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Michigan's non-economic damages cap ruled constitutional; the cap applies to EMTALA claims

The federal appellate court also holds that state law peer review privileges do not apply to EMTALA actions filed in federal court.

By Robert A. Bitterman,MD, JD, FACEP, Contributing Editor

The case of *Smith v. Botsford General Hospital*[1] contains a number of fascinating aspects and lessons for hospital-based emergency providers.

Kelly Smith was a 33-year-old 600-pound man injured in a high-speed SUV rollover accident. Emergency medical services took him to Botsford General Hospital in Detroit, Michigan. The emergency physician diagnosed and treated Smith for an open comminuted left femur fracture. Botsford then transferred Smith, stating the patient's size precluded its ability to assess the patient with a CT scan and its operating room lacked the facilities to hold the patient's weight if surgery became necessary. During the ambulance ride, Smith's condition deteriorated further, and 21 minutes into the transfer he died from extensive blood loss.[1]

Smith's family sued Botsford in federal district court, claiming the hospital transferred Smith before stabilizing his emergency medical condition in violation of federal law, EMTALA.[2] Botsford admitted that the patient had an emergency medical condition, but asserted it had stabilized the patient prior to transfer and that the patient's death could be attributed to his morbid obesity and his alcohol and cocaine use.

Plaintiffs sued the hospital under EMTALA, rather than under ordinary state malpractice law, intentionally to circumvent Michigan's cap on non-economic damages.

The Evidence

Interestingly, since the only theory of liability was the EMTALA 'failure to stabilize' claim, the court would not allow any 'standard of care' evidence or questioning of the expert witnesses. For example, the plaintiff could not assert that the hospital should have given fluids at more than 100cc/hour, or when Smith's blood

pressure was mid 70s that blood should have been administered prior to transfer. What the physicians and hospital *should have done* is a standard-of-care issue, not an EMTALA stabilization issue. Instead, the experts could only explain the nature of the patient's injuries, interpret the clinical and laboratory data, and then opine to the jury on whether the patient was stable, as that term is *defined by law*, at the time of transfer. Under EMTALA to 'stabilize' means:

> *"with respect to an emergency medical condition . . . to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility."*[3]

In other words, was it likely, within reasonable medical probability, that the patient would arrive safely at the receiving hospital, or was it foreseeable that the patient would materially deteriorate in route?

The plaintiff contended that due to the amount of blood loss from an open comminuted femur fracture in a restless patient thrashing around for 3 hours in the ED, an tracheal tube in the right main stem bronchus, a Hbg level of 11.6 with a base deficit in a major trauma patient with known sleep apnea, the hemodynamic ramifications of tachycardia in the 130s, respiratory rates in the low 30s, blood pressure dropping in the low 70s for more than 2 hours and entirely unobtainable at the time of transfer, pale and 'extremely cool extremities', zero urine output for the entire ED stay, and EMS's concerns at the time of transport (*see below*) … it was entirely *foreseeable*, certainly within reasonable medical probability, that the patient would materially deteriorate during a 30-minute transfer.

The hospital countered that Smith had been stable and that it had fully expected he would arrive safely at the receiving hospital and that his alcohol (level was 110 mg/dL) and cocaine use contributed to his unexpected demise. (The autopsy found evidence of cocaine use, but also determined that the sole cause of death was hemorrhagic shock due to blood loss from the femur fractures.)

The plaintiffs questioned why the hospital, if it thought the patient was so stable, didn't give the patient any intravenous pain medications? Botsford claimed that it didn't administer medicine to control the patient's pain or agitation out of concern for his airway (though the patient already had a secure airway due to the tracheostomy tube in place to treat his sleep apnea).

Expert Testimony

Defendant's emergency medicine expert testified that Smith's chronic alcoholism contributed to his death, and that his opinion stemmed from conversations with one of Smith's deceased relatives, who had once consulted the physician regarding Smith's drinking problems. However, neither the expert, who had a great deal of malpractice testimony experience, nor the defense counsel disclosed the information until it came out on cross-examination by the plaintiff, and they conceded that outside this personal knowledge no other admitted evidence supported the expert's opinion concerning Smith's chronic alcoholism.[1]

The federal rules of evidence impose an affirmative obligation on all parties to disclose in advance of trial "the data or other information considered by [its expert] in forming his opinions."[4] Furthermore, experts are not supposed to use personal knowledge to form their opinions, but instead rely on the record and their training, experience, and expertise alone. Consequentially, the judge excluded the witness's entire testimony, leaving the hospital without an emergency physician expert to support its case.[1]

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Botsford complained that exclusion of its emergency expert was highly prejudicial to its case and fundamentally unfair. However, the court stated that striking the expert's testimony was "not fundamentally unfair" to Botsford, given that the federal rules of civil procedure, authorizes—indeed, directs—exclusion of the witness as the primary sanction for such a disclosure violation.[5] The court could have imposed a less stringent sanction, but declined due to the nature of the violation and its conclusion that the expert's testimony was "largely cumulative" of the defense's toxicology expert.[1]

Admissibility of Evidence

Findings of Government Investigations. Plaintiffs reported Botsford to the Centers for Medicare and Medicaid (CMS), the federal agency charged with the regulatory enforcement of EMTALA, with the intent to later obtain the government's investigation materials to use to their advantage in preparation for trial or in settlement negotiations. At the conclusion of CMS's investigation, its findings become public information available via the Freedom of Information Act.[6] CMS determined that the hospital did not violate EMTALA, therefore, in a turnabout the hospital attempted to introduce the government's findings into evidence at trial. The court disallowed the evidence, however, declaring it 'untrustworthy' as defined by the federal evidence rules[7] for a number of reasons, such as the plaintiffs were not a party to the hearing or able to cross-examine witnesses or the physician reviewer did not have all the relevant data at the time of his review.

Typically, it's the plaintiffs who want to introduce CMS reports that a hospital violated EMTALA to sway the jury with an 'official' government judgment against the hospital. The courts usually do not allow use of CMS's finding against hospitals at trial because there is no due process in CMS's proceeding. The hospitals really can't challenge CMS or they loose their Medicare and Medicaid funding for years while the process unfolds. Hospitals, therefore, simply write a 'Plan of Correction' to come into compliance with the law, as mandated by CMS, to avoid bankruptcy and get CMS 'off its back.' (But an Alabama district court recently did allow the plaintiff to use CMS's report at trial, *Henderson v. Medical Center Enterprise*, 2006 U.S. Dist. LEXIS 57898.)

Peer Review Materials or Incident Reports. Plaintiffs subpoenaed an EMS incident report that was written immediately after Smith died. The report was extremely damaging to the hospital's case. For example, it noted that the patient kept saying 'I can't breathe… I can't breath.' and that he was uncooperative, agitated, pale, cool, and that one of the two IV units (D5 and water) wasn't running. At one point, the medic asked the physician for the second time if he believed the patient should be transported. Furthermore, the medics were instructed to delay transporting the patient while they waited 15 minutes for the patient's x-rays to be copied. The medic wrote that during this time that she repeatedly told the emergency physician and nursing staff about uncontrolled hemorrhaging from the wound, uncontrolled movement of the fracture sites, and expressed concern that no blood pressure could be obtained and that no blood was being administered. She even asked the physician if there was any way he could stop the bleeding or sedate Smith to stop his agitation or the movement of his fractured leg. The physician's alleged response was 'There is not much I can do at this time; he needs to get to the [accepting hospital].'

Both the EMS agency and Botsford argued vigorously that the report was inadmissible and privileged as 'peer review' material under Michigan law.[8] However, the court determined, consistent with federal common law precedent, that state law privileges do not apply in cases brought under federal law, such as EMTALA,[9] and allowed the report into evidence.

The court also noted that "the incident report was made by a neutral party who, presumably, was objective in stating Smith's condition", and that "since the objective reasonableness of Smith's transfer by Botsford is the crux of this case, production of the incident report is particularly relevant."[10] Interestingly, the medics were later sued by the plaintiffs in state court for their role in Smith's care, most remarkably for not refusing to transport Smith based on what they knew of his condition at that time.

Jury Verdict

After 15 days of trial, the jury sided with Smith's family, deciding that Smith was not stable, as defined by EMTALA, at the time of transfer. The jury returned a verdict for $35,000 in economic damages and *$5,000,000* in *non-economic damages* for Smith's pain and suffering and for the loss of love and companionship to his next of kin.

Michigan had enacted tort reform, which placed a cap on non-economic damages for medical malpractice at $359,000.[11] However, the judge ruled that an EMTALA claim was not a medical malpractice action, and therefore Michigan's non-economic damages cap did not apply.

With a mere $4,641,000 at stake, Botsford naturally appealed the judge's ruling regarding applicability of the cap to damages recovered under EMTALA.[1]

Appeal to the Federal Sixth Circuit Court of Appeals

The Sixth Circuit needed to determine whether the plaintiff's EMTALA failure-to-stabilize claim "sounds in medical malpractice"; i.e., would it constitute a malpractice claim or an ordinary negligence claim under Michigan law (ordinary negligence claims do not come under the cap law).[2] The court needed to make three determinations: (1) whether the claim is being brought against someone who, or an entity that, is capable of malpractice; (2) whether the claim pertains to an action that occurred within the course of a professional relationship'; and (3) whether the claim raises questions of medical judgment beyond the realm of common knowledge and experience.[1]

Clearly Botsford was an entity capable of malpractice and that the claim occurred within the course of a professional relationship. Therefore, the court only needed to decide if the claim raised questions of medical judgment beyond the realm of common knowledge and experience.

Smith argued that the EMTALA claim was not a malpractice action on the ground that it did not raise questions of "medical judgment" because violation of EMTALA requires no breach of the professional standard of care — the hallmark of traditional malpractice claims. However, the court identified the need for expert testimony as the key distinguishing feature of claims involving medical judgment:

> *"If the reasonableness of the health care professionals' action can be evaluated by lay jurors, on the basis of their common knowledge and experience, it is ordinary negligence. If, on the other hand, the reasonableness of the action can be evaluated by a jury only after having been presented the standards of care pertaining to the medical issue before the jury explained by experts, a medical malpractice claim is involved."*[12]

On this basis, the Sixth Circuit had no difficulty holding that EMTALA's failure-to-stabilize claim would constitute a malpractice action under Michigan law. It decided that "compliance with EMTALA's stabilization requirements entails medical judgment (assuring "*within reasonable medical probability*, that no material deterioration of the condition is likely"), which can be understood, as this case exemplifies, only through expert testimony."[13]

Thus, the court concluded that Michigan's cap on malpractice damages limited plaintiff's non-economic damages to $359,000, provided the cap survived a constitutional challenge.

Michigan's Non-Economic Damages Cap

Plaintiff's last argument was that Michigan's cap law[14] violates the *Seventh Amendment Right to Jury Trial* and the *Equal Protection Clause*. The court quickly rejected both assertions, agreeing with other courts that had found medical malpractice caps constitutional.[15] It summarily dismissed the Seventh Amendment argument by noting that "The jury's role as factfinder is to determine the extent of a plaintiff's injuries, not to determine the legal consequences of its factual findings"; and "If a legislature may completely abolish a cause of action without violating the right of trial by jury, we think it permissibly may limit damages recoverable for a cause of action as well."[16,17]

Plaintiff's equal-protection challenge fared no better. The court determined that a limitation on a common law measure of recovery is a classic example of an economic regulation, subject only to limited 'rational basis' review, and does not violate any fundamental right. Under a rational basis standard, a statute is valid if it 'rationally furthers a legitimate governmental interest.'[18] It also noted that the statute deserves 'a strong presumption of validity,' and should be upheld it 'if there is any reasonably conceivable state of facts that could provide a rational basis for the classification.'[1,19]

> *"The purpose of the damages limitation was to control increases in health care costs by reducing the liability of medical care providers, thereby reducing malpractice insurance premiums, a large component of health care costs. Controlling health care costs is a legitimate governmental purpose. By limiting at least one component of health care costs, the non-economic damages limitation is rationally related to its intended purpose."*[19]

Thus, plaintiff's equal-protection argument failed. The court held the Michigan's non-economic damages cap survived rational-basis scrutiny and serves a legitimate state interest in controlling health care costs. (Compare the reasoning of the Michigan courts and the Sixth Circuit Court of Appeals on the constitutionality of non-economic damages caps with that of the Wisconsin Supreme Court as discussed in the September issue of *ED Legal Letter*.)

The Sixth Circuit affirmed the judgment in all respects but remanded the case to the original district court for reduction of the non-economic damages to $359,000 in accordance with Michigan law.[20]

Final Judgment by District Court – July 2006

The lower court was to simply enter judgment according to the Sixth Circuit's direction, but the

plaintiff tried one last maneuver to increase the amount of damages recoverable: *Smith* asked the court to apply a special "higher cap" available under Michigan's cap law, and revise the judgment of non-economic damages up to $641,000, instead of $359,000.[14,21]

Any one of three exceptions to Michigan's $359,000 cap on non-economic damages can boost the award to the higher amount.[14] *Smith* argued that the exception under Mich. Comp. Law. §600.1483(1)(b) applied, which states:

> *"(b) The plaintiff has permanently impaired cognitive capacity rendering him or her incapable of making independent, responsible life decisions and permanently incapable of independently performing the activities of normal, daily living."*[14]

Since death tends to cause these things, *Smith* pleaded for damages under the higher cap. However, the court found that *Smith* erred by not raising the issue at the proper time during the legal proceedings and therefore waived her rights to invoke the higher cap.[21]

Therefore, the saga ended with Smith awarded $35,000 in economic damages and $359,000 in non-economic damages. ■

References

1. *Smith v. Botsford General Hospital*, 419 F.3d 513 (6th Cir. 2005).
2. Smith sued under EMTALA, 42 U.S.C. §1395dd, for damages available under Michigan's Wrongful Death Act, Mich. Comp. Laws §600.2922.
3. 42 U.S.C. §1395dd(e)(3)(A).
4. Fed. R. of Civ. P. 26(a)(2)(B).
5. Fed. R. Civ. P. 37 authorizes exclusion of an expert witness for a Fed. R. Civ. P. 26 violation. See *Roberts v. Galen of Virginia, Inc*., 325 F.3d 776, 782 (6th Cir. 2003).
6. 5 U.S.C. 532.
7. Fed. R. of Evid. 803(8).
8. Mich. Comp. Laws, Section 333.20175(6).
9. Fed. R. Evid. 501; and see for example *Burrows v. Red Bud Community Hospital District*, 187 F.R.D. 606 (N.D. Cal. 1998).
10. *Smith v. Botsford General Hospital*, Case No. 00-71459, Memorandum and Orders of U.S. District Court Judge Avern Cohn, September 28, 2000.
11. Mich. Comp. Laws §600.1483. The statute actually caps damages at $280,000, but the number changes as a result of yearly inflation adjustments. This case occurred in 2003, and the adjustment applicable then capped damages at $359,000.
12. See *Bryant v. Oakpointe Villa Nursing Ctr*., 684 N.W.2d 864 (Mich. 2004).
13. *Smith v. Botsford*, 419 F.3d 513 (6th Cir. 2005), quoting 42 U.S.C. §1395dd(e)(3)(A); (emphasis added).
14. Mich. Comp. Laws §600.1483. The statute actually caps non-economic damages at $280,000.00 but this number changes as a result of yearly adjustment. The 2003 adjustment, applicable at the time of trial, capped damages at $359,000.
15. Joining the majority of courts addressing the issue in finding that EMTALA's incorporation of state law extends to caps on damages. E.g., *Power v. Arlington Hosp. Assoc*., 42 F.3d 851, 862 (4th Cir. 1994); *Valencia v. St. Francis Hosp. & Health Ctr.*, 03-cv-0252-LJM-WTL, 2004 U.S. Dist. LEXIS 7929, at *7 (S.D. Ind. Mar. 1, 2004) (agreeing with Power and listing cases); *Barris v. County of Los Angeles*, 972 P.2d 966, 973 (Cal. 1999) (same); *Hughes v. PeaceHealth*, No. A123782 (Or. Ct. Appropriate. Mar. 15, 2006). But see *Cooper v. Gulf Breeze Hosp., Inc*., 839 F. Supp. 1538, 1542-43 (N.D. Fla. 1993) (discussing the differences between medical malpractice and EMTALA and declining to apply state procedural requirements applicable to malpractice claims), and *Jeff v. Universal Health Services, Inc.*, No.04-1507 (E.D. La. July 27, 2005) 2005 U.S. Dist. LEXIS 17819.
16. *Smith v. Botsford,* 419 F.3d 513 (6th Cir. 2005), quoting *Boyd v. Bulala*, 877 F.2d 1191 (4th Cir. 1989).
17. See also *Phillips v. Mirac, Inc*., 685 N.W.2d 174, 180 (Mich. 2004), echoing the reasoning in Boyd and finding a cap on damages lawful under the Michigan constitution's analogous jury right.
18. *LensCrafters, Inc. v. Robinson*, 403 F.3d 798, 806 (6th Cir. 2005).
19. Quoting *Zdrojewski v. Murphy*, 657 N.W.2d 721, 739 (Mich. Ct. App. 2002), a Michigan appellate court addressing an equal-protection challenge to Mich. Comp. Laws §600.1483 which concluded that the statute satisfies the rational basis test.
20. *Smith v. Botsford*, 419 F.3d 513 (6th Cir. 2005). Smith filed a petition for rehearing en banc, which was denied on November 22, 2005. The U.S. Supreme Court denied certiorari.
21. *Smith v. Botsford General Hospital*, 2006 U.S. Dist. LEXIS 48154 (July 17, 2006)

The biggest liability risks in the ED during disasters

Plan must be well-practiced to withstand allegations of poor care

By Staci Kusterbeck, Contributing Editor

To avoid legal problems for your ED during disasters, it's not enough to have a good plan in place—you must ensure that staff are familiar with procedures and follow them.

"If a health care facility doesn't have policies and procedures, then it could be considered negligent," says **Cheryl S. Camin**, an attorney with the Dallas office of the national law firm Fulbright & Jaworski. Camin works closely with health care providers in legal compliance matters. "But the policies and procedures can't be something that a health care provider

—continued on page 117

SPECIAL REPORT

Striking the Balance: HIPAA & the ED

by Meghan Cosgrove, Esq., Centers for Medicare and Medicaid Services[1]

Editor's note: *This article begins a two-part series on the legal basis and interpretation for several comomon HIPAA issues that challenge ED staff members.*

The public nature and crisis setting of an emergency department (ED) makes the protection of confidential health information under the Health Insurance Portability and Accountability Act (HIPAA) particularly challenging. This challenge requires a balance between the need for effective communication and the need to safeguard voluminous amounts of written, oral, and electronic interchanges.

Several factors unique to emergency care place HIPAA compliance and ED operations in tension and thus warrant particular consideration. HIPAA compliance is critical. As a society, Americans are more protective of their privacy than ever.[2] In a 2005 study by the California HealthCare Foundation, 67% of the patients surveyed were highly concerned about the privacy of their health information, yet remained unaware of their rights in this area.[3] Increasing reli-ance on technology, lack of adequate contingency plans and numerous high-profile data breaches speak to the validity of those concerns. Most industries, including education, defense, finance and health care have been the topic of articles that highlight the negligent receipt, storage and access to identifiable personal data, including the recent theft of computer disks containing information on 26.5 million veterans.[4]

However, the delivery of emergency care is often constrained by factors that hinder communication: time pressures, multiple providers treating one patient, and the hectic, noisy atmosphere that makes it a locus ill-suited for effective communication and comprehension. Environmental factors include the need for rapid decision making, the public function of a setting with 24-hour access, patient overcrowding, and the steady stream of visitors, law enforcement, and staff. EDs are also faced with a diverse patient population including foreign visitors, those with impaired cognitive functions, and those who present age, disability, language, cultural and literacy challenges. Finally, the sensitive clinical issues addressed in this setting include conditions such as mental illness, substance abuse, domestic violence, and sexually transmitted diseases. Adding the regulatory burden of HIPAA into this mix makes it difficult to balance these competing realities and create an environment that fosters the coexistence of free-flowing communication and patient privacy.

HIPAA Overview

HIPAA was signed into law on August 21, 1996. This major health reform initiative dealt with several areas of health care reform. This article focuses on one section that has captivated the attention of the health care industry: Title II, Subtitle F, known as *Administrative Simplification*.[5] Title II deals with the protection of identifiable health information through privacy and security mechanisms as well as tools to increase electronic efficiency such as standard transaction and code sets.[6]

Perhaps the most robust of the administrative simplification provisions is the *Privacy Rule*, weighing in at 369 pages. Beyond the pulp, however, are regulations and guidance that set a minimum federal floor of protection for uses and disclosures of what is termed *protected health information* or PHI.[7] *The Privacy Rule* sets out the rights of an individual to control the use and disclosure by "covered entities" of their own written, oral, or electronic PHI.[8] Covered entities include health care providers (those that furnish, bill, or receive payment for health care in the normal course of business) that conduct certain transactions electronically, a health care clearinghouse, or a health plan.[9] The Office for Civil Rights (OCR), within the U.S. Department of Health and Human Services (DHHS), is charged with its enforcement.[10]

A covered entity is required to disclose PHI in two situations: 1) when an individual specifically requests access to his or her PHI, or 2) when the DHHS seeks access for compliance or enforcement reasons.[11] A covered entity is permitted to use and disclose PHI *without* an individual's authorization in six limited situations:[12]

- To the individual who is the subject of the PHI
- For treatment, payment and health care operations
- Uses and disclosures that are incident to a permissible disclosure where reasonable safeguards were put into practice and the PHI disclosed was limited to the minimum necessary
- Uses and disclosures where an authorization is required
- Uses and disclosures where it is required that the individual have

an opportunity to agree or object

- Uses and disclosures where it is not required that the individual have an opportunity to agree or object. These include 12 national public interest and benefit activities[13] as part of a limited data set used for research, health care operations and public health activities where certain identifiers have been removed and the recipient promises to use specific safeguards in a data use agreement, for fundraising, and for underwriting purposes.

Uses and disclosures under the Privacy Rule must also be limited to the "minimum necessary" to accomplish the purpose of the disclosure.[14] Certain disclosures are not limited by the "minimum necessary" requirement, including disclosures to a health care provider for treatment, to the individual patient, or those required by other laws.[15]

The Security Rule became effective on April 21, 2005, for covered entities and only recently (April 21, 2006) for small health plans.[16] It focuses on internal and external threats to the storage, integrity, access, and transmission of electronic data and will be discussed in a future issue.

The goal of HIPAA was to set a minimum "federal floor" of privacy protection for individually identifiable health information. State laws that are contrary to any provision of HIPAA are preempted.[17] If the state law is not contrary to HIPAA, relates to the privacy of individually identifiable health information, and provides greater privacy protections than HIPAA, then the state law is controlling.[18]

Given the breadth of circumstances that EDs are confronted with that make the unusual and unexpected more common than in other settings it is impossible to address every possible HIPAA dilemma. In the end, the standard of "reasonableness" and a balancing of priorities will dictate the appropriate action.[19]

Caregiver Discussions

HIPAA's biggest impact is felt in the daily written, ora,l and electronic communications that are necessary to admit and treat patients in an ED.

Physicians, nurses and other clinical staff may breach patient confidentiality when caregiving discussions are overheard by other individuals. In a 1999 survey of ED patients, 36% reported overhearing a conversation in an adjacent room or hallway.[20] Surprisingly, this study also revealed that patients placed in walled rooms overheard only 5% less than patients in curtained areas.[21] The debate of walls versus curtains brings the issue of ED design as well as its associated costs to the forefront. Patient safety argues for open rooms to allow maximum visibility of all patients in the ED to guard against adverse events. However, respect for privacy argues for the limited visibility of walled rooms that provide more physical privacy and may provide more auditory privacy.

The location of the conversation overheard reveals a substantial difference between walls and curtains. Patients in walled rooms were 40% less likely to overhear a conversation taking place in the room next door than those in curtained areas.[22] Patients in curtained rooms, however, were 30% less likely to overhear conversations taking place at the nursing station and 10% less likely to overhear a hallway conversation than their walled counterparts.[23] This seems to suggest that the use of walls versus curtains is not as important as safeguarding the locations where conversations start.

Lack of background noise or soundproofing materials also can make it easier for conversations to be overheard. Sound-absorbing walls, floors, and ceilings help with the issue of auditory privacy. In addition, the use of music and television should not be underestimated in their ability to create more auditory privacy.[24] Background music and television can serve as a distracting noise and enhance the privacy of conversations for individuals located within close proximity to one another.[25] Some advocates even suggest the use of white noise machines in the ED to absorb sound and make conversations more difficult to overhear. The concern with any of these sound-absorbing techniques, however, is that they may also affect the clarity necessary for clinical communication.[26]

The ability to create and maintain physical and auditory privacy in the ED is a difficult task at best. Walls and curtains can go only so far in providing a sense of privacy amidst the endemic crowding of EDs. In reality, physicians and staff must implement a culture of privacy that extends beyond these safeguards through a constant awareness of the location, volume, and content of their conversations.

Medical Record Issues

Compared with physical and auditory privacy, the protection of written and electronic medical records may be easier to control in some ways. Written records are usually kept in a public workspace in order for them to be readily available. Every effort should be made to store these records in a single secure location where they are returned when not in active use.[27] The front of hard copy charts should be covered to further guard against prying eyes.[28]

The technology surrounding elec-

tronic medical records (EMRs) makes them better equipped than written medical records to limit access to PHI. While EMRs provide institutions and staff with a sense of greater control over the security and integrity of their medical records, patients may not be convinced. A recent patient survey on EMRs found that 70% of Americans are concerned that a data breach could cause their health information to be disclosed, while 69% think that EMRs may lead to their health information being shared without their consent.[29] Precautions surrounding EMRs include locating monitors in low traffic areas, the utilization of screen savers, automatic log-out features, and the use of role-based access (i.e., limiting screen access based on staff responsibilities). The placement of monitors is especially critical if an ED is utilizing an electronic patient tracking system. When accessing EMRs, staff should be aware of individuals reading over their shoulders, a term commonly referred to as 'shoulder surfing'. Staff should also be vigilant with new cell phones that may be equipped with camera and video capability.

The storage of written and electronic PHI also leads to questions of proper disposal. Shredders, disk erasers, and CD destruction machines should be incorporated into HIPAA compliance efforts. Finally, physician and staff training should include information on department policies and procedures related to record access, movement and disposal.

Medical Students and Physician Resident Issues

As part of the caregiving team, medical students and physician residents in academic EDs also are authorized to access medical records as part of HIPAA protected health care "operations." As such, students and residents should receive role-specific privacy and security education and training before they see patients.[30] HIPAA training varies by institution but often is incorporated into overall compliance training. Academic medical centers have used several different approaches, including online tutorials, which incorporate a post-test or quiz, live presentations or written documents. Many facilities also require residents and students to sign some version of a confidentiality agreement as part of their employee status. A record should be kept of all students and residents who have completed training as well as those subject to re-training due to a shift in job responsibilities.

A particular HIPAA concern with medical students and physician residents is the copying or removal of medical records by students and residents for classroom reasons.[31] While students and residents are allowed to use and disclose PHI within their training setting, use or disclosure outside the training setting requires patient authorization or de-identification. To avert problems in this area, HIPAA training must include a review of policies that address how much of the medical record may be accessed (up to and including the entire record), how to safeguard PHI, and removal of PHI from the training site. ■

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1 The author wishes to thank Charlotte Yeh, M.D., FACEP and Maureen Kerrigan, Esq. for their extensive HIPAA knowledge and for insights into the practice of emergency medicine.
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continued from page 113
prepared years ago and has not looked at since. People need to know what policies are there and practice using them."

In the eyes of a jury, a breach of policy may be worse than having no policy at all. That's why it's a mistake to make policies so specific that it's almost impossible to comply with them, says Camin. For example, instead of stating that something should be done within a specific time frame, use the terms "as soon as possible," or "take immediate action."

The best way to reduce liability risk is to document, says **Sandra Schneider**, MD, professor of emergency medicine at University of Rochester (NY) Medical Center. "At first glance, one would think this would be impossible during a disaster," she acknowledges.

However, individuals who want to volunteer help during a disaster can act as scribes, suggests Schneider. She recommends assigning a scribe to transcribe items given verbally by the ED physician or team leader. "In teaching hospitals the scribe can be a medical student, and in community hospitals, perhaps floor secretaries or retired nurses," says Schneider.

EDs can prepare for this by creating a disaster flow sheet and keeping them on hand along with patient identification tags and other disaster supplies, adds Schneider.

Document the patient's name, or what is known of the name, who treated the patient, and the amount of history available. "After the disaster, the director should make a record of how many patients were treated in what period of time by what number of staff," says Schneider. "This will help to make the case for limited resources if that played a part."

The patient's record should state "care given during disaster" and a separate file should be kept documenting the actual events during the disaster to reference if necessary, says Schneider. Document facts such as number of patients and conditions in the ED, including what staff believed at that moment in time, she advises.

"If the team felt patients were not going to make it and were suffering badly it should be noted," says Schneider. "If resources were too thin to save all, it should be included."

Post-Katrina Impact

During Hurricane Katrina, large numbers of evacuees sought refuge at hospitals, and many arrived in the ED. "Some of these people were sick and some not. It required significant resources to triage these people," says **Donna Klein**, managing partner and head of the healthcare section at McGlinchey Stafford in New Orleans. "Also, there were drug seekers entering EDs to steal drugs, which strained an already strained security force." A total breakdown in communications hindered the transfer and evacuation of patients, and made it nearly impossible to maintain documentation for every patient.

Although there haven't been any post-Katrina lawsuits dealing specifically with the ED, there have been many lawsuits filed for failure to follow a facility's disaster plan, failure to have an adequate disaster or evacuation plan, euthanasia or mercy killing, and inadequate security resulting in harm to patients, says Klein. She suggests the following actions to reduce liability risks:

- Make a decision in advance as to whether the hospital or the ED will continue to operate, or whether it will evacuate everyone pre-storm.
- Secure controlled substances.
- Make arrangements in advance for transfer agreements with other facilities.
- Develop a form to serve as an abbreviated medical record. During Katrina, there were significant problems at various staging areas, such as when patients arrived at the airport with literally no information accompanying them. "Something that is practical under the circumstances to reflect the patient's condition and what has been done needs to accompany the patient," says Klein.

Your policy should specify the individuals with authority to make administrative, legal and medical decisions during a disaster, says **Bettina Stopford**, RN, FAEN, PMP, director of public health and medical emergency preparedness for Science Applications International Corporation's Homeland Security Support Operation, based in McLean, VA.

"Having a solid, all-hazard operational plan, that is flexible enough to rapidly adapt to many contingen-

Key Points

Your ED should have a well-tested disaster plan in place, and staff must be familiar with policies and procedures.

- Avoid making policies too specific, such as stating time frames.
- Document patient information to the best of your ability.
- Create a form to send with patients who are transferred.
- Federal requirements may differ during a disaster.

cies, and that is practiced and known by all involved in it, is critical," says Stopford.

ED managers should work with hospital legal departments to ensure that the decision-making entity is well-documented and accessible, recommends Stopford.

For the ED, this might be a nursing director, nursing administrator, chief medical officer, or attending physician. That individual must be capable of making tough decisions, such as how to use limited resources, based on national standards of care and disaster response best practices, says Stopford.

Liability is reduced if the facility can show it is compliant with national standards and legislation. For example, your ED must adhere to the Joint Commission on Accreditation of Healthcare Organizations' emergency care standards, which includes using an incident command system, planning, training, and exercising with community responders, and having proof of plans for emergency evacuation and decontamination along with the necessary training and equipment.

"It would be nearly impossible to plan for every unforeseen contingency," Stopford says. "But having a decision making administrative capability rapidly available during a disaster is key to reducing liability."

More Leeway?

"During a disaster, the standard of care in certain instances would change," says **Sue Dill**, RN, MSN, JD, director of hospital risk management for OHIC Insurance Company in Columbus, OH.

Although state and federal regulations don't go out the window entirely during disasters, there is some flexibility in the requirements, says Camin. "To the extent that health care provider can stay 100% compliant with the law, of course you want to do so. But the government powers that be do allow some flexibility here and there."

What's reasonable on a normal day versus when a hurricane hits are two different things. "But even so, you're going to have to prove in retrospect that what you did was reasonable under the circumstances," Camin says.

Your policy should be clear about the specific circumstances in which different procedures are acceptable. "You will have to define when staff can kick in the emergency steps that might be outside the norm," she says.

In the event a malpractice lawsuit is filed and goes to trial, jurors would be more likely to sympathize with an ED nurse or physician under disaster conditions than they would otherwise. "They realize that things change when a hurricane hits. Had this same problem occurred during normal circumstances, a jury would probably be tougher on that health care provider," says Camin.

Here are some examples of accommodations in federal laws that could affect care in the ED during a disaster:

• **Health Insurance Portability and Accountability Act (HIPAA).** The Department of Health and Human Services' Office of Civil Rights issued a bulletin on disclosing protected health information during emergency situations, which emphasizes the broad range of permissible disclosures that covered entities may make in response to the needs of evacuees. (To download the bulletin, go to www.hhs.gov/ocr/hipaa/emergencyPPR.html.)

To comply with HIPAA, disclosures are permitted only if necessary to provide treatment, and otherwise you can tell people whether an individual is at your ED and his/her general condition, but nothing more.

However, during a disaster, you can provide information about a patient to locate a family member or anyone involved in the individual's care. You can also share patient information with anyone to prevent or lessen an imminent threat to the safety of a person or the public.

• **The Emergency Medical Treatment and Active Labor Act (EMTALA).** Know where to get legal information that would affect your ED during a disaster, such as knowing if EMTALA has been suspended, says Stopford. "The hospital should be able to query the state department responsible for this, usually through their local or county emergency management or public health agency," she says. "It is different in states and counties, but that decision-making body should be contacted in advance."

The federal law requires that a medical screening examination (MSE) be done on all patients who present to the ED requesting care or treatment. "But when there is a national disaster and 400 people arrive at the emergency department, it may not be humanly possible to provide a normal medical screening exam," says Dill.

EMTALA does not apply when patients are transferred to another location to receive a MSE when a state emergency preparedness plan is in effect or for the transfer of an unstable patient if the transfer arises out of hurricane-related emergency circumstances.

"Under normal circumstances, providers would be sanctioned if they were to redirect a patient for MSE who wasn't stabilized," says Camin. ■

Statute of limitations: How it affects ED cases

Patient claims may still be timely years after their ED visit

By Staci Kusterbeck, Contributing Editor

The "discovery rule" plays an important role in many medical malpractice cases, including those arising from ED care. Under this rule, the statute of limitations does not begin to run until the patient "knew or should have known" that a viable claim exists.

The discovery rule is not unique to malpractice cases, but because the signs and symptoms of malpractice-related injury may not become obvious until years after an error was committed, it comes into play more frequently in lawsuits against health care providers than anywhere else, explains **Jay C. Weaver**, JD, EMT-P, a health care attorney in private practice in Somerville, MA.

Usually, it is the nature and course of the patient's illness that determines whether the plaintiff "knew or should have known" about a health care practitioner's malpractice.

"A patient who returns to the ED after discharge knows that complications have arisen, of course, but those complications may have occurred naturally, and are not necessarily the result of negligence," says Weaver. "Thus, the statute of limitations does not always begin to run simply because the patient has experienced symptoms or has sought treatment."

Some disputes over the timeliness of a medical malpractice claim have nothing to do with the patient's condition, notes Weaver. For example, one health care facility argued unsuccessfully that the hiring of an attorney to review medical records was sufficient, by itself, to begin the statute of limitations. In another case, an appeals court held that a wrongful death claim was not barred by the Wisconsin statute of limitations because the parents of the patient could not have learned about the involvement of the defendant physician until after they had sued the physicians who had treated their daughter in the ED.[1]

"A trial court will dismiss a malpractice claim as untimely only when there is no doubt that the plaintiff knew or should have known that a claim was viable," says Weaver.

For a statute of limitations to begin running, a patient need not know, to any degree of certainty, that a particular person caused his or her injury, or even that the injury resulted from negligence. "Rather, it begins to run once the patient acquires information that would lead a reasonable person to inquire about the possibility of negligent behavior," says Weaver.

However, a patient who knows that negligence has been committed, but refrains from filing a claim in order to determine the full extent of his injuries, will be barred from recovery if the statutory period—calculated from the time of the error—has run.[2]

"This puts the patient in an awkward position," says Weaver. "If he files his claim early, he may not be fully compensated for his injuries. On the other hand, if he waits too long, the statute of limitations may bar his claim entirely."

Not all states have adopted the discovery rule. In a handful of states, the statute of limitations runs from the time the medical mistake or misdiagnosis occurred, whether the patient experienced any symptoms suggesting a problem or not.

In most jurisdictions, the statute of limitations is stopped, or "tolled," during any period in which the patient is legally incompetent. When the patient is a

CE/CME instructions

Physicians and nurses participate in this CE/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. ■

CE/CME objectives

After completing this activity, participants will be able to:

1. Identify legal issues relating to emergency medicine practice;
2. Explain how these issues affect nurses, physicians, legal counsel, management, and patients.
3. Integrate practical solutions to reduce risk into the ED practitioner's daily practices. ■

minor, for example, the statute of limitations may not begin to run until he has reached the age of majority. "Similarly, a health care provider's fraudulent concealment of an error or medical condition may prevent the statute of limitations from running," says Weaver. ■

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CE/CME *Questions*

44. Protected health information (PHI) may be disclosed without an individual's authorization in which of the following situations?
    A. To the individual who is the subject of the PHI
    B. For treatment, payment, and health care operations
    C. Uses and disclosures where it is required that the individual have an opportunity to agree or object
    D. Uses and disclosures where an authorization is required
    E. All of the above

45. Which of the following statements regarding federal laws during disasters is true?
    A. Patients may not be transferred without a medical screening examination regardless of the circumstance.
    B. Patient information can be shared as needed to prevent an imminent threat to public safety.
    C. Patient medical information cannot be disclosed even to family members.
    D. Medical screening examinations are not required under any circumstances.

46. When does the statute of limitations begin for ED malpractice cases?
    A. When the plaintiff "knew or should have known" that a viable claim exists
    B. When the patient is discharged from the ED or hospital
    C. The date of the patient's first visit to the ED
    D. When an attorney is consulted or hired

47. Which of the following conditions needs to occur for statute of limitations to begin running?
    A. The patient must know which individual caused his or her injury.
    B. The patient must know that the injury resulted from negligence.
    C. All individuals involved in the patient's injury must be identified.
    D. The patient must acquire information that would lead a reasonable person to inquire about the possibility of negligent behavior.

48. According to the Sixth Circuit Court of Appeals decision in *Smith V. Botsford General Hospital*, an EMTALA failure-to-stabilize claim constitutes a malpractice action under Michigan Law.
    A. True
    B. False

Answer Key:
44. E
45. B
46. A
47. D
48. A