SJÚKRAHÚSIÐ Á AKUREYRI
AKUREYRI HOSPITAL
A TEACHING HOSPITAL AFFILIATED WITH THE UNIVERSITY OF ICELAND AND THE UNIVERSITY OF AKUREYRI

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Alþingi
Erindi nr. Þ 138/522
komudagur 9.12.2009

Nefndasvið Alþingis
v/heilbrigðisnefndar Alþingis
Austurstræti 8-10,
150 Reykjavík.

Akureyri 8. desember 2009.

Efni: Umsögn um frumvarp til laga um heilbrigðisstarfsmenn.

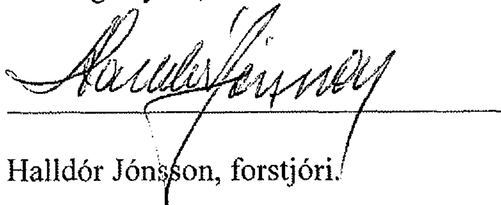
Með bréfi dags. 12. nóvember s.l. sem sent var í tölvupósti þann sama dag, óskaði heilbrigðisnefnd Alþingis eftir umsögn Sjúkrahússins á Akureyri um frumvarp til laga um heilbrigðisstarfsmenn, 116. mál.

Sjúkrahúsið á Akureyri fagnar því að stefnt sé að einum samræmdum rammalögum um heilbrigðisstarfsmenn. Slík rammalög munu tryggja betri samræmingu ákvæða í lögum um heilbrigðisstarfsmenn og einfalda framkvæmd.

Framkvæmdastjórn Sjúkrahússins á Akureyri sendi frumvarp til laga um heilbrigðisstarfsmenn til hjúkrunarráðs Sjúkrahússins á Akureyri og læknaráðs Sjúkrahússins á Akureyri og óskaði eftir umsögn þeirra um frumvarpið. Í umsögnum beggja ráðanna eru gerðar nokkrar athugasemdir eða bent á atriði til frekari skoðunar. Ljóst er að nokkur skoðanamunur getur verið á einstökum ákvæðum frumvarpsins og er það ekki óeðlilegt þar sem frumvarpið fjallar um margar starfsstéttir á heilbrigðissviði.

Framkvæmdastjórn ákvað að senda umsagnir hjúkrunarráðs Sjúkrahússins á Akureyri og læknaráðs Sjúkrahússins á Akureyri með þessu bréfi.

Virðingarfyllst,



Halldór Jónsson, forstjóri.

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hjúkrunarráð FSA

4. desember, 2009

Hr. Halldór Jónsson
forstjóri,
Sjúkrahússins á Akureyri (FSA).

Efni: Umsögn stjórnar hjúkrunarráðs FSA um frumvarp til laga um heilbrigðisstarfsmenn sem lagt var fyrir Alþingi, í 2. skipti í nóvember 2009.

Stjórn hjúkrunarráðs hefur fjallað um ofangreint lagafrumvarp og gerir eftirfarandi athugsemdir. Við gerð umsagnar þessarar, höfum við fyrst og fremst haft að leiðarljósi hvernig frumvarpsdrögin snúa að hjúkrunarfræðingum og ljósmæðrum.

1. Hjúkrunarráð FSA andmælir harðlega þeirri áætlan að feld verði úr gildi núgildandi lög um hjúkrunarfræðinga (lög nr. 8 frá 1974) og lög um ljósmæður (lög nr. 76 frá 1984).

2. Gera þarf skýran greinamun á háskólamenntuðum fagstéttum og ábyrgðarsviði þeirra og framhaldsskólamenntuðum starfstéttum og starfssviði þeirra.

3. Skilgreina verður hvað fellst í orðunum „lögverndað starfsvið" í 9. gr.

4. Hjúkrunarráð andmælir því út frá öryggi sjúklinga að lögleitt verði að nemandi geti fengið tímabundið starfsleyfi áður en hann hefur lokið námi sínu.

5. Hvergi er fjallað um skyldur heilbrigðisstarfsmanna til að mennta nemendur í klínísku námi og skýra þarf ákvæði um aðstoðarmenn og hvaða fagstéttir mega ráða sér þá.

Rökstuðningur við ofangreindar athugasemdir:

1. Í kaflanum „Athugsemdir við lagafrumvarp þetta" koma fram að rökin: *Gildandi laga- og reglugerðaákvæði um heilbrigðisstéttir eru að ýmsu leyti úrelt og gætir talsverðs ósamræmis, t.d. varðandi það hvaða heilbrigðisstéttir geta starfað sjálfstætt og hverjar starfa á ábyrgð annarrar heilbrigðisstéttar, hvaða heilbrigðisstéttir mega hafa aðstoðarmenn og hverjar ekki, hvaða heilbrigðisstéttir þurfa að halda skýrslur um störf sín og hverjar ekki.*
   Skiljanlegt er að setja þurfi lög um þær 19 heilbrigðisstéttir sem ekki hafa lög á bak við störf sín. Núgildandi lög um Hjúkrunarfræðinga (lög nr. 8 frá 1974) og lög um Ljósmæður (lög nr. 76 frá 1984) eru hins vegar skýr og ástæðulaust að breyta þeim.

2. Í fyrstu gr. lagafrumvarpsins koma fram skýr markmið með lagasetningunni: að tryggja gæði heilbrigðisþjónustu og öryggi sjúklinga með því að skilgreina kröfur um kunnáttu og færni heilbrigðisstarfsmanna og starfshætti þeirra. Ekkert í fyrirliggjandi frumvarpi tekur á kröfum um nám, kunnáttu, færni eða menntun. Þessu virðist öllu eiga að koma fyrir í reglugerðum. Hér er farið út á vafasama braut að mati hjúkrunarráðs. Tryggja verður í lögum út frá öryggi sjúklinga, t.d. menntun, starfssvið og ábyrgðarsvið heilbrigðisstétta og hafa að leiðarljósi

hvort um er að ræða starfsstétt eða fagstétt, út frá lengd náms og skólastigi. (Sjá í núgildandi lögum um hjúkrunarfræðinga og ljósmæður).

3. Hvergi í frumvarpinu kemur fram skilgreining á hvað fellst í "lögvernduðu starfssviði" en stjórn hjúkrunarráðs vill leggja áherslu á að tryggt sé samanber núverandi hjúkrunarlög og ljósmæðralög, hvað fellur undir lögverndað starfssvið þessar tveggja fagstétta.
   Í núgildandi hjúkrunarlögum fjallar 4. gr. um lögverndað starfssvið: *Ekki má ráða aðra en [hjúkrunarfræðinga]*[1] *skv. 1. gr. til sjálfstæðra hjúkrunarstarfa við sjúkrastofnanir, elliheimili, heilsuvernd eða hjúkrun í heimahúsum.* Tryggja verður þetta lögverndaða starfsvið hjúkrunarfræðinga.
   Í núgildandi ljósmæðralögum fjallar 4. gr. um lögverndað starfssvið: *Ljósmæður annast eftirlit með barnshafandi konum og foreldrafræðslu um meðgöngu og fæðingu. Ljósmæður starfa að fæðingarhjálp og mæðravernd.* Tryggja verður þetta lögverndaða starfssvið ljósmæðra.

4. Hjúkrunarráð andmælir því út frá öryggi sjúklinga að lögleitt verði að nemandi geti fengið tímabundið starfsleyfi áður en hann hefur lokið námi sínu. Nemandi hefur ekki náð þeirri kunnáttu og færni sem þarf til að tryggja gæði starfa sinna fyrr en eftir útskrift út námi. Það væri því ábyrgðarhluti að festa það í lög að veita megi tímabundið starfsleyfi til nemanda. Einnig vantar í lögin skilgreiningu á "ef nauðsyn krefur" sem og á "tímabundnu starfsleyfi". Hve lengi getur það verið gilt? Er hægt að endurnýja það aftur með sömu rökum og hvað þá lengi?

5. Í 16. grein er fjallað um aðstoðarmenn og nema. Ein af þeim rökum með þessu nýja lagafrumvarpi er að ósamræmi sé um hvaða stéttir megi ráða sér aðstoðarmenn. Drögin gera enga tilraun til að skýra þessi ákvæði og einungis er ætlað að fella þetta inn í reglugerð. Kennsla nemenda í klínísku námi er mjög mikilvægur hluti af skyldum og ábyrgðarsviði hjúkrunarfræðinga og ljósmæðra. Bæta verður inn í lögin þessu mikilvæga hlutverki hjúkrunarfræðinga og ljósmæðra.

Stjórn hjúkrunarráðs vill að endingu leggja áherslu á verið þessi lagadrög samþykkt sem lög, séu þau skýr og hafin yfir allan túlkunarlegan vafa og varast að framangreind atriði verði meira og minna eingöngu sett í reglugerðir.

Virðingarfyllst,

Fyrir hönd stjórnar hjúkrunarráðs,

Sigríður Sía Jónsdóttir,
Formaður hjúkrunarráðs FSA

Afrit sent: Ólínu Torfadóttur,
framkvæmdastjóra hjúkrunar á FSA

Akureyri 6. desember 2009

Halldór Jónsson
Forstjóri
FSA

Læknaráð FSA hefur fengið beiðni frá framkvæmdastjórn FSA um umsögn um frumvarp til laga um heilbrigðisstarfsmenn. Stjórn læknaráðs fjallaði um erindið á fundum þann 4.12.2009.

Stjórn læknaráð fagnar megininntaki nýrra laga, sem einfaldar og samræmir lagaumhverfi heilbrigðisstarfsmanna. Eins skýra þau lögvernduð starfsheiti og gera tilraun til að afmarka viðurkennd heilbrigðisfræði. Þá er með nýju fyrirkomulagi um veitingu starfsleyfa komið á kæruleið sem samrýmist stjórnsýslulögum.

Læknaráð bendir þó á nokkra vankanta lagafrumvarpsins:

Varðandi **5. gr. 1. mgr.** frumvarps : Í læknalögum nr 53/1988 eru skilmerki fyrir veitingu starfsleyfis læknis felld í lög. Í frumvarpi til laga um heilbrigðisstarfsmenn færist útfærsla þess til ráðherra með reglugerðarsmíð, reyndar í samvinnu við landlækni, fagfélag og menntastofnun. Með öðrum orðum færist ákvörðunin frá löggjafarvaldi til framkvæmdavalds. Stjórn læknaráðs telur þetta hugsanlega veikja réttarstöðu læknastéttarinnar og annarra heilbrigðisstétta og útsetja heilbrigðisstarfsfólk fyrir hentistefnu framkvæmdarvalds.

Varðandi **13. gr. 3.mgr.** um ábyrgð heilbrigðisstarfsmanns á meðferð og greiningu. Þessi málsgrein er vandmeðfarin og segir lítið. Er sjúklingur á sjúkrahúsi að flytjast milli ábyrgra aðila margoft á dag? Varla er það tilgangur laganna. Ef sjúklingur leitar til tveggja aðila vegna sama vandamáls, hver ber þá ábyrgð á að úr vandanum sé leyst? Geta báðir aðilar firrt sig ábyrgð í tilvikum þar sem greining yfirsést? Hver er ábyrgur eftir að tilvísun er send en áður en viðtakandi tilvísunar hittir sjúkling?
Stjórn læknaráðs FSA telur þörf á skýrari ákvæðum um ábyrgð í heilbrigðislögum og lögum um heilbrigðisstarfsmenn. Þetta frumvarp til laga leitast í of miklum mæli eftir að vera hlutlaust með tilliti til starfsstétta. Æskilegt er að ábyrgð (og með því boðvald) sé skilgreind þar sem fleiri starfsstéttir vinna saman um einn sjúkling, og fleiri aðilar innan sömu fagstéttar.

Varðandi **15. gr.** um áfengi og vímuefni

1. skarast við önnur lög
2. vímuefni eru ekki skilgreind. Falla lyfsseðilsskyld lyf (kódein, rítalín og fleirí) hér undir, eða níkótín?
3. Er hver heilbrigðisstofnun um sig best til þess fallin að ákvarða hvað sé forsvaranlegt. Er eðlilegt að heilbrigðisstarfsmenn HSU hafi aðrar reglur en heilbrigðisstarfsmenn FSA?
4. Við brot á slíkum reglum – hver hefur umboð til eftirfylgdar (mælinga) og hver eru viðurlög?

Stjórn læknaráðs telur eðlilegt að ákvæði um áfengi og vímuefni séu nánar útfærð hér. Óþarft er að hafa heimildir um reglur fyrir einstakar stofnanir. Önnur lög um opinbera starfsmenn og lög um starfssemi sem fæst við velferð fólks (barnavernd, lögregla, prestar og svo framvegis) þurfa að hafa sama innihald.

Varðandi **22. grein**, um skyldu til að veita hjálp.

„Heilbrigðisstarfsmanni ber, sé hann nærstaddur eða sé til hans leitað, að veita fyrstu nauðsynlegu aðstoð í skyndilegum og alvarlegum sjúkdóms- eða slysatilfellum, í samræmi við menntun sína og þjálfun, nema þeim mun alvarlegri forföll hamli."

Ákvæðið er mjög matskennt með tilliti til alvarlegra forfalla. Hvernig myndu dómstólar taka á máli þar sem heilbrigðisstarfsmaður telur það vera alvarleg forföll að hafa neytt áfengis í litlu magni? Er niðurstaða dóma háð útkomu slyssins eða veikindanna?
Ákvæðið er einnig matskennt með tilliti til alvarleika vandamáls. Á að kalla út lækni á frívakt til að sinna blæðingu í meltingavegi á Akureyri, þegar mögulegt er að leysa vandamálið með að senda til Reykjavíkur, sem er dýrari og hugsanlega áhættusamari kostur. Ef viðkomandi hefur fengið símtalið og fyrirspurnina, brýtur hann lög ef hann neitar? Á að kalla út barnagjörgæslulækni á frívakt við öll gjörgæslukrefjandi veikindi barna eða sjúkraflug barna í samræmi við 13. grein, 4. málsgrein (..vísa sjúklingi til annars heilbrigðisstarfsmanns ef ætla má að hann sé hæfari til að veita honum viðeigandi heilbrigðisþjónustu)? Hvað réttlætir að segja „nei, ég er í fríi"? Vísað er í dómsmál frá Kanada um efnið þar sem læknir á leið úr vinnu neitar að taka við nýjum sjúklingi á bráðamóttöku og er sakfelldur fyrir vanrækslu. Svipuð aðstaða getur komið upp ef hjúkrunarfræðingur er beðinn að koma á forfallavakt á deild með bráðveikum sjúklingum.

Líklega er ákvæðinu ætlað að gilda fyrir skyndilegar og óvæntar aðstæður þar sem enginn annar valkostur er til að veita lífsbjörg. Það er þó viss ómenning á Íslandi að leita starfmanna sem eru í fríi um að leysa úr aðsteðjandi vanda, þetta helgast af smæð eininganna.

Varðandi aldur og starfsleyfi í **26. grein.** Tilgangur laganna er væntanlega að fyrirbyggja aðstæður þar sem einyrkjar í starfi halda áfram störfum eftir að elliglöp með mögulegu dómgreindarleysi fer að hrjá fólk. Þetta hefur ekki beint með rekstur eigin starfsstofu að gera, þótt algengast sé að einyrkjaaðstaðan komi upp þar.
Einnig veltir læknaráð upp spurningu um það, að þótt venja sé að opinberir starfsmenn hætti störfum 70 ára, geta komið upp aðstæður þar sem bæði er þörf fyrir viðkomandi og hann æskir þess að halda áfram störfum. Lögin gera ekki ráð fyrir framlengingu starfsleyfis eftir sjötugt hjá heilbrigðisstarfsmanni í opinberri stöðu og þetta er mismunun.
Orðalagi mætti breyta einhvern veginn í þá veru að starfsleyfi renni að óbreyttu út við 70 ára aldur. Starfi heilbrigðisstarfsmaður í náinni samvinnu við jafningja, eða undir eftirliti yfirmanns, þannig að eftirlit með starfsháttum sé tryggt, sé landlækni heimilt að framlengja leyfi til tveggja ára í senn o.s.frv. Annar valkostur er að hætta þessum undanþágum alveg.

Fyrir hönd stjórnar læknaráðs FSA

Gróa B. Jóhannesdóttir, formaður læknaráðs

The legal duty of physicians and hospitals to provide emergency care

Anne F. Walker

Abstract

ACCESSIBILITY OF HOSPITAL EMERGENCY SERVICES HAS BEEN an issue of increasing concern and was recently brought into public focus in Ontario by the tragic death of Joshua Fleuelling, whose ambulance was redirected from the nearest hospital. As will be reviewed, the limited case law has identified a legal duty for physicians and hospitals to provide treatment to people in need of emergency care, a duty that should be considered when formulating hospital policies. The impact of this duty of care on the existing standard of medical practice will be considered.

Review

Synthèse

At the time of writing, Dr. Walker was an articling student in Toronto, Ont.; she is to be called to the Ontario Bar later this month. She also practises as a veterinary consultant.

This article has been peer reviewed.

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ß See related article page 445

At 1:00 am on the morning of Jan. 14, 2000, 18-year-old Joshua Fleuelling was having trouble breathing. He had a history of asthma. Despite being given Ventolin and Serevent by his mother, he experienced severe respiratory distress, and at 1:48 am a call was made to 911 asking for an ambulance to transport him to the hospital. Fire personnel arrived first and administered oxygen. At 1:57 am a basic life-support ambulance crew arrived. As they began their assessment, Fleuelling collapsed and experienced full body convulsions. He did not have a pulse. Cardiopulmonary resuscitation (CPR) was initiated and an oral airway inserted. The ambulance crew was advised by the dispatch centre that an advanced life-support unit was not available in the area. Two unsuccessful attempts were made to defibrillate his heart, and CPR was continued. A second request was made for advanced life-support, but a unit was still unavailable. The dispatch centre informed the crew that the nearest emergency department was on critical care bypass. A decision was made to go to another hospital, and the ambulance departed at 2:11 am. The emergency department at the first hospital was not contacted. Defibrillation was attempted again en route, but Fleuelling's heart remained asystolic. CPR was continued, and the ambulance arrived at the emergency department at 2:23 am. An endotracheal tube was inserted and a normal cardiac rhythm was eventually established; however, there was irreversible brain damage, and on Jan. 16, 2000, Fleuelling was declared dead.[1]

Estimates vary as to the extent of the delay in reaching the emergency department. Newspaper reports suggested that the closest hospital was a 10-minute drive from the Fleuelling's home and that the second hospital was 18 minutes away.[2] The family has estimated that only 3 to 4 minutes would have been needed to reach the first hospital and that the ambulance was required to travel 4 times as far.[3,4] A coroner's inquest was held to examine the circumstances surrounding the death.[5] The jury made recommendations with respect to asthma prevention, improvements in the ability of emergency personnel to respond to a problem and to provide advanced life-support, and resolution of emergency department overcrowding. The family has recently commenced legal actions against the Government of Ontario alleging negligence, breach of contract and breach of fiduciary duty,[3] and against the ambulance service and the hospital that was on critical care bypass alleging negligence and breach of contract.[4]

Ambulance diversion policies

At the time of Joshua Fleuelling's death, emergency departments in the Toronto area were experiencing severe overcrowding. An ambulance redirect program permitted hospitals to control emergency ward admissions when additional admissions

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would compromise patient care.[6] Emergency departments on redirect consideration were accepting only critically ill patients, and those on critical care bypass were being bypassed and all patients were being transported to other emergency departments unless special arrangements were made.

Following the Fleuelling incident, the Toronto ambulance dispatch centre directed its personnel to transport critically ill patients to the nearest hospital regardless of its emergency status.[7] In March 2001 the Ontario Ministry of Health and Long-Term Care announced plans to replace the ambulance redirect program with the Patient Priority System.[8] The new system, implemented province wide in October 2001, has standardized communication between paramedics, dispatch staff and hospital emergency personnel by having them use the Canadian Triage and Acuity Scale (CTAS) to evaluate and describe the needs of patients. Critically ill patients are to be transported to the nearest hospital regardless of how busy the emergency department is, and less seriously ill patients are to be transported to the hospital providing the most appropriate treatment.

Duty of care

The duty of care is one component of the law of negligence. In order to establish a defendant's liability in negligence, 4 requirements must be met: the defendant must owe the plaintiff a duty of care; the defendant must fail to meet the standard of care established by law; the plaintiff must suffer an injury or loss; and the defendant's conduct must have been the actual and legal cause of the plaintiff's injury.[9]

There are 2 sources of law in Canada: legislation, and common law derived from judicial considerations of legal cases. Case law considering the duty of care in emergency situations is limited in Canada and the rest of the Commonwealth. Although case law in the United States has no binding precedential effect in Canada, relevant US cases have been included in this review, because it is anticipated that, should this issue be litigated, the dearth of Canadian case law will prompt the courts to search for guidance from the US courts.

Under common law a physician has traditionally not been required to undertake the care of someone who is not already a patient. This reflects the position that no person is required to provide assistance to another except in exceptional circumstances.[10–12] As summarized in *St. John* v. *Pope* (Texas Supreme Court, 1995), "Professionals do not owe a duty to exercise their particular talents, knowledge, and skill on behalf of every person they encounter in the course of the day ... It is only with a physician's consent, whether express or implied, that the doctor–patient relationship comes into being."[13] On the basis of the principle of contract law, that both parties must assent to the creation of a relationship, the right of refusal has been extended to emergency situations even when no other physician is available.[14,15]

However, the common law has been evolving with respect to the provision of emergency medical services. It appears from recent case law that there is now a positive duty for physicians and hospitals to provide emergency care. The common law has been modified in several ways: first, by using the principles of negligence law, specifically those of proximity and foreseeability, to establish that the relationship between the individual and the physician and hospital is sufficiently close to require a duty of care and by using the principle of reliance to establish that the individual has relied upon the services offered by the physician or hospital; second, as a result of ethical considerations; third, by finding a pre-existing relationship between the patient and the physician and hospital; fourth, through public policy considerations; and fifth, in certain jurisdictions, by legislation.

Principles of proximity, foreseeability and reliance to establish a duty of care

The concept of a duty of care as applied in Canada was first articulated in the 1932 case of *Donoghue* v. *Stevenson*,[16] in which it was held that "You must take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbour. Who, then, in law, is my neighbour? The answer seems to be 'persons who are so closely and directly affected by my act that I ought reasonably to have them in contemplation as being so affected when I am directing my mind to the acts or omissions which are called in question.'" In order to limit the scope of the duty, the neighbour principle "ought to apply unless there is some justification or valid explanation for its exclusion."[17]

Only one Canadian case has considered the duty of a physician to treat an individual in an emergency situation. In the 1993 British Columbia Court of Appeal case of *Egedebo* v. *Windermere District Hospital Association*,[18] a doctor who was working in the emergency department, but not on call, was advised that a person had arrived in need of emergency care. The doctor decided that the patient should wait to see the on-call physician, even though he knew that this doctor was occupied. The patient suffered permanent injuries. In the subsequent negligence action the court held that, even though the doctor was not on call, there was a sufficient relationship of proximity between the patient and the doctor such that, in the reasonable contemplation of the doctor, his acts or omissions would be likely to affect the patient. His refusal to provide treatment where he knew or ought to have known that no other physician was available constituted a breach of his duty of care to the patient. The court also held that the physician had an ethical obligation to provide assistance.

Similarly, in the 1995 Australian case of *Woods* v. *Lowns*,[19] the defendant physician refused a request to assist a person experiencing an epileptic seizure a short distance from his office. The court concluded that the physician had a duty to provide emergency care because there was a rela-

tionship of sufficient proximity between the parties. Public policy was also found to support such a duty.

In 1969 the English case of *Barnett* v. *Chelsea and Kensington Hospital Management Committee*[20] established the duty of an emergency ward to accept a person in need of emergency treatment, based on the finding of a sufficiently close and direct relationship between the doctor and the hospital and the person in need of care.

The principle of reliance has also been used to establish a duty for hospitals to provide emergency treatment. Courts in the United States have held that a private hospital with a well-established custom of providing emergency care owes a duty to treat anyone relying on that custom.[21] A reliance interest may also exist when the failure to treat aggravates the person's injuries.[22]

Ethical considerations

Medical associations in Canada and the United States[23,24] have established an ethical duty for physicians to provide assistance to individuals requiring emergency care. Section 9 of the Canadian Medical Association's Code of Ethics[25] states that a physician is to "provide whatever appropriate assistance ... to any person with an urgent need for medical care." Ethical considerations have been used by the courts to establish a duty of care.[18,19]

Pre-existing relationship between a patient and a physician or hospital

Although this issue has yet to be litigated in Canada, US courts have held that only minimal, indirect involvement with a patient may be sufficient to establish a physician–patient relationship and therefore a duty of care.[26,27] A hospital–patient relationship begins when the patient signs in at the emergency department; however, the mere presence of an injured person in an emergency department may be sufficient to establish such a relationship.[28] A hospital was deemed to have accepted a person as a patient by detaining him before deciding to reject him and send him elsewhere.[29]

Public policy

Public policy has been used to support a duty to treat people in need of emergency care.[30] In the 1973 case of *Mercy Medical Center of Oshkosh* v. *Winnebago City*, for example, the Wisconsin Supreme Court stated that "... the public support of a hospital and the governmental grants in aid to hospitals to increase their facilities all substantiate the fact that hospitals with emergency service cannot refuse it to the needy."[31]

Although a public policy argument has not been used in Canada to support a duty to treat in emergency situations, Canadian courts have expressed sentiments similar to those of the US courts with respect to the role played by hospital emergency departments. Public policy and reliance principles can be found in the reasoning in the 1993 case of *Baynham* v. *Robertson*.[32] The Ontario Court of Justice (General Division) confirmed that, if a hospital wishes to discontinue or curtail its emergency services, it has a duty to take reasonable steps to notify the public of these changes. The court referred to the 1980 decision of the Ontario Court of Appeal in *Yepremian* v. *Scarborough General Hospital*,[33] in which it was noted that "the recognition of a direct duty of hospitals to provide non-negligent medical treatment reflects the reality of the relationship between hospitals and the public in contemporary society ... The public increasingly relies on hospitals to provide medical treatment and, in particular, on emergency services. Hospitals to a growing extent hold out to the public that they provide such treatment and such services."

Legislation

Except in Quebec,[34] there are no currently enforced legislated requirements in Canada for physicians or hospitals to provide emergency care. In Quebec the legislated duty to treat is based on the civil law duty to rescue.[35–37] However, section 21 of the Ontario Public Hospitals Act alludes to the special status of individuals requiring emergency care and may be interpreted by the courts as mandating a duty to treat such individuals. The section provides that "nothing in this Act requires any hospital to admit as a patient, (a) any person who is not a resident or a dependant of a resident of Ontario, unless by refusal of admission life would thereby be endangered ... "[38]

The impact of a duty to treat on physicians and hospitals

On the basis of the legal principles and case law, it can be concluded that physicians and hospitals in Ontario owe a duty of care to individuals presenting in need of emergency treatment. There is a sufficient relationship of proximity between the individual and the physician and hospital to create a duty of care. It is foreseeable that failure to provide such treatment will be injurious to the individual. Ethical duties of the physician mandate the provision of emergency treatment, and statements of public policy point to the reliance placed by the community on the services offered by hospital emergency departments.

The reliance principle is particularly important to a consideration of the duty of emergency departments to accept ambulance admissions. It can be argued that most people in need of emergency care would choose to get to hospital by ambulance instead of by private transportation, based on the belief that better care can be provided en route by ambulance personnel. It is expected that few people are aware that hospitals will not refuse admission to people arriving by private transportation, in contrast to those arriving by

ambulance.[39] As such, a situation of reliance is created, and a hospital that elects to provide emergency services must do so for all people arriving in need of care, irrespective of their mode of transportation.

To meet this duty of care, physicians and emergency departments may be required at times to accept more patients than can reasonably be accommodated. The impact of this duty of care on the other duties owed to the patients already in the emergency department, particularly the duty to practise in accordance with a reasonable standard of care, must be addressed.

Physicians and hospitals must practise according to a reasonable standard of care.[40–43] "Every medical practitioner must bring to this task a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. He is bound to exercise that degree of care and skill which could reasonably be expected of a normal, prudent practitioner of the same experience and standing, and if he holds himself out as a specialist, a higher degree is required of him than of one who does not profess to be so qualified by special training and ability."[44] In Ontario the Public Hospitals Act[38] and regulation[45] require hospitals to maintain a reasonable standard of care in their management, staffing and provision of services.[40–43]

Is the standard of care required of physicians and hospitals sufficiently flexible to accommodate a potential variation in the level of care necessitated by an excess number of patients. To date, the legal impact of budgetary restraints in the funding of medical services on the practice of medicine has received minimal attention from the courts. Although the courts have not considered the impact of patient overcrowding on the standard of medical care, the limited case law suggests that they are willing to adjust the standard of care when personnel or equipment are limited as a result of an actual scarcity of resources beyond the control of the physician or the hospital. The availability of such resources has an impact on what can reasonably be expected of the physician and the hospital in such circumstances. In contrast, it is anticipated that courts will be reluctant to permit a reduction in the standard of care when conscious decisions are made to withhold available services for reasons of cost containment alone.[46–49]

In the 1991 case of *Bateman* v. *Doiron*[50] the New Brunswick Court of Appeal held that the defendant hospital was not liable for staffing its emergency department with general practitioners because specialists were unavailable. The court stated that the hospital must be judged according to the standards reasonably expected by the community it serves, not by those of communities served by large teaching hospitals. Similarly, in the 1993 Ontario case of *Baynham* v. *Robertson*,[32] the court concluded that the hospital was not negligent in its replacement of 24-hour onsite physician emergency services with on-call physician services, because it attained the standards reasonably expected by the community. In the 1990 negligence case of *Sweeney Estate* v. *O'Brien*,[51] an excessive delay in the transfer of a patient from the emergency ward to the intensive care unit because no bed was available was not considered by the Nova Scotia Court of Appeal to be the fault of the physicians or the hospital. It must be noted that these cases differ from those in which hospitals were found to have breached the standard of care by the fact that these hospitals did not choose to ration resources that were otherwise available. In the Ontario Court of Appeal case of *Jinks* v. *Cardwell*,[43] for example, the defendant hospital was held to have breached the standard of care as a result of inadequate staffing levels. The hospital was not experiencing an excess patient load or a reduction in staffing when it negligently elected to place 2 nurses in charge of supervising 33 patients with mental illness. Even in situations of financial restraint, US courts have found hospitals to have breached the standard of care when available resources have been inappropriately withheld. In *Horton* v. *Niagara Falls Memorial Medical Center*[52] a New York appellate court held that a staff shortage should not have precluded the supervision of a patient had duties been assigned appropriately.

Similarly, decisions made by physicians to withhold potentially available services for reasons of budgetary restraint have been found to be negligent by the courts. In *Law Estate* v. *Simice*[53] the British Columbia Court of Appeal found a physician to be negligent when his concerns for cost containment led him to deny a CT scan to a patient. The court held that the physician's responsibility to his patient must take preference over his responsibility to the medicare system. A similar finding has been made by a US court.[54]

It has been suggested that defences such as "accepted medical practice" or "economic necessity" eventually may be accepted when the standard of care has fallen because of medical decision-making influenced by considerations of financial restraint. Courts may be reluctant at first to support such a decline in the medical standard, but ultimately, negligence law must adjust to the realities of health care economics.[47,49,55]

Based on these judicial and academic opinions, it is reasonable to suggest that, as long as emergency physicians maintain as their primary responsibility the goal of providing the best possible care to their patients, the standard of care will be sufficiently flexible to accommodate any reasonable medical decisions made in response to a situation of overcrowding. Hospitals should also focus their efforts on providing the appropriate level of care to each patient. US courts have stated that, when faced with resource constraints, hospitals must make adequate use of their available resources. As stated in *Greater Washington DC Area Council of Senior Citizens* v. *District of Columbia Government*, "Their excuse that the conditions are a product of fiscal constraints is unacceptable absent a clear demonstration that even within those constraints, timely and positive efforts have been launched by exacting, sensitive and demanding administrators."[56] Therefore, it is expected that hospitals, when faced with overcrowding in their emergency departments, must initiate responses aimed at providing accept-

able patient triage and alleviating patient overcrowding, including mobilization of staff and equipment and facilitating patient transfer. However, the liability issues may be more complex for hospitals than for physicians. Courts may find in the hospital's global decision-making process a deliberate intention to reduce the availability of staff, equipment and services within the emergency department. Although Canadian courts have not addressed this issue, it is possible that they may interpret these decisions as attempts to restrict patient access to potentially available resources and consequently, in an action for negligence, may be reluctant to accept a reduced standard of medical care.

If the problems associated with cost containment in the health care system remain unresolved, one can reasonably expect that these issues will ultimately be addressed by the courts. It is anticipated that, should the Fleuelling case be litigated, physicians and hospitals will be provided with some much needed guidance respecting the scope of their duty to provide emergency medical services.

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