

ED Legal Letter™

The Essential Monthly Guide to Emergency Medicine Malpractice Prevention and Risk Management

From the publishers of *Emergency Medicine Reports* and *ED Management*

AHC Media

Will Camera Photos from Your ED Wind Up on the Web — or in Court? 42

ED Patient's Pic Posted? HIPAA Violation Possible 43

Reduce Legal Risks of "No-Show" ED Consultants. 44

If a Consultant Doesn't Show, What Can You Prove in Court? 46

Financial Disclosure: The following individuals disclose that they have no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study: Larry Mellick, MD, MS, FAAP, FACEP (Editor-in-Chief), Professor of Emergency Medicine and Pediatrics, Department of Emergency Medicine, Medical College of Georgia, Augusta; N. Beth Dorsey, Esq. (Writer); Timothy A. Litzenburg, Esq. (Writer); Frank LoVecchio (writer), Kay Ball RN, PhD, CNOR, FAAN, Consultant/ Educator, K&D Medical Inc., Lewis Center, OH (Nurse Planner); Stacey Kusterbeck (Contributing Editor); and Leslie Hamlin (Managing Editor), and Shelly Morrow Mark (Executive Editor).

Medical-Legal Pitfalls in Managing Acetaminophen Toxicity

By Frank LoVecchio, DO, MPH, FACEP, Co-Medical Director, Banner Poison and Drug Information Center; Vice Chairman, Research Director, Maricopa Medical Center, Phoenix, AZ

Case: A 40-year-old man with a history of hepatitis C and alcoholism presents to the ED with dental caries. A brief history and unremarkable physical examination is documented. The patient is discharged and fills his prescription for hydrocodone 5 mg/acetaminophen 500 mg (1-2 tablets every 4-6 hours as needed, #25). Two weeks later he dies of fulminant liver failure, and the family initiates litigation for your excessive acetaminophen prescription.

On January 13, 2011, the U.S. Food and Drug Administration (FDA) limited acetaminophen in prescription combination products, and now requires liver-toxicity warnings. The agency specifically capped the maximum at 325 mg in combination products in an attempt to reduce risk of liver toxicity.¹ An advisory committee to the FDA hearings concerning acetaminophen and acetaminophen-induced hepatotoxicity in 2002 and 2009 concluded that much of the concern is not evidence-based and is debatable.² Independently, *The Medical Letter on Drugs and Therapeutics* conducted an extensive review on acetaminophen toxicity in 2002; a second review in 2009 found no risk of hepatotoxicity if less than 4 g of acetaminophen is ingested daily.³

Pharmacokinetics/Pharmacodynamics

Acetaminophen is rapidly absorbed from the gastrointestinal tract, with a half-life of approximately 1.5-2.5 hours, although it can be slightly prolonged at supratherapeutic concentrations. In adults, 45%-55% of acetaminophen is glucuronidated, while 20%-30% is sulfonated. In pediatric patients, sulfation is the primary pathway, and glucuronidation is a trivial component; thus, toxicity is more difficult to attain. The remainder of acetaminophen is metabolized via the cytochrome P450 isoenzyme CYP2E1 to form a substance called N-acetyl-para-benzoquinone imine (NAPQI). Normally, the body's endogenous glutathione supplies are able to bind to and reduce NAPQI, resulting in renal excretion in the form of cysteine or mercaptopuric acid conjugates. In overdose, NAPQI production exceeds the body's endogenous glutathione supply, and hepatotoxicity can result.^{4,5}

Risk Factors for Liver Failure

Acetaminophen's toxicity is due to the metabolism of NAPQI by the cytochrome P450 isoenzyme CYP2E1. Thus, any xenobiotic that induces the P450 isoenzyme CYP2E1 theoretically can increase the risk for acetaminophen-induced hepatotoxicity. The best studied agent for inducing CYP2E1 is ethanol. Chronic ethanol consumption leads to increased CYP2E1 activity and, theoretically, increases the risk of hepatotoxicity but, at least in the short term, exposure to acetaminophen is not substantiated.⁶ The co-ingestion of ethanol with acetaminophen may result in inhibition of the microsomal oxidation of acetaminophen, thereby providing some degree of protection from acetaminophen-induced hepatotoxicity during acute intoxication.⁶⁻⁷ The strongest risk factor for developing

ED Legal Letter™, ISSN 1087-7347, is published monthly by AHC Media, 3525 Piedmont Road N.E., Bldg. 6, Suite 400, Atlanta, GA 30305. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to ED Legal Letter, P.O. Box 105109, Atlanta, GA 30348.

Subscriber Information: Customer Service: (800) 688-2421. Customer Service E-Mail Address: customerservice@ahcmedia.com. Editorial E-Mail Address: leslie.coplin@ahcmedia.com. World Wide Web: <http://www.ahcmedia.com>. Subscription Prices: United States: \$499 per year. Add \$17.95 for shipping & handling. Multiple Copies: Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Canada: \$529 per year plus GST. Elsewhere: \$529 per year. Back issues: \$83. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue's date. GST Registration Number: R128870672.

AHC Media is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

AHC Media designates this educational activity for a maximum of 18 *AMA PRA Category 1 Credits™*. Physicians should only claim credit commensurate with the extent of their participation in the activity.

Approved by the American College of Emergency Physicians for 18 hours of ACEP Category 1 credit.

AHC Media is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider #14749, for 15 Contact Hours.

This activity is intended for emergency physicians and nurses. It is in effect for 36 months from the date of the publication.

Opinions expressed are not necessarily those of this publication, the executive editor, or the editorial board. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought in specific situations.

Vice President / Group Publisher: Donald R. Johnston

Managing Editor: Leslie Hamlin

Executive Editor: Shelly Morrow Mark

Editor-in-Chief: Larry B. Mellick, MD, MS, FAAP, FACEP

Contributing Editors: Robert Bitterman, MD, JD, FACEP; and Stacey Kusterbeck.

Copyright 2011 by AHC Media. All rights reserved. No part of this newsletter may be reproduced in any form or incorporated into any information-retrieval system without the written permission of the copyright owner.

AHC Media

Questions & Comments

Please contact **Leslie Hamlin, Managing Editor**, at leslie.hamlin@ahcmedia.com.

hepatotoxicity is the time from a toxic ingestion until the antidote, N-acetylcysteine, is administered. The risk of hepatotoxicity, if N-acetylcysteine is started within the first eight hours of the overdose, is exceedingly low, while the risk increases substantially with delays more than eight hours and longer.⁸

Clinical Presentation

Acute acetaminophen toxicity traditionally has been divided into four stages, with the time of each stage being imprecise. The first stage, which occurs during the first 24 hours of overdose, results in gastrointestinal symptoms, or may be asymptomatic. The second stage, which occurs from 24-72 hours post-ingestion, is characterized by the initial development of hepatic failure. During the third phase, which can begin as early as 72 hours post-ingestion, the clinical symptoms depend on the degree of liver failure. Coma, encephalopathy, renal failure, coagulopathy, severe metabolic acidosis, and hypoglycemia can occur.⁹ At this stage, the patient either will improve or will continue to worsen until he or she either dies or receives a liver transplant. Stage IV is characterized by resolution of liver damage. Following stage III, the patient either will die or will recover (stage IV). Unlike other causes of hepatic injury (e.g., alcohol-induced cirrhosis), acetaminophen-induced liver injury is not associated with long-term liver damage, if recovery occurs.

Diagnosis and Treatment

The diagnosis of acetaminophen toxicity relies in history and laboratory studies. Given vague symptoms in the early stage of acetaminophen toxicity, along with patient's occasional inadvertent confusion of acetaminophen, ibuprofen, and salicylates, it is recommended that all known or suspected overdoses have an acetaminophen level drawn. Because acetaminophen is present in so many different pharmaceutical agents, it is not uncommon that a patient may inadvertently overdose on acetaminophen by consuming multiple acetaminophen-containing products, each at the recommended dosage.

The need for treatment depends on the history, the physical exam, and laboratory studies. If treatment is desired, the preferred antidote is N-acetylcysteine (NAC).¹⁰ Any detectable acetaminophen 24 hours or more after acute ingestion is an indication for treatment, as per the standard used in the United States, referred to as the Rumack-Matthew nomogram. Treatment with NAC is indicated when the acetaminophen concentration is above the line on the Rumack-Matthew nomogram.

Although FDA-approved dosing regimens are of

Table 1. Differential Diagnosis

While many causes of fulminant hepatic failure exist, some of the more well-known etiologies are presented below.

<u>Toxin</u>	<u>Vascular</u>	<u>Infections</u>	<u>Misc.</u>
Acetaminophen, Amiodarone	Budd-Chiari syndrome	Cytomegalovirus (CMV)	Fatty liver of pregnancy
Inorganic arsenicals, thallium, and borates	Shock liver	Epstein-Barr virus	Heat stroke
Borates	Veno-occlusive disorder	Hepatitis A	HELLP syndrome
Carbon tetrachloride		Hepatitis B	Wilson's disease
Cocaine, copper		Hepatitis E (if pregnant)	<i>Amanita phalloides</i> (Hepatotoxic mushrooms)
Ecstasy (MDMA)		Herpes simplex virus	
Halothane		Varicella zoster virus	
Iron			
Isoniazid			
Non-steroidal anti- inflammatory drugs			
Phenytoin			
Thallium			
Troglitazone			
Valproic acid			
White phosphorus			

fixed durations, virtually all experts tailor the duration of therapy to the patient's clinical condition. After the patient has received at least 21-24 hours of intravenous therapy, transaminases and prothrombin levels should be rechecked before discontinuing therapy. If the liver functions and prothrombin time are normal, and the patient is clinically well (neither vomiting nor complaining of abdominal pain), the NAC can be discontinued. Some institutions recommend checking a repeat acetaminophen level before discontinuing therapy, although this is not an evidence-based practice.

It is important to recall that the Rumack-Matthew nomogram was designed for a single acute ingestion when the phlebotomy occurs between 4 and 24 hours post-ingestion. Many times patients do not present following a single acute ingestion,

but rather consume some pills, and a few hours later consume additional pills. In this case, in order to use the nomogram, the safest method is to assume all pills were ingested at the first time, and plot the level based on that time.

Not uncommonly, patients will present with an unknown time of ingestion. In these cases, an acetaminophen level, liver function tests, and a prothrombin time (PT) should be obtained. If there is no detectable acetaminophen, and the liver functions and PT are normal, no treatment for the acetaminophen ingestion is needed. If there is any detectable acetaminophen, or if there are elevated transaminases or PT, treatment with NAC is indicated. Chronic ingestions, in which the patients have taken supratherapeutic ingestions for several

Table 2. Common Pitfalls in Management of Acetaminophen Toxicity

- Failure to interpret the acetaminophen concentration in context of the time since ingestion
- Stopping N-acetylcysteine therapy in the face of worsening clinical or laboratory parameters or when apap is still present
- Failing to obtain a psychiatry consult when indicated
- Failure to consider co-ingestants
- Failure to treat or recognize chronic supratherapeutic acetaminophen toxicity

days, should be managed the same as when the time of ingestion is not known.

In 1994, McNeil Pharmaceuticals released an “extended-release formulation” of acetaminophen, marketed under the name Tylenol Extended Relief™. The pharmacokinetic profile between the regular-release and the extended-relief formulation are similar; it appears both safe and reasonable to use a single four-hour acetaminophen concentration and determine treatment based on the Rumack-Matthew nomogram for either the regular-release or the extended-release acetaminophen products, although not all experts agree on this approach.

Differential Diagnosis

It is important to consider acetaminophen in the differential diagnosis of any patient with hepatic failure. Although many drugs can cause a toxin-induced hepatitis, there are few xenobiotics that can cause fulminant hepatic failure. Among these drugs are acetaminophen, amoxicillin-clavulanate, isoniazid, nitrofurantoin, iron, herbals (e.g., pennyroyal and chaparral), non-steroidal anti-inflammatory medications (especially diclofenac or sulindac), phenytoin, and the thiazolidinedione troglitazone. In addition, the recreational drugs cocaine and 3,4 methylenedioxymethamphetamine (MDMA or ecstasy), as well as carbon tetrachloride, white phosphorus, arsenic, thallium, and borates can cause acute hepatic failure. It should be noted that the cause of acute hepatic failure is dose-dependent in some of these agents (e.g., acetaminophen), yet is idiosyncratic with other agents (e.g., troglitazone). Furthermore, any drug that produces profound hypotension can result in hepatic failure from shock liver. In addition, many drugs, such as the HMG-CoA reductase inhibitors (“statins”), can cause a liver injury, but not fulminant hepatic failure.

Although a full review of all causes of hepatic fail-

ure is beyond the scope of this paper, the emergency physician should always consider infectious etiologies (e.g., hepatitis B, hepatitis C, Epstein-Barr virus, herpes simplex virus, and cytomegalovirus); other causes include vascular etiologies (e.g. Budd-Chiari syndrome, ischemic hepatitis, veno-occlusive disorders), as well as miscellaneous etiologies such as Wilson’s disease, autoimmune hepatitis, fatty liver of pregnancy, heat stroke, and HELLP syndrome.

Although the history may be helpful in distinguishing the etiology of fulminant hepatic failure, several additional laboratory features might be helpful as well. Frequently, the aspartate aminotransferase (AST) rises faster and peaks sooner than the alanine aminotransferase (ALT). In addition, unlike some other etiologies of hepatic failure, there is synthetic dysfunction occurring as well, which results in a rise in the prothrombin time.

Liver Failure

The greatest concern following acetaminophen ingestions is the potential to develop hepatotoxicity. The risk of hepatotoxicity is substantially increased when NAC therapy is begun more than 8-10 hours post-acute ingestion.¹¹ The development of liver failure is characterized not only by the development of transaminitis, but also encephalopathy, acidosis, renal failure, coagulopathy, and hypoglycemia. The proximate cause of death in acetaminophen-induced hepatic failure is usually cerebral edema.

NAC should be continued until one of three major endpoints happens: clinical and laboratory improvement, the patient receives a liver transplant, or death.

Special Populations

Pregnancy: Acetaminophen readily crosses the placenta, which places the fetus at potential risk of hepatotoxicity.¹² However, because NAPQI does not cross the placenta, the fetus itself must metabolize the acetaminophen in order for hepatotoxicity to occur. The fetus is able to start metabolizing acetaminophen into both toxic and non-toxic metabolites beginning at approximately 18 weeks gestational age.¹² NAC does cross the placenta in both animal models and humans, and its use is indicated in pregnant women whose serum concentration is above the treatment line on the Rumack-Matthew nomogram. Fetal outcome appears to be worse with delays in commencing NAC.

Alcoholics: Chronic alcohol consumption results in depletion of hepatic glutathione, and upregulation of CYP2E1, the isoenzyme that metabolizes acetaminophen to NAPQI. As such, there is concern that chronic alcoholics may be more susceptible to

acetaminophen-induced hepatotoxicity. Kuffner and colleagues examined the effects of administering 4 g of acetaminophen daily to alcoholics entering an alcohol-detox facility. These patients are hypothesized to be at the highest risk of hepatotoxicity, as at the time these patients enter a detox facility, they will likely have their lowest glutathione supplies, while being at maximal induction of CYP2E1. While at the maximal recommended daily dose, they failed to demonstrate any increased risk of hepatotoxicity, including in those patients with alcoholic hepatitis.^{13,14} However, chronic alcohol abuse is associated with worsened outcomes in acute acetaminophen poisoning.

Opiates: Watkins and colleagues attempted to determine if the co-administration of opiates along with acetaminophen resulted in increased hepatotoxicity. In their study, 147 patients were randomized to receive placebo, acetaminophen, morphine and acetaminophen, hydromorphone and acetaminophen, or oxycodone and acetaminophen. All patients who received acetaminophen received 4 g daily. In the placebo group, only one patient had a rise in the ALT twice the upper limit of normal. In contrast, more than 19% of participants in each of the four active treatment groups had an ALT five times the upper limit of normal. All three of the opioid/acetaminophen treatments frequently resulted in elevation of the ALT.¹⁵ There is some concern that the co-administration of opiates with acetaminophen may result in increased incidence of hepatotoxicity.

Pediatrics: It appears that the increased rate of sulfation, along with possibly an increased relative size of the liver, affords some hepato-protective effects to pediatric patients. In fact, many authors have suggested that 200 mg/kg should be the potentially hepatic-toxic dose in pediatrics, as compared with the lower dose for adults.¹⁶

Prognosis

In general, patients who have NAC started within 8 hours of the overdose will do well. Once hepatic injury occurs, the King's College Criteria can be used to help predict which patients may benefit from liver transplant. According to these criteria, patients should be considered for liver transplant if 24 hours after admission, the arterial pH is less than 7.25 after fluid resuscitation, or if there is a combination of a prothrombin time longer than 100 seconds, grade III or IV encephalopathy, and a serum creatinine higher than 3.4 mg/dL.¹⁷

Pitfalls in Management

There are several common scenarios in which

mistakes in management commonly occur. Perhaps the most common source of error is failure to interpret the acetaminophen level in the context of the time ingested. A single acetaminophen level is not helpful without knowing the time of ingestion. Thus, it is critical to interpret the acetaminophen level based on the time of ingestion, and plot the concentration on the Rumack-Matthew nomogram. If the time of ingestion is not known, it is important that the patient be started on N-acetylcysteine if any acetaminophen is detected, or if there are abnormal liver function tests or prothrombin time.

A second common source of error is discontinuing the NAC at 21 hours, simply because the time course for therapy is over. If the patient is having rising liver function tests or persistent right upper-quadrant tenderness, then therapy with NAC should be continued until these are improving. Patients meeting criteria for transplantation should be referred when indicated.

A third common source of error for the EP is failure to exclude other ingestions. Simply because a patient admits to ingesting acetaminophen, other potentially life-threatening ingestions, including salicylates, need to be evaluated in all patients.

A fourth common source of error for the EP is failure to obtain appropriate psychiatry consult when indicated. If a patient is being admitted to the hospital, then the consultation can be done once the patient is admitted. If the initial acetaminophen level does not warrant therapy, and the patient is to be medically cleared from the ED, it is important to obtain a psychiatric consultation, if indicated. Finally, not documenting a clear medication history, and not counseling a patient on limiting total daily acetaminophen to no more than 4 g daily, is a source for error.

Summary

Acetaminophen overdose remains a common cause of hepatic failure. To ensure optimal care, the diagnosis must be made early and treatment should be started within 8 hours. With prompt treatment with NAC, the incidence of hepatic failure can be reduced. The new FDA regulations serve as a reminder for better documentation. ■

References

1. U.S. FDA. FDA drug safety communication: Prescription acetaminophen products to be limited to 325 mg per dosage unit; boxed warning will highlight potential for severe liver failure. Available at: www.fda.gov/drugs/drugsafety/ucm239821.htm. Accessed Jan. 31, 2011.
2. U.S. FDA. Docket No. FDA-2009-N-0138. *Fed Reg.* 2009;74:18731.

3. Acetaminophen safety — déjà vu. *Med Lett Drugs Ther.* 2009;51:53-54.
4. Rumore MM, Blaiklock RG. Influence of age-dependent pharmacokinetics and metabolism on acetaminophen hepatotoxicity. *J Pharm Sci.* 1992;81:203-207.
5. Heard KJ. Acetylcysteine for acetaminophen poisoning. *N Engl J Med.* 2008;359:285-292.
6. Riordan SM, Williams R. Alcohol exposure and paracetamol-induced hepatotoxicity. *Addict Biol.* 2002; 7:191-206.
7. Prescott LF. Paracetamol, alcohol, and the liver. *Br J Clin Pharmacol.* 2000;49:291-301.
8. Zed PJ, Krenzelok EP. Treatment of acetaminophen overdose. *Am J Health Syst Pharm.* 1999;56:1081-1091.
9. O'Grady JG, et al. Early indicators of prognosis in fulminant hepatic failure. *Gastroenterology.* 1989;97:439-445.
10. Rumack BH, et al. Acetaminophen overdose. 662 cases with evaluation of oral acetylcysteine treatment. *Arch Intern Med.* 1981;141(3 Spec No):380-385.
11. Smilkstein MJ, et al. Efficacy of oral N-acetylcysteine in the treatment of acetaminophen overdose. Analysis of the national multicenter study (1976 to 1985). *N Engl J Med.* 1988;319:1557-1562.
12. Wang LH, et al. Pharmacokinetic studies of the disposition of acetaminophen in the sheep maternal-placental fetal unit. *J Pharmacol Exp Ther.* 1986;238:198-205.
13. Kuffner EK, et al. The effect of acetaminophen (four grams a day for three consecutive days) on hepatic tests in alcoholic patients — A multicenter randomized study. *BMC Med.* 2007;5:14.
14. Kuffner EK, et al. Effect of maximal daily doses of acetaminophen on the liver of alcoholic patients: A randomized, double-blind, placebo-controlled trial. *Arch Intern Med.* 2001;161:2247-2252.
15. Watkins PB, et al. Aminotransferase elevations in healthy adults receiving 4 grams of acetaminophen daily: A randomized controlled trial. *JAMA.* 2006;296:87-93.
16. Moher CR, et al. Prospective evaluation of mild to moderate pediatric acetaminophen exposures. *Ann Emerg Med.* 2000;35:239-244.
17. Anand AC, et al. Early indicators of prognosis in fulminant hepatic failure: An assessment of the King's criteria. *J Hepatol.* 1997;26:62-68.

Will Camera Photos from Your ED Wind Up on the Web — or in Court?

Identifiable pics have been posted

Given the fact that almost every patient, family member, and ED staff member is carrying a cell phone, it's not surprising that inappropriate photos or videos have been posted online — which means

increased legal risks for EDs.

“There have been cases in which doctors and hospital employees have been terminated by posting pictures on social media sites,” says William Sullivan, DO, JD, FACEP, director of emergency services at St. Margaret's Hospital in Spring Valley, IL, and a Frankfort, IL-based practicing attorney.

Don't Permit It

Matthew Rice, MD, JD, FACEP, former senior vice president and chief medical officer at Northwest Emergency Physicians of TEAM Health in Federal Way, WA, reports that the American College of Emergency Physician's Medical-Legal committee has looked at this specific issue. “There is such a potential for violation of confidentiality that some of us on the Committee felt that use of camera phones is not something that should be permitted,” says Rice.

While some EDs currently have policies against cell-phone use in the department in order to keep noise levels down, Rice says confidentiality is an even more important issue. He recommends posting signage stating that audiotaping or videotaping is not permitted in the ED.

If someone takes a cell-phone camera photo of an ED patient, Rice says this may well be admissible evidence in the event of a lawsuit. “There is pretty good legal precedent for discovery,” he says. “With cases involving videos of births and surgeries, there are some pretty significant case numbers that have come up.”

If signs are posted in the ED, however, Rice says that the argument could be made that the video or photo was illegally obtained and should, therefore, not be admissible. “The bigger issue, I think, is the privacy issue for all patients, particularly with the potential of live streaming,” he says. “You don't want to be Skyped when you are having a heart attack.”

Even if it's a family member using the cell-phone camera, Rice says to remember that the patient may not want to be photographed. “Think of the consequences,” he says. “They send it out to 100 friends who put it on YouTube, and now it's out all over the place. You can get an injunction and get it removed, but by then it could be all over the world.”

Whether the photo ultimately ends up being discoverable or not, says Rice, posting them “is not the right thing to do.”

Posting pictures of ED patients, Rice says, should be strictly avoided due to “confidentiality, professional norms, and risks of disclosure that may easily

go beyond the usual professional communication channels.”

Identifiable Patients

Unfortunately, there have been cases around the country of ED staff members posting photos of patients, says **Corey M. Slovis, MD**, professor and chairman of the Department of Emergency Medicine at Vanderbilt University Medical Center in Nashville, TN.

“Photos have been posted where one can clearly identify the individual in the photo, even though an amateurish attempt has been made to obscure the person’s identity,” he says. “I would be very surprised if there were not lawsuits relating to this already in the legal system.”

In some cases, he notes, parents have successfully sued ED physicians and hospitals for alleging child abuse, even when statutes provide immunity. If an ED physician’s Facebook page contained a photo of an allegedly abused child, or referred to seeing a child who had allegedly been abused, when, in fact, abuse hadn’t occurred, says Slovis, and the patient or family’s identity could be ascertained from that electronic transmission, either directly or indirectly, “that physician is, of course, liable.”

As for camera pictures taken by others, Slovis says that no one should be in the room except individuals that the patient has requested be present or members of the health-care team. “And no one on the health-care team should be transmitting any information about a patient that is not for the medical record,” he says.

What the patient’s visitors do is somewhat out of the ED’s control, acknowledges Slovis, but he recommends that a policy be in place regarding use of camera phones. Vanderbilt’s ED policy states that pictures of patients, regardless of whether they are taken by a high-resolution or cell-phone camera, may only be secured after a release of information has been signed and witnessed.

“Our only exception is that we videotape our Level 1 Trauma Center resuscitations under state stature-protected laws. Those are used only in our Trauma-Emergency Medicine conference,” says Slovis. No other photographs are permitted within the ED unless the patient has signed a form stating that the ED can use the photograph or electronic image, he says.

“Many patients are quite willing to do this, as long as it’s for medical education,” adds Slovis. Slovis says that posting pictures of patients is a clear violation of their privacy and should never be done.

“The releases that patients sign invariably have verbiage for medical education,” he says. “Their understanding is that this is potentially for use in a textbook, not, ‘Can I take your picture and show it to the world?’”

Slovis notes that until fairly recently, no strict policies existed on hand-hygiene practices either. “One didn’t need cell-phone camera policies 10 years ago. Now, some people have two or three phones on their bodies at all times,” he says. “It is incumbent on all hospitals to deal with potential problems, and this is a potential problem.” ■

Sources

For more information, contact:

- **Michael Blaivas, MD, RDMS**, Vice President, Emergency Ultrasound Consultants, Bear, DE. Phone: (302) 832-9054. E-mail: mike@blaivas.org.
- **Matthew Rice, MD, JD, FACEP**, Gig Harbor, WA. Phone: (206) 790-5371. E-mail: mricemd@gmail.com.
- **Corey M. Slovis, MD**, Professor and Chairman, Department of Emergency Medicine, Vanderbilt University Medical Center, Nashville, TN. Phone: (615) 936-1315. E-mail: corey.slovis@Vanderbilt.edu.
- **William Sullivan, DO, JD**, Frankfort, IL. Phone: (708) 323-1015. E-mail: wps013@gmail.com.

ED Patient’s Pic Posted? HIPAA Violation Possible

Corey M. Slovis, MD, professor and chairman of the Department of Emergency Medicine at Vanderbilt University Medical Center in Nashville, says to remember that requirements of the Health Insurance Portability and Accountability Act (HIPAA) apply not only to words, but also to images.

“Whatever images you take and display can, and potentially will, be used against you in a lawsuit,” he says.

HIPAA laws, however, do not apply to de-identified patient information, says **William Sullivan, DO, JD, FACEP**, director of emergency services at St. Margaret’s Hospital in Spring Valley, IL, and a

Frankfort, IL-based practicing attorney.

Therefore, a picture of an X-ray, EKG, or ankle fracture may not violate HIPAA laws, says Sullivan, *if* these do not contain identifying information.

Even if there is no HIPAA violation, though, posting an X-ray of a patient may violate hospital policies, says Sullivan, or violate a physician's contract with a hospital or contract management group.

Privacy Violations

Any medical provider who posts a patient's photograph, or protected health information, without that patient's explicit permission may be liable for a HIPAA violation, warns Sullivan.

"If you choose to discuss a case on a social-media site, consider changing or deleting identifying information about the patient before doing so," he advises.

Slovis says that the issue of public postings about ED patients "touches on the sanctity of medical care and the privacy that all of us expect when we go to see a physician."

If an emergency physician (EP) takes pictures of a patient and posts them, or writes in detail about a patient, on a blog, twitter, or Facebook page, that patient is likely to feel angry, exposed, and indignant, says Slovis, even if his or her identity *wasn't* revealed. "Private is private. That is the beginning and the end of this," he says.

Online Discussions

It is not unheard of, says Michael Blaivas, MD, RDMS, professor of emergency medicine in the Department of Emergency Medicine at Northside Hospital Forsyth in Cumming, GA, for both ancillary staff and EPs to discuss ED patients online. "In these discussions, they may not only provide incorrect information, but also inappropriate information, not to mention violate privacy laws," he says.

Blaivas advises ED staff to avoid any discussion of work on public sites. "The alternative is constantly policing what people write and post," he says. "However, it may surprise some people what may get them in trouble. A lawyer cannot review everything."

Since it may not be realistic to put a stop to all potentially risky posts of pictures or other information, Blaivas recommends having written guidelines in place. "That will help the social-media folks among us who may not have a lawyer's eye for potential problem spots," he says.

An ED's guidelines should remind people not to post pictures of patients, descriptions of patients,

symptoms, exact dates, times, or X-rays, says Blaivas, along with a general description of proper public conduct to use when representing the hospital or facility.

Slovis says that regardless of cultural norms of communication, patient visits are private, according to both the Hippocratic Oath and accepted standards of care. These should not be discussed in *any* form, he says, other than how a visit might have made the ED physician feel personally.

Slovis says that a posting stating, "I saw a really sick patient today. It is depressing to see someone who isn't doing well," allows the ED physician to express his feelings with no way of associating this with a specific patient. "On the other hand, a posting referring to a 27-year-old graduate student with metastatic cancer who came feeling terrible allows people to make some associations," he says.

Above all, says Slovis, the ED physician's role is to "take care of patients, protect them, and do the best we can for them. Never expose them to the outside world for something they came to us in private for." ■

Reduce Legal Risks of "No-Show" ED Consultants

Decision needs to be made

Did an ear, nose and throat consultant refuse to come in for a critical-airway patient, a neurosurgeon for an intracranial bleed, or a hand surgeon for a patient with a tendon rupture? "Any of these instances could lead to poor or unsafe patient care and strained future relationships," says Chad Kessler, MD, FACEP, FAAEM, section chief of emergency medicine at Jesse Brown VA Hospital in Chicago.

Your hospital may have an appropriate on-call specialist who cannot be reached, fails to appear in a reasonable amount of time, or outright refuses to come to the ED. If this occurs, says William Sullivan, DO, JD, FACEP, director of emergency medicine at St. Margaret's Hospital in Spring Valley, IL, the emergency physician (EP) must have contingency plans. If there is more than one physician in the necessary specialty on staff, the EP can attempt to contact other specialists who are not on call, notes Sullivan.

"While those physicians are not obligated to help,

often they will do so in an emergency,” says Sullivan. “Involving the department chairman in such calls may also be a good idea.”

When patients need emergent evaluation by a specialist, Sullivan advises documenting when and how attempts were made to contact the specialist.

If multiple calls were made, documenting the timing of those calls will help to create a written record showing that reasonable attempts were made to contact the specialist or an alternate, says Sullivan and, if no specialist was available, that transfer was arranged in a timely manner.

EP Bears Responsibility

Ultimately, the EP bears the burden of responsibility for assuring that the patient receives necessary specialty care in a timely and appropriate manner, 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.

However, sometimes consultants do not respond appropriately. Here are Garlisi’s recommendations:

- If a consultant is necessary, but unavailable, then the EP should arrange for transfer of the patient to an appropriate facility.
- If the consultant is available but unwilling to examine the patient who needs hands-on specialty care, it behooves the EP to take additional necessary steps on the patient’s behalf.

“This might mean requesting hospital leadership to intervene, or transfer the patient to another institution,” says Garlisi.

Problem Worsening

“If anything, the problem is getting worse,” 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. “There are a lot of consultants getting upset because they are not getting paid. ED call panels are getting thinner. Where certain specialties were covered before, they may not be covered now.”

If there is no official call panel for a given specialty, says Lawrence, “you are really at the mercy of the person who you call, because they have no legal obligation whatsoever to show up.”

It’s possible that a court might find the hospital liable because they didn’t adequately reimburse physicians for being on the call panel, notes Lawrence.

“The EP is not personally liable in this case — it’s

almost always the hospital which is on the hook here,” he says. “The problem, though, is if the hospital is unhappy with the EP or the ED group, then their future at the hospital may be in jeopardy. So it’s in the EP’s interest to get these problems worked out ahead of time.”

Lawrence notes that some hospitals are switching to reimbursement plans where specialists are paid for being on the panel whether the specialist gets a case or not.

“Of course, hospital budgets are tight, and it may be difficult to come to an agreement with a certain specialty,” says Lawrence. “This, in turn, is a problem because of EMTALA [Emergency Medical Treatment and Labor Act] laws. These clearly state that the hospital has to stabilize a patient within the capabilities of the hospital.”

If a type of case is routinely treated at the hospital, this would be considered within the capabilities of the hospital, adds Lawrence, regardless of whether there is a specialist on the call panel. All of this means added legal risks for the EP, says Lawrence, who is “caught between the proverbial rock and hard spot.”

If the consultant is on the call panel, however, Lawrence says that you are on much firmer ethical and legal grounds to demand they come to the ED. This is where the relationship between the ED group and the medical staff becomes very important, he says.

“If they see you as just a glorified house staff, they are not going to treat you with the respect you deserve,” says Lawrence. “If you have a good relationship, and they understand your group is capable and your medical judgment can be trusted, then they are less likely to dismiss a call to come in.” ■

Sources

For more information, contact:

- **Chad Kessler, MD, FACEP, FAAEM**, Section Chief, Emergency Medicine, Jesse Brown VA Hospital, Chicago. Phone: (312) 569-6508. E-mail: chad.kessler@va.gov
- **Andrew Garlisi, MD, MPH, MBA, VAQSF**, University Hospitals Geauga Medical Center, Chardon, OH. Phone: (330) 656-9304. E-mail: garlisi@adelphia.net.
- **Jonathan D. Lawrence, MD, JD, FACEP**, Emergency Department, St. Mary Medical Center, Long Beach, CA. Phone: (562) 491-9090. E-mail: jonlawrence48@cox.net

If a Consultant Doesn't Show, What Can You Prove in Court?

Documentation could save the day

Michael Blaivas, MD, RDMS, professor of Emergency medicine in the Department of Emergency Medicine at Northside Hospital Forsyth in Cumming, GA, says he has reviewed multiple cases involving consultants refusing to come to the ED, with a bad outcome resulting. "Mostly, this means an unhappy patient, but in critically ill ones can mean a lawsuit," he says.

Recently, Blaivas consulted on a case where a patient needed a general surgeon, but he was busy at another hospital and never came in. "No transfer was made to another facility. The patient exsanguinated four hours later. The EP [emergency physician] is being sued."

If you end up in this unfortunate situation, Blaivas says being able to prove you did all you possibly could will make the case more defensible. "Even though people do not like documenting unpleasant things or difficulties in managing patients, it is critical to document," he says. "Showing how many times you paged the consultant will show that you were not just letting the patient die there."

That message is what the jury will hear from the plaintiff, warns Blaivas. Ideally, he says, the EP will have a dictation showing multiple calls, multiple consultants, the thought process, and communication with the family and patient.

"That goes a long way to dispel that horrible image created by the plaintiff's attorney of a patient just rotting in this horrible ED room, with no one caring that she or he is expiring in front of them," says Blaivas.

Don't Hesitate to Call

Blaivas says not to be afraid to make the decision that a consultant has had enough time and you need to call someone else or transfer the patient. "Getting hospital administration involved and subtly documenting this will also help," he says. "It may expedite consultant actions, bring on a faster response, and also get the hospital on your side, if possible."

Remember that you can be held liable for failing to request consultations when they are appropri-

ate, warns Debra J. Gradick, MD, FACEP, medical director of the ED at Avista Adventist Hospital in Louisville, CO, and vice president of operations at Serio Physician Management in Littleton, CO, as "this could be considered substandard care."

"If a particular consultant is difficult to deal with, and perhaps doesn't want to be bothered in the middle of the night, an appropriate consult may not be called just because the ED physician doesn't want to hear a barrage of complaints," says Gradick.

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, recommends taking the time to document completely the urgent consultation process, including the following:

- **The time the consultant is paged;**
- **The time of the second page, if the consultant does not respond in a timely manner;**
- **Steps taken by the emergency physician if the consultant did not respond to pages, including notifying the administrator on call or a back-up consultant, or transferring the patient to another facility;**
- **The time when the phone consultation actually occurred;**
- **The exact nature of the consultant's response or recommendation;**
- **If applicable, the estimated time of arrival of consultant to the ED; and**
- **The actual time of arrival of the consultant.**

Document carefully, as opposed to angrily, adds Blaivas. "Just think of how you would explain yourself later to a friend, and foe, especially a critical attorney or the consultant," he says. "Be polite in your wording, if dictating, but also do not hang yourself and make your case ahead of time."

He Said/She Said

Michael M. Wilson, MD, JD, principal malpractice attorney at Michael M. Wilson & Associates in Washington, DC, says that when an ED patient needs care emergently from a subspecialist, there will be times when the ED physician attempts to contact the specialist and the specialist doesn't return the calls, or he or she refuses to come in to the hospital, or the consultant agrees to come in and then doesn't show.

"In the meanwhile, the patient is still under the care of the ED physician," says Wilson. "In many of these scenarios, the end result will be a bad outcome."

Typically, says Wilson, this results in a lawsuit against the ED, the EP, and the subspecialist who never showed up. “Then it will be left to the ED physician and the consultant to duke it out,” says Wilson.

The EP will claim he or she contacted the consultant and the consultant never showed up, says Wilson, while the consultant will testify that the EP never clearly explained the facts that would indicate that the patient needed emergent care.

Wilson says to take all possible measures to obtain the best possible care for the patient. “If the outcome is favorable, there will not be a lawsuit even if the documentation is poor,” he says.

On the other hand, if the patient outcome is terrible, a lawsuit will be forthcoming even if the EP’s documentation is impeccable.

Since it’s inevitable that specialists will be sick, unavailable, or even refuse to come to the ED in the middle of the night, Wilson recommends having a second consultant available in each of the major specialties.

“Have a plan to transfer the patient to another facility if the specialist is unavailable,” says Wilson. “Try to have a hospital problem solver on call to contact in the event of such an unavailable consultant, and then call that person.”

Wilson says to first develop a well-reasoned plan of action, then document that plan and the actions made pursuant to the plan. “If calls are made, state who made the call, who you talked to, what was said, and the time of the call,” says Wilson. “Too often the note just says, ‘Neurosurgery contacted.’”

This does not provide the critical information that will be required to defend you when the neurosurgeon doesn’t show up, says Wilson.

“If you can demonstrate to the jury that you were doing what a well-intentioned and caring EP would do under the circumstances, then the jury might decide to hold the hospital and specialist responsible and absolve you from responsibility,” says Wilson. “But good documentation can never make up for a bad outcome, particularly one that could have been prevented.”

Stick to the Facts

If a consultant refuses to come in, you’ll need to go up the chain of command, 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, starting with the department chair and then the chief of staff if you don’t get results.

If this doesn’t work, he says you can contact other consultants who are not on call to come in, go to the on-call hospital administrator and ask him or her to guarantee reimbursement, or try to get the patient transferred to a higher level of care. “Any steps taken have to be meticulously documented, while at the same time you are trying to manage a critically ill patient,” he says. “This is no easy task.”

Document not only whom you talked to, but when you spoke to him or her and what the result of the conversation was, says Lawrence.

“This will lay out a road map to at least defend what you did,” he says. “If it ever came to a trial and a jury saw a list of all the steps you took, it’s unlikely, though not impossible, that they would find you liable for the patient’s outcome. What you hope to do is extricate yourself as soon as possible. And that kind of documentation will get you there.”

Be factual and not inflammatory, such as saying the doctor “declined” to come in instead of using the word “refused,” says Lawrence. “Think about how this will appear in front of either a hospital disciplinary hearing, or in front of a courtroom, when you write it,” he says. ■

Sources

For more information, contact:

- **Debra J. Gradick, MD, FACEP**, Medical Director, Emergency Department, Avista Adventist Hospital, Louisville, CO. Phone: (303) 673-1003. E-mail: debragradick@centura.org.
- **Michael M. Wilson, MD, JD**, Wilson & Associates, Washington, DC. Phone: (202) 223-4488. E-mail: wilson@wilsonlaw.com.

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. ■

CNE/CME QUESTIONS

11. Which of the following is recommended to reduce liability risks regarding cell-phone camera use in the ED?
- A. Signage should not be posted stating that audiotaping or videotaping is not permitted in the ED.
 - B. It makes no difference whether signs are posted in the ED that photos are not permitted, because the argument cannot be made that the photo was illegally obtained and should not be admissible.
 - C. No legal risks are posed by a family member photographing a patient, since if a family member is the one who took a picture of a patient, the photo is not discoverable.
 - D. An ED's policy should state that pictures of patients may only be secured after a release of information has been signed and witnessed.
12. Which of the following is true regarding violations of the Health Insurance Portability and Accountability Act (HIPAA)?
- A. HIPAA applies even to de-identified patient information.
 - B. Requirements apply only to words, not images.
 - C. A picture of an X-ray may violate HIPAA, even if it does not contain identifying information.
 - D. To avoid violations, an ED's guidelines should remind people not to post pictures, symptoms, descriptions, or X-rays of patients.
13. Which of the following is recommended to reduce liability risks when an EP has difficulty obtaining a specialist consult for a patient who needs an emergent evaluation?
- A. If there is more than one physician in the necessary specialty on staff, do not attempt to contact other specialists unless they are on the call panel.
 - B. When patients need emergent evaluation by a specialist, document when and how attempts were made to contact the specialist.
 - C. If multiple calls were made, avoid documenting the timing of those calls.
 - D. When documenting a consultant's failure to come to the ED, use the word "refused" instead of "declined."

Answers: 11. D; 12. D; 13. B

EDITORIAL ADVISORY BOARD

EDITOR-IN-CHIEF

Larry B. Mellick, MD, MS, FAAP, FACEP
Professor of Emergency Medicine, Professor of Pediatrics,
Department of Emergency Medicine,
Medical College of Georgia, Augusta

EDITORIAL BOARD

Kay Ball, RN, PhD, CNOR,
FAAN

Consultant/Educator,
K&D Medical Inc.,
Lewis Center, OH

Sue A. Behrens, APRN, BC
Director of Emergency/ ECU/
Trauma Services, OSF Saint
Francis Medical Center,
Peoria, IL

Robert A. Bitterman, MD JD
FACEP

President, Bitterman Health
Law Consulting Group, Inc.
Harbor Springs, MI

Eric T. Boie, MD, FAAEM
Vice Chair and Clinical
Practice Chair, Department of
Emergency Medicine, Mayo
Clinic; Assistant Professor of
Emergency Medicine, Mayo
Graduate School of Medicine,
Rochester, MN

Theresa Rodier Finerty, MS,
RN, CNA, BC
Executive Director,
OSF Aviation, LLC,
Peoria, IL

James Hubler, MD, JD, FCLM,
FAAEM, FACEP
Clinical Assistant Professor
of Surgery, Department
of Emergency Medicine,
University of Illinois College of
Medicine at Peoria; OSF Saint
Francis Medical Center,
Peoria, IL

Jonathan D. Lawrence, MD,
JD, FACEP

Emergency Physician, St.
Mary Medical Center,
Long Beach, CA

Assistant Professor of
Medicine, Department of
Emergency Medicine,
Harbor/UCLA Medical Center,
Torrance, CA

J. Tucker Montgomery, MD,
JD, FCLM
Attorney, Knoxville, TN

Gregory P. Moore MD, JD
Attending Physician,
Emergency Medicine
Residency, Madigan Army
Medical Center,
Tacoma, WA

Richard J. Pawl, MD, JD,
FACEP
Associate Professor of
Emergency Medicine
Medical College of Georgia,
Augusta

William Sullivan, DO, JD,
FACEP, FCLM
Director of Emergency
Services, St. Margaret's
Hospital, Spring Valley,
IL; Clinical Instructor,
Department of Emergency
Medicine Midwestern
University, Downers
Grove, IL; Clinical Assistant
Professor, Department
of Emergency Medicine,
University of Illinois,
Chicago; Sullivan Law
Office, Frankfort, IL

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. ■