Conflict Resolution Between Emergency Physicians
And Consultant Physicians
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“It is important to recognize that Emergency Physicians have an independent body of knowledge and skills in their own right which forms the basis of their practice, and that they possess an independent, unrestricted license to practice medicine as a physician and surgeon. Emergency Physicians, unlike interns or residents, are not the trainees or apprentices of any other physician on the medical staff. This fact may not be as well recognized by attending or consultant physicians as it is by Emergency Physicians, a discrepancy that can be a source of conflict between Emergency Physicians, consultants and private attendings. This fact does not relieve the Emergency Physician of acting upon his/her own judgment concerning the best interests of the patient while in his care. The Emergency Physician owes an independent duty to the patient to see that the individual understands and agrees to whatever care is administered. When there is substantial disagreement regarding patient care between attending physicians, a potentially dangerous situation arises for physician and patient alike.

Six areas of potential misunderstanding exist regarding the relationship between the private attending and the Emergency Physician. These are briefly discussed below.

First, it is important to understand that the private attending does not "own" the patient, that is, they cannot dictate the course of the patient’s medical care against their will. Nor can such physicians direct other practitioners to agree to actions that may be against the patient’s will or the Emergency Physician’s best judgment. Attending physicians do have their own duty to patients, and that duty includes both follow-up and consultation. Not to do so would be abandonment, which is against the law. “Clearly, the Emergency Physician and the attending are inextricably intertwined in their respective care of the patient. A smooth working relationship is essential. It is also essential that each party understand his/her own independent duties to the patient.”

The Emergency Physicians duty to the patient is often one of patient advocacy. We believe that medicine should be practiced the same way at 3 am as 3 pm and that care should not be compromised to fit into another doctor’s social or medical schedule. It is the Emergency Physician’s job to make certain that all necessary and attainable care is rendered to the patient. The Emergency Physician does not have a duty to the attending or consultant physician. We are not his/her advocate. To assume the role of the physician’s advocate would be a direct conflict of interests. You can not be an advocate for two parties with different interests at the same time! “It is not the job of the Emergency Physician to manage the ego, the finances, or the schedule of the attending physician, nor to accommodate that physician's medical practice or sleep patterns!”

It is true that Emergency Physicians may be the bearers of bad news, requiring a physician to get out of bed in the middle of the night to take care of a patient. But emergency care often involves hard decisions, and the patient’s rights and needs must be the first priority.

“The most frequent area of potential conflict is patient admission to the hospital. If the Emergency Physician believes that a patient should be admitted to the hospital, and the attending physician disagrees, this conflict must be resolved.” Resolution should never occur on the phone. The attending must come personally to see and examine the patient. This will allow the attending to have the same knowledge base as the Emergency Physician has about the immediate condition of the patient. If the two physicians can still not agree, a third physician, a neutral party, can be asked to arbitrate the dispute.

“The timing of follow-up care can be a third area of serious conflict. If the patient's medical condition warrants that a repeat exam occur in the next 24 hours, and it happens to be Saturday night, that means that follow-up should occur on Sunday. To change the opinion on the timing of follow-up based upon usual office practice
hours may not be in the best interest of the patient. It's good to remember just whose advocate you are! The Emergency Physician should recommend that the attending conduct a follow-up exam regardless of the day of the week.”

A fourth area of conflict can arise over the choice of medication used, or the request of a consultant to be contacted before certain medications or treatments are instituted. If this is the desire, then he/she should come immediately to the E.D. to assume the care of the patient. Often times these requests lead to significant delays in care that may risk a poor outcome, as would be the case in the delay to provide thrombolytic therapy to a patient with an acute M.I. or an antibiotic to a patient with a life threatening infection.

“A fifth potential conflict may arise when the "private patient" presents to the E.D. with the expectation of seeing their own private physician. Such arrangements may even have been made. However, this does not relieve the Emergency Physician of his/her duty to examine the patient. While the arrival of the patient and the need for care are certain, the arrival of the consultant physician is not as certain. The Emergency Physician is the primary caregiver”1 of all patients in the E.D. until the private physician/consultant arrives and assumes that care.

“The sixth area of potential conflict is the recommendation that the patient needs the consultant physician on the spot. That may mean disrupting the attending physician's office hours, sleep, social commitments etc. which often creates friction between the consultant and the Emergency Physician.”1 In the example of surgical subspecialties this may mean breaking scrub or changing the O.R. schedule to accommodate a patient’s needs. In the heat of battle, always remember that the patient’s immediate need must come first.

Going up the ladder
In academic institutions especially, often there is disagreement between the interns and residents who are consulting on a specialty and the Emergency Physician. It is wise to remember who is faculty and who is student! The conflict must be resolved and may be best dealt with by "going up the ladder". This essentially means calling the faculty back-up for that specialty and insisting that the faculty member come to the Emergency Department to personally evaluate the patient (his/her responsibility anyway!). If the faculty defers to his resident’s opinion, go up the ladder again. Go to the next immediate superior- usually the Section Chief or the Department Chairman. If still no resolution can be reached (unusual) go up the ladder again, for example to the Chief of the Medical staff at your hospital or the Dean of the Medical School if it is an academic institution. Eventually, someone will listen and it is unlikely that you will have trouble again! However, care must be taken not to be vindictive. You will need mutual cooperation for future encounters in patient care.

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