Reconciling Legal and Medical Ethics in a Hospital Setting: A Hospital's Experience Implementing JCAHO's Rule on Medication Orders

By David N. Hoffman

Making improvements in the system of health care delivery is a lot like changing a flat tire on a moving bus.

It is a clear sign of the progress that medical ethics has made in influencing the delivery of health care that hospital lawyers are thinking and sounding more like doctors when discussing patient rights and institutional responsibility. It is also true, in my opinion, unfortunately, that doctors are thinking and sounding more like lawyers. This is a function of lawyers' increasing immersion in the culture of medicine and the growing sophistication of physicians, due to their administrative responsibilities and medical malpractice litigation experiences.

This emerging reality was on display recently when I took my usual spot in the corner of the hospital board room for a regularly scheduled meeting of the Medical Board. Among the many items on the agenda was a presentation by our Quality Management department on implementation of one of the new Joint Commission Patient Safety Goals. The freshly minted policy and procedure was the one implementing Joint Commission standards 3.10 and 3.20 which require that all medication orders be accompanied by an entry in the chart describing the condition indication or diagnosis (CID) for which the medication was being prescribed.

This appeared to be a straightforward proposal directed at further reducing the already small possibility of a medication error due to misinterpretation of the prescribed medication or the route and dosage to be administered. The theory, of course, is that if the pharmacist and/or allied health professional who is preparing or administering the physician's ordered medication knows the condition or the basis upon which the physician chose that particular medication, then he or she will be more likely to recognize if the medicine being drawn is not appropriate for the condition being treated, or that the dosage is out of proportion to the patient's condition. For example, a medication order for Inderol (a heart medication) to treat a post-operative inflammation or swelling is not likely to get past either a pharmacist, technician or a nurse.

The policy and procedure that was presented for consideration further required that the individual filling the medication order contact the prescriber to verify his or her medical intention if no CID was provided. This is a necessary feature because it would be unacceptable for the person administering the medication to assume that the doctor's scribble, which appeared to read Inderol, was actually Indocin (an anti-inflammatory) because even patients with pain and inflammation can suffer from heart conditions.

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Our approach to implementation of the Joint Commission's medication management standards called for the CID to be documented directly on the medication order sheet. This enables the individual receiving the order from the floor to avoid having to refer back to the progress notes in the medical record to verify that the medication and dosage was appropriate for the patient's complaints.

Notwithstanding the reality that the number of medication errors, as measured against the total number of patient dosages administered, is very small, the potential severity of an adverse event certainly warrants substantial additional effort on the part of practitioners.

Given that these quality assurance measures are not without their costs, in time, money and unintended consequences, a substantial amount of discussion and debate is necessary before implementing any particular Q/A measure.

Although the proposal to require charting of CID seemed warranted on its face, I anticipated a significant degree of debate over the cost/benefit justification. What I clearly did not anticipate, as the debate flowered, was the argument raised by members of the medical staff that orders written without the requisite CID on the order sheet should be filled anyway, to ensure timely provision of treatment. They proposed that the lapse in implementation of this new patient safety protocol should be dealt with subsequently through educational or disciplinary action.

This position triggered the entirely predictable response from the quality assurance staff, that if physicians were permitted to get orders filled without providing the requisite CID, the objective of changing physician behavior would likely never be accomplished. The truly disturbing aspect of the discussion was the response from members of the medical staff who insisted that orders had to be carried out immediately lest they and the hospital be subject to tort actions for failure to provide timely treatment. At that moment, as is so often the case, eyes turned in my direction for a legal determination of the hospital's obligation.

It is specifically in these situations that we, as hospital attorneys, have to first acknowledge and then confront the natural tension that exists between our obligation to insulate our institutions from liability and our obligation to promote and advance the hospital's patient care and patient safety missions. The position being advanced by the medical staff was that while it was all well and good to require documentation of CID, it would be dangerous and, therefore, irresponsible to actually hold a medication order in order to obtain that information. The Quality Assurance staff, long experienced in trying to change physician behavior in an institutional setting, argued for strict enforcement of the proposed new rule. They asserted that orders should be held until the responsible physician or other practitioner could be contacted, and the appropriate CID noted into the order.

In my often conflicted roles as hospital counsel and director of the Bio-Ethics Consultation Service, I immediately saw liability and safety issues on both sides of the argument. If we accepted the medical staff's position and filled orders without the necessary CID, we would be acting in explicit violation of the hospital's new policy and procedure. Our QA staff asserted that if such a patient were to then have an adverse reaction because the patient received the wrong medication (based on a misunderstanding of the physician's order and lack of confirming CID), liability would clearly attach. The proof of the violation of the standard of care would be the hospital's own policy and procedure. Carrying out the physician's order without the CID creates the very risk that the patient safety goal of charting CID was designed to prevent.

The arguments offered by the medical staff, however, were equally compelling on both liability and patient safety grounds. If we enforced the more stringent policy requiring charting of CID, and then delayed administering the ordered medication while waiting for the ordering physician to be identified, and obtaining his or her CID to justify the medication, patient safety would be compromised if, during that interval, the patient were to suffer harm due to the delay in administering the prescribed treatment.

An animated discussion ensued, and as is inevitably the case, it turned toward what many believed was the easiest and, therefore, arguably the best solution, "to make no change in our policy at all." The advocates of this position espoused that, by requiring that a CID be charted, we were exposing the hospital to liability whether we enforced the policy or not. Therefore, the safest course of action was to do nothing. In support of this view, several participants in the meeting cited back to me an argument that I had advanced on many occasions. The standard of care to which we are most strictly held is the one that we have created ourselves, where we have raised the bar to a higher level than is generally expected in the medical community. Nonetheless, for the reasons set forth below the "do nothing approach" was summarily rejected on medical-ethical grounds.

Hospital lawyers who divorce themselves from the fiduciary responsibility of promoting patient safety may find comfort in leaving the task of advancing the standard of care to others. But this is directly contrary to the legal-ethical obligation of an attorney who engages himself or herself in the representation of health care providers and institutions. The legal/ethical standard to which health lawyers must be held is to advance the medical and ethical obligations of their clients. It can be asserted, therefore, by extension, that a hospital lawyer's legal-ethical obligation incorporates—by reference—the medical-ethical obligations of his or her physician and institutional clients. While it may be true that in a strictly commercial setting a lawyer has an obligation to prioritze avoidance of liability over other ethical obligations of his commercial client, the same cannot be said for legal practitioners in the for-profit, or not-for-profit, health care sector. It is in this respect that representing health care providers and institutions fun-

damentally changes the legal-ethical obligations of hospital lawyers. If the medical standard of care requires the health care practitioner to strive to improve the quality of care and enhance patient safety, then the health care lawyer's legal-ethical obligation to promote and facilitate that objective must take priority over the historical obligation of lawyers to insulate their clients from legal liability.

With this legal-ethical framework in mind, I rejected the assertion made by members of my medical staff that we could simply forgo the proposed improvement in the medical standard of care or that we could implement the change in policy and procedure, but not enforce it. The "legal" advice I provided to the Medical Board was that, having identified a risk of medication errors, due to the absence of documentation of a CID, as a patient safety concern, the hospital was obligated to both implement the proposed change in practice and to enforce it at the time of the breach of that standard. From an ethical perspective this must be the case, even though such a course might expose the hospital to tort liability if treatment was delayed while the responsible physician was contacted to properly complete his or her order.

Our discussion then turned to the question of what resources and efforts would have to be incorporated into the new policy and procedure to ensure that any failure by a physician to write a proper order was corrected as soon as possible. The procedure was, therefore, further expanded at additional cost in terms of time and resources in order to insure that incomplete medication orders were identified and corrected immediately upon their discovery.

As with most changes in practice in medicine, the window of vulnerability should be small because the constant flow of new medical interns and residents provides many opportunities to establish good habits in the first instance. The medical staff agreed to closely monitor physician compliance through daily review of pharmacy records of prescriber practice. Our experience to date has been excellent. The medical staff has adopted this change in practice patterns as they have so many others; with some suspicion, but willingness, nonetheless, to do what is best for the patient in the long run.

This change is not so different, of course, from the numerous accommodations we as lawyers have demanded from them in the reimbursement and compliance arenas. No doctor in practice today would expect to be paid for the care she/he provides without proper documentation of medical necessity or preauthorization. This was not the case as recently as a decade ago.

Conclusion

It is incumbent upon health care lawyers to acknowledge both to themselves and to their institutional clients that the practice of health care, as well as the practice of law, in the representation of health care clients, is a fundamentally different enterprise than that carried out by legal practitioners in non-health care settings. What distinguishes health care from all other human endeavors is that the process cannot be stopped in order to study and analyze the effects of quality improvement initiatives. The patients keep coming and, unlike a car or computer, you can not turn them off. To make peace with this responsibility you must resign yourself to the fact that stopping the bus is simply not an option.

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