Health Law Bulletin

November 2004

Hospitalism in Ontario: Managing the Legal Risks

The crisis of family physicians withdrawing from inpatient care has prompted a growing interest in hospitalism. Originally seen as a "band-aid" solution to the problem of finding responsible physicians for unattached inpatients, the hospitalist model is being adopted across Canada as a way to manage physician behaviour and improve inpatient care. But care must be taken when operating a hospitalist program to effectively manage the associated legal risks.

The Legal Risks

A major concern for hospitalist programs is potential liability when a patient is harmed. Typically, patients will sue everyone involved in their care. With a hospitalist program, a hospital may be exposed to liability for the:

- acts and omissions of its hospitalists committed in the course of their engagement,
- failure to select competent hospitalists and monitor their continued competence, and
- failure to establish systems for the safe operation of the hospitalist program.

These risks, however, can be managed through prudent credentialing, contracts and communications.

Managing Risks through Credentialing

Hospitals must ensure that physicians are reasonably qualified to do the work expected of them. Credentialing is an important risk management tool in this regard. When implementing a hospitalist program, hospitals must consider the qualifications required of those hired to deliver the program. As the acuity and complexity of patient problems increase, so must the skills of those caring for hospitalized patients. In addressing these challenges, the first consideration is whether to hire family physicians or internists as hospitalists.

The credentialing process followed for physicians spending most of their time in the office is based on assessments of competence on the quality of the office practice rather than that of the hospital practice. Hospitalists spend all of their time in the hospital. This necessitates a change in the base measure of assessment. Hospitals must identify the core skills or body of knowledge needed to provide inpatient care. This, of course, is easier for organ-based, disease-based and population-based specialties than for site-defined specialties like hospital medicine. Hospitals must consider the unique set of skills and competencies needed of their hospitalists and refine their credentialing processes appropriately.

Managing Risks through Contracts

Written contracts offer another attractive risk management tool for hospitals. Written contracts with hospitalists should:

- set out their competencies as a representation in the contract, and have misrepresentations considered a breach of the contract
- clearly evidence the parties' intentions with respect to the status of the hospitalist, whether employee or independent contractor

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- describe the payment option chosen for the program, including any increases in income and the assignment of OHIP billings

  A number of payment options are available to hospitals, including fixed fee for service, fixed fee for service plus hospital top-up, fixed fee for patient plus OHIP billings, set salary (OHIP billings paid to hospital), set daily/ weekly rate plus OHIP billings, set sum divided by MD group, and set hourly rate and patient handover next day.

- describe the scheduling of the hospitalist

  This includes the hours of coverage at the hospital, responsibility for scheduling, hours of work, after hours, weekend, vacation, statutory holiday and CME leave coverage, and the protocol for hand-off of care to the most responsible physician.

- address patient load

  Establishing systems for the safe operation of the hospital requires consideration of the number of patients a hospitalist sees each day and the number of patients admitted each day for treatment by hospitalists. More established hospitalist programs, such as those in B.C., stress the importance of closely monitoring programs, including patient load. Failing to implement policies relating to the patient load of a program may attract liability if a hospitalist is seeing too many patients and failing to provide proper care or maintain appropriate records and follow-up communication.

- address scope of practice

  Surveys show the net cost of hospitalist programs ranging from $70,000 – $1,200,000 and average recoveries from OHIP are 39% of total program costs. Hospitalists are a low income-generating group in a hospital, with their costs difficult to predict because of the nature of the workload and staffing needs. There is also uncertainty of long term funding. Hospitalists could be required to perform services beyond their strictly medical functions to recover some of these costs. Additional services could include administrative, clinical, teaching, research, recruitment, patient safety services and responsibility for running a hospital clinic for unattached patients.

- include effective termination and identification provisions to protect the hospital from breach.

Managing Risks through Communication

A problem inherent in the hospitalist model is the possibility of information loss during the patient hand-off process between the primary care physician, the hospitalist, any specialist involved in the patient's care and the patient and their family. Systems must be put in place to promote communication among these parties. Such systems are integral to managing the risks of a hospitalist program.

Hospitals must address whether the physician or the hospital is legally responsible to ensure ongoing medical management of the patient. This issue is key to hospitalist programs, especially during patient discharge. Advice must be given as to when the patient should have further consultation with a family physician.

Where the patient has a family physician, the hospital should communicate with the family physician about ongoing care, and assist in scheduling a post-op visit with the physician. Where the patient does not have a family physician, the hospital should provide some support to the patient to find ongoing care. When necessary, arrangements should be made for a follow-up appointment with the appropriate specialist at the hospital or other health facility. Hospitals may also consider establishing an outpatient clinic for unattached patients staffed by hospitalists. If this is not feasible, hospitals could admit unattached patients and assign a practitioner to monitor their progress until they are no longer at risk.

Enhanced communication, efficient transfer of patient information and availability to respond to questions should also alleviate potential problems. The development of protocols for patients' treatment plans and follow-up care, including a standardized discharge summary or plan for each patient, is necessary. A hospital could develop the role of a hospitalist coordinator, and this person can be made responsible to ensure appropriate liaison between family physicians, specialists and hospitalists.

Conclusions

No generic hospitalist program applies to all hospitals. Each program will reflect the community the hospital serves and the pool of physicians available. To ensure an effective and risk-managed hospitalist program, hospitals must:

- assess the required competence of hospitalists,
- refine their credentialing processes,
- select competent staff,
- limit liability through contracts,
- develop effective policies and protocols, and
- communicate and stay informed.

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