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Did patient suffer harm due to doctor texting, emailing, or surfing the Web?

'This will be seen as a particularly damning piece of evidence'

Was a physician on Facebook or eBay during a procedure or surgery? "This will be seen as a particularly damning piece of evidence, implying that the physician wasn't concentrating on the case," says **Robert M. Wachter**, MD, professor and associate chairman of the Department of Medicine and chief of the Division of Hospital Medicine at University of California — San Francisco.

"This is an emerging issue, and I've only heard of a handful of lawsuits around this," says Wachter. "But you can be certain that it's now on the radar screen of plaintiff's attorneys. There will be more demands to see what the doctor was doing during a case that went bad."

According to **Peter J. Papadakos**, MD, professor of anesthesiology and director of critical care medicine at the University of Rochester (NY) Medical Center, "attorneys have become very cognizant in this. They know that younger physicians in particular are very much dependent on their devices."

"Over a 10-year period, people have become technology addicts," he says. "This addiction, in patient care, can cause deaths. But nobody has paid attention to this problem until recently."

While physicians have always dealt with distractions, they're now "constantly connected," says **Anne Huben-Kearney**, vice president of risk management for Coverys, a Boston-based provider of medical professional liability insurance and risk management services for healthcare professionals. "In the old days, a physician had a cell phone and beeper, but didn't have all the apps and games and bells and whistles," says Huben-Kearney. "It was more focused on work versus personal use."

Usage will come out

Attorneys now routinely look into whether physicians used portable devices to document and whether the doctors wrote the notes in their offices, homes, or cars,

INSIDE

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Papadakos says.

If documenting from home, physicians should indicate they are doing so, says Papadakos, such as, "I am writing this note from the quiet of my home office after I saw the patient in the hospital." "Otherwise, the attorney can say, 'You wrote these notes from home; obviously, you never went in to see the patient,'" he says.

A physician's texting, emailing, and posting might come out during a lawsuit because a patient or family noticed it or because other healthcare providers testify about it when they're deposed, says **Marylou Foley**, a senior claim manager at Coverys in Boston. "They will be asked what was going on at the time and asked about the actions of other people," says Foley. "Obviously, people have to tell the truth under oath."

Here are risk-reducing strategies for physicians:

• Physician groups should develop a policy for appropriate usage of social media and personal devices.

Pamela D. Tyner, JD, an attorney with Epstein Becker Green in Houston, TX, says, "This limits the likelihood that there will be information ripe for plaintiff attorneys to subpoena and possibly admit as evidence." *[To view University of California –San Francisco Medical Center's policy on social media, go to http://www.ucsf.edu/about. Click on "UCSF Social Media," "Guidelines," "University of California Electronic Communications Policy." The "Code of eConduct" policy used at the University of Rochester Medical Center is included with the online version of this month's* Physician Risk Management. *Go to http://bit.ly/PAABGS. On the right side of the page, select "Access your newsletters." You will need your subscriber number from your mailing label. For assistance, contact customer service at customerservice@ahcmedia.com or (800) 688-2421.]*

• Provide education to physicians.

Informing physicians that texts and emails might be discoverable can curb unwarranted and unprofessional posts, Tyner advises.

"When you educate people about this, a light bulb goes off. I tell them that A, you are going to hurt people, and B, you are going to get burned legally,'" says Papadakos. He notes that the University of Rochester now educates residents and physicians on the appropriate use of electronic devices. *[A free copy of the computerized graphic presentation used for training is included with the online version of this month's* Physician Risk Management.*]*

"We are at our infancy with including this in the curriculum," he says. "The question is, how do we make rules addressing such an overwhelming addiction to get information?"

If a patient notices a physician texting or using a laptop, it might appear that the doctor is distracted with something personal, even if this isn't the case. If a bad outcome occurs, this technology use might lead the patient to suspect the distraction was the reason, says Foley. "The use of technology may not have caused harm to the patient," she adds. "But if they perceive that it has, it can make it more difficult to defend a claim."

Coverys is handling an open claim involving a patient who felt she wasn't attended to in a timely manner because the physician was texting, which was observed by the patient's husband. "It may not have made any difference in the patient's outcome, and we may be able to defend it, but the fact the physician was texting does make it more difficult," says Foley.

Members of a jury might understand

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Executive Summary

Plaintiff attorneys are now routinely looking to see whether the doctor was texting, emailing, posting, or viewing websites during a procedure or surgery. Some risk-reducing strategies:

- ✦ Develop a policy for appropriate use of personal devices.
- ✦ Use separate devices for personal and professional use.
- ✦ Inform physicians that texts and emails might be discoverable.
- ✦ Tell patients if you are using a personal device to obtain medical information.

a physician getting distracted because of another patient, but they won't be sympathetic to a patient being neglected due to a doctor checking his email, says Foley. Even if a physician is using a personal device to obtain relevant medical information, the patient might assume otherwise and become angry, says Papadakos. "The computer is between the patient and the provider, so people get mad, saying, 'The guy was staring at the computer screen,'" he says, adding that angry patients are more likely to sue physicians.

Papadakos advises young physicians to explain to patients, "I apologize for turning my back, but I am entering the information you gave me, and I'm checking your labs."

"Treat the computer as a third person in the room. Introduce the computer as part of the health care team," he says. "Otherwise, people don't know what you are doing with a laptop open.

> *"Treat the computer as a third person in the room. Introduce the computer as part of the health care team."*

They won't know whether you're looking at their medical record or your Facebook page."

• Use separate devices for personal and professional use.

Huben-Kearney says she has "grave concerns" about physicians using the same device for personal and professional communications.

"It's no accident there is such an increase in data breaches," she says. "Devices are getting lost and getting stolen. You should literally use two different phones." *(See related story on whether a physician's texts and posts are discoverable, below.)*

SOURCES

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Lawyer can learn when and where doc texted

Electronic discovery often permitted by the courts

Would a court grant a motion to quash a subpoena to Facebook or some other social networking site? "The law in this area has not really been developed yet," says **Kenneth T. Lumb**, JD, an attorney with Corboy & Demetrio in Chicago. "We have only a few sporadic trial court orders or appellate court opinions to guide us."

Thus far, most subpoenas to social media sites have come from defense attorneys looking for information or photographs that might be inconsistent with a plaintiff's claimed injuries, according to Lumb.

"It seems that most courts have required some evidence that access to a social media site or an email account will produce relevant evidence before the court has allowed a subpoena to be enforced," he says.

Courts may also conduct an in camera inspection of the documents produced, which is a private inspection to determine which information will be turned over to the requesting party, says Lumb. "I think the same standard will likely become the majority approach in cases involving discovery of healthcare providers' use of the Internet or cell phones during patient care," he says.

If there is some indication that inappropriate use of electronic media could have contributed to a bad outcome, it might well be discoverable, Lumb explains.

Attorneys are going to ask doctors, nurses, and allied health professionals if electronic media are being used in the operating room, post-anesthesia care unit, or the intensive care unit while the patient was there, says Lumb.

Risk reduction for physicians should center on eliminating the distraction, Lumb advises. "I don't text while driving my car or while a witness is on the stand in a trial," he says. "I think a patient should be able to expect that while he's under general anesthesia, the people who hold his life in their hands are focused solely on him."

Here are some ways "distracted doctoring" could come up during a lawsuit:

• During depositions, colleagues might reveal that a physician was posting or texting before, during, or directly after a procedure.

If an opposing party sufficiently illustrates this action possibly contributed to an alleged negligence, it might be subpoenaed from the social media sites and/or the handheld device manufacturers, says **Pamela D. Tyner**, JD, an attorney with Epstein Becker Green in Houston, TX.

"Plaintiff attorneys are beginning to zero in on this type of evidence and 'e-discovery,'" she says.

• If a physician is sued, his or her social media posts might be discoverable if the plaintiff's attorney sufficiently illustrates the relevance of the evidence.

Marylou Foley, a senior claim manager at Coverys in Boston, says, "It's not a given that all this information will be allowed, but a plaintiff attorney could certainly petition the court to get it. My suspicion is that it would be allowed."

The court might permit discovery of private and hidden social media postings, says Tyner. A growing number of courts are siding with the argument that posting information on a social media site means that the poster of information does not have a reasonable expectation of privacy, she says.

• Under certain circumstances, plaintiff attorneys can get court orders to see what time something was texted or posted, much the way they can get telephone records to see what time calls were made.

Foley says, "The information would probably be considered relevant to the case, if it's alleged that a physician's negligence was caused by inappropriate distraction." ✦

When you can't locate nursing notes in your EMR

Legal risks will escalate

Would a jury be sympathetic if a physician failed to review nursing notes that could have prevented a patient's bad outcome, simply because they were buried somewhere within a voluminous electronic medical record (EMR)?

This situation is unlikely, says **Catherine Ballard**, JD, a partner and vice-chair of the health care group at Bricker & Eckler in Columbus, OH. A jury likely would find that the physician has a duty to look at all relevant information, regardless of whether it is easy or difficult to find it in the EMR, Ballard adds.

"I think it is highly unlikely that an EMR company will agree to indemnify a hospital or a physician if the hospital or the physician has a hard time finding nursing notes," she adds.

Executive Summary

Some electronic medical records (EMRs) make it difficult for physicians to view nursing notes, which increases legal risks due to missing crucial information.

✦ Engage in discussions with the vendor about the difficulty of finding notes.
✦ Inform the vendor that the inability to access nursing notes puts patients at risk.
✦ Consider "usability" when implementing an EMR.

There is a substantial population of healthcare providers who did not start out as computer literate, so their proficiency is not as good as it could be, says Ballard. "We are still at a point in time where hospitals are trying to fit into what is offered by companies, rather than companies giving the hospitals what they need," she adds. "This will improve over time. One day, people will be looking back on this time of transition and be amazed at how archaic we look."

Physicians should engage in ongoing discussions with the EMR vendor about the difficulty of locating nursing notes and how the inability to access the information is putting patients at risk, advises Ballard. *(See related story, below, on important questions to ask EMR vendors to reduce liability risks.)*

"Ask the nurses for assistance in getting the access that the physician needs," she advises. "The EMR is here to stay, and paper is not going to be an option." ✦

Vendors could share malpractice liability

Did a physician miss a piece of crucial information because multiple clicks were required to retrieve it from the electronic medical record (EMR)? If so, the EMR vendor possibly could be named alongside the physician in the event a malpractice lawsuit is filed, according to **Sharona Hoffman**, JD, LLM, co-director of the Law-Medicine

Center at Case Western Reserve University School of Law in Cleveland, OH.

"I'm actually surprised we are not hearing more about this," says Hoffman. "Plaintiff attorneys may not be sophisticated enough to realize that there is fertile ground there."

Attorneys still might consider EMRs to be similar to word processors, "but they are much more than that," she says. "When plaintiff attorneys come to realize that, they may think again about whether they want the vendors named as parties."

Order submission, record searches, alerts, and reminders all occur through the EMR, Hoffman explains. Some contracts with physician groups might shield vendors from liability, and this shield might be one reason vendors aren't being named in lawsuits routinely, she adds. "There is a lot of pressure on practices to adopt these systems quickly, because there are incentive payments available," says Hoffman. "There is perhaps not enough attention being paid to the 'usability' of the systems."

Here are Hoffman's recommendations to reduce legal risks involving EMRs:

• Learn as much as you can about potential problems with the system.

User complaints might be difficult to obtain, as vendors might include language in the contract requiring that problems not be publicized by facilities and because the Food and Drug Administration doesn't require problems with systems to be reported, says Hoffman. "But that communication line is going to have to open up," she says. "It is important to do as much research as possible about the satisfaction levels of other users."

• Consider the vendors' responsiveness to complaints or requests for changes.

A psychiatrist's needs from an EMR will be quite different from a neurologist's needs, notes Hoffman, and resources of physician practices vary. "Consider how sophisticated your own IT department will be when issues come up," she recommends. "A smaller provider is going to have to depend on the vendor."

• Consider "usability."

"Can you easily search for the data you need? How easy is it to distinguish information, if the nurse wants to be sure the physician sees Detail X?" asks Hoffman.

While paper records would reflect only what the patient told the doctor at the time of treatment, the EHR is ideally a comprehensive record of the patient from birth until the present date, she explains.

"Ironically, the availability of a huge amount of information can lead to liability, because there is no way the doctor can read the entire EHR," she says. "But if something is missed, and it was a few clicks away, a patient may say you are liable for not having looked at it."

SOURCE

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Spotlight on doctors' role in prescription drug abuse

Physicians can be held criminally liable

A Virginia physician was sentenced to four years for drug trafficking when patients resold their prescriptions.

In the 11th Circuit United States Court of Appeals case, U.S. v. Webb, a physician received three concurrent life sentences for deaths of patients who overdosed from his prescriptions.

In a Massachusetts case, a physician was found liable for a patient's drug overdose because he refilled the patient's opiate prescription earlier than he was supposed to.

In the Ohio Sixth District Court of Appeals Case Conrad - Hutsell v. Colturi, a court found it was a question to go to the jury to determine whether medical malpractice occurred when a patient was prescribed opiates by a gastrointestinal physician and became addicted.

"The court would not allow a directed verdict to stand on the case," says **Samantha L. Prokop**, JD, an associate at Brennan, Manna & Diamond in Akron, OH.

There are increasing numbers of cases, civil and criminal, involving physicians who prescribe narcotics to patients who sell the drugs or abuse them, warns Prokop. She adds that one of her firm's clients, a pain management practice, recently stopped prescribing opiates to patients because of the liability risks involved.

Here are risk-reducing strategies Prokop shares with hospitals during risk consultations in this area:

• Be sure all physicians in the practice or group are consistent in prescribing practices.

After several high school students died of overdoses, Prokop consulted with a local hospital to look at the prescribing practices of its physicians. One of the first things they learned was that physicians at the health system's EDs and multiple urgent care centers varied widely in their prescribing practices.

"It really didn't take much to get all the physicians together, once we told them, 'Look, in the long run this will keep drug-seeking patients from coming back here to obtain illegal drugs. It will

Executive Summary

Physicians are being held civilly and criminally liable for prescribing narcotics to patients who resell or abuse them, and state medical boards and legislatures are taking action.

- ✦ Use consistent prescribing practices.
- ✦ Review and document information from prescription monitoring databases.
- ✦ Be sure documentation supports the medical care provided.

make things safer for patients and will protect you legally," says Prokop.

• Access online prescription monitoring databases.

"There is a huge move toward this right now. The physician can go look and see how many times the prescription got refilled and who they are getting them from," she says.

While the databases have been available for some time in most states, there are now mandatory in some states, notes Prokop. "If the patient is getting controlled substances on a regular basis, there is a duty to continue to review that database on a regular basis," she says. "Our physicians don't have a choice anymore; in certain situations, it's mandated."

• Document carefully.

If you suspect a patient has a drug dependency, Prokop advises charting what you learned from the monitoring database, how many times the prescription was refilled, what the patient stated to you, and his or her symptoms, but keep the wording objective and not judgmental.

She gives this example of judgmental charting: "The patient came in today and advised that she was allergic to two out of the three pain medications I attempted to prescribe. She is adamant that she be prescribed _____, a narcotic. The patient cannot pinpoint the location of her back pain. Her symptoms appear to be a figment of her imagination. The patient has been to the ED five times in the past month. It is clear this patient is a drug-seeker. I am not prescribing narcotics today in hopes that this patient will not come back to our ED seeking drugs for illicit use.

> *"~ e physician can go look and see how many times the prescription got reÿlled and who they are getting them from."*

Prokop gives this example of objective documentation: "The patient came in today and reported that she was allergic to two out of three pain medications I suggested. I asked the patient what types of symptoms she exhibited with these medications, and she indicated she broke out in hives with each one. The patient complained of low back pain that was not present upon palpation. The patient's family expressed concern that the patient has not been taking her medications as prescribed. I reviewed the Ohio Automated Prescription Reporting System database. The patient has received early refills three out of the last four times for her pain medication. Due to the risks of the patient not taking medications as prescribed, I am ordering a urine test prior to prescribing narcotics for this patient. I discussed with the patient the concerns of taking medications as prescribed and the risk for drug dependency and potential abuse associated with these drugs. She admits to not taking medications as prescribed. The patient is willing to undergo counseling for drug dependency issues. I have referred her to _____ for follow-up."

"You don't want to get yourself in a position where you've got a defamation or libel case because the patient says you defamed them in a medical record or inappropriately labeled them as a drug-seeker," says Prokop. *(See related stories on what prosecutors are looking for, below, and what constitutes "corrupt intent," p. 19.)*

SOURCES

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Prosecutors looking at prescribing practices

As a federal prosecutor, **Michael E. Clark**, JD, LLM, prosecuted several physicians for illegally prescribing highly addictive controlled substances — mostly Schedule II narcotics — that while having legitimate medical purposes, were also not the first choice of treatment for patients.

"The law is clear that a physician cannot use his or her medical license as a means to engage in medical practice outside the accepted norms of legitimate medical standards," says Clark, now special counsel at Duane Morris in Houston, TX.

Such conduct not only would expose a physician to criminal prosecution, but it also could result could in civil actions filed by administrative agencies and/or malpractice lawsuits, adds Clark.

Typically, a physician who is a sub-

ject or target of an investigation involving allegations of illicit prescription drug prescribing won't be made aware of the investigation until the government is ready to file charges, according to Clark. "In drug diversion investigations, it's not uncommon in developing evidence to support a prosecution for undercover agents to pose as patients as a means to test the integrity of the physicians," he says.

Off-label use is issue

Clark says there "has long been a tension" between allowing pharmaceutical companies from engaging in off-label marketing activities that encourage physicians to prescribe products not properly submitted and approved by the Food and Drug Administration and the residual rights of physicians to prescribe products which they, in their professional judgment, decide are appropriate for treating their patients.

"Indeed, many off-label uses of prescription products are well within the mainstream, particularly in areas where drug manufacturers haven't sought approval, such as in pediatrics and oncology," he says.

However, physicians who do so always run the risk that the government could claim they have violated drug laws by prescribing controlled substances outside the course of legitimate medical practice or that plaintiffs' attorneys could sue them for alleged malpractice, says Clark. For example, in some states, a plaintiff's attorney could sue a physician for a catastrophic result from alleged misconduct in prescribing narcotics, such as a fatal car crash by an impaired patient. "There is always a causation and foreseeability issue involved which may or may not be something that can be proven, depending on the facts," says Clark.

In many states, the state medical boards and legislatures have responded to the claimed problems of prescription drug abuse by tightening up the standards for pain management practitioners and targeting those who are perceived to be engaging in drug diversion activities by prosecution and administrative sanctions, he says.

"The problem, of course, is that at some point such measures can result in limiting the access of needy individuals to legitimate medical treatments," says Clark. ✦

Did physician have 'corrupt intent?'

What makes a physician the subject of an investigation involving allegations of illicit prescription drug prescribing?

"Prosecutors are looking for high-profile cases," says **Michael E. Clark**, JD, LLM, special counsel at Duane Morris in Houston, TX, and a former federal prosecutor. "They will want to be able to demonstrate that a physician's practice was far off the norm of expected medical practice or that he or she made huge amounts of money engaging in outlier activities."

Such evidence will help to demonstrate the physician's "corrupt intent," he says. "On the other hand, having documentation and witnesses available to demonstrate otherwise will be critical in limiting a professional's exposure," adds Clark. He gives these risk-reducing strategies:

• Be particularly careful that your documentation supports the medical care provided.

• Pay close attention to applicable coding and billing rules and regulations.

• Have independent periodic reviews conducted by qualified third parties.

"Basically, prepare as though you could be placed in the position of having to justify your actions later on with a program integrity auditor, licensing board, plaintiffs' malpractice lawyer, or even a prosecutor," says Clark.

• Have an attorney review compliance measures.

"This will help to preserve any applicable privileges that may need to be observed and also demonstrate that the professional lacked the type of corrupt intent needed to prosecute," says Clark. ✦

Is there an incidental finding? No follow-up can get you sued

Inaction can be 'difficult to defend'

A patient's CT scan ruled out a pulmonary emboli, but showed a 1.5 cm nodule in the right upper lobe of the lung. When the patient returned six months later, the physician noticed the previous finding and referred the patient for follow-up, which revealed metastatic lung cancer.

The patient claimed that no one had told her of the initial finding and sued for delayed diagnosis, reports **Lizabeth Brott**, JD, regional vice president of risk management in the Okemos, MI, office of ProAssurance, a writer of medical professional liability insurance, who reviewed the case.

If an incidental finding is identified and the physician does nothing about it,

and the patient is later diagnosed with a serious problem related to that incidental finding, "that creates a serious risk for the physician," says Brott.

Incidental findings are surprisingly common, adds Brott. In one study, intracranial findings were identified in 6.6% of 953 children who underwent brain magnetic resonance imaging, with potentially serious or urgent findings in 0.6% of these.[1] Incidental findings were identified in 45% of 321 noncontrast "renal stone" abdominal CT scans done in an emergency department, with half of "moderate" or "serious" concern.[2]

"I am not suggesting every incidental finding poses a malpractice risk," says Brott. "But for the ones that aren't benign, the possibility is there." Avoid these risk-prone practices:

• Failure to discuss the incidental findings with the patient.

"This is especially important if you are the physician who referred the patient to the specialist or the hospital for the test," says Brott. "When there is a finding that has a moderate risk and it is completely ignored, that could be a difficult case to defend."

If the report with the incidental findings originated from a specialty practice or radiology, the radiologist or specialist should discuss it with the patient or refer the patient to the primary care physician to determine what follow up is needed, says Brott.

• Failure to include incidental findings in the report.

"If the referring physician doesn't have that information, he or she would obviously not have any liability," she says. "However, if the patient continues to experience symptoms and there is a lack of follow-up, the referring physician can get dragged into the claim."

Executive Summary

Failing to notice an incidental finding on a diagnostic test or failing to discuss this information with the patient can result in a successful suit for delayed diagnosis. Document these items:

✦ Your discussion with the patient regarding what follow-up care should be obtained.

✦ Whether the patient agrees or refuses to comply.

✦ The reason a particular a finding is not going to be worked up.

• Delegating to physician extenders and nurses without proper training and without a system in place to ensure findings are noted and addressed during the everyday provision of care by the doctor and staff.

D. Jay Davis Jr. JD, a partner at Young Clement Rivers in Charleston, SC, and chair of the firm's Medical Liability Practice Group, says, "The most common mistake I have seen is the rushed doctor who has developed great trust with an extender that does not thoroughly review the findings, conclusions, and follow up plan of his or her extender."

• Failure to document the patient's response.

Document the patient's agreement with your recommendation for follow-up, and document that the patient made an informed refusal if he or she refuses to comply, advises Brott.

The best practice is to have the patients sign an informed refusal form stating that they understand the risk of not following the doctor's recommendations, but if this signature is not possible, document that the patients understand the risks of not following your recommendations and choose not to pursue them, Brott says.

"A sentence in the chart will help tremendously in those situations," she says.

In some cases, the doctor and patient might agree not to pursue further testing. "It is possible that the patient might sue later," says Brott. "But that is a far more defensible situation than the doctor making the decision unilaterally and the patient saying, "Nobody told me.'" *(See related stories on documenting discussions about incidental findings, below, and how EMRs can affect liability risks involving incidental findings, p. 16.)*

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SOURCES

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No documentation of your discussion?

D. Jay Davis Jr., JD, a partner at Young Clement Rivers in Charleston, SC, and chair of the firm's Medical Liability Practice Group, was involved in a case in which a general surgeon consulted for appendicitis successfully treated the condition during surgery, with an abdominal CT scan ordered as part of the preoperative workup.

The radiologist identified a "questionable malignancy," and the doctor identified the problem and discussed it with the patient. "He spoke verbally to the patient about the findings. He

expressed some doubt as to the finding, but advised follow up with his a physician," says Davis.

After discharge, the patient did not return for postoperative visits. "The doctor did not document these discussions about the finding with the patient or that he had recommended follow up on the finding," says Davis. "The patient passed away from the cancer."

Although the doctor thoroughly documented his treatment of the surgery, he didn't do the same for the CT findings, since they were questionable, not related to the admission, and he expected the patient to return, Davis explains. "The patient then had the bad outcome. Suit was brought not for the surgery, but failure to follow up on an unrelated CT scan and refer to an oncologist," says Davis.

The case was a "perfect storm," since the doctor was not looking for cancer, wasn't not focused on documenting and planning for an unrelated and questionable finding in the hospital record, and the patient never came back, so no office records would confirm the discussion during follow up, Davis says. "The patient and his family denied any conversations occurred or that any follow up was ever recommended." says Davis.

Chart is major focus

"I really do not believe there is any such thing as an 'incidental' finding in the medical-legal arena," says Davis."A finding is just that in the eyes of the patient and, almost as importantly, in the eyes of a plaintiff's lawyer."

Plaintiff's lawyers will attack the physician for failure to follow up any serious problem that needs follow up, adds Davis. "It simply does not matter much to the plaintiffs' lawyer that the doctor was treating an unrelated problem at the time of the finding," he says. "Many times, labs and radiographic tests ordered for specific problems but covering a broad range of issues are the culprits in these cases."

Davis says that the most likely legal theories asserted by plaintiffs against physicians in this scenario include failure to advise the patient of the incidental finding, failure to document the incidental finding, failure to document actions taken, failure to run further tests to confirm or evaluate the finding, and failure to refer the patient to a specialist.

"Dovetailing with the failure to advise is the failure to properly document the medical chart, which is always a major focus in every case," says Davis. "If there is a finding that is not going to be worked up, you must document why and what the plan is going to be in light of the finding." ✦

Executive Summary

If physicians consult colleagues or co-defendants about the facts of the case after being named in a suit, they can lose credibility. Take these steps instead:

- ✦ Review the patient's chart.
- ✦ Restrict yourself to your involvement in the patient's care.
- ✦ Recommend research your attorney can perform on relevant issues.

Sued? Don't gather information from others

Review only your care when you receive letter from attorney asking for patient's records

(Editor's Note: This is the second part of a two-part series on actions physicians should take after being named in a suit. This month we give recommendations for what information doctors should review. Last month, we covered why physicians should avoid placing blame on colleagues.)

"Wasn't the anesthesiologist in the room when the bleeding started?" might be an innocent question asked by a physician named in a lawsuit to other staff who were in an operating room during a case. However, "it can look really bad, depending on the circumstances," says **Norm Jeddeloh**, JD, an attorney with Arnstein & Lehr in Chicago. "It may look like you are trying to create a story retrospectively, and that can be terribly damaging."

Similarly, it might look suspicious if a physician named in a suit asks a co-defendant, "Isn't it true that we responded immediately to that page?" when there's no documentation about it in the patient's chart.

David S. Waxman, JD, an attorney with Arnstein & Lehr, says, "When the other doctor recounts that conversation, it certainly makes it look like you were trying to rewrite history. You have to maintain your credibility at all points in the process. If it looks like you are trying to fudge the facts, you are in big trouble."

The initial reaction of physicians is to "get their arms around what led to the filing of a lawsuit," says Waxman. "Obviously, anything done outside the province of your counsel is subject to discovery. You don't want to give opportunities to the other side that they wouldn't otherwise have had."

Roger L. Hillman, JD, an attorney with Garvey Schubert Barer in Seattle, says that in his experience of defending physicians, not many can truthfully say they didn't speak to anyone else about the lawsuit. "The

first thing that's going to be asked at your deposition is, 'Did you talk to anybody about the case?' And every name you give them, they are going to depose," he warns. For this reason, Hillman says to avoid discussing the case as soon as you receive a letter from an attorney asking for a patient's records.

"Virtually every healthcare provider who is sued thinks, 'If I could just get them to understand what happened, they will go away.' That's not going to happen," says Hillman. "The more you explain, the more ammunition you give them." To avoid problems:

• Review the patient's chart.

Documented records are likely to be the most accurate source of what happened and often are the most important evidence that's presented, says Jeddeloh. "A judge once told me he didn't care what people testified to. He wanted to see what the documents said," he recalls.

• Review only your involvement in the patient's care.

Even if you only saw a patient the first two days after he or she was admitted, it might seem logical to also review the remaining eight days of hospitalization. "But if you review that, it's then fair game for the plaintiff attorney to ask you about it, even though it wasn't care you were involved in," explains Waxman.

> *"A judge once told me he didn't care what people testified to. He wanted to see what the documents said."*

"There is no reason to subject yourself to unnecessary questioning."

Limiting your review only to what you said and did is a lot easier to deal with, he explains. "If you educate yourself on a much bigger picture, you expose yourself to issues that you otherwise would not be exposed to," says Waxman. "You have made your situation much more difficult than it needs to be."

• Avoid researching issues in the lawsuit before your deposition.

Because you can be deposed about this research, it's better to recommend research that your attorney can perform on the various issues involved in the case, says Waxman.

"If you do it yourself, it may tip off the other side to your thought process or something they hadn't even considered," he explains. "If your attorney does it, that's privileged, and [the opposing attorney] will never know about it."

SOURCES

For more information on communicating with others during litigation, contact:

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Is 'expert' misleading jury, or outright lying?

Your attorney may be able to take counter-measures

[Editor's note: This is the first part of a two-part series on expert witness testimony in medical malpractice cases. This month, we cover possible approaches if witnesses for the plaintiff give inaccurate testimony. Next month, we report on how a witness can be prevented from testifying and what actions could put physicians at risk for being accused of witness tampering.]

Is the plaintiff's expert witness deliberately misrepresenting the standard of care? "Expertise, alone, does not guarantee truthfulness or candor," says **Dan Groszkruger**, JD, MPH, principal of rskmgmt.inc, a Solana Beach, CA-based healthcare risk management consulting firm and former director of claims and litigation management at Loma Linda (CA) University Medical Center. "Once an expert witness is deemed qualified by a court, there are a number of counter-measures useful to identify inaccuracies, or outright lies."

A skillful defense attorney will do the following, says Groszkruger:

• Carefully identify exactly what the witness reviewed in preparation for giving testimony.

"Actual time spent reviewing background information, documented in

Executive Summary

Expert witnesses might give inaccurate testimony during litigation, but defense attorneys can address this problem by discrediting the witness at trial or moving to strike the expert's testimony. Some approaches:

- ✦ Testimony can be compared to that given in previous, similar lawsuits.
- ✦ Evidence from outside sources can be used to dispute the testimony.
- ✦ Insufficient preparation or false claims about credentials can be identified.

the witness's own billing records, can be quite illuminating if obviously insufficient to gain an adequate familiarity with the patient's condition and treatment," he says.

• Identify all assumptions upon which the witness has relied in arriving at opinions and conclusions.

"The witness may have improperly disregarded, or failed to give appropriate weight to, key facts based on the witness's assumption that such details were not pertinent to the witness's investigation," he says.

• Compare the witness's proffered testimony in this case to his or her testimony offered in previous, similar lawsuits.

"Deposition transcripts documenting how the witness testified in previous cases can be located and copied from other defense colleagues, or from other medical malpractice defense sources such as societies and associations of defense attorneys who share such information," says Groszkruger.

Address inaccuracies

The first opportunity to directly address inaccurate testimony is on cross examination in the expert's deposition, says **Maureen M. Vogel**, JD, a shareholder with Polsinelli Shughart in Kansas City, MO. Here are some ways of doing this:

• The defense lawyer will pin down the expert's opinion and see how far he or she will take it.

Vogel says defense lawyers will ask the witness questions such as "Is the opinion you are offering an absolute in your profession?" "Would you expect that there are other physicians sharing your expertise who, when presented with the same facts, would disagree with your opinion?" and "Would you be surprised to learn that there is medical literature disputing the opinion?"

• If the witness offers testimony based only on the plaintiff's version of events and there are factual disputes, hypothetical questions may be asked.

For example, says Vogel, the attorney can ask the witness to assume that the physician's version of events is true, and if so, wouldn't he or she agree that the standard of care was met?

• The witnesses' claims about their own background and credentials will be explored.

Witnesses might testify falsely that they passed boards, graduated from a certain school, or were actively engaged in the clinical practice of medicine a certain percentage of the time to qualify as an expert under the state's law.

"In these cases, the defense can develop evidence from outside sources to dispute the testimony," says Vogel. "This evidence can be used in summary judgment motions, motions to strike the expert's testimony, or to discredit the witness at trial."

SOURCES

For more information on testimony of expert witnesses, contact:

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• **Dan Groszkruger,** JD, MPH, Principal, rskmgmt.inc., Solana Beach, CA. Phone: (619) 507-0257. Email: rskmgmtinc@msn.com.

• **Maureen M. Vogel,** JD, Shareholder, Polsinelli Shughart, Kansas City, MO. Phone: (816) 395-0605. Email: mvogel@polsinelli.com. ✦

COMING IN future MONths

✦ Common adverse actions by state medical boards

✦ Texting of orders puts patient at risk for harm

✦ EMRs might increase the risk of delayed diagnosis

✦ Practicing defensive medicine can increase legal risks

CME OBJECTIVES

After reading *Physican Risk Management*, the participant will be able to:

- describe the legal, clinical, financial, and managerial issues pertinent to physician risk management;
- explain the impact of risk management issues on patients, physicians, legal counsel, and management;
- identify solutions to risk management problems for physicians, administrators, risk managers, and insurers to use in overcoming the challenges they face in daily practice.

CME INSTRUCTIONS

To earn credit for this activity, please follow these instructions.

1. Read and study the activity, using the provided references for further research.

2. Log on to www.cmecity.com to take a post-test; tests can be taken after each issue or collectively at the end of the semester. First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.

3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.

4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.

5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly. ✦

CME Questions

1. Which is true regarding subpoenas to social networking sites, according to Kenneth T. Lumb, JD, at Corboy & Demetrio?

A. Most subpoenas to social media sites have come from defense attorneys looking for information or photographs that might be inconsistent with a plaintiff's claimed injuries.

B. Courts generally do not require any evidence that access to a social media site or email account will produce relevant evidence before allowing a subpoena to be enforced.

C. Even if an opposing party sufficiently illustrates a doctor's posting during a procedure possibly contributed to an alleged negligence, it cannot be subpoenaed from the social media sites.

2. Which is recommended to protect a physician against civil and criminal liability for prescribing narcotics to patients who resell or abuse them, according to Samantha L. Prokop, JD, at Brennan, Manna & Diamond?

A. Physicians should avoid accessing prescription monitoring databases unless the patient is a known drug seeker.

B. It is not advisable to chart what you learned from a prescription monitoring database if you suspect a patient has a drug dependency.

C. If the patient is getting controlled substances on a regular basis, physicians should continue to review the database regularly.

3. Which is true regarding liability risks of incidental findings on a diagnostic test, according to Lizabeth Brott, JD, at ProAssurance?

A. If an incidental finding is identified and the physician does nothing about it, and the patient is later diagnosed with a serious problem related to that incidental finding, this is a serious liability risk for the physician.

B. Every incidental finding poses a malpractice risk.

C. If the reports with the incidental findings originated from a specialty practice or radiology, the radiologist or specialist should not refer the patient to their primary care physician to determine what follow up is needed.

4. Which is recommended for physicians named in a lawsuit, according to David S. Waxman, JD, at Arnstein & Lehr?

A. Physician defendants should perform their own research on issues in the lawsuit, as opposed to requesting that attorneys do so.

B. It is advisable to consult with colleagues about the facts of the case immediately after a lawsuit is filed.

C. Physicians should discuss the facts of the case openly, but only with colleagues who were directly involved.

D. Physicians should limit their review of the patient's care to their own involvement.

Physician Legal Review & Commentary

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Anesthesiologist found negligent in brain injury death case, $1.23M verdict

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News: In the summer of 2008, a patient underwent thyroid surgery. She did not recover from the surgery, and she could not be revived in postanesthesia care. The patient's family brought a suit against the hospital, the anesthesiologist, and the anesthesiologist's medical group and alleged that during surgery, the anesthesiologist failed to correctly place the oxygen tube, thereby causing injury to the brain by depriving it of oxygen and leading to eventual death. An autopsy revealed that oxygen deprivation was the cause of death. The hospital was dismissed from the lawsuit. The jury found the anesthesiologist negligent and awarded the patient's family $1.23 million in damages.

Background: On Aug. 11, 2008, a 66-year-old mother of eight underwent surgery to remove the thyroid and parathyroid glands in her neck. Thyroid and parathyroid surgeries are common, although, the parathyroid surgery in particular is specialized due to the number of small nerves within the neck and surrounding the glands. The patient suffered from a severe lack of oxygen and extremely low blood pressure during the surgery. Doctors were unable to revive her in postanesthesia care, and she was placed on life support. Her family was forced to make the difficult decision to remove her from life support on Aug. 22, 2008.

The misplacement of the oxygen tube made it impossible for the patient to breathe independently and resulted in brain damage and death.

The patient's family brought a suit against the hospital, the anesthesiologist, and the anesthesiologist's medical group. Plaintiff alleged that the anesthesiologist failed to recognize that the oxygen tube had moved after the patient was given general anesthetic. The misplacement of the oxygen tube made it impossible for the patient to breathe independently and resulted in brain damage and death. Plaintiff also alleged that the anesthesiologist was negligent in failing to monitor the breathing apparatus, after anesthesia was administered, and the patient's blood pressure during the surgical procedure. Both of these situations can result in oxygen deprivation. Plaintiff claimed the patient's blood pressure was extremely low during surgery and cited that monitoring of heart rate, breathing pattern, blood pressure, and all vital signs are responsibilities of the anesthesiologist. An autopsy was performed on Aug. 22, 2008, three days after the patient was removed from life support and died. The autopsy failed to show any cause of death other than lack of oxygen during surgery.

The named hospital was dismissed from the lawsuit in October

FINANCIAL DISCLOSURE: Co-Authors **Jonathan D. Rubin**, Esq., **Elizabeth J. Janovic, Barbara K. Reding**, and Executive Editor **Joy Dickinson** report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

2011. The remaining defendants, the anesthesiologist and the anesthesiologist's medical group, denied negligence and contended that the anesthesiologist complied with all standards of care and properly monitored the patient.

The jury deliberated for three days and found that the anesthesiologist was "professionally negligent" in his care of the patient. The jury determined his negligence was the "proximate cause of death" of the patient. On March 1, 2012, the jury reached a verdict in favor of the patient's son, who filed the suit as a personal representative of the estate. The jury awarded $1.2 million in non-economic damages and $34,274 in economic damages.

Defendants were not satisfied with the verdict and have yet to decide whether they will seek an appeal of the decision.

What this means to you:
Cerebral hypoxia, a condition that occurs when there is insufficient oxygen to the brain, is an emergency condition that requires immediate intervention. Brain cells are extremely sensitive to a decrease in or absence of a life-sustaining supply of oxygen and will begin to die within minutes. The sooner the oxygen supply is restored, the lower the risk of severe brain damage or death. The longer a person is exposed to oxygen deprivation, the higher the risk for brain death and the lower the opportunity for recovery.

Administration of anesthesia in current healthcare settings requires in-depth technical training and extensive biological, anatomical, and physiological education. Due diligence, excellent assessment skills, and a constant and consistent vigilance are requirements, not options, when administering paralytic or anesthetic agents to patients.

To be deprived of oxygen in a healthcare setting might occur as the result of an unanticipated trauma, cardiac, hematologic, or birth event. In general, a state of hypoxia is an unexpected occurrence. Given the technical support of today's diagnostic monitoring equipment, failure to adequately assess patient status during a treatment or procedure, resulting in an anoxic or hypoxic outcome, is unacceptable and inexcusable. In addition to monitoring blood pressure status, oxygen saturation and perfusion rates must be closely observed to ensure the patient remains stable under the effects of anesthesia. If the assessment indicates otherwise, immediate intervention is not only prudent; it is mandatory.

~e anesthesiologist was deemed to own the duty to continuously monitor patient status and intervene when and if necessary.

Although defendants in this case denied any deviation from anesthesia standards of care, the inability to revive a 66-year-old patient post-procedure raises the question as to the type and quality of assessment and monitoring the patient received during the period of anesthesia. In this case, the postmortem found no cause of death other than a lack of oxygen during surgery. Signs and symptoms of oxygen deprivation, such as a decrease in blood pressure, heart rate, and oxygen saturation levels, would have been evident due to incorrect endotracheal intubation (ET tube) placement, especially because the patient was unable to breathe on her own for a prolonged period under anesthesia. If blood samples were drawn perioperatively, abnormal blood gas readings such as a decrease in PO_2 levels and an increase in CO_2 levels, or other variant blood chemistry results also would serve as indicators of an oxygen flow problem. One can only conclude such warning signals were ignored or not observed at all.

It is interesting to note the hospital was dismissed from litigation several months prior to trial. Hospitals are frequently considered to be ultimately or vicariously liable for the care rendered within their organization. The hospital's dismissal in this case appears to indicate appropriate policies, procedures, and protocols were considered to be in place to ensure a reliably safe outcome for patients undergoing surgical procedures. At the least, it is assumed the evidence presented did not support responsibility on the part of the hospital.

Based on the verdict, the jury found culpability to rest solely on the anesthesiologist's failure to adhere to the standard of care. The anesthesiologist was deemed to own the duty to continuously monitor patient status and intervene when and if necessary. The anesthesiologist was responsible for correctly inserting the ET tube, assessing and reassessing the tube's placement as needed, and diligently monitoring the patient throughout the procedure. The outcome for this 66-year-old mother of eight might have been different had suitable and correct assessment and intervention measures been identified and implemented in a timely manner.

Reference:

State of Michigan Circuit Court, JAS MI Ref. No. 268411 WL (Mich.Cir.Ct.), 2012 WL 1799084. ✦

Parents awarded $74M in brain injury birth

News: In 2009, a woman delivered a full-term baby with a prolonged second stage labor. Unfortunately, the baby was deprived of oxygen during the delivery and suffered from brain damage and cerebral palsy. The parents filed a lawsuit against the obstetrician and the hospital. The hospital settled with the family, but the lawsuit continued against the obstetrician. The parents alleged that the obstetrician neglected to assist delivery and adequately monitor the baby's heart rate, which resulted in brain damage and cerebral palsy. The obstetrician denied all claims. In 2012, a jury found for the plaintiff parents and awarded $74.225 million in damages.

Background: On April 19, 2009, a newborn girl was delivered to her parents by an obstetrician in their local hospital. The delivery was only three hours long, but the mother suffered a prolonged second stage labor that necessitated a resuscitation of the baby after she was born. The baby is now 3 years old and suffers from brain damage and cerebral palsy.

Plaintiff parents alleged that defendants, the obstetrician and the hospital, provided substandard care during the delivery. Both parents claimed to have suffered bystander emotional distress from observing the negligence inflicted upon their newborn daughter. The mother made a separate claim of emotional distress, because she was an independent patient of the obstetrician and hospital. Plaintiffs argued that the obstetrician neglected to assist delivery by using forceps, vacuum, or by performing an episiotomy. Plaintiffs also claimed that the baby's heart rate fluctuated wildly, and the heart rate monitor went out several times during the three hours prior to the baby's birth. Plaintiffs claimed that even after the fluctuating heart rate, defendant obstetrician did nothing to expedite the delivery after the baby's heart rate dropped several minutes before delivery. Plaintiffs also claimed that defendant obstetrician did not conduct a proper examination of the cord blood. Plaintiffs' attorney claimed that the umbilical cord was wrapped around the baby's neck when she was delivered, which with the prolonged second stage delivery was the cause of extensive oxygen deprivation. The baby was born "depressed" and suffered brain damage when the obstetrician neglected to assist the delivery and the hospital staff could not appropriately intubate or ventilate her. The now 3-year-old child suffers from severe physical and neurological injuries, including cerebral palsy, and requires significant, lifelong medical attention and 24-hour care.

Unfortunately, the baby was deprived of oxygen during the delivery and su° ered from brain damage and cerebral palsy.

Defendant hospital settled with the plaintiffs mid-trial for an undisclosed amount of money. According to the plaintiffs' attorney, defendant obstetrician desired to settle the case, but his insurance company refused to participate in a settlement of the allegations prior to trial. Defendant obstetrician denied all allegations of negligence related to the birth, and claimed the baby's parents assumed the risk of birth related injury and did not exercise ordinary care and caution. He asserted that if any damages were sustained by plaintiffs, those damages were directly and proximately caused by the negligence of the plaintiffs. Defendant obstetrician also claimed that any damages suffered by the plaintiffs were related to the negligence of outside entities, corporations, or persons, and the negligence inflicted by those outside entities comparatively reduces the percentage of negligence by defendant obstetrician if any were found.

Defendant obstetrician also claimed that a blockage of mucus in the airway was the cause of the loss of oxygen to the baby's brain and resulting cerebral palsy. This claim was in direct opposition to plaintiff's claim that the umbilical cord wrapped around the baby's neck was the cause of the loss of oxygen. Defendant obstetrician argued that the baby's heart rate was being appropriately monitored. The obstetrician claimed that the baby's heart rate appeared normal to the obstetrician and nurses throughout the delivery and that all involved thought it was safe to proceed with labor.

The trial lasted approximately seven weeks, and the jury only spent two days in deliberation. The jury unanimously found that the obstetrician breached his duty, failed to adhere to the standard of practice in the community with respect to medical treatment, acted negligently, and caused substantial harm to the infant. The jury also held that the child has a reduced life expectancy of 63 years and a lost earning capacity of $10 million. In his closing argument, plaintiffs' attorney asked the jury to award the family $78 million in damages. The jury elected

to award $53 million in future medical expenses, $225,000 in past non-economic damages, $7.5 million in future non-economic damages, $1.3 million to the father for past and future non-economic damages, and $2.5 million to the mother for past and future non-economic damages.

The verdict is one of the largest medical malpractice awards in the history of the court awarding it. Post-verdict interviews conducted by plaintiffs' attorneys revealed that jurors had been divided on the issue of damages, and some jurors wanted to award even more money to the family. Plaintiffs spoke to reporters outside of the court room after the damages were awarded. They said it was a difficult decision to bring a lawsuit and they hoped the result is a greater accountability in the medical community.

What this means to you: The term "cerebral palsy" describes a group of disorders impairing posture, muscle tone, or movement. It is known to be the most common disability among children in the United States. It is caused by events that occur before (abnormal development in utero), during, or after birth (injury-related). Premature birth contributes to 50% of all cerebral palsy diagnoses. Cerebral palsy is considered to be non-progressive, with no known cure, and might be difficult to diagnose in a child's first year of life unless symptoms are severe.

Some of the known causes of cerebral palsy, in addition to prematurity, are drug or alcohol abuse during pregnancy, an infection or anemia while pregnant, a difference in blood type between mother and baby, hydrocephalus, encephalitis, meningitis, lack of oxygen to the baby during development or delivery, severe head injury or convulsions in the baby, and postpartum jaundice. Hypoxia (oxygen deprivation) during the birth process might contribute to cerebral palsy as well as to mental retardation, epilepsy, lung infections, or multi-organ failure.

This case, involving an alleged prolonged and traumatic birth leading to cerebral palsy and permanent brain injury, is of particular interest with regard to its outcome. The hospital, in its decision to settle out of court, utilized a risk management strategy frequently seen in "bad" baby cases, where a sympathetic jury can pose an unpredictable threat in terms of an excessive damages award. The hospital opted not to chance a trial. Counsel for the obstetrician might have had no option but to take the case to trial due to defendant's insurance company refusing to successfully mediate the case, therefore accepting the risk of trial.

~e jury decided to send a message of zero tolerance for negligence and did so with a plainti award of $74.225 million.

The magnitude of the jury award at $74.225 million, in light of commonality and cause, is a surprise. It must have been a devastating surprise to the obstetrician and his insurance company. Factors in determining damage awards include the finding of negligence, followed by the severity and permanency of injuries sustained and the lifelong costs associated with caring for the injured plaintiff. Introduction into this case of the parents' "bystander emotional distress" also served to appeal to the need for an excessive punitive damages award and favorable verdict for the plaintiff. Bystander emotional distress paints a difficult and heart-wrenching picture. A monetary award of this degree equates to the enormity of negligence and subsequent pain and suffering perceived by the jury.

There is cost associated with deviation from standards of care. When healthcare providers consciously choose to ignore or inadvertently deviate from evidence-based, prudent, and safe methods of practice, loss occurs. For the practitioner, the loss is not only financial; it carries with it the burden of punishment and loss of reputation and trust. For patients, loss can be temporary or permanent, physical, emotional, and psychological, and it can alter their lifestyles or end their lives. For jurors and taxpayers, it is loss of time and the incurrence of judicial system expenses.

Is there an acceptable level of compensation for negligent events that cause harm or wrongful death? The jury, in this case, presumed so. Some of the jurors revealed they wanted to award even more, evidence of the emotional and judgmental costs involved. The jury decided to send a message of zero tolerance for negligence and did so with a plaintiff award of $74.225 million.

What does this mean? As healthcare providers and consumers, we must share a common goal of 100% compliance with regulatory requirements, as well as quality and excellence initiatives, and reinforce the expectation of doing things right by doing the right thing. Integrity should motivate us, not the fear of litigation or punitive financial awards.

Reference:

No. CV 10-0071 (Cal.Super.Ct. 2012), 2012 WL 1569734 (April 20, 2012). ✦

Electronic Distraction in Health Care: Is It a Real Problem? Is it Here?

PJ Papadakos MD FCCM

Professor Anesthesiology Surgery and Neurosurgery

University of Rochester

Please do not look at devices its Rude to the speaker.

Anesthesiology News Nov 2011

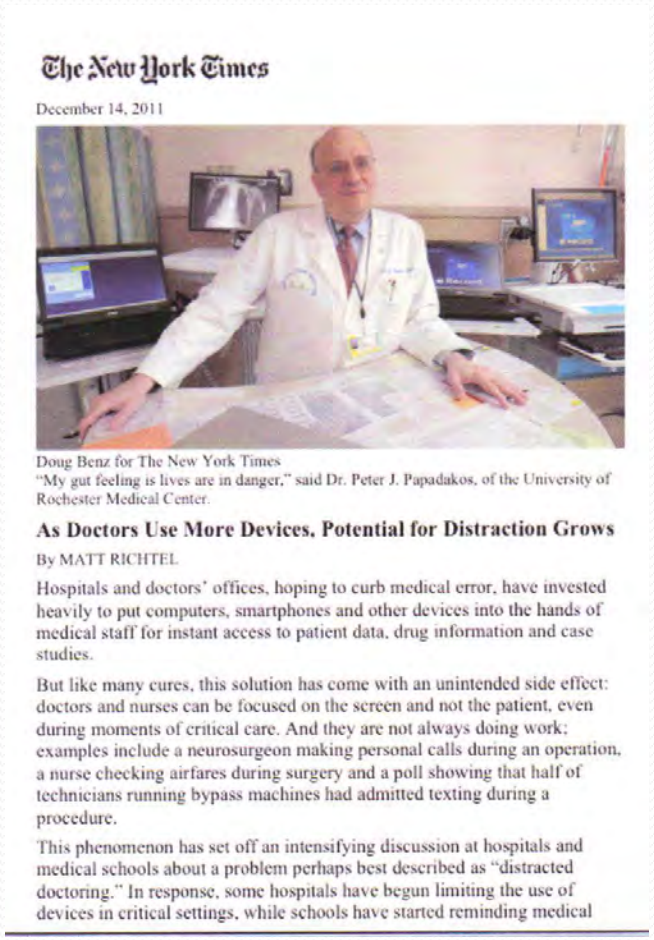
Electronic Distraction: An Unmeasured Variable in Modern Medicine

by Peter J Papadakos, MD

The supervising attending comes onto the ward passing the unit secretary, who is texting on her smartphone. She passes the nurse, who is surfing the Web. She then stops to watch the resident, who is gaming on his tablet.

As farcical as it might seem, this digital nightmare is increasingly common on hospital wards throughout the country and the world. Unfortunately, we have almost no data on how electronic distraction affects worker productivity and dedication to repetitive tasks in health care.

Media Coverage has exploded



The New York Times

December 14, 2011

Doug Benz for The New York Times
"My gut feeling is lives are in danger," said Dr. Peter J. Papadakos, of the University of Rochester Medical Center.

As Doctors Use More Devices, Potential for Distraction Grows

By MATT RICHTEL

Hospitals and doctors' offices, hoping to curb medical error, have invested heavily to put computers, smartphones and other devices into the hands of medical staff for instant access to patient data, drug information and case studies.

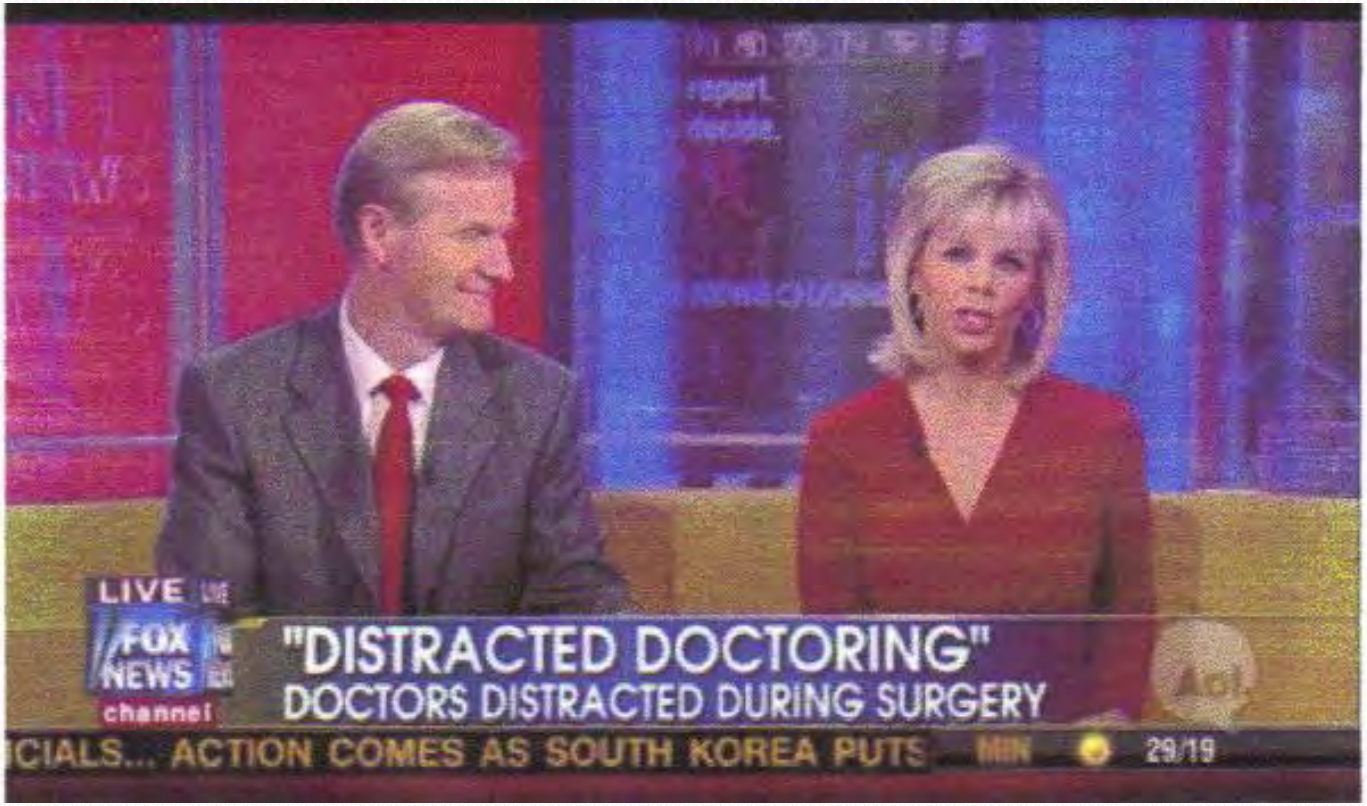
But like many cures, this solution has come with an unintended side effect: doctors and nurses can be focused on the screen and not the patient, even during moments of critical care. And they are not always doing work; examples include a neurosurgeon making personal calls during an operation, a nurse checking airfares during surgery and a poll showing that half of technicians running bypass machines had admitted texting during a procedure.

This phenomenon has set off an intensifying discussion at hospitals and medical schools about a problem perhaps best described as "distracted doctoring." In response, some hospitals have begun limiting the use of devices in critical settings, while schools have started reminding medical

Goals of this educational program

- Scope of electronic distraction in our daily life
- It is both a relationship and safety problem
- How the public views it during the care process
- Recognize and self correct your professional behavior
- Develop Good “Human to Device Interaction” skills
- Have Technology free times each day

Answer truthfully please



Do you text and drive

A. YES
B. NO

Do you check your e-mail social network etc while at work

- A Yes
- B No

Do you do it at least once a hour

- A Yes
- B No

Do you surf the web at work

- A Yes
- B No

Do you face the patient while entering data in the EMR

- A Yes
- B NO

During a medical conference do you check your media

- A Yes
- B No

Do you sign out patients electronically by e-mail or Text

- A Yes
- B No

Scope of Problem

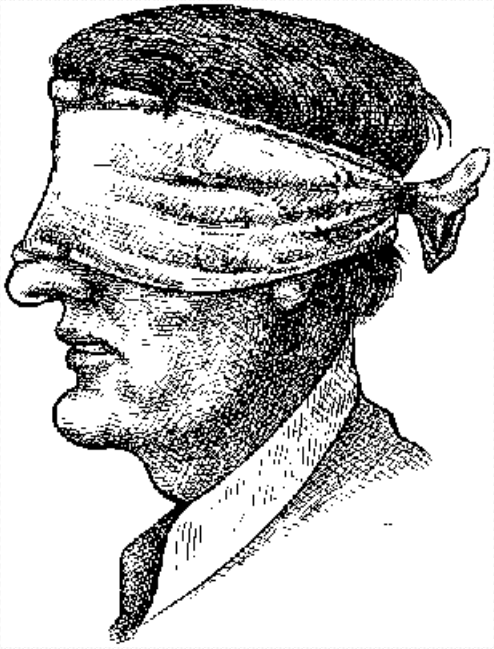
Driving data

- www.distraction.gov/stats-and-facts/

High profile cause of teen Automotive Fatalities

Impairment

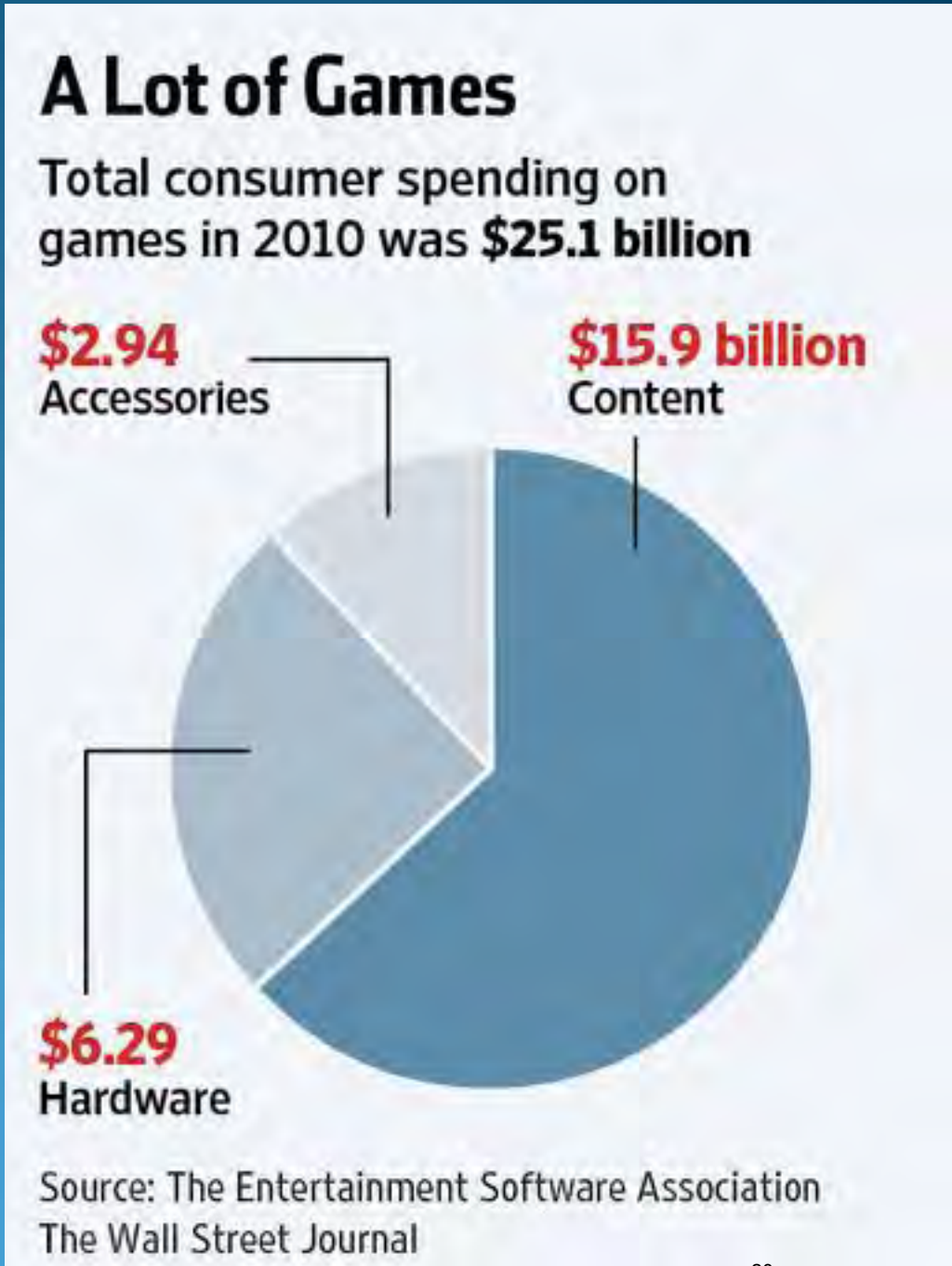
- Unimpaired: 0.54 seconds to brake
- Legally drunk: add 4 feet
- Reading e-mail: add 36 feet
- Sending a text: add 70 feet



Dash Board computers now an option 2011 models

Why is there a addiction to Electronics

Games $$


A Lot of Games
Total consumer spending on games in 2010 was $25.1 billion
$2.94
Accessories
$15.9 billion
Content
$6.29
Hardware
Source: The Entertainment Software Association
The Wall Street Journal

What is the data on games:

- Council on Science and Public Health of the AMA developed a 2 hour screen time rule
- 40% of players World of Warcraft stated they were addicted
- BBC in 2006 reported 12% of players report addicted behavior
- Major problem in Asia with government involvement
- FCC reports electronic gaming on of top ten reasons to drop out of college
- Reported deaths

Help

Video Game Addiction

When video games become more than just games...

Need a Treatment Program?
Call 866.869.4530

- What is Video Game Addiction
- Teen Internet Addictions
- Symptoms in Teens
- Symptoms in Adults
- Top 5 Signs You Need Help
- What Makes a Game Addictive
- The Most Addictive Games
- Video Game Ratings
- Physical Consequences
- Social Consequences
- Violence & Video Games
- Treatment for Video Game Addicts

Video Game Addiction

Anyone who has experienced it knows all too well – video game addiction is real. Although gaming addiction is not yet officially recognized as a diagnosable disorder by the American Medical Association, there is increasing evidence that people of all ages, especially teens and pre-teens, are facing very real, sometimes severe consequences associated with compulsive use of video and computer games.

Video games are becoming increasingly complex, detailed, and compelling to a growing international audience of players. With better graphics, more realistic characters, and greater strategic challenges, it's not surprising that some teens would rather play the latest video game than hang out with friends, play sports, or even watch television.

Of course, all gamers are not addicts – many teens can play video games a few hours a week, successfully balancing school activities, grades, friends, and family obligations. But for some, gaming has become an uncontrollable compulsion. Studies estimate that 10 percent to 15 percent of gamers exhibit signs that meet the World Health Organization's criteria for addiction. Just like gambling and other compulsive behaviors, teens can become so enthralled in the fantasy world of gaming that they neglect their family, friends, work, and school.

If you or a loved one shows signs of computer or video game addiction, this website is for you. Here, you will find up-to-date information and resources that will help you assess whether gaming

Why Wilderness Works

If your teen is obsessively playing games getting them in a wilderness environment helps them clear their heads and get a new perspective on what's important. Learn more about the value of the wilderness >>

Featured Articles

Boys and Video Games: A Natural Attraction?

An educational website sponsored by

CRC HEALTH GROUP

Texting

- Some teens text 10,000 texts each day
- Communicate with Communicating
- Adults on average spend 40 hours a month on cell phones
- Growing concern in Medical literature and lay press

Information poor communication

Addiction to Texting

Experts say that there are four distinct symptoms to diagnosing texting as a mental illness:
Excessive use (neglect day to day activities)
Withdrawal (feeling depressed when not accessible)
Tolerance (over texting)
Negative repercussion (social isolation)

Social Media

Common

- As per facebook 800 million users world wide 50% active each day
- One out of every 6 minutes of internet time
- Users have lower grade points

Question

- Are You Addicted to **Social Media**?

- Question 1 of 14
  Do you spend more time with Social Media than your family?

  1. Yes

  2. No

  3. I've lost touch with my family due to social media. I need to get them on a social network

Checking social media

- When I wake up in middle of night 19% under 25 and 11% over 25
- Sometimes when I wake up at night 27% under 25 and 20% over 25
- First thing when I wake up in AM 32% under 25 and 21% over 25

Do you receive messages and answer

New research face book and stress

CYBERPSYCHOLOGY, BEHAVIOR, AND SOCIAL NETWORKING
Volume 14, Number 12, 2011

DOI: 10.1089/cyber.2010.0377

Why Is Facebook So Successful? Psychophysiological Measures Describe a Core Flow State While Using Facebook

Maurizio Mauri, Ph.D.,[1,2] Pietro Cipresso, Ph.D.,[1,3] Anna Balgera, M.A.,[1]
Marco Villamira, Ph.D., M.D.,[1] and Giuseppe Riva, Ph.D.[3,4]

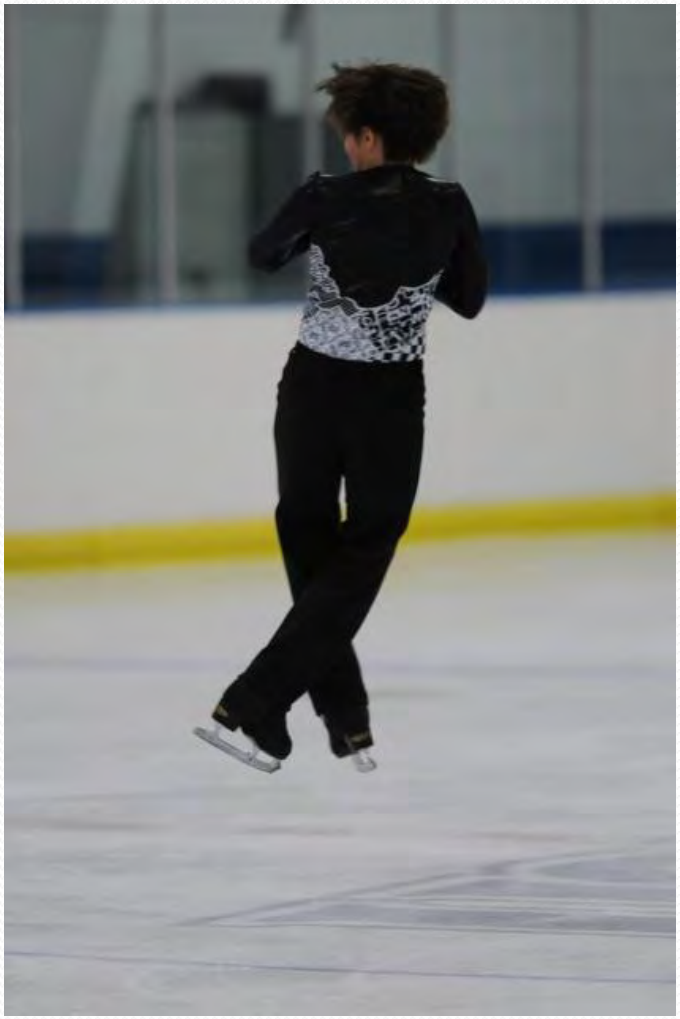
NOMOPHOBIA

May 2012
(CNN) — Are you addicted to your phone? According to recent research sponsored by SecurEnvoy, an internet security firm, more people feel anxious and tense when they are out of reach of their— and the younger they are, the more likely the stress. Known as “nomophobia,” or “no mobile-phone phobia,” a recent online survey of 1,000 people in the UK found that almost two thirds (66%) of respondents were afflicted, a rise of 11% when compared to a similar study four years ago.

Behavior Modification

- Track Your time
- Remember to speak
- Go outside
- Limit memberships
- Remove apps from cell phones
- Spend time with real people
- Have private time


NO
BALL/PUCK
PLAYING
IN LOBBY
NEW POLICY
All electronic
communications
are prohibited
while on the ice.



IN HEALTH CARE

Use of smart phones by clinicians

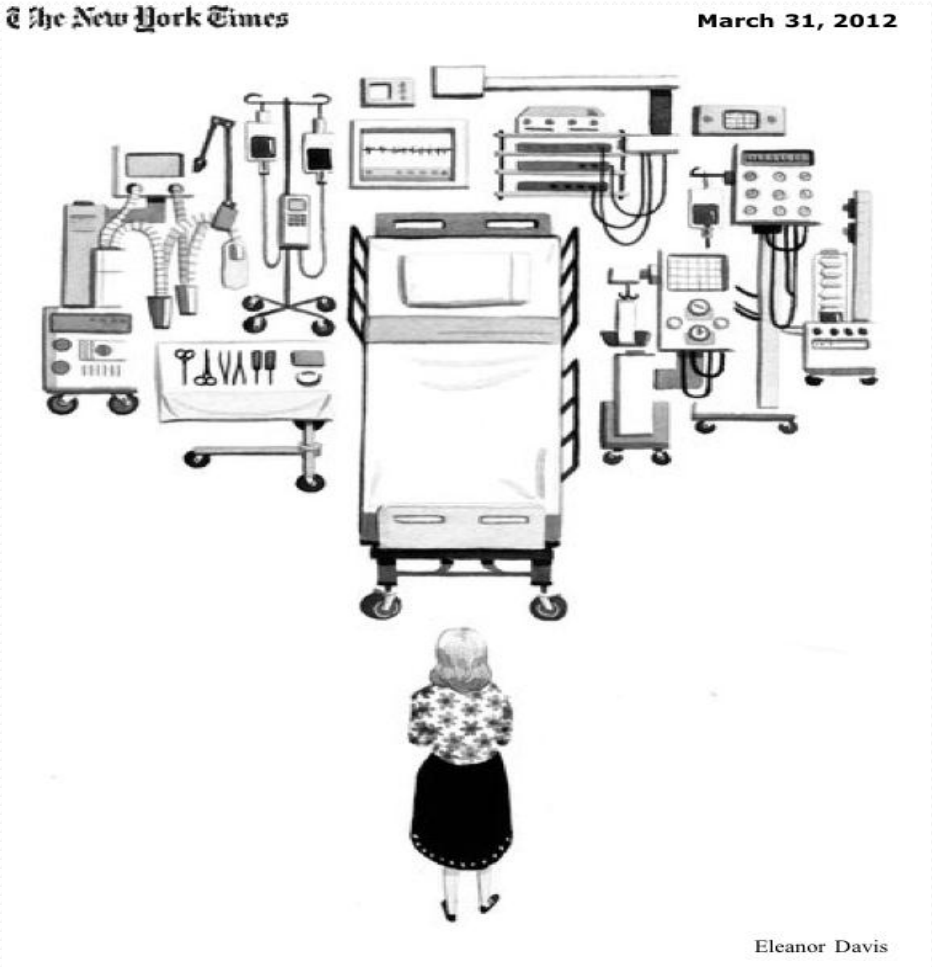
72%-94% use (1)

Example at the Beth Israel Deaconess Medical Center more than 1000 i-pads and 1600 i-phones have been purchased by physicians and nurses (2)

1-Versel N. Fierce Mobile Health Care July 27 2010

2- Halamka AHRQ Web M&M Dec 2011

Hospitals Have Become Computer Rich Environments



Why an explosion

- Electronic Medical records
- Apps used to get drug info and other info
- Computers make care safer (political and media pressure)
- Way to spread info to staff wide
- Use as teaching tool for patients

Common theme in 1990's EMR will save massive amounts of money decrease employees etc.

THE AMERICAN JOURNAL of MEDICINE®

Hospital Computing and the Costs and Quality of Care: A National Study

David U. Himmelstein, MD,[a] Adam Wright, PhD,[b] Steffie Woolhandler, MD, MPH[a]

[a]Department of Medicine, Cambridge Hospital/Harvard Medical School, Cambridge, Mass; [b]Clinical Informatics Research and Development, Partners Healthcare System, Boston, Mass.

ABSTRACT

BACKGROUND: Many believe that computerization will improve health care quality, reduce costs, and increase administrative efficiency. However, no previous studies have examined computerization's cost and quality impacts at a diverse national sample of hospitals.

METHODS: We linked data from an annual survey of computerization at approximately 4000 hospitals for the period from 2003 to 2007 with administrative cost data from Medicare Cost Reports and cost and quality data from the 2008 Dartmouth Health Atlas. We calculated an overall computerization score and 3 subscores based on 24 individual computer applications, including the use of computerized practitioner order entry and electronic medical records. We analyzed whether more computerized hospitals had lower costs of care or administration, or better quality. We also compared hospitals included on a list of the "100 Most Wired" with others.

RESULTS: More computerized hospitals had higher total costs in bivariate analyses ($r = 0.06$, $P = .001$) but not multivariate analyses ($P = .69$). Neither overall computerization scores nor subscores were consistently related to administrative costs, but hospitals that increased computerization faster had more rapid administrative cost increases ($P = .0001$). Higher overall computerization scores correlated weakly with better quality scores for acute myocardial infarction ($r = 0.07$, $P = .003$), but not for heart failure, pneumonia, or the 3 conditions combined. In multivariate analyses, more computerized hospitals had slightly better quality. Hospitals on the "Most Wired" list performed no better than others on quality, costs, or administrative costs.

CONCLUSION: As currently implemented, hospital computing might modestly improve process measures of quality but does not reduce administrative or overall costs.

 • *The American Journal of Medicine (2009) xx, xxx*

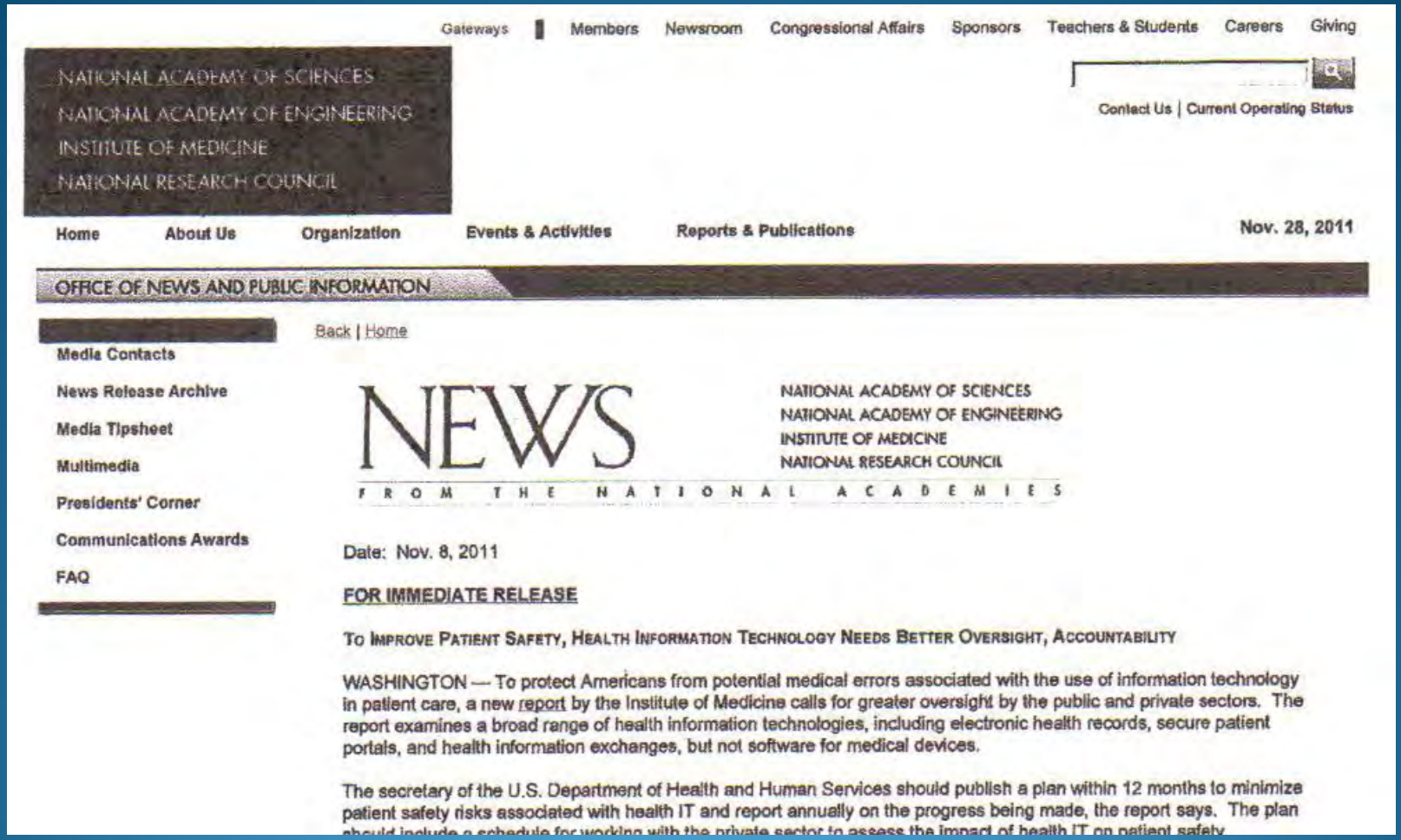
KEYWORDS: Hospital costs; Hospital quality; Information systems

Real Data

- Initial costs massive
- Need to buy more computers
- Training
- IT support
- Computers needs to be replaced
- Increase costs for storage of data
- Software updates
- Tied to a private company
- But if used correctly a boom for patient care

Medical Notes

- Have become check lists and templates
- No feeling for disease
- Cut and pasted from provider to provider
- Patients feel separated from there provider
- Information overload



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FROM THE NATIONAL ACADEMIES

NATIONAL ACADEMY OF SCIENCES
NATIONAL ACADEMY OF ENGINEERING
INSTITUTE OF MEDICINE
NATIONAL RESEARCH COUNCIL

Date: Nov. 8, 2011

FOR IMMEDIATE RELEASE

TO IMPROVE PATIENT SAFETY, HEALTH INFORMATION TECHNOLOGY NEEDS BETTER OVERSIGHT, ACCOUNTABILITY

WASHINGTON — To protect Americans from potential medical errors associated with the use of information technology in patient care, a new report by the Institute of Medicine calls for greater oversight by the public and private sectors. The report examines a broad range of health information technologies, including electronic health records, secure patient portals, and health information exchanges, but not software for medical devices.

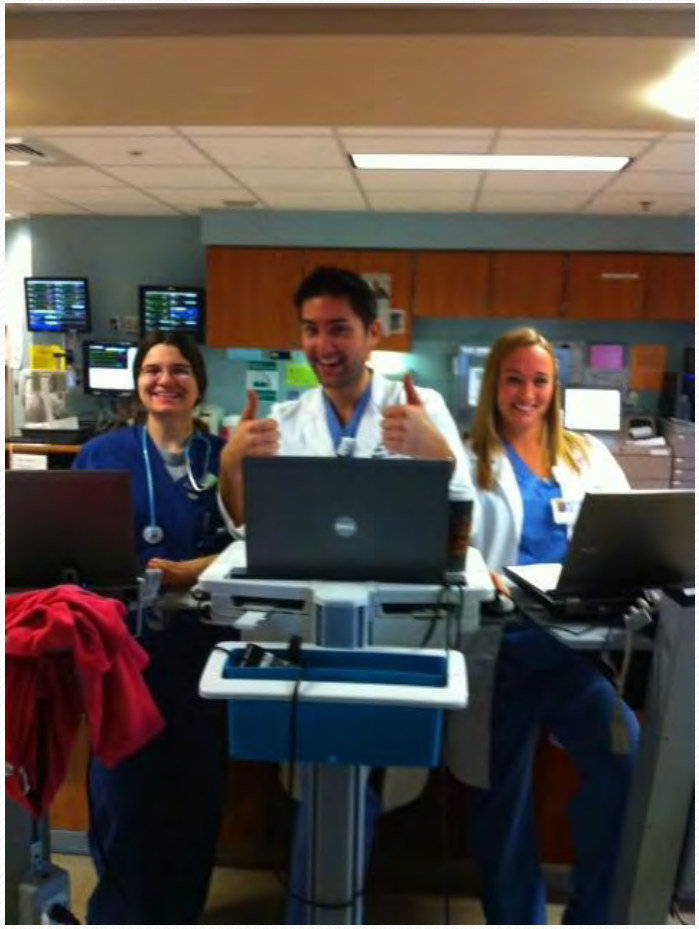
The secretary of the U.S. Department of Health and Human Services should publish a plan within 12 months to minimize patient safety risks associated with health IT and report annually on the progress being made, the report says. The plan

US Government has discovered there is a problem After Reading Anesthesiology News

Why Distraction

Staff in these photos are acting out scenarios which may be present at your facility

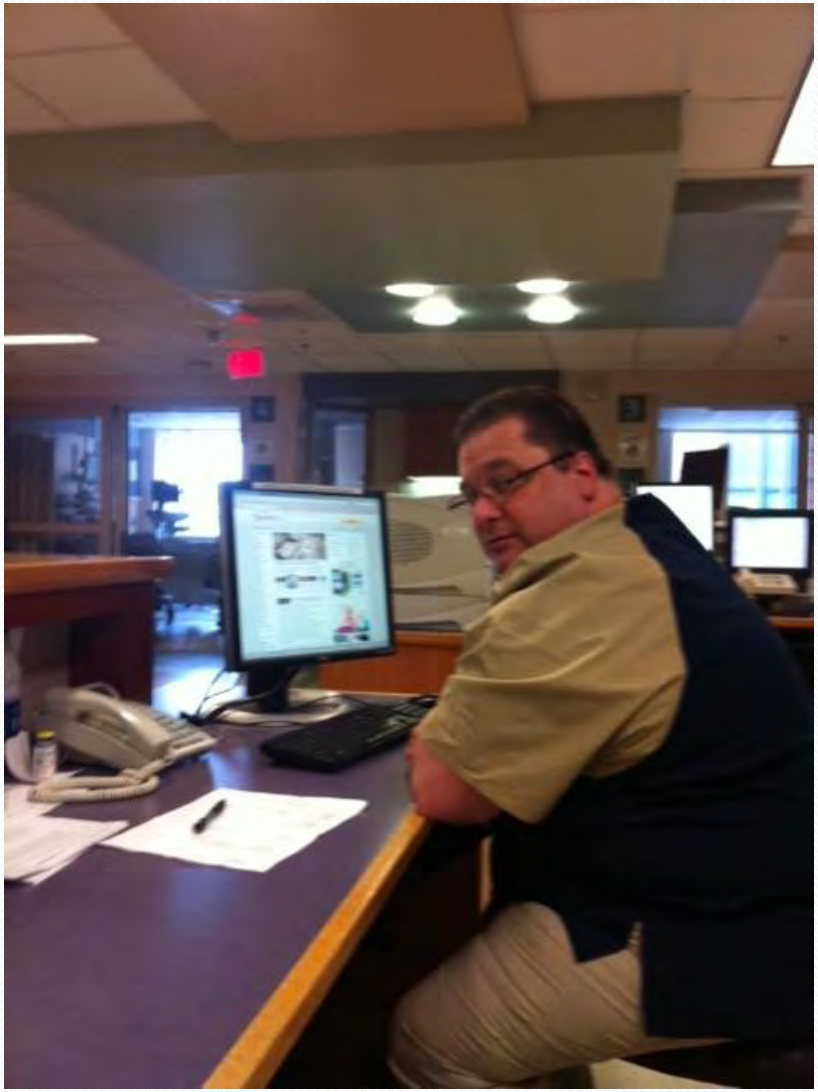
Rounds in the ICU 2012



How the Patient May View it Be Careful

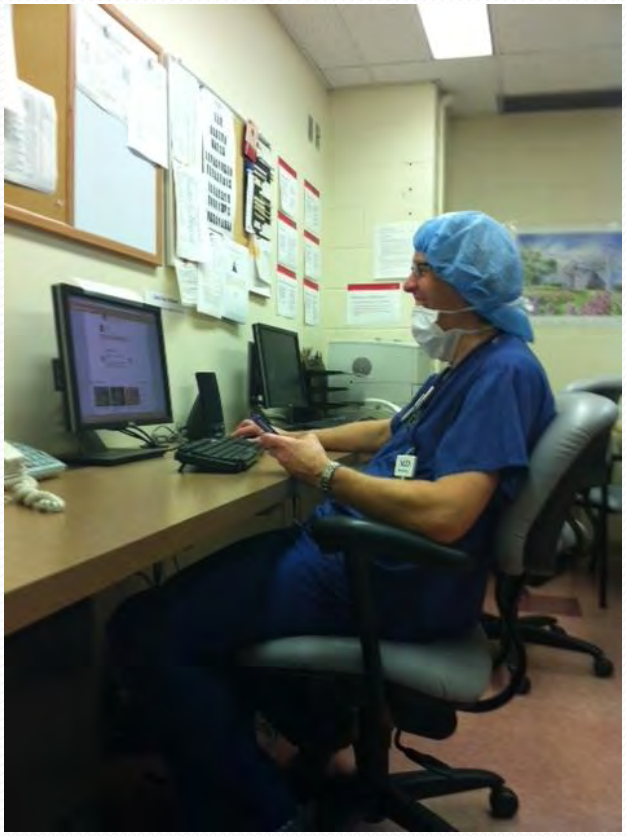
With permission New York Times

Lets Surf



Well Known Academic RT
Checking his publications

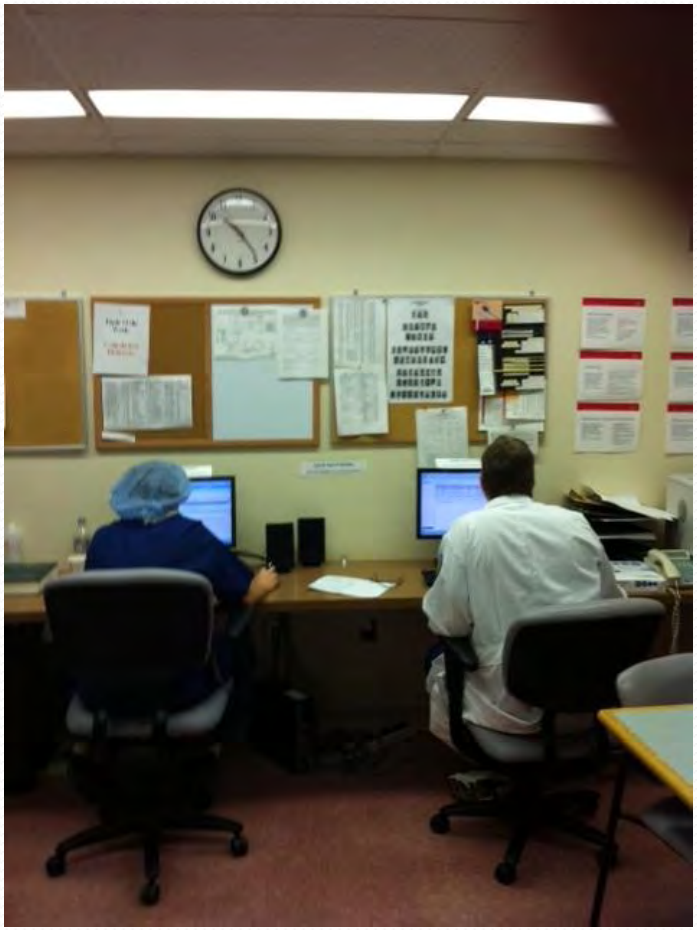
Checking on labs



Games are fun

Human nature

On working on Patient Care



Loss of Direct patient contact
Medical legal trap were the note was written

Perfusion May 2011

Perfusion

Perfusion
26(5) 375–380

DOI: 10.1177/0267659111409969
prf.sagepub.com
SAGE

2010 Survey on cell phone use while performing cardiopulmonary bypass

T Smith, E Darling, B Searles

Abstract

Cell phone use in the U.S. has increased dramatically over the past decade and text messaging among adults is now mainstream. In professions such as perfusion, where clinical vigilance is essential to patient care, the potential distraction of cell phones may be especially problematic. However, the extent of this as an issue is currently unknown. Therefore, the purpose of this study was to (1) determine the frequency of cell phone use in the perfusion community, and (2) to identify concerns and opinions among perfusionists regarding cell phone use.

In October 2010, a link to a 19-question survey (surveymonkey.com) was posted on the AmSECT (PerfList) and Perfusion.com (PerfMail) forums. There were 439 respondents. Demographic distribution is as follows; Chief Perfusionist (30.5%), Staff Perfusionist (62.0%), and Other (7.5%), with age ranges of 20-30 years (14.2%), 30-40 years (26.5%), 40-50 years (26.7%), 50-60 years (26.7%), >60 years (5.9%).

The use of a cell phone during the performance of cardiopulmonary bypass (CPB) was reported by 55.6% of perfusionists. Sending text messages while performing CPB was acknowledged by 49.2%, with clear generational differences detected when cross-referenced with age groups. For smart phone features, perfusionists report having accessed e-mail (21%), used the internet (15.1%), or have checked/posted on social networking sites (3.1%) while performing CPB.

Safety concerns were expressed by 78.3% who believe that cell phones can introduce a potentially significant safety risk to patients. Speaking on a cell phone and text messaging during CPB are regarded as "always an unsafe practice" by 42.3% and 51.7% of respondents, respectively. Personal distraction by cell phone use that negatively affected performance was admitted by 7.3%, whereas witnessing another perfusionist distracted with phone/text while on CPB was acknowledged by 33.7% of respondents.

This survey suggests that the majority of perfusionists believe cell phones raise significant safety issues while operating the heart-lung machine. However, the majority also have used a cell phone while performing this activity. There are clear generational differences in opinions on the role and/or appropriateness of cell phones during bypass. There is a need to further study this issue and, perhaps, to establish consensus on the use of various communication modes within the perfusion community.

Table 1. Percentage of respondents by age who believe it is always UNSAFE to operate a heart-lung machine when:

Age	20-30	31-40	41-50	51-60	>60
Speaking on a Cell Phone	46.4%	45.8%	37.5%	44.7%	50.0%
Texting	42.9%	43.9%	46.0%	64.9%	79.2%
Surfing the Internet	80.4%	93.5%	85.8%	92.0%	95.8%
Checking E-mail	71.4%	77.6%	74.3%	88.6%	95.8%
Sending E-mail	80.4%	85.0%	81.4%	89.5%	95.8%
Posting on a Social Networking Site	85.7%	96.3%	90.3%	95.5%	95.7%

Table 2. Percentage of respondents by age who have used a cell phone while on CPB to:

Age	20-30	31-40	41-50	51-60	>60
Speak on a Cell Phone	53.6%	53.7%	62.5%	48.2%	43.5%
Text	55.4%	58.3%	53.1%	40.2%	13.0%
Surfing the Internet	16.1%	17.8%	16.2%	12.5%	4.3%
Check/Send E-mail	23.2%	24.1%	25.5%	14.3%	8.7%
Post on a Social Networking Site	7.1%	5.6%	0.9%	0.9%	0.0%

ASA ABSTRACT 2011

Group showed both residents and CRNA's even when told they are under observation still in 54% of cases still used computer on the machine to surf the net

Abstract 1726

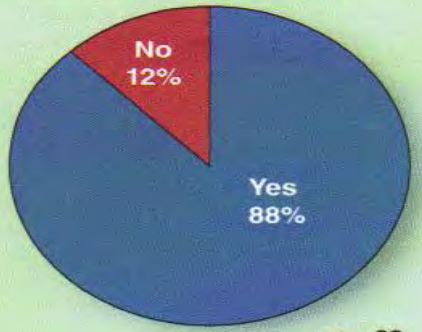
OR Manager Inc

OR Manager
Vol. 28 No. 4
April 2012

Does the policy apply only to employees or also to physicians?

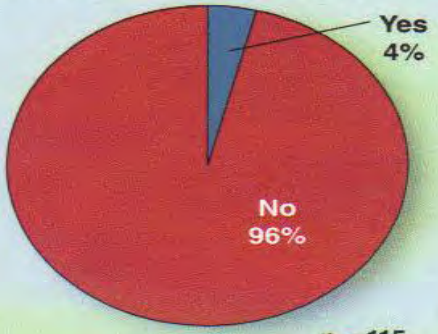
n = 89

Does your policy prohibit personal use of devices in patient care areas?



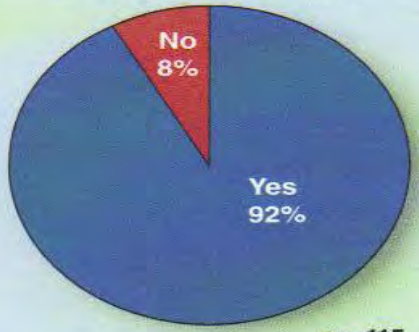
n = 89

Does your OR have a policy on physicians receiving pages and other messages during surgery?



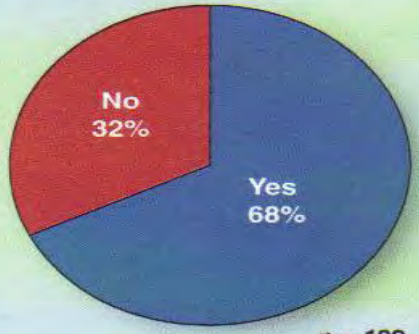
n = 115

Are clinicians able to use OR computers to access the internet?



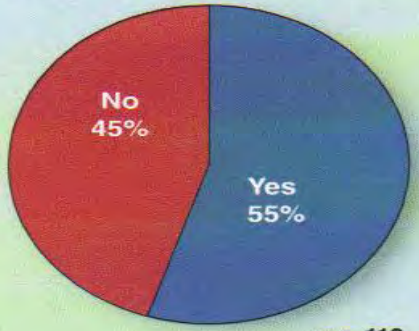
n = 115

Has there been abuse of internet access?



n = 109

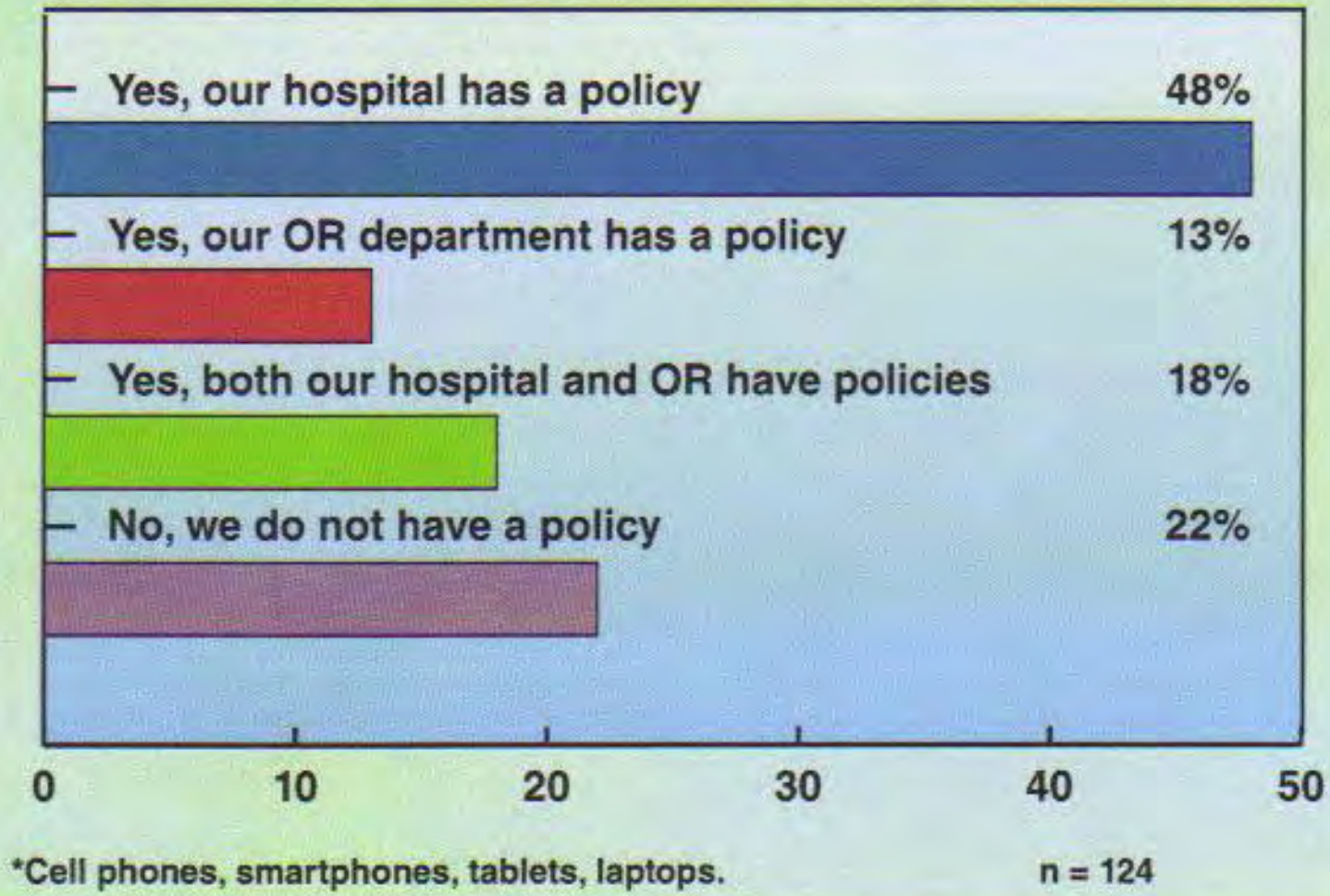
Do you believe that personal use of mobile devices in the OR sometimes distracts care providers from patient care?



n = 112

Mobile device survey

Does your hospital/OR department have a policy on personal use of mobile devices* in the OR?

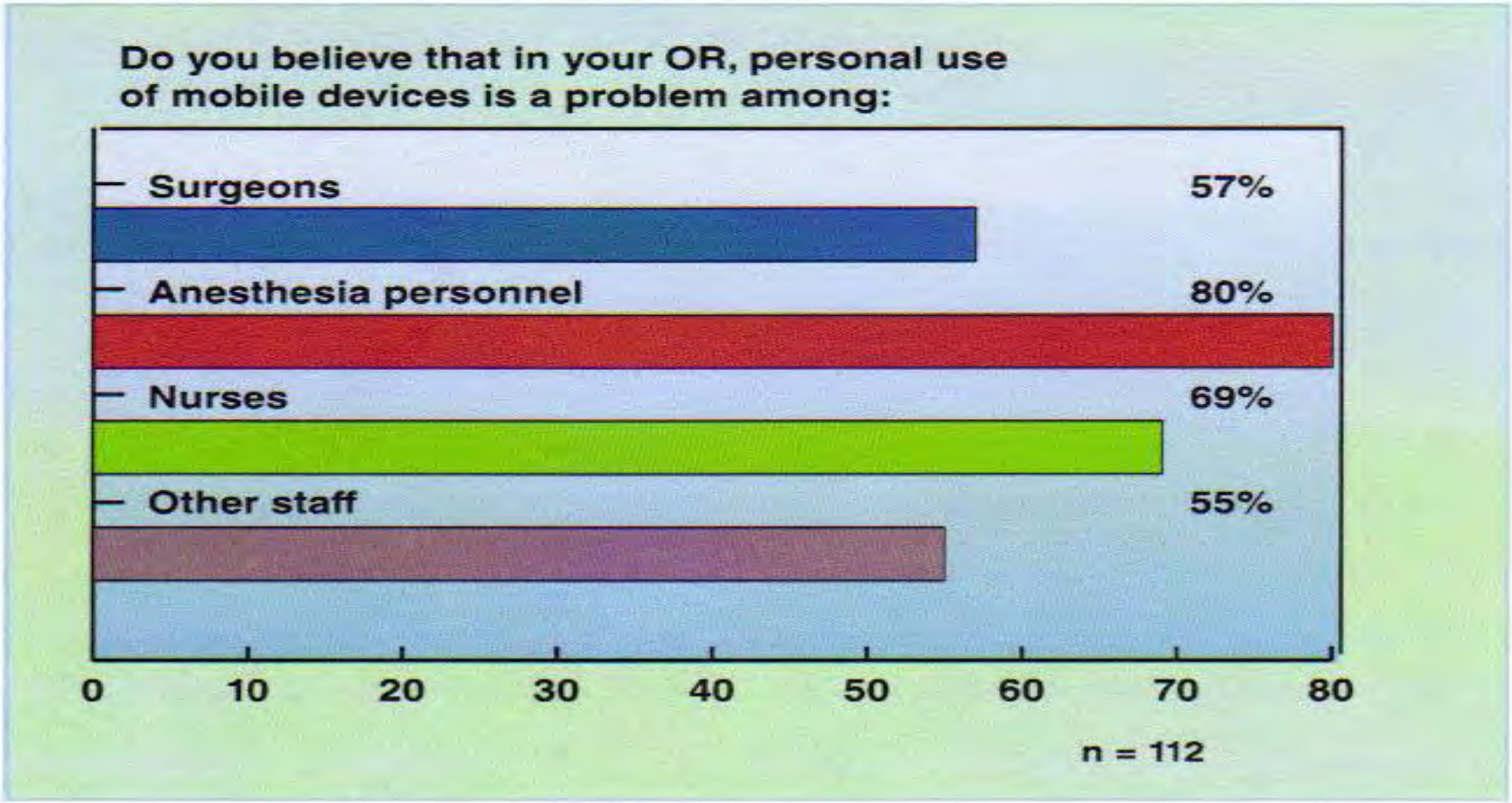


*Cell phones, smartphones, tablets, laptops.

n = 124

OR Manager April 2012

OR Manager Inc



Adverse Events From this Survey

- A Wrong Site Surgery
- A near miss “We almost left a specimen in a patient”

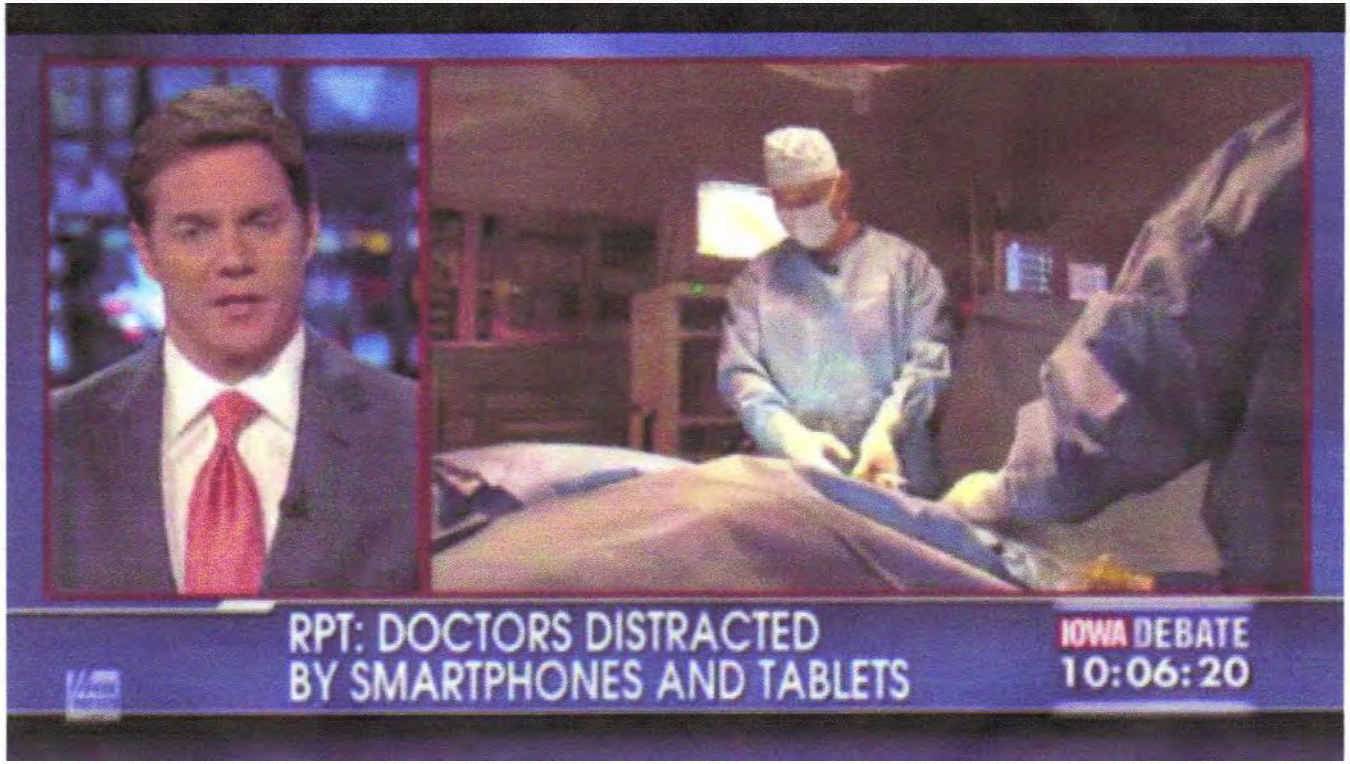
OR Manager April 2012

Distracted doctor 'killed two patients suffering just ulcers with TEN TIMES normal dose of morphine while he surfed the internet'
Both patients, aged 78 and 86, died of morphine poisoning
Computer records 'show he was checking cricket scores, emails and online banking in between seeing patients'

Read more: http://www.dailymail.co.uk/news/article-2131991/Rajendra-Kokkarner-killed-2-patients-TEN-TIMES-normal-dose-morphine.html#ixzz1uCtBhy1R

Daily Mail London May 2012

Pressure at the Work Place



Staff Demographics

- Younger Generation
- Do not feel comfortable speaking to people
- Most answer that e-mail
- Most check my social media
- Games are fun
- Video great way to make the shift go by

Loss of Hands on Care

- The Vitals will be down loaded
- There are alarms
- Computer charting is better
- The records are better
- I do not like speaking to patients and families or other providers

Medical Errors Questions

- Broad Range of Medical Errors poorly studied
- Is loss of personal responsibility a factor
- Is there a rise in errors due to distracted staff
- Pressure to provide check list care

Airline safety a common model for health care

- **Lawmakers target airline laptop distractions**
  By AOPA ePublishing staff

  In response to a recent airline incident where laptop use may have contributed to pilot distraction, lawmakers have introduced legislation that would ban certain electronic devices from airline cockpits.

  Sen. Byron Dorgan (D-N.D.), chairman of the Senate Commerce Committee's aviation subcommittee, introduced a bill this month to prohibit the use of personal wireless communications devices and laptop computers by the flight crew—except for flight-related purposes—during part 121 air carrier operations.

U.S. Department
of Transportation
**Federal Aviation
Administration**

InFO

Information for Operators

InFO 10003
DATE: 4/26/10

Flight Standards Service
Washington, DC

http://www.faa.gov/other_visit/aviation_industry/airline_operators/airline_safety/info

An InFO contains valuable information for operators that should help them meet certain administrative, regulatory, or operational requirements with relatively low urgency or impact on safety.

Subject: Cockpit distractions

Purpose: To emphasize to crewmembers and operators that engaging in tasks not directly related to required flight duties, including using personal electronic devices (PED), constitutes a safety risk.

Background: Recent incidents and accidents have revealed pilots using PEDs, including laptop computers and mobile telephones, for personal activities unrelated to the duties and responsibilities required for conduct of a flight. In one instance, two pilots were using their laptop computers during cruise and lost situational awareness, leading to a 150 mile fly-by of destination. In another instance, a pilot was texting after the aircraft pushed back from the gate and before the take-off sequence. In still another instance, a Federal Aviation Administration (FAA) inspector in the jump seat overheard a crewmember's mobile phone ring during the takeoff roll.

Recommended Action: Operators should create a safety culture that clearly establishes guidance, expectations and requirements to control cockpit distractions, including use of PEDs, during flight operations. Directors of Operations and Directors of Safety should review and reinforce these policies and guidance. Directors of training should review and reinforce crew training on this subject. Crewmembers should evaluate their personal practices, including those regarding the use of PEDs, to ensure they do not distract from or interfere with duties and responsibilities related to the flight.

Contact: Any questions regarding this InFO should be directed to the Part 121 Air Carrier

Maybe we should act like pilots!

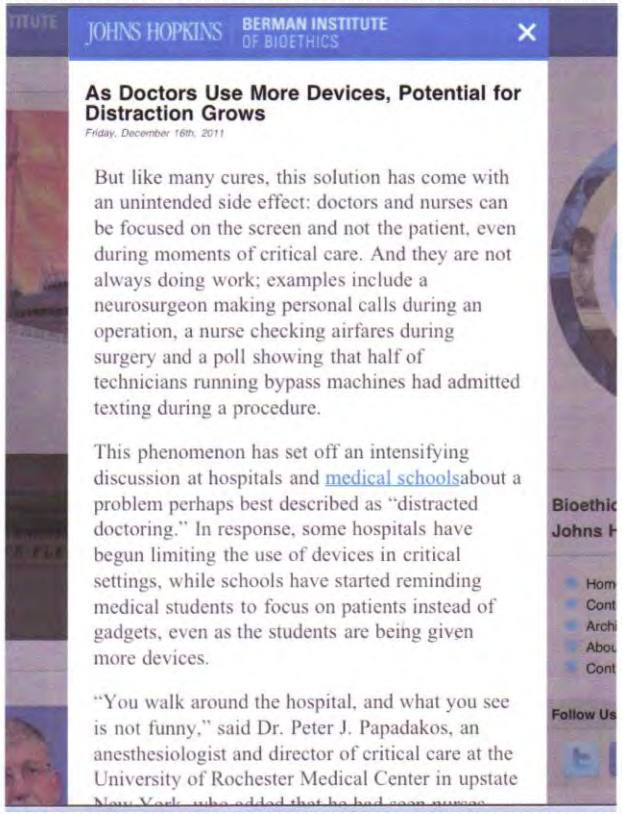
How to Address This Problem

EDUCATION

BEHAVIOR MODIFICATION

GUIDELINES

University of Rochester Is a Leader in this Field of Human to Device Relationships



JOHNS HOPKINS | BERMAN INSTITUTE OF BIOETHICS

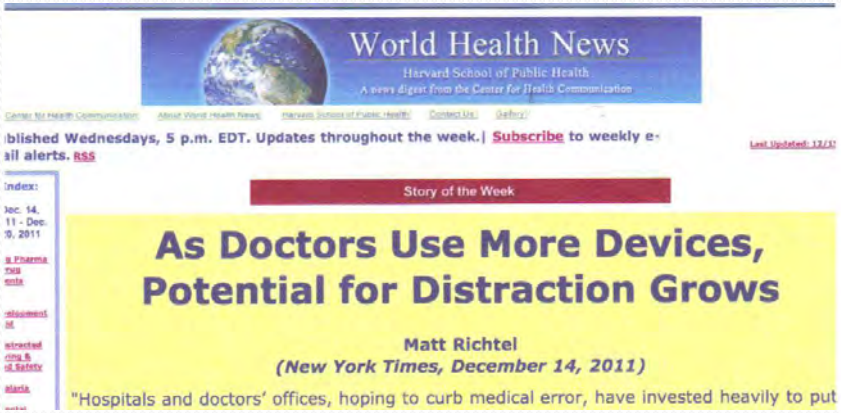
As Doctors Use More Devices, Potential for Distraction Grows

Friday, December 16th, 2011

But like many cures, this solution has come with an unintended side effect: doctors and nurses can be focused on the screen and not the patient, even during moments of critical care. And they are not always doing work; examples include a neurosurgeon making personal calls during an operation, a nurse checking airfares during surgery and a poll showing that half of technicians running bypass machines had admitted texting during a procedure.

This phenomenon has set off an intensifying discussion at hospitals and medical schoolsabout a problem perhaps best described as "distracted doctoring." In response, some hospitals have begun limiting the use of devices in critical settings, while schools have started reminding medical students to focus on patients instead of gadgets, even as the students are being given more devices.

"You walk around the hospital, and what you see is not funny," said Dr. Peter J. Papadakos, an anesthesiologist and director of critical care at the University of Rochester Medical Center in upstate



World Health News

Harvard School of Public Health

A news digest from the Center for Health Communication

blished Wednesdays, 5 p.m. EDT. Updates throughout the week.| Subscribe to weekly e-ail alerts. RSS

Story of the Week

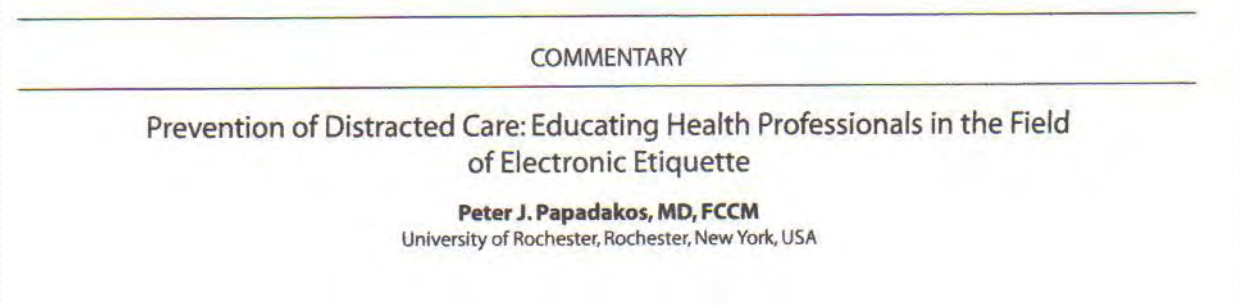
As Doctors Use More Devices, Potential for Distraction Grows

Matt Richtel

(New York Times, December 14, 2011)

"Hospitals and doctors' offices, hoping to curb medical error, have invested heavily to put

CSRT is Taking a lead



COMMENTARY

Prevention of Distracted Care: Educating Health Professionals in the Field of Electronic Etiquette

Peter J. Papadakos, MD, FCCM
University of Rochester, Rochester, New York, USA

Canadian J of Resp Therapy Spring 2012

Your Devices

- When in professional dress try not to be use your device in public (elevators, halls etc.) basic public relations
- Never use while in patient room
- Do not have out on rounds
- Do not use for patient data
- Silence you messaging system, ring tones, alerts etc
- If family emergency excuse yourself from the room use in private place both patients and fellow staff do not need to hear your private matters

Most important point

- The general public who uses these devices to an extreme expects a different standard from health professionals in multiple comments to “Distracted Doctoring” articles in the media. They get upset seeing you on the same device they use because you are expected to be focusing on them! Since the dawn of history we are held to a different standard.

Hospital Based Devices

- Never use for your private matters in the view of the patient or public go to office or staff lounge during your work brakes
- Do not have on any other screen than EMR, imaging etc in public areas
- Explain to patient and public that computer system is for patient care and has greatly improved our ability to review tests etc.

Remember the Computer is like a third person in the Exam Room

Do not create a i-patient Computers should not dehumanize medicine
PJ Papadakos Fox and Friends December 2011

Electronic Medical Record Use

- Enter the room introduce yourself make human contact patients in multiple commentaries of EMR complain of loss of eye to eye contact.
- Exam and care for the patient first
- Tell the patient you have to enter the information given to you by “them” into the EMR
- You may wish to state something like “I am sorry but I now have to enter your data into the computer so your health providers have access to it”

Legal issues

- Enter data correctly check your note/order prior to accepting just like you would do while on line shopping
- Actively educate staff on proper human device interaction
- Remember lawyers may review your note and where it was entered try to write co-sign notes in the patient care area. If from home clearly add a line or two that the note was done in another area for a reason.

Hyper-electronic age

Basic Electronic interfacing

1. Separate personal and professional use: Physicians should dedicate one of their handheld devices to only their professional work. This device should be stocked with professional e-mail, messaging, and medical applications. It should not include Facebook or social networks or fun applications that can lead to distractions.

2. Develop new methods of interaction: When entering an exam room, physicians must first focus on the patient. Once introductions have been made, physicians should explain what technology they will be using and why.

3. Expand the physician-patient conversation: Physicians must treat the electronic device as a third person in the exam room. When interacting with the technology, physicians should explain their actions to the patient. When reviewing information on the device, they should turn back to the patient and share their findings.

The key to eliminating distractions Papadakos says, is teaching healthcare workers "how to balance this highly promising technology with an unbroken focus on the patient."

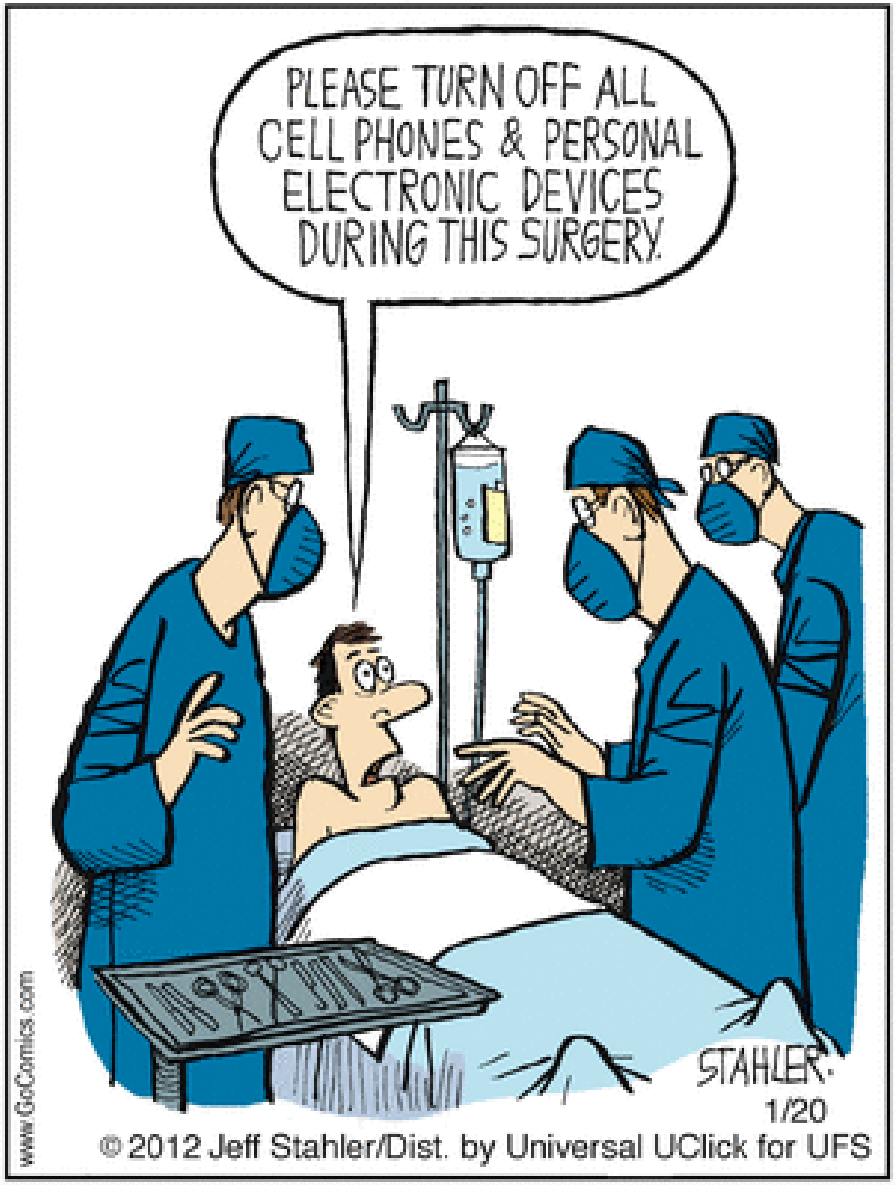
Take Home

- Mobile devices can enhance communication, access to literature enable us to connect to EMR's thus enhancing quality, safety and efficiency.
- Policies and technology upgrades should be implemented to mitigate risks and reducing harm caused by technology better "Human to Technology Interfacing".
- Transmission of infection, risks of privacy breaches, and increased errors induced by multitasking are significant.

Things you can do Summary

- Turn off your devices in patient care areas
- Realize there is a problem
- For family emergencies use the land line or page operator
- Correct your fellow worker
- Make eye contact with patients
- Develop unit based protocols to prevent electronic distraction
- Start open discussion with fellow professionals on this topic
- Develop studies collect Data

Thanks



SOURCE: Peter J. Papadakos, MD, University of Rochester (NY) Medical Center

Code of eConduct at the
University of Rochester Medical Center

Purpose:

1. To promote safe patient care through minimizing the distractions of eDevices in the workplace while allowing for optimal use of electronic support in the care and treatment of patients and families.
2. Promote professionalism and the perception that patients and families have of clinicians at SMH.
3. Assure confidentiality of protected health information
4. Clarify the expectations for all staff so that they can monitor themselves and their colleagues regarding eDevices conduct and provide constructive feedback/enforcement of the Standard Practices in order to promote I CARE and PFCC values and objectives.

A. Standard Practice for use of eDevices:

- All devices(e.g. Smart phones, cell phones, etc.) other than hospital issued pager/urgent on-call communication devices should be in "silent" mode whenever in a patient room or discussing patient information with the patient/family
- Clinicians will refrain from using computers and eDevices at clinical work stations to conduct personal business. Use of computers and eDevices for necessary personal use is allowable in break room/break areas out of view of patients and families. (Please refer to the SMH electronic device use policy)
- Use of personal and business eDevices in the clinical setting for collection and transmission of protected health information will be done through approved, secure networks in accordance with University of Rochester Medical Center HIPAA policies[i]. Protected health information (PHI) transmitted through or to secured business eDevices will not be stored on personal eDevices.

B. Optimal Practice for use of eDevices:

- Rounding: Departments will create guidelines that provide clear delineation of roles for clinicians when rounding.
- The Senior most rounding clinician (Round Leader) is in the primary role of communicating with the patient and teaching others during rounding. As such, the leader should refrain from computer and/or eDevice use while in patient rooms with the exception of using eDevices during the course of teaching or explaining to the patient and family their diagnosis and plan of care.
- Clinicians will introduce the function and use of eDevices for medical management to patients and families upon admission and when first introducing themselves to the patient and family.
- Clinicians should have a separate eDevice or device with the technology that allows for the separation of work related and personal communication. Work issued phones/blackberries, computers and "smart" devices, etc. should not be used for personal use in patient care and clinical work areas.

SMH HIPAA Privacy Policies: OP 29, OS 2, OS 8, OS 9
SMH Policy 6.2
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Westbrook JI, Woods A, Rob MI, Dunsmuir WT, Day RO. Association of interruptions with an increased risk and severity of medication administration errors. Arch Intern Med. 2010;170:683-690.
American College of Surgeons [ST-59]. Statement on use of cell phones in the operating room. Bulletin of the American College of Surgeons. Vol. 93, No. 9, September 2008.

SOURCE: University of Rochester (NY) Medical Center

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