PHYSICIANS' STAFF PRIVILEGES IN ONTARIO HOSPITALS*

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I. INTRODUCTION

It is not surprising that the manner of granting and revoking hospital medical staff appointments should have generated a continuing public controversy in Ontario in recent years. Decisions made by public hospital boards of trustees about staff appointments have a decisive effect not only on the ability of physicians to effectively pursue their profession, but also on the cost, quality and availability of health care for each member of the public.

Several Canadian provinces, including Ontario, have recently taken up the challenge of attempting, by legislative means, to reconcile the intractable conflicts between the physician's desire for maximum access to the facilities of public hospitals, the hospital's need to exercise control over the number of physicians working in the institution and their qualifications, and the wider public interest in physician resources across the province. [1]

In June, 1971, as a result of two particular cases of physicians being denied privileges at one Toronto hospital, the Minister of Health established the Committee of Inquiry into Hospital Privileges in Ontario, under the chairmanship of S. G. M. Grange, Q.C. After six months of extensive public hearings and interviews, the committee submitted its report in January, 1972. [2]

Soon after, legislation to amend the Public Hospitals Act, based on some of the recommendations in the Grange Report, was introduced. [3]

In line with the major impetus for establishing the Grange Committee,

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[1] Ontario: S.O. 1972 c. 90, S.O. 1973 c. 164, *amending* The Public Hospitals Act, R.S.O. 1970, c. 378; Quebec: Health Services and Social Services Act, S.Q. 1971 c. 48, O.C. 3322-72; Saskatchewan: S.S. 1972 c. 52, *amending* The Hospital Standards Act, R.S.S. 1965, c. 265, Sask. Reg. 146/72, 13/71; British Columbia: B.C. Reg. 289/73 under the Hospital Act, R.S.B.C. 1960, c. 178.

[2] Hereinafter referred to as the GRANGE REPORT.

[3] R.S.O. 1970, c. 378, *as amended* The Public Hospitals Amendment Act, S.O. 1972 c. 90.

the legislation deals with the specific problem of procedural fairness for physicians in disputes over granting, extending, restricting or cancelling staff privileges.

The Act provides for the giving of notice, time limits, rights to a full quasi-judicial hearing and written reasons at the initial stage of the application; it creates a Hospital Appeal Board, an independent tribunal which may rehear the application and alter or reverse an adverse decision by a hospital board; and it gives an unlimited right of appeal on any question of law or fact or both, first to the Appeal Board, and then to the Divisional Court.

The new procedures have now been in effect for over two years. Six cases have been disposed of by the Appeal Board.[4] The courts have reviewed two of these at length.[5] While it may be too early to form final judgments about the effectiveness of the changes, physicians, hospitals, and tribunals have acquired enough experience with the new process to make a tentative assessment possible. This article will examine circumstances which led to the 1972 amendments, and will assess their usefulness in furthering the dual object of providing a prompt, impartial and procedurally adequate hearing by the hospital, and of ensuring that decisions are made according to fair, reasonable standards.

Such an examination would be incomplete without reference to the wider context of staffing disputes: the nature of the hospital as an institution, and the province-wide organization of health care delivery. For it is arguable that in directing all its attention to the issue of "natural justice" for physicians, the legislature has misconceived the basic cause of friction between hospitals and physicians and has adopted the wrong approach to deal with the situation.

Furthermore, by purporting to offer a solution to the difficulties of deciding how hospital privileges can be most fairly allocated and who should make the decisions, the legislation has obscured the need for more effective responses, such as regional decision-making and area quotas for physicians, and has delayed any move toward implementing those measures.

II. The Nature and Significance of Hospital Privileges

Access to hospital staff appointments is of vital importance to most

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[4] Dr. A. H. M. Khan (Mar. 30, 1973); Dr. M. G. Schiller (Aug. 22, 1973); Dr. J. E. Sheriton (Dec. 6, 1973); Dr. C. MacDonald (Mar. 28, 1974); Dr. B. M. Hyde (Mar. 13, 1975); Dr. Ashwell (1976). Because of publication deadlines it has not been possible to include a discussion of the Ashwell case in this article.

[5] The order of the Hospital Appeal Board to appoint Dr. Schiller to the hospital staff was reversed by the Divisional Court: *Re* Board of Governors of the Scarborough Gen. Hosp., 4 O.R. (2d) 201, 47 D.L.R. (3d) 485 (1974), *appeal dismissed* (*sub. nom. Re* Schiller) 9 O.R. (2d) 648 (1976). An appeal from the Board's decision in the MacDonald case was dismissed by the Divisional Court: *Re* MacDonald, 9 O.R. (2d) 143 (1975).

physicians, and consequently to their patients. A brief explanation of what is meant by "hospital privileges" will serve to illustrate why this is so.

In Ontario a physician may not admit patients to a hospital, or treat them there, unless he has obtained a staff appointment from the hospital. Such appointments are not standard in form, but consist of a number of categories of "privileges" which entitle physicians, in varying degrees, to make use of hospital facilities and to participate in medical staff administrative duties.

Patients, too, are affected by their doctor's access to staff privileges. Section 31(1) of regulation 729,[6] made under the Public Hospitals Act,[7] states:

> No person shall be admitted to a hospital except,
>
> (a) on the order of a medical practitioner who is a member of the medical staff of that hospital . . .

and only on the judgment of *that* doctor that it is medically necessary to do so. Section 32(1) sets out similar provisions for discharge.

The *extent* of a physician's privileges, relative to others in the hospital, is also significant for patients; it will affect the priority according to which beds are available where competition for limited space arises among staff physicians. The problem has been particularly contentious in the case of teaching hospitals, where non-faculty staff have frequently complained about the setting aside of numbers of beds for the exclusive use of teaching staff for teaching purposes, while the rest of the beds are also available to those same doctors along with the other staff physicians.[8]

By section 2(1) of the regulation the hospital board is given the authority to govern the hospital and thus to exercise final say over staff appointments. It is required to pass by-laws providing for:

(1) the appointment and functioning of a medical staff;
(2) the method of determining the privileges to be accorded to each staff member;
(3) the establishment of a medical advisory committee (MAC);
(4) the making of recommendations by the MAC concerning every application for appointment or re-appointment to both the medical and dental staff, the hospital privileges of each staff member, and the dismissal, suspension or restriction of hospital privileges of any staff member who contravenes any one of several Acts, regulations thereunder, or the by-laws.[9]

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[6] R.R.O. 1970, *as amended.*

[7] R.S.O. 1970, c. 378, §§ 17(1) & 39(1)(*j*).

[8] The GRANGE REPORT, *supra* note 2, at 16-17 makes brief reference to the issue. In Manitoba the government established a Commission of Inquiry into Hospital Admissions, chaired by Mr. Justice J. M. Hunt of the Manitoba Court of Appeal. The Commission was formed in March, 1970, as a result of complaints from certain doctors that physicians who were members of the active staff of two Winnipeg-area teaching hospitals received unfair advantages over courtesy staff regarding access to hospital beds for their patients.

[9] R.R.O. 1970, Reg. 729, §§ 6(1) & (6).

The MAC (in hospitals with departments) is normally composed of the president, vice-president and secretary of the medical staff, the chiefs of the medical staff and dental staff, and the chiefs of each medical staff department. [10] Appointments are made annually, and may be revoked at any time. [11]

While the official powers of the committee are, as the name implies, only "advisory", in practice, boards of hospitals, especially smaller hospitals, rely heavily on their recommendations and seldom challenge the committee's advice on staff privileges. On the basis of case studies of hospitals of various sizes, it has been discovered that effective authority over staff appointments varies. In some hospitals, boards do act with considerable independence; in others, it may be the MAC, the staff as a whole, or individual chiefs of departments whose influence is decisive. [12]

A. *Categories of Staff Privileges*

Both terminology and actual staff organization vary among different kinds of hospitals. In general, however, a basic division is made between "indoor" and "outdoor" staff. Indoor staff members are allowed to treat hospital inpatients to some degree, while the outdoor staff comprises those physicians who may use hospital services, but who do not admit or treat inpatients. This might include specialists as well as general practitioners who attend patients in the outpatient department. [13]

Indoor staff are further divided, typically into five categories. The two principal classes of appointment are active staff and courtesy staff. [14] Active staff members have full privileges to admit and attend both personal patients and public ward patients. They also vote and participate fully in all medical staff committees. Courtesy staff typically consist of those physicians with privileges to admit and treat only their own patients. While these physicians may not vote or hold office, they may be required to attend medical staff meetings. [15] In departmentalized hospitals all physicians are appointed to a particular department and must restrict their hospital practice to that department. [16]

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[10] R.R.O. 1970, Reg. 729, § 6(1); Prototype by-law 83. These by-laws are issued jointly by the Ontario Medical Association and the Ontario Hospital Association to all Ontario hospitals, and are generally followed by hospitals as models for their own by-laws.

[11] Prototype by-laws 47 & 48.

[12] J. GROVE, ORGANIZED MEDICINE IN ONTARIO 68-79 (1969), a study undertaken for the Ontario Committee on the Healing Arts.

[13] 3 REPORT OF THE COMMITTEE ON THE HEALING ARTS 134 (1970) [hereinafter cited as HEALING ARTS REPORT].

[14] The other three categories, which are not relevant for the purpose of this article, are Honorary staff, Consulting staff (a variant of Active staff), and Associate staff (a temporary, probationary appointment under supervision). These designations are from prototype medical staff by-laws: see note 10 *supra*.

[15] Prototype by-laws 57 & 60; 3 HEALING ARTS REPORT, *supra* note 13, at 133.

[16] 3 HEALING ARTS REPORT, *supra* note 13, at 134.

B. *The Importance to the Doctor of Staff Privileges*

For reasons which are examined below, [17] hospital boards can, and in many circumstances do, decline a request by a competent, licensed physician to be appointed to the active, courtesy or outdoor staff of the hospital in the community where that physician lives and practises. A board may grant less extensive privileges than those requested, refuse to grant privileges where the applicant already has a staff appointment at another hospital (which was the situation in the *MacDonald* case [18]), or reject the application of a doctor having no access to any hospital.

For most physicians, the ability to practise medicine fully and effectively requires extensive use of hospital services, and the consequences for a doctor who fails to obtain adequate hospital privileges are frequently serious, and sometimes calamitous. Specialists have the most to gain or lose through access to staff privileges. Most of them spend the bulk of their practice in the hospital environment and depend on regular use of sophisticated services and equipment, assistance of other health professionals, and consultation with other doctors—all of which are available only in the hospital.

And not just any hospital will do. Hospitals range in size and function from small institutions of fewer than one hundred beds with no full-time medical staff, to giant university-affiliated teaching hospitals where the medical staff alone numbers seven hundred or more. [19] Naturally enough, these few large, sophisticated hospitals draw a disproportionate number of applications from specialists who are attracted by the many unique opportunities to study and participate in the treatment of rare and challenging medical problems or to acquire the most advanced knowledge and techniques in their field and to extend their expertise to new areas.

Even a general practitioner may see his practice heavily affected by the hospital he uses. If he is forced to send patients to a distant hospital, rather than the one in his immediate community, both he and his patients will be inconvenienced. Failure to obtain any privileges at all could result in the loss of a part of his practice and relegate him to the status of a referral agent for patients requiring hospital attention.

It should be pointed out, however, that this effect is by no means universal. Indeed, growing numbers of general practitioners are choosing not to apply for hospital privileges. [20] The nature of their practice, and perhaps their participation in a group practice having its own diagnostic, laboratory and support staff services, reduce the need for a hospital staff position.

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[17] See text between notes 155-189 *infra.*

[18] 9 O.R. (2d) at 149; however, the Divisional Court did not agree that this was a sufficient ground for denying privileges on the facts of this particular case.

[19] The Toronto General Hospital, for example, had, in 1974, a medical staff numbering 770, out of a total staff of 4,125. Annual Report, Toronto General Hospital 9 (1974).

[20] Interview with the late Dr. D. Wallace, Secretary-General, Canadian Medical Association, in Ottawa, March, 1975.

Meanwhile, the doctor is freed of the administrative duties which are the price of staff privileges. Such duties are especially time-consuming in smaller hospitals.

For any doctor the inability to acquire privileges, the loss of such privileges, or even undue restrictions placed on his ability to practice medicine in a hospital, may mean the loss of some or all of his practice or income. Once lost, privileges will be harder to acquire elsewhere. A doctor without privileges may suffer a deterioration in his professional standing and will be deprived of the experience of continuing education that is an informal but vital by-product of close association with other doctors in the hospital.

C. *The Patients' Interests*

Those physicians and others who favour unlimited access by physicians to the hospital in their community invoke the interests of patients as a justification. Patients are likely to want their personal doctor (where they have one) to be able to authorize their admission to the nearest and best-equipped hospital, and at the same time to take charge of their care and treatment while they remain there. Apart from convenience, patients have a general preference for being treated by a doctor who is familiar with their medical and personal history and whose skills and judgment they have come to value.

Certainly, it is today a truism that "[p]ublic hospitals are established, not for the benefit of the medical profession but for the benefit of those members of the public who are ill and in need of hospital care".[21] The principal basis for this proposition is the fact that hospital facilities and services are paid for overwhelmingly from public funds.[22] But that very fact tends to necessitate the tightening rather than the removal of controls over the granting of hospital privileges. This is occurring for two related reasons. As taxpayers, individuals have a stake in controlling escalating hospital costs. As patients, they are entitled to be guaranteed a high quality of care and treatment while in the hospital. Both of these concerns entail restrictions on the use by physicians (and patients) of hospital facilities.

D. *Controlling Hospital Costs*

Between 1960 and 1971, Ontario's expenditures on health care in-

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[21] Henderson v. Johnston, [1957] O.R. 627, at 635, 11 D.L.R. (2d) 19, at 25, *aff'd*, [1959] S.C.R. 655, 19 D.L.R. (2d) 201.

[22] From 88 to 100 percent of all hospital operating costs are provided by the Ministry of Health. Capital costs of teaching hospitals are entirely funded by the Ministry, while non-teaching hospitals receive two-thirds of their capital funding from the Province, and the rest from private contributions, municipal allocations, and, in some cases, surplus operating grants: Social Policy in Metropolitan Toronto 120 (1975) (a background study for the Royal Commission on Metropolitan Toronto).

creased by two hundred and sixty-three percent. [23] Recent cutbacks have reduced the annual rate of increase to roughly sixteen percent over the years 1973-74 and 1974-75, still in excess of inflation and real growth combined. [24] The cost of health care in the province during 1975-76 is expected to approach 2.3 billion dollars, or even one-quarter of the province's budget. [25] Seventy percent of the total relates to hospital costs (if specialists' incomes are included), while thirty percent is related to primary health care. Hospital expenditures have grown at an even higher annual rate than overall costs. [26]

As a result, current efforts to reduce the rate of growth in health costs have focussed on controlling expenditures on hospital services. At present, almost all such expenditures are directly financed by public funds; medicare premiums and general tax revenue go to pay for physicians' services and for the operating and capital expenditures of hospitals.

As dramatized by current government moves to close hospitals and remove hundreds of active care hospital beds from use, the present system of health care is expensively inefficient in a number of areas. There is over-use of hospital and laboratory diagnostic facilities, unnecessary surgery, duplication of service, and unequal distribution of health services across the province.

Efforts to correct such problems bring the interests of the public as taxpayers into conflict with their interests as patients. Thus the continuing public effort to control health costs will likely have the effect of limiting physicians' ability to make independent decisions about admitting their patients to hospital, the treatment they can provide there, and the particular hospital and area of the province in which they may choose to practise medicine. [27]

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[23] REPORT OF THE HEALTH PLANNING TASK FORCE 53 (Mustard, Dr. J. F. Chairman 1974).

[24] 1975 Ontario Budget A-5, C-11. In 1974, Ontario's rate of inflation was 10.6% while the G.N.P. grew 3.8%.

[25] *Id.* at C-11.

[26] *Supra* note 23.

[27] In Ontario, the most important recent indication that health services will be changing in this direction is the REPORT OF THE HEALTH PLANNING TASK FORCE, *supra* note 23. Published as a Green Paper in April, 1974, the controversial report has elicited strong objections to many of its major recommendations. In its response to the REPORT, the Ministry of Health indicated it would be moving gradually to implement the general goals of the Task Force, but rejected for the present time the most controversial proposals.

The Task Force proposed a comprehensive plan for organizing health services, based on the concepts of primary and secondary care. Primary care refers to those services provided in the first contact between the patient and the health professional, as well as health promotion, co-ordination of treatment, and referral of patients to the specialized resources of the secondary sector. The Task Force further endorsed the grouping of various health professionals to provide these services.

These along with other recommendations suggest changes in the way hospitals are presently used by physicians. One proposal which is being considered by the Health Ministry (for the Ministry's response to the REPORT, see generally ONTARIO MINISTRY OF HEALTH, REPORT, REACTION, RESPONSE (1975)) is that specialists be reimbursed at specialist rates only where the patient has been referred from the

E. *Maintaining Quality of Care*

Because of its functions, organization, and corresponding legal regulation, the hospital as an institution is ultimately responsible for supervising the health care and medical treatment that occurs within it. As a result, from both a practical and a legal point of view, hospitals through their trustees and officers consider it essential to restrict staff appointments to an appropriate number of physicians who possess the requisite competence and expertise.

1. *Modern Hospital Functions*

As hospitals have evolved from mere shelters for the destitute to their present role as collective providers of a full range of health services, there has developed a need to co-ordinate and supervise the activities of the physicians, nurses and technicians who must work together to provide those services.

For present purposes, "hospital" refers to public general hospitals, and mainly the larger ones where disputes over privileges usually arise.[28] These are hospitals which provide active treatment for a range of medical problems. While distinctions will not be made here, it should be remembered that hospitals vary widely according to size, function and ownership.[29]

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primary sector. If adopted in conjunction with the development of a primary care sector, the effect would be that more decisions about the referral of patients to specialized hospital care would be made within primary health groups, which include non-physicians as well as physicians who would not themselves use hospital facilities.

Another proposal affecting hospital privileges has been rejected by the Ministry, at least for some time to come. To reduce the geographical imbalance of physicians, the Task Force favoured the establishment of numerical guidelines for each health district in the province. A District Health Council would decide on the number of positions, and the number of general and special skills required to adequately serve the district. Any physician could practise in any district, but where a physician sought to establish a new practice, he would be reimbursed by the Ontario Health Insurance Plan only if he were appointed to fill a vacancy in the district for his service: see REPORT OF THE HEALTH PLANNING TASK FORCE, *supra* note 23, at 27.

If such a "quota" arrangement were adopted, it would superimpose an extra stage of "licensure" upon specialists seeking hospital appointments in major urban centres, where the oversupply of physicians is most acute.

However, the recommendation at present only serves to suggest what the trend will be, since the Ministry has decided to continue "using incentives rather than sanctions to bring practitioners to underserviced areas": REPORT, REACTION, RESPONSE 14.

[28] Based on the response to a questionnaire which the Ontario Medical Association circulated to its 10,000 Ontario members, and on individual representations to the Committee, the GRANGE REPORT concluded that the problem of doctors being treated unfairly, in relation to the matters the Committee was investigating, was "very small indeed". In addition, the GRANGE REPORT notes that "it has been evident that the problem is most acute in large metropolitan areas, and that specialists rather than general practitioners are most affected": *supra* note 2, at 5-6.

[29] For a description of these differences, see 2 HEALING ARTS REPORT, *supra* note 13, at 1-3. See also CANADIAN HOSPITAL DIRECTORY 29, Tables 1 & 2 (1975), where Ontario hospitals are classified by size, ownership, legal status and types of services provided.

It is ironic that the earliest hospitals were places with which no doctor would have the least desire to be associated. Founded and run as private charities by religious orders, the first hospitals were equipped only to provide food and shelter for the indigent. Since most poor people in need of refuge were also ill, some primitive medical attention also came to be given. [30] It is obvious that hospitals have undergone a total change from their original function, but what is less fully understood by many is the extent of that transformation. Advances in surgical procedures made it necessary, by the late nineteenth century, for physicians to have operating room facilities. These were so expensive to establish and maintain that it was usually practical to establish them only by co-operative means. As a result, hospitals came to provide operating rooms and staff, and physicians generally required access to these services to undertake surgery. [31] Since that time, there has been dramatic growth in the number and variety of treatment and diagnostic facilities and services provided by hospitals, so that the hospital "has been transformed from a place where the sick poor could seek refuge . . . into a place where rich and poor alike . . . go to find out what is wrong with them and to have it treated". [32]

Indeed, it may be said that the modern hospital as a collective enterprise itself "practises medicine", [33] and that the traditional concept of the hospital as the "doctor's workshop", which merely provided facilities to be used by the doctor to engage in his craft, is obsolete. Hospitals today provide active and not just custodial care, through the co-ordination of an elaborate physical plant with the work of a team of skilled employees and others associated with the institution. The physician works as a member, albeit the central one, of this team, rather than as an independent practitioner. In some instances, notably emergency department services, full-time employees such as nurses, interns or residents may be the only personnel to see a patient who comes to the hospital for treatment. While nominally supervised by a medical staff member, these employees generally work free of supervision. [34]

Hospital functions include the treatment of patients both within the hospital and in the community, *e.g.*, through outpatient and home care programs. They provide emergency services and rehabilitative programs, and also engage in extensive non-treatment functions: medical and other health professional education, research, and regulation of professions practising in the hospital.

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[30] *Id.* at 9.

[31] *Id.* at 10.

[32] *Id.* at 11.

[33] Although not as a matter of law. *See* The Medical Act, R.S.O. 1970, c. 268, and *see also* Campbell v. The Queen, [1974] 2 F.C. 658, at 667, 50 D.L.R. (3d) 467, at 474 (T.D.) (Heald, J.).

[34] 2 HEALING ARTS REPORT, *supra* note 13, at 41.

2. *Peer Review*

Within the hospital, it is the medical staff as a whole through its various committees, rather than physicians individually, who are responsible to the Board for maintaining standards of professional medical practice.[35] The supervisory function of the MAC is exercised by separate committees such as the tissue committee, which studies tissues removed by surgeons to ensure that their removal was warranted, and the medical audit committee, which reviews medical records, diagnoses and other measures taken by physicians.[36]

The head of each clinical department exercises a large measure of control over staff physicians by virtue of his authority under section 41 of the Public Hospitals Act.[37] Section 41 permits the hospital, by by-law, to make the head of each medical department, along with the president or chief of the medical staff, responsible for advising the MAC concerning the quality of care and treatment his department is providing. The section further requires the staff officer designated by such a by-law in certain circumstances to remove any patient from the care of the physician who is in charge of his case, and to replace him personally as the patient's doctor or to direct another staff member to do so. These measures are to be taken whenever the officer decides that, "in his opinion, a serious problem exists in the diagnosis, care or treatment of a patient or out-patient", unless prompt changes are made.[38]

The effect of this section is to require the designated staff officers to set up and supervise a careful system to continuously review the quality of care given by each doctor to each patient in the hospital. This review of doctors who already have staff privileges will take place on a day-to-day basis. But it will also involve controls over the granting and renewal of privileges. A major issue in the controversy over the propriety of restricting privileges is whether the responsibility for guaranteeing a high quality of care requires such screening in addition to a regime of peer review, and if so, to what extent.

3. *Expanding Tort Liability of Hospitals*

"As the hospital matures and develops into a true community health center, the legal result is the expansion of institutional responsibility for the quality of patient care."[39] This expansion has been occurring not only in the United States but also in Canada, albeit more tentatively, over the past forty years. The courts have stopped short of recognizing a direct responsibility on the part of the hospital for negligence in the course of a patient's treatment there, but by expanding traditional concepts of vicarious liability

[35] R.R.O. 1970, Reg. 729, §§ 6(6)(*a*)(vii) & (*b*).
[36] *Id.* § 6(1)(*d*).
[37] R.S.O. 1970, c. 378, §§ 41(1) & (2).
[38] *Id.* § 41(3).
[39] Southwick, *Hospital Medical Staff Privileges*, 18 DE PAUL L. REV. 665, at 657 (1969).

and by recognizing instances of negligence in the selection and supervision of professional staff, they are growing to accept the reality of the "corporate practice of medicine". [40]

In the leading United States case of *Darling v. Charleston Community Memorial Hospital*, [41] the Illinois Supreme Court relied on a quotation from an earlier New York case [42] for the rationale for placing substantial responsibility for patient care on the hospital:

> The conception that the hospital does not undertake to treat the patient, does not undertake to act through its doctors and nurses, but undertakes instead simply to procure them to act upon their own responsibility, no longer reflects the fact. Present-day hospitals, as their manner of operation plainly demonstrates, do far more than furnish facilities for treatment. They regularly employ on a salary basis a large staff of physicians, nurses and internes, as well as administrative and manual workers, and they charge patients for medical care and treatment, collecting for such services, if necessary, by legal action. Certainly the person who avails himself of "hospital facilities" expects that the hospital will attempt to cure him, not that its nurses or other employees will act on their own responsibility. [43]

In view of its extensive legal responsibility, the hospital has a substantial concern in scrutinizing the qualifications of physicians seeking privileges. This concern is most pressing where the relationship between the doctor and the hospital is one of employer and employee, but, apart from that, it arises in every case where the physician's participation in the collective efforts of the hospital's health team affects the quality of service the team provides.

III. The Problem of "Limited Licensure"

The clash between the needs of physicians for access to hospital facilities and the needs of hospitals to restrict that access appears most clearly where the question of an applicant's minimum competence is in issue.

In law, a physician who is licensed to practise medicine [43a] is qualified to perform any medical service, from surgery to psychiatry. In practice, medicine is a highly specialized field:

> [T]he physician will nowadays be limited in the areas he can choose because many specialties can be practised only within, or in association with, a hospital; and the hospital privileges of the man without a specialist qualifica-

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[40] For a review of the Canadian and English case law on this subject, see McDonald, Note, *Sisters of St. Joseph v. Villeneuve, 47 D.L.R.3d (Sup. Ct. 1974)*, 7 Ottawa L. Rev. 657 (1975); and Linden, *Changing Patterns of Hospital Liability in Canada*, 5 Alta L. Rev. 212 (1967).

[41] 33 Ill.2d 326, 211 N.E.2d 253 (1965).

[42] Bing v. Thunig, 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957).

[43] *Id.* at 666, 143 N.E.2d at 8, 163 N.Y.S.2d at 11.

[43a] Under the Medical Act, R.S.O. 1970, c. 268, § 19, a physician becomes licensed to practise medicine when he has complied with the provisions of the Act and the rules made thereunder by the Council of the College of Physicians and Surgeons and his name has accordingly been entered in the register of the Council.

> tion or not actively engaged in seeking one are very restricted, except in the smaller hospitals in the remoter parts of the province and in the small towns where the general practitioner still tends to be the factotum. [44]

To become qualified in a specialty a licensed physician must serve several years of residency and pass demanding oral and written examinations. If these are completed successfully, the physician will receive a certificate of specialization, or a fellowship, from the Royal College of Physicians and Surgeons of Canada, a voluntary organization. This qualification is officially recognized by the College of Physicians and Surgeons of Ontario. [45] Only where a physician possesses this specialty qualification will most larger public hospitals consider his application for an active specialist staff appointment.

The Grange Committee accepted the right of a hospital to refuse privileges to a doctor who is considered so incompetent, or disabled by addiction, as to be a danger to his patient. [46] In view of the hospital's statutory responsibility and growing liability for the negligence of its staff, it is accurate to say that there is not only a right but a duty to do so. At the same time, it is unsatisfactory that a physician's effective ability to practise medicine is determined not by the representative assembly of peers charged with the statutory power to license physicians, [46a] but by local, often unrepresentative hospital governing bodies, not accountable directly to the province, and under the strong influence of medical staffs.

The Committee on the Healing Arts emphasized the implications of the present system of granting hospital privileges:

> Wherever the range of practice is delimited—whether in confining the physician or surgeon to outdoor practice, to practice only within one department, or, indeed, to practice only of specified procedures, a form of "limited licensure" is in operation. As more and more of the provision of medical care takes place in the hospital, this limited licensure, whether or not recognized by the formal licensing body, the College of Physicians and Surgeons of Ontario, will become increasingly effective. [47]

This anomaly is at the heart of the issue of "natural justice" for applicants and is also a reason for devising new decision-making arrangements for determining the numbers and distribution of health manpower. [48]

The most frequent and contentious disputes over a hospital's decision to cancel, restrict or refuse to grant a staff appointment have arisen over selection criteria other than bare minimum competence. In some cases the physician was competing with a large number of highly qualified fellow applicants and so failed to meet the high standard of the particular hospital concerned. Or the applicant may not have possessed the special skills

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[44] J. GROVE, *supra* note 12, at 151.
[45] *Id.* at 151-52.
[46] GRANGE REPORT, *supra* note 2, at 10.
[46a] The Medical Act, R.S.O. 1970, c. 268, § 3.
[47] 3 HEALING ARTS REPORT, *supra* note 13, at 135.
[48] *See* note 27 *supra.*

being sought by the hospital. One recurring, although often unexpressed reason for the denial or restriction of privileges is the disruptive effect of a physician's personality on the efficiency and morale of the other health professionals with whom he works. Finally, the number of applicants may simply exceed the physical capacity of the hospital to accommodate them.

Since its creation in 1972, the Hospital Appeal Board (HAB) has had occasion to adjudicate disputes in which all of these issues have been raised. The detailed reasons for judgment of the Board—and of the Ontario courts which have reviewed those reasons—provide the best opportunity to consider to what extent hospital boards may legitimately resort to these criteria in exercising their authority over hospital staff appointments. They will be considered at some length below. [49]

A. *The Current Law*

The proposition that every licensed medical doctor enjoys the right to a staff appointment in the hospital of his choice still attracts dedicated and vocal adherents within the profession. And in recent years litigants in Canadian courts have produced a growing collection of decisions which turn on this ambiguous rallying cry. For, depending on the context in which it is used, the proposition may refer either to a substantive right to require the hospital to appoint the applicant or merely to an obligation resting on the body making the decision to observe the requirements of natural justice. Or it may refer to both.

Unfortunately, courts have tended to ignore the distinction. They have justifiably rejected the proposition in circumstances where the issue was the hospital's authority to refuse to appoint an applicant. But such cases have often been erroneously relied on to justify a decision denying a doctor the right to a hearing before the hospital body considering his application. In Ontario the courts' continuing confusion of these two issues was a major factor in amending the Public Hospitals Act.

B. *The Extent of the Hospital's Authority*

This confusion is well illustrated by the leading case of *Henderson v. Johnston* [50] and by its subsequent interpretation. Like many of the cases examined below, this dispute concerned the substantive criteria involved in a decision to reject applications, rather than any denial of procedural fairness. *Henderson v. Johnston* is invariably cited to support the bold proposition that a doctor does not have the right to be appointed to a hospital staff position. [51] But the true effect of the decision is much less sweeping.

The *Henderson* case was instituted by two doctors, members of the

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[49] See text between notes 155-189 *infra*.

[50] *Supra* note 21.

[51] *See, e.g.*, Roberts v. Grant, 34 D.L.R. (2d) 638, at 650 (B.C.S.C. 1962); Chakravorty v. Attorney General for Alberta, [1972] 4 W.W.R. 437, at 451, 28 D.L.R. (3d) 78, at 92 (Alta. S.C.).

courtesy staff of a London, Ontario, hospital, to declare ultra vires certain by-laws purportedly passed by its board. The case raised two basic issues: first, the validity of all by-laws which limited the use of the hospital to doctors who were members of the staff; second, the validity of a by-law which provided that a staff physician could be dismissed if he was found to have engaged in the practice of fee-splitting. The Supreme Court, in reasons delivered by Mr. Justice Judson, dealt with the position of the plaintiffs on the first issue in these words:

> The complaint of the plaintiffs is that the Board of Trustees of the hospital in the exercise of its power of management, cannot restrict them in the practice of their profession or determine who may be members of the Courtesy Staff. They claim that as members of the medical profession in good standing, they have an absolute right to attend their patients in private or semi-private rooms in the hospital and that no power is vested in the Board to limit this right. This is the substantial point of the attack on the first by-law. The issues in this branch of the case are therefore very narrow. They amount to no more than a bald assertion of a right and a denial of the Board's power to regulate in any way the matters in controversy for it is undisputed that, beyond this, no practitioner has been denied anything—whether right or privilege—in connection with his practice in the hospital. The claim is unsupported by authority and I am satisfied that there is no such absolute right as the one asserted. No common law or statutory origin was suggested and it cannot come from any statutory or other recognition of professional status. The right of entry into the hospital and the right to use the facilities there provided, in the exercise of the profession of these appellants, must be found in the regulations of the hospital authority for, apart from them, it has no independent existence. [52]

In dismissing the appeal, the Court also expressed its agreement with the reasons of Mr. Justice Roach in the Ontario Court of Appeal, who forcefully rejected the proposition that every licensed medical practitioner in the province had the absolute right to become a member of the staff of any public hospital:

> The proposition . . . must be based on the theory that the mere licensing of a practitioner gives him that right. I do not know of any authority that supports that theory. We can start with the proposition that public hospitals are established, not for the benefit of the medical profession but for the benefit of those members of the public who are ill and in need of hospital care. [53]

He went on to say that the hospital's managerial powers under the Regulations

> include the power to say who shall and who shall not be permitted to function as a medical practitioner in the hospital. Accordingly a Board of Trustees of a public hospital is under no obligation to designate a particular practitioner a member of the courtesy staff if in its honest, unbiased and reasonable opinion it would be detrimental to the

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[52] [1959] S.C.R. 655, at 658, 19 D.L.R. (2d) 201, at 203-04.
[53] [1957] O.R. 627, at 634-35, 11 D.L.R. (2d) 19, at 25.

> best interest of the hospital to have him functioning in it. On the other hand, if there is no good reason for excluding him then in my opinion the Trustees would be required to designate him to the courtesy staff, not because of any duty they owe to him but because of the duty they owe his patients as members of the public. If they could exclude a licensed practitioner from the courtesy staff without good reason then they could create a monopoly in favour of some practitioners to the exclusion of others, a result not intended by the Act or the Regulations passed thereunder. [54]

The Ontario Supreme Court also affirmed the power of the hospital to enact by-laws making participation in fee-splitting arrangements a ground for dismissal from the staff. [55] Mr. Justice Roach pointed out that the practice was universally condemned in the medical profession. The hospital had determined that it was against its best interests, having regard to its duty to its patients, to permit unethical doctors to continue to treat patients in the hospital. The court held that the hospital had the power to pass by-laws for that purpose, and furthermore, that it had exercised its power reasonably in this case. [56]

From the Court's disposition of these issues, two important qualifications of the basic principle emerge. The first arises from the dictum that a board must exercise its discretion to refuse an application on the basis that in its "honest, unbiased and reasonable opinion it would be detrimental to the best interest of the hospital to have him functioning in it". [57] It may be that Mr. Justice Roach had in mind a distinction between the hospital's right to pick and choose staff, and any *procedural requirements* that it might still be subject to. The latter issue did not, of course, arise in the *Henderson* case.

It is also very clear from the Court's treatment of both issues that it was prepared to recognize limits on the powers of the hospital to exercise its judgment about staff appointments and to enact by-laws with respect to staff appointments. This observation is based on the Court's emphasis on the existence of a duty on the part of the trustees toward the public to *admit* a physician if no good reason existed for excluding him, and upon the notion, raised in connection with the fee-splitting by-laws, that the power to enact by-laws must be exercised reasonably.

There is no other Canadian case relating specifically to hospitals which illustrates this principle, although there exists a well established line of authority (represented by such cases as *Roncarelli v. Duplessis* [58]) to support the general principle.

American courts, however, have considered the issue on a number of occasions in connection with hospitals. With respect to these cases, it has been said that "the courts have attempted to strike a balance between

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[54] *Id.* at 635-36, 11 D.L.R. (2d) at 26.
[55] *Supra* note 52, at 659-60, 19 D.L.R. (2d) at 205.
[56] *Supra* note 53, at 638-42, 11 D.L.R. (2d) at 28-32.
[57] *Id.* at 635, 11 D.L.R. (2d) at 26.
[58] [1959] S.C.R. 121, 16 D.L.R. (2d) 689.

reasonable standards and the public nature of the institution".[59] While the legal framework of the disputes may differ (for example, the cases largely turn on an interpretation of the terms of the fourteenth amendment to the United States Constitution), the policy issues remain the same.

In *Foster v. Mobile County Hospital Board*,[60] a public hospital was enjoined from refusing the applications of two highly qualified black doctors on the basis of two by-laws which made membership in the county medical society and the signatures of two doctors already on staff (to attest to character and general fitness) preconditions of every application. The applicants had been unable to fulfill either requirement.

While no evidence of racial discrimination was found, the court held the by-law requirements to be unreasonable and arbitrary. It found that the requirement of membership in the medical society was arbitrary in that it was not related to the primary function of the medical staff, namely, to ensure the best possible care for all patients treated in the hospital. The distinctions drawn between members and non-members of the organization lacked "any reasonable basis, such as the professional or ethical qualifications of the physicians . . .".[61] (The court was also influenced by the absence of any provision in the by-laws for a right to be heard or to appeal a refusal of an application.[62])

The need for an independent appellate body to correct errors in the merits of decisions (such as excess of authority) may, in light of the foregoing review, be exaggerated, since there is ample authority indicating that courts may exercise such control. The only advantages are speed, expertise and lower costs (although many of these advantages do not seem to have materialized with the establishment of the HAB).

IV. The Right to a Hearing

A. *Generally*

It has long been recognized at common law that parties affected by certain decisions of public authorities must first be given adequate notice and an opportunity to be heard. This principle of natural justice, known as *audi alteram partem*, does not apply to every decision made by a body or individual having statutory authority to do so, but only where the court determines that there exists a duty to act judicially.

In many cases, procedural rules will be specified by statute or by the

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[59] W. Curran & E. Shapiro, Law, Medicine and Forensic Science 608 (2d ed. 1970).

[60] 398 F.2d 227 (5th Cir. 1968).

[61] *Id.* at 230.

[62] *Id.* Courts have achieved the same result by other means. In Maricopa Cty. Medical Soc'y v. Blende, 104 Ariz. 12, 448 P.2d 68 (1968), the court ordered a medical society to admit a physician as a member where it was shown that membership was a prerequisite to hospital staff privileges.

by-laws and rules of the body itself. The relevant legislation may either expressly dispense with any procedural requirements or specifically require a certain form of hearing, with perhaps the right to written reasons and to an appeal. In Ontario, especially since the *Royal Commission Inquiry Into Civil Rights (McRuer Report)*, statutory rules of procedure are becoming increasingly common. [63] The amendments to The Public Hospitals Act [64] are one example of this development. Even prior to the statutory changes many hospitals had created hearing arrangements in their by-laws, with the advice and prodding of professional organizations and government departments. [65]

The answer is sometimes not to be found in any rule or statute, and, if a hearing is required, it is only by virtue of common law principles. Prior to the amendments to the Public Hospitals Act, it was this body of law to which hospitals, physicians and the courts had to turn in determining when the obligations of natural justice had to be met in making decisions concerning staff privileges. The case law continues to apply in provinces without legislation similar to that in Ontario.

The courts have developed a multitude of tests, labels and concepts in their attempt to determine which bodies are subject to the duties to observe natural justice. All too often, characterizing a body's function as either "administrative" or "judicial", and denoting the subject-matter of the decision as a "privilege" and not a "right", "can be seen as a contrivance to support a conclusion reached on non-conceptual grounds". [66] The cases on hospital privileges are a vivid illustration of this reliance upon empty verbal formulas and of the corresponding failure to clarify and express the practical factors that influenced the result.

The cases discussed below are grouped according to the stage of the process at which the dispute arose, rather than according to the particular administrative terminology the court happened to adopt. The issue is the same whether the court asked the question, "Is the tribunal exercising a judicial or an administrative function?" or the question, "Is a hospital staff appointment a right or a privilege?" On the other hand, the practical considerations may differ depending on whether the applicant seeks a new appointment or tries to retain an existing one, and whether the body being challenged is the MAC or the Board of Trustees.

B. *On an Initial Application for Privileges*

The Grange Committee [67] and other authorities [68] have asserted that

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[63] *See* The Civil Rights Statute Law Amendment Act, S.O. 1971 c. 50, and The Statutory Powers Procedure Act, S.O. 1971 c. 47.

[64] S.O. 1972 c. 90, S.O. 1973 c. 164.

[65] Interview with R. Walsh, Legislation Services Director for the Ontario Hospital Association, in Toronto, November, 1975.

[66] S. A. DE SMITH, JUDICIAL REVIEW OF ADMINISTRATIVE ACTION 58 (3d ed. 1973).

[67] GRANGE REPORT, *supra* note 2, at 4.

[68] L. Rozovsky, *Medical Staff Privileges and the Law*, CANADIAN HOSPITAL 25 (Aug. 1971).

there is no common law right to a hearing on an initial application for hospital privileges. While some support can be found for this assertion, the point is by no means settled. As argued above, [69] *Henderson v. Johnston* inclines *toward* providing procedural safeguards, to the extent that it addresses itself to the point at all. Those cases which deny a hearing where privileges have been cancelled are more applicable to situations where the applicant does not yet hold any position, but they are counterbalanced by cases which say the opposite.

Direct authority, however, is virtually non-existent. In *Andreas v. Edmonton Hospital Board*, [70] the court held that the hospital Board, in refusing an initial application for privileges, was not obliged to give any reasons. The court itself gave little in the way of reasoning to support this conclusion. The facts of the case were that the hospital extended to the applicant an opportunity to appear before the medical staff committee and the Board. The applicant declined the opportunity, demanding reasons for their decision to reject the application. That demand had been refused.

The recent Supreme Court of Canada case of *Roper v. Executive Committee of the Medical Board of the Royal Victoria Hospital* [71] also involved an initial application. The judgment of the Court leaves the implication that a hearing is required before the Board; however, the implication is strictly obiter, and never stated in so many words. The only issue facing the Court was the extent of hearing rights before the hospital's Executive Committee, and not before the Board. Furthermore, in the circumstances of the case, regulations under the Quebec Hospitals Act [72] required that notice be given to the applicant and that he have an opportunity to make representations to the Committee, either in person or through counsel.

C. *Cancellation of Privileges*

There is a definite, although not consistent, trend toward requiring a hearing where a board proposes to cancel existing privileges. But, again, there is little useful reasoning given for decisions which go either way.

Where procedures for notice and hearings have been provided for by by-laws, hospitals must follow them. [73] In complying with those by-laws hospital boards are performing judicial functions which they have imposed on themselves. [74] However, where the statute or the regulations have specified certain partial rights to be heard, there is no obligation to hold a full-

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[69] See text between notes 50-58 *supra*.

[70] [1944] 3 W.W.R. 599, [1944] 4 D.L.R. 747 (Alta.).

[71] 50 D.L.R. (3d) 725 (S.C.C. 1974), discussed between notes 100-107 *infra*.

[72] R.S.Q. 1964, c. 164.

[73] Sreedar v. Outlook Union Hosp. Bd., [1973] 2 W.W.R. 120, 32 D.L.R. (3d) 491 (Sask. 1972); *Re* Crux, 29 D.L.R. (3d) 601 (Sask. Q.B. 1972); *Re* Barik, 41 D.L.R. (3d) 757 (Sask. Q.B. 1973).

[74] Sreedar v. Outlook Union Hosp. Bd., *supra* note 73, at 125-26, 32 D.L.R. (3d) at 496-97.

fledged hearing along the lines of a court, provided such obligation would not exist absent the statutory arrangement. [75]

In some cases, however, no statutory or by-law-created hearing requirements exist. This was the situation in *Marian v. Board of Governors of University Hospital.* [76] In that case the Saskatchewan Court of Appeal dismissed an application for certiorari and prohibition to quash a dismissal from a hospital staff. The applicant complained that the dismissal was invalid since he had received no notice and had been given no opportunity to make his case before the medical staff or the Board. The court held that the wide power which the legislature gave to the hospital Board to manage, administer and control the affairs of the hospital made it an administrative body. Even though the court said that the Board was performing a judicial act, Mr. Justice Woods, speaking for the Court of Appeal, said: "An administrative body . . . has an absolute discretion and is not answerable for its decisions when it acts within its powers and prescribed procedural requirements." [77] Here the only prescribed procedural requirement was that the Board should consult with the MAC. Having done so, it was "not subject to control by the courts". [78]

The trial judge in the *Marian* case cited the remarks of Mr. Justice Masten in *Re Ashby* [79] identifying the distinguishing characteristics of an administrative body:

> The distinguishing mark of an administrative tribunal is that it possesses a complete, absolute and unfettered discretion and, having no fixed standard to follow, it is guided by its own ideas of policy and expendiency. Hence, acting within its proper province and observing any procedural formalities prescribed, it cannot err in substantive matters because there is no standard for it to follow and hence no standard to judge or correct it by. [80]

The view of the Ontario Court of Appeal in *Regina v. Board of Directors of Orillia Soldiers Memorial Hospital, Ex parte Newton,* [81] surely comes just as close to the real character of a decision over hospital privileges. Mr. Justice Arnup states:

> For the purposes of this appeal, we are all prepared to assume that the nature of the hearing before the board was such that the principles of natural justice were required to be observed by the board. To deal with the matter on any other basis is to suggest that the board had the right to take away the operating privileges previously granted to the applicant, and to do so in proceedings conducted in a way which were contrary to natural justice. [82]

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[75] Roper v. Executive Comm. of the Medical Bd. of the Royal Victoria Hosp., *supra* note 71, at 730.

[76] [1971] 1 W.W.R. 58, 15 D.L.R. (3d) 767 (Sask. 1970).

[77] *Id.* at 61, 15 D.L.R. (3d) at 769-70.

[78] *Id.* at 61, 15 D.L.R. (3d) at 770.

[79] [1934] O.R. 421, [1934] 3 D.L.R. 565.

[80] *Id.* at 428, [1934] 3 D.L.R. at 568.

[81] [1971] 2 O.R. 397, 18 D.L.R. (3d) 64 (1970).

[82] *Id.* at 398, 18 D.L.R. (3d) at 65.

The extraordinary feature of the *Marian* case and the *Newton* case is that the respective courts arrived at opposite characterizations of the decisions in question, yet each took its description to be entirely axiomatic. Neither cited any substantial authority or entered into any inquiry about the nature of the procedure to be followed. In the *Marian* case, for example, the by-laws did provide for hearings in certain situations, namely, where the character, teaching ability, ethics or competence of the doctor were impugned. The court found that the sole reason for the dismissal was that the hospital authorities had concluded that Dr. Marian was exercising a disturbing influence in the hospital, upsetting and demoralizing the staff so that the hospital was less efficient and more difficult to work in. Yet the court concluded that the by-law did not apply. [83]

The same Saskatchewan court compounded the confusion of the *Marian* case in *Re Crux.* [84] Dr. Crux had been appointed to the staff in January, 1970. Although his privileges had expired in January, 1971 (this happened automatically under the terms of the hospital by-laws), he continued to be a member of the active staff until May, 1972, when his privileges were withdrawn without notice and without any hearing. The trial court granted the application for certiorari and prohibition to prevent the Board from implementing its motion. Because the Board had failed to comply with the clear provisions of its own by-laws, the court found it easy to arrive at such a decision. The by-laws specified that an opportunity to appear should be given.

However, the court went on to distinguish the *Marian* case, on very questionable grounds, while approving it in principle. It was said that the *Crux* case involved charges against the doctor's reputation, whereas in *Marian* no allegations against the character or competence of the doctor had been advanced. [85] Even if the distinction is strictly accurate, the practical difference may be small. A charge that a doctor exerts an unduly disruptive influence on a hospital may well have as serious an effect on his professional reputation and his ability to obtain privileges elsewhere as an allegation that his work fell below a certain level of competence. Furthermore, dismissal from a hospital staff for any reason—or for no reason—is in itself a black mark on a doctor's record. In any event, the question of the grounds for the dismissal was only relevant in the *Marian* case because of the distinction made in the by-laws. If there had been no hearing provisions at all in *Marian*, the court there presumably would have held that no hearing was required, whatever the charges might have been.

Another distinction advanced by the court was that in the *Crux* case, unlike in the *Marian* case, the by-laws set out specific considerations which the Board was to take into account—character, professional competence, training and experience. The court asserted that because the hospital had en-

[83] *Supra* note 76, at 60-61, 15 D.L.R. (3d) at 769.
[84] 29 D.L.R. (3d) 601 (Sask. Q.B. 1972).
[85] *Id.* at 606.

acted such a by-law, the Board's decisions on staff privileges became judicial acts. [86] Yet, whether the by-laws had specified such considerations or not, a hospital board would canvass them in every case. Why should a board which keeps its standards unwritten not be under the same obligations?

A comparison of these two cases demonstrates how misconceived is the automatic application of the "administrative" label to hospital boards in their function of deciding on staff appointments.

D. *"Right" or "Privilege"*

In *Chakravorty v. Attorney-General for Alberta,* [87] the Alberta Supreme Court refused to make an order of certiorari to quash the recommendation of a medical executive committee, made without notice or a hearing, that a doctor's privileges be restricted because his work fell below the hospital's standards. One ground for the decision was that in making its decision, the Board was "dealing not with rights but with mere privileges . . .". [88]

In support of its conclusion, the court cited the decision in *Nakkuda Ali v. Jayaratne.* [89] There a textile dealer whose licence had been cancelled applied for certiorari to quash the cancellation order because there had been no prior inquiry such as the rules of natural justice would require. The Judicial Committee of the Privy Council dismissed his appeal, holding that the controller was not obliged to act judicially, despite the statutory requirement that there be reasonable grounds for believing the licensee to be unfit to be a dealer. One reason for the decision was that the controller was not determining a question affecting the rights of subjects, but was merely "taking executive action to withdraw a privilege . . .". [90]

As De Smith illustrates, this "conceptual" approach is as arbitrary in its results as use of the judicial-administrative formula:

> Demolition of a property-owner's uninhabitable house might be for him a supportible misfortune; deprivation of a licence to trade might mean a calamitous loss of livelihood; but the judicial flavour detected in the former function was held to be absent from the latter. [91]

The analogy between revoking a licence to trade and an appointment to a hospital medical staff is apt. In both cases the decision may drastically upset the individual's plans, cause him serious and continuing economic loss and possibly damage his reputation both among his peers and within the community.

Apart from its unfair consequences, the *Nakkuda Ali* decision is now

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[86] *Id.* at 606-07.
[87] [1972] 4 W.W.R. 437, 28 D.L.R. (3d) 78 (Alta. S.C.).
[88] *Id.* at 451, 28 D.L.R. (3d) at 91.
[89] [1951] A.C. 66, 66 T.L.R. (pt. 2) 214 (P.C. 1950).
[90] *Id.* at 78, 66 T.L.R. (pt. 2) at 220.
[91] S. A. DE SMITH, *supra* note 66, at 150.

in disrepute both in England [92] and Ontario, [93] and is out of line with the prevailing treatment of decisions revoking licences. [94]

E. *Non-Renewal of Privileges*

The general practice of hospitals is to make appointments annually and to terminate them after each one-year period, at which time a doctor may or may not be re-appointed. [95] The problem arises as to how the courts will characterize non-renewals. Are they to be regarded as new applications and treated in the same way as an initial application would be? Or can a doctor whose appointment has lapsed, and who has submitted a new application which has been turned down, assert that his hospital privileges have been cancelled?

In *Re Crux*, [96] the court took the latter approach. In that case, however, the doctor had been permitted to continue on the active staff for over a year after the expiry of his most recent appointment before he was told he was no longer on the staff. The court rejected the Board's attempt to say that it was not a cancellation because the doctor had no privileges left to cancel. [97]

F. *The Stage of the Proceedings at which a Hearing is Available*

It is necessay to recall once again that the decision of the hospital takes place in two stages. The proceedings in the *Newton* case [98] are probably fairly typical of the division of responsibility between the MAC and the hospital board. In that case it was the MAC which conducted a detailed investigation of all medical and professional matters upon which allegations against a staff physician had been based. Findings of fact were made with respect to these matters, and a recommendation about what decision the Board should come to on the findings was sent to the Board along with the findings of fact. The Board, being composed of laymen, did not enter into any inquiry of its own, but accepted the findings of the MAC. The Board then listened to arguments about the decision to be made in light of the findings.

If this is the usual course of events, then the most effective sort of hearing arrangement would be one which, following the pattern of the decision-making process, takes place in stages. Unfortunately, both the courts and legislatures have more often than not become hypnotized by artificial administrative law labels and failed to look beyond the formal legal characteristics of hospital decison-making structures to the way they actually function.

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[92] *See* Ridge v. Baldwin, [1964] A.C. 40, at 77-79, [1963] 2 All E.R. 66, at 79-89, [1963] 2 W.L.R. 935, at 950-52 (Lord Reid).

[93] *Re* Hershoran, 3 O.R. (2d) 423, at 424, 45 D.L.R. (3d) 533, at 534-35 (1974).

[94] D. MULLAN, ADMINISTRATIVE LAW 3-57, § 19, and cases cited in n. 22 (1973).

[95] Prototype by-law 47.

[96] *Supra* note 84.

[97] *Id.* at 606.

[98] *Supra* note 81. See text at note 112 for a detailed discussion.

The following statement from a recent handbook of hospital law for hospital officials illustrates the problems which formalism creates: "[T]he minimum requirement would be a right to be heard and to meet one's accusers at a meeting of the body which is in fact making the decision." [99] The author continues by suggesting, however, that a hearing before the MAC would not often need to be provided. It would only be necessary in the unusual case where the Board's practice is to ratify automatically any MAC proposal, so that it is the MAC which is actually making the decision. Clearly, such a situation is likely to be rare, if only because it is an improper—an unlawful—delegation by the board of its exclusive obligation under the regulations to make the decision itself. And it is in the ordinary case that a hearing is crucial before the MAC, since that is really the only effective opportunity to challenge the most vital aspects of the allegations.

The Supreme Court of Canada recently considered the problem of the stage of the proceedings at which an obligation to hold a hearing arises in the *Roper* case. [100] That case arose out of an application by the plaintiff, a psychiatrist, to join the staff of a Montreal hospital. He had been a member of that staff from 1959 until 1967, when the Board of Governors had declined to re-hire him. The application in issue was made in January, 1970, and was rejected in turn by the Credentials Committee, the MAC, and the Executive Committee of the Board of Management. The formal authority of all three of these bodies was advisory only. After receiving the recommendation of the Executive Committee, Dr. Roper requested a hearing before them, to which he was entitled by virtue of section 159 of the regulations made under the Quebec Hospitals Act. The section read:

> When the executive committee does not recommend a candidate to the board of management for appointment or a renewal of appointment, or it recommends a change in the status and privileges of a member of the medical staff, it must inform, in writing, the candidate or the member concerned of its recommendation.
>
> The candidate or member concerned may, within a delay of two (2) weeks, be heard or represented, according to his choice, before the executive committee or the board of management. [101]

During the course of the hearing, Dr. Roper asked that a number of witnesses who had signed written statements favourable to him be called as witnesses, to enable him to refute allegations made against himself before the Credentials Committee (the record there was part of the evidence before the Executive Committee). That request, and a further one to refer the whole matter back to the Credentials Committee once the witnesses had been heard, was refused.

In a cryptic judgment written by Mr. Justice De Grandpré, the Court upheld the majority of the Quebec Court of Appeal in finding that the

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[99] L. E. ROZOVSKY, CANADIAN HOSPITAL LAW 60 (1974).
[100] *Supra* note 71.
[101] O.C. 288/69.

Executive Committee had violated no requirement of natural justice or of the Act in refusing to accede to the appellant's requests. The Court's conclusion rests on its view that apart from the statutory hearing requirement, the maxim *audi alteram partem* does not require the procedures requested by the appellant in this case:

> The decision to be taken by the executive committee was undoubtedly administrative in nature, and would result in the making of a recommendation to the board of management. This is the actual wording of S. 159 of the Regulations, which wording moreover is in accordance with the philosophy of the Act, which makes the Board of Management wholly responsible for administering the hospital and for choosing and appointing its staff. In this context the *audi alteram partem* rule, relied on by appellant, loses its force considerably, as an administrative body may not transform itself into a *quasi*-judicial one. The fundamental obligation of the executive committee is to demonstrate the objectivity and fair play essential in such matters. If in doing that it is necessary to hear the parties, and even their witnesses, the rule applies, but on an exceptional basis only. [102]

The key word in this passage is "recommendation". The powers of the Executive Committee are limited to giving advice. The only body which actually renders a decision is the Board of Management. The Court appears to be saying that a body with exclusively advisory powers should not ordinarily be bound by a requirement to provide a hearing. Clearly, this proposition applies to medical advisory committees as well as to the executive committee of a board of trustees. The case, then, has important consequences for the common law relating to hearings in hospital staffing decisions.

While not giving any reasons of its own on this point, the Court does refer to its decision in *Guay v. Lafleur*. [103] That case is an instance of the currently prevailing principle [104] that bodies whose powers are not binding or conclusive of any rights of a party, but whose functions are merely investigatory or advisory, are not subject to the rules of natural justice. [105]

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[102] *Supra* note 71, at 728.

[103] [1965] S.C.R. 12, 47 D.L.R. (2d) 226 (1964).

[104] *E.g.*, St. John v. Fraser, [1935] S.C.R. 441, [1935] 3 D.L.R. 465; *Re* Township of York By-law 11996, [1942] O.R. 582; Samuels v. Council of College of Physicians and Surgeons of Saskatchewan, 57 W.W.R. 385, 58 D.L.R. (2d) 622 (Sask. Q.B. 1966); Regina v. Ontario Lab. Rel. Bd., [1966] 2 O.R. 513, 57 D.L.R. (2d) 521.

The full effect of the common law principle has been preserved by The Statutory Powers Procedure Act, S.O. 1971 c. 47. Part I of the Act establishes a code of "minimum rules" for the proceedings of most tribunals which exercise "statutory powers of decision", as that Act defines them, and which are required by law to afford an opportunity for a hearing. Among the proceedings specifically *excluded* from the Act are proceedings

> 3(2)(*g*) of one or more persons required to make an investigation and to make a report, with or without recommendations, where the report is for the information or advice of the person to whom it is made and does not in any way legally bind or limit that person in any decision he may have power to make.

[105] The principle is by no means as clear as cases such as Guay v. Lafleur, *supra* note 103, suggest. The Supreme Court itself has held that for some purposes

Ideally, the principle is simply a reflection of the flexible approach which courts ought to adopt in attempting to ensure procedural fairness, *i.e.*, "to look at the whole ambit of the decision-making process in issue and decide on the appropriateness of a hearing at the preliminary stage having regard to the procedural protections provided for, if at all, later in the same process". [106] In *Guay v. Lafleur*, for example, the Supreme Court reached a sensible result, in view of the existence of a full right of appeal from the decision of the Minister (to whom the recommendation in issue was made), and the right to call new evidence at such a hearing.

In *Roper*, however, it is not at all clear whether the physican had any further opportunity to be heard. The statute provided for a limited hearing before either the Executive Committee or the Board, but not for any right of appeal to the courts or to any other tribunal. In this case the applicant chose the Executive Committee. Did he nonetheless retain the right to be heard by the the Board in accordance with the requirement of *audi alteram partem*? In citing *Guay v. Lafleur* the Court seems to be suggesting that he was so entitled. Yet, as we have seen, [107] various Canadian authorities yield no consistent answer to the problem of when a hearing may be required at all. Thus, the effect of the decison in *Roper* may be to deprive a doctor of an opportunity to present his case at *any* stage, if the statute is silent.

Furthermore, an applicant's plight would not be much improved even if it were possible to read the judgment in *Roper* as acknowledging the right to a fair hearing before the Board of Management, since it is unlikely that a board would upset the recommendations of its medical staff or its executive committee. [108]

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an advisory tribunal may exercise a judicial function. In Bell v. Ontario Human Rights Comm'n, [1971] S.C.R. 756, 18 D.L.R. (3d) 1, the remedy of prohibition was granted to prevent the Commission, which only had the power to recommend a course of action to the Minister, from commencing an inquiry into a complaint of racial discrimination. (Prohibition is only available against bodies exercising judicial functions.)

And in England recent cases are reflecting the emergence of a "duty to act fairly" which cuts across the traditional classifications of decision-making functions and which imposes an obligation to observe the rudiments of natural justice for a limited purpose in the exercise of "investigative" and "administrative" as well as "judicial" functions. *See In re* Pergamon Press Ltd., [1971] Ch. 388, [1970] 3 All E.R. 535 (C.A.).

[106] D. MULLAN, *supra* note 94, at 3-59, citing Wiseman v. Borneman, [1971] A.C. 297, [1969] 3 All E.R. 275.

[107] See text between notes 67-96 *supra*.

[108] The Court in *Roper* provided some other reasons for its resolution of the case. It pointed out that the principle of a fair hearing does not always require an oral hearing or the right to call witnesses, as long as there is an adequate opportunity for the party to present his case. In this case there was a long and contentious record of previous dealings with the Board. In the Court's words, "the appellant was not a stranger" to the Board. This seems to imply that in the course of these disputes the appellant had already had a considerable opportunity to present his case, and that this reduced the need for a full re-examination of the facts during the subsequent application.

Having found no support for the appellant in the common law, the Court also

It is surprising that the new legislation in Ontario and Quebec perpetuates the absence of provisons for hearings at the medical staff level. There is no direction in the Ontario Public Hospitals Act [109] for any hearing before the MAC, although the Act does give the applicant a right to be heard and to call witnesses before the Board, and a right of appeal as well.

In Quebec, the Hospitals Act [110] has been superseded by the Health Services and Social Services Act. [111] Section 159 of the regulations made under the former Act (the section reproduced above) gave the doctor the option of appearing before the Board of Management itself or before the Board's Executive Committee, but not before the MAC. The regulation enacted under the new Act details a somewhat different model: the applicant may appeal a decison of the Board of Directors of a health centre to a permanent, three-person Board of Review. The Executive Committee, the MAC and the Board of Directors are required only to abide by time limits for releasing their recommendation and decision, and to give reasons for them.

In the *Newton* case, [112] the Ontario Court of Appeal approved a two-stage hearing format, which seems to be more appropriate for the situation of hospital staff appointments. The physician was given the opportunity, which he exercised, to appear before the MAC with counsel and to call witnesses. He was informed of all incidents upon which the Committee based its allegations. The court rejected his submissions that the Board of Governors, which also held a hearing, erred in refusing to permit him to challenge the findings of fact made by the MAC on the medical aspects of the charges made against the doctor. Speaking for the court, Mr. Justice Arnup pointed out that the MAC was composed almost entirely of doctors and that the issues before the Committee were "of a technical and professional nature". He continued:

> When the matter came before the board, which was composed on this occasion entirely of lay people (in the sense of non-medical persons), it was, in my view, clear that the medical facts had been ascertained by the medical staff advisory committee and that the real question before the board was what should be done by the board in the light of the findings by the committee and its recommendation on the facts which it had found. It is not necessary to decide whether counsel for the applicant had the right, before the board, to challenge findings of medical fact which had been made by the committee which was reporting to the board, because in fact he did not do so and I think it is clear that to have done so would have been a fruitless exercise, because the nature of the facts upon which the board was called upon to act were, as I have said, entirely of a medical nature. The board itself appears to have recognized this and was not

rejected the submission that the statute, in providing for some elements of a hearing, converted the Committee into a judicial body which must, as such, satisfy *all* the obligations of the judicial function.

[109] R.S.O. 1970, c. 378, *as amended* S.O. 1972 c. 90.

[110] R.S.Q. 1964, c. 259.

[111] S.Q. 1971 c. 48.

[112] *Supra* note 81.

> prepared to go behind the facts which had been found by the committee after its full and complete hearing.
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> . . . [T]here was no denial of natural justice in this case, and . . . there was in fact full disclosure of the nature of the allegations and full opportunity to make defence and submissions with respect thereto, albeit the hearing took place in two stages. [113]

The recent decision of the Saskatchewan Queen's Bench in *Re Cockings* [114] is in the same spirit as the *Newton* case, even though the court concluded that the hospital board was obliged to give the applicant additional rights at his hearing. The hospital authorities had charged the physican with refusing to follow certain directions of his department head. Unlike the Orillia Hospital, the University Hospital had a provision in its medical staff by-laws requiring a hearing at both stages. The section provided that the physician

> shall be given the opportunity of appearing in his own defense before the Executive Committee of the Medical Advisory Committee and subsequently, if necessary, shall be given the opportunity of appearing in his own defense before the University Hospital Board or its representatives. [115]

The Executive Committee convened a hearing at which both sides called extensive viva voce evidence. The hospital Board also granted a hearing but informed the doctor that he would be restricted to making submissions through his counsel on the basis of the transcript taken at the first hearing. The physican sought an order prohibiting the Board from proceeding further under the by-law. The court granted the application on the basis that the physician should be permitted to testify, if he wished, and to call witnesses. But the Board would also be permitted to receive and consider the transcript and the exhibits of the Executive Committee hearing.

V. The Grange Committee

The Minister of Health established the Committee of Inquiry Into Hospital Privileges in Ontario in June, 1971, in direct response to two controversial disputes which had arisen between the North York General Hospital and two doctors, Sheriton and MacDonald. Both cases had received extensive press attention. Hospitals and hospital boards were being criticized for allegedly operating "closed shops" and for improperly excluding highly qualified doctors from their staffs. The Minister had received other complaints of discrimination by reason of race and national origin. [116]

The Committee appears to have had a preconceived notion of the nature of the problem involved in disputes concerning hospital privileges.

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[113] *Id.* at 398-99, 18 D.L.R. (3d) at 65-66.
[114] 54 D.L.R. (3d) 581 (Sask. Q.B. 1975).
[115] *Id.* at 586.
[116] The Globe and Mail (Toronto), July 1, 1971, at 1.

To a large extent the kind of solution that was expected to emerge from the Committee's work was also predetermined. In spite of the fairly wide terms of reference which the Minister gave the Committee, it is clear from the Minister's statements, [117] from the composition of the Committee, [118] and from the way it interpreted its instructions, that what was sought was a set of procedures which would provide an independent review of decisons of boards of trustees and the creation of some substantial powers in an independent body for reversing or altering inequitable decisions made at the hospital level. Certainly no major alterations were envisioned for provincial health policy.

The Committee was asked to look into three aspects of hospital administration. First and foremost was the method of appointing doctors to hospital staffs, the nature of privileges granted to doctors on appointment, the limitations and restrictions placed on such privileges, and their cancellation. Two other related matters were included in the terms of reference: the allocation of beds in hospitals and the methods of admission and discharge of patients; and the special difficulties in allocating beds in teaching hospitals. The Committee spent little time in its *Report* on the latter two issues. [119]

The flaws which the Grange Committee uncovered in the old system were direct consequences of the character of the bodies empowered to rule upon staff appointments. As discussed above, [120] the Board of Trustees is the body which must make decisions on all appointments, after receiving the recommendations of the MAC. The procedures by which these decisions are made are to be found in the by-laws of the hospital. Because there are standard by-laws issued jointly by the Ontario Hospital Association and the Ontario Medical Association, and because of the necessity for all by-laws to be approved by the Ministry of Health, [121] there is considerable uniformity in these procedures.

The usual procedure is for the administrator of the hospital to refer each completed application through the chairman of the MAC to the Credentials Committee. That committee, after investigating the applicant's professional reputation and qualifications, then reports its findings and recommendations to the MAC. After considering this report, the MAC sends its recommendation to the Board. The Board either acts on the

[117] In announcing the establishment of the Committee, the Minister emphasized that he believed that the system was generally working well and said that "it is not our desire to interfere in the internal arrangements of these hospitals": *id.*

[118] S. G. M. Grange, Q.C. (Chairman), then a Toronto lawyer; H. T. Ewart, M.D., then the President, Ontario Hospital Association; A. D. Kelly, M.D., former General Secretary, Canadian Medical Association; Mrs. G. Pemberton, former President, Ontario Division, Consumer Association of Canada; J. V. Riches, M.D., then a member, Executive Committee, Ontario College of Physicians and Surgeons.

[119] GRANGE REPORT, *supra* note 2, at 16-17.

[120] See text at note 9 *supra.*

[121] The Public Hospitals Act, R.S.O. 1970, c. 378, § 9, *as amended* S.O. 1972 c. 90, §§ 8(1),(2) & (3).

recommendation or refers the application back to the MAC for reconsideration, and then either accepts or rejects the second recommendation.

The one specific time limit mentioned in the by-laws is one month, applicable where the board has referred a recommendation back to the MAC. In the other situations covered, the by-laws provide that applications be forwarded and notice of decisions be given "forthwith", and that recommendations be sent "without unnecessary delay". No specific provisions require a hearing of any kind.

This system, in the opinion of the Grange Committee, "works well in the ordinary case, but in the extraordinary case it is too inexact". [122] The Committee pointed to a number of "potential injustices" to which the existing arrangement could expose applicants:

(i) *Conflict of Interest.* The authority of the medical staff over staff appointments is limited formally to making recommendations to the Board, through the MAC. But because of the expert knowledge needed to assess the qualifications of an applicant, hospital boards are always strongly influenced by the MAC's judgment. With some boards that influence may be decisive in every case. It is thus fair to say that the assessment made by the MAC has more of the character of a decision than a mere recommendation.

The problem is that the members of the MAC, being members of the medical staff, may have a direct financial interest in limiting the number of doctors permitted to practise in the hospital. They may possibly also be concerned in maintaining their influence over hospital policy or in perpetuating certain specific policies. Any of these interests may conceivably influence a decision about accepting a new staff application or revoking an existing one. As the Committee said:

> Where a doctor seeking appointment to a hospital is informed by that hospital that there is no room for him and the decision is made by a body composed in part of doctors engaged in that specialty and enjoying privileges in that hospital, there may reasonably remain with the applicant the suspicion that his application was refused for selfish reasons. [123]

(ii) *No Right to a Hearing.* The prospects of a doctor succeeding in having a court enforce on a hospital the duty to respect the principle *audi alteram partem* are, as we have seen, uncertain. The kind of hearing available at various stages of the process is also unpredictable on the present state of the authorities. [124]

(iii) *Delay.* In spite of the general directions in the by-laws for processing applications expeditiously, the evidence before the Grange Committee revealed a number of examples of "discouragement amounting to rejection, even before the application got to the Medical Advisory Committee". [125]

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[122] GRANGE REPORT, *supra* note 2, at 6.
[123] *Id.* at 9-10.
[124] See text between notes 67-96 *supra.*
[125] GRANGE REPORT, *supra* note 2, at 7.

A. *The Focus of the Grange Report*

There are perhaps three main features of the Grange Committee *Report*. The Committee focussed almost immediately on the issue of "justice" for doctors as the main issue they would deal with. While they recognized the various competing interests involved in the problem, as well as the question of regional planning and the need for numerical guidelines, these issues were not effectively dealt with in any recommendation. To the extent that proposals appeared in the *Report*, they resulted in no legislative action.

Not only did the Committee isolate the issue of justice for doctors, but they also equated justice with "natural justice". With no real examination of alternative procedures (such as, for example, those in effect in Saskatchewan) the Committee adopted the traditional judicial model for its new procedural arrangement.

The third main feature of the *Report* is that it is, in at least one respect, an exercise in mystification. Throughout the *Report* there is a repeated insistence that the object of any changes ought to be the enhancement of the ability of hospital boards to exercise an independent, detached and effective voice in staffing decisions, so as to fulfill the responsibility which the Act and regulations place upon boards to manage and govern the hospital. Yet the ultimate effect of the Committee's proposals has probably been to further reduce, if not to eliminate, whatever independent judgment (and opportunity to exercise that judgment) which hospital boards possessed before the statutory change.

It may well be that such a result was inevitable, given the nature of the task entrusted to the Committee. There is no doubt that medical advisory committees will generally exert a preponderant influence on board staffing decisions. The whole strategy of the Committee's proposals is based upon the realization that the medical staff generally exercises a decisive influence on boards and that boards are by their very nature seldom able to consider questions of staffing fully or impartially. The real complaint is that by pretending to enhance, or at least to preserve, the independence of hospital boards, the Committee failed to face up to the deeper difficulties in hospital government and the organization of hospital services.

B. *The New Legislation* [126]

It will be convenient to outline here the main features of the legislation, since it follows the recommendations of the Committee fairly closely, and then to point out the ways in which it departs from those recommendations.

The amendments affirm the principle that hospital boards have the power but not the obligation (vis-à-vis doctors) to appoint physicians to hospital staffs, to define the extent of their privileges, and to revoke, suspend, or restrict the privileges of physicians on staff. The language of

[126] The Public Hospitals Amendment Act, S.O. 1972 c. 90, *as amended* S.O. 1973 c. 164.

sections 43 and 44 has been chosen to reflect this. Section 43 begins: "The board may, (a) appoint physicians . . . ." Section 44(1) states: "Every physician is *entitled to apply* for an appointment or a reappointment to any group of the medical staff of a hospital established by its by-laws or for a change in hospital privileges . . . ." [127]

The new provisions reveal a concern to ensure that prompt consideration is given to every application and to avoid the phenomenon the Grange Committee described as "discouragement amounting to rejection". Thus, the administrator is required to refer immediately to the MAC every application received. [128] The MAC must consider the application and send its recommendation to the Board within sixty days of receipt. If more time is needed, the MAC must give the Board and the applicant written reasons for the delay. [129] On making its recommendations, the MAC must give written notice of them to the applicant and the Board. The notice to the applicant informs him that he is entitled to written reasons from the MAC and to a hearing before the Board, and that he has seven days to request each of those rights. [130]

The statute directs the Board of Trustees to hold a hearing whenever an applicant requests one. [131] The applicant, the MAC and anyone else the Board may designate are parties to the hearing. [132] The party who requested the hearing has the right, prior to the hearing, to examine any written evidence, documents or reports which will be used at the hearing. [133] Questions of admissibility and judicial notice at the hearing are governed by sections 15 and 16 of the Statutory Powers Procedure Act. [134]

Section 46 of the Act then attempts to ensure that members of the Board who participate in the decision act only on information available to all parties and that they be present throughout the hearing to hear all the evidence and arguments presented. [135]

The most important feature of the amendments is the establishment of a permanent, five-member Hospital Appeal Board. The Board, whose members are appointed by the Cabinet, is composed of two physicians, one lawyer or judge, and "two members representing the public interest", one of whom is a member of a hospital board. [136]

The amendments entitle a doctor to appeal to the Hospital Appeal Board a decision not to appoint or reappoint him; to revoke, suspend or "substantially alter" his privileges; or to cancel his privileges as the attending

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[127] (Emphasis added.)

[128] The Public Hospitals Amendment Act, S.O. 1972 c. 90, § 44(3).

[129] *Id.* §§ 44(4) & (5).

[130] *Id.* §§ 44(6) & (7).

[131] *Id.* § 46(1).

[132] *Id.* § 46(2).

[133] *Id.* § 46(5).

[134] *Id.* § 46(6).

[135] *Id.* §§ 46(4) & (7). An aspect of § 46(4) was considered in *Re* Sutherland, 1 O.R. (2d) 438, 40 D.L.R. (3d) 526 (Div'l. Ct. 1973).

[136] The Public Hospitals Amendment Act, S.O. 1972 c. 90, § 47.

physician for a particular patient under section 41 of the Public Hospitals Act. [137] (In that case, the appeal would be directly from the MAC.) He may also demand written reasons for the decision of the person, board or committee (as the case may be) within seven days of receiving notice of the decision. [138]

The Hospital Appeal Board is obliged to follow the same arrangements for hearings which are imposed on hospital boards under section 46. [139]

The Grange Committee concluded that the Appeal Board should be granted "decisive powers", and the amendments gave effect to that conclusion. The Committee explained:

> We wish to encourage the Trustees to act more independently than they have in the past, but inevitably there will be reliance upon the advice of their Medical Advisory Committees. There can be no true impartiality without the ultimate power being with an independent body . . . . [140]

Section 48(5) provides:

> After a hearing, the Appeal Board may by order confirm the decision appealed from or direct the Board or other person or body making the decision appealed from to take such action as the Appeal Board considers ought to be taken in accordance with this Act, the regulations and the by-laws, and for such purposes may substitute its opinion for that of the Board, person or body making the decision appealed from.

There is a further right of appeal to the Supreme Court of Ontario "on questions of law or fact or both",

> and the court may exercise all the powers of the Appeal Board, and for such purpose the court may substitute its opinion for that of the Appeal Board or board or other person or body authorized to make the decision appealed from, or the court may refer the matter back to the Appeal Board for rehearing, in whole or in part, in accordance with such directions as the court considers proper. [141]

C. *Differences Between the Act and the Committee Recommendations*

The amendments depart from the Committee's recommendation in that they do not set out any standards for the Appeal Board to consider in the course of reviewing the merits of decisions of hospital boards, such as optimum numbers, personality and competence. Nor do they enact the Committee's recommendation that the Board be empowered to consider any problem raised on a regional basis. [142]

The amendments differ from the Committee's *Report* in other respects:

(a) The amendments do not give a MAC any right of appeal from a board decision which goes contrary to the recommendations of a committee.

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[137] *Id.* § 48(1).
[138] *Id.*
[139] *Id.* §§ 48(2) & (3).
[140] GRANGE REPORT, *supra* note 2, at 14-15.
[141] The Public Hospitals Amendment Act, S.O. 1972 c. 90, § 50(3).
[142] GRANGE REPORT, *supra* note 2, at 15.

(b) The Committee recommended that the Appeal Board be composed of three doctors, one lawyer or judge, and one lay person. [143]

(c) The Committee proposed that a doctor who alleged that he was experiencing discrimination or that the hospital was indulging in favoritism in the allocation of hospital beds among patients of various staff doctors be entitled to raise the matter before the Appeal Board. [144] The Act, however, does not provide this right. [145]

D. *Some Criticisms of the New Legislation*

(i) The goal of any procedural mechanism for hearings and appeal ought to be to ensure that decisions by tribunals or bodies of first instance are fair and that they are conducted so as to give each side an adequate opportunity to present its case. Where hearings are provided for, they should be conducted at the stage of the initial determination, where they will be most effective. This is especially true of hospitals, where the decision is made in stages. Appeal and review mechanisms should be inexpensive, as expeditious and informal as the circumstances permit, and administered by persons with an expert knowledge of the problems which commonly arise in the field.

Very few of these goals seem to have been achieved by the introduction of the amendments to the Public Hospitals Act. The very creation of the Hospital Appeal Board has resulted in the reduction of the authority of hospital boards and, apparently, in a tendency not to take seriously the hearing or decision of a hospital board. This phenomenon occurred in the *Schiller* case, [146] as appears from the reasons for judgment of Mr. Justice

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[143] *Id.* at 14.

[144] *Id.* at 17.

[145] Apart from the new sections for hearings and appeals, the Public Hospitals Act was amended (S.O. 1972 c. 90) in three other places as a result of Grange Committee recommendations. Section 40 had required the administrator of a hospital which had restricted or cancelled the privileges of a member of its medical staff by reason of that doctor's incompetence, negligence or misconduct to notify the College of Physicians and Surgeons of Ontario of that action. The section which replaced it added to this obligation a similar requirement to report the rejection of an initial application on any of those grounds or the resignation (voluntary or involuntary) from the medical staff of a physician during the course of an investigation into his competence, negligence or conduct.

Section 10 of the Act was amended to excuse hospital officials, hospital board members and witnesses from any liability for acts or statements occurring during a meeting, proceeding or investigation of the committee or board concerned.

An apparent conflict between the Act and regulations was resolved by amending § 17 of the Act. Formerly, a hospital had been under an obligation to accept as a patient any person in need of active treatment. The amended section provides that such an obligation exists only where a person in need of hospital care has been admitted to a hospital by a medical staff member pursuant to § 32(1) of regulation 729. This is a startling way to resolve an inconsistency and has conceivably brought about a serious restriction of the legal rights of patients vis-à-vis hospitals. The section has not been tested in the courts, and its implications are beyond the scope of this article.

[146] *Supra* note 5.

Cromarty in the Divisional Court. It is attributable to the fact that the hearing before the Hospital Appeal Board proceeds as a trial de novo. That the amendments to the Act envisaged the Board proceeding in this way was affirmed by the court in the *Schiller* case itself. If the experience of the *Schiller* case is typical, appeals are being taken, in effect, from the "decision" of the MAC. [147]

The Act provides for a hearing during the course of the initial determination, but at a stage where it is likely to be least effective, that is, before the hospital board. It is true that hospitals are now being advised to provide hearings before the MAC if so requested. [148] But the Act does not require such a hearing, nor does it provide any guidelines as to the character of any such hearing.

(ii) While hearings before the hospital board tend to be of little use to the parties, they have caused a great deal of resentment within hospitals for the excessive formality and the technicality of the process that results. It has been claimed that some hospitals have adopted a practice of automatically accepting all applications for staff privileges, rather than face the time-consuming and publicly embarrassing business of being subjected to hearings and appeals.

(iii) The unusually broad jurisdiction given to the Supreme Court to review decisions of the Hospital Appeal Board has had serious consequences. In its recent decision in the *Schiller* case, [149] the Ontario Court of Appeal examined the terms of section 50(3) and concluded that they contemplated the possibility that the Divisional Court could examine all the evidence that had been adduced before the lower tribunals, and could go so far, in proper cases, as to substitute its own findings of credibility for those arrived at by the other tribunals. [150]

Obviously, then, there is little incentive for an unsuccessful party before the Appeal Board to abide by the Board's decision. This is especially the case with the hospital, which can absorb the expense of an appeal more easily than physicians can. A hospital will tend to pursue its case to higher courts if it is unsuccessful at the Appeal Board. The effect of this is to make the process extremely drawn out and ruinously expensive for individual physicians. This is so much the situation that the Ontario Medical Association has been advising its members that an appeal is rarely worthwhile, especially from the refusal to accept an initial application. [151]

(iv) Hospital officials complain, predictably, that the legislation has had the undesirable effect of stirring up a great deal of misinformed public criticism of hospitals for unpopular decisions not to appoint certain doctors.

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[147] 47 D.L.R. (3d) at 491-94.

[148] *See* Ontario Hospital Association, Your Association Reports on Legislation, No. 323 (Oct. 13, 1972).

[149] *Supra* note 5.

[150] 7 O.R. (2d) at 333.

[151] Interview with Dr. T. Porter, General Secretary, Ontario Medical Association, April, 1975.

Rather than settling disagreements privately and amicably, hospitals feel they now must often "wash their dirty linen" in public. The response to this complaint, of course, is that the management or mismanagement of hospitals is a matter of legitimate public concern, and that it is perfectly appropriate for hospital governing bodies to have to justify their policies and decisions.

Openness apparently has its costs though. Formerly, information about applicants was gathered to a large extent through a tight but informal network of references known in hospital circles as "the old boy blower". Whether because of the new amendments or for other reasons, letters of recommendation solicited by MAC's and presented to hospital boards, the Appeal Board and the courts tend to be so cautious and bland that they are sometimes regarded as going against an applicant's qualifications. [152]

(v) The Act presents two more minor, but potentially troublesome difficulties:

(a) As section 48(1) is presently worded, it seems to give no right of appeal where a doctor's complaint is that he has applied for an extension of his existing privileges and has been turned down. An application of this sort could well be just as important as an application by a doctor with no existing privileges where, for example, a specialist has limited courtesy staff privileges and wishes to become a member of the active staff.

(b) The Hospital Appeal Board sooner or later is bound to order a hospital board to appoint a doctor to its staff, where the board had originally rejected his application, or had dismissed him as a staff doctor. (Indeed, it has already done so twice, in the *Schiller* case, [153] and the *Hyde* case [154] in Ottawa. The former case was reversed on appeal, and the latter is under appeal.) The Act does not help to answer the question of what the hospital's liability would be if a doctor, appointed by the Appeal Board against the wishes of the trustees, was negligent in circumstances in which the hospital would otherwise be liable.

VI. Selection Criteria Since 1972

The cases which have reached the Hospital Appeal Board since its creation in 1972 have served to confirm that in spite of the extensive new procedural rules, the substantive authority of hospital boards in selecting their medical staffs has not been significantly altered. A hospital continues to possess the right to establish its own standards of competence and its own mix of services. It may, in a proper case, revoke or refuse an appointment on grounds of a physician's personality or because it does not desire to increase the number of physicians on its staff.

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[152] *See Re* MacDonald, *supra* note 5, at 148.
[153] *Supra* note 4.
[154] *Supra* note 4.

A. *Excellence and Special Skills*

(i) The difficult aspect of the "competence" issue is not the assessment of whether a physician is competent to practise that particular specialty. Rather, the problem which has arisen in four of the Hospital Appeal Board's six cases has been whether the applicant possessed the desired *level* of skills, or combination of skills, which was being sought by the particular hospital in question.

Thus in the *Schiller* case, [155] the Ontario Divisional Court (Mr. Justice Donoghue dissenting) held that in considering the competence of Dr. Schiller with regard to the standard of practice in a *public hospital in Ontario*, the Hospital Appeal Board misdirected itself in law. The court asserted that the actual issue was whether the five instances of missed diagnoses reviewed by the Board amounted to failure "to show the degree of competency to be expected from an orthopedic surgeon in the Scarborough hospital . . .". [156] Medical and surgical practices differ among hospitals. Since "[a] doctor on staff does not work in isolation just with the patients whom he has admitted, but as a member of a complex and highly skilled team", [157] a physician may justly be required by the hospital to adopt and be proficient in the more advanced surgical methods its staff favours. [158]

(ii) A related issue is the extent to which an individual hospital is justified in establishing a unique character and combination of services, and selecting its staff with a view to those special objectives. Thus, a physician may be brilliant in his field, and yet be rejected by a hospital whose priorities do not include that specialty.

It is clear both from Appeal Board decisions and from government policy that hospitals will often, if not always, establish particular areas of emphasis, depending on the needs of the district or the province, or the personal goals of the hospital's governing board. Such decisions, of course, must be approved by the Ministry of Health, in the course of authorizing the construction of new facilities, approving operating budgets or purchasing necessary equipment. But this factor only underlines the legitimacy of such arrangements.

It is, indeed, the rule rather than the exception for hospitals to diverge from a uniform model. Ontario public hospitals include: Red Cross Outposts; community hospitals with under one hundred beds where all doctors are courtesy staff; larger community hospitals having both full-time specialists and general practitioners with limited privileges to admit private patients

[155] *Supra* note 5.

[156] 4 O.R. (2d) at 212, 47 D.L.R. (3d) at 496.

[157] *Id.* at 225, 47 D.L.R. (3d) at 509.

[158] The Ontario Court of Appeal has since dismissed an appeal from the decision of the Divisional Court: *supra* note 5. The question of the hospital's right to require a standard of training and ability beyond minimum competence was not directly argued. The court held that the appellant had not raised a question of law but had merely taken issue with the different conclusions which the court had reached on the facts. Consequently, it was without jurisdiction to hear the appeal.

only; very large university-affiliated teaching hospitals with several hundred staff physicians in all specialties; and institutes for the treatment of mental illness, cancer or drug addiction. [159]

From the hospital's viewpoint it is not only logical but inescapable that staff appointments should go only to physicians whose training is needed for the institution's purposes. Those purposes may be teaching of interns, research, community medicine, emergency medicine, or some combination of those or other skills. For the physician, however, this phenomenon represents a drastic restriction of his ability to obtain a desired appointment or privileges at a hospital of his choice.

In the Appeal Board case of Dr. A. H. M. Khan, [160] for example, the hospital had been purchased by the Province, which appointed a new Board of Governors through the Ontario Hospital Services Commission. The Board was directed to change the hospital's role from a specialized surgical and internal medicine treatment centre to a hospital structured to meet the needs of the surrounding urban community. To this end a policy was established of encouraging the appointment of family physicians, preferably with special skills and an extensive practice among one or more ethnic groups in the vicinity.

Dr. Khan, while well qualified as a specialist in internal medicine, offered the very sort of skill and practice which the hospital's policy was attempting to limit. The Appeal Board found that in rejecting the application on grounds that the hospital had a staff physician with such a specialty and that the heavy extra demand on beds would exacerbate the overutilization which the hospital had been instructed to reduce, the Board was carrying out the specific directives of the Province.

The *MacDonald* [161] and *Sheriton* [162] appeals involved (among other issues) the question of hospital goals. In the *Sheriton* case the Appeal Board upheld the refusal by North York General Hospital to accept the application of the applicant, a highly qualified obstetrician and gynecologist. The Board pointed out that the hospital was conceived as a community-type hospital: "Its principle [*sic*] purpose was to provide hospital facilities in which the family practitioner could treat his patients. The medical staff of the hospital was to be composed of a highly skilled and carefully balanced group of medical specialists who would counsel and assist the family practitioner" and promote continuing education within the hospital. The eventual aim was to establish a university-affiliated teaching staff. [163] "The cold hard facts of this matter", concluded the Appeal Board, after observing that the hospital had refused applications from over two hundred specialists, "are that the Board of Governors . . . decided that Dr. Sheriton, as well respected

[159] See R.R.O. 1970, Reg. 726, § 1, which establishes classifications of hospitals according to size and function.

[160] *Supra* note 4.

[161] *Supra* note 4.

[162] *Supra* note 4.

[163] *Id.* at 11.

and as highly skilled as he is within his specialty, did not offer that particular blend of experience and special skills needed by its hospital". [164]

B. *Personality*

As the Grange Committee acknowledged, one frequent, though often unexpressed, reason for the rejection of an application is the hospital's opinion that the applicant's personality is so unco-operative or abrasive as to impair the functioning of the hospital's medical team. The Committee, while recognizing personality as a legitimate cause for rejection, reiterated its basic view that such issues should not be within the exclusive power of the hospital to determine. [165]

Furthermore, the burden on a hospital of proving such an allegation, especially on an initial application, should be a heavy one. This strict view is concurred in by a spokesman for the Ontario Medical Association. In his opinion the uppermost criterion should be whether the physician's ability to function as a professional is seriously undermined or obstructed by the personality problem alleged. [166]

Representatives of the hospitals emphasize instead the tight network of peer review, teamwork, committee participation, mutual respect and co-operation which are necessary in the hospital. [167] The Divisional Court in its judgment in the *Schiller* case [168] leans toward the latter attitude. The court reviewed evidence of letters sent by the applicant, in the course of his efforts to gain an appointment, to the members of the Board of Directors, the Chief of the medical staff, the Chairman of the Hospital Appeal Board, and five to six hundred fellow doctors in Ontario. It held that portions of various letters included inaccurate allegations of bias, threats to embarrass the hospital, improper attempts at influencing the Appeal Board, and offensive allegations against the hospital Board's integrity. [169]

The court held that the Hospital Appeal Board had failed to give sufficient weight to the evidence of Dr. Schiller's conduct, characterized by the hospital MAC as "arrogant and abrasive". Personality was a factor which the court included as a basis for overturning the Appeal Board's order requiring the hospital to accept Dr. Schiller's application and appoint him to the associate staff. [170] The court adopted an attitude of considerable deference to the exercise of an independent judgment by hospital authorities:

> In exercising its undoubted right to select its own staff, that art which arises out of long study and continuous involvement with the practice of medicine in a hospital, the medical advisory committee and the hospital board must look at the whole man, at his personality traits, at all the circumstances surrounding his application before deciding that he is the man who ought to be on the staff of the hospital.

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[164] *Id.* at 13.
[165] GRANGE REPORT, *supra* note 2, at 10.
[166] *Supra* note 151.
[167] Interview with Mr. R. Slute, Ontario Hospital Association, April 11, 1975.
[168] *Supra* note 5.
[169] 4 O.R. (2d) at 219-23, 47 D.L.R. (3d) at 503-07.
[170] *Id.* at 223, 47 D.L.R. (3d) at 507.

> The hospital board must decide if this applicant is one who will fit in with and complement the existing staff, and who will co-operate and work well with his fellows.
>
> A doctor on staff does not work in isolation just with the patients whom he has admitted, but as a member of a complex and highly-skilled team. [171]

C. *Optimum Numbers*

In practically every decision regarding the granting, renewal, extension or withdrawal of staff privileges, a hospital will have to assess its requirements for numbers of staff in various categories of expertise. As mentioned above, such judgments have a lot to do with the orientation of the particular hospital. There are, however, other considerations which are more standard and objective and which should apply to all kinds of hospitals. A doctor would be justified in asking a hospital which asserted that it had sufficient staff in the applicant's specialty to demonstrate *some* objective criteria for that calculation, based on such factors as number of beds, the size and population density of the community being served, similar facilities in nearby hospitals, and productivity of individual doctors.

The first observation that must be made regarding the refusal of initial or additional privileges because of already adequate staff is that the problem (and indeed grievances about privileges *generally*) arises almost exclusively in large metropolitan areas, [172] and among specialists rather than general practitioners. [173] In St. Mary's Hospital in Kitchener, for example, disputes over staff privileges are not encountered, because the need for physicians balances the demand for appointments and because most local doctors hold joint privileges with the Kitchener-Waterloo General Hospital. [174]

The problem in remote areas is not that physicians cannot get staff appointments, but that hospitals and communities cannot attract enough doctors. Attempted solutions have thus far consisted of programs for the placement of recently graduated doctors in remote communities.

It is, in short, important to recognize that the problem of optimum numbers becomes an issue because of the extremely uneven geographic distribution of doctors. Cities such as Toronto are powerful magnets. Nearly five thousand [175] of Ontario's 14,472 [176] doctors have been drawn to the city

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[171] *Id.* at 225, 47 D.L.R. (3d) at 509.

[172] This pattern could soon change. Recent announcements by the Ontario Ministry of Health that several hospitals across the province will be closed and that the budgets of a large number of others will be reduced may well give rise to controversies over hospital privileges in smaller communities affected by these measures.

[173] 3 HEALING ARTS REPORT, *supra* note 13, at 136; GRANGE REPORT, *supra* note 2, at 5-6.

[174] Interview with Mr. R. Steinberg, Director of Hospital Services, St. Mary's General Hospital, in Kitchener, Ontario, February, 1975.

[175] Figure derived from College of Physicians and Surgeons of Ontario, Medical Directory (1975).

[176] As of Dec. 31, 1974: College of Physicians and Surgeons of Ontario, Interim Report 2 (Feb. 1976).

by the opportunities its teaching hospitals provide for challenging practice, continuing education, prestige and income, as well as by the allurements of Toronto's life-style.

Is it possible to devise reliable scientific standards for calculating the number of medical staff each hospital needs? Many attempts have certainly been made, and various tests exist. In the United Kingdom, hospitals select staff according to precise specifications on the basis of formulas embodying factors such as those listed above. Nowhere in Canada, however, with the exception of Quebec, [177] has any directive been issued on the subject of optimum numbers or ways of determining them.

It is widely conceded that decisions regarding numbers are always based partially on informed guessing. No reliable correlations of ratios of doctors to cases can be devised, since cases vary according to diagnosis and severity. For example, it can not be assumed that each "gall bladder case" is the same. In the *Sheriton* case the Hospital Appeal Board went so far as to reject the usefulness, in that particular case, of any statistical formula. [178] Guidelines such as the relative stay index or the ones devised by the World Health Organization and the Ontario Ministry of Health were felt to "have no practical significance to the issue of [the appeal of Dr. Sheriton]". [179] The Appeal Board asserted that the need for new staff appointments was a "value judgment" to be made by the board of governors of each hospital on the advice of its medical and administrative staff, in the interests of the local community to which it is accountable. [180]

Such an approach raises doubts about the accuracy of the belief, held by some, that the establishment of the Hospital Appeal Board and of a right of appeal has removed the possibility of arbitrary and anomalous decisions where, for example, two hospitals of the same size and character might decide on having surgical staffs of five and two persons respectively. But in the recently decided case of *Re MacDonald*, [181] the Divisional Court clearly accepts the relevance of objective criteria (contrary to the scepticism of the Hospital Appeal Board) to support the reasons which the Board of Governors gave for refusing Dr. MacDonald's application.

The court first considered the Appeal Board's stated reason that "this Hospital is at present adequately staffed with general surgeons bearing in mind the number of beds available". [182] It continued:

> We agree with the Hospital Appeal Board that the comparison of the hospital's record with this relative stay index published by the Ontario Hospital Services Commission has no valid application to the specific

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[177] GRANGE REPORT, *supra* note 2, at 9-10.
[178] *Supra* note 4, at 6-7.
[179] *Id.* at 6.
[180] *Id.*
[181] *Supra* note 5.
[182] 9 O.R. (2d) at 147.

> medical staff requirements of a public hospital. But if we accept the proposition, which seems reasonable, that the greater the number of surgeons on the medical staff, the greater will be the number of patients seeking admission to a hospital, then the physician/bed ratio is relevant. It was proved that the respondent Hospital had the following percentages of occupancy of surgical beds:
>
> 1971 — 94%
> 1972 — 92%
> 1973 (Jan. 1-April 30) — 95%
>
> Dr. Leonard Bradley, the Executive Director of the Canadian Council on Hospital Accreditation, was called as a witness pursuant to S. 8(6) of the Public Hospitals Act. He gave evidence that the optimum limit was 85%. These figures, of course, were not available in the same form to the board of governors of the hospital, but it must be assumed that they were known to them. The Hospital Appeal Board said:
>
> > The service area of each hospital possesses unique characteristics which must be recognized when determining the optimal size of the Medical Staff and this Appeal Board finds little relevance in the physician/bed ratio to the determination of this issue.
>
> It seems to me that unless a purely arbitrary figure is to be selected for the complement of active staff members, the physician/bed ratio is relevant in determining what ought to be the complement. [183]

The Board of Governors further asserted that "[t]he Department of Surgery has a full complement of active staff members and the special fields of Surgery as determined by the present policy of the Hospital are fully represented". [184]

The court pointed out that the Hospital had said, in effect, "we are filled up" and not, as the Hospital Appeal Board had treated it, "Dr. MacDonald fails to meet our criteria". [185] In the end the court agreed with the conclusion of the Appeal Board that the Hospital was justified in citing this reason. But they did so on the basis of the evidence before that Board which documented the contents of "the present policy of the hospital" and supported the assertion that the Hospital had sufficient surgical staff. [186]

The clear implication is that where the issue is one of numerical need, the Appeal Board is obliged to go beyond the proposition that a hospital has the discretion to set such criteria for staff appointments as it finds desirable to achieve the hospital's goals. It must produce as much objective evidence of the non-existence of such need as is possible given the imponderables involved. It is also apparent, though, that as long as individual hospitals retain the power to shape policies concerning the kinds of specialist treatment they will provide and to choose their own staff, a large subjective element will remain and the Appeal Board will be reluctant to second-guess the hospital boards.

It seems to be universally agreed that the eventual solution to the

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[183] *Id.* at 149-50.
[184] *Id.* at 147.
[185] *Id.* at 150.
[186] *Id.* at 151-53.

difficulties of arriving at fair decisions about numbers will entail a combination of universal, objective guidelines establishing at least a range of permissible staff sizes, with the development of mechanisms for making appointments on a regional or district basis: "A formula, or guidelines, are badly needed. It can't be left up to the hospital to decide." [187]

The problem remains at present that hospitals are slow to accept the need for collective decision-making. The development of regional structures is farthest advanced in Hamilton, where a Hospital Planning Council and District Health Council are active. The Grange Committee points to a number of province-wide voluntary efforts in this direction. In Toronto, however, the Grange Committee discovered a lack of any method for making or receiving applications on behalf of the whole city region and strongly recommended the development of some such methods. [188] While there exist in Toronto a Hospital Planning Council and a Teaching Hospital Association, they have "had a rocky history", according to one observer, and have not exerted much influence. [189]

VII. Possible Reforms

This article has suggested that a comprehensive approach to dealing with conflicts between doctors and hospitals over access to hospital staff appointments requires changes at a number of different levels of the health care system. The most immediate problem, perhaps, has been to establish a standard, impartial process which must be followed by hospitals for all decisions concerning staff privileges.

The fundamental problems, however, occur in other areas. First, there is the question of the appropriateness of the very notion and structure of the system of hospital privileges. Should a doctor's access to hospital resources, or his power to authorize his patients' admission to a hospital, depend on the granting of permission to do so by the individual hospital? And should the conferring of privileges on a doctor give him the authority to make decisions individually regarding admissions and treatment?

Another question involves the way in which decisions about the distribution of physician manpower and of various specialized hospital services are to be made, and the policies that should form the basis of such decisions.

Finally, even assuming the existing structure of hospital privileges, and of considerable local autonomy in hospital policies and internal management, is the present structure of hospital government appropriate?

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[187] Interview with Dr. J. S. Melvin, former President, Ontario Medical Association, March, 1975.

[188] Grange Report, *supra* note 2, at 11. For a description of existing regional structures in Metropolitan Toronto, see Social Policy in Metropolitan Toronto, *supra* note 22.

[189] Interview with Professor G. Palin, School of Hygiene, University of Toronto, January, 1975.

In light of these other issues, and before evaluating the work of the Grange Committee, some alternative directions for reform should be pointed out.

One route to follow would involve alterations in the authority, within the individual hospital, for making staffing decisions. The present mechanisms for regulating medical treatment within the hospital are based on an obsolete theory of the organization and functions of hospitals. Effective control over the maintenance of standards of clinical care rests with the MAC, composed exclusively of doctors (in some cases, it may include the chief of the dental staff). The arrangement may have made some sense in the days when the hospital was largely a passive institution, the repository of facilities and assistance for individual physicians to draw on in the private practice of their profession. The Ontario Committee on the Healing Arts identified the problem and concluded that a basic alteration was desirable in the composition of the MAC:

> The regulatory system based upon the "workshop" theory has the Medical Advisory Committee in effective control of the maintenance of standards of clinical care, even when this care is provided in practice entirely or almost entirely by hospital employees. In daily practice, considerable interprofessional conflict arises from the confusion of lines of authority . . . .
>
> If indeed those who work within the hospital are members of a team whose purpose is the provision of care to patients, control of the practice of all members of the team by a select group, the medical profession, becomes increasingly indefensible. The foremost practical implication of a change from the concept of the hospital as workshop to the hospital as organization is hence either the representation of other health disciplines on the Medical Advisory Committee, at least for certain of its deliberations, or the creation of a new interdisciplinary advisory board. [190]

The Committee indicates that decisions about hospital staff privileges would be one important area in which an interdisciplinary Committee would participate. [191] This would be desirable not only because doctors must be chosen for their appropriateness as part of the hospital team, but also because the MAC grants privileges to dentists as well as physicians.

Such a change could have several positive effects on the system of hospital staff appointments. It would lessen the possibility and suspicion of conflicts of interest. It would increase the responsiveness of the MAC to the views of a cross-section of the hospital's professional staff concerning delicate issues such as personality. It could also foster more independence on the part of hospital boards.

Other changes in this area could involve a strengthening of hospital boards to foster more independent consideration of staffing decisions. This could be done by developing regional structures for decision-making, by providing more extensive training for members of hospital boards, and by

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[190] 3 HEALING ARTS REPORT, *supra* note 13, at 132.

[191] *Id.*

supplying boards with their own professional support staff. The composition and manner of selection of boards also calls for changes. It has been suggested that appointing rather than electing hospital boards (some are now appointed) would result in a higher calibre of board member. The requirement of elections has discouraged many desirable candidates who are not prepared to campaign publicly for board positions. There should also be a more systematic attempt to make hospital boards representative of the interests of the community, both local and provincial.

Possible approaches to the procedural inadequacies are not limited to the conventional model of hearings and appeals as of right. In Saskatchewan, for example, an amendment to the Hospital Standards Act [192] gives the Minister of Health discretionary authority to act on the request of a doctor who has a complaint regarding his hospital staff privileges by referring the complaint to an Appeal Board, provided the Minister is of the opinion that the complaint is of sufficient public importance. The Appeal Board is empowered to inquire into the matter and to make any decision which it deems proper. It has the power to reverse, alter or confirm the decision of the board of trustees.

VIII. Conclusion

The investigations undertaken by the Grange Committee showed that the system by which Ontario hospitals granted, restricted and withdrew medical staff privileges before 1971 exposed doctors to the possibility (although infrequent) of being unfairly dealt with. However, it is very difficult to say whether doctors, hospitals or patients are any better off as a result of the 1972 amendments to the Public Hospitals Act.

It is probably misleading to judge the success of the legislation simply by the handful of cases which have reached the Appeal Board. Still, they do indicate that the Board is determined to allow hospitals to exercise a large degree of independent judgment regarding the issues that most frequently produce disputes. It is probably the Board's attitude, rather than the undoubted high cost of appeals which is the principal reason discouraging doctors from appealing adverse Board decisions. Indeed, a major complaint from doctors has been the composition of the present Appeal Board. Three out of the five members of the Appeal Board have been members of hospital boards, although only one continues to be such a board member. [193] While the Appeal Board's critics argue that this composition results in undue sympathy for the arguments of hospitals, its defenders insist that it is necessary and desirable for some Board members to have an expert understanding of hospital government and organization.

[192] S.S. 1972 c. 52, § 23, *amending* R.S.S. 1965, c. 265.

[193] Information supplied by Health Boards Secretariat, Ministry of Health (as of March, 1976). It should be recalled that the Public Hospitals Act requires that one of the two representatives of the public interest on the Hospital Appeal Board also be a member of a hospital governing body.

One positive, though invisible, effect of the Act has probably been to improve communications within the hospital and to regularize the procedures for granting staff privileges. And yet most hospitals in which disputes over privileges are likely to arise had already begun to abide by standard procedures (to give notice and to provide a hearing if one was requested) even before the Act was amended. [194]

The most persistent worry the legislation creates is whether it can really be effective against a genuine case of discrimination, for example, on the basis of race or a doctor's opinions concerning a controversial hospital policy such as the performance of therapeutic abortions. Hospital boards are still influenced strongly by medical staffs. They retain the autonomy to hire their own staff and to exercise a very wide judgment in doing so. It would be difficult indeed to penetrate a hospital's ostensible justifications of "personality conflict" or "sufficient surgeons" to obtain proof of discrimination.

There may be no means of preventing discrimination entirely as long as hospitals are left with the authority to manage and govern themselves. Yet no one who has examined the needs of hospitals—not the Grange Committee, the Appeal Board, the courts, or even the Ontario Medical Association [195]—has suggested that there is any alternative to leaving *some* substantial management discretion with the hospital. It was in view of the need for this discretion that this article suggested that the most effective response to doctors' legitimate demands for fairness was to be found in reorganizing decision-making in hospital matters so as to make the system as representative as possible of the entire hospital health team, of the taxpayers who finance it, and of the patients whom it serves.

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[194] *Supra* note 68, at 27.

[195] The O.M.A., at its 1975 annual convention, adopted a modified position on "open hospitals" which was expressed as follows:

> The OMA recognizes the responsibility of the medical advisory committee to advise the Board of Governors of its hospital to exercise its responsibility on granting, limiting or refusing privileges to a physician applying for hospital privileges, providing that an appeal mechanism continues to exist on a local and provincial level. (*Transactions of Council*, ONTARIO MEDICAL REVIEW 145 (March, 1975).

The Globe and Mail (Toronto) in an editorial on Feb. 7, 1975, criticized this resolution as a retreat from the view which the Ontario Medical Association advanced in its brief to the Grange Committee, according to which:

> All physicians should have an appointment on the medical staff of a hospital serving the community in which they practise.

The O.M.A., however, takes the position that the above resolution reaffirms its long-standing policy and simply acknowledges the present state of the law in Ontario.