RISK MANAGEMENT: A DESCRIPTIVE ANALYSIS AS A BASIS FOR PLANNING IN BRITISH COLUMBIA ACUTE CARE HOSPITALS

by

MARLENE HOPE MYSAK

B.Sc. (Nu.), The University of Alberta, 1975

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF

THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF SCIENCE

in

THE FACULTY OF GRADUATE STUDIES

(Department of Health Care and Epidemiology)

We accept this thesis as conforming

to the required standard

THE UNIVERSITY OF BRITISH COLUMBIA

September 1982

In presenting this thesis in partial fulfilment of the requirements for an advanced degree at the University of British Columbia, I agree that the Library shall make it freely available for reference and study. I further agree that permission for extensive copying of this thesis for scholarly purposes may be granted by the head of my department or by his or her representatives. It is understood that copying or publication of this thesis for financial gain shall not be allowed without my written permission.

Department of Health Care and Epidemiology

The University of British Columbia
1956 Main Mall
Vancouver, Canada
V6T 1Y3

Date October 1, 1982

ABSTRACT

During the past five (5) to seven (7) years, the American hospital literature has reflected a growing interest in the concept of Risk Management. Today, Risk Management, as an administrative control mechanism, is well established in many hospitals in the United States. Risk Management focuses on a system of identifying, monitoring and taking corrective action for potential or actual problems (the risks) that may result in unwarranted and unplanned personal injury, property damage, or other form of loss. Ultimately, Risk Management is concerned with the hospital's overall objectives of providing safe, quality patient care while using available resources efficiently.

The expression, Risk Management, has not been defined with any regularity or consistency with respect to British Columbia Acute Care Hospitals. A generalized concept of protection against risks has been evident for many years, although in Canada (and specifically, British Columbia), it has been approached functionally. For example, hospital administrators have been accustomed to providing a safe and secure environment through such means as guidelines, accreditation standards and quality assurance. In addition, they are obligated to consider legal issues relating to hospital care and to obtain appropriate insurance coverage for the various types of losses the hospital might be exposed to. A new interest in Risk Management appears to represent a possibly defensive position taken by those who anticipate increasing amounts of risk and subsequent litigation.

The question to be studied in this paper is whether there is any need for British Columbia Acute Care Hospital Administrators to move from their present rather pragmatic decision-making process for problem solving in selected areas to the more assertive and defensive approach of Risk Management. The answers were be sought by:

1. Reviewing the pertinent American literature on risk management.
2. Considering whether this presented an applicable approach to the British Columbia situation by:
    a. reviewing pertinent Canadian (and specifically British Columbian) literature on the same topic.
    b. reviewing Canadian (and specifically British Columbian) health services against their ideological background.
3. Discussing selected Risk Management considerations with:
    a. British Columbia legal experts in the health field.
    b. British Columbia insurance experts in the health field.
4. Discussing selected Risk Management considerations vis à vis present practices and procedures with hospital administrators (at senior and department head level) in two (2) British Columbia Community General Hospitals and covering three (3) hospital departments. The information collected from these interviews was presented in a case study format.

The discussions focus on the major differences between the Canadian and American hospital industries. In addition, the variances between the findings in the literature review and the

responses by the case study participants will be described. The analysis will draw conclusions about the need for British Columbia hospital administrators to change their present practices and move to a system of Risk Management. Recommendations for planning the introduction and evaluation of Risk Management in British Columbia Acute Care Hospitals are presented at the end of the study.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

ACKNOWLEDGMENTS

This type of manuscript could not have been possible without the cooperation of those working in or associated with the hospital industry. These persons willingly gave of their time, often, during busy schedules and to them I extend my warmest thanks. In addition, the members of my thesis committee proved to be patient and helpful as I grappled with the thesis process. Finally, I am grateful for the encouragement and support of my friends and family.

CHAPTER I

DEVELOPING A FRAMEWORK FOR RISK MANAGEMENT IN ACUTE CARE HOSPITALS

A. Introduction

During the 1970's American health services were being severely criticized. Issues of equity, accessibility and cost of services were common debates to be heard across the country. The hospital industry was struck with what has come to be known as the "malpractice crisis". Allegations of malpractice with a general decrease in the immunity of a hospital from liability seemed to have become one more element in a changing health care industry. Some may think that "crisis" was too powerful a word to describe the American experience. However, it is clear that the method of controlling hospital liability often determined whether or not a hospital could continue to function. One of the developments for controlling liability was the introduction of Risk Management for Hospitals. The introduction and outcomes of this concept has been well documented in the American literature.

At present, it is inconceivable that British Columbia hospitals should be confronted with a similar experience, and yet, over the past (two) to (three) years, a growing interest in the concept has been demonstrated. The expression, Risk Management, is being used with more familiarity. Some hospital administrators in British Columbia have designated one of their administrative staff as Risk Manager. Seminars, conferences and articles on Risk

Management are appearing in the Canadian context. However, introducing comprehensive Risk Management programs into British Columbia hospitals would be a shift from present management practices and warrants further examination.

1. Purpose of the Study

The question to be studied in this paper is whether British Columbia Acute Care Hospital Administrators need to move from their present decision-making process of problem-solving in dealing with selected risk areas to the more assertive and defensive approach of Risk Management.

This descriptive study will attempt to answer the question by analyzing:

a. pertinent American, Canadian and, specificially British Columbia literature on Risk Management and selected issues related to Risk Management;

b. interviews with British Columbia legal and insurance experts in the health field;

c. interviews with British Columbian hospital administrators (at senior and department head level) in two (2) Community General Hospitals with special attention to the present practices and procedures of three (3) hospital departments.

The analysis of the literature and case study will include discussions about the major differences between the American and Canadian hospital industries and the variances found between the findings in the literature and the responses of the case study

participants. Conclusions will be drawn about the need to change the present practices of British Columbia Acute Care hospitals. The major advantages/disadvantages of introducing Risk Management will be summarized and followed with recommendations for planning.

2. Description of the Study

This study represents a methodological presentation of major issues surrounding the potential introduction of a new concept. The subsequent chapter begins with the development of a framework for Risk Management by introducing definitions, comparing Risk Management with Quality Assurance and addressing what relevance Risk Management has for British Columbia Acute Care Hospitals.

Chapter III introduces the model from which the literature review is discussed. The four constant variables are the subject matter for Chapters III through V with both the American and Canadian perspectives being presented. Chapter VI introduces the reasoning behind a case study in addition to reporting the findings and analysis.

In the final chapter, conclusions are drawn regarding the need to change present management practices relating to risks. The major advantages/disadvantages of introducing Risk Management are summarized and supplemented by recommendations for planning.

CHAPTER II

DESCRIBING RISK MANAGEMENT FOR ACUTE CARE HOSPITALS

A. Definitions

Risk and risk management have several definitions and interpretations as evidenced by the plethora of primarily American literature on the subject. However, there are commonalities and, from these, a framework will be established for the purpose of this paper.

Webster's New World Dictionary defines risk as the chance of injury, damage or loss, and management as the control or direction of behavior. Thus, risk management becomes a control or direction of the chance of injury, damage, or loss.

Lowrence preferred to define risk "as a compound measure of the probability and magnitude of adverse effect".[2] Presenting a paper at a conference on Societal Risk Assessment, he viewed risk statements as a statement of the likelihood and consequences of harmful effect whether they be determined by empirical methods or guesstimate.

Brown, writing about Risk Management for Hospitals, stated that risk had a negative connotation and implied the need for avoidance. He combined this with a description of management which he considered an active effort to achieve positive results. Thus, his definition of risk management intimated a program that provides positive avoidance of negative results.[3]

How this positive avoidance can be achieved is illustrated

in some of the more common definitions of risk management:

> "... the science for the identification, evaluation and treatment of the risk of financial loss.[4]
>
> "... the identification, interpretation, isolation, and eradication of incidents that may give rise to unwarranted, unplanned, or unexpected patient conditions or results."[5]
>
> "... surveillance of all patient care operations in order to identify, evaluate and take corrective action that may lead to patient injury and the loss or damage of property, with resulting financial loss."[6]
>
> "... a detection system designed to predict when the next person failure will occur and to prevent it from happening."[7]

An acute care hospital is a facility providing services...

> "for the stabilization of vital processes, the relief of distress, the establishment of diagnoses, the provision of treatment, the restoration of function and the education and training of persons for self care and maintenance of optimal health care status. This requires medical, nursing and paramedical staff in a broad range of diagnostic and treatment specialties and equipment for a variety of care requirements."[8]

For the purpose of this paper, psychiatric acute care facilities are excluded from this framework. In addition, the term "hospital", unless specified otherwise, will refer to acute care hospital throughout the text of this paper.

B. The Overlap with Quality Assurance

Quality assurance, a clinical program that focuses on quality of patient care, has obvious overlaps with risk management. The overlap can be determined by reviewing the function of each program (Table one). It is noteworthy that although the functions and process of both activities are similar, the differences in focus is sufficient to preclude the collapsing of both functions into one.[9] This can be further illustrated by the conceptual model presented in Figure One.

Instead, it has been proposed that an integrated approach may be more beneficial to the hospital. The distinct advantages of integration include:

1. Maximum use and benefit from limited resources;
2. Establishment of an optimal communication link;
3. Promotion of the development of relevant staff education programs.

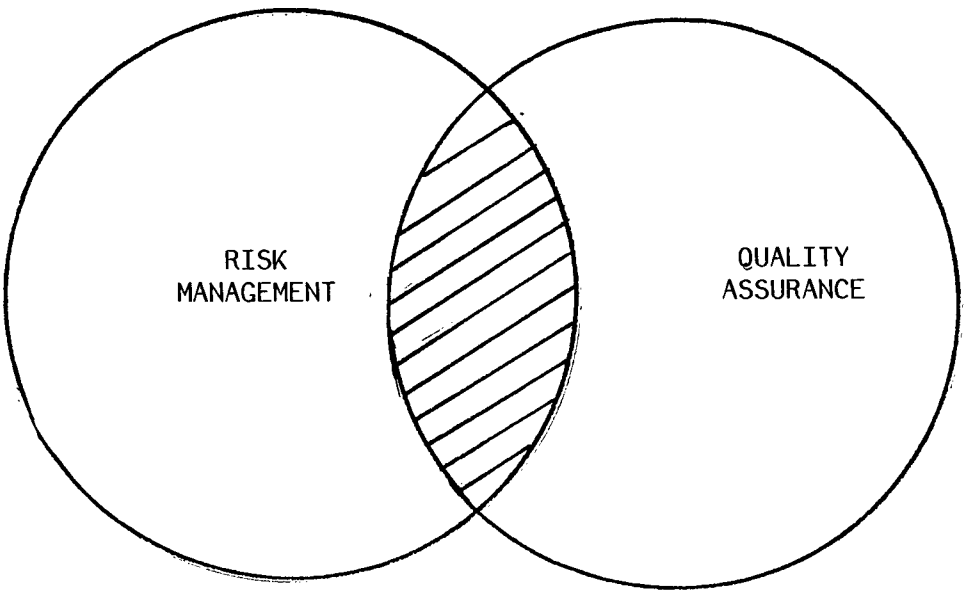
The American Hospital Association (AHA) has studied the relationship between quality assurance and risk management and has emphasized the need for both types of programs.[10] The integrated framework has already been adapted for use in one British Columbia hospital and is shown in Table Two.[11] The AHA manual, published

TABLE ONE
FUNCTIONS OF RISK MANAGEMENT AND QUALITY ASSURANCE

RISK MANAGEMENT	QUALITY ASSURANCE
1. Protect financial assets of the hospital.	1. Tied to philosophy of the hospital.
2. Protect human and intangible resources.	2. Improve the performance of professionals, protect patients.
3. Prevent injury to patients, visitors, employees, and property.	3. Focus on quality of patient care.
4. Loss reduction focusing on individual loss or on single incidents.	4. Sets quality of care delivered against standards and measurable criteria.
5. Loss prevention to prevent incidents by improving quality of care through continuing and ongoing monitoring.	5. Prevents future losses or patient injuries by continuous monitoring of problem resolution areas.
6. Review of each incident and the patterns of incidents through the application of the steps in the R.M. process.	6. Searches for noncompliance with goals, objectives and standards through quality assurance process.

Illustrated with permission:
Source: Orlikoff, J. and Langham, G.
"WHY RISK MANAGEMENT AND QUALITY ASSURANCE SHOULD BE INTEGRATED"
Hospitals, June 1, 1981.

FIGURE ONE
OVERLAP BETWEEN FUNCTIONS OF RISK MANAGEMENT
AND QUALITY ASSURANCE



Illustrated with permission:
Source: Orlikoff, J. and Langham, G.
"WHY RISK MANAGEMENT AND QUALITY ASSURANCE SHOULD BE INTEGRATED"
Hospitals, June 1, 1981.

TABLE TWO

RELATIONSHIP BETWEEN RISK MANAGEMENT & QUALITY ASSURANCE PROGRAMS

CHARACTERISTICS	RISK MANAGEMENT	QUALITY ASSURANCE
Purpose	Minimize the Hospital's losses - protect the Hospital.	Assure that quality of care provided is optimal - evaluate staff performance and and protect patients.
Character	Crisis intervention	Education & remedial
Function	Detect risks to the Hospital, then prevent their recurrence or minimize their effect when they occur.	Measure actual care against standards and take remedial action where care does not meet standards.
Patients Involved	Single patient discharged or still hospitalized -- isolated events.	Single patient or groups of patients, discharged or still hospitalized -- patterns.
Standard	Unwritten and implicit criteria (what staff consider and "incident" or "occurrence").	Written and explicit clinically based criteria.
Process of Patient Care Review	Review of health record after report received; possibly a medical examination of the patient.	Review of completed health record.
Reason for an Individual Patient's Care Scrutinized	Patient suffered an injury which was reported or the Hospital receives legal notice.	Care provided did not meet established standards.
Analysis	Why is the lawyer suing? Is there harm? Who or what caused harm?	Explanation of variance explicit criteria. Can the variation be justified clinically?
Action	May be direct immediate patient intervention to handle a single patient. Generally not remedially oriented for Hospital staff.	No direct patient intervention as it affects future patients Remedially oriented for Hospital staff.
System	Part of a monitoring system.	Part of an overall system based on a feedback loop with continuing education, staff evaluation and other study activities.

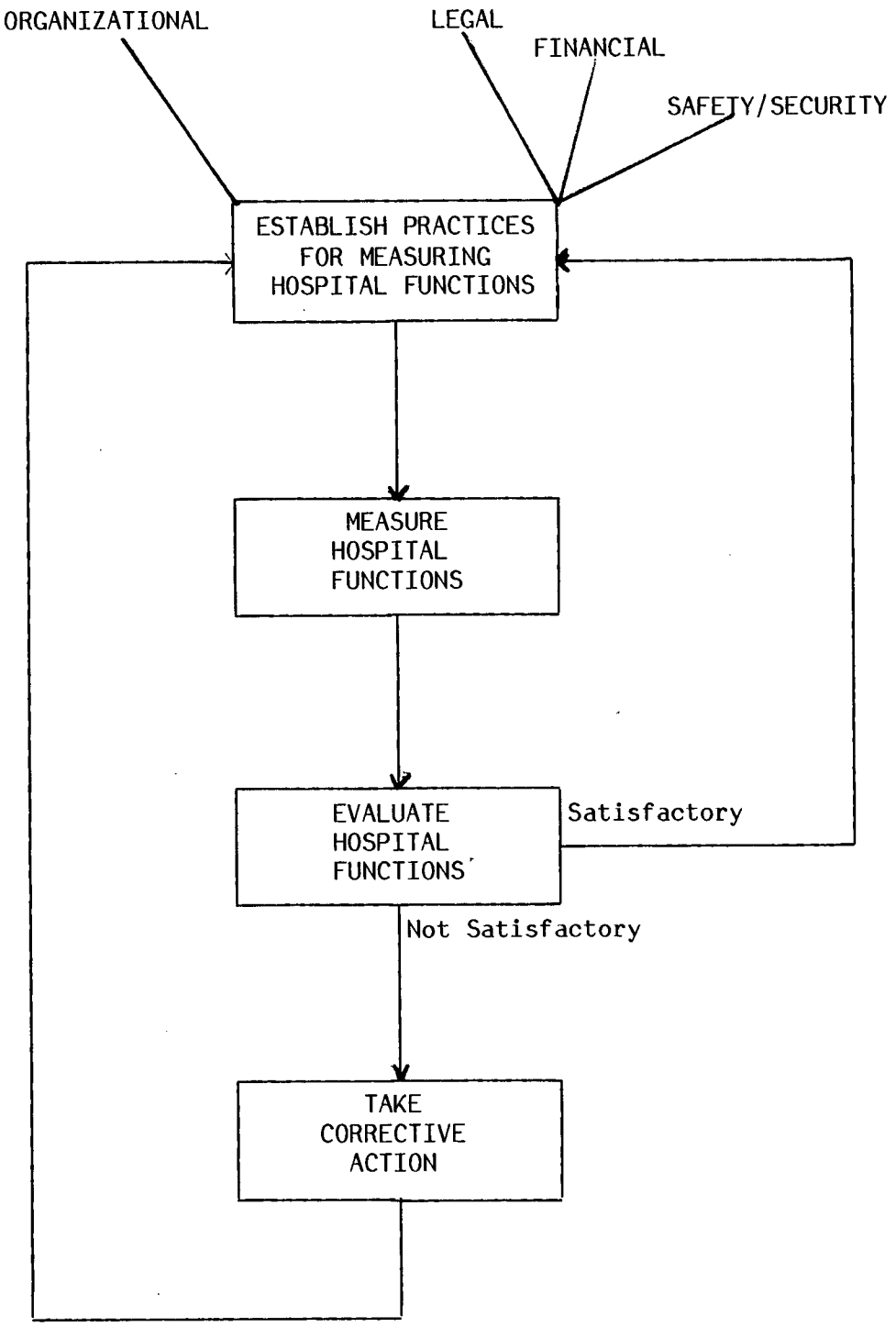
in 1980, also examines the commonalities and demonstrates how the functions of quality assurance and risk management can work together for a more effective outcome.[12]

C. Establishing a Framework for Risk Management

Given the latitude that is apparent when discussing Risk Management, it is important to outline how Risk Management will be defined in this manuscript. Thus, for the purpose of this study Risk Management is a management process that includes surveillance of all hospital operations in order to identify, evaluate and take corrective action for unwarranted, unplanned and unexpected situations that may lead to an individual's injury, property damage or loss.

The process, as illustrated in Figure Two, can be viewed as an organized or formalized control mechanism for monitoring hospital operations. The practices referred to in the framework include policies, practices, and standards that may affect hospital operations or functions. The primary considerations can be delineated into four (4) categories that include legal, financial, safety and security, and organizational aspects that may influence the character of the hospital practices as societal expectations and demands change and feedback through the system. In addition, the overlap and relationship with quality assurance is acknowledged and is included as part of the Risk Management concept in so far has been outlined in the previous section.

FIGURE TWO
FRAMEWORK TO DEMONSTRATE THE CONTROL PROCESS RELATED TO RISK MANAGEMENT IN A HOSPITAL ORGANIZATION



D. Relevance to British Columbia Acute Care Hospitals

During the first half of this century, there were several hundred Canadian hospitals of varying size and varying standards. Most were located in the larger communities and spread across a vast country that was, in most areas, sparsely populated. The pioneers in the Canadian hospital and medicine fields interacted frequently with their American counterparts and it was not unusual to find Canadians in influential positions in the United States.[13],[14] Because of this close association, the developments of the American and Canadian hospital would demonstrate many similarities both in their accomplishments and in their problems. What follows is a brief chronicle of the historical aspects in the American and Canadian hospital industry that have led to the creation of Risk Management for hospitals. Emerging patterns in Canada suggest it is timely to examine the need for Risk Management in British Columbia acute care hospitals.

1. Background of the United States Hospital

During the 18th and first half of the 19th century, the American hospital was a place where the destitute could find shelter and sympathy. More often than not it was a place to die.[15] This did not change until the latter half of the 19th century with the establishment of schools of nursing and advances in the field of medicine. However, by the turn of the century, the hospitals had changed in purpose, function and number. Significantly, the public was beginning to realize that some forms

of disease and injury could better be treated in a hospital environment.[16]

Following the Flexner Report of 1910, activities escalated in the organization and delivery of health services.[17] Medical schools became associated with specific hospitals that were encouraged to meet certain standards that would enhance the learning environment of the aspiring intern or specialty resident. Foundations were established to promote special studies in medical and health care; associations (medical and hospital) were formed to assist in the improvement of administrative procedures, professional practice and hospital functions; and books and journals shared new experiences and knowledge. By mid century, people had been educated to appreciate a scientific good hospital service.[18]

In 1953, the American College of Physicians and Surgeons and the American Hospital Association joined forces to establish the Joint Commission on Accreditation of Hospitals (JCAH) in order to standarize certain practices and administration of all kinds of hospitals in the United States. By 1965, about sixty (60) percent of American hospitals were being accredited by JCAH.[19] However, some individuals have expressed concern that JCAH standards were too low as was evidenced by the alarming increase in malpractice and liability suits.[20] Part of this trend was related to the changing image of the hospital. Since 1957, hospitals had not been covered under charitable immunity and had been subject to corporate liability.[21] Hospital liability added fuel to another

problem - the cost of hospital care. Malpractice insurance premiums were increasing to the point where many hospitals could not afford them. In the mid 1960's hospital administrators sought alternatives that included group insurance, self-insurance and patient protection programs.[22] In the early 1970's, the protection program was expanded to include such elements as employees, visitors, fire and theft.[23] Comprehensive risk management programs were the outgrowth of these early deliberations and are now ensconsed in the American hospital industry.[24]

In addition to the changing image of the hospital, several other factors have been put forth to explain the American shift toward Risk Management. These include:

1. Increased medical technology - resulting in patient expectations being raised to unrealistically high levels at high cost.

2. Increased specialization by physicians - resulting in a breakdown of the doctor-patient relationship and an increase in the risk of errors in communication and follow-up.

3. Increased number of possible claimants and increased number of patients willing to file claims - resulting from easier accessibility to health care, a generally more litigous environment, and the courtroom being viewed as the first place a dissatisfied patient could turn to, as opposed to the area of last resort.

4. Increased number of attorneys - especially those who specialize in malpractice cases. The reluctance to sue because cases were too complicated had been eliminated.

5. Changes in law - primarily the removal of immunities for governmental and charitable institutions, liberalization of the Limitations ACT, and changes in regard to locale and training of expert witnesses.

6. Unsophisticated methods of Risk Management which permitted many incidents to occur which could have been prevented.

7. Awareness of Malpractice Insurance - which has, once again, removed reluctance to sue an individual.[25]

2. Emerging Patterns in Canada and British Columbia

To date, there is no indication that British Columbia or other Canadian provinces will enter into a liability problem of the proportion exhibited in the United States. However, the potential for a significant increase in claims appears to exist.

Of the contributing factors put forth in the previous section, four (4) are apparent in the Canadian context. They include:

1. increased technology
2. increased specialization
3. changes in law
4. unsophisticated risk management methods

The number of attorneys specializing in health or hospital law is unknown. However, there is certainly a communicated interest in the legal community and evidence that there are some lawyers on the lookout for potential litigants.[26],[27] Economic instability and the existence of only a handful of insurance companies willing to provide liability coverage have accentuated the problem in the United States and have the potential to do the same in British Columbia and across Canada.

Several factors also act as deterrents or preclude the development of a liability problem. The most significant of these

is the national health insurance program. It has increased accessibility to health care. In addition, Canadians are reluctant to sue for something that is given to them at what is perceived as low cost. The awareness of Canadians about malpractice and liability insurance is unknown. However, there is evidence that demonstrates patients are greatly misinformed about health care benefits and costs.[28] One other factor is worth relating. Canadian physicians are well organized to protect themselves from litigation through the Canadian Medical Protective Association (CMPA). This is a nonprofit professional association whose annual membership fee had for the past six years remained at $200 per annum until recently.[29] This is quite distinct from the American physicians who must maintain protection from a private insurance company.

At a National Conference on Health and the Law, Mr. F. Kendrick, an executive with the Marsh McLennan Insurance firm presented his views on malpractice and hospital liability in the Canadian context. He urged the conference participants to give careful consideration and action toward the following:

1. Improved working relationships among health care workers, lawyers and the insurance industry to provide direction for the future.
2. Improved management of loss prevention activities.
3. New approaches to risk assumption and risk transfer.

He strongly believed that the possibility for a malpractice problem was present.[30] Similarly, a lawyer at the same conference stated that the legal situation with regard to malpractice was

lively in Canada. He felt health care had no national boundaries in the problems it presented and, therefore, Canada could not be blind to developments in other jurisdictions.[31]

More recently, Ontario hospitals have faced large increases in their insurance premiums and, for the first time ever, insurance companies have experienced investment income falling below underwriting losses.[32] The legal profession has been stating with increasing frequency that Canadian hospitals must establish mechanisms to ensure their legal duty is carried out.[33],[34] One noted professor of law has stated that Canadian hospitals have a duty to implement risk management systems ... or they might be imposed upon them.[35] British Columbia Hospitals cannot afford to ignore these developments. It is, therefore, timely to see if there is a need for British Columbia Acute Care Hospitals to move from their present practices to a system of Risk Management.

CHAPTER II FOOTNOTES

[1]Webster, New World Dictionary (Second College Edition 1973, pp. 493, 348,

[2]W. Lowrance, "The Nature of Risk," in Societal Risk Assessment: How Safe is Safe Enough edited by R. Schwing, W. Albers (New York: Plenum Press, 1980) p. 6.

[3]B. Brown, Risk Management for Hospitals (Germantown, Maryland: Aspen Systems Corporation, 1979), p. 1.

[4]T. Donkmyer & J. Groves, "Taking Steps for Safety's Sake," Hospitals, (May 16, 1977), p. 60.

[5]K. Stewart, "Risk Management: No Tasks for the Timid," Trustee, (April, 1979), p. 10.

[6]N. Dixon, "The Board's Role in Risk Management," Trustee, (September, 1979), p. 55.

[7]Wm. Fifer, "Risk Management: the art of preventing 'people failure'," Trustee, (September, 1977), p. 52.

[8]British Columbia Department of Health, British Columbia Classification of Types of Health Care (Victoria: Department of Health, 1973).

[9]J. Orlikoff and G. Lanlam, "Why Risk Management and Quality Assurance Should be Integrated," Hospitals, (June 1, 1981), pp. 54-55.

[10]American Hospital Association, Quality, Trending & Management for the 1980's, (QTM 80), (Chicago: AHA, 1980) M-14, M-15.

[11]K. Mitchell, Risk Management Program (Internal documents Health Services Centre, UBC, 1981).

[12]American Hospital Association, QTM 80, M-16, M-18.

[13]Commission on Hospital Care, Hospital Care in the U.S. (New York: Commonwealth Fund, 1947), pp. 432-453.

[16]Ibid, pp. 454-477.

[17]A. Flexner, Medical Education in the United States and Canada. A Report to the Carnegie Foundation for the Advancement of Teaching (New York: Carnegie Foundation, 1910).

[18]Commission on Hospital Care, Hospital Care in the United States, pp. 478-5B.

[19]E. Hoyt, Condition Critical: Our Hospital Crisis (New York: Holt, Rinehart and Winston, 1966), pp. 3-23.

[20]Ibid, p. 197.

[21]J. Orlikoff, Wm. Fifer, A. Greely, Malpractice Prevention and Liability Control for Hospitals (Chicago: Amer. Hosp. Assoc., 1981), pp. 5-16.

[22]G. Morse, R. Morse, Protecting the Health Care Facility: A System of Loss Prevention Management Effective for all Industry (Baltimore: Williams & Wilkins Co. 1974), pp. 5-10.

[23]Brown, Risk Management for Hospitals: A Practical Approach, forwards.

[24]Orlikoff, et. al., Malpractice Prevention and Liability Control for Hospitals, p. 19-22.

[25]International Hospital Federation, International Seminars on Hospital Liability (Lyon, France, April 24-25, 1981).

[26]As will be noted in Chapter V, much of the literature related to Risk Management in the Canadian context comes from the legal community.

[27]G. Clements, interview, May 9, 1982.

[28]Le Riche et al., eds., People Look at Doctors: The Sunnybrook Health Attitude Survey (1971), p. 103.

[29]J. Dillon, interview, April 19, 1982.

[30]F. Kendrick, "Malpractice - 'The Insurance Problem," in Proceedings, National Conference on Health and Law (September 23, 1975), pp. 66-75.

[31]C. Scott, "Malpractice - The Legal Situation," in Proceedings pp. 1-9.

[32]H. Martin, "Hospital Risk Management : A Canadian Perspective, "Health Management Forum," (Autumn, 1981), pp. 23-24.

[33]L. Rozovsky, "The Hospital's Responsibility for Quality of Care Under English Common Law," Chitty's Law Journal, (4), (1976), pp. 132-136.

[34]E. Picard, "The Liability of Hospitals" (unpublished manuscript, Health Law Seminar, UBC, Spring, 1982).

[35]J. Magnet, "Preventing Medical Malpractice in Hospitals: Perspectives from Law and Policy," 3 Legal-Medical Quarterly, (1979), p. 197.

CHAPTER III

MAJOR CONSIDERATIONS ASSOCIATED WITH HOSPITAL RISK MANAGEMENT IN THE UNITED STATES

A topic with as broad a scope as Risk Management requires a model for purposes of manageable discussion. The considerations were identified following a review of pertinent American literature on Risk Management for hospitals. Consistently, four threads - legal, financial, safety and security and organizational - could be recognized. Their interrelationship is demonstrated in Figure Three. A change or action in anyone of the "areas" can result in a reaction in another area. For example, a breach in safety practices could result in a legal situation that may affect the financial resources of the hospital and thus, influence the management of the safety practices. The organizational considerations (the hospital as an organization) is at the centre with both internal and external influences acting upon it.

An overwhelming amount of applicable material could be presented with respect to each of the considerations. To establish some parameters, each of the considerations will be discussed using the following approach:

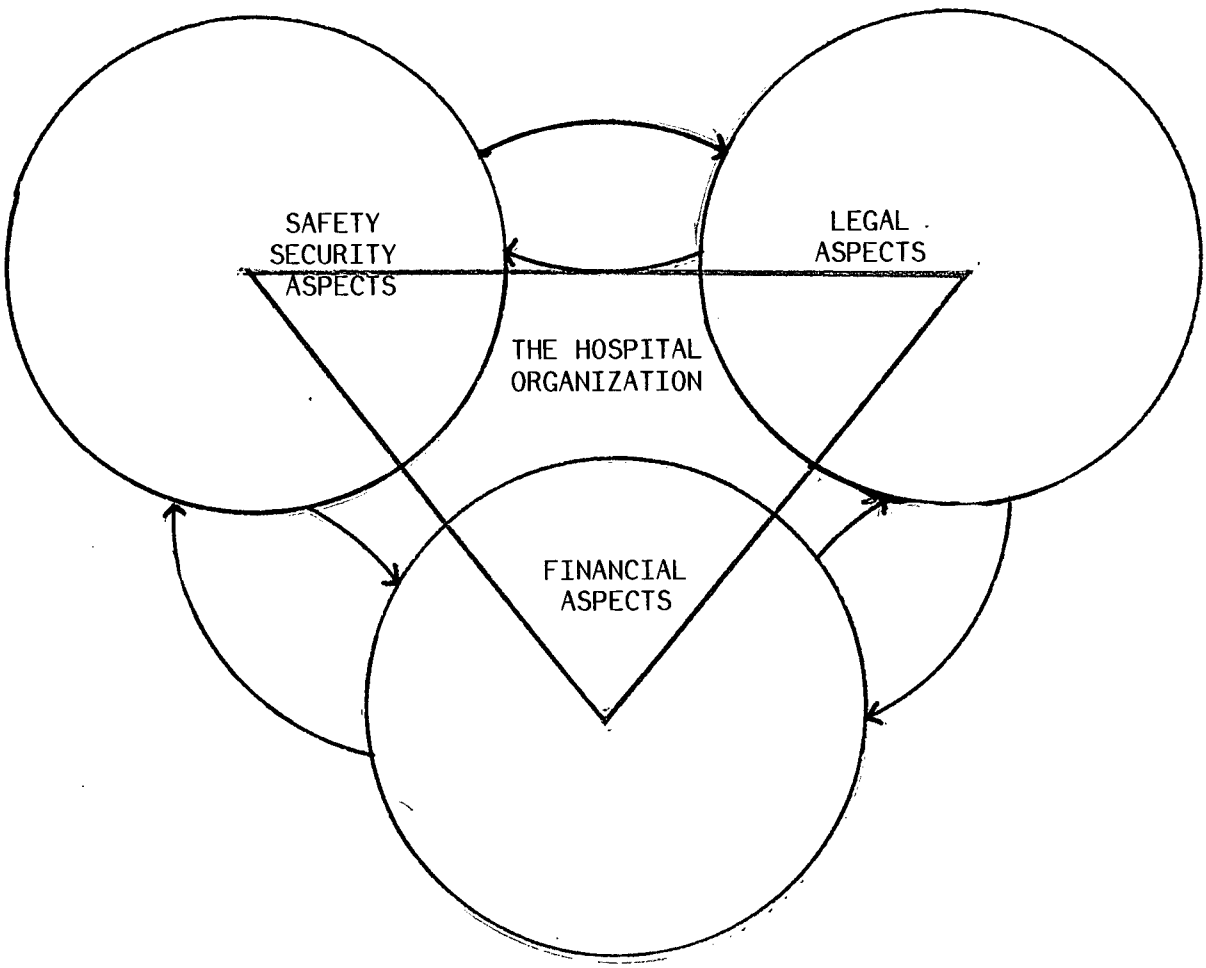
a. the primary problems(s) perceived

b. supplementary information

c. relationship to Risk Management

Where applicable, additional explanatory information will be supplied in the appendices. In this manner, a broader spectrum of

FIGURE THREE
INTERRELATIONSHIP OF PRIMARY CONSIDERATIONS RELATED
TO HOSPITAL RISK MANAGEMENT



material can be discussed without interruption of definitions or explanation of principles. Basically, the purpose of the next two chapters is to demonstrate the significance of each consideration upon the American hospital organization and ultimately, define the consideration's importance in the Risk Management process.

A. Selected Legal Aspects

The expressed concern for hospital liability and accountability is a relatively contemporary issue. For many years, hospitals were covered by a charitable immunity doctrine. Then, in 1957, the New York Court of appeals established a precedent by claiming that the doctrine of charitable immunity was no longer applicable to hospitals. This coincided with and confirmed the changing image of the hospital discussed in the previous chapter. In addition, state medical practice acts limited license of physicians to 'natural persons'. Since, hospitals were a legal entity only, they could not "practice" medicine. The hospitals' inability to control the actions of the Medical staff prevented them from employing physicians.[2] During the succeeding years, the hospital, as an organization, continued to change with the times. Incidental to these changes were two factors that would strike at the very core of the hospital's operations:

1. changes in the law
2. development of a claims concious society.

The combination of these two factors has assisted in supporting a

litigating environment that presents itself as a predominant problem for the American hospital industry. Because litigation or the potential for litigous claims is a problem of such great magnitude[3], the significant changes in the law and the reasons for a claims conscious society will be discussed in greater detail. This will be supplemented by important legal definitions, types of legal action and principles of hospital liability documented in Appendix A.

1. Basic facts about the Anglo-American legal system

American Law can be classified as public or private law depending upon its subject content.[4] Table Three demonstrates the type of laws or regulations applicable under each.

TABLE THREE
CLASSIFICATION OF AMERICAN LAW

PUBLIC	PRIVATE
CONSTITUTION	CONTRACT
CRIMINAL	PROPERTY
ADMINISTRATION (GOVT. AGENCIES)	TORTS
	COMMON LAW

Public law defines, regulates and enforces rights where any part or agency of government is a part to the subject matter. This includes defining relationships between various components of the federal state, considerations relating to the Bill of Rights and protection of fundamental freedoms, crimes against the state

and the people and administrative organizations which regulate particular matters in the public interest. Statutes (or Public laws) are enactments of legislative bodies. They may deal with matters of public or private law. It is important to note that the legislative distribution of power for public affairs is divided amongst federal, state and municipal levels. Ultimately, health is a federal jurisdiction and the responsibility of the Department of Health, Education and Welfare.[5]

In the area of private law, the law of contracts is concerned with the sale of goods, the furnishing of services, the employment of others, and the loan of money. Property law regulates the ownership, employment, and disposition of property while the law of Torts defines and enforces respective duties and rights that exist between individuals but are independent of contractual agreements.[6] Contract, property and tort law have developed historically through judicial decisions and are referred to as common (i.e. common to England) law guided by the doctrine of **stare decisis** (translated to mean to abide by decided cases). However, it is important to note that **stare decisis** is applied vertically, but not horizontally, to equal or lower courts in the same system or to courts from other systems. Thus, a state trial court would be bound by decisions of their appellate or supreme courts but would not be bound by other trial courts in the same state or out of state. The same holds true for the federal court system.[7]

Few areas of the Americans' daily life are not governed by some type of law. One American scholar described law as the repository for the wisdom of the ages and said that existing laws reflect societal values that have reached expression through a complex socio-economic-political process.[8] Americans pride themselves in their liberty to pursue self-interests. However, it is the pursuit of self-interest that introduces conflict and, in the American context, it is the legal system that helps to establish limits in order to protect the interests of others.[9] What both of these statements suggest is that changes in societal values and, therefore, the laws of the land are both desirable and inevitable if they are to be of service to the American populace.

2. The changing law

With the change to corporate status, the hospital became subject to certain legal duties for its patients, employees and visitors. These duties are not delegable to medical staff or other personnel.[10] The central issue in defining the scope of duties is what the hospital undertakes to do. In theory, this should be outlined in the hospital's statement of purpose. Although the courts are still defining these duties, three situations traditionally and historically reflect a hospital's duties.

Maintenance of grounds and buildings is the first duty, and one often guided by statutory or accreditation standards. In the absence of these, the courts will make their decision according to the "reasonable man" standard. The plaintiff, however, must prove that the hospital, through its employees, knew or should have known of a defective or dangerous condition likely to cause

injury. Secondly, the hospital has duty to exercise reasonable care in both the selection and maintenance of equipment. It is expected that equipment will be properly selected to suit a given purpose and the patient's particular condition, and that the equipment will be properly maintained in order to discover defects. Again, licensing, accreditation, manufacturer's standards and safety standards under the Federal Occupational Safety and Health Act (OSHA) would prevail. There is no duty on the part of the hospital to provide or possess the newest, most modern equipment available. Finally, the hospital, as a corporation has a duty to exercise reasonable care in the selection and retention of professional and unprofessional staff. In addition to checking credentials, background, valid licensure and references, hospital administration must ensure that:

- inservice-training programs are up to date,
- employees are discharged or transferred when it is apparent that they cannot do their assigned jobs and professionals are properly supervising those for whom they are responsible.[12]

Failure to conform to any of these duties can result in a corporate negligence allegation or decision.

Negligence is defined as "conduct which falls below the standard established by law for the protection of others against unreasonably great risk of harm."[13] It is the act of an unreasonable man and is usually the result of poor judgement, ignorance or stupidity. Negligence is measured by a standard of "reasonable-

ness" which is based upon what is expected of the individual by individual by society rather than what the individual expects of himself. The reasonable man is assumed to have minimum perception, memory, experience and information common to the community. If he/she is an individual with specialized skills, the minimum standards for that occupation or profession prevail. Four elements must be proven in order for a court to award negligence to an injured party. They include:

1. an existence of a legal duty to provide a standard of care which a prudent, reasonable man would consider necessary in order to protect another from unreasonable and unnecessary harm.
2. a failure to perform that duty.
3. a wrong or injury must be suffered
4. approximate cause between the breach of duty and the injury.[14]

Most negligence suits in health care have been related to professional malpractice. However, with the transition to viewing a hospital as a corporation, the vulnerability for hospitals has increased. Some examples, of legal action suits brought against hospitals include:

Greater Washington, D.C., Area Council of Senior Citizens v. District of Columbia where the court found the D.C. General Hospital negligent in providing adequate staff, drugs and supplies and physical maintenance.[15]

South Highlands Infirmary v. Camp where a patient was awarded damages for injuries caused by a defective electrical-surgical instrument.[16]

and the more frequently occurring liability suits for negligence of hospital employees and medical staff:

The precedent setting **Darling v. Charleston Community Memorial Hospital** held the hospital liable for having an insufficient number of trained nurses who could recognize the progressive deterioration of the plaintiff's right leg, and who would report it appropriately. They were additionally held liable for not requiring consultation with medical staff skilled in specific treatments.[17]

Foley v. Bishop Clarkson Memorial Hospital, a case where the hospital was in breach of standard of care by failing to obey its own rules regarding history, physical examination and observation of a newly admitted patient which resulted in the plaintiff's newborn's death.[18]

In **Parker v. Port Huron Hospital** the hospital was held liable for an overworked laboratory technician who had failed to follow the prescribed procedure in identifying a tube of blood sampling which ultimately resulted in a patient's death from the wrong administration of blood.[19]

The last cases that include the negligence of hospital employees and possibly medical staff have the potential to overlap with the application of the doctrine of respondeat superior.

Respondeat Superior

Respondeat Superior literally translated as "let the master answer", is also known as vicarious liability. In this situation an employer is held liable for the wrongful acts of an employee

even though the employer's conduct is without fault.[20] There must be a master-servant relationship and the employer must have the right to control the physical conduct of the employee in the performance of the employees' specified duties. Respondeat superior does not absolve the employee of the wrongful act and the hospital may under some circumstances seek indemnification from such an employee. The doctrine of respondeat superior does not apply to independent contractors for the hospital but may apply under the "borrowed servant" doctrine in certain fact situations. This latter consideration has been most obvious in operating room cases where the surgeon was once deemed "captain of the ship" with the nurses his "borrowed servants." Under this rule, the surgeon was held responsible for any wrongful acts of the "servants". More recently, the American courts have been deciding that the surgeon has no right to control the "servants" and, thus, the hospital has been held liable under respondeat superior.[21] This doctrine has also extended the liability of hospitals for its medical staff, particularly if they are full-time employees of the hospital, but also for the independent practitioners if it is deemed that the hospital was negligent in selecting him or if the hospital was found to have directed the physician in the way and manner of treating patients.[22]

In summary, it is evident that a shift or changes in the law, with respect to hospital liability, have occurred since the hospital's change to corporate status. In addition to addressing corporate duties, one law professor has noted the following:

- the courts have difficulty in discriminating between corporate negligence and respondeat superior.
- respondeat superior judgements are now addressing both administrative and professional activities.
- the "borrowed servant" doctrine is slowly disappearing and hospitals are held accountable for all activities.
- the courts tendency to find an employment relationship between the hospital and the physician.[23]

Clearly, the scope of hospital liability has increased in definition and has no clear boundaries. This affirms the position taken earlier that the law is a reflection of societal values. The succeeding discussion will address some of the changing expectations and values of the American people.

3. The Changing Values

Ninety (90) percent of all suits brought against hospitals and doctors have occurred since 1964.[24] Clearly the American people are more willing to seek legal action. Why it is so may depend on how the problem is defined. Some of the more common arguments include:

- what today is considered malpractice, yesterday (15-20 years ago) was considered an unfortunate mistake
- the "physician's fraternity" is diminishing and there is a great likelihood in finding a physician who will testify against another physician.
- malpractice suits were costly and above the means of the average American citizen.
- the physician cared for the whole family and often was a friend of the family.
- there were less choices (of treatment, etc.) available and the patient had fewer expectations.[25]

These are augmented by:

- consumer's view of health care as a product
- patients' awareness of their rights
- breakdown of the physician-patient relationship
- high consumer expectations
- inevitability
- lack of informed consent[26]

and

- the growth in medical technology
- involvement of more personnel in the treatment sequence
- inadequate efforts by hospitals to prevent adverse incidents
- rapid escalation in the dollar amount of damages.[27]

The role of the hospital has expanded. Today, more than ever, more types of health care are delivered through the hospital. In turn, the "duties" of the hospital have increased and it should not be surprising that there is an increased probability that the hospital will be accused when something goes wrong.[28]

Among this deluge of reasoning a pattern does begin to surface that relates to the proposition stated at the beginning of this section. The image of health care, health care institutions and health care workers has changed. Concurrently, the consumers of health care have changed in their awareness, their expectations and their demands for compensation when, and if, personal injury or insult arises. Logically, one could expect a change in one (hospital structure, purpose) triggering a change in the other (public awareness, expectations) and, as noted earlier, reflecting itself in a change in the laws.

4. The Relationship to Risk Management

The preceding discussion outlined the significance of the law in the hospital's operations. The law can provide impetus for the hospital changing its ways or the hospital, through its own design, can provide a basis for changes in the law. It is also apparent that in the past ten (10) to fifteen (15) years, the hospital industry has had to face a problem of increasing litigation. Seemingly, controlling hospital liability has become as important a goal as patient care. One method that has been well received by the hospital industry is the Risk Management process. It addresses liability control through a comprehensive process of attempting to prevent, or at least minimize untoward or negative results of patient care. It has expanded to include minimization of problems that could potentially harm employees, visitors or the organization itself. Fundamentally, legal aspects of hospital and health care administration proved to be a primary reason for the development of Risk Management in the hospital sector.

B. Selected Financial Aspects

The health care system in the United States is under severe criticism.[29] One of the primary concerns is the cost of health care and there is considerable quantitative data to support this concern. Total national expenditures for health care more than quadrupled between 1960 and 1974,[30] and increased somewhat more in the latter 1970's.[31] Table Four illustrates what the trend is in

TABLE FOUR

NATIONAL HEALTH EXPENDITURES AS PERCENT OF GNP, UNITED STATES, SELECTED YEARS 1960-1977.

Fiscal Year	Percent of Gross National Product
1960	5.2
1965	5.9
1970	7.2
1975	8.5
1977	8.8

Source: Williams, S.J. & Torrens, P.R. Introduction to Health Services New York: John Wiley & Sons, 1980, p. 289

terms of the Gross National Product (GNP). An additional concern is that health care expenditures are increasing at a faster rate than the GNP as a whole.[32]

Noted earlier was the image of the modern hospital - the place for patients to receive many of the health care services, the hub of the American health care system. This gives the hospital high profile, subject to scrutiny, and makes it very expensive. Nearly sixty (60) percent of all federal health expenditures and fifty (50) percent of all state and local government health expenditures are spent on hospital care.[33]

Clearly, hospitals are an expensive enterprise. This presents another problem of great magnitude to the hospital industry and it is under increasing pressure, bothinternally and externally, to curb health expenditures.

As changes in the law and societal values were significant in the legal environment, so it will be demonstrated that changes in revenue structure, controls and, indirectly, societal values or attitudes toward the health care system have a significant impact on the financial management of the hospital. The demands are clear - decrease or control cost, increase or maintain quality of care. In turn, one of the issues the hospital industry must address is how best to protect the hospital's resources within the turbulent environment.

1. Changes in revenue sources and regulatory activities

There are two principal modes of hospital ownership in the United States:

- public: ownership at federal, state or municipal government level
- private: voluntary (not-for-profit)
  proprietary (for-profit).[34]

Revenue sources for these hospitals have come from direct payment, government subsidy or third party reimbursement.[35] In the past, proprietary hospitals relied upon philanthropic donations. These have been fewer in recent years and this type of hospital is more likely to resort to debt financing for new projects.[36] Following the acceptance and utilization of hospital insurance, most hospitals have become voluntary and must depend upon third parties

as their major source of revenue.[37] This presents another type of problem because even with dependable payments from the third party, concern has been expressed that the reimbursable costs are far different from full operating costs.[38] This means that hospital administrators are often hard pressed to meet the financial requirements for progressive patient care.

The high and persistently climbing cost of hospital care is of such great concern that it is central to much of the public policy in health care.[39] Some of the factors cited for the inflationary costs are increased accessibility and utilization by a more educated and affluent society, hospital services that are changed in intensity, scope and sophistication because of advanced medical technology and knowledge, and administrative costs for complying with regulatory acts.[40] Many of these acts were an attempt by the federal government to provide financial assistance and to control costs within the hospital industry. They have a significant impact on both the operating and capital budgets of the hospital and therefore shall be described in brief.

Control on Facilities and Services

The Hill-Burton Act (1946) was the first form of planning legislation enacted by the federal government. In order to participate the state had to submit and adopt a plan that was based upon a needs assessment. In turn, a hospital could apply for federal assistance if its project was in alignment with the state plan.[41]

The Comprehensive Health Planning and Public Service Amendments (1966) was another federal enactment that provided assistance to states for some of the cost of comprehensive planning efforts. Again, the focus was for a state plan and monetary assistance for construction of health facilities providing the facility was part of the state plan.[42]

In 1972, the Social Security Amendment (Section 1122) demanded that medicare and medicaid participant capital projects over $150,000 be rejected unless they were approved by a state agency. In addition, each participant was required to submit an annual operating budget and a three year projected capital expenditures budget.[43]

Most recently, the National Health Planning and Resources Development Act (1974) established a network of statewide and areawide planning agencies. The program is designed to link federal funding more closely with state regulation. A major emphasis was the implementation of "certificates of need" approved by the state agency for any capital projects in excess of Control of Utilization.

With the establishment of Medicare in 1965, participating hospitals were mandated to set up Utilization Review Committees to determine whether patients required hospitalization and to determine whether their length of stay was appropriate. This was followed, in 1972 by the Social Security Amendments which created Professional Standards Review Organizations (PSRO). These organizations were empowered to determine that Medicare/Medicaid

patients were receiving only appropriate and necessary services.[45]

In addition, there are state and other forms of control that have the potential to affect the hospitals' revenues. These take the form of controls on quality.

All states license their hospitals and are obligated to set standards, conduct inspections, issue licenses, close facilties that do not meet standards, and provide consultative services. However, there does not appear to be consistency in these standards or how they are enforced.[46]

Hospitals participating in medicare and medicaid must be certified by a state agency in order that the beneficiaries of care receive a minimal acceptable standard of care. Again, the enforcement of the standards does not appear to be consistently or stringently administered.[47]

Accreditation is a professionally sponsored and voluntary process carried out by the Joint Commission on Accreditation of Hospitals (JCAH). Accreditation focuses on highest relative standards of performance rather than minimal standards.[48]

Cost Controls

Since hospital operating revenues are largely attained from actual use of services, a significant cost constraint has been the contractual agreements of Blue Cross, Medicare/Medicaid Programs and other third parties that reimburse hospitals for certain costs only - in effect dictating the day to day charge (rate) suitable

for a particular hospital.[49] In addition, some states have instituted public rate setting agencies that establish, in advance, the rates at which hospitals will be reimbursed for care provided to certain groups of patients.[50]

This background information provides evidence of a pattern that has been emerging and most certainly affects the financial management of a hospital. First of all, there is evidence of alarming increases in costs of health care and particularly in the hospital sector. Second, the hospital is a big and visible business and one, that the consumer is willing and ready to use. The consumer is also willing and ready to seek financial compensation for any injury or insult occurring during the period of being a patient. Finally, there is evidence that the revenue sources and regulatory activities, as they are today, decrease the flexibility of hospital revenues and leave minimal maneuverability in the financial management of the hospital.

Other factors could adversely affect the hospital's financial stability. These include such things as property damage and theft. The hospital has always been in a position to protect its resources. In the past, different forms of loss transfer were relied upon to cover accidental or unplanned expenditures. There were many commercial insurer carriers that offered this service. It was also common for the insurance carriers to provide claim surveillance and management, incident investigation and equipment safety as part of the conditions of coverage.[51] This worked well until the "malpractice crisis" of 1974-75. During this period

hospital insurance premiums quadrupled.[52] Even so, many commercial carriers could not withstand the number of claims and high settlement awards and withdrew from the market.[53] Since that time, insurance management has become a more critical aspect of maintaining the financial stability of the hospital and for this reason warrants further discussion.

2. Insurance Management

The American Hospital Association believes that insurance should be purchased for those risks that could involve loss so great that the hospital's financial structure would be threatened.[54] In addition, it is the potential amount of the loss rather than the probability of loss that is of utmost importance.

Regulatory agencies within each state control insurance activities of each company doing business within the state. The controls oversee premium rates, insurer's solvency, policy form, permitted investments, cancellations and refusals to renew existing policies.[55] The other major considerations with respect to purchase of insurance are 1) the availability and capability of the insurance mechanism and 2) the current state of the underwriting art.[56] There are four divisions of insurance that apply directly to hospitals:

1. Property Insurance provides protection against or destruction of the hospital's physical property. e.g. fire, radioactive contamination, water damage, vandalism.

2. Consequential Loss Insurance provides protection for indirect loss of profits, commissions and income.

3. Liability Insurance for loss through legal imposition.

4. Theft Insurance for loss from theft by employees and non-employees.[57]

Liability insurance has been the most unstable of these divisions. Traditionally, commercial carriers offered this type of policy in one of two forms. A claims-made policy covered only those claims that were made during the tenure of the policy. An occurrence policy would cover claims filed after the expiry date of the policy providing that the incident occurred during the time the policy was in effect.[58] This proved to be inadequate for both the insurance carriers and the hospitals. Insurance carriers were suffering the effects of heavy financial losses from the economic instability and the increase in claims and amount of awards. Hospitals were having difficulty finding the resources to put toward spiraling premiums.[59] Because of the acuteness of the problem, hospitals were forced to seek alternatives to the conventional commercial liability insurance. This latter form is compared with some of the options in Table Five.[60]

All of these alternatives required the hospital to establish internal activities in order to reduce exposure to their risks. In addition, the remaining commercial carriers demanded that hospitals develop their own formal internal risk management programs as a condition of coverage.[61]

3. Relationship to Risk Management

In the preceding section, it was suggested that the legal

TABLE FIVE
COMPARISON OF VARIOUS FORMS OF MALPRACTICE LIABILITY INSURANCE*

TYPE OF INSURANCE	ADVANTAGES	DISADVANTAGES
Commercial Insurance	1. Transfer liability for catastrophic loss to another party. 2. May give hospital the services of an experienced risk management and claims investigation/defence team. 3. More "comfortable" than other alternatives.	1. Cost of premiums may sharply exceed hospital's own loss experience. 2. Cost of agent/broker commissions. 3. Limited incentive for hospital to control risks. 4. Future malpractic crisis may induce the insurer to suddenly withdraw from the market.
Joint Underwriting Associations	1. By acting as an underwriting agent or reinsurer, such associations can provide an insurance market where no other market exists.	1. Limited coverage is subject to rigid terms. 2. Limited excess insurance is available through commercial carriers. 3. Limited risk management services are available. 4. Temporary measure only; will not provide long-term solutions to to hospital's insurance ance problems.
Captive Insurance Companies	1. Pooling risks stabilizes cost. 2. Larger limits of liability possible. 3. Can be less expensive than commercial or self-insurance. 4. Hospitals can benefit from the risk management experiences of other participating hospitals.	1. Gaining consensus on captive's goals and strategies can be difficult. 2. Obtaining initial financing sufficient to cover all members can be difficult. 3. Possible inefficient operation due to inexperience.

TABLE FIVE CONTINUED

Funded Self-Insurance	1. Can be less expensive if hospital can predict and control risks effectively. 2. Provides definite incentives for hospital to prevent and control risks. 3. Risk management program can be finetuned to the needs of the hospital.	1. Hospital must assess its own risks. 2. Excess liability insurance may be difficult to obtain. 3. Complex accounting problems, especially given the possibility of "once in a lifetime claim." 4. Mechanisms must conform to third part payer guidelines in order to receive reimbursement.
Nonfunded Self-Insurance (going bare)	1. May be necessary alternative for hospitals with severe cash flow problems.	1. A single successful claim, or a series of claims, could bankrupt the hospital.

impetus provided a fundamental reasoning for the development of Risk Management Programs in the hospital sector. This section has attempted to examine selected financial aspects - the constraints, the public expectations, and the means of protecting the hospital's assets. The latter could not be brought forward without a brief discussion on insurance management. Once again, controlling liability, this time from a financial and insurance viewpoint became an important objective for the hospital. Risk Management originated in the insurance industry in order to minimize, through insurance, predictable losses.[62] The term "risk management" has taken on a more focused meaning for hospitals - encompassing prediction of risk of patient injury, avoidance of exposure to predicted and other risk, and minimization of claims loss.[63] In this way Risk Management is directed toward protecting the vast quantity of resources in the hospital industry and curbing the costs associated with the litigation and insurance process.

C. Selected Safety and Security Aspects

A hospital exists to provide health care services and society demands that the care be exceptionally well provided.[64] In this respect, there is little room for mediocrity. A hospital must provide a safe and secure environment for the patient, visitor and employee. Not to do so would be incongruous with its purpose, the outcome of which could be personal injury and subsequent legal action and financial loss.[65]

The planning for a safe and secure environment should be a relatively straightforward procedure. The elements are easily identifiable, the measures are directed toward and for people and the objectives are to reduce the hazards ever present in the hospital environment. The major problem for any safety and security program has been the compliance of those involved or those who should be involved.[66]

As with the preceding discussions on legal and financial aspects, two dominant themes stand out:

a. historical background and developments

b. attitudes of those directly involved.

In addition , because of the nature of the organization, some problems unique to the hospital setting will be discussed.

1. Background

It was not until the mid 1940's that the American Hospital became actively involved with safety. A Hospital Safety service was established in 1949 in cooperation with the National Safety Council. Only in the last two decades have hospitals examined their safety status and closed the gap between their accident rates and those of other industries.[67] The problem was significant enough that regulations have been established through agencies such as the Joint Commission on Accreditaton of Hospitals, Federal Social Security Safety Law and the Occupational Safety and Health Act (OSHA) of 1970. Thus, the hospital's responsibility to protect patients, visitors and employees became a legal as well as a moral responsibility.[68]

The development of safety programs for hospitals paralleled other developments in the hospital sector. For example, it was during this time period that work had begun on standardizing acceptable practices for hospitals. This work eventually culminated in the organization of the Joint Commission on Accreditation of Hospitals (1953). Safety practices had been acknowledged prior to this time but had been largely part of the employee's or professional's training program. Now, however, there was acknowledgment that safety was a legitimized issue and one that the hospital administration must concern itself with.[69]

One of the early problems experienced in promoting safety programs was motivating the patient, the employee and the visitor to practice safe habits.[70] To some degree, the attitudes and practices of these individuals remain a problem, today. Thus, the problems and the advances with each group will be discussed briefly.

2. Patient Safety

The patient is the main factor in the safety program of a hospital since the system is built around the patient's incapacity.[71] Many studies have shown that the greatest patient hazard in the hospital setting is related to falls.[72],[73],[74] Other types of problems that directly affect patients or patient care include defective electrical and mechanical devices, administration of medications and treatments, transportation and identification procedures. Special considerations must be given

to pediatric and mentally disoriented patients.[75],[76],[77] Up until 1973, the literature was sparse in reference to hospital safety. Much has been written since, and patient safety through accident prevention is a recognized objective for hospitals.[78]

Initially, patient safety programs were directed at employees. That is, the emphasis was on reducing patient injuries through employee actions.[79] This approach failed to recognize the patient's behavior and response to the hospital environment. In more recent years, the staff are encouraged, where appropriate, to orient the patient to safety practices.[80]

3. Employee Safety

Studies of employee accidents in hospitals indicate that falls and improper lifting of heavy objects or patients account for two-thirds of the more serious disabling injuries.[81],[82] The remaining accidents involve electricity, moving machinery, transportation, incorrect use of tools and improper handling of equipment, explosive gases and flammables.[83] A study by the National Institute for Occupational Safety in Health (NIOSH) determined that less than eight (8) percent of the participating hospitals had inferior and ineffective occupational Safety and Health programs for their employees despite the fact that OSHA was seven years old.[84] An additional concern in recent years has been the effect of stress on the hospital employee.[85],[86] The problem areas in employee safety have been recognized. One of the challenges for administrators and employee representatives

continues to be determining what strategies would best overcome the problems.[87,88,89]

Once again, a major factor in the success of any program established is the compliance rate. No amount of rules, regulations or guidelines will motivate the employee unless there is a positive interest to conform with them.[90] In motivating employees to perform safely, attitude, acceptance and enthusiasm for the subject are critical to the whole process.[91]

The foregoing comments relate to all hospital employees. In addition, many of the health professional associations have established standards by which safety to practice issues are monitored.

4. Visitor Safety

On an around-the-clock basis, the hospital is entered by many visitors to every department and to virtually every room.[92] The visitors are a broad but identifiable group that the hospital staff have minimal contact with - and thus are difficult to forewarn, reprove or reprimand for failure to respect established safety codes. Visitors are highly susceptible to injury, either through their own negligence or unfamiliarity with safety standards or through the negligence of hospital employees.[93]

The visitor can be an unsuspecting victim of the hazards inherent in a hospital environment. He simply does not know, he is not motivated to think "safety." In many cases, he may be preoccupied with the reason for his visit to the hospital. That is why a visitor safety program should provide a broad base

covering both internal and external (anywhere on hospital grounds) areas. It is well to remember that this type of visitor protection plan also protects patients and employees.[94] A comprehensive protection plan would provide consideration for grounds, emergency areas, entrances, auxilary buildings, construction sites, smoking areas, stairs, corridors and floors, cafeteria, and elevators.[95]

5. Special Problem Areas:

Fire is a hazard that confronts every industry. However, the fact that one survey demonstrated that there were fifteen hospital fires occuring each day in the United States points to the severity of the problem.[96] The two leading causes of hospital fires were, unsurprisingly, smoking and electricity - both preventable. At this time, fire prevention is a moral obligation ... and a voluntary process under JCAH standards. In addition there may be statutory regulations that dictate such things as the use of sprinklers or fire detection devices, number and description of fire exits and the use of fire-resistant construction materials.[97]

The very nature of the hospital's business presents two additional problems that are generally uncommon to other industries. Microrganisms of various types are easily transmitted in the hospital environment. Thus, most hospitals have adopted minimal standards of infection control that are recommended by JCAH.[98] Once again, the danger of exposure is to patients, staff

and visitors. Finally, one of the unpredictable events in life are disasters and hospitals must be prepared to deal with the results. Thankfully, disaster plans rarely have to be activated. However, because it is often a question of "when", hospitals are encouraged to formally plan and to test their plan for its effectiveness.[99]

From the preceding discussion, the hospital can be viewed as a "warring zone" with potential dangers for anyone who dares enter its borders. However, it is also known that prevention and preparedness help to reduce the dangers and hazards. Safety programs have become more sophisticated and comprehensive with the development of such organizations as the National Safety Council and NIOSH. A key factor that came out of the discussions is the problem of keeping the individuals (patients, employees and visitors) enthusiastic, motivated and educated in safety practices. Although, patient, employee and visitor groups and some unique problems were discussed, it is recommended that a comprehensive safety program be conducted by all employees and for everyone. The program must deal with the problems of the entire facility - not with certain trouble areas, or with certain people. It must encompass every employee, every patient, and every visitor if it is to be successful.[100]

6. Relationship to Risk Management

Legal and financial activities can be the outcome of people-related, safety and security problems. Individuals with

safety and security responsibilities must choose the specific procedures that will assist in meeting the needs of the hospital and the people who enter it. Ideally, the process of planning a safety program follows the process of Risk Management. In point of fact, safety and security conciousness may be the vehicle by which Risk Management can achieve its objectives. To neglect or downplay this function is to invite legal action and financial loss.

CHAPTER III FOOTNOTES

Section A

[1]J. Orlikoff, Wm. Fifer, H. Greeley, Malpractice Prevention and Liability Control for Hospitals (Chicago: American Hospital Association, 1981), pp. 5-18.

[2]Ibid.

[3]Ibid, pp. 17-24.

[4]A. Southwick, The Law of Hospital and Health Care Administration (University of Michigan: Health Administration Press, 1978), Chapter 1.

[5]Ibid.

[6]Ibid.

[7]Ibid.

[8]H. Green, "The Role of Law in Determining the Acceptability of Risk," in Societal Risk Assessment: How Safe is Safe Enough? ed. by R. Schwing and W. Albers (New York: Plenum Press, 1980) pp. 255-267.

[9]Ibid.

[10]Southwick, The Law of Hospital and Health Care Administration Chapter XII.

[11]Ibid.

[12]Ibid.

[13]R. Mehr and B. Hedges, Risk Management: Concepts and Applications (Homewood, Illinois: Richard D. Irwin Inc., 1974) Chapter 9.

[14]Ibid.

[15]Greater Washington, D.C., Area Council of Senior Citizens v. District of Columbia, 406 F. Supp. 768 (1975).

[16]SouthHighlands Infirmary v. Camp, 180 So 2d 904 (Ala. 1965).

[17]Darling v. Charleston Community Memorial Hospital, 211 N.E. 2nd 253 (III. 1965).

[18]Foley v. Bishop Clarkson Memorial Hospital, 173 N.W. 2d 881 (Nebr. 1970).

[19]Parker v. Port Huron Hospital, 105 N.W. 1 (Mich. 1960).

[20]D. Warren, Problems in Hospital Law (Germantown, Maryland: Aspen Systems Corporation, 1978), Chapter 7.

[22]Ibid.

[23]Southwick, The Law of Hospital and Health Care Administration, Chapter XII.

[24]A. Salmon, "A System Approach Can Ensure High Quality Care and Low Costs", Hospitals, March 16, 1979, p. 53.

[25]International Hospital Federation, United States Presentation to the International Seminar on Hospital Liability, Lyon, France, April 24-25, 1981.

[26]A. Salmon, "A System Approach Can Ensure High Quality Care and Low Costs", pp. 53 & 79.

[27]Orlikoff et al., Malpractice Prevention and Liability Control for Hospitals, p. 21.

[28]Southwick, The Law of Hospital and Health Care Administration, Chapter XII.

Section B

[29]V. Sidel and R. Sidel, A Healthy State: An International Perspective on the Crisis in United States Medical Care (New York: Pantheon Books, 1977) 104.

[30]U.S. Department of Health, Education, & Welfare, Trends Affecting the U.S. Health Care System, Cambridge Research Institute, Pubs. HRA 76-14503. (Germantown, Md. Aspens Systems Corporation, 1976), p. 151.

[31]S. Williams and P. Torrens, Introduction to Health Services (New York: John Wiley & Sons, 1980), p. 289-291.

[32]Ibid.

[33]Ibid.

[34]S. Jonas et al, Health Care Delivery in the United States (New York: Springer Publishing Company, 1977), Chapter 7.

[35]Ibid, Chapter 9.

[36]Ibid.

[37]H. Berman and H. Weeks, The Financial Management of Hospitals, 3rd edition (Annarbor: Hospital Administration Press, 1976), Chapter 4.

[38]Ibid.

[39]Williams and Torrens, Introduction to Health Services, Chapter 5.

[40]Ibid.

[41]Warren, Problems in Hospital Law, Chapter 14.

[42]Ibid.

[43]Ibid.

[44]Ibid.

[45]U.S. Department of Health, Education and Welfare, Trends affecting the U.S. Health Care System, p. 137.

[46]Williams and Torrens, Introduction to Health Services, Chapter 10.

[47]Ibid.

[48]Ibid.

[49]Berman and Weeks, Financial Management of Hospitals, Chapter 6.

[50]U.S. Department of Health, Education and Welfare, Trends Affecting the U.S. Health Care System, p. 137.

[51]B. Brown, Risk Management for Hospitals (Germantown Aspen Systems Corporations, 1979), p. 108.

[52]V. DiPaulo, "Risk Management: Spiraling Premiums Predicted," Modern Health Care, (December, 1979), pp. 56-62.

[53]J. Orlikoff, Wm. Fifer, and H. Greeley, Malpractice Prevention and Liability Control for Hospitals (Chicago: American Hospital Association, 1981), p. 29.

[54]American Hospital Association, Manual on Insurance for Hospitals and Related Health Care Facilities (Chicago: AHA, 1965), Chapter 1.

[55]Warren, Problems in Hospital Law, Chapter 14.

[56]Mehr and Hedges, Risk Management: Concepts and Applications, Chapter 6.

[57]American Hospital Association, Manual on Insurance for Hospitals and Related Health Care Facilities, Chapter 1.

[58]Orlikoff, et al., Malpractice Prevention and Liability Control for Hospitals, Chapter 4.

[59]International Hospital Federation, Proceedings from International Services on Hospital Liability, Lyon, France, April 24-25, 1981.

[61]Orlikoff et al, Malpractice Prevention and Liability Control for Hospitals, Chapter 4.

[62]Mehr and Hedges, Risk Management: Concepts and Application, Chapter 6.

[63]Orlikoff et al, Malpractice Prevention and Liability Control, Chapter 4.

Section C

[64]G. Newman, "Basic Elements of a Loss Control Program," Hospital Progress, (November, 1974), pp. 46-49.

[65]American Hospital Association and National Safety Council, Safety Guide for Health Care Institutions (Chicago: American Hospital Association and National Safety Council, 1972), Chapter 1.

[66]C. Oppman, "Staff Training Vital For Risk Management," Hospitals, (December 16, 1979), pp. 95-98.

[67]American Hospital Association and National Safety Council, Safety Guide for Health Care Institutions, Chapter 1.

[68]Ibid.

[69]R. Bond and N. Vick, "Historic and Administrative Aspects of Environmental Health and Safety in Health Care Facilities," in Environmental Health & Safety in Health Care Facilities, ed. by R. Bond, G. Michaelson, and R. DeRoss (New York: McMillan Publishing Company, 1973), pp. 2-25.

[70]American Hospital Association and National Safety Council, Hospital Safety Manual (U.S.A. American Hospital Association and National Safety Council, 1954), pp. 27-31.

[71]R. Waite, "Hospital Safety Needed," Journal of Environmental Health, (November/December, 1969), p. 124.

[72]American Hospital Association and National Safety Council, Safety Guide for Health Care Institutions, Chapter 6.

[73]_____" 'Bed bugs' help patients," Hospitals, (July 1, 1975), p. 33.

[74]P. Sehested and T. Severin-Neilson, "Falls By Hospitalized Elderly Patients: Causes and Prevention," Geriatrics, (April, 1977), pp. 101-108.

[75]American Hospital Association and National Safety Council, Safety Guide for Health Care Institutions, pp. 73-96.

[76]V. Simpson, "Safety and Security: Annual Administrative Review," Hospitals, (April 1, 1974), pp. 97-101.

[77]W. Regan, "Patient who Fell into Convex Wall Mirror Sued Clinic," Hospital Progress, (March, 1978), pp. 32-37.

[78]R. Brandt, "Accident Prevention: The Past Holds the Key to the Future," Modern Hospital, (July, 1973), p. 98.

[79]American Hospital Associationand National Safety Council, Hospital Safety Manual, pp. 71-82.

[80]American Hospital Association and National Safety Council, Safety Guide for Health Care Institutions, pp. 73-96.

[81]_____, "Study Says Hospitals Neglect Their Employee's Health, Safety", Hospitals, Aug. 16, 1975, pp. 114-115.

[82]American Hospital Association and National Safety Council, Safety Guide for Health Care Institutions, pp. 59-71.

[83]Ibid.

[84]I. Shepard, "Hospitals Aren't Safe Enough", Hospital Progress, November, 1977, pp. 85-87.

[85]G. Calhoun, "Hospitals are High Stress Employers", Hospitals, June 16, 1980.

[86]R. Smith, "Those People Aren't People Anymore...," Hospital Topics, (November/December, 1979), pp. 14-15.

[87]E. Bertz, R. Monda, J. Sprague, "Viewing the Hospital as a Working Environment," Hospitals, (October 16, 1976), pp. 107-112.

[88]J. Morgan and P. Wozniak, "Reducing Direct and Indirect Losses," Hospital Progress, (November, 1977), pp. 88-89.

[89]M. Brown, "Hazards in the Hospital: Educating the Workforce Through the Union," American Journal of Public Health, (October, 1979), pp. 1040-1043.

[90]American Hospital Association and National Safety Council Safety Guide for Health Care Institutions, pp. 13-27.

[91]Ibid.

[92]American Hospital Association and National Safety Council, Safety Guide for Health Care Institutions, pp. 45-56.

[93]Ibid.

[94]W. Regan, "Safeguards at Construction Site Protect Hospital from Liability," Hospital Progress, (July, 1979), pp. 28-30.

[95]American Hospital Association and National Safety Council, Safety Guide for Health Care Institutions, pp. 45-56.

[96]Ibid, pp. 185-208.

[97]Ibid.

[98]E. Bertz, R. diMonda, J. Sprague, "Viewing the Hospital as a Working Environment,".

[99]V.E. Simpson, "Safety and Security: Annual Administrative Review,".

[100]American Hospital Association and National Safety Council, Safety Guide for Health Care Institutions, pp. 8, 9.

CHAPTER IV

SELECTED ORGANIZATIONAL ASPECTS

In the previous two chapters, two paradigms were introduced (Figure Two and Figure Three) that described different aspects of Risk Management. In each of these paradigms, the organizational aspects were treated differently than the legal, financial and safety/security aspects. This was planned for two reasons:

1. The organization is unique and the differences can affect the implementation of Risk Management.
2. The other three aspects act upon the organization and are highly interdependent within the organization.

However, the discussion on organizational aspects will follow a pattern similiar to that seen in the previous chapter. First of all, the evolution of the modern hospital brought with it characteristics that even today, make the organization different from organizations in other industries. Secondly, the attitudes and actions, both internal and external, can potentially have a great impact on the hospital's operations. These issues will be discussed in the context of an organization striving toward meeting the needs of the society it serves. Finally, Risk Management will be discussed in terms of an administrative response to the growing demand for accountability and control.

A. The Hospital as a Corporation*

The historical background of the American hospital was

* Since the majority of hospitals are voluntary, not-for-profit, discussion is limited to this type of hospital.

discussed in Chapter II and need not be repeated here. However, it is important to re-emphasize the role of the medical profession in the development of the modern hospital.

What follows is a description of the modern hospital. A general (acute care) hospital is an organization that mobilizes the skills and efforts of a number of widely divergent groups of professional, semiprofessional and nonprofessional personnel in order to provide a highly personalized service to its patients.[1] Although it may define other objectives, the hospital's chief and singular concern is the life and health of its patients. In general, the hospital's objectives tend to be more abstract than those of other industries.[2] However, because of its uniqueness, it is clear that the hospital, as a corporate organization, has certain duties toward the public it serves.

As an organization, the hospital relies upon an extensive division of labor among its members, upon a complex organizational structure which encompasses many different departments, staffs, offices and positions, and upon an elaborate system of coordination of tasks, functions and social interactions.[3] All of these factors make the individuals working within the hospital highly dependent on each other and necessitate heavy reliance for coordination of activities on a voluntary, informal and expedient basis.

The hospital is very much a labor-intensive, human system. It has developed into a quasi-bureaucratic organization that relies upon formal policies, formal written rules and regulations and formal authority for controlling the behaviour and worker

relationships of its members.[4] The authoritarian nature of the hospital is one of its distinct characteristics and is deemed necessary in order to mobilize resources in times of crises or emergencies. Therefore, lines of authority and responsibility should be clearly drawn. Simultaneously, basic acceptance of authority has to be assured and discipline has to be maintained.[5]

In reality, the lines of authority are anything but clear. During the developmental period of the American hospital, it became evident that two lines of authority-lay and professional-exist in the hospital.[6] Most hospital organization charts do not reflect the true influence of the professional medical staff. The dual authority issue is often a source of conflict and frustration when administrative (hierarchial) concerns overlap professional (functional) concerns.

This conflict has been heightened post 1965 with more government involvement in health care, increased expectations and demands by the public and the critical pressures from ever-rising health care costs.[7] As a result, a "management revolution" occurred with enormous pressure for greater accountability by health care organizations for increased efficiency--that is, quality care at less cost. To complicate the issue, authority is also shared to some degree by the governing body (board of trustees). Thus, the power base in the modern American Hospital is shared (unequally) and fragmented into what is commonly known as the "troika".[8]

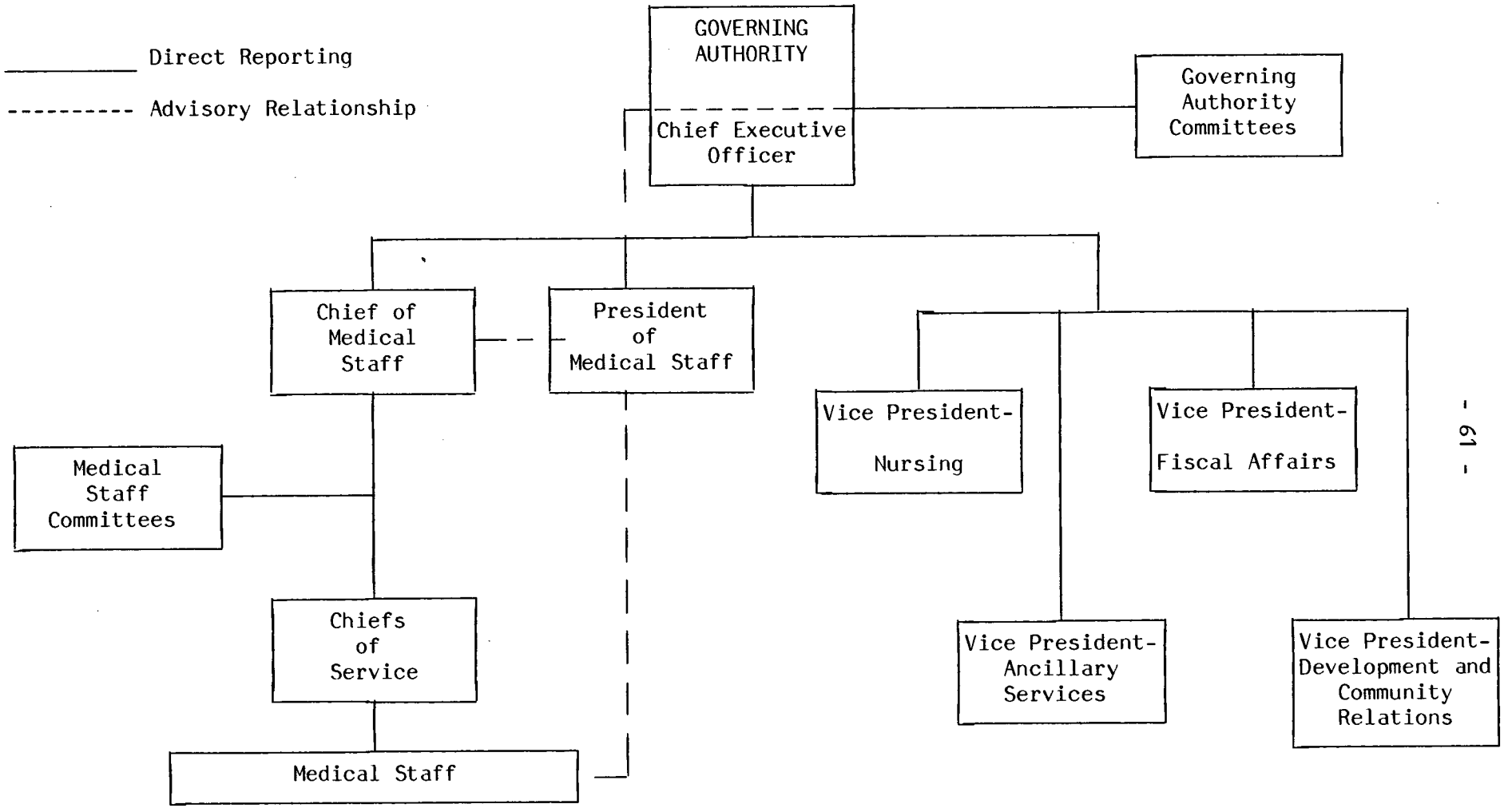
Recently, many hospitals have been adopting a corporate

organizational model. (See Figure Four) In this form, the governing authority delegates power to the chief executive officer (CEO) who is responsible for all activities within the hospital, including medical care. Although, this may be desirable administratively, it ignores the influence of the medical staff and is unlikely to be fully accepted by them.[9]

With the courts declaring the hospital, through its governing authority, as responsible for the medical practice rendered, it is inevitable that there will be increased control on what physicians do in the hospital setting. Even with the corporate structure, and administrative intrusion into medical activities, it is anticipated that the troika will remain as a dominant characteristic of the American hospital.[10] However, one of the concerns about this authority structure is that the relationships and power bases within the troika are always in a negotiable state. As a result, the hospital is left, on a day-to-day basis, with no legal or organizational means of controlling the services that it was set up to render.[11] Ultimately, this has the potential to effect the accountability of the hospital (as a corporation)--the very thing for which there are both increased demands and expectations. Since this authority structure can be so volatile, the roles and relationships of the troika will be discussed following a brief description on how the hospital corporation is formed.

The hospital is designated as a corporation following the issuance of a charter by the state. It possesses only those

FIGURE FOUR
HOSPITAL ORGANIZATION
EVOLVING CORPORATE STRUCTURE



Source: With permission of:
J. Rakich and K. Darr, editors
Hospital Organization and Management: Textbook and Readings
(New York, Spectrum Publications Inc., 1978), p. 6.

powers that are granted by virtue of the statute under which the corporation is formed. Some states have general incorporation laws pertaining to non-profit institutions which are quite separate from laws governing charitable institutions. Non-profit institutions do not require a membership to perpetuate their governing boards. In a non-elective type of corporation, members of the board may select new members. In a membership type of corporation, members elect the governing board-and in some instances this could be a nonmember.[12]

Board of Governors

The board members are the bridge between the hospital and the local community. Legally and morally, the board has the ultimate responsibility and authority for operation of the hospital. Their functions include determining policies with relation to community needs, maintaining proper professional standards through appointment and review of medical staff, coordinating clinical professional interests with the adminstrative, financial and community needs, providing adequate financing and control of expenses, keeping fully informed on hospital matters and selecting an administrator for the hospital.[13] The degree of supervision over adminstration varies, but generally board members do not become involved with routine operational matters. The board deals chiefly with the adminstrator and medical staff. In both cases, the relationship can be strained by the problem of lay versus

expert authority.[14] Another important issue in hospital governance is the absence of clearly-established standards of conduct that members of the board should demonstrate to properly perform their duties and avoid liability.[15] This issue reflects itself in the board's ability to assess the nature and limits of its institutional accountability.

The Administrator

The administrator is formally responsible to the sponsors of the organization (ie. the board of goverors). His/Her function is to "manage" the hospital. In this role the administrator is expected to create and adhere to a set of objectives, to attain and distribute economic resources efficiently, to utilize human resources and to facilitate change within the hospital setting.[16] He/She must work for and along with the hospital board members to whom he/she are accountable. The administrator must also be able to work with and gain cooperation of the medical staff. When the board members hire and set conditions of employment for administrators and when physicians direct the hospital's financial future by controlling patient admissions and discharges, it is often the administrative leverage that is lost during a major conflict of the troika.[17] Because of the subleties in medical staff and board member relationships, the greatest skill an administrator can develop is the art of developing rapport with others.

The Medical Staff

The medical staff is the organization of physicians who have appointments to admit and treat patients in the hospital. Accreditation standards require that the physicians be "organized" and have overall responsibility for the quality of all medical care provided to patients. They must monitor the ethical conduct and professional practices of their members and be accountable to the governing board.[18] In this respect, they must establish medical staff bylaws, rules and regulations in order to maintain a framework for self-government. The Chief of Staff (appointed by the board) has the responsibility for enforcing medical staff bylaws. The President or Chairman of the medical staff is elected by the physicians and works closely with the Chief of Staff. Undoubtedly, the greatest single factor that can affect the smooth operations of a hospital is the type of working relationship developed with the medical staff. For this reason, there has been a move toward providing increased participation by physicians in the organization's management.[19]

B. Selected Environmental Influences

Other Professional Groups

One of the important underlying purposes of a hospital is that it provides a base that allows for career opportunities for its employees and medical staff.[20] Many of the other groups employed within the hospital are struggling for professional status (nursing, pharmacy, technologists) and undoubtedly, this

produces additional stress on an organization with an already fragmented power base.[21] In addition, it has been suggested that the specialization and proliferation of health "professionals" has led to a substantial misunderstanding of the roles, functions and qualifications of these groups.[27] In turn, this can affect the use, cost and ability to control the quality and mobility of these health care workers. A conflict between the aspiring or established professional group and administration often arises if administration attempts to place controls on a group that considers itself capable and responsible for "practice" issues. One of the weapons used against the employer to address this issue is unionism.

Unions

Whether the group is professional or nonprofessional, the union objectives remain similar. Unions are concerned with socio-economic issues such as wages, security and the work environment.[23] The professionals are particularly concerned that they have the weight to carry out professional judgments in the areas of standard, performance and quality of services that they themselves provide.[24] This by itself is not a problem and considering the specialization of the groups appears quite justifiable. However, the cumulative effect to define standards, performance and quality by several unions, often in competition with each other, can be costly to the hospital organization. In the United States a hospital is an organization that has an uncertain revenue

base and is guided by federal government controls and third party reimbursement schemes. Add to this the administrative cost to the hospital for each of the group's preferred method of monitoring quality and standards, and it is no wonder that the American hospital industry fears the cost of unionism. Approximately twelve (12) percent of American hospital workers are organized. Hospital unionization has the potential to place additional pressure on an organization that already has a fragmented authority/power structure and difficulty in maintaining credibility with a public which increasingly questions its accountability.

C. Risk Management: A Response by the Hospital Organization

As noted in Chapter II, during the latter part of this century both the American hospital and its problems became more visible to the general public. Concurrently, the era of consumerism and demand for health care as a right came to the forefront. Given the enormity and variety of pressures the hospital organization was being confronted with, it had little in the way of alternatives when trying to demonstrate that it was doing everything reasonable to provide safe, good care at a reasonable cost. One of the popular alternatives during the 1970's became Risk Management - a process designed to eliminate claims against a hospital (and financial loss) by attempting to prevent incidents that could result in personal injury, property damage or other form of harm.

Risk Management can also be designated as a control process. (Figure II) Theoretically, a control process is technical in nature and focuses on monitoring the organization's activities or operations for it is believed that the gathering and utilization of resources should result in the accomplishment of predetermined objectives. The controlling process entails such actions as determining standards against which the organization's resultant activity can be measured, establishing techniques for measurement and establishing methods for taking corrective action.[25] Historically, these tasks have been difficult for the hospital because "the product" is, in fact, a service. However, this does not mean that the process is impossible, nor should it be ignored. The investigation of the legal duties (of the hospital), the fiduciary responsibility of the board and the accountability of the key actors (the troika), along with other developments outlined in the previous chapters, point out the need for an effective control process. Risk Management was one of the alternatives available and one the hospital introduced on its own initiative. This method of self-regulation fitted well with the American ideology of liberty and free enterprise. Its effectiveness and scope are yet to be determined.[26]

CHAPTER IV FOOTNOTES

[1] B. Georgopoulous and F. Mann, "The Hospital as an Organization," in Patients, Physicians and Illness, 3rd ed. by E.G. Jaco (New York: The Free Press, 1979) pp. 296-305.

[2] L. Ranta, Health Law Class, University of British Columbia, April 6, 1982.

[3] Georgopoulous and Mann, "The Hospital as an Organization."

[4] Ibid.

[5] Ibid.

[6] H. Smith, "Two Lines of Authority: The Hospital's Dilemma," in Patients, Physicians and Illness, ed. by E. Jaco (New York: The Free Press, 1958) pp. 468-477.

[7] J. Rakich, B. Longest and T. O'Donovan, Managing Health Care Organizations (Philadelphia: W.B. Saunders Company, 1977), pp. 1-14.

[8] J. Rakich and K. Darr, eds., Hospital Organization and Management: Text and Readings (New York: Spectrum Publication Inc., 1978), pp. 1-13.

[9] Ibid.

[10] Ibid.

[11] Rakich, Longest, O'Donovan, Managing Health Care Organizations, pp. 183-194.

[14] T. Burling, E. Lentz, R. Wilson, "The Board of Trustees," in Hospital Organization and Management: Textbook and Readings, ed. by J. Rakich and K. Darr, pp. 75-83.

[15] L. Prybil and D. Starkweather, "Current Perspectives on Hospital Governance," in Hospital Organization and Management: Textbook and Readings, ed. by J. Rakich and K. Darr, pp. 84-89.

[16] Rakich, Longest and O'Donovan, Managing Health Care Organizations, pp. 183-194.

[17] E. Johnson, "The Lessons of a Profession," in Hospital Organization and Management, ed. by J. Rakich and K. Darr, pp. 117-123.

[18] Joint Commission on Accreditation of Hospitals: Accreditation Manual (Chicago: JCAH, 1973).

[19]Rakich, Longest and O'Donovan, Managing Health Care Organizations, p. 194.

[20]J. Stoner, Management, (Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1978) p. 10.

[21]R. Schulz and A. Johnson, Management of Hospitals, (New York: McGraw-Hill Book Company, 1976) pp. 90-126.

[22]Ibid.

[23]Ibid, pp. 237-254.

[24]D. Matlock, "Goals and Trends in the Union of Health Professionals," Hospital Progress, (Feb. 1972), pp. 40-43.

[25]Stoner, Management, p. 565-589.

[26]J. Orlikoff, W. Fifer, & H Greely, Malpractice Prevention and Liability Control for Hospitals, (Chicago, American Hospital Association, 1981) p. 34.

CHAPTER V

COMPARISON OF MAJOR CONSIDERATIONS TO CANADA, BRITISH COLUMBIA

In order to determine whether there is a need for British Columbia Acute Care Hospital Administrators to move toward Risk Management, one must go beyond describing the motivating variables in the United States and speculating whether they are or are not applicable in Canada or particularly in British Columbia. The next step, and the theme of this chapter is to address the same considerations-legal, financial, safety/security, and organizational-but in the Canadian context. Where it is required, or reasonable, specific reference is made to the situation in British Columbia. The format will be much the same as that seen in Chapters III and IV except that, the similarities and differences between the Canadian hospital and its American counterpart will be emphasized. In addition, there is no discussion on the relationship to Risk Management. This approach will aid the reader in interpreting the significance of the results of the case study and the conclusions in the subsequent chapters.

A. Selected Legal Aspects

In Chapter II, it was noted that British Columbia (possibly, most Canadian provinces), had the potential to experience an increase in hospital related liability claims. That there are similarities in the historical developments of the Canadian and American hospitals is not surprising. For many years

they shared a common base within the Hospital Association of the United States and Canada. Although this organization eventually split into two separate entities, both Associations' members have continued to share their knowledge and experiences though journals and combined conferences and seminars.

One of the major differences between the two countries is their respective legal systems. This section begins with a description of some of the (few) similarities and outlines the impact of statutory law (the major difference). The two "legal aspects" that so affected the future and operations of the American hospital will be discussed in the Canadian (particularly British Columbia) context. These include changes in the law and public attitudes/values toward litigation.

1. Basic facts about the Canadian legal system

Superficially, the American and Canadian legal systems share a few similiarities. Both systems include public and private law, the latter also developing historically through judicial decisions based upon the principles of English common law and supplemented by statute law.[2] Both systems use a hierarchial approach to make binding the decisions of higher courts. However, the similarity ends there.

In Canada, the primary source of law is statutory - an act of the Parliament of Canada or of a Provincial Legislature.[3] Through the provisions of the original British North American Act (B.N.A.) of 1867 and retitled the Constitution Act, 1867 in

the Constitution Act, 1982, the divisions for legislative authority were established. In this manner, Health (and hospitals) became primarily a provincial matter. In addition, "subordinate legislation" in the form of bylaws, ordinances, statutory instruments, orders-in-council, rules and regulations may be enacted by a person, body or tribunal granted the authority through a sovereign legislative body.[4]

Under the British doctrine of parliamentary sovereignty, Canadian legislatures can make or unmake any laws, provided they do so in accordance with the limitations set out in the Constitution Acts.[5] In turn, this affects the relationship between statutory and common/case law. First, Parliament has the authority to repeal or modify any principles set out in case law. Secondly, much of common law is developed through adjudication of new fact situations and interpretation of existing statutory provisions.[6]

Other, less significant, sources of law include the royal prerogative that is exercised through the Governor-General of Canada or Lieutenant-Governor of a province. An example of this practiced in some provinces is tortious immunity for the Crown. Custom and convention, morality and juristic writings of scholars are additional, miscellaneous sources of law.[7]

The province of British Columbia acquired English law through the early settlement by the Hudson's Bay Company. However, the Law and Equity Act, R.S.B.C., 1979, c. 224, expressly provides for the reception of English law as it existed on

November 19th, 1858. Of course many statutes have been added or changed since that date. Those significant to the British Columbia hospital industry are*:

Hospital Act, RSBC, 1979, c. 176
Hospital District Finance Act, RSBC, 1979, c. 179
Hospital Act Regulations, Amended, 1979
Hospital Insurance Act RSBC, 1979, c. 180
Limitations Act, RSBC, 1979, c. 37
Medical Practitioners Act, RSBC, 1979, c. 254
Societies Act, R.S.B.C., 1979, c. 390

Early Canadian hospitals, as charitable institutions, had inherited some protection against liability through English common law. This protection ended in 1909 when an English Court of Appeal concluded that a hospital had certain undertakings toward the patient. The charitable status was never tested in the Canadian courts.[8] As in the United States, Medical Practioners' Acts (RSBC, 1979, c. 254 as example) allow only a person to be registered for the practice of medicine. A hospital cannot be licensed to practise medicine, only to provide medical services.

2. The changing law

Similar to the American situation a patient in Canada may be in a position to take legal action against a hospital on a contractual or tortious matter providing that a duty of care (to the patient) is established and has been violated in some manner.

A duty of care is found where there is a relationship

---

*Some specific notations in relation to these Acts and other legal aspects are made in Appendix B.

between the parties such that each is required to avoid acts or omissions which could be foreseen as likely to injure the other. In Canada, duties may be created through statutes (eg. Hospital Act), hospital bylaws and regulations of professional bodies.[9] To date, the following precedents have been established as direct duties of a hospital to a patient:

1. to select competent and qualified employees
2. to instruct, and supervise them
3. to provide proper facilities and equipment
4. to establish systems necessary to the safe operation of the hospital.[10]

One authority on hospital law states that the key factor in establishing duty and the patient-hospital relationship is to determine what the hospital undertakes to do for the patient. However, this factor is also the major difficulty in applying tort and contract theories of law. Today, there is still uncertainty in Canada as to which of two things a hospital is obliged to provide: 1. medical treatment, or 2. competent medical staff and appropriate supervision.[11] Thus far the most significant Canadian case related to legal duty has been **Yepremian v. Scarborough General Hospital.** In this case a 17 year old man was taken to a doctor's office with a recent stated onset of polyuria and polydipsia and, subsequently diagnosed with tonsillitis. As his condition deteriotated, he was taken to the defendant hospital where he was examined by an emergency physician. Because of his comatose state he was admitted to intensive care and examined further by an internist. A day later, a nurses' observation led to the diagnosis of diabetes. However, the internist's treatment is believed to have led to Ypremian's cardiac arrest and resultant permanent brain damage. The question of medical negligence put aside, the trial court found the hospital liable for breach of duty because:

a. Yepremian had no freedom of choice on the matter of which hospital or which doctor would treat him.

b. The hospital by virtue of the provisions of the Public Hospitals Act had an obligation to provide service to the public and had the opportunity of controlling the quality of medical service.

c. The expectations of the public are that a hospital will provide a complete range of treatment.[12]

This decision was overturned in the appeals court and settled prior to a hearing at the Supreme Court of Canada level. The matter of legal duty had been briefly explored with no clear direction for interpretation. As will be seen in subsequent cases, the question and scope of legal duty (of the hospital) is at the base of most action suits against a hospital.

Historically, a hospital's direct liability to the patient was usually founded on the contract between it and the patient. Aside from express or written contracts, factors relevant to finding implied terms (of contract) include legislation, hospital by-laws and public expectations.[13] However, ascertaining terms and breaches in contract have been difficult and the courts appear reluctant to subject the hospital-patient relationship to a thorough, conclusive contractual analysis. Technically, the contract between hospital-patient is intertwined with the legal duties of the hospital. Contract actions generally have a substantially longer limitation period, and are less expensive to prove. However, the scope of liability is much broader in

Canadian tort law, and most actions against hospitals are in this area or a combination of contract and tort law.[15] The premises for tort and contract law violations are imbued in the determination of legal duties and standards of care. The Canadian courts look toward the "reasonable man" principle in determining what is an acceptable level of care. In addition, they will examine legislation, regulations, hospital by-laws and ask for evidence from accreditation and professional bodies. It is by no means an easy determination. The lack of clarity in these areas appears to have the potential for increasing the scope of hospital liability in Canada.

In Canada, the hospital has been viewed as a corporation with organizational duties and liable under the doctrine of corporate negligence since 1915.[16] The duties which are non-delegable, have been noted at the beginning of this section and need not be repeated. A key aspect of the theory of corporate negligence is that the relationship of the hospital and the professional is irrelevant. Where the courts have held that the hospital has a non-delegable duty, that duty arises and persists whether the corporation acts through independent contractors or through its own employees.[17] It, therefore, goes beyond the doctrines of vicarious liability (respondeat superior) and significantly broadens the base for hospital liability. In essence, it has been the decided cases supra 1915 that have established the legal duties of hospital corporations. Case examples that involve legal duty and/or corporate negligence include:

AYNSLEY V. TORONTO GENERAL HOSPITAL where the defendant hospital was held liable for not providing sufficient care and control over an anesthetist resident, thus, contributing to a patient's cardiac arrest and subsequent permanent brain damage.[18]

or

LAIDLAW V. LIONS GATE HOSPITAL where the hospital was held liable for the actions of two recovery room nurses. The staffing and break period for the defendent nurses contributed to a patient's respiratory distress and subsequent permanent brain damage.[19]or

MILLER V. UNITY UNION HOSPITAL where the hospital was sued but acquitted from a patient's allegations of sustaining severe injuries from slipping on "water spots" on the hospital hallway floors. The court held that the defendent hospital took reasonable precautions in attempting to prevent damage from an unusual danger.[20]

In MURPHY V. ST. CATHERINE'S GENERAL HOSPITAL, a hospital was held liable for the injury suffered by a patient when an intern, in giving an intravenous injection, severed the catheter leaving over nine inches of it in the patient's vein. It was found that the hospital was responsible for providing instruction, direction and supervision to its staff for the use of the Intracath ... and not having done so is negligence.[21]

The principles of Respondeat Superior or vicarious liability have been undergoing changes since 1942 when an English Court of Appeal held a hospital liable for a radiology technician

who negligently administered some grenz ray treatments.[22] From this time until the present, the question of vicarious liability for the professional, particularly the physician, within the hospital setting has been undecided. One legal authority suggests that the principle is antiquated and should have been extinguished and replaced with a more practical doctrine.[23] It does have a positive aspect in providing a means for shifting the burden of losses. Thus, in the Canadian courts emphasis has been placed on establishing a means to test for vicarious liability. In its application to hospitals, two tests have been established:

1. The control test asks whether the hospital has control over "how" the employee does a job. In the past, professionals were excluded from the control test. However, in YPREMIAN V. SCARBOROUGH GENERAL HOSPITAL, the control test was used, and the hospital was not liable for the actions of the named physicians.[24]

2. The organization test focuses on the "when" and "where" of the action. That is, it is significant to determine the relationship of the employee (full time or independent contractor) and to differentiate whether this person's work is an integral part of the organization or an accessory to it. However, it seems that neither test has been applied consistently or with totally satisfactory results.[25] The test is most crucial in legal actions involving medical malpractice. This is evident in HOSPITAL NOTRE DAME de l'ESPERANCE V. LAURENT where the courts at various levels followed different patterns of reasoning for the liability of the defendent hospital. In this case, a surgeon failed to properly diagnose and treat a fracture. At the Supreme Court of Canada

level, it was resolved that the hospital could not be held liable for the actions of medical staff who were in an independent contractor position. This decision was questioned by Justice Holland (at trial level) and Justice Blair (at appeal level) in the YEPREMIAN V. SCARBOROUGH GENERAL HOSPITAL.

The preceding discussion has made clear the fundamental difference between the American and Canadian legal systems, particularly in the area of legislative/statutory authority. In addition, the Canadian hospital has been legally recognized as a corporation since 1909. Even with these differences, the courts of both countries appear to confront the same type of issues for which there are no clear directions or answers. These include:

1. the scope of a hospital's legal duties.
2. the acceptable standards of care intertwined with legal duties.
3. the employment relationship between hospital-physician, and consistent application of respondeat superior.

3. The changing values

The extent of hospital related liability is unknown both from a national and provincial viewpoint. Hospitals are insured through private companies. Statistics need not be nor are they made public. In many cases, hospitals are served notice of writ along with the doctors. Therefore, statistics released by the Canadian Medical Protective Association (CMPA) may or may not be reflective of what is happening in the hospital industry (Table Six). There is no way of identifying those actions where hospitals were involved.

TABLE SIX
CMPA RECEIPTS, ACTIONS, EXPENDITURES
Selected Years, 1945-1979

YEAR	DUES $	NO. OF WRITS SERVED	AWARDS SETTLEMENTS	LEGAL COSTS	MEMBERSHIP
1945	5	9	nil	$ 6,216	3,367
1950	5	11	11,770 (4 settlements)	7,616	6,389
1955	20	11	54,864 (3 awards, 9 settlements)	21,056	8,983
1960	20	16	49,259 (1 award, 5 settlements)	23,755	12,243
1965	15	49	168,119 (3 awards, 12 settlements)	67,553	15,940
1970	35	80	223,951 (8 awards, 21 settlements)	238,818	21,959
1972	50	152	253,371 (4 awards, 29 settlements)	427,250	24,945
1974	50	168	896,858 (9 awards, 58 settlements)	766,916	29,096
1976	200	234	2,664,103 (7 awards, 64 settlements)	1,119,657	31,421
1978	200	323	1,280,861 (14 awards, 67 settlements)	1,455,587	32,175
1979	200	343	5,358,311 (17 awards, 92 settlements)	1,834,392	33,202

Source: Canadian Medical Protective Association
Annual Reports, 1955-1980.

One must look upon these statistics with a critical eye and remember that there is a four (4) to six (6) year lag from the time the writ is served to the time of settlement. It is difficult to ascertain what the range (in dollars) of the awards and settlements might have been. It is apparent that during the 1970's, more writs were served and settled at higher cost. It is likely that more Canadians are now willing to settle their personal injury/insult claims in the legal arena. However, precedents have been established by way of three (3) judgements delivered by the Supreme Court of Canada in 1978. The "trilogy" outlines principles to guide trial courts in the assessment of damages in personal injury cases. In this manner, $100,000 has been established as a maximum for non-pecuniary loss although it was acknowledged that this amount can and should be exceeded in exceptional cases.[28]

The lack of statistics and empirical data has not stopped subjective discussion regarding changing trends in hospital litigation. Notably, most of the discussion has come from the legal profession. Rozovsky, a leading spokesman in Canadian hospital law, has emphasized that a hospital's duty (to a patient) is determined by public expectaction. In turn, public expectations are formed by the services the hospital undertakes to provide for the patient. Clearly, he feels that the public "reasonably" expects the hospital to be the hub of health care services - services that are provided with "reasonable" standard and skill.[29] Another stresses that the modern patient has strong,

well-defined legal relationships with his hospital. If the hospital is in breach of the duties owed a patient, the hospital may be found to be in a position of reimbursing the patient for a wrongdoing.[30] Finally, an Ontario professor of law states that the grand age of consumer protectionism has not bypassed the hospital corporations. Segments of the Canadian legal community support expansion of civil liability and view hospital corporation as having deep pockets, well able to absorb financial losses.[31] There is also speculation about the potential fueling effect of the enshrined rights in the new Constitution Act.[32]

There are several major differences between the Canadian and American legal and health care systems. Amongst these differences, there are some common public reactions. Both Americans and Canadians have high expectations of what health care services should offer or bring to them, and both appear disillusioned with the breakdown in patient-hospital and patient-doctor relationships. Combined with a willing legal community, this can provide a fertile ground for potential litigation against a hospital. It is only recently that Canadian courts have come squarely to the crossroads of hospital liability.[33] At this time, it is not clear the direction they will take. Canadian, and particularly British Columbia courts of law have not been subject to the same type or frequency of experiences/changes as their American counterparts. However, it seems inevitable that changes (in law) will occur over the next decade that may effect the health consumer's potential to sue a

hospital and the hospital's immunity against these suits. In turn, this directly challenges the hospital's ability to defend the activities that occur within the hospital setting.

B. Selected Financial Aspects

Similarly to the United States, the debate about Canadian health care costs both nationally and provincially has increased in both scope and frequency. Whether Canada is in a crisis state is often a matter of opinion. Certainly, health costs as a proportion of GNP appears to have stabilized as can be noted in Table Seven. It is the yearly percentage growth (in absolute

TABLE SEVEN

HEALTH EXPENDITURES AS PERCENT OF CANADIAN GNP:
SELECTED YEARS 1960-1978

YEAR	1960	1971	1978
Total percent of GNP - to Health	5.62	7.3	7.0
To Hospitals	1.65	2.68	2.89
To Physicians	0.93	1.32	1.11

Source: R.G. Evans, Professor of Economics
University of British Columbia
Vancouver, B.C., 1981.

terms) that translates into millions of dollars that has the federal and provincial governments concerned about the cost of health care services.[34] This is especially true at a time of

declining revenues. As early as 1970, the insatiable demand of our health care system was recognized.[35] The various provincial governments have responded differently to the pressure of cost control. In British Columbia, the pressure began to become more evident in 1980 with an apparent attempt by the government in Victoria to gain better financial control within Health and other public spending sectors.[36] This has become more overt in recent months with Premier Bennett's announcement of a restraint program that would limit public expenditures to 10% per annum over the next two years. Hospitals continue to be a major target of any cost control efforts as they remain the most visible and most expensive of health care services.

Even though institutional service (primarily hospital) costs during the late 1970's were reduced from approximately 85 percent to 65 percent per health dollar, concern continues over the financing and the alternatives to institutional services that are supported by the provincial governments.[37] Considering that since 1964 and the Report of the Royal Commission on Health Services, provinces have steadily worked toward achieving the principles outlined in the Health Charter for Canadians, it is not surprising that the Canadian public's expectations for health services (particularly hospital services) are rightfully high. Subsequently, any government debate over cost control or cost sharing is as much political as it is financial. The stakes are high in both cases.

1. Revenue Sources for Hospitals

Today, acute care hospitals in Canada are non-profit, public or voluntary institutions. All of these hospitals receive payment from government for the services they provide. The method and nature of government financing for hospital services has changed dramatically over the past thirty-five years.

The government of Saskatchewan led the way for providing universal and compulsory hospitalization coverage with the introduction of the Saskatchewan Hospital Services Plan in January, 1947. British Columbia followed suit and implemented a similar plan in 1949. These plans were financed by premiums and provincial tax revenues. During the same period, the federal government had gained sufficient support to introduce National Health Grants which were to aid the provinces in health planning, hospital construction and professional training. This was followed by the Hospital Insurance and Diagnostic Services Act of 1958 which allowed for participating provinces to receive national funding in order to provide necessary inpatient services and facilities at the standard ward level. British Columbia was one of the five provinces that pressed for the program. Under this arrangement, the Government of Canada contributed, out of consolidated revenue, approximately fifty (50) percent of hospital operating costs based on a formula which gave special help to the poorer provinces. The provincial governments were responsible for the remaining costs and were also responsible for distributing the funds to the hospitals in their particular province.[38]

Insurance coverage for physician services was incorporated in 1967, and this ten (10) year delay is often cited as the major reason for the rapid escalation in hospital utilization and cost in the 1960's because patients came to hospitals rather than doctor's offices. Furthermore, the cost-sharing formula appeared to reduce the incentive to economize as provincial governments opted for programs that could be cost-shared with the Government of Canada and gave lesser priority to extended care and community oriented programs.[39] The increasing costs during the 1970's, particularly for hospital services, and beginning criticism of these public expenditures led to renewed financing negotiations which ultimately resulted in the Federal-Provincial Fiscal Arrangements and Established Programs Financing Act, (EPF) 1977. In general, the EPF Act allowed for a reduction in federal block grant, an increase in tax points for the provinces and a block grant for extended health services. The ultimate aims of these fiscal arrangements were to make federal expenditures more predictable, give more flexibility to the provinces in allocation of funds and to provide incentives for controlling health costs.[40] The EPF Act is currently being renegotiated and although it is unclear what type of changes will be made, it is a certainty that there will be changes to reflect the ever-present concern of hospital expenditures.

Since 1958, British Columbia hospital operating and capital costs (including building) have been covered primarily through government programs. In British Columbia, other sources of

revenue, that usually represent ten (10) percent of the total include monies received from the Worker's Compensation Board, Federal government and residents from other provinces. Revenues can also be generated through charges for private and semi-private accommodation, emergency and out patient services,cafeteria sales and services to other organizations.

There have been few successful regulatory controls in health and particularly hospital services. Bed closures, or closing of some institutions, and enforced budget allotments have been politically unpalatable. Furthermore, it has been difficult to measure hospital efficiency, to compare one hospital's performance against another or to decrease the impact of physician desires in the hospital setting. This along with monetary rewards for inpatient days and per diems reduces the effect of the few controls there are.[41] It appears inevitable, that as the health care crunch continues, existing controls will be enforced more consistently and/or newer, wider reaching controls will be implemented. It is also certain that, as the rhetoric on cost-control and individual responsibility continues, there is bound to be an impact on both the quantity and quality of hospital services available. To date, there have been no specified controls on quality or utilization comparable to the American scene. The controls, such as they are, have been enforced through the government holding the purse strings. Whatever the outcome of the current hospital crisis debate, the fact remains that hospitals are a big business in British Columbia. As such, they

have accumulated a wealth of resources (capital and manpower) over the years. They, like their American counterparts, have looked at various methods of protecting their assets and preparing for loss transfer through insurance management.

2. Insurance Management for Hospitals

The importance of obtaining a comprehensive insurance package for hospitals has been recognized for many years.[42] Especially since many early hospitals originated in what were once private homes, and with fewer fire regulations to adhere to, the probability of a fire occurring was quite high. Other concerns included public liability, theft and destruction of hospital property and damage to the boiler system.[43] The determination of the type and scope of coverage needed was managed by either the chief hospital clerk (smaller hospitals) or a committee with special skills in the insurance field that could review the alternatives available. Insurance coverage was to a degree optional, and the government had, quietly on occasion, provided the funding for a liability award.[44] Until the 1970's, most insurance brokerage firms handled insurance for hospitals with reasonably priced premiums. Suddenly, during the early 1970's hospital premiums increased rather rapidly and concurrently brokerage firms started to withdraw from providing coverage for hospitals. The reasons for this are unclear, although many in the industry believe it was a reflection of what was then happening in the United States.[45] British Columbia hospitals responded to this

by working together through the cooperation of the British Columbia Health Association (BCHA) and Marsh & McLennan Insurance to develop a comprehensive insurance package. The insurance program is voluntary and open to all member hospitals of BCHA. The program includes coverage for property, liability, crime, boiler & machinery, travel & volunteer accidents.[46] Each participating hospital, in consultation with Marsh & McLennan, determines the amount and scope of coverage required for their needs. Premiums are based solely upon size of hospital. Presently, there are no discussions regarding captive or self-insurance, nor is there any apparent need for them. Although Risk Management has been discussed at the BCHA level, it is primarily at investigating the educational role that can be undertaken. At this time, Marsh & McLennan has no intention of introducing a Risk Management option in Canada or introducing special rates for those hospitals that introduce formalized Risk Management Practices.

Insurance premiums for hospitals have remained relatively stable over the past five years. For example, the average cost of liability insurance per hospital increased 0.4% between March 1978 and March 1982 in the Marsh & Mchennen plan. This time period also demonstrated actual decreases for three successive years.[47] Unless claims settled increase rapidly or a trend toward hospital liability for professional medical malpractice develops, the premiums are expected to increase at a nominal rate. Evidently, insurance management for British Columbia hospital is not a major concern during this time period.

From a financial viewpoint, the resource structure between the American and Canadian hospital industries is quite different. Remarkably, the outcome of their efforts appears much the same. Both, are concerned with hospital costs, both are perceived as large, expensive and visible businesses, and both are struggling for more financial maneuverability within the restraints of government controls. Here, the United States appears to have more formalized enactments while the Canadians have comprehensive government control, largely interpreted through the provinces Hospital Insurance Act and Hospital Act. As was seen in the previous section, Canadians are willing to take legal action, although certainly not to the degree the Americans do so. Thus, although insurance management is important, it is not percieved as a problem in the Canadian context and the hospital industry has not actively had to look at alternatives.

C. Selected Safety and Security Aspects

The development of safety and security programs in Canadian hospitals is difficult to trace. There is no Canadian counterpart to NIOSH and little documentation that provides the historical, political and organizational perspective of changing trends in this area. However, this is not to say that safety and security measures/programs were, or are not, an issue.

Surveying old issues of Canadian Hospital, the official publication of the Canadian Hospital Association, gives some indication of what hospital administrators/trustees of the day

were concerned about. During the post war and reconstruction period, many articles appeared on the importance and implementation of both disaster and fire protection plans.[48,49,50,51,52] Fire protection was important because many of the hospitals were wooden frames and the fire regulations were less stringent. The impact of the atomic bomb initiated much of the disaster planning. Considering that hospital construction reached a peak during the 1950's, it was not surprising to see frequent articles on the new hospitals supplemented with articles outlining how to wash walls, care for floors, and equipment. The latter appeared to be more technical in nature rather than focusing on the inherent safety aspects. The 1960's proved to be a developmental period for hospital standards. Although the Canadian College on Hospital Accreditation was initiated in 1950 with assistance from the United States, Canadians did not assume full responsibility until 1959. Accreditation was encouraged and concern for safety procedures with a focus on patient care were outlined.[53,54,55,56] By 1970, approximately 62% of Canadian hospitals had entered the accreditation program. During the early 1970's, legal issues related to hospital service started to appear. Between 1973 and 1975, regular, monthly articles were appearing concerning the legalities of manufacturers' responsibility, licensure, theft, negligence and patient care issues.[58,59,60] The latter part of the 1970's returned to hospital standards issues with a focus on both patient care and employee practices and benefits.[61,62,63] In addition, quality

care and patient care issues are documented in the medical, nursing and other health care worker journals based from experiences in Canada, the U.S. and other countries. The impact of the hospital on the employee is more difficult to trace historically. However, it appears that changes have occurred concurrent with union organization and development, Worker's Compensation developments and general knowledge of stresses in the hospital environment that could affect employee performance. These type of issues .... standards, patient safety, employer safety and legal aspects continue to be important in the 1980's.[64],[65],[66],[67] Another equally important concern that has evolved over the past few years is the potential impact from advances in the health technologies.[68],[69]

With respect to safety and security programs, Canadian hospitals appeared to follow a similar pattern to the United States. Safety and security developments progressed with developments in other parts of the hospital sector. The accreditation bodies contributed a great deal to increasing standards. Other outside agencies -- government, WCB, Fire Protection, unions and professions appeared to have an influence on the industry as well. The process may have differed because of differences noted in other chapters of this manuscript. However, the problem for both countries is the same -- compliance with safety practices and attempting to make safety everybody's business.

D. Selected Organizational Aspects

The developments in the Canadian and American hospital industry very nearly paralleled each other. Structurally, the Canadian and American hospital share many similarities.[70] These will be outlined followed by a description of some of the differences.

In Chapter IV, the modern American hospital was described with emphasis placed on some of its unique characteristics. These same characteristics, which include an extensive division of labor in a labor-intensive industry, a semi-bureaucratic status and a fragmented authority structure that could effect the efficiency and effectivess of the organization, could very well describe the Canadian hospital. In addition, many British Columbia hospitals are converting to a corporate organizational model and are attempting to achieve active medical participation at the executive administrative level.

The Canadian hospital is also shaped by legislation and by the principles of corporate law.[71] However, in contrast to the United States, the majority of hospitals are formed by a society. The society is comprised of community people who are interested in the development of a hospital. The Societies Act requires that all Societies be registered with the Registrar of Companies. Notably, the Society does not control the hospital but only sponsors it. Thus, it provides a means to perpetuate the board of governors and allow for the operation of a hospital. In practical

terms there is no relationship between the Society and the hospital. The Society does have Directors who may or may not be members of the hospital board. The responsibilities of the board are conferred by statute (eg. Hospital Act). The Society is obligated to develop a constitution, but the hospital is not. Societies do not require insurance coverage and most do not. However, unlike the practice in the United States, a board member must be a Society member. As a board member, the individual has no protection from legal suit.[72]

Two significant British Columbia legislative changes directly affect the hospital's operations. The first is the provincial government's Hospital Insurance Act which totally controls the amount of the hospital's operating expenditures. The second is a 1970 change in the Hospital Act which allows the Minister of Health to replace a hospital board, appoint a public administrator, implement a board of review on the hospital and withhold funds if necessary. These type of policies are a strong indicator of the power of government in the structure and adminstration of the British Columbia hospital. What is less clear is the legal accountability of government if a hospital is liable for breach of duty because of financial difficulties or during a period of time when a public administrator or board of review is installed. At this time, it appears that legal accountability for a hospital is retained at the Board level.

Two other factors can alter the hospital's operations -- the professions and the unions. Bearing resemblance to those in

the United States, the professions unquestionably influence the type and quality of services a hospital provides. In British Columbia, there are twenty health professions empowered by fourteen statutory acts and there are several more groups pressing for this status and power. The unions, because of their purpose, are noticeably more visible. In contrast to the United States, with the exception of most management, almost all personnel are unionized in Canadian hospitals. In British Columbia, each health care group has a certified bargaining agent that negotiates with a centralized unit, the Health Labour Relations Association (HLRA). HLRA represents the hospitals directly and the government indirectly -- but the hospitals are obligated comply with the outcome of the bargaining process even though their funding levels from government may not be changed. The physicians negotiate directly with the government since their fee payments come out of the government controlled Medical Services Plan. Recently, concern has been expressed that unionism is overshadowing professionalism and that the power of the union movement has the potential to imbalance the administrator's already fragile power base.[73]

Structurally, the Canadian and American hospitals appear to have many similarities. From a macroscopic viewpoint the Canadian hospital very much resembles the American hospital. And yet there are differences -- differences in regulation that directly affect the hospital's cash flow and governance. In addition, unionism is alive and prospering in the Canadian hospital industry.

Fundamental to all of the variances noted in this chapter, is a difference in ideology. The Americans value liberty, entrepreneurism and tend to shy away from state regulations. The Canadians, in direct contrast appear more comfortable and concerned with equity issues, looking to and depending upon the government to solve the nation's/provinces' problems -- particularly with social issues. State regulation is common -- a fact of life for every Canadian.

CHAPTER V FOOTNOTES

[1]G. Agnew, Canadian Hospital, 1920 to 1970, A Dramatic Half Century (Toronto: University of Toronto Press, 1974), p. 58-78.

[2]The exception is Quebec which for historical reasons has a system similar to that found in Continental Europe. Quebec will not be discussed in this paper.

[3]E. Picard, Legal Liability of Doctors and Hospitals in Canada (Toronto: Carswell Company Ltd., 1978), p. 2.

[4]G. Gall, The Canadian Legal System (Toronto: Carswell Company Ltd., 1977), pp. 23-24.

[5]J. Dillon, Interview, April 19, 1982.

[6]Gall, The Canadian Legal System, p. 26-27.

[7]Ibid., pp. 28-29.

[8]E. Picard, The Liability of Hospitals, Health Law Seminar, UBC, (Spring, 1982). (unpublished paper).

[9]Ibid.

[10]Picard, Legal Liability of Doctors and Hospitals in Canada, pp. 251-326.

[11]L. Rozovsky, "The Hospital's Responsibility for Quality of Care Under English Common Law," Chitty's Law Journal, Vol. 24, No. 4, (1976), pp. 132-136.

[12]Yepremian V. Scarborough General Hospital (1980) 13 C.C.L.T., 105 (Ont. C.A.)

[13]Picard, Legal Liability of Doctors and Hospitals in Canada, p. 248-250.

[14]J. Magnet, "Liability of a Hospital for the Negligent Acts of Professionals," (1978), 3 C.C.L.T., 135.

[15]Picard, Legal Liability of Doctors and Hospitals in Canada, pp. 51-58, 249.

[16]J. Magnet, "Corporate Negligence as a Basis for Hospital Liability -- A Comment on Ypremian v. Scarborough General Hospital," (1978), 6 C.C.L.T., 121-131.

[17]Ibid.

[18]Aynslev, V. Toronto General Hospital (1972), S.C.R., 435 (S.C.C.).

[19]Laidlaw V. Lions Gate Hospital (1969), 20 W.W.R., 727 (B.C.S.C.)

[20]Miller v. Unity Union Hospital (1975), 55 D.L.R. (3d) 475 (Sask, C.A.).

[21]Murphy v. St. Catherine's General Hospital (1963), 41 D.L.R. (2d), 697 (Ont. H.C.).

[22]A.Linden, "Changing Patterns of Hospital Liability in Canada" (1966-67) 5 Alta. L.R., 212.

[23]J. Magnet, "Vicarious Liability and the Professional Employee" (1978), 6 C.C.L.T., 208.

[24]J. Dillon, Health Law Seminar, University of British Columbia, March 22, 1982.

[25]Magnet, "Vicarious Liability and the Professional Employee".

[26]Hospital Notre Dame de l'Esperance v. Laurent (1978), 3 C.C.L.T., 109 (S.C.C.).

[27]Yepremian v. Scarborough General Hospital (1980), 13 C.C.L.), 105 (Ont. C.A.).

[28]Lindal v. Lindal (1981) 129 D.L.R. (3d) 263 (S.C.C.).

[29]Rozovsky, "The Hospital's Responsibility for Quality of Care Under English Common Law".

[30]Picard, Liability of Hospitals.

[31]J. Magnet, "Preventing Medical Malpractice in Hospitals: Perspectives from Law and Policy, "Legal Medical Quarterly, Vol. 3, No. 3, (1979), pp. 197-203.

[32]J. Dillon, Interview, April, 1982.

[33]Magnet, "Preventing Medical Malpractice in Hospitals: Perspectives from Law and Policy".

Financial Aspects

[34]J. Bennett and J. Krasny, "Health-Care in Canada: A Series on the Nation's Health", The Financial Post, (March 26 - May 7, 1977).

[35]Canada, Department of National Health and Welfare, Task Force Reports on the Cost of Health Services in Canada, 1-3 (Toronto: Queen's Printer, 1970).

[36]A. Campbell, J. Miller, M. Mysak and M. Warner, Changing Strategies for British Columbia Health Management: From Program Development to Cost Control, Health Services Planning Discussion University of British Columbia, May, 1981.

[37]M. Warner, "Governments and Health Care in Canada: The Sharing of Costs and Control, "Journal of Contemporary Business, Vol. 9, No. 4, pp. 111-125.

[38]J. Hastings, "Federal-Provincial Insurance for Hospital and Physicians' Care in Canada, "International Journal of Health Services, Vol. 1, No. 4, (1971), pp. 398-414.

[39]J. Van Loon, "From Shared Cost to Block Funding and Beyond: The Politics of Health Insurance in Canada", Journal of Health Politics and Law, Winter, (1978), pp. 454-478.

[40]Ibid.

[41]J. Migue and G. Bélanger, The Price of Health (Toronto: The MacMillan Company of Canada, 1974), pp. 21-42.

[42]"Are You Insured? Coverage via Committee," Canadian Hospital, (July, 1958), pp. 60-61.

[43]Ibid.

[44]L. Detwiller, Interview, June 11, 1982.

[45]J. Atkins, Interview, June 1982.

[46]Marsh and McLennan, Insurance Booklet (Vancouver: Marsh and McLennan, 1982).

[47]Atkins, Interview, June 1982.

Safety and Security

[48]Wm. Loveday, "Every Hospital Must Stand Prepared," Canadian Hospitals, (September, 1950), pp. 44, 102.

[49]F. Silversides, "Evacuation Reaction," Canadian Hospital, (October, 1950), pp. 35, 80.

[50]R. McLean, "Let's Not Have Fire, Part I," Canadian Hospital, (April, 1951), pp. 43-45.

[51]C. Thompson, "Eliminate Fire Hazard," Canadian Hospital (December, 1951), pp. 35, 84.

[52]G. Frith, "At Nanaimo: A Disaster Plan in Readiness," Canadian Hospital, (July, 1958), pp. 48-50.

[53]J. Turner, "Hospital Standards," Canadian Hospital, (March, 1962), pp. 36-38.

[54]M. Blair, "Hospital accidents and the two hundred dollar stitch," Canadian Hospital, (April 1967), pp. 50-51.

[55]C. Hartleib, "Medication Procedures in Hospitals," Canadian Hospital, (July, 1967), pp. 44-46.

[56]J. Dixon, "Infection Control in the OR," Canadian Hospital, (July, 1967), pp. 48-51.

[57]G. Agnew, Canadian Hospitals, 1920 to 1970: A Dramatic Half Century (Toronto: University of Toronto Press, 1974), p. 39.

[58]L. Rozovsky, "Malpractice and Professional Liability," Canadian Hospital, (April, 1970), pp. 20-22.

[59]L. Rozovsky, "Do Hospitals Deserve Special Protection," Dimensions in Health Service, (June, 1974), pp. 17-19.

[60]L. Rozovsky, "The Hospital's Responsibility to Visitors," Dimension Health Service, (August, 1974), pp. 10-12.

[61]N. Maguire, R.E. Van Wagoner, "Hearing Loss Among Hospital Employees", Dimensions in Health Service, (January, 1977), pp. 16-17.

[62]E. LeBourdais, "Accidents in Canadian Hospitals: ACHA Survey," Dimensions in Health Service, (February, 1977), pp. 25-28.

[63]S. Hnatko, "Protection Protocol for Hepatitis B," Dimensions in Health Service, (February, 1977), pp. 36-38.

[64]R. Shaw, "Creating Back Care Awareness," Dimensions in Health Service, (February, 1981), pp. 32-33.

[65]E. Robertson, "The Invisible Fire Safety Feature -- Attitude," Dimensions in Health Service, (April, 1981), pp. 20-23.

[66]G. Barnes, "Promises, Promises, the legal status of sales talk," Dimensions in Health Service, Part I, (September, 1981), pp. 20-25.

[67]G. Barnes, "Hospital Liability -- no fat left to trim" Dimensions in Health Services, (March, 1982), pp. 38-40.

[68]L. LaVecchin, "Health Care Technological Standards," Dimensions in Health Service, (February, 1981), pp. 28-29.

[69]M. Lee, "Eliminating Chemical Redundancy, Cost and Hazard," Dimensions in Health Service, (April, 1982), pp. 14, 15.

[70]O. Hall, "Some Perspectives in the provision of Medical Services," Canadian Journal of Economics and Political Science, (November, 1954), pp. 456-466.

[71]Picard, Liability of Hospitals.

[72]L. Ranta, Health Law Class, University of British Columbia, April 6, 1982.

[73]E. Grossman, "Administration and the Professional Associations," Dimensions in Health Service, (February, 1978), pp. 23-24.

CHAPTER VI

EXAMINATION OF RISK MANAGEMENT FOR HOSPITALS IN THE BRITISH COLUMBIA CONTEXT

A. Introduction

Thus far, the relevant American and Canadian literature applicable to Risk Management has been reviewed. Notations related to British Columbia have been made where it was possible. However, in keeping with the purpose of this project, (to determine a need in British Columbia) it was obvious that more information and data were required about the opinons, attitudes, and activities of the key actors. This would include minimally, the hospital administrators, and ideally, other hospital personnel and representatives from the legal and insurance community. This chapter addresses how this was achieved and is followed by a discussion of the findings.

Initially, the investigator had planned to use a survey questionnaire that would be sent to all hospital administrators in the province. The tool was to attempt to identify what hospital administrators were thinking and doing along the lines of Risk Management. Anonymity would be maintained and analysis would include such variables as bed size, employee numbers and types of services. The task of developing an appropriate questionnaire soon became horrendous for the following reasons:

1. There was no clear or universally accepted definition of Risk Management.

2. The boundaries or parameters of Risk Management appeared to adapt to a hospital's needs. Therefore, it became difficult to determine what issues should or should not be included in a questionnaire of reasonable length.
3. It was not known how familiar the population group was with the subject matter. It was difficult to phrase non-leading questions that were sufficiently clear to these unfamiliar, and concurrently, were not too simplistic for those who were familiar with the subject matter.
4. Some of the requested data would be of a sensitive nature and concern was expressed about the response rate.

After several attempts, this approach was abandoned in favour of a case study. In this manner, the investigator would be in face to face contact with the subject being questioned. The study parameters were more easily defined and clarifications about any of the questions could be made immediately.

B. Methodology

This investigation is a descriptive survey using interview schedules in a case study approach to collect the data. The data are largely subjective in nature.

The sample is purposive and includes representatives from two (2) Community General Hospitals in one (1) British Columbia

regional hospital district. The hospitals were chosen because they are similar in size and in the services they offer. The major difference is that Hospital A has designated a Risk Manager while Hospital B has not. The hospital representatives include the chief executive officer and three (3) line managers -- two (2) of which are professional (nursing and pharmacy), one (1) is managing a non-professional department (housekeeping). In addition two (2) lawyers and two (2) insurance executives familiar with the hospital industry were interviewed.

Each interviewee was approached individually by telephone to request participation in the study. This contact was followed by a letter of thanks that included purpose of the study and some common definitions of Risk Management (Appendix C). Anonymity of the individuals and agencies was offered, and, therefore, many of the participants have not been identified. The interviews were all conducted by the investigator during the period of May-June, 1982. Each interview was approximately one and one half (1-1/2) hours long. All interview questions evolved around the four major considerations -- legal, financial, safety/security and organizational. In addition, an attempt was made to identify the respondents' understanding of Risk Management (Appendix D - interview schedules). The interview schedules were pre-tested in March and April, 1982 using non-participants of the study but individuals with similar backgrounds. This field testing was done in order to:

1. Determine whether necessary data could be collected from the respondent during the time predicted.
2. Test the clarity of the questions.
3. Test the appropriateness of the questions.
4. Test the sensitivity of the questions.

The analysis of the responses was accomplished by allocating the questions into the previously mentioned categories. Thus, each of the responses was recorded by category and the variances amongst the respondents were compared and noted.

The study group is small and selected and, therefore, could not be considered truly representative of British Columbia's hospital industry. However, the study group does legitimately give an indication of the type of expression of ideas that can be generated using this method.

C. Findings

The findings will include a summary of responses by the Hospitals A and B lawyer and insurance representatives. This will be suceeded by a discussion of the similarities and differences amongst all the respondents.

1. The Hospitals (Table Eight summarizes the responses of the hospital groups)

Hospital A

Hospital A is the facility with the designated Risk Manager. The Risk Manager responsibilities are assigned to one of the Assistant Administrators. These duties were assigned in 1975 following what appeared to be an insurance "crunch". His terms of

TABLE EIGHT

SUMMARY OF SELECTED RESPONSES BY HOSPITAL RESPONDENTS
JUNE, 1981

CATEGORY	HOSPITAL A				HOSPITAL B			
	Administrator	Nursing	Pharmacy	Housekeeping	Administrator	Nursing	Pharmacy	Housekeeping
General: Definition	Identify risks, reduce their frequency, and effects , maintain insurance costs	Promote patient safety through employee safety, legal/financial implications	Identify risks, and act to prevent harmful effects	Identify risks and do something about them	Insurance coverage, preventative practices that lead to safe environment	Identify risks and take corrective action. *Dislikes term "risk".	Not familiar	Not familiar
Methods for Identifying risks	Incident reports Staff reports Committee Work Inspections Audits	Safety committee Staff reports Incident Reports Employee health WCB	Drug monitoring Drug usage Incident reports Special studies	Staff reports Safety committee Inspections Infection control	Staff reports Committee reports Incident reports WCB reports *Methods as good as people using them.	Incident reports Staff reports Committee reports Assistant Director of Nursing reports	Self-monitoring Staff reports Other unit reports	Inspections Staff reports Incident reports Written complaints Supervisory activities

TABLE EIGHT CONTINUED

CATEGORY	HOSPITAL A				HOSPITAL B			
	Administrator	Nursing	Pharmacy	Housekeeping	Administrator	Nursing	Pharmacy	Housekeeping
Managing	Quality assurance Measuring standards Audits	Committees Quality assurance elements - audits, Nurse Scheduling procedure	Quality assurance Education Counselling Newsletter	Supervising Education/ counselling Investigating *Consistent enforcement of standards & procedures a problem	Quality assurance (nursing only) Audits Professional responsibilities Education/ counselling	Quality assurance - although too new to determine impact	Education	Training Maintaining standards
Legal: Concerns	No. and cost of investigating claims that hospitals should not be involved with				Loss of property, mostly patients rings, glasses, dentures.			

TABLE EIGHT CONTINUED

CATEGORY	HOSPITAL A				HOSPITAL B			
	Administrator	Nursing	Pharmacy	Housekeeping	Administrator	Nursing	Pharmacy	Housekeeping
Pt. care: Employees	Dept./professional responsibility.	Professional responsibility.	Professional responsibility; dept. inservice	Director responsible for keeping staff aware of legal issues.	Dept./Professional responsibility.	Professional responsibility although need to be more aware; dept. inservice.	Professional responsibility.	Director informs staff of legal aspects.
Med. Staff	Support medical staff activities, indep. status of M.D.				Support Medical staff activities-resistance to audits, etc.			
Attorney	Meet regularly, should be aware of hospital, activities.				Meet as need arises.			
Financial: Costs of R.M.	Too diffuse to determine	Depends on how structured.	Probably no more than now.	Additional: fulltime Risk manager, documentation	Need to define boundaries first.	No comment	Don't know, perhaps extra staff.	Additional staff and training.

TABLE EIGHT CONTINUED

CATEGORY	HOSPITAL A				HOSPITAL B			
	Administrator	Nursing	Pharmacy	Housekeeping	Administrator	Nursing	Pharmacy	Housekeeping
Incentive	Is financial incentive-age of consumer-ism.				No incentives for R.M.			
Insurance	Based on hospital's performance, services and hospital in-dustry. No changes required.				Premium based on hospital industry & other factors. No changes required.			
Safety/ Security: Responsibi-lity	Delegated to safety commi-ttee-depart-mental re-presentation. Also pro-fessional responsi-bilities Everyone's concern.	Safety commi-tee and pro-fessional committees eg. Infection control I.V. admini-stration, patient care.	Safety and professional committees eg. Pharmacy & Thera-peutics, Intravenous	Safety comm-tee, internal responsi-bilities.	Safety every-one's busi-ness- princi-ples as good as people using them; delegated functionally.	Dept. res-ponsibility, committees internal & interdept. as needed.	Dept. respon-sible. In-terdept com-mittee as needed.	Dept. respon-sible. In-terdep com-munication as needed.

TABLE EIGHT CONTINUED

CATEGORY	HOSPITAL A				HOSPITAL B			
	Administrator	Nursing	Pharmacy	Housekeeping	Administrator	Nursing	Pharmacy	Housekeeping
Organizational: Accountability	Must be able to justify services & quality of services.				Public more aware of hospital, board; more visible & demanding more from administration.			
Med. Staff	More Admin. intrusion.				More admin. control, necessity for documentation			
Control Process	Very necessary - hospitals more complex	Necessary	Necessary	Necessary	Require some form of monitoring, will vary by institutions	Develop professionally dept. monitors themselves	For some places	Sometimes all need a watchdog
Risk Management: Differences to US	A matter of degree; how, what strategies used.	More formalized & comprehensive.	More advanced.	Better capability of enforcing policies & procedures.	Don't know	Few differences, or unclear.	Don't know	Don't know

TABLE EIGHT CONTINUED

CATEGORY	HOSPITAL A				HOSPITAL B			
	Administrator	Nursing	Pharmacy	Housekeeping	Administrator	Nursing	Pharmacy	Housekeeping
Strategy	US more aggressive than Canada, an offensive move.	No comment.	Shift to efficiency.	Shift to consistency.	Not a shift, only formalizing what is done now.	A defensive shift.	Don't know.	Don't know.
Rating for B.C.	High	Justifiable if caught loopholes in present system	High	High	High for some hospitals.	High	Maybe high for some.	Depends on hospital.

reference were to investigate, plan and implement those measures that would reduce the frequency of risk related accidents and help to maintain insurance costs at a reasonable level. A formalized Risk management program has not been implemented. The Risk Manager serves on risk-oriented committees (e.g. safety, employee relations) and screens reports of incidents that may lead to a claim against the hospital.

All of Hospital A's respondents demonstrated familiarity with the concept of Risk Management. Although they had differing definitions, they appeared to have a clear conception of what a "risk" was -- and that the management included varying degrees of "doing something about it". Further questioning elucidated the methods used in identifying risks. The most common were the reports (staff and hazard) received by the safety committee and the different types of inspections (internal and external) and audits. The other methods used were review of incident reports, employee health reports and departmental reports. Monitoring the risk situations was handled in various ways that included quality assurance and audits (professional departments), and measurement of standards and supervision (non-professional departments). Education and counselling were seen to be key factors in correcting an unacceptable standard. The safety committee was deemed important and influential in keeping staff aware of safety and for acting upon the complaints they received. The hospital adminstration and other departments had established policies, procedures, and standards. Of all types listed in the survey,

nine (9) were not written. However, the two (2) professional departments both added significant policy listings. All of the policies and procedures were developed through committee structure. All the line managers thought that most policies, procedures had a safety focus. The chief executive officer tended to view them from an organizational/administrative viewpoint. Enforcement of these policies was a major task. Evaluation and feedback was done primarily by the line manager or occasionally through committee structure. The Risk Manager reviewed the available data and reported significant events to the Executive Committee.

In respect to legal aspects, none of the respondents had any major concerns. The administrator interviewed thought the hospital had "fared" well as far as number and type of claims. His major complaint was that hospitals were often named on a writ when it was a medical concern. This cost the hospital in terms of time to carry out an investigation. At this time, there were no salaried physicians on staff apart from the Medical Director and this was a situation the board and administration wanted to maintain. Employee obligations/duties were largely a departmental concern. This was confirmed by the line managers, although the two (2) professional managers also considered it a professional responsibility. Finally, the Chief Executive Officer thought it important to communicate regularly with the hospital attorney. This person should be aware of what the major events/concerns were. The Risk Manager should also have easy access to the hospital attorney.

From a financial viewpoint, none of the respondents could identify actual costs of implementing a Risk Management program. The "costs" were thought to be too diffuse and spread amongst many employees in many departments. One manager thought that the only additional cost of a formalized program might be the additional documentation as other mechanisms were already in place. The adminstrator thought there was a financial incentive in promoting Risk Management because this was the age of consumerism. The administrator believed that the hospital insurance program was comprehensive and that no changes were required. He also believed that the insurance premium was based upon the hospital's performance, the services it offered (e.g. number of high risk areas) and what was happening in the hospital industry in general.

Safety and security issues were largely the responsibility of the Safety Committee. Since this committee had representation from every Department and all levels of the hospital hierarchy, it was felt to be effective and influential in maintaining and promoting prevention activities. In addition to this, each department had some method of planning and monitoring safety activities. This included patient care, employee and visitor related issues. There was also a mechanism for interdepartmental cooperation and coordination as the need arose.

Organizationally, all the respondents felt that the board, and in particular, administration were in a position to justify the services and the quality of services rendered. In turn, the line managers felt they had been delegated responsibility and

authority for operational matters within their juridiction. It is interesting to note that the managers of the professional departments responded more in the context of professional standards while the non-professional manager spoke of complying with internal and Worker's Compensation Board policies. All respondents spoke positively about both professional and union activities. The professional activities, particularly regarding clinical issues, were seen as contributing to the quality of patient care. The hospital administrator did think that in the past few years, there had been more administrative intrusion into medical activities. This was largely because hospitals were being named as co-defendents in medical malpractice suits. It was felt that union activities generated more employee participation and responsibility and had assisted in improving services by promoting a safer environment, and thus "safer" patient care. This type of activity was not seen as contributing toward or inhibiting the implementation of Risk Management programs.

Finally, all respondents agreed that a control process such as Risk Management was essential in the hospital setting. Because they considered their present activities as less formalized and less comprehensive than in the United States, they considered that Canadians (British Columbians) should be more proactive on this issue. In addition, this should not be looked upon as a defensive strategy -- but a offensive move that would facilitate consistency and improve efficiency. In this respect, all

respondents rated the need to move toward a formalized Risk Management as a high priority.

Hospital B

Hospital B is the facility without a designated Risk Manager. They have, however, established mechanisms in order to promote preventive practices that lead to a safe hospital environment. These will be delineated shortly.

The respondents from hospital B demonstrated varying degrees of familiarity with the concept of Risk Management. Two (2) of the line managers had not heard about it in any context prior to the investigator's contact. One of the managers had heard and read about it and gave one of the common definitions. This individual also suggested that the term "risk" could be confusing and because of the complexity of the hospital setting gave too broad a base for a viable program. She also thought that it had a negative connotation. The hospital administrator (chief executive officer) related the preventive practices to insurance coverage and financial loss.

As noted earlier, mechanisms were in place to promote preventive activities. The most common method of identifying safe or unsafe practices was through direct staff reporting and supervisory type of activities including inspection. Other incidents or patterns were identified through committee discussion and reports, analysis of incident reports, departmental reports, and external agency reports (e.g. WCB). The administrator stressed that these type of activities were only as good as the

people using them. Monitoring safety practices was largely a departmental concern and handled in a variety of ways. Audits had been introduced in the nursing and medical departments. Recently, nursing has also initiated a quality assurance program. The professional departments were expected to follow professional standards. Training and educational activities were considered to be key elements in monitoring and managing "risk" areas. There was a strong belief by one (1) manager that developing awareness would help to change behaviour. Administration and other departments have developed policies, procedures and standards. Of the twenty eight (28) listed, there were no indexes for ten (10). Each of the line managers identified additional policies which could be significant to Risk Management. All of the procedures and standards were developed through departmental delegation. The emphasis-safety, administrative efficiency or other-depended on the type of policy and the frame of reference of the individual who developed it. The departments were also delegated the responsibility of enforcement. The line managers felt that the policies, procedures and standards were effective. The hospital administrator, once again, stressed that the policies et al were only as effective as the people using them. He conjectured that there would probably be gaps in their use and enforcement. Evaluation and feedback was done primarily by the line manager and sometimes through committee structure. Committees were also used for interdepartmental concerns. The senior executive staff rarely became involved in the process.

In respect to legal aspects, none of the respondents had any major concerns. The administrator stated that liability for personal injury was not a problem. The greatest concern was loss of property such as patients' dentures, glasses and rings. Patient care, in general, was not a legal concern. The administrator did state some concern for the medical staff's resistance to such activities as peer reviews. Employee duties/obligations were a departmental concern. Once again, the professionals were expected to be self-motivated in keeping abreast of legal issues. However, one (1) of the managers felt this was not carried out to the degree it should be. The manager of the non-professional department thought it was his duty to inform his staff about legal considerations. Most of this information was related to Workers' Compensation regulations. Finally, communication with the hospital attorney occurred on a need basis. If a claim was involved, the insurance lawyer was included in the investigation. However, the role of the hospital staff was perceived to be just to provide the requested data.

From a financial viewpoint, none of the respondents wanted to speculate about the costs of a Risk Management program. Two of the line managers did not anticipate additional costs because from what had been discussed thus far, it appeared that they had the elements of a Risk Management program. The other line manager thought that additional costs might be needed for more staff and training programs. Not to implement Risk Management translated into maintaining the status quo. The hospital administrator

declined discussion of cost unless boundaries and terms of reference were established. He did not see any incentives to move toward Risk Management (financial or otherwise) and questioned whether it was wise to delegate the management of risks to one person (ie. it should be everybody's business). The administrator also thought that the present insurance program was comprehensive and met the needs of the hospital. He believed that the insurance premium was related to what was happening in the hospital industry and speculated that other factors might be included since insurance was a for-profit business.

It was clear that safety and security issues were a responsibility of the line managers. The hospital administrator confirmed this practice. In turn, issues that required discussion were handled internally, within a specific department, and generally on a one to one basis. If other departments were involved, either a committee or direct contact with the specific manager(s) involved resolved the problem. Once again the administrator emphasized that safety was everyone's business, and that safety principles were only as good as the people using them.

Organizationally, the administrator thought that the public was now more aware of the hospital and its functions. The hospital board had become more visible and because of this was demanding more from administrators in all areas of hospital operations. The line managers thought they had been delegated full responsibility and authority for all professional and departmental operations. This also translated into having total

discretion over how risk situations should be managed. There were mixed reactions toward the question referring to the impact of professionals and unions. The professional managers valued the input of their professional staff in decisions about departmental affairs. The unions, or rather the results of the collective bargaining process, were considered a fact of life, something you had to abide by. One manager stated that collective bargaining may have contributed to an improved working environment and staff scheduling but it also contributed to low morale because the combination of high wage settlements and a recent restraint program necessitated many staff layoffs. The hospital administrator expressed concern that professional standards were losing their grip because of union demands. To the organization (hospital), this was a counter productive element. The administrator also stated that there was likely to be more and imposed administrative control over the medical staff and particularly a need for more documentation from medical staff committees as more pressure was placed on the board to justify quality of service.

Finally, there were varying degrees of agreement regarding the need for a control process in the hospital setting. The administrator thought some type of monitoring was needed although it would vary by hospital. His general feeling was that the human element (for mistakes, accidents) would always be present, could not be controlled, and one would have to hope that the "reasonable man" standard would prevail. The line managers all had different opinions. One of the managers (professional department) felt that

controls were necessary but should be monitored by the professionals. Another felt that some hospitals would benefit from such a process. He did not think that Hospital B needed Risk Management. The third manager thought that everyone needed a watchdog some of the time. The respondents saw none or few differences between their perception of Risk Management and what they were doing at present. Interestingly, all but one (1) line manager considered that it was a high priority for hospitals to move toward Risk Management programs. The reason for this discrepancy was that two of the respondents thought other hospitals (and indirectly, Hospital B) would benefit more from the structure. One respondent thought it was necessary for Hospital B to move toward Risk Management because public pressure was beginning to demand it. The one dissenting manager stated it was not a high priority for Hospital B but might be useful to some of the other hospitals.

2. The Lawyers (Table Nine summarizes responses from the lawyers and insurance representatives)

Lawyer A had been in private practice for several years and had acted as counsel for both patients and hospitals. In more recent years he has worked with government agencies as a legal consultant for health care issues. He described Risk Management as establishing policies and procedures to protect the organization (hospital) from exposure to legal suit.

From a legal perspective, he was concerned that issues relating to systems within the hospital setting were not being

TABLE NINE
SUMMARY OF SELECTED RESPONSES BY LEGAL AND INSURANCE REPRESENTATIVES

CATEGORY	LAWYER A	LAWYER B	INSURER A	INSURER B
General: Definition	Establishing policies, procedures to protect the hospital from legal suit.	Assumes it refers to monitoring functions within hospital.	Identifying, monitoring, evaluating, and taking corrective action for risk situations.	Decreasing risk situations and thereby decreasing possibility of financial loss.
Legal: Concerns	Consistency in doing peer reviews, reviewing bylaws, policies, access and confidentialty of medical records, elements present that provoke increase in legal suits.	Differentiation of roles in corporate structure, liability of hospital trustees, information management, decreasing standards of care, impact of labor issues	Potential to follow US pattern, many gaps in present control mechanisms, dealing with more aggressive public and lawyers.	Need to monitor legal cases, no major concerns - Canada will not follow US pattern because of financing formulae
Controlling Liability	Hospital should retain lawyer skilled in health law, who attends professional seminars, conducts legal audits of hospitals' policies and procedures, encourages to become human again in their patient relationships.	Lawyers (hospital) could be more active by informing hospitals of changes in legislation, monitoring legal cases and conducting legal audits.	Fully support need to become more sophisticated in control programs. Hospitals in a bubble about to burst - will soon feel social impact of public, lawyers and judges.	Liability not a problem in B.C. Hospitals, have mechanisms for providing high standard of care.

TABLE NINE CONTINUED

CATEGORY	LAWYER A	LAWYER B	INSURER A	INSURER B
Educational Role	Continuing education on legal aspects important on regular basis (informed and formal).	On invitational basis-but important.	Very important - and part of company's role/ position. Firm has the resources to help.	Only within the insurance framework. Health Association should take the lead.
Attorney Relationship	Hospital lawyer should visit regularly - know it sufficiently well to be able to identify legal risks.	Hospital lawyer contacted on need basis. Larger hospitals should consider in-house attorney.	Attorney retained to review claims, provide consultant services for program.	Attorney retained to review claims. Hospitals should have own attorney.
Financial: Premium			Based on hospital size, service, performance, hospital industry, type of employees and other factors.	Based on hospital size.
Incentive			Not right now, firm's program and marketing may be influencing competitor to keep premiums down. Questions gov't role.	None - coverage adequate at very reasonable cost.

TABLE NINE CONTINUED

CATEGORY	LAWYER A	LAWYER B	INSURER A	INSURER B
Organizational Relationships: (Dr./Hospital)	Needs to be resolved: granting of privileges and to what extent relationship is changing.	This area has the greatest potential to change dramatically.	Requires monitoring but not the greatest concern right now.	Requires careful monitoring - this is what could change insurance management.
Control Process	Essential to close gaps in present system	Some form of consistent monitoring required.	Require more than basic insurance - need a control program.	Mechanisms in place now to provide high standard of care.
Risk Management: Differences to US	US organized, formalized. Someone is accountable for closing the loopholes.	Don't know	Level of sophistication, coverage and service.	Don't know - achieving high standards is the important thing.
Strategy	Need to change - hospitals leaving themselves open to litigation, present system inadequate.	Changes required that will address concerns.	May not be incentive to change - but need is there.	Only need to change if known it would increase quality of care.
Rating for B.C.	HIGH	R.M. could help in monitoring function, but not really essential or high priority.	HIGH	NONE - not convinced R.M. has done much for controlling liability, patient care is the issue and if that is taken care of - so is liability.

addressed adequately. Some examples of these issues included consistency in doing peer reviews and audits, consistency in reviewing hospital bylaws and policies, and access to and confidentiality of medical records. At present, he did not think it was likely that British Columbia hospitals would experience a liability problem of a magnitude similar to the United States. However, he thought there were many of the elements present. These included advancements in medical technology, breakdown in communication, high expectations and a litigious environment. He noted that the deterring factors were no jury duty (juries tend to favour the plaintiff), the National Health Insurance scheme, and the fact that there were many more lawyers in the United States who actively looked for people in a position to sue.

Lawyer A also thought that it would be advantageous for hospitals to obtain and use their legal counsel more wisely. This incorporated retaining lawyers skilled in health law, encouraging them to attend and report on professional health law seminars, commanding legal audits on hospital policies and procedures on a regular basis, receiving assistance in developing consent manuals and requesting both formal and informal educational seminars on legal aspects for the hospital staff. He also thought that the hospital attorney had a role in identifying legal risks for the hospital. In this respect the attorney should be a regular visitor to the hospital and know it sufficiently well to provide legal advice. The larger hospitals should consider employing an in-house attorney.

In response to questions related to organizational issues, lawyer A's chief concern was that the doctor-hospital relationship had to be examined and resolved. This included examining such aspects as the extent to which the relationship had changed and the method of granting and renewing medical privileges. Lawyer A did not think that the professional or union demands were of concern at present. However, there was a potential for serious conflict if quality care issues were negotiated at the bargaining table.

Finally, Lawyer A was of the opinion that a formalized and organized process such as Risk Management was required in British Columbia hospitals. Someone should be accountable for closing the loopholes in the present system. To not change the inadequacy of the present system would be to sanction leaving the hospitals open to litigation.

Lawyer B

Lawyer B had been in practice for several years and had both patients and hospitals as clients. She was not familiar with the concept of Risk Management although assumed it related to monitoring functions carried out in the hospital setting.

As a lawyer working with health care clients, her chief concerns were the unsettled state of health care issues that had a legal impact. The differentiation of society, administrative and government roles within the corporate structure, the liability of hospital trustees, confidentiality of medical records, decreasing

standards of care and the financial impact of labor disputes were some of the issues mentioned. Lawyer B did not think that British Columbia hospitals were in a position to experience a serious liability problem because there were too few successful cases, the costs were high and the awards low, the national insurance system acted as a psychological deterrent, British Columbians were not a litigious society, and suits were often the result of interpersonal conflicts that could be settled out of court.

Lawyer B also thought the hospital attorney could be of more assistance in controlling liability. At present, lawyers are often called in after a problem has arisen. However, the attorney could monitor and inform the hospital about the outcomes of applicable cases, inform the hospital about changes in legislation and review hospital policies from a legal perspective. The attorney could also be invited to provide educational seminars. Large hospitals should consider retaining an in-house lawyer. Small and average sized hospitals should retain a lawyer and contract on a need-be basis. The latter incorporates presentative measures that use the attorney to help control liability.

Regarding, the organizational issues, Lawyer B thought that the whole area of doctor-hospital relationships and accountability was wide open and had the potential to change dramatically over the next few years. A critical detail would always be what the hospital undertakes to do. Lawyer B did not think that professional or union demands were of particular concern at

present. From a collective bargaining point of view, hospitals did not have the authority to give control of standards to unions or practitioners other than what was already covered in the various practitioner acts.

Finally, Lawyer B did not have any firm opinion about the need for Risk Management. Although changes were necessary, she was not familiar enough with Risk Management to state whether it would make a difference.

3. The Insurance Representatives

Insurer A

Insurer A is a representative of a firm that offers Risk Management/Insurance Brokerage Services, and management consultant services particularly in the areas of employee benefits and loss control. The firm has been attempting to interest British Columbian hospitals toward implementing Risk Management. Insurer A described Risk Management in terms of identifying, monitoring, evaluating and taking corrective action for unplanned, amd unwarranted (risk) situations. He stated that his impression was that the concept was not well known and not at all practiced in the British Columbia hospital industry. However, through his contacts with hospital and government representatives, a definite interest in the topic had been expressed.

For Insurer A, marketing insurance coverage was considered to be only one aspect to the tasks set before him. He was concerned that there were so few insurance carriers willing to

provide liability coverage for hospitals. He was equally concerned that there were insufficient carriers with the financial security to provide adequate coverage for hospitals. Stated in another form, he was concerned about the insolvency of carriers presently providing hospital coverage. For these type of reasons, his firm has taken an affirmative position on Risk Management. It is the firm's hope that with a move toward Risk Management, more of the secure insurance carriers will re-enter the market.

Insurer A's firm has developed an in-house 'control' program that incorporates identifying conditions that may lead to loss, reducing the chance of loss through prevention activities, minimizing the effect of loss if it occurs and financial planning for loss. This is supplemented by an external professional team that can provide loss control assistance. Educational assistance would also be provided through this resource team. The risk financing (insurance purchase) aspect is planned in conjunction with the firm. An assessment is completed that considers such factors as hospital size, type and number of services, numbers and types of employees (including students), the hospital's past performance, type of policy (claims vs. occurrence), and general indicators in the hospital industry. The compilation and review of these factors results in the development of a comprehensive insurance plan with a premium adjusted to reflect the amount of the hospital's risk transfer. There is only one major competitor for risk transfer plans in British Columbia. Insurer A believed that his firm's marketing of Risk Management had kept hospital

insurance premiums at below market value. This left the hospitals with no present financial incentive to move toward Risk Management. He also questioned whether government, during a time of economic restraint, would allow apportionment of costs to a new program. Regardless, Insurer A thought there were numerous advantages for the firm, insuring agency and hospital to implement a control program such as Risk Management. The advantages include less likelihood of high indemnity claims, more insurance carriers in the market, more probability of profits and a more secure income from the consulting component. In addition, the hospitals had the benefit of using the expertise and experience of their American counterparts and closing the gaps in their presently unsophisticated methods. They could manage risks and prepare for the increasing aggressiveness of the public and the lawyers.

The latter is viewed as an impact resulting from social inflation. If anything, it underlines the inadequacy of a basic insurance coverage and stresses the need for a more comprehensive control program.

Insurer B

Insurer B is a representative of a firm that offers primarily Insurance Brokerage Services. The firm represents the majority of British Columbian acute care hospitals and does not have an official position on Risk Management for Canadian hospitals. Insurer B described Risk Management as a method of decreasing risks in order to decrease the likelihood of financial

loss. He considered the level of knowledge amongst hospital administrators as being generally low. However he considered their level of practice, or methods that they were presently using, as being generally high. Insurer B thought that the British Columbian standard of hospital care was very good.

Marketing insurance or risk transfer plans was Insurer B's primary responsibility. Educational services could be provided within the insurance framework, but generally, he thought that this should be a function of the Health Association. He was not particularly concerned about the number of insuring agencies in the market. He stated that some underwriters had cash flow problems and did not follow principles. However, this did not automatically result in increased premiums or an insurance crunch. He still had the maneuverability to negotiate a comprehensive insurance plan at a very reasonable premium for his hospital clients. The premium is based upon hospital size. Insurer B was responsible for designing the insurance package, answering clients' questions and providing reassurance about the coverage. He stated that there was flexibility within the basic design so that a policy could be developed to meet a hospital's needs.

Insurer B did not think there were any incentives for hospitals to implement Risk Management. He noted that monitoring and improving the quality of care was important and thought Risk Management might assist in that respect. He is unconvinced that Risk Management has been effective in controlling liability.

Furthermore, he did not think controlling liability would ever become a problem in British Columbia or anywhere in Canada because of the type of hospital financing. He thought that the only situation that might trigger a sudden increase in premiums would be a decision by the courts to change the independent contractor status between doctor and hospital. For the time being, he believed hospitals' were maintaining high standards of care and there was no urgency to consider Risk Management or make provisions for changes in a premium adjustment for those hospitals who decide to implement Risk Management.

D. Discussion

The discussion will take the approach of a comparative analysis incorporating issues arising from the literature review and results from the case study. It is subdivided into three (3) areas: the concept, the major considerations and the need for a control process such as Risk Management in British Columbia hospitals.

1. The Concept

Three issues warrant further discussion. These include the definition(s), process and evaluation of Risk Management as a process.

Definitions should provide clarity of meaning. This was not be found during this investigation of Risk Management for Hospitals. Certainly there are commonalities in the definitions that were presented in Chapter II. However, it was also evident

that the various writers had different foci when addressing the term Risk Management. For example, preventative medical malpractice was a common focus, loss control and loss transfer, another, while a third author addressed preventing people problems. Although the variation provides some originality, it also confuses the reader who is left wondering about the parameters of Risk Management. This is confirmed by the respondents in the case study. Each individual described Risk Management in a different manner. Once again, the different foci were present -- promoting patient safety, reducing risks to reduce loss, and protecting the hospital. One respondent related her confusion about the concept. She also expressed concern regarding the negativism associated with the term "risk". It was not a term that would instill confidence in a public that was becoming increasingly aggressive and angry. The concept, whatever it is called, should be flexible and adaptable to each organization if it is to survive. Moreover, it should also have a clear definition and purpose if its underlying principles are to be correctly applied.

The Risk Management process has several identifiable steps. Unsurprisingly, the steps may vary according to the particular author being read. Whatever the division, the methods of identifying risks remain common. The more popular include incident reporting, audits, staff and committee reports, and inspection. Management of potential risks often include quality assurance programs, education and counselling and development of

policies, procedures and standards. The obscure feature in all of this is the level of sophistication used in coordinating all of these activities. They can only be effective if there is ongoing planning, coordinating and review. In the United States it is common practice for these functions to be carried out by a full time Risk Manager.

The hospital respondents in the case study were able to identify the same methods as measures they used to identify risk or problem type situations. However, Hospital A respondents, who were willing to comment on differences between Risk Management and present practices, thought it was a matter of comprehensiveness, organization and consistency. These characteristics are probably more congruent with a fulltime Risk Manager. Similiarly, Lawyer A and Insurer A, who were both familiar with Risk Management, were able to identify the steps and the more common methods of identifying and managing risks. The difference for them was in the level of sophistication and followthrough. Until someone was delegated to "catch the loopholes," Canadian hospitals would continue to expose themselves to unnecessary risks.

There has been much written on Risk Management and most of its elements. One salient observation has been the lack of empirical data to demonstrate the effectiveness of Risk Management programs. Indeed, following the review of the literature one still has to wonder if Risk Management makes any difference and if so, to what. It appears, that in the American context, Risk Management does make a difference to the financial viability of a

hospital. However, it is less clear whether Risk Management techniques have increased safety and security practices and decreased legal concerns. This confusion may be partially directed to the equivocal parameters of Risk Management. These perplexities are confirmed in the responses obtained in the case study. Insurer B was not at all convinced that Risk Management would change the performance of the hospitals. The hospitals thought they were doing an adequate and good job but could not attribute it to anything as specific as Risk Management techniques. However, Risk Management has continued to thrive in the United States. It may be that it is very effective or it may be that there is a lack of other alternatives or that environmental pressures differ.

2. The Major Considerations

Legal

In the review of the American and Canadian legal systems several similarities were noted. These similarities included legal structure, law as a reflection of societal values and most significant to this study, the potential for hospital liability. Even though the public laws in each jurisdiction greatly influenced the application of the law, the legal concerns in relation to hospital liability were basically the same. The courts' translation of corporate duties, vicarious liability and corporate negligence coupled with an unpredictable and seemingly aggressive society greatly enhanced the scope of hospital liability.

Alarmingly, some members of the Canadian legal community were subtly suggesting in their writings that hospitals implement

mechanisms such as Risk Management or that they may be forced to do so. This type of posturing was not foreign to the hospital respondents, lawyer A or Insurer A. It seems that a threat, real or perceived, was being felt.

Aside from these general concerns, specific issues were brought forward. Significant among these was the clarification of the hospital-doctor relationship. In the United States there has been a tendency to find an employment relationship between the hospital and physician. The Canadian courts have been examining this more in the context of corporate duties, regardless of whether the action is performed through independent contractors or through the corporation's employees. At present, there does not appear to be clear direction by the courts. However, the hospital administrators in the case study were clearly feeling the pressure to place more administrative controls on medical activities in the hospital setting.

The lawyers were equally concerned that it was this particular issue that had the potential to change the scope of hospital liability dramatically. Two issues that were directly related to the hospital-doctor relationship are informed consent and confidentiality of medical records. Once again, it was the lawyers who were concerned about the urgency of coming to terms with them.

In the United States, controlling hospital liability is a significant problem and one that hospital administrators and other key figures have had to confront. Although there has been some

tension between the lawyers and health professionals, cooperation of key personnel has been significant in working together in the development of Risk Management programs. By contrast, controlling liability does not appear to have the same degree of concern in Canada. Hospital administrators viewed it as a responsibility, but in general, not a problem. It has been the legal community which has expressed the concerns regarding the potential for increasing the scope of hospital liability. This was confirmed by the hospital respondents and Insurer B who felt that hospitals were doing a good job and that hospital liability was not a problem. The hospital respondents did feel somewhat uneasy with the changing environmental climate (i.e. public attitude and expectations), but essentially thought they were carrying out their duties. Both lawyers expressed a need and means to address their concerns regarding hospital liability. Insurer A was equally concerned that hospitals were "in a bubble about to burst" and that hospitals had better prepare themselves for the inevitable.

Financial

The American hospitals are expensive and visible enterprises that receive frequent criticisms regarding their ever increasing costs. Their methods of financing and raising revenues has been dependent upon the type of hospital. Increasingly, federal government programs have become involved in the financing which, then, have exposed the hospitals to more forms of controls and regulations. The American public has viewed the hospital industry as being capable of absorbing large costs.

Financing loss has always been a responsibility of the hospital administrator and accomplished through risk transfers or insurance management. This proved inadequate during the insurance/Malpractice crisis of the 1970's. At present, Risk Management programs (within the hospital) are considered to be a condition of coverage for hospitals applying for insurance coverage. The Canadian situation has several distinct variances. All acute care hospital capital and operational revenues have been "negotiated" through government financing. Philanthropic efforts have been largely insignificant. Although the federal and provincial governments have not enacted numerous controls/regulations, it has been obvious that the provincial governments "guard the purse strings". Indirectly, and to varying degrees of success, government has controlled the number and type of services of each hospital in a province. Canadian hospital administrators have also considered loss financing to be one of their responsibilities. However, in British Columbia, the case study respondents noted that loss financing and risk transfer were not a problem. Hospital administrators were able to purchase what they considered to be comprehensive coverage at a very reasonable rate and without any conditions for risk control programs. This was confirmed by Insurer B, the insurer for the majority of hospitals in the province. Insurer A was less optimistic about the stability of insurance premiums and the present methods of risk control. His position was that if the hospital administrators were aware of the financial security of their insurance carrier, they would not feel

so self-assured. Insurer A was also concerned that the current, tight government controls on hospital costs provided a deterrent for hospitals to move toward Risk Management. He stressed the inadequacy of the present methods to deal with the complexities of the modern hospital.

Safety and Security

American hospitals have for many years focused on establishing a safe and secure environment for patients, employees and visitors. The intent has been that all individuals who enter ther hospital environment should be aware of the actual and potential problems that could result in personal injury, property damage or other forms of loss. This has included the concerns related to specific areas such as fire prevention, infection control and disaster planning. In practice, there appears to have been problems in achieving compliance in working toward these goals. The Canadian response to safety and security has been quite similar.

It is believed that regulations and accreditation standards have significantly improved practices. The respondents in the study expressed differing opinions regarding the state of the art. Insurer B thought British Columbia hospitals were maintaining high standards. The hospital personnel (administrators and line managers) thought they were generally doing a good job. Although each hospital managed safety and security in a different manner, both hospitals emphasized the need for staff involvement. Their belief was that safety should be every person's business. They concurred that consistency in practice and enforcement was an

ongoing problem. By contrast, Insurer A and the lawyers thought the hospitals could do more both in the areas of organization and practice.

Organizational

An American hospital corporation can be described as a semibureaucratic organization with a splintered authority structure. Similar to other industries or corporations it has numerous demanding pressures placed upon it that have often originated from a legal or financial base. Primary among these pressures has been a call for accountability of safe and secure practices at reasonable cost. The "troika" had to respond to the growing environmental pressures. Collectively, and sometimes, individually, the response initiated by many hospitals was a control process in the form of Risk Management. The Canadian hospitals share a similar structure and a similar problems regarding increasing pressures for accountability. A condition that may continue to complicate the resolution of this hospital accountability issue has been the undefined role and accountability of government in hospital affairs. In this respect, a difference in ideology was noted ... the American's preference for free enterprise vis à vis the Canadian's acceptance of state control. Unquestionably, the hospital respondents in the case study perceived an increased demand for accountability in all hospital operations. Both hospital administrators thought there would be increasing administrative intrusion into medical activities. Professional and union activities were a concern to them primarily because of their

financial impact. However one of the hospital administrators pondered whether professional standards were losing out to union demands. Concurrently, one lawyer expressed concern regarding decreased standards of care. The greatest number of variances in the responses was brought forward by the question regarding a need for a control process in the hospital setting. Hospital B respondents had a qualified "yes" in that some form of monitoring was required some of the time in some places and sometimes by certain groups, but Hospital B had developed strong decentralized policies generally (e.g. budgeting). All of Hospital A's respondents thought some form of control process or monitoring was necessary. Insurer B thought that if a control process would help to maintain or increase quality of care, it should be implemented. Lawyer A and Insurer A both regarded a centralized control process as a necessity for the modern hospital.

3. The Need

The need for a control process such as Risk Management in British Columbia hospitals will be addressed from three (3) perspectives: the apparent differences between Risk Management and present practices, the need to change present practices and finally, discussion of Risk Management as a reasonable alternative.

The American hospital literature has outlined the various elements of its Risk Management programs. These elements vary according to the author and apparently, according to the needs of the individual hospital. The Canadian hospital literature has

reflected minimal interest in the area of Risk Management. However, various elements (quality assurance, audits, education) are discussed from professional, administrative and organizational perspectives. Seemingly, the differences appear to be in acknowledging risk oriented programs, the degree of sophistication and the coordination of risk orientated activities. These types of differences were identified by the case study respondents who were most familiar with the Risk Management concept. An additional perspective lie in questioning whether Risk Management programs have had a difference on outcome. The degree of effectiveness in the United States is unknown. However, it is known that controlling liability is still a concern although apparently now to a lesser extent than during the malpractice crisis. The degree to which Risk Management is practiced in Canada is unknown. Although interest appears to have been increasing across Canada, there has been no evidence to suggest that hospitals have been implementing full-scale Risk Management programs. Aside from members of the legal community, there has been no visible concern regarding hospital liability. However, the majority of case study respondents seemed to agree that present practices could be better coordinated to ensure a more effective outcome. The latter suggests that there may be a need for change.

To examine the need for change, one must ascertain what incentives there may be to introduce change. The American hospitals had strong motivators in the form of increasing numbers of legal suits and the inability to purchase loss financing/risk

transfer programs. Risk Management became an administrative response and quickly became a condition for purchase of insurance. In Canada, there has been no discernable method of determining whether hospital related suits are on the rise. The legal community has stated that the potential is there. Insurance premiums for Ontario hospitals rose dramatically during 1980-1981. In Ontario, there may be a financial incentive to move toward Risk Management. However, from the majority of case study respondents, it seems that there is, at present, neither legal or financial incentives to more toward Risk Management in British Columbia. One respondent noted that there may be a moral incentive and as was previously noted, the hospital respondents were feeling some public pressure to increase their accountability. It seems, therefore, that in describing a need for change, a cautious "maybe" might best be appropriate. Clearly, there are arguments both for and against. There does, however, seem to be a climate for change.

Finally, given that changes are likely to occur, it will be worthwhile to discuss Risk Management in terms of a reasonable alternative for British Columbia hospitals. From the American literature, it is evident that Risk Management programs are used extensively. They are endorsed by the American Hospital Association, recommended by the Joint Commission on Accreditation of Hospitals and are an essential condition to qualify for insurance coverage. Quantative data in terms of use, cost and effectiveness has not been available and may not have been evaluated. In the way of contrast, Canadian hospitals have not been obliged to

introduce Risk Management. The Canadian Hospital Association and the Association for Accreditation of Hospitals have not published formal positions either for or against Risk Management. Paul Brown, Assistant Executive Director of the Canadian Hospital Association (CHA) stated that this did not mean Canadian hospitals should not be examining Risk Management. From the CHA perspective, an investigation had not as yet been conducted as the basis for the issuing a policy statement. In addition, insurance coverage can still be purchased without conditions for internal control procedures. However, the case study respondents recognized a need for some type of control process. One of the hospital administrators noted that Risk Management would provide an offensive strategy should the conditions in British Columbia change to demand a control process. One of the line managers noted that, given the growing interest in Risk Management, some factors must be present that have been contributing toward the need for it.

There are also the concerns expressed by the legal community regarding the potential for increasing the scope of hospital liability. These factors and the emerging patterns established in Chapter II cannot be ignored. Risk Management may be a reasonable alternative. If and how British Columbia hospitals should move toward Risk Management will be addressed in the concluding chapter.

CHAPTER VII

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS FOR PLANNING

The intent of this study was to identify whether there was a need for British Columbia acute care hospitals to change from their present practices of controlling risk to a system of Risk Management. From the beginning, this was considered to be a large undertaking that would cover many boundaries. For this reason, it was important to establish a model that would reflect the parameters of the study. This was accomplished and the four "constants" were examined from the American, Canadian and British Columbia perspective. The outcome has been that only part of the original question (need to change) can be answered with the findings of the literature review and the case study. Table Ten summarizes the major distinct advantages/disadvantages of moving toward Risk Management.

This table suggests that there is slightly more to gain from introducing Risk Management. However, this could be deceiving. Clearly, there are many warning signals that are evident throughout the literature review and the responses of the case study participants. These signs are sufficient to state, with some degree of confidence, that a change from present practices is inevitable and desirable. It can also be stated that Risk management may be a reasonable alternative to present practices. On this matter, the investigator is less clear because there are neither overt legal nor financial incentives to implement a program that has at its base controlling liability. The

TABLE TEN
MAJOR ADVANTAGES AND DISADVANTAGES FOR
BRITISH COLUMBIA HOSPITALS TO INTRODUCE RISK MANAGEMENT

ADVANTAGES	DISADVANTAGES
1. Similarities to the United States: - increase in technology - increase in specialization and number of hospital personnel - increase in communication breakdown - possibility of easier access to courtroom - unsophisticated risk management methods - patient's increased awareness of rights - high consumer expectations - unstable economy - interest by legal community - expanded role of hospital	1. Differences from United States: - national health insurance program - few lawyers specialized in hospital law - no jury duty - few cases with low awards - public still misinformed about health care issues - medical professionals well organized with Canadian Medical Protective Association. - Ceiling for non-pecuniary awards.
2. Lack of clarity in Law: - corporate duties - standards of care - vicarious liability doctor-patient relationship - enshrined rights - informed consent - role of government	2. Legal incentives neither overt nor immediate urgency to resolve.
3. Uncertainty whether hospital resources adequately protected.	3. Financial incentives not overt - i.e. hospital insurance still purchased at reasonable cost without conditions for internal control.
4. Need expressed to justify quality and quantity of services.	4. New cost controls inevitable, lack of financial maneuverability without government support.
5. Concern that present hospital systems inadequate to assure safe environment and to maintain standards of care.	5. Lack of data base to support effectiveness of Risk Management.
6. Proactive move to increase consistency and efficiency.	6. Definition and purpose of Risk Management lack clarity.

benefits for Risk Management from a British Columbia perspective, are those related to quality of patient care and organizational efficiency. These are also goals of quality assurance programs.

It is not unusual for a study of this nature to raise additional questions for investigation. This certainly applies to what has been described in the preceding chapters. Those questions that appeared to be particularly salient include:

1. Can Risk Management be better described? What are its definitive purpose(s) and can the achievement of these be measured?

2. Can a data base be established to monitor hospital liability activities in British Columbia?

3. What clear direction can be drawn from the perceived need to change? Specifically, if quality patient care is the issue, would quality assurance suffice as an alternative?

4. What is the role of government in relation to hospital liability? Would the government support financially an independent move by the hospitals to introduce Risk Management or would the support be accompanied by legislative authority?

5. Are the hospital resources adequately protected through the present insurance Management programs?

6. Why should the hospitals be proactive on this issue when they have been reactive on other issues?

In conclusion, the intent of this study is only partially realized. Although the information brought forward through this study will serve as a basis for planning, the true utility of Risk

Management for British Columbia Acute Care Hospitals will remain undetermined until more information can be obtained. These data will be more directive and should provide hospital planners with the type of "cost-benefit" information that is required for tough decision making in an increasingly turbulent environment.

Therefore, given that changes from the present practices are inevitable, that there is no pressure to introduce change and that there is minimally a three (3) to five (5) year time frame, the following recommendations for planning are put forward:

1. **Define if and what the problems are surrounding the need for change.**
   - The "problem" is not clearly defined. Goals and alternatives cannot be established without clarifying what it is that should be improved or changed.
2. **Define the purposes and processes of Risk Management and Quality Assurance.**
   - There is overlap between the two (2) concepts. Commentators and respondents appeared to view the purposes and processes as similar. Whether their outcomes are any different should be clarified.
3. **Establish a planning advisory group that includes the key actors.**
   - No program will be introduced successfully without the commitment and support of the key players. This includes hospital, legal and insurance representation. In addition, the hospital representation

requires participation from the medical and government communities.

4. **Collect and Analyze a data base.**

   - This includes the introduction of Risk Management (if it is seen to be the best alternative to the problem) into at least two hospitals of comparable size and service. Preferably, one hospital would have a history of numerous litigation cases while the other would not. Structure, process and outcome evaluations would be conducted over at least a five (5) year period. These results could be compared to hospitals which have not introduced Risk Management.
   - The data base should also include factors that have been brought forward throughout this study.

BIBLIOGRAPHY

Books

Agnew, G.H. Canadian Hospitals, 1920-1970, A Dramatic Half Century. Toronto: University of Toronto Press, 1974.

American Hospital Association. Manual on Insurance for Hospitals and Related Health Care Facilities. Chicago: American Hospitals Association, 1965.

American Hospital Association. Quality, Trending and Management for the 1980's. Chicago: American Hospital Association, 1980.

American Hospital Association and National Safety Council. Safety Guide for Health Care Institutions. Chicago: American Hospital Association and National Safety Council, 1972.

Berman, H. and Weeks, L. The Financial Management of Hospitals. 3rd ed. Ann Arbor: Hospital Administration Press, 1976.

Bond, R. and Vick, N. "Historic and Administrative Aspects of Environmental Health and Safety in Health Care Facilities." Environmental Health and Safety in Health Care Facilities. Edited by R. Bond, G. Michaelson and R. De Ros. New York: McMillan Publishing Company, 1973.

British Columbia Health Association. Guide to Policies for Health Care Centres. Vancouver: British Columbia Health Association, 1980.

Brown, B. Risk Management for Hospitals. Germantown, Maryland: Aspen Systems Corporation, 1979.

Burling, T., Lentz, E. and Wilson, R. "The Board of Trustees." Hospital Organization and Management: Text and Readings. Edited by J. Rakich and K. Darr. New York: Spectrum Publications, Inc., 1978.

Canada: Department of National Health and Welfare. Task Force Reports on the Cost of Health Services in Canada. Vo. 1-3. Toronto: Queen's Printer, 1970.

Canadian Council on Hospital Accreditation. Guide to Hospital Accreditation. Ottawa: Canadian Council on Hospital Accreditation, 1972.

Canadian Hospital Association. Trustee Development Program. Ottawa: Canadian Hospital Association, 1980.

Canadian Hospital Association. Papers and Proceedings of the National Conference on Health and the Law. Ottawa: Canadian Hospital Association, 1975.

Clark, Wm. "Witches, Floods and Wonder Drugs: Historical Perspectives on Risk Management." Societal Risk Assessment: How Safe is Safe Enough? Edited by R. Schwing and W. Albers. New York: Plenum Press, 1980.

Commission on Hospital Care. Hospital Care in the United States. New York: The Commonwealth Fund, 1947.

Dixon, N., Lanham, G., Ladenenberger, M., Fifer, Wm., Greely, H., and Vanagunas, M. Quality, Trending and Management for the 80's. Chicago: American Hospital Association, 1980.

Emory, C. Business Research Methods. Revised ed. Homeword, Ill.: Richard D. Irwin, Inc., 1980.

Fox, D. The Research Procession Education. New York: Holt, Rinehart and Winston, Ine., 1969.

Gall, G. The Canadian Legal System. Toronto: The Carswell Company, 1977.

Georgopoulous, B. and Mann, F. "The Hospital As An Organization." Patients, Physicians and Illness. 3rd ed. Edited by E. Jaco. New York: The Free Press, 1979.

Goodman, R. and Goldsmith, H. Modern Hospital Liability - Law and Tactics. New York: Practising Law Institute, 1972.

Green, H. "The Role of Law in Determining Acceptability of Risk." Societal Risk Assessment: How Safe is Safe Enough? Edited by R. Schwing and W. Albers. New York: Plenum Press, 1980.

Hammond, J. "Risk Spreading Through Underwriting and the Insurance Institution." Societal Risk Assessment: How Safe is Safe Enough? Edited by R. Schwing and W. Albers. New York: Plenum Press, 1980.

Howard, R. "In Making Life and Death Decisions." Societal Risk Assessment: How Safe is Safe Enough? Edited by R. Schwing and W. Albers. New York: Plenum Press, 1980.

Hoyt, E. Condition Critical: Our Hospital Crisis. New York: Holt, Rinehart and Winston, 1966.

Hoyt, E., Hoyt, L. and Groeschel, A. Law of Hospital, Physician and Patient, 3rd ed. Berwyn, Ill.: Physician's Record Company, 1972.

Johnson, E., "The Lessons of a Profession." Hospital Organization and Management: Text and Readings. Edited by J. Rakich and K. Darr. New York: Spectrum Publications, Inc., 1978.

Joint Commission on Accreditation of Hospitals. Accreditation Manual. Chicago: Joint Commission on Accreditation of Hospitals, 1974.

Jonas, S. and contributors. Health Care Delivery in the United States. New York: Springer Publishing Company, 1977.

Kasper, R. "Perceptions of Risk and their Effects on Decisionmaking." Societal Risk Assessment: How Safe is Safe Enough? Edited by R. Schwing and W. Albers. New York: Plenum Press, 1980.

Leavitt, H., Dill, Wm. and Eyring, H. The Organizational World. New York: Harcourt Brace Jovanich, Inc., 1973.

Lowrance, Wm. "The Nature of Risk." Societal Risk Assessment: How Safe is Safe Enough? Edited by R. Schwing and W. Albers. New York: Plenum Press, 1980.

Marsh and McLennon. Insurance Booklet. Vancouver: Marsh and McLennon, 1982.

Marsh and McLennon. Quality Assurance/Patient Safety Program Development Guide. 2nd ed. New York: M&M Protection Consultants, 1981.

Marsh and McLennon. Risk Management for Hospitals. New York: Marsh and McLennon, Inc., 1980.

Maryland Hospital Education Institute. Controlling Hospital Liability: A Systems Approach. Chicago: American Hospital Association, 1976.

Mehr, R. and Hedges, B. Risk Management: Concepts and Applications. Homewood, Ill.: Richard, D. Irwin, Inc., 1974.

Meilicke, C. and Storch, J. ed. Perspectives on Canadian Health and Social Services Policy: History and Emerging Trends. Ann Arbor: Health Administration Press, 1980.

Migue, J. and Belanger, G. The Price of Health. Toronto: MacMillan Company of Canada, 1974.

Miles, R. ed. Resource book in Macro Organizational Behavior. Santa Monica: Goodyear Publishing, Inc., 1980.

Morse, G. and Morse, R. Protecting the Health Care Facility: A System of Loss Prevention Management Effective for all Industry. Baltimore: William and Williams, Company, 1974.

Orlikoff, J., Fifer, Wm. and Greeley, H. Malpractice Prevention and Liability Control for Hospitals. Chicago: American Hospital Association, 1981.

Picard, E. Legal Liability of Doctors and Hospitals in Canada. Toronto: Carswell Company, Ltd., 1978.

Practising Law Institute. Risk Management for Hospitals and Health Care Institutions. Litigation and Administrative Practice Series, Course Handbook Series, Number 132, 1979.

Proser, Wm. Handbook of the Law of Torts. 4th ed. St. Paul: West Publishing Company, 1971.

Prybil and Starkweather, D. "Current Perspectives on Hospital Governance." Hospital Organization and Management: Text and Readings. Edited by J. Rakish and K. Darr. New York: Spectrum Publications, Inc., 1978.

Rakich, J. and Darr, K. ed. Hospital Organization and Management: Text and Readings. New York: Spectrum Publications, Inc., 1978.

Rakich, J., Longest, B. and O'Donovan, T. Managing Health Care Organizations. Philadelphia: W.B. Saunders Company, 1977.

Rozovsky, L. Canadian Manual of Hospital Law. Ottawa: Canadian Hospital Association, 1979.

Rozovsky L. and Dunlop, W. Canadian Manual of Hospital By-laws. Ottawa: Canadian Hospital Association, 1975.

Schulz, R. and Johnson, A. Management of Hospitals. New York. McGraw & Hill Book Company, 1976.

Schwing, R. and Albers, W. eds. Societal Risk Assessment: How Safe Is Safe Enough? New York: Plenum Press, 1980.

Sidel, V. and Sidel R. A Healthy State: An International Perspective on the Crisis in United States Medical Care. New York: Pantheon Books, 1977.

Skillicorn, S. Quality and Accountability: A New Era in American Hospitals. San Francisco: Editorial Consultants, Inc., 1980.

Smith, H. "Two Lines of Authority: The Hospital's Dilemma." Patient's, Physician's and Illness. Edited by E. Jaco. New York: The Free Press, 1958.

Soderstrom, L. The Canadian Health System. London: Croom-Helm Ltd., 1978.

Southwick, A. The Law of Hospital and Health Care Administration. University of Michigan: Health Administration Press, 1978.

Stoner, J. Management. Englewood, Cliffs, N.J.: Prentice Hall Inc., 1978.

Thompson, M. "Aesthetics of Risk: Culture or Context:" Societal Risk Assessment: How Safe is Safe Enough? Edited by R. Schwing and W. Albers, New York: Plenum Press, 1980.

Turabin, K. A Manual for Writers of Term Papers, Thesis and Dissertations, 3rd ed. Revised. Chicago: University of Chicago Press, 1967.

Warren, S. Problems in Hospital Law, 3rd ed. Germantown: Aspen Systems Corporation, 1978.

Williams, S. and Torrens, P. eds. Introduction to Health Services. New York: John Wiley and Sons, 1980.

Websters, Websters' New World Dictionary. Toronto: World Publishing Company.

Wright, C. and Linden, A. The Law of Torts, 5th ed.: Cases, Notes Materials. Toronto: Butterworth and Co., 1970.

ARTICLES AND REPORTS

American Hospital Association. Hospital Regulation: Report of the Special Committee on the Regulatory Process: Chicago, Ill.: American Hospital Association, 1977.

_____. "Are you Insured? Coverage Via Committee." Canadian Hospital, (July, 1958), 60-61.

Barnes, G. "Promises, Promises, The Legal States of Sales Talk." Part I. Dimensions in Health Service, (September, 1981), 20-25.

Barnes, G. "Hospital Liability - No Fat Left To Trim." Dimensions in Health Service, (March, 1982), 38-40.

_____. "Bed bugs help Patients." Hospitals, (July 1, 1975), 33.

Bennett, J. and Krasny, J. "Health Care in Canada: A Series on the Nation's Health." The Financial Post, March 26 - May 7, 1977.

Bernstein, A. "Liability of Hospitals: A Continuing Challenge." Hospitals, (April 1, 1977), 163-166.

Bernstein, A. "Why Another Hospital Malpractice Insurance Crisis?" Hospitals, (November 1, 1980), 54-56.

Bertz, E., Dimonde, R. and Sprague, J. "Viewing the Hospital As a Working Environment." Hospitals, (October 16, 1976), 107-112.

Blair, M. "Hospital Accidents and the Two Hundred Dollar Stitch." Canadian Hospital. (April, 1967), 50-51.

Brandt, R. "Accident Prevention: The Past Holds the Key To The Future." Modern Hospital. (July, 1973), 98.

British Columbia Department of Health. British Columbia Classification of Types of Health Care. Victoria: Department of Health, 1973.

Bromberg, R. and Truly, E. "Tax and Medicare Aspects of Hospital Malpractice Insurance." Hospitals. (April 16, 1978), 67-70.

Brown, M. "Hazards in the Workforce: Educating the Workforce Through The Union." American Journal of Public Health. (October, 1979), 1040-1043.

Calhoun, G. "Hospitals are High Stress Employers." Hospitals. (June 16, 1980), 171-172, 175.

Campbell, A., Miller, J., Mysak, M., and Warner, M. Changing Strategies for British Columbia Health Management: From Program Development to Cost Control. Health Services Planning Discussion Paper, No. 1. Vancouver Department of Health Care and Epidemiology, University of British Columbia, 1981.

Canada: Law Reform Comission. Protection of Life: Medical Treatment and Criminal Law. Working Paper 26. Ottawa: Minister of Supply and Services, 1980.

Clark, M. "Management Approaches to Basic Risks." Hospital Progress (November, 1974), 43-45.

Collins, P. "Hospital Aims Quality Assurance, Risk Management Education at Staff. Hospitals. (June 1, 1981), 93-95.

Connecticut Medical Society. "CSMS Patient Risk Prevention Plan." Connecticut Medicine. (September, 1980), 573-575.

Craddick, J. "Use Existing Motivations to Involve Physicians in Risk Management." Hospitals. (June 1, 1981), 63-64, 85.

Di Paulo, V. "Risk Management: Spiraling Premiums Predicted." Modern Health Care. (December, 1979), 56-62.

Dixon, N. "The Board's Role in Risk Management." Trustee. (September, 1979), 55-62.

Dixon, J. "Infection Control in the OR." Canadian Hospital. (July, 1967), 48-51.

Donkmyer, T. and Groves, J. "Taking Steps for Safety's Sake." Hospitals. (May 16, 1977), p. 60.

Fifer, Wm. "Cost/Quality Trade offs will be the next Medical Care 'Crisis.'" Hospitals. (June 1, 1981), 56-59.

Fifer, Wm. "Risk Management: the art of preventing people failure." Trustee. (September, 1977), 52-53.

Flexner, A, Medical Education in the United States and Canada: A Report To the Carnegie Foundation for the Advancement of Teaching. New York: Carnegie Foundation, 1910.

Freilich, H. "Public Hospital System Institute Loss Control Program." Hospitals. (May 16, 1980), 10, 14.

Frith, G. "At Nanaimo: A Disaster Plan in Readiness." Canadian Hospital. (July, 1958), 48-50.

Geekie, D. "The Crisis in Medical Malpractice: Will it spread to Canada?" Canadian Medical Association Journal. (August 23, 1975), 327-334.

Grossman, E. "Administration and the Professional Associations." Dimensions in Health Service. (February, 1978), 23-24.

Groves, J. and Korsak, A. "Worth Looking Into." Trustee. (August, 1978), 63,65.

Gustafson-Marshik, J., Kopher, S. and Terze, M. "Planning is Key to Successful Q/A Programs." Hospitals. (June 1, 1981), 67-73.

Hall, O. "Some Perspectives on the Provision of Medical Services." Canadian Journal of Economics and Political Science. (November, 1954), 456-466.

Harbord Company, Control: Progressive Risk Management for Canadian Hospitals. Risk Management Program Proposal prepared for British Columbia Health Association. Vancouver: Harbord Company, 1981.

Hartleib, C. "Medication Procedures in Hospitals." Canadian Hospitals. (July, 1967), 44-46.

International Hospital Federation. Proceedings of the International Seminar on Hospital Liability. Lyon, France, 1981.

Kearns, P. "Utilization Review Expanded into Quality Assurance Program." Hospitals. (September 1, 1980), 62-63.

Keys, P. "Drug Use Review and Risk Management." American Journal of Hospital Pharmacy. (October, 1981), 1533-1534.

Korsak, A. "New Concept Calls for Definitional Refinement In Use of Term." Hospitals. (June 1, 1981), 48, 50.

Kucera, Wm. and Ator, N. "Controlling Liability," Hospital Financial Management. (January, 1979), 28-33.

Langhill, G. "Incident Reporting Through Computers," Dimensions in Health Service. (June, 1977), 36, 38.

La Vecchin, L. "Health Technological Standards." Dimensions in Health Service. (February, 1981). 28, 29.

Le Bourdais, E. "A Canadian Survey: Accidents in Hospitals," Dimensions in Health Service. (February, 1977), 25-28.

Linden, A. "Changing Patterns of Hospital Liability in Canada," Alberta Law Review (1966-1967), 212-225.

Loveday, Wm. "Every Hospital Must Stand Prepared," Canadian Hospital. (September, 1980), 44, 102.

McCarthy, Sr. C. and Partell, D. "Hospital Legal Audit." Information presented at the 12th Annual Meeting of the American Society of Hospital Attorneys, Innisbrook, Florida, June 10-13, 1979.

McCollum, W. "Hospital System Works To Ensure Risk Management, Quality of Care," Hospitals. (October 1, 1978), 86-88.

McCollum, W. "Multifacility Program Addresses Both QA and Risk Management," Hospitals. (June 1, 1981), 96-97.

McLean, R. "Let's Not Have Fire, Part I." Canadian Hospital. (April, 1951), 43-45.

Madio, R. "Risk Management and Investigation of Incidents." Information presented at the 12th Annual Meeting of the American Society of Hospital Attorneys, Innis Brook, Florida, June 10-13, 1979.

Magnet, J. "Liability of a Hospital for the Negligent Act of Professionals." Canadian Cases on the Law of Torts. Vol. 3 (1978) 135.

Magnet, J. "Corporate Negligence As a Basis for Hospital Liability A comment on Ypremian v, Scarborough General Hospital," Canadian Cases on the Law of Torts. vol. 6 (1978) 121-131.

Hastings, J. "Federal-Provincial Insurance for Hospital and Physician's Care in Canada." International Journal of Health Services. Vol. 1, No. 4 (1971), 398-414.

Hnatko, S. "Protection Protocol for Hepatitis B." Dimensions in Health Service. (February, 1977) 36-38.

Hollowell, E. "Liability of Hospital Staff Committees." Connecticut Medicine. (September, 1980), 577-578.

Magnet, J. "Preventing Medical Malpractice in Hospitals: Perspectives from Law and Policy." Legal Medical Quarterly. Vol. 3, No. 3, (1979), 197-203.

Magnet, J. "Vicarious Liability and the Professional Employee." Canadian Cases on the Law of Torts. Vol. 6 (1978), 208-226.

Magnet, J. "Corporate Negligence As a Basis For Hospital Liability - a Comment on Ypremian V. Scarborough General Hospital." Canadian Cases on the Law of Torts. Vol. 6 (1978), 121-131.

Magnet, J. "Liability of a Hospital for the Negligent Acts of Professionals." Canadian Cases on the Law of Torts. Vol. 3 (1978), 135-150.

Maquire, W and Van Wagoner, R. "Hearing Loss Among Hospital Employees." Dimensions in Health Service. (January, 1977), 16-17.

Martin, H. "Hospital Risk Management: A Canadian Perspective." Health Management Forum. (Autumn, 1981), 23-34.

Martin, H. "Reduce the Risk of Liability." Health Care. (November, 1981), 16-18.

Matlock, D. "Goals and Trends in the Union of Health Professionals." Hospital Progress. (February, 1972), 40-43.

Miccio, B. "Rate setting Promotes Interdepartmental Cooperation in QA." Hospitals. (June 1, 1981), 83-85.

Mills, D. and Traynor, R. The Notification System. Sacramento, California Hospital Association, 1980. (Unpublished).

Mitchell, K. Risk Management Program. Vancouver, Health Services Centre, University of British Columbia, 1981. (Unpublished).

Moeller, D. "What's So Different About Quality Assurance in Small Rural Hospitals?" Hospitals. (June 1, 1981), 77-80.

Monagle, J. "Risk Management Is Linked With Quality of Care." Hospitals. (September 1, 1980), 57-61.

Morgan, J. and Wozniak, P. "Reducing Direct and Indirect Loss." Hospital Progress. (November, 1977), 88-89.

Newman, G. "Basic Elements of Loss Control Programs." Hospital Progress. (November, 1974), 46-49.

O'Connel, J. "Risk Management for Hospitals." Hospital Progress. (November, 1974), 40-42.

Oppman, C. "Staff training Vital for Risk Management." Hospitals. (December 16, 1979), 95-98.

Orlikoff, J. and Lanham, G. "Why Risk Management and Quality Assurance Should Be Integrated." Hospitals. (June 1, 1981), 54-56.

Parker, S. "Risk Management: Many Solutions Proposed and Successes Noted." Hospitals. (April 1, 1978), 156-158.

Philip, C. and Faust, R. "Study of Malpractice Panels Notes Advantages, Problems, Gaps in Data." Hospitals. (October 1, 1978), 84-85.

Picard, E. The Liability of Hospitals. Health Law Seminar, University of British Columbia, Spring, 1982. (Unpublished paper).

Regan, W. "Patient Who Fell Into Convex Wall Mirror Sued Clinic." Hospital Progress. (March, 1978), 32, 37.

Regan, W. "Safeguards at Construction Site Protect Hospital From Liability." Hospital Progress. (July, 1979), 28, 30.

Robertson, E. "The Invisible Fire Safety Feature - Attitude." Dimensions in Health Service. (April, 1981), 20-23.

Rosenkratz, B. "Damaged Goods: Dilemmas of Responsibility for Risk." Millbank Memorial Fund Quarterly/Health and Society. Vol. 57, No. 1, (1979), 1-37.

Rozovsky, L. "Do Hospitals Deserve Special Protection?" Dimensions in Health Service. (June, 1974), 17-19.

Rozovsky, L. "How to Avoid Law Suits," Dimensions in Health Service. (September, 1975), 12-13.

Rozovsky, L. "The Hospital's Responsibility for Quality of Care under English Common Law." Chitty's Law Journal. Vol. 24, No. 4, (1976), 132-136.

Rozovsky, L. "The Hospital's Responsibility To Visitors." Dimensions in Health Service. (August, 1974), 10-12.

Rozovsky, L. and Rozovsky, F. "Protecting the Hospital With Risk Management." Hospital Trustee. (July/August, 1980), 9-10.

Salmon, S. "A Systems Approach Can Ensure High-Quality Care and Low Costs." Hospitals. (March 16, 1979), 53.

Sehested, P. and Severin-Neilson, T. "Falls by Hospitalized Elderly Patients: Causes, Preventions." Geriatrics. (April, 1977), 101-108.

Shepherd, I. "Hospitals Aren't Safe Enough." Hospital Progress (November, 1977), 85-87.

Shaffer, K., Lindens ten, J. and Jennings, T. "Successful Q/A Program Integrates new JCAH Standards." Hospitals. (August 16, 1978), 117-120.

Sharpe, G. "Hospital Responsibility for Acts of Patients." Chitty's Law Journal. Vol. 24, No. 4, (1976), 140-144.

Shaw, R. "Creating Back Awareness." Dimensions in Health Service. (February, 1981), 32-33.

Silversides, F. "Evacuation Peacetime." Canadian Hospital. (October, 1950), 35, 80.

Simpson, V. "Safety and Security: Annual Administrative Review." Hospitals. (April 1, 1974), 97-101.

Smith, R. "Those People Aren't People Anymore." Hospital Topics. (November/December, 1979), 14-15.

Stewart, K. "Risk Management: No Task for the Timid." Trustee. (April, 1979), 10-13.

_____. "Study Says Hospitals Neglect Their Employees Health, Safety." Hospitals. (August 16, 1975), 114-115.

Tilson, J. "The Hospital Trustee and Quality Assurance." Connecticut Medicine. Vol. 4, No. 4. (April, 1981), 245.

Thompson, C. "Eliminate Fire Hazards." Canadian Hospital. (December, 1951), 35, 84.

Troyer, G. and Salmon, S. "Committees Can Help Oversee Hospital's QA Activities." Hospitals. (June 1, 1981), 87-91.

Turner, J. "Hospital Standards." Canadian Hospital. (March, 1962), 36-38.

United States Department of Health, Education and Welfare. Trends Affecting the U.S. Health Care System, (Cambridge Research Institute.) Germantown: Aspen Systems Corporation, October, 1975.

Van Loon, J. "From Shared Cost to Block Funding and Beyond: The Politics of Health Insurance in Canada." Journal of Health Politics, Policy and Law. (Winter, 1978), 454-478.

Van Sluyter, C. and Hays, P. "Interdisciplinery Task Force Designs Risk Management Program." Hospitals. (August, 1978), 87-89.

Waite, R. "Hospital Safety Needed." Journal of Environmental Health. (November/December, 1969), 124.

Warner, M. "Governments and Health Care In Canada: The Sharing of Costs and Control." Journal of Contemporary Business. Vol. 9. No. 4., 111-125.

Yanish, D. "Aggressive Incident Reporting Saves Hospital Millions of Dollars." Modern Health Care. (December, 1979), 64.

Legal Cases

Aynsley v. Toronto General Hospital (1972) S.C.R. 435 (S.C.C.).

Blanton, v. U.S., 428 F Supp. 360 (D.C., 1977).

Darling v. Charleston Community Memorial Hospital, 211 N.E. 2nd 253 (Ill. 1965).

Foley v. Bishop Clarkson Memorial Hospital, 173 N.W. 2d 881 (Nebr. 1970).

Gadsden General Hospital v. Hamilton, 103 So. 553 (1925).

Greater Washington, D.C. Area Council of Senior Citazens v. District of Columbia, 406 F. Supp. 768 (1975).

Holmes v. London Hospital Trustee Board (1977), 5 CCLT 1 (Ont. H.C.).

Hospital Notre Dame de l'Esperance v. Laurent (1978) 3 CCLT. 109 (SCC).

Inderbitzen v. Lane Hospital, 12 p. 2d 744 (1932).

Laidlaw v. Lions' Gate Hospital (1969) 70 W.W.R. 727 (B.C.S.C.).

Meyer v. Gordon (1981), 17 CCLT 1 (B.C.S.C.).

Miller v. Unity Union Hospital (1975) 55 D.L.R. (3d) 475 (Sask. C.A.).

Murphy v. St. Catherine's General Hospital (1963) 41 D.L.R. (2d) 697 (Ont. H.C.).

Parker v. Port Huron Hospital, 105 N.W. 2d, (Mich. 1960).

South Highlands Infirmary v. Camp, 180 So. 2d 904 (Ala. 1965).

Worth v. Royal Jubilee Hospital (1980), 4 LMG 59 (B.C.C.A.).

Yepremian v. Scarborough General Hospital, (1980) 13 C.C.L.T. 105 (Ont. C.A.).

Statutes and Regulations

British Columbia, Hospital Act, 1979. revised, ch. 176.

British Columbia, Hospital Act Regulations, 1979. revised.

British Columbia, Hospital District Finance Act, 1979. revised, ch. 179.

British Columbia, Hospital Insurance Act, 1979. revised, ch. 180.

British Columbia, Limitation Act, 1979. revised, ch. 236.

British Columbia, Medical Practitioners' Act, 1979. revised, 254.

British Columbia, Society Act, 1979, revised, ch. 390.

APPENDIX A

AMERICAN LEGAL ASPECTS SUPPLEMENT

Types of Legal Action

"Breach of Contract" is alleged when a service has been agreed upon and the service is performed without reasonable care and skill, or a different service is performed, or a specific outcome is promised and this does not occur.[1]

Most liability actions against hospitals fall under tort law. A tort is defined as "a civil wrong, other than breach of contract, for which the court will award damages."[2] Thus, if an individual suffers a loss because of the failure of the hospital to perform its legal duties, the injured party is entitled to a legal remedy in the form of action for damages.[3]

There are both intentional and unintentional torts. An intentional tort is committed when an intentional act is done with the objective of accomplishing a given result which causes injury to another.[4] Unintentional torts result when the wrongdoer fails to exercise due care and the outcome is injury to another party.

Intentional Torts

Assault is a deliberate attempt or offer, with force and violence, directed toward the person of another, to do corporal injury. No physical contact need take place.[5]

Battery is an unpermitted, unprivileged contact with another person.[6] Every battery includes assault, although not every assault involves a battery.[7] Many consent related cases

result in assault/battery allegations. An example of this is the case of **Inderbitzen V. Lane Hospital** whereby a patient alleged that medical students examined her without her consent. The hospital, as the employer of the medical students, was liable for nonconsensual touching of the patient.[8]

Mental Distress - A hospital may be held liable if an intentional act produces severe mental or emotional distress. In the case of Blanton V. U.S., damages were awarded for emotional injury when an experimental drug was given to the patient, even though she had refused to participate in the study.[9]

Defamation is the injuring of another's reputation without good reason or justification. It can take the form of libel (written defamation) or slander (oral defamation). Defamation suits are most often seen in relation to release of confidential information from medical records without consent. However, in practice defamation cases are rarely sucessful for the plaintiff because they must prove that actual damage was done from the communication and, in addition, most States have a clause of immunity for the defendant if the communication was true.[10]

False Imprisonment occurs when one person's freedom of movement is intentionally restrained by another without legal justification.[11] For example, in **Gadsden General Hospital V. Hamilton,** the court held that a patient detained against her will because she was unable to pay her bill could recover damages for false imprisonment.[12]

Unintentional Torts

The most common type of intentional tort is negligence. This was given considerable discussion in Chapter III and does not require further explanation.

Principles of Hospital Liability

The more common types of class action suits that have been brought against hospitals were discussed in the previous section and in Chapter III. In general, a hospital can be held liable for any injuries suffered by patients, visitors to the hospital, or employees. The reasons for litigation can be categorized into five broad areas:

1. standard of care
2. respondeat superior
3. corporation/organization duties
4. resipsa loquitor

Two of these, respondeat superior and corporate duties have already been discussed in Chapter III. The remaining two will be reviewed here.

Standard of Care

The rule under which the hospital's standard of care prevails is the one which provides that the hospital owes its patients that degree of care, skill and diligence exercised by hospitals generally in similiar localities or communities. The "standard" may vary from state-to-state; however, knowledge of

what constitutes good practice is more accessible today through the Joint Commission on Accreditation of Hospitals, Medicare regulations, periodicals and proceedings or national meetings at which methods of good practice are discussed and shared.[13]

Res Ipsa Loquitur

Res ipsa loquitur ("the things speaks for itself") is a legal doctrine sometimes considered even though no specific acts of negligence have been alleged or proven. It is used when the plaintiff can prove:

1. that the event is such that it would not ordinarily occur in the absence of negligence,
2. that the agency or instrument-ability causing this event was in the exclusive control of the defendant, and
3. that the event was not due to any conduct in the part of the plaintiff.

Courts have been reluctant to use res ipsa loquitur because of its harsh effects on defendents, and because it is often difficult to determine the cause of a patient's injuries when he/she is undergoing complex care and treatments.

Exceptions, Constraints and Defences

The very nature and purpose of a hospital places it in a vulnerable position. However, justice allows for protective considerations that apply as well to hospitals as to any

corporation.

Points of Privilege

Privilege is used to indicate the circumstances under which liability is avoided for intentional acts that otherwise would have involved liability. The objective of privilege is to grant a person freedom to act in a manner that best serves the public good. Ultimately, it is a question of whose interests should have greater protection, the interferer or interferee. The considerations given attention in determining privilege include:
Mistakes - privilege can be granted when the actor believes he/she must move quickly in order to protect a right.
Consent - an individual is privileged to infer consent when an action or custom could be interpreted by the reasonable man as assent.
Protective Acts - an individual is privileged to use all the reasonable force causing to prevent intentional or negligent interference with his or another person, especially when the other person is able to defend himself.[15]

Modifications of Negligence

Even though all elements of a negligent act are proven to be present, the defendent can be relieved of equal responsibility if one of the following apply:

Contributing Negligence - if the conduct of the injured party contributed to the loss or injury, the defendant may not be liable. There are exceptions for use of this defence such as

physical and mental age of the injured.[16]

Assumption of Risk - if the plaintiff has consented expressly or by implication to relieve the defendant of his duty to protect (i.e. a contract is established), the defendant may not be held liable providing the contract is not against public policy.[17]

Statutes of Limitations

Statutes of Limitations set forth the period within which actions can be brought. The times vary from state to state and can also vary within a state according to the type of action. If the action is not started within a certain time frame, the plaintiff cannot recover damages.[18] Some states have extended the "time of reasonable discovery" or point in time when the statute of limitations begins to run.[19]

Use of Expert Witnesses

Two changes have occurred that effect the selection of an expert witness, particularly, in medical malpractice cases. First, experts need not be specialists in the field in which they give opinion. The courts determine the qualifications of experts and their admissability of evidence. Secondly, an expert witness need not be a resident in the community in which he testifies. Both of these changes were directed at overcoming the "conspiracy of silence," or the willingness of one colleague to testify against another.[20]

FOOTNOTES TO APPENDIX A

[1]A. Southwick, The Law of Hospital and Health Care Administration (University of Michigan: Health Administration Press, 1978), Chapter IV.

[2]Wm. Proser, Handbook of the Law of Torts, 4th ed. (St. Paul, Minn. West Publishing Co., 1971) p. 2.

[3]R. Mehr and B. Hedges, Risk Management: Concepts and Applications (Homeworth, Illinios: Richard D. Irwin Inc., 1974), Chapter 9.

[4]Ibid.

[5]E. Hoyt, L. Hoyt and A. Groeschel, Law of Hospital, Physician and Patient, 3rd ed. (Berwyn, Illinois: Physicians Record Company, 1972), Chapter 2.

[6]Mehr and Hedges, Risk Management: Concepts and Applications.

[7]Hoyt et al, Law of Hospital, Physician and Patient.

[8]Inderbitzen v. Lane Hospital, 12 P. 2d 744 (1932).

[9]Blanton v. U.S. 428 F. Supp. 360 (D.C., 1977).

[10]Southwick, The Law of Hospital and Health Care Administration, Chapter XI.

[11]Mehr and Hedges, Risk Management: Concepts and Applications.

[12]Gadsden General Hospital v. Hamilton, 103 So. 553 (1925).

[13]D. Warren, Problems in Hospital Law (Germantown, Maryland: Aspen Systems Corporation, 1978), Chapter 7.

[14]Ibid.

[15]Mehr and Hedges, Risk Management: Concepts and Applications.

[16]Ibid.

[17]Ibid.

[18]Southwick, The Law of Hospitals and Health Care Administration, Chapter XII.

[19]R. Goodman and L. Goldsmith, Modern Hospital Liability-Law and Tactics (New York: Practising law Institute, 1972), pp. 407-414.

[20]Ibid, pp. 560-561.

APPENDIX B

CANADIAN LEGAL ASPECTS SUPPLEMENT

Principles of Liability.

Standard of Care

The duty of care and subsequent standards of care are at the crux of controlling hospital liability. Similar to the United States, the Canadian courts look toward the "reasonable man" principle in determining what is an acceptable standard of care. In addition, they will examine legislation, regulations, hospital-bylaws and ask for evidence from accreditation and professional bodies. For example in MEYER V. GORDON, the courts looked for acceptable standards for hospitals and acceptable standards of care by nurses. In this case an expectant mother, the plaintiff, went to hospital when the birth of her child was imminent. She had a history of rapid births, but was left unattended by the nursing staff. The hospital was held negligent due to actions by the staff which resulted in a breach of duty to provide a standard of care that would provide for determination of fetal distress.[1]

In an earlier case, **WORTH V. ROYAL JUBILEE HOSPITAL,** the action against the hospital was dismissed because the courts determined that the hospital had conformed to the required standard of care.[2]

RES IPSA LOQUITOR

RES IPSA LOQUITOR has been applied in the Canadian courts

with some caution. One of the difficulties in using this doctrine is the determination or differentiation between the non-negligent accident and the negligent action(s) that could inflict injury. Although RES IPSA LOQUITOR implies negligence, the cause or incidents leading up to the injury can not be clearly ascertained.[3]

The case of **HOLMES V. LONDON HOSPITAL TRUSTEES' BOARD** demonstrates the complexity of this doctrine. A patient was admitted to hospital for what was considered a minor diagnostic test, laryngoscopy. The anesthetist did not place the tracheal cannula correctly and the patient sustained tissue emphysema in the area of her neck and chest. The patient was admitted to ICU and over the next few days developed full paralysis which could not be related to the emphysema condition. However, the attending and consultant physician did not read the x-rays expeditiously. This action may have made a significant difference in the patient's outcome. The anesthetist, attending and consultative physicians were negligent by res ipsa loquitor. The hospital was not liable since the negligent actions of the physicians were considered to be outside the control of the hospital.[4]

Exceptions, Constraints and Defences

As with the American legal system, defences are available, particularly in negligence actions. First of all, if the plaintiff fails to establish a duty, breach in standard of care, injury or causation, the defendant can file for "non-suit" and

have the charges dropped. Secondly, the defendant can attempt to discredit the plaintiff's allegations through introduction of new evidence and cross-examination. The more common defences include an attempt to prove that standards of practice were being followed, the caused action was an error in judgement or an accident, the patient was a contributory party to his/her injury or, when applicable, the use of the Limitations Act.[5] In British Columbia, statutory regulations limit contract or tort actions to within two years, while other actions not covered witin the Act must be initiated within six years. This is especially true for hospitals unless it can be proven that unusual circumstances needfully postponed or extended the expiration date.[6]

The Use of Expert Witness

Obtaining witnesses can be difficult for Canadian courts, as well. Studies and empirical evidence have demonstrated that physicians and health care professionals are reluctant to testify. However, Canadian courts never were exposed to the qualifications or locale ruling. More recently, steps have been undertaken to bring Canadian health professionals and lawyers together for the benefit of their patients and clients.[7]

HOSPITAL ACT R.S.B.C. (176)

This is probably the most important statute as it defines what a hospital is under the laws of British Columbia. Part 1 of the Act reflects operational considerations. For example, the hospital's board of management is to have full control of expenditures and revenues. The Lieutenant-Governor in council may appoint person(s) to the hospital board for a period of two (2) consecutive years. Part 2 states the provisions for private hospitals, licensure and revocation of the license. Conditions for revocation can include unsanitary conditions, lack of fire protection and poor management. This section also deals with advertising restrictions, requirements for a superintendent, hospital inspections and unauthorized use of licensed hospitals. In Part 3, provisions are stated for the convalescent/rehabilitation hospital. The last section, Part 4, probably best reflects the powers of the Minister of Health or Lieutenant-Governor in Council in the operations of a hospital. These powers include appointment of inspectors, ordering revision of by-laws, enacting regulations, withholding payment to hospitals, establishing conditions for financial assistance, establishing a medical appeals board, designating a Community Care Facility as a hospital and appointing an examining board or public administrator for a hospital. This section also makes note that members of medical staff committees cannot be held liable if they have carried out their obligations in good faith.

HOSPITAL ACT REGULATIONS (amended July 19, 1979)

These regulations are meant to supplement the Hospital Act, and particularly affect the operations of a hospital. There are twenty-nine (29) regulations in all, with statements covering the admission, medical treatment and discharge of patients, establishment of a medical staff committee with written bylaws and obligations, designation of an administrator as a representative of the Board, installing a system of accounting that is satisfactory to the minister, the procedure for a patient not requiring further care, whose discharge is delayed or prevented, provisions for the private hospital, the initiation, storage and destruction of medical records, the granting of medical privileges and the establishment and procedure for a Medical Review Board.

HOSPITAL DISTRICT FINANCE ACT R.S.B.C. (179)

This act is administered by the Ministry of Finance and provides for financing of hospital projects, medical and health facilities, community human resources and health centres and other community facilities for the social and welfare benefit of the community. It focuses on the terms for borrowing of monies.

HOSPITAL INSURANCE ACT R.S.B.C. (180)

This Act covers those conditions related to the implementation of those services agreed to with Canada under the Hospital Insurance and Diagnostic Services Act. This includes a description of who the beneficiaries are and the benefits provided to them, the services a hospital must provide to the beneficiaries

and, the status of non benificiaries. It also outlines the terms of payment to the hospitals - as determined by the Minister. Other sections address responsibility for payment other than public ward coverage, the Hospital Insurance Fund, requirements for accounting, audits and reports, agreements with Canada and other provinces, coordination with the Worker's Compensation Board, special services and managing disputes over services. Another important section includes the power of Cabinet to implement Regulations which have far-reaching effects over the hospital's operations. This section allows the Lieutenant-Governor in Council to determine such conditions as the type and number of services, the utilization and length of stay by patients, treatment of patients and orders regarding the inspection, control, government, management and conduct of hospitals.

LIMITATION ACT R.S.B.C. (236)

This Act is administered by the Ministry of the Attorney General and addresses the time period(s) within which legal actions may take place in British Columbia. The expiration date for most actions based on contract, tort or statutory duty is between two (2) and ten (10) years depending on the circumstances. Section seven (7) addresses the ultimate limitation period for an action against the hospital, hospital employee or medical practitioner as expiring six (6) years from the date from which the right to do so arose. This is subject to a just cause for postponing the running time or if the plaintiff is under a liability.

MEDICAL PRACTITIONERS ACT R.S.B.C. (254)

Chapter 254 addresses those conditions related to the practice of medicine in British Columbia. This includes the organization of the medical members, conditions and requirements for register, obligations for self-regulation, procedures for suspension and appeal, a description that encompasses the practice of medicine and the persons to whom this Act does not apply. Section fifty-five does state the conditions under which a hospital administrator must inform the registrar of an admission of a physician. More importantly, it limits the practice of medicine to a person and does not include an organizational entity.

SOCIETIES ACT R.S.B.C. (390)

In addition to legislated corporations, the Society Act allows for the hospital to become a legal organizational entity. In this respect is outlines conditions for membership, conduct and proceedings of meetings, the establishment and proceedings of the Directors, duties of officers and such factors related to auditors, borrowing, motives to members and bylaws. Hospital bylaws and their amendments must be approved by the Minister of Health.

FOOTNOTES TO APPENDIX B

[1]Meyer V. Gordon (1981) 17 CCLT 1 (BCSC)

[2]Worth V., Royal Jubilee Hospital (1980) 4 LMG 59 (BCCA)

[3]Picard, E., Liability of Doctors and Hospitals in Canada, (Toronto: The Carswell Company, 1978), pp. 204-219.

[4]Holmes V., London Hospital Trustee Board (1977) 5 CCLT 1 (Ont. H.C.).

[5]Picard, E., Liability of Doctors and Hospitals in Canada, pp. 169-194.

[6]Limitation Act, RSBC, 1979, c. 236.

[7]Picard, E., Liability of Doctors and Hospitals in Canada, pp. 216-217.

BACKGROUND AND PURPOSE OF THE STUDY

During the past 5 to 10 years, the American literature on hospitals has illustrated the development of the concept of Risk Management for hospitals.

Risk management, as an administrative control mechanism, is well established in many United States hospitals. The controls may be related to safety and security standards, cost containment, and hospital liability. Risk Management focuses on identifying, monitoring and taking corrective action on actual or potential problems (risks) that may result in unwarranted and unplanned personal injury, property damage or other form of loss. Ultimately, risk management is concerned with the overall hospital's objectives of providing safe patient care while using the available resources efficiently.

The expression Risk Management has not been used with any regularity or consistency (in definition) with respect to British Columbia (B.C.) Acute Care Hospitals. A protective concept has been around for many years and hospital administrators have established mechanisms to provide a safe and secure hospital environment for patients, employees and visitors. What may be new for the administrators is an anticipated need to assume a more defensive position as "the hospital" increases in complexity and in the services it offers.

The question to be studied in the paper is whether there is any need for B.C. hospital administrators to change the management of their "risk" situations. In addition, the

advantages/disadvantages of moving toward risk management vis à vis/present practices will be addressed.

COMMON DEFINITIONS/DESCRIPTIONS OF RISK MANAGEMENT FOR HOSPITALS

"...a program that provides positive avoidance of negative results....Its purpose is to eliminate problems that may result in harm to the organization, its staff, and, most important, its public." (B. Brown, Risk Management for Hospitals: A Practical Approach, Germantown, Maryland: Aspen Systems Corp., 1979, p. 1)

"...Risk Management represents a functional planning approach to risk problems, particularly those of professional liability to hospitals. The process includes three steps: risk identification, risk control, and risk financing." (M. Thistly, "A Look at the Causes and Possible Solutions," Risk Management, July, 1977, p. 10)

"...Risk Management may be defined as a detection system designed to predict when the next 'person failure' will occur and to prevent it from happening." (Wm. Fifer, "Risk Management: The act of preventing people failure," Trustee, September, 1977, p. 52.)

"...Risk Management...encompasses prediction of patient injury, avoidance of exposure to predicted and other risks, and minimization of malpractice claims loss." (J. Orlikoff, Wm. Fifer, H. Greely, Malpractice Prevention and Liability Control for Hospitals, Chicago: American Hospital Association, 1981, p. 29.)

APPENDIX D

Hospital Administrator

1. Do you ever think in terms of "risk management" for your hospital?

   a. If so, what does this mean to you?

   - For purposes of my study, I am defining R.M. as a management function that includes surveillance of all hospital operations in order to identify, monitor, evaluate and take corrective actions for unplanned, unwarranted or unexpected situations (the risks, or problems) that may lead to an individual's injury, property damage or other form of loss.

   - It could be viewed as a formalized control process with the hospital organization.

_____YES

   b. What is the historical background of R.M. in your hospital? ie. How did it come to be implemented?

   c. How are you using R.M. in your organization?

   d. Are the primary responsibilities for R.M. delegated to someone? If yes, to whom?

OR_____NO

   e. I have described "risks" as a problem or potential problem that is unplanned, etc. and that may result in damage to person, property or other. Can you share with me how these situations are handled/managed in your hospital?

The American literature seems to identify four areas in which Risk Management is most obviously involved: safety/security, legal and financial, and organizational. I would like to focus most of the remaining questions in relation to these areas.

2. Previously you mentioned that hospital procedures, policies and standards were in effect that assisted both in the prevention of a problem/risk or in directing the situation if a problem/risk occurred.

   a. Do these procedures, policies, etc. have a safety focus? Explain. Who has the responsibility for development?

   b. In your opinion, how effective have these policies, etc. been? Or, in what areas have they been effective? Not effective?

c. Can you share with me some examples of how problem/potential problem (risks) situations are identified?

d. The professional and technologist groups have been actively developing quality assurance programs. Have these been developed here? In which departments? What has been the impact?

e. How is quality controlled, monitored in the nonprofessional departments?

3. With respect to managing "risks",

a. What would you consider to be the major legal concerns for the hospital?

b. Are there specific considerations, (eg. accountability and responsibility) you could give me for the following areas:

i. patient care: medical staff actions
employee responsibilities
ii. employees and students
iii. visitors

c. One legal author has summarized the hospital's direct duties to a patient as:
i. to select competent and qualified employees;
ii. to instruct and supervise them;
iii. to provide proper facilities and equipment;
iv. to establish systems necessary to the safe operation of the hospital.
Is there anything you would add or delete from that statement?

d. How would you describe your ongoing relationship with the hospital attorney?

4. a. How would you describe your relationship with the hopital's insurance company in the development of the overall insurance program?

b. How closely do you think the hospital's premium is related to the probability of risks (such as we have talked about) occurring? Do you think there might be other factors involved? Explain.

c. Are there any financial or other incentives for you to move toward a Risk Management program? Explain.

d. Are there any disincentives? Explain.

e. If you opted for a Risk Management program, what costs (to the hospital) do you perceive? Explain.

f. Are there any changes you would like to see with policy coverage, options, other?

One more aspect needs to be addressed - risk management in the context of the hospital organization.

5. a. Earlier, I described R.M. as a control process. Do you think hospital care/services require this type of monitoring? Explain.

b. Has the accountability of a. the board, b. administration changed during the past 10 years? Explain.

c. Has the relationship between administration-medical staff changed during the past 10 years? Explain.

d. Have a. the professionals, b. the unions had any impact structurally and operationally on the hospital organization? Explain.

6. a. How would you describe your level of satisfaction with present practices in the management of risk situations? Explain.

b. Would you recommend or make any changes? Explain.

7. In the past hour we have discussed American Risk Management concepts and compared them to the present practices in the B.C. hospital setting.

a. In your opinion, what is/are the major differences between Risk Management and present practices?

b. Would you consider the Risk Management approach as a shift in strategy? Explain.

c. How would you rate the necessity for moving to this type of approach in British Columbia?

8. Additional Comments:

HOSPITAL DEPARTMENT PROFILE

General Information

1. Have you read about or discussed Risk Management for Hospitals? If so, in what context?

   For purposes of my study, I am defining R.M. as a management function that includes surveillance of all hospital operations in order to identify, monitor, evaluate and take corrective action for unplanned, and unexpected situations (the risks or problems) that may lead to an individual's injury, property damage or other form of loss.

   - it could be viewed as a formalized control process within the hospital setting.

   The issues surrounding R.M. may be designated into four areas: safety and security, organizational, financial and legal. My questions for you will be related to these four areas.

2. a. As a Department Head, what do you consider your responsibilities for:
      1. they way in which the unit is operated; i.e. practices, procedures, standards, etc.;
      2. Employee activities. ie performance

   b. What are the hospital's responsibilities in these areas?

3. How would you describe your structural relationship...
   a. with other departments? (including senior execs.)...
   b. when a problem (risk) arises or if you are concerned about a potential problem?

4. Reflecting over the past year, can you share with me what have been the major problems you have had to deal with?

5. How was the problem identified?

6. How was the problem managed?

7. In retrospect, or at the time the problem occurred, did you (or staff members) think of ways or means that the problem could have been prevented or averted? Explain

8. If yes, was it possible to incorporate the preventative measure into the department's daily activities. Explain.

9. How do you incorporate into your daily department activities ways and means to identify and monitor potential problems (risks)? Explain.

The remaining questions are more specific to your department.

Nursing

1. Does the (hospital) orientation program include the hospital's expectations of general safety practices? Specific practices related to nursing?

2. For each item listed, identify whether your department has an established and written procedure, standard, policy, etc.

General:	Who Respon.	What H/P: Proc.	Pol.	Stan.	Other	How Enforced	How Corrective Action Taken
a. reporting unsafe conditions							
b. working with hazardous materials, eg. 02							
c. dress code							
e. transferring and lifting patients							
f. handling "sharps" - glass, needles, etc.							
g. securing stretchers, wheelchairs, examining tables							
h. using electrical equipment							
i. using side rails, restraints							
Specific:							
a. wet mopped areas							
b. foreign materials on floor							
c. defective or inoperative equipment							
d. floor traffic patterns							
e. arrangement of patient room furnishings							
f. soiled linen							
g. patient food trays							
h. use of acid, chemicals							
i. responsibility of nursing staff for ensuring compliance of fire rules							
j. controls for patients/visitors who smoke							
k. carrying out doctors' orders							
l. assessment of nursing needs							
m. assignment of care							
n. administration of medications							
o. infection control							
p. recording and reporting							
q. introduction and evaluation of new equipment							

General:	Who Respon.	What H/P: Proc.	Pol.	Stan.	Other	How Enforced	How Corrective Action Taken
r. introduction and evaluation of new forms of therapy, including drugs							
s. delegation of medical functions to nursing committees							
t. other: unusual occurrence employee recruitment recognition evaluation							

5. Do you see that there is any overlap between Risk Management and Management and Quality Assurance? Explain.

   ie. Both have a common goal of safe, quality patient care - process and rationale may differ.

4. Does your department implement a quality assurance program? Explain. Who is responsible, How is the data used, what is the impact?

6. Are any of the staff development programs related to managing "risk" factors? How is this achieved?

7. Who is responsible for keeping the nursing staff aware of legal issues relating to nursing care, hospital employment?

8. The standards, quality assurance, audits, staff development programs, etc. are all part of the American concept of Risk Management.

   a. What type of costs could you identify if you were to operationalize such a program?

   b. Would there be any costs associated with <u>not</u> implementing this type of program?

9. a. How would you describe the effectiveness of the present practices (standards, policies, procedures)? Explain.

   b. If you could make any changes, in what area(s) would they be?

10. In the past hour we have discussed American Risk Management concepts and compared them to the present practices in the B.C. hospital setting.

    a. In your opinion, what is/are the major difference(s) between Risk management and present practices?

    b. Would you consider the Risk Management approach as a shift in strategy in managing risks in the hospital setting? Explain.

    c. How would you rate the necessity for moving to this type of approach in British Columbia?

11. Additional comments:

- How much, and what type of professional discretion is allowed in the management of risk-type situations? Is the "discretion" applicable to all staff members?

- Can you see any effects on the management of risks from the collective bargaining process?

Pharmacy

1. Does the orientation program include the hospital's expectations of general safety practices? Specific practices related to pharmaceutical services?

2. Does your department have an established and written procedure, standard, etc. for the following? For each item identify:

General:	Who Respon.	What H/P Proc.	Pol.	Stan.	Other	How Enforced	How Corrective Action Taken
a) reporting unsafe conditions							
b) working with hazardous materials; eg. acids							
c) fire protection							
d) handling materials: glass equip., needles, instruments							
e) using electrical equipment							
Specific:							
a) establishing specifications for procurement of all approved drugs, chemicals, biologicals							
b) compounding drugs; eg. admixture							
c) storage of drugs							
- in pharmacy							
- other hospital departments specifically:							
- disinfectants, drugs for external use							
- internal & injectables							
- drugs requiring specific conditions, eg. refrig.							
- checking for outdatedness, discontinued stock							
- emergency drugs							
- controlled drugs							
d) use of apothecary & metric systems for weight & measure							
e) dispensing drugs in pharmacy							
- filling & labelling drug containers issued to depts.							

	What H/P						
	Who Respon.	Proc.	Pol.	Stan.	Other	How Enforced	How Corrective Action Taken
- control drugs							
f) references: pharmacopias, text-books, periodicals							
g) messenger and delivery service							
h) controls and records for the requisitioning & dispensing of supplies to other units							
i) pharm. orientation & instruction of hospital staff							
j) drug recall procedure							
k) administration of drugs - e.g. licensed personnel only							
l) stop order procedure: narcotics, antibiotics, hypnotics, sedatives							
m) recording administration of drugs							
n) recording drug errors/reactions							
o) storage of patient's own drugs							
p) use of investigational drugs							
q) relationship, participation in pharmacy & therapeutics committee							
r) maintaining and keeping available approved stock of antidote and other emergency drugs							
s) association with Regional Poison Control Information Centre							
t) other: employee recruitment employee recognition employee evaluation in-house security measures							

3. a) Does your department implement quality assurance? Explain. Who is responsible, how is data used, what is the impact?
   b) Do you see that there is a relationship between R.M. and Q.A.?
   - Both have goals for safe, quality patient care - process and rationale differ.
4. Are staff development programs related to managing "risk" factors? Explain.
5. Who is responsible for keeping the pharmacy staff aware of legal issues relating to hospital pharmaceutical services? How is it done?

6. The standards, quality assurance, audits, staff development programs, etc. are all part of the American concept of Risk Management.

   a) What type of costs could you identify, if you were to operationalize such a program?
   b) Would there be any costs associated with not implementing this type of program?

7. a) How would you describe the effectiveness of the present practices (standards, policies, procedures)? Explain.
   b) If you could make any changes, in what area(s) would they be?

8. In the past hour we have discussed American Risk Management concepts and compared them to the present practices in the B.C. hospital setting.
   a) In your opinion, what is/are the major differenc(s) between Risk Management and present practices?
   b) Would you consider the Risk Management approach to be a shift in strategy in managing risks in the hospital setting? Explain.
   c) How would you rate the necessity for moving to this type of approach in British Columbia?

9. Additional comments:
   - How much professional discretion is allowed in the management of risks? Is this applicable to all staff members?
   - Has there been any impact from the collective bargaining process on the management of risks?

Housekeeping

1. Does the (hospital) orientation program include the hospital's expectations for general safety practices? specific practices related to housekeeping?

2. Does your department have a written procedure, standard, etc. for each of the following?

General:	Who Respons.	What H/P Proc.	What H/P Stan. Pol.	What H/P Other	How Enforced	How Corrective Action Taken
a. reporting unsafe conditons						
b. working with hazardous materials						
c) fire protection						
d) handling "sharps" materials						
e) using electrical equipment properly grounded cords, plugs in good repair storages						
f) dress code, use of protective clothing						
g) transferring/lifting heavy articles						
h) securing moveables (tables, trolley, etc.						
Specific:						
a) using materials & equipment appropriately wood handle tools free from slivers buckets in good repair						
b) wet floor, waxing procedures						
c) use of elevated platforms						
d) awareness of special hazard areas x-ray, surgery, isolation						
e) clearance of materials, equipment from aisles, passageways and stairways						
f) storage of brooms, buckets, etc.						
g) storage of flammable liquids						
h) storage, disposition of cleaning rags & waste						

General:	Who Respon.	What H/P: Proc.	Pol.	Stan.	Other	How Enforced	How Corrective Action Taken
i) storage, disposition of ash-tray waste							
j) standards for "good" house-keeping							
k) other; committee particip.							
employee recruitment							
recognition							
evaluation							

3. a) How is quality monitored in your department?
   b) Do you think that quality control would be an important part of Risk Management? Explain.
4. Are staff development and training programs related to management of "risk" factors? Explain.
5. Are there any legal considerations that you present to the staff (housekeeping)? Explain.
6. The standards, safety and training programs are all part of the American concept of Risk Management.
   a) What type of costs could you identify if you were to operationalize such a program?
   b) Would there be costs associated with <u>not</u> implementing this type of program?
7. a) How would you describe the effectiveness of the present practices (standards, procedures)? Explain.
   b) If you could make any changes, in what area(s) would they be?
8. In the past hour, we have discussed American Risk Management concepts and compared them to the present practices in the B.C. hospital setting.
   a) In your opinion, what is/are the major differences(s) between Risk Management and present practices?
   b) Would you consider the Risk Management approach to be a shift in strategy in managing risks in the hospital setting? Explain.
   c) How could you rate the necessity for moving to this type of approach in British Columbia?
9. Additional comments.

Insurer

1. a) How do you describe Risk Management?

   b) What do you think is the level of knowledge and practice of the Risk Management concept amongst B.C. hospital administrators?

   c) Does your company have a responsibility for educating clients (hospitals) in controlling liability or changing strategies in controlling liability?

2. a) As an insuring agency, approximately what number or proportion of B.C. acute care hospitals do you provide coverage for?

   b) Your basic package includes coverage for property, liability, crime, boiler and machinery, travel and volunteer workers. What type(s) of option(s) do you provide?

3. What is your company's position on Risk Management for hospitals? Explain.

4. What factors contribute to the amount of the premium? How is it adjusted?

5. During 1980-81 insurance premiums for Ontario hospitals increased dramatically, and for the first time insurance companies were experiencing investment income falling below underwriting losses. Do you foresee a similar trend occuring in B.C.? Explain.

6. a) Risk Management is a well established practice in the U.S. hospital. Are there any incentives to move in this direction for B.C. hospitals?

   b) What advantages do you perceive if the hospitals choose this option?
   For the insurer...
   For the hospital...

7. Do you think that over the past 5-10 years Canadian/B.C. hospitals have become less immune to liability? Explain.

8. a) What is the insurer's view of decisions such as Yepremian (Ontario) and Osburn (N.B.)? Do you foresee any changes (in coverage, premiums, etc.) because of these decisions?

   b) How would you describe your relationship with legal counsel in matters relating to hospital liability?

9. a) What would you consider to be the high risk areas/situations in a hospital?

   b) How do you see hospital personnel managing these situations?
   c) Do you think the union influence in B.C. has had any impact on how hospitals manage risk situations? Explain.
   d) How would you describe the difference between present hospital practices and Risk Management in dealing with these situations?

10. If you offered a Risk Management package, and a hospital chose that option, would the premium be lower? Explain.

11. Would you be willing to share any of your company's statistics with me if hospital anonimity is maintained?
   ie. number of claims
   cost of premiums
   amount of awards

12. Additional comments:

Lawyer

1. Are you familiar with Risk Management... for hospitals? What does this mean to you?
   - For purposes of my study, I am defining Risk Management as a management function that includes surveillance of all hospital operations in order to identify, monitor, evaluate and take corrective action for unplanned, unwarranted or unexpected situations (risks or problems) that may lead to an individual's injury, property damage or other form of loss. It can be viewed as a formalized control process within the hospital organization.

2. In your opinion what are the major legal problems facing Canadian/B.C. hospitals today? Explain.

3. Hospital liability has reached incredible proportions in the United States. Do you think B.C. hospitals could ever be in a comparable position? Explain.

4. a) What would you consider to be the high risk areas/situations in a hospital?

   b) How do you see hospital staff organizing for prevention of these situations?

   c) Do you think that unions have had any impact on how hospitals manage risk situations? Explain.

5. If you were the chief legal advisor for a hospital in B.C. ...

   a) What advice would you give re: controlling liability?

   b) What would be your role in educating administration, and the board regarding controlling liability?

   c) What type of relationship should the lawyer maintain between hospital and the insurer?

6. a) Do you think that Risk Management can help a hospital protect itself from liability? Explain.

   b) How do you think Risk Management differs from present "protective" practices? Explain.

   c) Do you think a change in managing risk situations is necessary for B.C. hospitals? Explain.

7. In Ontario, hospital liability insurance premiums are increasing. The Ypremian (Ont.) and Osbourne (N.B.) cases have left lawyers, insurers and hospital adminstrators questioning the parameters of hospital liability. What implications do you see from these cases? Explain.

8. Additional comments: