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HIPAA and Privacy in the ED: Disclosure Scenarios You Should Know

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Your daughter calls you from a party and tells you that she is on her way home. Two hours later, she hasn't arrived and she does not answer her cell phone. You call the emergency department (ED) and ask if she is registered as a patient there.

The person on the other end of the line states, "I'm sorry, sir, but federal privacy laws do not allow us to tell you whether or not that person in the emergency department."

Exactly what information may be disclosed under federal Health Insurance Portability and Accountability Act (HIPAA) privacy laws?

While not intended to be a comprehensive review of HIPAA legislation, this article will explore some of the more common scenarios where HIPAA privacy laws could apply to an ED healthcare provider's actions.

Background

HIPAA was enacted in 1996 as an amendment to the Internal Revenue Code in order to "improve ... the efficiency and effectiveness of the health care system, by [standardizing] electronic transmission of certain health information."[1] Despite being codified for well more than a decade, there is still significant misinformation about HIPAA's rules and regulations.

Definitions

HIPAA contains a long list of definitions. Several definitions within HIPAA's privacy section are important in understanding the scope of the law's requirements.

HIPAA privacy laws apply to "covered entities," which are defined as any health care provider that transmits any health information in electronic form.[2] For the purposes of this article, all health care providers will be considered covered entities. With the recent implementation of the Health Information Technology for Economic and Clinical Health (HITECH) Act, "business associates," or those that perform services utilizing individually identifiable health information on behalf of covered entities,[3] are now held to

the same standards and subject to the same penalties as covered entities.[4] HIPAA laws limit use and disclosure of "protected health information," which is considered as any information that could reasonably likely be used to identify an individual patient.[5]

Protected health information may be disclosed without a patient's permission only under the circumstances delineated within the HIPAA statute. Absent those exceptions, a patient must provide written authorization for use or disclosure of protected health information.[6]

Health care providers may use and/or disclose protected health information without a patient's consent when the information is used for treatment activities, payment activities, and health care operations of themselves or of any other health care provider.[7] Health care operations include activities such as quality control, evaluating practitioner performance, and training non-health care professionals.[8]

When protected health information is disclosed, the disclosures must generally be the "minimum necessary" to accomplish the intended purpose.[9] There are several exceptions to the "minimum necessary" standard in which any patient information may be disclosed. Those exceptions include disclosures or requests by a health care provider for medical treatment, disclosures made to the patient, and uses or disclosures required by law.[10]

ED Situations Involving HIPAA Disclosures

Notifying a Caller of a Patient's Presence in the ED or Hospital. HIPAA allows hospitals to create a facility directory containing a patient's name, location in the facility, and general condition.[11] The patient must be informed about the information to be included in the directory, and must have the opportunity to restrict the information or opt out of being included in the directory. Unless a patient opts out of being included in the directory, a hospital may inform visitors or callers who ask for a patient by name about the patient's location in the facility and the patient's general condition.

Going back to the example at the beginning of this article, unless the patient requests that such information not be disclosed, it is perfectly acceptable under HIPAA to inform a caller asking for a patient by name whether the patient is in the ED and, if so, the patient's location and the patient's general condition. Note that the law requires that callers ask for an individual by name. It would not be proper to disclose information to callers seeking information about "the stabbing victim."

An example of circumstances in which a patient might not want to be included in a hospital directory and in which disclosure might not be in the best interests of the patient could involve a victim of domestic abuse or a potential crime victim where the patient fears further attacks or retribution for reporting the incident.

Disclosing Information to Family Members. In emergency treatment situations, a health care provider may use or disclose protected health information without a patient's consent if the provider attempts to obtain such consent "as soon as reasonably practicable after the delivery of such treatment.[12] Under this exception, disclosures to patient contacts would be permissible when a patient requires emergency treatment for major medical issues such as respiratory failure, cardiovascular

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collapse, or major trauma.

In addition to the emergency exception, relatives or close personal friends may be informed of information that is directly relevant to their involvement with the patient's care.[13] If the patient is present and has decision-making capacity, HIPAA requires that the patient either expressly agree with the disclosure,[14] that the patient has the opportunity to object to the disclosure and does not do so,[15] or that, under the circumstances, a reasonable person would not object to the disclosure.[16] If the patient is not present, does not have decision-making capacity, or is unable to consent due to incapacity, a covered entity may disclose that information it judges to be in the best interests of the patient.[17] Any such disclosures must be directly relevant to the person's involvement with the patient's healthcare.

An example of a situation in which one would likely need to obtain permission from the patient before disclosing the patient's protected health information might be informing another party that the patient has contracted a sexually transmitted disease. Prefacing such information by asking the patient whether she wants other people in the room while you discuss the problem – giving the patient the opportunity to object to the disclosure – would satisfy one's duties under HIPAA laws. Similarly, telling a family member that a patient's chest pain is not due to a heart attack would likely not need a patient's permission since a reasonable person would not normally object to such a disclosure, but telling the family member that the patient's cocaine use is the cause of his chest pain would likely require the patient's permission.

Disclosure to Other Medical Providers. Medical providers often contact each other seeking information about a patient's previous visits or medical testing. Although hospital policies often require that a faxed authorization be obtained before disclosing such information, HIPAA permits protected health information to be disclosed without a patient's consent when the information is used for treatment activities of any health care provider.[18] In addition, the "minimum necessary" standard does not apply when information is disclosed to another medical provider for purposes of medical treatment.[19]

Notifying Third Parties of an Imminent Threat. Suppose that a patient describes to you an elaborate plan to kill his ex-wife. Do HIPAA laws permit disclosure of this information to the police or to the patient's ex-wife?

Protected health information may be disclosed to avert a "serious and imminent threat" to health or safety of a person or the public if the disclosure is made to a person "reasonably able to prevent or lessen the threat, including the target of the threat."[20]

Not only is it permissible for medical providers to disclose imminent threats to others, many state statutes and court holdings require that physicians notify known parties of a specific threat. For example, Minnesota statutes state that:

"The duty to … warn of ... violent behavior arises only when a client or other person has communicated to the licensee a specific, serious threat of physical violence against a specific, clearly identified or identifiable potential victim."[21]

Similarly, in *Emerich v. Philadelphia Center for Human Development,* the Pennsylvania Supreme Court held that:

"...a duty to warn arises only where a specific and immediate threat of serious bodily injury has been conveyed by the patient to the professional regarding a specifically identified or readily identifiable victim."[22]

Disclosing Protected Health Information to Law Enforcement

Healthcare providers may report victims of abuse, neglect, or domestic violence if the individual agrees with the disclosure, in order to comply with state laws, or if the disclosure is authorized by state regulations and the covered entity believes that disclosure is necessary to prevent serious harm to the individual or to other potential victims.[23]

Additional permissible disclosures for law enforcement purposes include any disclosures "required by law"; made pursuant to a court order, subpoena, or summons; made pursuant to administrative subpoena or summons; made in response to an authorized investigative demand; or occurring pursuant to a similar process authorized under law.[24] If protected health information is disclosed pursuant to a civil or authorized investigative demand, the information must be "relevant and material" to a legitimate law enforcement inquiry and limited in scope to the purpose for which the information is sought.[25] In other words, an investigative demand for disclosure of a patient's blood alcohol level after being involved in a motor vehicle accident would not permit disclosure of a patient's HIV status since HIV status is neither relevant nor material to a DUI investigation. However, if a patient's HIV status is relevant to a police investigation, the status may be disclosed. For example, in *State v. Mubita*,[26] the Idaho Supreme Court held

that a county prosecutor's request for disclosure of a patient's HIV status did not violate HIPAA when an HIV positive patient was accused of purposely having unprotected sex with multiple women. Another criminal case addressing this section of the HIPAA statute was *State v. Carter*.[27] Here, a Florida appellate court held that no HIPAA violation occurred when a pharmacy disclosed a patient's prescription records to a law enforcement officer investigating the patient for violation of Florida's "doctor shopping" statute.[28] The language in Florida's statue requires that pharmacies "produce, for inspection and copying by law enforcement officers, records of controlled substances sold and dispensed." Therefore, the court held that disclosures were proper under Section 164.512(f)(1) of the HIPAA statute.

Certain protected health information may be disclosed for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person.[29] Under this section, the permissible disclosures are limited to a person's name, address, date of birth, Social Security number, blood type, type of injury, date and time of treatment, and a description of any distinguishing physical characteristics. Specifically prohibited disclosures for this purpose are any information "related to the individual's DNA or DNA analysis, dental records, or typing, samples or analysis of body fluids or tissue." Using these rules, a healthcare provider would be permitted to disclose to law enforcement officers a description of a shooting victim and his injuries. However, this subsection would not allow healthcare providers to disclose to law enforcement officers the blood alcohol level or urine toxicology results of a suspected intoxicated driver since those results involve "analysis of body fluids."

Photographing Patients. Photography of hospital patients has become a contentious issue in the news. In December 2007, an Arizona Mayo Clinic surgeon was fired for taking pictures of a tattoo on a patient's genitals with his cellular telephone.[30] In February 2009, two Wisconsin nurses were fired after being accused of taking pictures of a patient's X-rays and posting the pictures to the Internet. The X-rays demonstrated a foreign body in the patient's rectum. Subsequently, the case was referred to the FBI for investigation of possible HIPAA violations.[31]

Absent a patient's written authorization, individually identifiable data may not be used in any way not permitted under the HIPAA statute. For example, HIPAA permits pictures of a trauma patient's injuries to be placed in the patient's medical records and sent to a trauma center upon a patient's transfer since all of those actions are in furtherance of the patient's medical treatment.[32] Additionally, maintaining "teaching files" of radiographic, laboratory, or other data falls under the definition of "health care operations"[33] and would be permissible to maintain and use for educational purposes.[34]

While HIPAA laws do not permit obtaining a patient's protected health information for personal purposes or posting such information to the internet without the patient's permission, HIPAA laws do not apply to any protected health information that has been "de-identified."[35] HIPAA contains an extensive list of information that must be removed from protected health information in order for it to be considered "de-identified." Included in that list is almost any unique information related to the patient, such as name, address, birth date, social security number, medical record number, etc.[36] In addition, any "full face photographic images and any comparable images" and other "unique … characteristic[s]" must be removed.[37]

In the first example given above, taking a picture of a patient's body part is unlikely to result in a violation of HIPAA, unless that body part is uniquely identifiable. For example, the picture of a rash on a patient's back would likely not be able to be traced back to the patient. However, a photograph of a tattoo on a patient's genitals is unique enough that it would likely be considered "uniquely identifiable." Therefore, the surgeon's actions most likely did violate HIPAA laws. Even assuming that there was no HIPAA violation, making recordings of another person's genitals may also violate state pornography or obscenity laws and photographing a child's genitals would likely violate state and federal child pornography laws.

In the second example above, pictures of an X-ray, unless demonstrating an extremely unique physical characteristic or showing hospital identifying data, would be very difficult to link to a given individual. Imagine jumbling 20 wrist X-rays and then trying to match them to 20 patients who had injured their wrists. Pictures of an isolated X-ray image would likely not violate federal HIPAA laws.

Whether HIPAA applies to pictures taken of patients or of protected health information is only one of the privacy issues involving patient photographs. In addition to state pornography laws, many state privacy laws prevent any photography of patients without their permission when a reason-

able person would have an expectation of privacy. Hospital policies, employment policies, and physician contracts may also limit the disclosure and use of any patient data. Confidentiality clauses are common in physician contracts. Agreeing to a clause stating that "Physician may not copy, retain, or disseminate information related to services provided under this Agreement without advanced written permission from Corporation" and then taking a patient's picture would likely be considered a breach of the contract. Hospital policies may forbid taking a patient's picture without the patient's written consent – even if the picture is used for treatment purposes. Taking a picture without written consent, even though the action would comply with HIPAA laws, may still subject the employee to termination for violating the hospital policies.

Although HIPAA administrative safeguards require that covered entities apply "appropriate sanctions" against workforce members who fail to comply with the covered entity's security policies,[38] violations of hospital privacy policies are not per se violations of HIPAA privacy laws and bald accusations of HIPAA violations against employees should be discouraged.

Penalties for HIPAA Violations

Patients do not have a private right of action against covered entities for HIPAA violations.[39] The U.S. Supreme Court has stated that Congress must specifically create a private right of action before individuals may attempt to enforce a federal law.[40] HIPAA contains no such language. Therefore, patients can't "sue you" for HIPAA violations. Until recently, the HIPAA statute permitted only the Secretary of the Department of Health and Human Services to impose civil fines on violators. However, the HITECH Act amended the HIPAA statute to permit state attorneys general to file civil actions against providers and obtain statutory damages against providers on behalf of state residents.[41]

Initially, HIPAA laws were rather forgiving.[42] With enactment of the HITECH Act, penalties for HIPAA violations have increased to a minimum of $100 per violation for "unknowing" violations, $1,000 per incident for violations involving "reasonable cause," and up to $50,000 per incident for violations involving "willful neglect." Penalties for "unknowing" or "reasonable" violations may not be imposed if the violations are corrected within 30 days.[43] Violations involving willful neglect incur minimum penalties of $10,000 per incident if corrected and $50,000 per incident if not corrected.[44] Criminal HIPAA penalties are more severe. If a person knowingly obtains or discloses individually identifiable health information, that person can be fined up to $250,000 and imprisoned for up to 10 years.[45] Violators have been convicted and sentenced under HIPAA for actions such as stealing medical data to create counterfeit identification documents,[46] obtaining and disclosing information to be used against a patient in a court proceeding,[47] and for viewing celebrity medical records without a permissible purpose.[48]

As of January 2010, just under 50,000 privacy complaints have been made in the nearly seven years since HIPAA enforcement began. Of those complaints, just over 10,050 required "corrective action," but not one case has resulted in imposition of a civil monetary penalty.[49] The Office of Civil Rights has so far referred 469 cases to the Justice Department for possible criminal prosecution.[50]

As the financial incentives for prosecuting cases increases, and as states may now use HIPAA fines as an income source, the number of HIPAA investigations and prosecutions is expected to increase.

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Will Longer Wait Times Mean More ED Lawsuits?

[Editor's Note: This is a two-part series on liability risks involving ED triage processes. This month, we cover the impact of wait times on ED lawsuits, and ways to reduce risks during long wait times. Next month, we explore actions to take if triage itself is taking too long, policies for reassessment of patients in ED waiting rooms, and the impact of triage performed by ED physicians on liability risks.]

Did a patient wait a long time in your ED, and did that patient have an adverse outcome? If these two events can be linked together by a plaintiff's attorney, it could result in a successful malpractice lawsuit against you or your institution.

It may not be too surprising that wait times are longer when EDs are more crowded. However, this occurs even for patients with life-threatening emergencies, according to a recent study. Researchers found that during crowded periods at four EDs, the adjusted median waiting room times of high-acuity level 2 patients were 3% to 35% higher than during normal periods.[1]

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, says that he was surprised by this statistic from a recent Centers for Disease Control and Prevention (CDC) report: Patients needing immediate care waited an average of 28 minutes to be seen by a physician.[2]

"These are obviously the critically ill or injured and unstable populations with the highest risk of death, and permanent disability," says Garlisi. "The CDC study did not expound on why these patients waited an average of 28 minutes or whether there were nurses, physician assistants or nurse practitioners engaged in the care of the patient until the physician became available. Whether the physicians were otherwise engaged in the care of other critical patients is unknown. But certainly it would be worth investigating the reasons for delays on this subset of high-risk patients."

With "time-sensitive" issues such as respiratory distress, trauma, or myocardial infarction, the burden is on the emergency physician to see patients and make correct accurate decisions quickly, while performing a myriad of other activities, says Garlisi.

Sources

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"If the physician is overwhelmed, or if the ED is understaffed, or rendered dysfunctional for any of a number of reasons, the patient may suffer an untoward outcome, and liability increases exponentially," says Garlisi.

Sympathy Is Unlikely

"Long waits make for unhappy patients, and unhappy patients are more likely to sue," says **Sandra Schneider, MD**, professor of emergency medicine at University of Rochester (NY) Medical Center. "Waiting room deaths have made national news. It is clear that society is not forgiving of long waits."

Once patients are seen, adds Schneider, crowding can still cause delays in care which can lead to increased morbidity and mortality. For example, patients with chest pain may have a delay in thrombolytics or percutaneous coronary interventions and develop more severe cardiac damage, an appendix may burst, or delays in the recognition of stroke may preclude the use of thrombolytics.

"If the attorney can create the sense that the staff did not care, or that they downplayed the patient's symptoms, it is easier to convince the jury of malpractice," says Schneider.

"We have all seen the major news stories where a significantly ill patient collapses in the ED, which of course, is a disaster," says **Emory Petrack, MD, FAAP, FACEP**, a medical-legal consultant and principle of Shaker Heights, OH-based Petrack Consulting. "There is certainly concern about liability for physicians, and perhaps even more for the institution."

Petrack says, though, that he suspects it would be difficult to bring a successful medical legal action against an ED physician who has not yet seen the patient, unless a problem occurred which he or she didn't respond appropriately to.

Garlisi says that he fully expects attorneys to take advantage of the pitfalls created by overburdened EDs, "especially since it is clear that hospital leaders realize there are delays, even for critically ill or injured patients. If we fail to apply some reasonable solutions in a coordinated fashion, with hospital teams working side-by-side with emergency physicians, we can only blame ourselves."

One such solution involves taking patient acuity into account for ED staffing. "One critically ill or injured patient can tie up a physician and two nurses long enough to "paralyze" the ED," says Garlisi.

Petrack says that the primary thing to be aware of is that as waiting times increase, so do your medical legal risks. "So there need to be some systems put in place to handle those problems as they occur."

Patients Aware of Problem

Jonathan D. Lawrence, MD, JD, FACEP, an ED physician and medical staff risk management liaison at St. Mary Medical Center in Long Beach, CA, says that in his own practice, patients have come in right after one of the highly publicized waiting room deaths and made comments such as, "You're not going to make me wait and die like that other patient, are you?"

"So they are well aware of the problem of crowding," says Lawrence. "And if they are already sensitized that bad things can happen, and then something bad does happen, I am sure they are going to be quite inflamed. There is no question that it is a difficult problem, and one fraught with legal difficulties."

Lawrence notes, however, that only a small minority of patients to whom bad things happen ever sue. "Most of the time, physicians and hospitals get away with malpractice without ever having a suit. Anything that increases the possibility that somebody would be more likely to sue increases your risk," he says.

If an adverse outcome occurs to a patient who was left sitting out in the waiting room, "it obviously wouldn't look good in front of a jury," says Lawrence. "These are difficult cases. It raises all kinds of questions as to the adequacy of your triage procedures, for example. Juries may or may not be sympathetic to the crush of other patients being seen at the same time. It's a little less problematic if somebody finally gets seen and then something bad happens. At least they were seen."

Linda M. Stimmel, JD, a partner with the Dallas, TX-based law firm of Stewart Stimmel, says that "Increased wait times in EDs will of course mean that some patients may suffer injury and death due to the delay. A good plaintiff's attorney will use that "delay" to prove causation in a lawsuit against a hospital, physician, or triage nurse."

However, the plaintiff's attorney will have to show that the "delay" or increased wait time was unreasonable or that the ED did not have a competent triage system to identify the more seriously ill patients. "A jury will not be able to blame a hospital or physician if the only fault that can

be shown is increased traffic due to a population without health insurance," says Stimmel.

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Consider Liability Risks in Post-discharge Contact

Was an abnormal lab result missed, such as a potassium level of 2.5? Was an incorrect medication prescribed? Or was a radiology study misinterpreted which revealed a pneumothorax? In every one of these scenarios, it is necessary for the ED physician to call the patient, 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 emergency physician makes thousands of decisions during each shift, and sifts through reams of data," says Garlisi. "The odds are that mistakes will occur in the inspection, interpretation, and analysis of the ancillary data. Despite electronic health records, radiology over-reads, and electronic discharge software, mistakes still occur."

Missed Findings?

"Incidentalomas," incidental findings on X-rays, are occasionally received by the ED physician after the patient is discharged. If the providing ED physician is still there, **Audie Liametz, MD, JD,** assistant medical director of the ED and chairman of the ED Quality Improvement Committee at Mineola, NY-based Winthrop University Hospital, says that physician or his or her representative in the department should follow up with the patient and/or their physician to communicate the findings and recommend appropriate follow up.

"Direct communication with the patient should be done by phone, if possible. This communication should be documented in the medical record as an addendum, with time and date noted," says

Wait Time Too Long? Reduce Risks this Way

To reduce legal risks, **Linda M. Stimmel, JD,** a partner with the Dallas, TX-based law firm of Stewart Stimmel, says the best strategy is to "show diligence." Document your ED's efforts to provide adequate staffing and educate staff and physicians on improved triage techniques, such as attendance logs on inservices to improve triage. Here are other risk-reducing practices:

- *Address concerns of a patient or family member by providing an immediate reassessment.*

"When someone comes to a staff member, whether a physician, nurse, clerk or anybody, and expresses concern about their loved one, do not blow that off," says **Emory Petrack, MD, FAAP, FACEP,** a medical-legal consultant and principle of Shaker Heights, OH-based Petrack Consulting. "Take the minute to make sure that that family member is in fact okay and able to wait."

In general, Petrack says ED staff need to have "a heightened awareness that when things are getting backed up, the potential for an adverse event in the ED increases."

- *Have a greeter or other individual serving as the "eyes and ears" of a busy waiting room.*

"That can be very helpful, both from a customer service and risk reduction standpoint," says Petrack.

- *Post signage and verbally inform patients to let the nurse know if their condition worsens.*

"On some level, you are putting that responsibility on the patient," says Petrack. "I think it's fine to let people know that it's a busy ED, and you need to work with us to make sure you are taken care of."

- *Give patients more realistic expectations about wait times.*

Petrack says that while concern about patients deteriorating during long ED waits is valid, "on the flip side, patients have increasingly unrealistic expectations about wait times. This is a huge problem." He recommends telling patients who are angry over their wait time that "the good news is that you weren't rushed back, because we do have to see patients in the order of how sick they are."

"However, even this attempt to maintain communication can backfire if not delivered diplomati-

cally, as patients sometimes do not understand why their loved one is not a priority," says Petrack.

While long wait times may result in patient complaints, this doesn't meet the requirements for a successful lawsuit. "No attorney is going to take on someone who is mad just because they waited a long time. The issue comes when this is coupled with a specific adverse outcome that can clearly be linked to the wait time," says Petrack.

However, Petrack says that if a case involving a long ED wait time that wasn't clearly linked to an adverse outcome goes to trial, "this could potentially become a difficult case. If it was determined that there were process issues which resulted in the long wait time, the potential would be there for some liability."

- *Keep patients informed continuously.*

"From a consumer standpoint, people often don't mind waiting, as long as they know what they're waiting for," says **Jonathan D. Lawrence, MD, JD, FACEP**, an ED physician and medical staff risk management liaison at St. Mary Medical Center in Long Beach, CA. "But when it's busy, usually the triage nurse doesn't have time to go out there and make nice. And those are exactly those times that are most tension-filled."

Instead, an administrator might go out and tell patients that an ambulance just brought in additional patients from a motor vehicle crash, and the ED staff is doing the best they can but an exact wait time can't be given.

"Even if we have to tell the waiting patients time and time again that we are doing our best and will be with them as soon as possible, that will be much better than no communication," says Stimmel.

In one lawsuit defended by Stimmel, a quiet and non-demanding patient sat in the ED waiting room for hours, never complaining and died. "If the patient had spoken up, the triage nurse would have probably acted," she says. "In that case, the jury was furious that the patient was ignored and never spoken to during the wait."

Stimmel adds that in her experience, the majority of patients who later become plaintiffs state that they felt ignored, or "not valued." "Patients will usually understand the situation if someone at least pays attention to them and keeps them updated," says Stimmel. "It will not stop all anger at long waits. But, we know for sure that feeling 'ignored' and then having a bad result almost always leads to litigation."

Liametz. "Communication with the patient's physician, or with their authorized representative, should be done by either phone, fax, and perhaps e-mail. This communication should be documented as well, noting with whom this communication was had."

Liametz says that if on the other hand, the information is received by the ED physician after the patient is discharged and after the providing ED physician has completed his or her shift, an "X-ray recall system" should be in place.

"There should be a mechanism established in the department and coordinated with radiology whereby these incidental findings are reported as an X-ray recall to someone in the department, preferable someone in the administrative capacity," says Liametz.

He says that the system should designate a responsible person in the ED, whether a physician, physician's assistant, nurse practitioner, or quality assurance individual, whose role it is to communicate this information to the patient and/or his physician.

"This communication and findings are then made part of the official medical record, with time and date stated," says Liametz. "It is critical that this follow-up information gets sent to the medical records department and becomes part of the official medical record, rather than simply being kept in the ED."

Keeping the information only in the ED can result in a potential problem years later if a plaintiff's attorney subpoenas the official medical record, because this critical follow-up information will not be included. It may not even be able to be located. "If this information were made a part of the medical record at the beginning, when the findings were discovered and acted on by the ED, it would potentially save unnecessary strife later on," says Liametz.

Liametz says that increased use of electronic medical records will make this an easier task. "The person who makes the notation and/or communication will be able to place an addendum in the ED medical record about what information was communicated and to whom," says Liametz. "This information will be time and date stamped as an addendum. This chart can be flagged to be resent to medical records for an update of the official medical record."

Once a system is in place, the information can be communicated by a physician's representative, physician's assistant, nurse practitioner, or nurse manager. "The point is that the information needs to be communicated by a clinical person, and this

communication needs to be documented in the official medical record," says Liametz.

Liametz says the same process can be used for missed critical findings. However, there should be an understanding that it is the responsibility of the radiologist to flag serious or critical missed findings by the ED, and communicate missed findings by the radiology resident to the appropriate ED personnel.

"For example, serious or potentially life-threatening radiographic findings such as missed cervical spine fractures, subarachnoid hemorrhages, pneumothoraces, appendicitis, ectopic pregnancy, to name a few, need to be communicated urgently to the ED," says Liametz. "The more urgent the finding, the more quickly the finding needs to be acted upon."

Patient Can't Be Reached?

If the patient can't be reached with the contact information he or she provided to the ED, **Sandra Schneider, MD**, professor of emergency medicine at University of Rochester (NY) Medical Center, says that additional efforts should be made only "when there is true concern, such as when the doctor is worried, the patient leaves against medical advice, or when lab tests come back after discharge."

Garlisi recommends these practices:

• Intercede as soon as possible if the patient is discharged prior to finding the mistake.

• If the patient cannot be reached by phone, send a registered letter to the patient address on file.

• Advise the patient during the registration process that it might be necessary to contact them regarding unexpected or unanticipated issues stemming from their care, or test results.

• Explain that in the event that the patient needs to be contacted to relay important information discovered at a later time, it is essential that the ED has accurate phone contact information, even third party if necessary, as well as the patient's mailing address.

However, be careful about drafting any additional forms stating that it's okay to give information to a designated third party identified by the patient at registration. "This may be construed as imposing a duty upon a hospital to contact any such designated person, and to provide them with the patient's medical diagnosis," says **Marlow J. Muldoon II, JD,** an attorney at Dallas-based Stewart Stimmel LLP. If your ED routinely requests emergency contact information, that should be sufficient to allow a generic message to be left as needed, says Muldoon

The fact is that patients have a variety of reasons to not provide accurate information. "Even if the person provides their correct name, there are instances where the addresses are wrong, either intentionally or unintentionally, the phone contact number is wrong or the entire name and demographic information is inaccurate," says Liametz. "We can only go by what we have." He says to follow these steps:

• For less life-threatening problems, all attempts to contact the patient should be documented.

"It may be useful to send a certified letter, telegram, or mailgram, and document such in the record," says Liametz.

• In cases of severe and/or life threatening possible consequences, the ED staff should make reasonable efforts.

This may include enlisting the assistance of other personnel such as local police or emergency medical services to try to make contact with the individual. These steps should be documented, as well.

• Use caution when leaving phone messages to avoid violating patient privacy regulations.

"We do not know who is going to receive this information," says Liametz. "It would be wise for the practitioner to leave a basic message for the person to recall the ED without providing specifics. Provide them with a contact number and person with whom to speak with."

"Patients have an obligation and responsibility to help their physician with their care," says Liametz. "If the patient provides incomplete

Sources

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and/or inaccurate contact information, all the ED physician can do is use their best and most reasonable efforts to try to communicate the information to the patient."

Muldoon advises taking the following actions for this circumstance:

- If the patient's next of kin or emergency contact person is contacted, inform them only that the patient needs to contact the ED as soon as possible.
- Provide only general statements such as "it is very important" when leaving the message, to ensure patient confidentiality.
- When possible, contact the patient's primary care physician.
- Send the patient a certified letter informing the patient of the need to contact the ED and/or their primary care physician. "The ED should document all of its reasonable efforts to contact the patient, but it is not under a duty to hire a private investigator," says Muldoon.

"The patient should be advised to return to the ED, call the ED to speak with an ED physician, or contact their primary care physician," says Muldoon. "This should be done only after informing the ED physician first. The ED should refrain from making specific recommendations or providing specific information regarding the test results or the diagnosis."

CNE/CME QUESTIONS

15. Which of the following is true regarding ED litigation involving allegations of long wait times?
    A. Patients have successfully sued ED physicians who had not seen the patients.
    B. The plaintiff's attorney have to show that the wait time was unreasonable or that the ED did not have a competent triage system to identify the more seriously ill patients.
    C. Patients can successfully sue for long wait times in the ED even if no specific adverse outcome can be linked to it.
    D. Long wait times do not make it easier to convince a jury of malpractice.

16. Which of the following is recommended to reduce liability risks during crowded periods?
    A. Avoid posting signage or verbally informing patients to let the nurse know if their condition worsens, since it would appear that the ED is placing responsibility on the patient instead of the institution.
    B. Written policies should specify that all patients still waiting should be reassessed within a specific time frame.
    C. Avoid documenting efforts to improve triage techniques and providing adequate staffing, as these could be used to show that personnel were aware of existing problems.
    D. When a patient or family member expresses concern, always provide an immediate assessment to ensure the patient is able to wait.

17. Which of the following is recommended if an ED patient can't be reached post-discharge?
    A. EDs should have all patients sign an additional form stating that it's okay to give information to a designated third party identified by the patient at registration.
    B. It is not necessary to document efforts to contact the patient for problems that are not life-threatening.
    C. For information with possibly life-

threatening consequences, EDs should enlist the assistance of other personnel, such as local police or emergency medical services, to try to make contact with the individual, and should document these steps.

D. If a message is left with the patient's emergency contact person, this individual can be legally informed of the details of the situation.

18. Which of the following information disclosures is permitted under HIPAA privacy rules?
    A. Disclosure of protected health information without a patient's consent when the information is used for treatment activities of any health care provider.
    B. Informing visitors or callers who ask for a patient by name about the patient's location in the facility and the patient's general condition.
    C. Photographing a trauma patient's injuries without his or her consent and sending those photos to the trauma center where the patient is transferred.
    D. All of the above are permitted under HIPAA.

Answers: 15. B, 16. D, 17. C,. 18. D

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. ■