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IN ANY DISCUSSION of an emergency room or an emergency department or an emergency service, a definition of the terms of reference is always helpful at the start. Unfortunately, definitions of what constitutes an "emergency room" are not easily found and although numerous regulations governing hospitals refer to the provision of emergency service, none have hazarded a precise definition. For example the *Conditions of Participation for Hospitals in the Program of Health Insurance for the Aged*[1] requires only that "the hospital has at least a procedure for taking care of the occasional emergency case it might be called upon to handle." It goes on to say how the emergency service should be organized but this leaves a considerable latitude for the hospital and the medical staff of the hospital to organize as they think best.

The American Hospital Association has similarly published a guide[2] to organization and management of an emergency department which is vague at best in its description of the emergency service. The American College of Surgeons established Standards for the Emergency Department[3] in hospitals which were formulated by its Committee on Trauma.

The key statement is:

> The function of an emergency department is to give adequate appraisal and initial treatment or advice to every person who considers himself acutely ill or injured and presents himself at the emergency department door.

All of the documents quoted above, however, appear to be uniform in one respect and that is the availability of immediate or prompt care. Thus the *Conditions of Participation*[4] require (Standard B) that "Facilities are provided to assure prompt diagnosis and emergency treatment." The American Hospital Association document[5] states that:

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[*Note*: This paper is a revision of one delivered at the 1966 Annual Meeting of the American College of Legal Medicine.]

[1] Social Security Administration, Document HIM—1 p. 35 (1966).

[2] American Hospital Association, The Emergency Department in the Hospital (1962).

[3] American College of Surgeons, Standards for the Emergency Department, Approved by The Board of Regents, February 23 and 24, 1963.

[4] Social Security Administration, *op. cit. supra* n. 1 at p. 35.

[5] American Hospital Association, *op. cit. supra* n. 2 at p. 5.

> . . . it [the emergency department] is created to provide immediate care for ambulatory patients as well as for the critically ill and injured.

Thus far, definitions all seem to be in agreement that personnel, materials and regulations should be present to insure *immediacy* or *promptness* of care. But uniform agreement on how immediacy and promptness are to be provided does not seem to be present in the authorities that we have consulted.

Standards

Tort liability of a physician, a nurse or a hospital does not arise unless there has been a departure from certain standards. It would be most important to identify what standards we could apply to the emergency service. An emergency service varies widely from hospital to hospital. A small rural hospital might have an emergency service consisting of one room with limited personnel and materials for the physician to work with. On the other hand, the emergency service in a large urban hospital might have a full complement of interns, residents, registered nurses and technologists of all kinds as well as the very latest in resuscitation equipment, inhalation therapy and consultation facilities. Obviously, the physician who has the most to work with should be held to a higher standard of care than the physician who has little to work with. Thus the location, layout, personnel, equipment and supplies should be an important consideration in establishing a standard of care that will be demanded of a physician functioning in the emergency room.

The most recent report on the state of emergency services in the United States was published by Dr. William P. Clough.[6] He states flatly that "the physical plant of most hospital emergency rooms is outdated." So far as equipment and personnel are concerned, it is fairly well-settled law[7] that a physician cannot be held liable for damages caused by faulty equipment provided by the hospital if the defects in the equipment were not easily perceptible by him using reasonable care. But it is equally well-settled that a physician has some responsibility for examining the equipment and supplies that he is using. In other words, the use of due and reasonable care in the emergency room is about the same as the use of due and reasonable care in a non-emergency situation. The difference is that the physician has less time to think about it if the situation is a true emergency and this factor would undoubtedly be a consideration in the event of a suit for negligence.

So far as the hospital is concerned, the *Conditions of Partici-*

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[6] Clough, Surveys of The Emergency Room, Bulletin of the American College of Surgeons, p. 125 (May-June, 1966).

[7] South Highlands Infirmary v. Camp, 180 So. 2d 904 (Ala., 1965).

pation[8] do indicate that the hospital should be organized in such a way as to be able to respond promptly to a demand for emergency diagnosis and treatment. The American College of Surgeons[9] recommends that certain facilities should be present in all emergency rooms. These emergency facilities represent the only specific standard that has been recommended by any professional body although there are numerous directives of a general nature issued by some authoritative bodies which are useful as guidelines.

Facilities

The facilities recommended by the American College of Surgeons[10] are as follows:

> The emergency department should be located on the ground floor, easily accessible from the main hospital but separated from the main entrance.
>
> The emergency department entrance should be well marked and illuminated, easily accessible from the street, without curbs or platforms, and sufficiently covered and enclosed to protect ambulance patients from the elements during unloading.
>
> Space for stretchers and wheelchairs should be reserved immediately adjacent to the entrance. Stretchers should be sturdy enough to serve as examining tables and ideally should be X-ray permeable.
>
> There should be waiting room space, separated from the working area of the emergency department, and containing telephone, toilet and drinking fountain. An explanatory brochure for patients and relatives is valuable.
>
> X-ray and laboratory services in and easily accessible to the emergency department should be available at all times.
>
> Laboratory facilities sufficient for urinalyses and blood counts should be present in the emergency room.
>
> A poison control chart and the telephone number of the nearest poison control center should be displayed in a prominent place.
>
> A manual of standard emergency department rules and routine procedures, both administrative and professional, as formulated or approved by the Emergency Department Committee, up to date textbooks and a poison manual should be available for the guidance of the staff.
>
> All instruments in the emergency department should be of the same quality as prevails throughout the hospital.

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[8] Social Security Administration, *op. cit. supra* n. 1.

[9] *Op. cit. supra* n. 3.

[10] Bulletin of the American College of Surgeons, p. 112 (May-June, 1963).

Air conditioning in many parts of the country and good communications are essential.

The necessity for observation beds, doctors' call room, security room for disturbed patients, police, ambulance attendants and reporters room and pantry should be considered, according to the community.

It goes without saying that emergency surgical packs such as a tracheotomy set should be available at all times and ready for use. Resuscitation apparatus should also be ready.

Although the standards of the American College of Surgeons do not have the binding force of law, it is entirely possible that they will be applied in a court of law in the not too distant future. The gradual disappearance of the principle of using the standards of the same or similar communities has been attacked recently[11] which has led Professor William J. Curran[12] to observe that "the trend is towards imposing a legal obligation on all hospitals to admit emergency patients" and if there is such a legal obligation, then it is entirely probable that each hospital will be legally bound to supply emergency service of a certain standard of quality. At the present time the only specific standards are those recommended by the American College of Surgeons.[13] Thus, the physician on duty in the emergency room should make certain that he checks the facilities that are available for his use and, more important, he should ascertain the qualifications of the personnel who are expected to help him and to work with him. A physician in the emergency room could be liable for the negligence of an intern, a resident, a nurse or a technologist who was working with him and, theoretically or practically, "under his supervision." [14]

Although the hospital would probably be liable primarily for the acts of its employees which it furnished to the physician, the latter's obligation to the patient supersedes the responsibility of the hospital and he must make certain in his own mind that the persons who are ministering to the patient under his direction are competent. Some medico-legal authorities take the attitude that the physician has a right to assume that the hospital has provided him with the highest quality of personnel available and that such further checking on his part is unnecessary. It is a good question that has not been resolved satisfactorily.

Responsibility for staffing the emergency room has been

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[11] Favalora v. Aetna Casualty and Surety Company, 144 So. 2d 544 (La. App. 1st Cir., 1962); Darling v. Charleston Community Hospital, 50 Ill. App. 2d 253, 211 N. E. 2d 253 (1965).

[12] Curran, Institute of Continuing Legal Education, Medical Malpractice Advocacy Institute Lectures p. 25 (1965).

[13] *Op. cit. supra* n. 3.

[14] Letourneau, Medical Malpractice—Liability for the Acts of Others, Med. Trial T. Q. 27 (Sept., 1965).

placed upon the medical staff of the hospital with the hospital administration bearing responsibility for the administrative functions. The *Conditions of Participation* spells out carefully the matter of responsibility. They state: [15]

> Standard A. Factor 3. The emergency service is supervised by a qualified member of the medical staff and the nursing functions are the responsibility of a registered, professional nurse.
>
> Standard C. Factor 1. The medical staff is responsible for insuring adequate medical coverage for emergency services.
>
> Standard C. Factor 2. Qualified physicians are regularly available at all times for the emergency service, either on day or on call.
>
> Standard C. Factor 3. A physician sees all patients who arrive for treatment in the emergency service.
>
> Standard C. Factor 4. Qualified nurses are available on duty at all times and in sufficient number to deal with the number and extent of emergency services.

Any hospital which participates in the Health Insurance for Aged must be presumed to have met the *Conditions for Participation* established by the Social Security Administration. If there is any deviation from these *Conditions*, a presumption of negligence may arise.

The American College of Surgeons recommends that authority should be vested in an Emergency Department Committee, representing the major medical services and the administration, including the nursing service. The College further recommends that there should be a single director responsible only to the Emergency Department Committee for the implementation of policy and the supervision of professional services. Although the American College of Surgeons recommendations do not have any legal status at this time it is quite probable that a court of law may confer such a status upon them, even as the Supreme Court of Illinois conferred such a status upon the *Standards of the Joint Commission on Accreditation of Hospitals* in the case of *Darling v. Charleston Community Hospital.*[16]

If the emergency department is organized according to the legal requirements and the recommendations of the American College of Surgeons, then certain implications immediately arise. In the first place, there is a responsibility on the part of the medical staff for assigning "adequate medical coverage" for emergency services. This means that physicians are physically assigned either by a committee of the medical staff or by the director of the emergency department.

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[15] Social Security Administration, *op. cit. supra* n. 1, at p. 35.

[16] *Supra* n. 11.

What then is the responsibility of the physician who has been assigned to duty in the emergency department? Although there is no jurisprudence on this point, medico-legal authorities seem to be generally agreed that a contract is created whereby the physician has given an undertaking in advance that he will render service in the emergency room. The contract, in this case, would appear to be between the physician and hospital or the medical staff acting on behalf of the hospital. But so far as the patient is concerned, it is hardly likely that any court of law would rule that a physician had a contract of responsibility for some patient whom he had never seen.

If we follow the recommendations of the American College of Surgeons, a considerable responsibility is imposed upon the physician who is assigned to service in the emergency room. These standards[17] state that "medical staff coverage should be adequate to insure that an applicant for treatment will be seen by a physician within 15 minutes after arrival." In some hospitals, the 15 minute rule has led the medical staff to require that the physician on call in the emergency room should be physically present on the premises. If this is the requirement, and the physician does not render treatment within the recommended 15 minutes after arrival, a *prima facie* case of negligence might be made out against him. This has never happened but the possibilities are not remote. American College of Surgeons recommendations under the heading of *Personnel* go further to state that:

> A physician on second call should be available against unexpected or unusual contingencies.
> There should be a mechanism whereby specialized medical services can be obtained as promptly as possible when needed.
> A roster of available specialists should be posted in the emergency department.
> The nursing staff should be adequate to handle the average load with provision for additional nursing help during peak hours or unusual circumstances. Permanent tenure of the senior nursing staff or supervisor is essential to good patient care.

Lack of control in most emergency rooms appears to be the greatest deficiency. Except in a few hospitals, no one seems to be responsible for the management of the emergency room. Doctor Clough noted[18] that the greatest deficiency that he found was the lack of an Emergency Room Committee. Another important deficiency that he noted was the lack of a Manual of Procedures. He found that there was no delineation of privileges in the

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[17] *Op. cit. supra* n. 10, at p. 112.

[18] Clough, *op. cit. supra* n. 6, at p. 125.

emergency room and it seemed to him that anyone could do anything that he wanted to do if he were on call in the emergency room. To cap the observations, he noted that the records were terrible. In many instances, people were unable to recall what had happened or what had been done in the emergency room. Standards do not seem to provide for consultation but the rule is implied in the Standards of the American College of Surgeons and in the *Darling v. Charleston Community Hospital*[19] case where parts of the verdict were based upon what had happened in the emergency room when the physician who was found guilty of malpractice failed to call for a consultation although the by-laws of the hospital provided that this should be done. Dr. Clough pointed out[20] that although privileges were carefully delineated in most hospitals as regards in-patients, it was extremely rare to find such a delineation of privileges applicable to the emergency room.

Numerous physicians have complained verbally and in print that the term "emergency service" is a misnomer because so many patients come to the emergency room who are not emergencies and many of them are actually trying to avoid payment of a private physician. The American College of Surgeons has recognized this form of abuse in its statement of recommended standards: [21]

> The function of an emergency department is to give adequate appraisal and initial treatment or advice to any person who considers himself acutely ill or injured and presents himself to the emergency department door. This should assume the probability of obtaining care of the highest order.
> The fact of constantly increasing emergency department use must be recognized. This use is not limited to real emergencies, since to the individual any complaint may become an emergency if he can't locate his physician at the moment. This makes the hospital and its medical staff responsible for the organization and operation of the emergency department in a manner that will assure the same high standard of care as prevails in other areas of the hospital.

Flint[22] deplores the abuse of emergency facilities in hospitals. He states:

> Public utilization of emergency facilities as convenient 24 hour a day, drop in clinics for non-urgent care has been more and more alarming during the last few years. Analyses of emergency department case loads indicate that in many

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[19] *Supra* n. 11.

[20] Clough, *op. cit. supra* n. 6, at p. 125.

[21] *Op. cit. supra* n. 10, at p. 112.

[22] Flint, Emergency Treatment and Management 3 (3rd. ed., 1965).

> localities the ratio between non-urgent and urgent cases is as high as ten to one. As a result, facilities designed, equipped and staffed for handling emergency conditions have been swamped with non-urgent patients at times when care for true emergencies suddenly and unexpectedly has become imperative. In several instances in my own personal experience, this unfortunate blocking of emergency facilities has been the direct cause of detrimental delay in treatment of persons with legitimate, urgent emergency conditions.

The *Standards* of the American College of Surgeons[23] recommend that:

> The scope of treatment allowed in the emergency department should be specified by the Emergency Department Committee and enforced by the director.

Even so, both the Federal government (*Conditions of Participation*) and the American College of Surgeons (*Standard for Emergency Departments in Hospitals*) specify that "every applicant for treatment should be seen by a physician." Therefore, whether the patient is an emergency or not, the rule imposed by the Standards is that a physician must attend to every patient who presents himself, regardless of his condition. This is both annoying and irritating but it is the Standard. Physicians who have agreed, either voluntarily or through assignment, to serve in the emergency room are not free to refuse a patient under these circumstances.

What would happen to a physician who failed to respond to a call or having responded, refused to care for the patient? There is no ready answer for this but many attorneys agree that a jury would probably be very unsympathetic unless he had a very good reason for his actions.

What is a true emergency? Here again, we are frustrated by a lack of definition by authoritative bodies. Although there are admonitions to physicians by the medical societies, there is no definition. The American Medical Association has stated on several occasions that doctors should do the best they can in an emergency without defining an emergency. The American College of Surgeons has similarly defined the function of an emergency department but has made this so broad that one can interpret an emergency as any kind of a situation where a patient thinks himself acutely ill or injured. Obviously, this is not very satisfactory from the physicians' point of view. William Regan, publisher of the weekly Regan Report, in a personal communication, raises the possibility that a physician who fails to respond to an emergency call might be charged with abandonment of an emergency patient whom he has never seen but whom he had theoretically agreed to serve by reason of his appointment

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[23] *Op. cit. supra* n. 10, at p. 112.

on the medical staff and assignment by the Emergency Room Committee or by volunteering to serve. In his article on *Surveys of the Emergency Room,* Doctor Clough[24] makes an unfortunate observation about physicians when he says,

> Doctors are disinclined to cover the department as they are not interested in emergency work.

At first blush this might sound like an indictment of the motives of the physician, but in actual fact, what the average doctor resents is being called to treat a patient who is not a true emergency.

Lack of an adequate definition of what constitutes an emergency has prompted me to coin one as follows: [25]

> An emergency is a situation where a human being is in immediate danger of death.

In a true emergency, the need to preserve life takes rank and precedence over the personal rights of the human being who is in danger and gives to the physician the legal authority to render the medical services required to save a life.

Shartel and Plant[26] imply a much broader definition than that noted above. They state:

> The authority to perform an emergency operation involves these essentials:
>
> (a) The injured person must be unconscious (or otherwise unable to give a valid consent, e.g., a child of tender years or a person of unsound mind).
>
> (b) The situation must be such as makes it actually or apparently necessary to act before there is an opportunity to obtain consent.
>
> (c) The surgeon in the exercise of his best judgment must believe that the injured person will die, or lose a member, or be seriously impaired in health, unless an operation is performed at once.
>
> (d) Though this is a counsel of caution, not a legal requirement, the surgeon ought to hold a consultation with one or more medical colleagues, if time permits, and obtain their supporting opinions to the effect that the essential conditions for emergency action do exist.

These authorities refer to *Moss v. Richworth,*[27] where the Court of Appeals is quoted as follows:

> The evidence shows that there was an absolute necessity for prompt operation, but not emergent in the sense that death would likely result immediately upon failure to per-

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[24] Clough, *op. cit. supra* n. 6, at p. 125.

[25] Letourneau, The Hospital Medical Staff 56 (1964).

[26] Shartel and Plant, The Law of Medical Practice 14 (1959).

[27] Moss v. Richworth, 222 S. W. 225 (Tex., 1920).

> form it. In fact, it is not contended that any real danger would have resulted to the child had time been taken to consult the parent with reference to the operation (Tonsillectomy). Therefore the operation was not justified upon the ground that an emergency existed.

All of the medico-legal authorities consulted seem to be in agreement that only a physician may diagnose an emergency. Even so, Shartel and Plant[28] says that:

> The physician should beware of assuming—it hardly need be said—that the need for a prompt operation is tantamount to an emergency. He must act only if there is a real emergency.

In the face of a true emergency, the 15 minute rule recommended by the American College of Surgeons does not seem to be unreasonable.

Some hospitals have followed the practice of staffing the emergency room with a nurse exclusively. This is wrong. No one but a physician can say whether or not a true emergency exists. A nurse should never be placed in the position of having to diagnose an emergency, whether one exists or not. Nor should a physician make a decision concerning an emergency over the telephone upon the description of a nurse. One Court of Appeals did suggest[29] that it is only in cases where the patient's condition is so desperate that it would be obvious to a layman that he is in immediate danger of death that a nurse would be permitted to state that an emergency exists. This type of emergency, of course, is obvious to any well-trained Boy Scout. Indeed, persons trained in first aid are encouraged to take life-saving measures. Obviously, if a well-trained nurse sees that a person is choking to death, she might be reasonably permitted to undertake a tracheotomy.

But it is otherwise when an emergency is not so obvious. In a recent Florida case[30] a man was brought into the hospital emergency room after suffering from a coronary infarction. The nurses on duty examined him and refused to admit him or to call the physician on call on the ground that there was no emergency. Later, a physician examined the man and had him admitted to the hospital as an emergency patient. He died in the hospital 48 hours later. The hospital was not found liable for the reason that there was medical testimony that the delay in admitting the man to the hospital made no difference in respect to his death.

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[28] Shartel and Plant, *op. cit. supra* n. 26, at 15.

[29] Manlove v. Wilmington General Hospital, 53 Del. 338, 169 A. 2d 18 (1961), affd. 174 A. 2d 135 (1961).

[30] Ruvio v. North Broward Hospital District, 186 So. 2d 45 (Fla. App., 4th Dist., 1966).

According to Curran[31] the Delaware court in the case of *Manlove v. Wilmington General Hospital*[32] held the hospital liable for care of an emergency case on the grounds that the maintenance of an emergency ward created a reliance on the part of the public that emergency care would be available whenever a true emergency presented itself. Curran went on to say:

> The court pointed out that a refusal of care might well result in worsening the condition of the injured person because of the time lost in a useless attempt to obtain medical aid. The court faced the issue squarely and decided that a duty to admit the emergency patients exists once a hospital, private or public, has established an emergency ward.

There is a possibility that the nurse on duty in the emergency ward who notifies a physician of a patient in the emergency ward and causes him to rely upon her statement that the case is not an emergency might be construed as an agent of the physician on call and so engage his liability. True emergencies are not easy to diagnose even though there are some which are obvious to anyone.

Flint[33] states that:

> Classification of emergency cases by the urgency with which treatment is required is one of the most important functions and responsibilities of a physician called upon to treat such cases.

In addition, Doctor Flint lists the emergency room conditions which require the immediate attention of the physician. He states:

> Immediate recognition and prompt, effective management of the conditions listed below may be lifesaving:
>
> A. Massive hemorrhage from major vessels.
> B. Cardiac arrest.
> C. Cessation or acute embarrassment of respiration.
> D. Profound shock from any cause.
> E. Rapidly acting poison.
> F. Anaphylactic reactions.
> G. Acute epidural hemorrhage.
> H. Acute overwhelming bacteremia and toxemia.
> I. Severe head injuries with rapidly degenerating vital signs.
> J. Penetrating wounds of the pleura or pericardium.
> K. Rupture of an abdominal viscus.
> L. Acute maniacal states.

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[31] Curran, *op. cit. supra* n. 12, at p. 25.

[32] *Supra* n. 29.

[33] Flint, *op. cit. supra* n. 22, at 88.

Continues Doctor Flint:

> Only through experience and complete confidence in his own knowledge and judgment will the emergency physician develop the ability to distinguish between an individual dying from an uncontrollable irreparable condition and a less spectacularly injured or sick person for whom his knowledge and skill may be life or function saving.

Continuing, Flint outlines the major responsibilities of physicians examining and treating emergency cases as follows:

> A. To examine, evaluate and, if possible, establish a diagnosis on all persons with conditions requiring emergency care. . . .
>
> B. To decide whether or not persons requesting examinations and treatment do, in fact, require emergency care. This very important decision is the responsibility solely of the emergency physician. Under no circumstances should it be made by a nurse, orderly, aide or clerk.

The conclusions are fairly straightforward—only a physician should be permitted to make a diagnosis of an emergency.

What should he do after he has made the diagnosis? In the presence of a genuine emergency, the advice of the American Medical Association is that the physician should render service to the best of his ability. Having made the diagnosis, he should do everything within his power to prevent death if such a possibility exists. Once he ascertains that the patient has a condition that is not within the scope of his specialty or his knowledge, then he should call a consultation immediately, making the decision as to which specialist should be called. This is all that is required of a physician in response to a true emergency. Any physician with a license to practice medicine should be able to discharge this responsibility routinely.[34]

There are situations in the emergency room, however, whereby a physician is on call as a consultant while the emergency room is manned by interns and residents. It is a fairly well documented requirement now that the hospital emergency room should be staffed by a licensed doctor of medicine and not by an unlicensed student, intern, house physician or foreign medical graduate. Delegation by a licensed physician over the telephone to an unlicensed person of his authority to diagnose and prescribe might be considered to be an abdication of the responsibility of the physician or, as suggested by Regan, an abandonment of that patient. If an X-ray has to be taken, the physician should indicate where and how the X-ray is to be taken and should then examine the X-ray himself before prescribing for it. Granted that some X-ray technicians are very knowledgeable in the interpretation of X-rays, the facts remain

[34] Letourneau, *op. cit. supra* n. 25, at 86.

that the law does not permit them to do so and delegation of the diagnostic function to an X-ray technician might be interpreted as a violation of the law.

Consent

The matter of consent is most important in the emergency room. As pointed out by Shartel and Plant,[35] the rules concerning consent are to be interpreted very narrowly. In urgent but non-emergency cases being treated in the emergency room, there are certain rules which apply. Assuming that an operation is urgent but not an emergency, it seems to be a generally accepted principle that a child over the age of 15 may give a valid consent. In some instances, a younger, knowledgeable child might consent validly.

The basic principle is that the preservation of human life takes rank and precedence over anything else, provided, of course, that the patient is unable to decide for himself what should be done with his body. Where a patient is unconscious, and the physician feels that he is in immediate danger of death, no consent is necessary because the law will presume a consent. This principle is applicable even to children and to people of unsound mind. Where the patient is conscious, however, his wishes must be respected as regards such things as the administration of blood or the performance of surgery on his person provided that he has capacity to consent. The physician may not trespass on his person if he is under his own control. But where the patient is a child the parent may not withhold life-saving treatment from him on religious or moral grounds. Likewise, the interests of a child *in utero* take precedence over the religious beliefs of the mother and father.

Medical and surgical emergencies are often the result of accidents which eventually lead to litigation. Records of what was done in the emergency room should be as accurate as time and circumstances permit. Even hearsay evidence should be recorded. Statutory reporting of injuries by deadly weapons must be done promptly as called for by the law. On the matter of records in the emergency room, the recommendations of Dr. James A. Spencer,[36] Assistant Director of the American College of Surgeons are worthy of consideration. He states:

> Assuming that the need for adequate emergency room records have been established, who is responsible for them? Responsibility of this kind cannot be placed on certain people: It belongs to a certain person. That person is the doctor who examines and treats the patient.

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[35] Shartel and Plant, *op. cit. supra* n. 26.

[36] Spencer, Emergency Rooms in General Hospital, 25 No. Car. Med. J. 1 (Aug., 1964).

He also feels that emergency department record forms should be well planned and should be:

1. Complete.
2. Concise, yet with essential details.
3. Easy to read.
4. Easy to fill out.

Documentation is of the utmost importance in the emergency room. Adequate documentation may spell the difference between success and failure of a law suit.

Wherever consent appears to be necessary, as in the case of blood transfusions or therapeutic injections, standard consent forms are available and should be required. This is usually a responsibility of the registered nurse in charge of the emergency room. In the same way refusal of diagnostic procedures or therapy must be documented. The patient should be required to sign a standard form of refusal to submit to treatment which should be attested or witnessed by a nurse or other adult persons in the emergency room. In the event that the patient refuses to sign, this fact should be noted on the standard form. Standard forms[37] have been published by the law department of the American Medical Association and every hospital should have copies as recommended by this body. The American Medical Association even provides a form of "Acknowledgment of Emergency Treatment" whereby the physician who renders the emergency care limits his responsibility to emergency treatment only and the patient is put on notice that another physician will have to be selected to carry on the complete diagnostic and therapeutic procedure.

Psychiatric Emergencies

The psychiatric emergency presents a special problem in the hospital emergency room.[38] According to our definition, a psychiatric emergency is not a true emergency but is a potential emergency. Initially, consideration must be given to the emergency detention of the patient who may do harm to himself or to others. The purpose is the protection of the patient and the other persons and the prevention of dangerous conduct. The success of this measure is dependent almost entirely upon the availability of emergency detention facilities in the hospital. If none exists in the hospital, then a temporary sojourn in jail appears to be indicated. It is not ordinarily within the purview of the physician on duty to give active treatment to the psychiatric

[37] American Medical Association (Law Department), Medical-Legal Forms with Legal Analysis (1961).

[38] American Hospital Association, M-51, Psychiatric Emergencies and The General Hospital (1965).

case. But it is a matter of his own judgment to determine whether or not he can usefully undertake some form of therapy to tide the patient over his acute phase until a psychiatrist can be reached to handle the case.

In the event that the patient is violent and needs to be restrained, the legal requirements are that only such force may be applied to the patient as is necessary to prevent him from hurting himself or hurting those around him.

Summary and Discussion

Service in the emergency room is a matter of common sense which is governed by the ordinary rules of due and reasonable care. To discharge his responsibilities correctly, the physician on emergency room call should see the patient personally and should not place too much importance upon the reports which come to him by telephone from interns or nurses who are not licensed doctors of medicine. The physician who makes a diagnosis over the telephone without personally examining the patient is asking for trouble. He may not have understood well what was said to him and the nurse or the intern may not have understood well the instructions he gave over the telephone. In the last analysis, the burden of proof may fall upon him to show that he was not negligent in failing to see the patient personally.

In some instances, physicians may order an X-ray over the telephone without knowing precisely which parts of the anatomy are to be X-rayed. It is a hazardous thing to ask an X-ray technician to use his own best judgment in taking an X-ray of an injured portion of the anatomy and even more hazardous to ask him to give a report on what the X-ray has shown. Moreover, if the injury is a potentially serious one, there is always the possibility that an X-ray technician may aggravate a fracture or a traumatic injury in attempting to obtain the best possible picture.

Most hazardous of all practices in the emergency room when the physician does not see the patient is to permit an intern or a nurse to discharge the patient and tell him to return to the office of the physician on call the following day. If the patient does not return, some nasty consequences may ensue. In one instance, a physician had actually sent a bill to an insurance company for work done by an intern in the emergency room. When the patient subsequently went to another physician he also sent a bill for the same injury and to the same insurance company. The first physician narrowly escaped a criminal suit for using the mails to defraud the insurance company. Undoubtedly, there are many situations which occur in emergency rooms every day which are unforeseen and for which there is no precedent. For such situations it is impossible to give precise advice beyond the admonition to use common sense in handling the case.