ED Legal Letter™

The Essential Monthly Guide to Emergency Medicine Malpractice Prevention and Risk Management

From the publishers of *Emergency Medicine Reports* and *ED Management*

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January 2011
Vol. 22 • No. 1 • Pages 1-12

Liability in Ordering and Prescribing Medication

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Administering medication in the emergency department (ED) or prescribing medication upon discharge exposes the ED physician to liability. When there are resultant complications, side effects, or injury as a result of a medication, lawsuits often are filed. This article will discuss the ED physician's duty to warn and will provide general guidelines on whether a pharmacist or a physician will assume liability in a given situation.

Duty to Warn

The confidential nature of the therapeutic relationship between physician and patient is an integral component of the practice of medicine. An expectation of confidentiality between physician and patient is an essential component of the therapeutic relationship. This duty to maintain confidentiality enables the transfer of potentially sensitive patient information to best serve the patient. The landmark case of *Tarasoff v. Regents of University of California* established a new duty for a physician to warn a third party regardless of this obligation of confidentiality, concluding that the "protective privilege ends where the public peril begins."[1]

In 1969, Prosenjit Poddar was detained by campus police on the request of his psychologist, Dr. Moore, after confiding his intention to kill Tatiana Tarasoff. Neither the victim nor her parents were warned before Poddar successfully carried out his deadly threat. In *Tarasoff v. Regents of University of California*, the parents of Tatiana Tarasoff argued to the California Supreme Court that their daughter's death occurred after Dr. Moore and others negligently failed to warn them.[1] They alleged that the therapists predicted that Poddar would kill and that harm to a third party (Tatiana) was foreseeable. The court found that the therapists not only had a duty to the patient, but also had a duty to warn a third party of foreseeable violence.[1]

The Tarasoff opinion stated not only that "a hospital must exercise reasonable care to control the behavior of a patient which may endanger other persons" but also that a "doctor must also warn a patient if the patient's

condition or medication renders certain conduct, such as driving a car, dangerous to others."[1]

Multiple cases in various states have legally addressed the Tarasoff opinion with regard to warning about medication. In a Hawaii case, the Tarasoff opinion was upheld. Three days after being prescribed prazosin hydrochloride (Prazosin) to treat hypertension, a patient fainted while driving and struck a pedestrian, Kathyrn McKenzie. The court allowed the injured pedestrian to sue the hospital/physician and ruled that a "physician owes a duty to non-patient third parties injured in an automobile accident caused by an adverse reaction to the medication prescribed…where the physician has negligently failed to warn the patient that the medication may impair driving ability and where the circumstances are such that the reasonable patient could not have been expected to be aware of the risk without the physician's warning."[2]

Two recent ED cases further illustrate the medico-legal importance of the "duty to warn." In the first, Rosemary Schmidt presented to the ED complaining of a headache. After her initial assessment, she was treated with an intravenous dose of 5 mg prochlorperazine (Compazine), a non-narcotic medication commonly used to treat nausea. Thirty-five minutes after receiving the medication and without alerting the staff, Schmidt spontaneously left the hospital's ED. Consequently, she failed to receive the appropriate discharge assessment and warnings with regard to her symptoms and prescribed treatment. Prochlorperazine is known to cause drowsiness, dizziness, and hypotension. Ten minutes after departure, the patient had a head-on collision, inflicting severe injuries on another party. The injured person sued the physician/hospital for "failing to warn" and was supported by the court. The doctor's defense was that there was no duty to the "general public." The court stated that a doctor can anticipate which drugs will impair driving and cause a danger to the public. The judge also announced anyone would find fault with someone who administers an impairing drug and doesn't warn of this, and it can be assumed that a reasonable person would not drive after being warned.[3] It is likely that this patient had akasthisia as a side effect of compazine, which led her to leave prematurely. It is important to realize that this did not absolve the physician of liability. One should either prevent akasthisia with antihistamines or treat a patient who may develop it in an area of the ED from which the patient is unable to escape.

In a second case, a 52-year-old woman came to the ED with chronic migraines and was given nalbuphine (Nubain) and promethazine (Phenergen) in dosages that had been administered to the same patient 200 times before in the ED. No warning was given to the patient. One hour after discharge, she was found in a single-car motor vehicle accident, leaving her a quadriplegic. The patient recovered $1.3 million, despite the fact that she appeared alert at discharge.[4]

Many state courts do not support the Tarasoff decision. For example, a patient was prescribed fluphenazine (Prolixin) and chlorpromazine (Thorazine) and then consumed alcohol. He struck a tree while driving, injuring the car's passenger. The passenger sued the prescribing physician, but liability was not imposed on a physician when the court found that the physician had no duty to the passenger who was not a foreseeable victim.[5]

It is critical to realize that a physician may be responsible to warn patients or others when a

ED Legal Letter™, ISSN 1087-7347, is published monthly by AHC Media LLC, 3525 Piedmont Road N.E., Bldg. 6, Suite 400, Atlanta, GA 30305. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to ED Legal Letter, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information: Customer Service: (800) 688-2421. Customer Service E-Mail Address: customerservice@ahcmedia.com. Editorial E-Mail Address: leslie.coplin@ahcmedia.com. World Wide Web: http://www.ahcmedia.com. Subscription Prices: United States: $499 per year. Add $17.95 for shipping & handling. Multiple Copies: Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Canada: $529 per year plus GST. Elsewhere: $529 per year. Back issues: $83. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue's date. GST Registration Number: R128870672.

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patient has received medication that exposes the public or patient to danger of injury. This applies not only to narcotics but also to other sedating medications such as benzodiazepines, anti-emetics, or antihistamines. Not all states mandate a duty to warn the public. Physicians should know their state laws regarding duty to warn. However, it is easy to simply warn all patients and not worry about state law support. The warning should be clearly documented on the chart and should be given to a competent person. If the physician gives a warning to a patient who is already impaired or under the influence of medication, then it could be argued that the warning was given inadequately.

Who is Liable for Side Effects: The Physician or the Pharmacist?

Side effects and untoward reactions to medication are a known consequence. They may range from mild to severe and often result in litigation by patients. It is important to understand in a given situation if the pharmacist or the physician is responsible for educating and warning the patient, and thus is liable for bad outcomes. Case law provides general guidelines.

A 12-year-old boy was diagnosed with ADHD by his physician and it was decided to begin desipramine (Norpramin). The physician testified that she showed the patient's mother an entry for tricyclic antidepressants in the *Physician's Desk Reference* (*PDR*). The entry described common side effects associated with the group of antidepressants, such as dry eyes and mouth and increased pulse rate. The physician also explained that the child should be watched closely for rapid heartbeat. Two years later, after multiple medical visits to a variety of settings, for multiple complaints, the child died from hypereosinophilic syndrome, which is a rare but known complication of desipramine. The parents brought suit against Walmart alleging that it was negligent in the sale of desipramine "by failing to properly warn intended users of the hazards and harms associated with the use of the product." The court ruled that the pharmacist had no duty to warn the patient of side effects. The physician was held liable for $1.012 million.[6]

Thus, a pharmacist is not held to have a duty to warn a patient of side effects; this is considered the physician's responsibility. Multiple state courts have reached the same conclusion. Courts feel that "to impose a duty to warn on the pharmacist would be to place the pharmacist in the middle of the doctor-patient relationship, without the physician's knowledge of the patient."[6]

The ED physician erroneously may think the pharmacist will tell the patient things to watch for, and put labels on the bottles. Although this may happen, the courts do not feel this is the pharmacist's duty or obligation.

In another court case, a patient argued that once pharmacists put warning labels on bottles, they agree to be part of the warning process. The court said the pharmacist did not undertake the obligation to warn of all the potential dangers in taking a drug by placing a single warning sticker on the package. Requiring such a duty would discourage pharmacists from placing any warning labels on drug containers. The court said "consumers should principally look to their prescribing physicians to convey the appropriate warning regarding drugs, and it is the prescribing physician's duty to convey these warning to the patients."[7]

ED physicians will be held responsible and liable for all problems with medications that they dispense and prescribe. How can ED physicians take the time to warn of all side effects in the fast-paced and pressured environment in which they work? Common and anticipated side effects should be communicated clearly to patients. For rarer side effects and problems, general warning and transfer of some obligation to the patient can be accomplished by a discharge instruction of "read all medication package inserts and call me with questions."

Pharmacists can be held liable when a prescription is dispensed and an untoward patient outcome ensues. Courts have held that pharmacists owe purchasers of prescription medication "the highest practicable degree of prudence, thoughtfulness, and vigilance and the most exact and reliable safeguards consistent with the reasonable conduct of the business in order that human life may not constantly be exposed to the danger flowing from the substitution of deadly poisons for harmless medicines."[8] A pharmacist who inaccurately fills a prescription therefore is liable to the customer for resulting harm. A pharmacist is bound to safely fill a medication.

For example, a physician prescribed a patient prednisone 80 mg QID, which amounted to 320 mg of prednisone daily. This is clearly an excessive dose. The pharmacist recognized this and called the physician to confirm the dosage. The physician stated that patient should take that dose, so the prescription was filled. Two days later the patient was seen in the ED for thrush. The medication error was recognized and corrected 10 days

later. The patient, however, developed a nocardial lung infection and an aspergillosis infection of the brain. He required multiple hospital admissions and surgeries and was left with permanent kidney failure requiring dialysis. The court said, "A pharmacist must exercise his own judgment as to whether any dosage prescribed, even if confirmed by the prescriber, would be harmful to the patient. If he determines the dosage would be harmful, he has an obligation not to fill it." The patient was awarded $2.5 million.[9]

Liability in Prescribing: Learned Intermediary Doctrine

A prescribing physician may embrace the logic, "it's not my fault that the patient had the side effect; it is the drug company's product that caused the damage." Manufacturers often avoid liability via the Learned Intermediary Doctrine, which states that the manufacturer of a prescription drug has a duty to adequately warn the prescribing physician of the drug's dangers. The physician, relying on his medical training, experience, and knowledge of the individual patient, then chooses the type and quantity of drug to be prescribed.[10] The physician assumes the duty to warn the patient of dangers associated with a particular prescribed drug. The drug manufacturers "warn" the prescribing physician by publishing the *PDR*, which alleges to make all prescribers aware of side effects and complications.

An example of the court's view of the relationship between drug manufacturer, pharmacist, and physician is illustrated in the following prominent legal case. A woman received prescriptions from her doctor for an appetite suppressant known as phendimetrazine (Plegine). The *PDR* entry for phendimetrazine notes that it is a potentially addictive amphetamine; therefore, its use should be discontinued within a few weeks to avoid addiction. Nevertheless, her doctor authorized refills of the drug for 10 years, and two pharmacists filled the prescriptions without warning her of the possible side effects of extended use. The patient sued the drug manufacturer, the prescribing physician, and the pharmacists for damages sustained as a result of her phendimetrazine addiction. She argued that her pharmacists were negligent in selling her phendimetrazine without warning of its adverse effects and for failing to provide the drug manufacturer's package insert. The Washington Supreme Court concluded that the learned intermediary doctrine, normally applied to the relationship among physician, patient, and manufacturer, applied with equal force to the relationship among physician, patient, and pharmacist. The court stated the physician was in the best position to "relate the propensities of the drug to the physical idiosyncrasies of the patient." The court held that the pharmacists did not have a duty to warn her of the dangerous propensities of phendimetrazine, nor were they legally obligated to give her the drug manufacturer's package insert containing such warnings.[11]

Conclusion

ED physicians are liable for drugs that are administered and prescribed from the ED. They may hold liability not only for their patients but also may be responsible for others injured by their patients. Pharmacists are required only to safely dispense a medication and they are not responsible to warn of side effects. Prescribers are solely responsible for patient side effects and complications of medications they utilize and prescribe. Prescribers assume this responsibility via the Learned Intermediary Doctrine and this concept allows drug manufacturers, in most cases, to abdicate their liability to prescribers by warning them of side effects with publication of the *PDR*. When confronted with the overwhelming responsibility of warning patients of all side effects and dangers, physicians should clearly warn and document that patients should not undertake dangerous activity/behavior and should read package inserts.

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When Inpatient Boards in ED, Who is Responsible?

Confusion Leads to Lawsuits

When an admitted patient is boarded in the ED for extended periods, there may be confusion over who is responsible for the patient—is it the ED physician, the hospitalist, the surgical specialist, or the medical specialist?

Unfortunately, it's likely that the ED physician would share in the liability for bad outcomes that occur due to negligence, delay in care, or outright medical error. "For the sole physician working in a typical community ED with limited backup, this is not good news," says **Andrew Garlisi, MD, MPH, MBA, VAQSF**, medical director for Geauga County EMS and co-director of University Hospitals Geauga Medical Center's Chest Pain Center in Chardon, OH.

The admitted, boarded patient may not have been examined personally by the admitting physician, which is common on nights and weekends. In this scenario, Garlisi says it would be difficult for the ED physician to evade liability.

This may be true even if the boarded patient *has* been examined by the primary care physician or hospitalist, and experiences a deterioration in clinical status requiring immediate attention. "Would not the emergency physician—who already had been involved in the patient's management and is readily available—be expected to intercede on the patient's behalf?" asks Garlisi.

Joseph P. McMenamin, MD, JD, FCLM, a partner at Richmond, VA-based McGuireWoods and a former practicing emergency physician, says that the ED doctor is the physician in charge until the patient is admitted.

"In a perfect world, responsibility for the patient would be transferred at the time the decision is made to admit," McMenamin says. "The problem is that it's not at all unusual, and in some cases it is becoming the rule rather than the exception, for the patient to spend some length of time in the ED. That is where the difficulties arise."

In the event a patient sues alleging a bad outcome due to boarding, **Debra J. Gradick, MD, FACEP**, medical director of the ED at Avista Adventist Hospital in Louisville, CO, and vice president of operations at Serio Physician Management in Littleton, CO, says that she believes the ED physician faces greater liability exposure than other physicians do.

"We are actually the physician who treated the patient last. The finger is pointed at us. The admitting physician, in my experience, can often get off the hook." says Gradick.

Responsibility Is Shared

The primary problem, says **Sandra Schneider, MD**, professor of emergency medicine at University of Rochester (NY) Medical Center, is that the admitted patient is under the care of the admitting physician. However, because the patient is still in the ED with a doctor working in close proximity, there may be shared responsibility.

The best protection for the ED physician is medical staff bylaws, which clearly state the physician responsibility for admitted patients. "That responsibility should be, as with any other inpatient, the admitting physician's," says Schneider. "However, if the medical staff bylaws cannot be changed or are unclear, the ED physician is in a difficult position."

William Sullivan, DO, JD, FACEP, director of emergency services at St. Margaret's Hospital in Spring Valley, IL, and a practicing attorney says to take these steps to avoid confusion over who is responsible for a patient's care:

- Tell the admitting physician you are going to have the floor nurses call for further orders.
- Document that the admitting physician accepted responsibility for the patient at the time of admission.
- When patients require intensive medical management, request that an admitting physician come to evaluate the patient.
- Write orders stating that the admitting physician must be called to review current orders, and to provide any necessary additional orders.
- If a patient requires a non-emergent order yet is being boarded in the ED, ask the nurses to contact the admitting physician.

"A consistent requirement that the admitting physician provide all non-emergent orders will prevent confusion as to who is responsible for the patient's care," says Sullivan.

'It's Still Your Patient'

Frank Peacock, MD, vice chief of emergency medicine at The Cleveland (OH) Clinic Foundation, says that "ethically, morally, and usually legally, it's still your patient. Someone who has never seen the patient but talked to you on the phone cannot possibly be responsible."

Peacock says that until the admitting physician comes to see the patient, or the patient leaves the ED and goes upstairs and now is admitted, the ED physician remains legally responsible.

"I am responsible for everything in my department, even if the consultant is there," says Peacock. "If a consultant comes in and does something to the patient, it's still your patient. You share the liability on that."

It can be argued that the admitted, boarded patient has "changed hands" in terms of physician responsibility. It can also be argued that all patients boarded in the ED fall under the responsibility of the ED physician and emergency staff, until such time when the patient is physically removed from the ED environment, says Garlisi.

ED physicians may believe they are transferring responsibility to the admitting physician by taking orders over the phone. However, this is not necessarily the case, says Peacock.

"How could you think you're going to win a lawsuit if you claim that it's not your responsibility, because you took an order over the phone from a doctor who didn't see the patient—a patient that you just talked to five minutes ago?" asks Peacock. "The jury will not buy that the doctor at home was responsible, not the one standing next to the patient. These guys may think they are shifting their liability, but that makes no sense."

McMenamin notes there have been cases where courts have analyzed the relative obligations of physicians conferring with each other over the phone. "Some cases have indeed held liable physicians who did nothing more than answer the phone. Others have not," he says.

This varies depending on the state and the facts of the case, including the practices prevailing at the hospital in question and the extent of information conveyed to the consultant over the phone.

"Some cases have held that once the emergency physician gets the consultant involved, and the consultant starts to give orders, the ER doc is out of the picture," notes McMenamin. "It is a viable theory in certain circumstances."

Sources

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Tempted to Point Finger at Other Doc?

Think Again. It Helps Only Plaintiff's Attorney

William Sullivan, DO, JD, FACEP, director of emergency services at St. Margaret's Hospital in Spring Valley, IL, and a practicing attorney, helped an ED physician defend a case involving a patient who died after being boarded in the ED for more than 5 hours. The ED physician stated that the admitting physician accepted responsibility for the patient. The admitting physician denied responsibility since the patient was not admitted to the floor.

"The resultant finger-pointing ended up in both the emergency physician and the admitting physician settling for a proportion of the liability," says Sullivan.

The admitting physician may claim that the ED physician didn't provide pertinent information. "When there is a bad outcome and the other doctor has not seen the patient, there will be all sorts of finger pointing," says **Frank Peacock, MD,** vice chief of emergency medicine at The Cleveland (OH) Clinic Foundation. "You can document your tail off, but it's still your problem. A better use of your time might be taking care of the patient, instead of writing a 14-page note."

Expect Discrepancies

The admitting physician physically may see the patient in the ED, but the patient stays in the department. In this scenario, says Peacock, "you are still the doctor standing next to the patient, so you still have liability. Now that the other doctor has seen the patient, they have joined you in the liability, unless that patient leaves your department."

Peacock notes that when a patient is transferred to another facility, the transferring physician is responsible until that patient arrives at the destination. That likely would hold true for transfers occurring within hospitals.

"If they live in my ER, even though the ICU [intensive care unit] doc has come down and seen them, I think it's shared culpability until they arrive at the ICU," says Peacock. "The reality is that I am there at the bedside. It would be patient abandonment to ignore them."

The bottom line is that ED physicians are assuming increased liability as a result of boarding. "We are left holding the bag for a patient who we do not have the expertise to care for," says Peacock. "If you go to a jury and say, 'We were really busy,' you get no sympathy for that. The system is broken, but you can't plead that to the jury. Even if the hospital was full and there was no place to put these people, the jury still feels like it's your fault."

When litigation occurs and different physicians are involved, the question often becomes what one person told the other. There may be discrepancies between what the admitting physician says the ED physician told them, and what the ED physician recalls stating.

"It's not at all uncommon to have the accepting physician say, 'If the ED physician had only told me this, then I would have responded differently, so it's not my fault. They didn't present the patient to me with the right information,'" says **Matthew Rice, MD, JD, FACEP**, former senior vice president and chief medical officer at Northwest Emergency Physicians of TEAMHealth in Federal Way, WA.

Avoid Warfare in Chart

Joseph P. McMenamin, MD, JD, FCLM, a partner at Richmond, VA-based McGuireWoods and a former practicing emergency physician, says that the ED physician would be well advised to document conversations with consultants, such as "At 4:52, a conversation with Dr. Jones took place. We both agreed that patient X needs to be admitted to the service of Dr. Jones, third floor, East wing. Dr. Jones is writing admission orders and taking over care of the case."

The problem is that the patient remains in the ED. "By documenting the conversation, the ED doctor may well be better able to argue that now responsibility rests with Dr. Jones," says McMenamin. "But the plaintiffs' attorney is not going to sue just Dr. Jones. He or she will also sue the hospital and the emergency physician."

Each physician may engage in documentation that tries to shift responsibility to the other. "Soon we have warfare going on between the defendants, and the plaintiff is the winner," says McMenamin. "I hate to see this happen, and it can be avoided with a little care and forethought."

Although it is common for the ED physician to maintain responsibility for the patient while he or she is physically in the ED, "the trouble is that the ED doctor has other duties and can't be running an inpatient service," says McMenamin. Also, EDs lack sufficient nursing staff to provide what amounts to inpatient nursing services.

"Too often, ED physicians are needlessly exposed to liability because patients who need to be upstairs are simply being housed in the ED for lack of space someplace else," says McMenamin.

Should ED Be Held to ICU Standard of Care?

One legal question is what standard of care the ED would be held to in the event of a lawsuit involving an admitted boarded patient's bad outcome. "We cannot meet the ICU standard of care, not because we don't want to, but because we do not have the resources. We are an ED. We are not here for the people who are going to be here for the next three days. We are here for the next urgent patient who comes in," says **Frank Peacock, MD**, vice chief of emergency medicine at The Cleveland (OH) Clinic Foundation.

EDs typically lack equipment and the ability to perform invasive or noninvasive testing. "It is folly to think that the ED provides anything like the standard of care of any unit. It is absurd for anyone to expect that the ED would provide that level of care," says Peacock. "That's why I have a 60-bed ED in a 1,460-bed hospital."

For this reason, Peacock believes the ED legally would be held to the standard of care for the ED, not an ICU. "But the next question is, 'So why didn't they have an internal medicine doctor come

down from upstairs?' And that's a difficult one for me to answer," says Peacock. "You are now in the position of having to throw the hospital—your employer—under the bus."

In this scenario, no one wins. "The patient is harmed, the ED physician is left holding the bag, and the hospital gets to join him," says Peacock. "We take care of emergencies—we are not chronic care people. The crises should take priority and because they do, chronic care patients get ignored. That's why it's a bad place to put a chronic care patient, unless you want to put a whole lot more staff down in the ER, and a whole lot more beds."

Plaintiff Argues Otherwise

A plaintiff's attorney presumably would argue that the patient was admitted to an ICU, precisely because ICUs are equipped to provide services that you can't get on an ordinary floor, much less the ED. "They will argue that the fact that you chose to house this patient in the ED is your business, but he was entitled to ICU care—that is why he was admitted," says **Joseph P. McMenamin, MD, JD, FCLM**, a partner at Richmond, VA-based McGuireWoods and a former practicing emergency physician. "So the dopamine drip that would have been provided there, is what you should have done."

Although ED nursing staffing is based on census and history, these calculations don't take into account admitted patients. "You assign staff based on when you think you're going to need them, but all of that presupposes that an admission is no longer your baby—the admission is upstairs. If that's not true, then your calculations can't be right," says McMenamin.

If the ED averages 10 patients at a time, which is the number that two nurses can handle, those same two nurses presumably won't be able to handle 15 or 20 patients. "If you had twice as many patients and didn't increase the number of nurses, there may be a host of good reasons for that. But I can easily see a plaintiffs' attorney making hay out of it," says McMenamin.

What Does ACEP Say on Boarded Inpatients?

Two of the American College of Emergency Physicians (ACEP)'s policies address the issue of who is responsible for inpatients being held in EDs. The October 2007 policy, "Responsibility for Admitted Patients" recognizes that the patient benefits when there is a clear delineation of who is responsible for the patient's care.

The policy states: "Regardless of the location of an admitted patient within the hospital, the ultimate responsibility for an admitted patient's medical care rests with the admitting physician."

The policy also recommends that hospital policies clearly state that once an admitting physician has accepted a patient, that the admitting physician has assumed responsibility for the patient.

"The reasoning behind this policy is important," says **William Sullivan, DO, JD, FACEP**, director of emergency services at St. Margaret's Hospital in Spring Valley, IL, and a practicing attorney. Some admitting physicians argue that because an admitted patient is still in the ED, that the emergency physician is responsible for the patient's care.

"The idea that a patient's location determines what doctor is responsible for the patient's care really doesn't make much sense," says Sullivan. If a patient is in radiology having a chest X-ray, it isn't the radiologist's responsibility to write routine orders for intravenous lines. "Admitted patients in the emergency department are not, and should not be, any different," says Sullivan. "Of course, any physician is available to help in an emergency, but routine care should be handled by the admitting physician."

Outside Scope of Training

Another reason admission should be the point at which care transfers to the admitting physician is that ED physicians generally aren't credentialed to provide routine inpatient care.

"The emergency department is considered an outpatient setting," says Sullivan. If an ED physician provides routine care for admitted patients, the physician could be liable for exceeding his scope of training or credentialing.

The hospital also could be liable for allowing the physician to practice outside the scope of his or her training and credentialing. "We wouldn't allow an orthopedic surgeon to perform an appendectomy without demonstrating competence in performing that surgical procedure," says Sullivan. "Nor should hospitals allow emergency physicians to perform routine inpatient care without demonstrating competence in performing such care."

Finally, medical malpractice insurance may not cover ED physicians for providing routine inpatient care. "It would be important to review one's policy language to determine the exact scope of

coverage in this regard," says Sullivan.

ACEP's policy, "Writing Admission and Transition Orders" states that even if an ED physician writes temporary admission orders, the admitting physician should retain responsibility for the patient's care.

"Admission orders signed by an emergency physician may appear to extend responsibility for a patient's care past the admission point, or even onto the medical floor," says Sullivan. "This may cause confusion with the nurses, especially in the middle of the night if an admitting physician is unavailable."

ACEP recommends that hospital policies clearly state that the responsibility for a patient's care changes when the patient is admitted. "Such a policy would prevent any misunderstandings and lapses in patient care," says Sullivan.

Policies not Legally Binding

Ultimately, the legal responsibility for an admitted patient is determined by the jury in a medical malpractice case or by a government agency during an investigation. "While ACEP's policies may be persuasive, they are not binding on a jury or on a government agency," says Sullivan.

Sullivan notes that a search of legal databases shows no appellate case involving transition of care issues in the ED. "But most medical malpractice cases do not advance to an appellate level. The legal databases may not reflect the true incidence of such cases," he adds.

Sullivan advises using ACEP policies to lobby hospital administrators or hospital board members to create a hospital policy regarding responsibility for admitted patients.

Who's Responsible? Clarify *Before* Lawsuit

After a lawsuit is filed alleging poor care of a boarded patient is not the time to figure out who was legally responsible.

"The wiser hospitals have worked out who is responsible on the physician side from the time they are admitted, until they leave the ED," says **Matthew Rice, MD, JD, FACEP**, former senior vice president and chief medical officer at Northwest Emergency Physicians of TEAMHealth in Federal Way, WA.

Above all, it needs to be clear who is going to provide the orders. "The real risk occurs when it's unclear whether it's an ED patient or a specialty patient. There may be confusion about what orders the nurse should follow in providing that care," says Rice. "Nursing staff need to know who to make aware of changes in the patient's condition."

The ED's policy should specify at what specific point it becomes the responsibility of the admitting physician to provide care to the patient, says Rice.

"It may be the time of the call, or within 30 minutes of the call, whether the patient is in the ED or the ICU," says Rice. "If you don't have that worked out ahead of time, it gets very confusing who to even talk to about a changing condition, let alone which action should be taken to treat the patient."

Don't Leave It Unaddressed

Joseph P. McMenamin, MD, JD, FCLM, a partner at Richmond, VA-based McGuireWoods and a former practicing emergency physician, says that each facility should first evaluate its own situation to determine how extensive boarding is. "If the problem comes up regularly, then the doctors in the hospital, including the medical staff perhaps, should probably develop a protocol to delineate just where the ED doctor's responsibility ends and someone else's picks up," he says.

From the ED physician's point of view, the ideal arrangement would be for responsibility to be transferred at the point in time the decision is made to admit the patient.

"Then the ED physician is freed up to turn to the next case in the department without having to worry about someone who is admitted, and therefore, is in some sense no longer 'his,'" says McMenamin.

It is better to have an agreed-upon protocol for this scenario, than to leave it unaddressed.

Clearly delineate in the bylaws when the transfer of responsibility occurs, advises **Robert B. Takla, MD, FACEP**, chief of the Emergency Center at St. John Hospital and Medical Center in Detroit, MI. It may be at the time that the phone call is made, and you discuss the case with the admitting physician, or when the admitting physician sees the patient.

"When I've called the physician to admit the patient, I would make him or her give the admission orders to the nurse. He or she can transcribe the verbal admission orders. Now he's giving the orders for admission, and I'm out of it," says Takla. "I feel that is a little bit safer in him or her accepting the transfer of responsibility, rather than me writing orders on the patient for admission if

the bylaws say that doctor has 12 or 24 hours to see the patient."

Was Specialist Involved in Your Patient's Care?

Protect Yourself Legally

Did a surgeon examine your abdominal pain patient, or did a gastroenterologist give a second opinion on a complex issue? Unless this is documented appropriately, the ED physician may be the only one left "on the hook" if a bad outcome occurs.

"Even with proper documentation and appropriate consultation, the emergency physician may be dragged into the widely cast medical malpractice net in the event of an untoward clinical outcome," says **Andrew Garlisi, MD, MPH, MBA, VAQSF**, medical director for Geauga County EMS and co-director of University Hospitals Geauga Medical Center's Chest Pain Center in Chardon, OH. "A meticulously well-documented medical record is often the emergency physician's best, and only, hope for a favorable judgment."

You are Responsible

Emory Petrack, MD, FAAP, FACEP, a medical-legal consultant and principle of Shaker Heights, OH-based Petrack Consulting, says that unless it is clear and clearly documented that a specialist is actually assuming all care for an ED patient, the ED attending clearly remains responsible and liable for care.

"Consultants are just that—consultants!" says Petrack. "If an orthopedist comes in to reduce a bad fracture, or a plastic surgeon to take care of a pediatric facial laceration, the overall care of the patient remains the responsibility of the ED staff."

It is important to document clearly who is doing what, along with the times that any consultants are called and provide service.

"The best way to think about documentation is to assume that there will be a medical legal action two years later, and you won't remember anything," says Petrack. "If a chart is documented with this orientation in mind, the documentation will be clear. It is also worth noting that this is truly better patient care, since the patient may return when that provider is not on duty. Good documentation really does help everyone do the right thing."

In Person or Phone?

If a consultant gives a recommendation over the phone without seeing the patient, it could be argued that he or she hasn't legally established a patient-physician relationship, says **Debra J. Gradick, MD, FACEP**, medical director of the ED at Avista Adventist Hospital in Louisville, CO, and vice president of operations at Serio Physician Management in Littleton, CO.

However, if the consultant actually comes to the ED to examine the patient, this should be made clear in the record. Gradick suggests charting, "Dr. Smith of cardiology responded to the ED and evaluated the patient while he or she was in the ED. Refer to his consultation for full details."

"If the consultant recommends a specific treatment and you don't document that, you are leaving out part of the record," says Gradick.

Chad Kessler, MD, FACEP, FAAEM, section chief of emergency medicine at Jesse Brown VA Hospital and associate program director for the combined internal medicine/emergency medicine residency at the University of Illinois in Chicago, says that one of the most legally dangerous situations is when the ED physicians takes orders or recommendations, but there is nothing about this documented in the chart either by the ED physician or the consultant.

"Both parties should write detailed notes, and likely use a standardized template to complete this interaction," advises Kessler. "ED physicians or the ED staff should always keep a detailed log of calls to specialty consultants. Document the name, the time of the call, and the plan."

Gradick says that telephone consults present more legal risks for ED physicians, because the consulting physician hasn't seen and examined the patient. "If you have someone you feel is sick enough that he or she needs to be seen emergently, it is incumbent on the ED physician to insist that the consultant physically see the patient," she says.

Sources

For more information, contact:

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Danger of Phone Consults

Sullivan notes that if consultants come to the ED and evaluate patients personally, the consultants will perform independent history and physical examinations and come to their own conclusions about diagnosis and treatment options.

"The danger in interactions with specialists arises during telephone consultations in which one party must rely upon the other party's description of the patient's history and physical findings, or on a description of the interpretation of test results," says Sullivan.

If an ED physician fails to properly describe a patient's physical findings or misinterprets a test, the specialist may develop a false sense of security regarding the patient's condition, he says.

Similarly, if a consultant misunderstands an ED physician's description of a patient's condition, the severity of a patient's illness may also be underestimated. "On the other hand, a specialist may call the emergency physician with an interpretation of a test result, but then may change his or her mind after further review of the test," says Sullivan. "In either case, a bad outcome could prove costly."

For example, an ED physician may contact an orthopedist for an open fracture dislocation of a patient's ankle which the ED physician reduced and splinted. If the orthopedist did not understand that the fracture was open, he might underestimate the severity of the injury and recommend discharge with outpatient follow up.

If the ED physician followed the orthopedist's recommendations in this scenario, and the patient later developed osteomyelitis, Sullivan says the issue in a medical malpractice case would involve whether or not the ED physician properly described the patient's injury.

"A common problem in obtaining verbal reports from radiologists is that preliminary reports may be different than the final reports," adds Sullivan. If an ED physician bases a treatment on a verbal preliminary report such as a normal wrist X-ray, a final report showing a subtle fracture may make it appear as if the ED physician provided substandard treatment to the patient.

Sullivan recommends taking these steps to minimize misunderstandings:

- If a patient has a condition that is likely to result in a bad outcome, have the consultant personally evaluate the patient in the ED and write a short note describing the consultant's recommendations.
- If a consultant does not believe that a personal evaluation in the ED is necessary, document what was discussed with the consultant and the consultant's specific recommendations.
- If the consultant believes that a patient with an open fracture, for example, can be managed as an outpatient, describe the fracture in detail and document both the description and the consultant's response in quotation marks, advises Sullivan.

"This may not prevent a lawsuit, but it will certainly go a long way toward resolving discrepancies about what information was relayed during the conversation," says Sullivan.

For example, a note in the chart might state, "Consultant is aware that fracture is open and states that 'open fractures without gross contamination are able to be managed as an outpatient.'"

"This chart entry shows both that the consultant knew the fracture was open, and shows the reasoning behind the consultant's decision," says Sullivan.

When relying on a consultant's interpretation of a test, get everything in writing. "Do not settle for verbal reports, especially in critically ill patients," says Sullivan.

CNE/CME OBJECTIVES

After completing this activity, participants will be able to:

1. Identify legal issues related to emergency medicine practice;
2. Explain how the legal issues related to emergency medicine practice affect nurses, physicians, legal counsel, management and patients; and
3. Integrate practical solutions to reduce risk into daily practice. ■

CNE/CME INSTRUCTIONS

Physicians and nurses participate in this CNE/CME program by reading the issue, using the references for research, and studying the questions. Participants should select what they believe to be the correct answers, then refer to the answer key to test their knowledge. To clarify confusion on any questions answered incorrectly, consult the source material. After completing the semester's activity, you must complete the evaluation form provided and return it in the reply envelope to receive a letter of credit. When your evaluation is received, a letter of credit will be mailed to you. ■

CNE/CME QUESTIONS

1. Which is true regarding legal responsibility for an inpatient boarded in the ED?
   A. The ED physician is not liable for the admitted, boarded patient under any circumstances, even if he or she was personally examined by the admitting physician.
   B. The ED physician is not expected to intercede on the patient's behalf for a boarded patient who was examined by the primary care physician or hospitalist, even if the patient experiences a deterioration in clinical status requiring immediate attention.
   C. If a decision to admit is made jointly by the ED physician and admitting physician, the legal responsibility is always transferred to the admitting physician even if he or she has not yet physically evaluated the patient.
   D. ED physicians are not necessarily transferring responsibility to the admitting physician simply by taking orders over the phone.
2. Which is recommended to reduce risks regarding confusion over who is responsible for an inpatient boarded in the ED?
   A. Include "finger pointing" statements in your documentation that attempt to shift responsibility over to the admitting physician.
   B. Clearly delineate who is responsible on the physician side from the time the patient is admitted until he/she leaves the ED.
   C. Avoid specifying at what point it becomes the responsibility of the admitting physician to provide care to the patient.
   D. When calling the admitting physician, do not request that he or she give the admission orders to the nurse.
3. Which is true regarding liability issues involving consultants and ED patients?
   A. If a consultant does not believe a personal evaluation in the ED is necessary, it is not advisable for the ED physician to document the consultant's specific recommendations.
   B. It is not advisable for the ED physician to indicate in the chart whether the consult occurred via telephone or at the bedside.
   C. If a consultant does not believe that a personal evaluation in the ED is necessary, it is advisable for the ED physician to document what was discussed with the consultant and the consultant's specific recommendations.

Answers: 1. D, 2. B, 3. C.

Dear *ED Legal Letter* Subscriber:

This issue of your newsletter marks the start of a new continuing medical education (CNE/CME) semester and provides us with an opportunity to review the procedures.

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Upon completion of this educational activity, participants should be able to:
- identify legal issues relating to emergency medicine practice;
- explain how these issues affect nurses, physicians, legal counsel, management, and patients;
- integrate practical solutions to reduce risk into the ED practitioner's daily practices.

Each issue of your newsletter contains questions relating to the information provided in that issue. After reading the issue, answer the questions at the end of the issue to the best of your ability. You can then compare your answers against the correct answers provided in an answer key in the newsletter. If any of your answers were incorrect, please refer back to the source material to clarify any misunderstanding.

At the end of each semester you will receive an evaluation form to complete and return in an envelope we will provide. Please make sure you sign the attestation verifying that you have completed the activity as designed. Once we have received your completed evaluation form we will mail you a letter of credit. This activity is valid 24 months from the date of publication. The target audience for this activity includes emergency medicine and family physicians.

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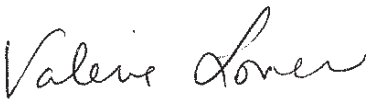

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