

Potential Legal Liability in the Allocation of Scarce Health-Care Resources

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Summary

This article addresses the legal implications of rationing medical resources from the perspective of both plaintiffs and defendants. Physicians, hospitals and government will all be cast in the potential role of defendant. Given that this issue is still in its infancy in Canada, much of the analysis has been drawn from the American and European experience with adaptations made for Canada's unique set of legal, medical and legislative infrastructures.

Sommaire

Cet article traite des implications légales de la rationalisation des effectifs, tant du point de vue du plaignant que de celui du défendeur. Les médecins, les hôpitaux et le gouvernement pourraient tous être défendeurs. La question n'en est qu'à ses débuts au Canada, c'est pourquoi l'analyse est fondée sur des expériences américaines et européennes et adaptée en fonction du contexte juridique, médical et législatif du Canada.

Introduction

Rationing health-care resources has become both necessary and common in Canada. Gone are the days when physicians and hospitals could take a "spare-no-expense" approach. Instead, many factors have contributed to escalating health-care costs: less government funding, inflation, an aging population, the development of costly technologies, increasing numbers of hospital facilities and qualified medical practitioners, and the practice of defensive medicine, defined as the practice of "ordering tests and procedures and obtaining consultations primarily to decrease the likelihood of being sued."¹ Some will say that fewer resources may not reduce the quality of patient-care. Professor Barry Furrow argues that cost constraints need not diminish the quality of care. Instead, he blames society's inordinate concern with the uncertainties of medicine, which have led to the overuse of medical technology, and needless medical intervention.² There must, however, be a relationship between the amount of available resources and the quality of health care.

A tragedy occurred recently in southwestern Ontario. An expectant mother went to a small community hospital, experiencing fetal distress and needing care from the staff of a neonatal intensive care unit. The nearest tertiary-care centre was full, so doctors had to search for a bed in another facility. An off-duty obstetrics nurse had to be called to travel to the facility with the ambulance, because the hospital had no on-duty staff to spare. The ambulance was further delayed when the attendants had to respond to another emergency call. Following incorrect directions, the attendants delivered the mother to the wrong floor of the hospital. All this took over five hours. The baby was delivered, but died shortly after birth. Sadly, his death could have been avoided. In the attending physician's opinion, the baby was not in life-threatening distress until approximately 30 minutes before arrival at the neonatal unit.

Rationing health-care resources - whether through staff reductions, inadequate diagnostic equipment or a lack of facilities - can have dire results. Increasingly, patients and their families

will become plaintiffs, requesting that courts determine who should be responsible for the consequences of health-care rationing.

The legal implications will be shouldered by Canadian health-care providers and ultimately by taxpayers. Hospitals, physicians and governments will all be exposed to liability when cost-cutting measures reduce the quality or quantity of patient-care. In Canada, federal and provincial governments determine at a macro level how public funds will be allocated among areas such as health care, education and law enforcement. Each provincial government also acts as an insurer providing basic medical coverage to all Canadians.

A difficult question to answer is how liability will be apportioned among hospitals, physicians and governments. Will traditional concepts of medical negligence be re-worked? (The term "medical negligence" is the Canadian equivalent of the term "medical malpractice," which is used in the United States.) Will new legal standards accommodate the tension between patient-need and financial constraints? And will the Canadian Charter of Rights and Freedoms protect patient-plaintiff rights by ensuring that the government's allocation of resources is fair?

What obscures a discussion of legal liability in the context of scarce resources is the interaction among health-care providers. Apportioning liability among them is a complex process. A physician who provides substandard health-care due to inadequate resources may be found liable for medical negligence. For example, a surgeon who delays emergency surgery to accommodate existing waiting lists may be held responsible for any harm the patient suffers due to the delay.³ At the same time, hospitals may be held liable for a physician's substandard patient-care. Hospitals may also be found to have breached the

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standard of care to which they must adhere as a medical facility. Furthermore, the federal and provincial governments, when acting as health-care insurers, could be held to a standard of care commensurate with that expected of other health-care providers.

In the United States, third-party payers of health-care services have been held legally accountable when patients suffer harm due to defects in the design or implementation of insurer cost-containment mechanisms.⁴ In addition, an attending physician may also bear liability for complying with an insurer's instructions. For example, a physician may be forced to discharge a patient before he or she is fully recovered because the insurers will not fund an extended hospital stay.⁴

The government's rationing decisions are so removed from the eventual harm patients may suffer, that hospitals and physicians may face the adverse legal consequences instead. The government, however, could be held accountable for its decisions about medical-resource rationing through the application of the Canadian Charter of Rights and Freedoms. If the government rations resources by discriminating against certain patients on the basis of age or sex, and the patient suffers harm as a result, he or she could allege that the government violated his or her right to equality.

Implications For Physicians

Physicians have become the gatekeepers of cost-containment schemes, since they control approximately 80 per cent of Canadian health-care spending through the services and products that they order on behalf of their patients.⁵ Forced into a "tug-of-war," physicians have been asked to balance their fiduciary duty to provide competent patient-care against pressure from hospitals, government and insurers to cut costs. The physician-patient relationship has not been traditionally characterized as a fiduciary relationship. In two Supreme Court of Canada decisions,^{6,7} however, some judges held that the relationship is fiduciary and duties of good faith, loyalty and the avoidance of a conflict of interest are owed by a physician to his or her patient. Some pro-plaintiff advocates suggest that the law should continue to ensure that physicians view patients' well-being as their top priority: "The battles of cost containment should not be fought at the bedside but rather in administrative offices, in boardrooms, and in legislative chambers. To permit cost constraints as a liability defence may make it too easy for physicians to compromise patient-care instead of undertaking the effort to streamline medical standards and to improve resource availability and allocation."²

On the other hand, it seems unfair that physicians should be responsible for the medical consequences of economic decisions made by others, especially when physicians have little control over macro resource allocation. These arguments will be reflected in the changing economic realities of rationed medical care and the allocation of legal liability. The most likely outcome is that physicians will be held liable for certain consequences of resource rationing.

Nature of Cost Constraints

Which cost-containment consequences directly involve physicians? Unlike other health-care providers, physicians will have little input into macro decisions allocating scarce health-care resources. As gatekeepers, however, physicians are the instruments by which the cost-saving techniques of governments and hospitals are implemented. The first consequence of resource rationing to which physicians are exposed, and for which they may be found liable, is a decline in service delivery.

Several developments will affect physicians' ability to provide a reasonable standard of patient-care. For example, government policies of euphimization could preclude men over the age of 50 from having renal dialysis (euphimization is a form of cost containment practised in England whereby age, sex or physical parameters are established as limits beyond which certain medical procedures will not be performed).

Governmental insurance initiatives, such as utilization review (UR), could prohibit a patient's surgical treatment due to costs. UR uses clinical criteria to evaluate the appropriateness of medical care. Concurrent UR monitors a patient's status and medical costs during treatment, while prospective UR requires preauthorization for hospital procedures.

Another example would be a hospital's allocation decision to increase intensive care unit staffing instead of buying a magnetic resonance imager (MRI). As scarce resources compromise patient-care, medical-negligence suits will likely increase. Whether these suits will succeed, however, hinges on how the standard of care is modified to reflect resource limitations.

Another consequence of cost containment involving physicians is the emergence of practice parameters. Practice parameters or guidelines are "systematic, scientifically derived statements of appropriate measures to be taken by physicians in the diagnosis and treatment of disease."⁸ Practice guidelines are extolled as a solution to many of the health-care industry's most pressing problems. Proponents contend that practice guidelines have many beneficial applications: they may help physicians provide better patient-care, insurers may be better able to determine which treatments are worth reimbursing, physicians' need to practise defensive medicine could be reduced, and the guidelines could be used as standards of care in medical-negligence actions.

The most advanced application of practice parameters involves the development of competing guidelines which, when used together, will create a range of acceptable conduct from which medical professionals, providers and consumers can choose.

Proponents of practice guidelines envision associations such as the Canadian Medical Association and Ontario Blue Cross each publishing their practice guidelines on the treatment of heart-bypass patients. The two sets of guidelines could then be combined by health-care providers and users to define an acceptable range of practice.

Skeptics note that practice guidelines are often developed by medical professionals removed from practice, who delineate the standards in an environment of unlimited resources and peer support.¹⁰ Moreover, those who question the use of practice guidelines as an instrument of cost containment state that practice standards are rarely based on scientific evidence and can be misunderstood by the public, thereby creating unrealistic health-care expectations.¹¹

Inadequate disclosure is another possible consequence of medical-resource rationing for which physicians may be held liable. As diagnostic procedures and treatments are rationed, the legal concept of "informed consent" may take on new meaning. Canadian physicians are legally bound to disclose material information about care that could affect a patient's ability to make an informed decision about his or her treatment. Material information entails all treatment alternatives including the possibility of taking no action.^{12,13} When resources are scarce, the duty to disclose could create an interesting situation. If a physician is aware of alternative modes of treating a patient's disorder but only one is "available" due to resource rationing, must the physician disclose all treatment options? Inadequate disclosure due to resource inadequacies may broaden physicians' obligations in securing patients' consent to treatment.

A fourth consequence of cost containment is a reduced number of physicians willing to practise in specialties that are susceptible to negligence suits. High-risk procedures that involve a disproportionate number of negligence suits filed, and low-fee services (referring to the standard tariff in OHIP's annual schedule of benefits manual) such as obstetrics, are becoming unpopular with practising physicians.¹⁴ Instead, new graduates and practitioners will start practices in which they treat only patients having illnesses for which adequate financial reimbursement is possible, and in which the medical-negligence risks are minimal. Similarly, in the United States, the medical-fee format of diagnosis-related groups (DRGs) is partly affecting physicians' decisions about their preferred areas of specialization.¹⁵ While DRGs may affect practice diversity negatively, they do have redeeming value. In some payment schemes, American physicians can pocket any reimbursement payments that exceed the patient's cost of care. Thus, DRGs seem to encourage the efficient use of resources and are unlikely to lead to under-use of resources given the controlling effects of practice standards.

To the extent that provincial health insurance plans' schedule of benefits accurately reflects the value of different medical services, it too could encourage physicians to be more efficient, and provide patient-care at a cost equal to or less than the schedule allotment. However, Ontario's 1991 utilization fee program takes three per cent of each physician's earnings to the extent the profession bills in excess of the pre-determined OHIP annual limit. This renders individual physicians liable for their colleagues' excesses, regardless of how efficient an individual physician may have been. Under the Budget Reconciliation Act of 1991, Medicare instituted a similar approach.

Inadequate fees, and to a lesser extent, increasing numbers of medical-negligence suits may cause Canadian physicians to avoid certain specialties. Unfortunately, this trend is not balanced with individual physician rewards for efficient resource use.

Legal Effect of Cost Constraints

The impact of resource rationing is only starting to be felt by the Canadian public. Canadian courts have yet to set precedents defining the extent to which they will hold physicians liable for the effects of cost containment. However, an examination of both the American and European experience, with existing Canadian medical-negligence law, provides a basis for a theory. Four consequences of resource rationing have been identified as affecting physician liability: a decline in the quality of patient-care, the codification of practice parameters, inadequate patient-disclosure and the development of selective anti-risk practices.

Inferior Patient-Care

If scarce resources lead to an increased number of patients receiving inadequate care, medical-negligence cases will also increase. Medical-negligence claims are predicated on the establishment of four facts: that a duty of care existed between the physician and patient, that the physician breached the standard of care, that the physician's substandard care caused the injury, and that the harm can be proven and may be compensated. Once a physician-patient relationship is established, the physician owes the patient a standard of care commensurate with the knowledge, skill and care that would be used in the same situation by a physician in good standing who is adequately trained. In treating their patients, physicians are not required to provide the highest possible level of care. Physicians are expected to meet

a reasonable standard of care as practised by a prudent practitioner of the same experience and expertise working in similar circumstances.^{16,17} To avoid an explosion of medical-negligence claims, the courts may redefine "a reasonable standard of care in similar circumstances" to include an allowance for conditions of scarce resources. There are three methods by which conditions of resource scarcity can be built into the standard of care equation.

The Modified Locality Rule

In the early 1900s, varying skill levels in the medical profession were attributed to the fact that medical practitioners did not have access to the same learning and practice opportunities. In response to this, the locality rule evolved, so that physicians practising in rural areas would not be subject to the same standards as their peers in urban centres with access to superior educational and practice facilities. Today in Canada, the locality rule has received enough sustained attention to survive in its original form.¹⁸⁻²⁰ Academic commentators and some judges, however, suggest that, if the locality rule is not already dead, it should be, as standardized education, certification and improved communication have eliminated geographical differences of competency among medical practitioners.²¹⁻²³

As medical resources become scarce, the locality rule may survive, albeit in a different form. A modified locality or "similar circumstances" rule could be used to accommodate regional differences in resource allocation.²⁴⁻²⁹ This analysis has been used by the Mississippi Supreme Court.²⁶ Citing distinctions between rural and urban resources, the court stated that physicians should be held to "a national standard of care as practised by those in their field and by those physicians having access to the same general facilities, services, equipment and options."²⁶

The British Columbia Supreme Court has also taken resource availability into account.²⁵ At issue was whether a physician practising in rural Gold River, B.C., was negligent in the delivery of a brain-damaged infant, born in a difficult twin delivery. The court determined that the physician was not negligent. In addition to other mitigating factors, the trial judge acknowledged that the attending physician was neither trained for nor equipped to handle a complicated delivery of twins in the remote community. Access to resources was also considered when an inmate sued a prison physician, alleging medical negligence.²⁴ The Federal Court of Canada considered the available equipment and facilities at the Joyceville Institution to determine whether the physician had met the appropriate standard of care.

Canadian courts will probably continue to support a form of the locality rule, which will protect the interests of physicians who do not have access to suitable facilities, equipment or support services. Thus, physicians practising in remote areas of northern Ontario without, for example, access to a computer-assisted tomography (C.A.T.) scan will be held to a standard of care in diagnosis, commensurate with the standard of care applicable to physicians practising under similar resource constraints.

While the locality rule may be used to modify Canadian physicians' standard of care, it has not yet been applied to modify the standard of care expected of macro or meso actors who allocate scarce health-care resources.³⁰ This form of rationing limits access to required medical care because available resources cannot provide all the care needed by all individuals. Consider an example. Should one patient's life be saved, using a million dollars worth of treatment, or should the same sum be used to fund preventive pediatric care for 100 infants? These decisions are value judgments, raising more ethical than legal

issues. Generally, the courts have favored the use of existing resources if there is a reasonable possibility that they will help the patient.³¹ Canadian courts have not yet had to rationalize a limit to health-care resources.

A Rebuttable Presumption

An alternative method of incorporating resource constraints into the "uniform" standard of care is the creation of a rebuttable presumption.³⁰ This approach starts with the presumption that all physicians owe all their patients the same level of reasonable care. Physicians then have an opportunity to present evidence that they could not meet the level of reasonable care because of inadequate resources.³⁰ Professor Haavi Morreim, who first stated this theory, cautions that a physician's burden of proof must be substantial to protect the fiduciary nature of the physician-patient relationship. In addition, physicians should be required to produce evidence detailing the severity of their resource constraints, and to show that the general allocation principles guiding their patient-care decisions were reasonable.

In 1986, the New Brunswick Court of Appeal, taking its lead from the English House of Lords, seemed to apply a modified rebuttable presumption approach.³² On appeal to the Supreme Court of Canada, however, the rebuttable presumption approach was rejected on the basis that it could lead to a scenario in which a plaintiff could be compensated although the injury could have been caused by factors unrelated to the defendant.³³ Thus, even a modified rebuttable presumption theory is unlikely to be applied in Canada, barring the Supreme Court of Canada's departure from its earlier decision.

Standard of Care

Professor Morreim also proposes a second means of reorganizing standard-of-care inquiries in medical-negligence suits to reflect economic constraints. The standard of care could be divided into two: the standard of medical expertise (SME), which considers the professional knowledge and skill owed by physicians to their patients; and the standard of resource use (SRU), which considers whether physicians are meeting their advisory and advocacy duties of care.³⁴

The SME refers to traditional standard of care principles, which existed before cost containment. Thus, physicians are expected to have medical expertise commensurate with those of their peers in the same specialty, according to one standard across Canada.

The SRU reflects the influence that scarce resources have on a physician's ability to deliver reasonable patient-care. To meet their duty of care under SRU, physicians must work with insurers and hospitals as patient-advocates to ensure that economic decisions guiding resource use are medically suitable.³⁴ There is a trend in the United States which, if continued, may crystallize a physician's duty to act as a patient-advocate. In this trend, physicians may be held liable for observing harmful cost-constraint guidelines established by insurers or hospitals, instead of challenging the guidelines.

For example,⁴ a patient brought an action against her physician and insurer alleging that her leg was amputated as a result of her premature discharge from hospital. The physician discharged the patient pursuant to UR guidelines set by the patient's insurer, Medi-Cal. The discharge guidelines had already been extended by four days at the physician's request. This extension, however, was a compromise. The treating physician had requested eight additional days of hospitalization for Mrs. Wickline. The California Court of Appeal (Second District) held that insurers must meet the standard of care expected of other health-care

providers in implementing their cost-containment guidelines. The court then observed that if a physician complies with inappropriate insurer guidelines, when his or her medical judgment dictates otherwise, the physician cannot avoid responsibility for his or her patients' care. Thus, physicians may be held liable for applying the medically inappropriate cost-constraint guidelines of a third party. The California Court of Appeal exonerated both Medi-Cal and the physician. Medi-Cal's guidelines were found to be appropriate and the court determined that the physician did not discharge Mrs. Wickline contrary to his medical opinion.

If Canadian courts adopt any or all of the above theories, changes will be made to the standard of care in medical-negligence suits. An expanded locality rule could modify the standard of care to be applied in situations where defendant physicians were caring for patients who suffered harm because resources were unavailable. The SME-SRU theories can protect patients' rights. These strategies may ensure that allocation decisions reflect a balance between individual and aggregate patients' needs by placing physicians on the patient's side of the scales.

Practice Parameters Affecting Liability?

The standard of care expected of the medical community is largely based on the customary practice of its members.^{12,19} If practice parameters are implemented, they will affect how the standard of care in medical-negligence suits is defined. Practice parameters or guidelines for quality assurance may be developed by many players including government, private research and payer groups, and the medical profession.⁹ Who sponsors the parameters and their intended use will influence how they are used and accepted.

There are two types of practice standards. Clinical-practice protocols "describe or recommend specific steps in the diagnosis or treatment of particular diseases or the performance of medical procedures."³⁵ UR protocols "compare the use of health-care services for a particular patient against some established norm for the utilization of similar services for comparable patients."³⁵ Courts find practice parameters appealing as a means to overcome the inadequacies of lay jurors, who, on a case-by-case basis, must choose among the competing opinions of paid medical experts. In addition, practice parameters will *prima facie* take into account fiscal restraints within which physicians must operate. While physicians acknowledge that practice parameters will ensure the consideration of resource constraints in negligence claims, practice standards could also be used as rules that physicians must observe to avoid liability, regardless of a patient's unique needs. Some American academics have suggested that physicians who comply with practice parameters should receive civil-tort immunity.³⁶ Rather than penalize or absolve physicians solely on the basis of practice parameters, Canadian courts may use practice protocols as evidence of what the standard of care should be rather than as inflexible standards of care.

One further legal consequence implicit in the concept of practice parameters is the risk that the plaintiff may claim against the organization(s) that established the practice standard. The risk of such liability is minimal in light of current requirements involving causation. For example, it is difficult to establish the existence of a link between the organization creating a practice standard and the harm subsequently suffered by a patient.³⁷ Whether the drafters of inappropriate standards will be found responsible is difficult to predict. Health-care practitioners, however, could be found liable for following inappropriate practice standards. While the last clear chance doctrine has not survived

in Canada, it remains open for a court to resurrect the concept in the sense that a physician, as the ultimate provider of health care, cannot use inappropriate standards as a shield from liability. The American courts have stated that physicians may not pass liability on to third parties. The reasoning in *Wickline*,⁴ if applied in Canada, may render physicians liable for complying with inappropriate standards in delivering patient-care, if they knew or should have known the standards were inadequate.

Legal Implications of Informed Consent

Must a physician disclose all possible interventions to a patient, even though scarce resources render one or more of the alternatives unavailable? When health-care rationing was first required, some academics suggested that informed consent could mitigate against the dangers of the expected diminution of patient-care.² If physicians disclosed resource unavailability to patients, patients could choose one of the following: continue with the available treatment and accept the inherent risks, undertake superior but more expensive treatment using their own resources (in Canada, the patient would have to leave the country, as medical resources are not for sale), or try to lobby for a different resource allocation. Such an approach, however, could harm the physician-patient fiduciary relationship. Would a physician then disclose to a patient that needed medical treatment is being withheld at the physician's discretion because of its cost or another patient's greater need? What obligations to disclose this information will Canadian courts impose on physicians?

The law of informed consent in Canada requires physicians to inform patients of all matters that a reasonable person in the patient's position would consider material and necessary to making his or her health-care decisions.^{12,13,29} The consequences of resource rationing place a greater responsibility on physicians to know their patients. If physicians are aware of alternative interventions that will be unavailable to the patient but could be available at a different facility, in a different country or at personal cost, the physician must know each patient's circumstances. If the treatment is beyond the patient's means or inaccessible given the patient's geographical constraints, the treatment's unavailability will not affect the patient's choice of health care and the physician will not be required to disclose the alternative intervention(s).³⁷ Conversely, if the physician knew or should have known that the patient would seek or has customarily sought health care outside the patient's jurisdiction or at personal cost, disclosure of alternative treatments would be mandatory, because such information would influence the decision of a reasonable person in the patient's position.³⁷ Unless physicians know their patients well, they would be advised to disclose all forms of intervention no matter how "unavailable" they may seem to be.

Selectively Choosing Specialization

As soon as a physician establishes a relationship with a patient, the physician owes that patient a duty of care consistent with a reasonable standard of skill and expertise. If a physician unilaterally ends a relationship or fails to deliver treatment for nonmedical reasons, the physician may be liable for abandonment.^{22,30,34,38,39} Some physicians are choosing their area of specialization based on fee reimbursement and the potential risk of medical-negligence claims. Physicians who develop low-risk practices will not attract any legal liability for doing so, as long as they deal with existing patients appropriately before establishing their low-risk practices. These physicians must ensure

that any new patients are provided with suitable care in keeping with reasonable standards of skill and expertise.

Implications For Hospitals

Health-care institutions in Canada, specifically hospitals, are in peril. Government funding cuts continue to reduce budgets. As a result, hospitals have begun to implement cost-constraint strategies. Where a patient's injury can be linked to institutional resource-rationing, hospitals may be held responsible. Hospitals are liable to patients for both the hospitals' negligence and their employees' negligence. Such liability may even include responsibility for contract and specialty professional staff.

Cost-Containment Strategies

As health-care budgets are reduced, hospitals have been forced to institute resource-rationing strategies. Health-care institutions make "meso" decisions about how resources should be allocated among patient-groups and fields of medicine.⁴⁰ The direct cost-cutting schemes of hospitals are similar to the constraints imposed by government. Hospitals may try to ration resources through "cut-off points" and euphemization, by specializing in a specific group of patients, and through their compliance with insurer programs of DRGs. DRGs are "rules" and associated costs for treatment. For example, an insurer will establish a specific hospital stay, standard follow-up and treatment for patients with appendicitis. Hospitals would comply with the standards because they would be financially responsible for any deviations from the "rules."

The practice of "cut-off points" is illustrated in the following hypothetical story by Dr. A. Goldbloom, pediatrician-in-chief at the Hospital for Sick Children in Toronto. A revolutionary program of liver transplantation is discovered at the hospital. It has the potential to save children who would otherwise die of chronic liver disease. The provincial government agrees to fund six transplants in the first year. Within eight months, six patients undergo the procedure successfully, and three patients remain on the waiting list. The hospital is advised that further funds will not be forthcoming. Then, a donor liver becomes available for a patient on the waiting list. Without the treatment, the patient will likely die. To fund the operation, however, the hospital must divert \$200,000 away from other needy patients.

Cut-off points evolved as a result of these types of situations. Though technology and expertise exist, inadequate funding forces hospitals to draw a cut-off point beyond which patients are delayed or turned away.⁴¹ Canadian courts may find liability against hospitals for the negative consequences of their direct resource rationing decisions especially if it can be shown that a hospital's apportionment of its resources was unreasonable.

Hospitals also engage in a more subtle form of resource rationing. Indirect cost-constraints include decisions to delay the replacement of obsolete or worn-out equipment; rewarding or penalizing physicians through promotions or privileges in light of their cost-constraint initiatives; reductions or reallocation of staff; and reducing the number or scope of residency training programs.⁴² The development of a two-tiered pharmaceutical system is another indirect form of rationing resources. In this system, the most expensive medications can only be prescribed by physicians in certain subspecialties who are expected to comply with hospital guidelines on these drugs.

Indirect rationing decisions by hospitals are less likely to result in liability given the difficulty of establishing causation. For example, a plaintiff would find it difficult to prove that the hospital's failure to replace an obsolete machine caused the

patient's injury. Canadian courts, however, have held institutions responsible for their indirect rationing decisions through the application of an institutional standard of care.^{43,44}

Legal Effect of Cost Constraints

Hospitals may be found liable for their cost-containment strategies such as cut-off points, euphimization, DRG compliance, reduced equipment, staffing, physician (dis)incentives and pharmaceutical controls. These cost-constraint strategies could render the hospital vulnerable to negligence liability in one of two ways. First, the hospital may be vicariously liable for the negligent acts of its employees, both professional and non-professional. The concept of vicarious liability holds a financially responsible defendant responsible for the acts of a wrongdoer because of the relationship between the defendant and wrongdoer. For example, a corporation would be responsible for its employees who in the course of employment are negligent. Second, the hospital may be found negligent as a corporate entity for breaching the standard of care demanded of health-care institutions.

Canadian hospitals are vicariously liable for the acts of those in their employ. In a divided decision, the Ontario Court of Appeal held that hospitals are not liable for the negligence of physicians having hospital privileges or specialist status who are not the hospital's employees.⁴⁵ Thus, if resource rationing causes a physician to provide negligent care to a patient in a hospital, the hospital will only be vicariously liable for that harm if the physician is its employee. In the United States, some plaintiffs have argued that a hospital is liable for staff professionals such as radiologists and anesthesiologists. Though these professionals may not be employees, the courts have held hospitals responsible for professionals' negligent actions through the doctrine of ostensible authority. This doctrine has been applied where "the hospital's actions lead a patient to conclude that a physician is an employee and the patient justifiably relies on the physician's services."⁴⁶ Canadian courts have not, to date, adopted this approach.

Canadian law absolves hospitals of any responsibility for professionals who are not their employees. But a hospital may be liable if the court determines that the staff doctor, though not a hospital employee, was unqualified or incompetent, or that the hospital did not exercise good judgment in appointing that professional to its staff.⁴⁷ A Canadian hospital may be liable for inadequate patient-care due to resource scarcity if the care was delivered by an unqualified physician or by a physician who was given hospital privileges indiscriminately.

Apart from vicarious liability, a hospital may also be liable for failing to meet its corporate responsibility to its patients. Canadian hospitals have a duty to maintain a reasonable standard of care.^{42,47} A strict standard of care has been enunciated, so that hospitals owe a duty of care to patients to provide adequate and safe equipment, reasonable levels of staffing, and qualified personnel.⁴⁸ While there is no requirement that an institution carry the latest equipment, a hospital is obliged to have equipment adequate to perform those services that it holds itself out as capable of doing.⁴⁶ The hospital may breach this standard of care in certain ways. A defendant hospital has been found to have breached the standard of care for failing to have a necessary drug, Ventolin, available in the emergency room.⁴³ Another defendant hospital was held to have breached the standard of care due to inadequate staffing.⁴⁴ The court found that placing two nurses in charge of supervising 33 patients with mental illnesses constituted inadequate staffing that fell below the expected standard of care.

Implications For Government

Canada's federal and provincial governments have three strategies for implementing medical cost-containment. Each strategy embodies potential liability implications. Furthermore, the choice of a strategy affects the parameters within which meso and micro decision-makers operate. First, federal and provincial governments can make macro decisions about how public resources are allocated among competing social interests such as health care and education. Second, governments may legislate cost-containment policies. Last, provincial governments, in compliance with both the Canada Health Act and federal transfer payment regulations, hold a monopoly on the provision of basic health-care insurance for all Canadians. As a result, provincial governments could institute any one of many insurer cost-containment schemes.

Government strategies of medical cost-containment have different legal implications. Public-funding decisions will rarely result in government liability as these decisions are so removed from the eventual harm that a patient may suffer. To the extent that a strategy discriminates against an individual or group, however, the Canadian Charter of Rights and Freedoms may be used to hold the government responsible for its rationing decisions. Finally, in their capacity as insurers, provincial governments may be held responsible for medically unreasonable or defective cost-containment strategies as manifested in insurance policies.

Government Policies

Government cost-containment strategies in health care may take many forms. One example of our government's intervention in medical resource-rationing is the process by which diminishing public funds are allocated. The federal government will earmark funds for public programs, only one of which is health care. These macro decisions about resource allocation will affect each subsequent level of decision-maker. If the federal government reduces the amount of resources devoted to health care, provincial transfer payments are similarly reduced, thereby affecting geographical and institutional funding. Meso levels of institutional decision-making will be constrained in allocating funds among patients and medical specialties. These decisions could include reductions in staff, increased numbers of patients on waiting lists, and bed or facility closures. In turn, physicians' micro allocation decisions about whether individual patients should be given access to services or treatments will also be limited. The government's ability to determine how public funds will be distributed on a macro level is a powerful vehicle for medical cost-containment.

Another means by which governments may try to contain medical costs is through legislation. The government could codify euphimization policies whereby certain individuals on the basis of their illness, age or sex would be precluded from receiving public medical care. Alternatively, the government could pass legislation that has an incidental effect on medical cost-containment. For example, the Income Tax Act could be modified so that corporations would be discouraged from investing in medical research and development. The reduction in medical technology could then reduce the range of treatment alternatives from which patients could choose, thereby lessening aggregate medical-care costs.⁴⁹

The provincial governments have a monopoly over the provision of every Canadian's basic health-care insurance. As a result, provincial governments can be compared with the private or state-funded insurers in the U.S. As an insurer, a government

can implement cost-constraint policies. The development of clinical criteria to assess the need for medical care, either during a patient's hospitalization or before any treatment, is known as utilization review (UR).⁵⁰ UR has become popular in the United States because it provides insurers with the means to control medical expenditures made on a patient's behalf. Provincial insurers in Canada have not yet adopted UR as a cost-containment strategy. However, the fact that the Ontario Hospital Insurance Plan (OHIP) has produced a "schedule of benefits," which assigns a cost to every medical intervention, could mean that UR may be coming.

Another means by which government insurers could curtail medical costs is through "cut-off" strategies. In the United States, one manifestation of this concept has been the placement of treatment or lifetime caps on the allowable cost of a patient's care.⁵¹ Provincial medical insurers in Canada have modified this by identifying medical services which, upon being labelled unnecessary, are no longer funded under the insurance plan. For example, OHIP has determined that requisite school check-ups for children and the completion of medical forms for employers must be paid for by patients. The next phase for the provinces in the context of cut-off points may be that pursued in New Zealand and the Netherlands, where insurance funding is being reduced to cover only a core of primary treatments. The task of identifying what treatments are primary, however, is proving difficult.⁵²

Legal Effect

The legal implications that may flow from the federal government's allocation of public funds and subsequent reduction in provincial transfer payments will likely be minimal. A finding of government liability for medical negligence is unlikely, even though an insufficient allocation of public funds could, for example, cause a chain reaction culminating in a patient's substandard medical care. It is difficult to establish a causal link between the government's macro allocation decisions and a patient's receipt of substandard medical care. As a result, it is more likely that hospitals and physicians will be held liable for substandard care caused by inadequate macro resource allocation, as they are directly involved with the health-care consumer.

The Charter of Rights and Freedoms could be used by Canadians to establish liability against the government for certain cost-constraint policies. There are, however, exceptions. While a minimum level of health care is often considered a human right, health care is not a fundamental right enforceable against the state.^{37,40} If public-funding decisions or the passage of cost-constraint legislation prohibit individuals from receiving medical care because of their age, sex or illness, the government may be in breach of the Charter's equality provision. Section 15 of the Charter (equality rights) establishes that all Canadians are entitled to the equal benefit of the law, without restriction on the basis of characteristics such as age or sex. Legislating a policy whereby individuals over the age of 65 receive only maintenance care as opposed to proactive treatment such as a hip replacement could be considered discriminatory. The difficulty that an individual may encounter in Charter litigation is the court's obligation, under section 1 of the Charter, to balance the public's interest against that of the individual affected by the legislation. Where the public's interest is considered paramount, the court may tolerate government cost-constraint strategies, although they may be discriminatory.

To the extent that provincial governments have excluded private insurers from basic health-care insurance, an argument could be made that provincial governments have assumed responsibility for, and provincial residents now rely on,

governments' reasonable provision of basic medical coverage. Thus, where a provincial government undertakes to provide basic medical insurance coverage, the government may be held liable for failing to meet the obligation that it voluntarily assumed. This type of negligent conduct is called misfeasance, which occurs when a party voluntarily engages in an activity then acts negligently.²¹ For example, a municipality was found to owe a prima facie duty of care to the users of its highways when it voluntarily undertook to maintain them.⁵³ The court held that in addition to the existence of a prima facie duty, the public authority must also be found to have negligently engaged in practices contrary to its mandate or in excess of its delegated sphere of power.⁵⁴ This two-part test could be used to advance the proposition that provincial governments owe a duty of care to those individuals whom they have voluntarily undertaken to insure. Should a public authority then negligently engage in practices beyond its health-care mandate, that public authority could be found liable in negligence.

More recently, the Supreme Court of Canada⁵⁵ seems to have clarified the test set out in *Barratt*,⁵³ which must be met to establish that a government body has been negligent. There must be a prima facie duty of care owed by the government that is not excluded by statute. Furthermore, even if a duty of care is found to exist and is not excluded by statute, the government will be insulated from liability if the decision is one of policy. Policy decisions are those matters of finance and personnel that are shaped by social, political and economic factors. Thus, a government body can only be found to be negligent for operational decisions and acts that harm individuals to whom the government owes a private law duty of care. As macro resource-allocation decisions could be characterized as policy decisions, this approach to rendering a government body liable for substandard health care will be difficult.

The possibility remains, however, as outlined in *Brown*,⁵⁵ that a government may be held liable for negligent operational decisions made, for example, in the course of discharging its health care mandate. This approach has been accepted in the United States where a new standard of care has emerged rendering health-care insurers liable for the defective implementation of cost-containment strategies that harm patients.^{4,50,56} For example, a government insurer could implement a prospective UR requiring that physicians obtain authorization from insurers before treating a patient. If the insurer refuses to authorize the procedure or negligently authorizes an unreasonably short hospital stay, which in turn harms the patient, the insurer will be held responsible. The standard of care that insurers are expected to meet in the implementation of cost-constraint strategies such as UR has been set.⁵⁷ The California Court of Appeal (1st District) held that the insurer had a "substantive duty to use a standard of medical necessity consistent with community medical standards and a procedural duty to properly investigate its insured's claim."⁵⁰ If Canadian courts were to accept this standard of care and apply it to the test enunciated in *Brown*,⁵⁰ governments in their capacity as insurers could be forced to consider patient-interests in their efforts to contain medical costs.

Conclusion

In August 1992, Dr. William Davis wrote a letter to the Canadian Medical Protection Association (CMPA).⁵⁸ In this letter, Dr. Davis said that he hoped the CMPA could reassure him and other physicians "that we will not be held responsible for misadventures to our patients that are a result of rationing or other restrictive measures and to also, perhaps, assist in the appropriate education of health administrators."⁵⁸ In its reply,

the CMPA, while acknowledging that shortages of personnel and materials will affect the medicolegal experience, did not offer the reassurance Davis sought. Instead, the CMPA stated that the courts will be left with the responsibility of assigning liability to medical providers where the facts confirm that scarce resources contributed to a deficient outcome for a patient.

This response should serve as a warning to physicians, hospitals and government. Health-care resources are diminishing. Our courts seem to be the likely forum to determine which health-care actors will be responsible for any resulting diminution in patient-care. Given the nature of medical-negligence suits, those health-care providers closest to the patient will initially bear the brunt of any legal liability that will result from inadequate resources. The federal and provincial governments, however, will not be insulated from the explosion of medical-negligence suits. Existing legal principles could be applied to make governments legally liable for the consequences of their health-care allocation decisions.

Canada's reputation for both high standards of patient-care and professional expertise hangs in the balance. Physicians, hospitals and governments must focus their efforts on identifying economies of scale in medical-resource allocation. Patients must be educated to reject unnecessary medical treatment. And a balance must be struck between the reasonable allocation of scarce health-care resources and the maintenance of a high-quality health-care system for all Canadians.

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