. As well, academic hospitals generally provide the most complex and urgent care services in the province and are the sites of basic and clinical research programs.

The *Public Hospitals Act*, Regulation 964,[1] categorizes hospitals in Ontario. There are three categories of academic hospitals:

- Group A hospitals, being general hospitals providing facilities for giving instruction to medical students of any university, as evidenced by a written agreement between the hospital and the university with which it is affiliated, and hospitals approved in writing by the Royal College of Physicians and Surgeons for providing post-graduate education leading to certification or a fellowship in one or more of the specialties recognized by the Royal College of Physicians and Surgeons.
- Group H hospitals, being psychiatric hospitals providing facilities for giving instruction to medical students of any university.

1 *Public Hospitals Act*, R.R.O. 1990, Reg. 964, Classification of Hospitals.

- Group L hospitals, being hospitals for the treatment of patients suffering from alcoholism and drug addiction and providing facilities for giving instruction to medical students of any university as evidenced by a written agreement between the hospital and the university with which it is affiliated.

There are 24 hospitals in Ontario that have teaching or research affiliations with one of the six university medical (or health sciences) schools. These are in London (University of Western Ontario), Hamilton (McMaster University), Toronto (University of Toronto), Kingston (Queen's University), Ottawa (University of Ottawa) and Northern Ontario (Northern Ontario School of Medicine).

Key Players

In this chapter, we will introduce key players in the legal framework for credentialing in an academic context. A few of these players were introduced in Chapter 3, Roles and Responsibilities, and will receive more thorough review here.

CAHO – The Council of Academic Hospitals of Ontario (CAHO) is the non-profit association of Ontario's 24 academic hospitals and their research institutes. CAHO provides a focal point for strategic initiatives on behalf of these academic hospitals.

CaRMS – The Canadian Resident Matching Service provides an electronic application service and a computer match for entry into post-graduate medical training throughout Canada. To date, CaRMS administers the matching process for: post-graduate Year 1 entry residency positions; Year 3 Family Medicine - Emergency Medicine residency positions; Internal Medicine subspecialty residency positions; and Pediatric subspecialty residency positions.

Clinical faculty members are licensed clinicians who hold joint appointments between a hospital and a clinical department at an affiliated university and are responsible for supervision (including teaching and evaluation) of undergraduate and post-graduate trainees enrolled with the university. The terms of appointment at a university may differ and are determined through university policies, affiliation agreements and other contracts. These terms of appointment may include financial requirements such as conforming to practice plan membership. Some appointments, such as "Geographic Full-Time", may involve a salary, an office and other supports and an income ceiling for redistribution of funds for teaching and research purposes within the Faculty/Department.

Clinical fellows are clinicians or dentists who are doing additional subspecialty training that usually begins after completion of a standard resident program. They must be registered as clinical fellows at an affiliated university and must be engaged in academic activities. Depending on the subspecialty, a fellowship can last from one to three years beyond residency. They may or may not require privileges at a hospital (depending on the hospital's by-laws). Their practice in a hospital is generally supervised by a member of the Professional Staff.

House staff may be a term used in hospital by-laws to refer to a category of privileges for post-graduate trainees who are enrolled in an academic program at an affiliated university, and who hold a professional license of registration with the relevant regulatory college.

Observer is a person who informally observes patient care at the hospital, unrelated to a formal supervisory or training program.

PARO is the Professional Association of Residents of Ontario (PARO), which represents medical residents in Ontario.

Post-doctoral fellows or **PDFs** are individuals who hold a Ph.D. degree and are appointed to an academic hospital to do research under supervision.

Post-graduate Medical Education Office at a university is usually the liaison between academic hospitals and universities for residency and fellowship placements.

Post-graduate trainees is a term sometimes used to include residents, clinical fellows, research fellows and PDFs.

Research fellows are trainees who perform research duties. They may be licensed as post-graduate trainees by a regulatory college, and sometimes have patient contact.

Residents are clinicians who complete specialty training in a two to five year program that starts after completion of their clinical degree. They must be registered in a Residency Program with an affiliated university and must be engaged in academic activities. They may or may not require privileges at a hospital (depending on the hospital's by-laws). Their practice in a hospital is supervised by a member of the clinical faculty.

Supervisors are clinical faculty who are delegated by their respective training programs to educate, observe, assess, and supervise the educational activities of students. They may also be the most responsible clinicians for the patients receiving care in the hospital.

Undergraduate students are university students enrolled in an undergraduate education program. They do not hold any special status or membership with a regulatory body.

Additional Legal Context

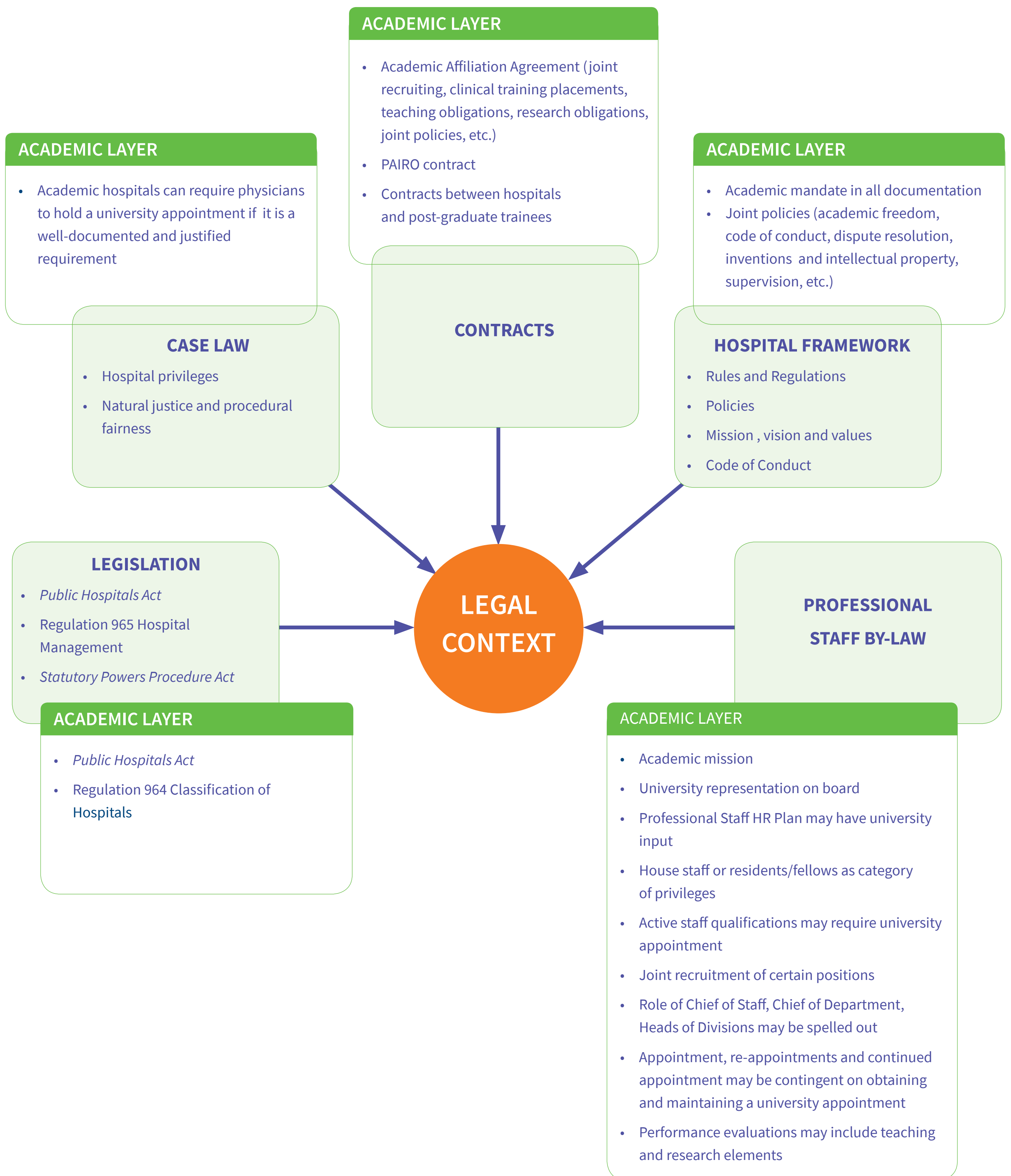
In Chapter 2, Legal Context, we highlighted the legal context in which hospitals perform their credentialing functions. When dealing with credentialing issues in an academic hospital, there are additional issues to consider:

- **LEGISLATION:** The *Public Hospitals Act*, Regulation 964, defines three categories of academic hospitals and the Ministry of Health maintains an online list of those hospitals.[2]
- **PROFESSIONAL STAFF BY-LAW:** The Professional Staff by-law of an academic hospital will have an additional layer of academic content, such as:
    - Acknowledgement of the mission of the hospital as an academic hospital (such as a tripartite mission of teaching, research and clinical service)
    - University representation on the board
    - Professional Staff Human Resources Plans may require university input
    - Special qualification requirements for appointment or re-appointment to the active staff such as:
        a. Holding a university appointment
        b. Academic or research achievements
        c. Meeting requirements set forth in an affiliation agreement
    - Processing of applications may need to be done in accordance with an affiliation agreement and there may be joint recruitment efforts with the university
    - Acknowledgement that the hospital board may refuse to appoint or re-appoint a candidate for failure of the applicant to obtain an academic appointment where such academic appointment was a condition of the appointment
    - Acknowledgement that the hospital board may suspend, restrict, or revoke privileges for failure to maintain an academic appointment if it was a requirement for appointment
    - Additional categories of Professional Staff may include "house staff" or "residents/fellows" and specific qualification, appointment and re-appointment criteria for that new category
    - Joint recruitment and appointment of Chiefs of Departments or Heads of Divisions with the University
    - Additional roles and responsibilities for Chief of Staff/Chair of the Medical Advisory Commitee (MAC), Chief of Department, Head of Division with respect to teaching and research in addition to clinical service
    - Performance evaluations of Professional Staff may include teaching and research elements

Community hospital by-laws may also need to acknowledge academic pursuits and university affiliations. The Dittmer case described later in this chapter underscores that if a hospital wishes to give preferential access to hospital resources for Professional Staff who hold an appointment at a university, denying or removing

2 See the Ministry of Health website at: http://www.health.gov.on.ca/en/common/system/services/hosp/hospcode.aspx#groups

Academic Hospital Legal Context



access to those resources for Professional Staff who do not hold an appointment at a university, the close relationship between the hospital and the university must be clearly set out in the Professional Staff by-law of the hospital.

- **HOSPITAL FRAMEWORK:** There is an additional layer of hospital documentation and policies when dealing with academic issues, such as:
  - In an academic hospital, the "academic" mandate is often woven through the foundational documents (mission, vision, values, and policies).
  - Through the affiliation agreement, there may be joint or university policies that will also apply to the hospital, clinical faculty, and students, residents and fellows, such as:
    a. Academic freedom
    b. Code of Conduct
    c. Dispute resolution
    d. Inventions and intellectual property
    e. Moonlighting
    f. Research
    g. Sexual harassment
    h. Supervision of trainees
- **CONTRACTS:** Academic affiliation agreements include binding requirements on hospitals for matters such as:
  - Joint recruitment and appointment of Chiefs of Department/Heads of Divisions, active staff/clinical faculty, and scientists
  - Clinical training opportunities for students, residents and fellows
  - Teaching obligations
  - Research obligations
  - Joint policies

These contracts may be signed by fully-affiliated "teaching" hospitals as well as community hospitals that have specific academic mandates. Again, the Dittmer case described below demonstrates that if a hospital gives Professional Staff who hold an appointment at a university preferential access to hospital resources, and denies or removes this access for Professional Staff who do not hold an appointment at a university, the affiliation between the hospital and the university must be clearly documented (in addition to having the access rules set out in the Professional Staff By-law of the hospital).

The contract between PARO and CAHO is also relevant with respect to resident compensation.

There may also be contracts between hospitals and post-graduate trainees that set out certain conditions to be met.

- **CASE LAW:** As described later in this chapter, there are cases specific to the academic hospital context.
- **COLLEGE POLICIES:** As an additional layer, there are specific College of Physicians and Surgeons of Ontario policies with respect to:
  - Professional Responsibilities in Undergraduate Medical Education.[3]
  - Professional Responsibilities in Post-graduate Medical Education.[4]

Planning and Recruitment

Chapter 4, Planning and Recruitment, underscored the importance of the Professional Staff Human Resources Plans as credentialing tools. The Professional Staff Human Resources Plans can play a significant role in documenting the academic goals of a hospital and can be used as joint planning tools between a hospital and its affiliated university. They can also be used to explain refusals to

3 College of Physicians and Surgeons of Ontario, "Professional Responsibilities in Undergraduate Medical Education" (May 2012), online: CPSO < https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Professional-Responsibilities-in-Undergraduate-Med >.

4 College of Physicians and Surgeons of Ontario, "Professional Responsibilities in Postgraduate Medical Education", (May 2011), online: CPSO < https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Professional-Responsibilities-in-Postgraduate-Medi >.

appoint to the Professional Staff applicants who do not meet the academic (i.e., teaching or research) aspects of the position.

Credentialing of Residents, Fellows, and Post-Doctoral Fellows

Residents may be hospital employees who are hired through an agreement negotiated between CAHO and PARO.

Practices differ between hospitals as to whether they credential residents and fellows. In many cases, residents and fellows are simply registered with the affiliated university and overseen by clinical faculty at the hospital without undertaking a separate credentialing process by the hospital. In other cases, hospitals perform additional credentialing practices for post-graduate trainees (such as checking to see that the applicant has proof of immunization and evidence of professional liability protection coverage (insurance), and require signed contracts).

If a hospital has residents or fellows, it may choose to include in its Professional Staff By-law a separate category of Professional Staff such as:

House Staff

Residents and fellows as members of the House Staff:

(a) may undertake such academic, clinical, research and administrative duties and responsibilities as assigned;

(b) shall be appointed annually or for any shorter period to the House Staff by the board upon the recommendation of the MAC;

(c) shall participate in the care of patients under, and subject to the supervision and direction of the Professional Staff, and in concurrence with the guidelines provided by their respective regulatory college;

(d) shall be registered in a post-graduate program of the university for the purpose of fulfilling the requirements for a regulatory College Certificate of Registration, including International Medical Graduate residency programs or pre-residency clerkships, and/or fulfilling the specialty or sub-specialty requirements to obtain a regulatory certificate; and

(e) shall be on the educational registry or fully licensed by the respective regulatory college.

Please note, the *OHA/OMA Prototype Board-Appointed Professional Staff By-law, 2011* (OHA/OMA Prototype By-law) does not include a category of House Staff.

Resident allocation to different universities and programs of study is often done through CaRMS, through its matching process. Once a resident is assigned to a university program, it is the university program that makes arrangements for placement at various different hospitals or community teaching sites. All residents are registered through the Post-graduate Medical Education Office of their university. With respect to fellows, they too are registered through the university Post-graduate Medical Education Office. If they are not so registered, they are not considered by the Ministry of Health as a fellow. International medical graduates may also pursue placements through HealthForce Ontario's Access Centre and Ontario's Repatriation Program.

Until a post-graduate trainee is registered with an affiliated university, they may not be entitled to apply directly to an academic hospital for a placement. Separate or slightly different application expectations for post-graduate trainees may exist in the Professional Staff By-law, in contrast to other categories of Professional Staff, to acknowledge the coordinating role of the Post-graduate Medical Education Office.

Hospitals and affiliated universities have a vested interest to share responsibility for ensuring that applicants to post-graduate trainee programs are legitimate graduates of their referring programs. Given the international opportunities for students, there may be additional immigration issues for universities and hospitals to manage. Just as with applicants to the general Professional Staff, it is important for hospitals and universities to ensure they verify an applicant's credentials.

Academic Disputes and Dispute Resolution

There are a number of additional academic disputes that can affect privileges, including: academic qualifications, academic performance evaluations, academic freedom, and intellectual property issues. Depending on the terms of the affiliation agreement, those disputes may be managed utilizing dispute resolution processes determined by the university alone or a joint hospital/university dispute resolution process (that is, the affiliation agreement may not permit the hospital to manage certain disputes without consulting with the university or following university policies).

Regardless of the reason for the dispute or the dispute resolution process articulated in an affiliation agreement, a hospital board always retains the exclusive authority under the *Public Hospitals Act* to make decisions about appointments or re-appointments to the Medical Staff or about suspending, restricting or revoking Medical Staff privileges (and this authority may be extended to apply to all members of the Professional Staff through the by-laws).[5] Even if a university makes a decision to terminate a relationship with an individual who is jointly appointed to a hospital, the hospital must give the individual the procedural process owed under the Public Hospitals Act and the hospital by-laws before taking any action with respect to the individual's hospital privileges.

However, if through a contract, a university has the sole discretion to make decisions (for example, about academic performance or the rotation of residents to hospital programs), changes in those decisions do not grant entitlement to a hospital privileges hearing or a cause of action against the hospital.

In the case of *Dr. Phillips v. Foothills Provincial General Hospital*,[6] Dr. Phillips entered into a contract for a residency training position in neurosurgery with Foothills Provincial General Hospital in accordance with the terms of an affiliation agreement between the hospital and the University of Calgary. Continuation of Dr. Phillips' contract with the hospital was subject to the receipt of, and the maintenance of, a satisfactory evaluation by the university. The hospital terminated Dr. Phillips' residency upon receiving from the University of Calgary a six-month evaluation of Dr. Phillips' performance indicating that Dr. Phillips was not academically qualified to continue in the university's post-graduate clinical program in neurosurgery. Dr. Phillips argued that the procedures set out in the university's Terms of Reference had not been followed and that the rules of natural justice were not observed. The hospital argued that the evaluation of Dr. Phillips' qualifications in neurosurgery and the conduct of the appeals were academic matters within the exclusive jurisdiction of the university. Once the university made a determination that Dr. Phillips was not qualified, the hospital was authorized by contract with Dr. Phillips to terminate his residency. The court concluded that the offer of a position as a resident in neurosurgery at the hospital was based on the selection, interview and acceptance process which lay solely and exclusively within the purview of the university. The court also concluded that there were no procedural defects by the university. The court found that Dr. Phillips did not have a cause of action against the hospital for the academic appeals offered through the university. His claims against the hospital were dismissed.

Refusing Appointments and Re-appointments and Suspending, Restricting or Revoking Privileges

A body of case law exists with respect to refusing appointments and re-appointments and suspending, restricting or revoking privileges specific to the academic context. The following are the key messages from that case law:

- Under certain circumstances determined by the documentation of the academic affiliation, it may be justifiable for an academic hospital to revoke a member of the active staff's privileges if they fail to maintain an appointment with the affiliated university (*Matangi*[7]).

5 See below the discussion of *Dr. Matangi v. Kingston General Hospital,* [1998] 40 0.R. (3d) 41 (Gen. Div.) for clarification that a hospital cannot abdicate to a university its responsibilities with respect to privileges.

6 *Phillips v. Foothills Provincial General Hospital* [1989] A.J. No. 349, 95 A.R. 268 (AB. Q.B.)

7 *Dr. Matangi v. Kingston General Hospital,* [1998] 40 0.R. (3d) 41 (Gen. Div.).

- If a hospital is going to give Professional Staff who hold an appointment at a university preferential access to hospital resources, and if a hospital proposes to deny or remove access to those resources for Professional Staff who do not hold an appointment at a university, the affiliation between the hospital and the university must be clearly documented and the rules should be set out in the Professional Staff by-laws of the hospital (*Dittmer*[8]).
- If a hospital revokes a physician's access to interns or residents (material and human resources of the hospital), such revocation may constitute a substantial alteration in privileges even if the physician continues to enjoy the same category of privileges – and the physician may have a right to a hearing under the *Public Hospitals Act (Dittmer*[9], *Peterson*[10] and *Rabin, Posen and Jindal*[11]).

CASE OF *HORNE V. QUEEN ELIZABETH II HEALTH SCIENCES CENTRE AND CAPITAL DISTRICT HEALTH AUTHORITY* (Nova Scotia Court of Appeal, 2018)

Dr. Horne was a cardiologist and researcher at the Queen Elizabeth II Heath Sciences Centre. Her appointment began in 1998 when she was offered a joint position as an assistant professor of cardiology at Dalhousie's Department of Medicine and as a staff physician in the Hospital's Division of Cardiology. Upon appointment, the allocation of her time was 30% clinical, 10% teaching and 60% research.

Dr. Horne enrolled study participants for her research at the hospital's heart function clinic, where she was on medical staff. Dr. Horne and the director of the clinic, Dr. Howlett, had a difficult relationship. Following escalating tension, Dr. Horne's hospital privileges were summarily varied to restrict her enrollment of the clinic's patients and she was unable to continue her research.

Four years after the variation of Dr. Horne's privileges, the Health Authority's board of directors, which had ultimate authority over privileges, decided that the summary variation had not been justified, and reinstated Dr. Horne's privileges.

Dr. Horne then sued the Capital District Health Authority, claiming that her privileges had been summarily varied in bad faith and in breach of her contract, causing compensable harm to her research career. A jury awarded Dr. Horne damages of $1.4 million for administrative bad faith. Dr. Horne appealed and the Health Authority cross-appealed to the Nova Scotia Court of Appeal, where the damages award was reduced to $800,000.

The Court of Appeal confirmed that the wrongfulness of the summary variation of Dr. Horne's privileges was to be assessed administratively, not contractually and that the trial judge correctly concluded that the only appropriate cause of action was administrative bad faith.

The Court of Appeal set aside the damages award of $1.4 million though because of a confusing and deficient jury charge. In determining the quantum of damages, the Court of Appeal stated that it was assessing "as general damages, a non-pecuniary lump sum to compensate Dr. Horne for her suffering from Capital Health's actionable conduct," and clarified that the damages award was "not an arithmetically calculated pecuniary loss," nor was it lost income, nor was "it to punish Capital Health for its bad faith." The Court of Appeal assessed Dr. Horne's general damages for loss of reputation and loss to her research career at $800,000.

8 *Dr. Dittmer v. The Board of Directors of Parkwood Hospital,* August 6, 1998, Ontario Hospital Appeal Board.

9 Ibid.

10 *Dr. Peterson v. Board of Trustees of Ottawa Civic Hospital* #2 November 1, 1984 (Ontario Hospital Appeal Board).

11 *Drs. Rabin, Posen & Jindal v. Board of Trustees of Ottawa Civic Hospital*, September 16, 1992 (Ontario Hospital Appeal Board).

Observers

Hospitals receive many requests to observe clinical encounters as part of educational sessions (and for other reasons). Privacy issues arise with the introduction of observers to a clinical interaction. Because of this, many hospitals have in places policies with respect to observers. Such policies usually explain how observers are to be registered within the hospital and supervised, and the confidentiality expectations for the observer.

From a credentialing perspective, it should be clear that observers may not diagnose, care for or treat patients. If not engaged in clinical care, they do not need to apply for or receive privileges. However, in the event that an observer is called on to provide clinical care, privileges must first be obtained.

FAQs

1. What is the agreement between PARO and CAHO?

At the time of writing, the 2016-2020 version of the agreement between the PARO and CAHO is available online.[12] It sets out the employment relationship between residents and academic hospitals in Ontario.

2. Under what conditions can residents or students be removed from the supervision of an academic instructor?

Just as with any professional relationship, problems can arise between residents/students and their academic instructors. A variety of strategies may be employed depending on the nature of the concerns or dispute (the issues could range from personality conflicts, academic misconduct, loss of academic appointment, incompetency, harassment, or incapacity among others). The terms of the academic relationship are set out in academic affiliation agreements and policies of participating universities and hospitals. It is important to identify and follow applicable rules with respect to investigations, dispute resolution, hearings and appeals.

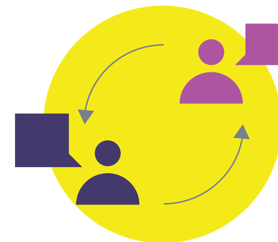
12 See http://www.myparo.ca/your-contract/.

3. If a physician does not meet productivity expectations of their division and that negatively impacts their appointment at the hospital, what appeal processes are available?

Productivity expectations of academic clinicians may be set out in affiliation agreements, contracts for services, appointment letters, policies, or performance reviews by either the participating university or hospital or both. Dispute resolution clauses will guide the appeal processes available to individuals. If a Professional Staff member's privileges are suspended, restricted, or revoked, they are entitled to a hearing before the hospital board.

4. Should resident trainees who are "moonlighting" be credentialed at institutions that are not their base hospital?

The Royal College of Physicians and Surgeons of Canada defines "moonlighting" as extracurricular (i.e. outside of a residency training program) provision of clinical services for remuneration, by residents registered in a postgraduate medical education program leading to certification with the College of Family Physicians of Canada (CFPC) or with the Royal College of Physicians and Surgeons of Canada (RCPSC).[13] Hospitals should review their affiliation agreements, by-laws and policies to determine whether external resident trainees should provide clinical services and should follow any credentialing requirements they would otherwise apply to their own residents.



13 Royal College of Physicians and Surgeons of Canada, "CBD Policy: Moonlighting" (2016), online: RCPSC < http://www.royalcollege.ca/rcsite/documents/cbd/cbd-policy-comm-moon-e.pdf >.

Appendix I: Glossary of Terms

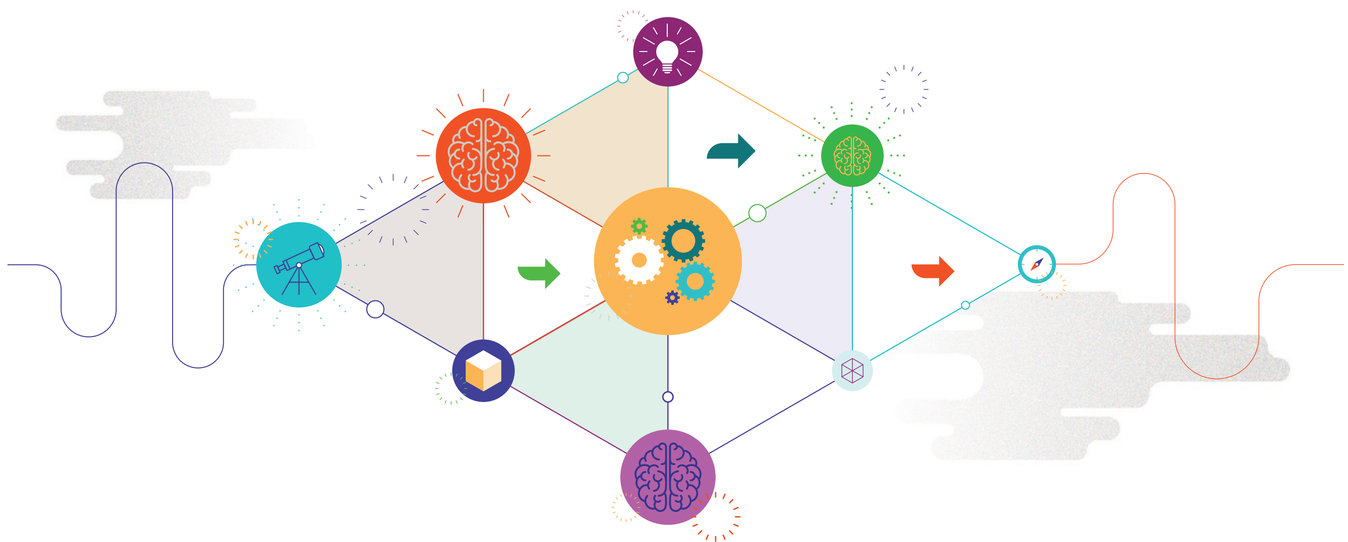
This Toolkit generally relies on the same definitions set out in the *OHA/OMA Hospital Prototype Board-Appointed Professional Staff By-law*, 2011(OHA/OMA Prototype By-law). The following words and phrases have the following meanings:

WORDS AND PHRASES	MEANINGS
Board	Board of Directors of the Hospital.
Chair of the Medical Advisory Committee (Chair of the MAC) or Chief of Staff	The member of the Professional Staff appointed to serve as Chair of the MAC. Must be a member of the MAC.
Chief Executive Officer (CEO)	In addition to "administrator," as defined in the *Public Hospitals Act*, the President and Chief Executive Office of the Corporation.
Chief Nursing Executive	The senior nurse employed by a hospital who reports directly to the Chief Executive Officer and is responsible for nursing services provided in the hospital.
Chief of Department	A member of the Professional Staff appointed by the board to be responsible for the professional standards and quality of care rendered by the members of that department at the Hospital.
Chief of Staff	See Chair of the MAC.
Credentials	A license, certificate or other documented qualification that establishes that a person has achieved a particular form of competency.
Credentialing	The process by which a hospital reviews a prospective Professional Staff member's qualifications, experiences, licenses, etc., to determine whether the individual meets the requirements of the hospital for privileges.
Credentials Committee	The committee established by the MAC to review applications for appointment and re-appointment to the Professional Staff and to make recommendations to the MAC; if no such committee is established it shall mean the MAC itself.
Dental Staff	Those dentists appointed by the board to attend or perform dental services for patients in the Hospital.
Department	An organizational unit of the Professional Staff to which members with a similar field of practice have been assigned.
Division	An organizational unit of a Department.

WORDS AND PHRASES	MEANINGS
Extended Class Nursing Staff	Those Registered Nurses in the Extended Class who are: 1. Nurses who are employed by a hospital and are authorized to diagnose, prescribe for or treat out-patients in the hospital. 2. Nurses who are not employed by a hospital and to whom the board has granted Privileges to diagnose, prescribe for or treat out patients in the hospital. (Note that this Toolkit applies only to Extended Class Nursing Staff who fall under paragraph 2 above.)
Head of a Division	The member of the Professional Staff appointed to be in charge of one of the organized Divisions of a Department.
HPARB or Appeal Board	The Health Professions Appeal and Review Board, which has the statutory authority to reconsider any decision made by a hospital board relating to a physician's privileges.
Impact Analysis	A study to determine the impact upon the resources of the hospital corporation of the proposed appointment of an applicant for appointment to the Professional Staff.
In Camera	A closed proceeding of the board.
Medical Advisory Committee (MAC)	The committee established pursuant to the OHA/OMA Prototype By-law that is required by the *Public Hospitals Act* to advise the board on credentialing of Professional Staff and other quality of care issues.
Medical Staff	Those physicians who are appointed by the board and who are granted privileges to practice medicine in a hospital.
Midwifery Staff	Those Midwives who are appointed by the board and granted Privileges to practice Midwifery in a hospital.
Natural Justice	Explained in Chapter 2, Legal Overview.
Patient	Unless otherwise specified or the context otherwise requires, any in-patient or out-patient of a hospital.
Policies	The administrative, human resources, clinical and professional policies of a hospital and includes policies and procedures adopted by the board.
Professional Staff	The Medical Staff, Dental Staff, Midwifery Staff and members of Extended Class Nursing Staff who are not employees of a hospital.
Professional Staff Human Resources Plan(s)	A hospital's plan from time to time which provides information and future projections with respect to the management and appointment of the Professional Staff based on the mission and strategic plan of the hospital corporation.

Public Hospitals Act	The *Public Hospitals Act* (Ontario), and, where the context requires, includes the regulations made thereunder.
Registered Nurse in the Extended Class	A member of the College of Nurses of Ontario who is a registered nurse and who holds an extended certificate of registration under the *Nursing Act*, 1991.
PUBLIC HOSPITALS ACT DEFINITIONS:	
administrator	The person who has for the time being the direct and actual superintendence and charge of a hospital.
Appeal Board	The Health Professions Appeal and Review Board under the Ministry of *Health and Long-Term Care Appeal and Review Boards Act*, 1998.
board	The board of directors, governors, trustees, commission or other governing body or authority of a hospital.
hospital	Any institution, building or other premises or place that is established for the purposes of the treatment of patients and that is approved under this Act as a public hospital.
medical advisory committee	A committee established under Section 35 of the *Public Hospitals Act.*
physician	A legally qualified medical practitioner.
treatment	The maintenance, observation, medical care and supervision and skilled nursing care of a patient and, if dental service is made available in a hospital by its board, includes the dental care and supervision of the patient.
HOSPITAL MANAGEMENT REGULATION 965 DEFINITIONS:	
admitted	Received and lodged in a hospital but does not include registered as an out-patient.
attending dentist	A member of the Dental Staff who attends a patient in the hospital.
attending midwife	A member of the Midwifery staff who attends a patient in the hospital.
attending physician	A member of the Medical Staff who attends a patient in the hospital.
attending registered nurse in the extended class	A registered nurse in the extended class who attends an out-patient in the hospital.
dental staff	1. The oral and maxillofacial surgeons to whom the board has granted the privilege of diagnosing, prescribing for or treating patients in the hospital, and 2. The dentists to whom the board has granted the privilege of attending patients in the hospital in co-operation with a member of the medical staff.
dentist	A member of the Royal College of Dental Surgeons of Ontario.
extended class nursing staff	Those registered nurses in the extended class in a hospital, 1. Who are employed by the hospital and are authorized to diagnose, prescribe for or treat out-patients in the hospital, and 2. Who are not employed by the hospital and to whomthe board has granted privileges to diagnose, prescribe for or treat out-patients in the hospital.

medical staff	Those physicians to whom the board has granted privileges of diagnosing, prescribing for or treating patients in the hospital.
midwife	A member of the College of Midwives of Ontario.
midwifery staff	Those midwives to whom the Board has granted privileges of assessing, monitoring, prescribing for or treating patients in the hospital.
nurse	A member of the College of Nurses of Ontario who is a registered nurse.
registered nurse in the extended class	A member of the College of Nurses of Ontario who is a registered nurse and who holds an extended certificate of registration under the *Nursing Act,* 1991. For the purposes of this Regulation, a reference to a patient includes an out-patient, except where the context otherwise requires.



Appendix II: *Public Hospitals Act (and Regulation 965), Regulated Health Professions Act, 1991, and OHA/OMA Hospital Prototype Board-Appointed Professional Staff By-law, 2011*

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Regulated Health Professions Act, 1991 Regulated Health Professions Act, 1991, S.O. 1991, c. 18 (ontario.ca)

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