Admission orders

To the editor:

Who should write admission orders? When I returned to Canada after completing an emergency medicine (EM) residency in the United States, I knew I would have to make adjustments to my practice. One of these involved the writing of admission orders. In the US it is uncommon for emergency physicians (EPs) to write admission orders, except in low-volume, rural EDs. In Canada, EPs often write admission orders, even in high-volume settings. Uncomfortable with this, I started writing admission orders with expiration times, thinking this was a reasonable compromise. But others did not share my opinion; many felt I was just making things difficult. To avoid alienating everyone, I stopped including expiration times.

Who should write admission orders? It depends on the setting. In low-volume rural EDs, the family physician (FP) or on-call physician who will provide ongoing care usually has the responsibility for admission orders. In academic centres, housestaff from the admitting inpatient service generally write admission orders. In these settings, the question "Who should write admission orders?" is a non-issue. However, most Canadians pass through moderately high volume community EDs. It is here that the EP should not be writing admission orders.

The need to get patients in and out of hospital quickly has never been greater. Does this happen when the EP writes admission orders? Probably not. Admission orders written by EPs are usually of the "baby-sitting" variety: enough to cover the basics and get the patient through his or her first few hours. The most responsible physician (MRP) will later write comprehensive orders, but sometimes patients are not examined by the MRP for 24 hours or more. This is 24 hours wasted, and EPs who write admission orders open the door for this to happen.

Why do EPs write minimal admission orders? Is it because they are lazy or stupid? No. The EP is responsible for critical, time-dependent decisions; however, MRPs are more familiar with the patient's past history and are better placed to fine-tune patient management. These different roles are reflected in the training that the EP and MRP receive.

Other patients suffer when the EP writes admission orders. On an average shift, I spend at least 30 minutes writing even minimal admission orders. This is time spent not seeing patients, and it has an obvious impact on ED throughput and client service, somewhat foreign concepts in a health care system that is relatively devoid of market pressures. The more time I spend writing admission orders, the longer will be the embarrassing lineup of stretchers in the corridor.

Further, until an EP discusses a case with the admitting physician, the EP shoulders much of the medicolegal responsibility for care. Writing admission orders extends our period of liability into the inpatient phase, particularly for the period prior to assessment by the MRP.

My ideas are not new. CAEP's official position is that emergency physicians should not write admission orders unless they are assuming ongoing care and responsibility for the patient.[1] Unfortunately, this position is easier stated than implemented.

The solutions and obstacles are unique to each hospital. In trying to assign the responsibility of writing admission orders to the appropriate service, every ED must choose either the slow, politically correct pathway of least resistance or the "in-your-face, take a stand" approach. But regardless of our method, until we make this change we will continue to do a disservice to our patients as we do a favour for our colleagues.

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Reference

1. Murray M. Three position statements developed. CAEP/ACMU Communiqué 1997;Spring:14-5.

To the editor:

I read with interest the two letters in the last issue of *Communiqué* concerning ED physicians writing admission orders on behalf of attending physicians.[1,2] I strongly support the views presented by both writers. To call the CAEP position statement[3] "laudable"[1] is to be very charitable. "Unrealistic in the Canadian context" is perhaps a more appropriate evaluation.

The heart of the matter is illustrated by the case referred to in the first letter[1] (an emergency physician was held partially liable for a bad outcome occurring days later). It is not the act of writing or, for that matter, refusing to write admission orders that creates any additional liability for the ED physician. Rather, it is the adequacy of the ED physician assessment and the initial treatment flowing from that assessment that will impact on the ED physician's potential liability. Adopting a relatively rigid position (as does the American College of

Emergency Physicians) on this issue simply clouds the question and gives the ED physician a false sense of liability protection.

In the case of the stable and appropriately assessed patient in the ED, it is entirely reasonable, and clearly a courtesy to a colleague in small and mid-size Canadian hospitals, to write initial orders on behalf of the attending physician. Needless to say, that physician must have been notified by the emergency department physician at the time of admission, but to insist that he or she come to the hospital to re-evaluate a stable patient (especially at night) is neither reasonable nor prudent.

It is vital that CAEP continues to develop useful clinical guidelines and standards of practice for emergency medicine based on broad consensus and a careful reflection of reality. The present position statement is appropriate for large urban and especially teaching hospitals, but misses the mark in the majority of hospitals offering emergency services across the country.

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References

1. Gauthier C. Emergency physicians and admission orders [letter]. CAEP/ACMU Communiqué 1998;Winter 98–99:3-4.
2. Thompson J. Emergency physicians and admission orders [letter]. CAEP/ACMU Communiqué 1998;Winter 98–99:4.
3. CAEP Position Statement on the writing of patient admission orders. CAEP/ACMU Communiqué 1998;Winter 98–99:4.

Inappropriate patients

To the editor:
Although it is true that our society is "over-Medicared" (e.g., walk-in-clinics), perhaps the problem is not inappropriate ED use but, rather, lack of patient knowledge. If patients are asked what their perception of their medical problem is, and what their understanding of the real, possible, and most frightening consequences might be, then one might come up with answers that are closer to the truth.

We surveyed our ED patients for a month and found that those with minor problems came to the ED because of convenience, because of concern that they might have a "serious" problem, or because of perceived acuity. These are not bad people misusing our treasured yet crumbling health care system; they are just uninformed. Education is a powerful tool, and doctors, nurses, media and educators can help us solve this.

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To the editor:
The question of inappropriate emergency visits is a sensitive one; it forces us to examine a couple of key points. First and foremost is the issue of resource allocation. It is hard to suppress the feeling of frustration when we perceive the needless use of both emergency personnel and limited physical space. Both are in rather short supply, and we are all looking for ways to decompress our emergency wards. Limiting patient encounters that could otherwise be dealt with in another setting would be a useful step toward achieving this goal.

Second is the issue of patient rights. According to the *Canada Health Act*, every Canadian citizen has a universal right to health care — health care that is not restricted to certain hours or specific locations. It is not appropriate for emergency personnel to decide what a patient's threshold for seeking medical advice should be. These acts are driven by anxieties and health concerns that are unique to every patient. They should be respected and not scrutinized or minimized.

That's not to say that all stubbed toes require costly ED registration and emergent attention. I simply feel that the present format of emergency triage is inadequate when faced with this type of patient. I believe it is our responsibility to provide a viable alternative for patients who arrive with non-emergent complaints. Many centres in the United States have walk-in clinics within the ED itself. The clinic is essentially a separate entity run by a nurse practitioner who may then refer a patient on for emergency evaluation. Registration costs are much lower than those incurred with ED visits, and personnel are kept to a minimum. This, along with ongoing patient education, could serve as a more efficient way to deliver emergency care.

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