

Law & Governance

Legal Focus on Healthcare and Insurance

Policies, programs, practices & opinions for the providers, administrators & insurers of healthcare services

Clinicians' Duty to Care

A Kantian Analysis

Robyna Irshad Khan

"On medical wards that treated patients with Severe Acute Respiratory Syndrome (SARS), some staff reported anxiety about infection and resentment about being chosen for the task. Nurses who were assigned to patients with SARS were not allowed to refuse the assignment ... there were incidents of professional and nonprofessional staff refusing to care for patients with SARS in respiratory isolation on general medical floors."¹

"WASHINGTON – The National AIDS Commission said Tuesday that a 'shocking' number of physicians and other healthcare professionals across the nation are still refusing to care for AIDS patients."²

These are two examples where clinicians' "duty to care" for their patients under unfavourable and unexpected circumstances came under discussion and started an ethical debate. I examine clinicians' (physicians' and nurses') duty to care for their patients under unusual circumstances especially – epidemics of new, virulent diseases – and analyze it using the moral philosophy of Immanuel Kant to support the argument that their moral responsibility does not change with changing disease scenarios.

Context – Duty to Care

The World Medical Association's International Code of Medical Ethics³, specifies in the duties of a physician that, "A physician shall observe the principle of the

1 Maunder R., J. Hunter, L. Vincent, J. Bennett, N. Peladeau, M. Leszcz, et al. 2003. The Immediate Psychological and Occupational Impact of the 2003 SARS Outbreak in a Teaching Hospital. *CMAJ*; 168(10):1245-51.

2 Cimons M. 1990. "Panel Criticizes Doctors Who Won't Treat AIDS Patients-- Health: U.S. Report says a 'Shocking' Number Avoid the Disease. It Adds That Such an Attitude is Unacceptable." *Los Angeles Times*. Orange County Edition Page: 3.

3 World Medical Association. 1983. *International Code of Medical Ethics*. www.wma.net/e/policy/c8.htm

Declaration of Geneva." One of the clauses of the Declaration of Geneva is, "I will not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, or social standing to intervene between my duty and my patient. I make these promises solemnly, freely and upon my honour." Similarly, the Canadian Nurses Association's *Code of Ethics for Registered Nurses*⁴ stipulates, "Once care of a patient has been undertaken, a registered nurse has the ethical and legal responsibility to continue to provide care for the assigned period of time."

Do these stipulations define the duty to care beyond reasonable doubt, or is the concept still vague? There is not much ambiguity about what is meant by duty to care when a clinician is treating patients under routine, everyday circumstances. The controversy starts when the routine is changed to crisis, with its associated uncertainties. Recently, this issue was evoked in the context of SARS in Canada. Clinicians were expected to take care of SARS patients in the line of duty and when some refused, citing personal risks as the reason, the discussion of the limits to the duty to care was initiated. One thing that transpired from this discussion was that the duty to care has no single unambiguous definition.⁵ There are no preset boundaries or limits to this duty, and it is subject to individual interpretations. The phrase "duty to care" is seldom used by medical ethicists, who resort instead to more specific rules and duties to underpin obligations. From 1975 to 2004, no article has included the phrase "duty to care" in its title in the *Journal of Medical Ethics*, and the *Journal of Medicine and Philosophy* has no result under "duty" in its 25-year subject index. The vague definition of the duty to care renders its use confusing and unhelpful. One way to reduce the ambiguity of the term is to have a detailed discourse around it. I examine the duty to care and its limits using Immanuel Kant's philosophy and hope that discussion will be furthered by similar or opposing points of view till we reach a conclusion.

Description – Duty to Care

Physicians and nurses have more stringent obligations of beneficence towards their patients than any other profession. The term "duty to care" refers to these special obligations. Part of this duty is to treat patients in spite of the inherent dangers associated with close physical contact, when physicians or nurses expose themselves to the possibility of contracting the patient's disease. This duty may vary among different specialties of medicine; for example, a physician working in the emergency department or intensive care unit is more exposed to virulent diseases than a radiologist. But physicians are expected to know the extended limits of their duty when they enter their field of

4 Canadian Nurses' Association. 2004. *Code of Ethics for Registered Nurses*. www.cna-nurses.ca/pages/ethics/ethicsframe.htm

5 Sokol D. 2004. *Healthcare Workers' Duty to Care and Severe Infectious Diseases*. www.medicalethicist.net/Thesis3.doc

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choice. With the acquisition of additional duties and rights conferred by their professions, physicians and nurses relinquish certain rights enjoyed by others. By entering into the profession, a clinician agrees not only to abide by new rules but also to accept dangers that would be unacceptable to most.

and to others, and perfect and imperfect duties. Perfect duties are prohibitions of specific kinds of actions, and violating them is morally blameworthy. Imperfect duties are recommendations of certain acts, and fulfilling them is praiseworthy. In the later *Metaphysics of Morals*,⁸ Kant writes about duties in a similar pattern, but with

*Duty to care for a patient by the physician is a duty of virtue.
A person who decides to become a physician takes on the promise of using
his or her abilities to the best advantage in taking care of the sick.*

Kant's Moral Philosophy and Duty to Care

Immanuel Kant was born in 1724 near Königsberg, Germany. He is undeniably one of the most influential philosophers in the realm of moral thinking. In his book *Groundwork for the Metaphysics of Morals*, Kant defines the concept of "categorical imperative."⁶ Kant's philosophy deals with ethical duties of the individual moral agent, and he bases his system upon principles of universality. A moral obligation, according to Kant, must be universalizable, that is, applicable to all people at all times and in all similar situations. A system of morality must provide give a solid moral path regardless of the specific situation, and must be accessible and rationally acceptable to all.⁷ The distinct character of Kantian universalizability is its appeal to what can be willed for all rather than what actually is or hypothetically would be willed by all. His main thesis is that the moral worth of an act is related not to the outcome it brings but to whether it is done from a sense of duty or obligation. Kant states, "The moral worth of an action does not lie in the effect expected from it and so too does not lie in any principle of action that needs to borrow its motives from this expected effect." Duty is described as "that action to which someone is bound."

According to Kant, "All duties are either duties of right, that is, duties for which external law giving is possible, or duties of virtue, for which external lawgiving is not possible." In the *Groundwork*, Kant's principle of morality classifies duties into four categories: duties to oneself

one key distinction: duties of justice are those that can appropriately be enforced by means of coercion, and the remainder are duties of virtue, by which a person can be morally assessed but not coerced. Kant considers freedom to be of main value for a human being, and he permits coercion only where it is both essential to protect freedom and possible for it to do so. This means that only a small subset of our duties, namely some but not all of our perfect duties to others, are duties of justice, thus proper subjects for public legislation. The majority of our moral duties are duties of virtue, which are not appropriate subjects for coercive legal enforcement.⁹ The reason the latter cannot properly be made the subject of public legislation is that they relate to an end or purpose which is a duty upon the individual. But no public legislation can cause anyone to adopt a particular intention, or propose to him or her a certain purpose, for this depends upon an internal condition or act of the mind itself. However, certain external actions to enforce such a mental condition may be commanded.

Duty to care for a patient by physician is a duty of virtue. A person who decides to become a physician takes on the promise of using his or her abilities to the best advantage. Such a promise can be explicit (e.g., taking an oath) or implicit, but there is no denying its existence. This promise is a duty in itself, and the physician is morally bound to fulfill that duty. It is

⁶ Immanuel Kant – About the philosopher. Essays on Kant. 2004. www.kant-essays.com/about.html .

⁷ Universalism in Ethics. 2004. www.caae.phil.cmu.edu/Cavalier/80130/part2/Routledge/R_Deontology.html

⁸ Introduction to the *Metaphysics of Morals*. *Division of the Metaphysics of Morals as a System Duties Generally*. Translated by W. Hastie. Source: Steve Palmquist's website.

⁹ Guyer P. Kant, Immanuel. In E. Craig (Ed.). 2004. *Routledge Encyclopedia of Philosophy*. London: Routledge. www.rep.routledge.com/article/DB047SECT10 .

based on and oftentimes limited by the capabilities of a physician; for example, an anesthesiologist can anesthetize patients but cannot perform surgery on them. It is definitely not based on the patient's circumstances. For example, an anesthesiologist cannot refuse to anesthetize a patient who is suffering from a communicable disease, presents to the hospital and requires surgery. The physician can take all necessary precautions to protect self and others from that disease but is duty-bound to anesthetize the patient. If the physician chooses to refuse this duty, external conditions – for example, peer pressure or a reminder of commitment to one's duty – can be applied.

On the other hand, one of Kant's assertions is that the moral worth of an action depends on the moral acceptability of the "maxim" or rule of obligation on which the person acts. Kant emphasizes that one must act not only in accordance with but for the sake of obligation. To Kant, a person's actions can be morally worthy only if his or her intentions are what is morally required. In the case of duty to care, if clinicians perform their duty only because of peer pressure or because the public expects them to do so, their actions will not be morally worthy. For their actions to be morally worthy, clinicians must perform their duty to care for their patients with an obligation of fulfilling a promise to their profession and towards their patients.

One of Kant's most important claims is that the moral worth of an individual's actions depends exclusively on the moral acceptability of the maxim on which the person acts. For Kant, rationality implies something much different than the rational pursuit of desires and preferences with foresight and critical reflection.¹⁰ Rationality requires logical consistence such that one could will that the maxims of one's actions become universal laws. If the physician wants to state his or her duty as, "I will fulfill my duty to my patients, when and where I see appropriate, and abstain from it when I sense a personal danger," this maxim, according to Kant cannot pass a test that he calls the categorical imperative.

Kant formulates his categorical imperative in at least three different ways.¹¹ Each formulation, he says, is strictly equivalent to the others. That is, each will pick out the same actions as morally wrong, and each will allow the same actions as morally permissible. His first

formulation – "I ought never to act except in such a way that I can at the same time will that my maxim should become a universal law" – is a test for logical consistency. To see how Kant would judge the moral worth of an action, imagine a Western physician trained in infectious diseases, who takes an oath to treat a patient that he is capable of treating according to the best of his abilities at the time of his graduation. He is aware of all the protections that are available to him in case of treating a patient suffering from a communicable disease. He also knows that there are newer diseases erupting every so often, for which medical knowledge is limited. Now imagine the same physician employed by a hospital where several patients suffering from an epidemic disease are brought for treatment. This physician cannot refuse treatment to these patients even if it entails exposing himself to the risk of contracting the disease, without breaking his promise (oath). He cannot break his promise to fulfill his duty whenever he foresees an obstruction to smooth sailing in his professional life. By the standard of Kant's first formulation of the categorical imperative, a physician who abstains from duty of self-concern cannot universalize his maxim.

Kant's second formulation states, "Act in such a way that you always treat humanity, whether in your own person or in the person of another, never simply as a means, but always at the same time as an end." For Kant, all rational beings are genuine participants in the realm of morality. It is their rationality and autonomy (the ability and requirement to "give the law unto oneself") that makes them creatures worthy of respect. One should never use other people merely as means because one would not accept as legitimate any reason for an unacceptable action directed at oneself. Therefore it would be inconsistent to treat another rational being any differently than one would want to be treated. If the physician in the above example were suffering from the same epidemic disease, he would expect another capable physician to treat, and if possible, to cure him. He should treat his patients in the same way that he wants to be treated if he himself were a patient. In short, for Kant rational beings are creatures that both give and require respect on a reciprocal and equal basis.

The third formulation of Kant's categorical impera-

10 Beauchamp T.L., J.F. Childress. 2001. *Principles of Biomedical Ethics*. 5th ed. New York: Oxford University Press. p 349-350.

11 The Internet Encyclopedia of Philosophy. *The Categorical Imperative*. 2004. www.nd.edu/~rbarger/categorical-imperative.html.

12 Kantian Ethics. www.duke.usask.ca/~wib289/PHL235/transparencies/Kantian_Ethics.PDF.

tive is, "So act as if you were through your maxims a law-making member of a kingdom of ends." Treat yourself and every other rational being as jointly constituting a community of agents who, as ends in themselves, can accept only those laws that they have given themselves.¹² If made into a law, the physician's oath, "I will fulfill my duty to my patients, when and where I see appropriate, and abstain from it when I sense a personal danger" would not be acceptable to patients, as it would make their treatment unpredictable. There would also be no one to care for patients whenever an epidemic struck. The community of physicians could not accept this law either, owing to its inconsistency in fulfilling the promise of duty to care for patients indiscriminately and also because physicians must accept the same law when they are patients themselves. It can be argued that the abandonment of patients by healthcare personnel would result in the harm or even death of these patients. Public trust in them would therefore diminish as people realize that they might, as soon as the risk reaches a certain level, be left on their own.

In his thesis, *Healthcare Workers' Duty to Care and Severe Infectious Diseases*,¹³ Daniel K. Sokol writes, "Religion, financial gain, reputation, personal character, social context, geographical location, severity and nature of disease, the climate of fear – these are all influential factors in doctors' decision to treat, perhaps more so than in any other historical period." Kant would disagree with this statement. According to Kant, persons have "autonomy of will" if and only if they knowingly act in accordance with the universally valid moral principles that pass the requirements of the categorical imperative. He contrasts his moral autonomy with "heteronomy," which refers to any controlling influence over the will other than motivation by moral principles.¹⁴ If, for example, people act from passion, ambition or self-interest, they act heteronomously, and not autonomously. Kant regards acting from desire, fear, impulse, personal projects and habit as no less heteronomous than actions manipulated or coerced by others.

Utilitarian View - Duty to Care

Duty to care could also be evaluated from a utilitarian perspective. The agent in this case is relegated to the background and the focus shifts to outcomes. If the suffering prevented by the duty to care causes more suffer-

ing to others, then this would be grounds for not fulfilling the duty. The limits of duty to care are dictated here by calculating which option will produce the maximal outcome. That would be acceptable if taking care of one patient would mean failing to care for other patients, as the conflict would be between the duty to care for this one patient and the duty to care for all the other patients. Clearly, all other things being equal, the latter is the preferable option. Needless to say, the practical difficulties of calculating maximal outcomes seriously limit the use of the utilitarian argument to resolve problems in real life scenarios.

Conclusion

Kantian ethics has been influential in formulating bioethical theories for moral guidance of healthcare professionals. It is apparent from analysis of his moral philosophy that Kant would have emphasized a uniform duty of care for all healthcare personnel under all circumstances. Kant's philosophy does not permit changes of limit to duty to care with changing disease scenarios. He would consider a physician's duty to care for patients binding without any considerations of a personal nature. Healthcare personnel are usually aware of the perils of treating infected patients. The appearance of a new, highly virulent disease, therefore, should not cause them to challenge their duties. Although outbreaks of infectious diseases in the Western world are still a rare occurrence, with globalization, this situation is bound to change. Does this change the responsibilities and loyalties of doctors to their patients? Should physicians in the West have different limits of duty to care than physicians in the East because Westerners have less chance of exposure to an epidemic due to availability of better healthcare services? Will that reasoning satisfy the universalizability of ethics that we all try to achieve? Kant would give a negative answer to all these questions. **L&G**

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13 Sokol D. 2004. *Healthcare Workers' Duty to Care and Severe Infectious Diseases*. www.medicalethicist.net/Thesis3.doc.

14 Beauchamp T.L., J.F. Childress. 2001. *Principles of Biomedical Ethics*. 5th ed. New York: Oxford University Press. p 349-350.

Commentary

Kevin Smith
and John Woods

Robyna Irshad Khan cleverly applies Kantian ideas of "morality" and "duty" to the current moral and ethical dilemmas facing clinicians when dealing with the inherent dangers associated with patients suffering from communicable diseases. This is an issue that we most recently recall from the SARS crisis, particularly in relation to the anxieties of staff.

In a series of lectures at the University of Illinois early in the 20th century, Durant Drake offered a description of "duty" as "the name we give virtue when she is opposed to inclination" and went on to say "the saints have no need of the concept; virtue to them is easy and agreeable; they have learned the beauty of holiness and have no unruly longings."

Most of us are, of course, not saints, and often face very real conflicts of duty. In the case of treating a patient with a communicable disease one could ask, "Is my greater duty to the patient or to my family?" not just in terms of the risk of infection but also long-term responsibilities as a parent, child or family provider.

Physicians, nurses and other professionals often aspire to a noble oath or code of conduct that is deeply rooted in history and high moral ideals. Most of us expect clinicians to care for us under virtually all circumstances of ill health. However, duty can also be a burden. As the CEO of a teaching hospital built by the Sisters of St. Joseph's of Hamilton, I am familiar with a history in which the Sisters' commitment to service of the marginalized and dispossessed required them to care for people during terrible epidemics of cholera and typhoid.

Kant espoused a morality based upon a universality that is greater than can be justified by utility or outcomes. In the hands of Khan, his framework for "morality" and "duty" provides a useful lens for our challenges today. Universality is of course the subject of great debate, and to quote Ruth Benedict (1933), "We recognize that morality differs in every society, and is a convenient term for socially approved habits."

Perhaps as we try to tackle the very real issues faced by the clinicians who place themselves at personal risk to care for us, we should be thankful and reflect upon the words of Charles Darwin: "It must not be forgotten

that although a high standard of morality gives a slight or no advantage to each individual man and his children over the other men of the same tribe, yet an advancement in the standard of morality will certainly give an immense advantage to one tribe over another."

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The New Canada Not-for-profit Corporations Act

An Overview

Lynne Golding

The current legislative regime governing the federal not-for-profit sector has not undergone any significant modification since 1917. On November 15, 2004, following much public consultation, the federal government introduced An Act Respecting Not-for-profit Corporations and Other Corporations Without Share Capital (Bill C-21) (the “*Canada Not-for-profit Corporations Act*”) (hereinafter “the Act”) which provides a modern system of corporate governance for federal not-for-profit corporations and special act corporations without share capital currently regulated by the *Canada Corporations Act*. The federal government has predicted that it will take more than a year for the new legislation to be passed, and amendments and changes to its current provisions remain likely as it proceeds through the legislative process. The following summary highlights some of the most important aspects of this highly detailed and comprehensive piece of legislation.

1. Transitional Procedures for New Corporations

Once the legislation is enacted, all corporations that are currently governed by Part II of the *Canada Corporations Act* will be required to apply for a certificate of continuance in order to achieve corporate status under the new regime. No fees will be required for this application, but if an existing corporation fails to take this step within three years after the coming into force of the Act, it may be subject to dissolution. Existing corporations therefore have a significant incentive to comply with the new legislation, as well as a lengthy period in which to do so.

2. Incorporation

The new legislation will replace the current system of federal incorporation (i.e., the discretionary “letters patent” system) with the faster and more efficient system of incorporation “as of right.” In addition, the new legislation will no longer require that three individuals incorporate new corporations. Instead, one or more individuals or corporations will be able to incorporate by sending signed articles of incorporation and other specified documents to the Director, who upon receipt will issue a certificate of incorporation. The Director is a position created by the new legislation that is somewhat similar to that of the Director under the *Canada Business Corporations Act*, in that the Director’s role is to exercise regulatory powers and act as a public registrar of corporations.

3. Capacity and Powers of the Corporation

The new legislation provides not-for-profit corporations with the capacity, rights, powers and privileges of natural persons, and it does not require the passage of by-laws in order to confer any power on a corporation or its directors. Corporations will still be required, however, to refrain from carrying on activities or exercising powers in a manner contrary to their mission as articulated in their articles. As a result of these new provisions, directors should be less exposed for actions that are ultra vires the corporation’s powers.

4. Financial Accountability and Disclosure

The new legislation introduces a distinction between two different types of corporations: “soliciting corporations”

and “non-soliciting corporations.” When a corporation requests donations or gifts of money from the public, receives a grant or similar financial assistance from a government or government agency, or accepts money or other property, then such corporation is considered to be “soliciting”, according to the new legislation.

With a view to enhancing and protecting the rights of members, the new legislation will impose additional financial disclosure obligations on corporations by requiring that they make financial statements available to members on request. Soliciting corporations will also be required to file their financial statements with the Director, who will then make them available to the public.

Different levels of financial accountability will be imposed on different types of corporations depending on their level of annual revenue and whether they are a soliciting corporation. Soliciting corporations with annual revenues greater than \$250,000 require an audit, whereas non-soliciting corporations are required to have an audit only where their annual revenues are greater than \$1 million. Members of both soliciting and non-soliciting corporations with annual revenues below these prescribed annual revenue levels will have some limited choice in the level of financial scrutiny they wish to impose on the corporation – an audit engagement, a review engagement with a lesser scope of examination or no review or engagement whatsoever.

5. Administrative Obligations

The new legislation requires all corporations to file annual returns and keep registered offices. Corporations will also be required to maintain corporate records for specific periods of time. Required records will include registers of directors, officers, members and debt obligations, minutes of members' meetings, adequate accounting records and important corporate documents such as articles and by-laws. The new legislation requires corporations to grant access to these corporate records for certain groups, depending on the type of record involved.

6. Directors

Under the new legislation, directors of non-profit corporations will be subject to modern governance rules, bringing their duties and responsibilities more in line with those of their for-profit counterparts.

a) Composition of Board and Meeting of Directors

A corporation, pursuant to the new legislation, has more flexibility in determining the number of directors required to manage its affairs. Non-soliciting corporations must have at least one director, whereas soliciting

corporations must have a minimum of three directors, at least two of whom are not officers or employees of the corporation or its affiliates. In addition, the Act makes provision for directors' written resolution in lieu of holding a meeting, a flexible and rotating board and a maximum term of three years.

b) Duties

Under the current legislative regime, the standard of care to which non-profit directors and officers are subject is determined by a fluctuating common law. The new legislation specifically provides directors with a duty of care that requires them to act honestly and in good faith with a view to the best interests of the corporation, to exercise the care, diligence and skill that a reasonably prudent person would exercise in comparable circumstances and to comply with the new legislation and any governing corporate documents. The legislation also gives directors other express duties, including the duty to manage or supervise the activities and affairs of the corporation, and a duty to disclose all conflicts of interest.

c) Defences

The current non-profit regime provides no explicit defence for directors facing liability claims. The new legislation rectifies this by providing a due diligence defence for directors who can demonstrate that they exercised the care, diligence and skill that reasonably prudent persons would have demonstrated in comparable circumstances, including the reliance in good faith on corporate financial statements or reports made by professionals. The introduction of this defence clarifies and limits the potential liabilities of directors, and may encourage recruitment of directors in this sector. Recruitment may also be encouraged by provisions in the new legislation that allow corporations to indemnify present and former directors and officers in certain circumstances and to purchase and maintain insurance for the benefit of such individuals.

d) Potential Liabilities

The new legislation outlines specific potential liabilities of directors, including the provision that directors can be liable to employees of the corporation for all debts (not exceeding six months' wages) for services performed during their directorship. In addition, directors who authorize, permit or acquiesce to an offence committed by the corporation under the new legislation will be party to and guilty of the offence as well, unless they establish that they exercised due diligence in preventing its commission.

7. Members' Rights

The new legislation expands the rights of members, as well as the corresponding duties that a corporation owes to these members. Further, the new legislation provides more details and includes matters previously dealt with only by policy guidelines or by by-law.

a) Member Meetings

Directors are required to call annual meetings of members within specific time periods under the new legislation, which also regulates the manner in which corporations must notify members of such meetings. New provisions also give members the right to requisition the directors to call meetings, a right not provided under the current legislative regime. The requirements of what constitutes a proper meeting are now clearly outlined in the new legislation by the inclusion of such matters as the conduct of electronic meetings, voting in absentia (which now includes voting by telephone or other electronic means) and the replacement of meetings by written resolution of the members in lieu of a meeting.

b) Voting and Member Proposals

Under the new legislation, at least one class or group of members must have the right to vote at any meeting of members. Voting members will be able to submit to the corporation notice of a proposal that they wish to raise at a members' meeting, and subject to some broad exceptions, the corporation will be required to include the proposal in the notice of the meeting.

c) Unanimous Member Agreements

The mechanism of a "unanimous member agreement" will become available to members under the new legislation. Through this instrument, all members of a non-soliciting corporation can restrict the powers of the directors to manage or supervise the activities and affairs of the corporation.

d) Member Remedies

Derivative actions, rights and the oppression remedy are made available to members, as well as other complainants, under the new legislation. The derivative action can be used by members to launch actions in the name of the corporation, and the oppression remedy allows members to bring claims seeking relief from the oppression of their rights. The new legislation gives courts wide latitude to order remedies and impose obligations on corporations when satisfied of the merits of a derivative or oppression action, although a faith-based defence for religious non-profit organizations is available.

8. Fundamental Changes to the Corporation

The new legislation outlines specific circumstances in which special resolutions (two-thirds vote) of members are required in order to make fundamental changes to the corporation. Such fundamental changes include altering the conditions and rights of membership, the number of required directors and/or the distribution of assets upon dissolution. Detailed provisions also govern occasions where two or more corporations wish to amalgamate and continue as one corporation, situations in which corporations are liquidated and dissolved, and circumstances where corporations wish to continue under the laws of another legal jurisdiction.

9. Special Issues

a) Debt Obligations

There are numerous and detailed provisions regarding debt obligations in the new legislation that are similar to those that apply to share capital corporations. There are provisions regarding the proper form, delivery, registration and enforcement of debt obligations, the duties and rights of purchasers, guarantors and issuers and the use of trust indentures for debt obligations. These provisions may have special significance for those corporations that borrow money from their members, and therefore should be examined closely by organizations engaging in such activities.

b) Receivers and Receiver-Managers

The new legislation specifically provides for the appointment of receivers and receiver-managers of non-profit corporations, thereby clarifying the uncertainty that exists under the current legislative regime as to whether this is possible.

10. Conclusion

This proposed legislation will have tremendous impact on the conduct and affairs of the not-for-profit sector in Canada, specifically the over 18,000 corporations that currently fall under the federal non-profit regime. Although it will be some time before this legislation becomes law, federal non-profit corporations would be well advised to monitor the status of the legislation and govern their planning and affairs accordingly. **L&G**

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Cornerstone of the Board

The New Steps of Director Search

Julie Hembrock Daum and Tom Neff

The new director recruiting process is not simply a reaction to regulation. Although it is true that most boards now are required to have a totally independent nominating committee, many companies had this prior to the legislative change. The difference is that nominating committees clearly are taking the lead responsibility for selecting new directors. They are putting in place a process that is thoughtful and will result in more targeted, strategic recruitment.

While both boards and board prospects are following a more rigorous process, both sides benefit from the increased intensity. Boards are giving careful consideration to the skills and characteristics they need to add to their board and are thus extending offers to people who are best suited to the position. They also are making more use of experts to help them make these decisions. Board prospects are making more careful choices, as they now have to restrict the amount of board activity. Boards are feeling pressure from increased competition for the decreasing number of interested candidates.

Demand for directors has increased for the following reasons:

- The tightened definition of “independence” means some boards have to add directors who meet the definition.
- Audit, compensation and nominating committees must be independent. Because more work is being done by committee, increasing the workload of the independent directors, new directors are being sought to staff the committees.
- Audit committees must have a financial expert who meets the Sarbanes–Oxley definition.
- Turnover is increasing as directors pare back their board commitments.

While demand has increased, the supply of willing and capable candidates has decreased. There are several causes for the shrinking pool:

- Board service now requires a heavier time commitment. A typical director now spends as much as four to six weeks a year on board duties – even more if on the audit committee. Therefore, people can serve on fewer boards.
- Some companies are restricting or forbidding “outside” board service for executives.
- Candidates are more risk averse and concerned about the potential financial or reputational liability of board service.

Even before Sarbanes–Oxley, 75% of S&P 500 company boards had a nominating committee, yet it wasn’t necessarily an integral part of the director recruiting process. In the past, the CEO often took responsibility for choosing new directors even if a nominating committee existed. Today, the independent nominating committee drives the process. This is a dramatic change. Reflecting the new complexity in the execution of a search, the recruitment process is now more complicated, formal and detailed. A generic director search is outlined in the following 10 steps:

1. Design a selection process and communicate it to all involved parties.
2. Assess the board’s needs.
3. Develop a director specification.
4. Decide whether to hire an executive search firm.
5. Create a long list of board prospects from a wide range of inputs.
6. Review the long list for any potential conflicts.
7. Narrow the long list to a short list.
8. Research the prospects on the short list.
9. Design and conduct a thorough interview process.
10. Extend an offer.

To view full text of the article, visit: www.lawandgovernance.com.

Call to Responsibility

In an effort to clarify the responsibilities of a hospital governing board's role in ensuring quality care, NQF developed and approved clinical quality guidelines for hospital board members. The guidelines are entitled "Call to Responsibility." The guidelines review four principles that should be consistent with the policies and practices of every hospital:

- Governing boards should take concrete steps to fulfill their role in ensuring quality.
- Governing boards should enable effective evaluation of their role.
- Governing boards should become knowledgeable about standards and issues related to patient safety, clinical care and outcomes.
- Governing boards should oversee and be accountable for their institution's national quality measurement efforts and improvement activities.

To read the guidelines in more detail, go to www.qualityforum.org/txcalltoresponsibilityFINAL-WEB02-15-05.pdf.

Source: *National Quality Forum*

Rise in Adverse Events Reporting

Adverse events reported to the FDA reached a record high in 2004, according to a government estimate. The agency received approximately 422,500 adverse event reports from drug companies, healthcare providers and patients last year – an increase of almost 14% from 2003. While Paul Seligman, director of the FDA's Office of Pharmacoeconomics and Statistical Sciences, attributed the increase to "more drugs on the market and more use of pharmaceuticals in general" rather than increased health risk, others suggest that higher public awareness of the potential for adverse events was also a key contributor.

Source: *USA Today*, March 14, 2005

Will Public Disclosure of Adverse Events Discourage Reporting?

Most hospital CEOs think so. A survey of hospital CEOs in two states with mandatory public reporting of medical errors, two states with mandatory confidential reporting and two states with no mandates for reporting revealed most CEOs felt that state reporting – whether confidential or public – would discourage internal hospital error reporting. CEOs were presented with three vignettes:

- Situations with a serious error causing harm
- Situations causing temporary harm
- Situations causing no impact on the patient

CEOs were more likely to say they would report all but the most serious events in states with confidential re-

porting than in states with public reporting. They were also more likely to report moderate events or errors with no injury to the patient than the state – even in states with confidential reporting. CEOs felt that all forms of state reporting encourage lawsuits, and most felt that state reporting had no effect or a negative effect on patient safety. Only 53% of the hospital CEOs surveyed always have patient safety formally on board meeting agendas. Most (83%) said that finding the cause of patient harm was a "very high" priority; identifying procedures to improve safety was a very high priority for 62%; protecting those that report errors was a very high priority for 60%, but finding who was at fault was a very high priority for only 33%. Eighty-five percent of the hospitals had a policy recommending disclosure of unanticipated outcomes. Of these, 98% recommend reporting a serious injury thought to be the result of an error, 65% report harm not caused by an error and only 31% have policies recommending disclosure of errors that cause no harm to patients. The bottom line: we still have a long way to go to make reporting of errors second nature and to have a complete picture of errors and harm occurring in hospitals.

Source: Joel Weissman et al., "Error Reporting and Disclosure Systems: Views from Hospital Leaders.," *JAMA*, March 16, 2005

Email the Doc

Most Americans are interested in communicating with their physicians over the Internet, but few are still willing to pay for it, according to the latest WSJ/Harris Interactive poll. Roughly 80% of the 2,638 adults surveyed would like to be able to email their physicians questions if no visit is necessary, and close to 70% would like to schedule appointments or receive test results online, but only slightly more than a third would be willing to pay to do so. The poll also found that while a majority of respondents believe that electronic medical records can decrease medical errors and reduce the overall cost of healthcare, two-thirds are still concerned that EMRs will make it more difficult to ensure patients' privacy.

Source: *WSJ*, March 1, 2005

Inefficient Documentation Costly

Inefficient documentation and improper coding costs the healthcare industry as much as \$100 billion a year in "unnecessary costs." The estimate is based on data from a recent CMS report that claims a 9% error rate in 2004 around Medicare fee-for-service coding led to "wasteful federal spending" of \$19.9 billion.

Source: *Health-IT World News*, March 17, 2005

Abstracts

Here's a look at some of the recent additions to our online searchable database, *Law&Governance*. Please visit www.lawandgovernance.com to access the entire database.

Accountability and Privacy Issues in Hospital Outsourcing Arrangements

By Lynne Golding and John P. Beardwood

The retention of an outside third party to perform non-core functions on a long-term basis – or “outsourcing” – is something in which more hospitals are becoming engaged. Whether it be the operation of food and cafeteria services, pharmacy services, security and facilities maintenance, parking operations, physiotherapy services, the management of ancillary long-term care operations, ordering and stocking of supplies, contract tendering or data processing and other information technology functions, public hospitals are joining thousands of businesses across the world in feeding the global outsourcing market expected to generate revenues of US\$406 billion in 2004.

Strong Boards, Weak Managers

By B. Espen Eckbo

Directors of corporate boards today are expected to implement stringent corporate governance practices, even if this means playing an adversarial role vis-à-vis management. Unfortunately, while most directors are intelligent, honourable and dedicated, they also tend to be consensus builders. Many have difficulty asking tough questions. And shareholders are a distant and impersonal constituency, so why rock the boat?

Issues in the Governance of Canadian Hospitals, Part I: Structure and Process

By Mark Hundert and Robert Crawford

Despite the myriad changes in the healthcare system over the past decade, many hospital and health system boards have concentrated on advocating on behalf of their organizations with not enough attention being paid to rethinking

and restructuring hospital governance to better meet the challenges of change. This article elaborates on what governance is, the responsibilities of governance and some of the issues related to its structure and process.

Issues in the Governance of Canadian Hospitals, Part II: Hospital Planning

By Mark Hundert and Robert Crawford

The healthcare industry has clearly recognized the importance for hospitals to develop coherent sets of objectives and plans. Planning is recognized as a critical component of hospital governance and management. Hospitals should develop plans in response to the needs of the community and other healthcare and social service agencies. This article explores the role of the board of trustees in defining the purposes, principles and objectives of hospital planning.

Issues in the Governance of Canadian Hospitals III: Financial Oversight

By Mark Hundert

This is the third in a series of articles examining governance in Canadian hospitals. This article draws upon experiences gained from operational reviews of hospitals across Canada to suggest approaches to building more effective hospital governance. Find out what the role of the board of trustees in overseeing and directing the financial performance of the hospital so as to ensure its fiscal integrity and long-term future.

Issues in the Governance of Canadian Hospitals IV: Quality of Hospital Care

By Mark Hundert and Adam Topp

The quality of hospital services is a fundamental responsibility of governance. This responsibility can be thought of in terms of three components: monitoring the quality of services; ensuring that management processes are in place to measure, monitor and maintain quality of services; and ensuring quality in all aspects of hospital operations.

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