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IN THIS ISSUE

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Beware of Long QT Syndrome in the ED: How Long Will You Be Liable?

The legal concept of proximate cause and foreseeable consequences

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The authors appreciate the contributions of Malia J. Moore, UC-Santa Cruz, in the preparation of this manuscript.

Legal Concept: Proximate Cause and Foreseeable Consequences

How can a misread on an EKG years prior, which led to no immediate negative outcome, be held up at a distant time in the future as malpractice? It doesn't seem right to the practicing ED physician. One needs to be aware that two of the key concepts in establishing negligence in general, and malpractice specifically, are proximate cause and foreseeability.

Proximate cause can be confusing. The governing rules, and how they work, are sometimes uncertain. The topic is controversial and the subject of numerous articles in the legal literature. Proximate cause may be thought of as a legal policy that states that even when someone has behaved negligently, they should not be responsible for *all* of the consequences, no matter how unlikely or far-reaching. The plaintiff must show that the mistake or negligence was the actual "cause in fact" of the injury.

In deciding what is proximate cause, there are two conflicting views: direct causation and foreseeability. In the medical arena, direct causation would impose liability for any harm that directly resulted from the provider's negligence no matter how unforeseeable or unlikely it may have been at the time the provider rendered care. As long as the injury flowed directly from the negligent act, the provider is liable. If some other intervening cause for the injury occurred, it would break the chain of direct causation. Even though there was a prior negligent act, the injury was not directly caused by it.

Foreseeability is the view that more often is utilized to determine proximate cause. This concept advocates that the provider is only liable for negligent acts that were reasonably foreseeable at the time that they acted. Two classic legal cases

illustrate how foreseeability is determined in the courts. It is interesting that "non-medical" legal cases determine how malpractice cases are evaluated.

Palsgraf v. Long Island R.R. Co. This is one of the most famous cases,[1] in which a man running to catch a train was about to fall as he rushed to board. A train employee pushed him from behind to help him make the train. This push dislodged a package from the man's arms which contained fireworks that exploded. The explosion caused something to fall at the other end of the platform, injuring another bystander.

The bystander then sued the train company because their employee had pushed the passenger and caused the package to fall, which then caused the explosion that caused the item to fall on them. Even though it was clearly negligent for the employee to push the passenger, the court ruled that this was not a foreseeable event and that the defendant was not liable. While it was foreseeable that a pushed passenger could be hurt by the negligence; it couldn't be foreseeable that a pushed passenger would have a package of explosives in his arms that would explode and dislodge something far away. This verdict may have been different if a "direct cause" viewpoint had been used.

Marshall v. Nugent. Another classic legal case on foreseeability comes up with a different ruling. In *Marshall v. Nugent,*[2] a man was a passenger in a car driving up a snowy hill. An oil truck coming down the hill made a wide turn and forced the car off of the road. The passenger was not hurt. The passenger then began to walk up the hill on the side of the road to summon help. Another car, coming down the hill, swerved to avoid the oil truck in the road, and hit the passenger, injuring him. The passenger sued the oil truck driver even though he had not directly injured the passenger in the original accident. The court ruled that the liability did not end with the initial episode, it was foreseeable that having the truck in the road could lead to further accidents. Often it is the jury who must decide what is foreseeable. This leads to outcomes like the long QT syndrome cases that will be mentioned later in the article and the one noted below.

Estate of Jordan Carlson v. Community Medical Center. A 3-year-old had a splenectomy for which he received a single dose of pneumococcal vaccine, because asplenics have increased risk of fatal pneumococcal infection. On Nov. 10, 1996, the child, now a 12-year old presented with a 103.6 °F fever and secondary bacterial infections. Despite the 1996 Center's for Disease Control and Prevention (CDC) recommendation that asplenic patients be reconsidered for revaccination, the physician assistant did not verify the boy's immunization status and left that portion of his chart blank. He was not seen by a physician on this visit. The child recovered fully from the episode.

The decedent returned to the hospital on Sept. 19, 2000, with a fever and disorientation; he died of pneumococcal sepsis shortly later. The plaintiff claimed that the physician assistant's failure to identify vaccination status and administer an immunization during the boy's 1996 hospital visit played a significant part in his death. The defense contended that the immunization was irrelevant to the treatment the boy received; his symptoms were treated, and he recovered from them after that visit. The plaintiff was awarded $1,365,092 in damages by a jury.[3]

Long QT Syndrome: What is it and how is it identified?

Long QT syndrome (LQTS) is an electrophysiologic disorder in which ventricular repolarization is delayed. This disorder can be either hereditary or can be acquired, as occurs in the case of electrolyte abnormalities or medications that can cause the QT interval to be prolonged. LQTS, in its congenital form, has an

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Questions & Comments

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Table 1

Some medications that prolong the QT interval

Cardiac medications
Amiodarone
Procainamide
Quinidine
Diltiazem
Verapamil

Antidepressants
Amitriptyline
Desipramine
Imipramine

Protease inhibitors
Delavirdine
Indinavir
Saquinavir
Nelfinavir
Ritonavir

Antimicrobials
Levofloxacin
Moxifloxacin
Azithromycin
Clarithromycin
Erythromycin
Fluconazole
Itraconazole
Ketoconazole

Antipsychotics
Droperidol
Haloperidol
Ziprasidone

estimated incidence of 1 per 10,000 to 1 per 15,000 and is thought to be the cause of 3000-4000 cases of sudden death annually in the United States.[4] The LQTS is manifested as a prolonged QT interval of greater than 440 milliseconds in men and greater than 460 milliseconds in women. QT interval prolongation, in the absence of structural heart disease, electrolyte abnormalities, or medications known to prolong the QT interval, suggests congenital LQTS. Patients with this syndrome may present with syncopal or near-syncopal events that may be mistaken for seizures. Milder presentations may include palpitations or lightheadedness. These events most often are triggered by emotional stress, vigorous physical activity, or even a startle response to a loud noise or frightening experience;[5] however, sudden death is the only event in 30-40% of patients. The clinical significance of this QT abnormality is that it can be associated with the development of polymorphic ventricular tachycardia, also known as torsades de pointes.[6] During this dysrhythmia the cardiac output is impaired and although the event may be self-limited, it can degenerate into ventricular fibrillation and sudden death.

In any patient who presents with a history of syncope or near-syncope, the possibility of LQTS should be considered and an EKG should be obtained. Suspicion for this disorder particularly should be raised in any patient with a family history of syncope, seizure, SIDS (sudden infant death syndrome), or sudden death.[7] While symptomatic congenital LQTS most often presents in patients ages 9-15, acquired LQTS usually occurs in the fifth or sixth decades of life.[4] Acquired LQTS may be caused by a variety of medications, including antiarrhythmics, antipsychotics, antifungals, antimicrobials, organophosphate insecticides, and tricyclic antidepressants.[8,9] **(See Table 1.)** Electrolyte abnormalities that can cause LQTS include hyperkalemia, hypokalemia, and hypocalcemia. In the setting of hypokalemia, the QT interval appears to be prolonged even though the QT interval is actually normal. This abnormally prolonged appearance is due to a fusion of the T-wave with a U-wave.[10]

Cases of QT Prolongation Patients not Immediately Identified

Case of "heat stroke." A 15-year-old female was playing softball in the summer. While rounding the bases during a game in 1993, she experienced a seizure-like episode. A neurologist was consulted and diagnosed "heat stroke." A year later she began complaining of headaches, nauseas, and dizziness, and a year after that she had several near fainting spells. She went to a Kaiser ED in June 1995 but had no work-up or diagnosis. On Sept. 22, 1995, she was seen at the same hospital and her mother demanded further evaluation and testing. An EKG was done that revealed QT prolongation, but this was not mentioned to the mother and no treatment was done. On June 30, 1997, as she was rounding the bases in a baseball game, she felt a "seizure" coming on so she laid down on the ground. She then lost consciousness and stopped breathing. She died. A suit was filed for failure to diagnose and treat prolonged QT syndrome. The case was settled for $225,000.[11]

Case with patient history of seizures and dizziness. A 22-year-old mother of two presented to the ED of Brooke Army Medical Center. She reported a history of seizures and dizziness and a frightening episode the day before in which she dropped to her knees. She was evaluated by a medical student and a resident who felt it was unlikely she had experienced a seizure since there had been no postictal period.

No EKG was generated. Her pulse was slow and she was released with a diagnosis of vasovagal syndrome. Eighteen days later, she was transported to the same ED by EMS.

During this visit, the rhythm strip clearly suggested prolonged QT syndrome. A resident again doubted a seizure and an EKG was not ordered. She was released. Over the next 24 hours she experienced a "strange" heartbeat and overwhelming fear. She said she was afraid they would "let me die" if she returned

to the same facility. She was brought to Northeast Methodist Hospital, where she was placed in a quiet room. The ED physician prescribed a tranquilizer and discharged her home based on the nursing assessment of anxiety. The next day she was found unresponsive, without pulse or respiration. Her father performed CPR until EMS arrived.

An EKG was done and revealed prolonged QT syndrome. She was resuscitated but survived with severe brain damage due to anoxia. She required a long-term care facility.

Family members were then tested, and all have prolonged QT syndrome. They have subsequently been treated without complications. Her family sued the hospital. A jury returned a verdict of $16,662,154.[12]

Case of apnea and posturing. A 6-year-old boy suffered three episodes of apnea and posturing of his right arm at 1 a.m. He was taken by his parents to the ED where he was seen by a physician. He was alert and appeared normal upon arrival. A pediatrician was consulted, and the patient was admitted. An EKG was ordered the next day; it was normal. He was discharged with a diagnosis of questionable seizure. Two months later, the child had a similar episode but suffered cardiac arrest and suffered severe brain damage. He was hospitalized and diagnosed with long QT syndrome and died several days later of brain damage and dysrhythmias. The administrator of the estate then sued, claiming a failure to diagnose a congenital syndrome that would have led to transfer to an appropriate facility and proper and life-saving treatment.[13]

The defendants claimed that the child's seizure led to a cardiac arrest and that the arrest led to a resultant acquired long QT syndrome. Thus, an EKG on the initial visit would not have revealed the condition. The jury awarded $885,000.[13]

What is the ED treatment and disposition of a patient presenting with symptomatic LQTS?

QT interval prolongation alone does not necessarily predict risk, and risk stratification should take into consideration the context of the clinical presentation and family history.

In a patient presenting with an episode of torsades de pointes or polymorphic ventricular tachycardia, immediate intervention should consist of IV magnesium (25-50 mg/kg IV, maximum 2 g). Beta blocker therapy also may be used acutely to suppress catecholamines, thereby preventing further dysrhythmia. Use of beta blockers is effective for ongoing suppressive treatment of LQTS and has been shown to substantially decrease mortality in this population of patients. In some patients, an implantable cardioverter defibrillator may become necessary.[14] Cardiology consultation should be obtained and admission should be arranged in patients with symptomatic LQTS, especially in the scenario of ongoing symptoms and cardiovascular compromise. Outpatient follow-up with cardiology is acceptable in stable, asymptomatic patients with LQTS. Potentially contributing medications should be stopped, and electrolyte abnormalities should be corrected. Individuals with this diagnosis should be restricted from competitive, but not necessarily from recreational sports. They also should be instructed regarding avoidance of precipitating events including emotional stress, potentially startling/frightening situations, and dehydration. If a patient is diagnosed with congenital LQTS, family members should be advised to have EKGs to screen for this disorder.[15]

How is LQTS diagnosed?

Computerized EKG readings automatically calculate QT and QTc intervals (adjusting for heart rate since the QT interval is inversely related to the QT interval length). However, the most accurate method consists of measuring three consecutive QT and RR intervals, taking an average, then calculating the QT interval using the Bazett formula $QTc = QT/\sqrt{RR}$.[4] Unfortunately, 6-12% of cases of individuals with congenital LQTS may present with a normal QTc.[6]

Caveats in LQTS

1. Consider dysrhythmias and conduction problems in patients with syncope or seizures.
2. Get an EKG on all patients with syncope and consider it in patients with "seizures." They may not be actual seizures, and pre-existing seizure patients may have a conduction abnormality as a result of medication.
3. When evaluating an EKG, be sure to focus on the QT interval.
4. Beware of the diagnosis of anxiety ... patients get anxious when they are dying. This is a common complaint in undiagnosed dysrhythmias, cardiac ischemia, and pulmonary embolus in young patients and in sepsis in the elderly.
5. Realize that you may be medicolegally responsible for an unapparent mistake, far into the future, until it becomes obvious. ■

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Are curtained dividers a setup for a lawsuit?

Curtained dividers are permissible under HIPAA, state laws vary

Caring for patients with little privacy other than thin curtains in a crowded emergency department seems to fly in the face of the requirements of the Health Insurance Portability and Accountability Act (HIPAA). But what are the actual liability risks of this practice?

A patient cannot bring a lawsuit directly under HIPAA, because the federal statute does not provide for a private right of action. "Because of this, even if the person believes that the provider has violated HIPAA, the person would still need to bring the claim under state law," says **Helen Oscislawski,** a health care attorney at the Lawrenceville, NJ office of Fox Rothschild, who has substantial experience with HIPAA compliance.

Under HIPAA, patients are able to submit their complaints alleging that a violation has occurred to the U. S. Department of Health and Human Services (HHS) Office of Civil Rights. Otherwise, the patient would need to look to state law to see if there is an actionable complaint, since standards vary by state as to what is "actionable" and what is not.

"I have yet to hear of a case where overheard comments through dividers amounted to a breach of duty. But that is not to say that such a case has never been filed or may never be filed," Oscislawski says.

In fact, there have been a recent smattering of cases with plaintiffs bringing lawsuits based on state law claims for negligence, and have successfully argued that the failure to adhere to a HIPAA standard is evidence that the provider breached its duty to keep a patient's information confidential, she says. "This makes proving negligence a lot easier," Oscislawski says.

"Although curtains may present a visual barrier, and we all know that this is no more guaranteed than the typical hospital gown, they provide minimal barrier to sound," says **Jeffrey Freeman,** MD, clinical assistant professor of the department of emergency medicine at University of Michigan Health System in Ann Arbor.

In fact, the perception that there is a barrier may increase the likelihood of conversations or private information being overheard, adds Freeman. Patients may be reluctant to provide medical information or undergo physical examinations, and physicians may be reluctant to be complete due to privacy concerns, he adds.

In addition, privacy curtains often are used in areas which otherwise would not be considered rooms, including hallways and alcoves.

There have been a few, limited studies on the effects of privacy barriers in the emergency department, notes Freeman.[1-3]

"These studies confirm that patients feel their conversations are overheard when privacy curtains are the barriers between patients," Freeman says. A small percentage of patients withhold medical information or refuse part of the physical examination because of privacy concerns, according to the research.

"Although patients often perceive that their privacy is being respected with curtains, we know in fact that occasional oversights occur and personal information and privacy is not ensured," says Freeman. "This is more likely to occur in larger or crowded institutions,

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SPECIAL REPORT

Between a Rock and a Hard Place: When Parents Refuse Treatment for their Children in the ED

*By **William M. McDonnell, MD, JD,** Assistant Professor, Division of Pediatric Emergency Medicine, Adjunct Professor of Health Law, S.J. Quinney College of Law, University of Utah, Salt Lake City.*

Introduction

Not infrequently, parents are reluctant to proceed with medical treatment for their children in the emergency department (ED). When the treatment is clearly indicated, and when parental reluctance progresses to outright refusal, ED physicians are faced with difficult choices.

Informed consent rules limit the medical interventions that physicians can perform. The law recognizes a strong public interest in allowing parents to make reasonable medical decisions on behalf of their minor children. However, every state has enacted some form of mandatory child abuse and neglect reporting statute, which requires ED physicians to take action when a child is denied necessary medical care. Furthermore, all states have some mechanism for obtaining temporary custody of a child in order to provide necessary consent for medical treatment.

ED physicians often feel torn between their obligations to respect parental decisions regarding treatment, and their responsibilities to provide necessary medical care to children. These sometimes conflicting duties can present not only emotional conflict for the ED physician, but also the potential for legal liability. This article will explore the various competing legal principles at issue in these situations and will provide some guidance for ED physicians in these difficult cases.

Informed Consent

It is a well-established principle in American health law that medical personnel must obtain informed consent prior to performing medical procedures on a patient. To protect individuals' autonomy and prevent unwanted bodily contact, physicians must obtain the agreement of the patient prior to any physical contact.[1]

Failure to obtain such consent exposes physicians to tort claims for assault and battery. Some plaintiffs have used the theory of battery as a substitute for malpractice claims against physicians, arguing that the patient only consented to non-negligent medical touching. In most states, however, a claim of battery will only prevail when the consent is totally absent (or expressly refused) for a given examination or procedure. Nevertheless, even in jurisdictions where a cause of action for battery is limited, patients may have an independent legal claim for failure to obtain informed consent.

The courts have widely recognized that under certain emergency circumstances, an exception to the requirement of informed consent is available.[2] When a patient is unconscious or is otherwise rendered incompetent to provide informed consent, and when a reasonable person would consent to medical care, the patient's consent may be implied from the circumstances. This exception is only available when time is of the essence, and no legally authorized patient representative is available. Under such circumstances, ED physicians are required by federal law to provide an appropriate examination and any necessary stabilizing treatment.[3]

On the other hand, consent cannot be implied when the patient has plainly indicated that he or she would refuse consent. The courts have been quite clear that when the patient has refused care, an emergency situation, even a life-threatening one, cannot override the patient's decision.[4] For example, in *Shine v. Vega,* a patient with an acute asthma exacerbation sought care in an emergency department. After initial treatment with nebulized bronchodilators, the patient refused further treatment and attempted to leave the hospital. Against the patient's wishes, she was placed in restraints and ultimately intubated. The Massachusetts Supreme Court rejected the defense's argument that consent was not necessary because the patient had a life-threatening emergency, stating "the emergency treatment exception ... does not and cannot override the refusal of treatment by a patient who is capable of providing consent."[5]

Unlike competent adults, minor children do not have the legal capacity to provide informed consent for medical care. Instead, the capacity and responsibility for granting or denying consent lies with the parent or other legal guardian. The courts have long given great deference to parental decisions regarding medical treatment for their minor children. Parental rights "to make decisions concerning the care, custody, and control of their children," have been recognized by the U.S. Supreme Court as protected by the 14th Amendment to the U.S. Constitution.[6]

State *Parens Patriae* Power

Like all constitutionally protected rights, parents' rights to grant or deny consent for medical treatment are not absolute. Under the principle of *parens patriae* ("parent of the state"), the State is deemed to have an interest in the welfare of all of its citizens, including minor children.

In 1944, the U.S. Supreme Court declared that this State interest in protecting minors against imminent harm can overrule parental rights to raise their children as they see fit.[7] Since that time, the principle of *parens patriae* has been applied in numerous circumstances. For example, in *Schmidt v. Mutual Hospital Services, Inc.,* an infant was born to parents whose religious beliefs rejected all medical care. When the parents refused to pay medical bills for the infant's care, the Indiana Court of Appeals noted that "although an adult generally cannot be forced to undergo medical treatment against his religious principles, a parent's decision to refuse lifesaving medical treatment for a minor child must yield to the State's interest in protecting the health and welfare of the child."[8]

In *Guardianship of L.S. and H.S.,* the Nevada Supreme Court upheld the State's right to appoint a temporary guardian to consent to medically-necessary blood transfusions, despite the parents' religious objections.[9] In *In Re K.I., B.I., and D.M.,* the District of Columbia Court of Appeals held that a lower court properly exercised its *parens patriae* power, in the best interests of the child, to enter a "do not resuscitate" order for a neurologically devastated child over the objections of one parent.[10] In *Matter of Cabrera,* the Superior Court of Pennsylvania appointed a guardian to consent to medical treatment reducing a high risk of debilitating stroke in a patient with sickle cell disease, despite the objections of her parents.[11]

Parens patriae is applied as a matter of state law, and thus varies from state to state in the circumstances under which it will be applied.

Physicians must remember that *parens patriae* is a mechanism for the State, not the individual physician or hospital, to override parental rights and provide substituted consent. The physician who overrides the parents' wishes, in the absence of substituted consent from the State, may be providing medical care in violation of the consent requirement, and may be liable for violating battery and informed consent laws.[12]

In truly life-threatening circumstances, however, some courts have allowed physicians to briefly provide life-sustaining emergent care to children over the objections of parents while state intervention is sought.[13]

Reporting Requirements

In order to ensure that the state's interest in the welfare of its child citizens is protected, all states have enacted some form of mandatory reporting statute for abuse and neglect of children. Although these statutes typically do not call on medical personnel to conduct independent investigations of possible abuse or neglect, they clearly require that physicians make timely reports to designated law enforcement and/or social services officials when the physician has reasonable cause to suspect abuse or neglect.

These state laws have variable definitions of abuse and neglect, but generally include actions and omissions that endanger a child's health or well being. Failure to obtain necessary medical care for a child, and to provide consent for such care, generally constitutes abuse and neglect under these statutes.

Physicians are not called upon by these statutes to determine in fact whether abuse and neglect have occurred, but rather are required to report reasonable suspicions of abuse and neglect. Failure to report these suspicions generally carries criminal penalties for the physician under the state reporting statutes.

The Dilemma

The combination of informed consent requirements, parental rights, and mandatory reporting requirements, as well as ethical obligations to provide the best and most appropriate care to patients, has placed ED physicians in a difficult position. The physician must report suspected abuse and neglect, yet generally cannot provide medical care over parental objections until the State intervenes. When making a report of suspected medical neglect based on refusal of treatment, physicians must be careful to provide accurate information to State officials, and not allow any bias to color that report.

In *Mueller v. Auker*, a 5-week-old infant with fever was brought to the ED by her mother, who consented to blood and urine tests, but refused a lumbar puncture and intravenous antibiotics.[14] Concerned that the parental refusal of consent placed the infant in imminent danger, the ED physician contacted State officials who took custody of the patient for purposes of consenting to medical care. The parents later sued the ED physician, alleging that he conspired to deprive them of their constitutional rights by knowingly exaggerating the medical risks to the child. The Court allowed the case to proceed, noting that the state reporting statute would provide immunity to the physician if he made a good faith report of suspected medical neglect, but would not protect knowingly false estimates of risk. The case is currently pending.

Limit Liability Risks

To limit their potential liability when parents refuse medical care for their children in the ED, physicians should consider the following measures.

- Fully disclose your medical concerns to parents, discuss their concerns and objections, and attempt to provide them with diagnostic and treatment options that meet the child's medical

needs as well as the parents' concerns. For example, in some cases blood and urine cultures and hospital admission for a febrile infant might be an acceptable alternative to lumbar puncture and intravenous antibiotics.
- If the family has an established relationship with a primary care provider, it may be appropriate to involve that physician in difficult discussions.
- *Be prepared.* Know your state's abuse and neglect reporting requirements. Time may be critical, so establish a procedure in advance for notifying the appropriate state officials, and determine whether reporting will be done by the ED physician, hospital social workers, or hospital administrators.
- Promptly involve state authorities when indicated, and do not proceed with medical care over parental objections until authorized to do so by the appropriate governmental authorities. If absolutely necessary to preserve life, it may be appropriate to provide care until state authorities can be notified.
- Be careful to provide state authorities and family members with accurate information. If you are estimating risks or benefits, make it clear that you are estimating. If you don't know a particular fact or statistic, disclose that you don't know that fact or statistic, and attempt to obtain the needed information from reliable resources such as medical literature and consultant services.
- Document communications, thought processes, and treatment authorization from parents or governmental authorities.

Conclusion

The sometimes contradictory obligations of providing appropriate emergency care to children and respecting their parents' right to informed consent may place ED physicians in a difficult situation. The best resolution would be an agreement by all parties, reached through full disclosure, good communication, and consideration of all reasonable options. However, when a reasonable agreement cannot be negotiated, advance planning and careful compliance with reporting and informed consent rules will best protect the ill or injured child, as well as the ED physician. ■

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3. Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd; *see* Mark M. Moy. *The EMTALA Answer Book.* 3rd ed. Aspen: New York, NY; 2001. ("A request for treatment ... may be inferred by mere presentation [to the ED].")
4. See, e.g., *Shine v. Vega,* 709 N.E.2d 58 (Mass. 1999); *Miller v. Rhode Island Hosp.,* 625 A.2d 778 (R.I. 1993).
5. 709 N.E.2d at 64.
6. *Troxel v. Granville,* 530 U.S. 57 (2000).
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where chaos and larger numbers of staff, trainees, and visitors increase the chance of privacy blunders."

For example, in large, busy EDs, it is not unusual for patients to be boarded next to nursing and physician stations behind curtains. "Although this may improve supervision of patients, it also virtually ensures that conversations can be overheard," says Freeman.

Although Freeman says he is not aware of specific legal suits that have arisen directly from these issues, he points to the potential for state civil penalties for breaches of privacy, administrative sanctions from licensing boards, and federal penalties for violation of HIPAA.

"These could include monetary and criminal penalties," says Freeman. "Poor patient satisfaction with privacy and confidentiality also may increase the likelihood of action if medical negligence also is perceived."

Take "reasonable" steps

Under HIPAA, "incidental disclosures," such as those that occur when two patients are in adjacent rooms or cubicles, do not automatically amount to a privacy violation. "However, if reasonable steps could have been taken to minimize the chances of the incidental disclosure from occurring, then the ED group or hospital may be at a greater risk that they could be subjected to lawsuit if the wrong set of facts were to unfold," Oscislawski says.

An example of "bad facts" would be an ED patient told of a new positive test for a sexually transmitted disease (STD) while another patient, or person visiting another patient, happens to overhear the information and also happens to know the patient's spouse well.

"If that information is then communicated back to the spouse by the person who 'incidentally' overheard the STD diagnosis, you can imagine how that situation

can go from bad to much worse for the patient as a result of his or her privacy not being adequately protected," says Oscislawski. "These kinds of facts set the ED up for potential lawsuits."

For a typical ED, what would be considered "reasonable steps" to prevent patients from overhearing protected health information (PHI)? "Almost anything that the provider can implement as an attempt to minimize incidental disclosures is fair game," says Oscislawski. "Room dividers are tough. Absent major construction, there is not a lot you can really do to diminish this without significantly interrupting the ED workflow."

The guidance from HHS on HIPAA is that physical safeguards to protect PHI must be "reasonable" and "appropriate," she notes. "The guidance also specifically says that the HIPAA privacy rule does not require private rooms nor soundproofing of rooms," she says.

Curtained room dividers in an ED would be considered 'reasonable and appropriate,'" Oscislawski says. In addition, if the department is not too busy, the triage nurse may consider putting patients at the farthest point in the ED away from each other, until that becomes impossible due to capacity being filled up.

"However, the reality is, as we know, EDs are generally maxed out, overcrowded and do not have this luxury," Oscislawski says. "Thus, the only other answer would be to put up more solid barriers. Yet, this is not mandatory if it is not cost effective for the hospital."

Consider using thicker curtains, Plexiglas or similar auditory barriers, or sliding glass doors that improve auditory barriers while allowing visual oversight, suggests Freeman. "Specific rooms may be designated for private conversations or examination, moving patients in and out temporarily as needed," he adds.

Sources

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HIV status is higher risk

As for what EDs could possibly be sued for, any situation is a potential risk because people have individual thresholds for what they are willing to consider a privacy breach, Oscislawski says. "That said, I would think that cases where there is sensitive information being discussed, like an STD, drug test results, HIV status, and communicable diseases, tend to have a higher risk because of the potential implication to that patient if such highly sensitive information were to be overheard by the wrong person," she adds.

"Generally, an individual would have to sustain some sort of harm in order to sue, but it is not clear what harm might be sustained from simply another overhearing private information," says **Sheila M. Sokolowski,** a health care attorney with Fulbright & Jaworski, LLP in Austin, TX.

On the other hand, in Texas and a number of other states, HIV test results have greater protection than other types of health information, she notes. "So if HIV status is what is at issue in Texas, there is no need to show harm to recover an award from a person who unlawfully disclosed that information, though if harm is shown, actual damages could also be awarded," Sokolowski says. "As for disclosures of other types of health care information, the individual might be able to maintain an action for defamation, but truth is a complete defense to defamation."

If ED nurses or physicians speak too loudly when there is a lack of privacy, this would generally be considered an incidental disclosure, Oscislawski says.

"However, as noted above, under HIPAA ED physicians and other staff must take reasonable precautions to minimize such incidental disclosures," Oscislawski says "Therefore, staff should be reminded not to yell, and to be careful in particular when highly-sensitive information is involved." ■

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Unauthorized file access: How to avoid lawsuits

Implement safeguards to reduce risks

Recently, over two dozen ED staff members at Palisades Medical Center in North Bergen, NJ were suspended for "sneaking a peek" of the medical record of George Clooney, who was being treated for injuries he sustained after a motorcycle accident.

Unfortunately, it's not unheard of for ED staff to access patient medical files without authorization — whether it's a celebrity, a relative, or a colleague. Under what circumstances would Clooney or others have the right to sue a hospital for unauthorized access of their medical records?

In order for a person to sue a hospital because information was released to a third party in an unauthorized manner, the patient would typically have to bring a "invasion of privacy" or "negligence" type of action, says **Helen Oscislawski**, a health care attorney at the Lawrenceville, NJ office of Fox Rothschild.

However, the patient must have suffered some sort of damage or harm as a result of the disclosure. "Depending on state law, emotional distress alone, without concurrent physical harm, may not be enough to sustain such a claim," Oscislawski says.

However, the Health Insurance Portability and Accountability Act (HIPAA) does allow individuals to file complaints with the federal government, which will result in the government evaluating the complaint and possibly investigating the provider further to determine if there was a true violation of HIPAA's standards.

Whether a celebrity could sue for "file peeking" depends on state law and tort actions for invasion of privacy, but he or she could definitely file a grievance with the government. "Hospitals should take this extremely seriously, because they risk huge monetary sanctions and criminal penalties which ultimately could affect accreditation," says **Erin McAlpin Eiselein,** an attorney with Davis Graham & Stubbs LLP, in Denver, CO.

Policies are key

In the Clooney case, it appears that the hospital reacted appropriately by complying with their internal policy and immediately conducting an internal investigation, Eiselein says. "HIPAA requires hospitals to have sanction policies and I assume that the actions they took were in compliance with such a policy," she says.

If you learn of an incident involving unauthorized access of a patient's medical record, you must immediately document this, advises Eiselein. You also need to mitigate any damage done, such as instructing anyone involved not to disclose any information, and comply with your ED's sanctioning policy, which might require a written warning in the employee's personnel file or suspension without pay.

If the patient discovers that their privacy was violated and files a grievance, the Office of Civil Rights will look to see if the hospital properly documented the incident, mitigated any damages, and complied with its sanctions policy. "Chances are if the hospital acts quickly and complies with HIPAA, those actions will weigh in favor of the hospital," Eiselein says. "Where there would be risk is if the hospital took no corrective action."

Your ED's policy should restrict access of protected health information (PHI) to authorized employees. "There are a number of reasons why it is "not permissible" for unauthorized employees to "peek" at patients' records for no legitimate reason," Oscislawski says.

HIPAA sets forth the minimum requirements with regard to what is considered a "permissible" use and disclosure of patients' health information. In addition, in many states, including New Jersey, licensing regulations governing hospitals afford patients admitted to a general hospital certain additional rights with respect to the privacy and confidentiality of patient records pertaining to their treatment, she emphasizes.

As such, your ED must develop and implement technological, administrative, and physical safeguards to assure that only authorized individuals are accessing PHI about patients. Under the Security Regulations of HIPAA, safeguards such as passwords are required. Employee levels of access to electronic protected health information must be defined by employee-categories and limited by those who may need that information for authorized uses, says Oscislawski.

Once a safeguard policy is developed, it is just as important for the facility to train employees regarding policies prohibiting unauthorized access and sharing of information, and provide them with regular reminders about what is expected of them, and what the repercussions are if policies are not followed, Oscislawski says.

"Appropriate sanctions should be developed and implemented when HIPAA policies are breached,"

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Oscislawski says. "There should be essentially a 'zero tolerance' policy implemented for employees who 'peek' at records in an unauthorized manner."

One of the worst scenarios would be if ED staff attempted to sell or profit from a celebrity's medical information, Eiselein says. To commit a criminal offense, an individual must knowingly, in violation of the rules, disclose an individual's PHI to another person.

"There have been four criminal enforcement actions under HIPAA, and all involved attempting to profit from stolen PHI," Eiselein says. "If anybody profited financially, let's say by taking a picture of the celebrity on their camera phone and selling it to a tabloid, that would be enough to kick an offense up to a criminal violation." ■

When interviewing, "harmless" questions could get you sued

Avoid remarks involving "protected categories"

Whether you are interviewing emergency medicine physicians, mid-level providers, or technicians in your ED, certain questions or remarks can get you into legal trouble. What should you avoid saying during the hiring process?

Any comments about a person's race, national origin, religion, age, family, military or marital status, or disability are off limits, says **John W. Robinson IV**, a shareholder in the employee litigation department in the Tampa, FL, office of Fowler White Boggs Banker.

Avoid any attempts at humor involving these topics, which are "protected categories" under the law, advises Robinson. "In fact, the joke will be on the interviewer," he says.

One interviewer commented negatively about how "everyone from Miami is Cuban." "Little did the interviewer know that this highly qualified female interviewee, with an Anglo married name, was the daughter of a prominent businessman from Cuba, and turned down the job offer," he says. "So, you never know."

You can—and probably should—ask questions about past job performance, licenses, skills, experience, abilities, education, and dependability, says Robinson. Questions may include: Why did the applicant leave his or her last job? Does the applicant have dependable transportation? Can the applicant work all shifts, overtime and on-call?

"These are all job fitness issues, not family or disability issues," says Robinson. "Rarely do you need to know why someone is unfit for the job. You just need to know whether the applicant is minimally fit for the job and, ideally, whether he or she is the best fit for the job."

By the same token, you do not need to take an applicant's word that the applicant can perform under pressure and reliably. "You usually have a probation period and reference checks to help figure out those issues," says Robinson.

There are far fewer claims of illegal failures to hire versus illegal discharges, adds Robinson. "One reason is the unsuccessful applicant rarely knows who got the job," he says. "If the applicant does know who got the job, and that may happen in the emergency department community in a town, be prepared to document that you hired the objectively best qualified candidate."

Gratuitous questions or statements about gender, race, religion, age, disabilities, or national origin can "really backfire" with an unsuccessful applicant, says Robinson. "Nobody blames herself when she does not get a job. She is looking for other reasons," says Robinson. "If the interviewer plants the seed of suspicion that the 'real' reason was a discriminatory reason, look out!"

Don't ask "creative" questions

Interviewees generally do not intend to focus on protected characteristics. "Often, they resort to seemingly harmless jokes and small talk to fill in dead space during the interview, or to try to establish rapport with the candidate," says **Katrina Campbell,** general counsel at Brightline Compliance, a Washington, DC, firm specializing in workplace issues. But inappropriate comments can lead to Equal Employment Opportunity Commission charges and litigation by rejected candidates, she warns.

When trying to create a rapport, be careful to avoid "creative" questions or remarks that could lead you

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down an inappropriate path, advises Campbell. For example, interviewers should not joke or comment about their own age or the age of the population by saying "There are a lot of gray hairs around here," or "It's like a college campus here."

Candidates may take these statements as signs that they will not fit in, or if they are not hired later, may conclude it had something to do with their age, says Campbell.

In addition, questions that seem to relate to protected categories can be risky. For example, questions about whether a person has children and how old they are may indicate to a candidate that the interviewer questions the candidate's ability to work certain hours.

Instead, ask direct questions about the candidate's ability to work the specified schedule, to travel if that is necessary, to working overtime, and other job requirements. For example, an interviewer can say: "Working in the emergency department requires that you work different shifts, including overnight shifts. Can you meet this job requirement?"

Family status can be a protected category in certain states and localities, and is a protected category under the new EEOC guidelines on discrimination against caregivers, adds Campbell. Lawsuits generally claim illegal discrimination under Title VII of the Civil Rights Act of 1964 and similar state laws, and may also be brought under the Pregnancy Discrimination Act, Americans with Disabilities Act of 1990, and the Age Discrimination in Employment Act of 1967.

To avoid problems, give everyone involved in the interviewing process training on appropriate interviewing and hiring behaviors, recommends Campbell. Options include online training, with interactive scenarios about interviews and hiring decisions, or in-person training using slides and written scenarios in a training room or offsite conference room. "When you run a 24-hour operation, scheduling for in-person training can be difficult," acknowledges Campbell. "However, this option is low-tech and can be good for small groups." ■

CNE/CME *Questions*

1. Which of the following is recommended to reduce risks if ED staff access a patient's medical records without authorization?
   A. Avoid any documentation of the incident.
   B. Do not speak to staff members involved.
   C. Take corrective action only if required by investigators.
   D. Instruct all staff involved not to disclose information.

2. It is a well-established principle in American health law that medical personnel must obtain informed consent:
   A. prior to performing medical procedures on a patient.
   B. prior to any physical contact.
   C. only occasionally when treating patients.
   D. Both A and B are correct.

3. What does an ED need to do to comply with Health Insurance Portability and Accountability Act (HIPAA)?
   A. Replace curtained room dividers with soundproof barriers.
   B. Retrofit the ED with private rooms.
   C. Take "reasonable and appropriate" steps to maximize patient privacy.
   D. Soundproof all rooms.

4. Which of the following should be avoided during interviews due to risk of litigation against the ED?
   A. Comments about the applicant's marital or family status.
   B. Casual remarks about the applicant's religion.
   C. Jokes about the age of the staff.
   D. All of the above.

Answers: 1. D; 2. D; 3. C; 4. D