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Covert video surveillance can be useful in abuse cases, but some reason for caution

Policies and right equipment are keys to success

Risk managers should consider using covert video surveillance (CVS) when patient abuse is suspected and not be deterred by worries about invasion of privacy or liability, says **Mary Anne Hilliard**, JD, BSN, CPHRM, chief risk counsel at Children's National Medical Center in Washington, DC. While those concerns are valid and must be addressed, CVS is too valuable a tool to let it go unused because of fears that it might cause legal difficulties.

Hilliard has worked in risk management at the pediatric facility for 10 years. In that time, she has used CVS several times to investigate suspected cases of Munchausen's syndrome by proxy (MSBP), in which parents or other caregivers secretly injure a child or cause illness to feed their own need for drama and attention. Proving MSBP can be very difficult because the perpetrators are careful to hide their actions and often know how to simulate medical conditions that could be attributed to other causes, Hilliard says. **(See p. 17 for research regarding the use of CVS to detect MSBP.)**

She receives about two inquiries every year regarding staff and physician suspicions that a child is the victim of MSBP. When physicians and staff suspect MSBP, CVS sometimes is the only option for proving or disproving that

EXECUTIVE SUMMARY

Covert video surveillance (CVS) can be used to detect and prevent patient abuse, but it carries significant risks. There are many legal and regulatory issues to consider before employing this strategy.

- CVS questions often arise in nursing homes, but it can be used in any health care setting.
- State laws regarding CVS vary widely.
- The strategy can be a good option if used properly.

that the child is intentionally being harmed. Hilliard must approve any requests to conduct surveillance, but she says she does not shy away from the strategy.

MSBP isn't the only use for CVS. Nursing homes sometimes utilize CVS because of the patients' particular vulnerability, says **Andrew R. Rogoff**, JD, a partner in the Philadelphia office of the law firm Pepper Hamilton, who has nearly three decades of litigation experience in the pharmaceutical and health care industries.

Many nursing homes have been sanctioned for putting their elderly residents at risk, and more cases of abuse go unreported, so CVS can be an attractive option for proving abuse by staff, notes **DaQuana L. Carter**, JD. Carter is an associate with Pepper Hamilton who specializes in the area of health effects litigation. On the other hand, Carter says, residents also experience injuries that are not the fault of their caregivers. **(See p. 16 for a case study involving CVS.)**

It is not unusual for a family member or concerned staff to suggest CVS as a possible solution, but as the risk manager, how should you respond? Will the tapes provide ammunition for a lawsuit? Will the presence of cameras in the rooms cause your staff to quit? Will the video invade your patients' or your employees' privacy?

CVS can be a valuable tool, but it does come with some thorny issues for risk managers to consider, Hilliard says. The legality of secretly videotaping is well established when abuse is suspected, she says, but it still is a good idea to check with your counsel about state and local laws that may restrict its use. A subpoena usually is not required, but Hilliard says a conservative approach would be to get one from the police anyway to provide more support if the targets choose to sue later.

Another issue to consider is how you will monitor the videotaping. Will you simply turn the cameras on and review the videotapes at a later time? Or will you have the cameras monitored in real time? The answer may depend on the circumstances, especially the nature of the suspected abuse and how much an immediate intervention would help, Hilliard says.

"If you end up with a videotape that shows abuse and no one was watching the cameras so they could intervene, you could end up with allegations of failure to intervene," she says. "But it can be demanding to have someone sit and monitor that feed 24 hours a day, so that's an important decision. Sometimes when the abuse happens, it is quick and the parents call for medical help immediately anyway, so monitoring is not always absolutely necessary."

At Children's National Medical Center, the use of CVS has not yet proven MSBP in any suspected cases, but Hilliard points out that many other facilities have been successful in saving children from continued abuse by secretly videotaping. In the cases in which her facility has used CVS, she says the abuse could not be proven because the camera did not cover all angles of the room; thus, the abuse still could be hidden. In MSBP, the parent often hides the abuse by holding the child tightly or blocking others' view with his or her own body.

"The lesson we learned was that the equipment

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is a key element to making this work," Hilliard says. "You've got to have enough cameras to cover all parts of that room from different angles so you can see what happens everywhere. That might mean six or seven pinhole cameras hidden in the room."

For the cases at Children's National Medical Center, Hilliard authorized the security department to install a secret camera in the patient's room. Hilliard notes that some pediatric facilities have constructed special inpatient rooms that are equipped with multiple cameras, all hidden and unknown to patients and family. When MSBP is suspected, the patient is transferred to that room under some pretense. Hilliard says that is a good solution if you have the capital for constructing such a room. She notes that the cost of such a room can vary greatly depending on whether you need to construct a room from scratch to accommodate the equipment or can retrofit an existing room. Even in the best case, in which you retrofit a room using the labor of your own security and facilities staff, setting up a CVS surveillance room probably will cost several thousand dollars for the necessary equipment.

A good relationship with the local child protective services agency and the local police department also will prove helpful. You may need their support during and after the videotaping, especially if you find evidence of abuse. Hilliard suggests meeting with those representatives beforehand to discuss the best procedure for contacting them with suspicions, and to establish a rapport.

Surveillance policies needed

Patients and family members should be reminded in admission and consent forms "that they don't enjoy the same privacy in a hospital setting that they might at home, that there are times when the diagnostic process might involve videotaping," Hilliard says. Rogoff and Carter agree that risk managers should develop policies about video surveillance.

"They can model their policy after a Texas statute that allows electronic monitoring in nursing homes with written consent by a resident or a legal guardian of the resident," Rogoff says. "As in the Texas statute, the health care provider can add a provision to the consent form to release the institution from civil liability arising from any privacy violation directly related to the use of surveillance." **(For information on how to access the Texas statute, see resource box, right.)**

Rogoff suggests posting a notice to visitors and employees at the entrance of the facility and, if the surveillance is not secret, outside the patient's room. **(See p. 16 for more on the legal aspects of CVS.)**

Hilliard's policy states that CVS will only be used when two physicians document a reasonable suspicion of MSBP (or other abuse that could be detected on videotape) and other less intrusive diagnostic steps already have been exhausted. The policy also explains exactly how the orders must be written, which includes not referring to the secret videotaping in patient records that can be viewed by the family or immediate caregivers, who might tip off the family. After videotaping, the policy calls for the destruction of any tape that does not show abuse.

A well-crafted policy can protect the hospital from many of the legal issues involved with CVS, Carter says.

"These established policies will make it easier for patients and legal guardians to raise concerns with administrators and reduce the chance of employer liability," Carter says.

What is the bottom line for risk managers? If patients or their families claim that an abusive situation exists, and the risk manager believes the only way to prove the innocence of staff members and

SOURCES/RESOURCE

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The Texas statue on electronic monitoring can be found online by going to the web site tlo2.tlc.state.tx.us. Select "Texas statutes" and then the "search" tab. In the search box, enter "Health & Safety Code Chapter 242. Convalescent and nursing homes and related institutions subchapter." Open that document and go to Subsection 242.841.

avoid costly litigation is by means of CVS, it can be legally utilized as a last resort, Rogoff says. Carefully implemented, CVS can be integral in uncovering the truth behind accusations of patient abuse, which protects caregivers and their patients, he says.

Hilliard is an even stronger proponent, saying legal concerns should not prompt risk managers to shy away from CVS when it could protect patients from abuse. The easier path is to say the liability risks are too high and forbid surveillance, but that could lead to continued abuse of your patients.

"This is something that we as the risk management profession should be advocating for, speaking as one voice," she says. "This is an area where people will look to risk management for advice, and we should be leaders. Don't be afraid to take some risks to do the right thing." ■

What you need to know about liability and video

Risk managers are understandably cautious about utilizing covert video surveillance (CVS). Its use can expose your organization to several legal claims in the areas of state wiretap statutes, privacy rights of patients, and privacy rights of employees, says **Andrew R. Rogoff**, JD, a partner in the Philadelphia office of the law firm Pepper Hamilton.

To complicate matters, the legal implications of covert video surveillance vary from state to state, he says. Some prohibit the practice outright, while some permit it — with caveats. Other states are silent on the issue. So, what do risk managers need to know before utilizing CVS?

First, risk managers should be aware of the specific limitations of their state's wiretap statute, Rogoff says. Violations carry not only legal and financial risk, but they jeopardize the reputation of a health care provider. In some states, the taping could be a crime. To avoid violating a state's wiretap statute, a health provider should get consent from patients (or, in the case of patients who are incompetent, from their legal guardian or representative) to use video surveillance.

Rogoff explains that, though each state's statute may define "consent" differently, based on past federal cases, several techniques can be used to legally ensure that patients are adequately informed about video surveillance. Risk managers should ensure that all patients sign a consent form acknowledging that there may be cameras in their rooms or in the common areas of the facility. In addition, a sign should be placed at the entrance to the facility informing visitors and employees that the activity is monitored and recorded by hidden cameras, he says.

Consider right to privacy

Second, employing CVS to investigate potential abuse raises the legal question of whether such surveillance violates the patient's right to privacy and the employee's right to privacy. In many states, proving that CVS violates the legal definition of "a right to privacy" is a difficult task, Rogoff says. Most states have a high threshold. To determine whether an individual's right to privacy has been violated, courts often consider the surrounding circumstances, including the degree of the intrusion, context, conduct, and circumstances, he explains.

Employee privacy is another concern. Generally, employees in private settings have little right to privacy, Rogoff says. "Although surveillance in the workplace is believed to foster low morale, companies routinely monitor for security concerns, quality assurance, or investigation of employees' behaviors," he says. "Employees are generally not protected from surveillance because the building, equipment, and supplies are the property of the employer."

Rogoff notes that the Electronic Communications Privacy Act of 1986 prohibits the interception of communication by any electronic means, but it provides exceptions with regard to employees. One exception under the act allows the employer to monitor employees when the employee has been made aware of the monitoring or where there is an established monitoring policy.

"Under this exception, continued employment implies that the employee consented to the monitoring," Rogoff says. ■

Case study shows how video helps avoid lawsuit

This case study involving covert video surveillance (CVS) is provided by **Andrew R. Rogoff**, JD, a partner in the Philadelphia office of the law firm Pepper Hamilton, and **DaQuana L. Carter**, JD, an associate with the firm. They say the case

illustrates how the technique can be beneficial to health care organizations. The names have been changed to protect the identity of those involved.

Patrick Sullivan watched his father's health rapidly deteriorate after strokes severely diminished his mental and physical capacities. Unable to provide adequate care for him, Patrick and his sister chose to place their father in a nursing home. Almost immediately the family began noticing bumps and bruises on his body.

Patrick suspected the injuries were a result of abuse by a nurse or other employee. He asked his father, but in his confused state, he couldn't explain his injuries.

Patrick voiced his concerns to the nursing home's administrators, who jumped to the defense of their employees and assured him that they were not to blame. But after a few more weeks and no improvement in his father's condition, Patrick met with nursing home officials again and demanded an investigation. Although reluctant to pursue it at first, the owner of the nursing home did want to establish the innocence of his staff, and Patrick's persistence left him little choice but to agree when the son offered, at his own expense, to install a covert video camera that would monitor all the activities in his father's room. First, the owner needed the consent of his father, who was the sole occupant of a private room in the nursing home. Meanwhile, nursing home administrators posted signs alerting employees and visitors to the possibility of video surveillance within the facility.

Video reveals true source of injuries

After the system was installed, Patrick waited a week and then viewed the tape. What he saw surprised him. The video clearly showed that the father, a restless and fitful sleeper, was repeatedly banging his arms and legs against the bed rail. Patrick concluded that his father's bruises were simply the result of his agitated sleeping patterns. Patrick and the home's owner were relieved to know that his father was not the victim of abuse, and steps were taken to prevent him from injuring himself further while sleeping.

In this case, Rogoff explains, video surveillance was able to absolve the nursing home and its resident's primary caregivers of any wrongdoing.

"In other cases, the use of video cameras in residents' rooms has been shown to discourage abuse and neglect, simply because employees know they are being watched," Rogoff says. "Under any circumstance, however, the use of video surveillance can be a positive step in reducing the potential for abuse of the elderly." ■

Hospital shows value of CVS in abuse cases

In 1993, Children's Healthcare of Atlanta at Scottish Rite added rooms to perform inpatient covert video surveillance (CVS) of suspected cases of Munchausen's syndrome by proxy (MSBP). A report seven years later concluded that the secret cameras can be invaluable in proving that children are being abused.[1]

Forty-one patients were monitored from 1993 to 1997 and then their records were reviewed retrospectively by a team of physicians, risk managers, and social workers. They found that a diagnosis of Munchausen's syndrome by proxy was made in 23 of 41 patients monitored. CVS was required to make the diagnosis in 13 (56.1%) of these 23 cases and was supportive of the diagnosis in five (21.7%) cases.

In four patients, the surveillance was instrumental in establishing innocence of the parents. The analysis revealed that Munchausen's syndrome by proxy was more common in Caucasian patients than in other ethnic groups at the hospital. "Fifty-five percent of mothers [suspected of MSBP] gave a history of health care work or study, and another 25% had previously worked in day care," the report said. "Although many of the caretakers fit the profile of MSBP, such as excessive familiarity with medical staff, eagerness for invasive medical testing, and history of health care work, these characteristics were not sensitive indicators of MSBP in our study. Even when present, they were not sufficiently compelling to make the diagnosis."

The Scottish Rite team concluded that CVS is required to make a definitive and timely diagnosis in most cases of MSBP. "Without this medical diagnostic tool, many cases will go undetected, placing children at risk," the report said. All tertiary care children's hospitals should develop facilities to perform CVS in suspected cases."

Reference

1. Hall DE, Eubanks L, Meyyazhagan S, et al. Evaluation of covert video surveillance in the diagnosis of Munchausen syndrome by proxy: Lessons from 41 cases. *Pediatrics* 2000; 105:1,305-1,312. ■

Critical lab result policy cuts hospital's med errors

A system that requires calling physicians directly with critical lab test results can greatly improve patient safety, according to a hospital team that has had such a policy in place for years. Many hospitals will have to develop a whole new way of communicating test results, they say, but the effort is worthwhile.

Mount Auburn Hospital in Cambridge, MA, a teaching hospital of Harvard Medical School, has used such a system for 15 years, and now other hospitals are catching on to the idea, says **Susan A. Abookire**, MD, MPH, chair of quality and safety at Mount Auburn. The idea itself is simple — call the doctor directly when the test results are critical — but implementing it can be a challenge.

Gayla Jackson, RN, BSN, a nurse manager at Mount Auburn who has been a key leader in the patient safety initiative, says the hospital was spurred to improve its critical test reporting by an adverse event at the hospital that was traced back to a lapse in communication. Jackson witnessed the tragic result and realized the hospital needed a better system.

"Afterward, with everyone looking at each other and saying, 'What happened? What happened?' we realized it happened because we didn't have a good system in place," Jackson says. "It was over 20 years ago, but we don't forget that incident. It showed us how important this is."

Abookire points out that it still is not the norm for hospitals to have firm, detailed policies on communicating critical test results. Too often, she says, clinicians rely on written messages, voice mail, or someone's promise to pass on the information to the right person. "There are people whose lives have been lost because of a Post-It note falling off a piece of paper," Abookire says.

EXECUTIVE SUMMARY

Reporting critical test results directly to the patient's physician is an important step in improving patient safety. One hospital reports success with a detailed policy that ensures direct communication.

- Many critical test results are reported in a haphazard way that jeopardizes patients.
- A good policy will outline exactly what results are considered critical.
- Physicians must be educated about their key role in accepting the calls.

Little structure in previous system

Before Mount Auburn implemented the current system, getting critical test results to the physician was more haphazard. The laboratory called the unit secretary with a critical test result, and the secretary wrote down the critical result in order to hand it off to the registered nurse on the unit, who would then identify and page the ordering physician. When the physician called, the nurse would pass on the test results.

"Clearly the potential for error was enormous," Abookire says. "Reliability, hand-offs, turnaround time, and receipt and acknowledgment of the critical test result are all crucial elements of our process that had to be examined."

Twenty years ago, the hospital's initial attempt to improve the communication of critical test results started in its laboratory, where staff began calling all the defined critical test results to the ordering physician. But even with a popular decision to do this, the staff found that the volume of calls from the lab to the ordering physician was too large and too time-consuming to be realistic.

To improve upon the original idea, the lab began calling for "first-time criticals" only and not subsequent criticals. This change brought the number of calls down to a reasonable number. Jackson says the lab staff make an average of 600 calls per month for critical results on inpatients. That number works out to about 20 calls every 24 hours or one or two calls per tech on an average day, she says. **(See p. 19 for more on how the system works.)**

As the policy continued to evolve, Mount Auburn added the verification "read-back" by the physician receiving the critical result. This acknowledgment is documented with the result in the hospital computer system and includes the physician's name, beeper number, and the date and time the result was acknowledged. Critical results are never released to an answering service or voice mail. Instead, the lab requests that the doctor call back immediately.

Must be able to reach physician

Of course, the system relies on being able to contact the physician directly. Jackson says the hospital's ability to identify and locate the ordering

SOURCES

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- **Gayla Jackson**, RN, BSN, Nurse Manager, Mount Auburn Hospital, 330 Mount Auburn St., Cambridge, MA 02138. Telephone: (617) 492-3500.

physician is made possible by the telecommunications department, which is responsible for maintaining all physician call schedules, beeper numbers, and private practice numbers.

If the ordering physician is not found, the staff member calls a resident, then an attending, and lastly the pathologist on call and present in the hospital, Jackson says. Attempts to call the physician have been shortened from 30-minute to 10-minute intervals, for a total of three calls. Each physician receives calls only for his or her own patients' critical results, so the doctor doesn't receive an excess of phone calls.

"But still, when we first introduced the idea, we had physicians say they're too busy to be called directly. My reaction was, 'I'm glad you're not my physician,'" Jackson says. "Now that they see the volume is not excessive, we have good support."

Physician education is key

With the success of the lab policy, the process for reporting critical test results was expanded to other departments at Mount Auburn. Abookire says the standard has been systematically implemented in radiology, cardiology, and now across the discharge process. **(See p. 20 for more on implementing the policy in other departments.)**

Instituting this type of policy requires a culture change, Abookire says. Even with clearly defined policies and procedures, the whole plan can fall apart if the doctor does not accept the call, she says. The Mount Auburn team spent a lot of time meeting with physician leaders to show that they would be called only when the test results are critical and he or she must hear them immediately.

"When the physician is backed up and has 10 patients in the waiting room and he's in with a patient, it's very tempting for him to say, 'Just take a message,'" Abookire says. "But that defeats the whole purpose of the system, so we have to educate the physicians about how important this is, that these are the kind of results they want to know right away, the kind that would make them jump out of bed at 3 a.m. and rush to the hospital." ■

How the critical result reporting system works

At Mount Auburn Hospital in Cambridge, MA, critical lab test results are defined as test results with abnormal or "critical" values, resulting in a potentially life threatening situation for the patient, explains **Gregory Gauvin**, MD, chair of pathology at Mount Auburn.

For example, a white blood cell count lower than 1,000 or greater than 20,000 is deemed critical. A low white blood cell count typically means the body can't fight off a simple infection as easily, and the patient's condition could become serious very quickly. Chemotherapy could put cancer patients at risk for infection if their white blood cell counts are too low.

Gauvin says a list of various tests and values was derived years ago and is continually updated based on the latest medical information gathered from a number of internal and external sources, including recommendations from the College of American Pathologists. He adds that most of the time, test results with critical values may not be expected, especially in the outpatient setting, which is why it is vital to have a streamlined critical test results communication system.

Gauvin says when an inpatient test comes back with critical values, the physician (usually a resident) is paged immediately. According to statistics from the Mount Auburn Hospital pathology department, 99% of all critical values were called in within 60 minutes in 2005. "If physicians don't answer within 10 to 15 minutes, we'll call back,"

SOURCE

For more information on the critical result reporting system, contact:

- **Gregory Gauvin**, MD, Chair of Pathology, Mount Auburn Hospital, 330 Mount Auburn St., Cambridge, MA 02138. Telephone: (617) 492-3500.

he says. "We can't sit on these results and say we'll get to them three hours from now. It has to be as soon as possible because it's potentially life-threatening."

The "read-back" policy, in which physicians always should be able to read back exactly what the pathologist or technologist has just communicated to them, also is an important part of the process, Gauvin says. "That's just another way of checking to make sure the physician has heard the message and understands it," Gauvin says. The lab monitors the "read-back compliance" monthly as part of the lab's quality assurance program, and it currently averages 95%. ■

With lab result success, other departments follow

Once the lab at Mount Auburn Hospital in Cambridge, MA, met its goal of communicating first-time critical results to the physician in less than 60 minutes, 100% of the time, the next step was to take the policy to other departments. Radiology and cardiology were next in line, says **Susan A. Abookire**, MD, MPH, chair of quality and safety at Mount Auburn.

Each of these areas created specific critical value lists and policies and explicit time frames for calling critical results, where previously none had existed. All lists and policies now are reviewed/evaluated annually or as needed, with approval from the Medical Staff Executive Committee. Critical value lists and categories were placed in "reading stations" in common areas so staff could study them and refer to them as needed.

In radiology, a change to the computer system helped improve reporting times, she says.

"This change allowed all information collected during patient registration to automatically cross over from our admitting module to our radiology module, thereby giving the interpreting physician information on who to call with their final result, which improved our turnaround times in radiology," Abookire says.

Additionally, radiology monitors all positive tests, not just those determined to be critical. The current monitoring process is that all positive results are called at the time the study is being read. If contact is immediately made, this contact is documented in the official dictated report. To make sure that all positive and critical results are reported to the appropriate physician, the billing slip is held aside until the contact has been made.

Documentation in the report that the radiologist has discussed the case with the ordering physician is considered to comply with the "read-back" requirements, Abookire notes. If a result is given to a covering physician, a formal read-back including the patient's name and the findings is expected.

Prior to this initiative, the cardiology department had no formal criteria for calling critical results. Individual interpreting cardiologists decided what a "critical result" was and what needed to be called, Abookire says. Nurses and techs performing stress tests, echocardiograms, vascular exams, and Holter monitors also independently decided if something was to be brought to the attention of a cardiologist for stat interpretation. Documentation of results reported varied, and inconsistencies existed as to what results should be considered critical and called within one hour.

The cardiology department followed the lead of the lab and radiology and devised a set of critical results that must be reported immediately. All cardiology critical results are documented in a log book and monitored monthly, she says. ■

Look for rapport, access when choosing counsel

Risk managers spend a lot of time working with outside counsel, so choosing the right attorneys to handle your organization's legal matters can have a major impact on your department's success. But how do you go about choosing the right counsel?

EXECUTIVE SUMMARY

Choosing outside counsel to assist with legal matters is an important decision for risk managers. Good rapport with the lawyer can be as important as good credentials.

- Focus on individual attorneys, not the credentials of the law firm.
- Provide enough business to the lawyers to keep them interested.
- Look for attorneys who can be legal resources for a broad range of issues.

Seven questions to ask when choosing a lawyer

John Metcalfe, JD, vice president of risk management services at Memorial Health Services in Long Beach, CA, suggests asking these questions when selecting a lawyer to work with your organization:

1. Does the lawyer have a personality that meshes with your own? There is no science to this, Metcalfe says, but remember that you may be working quite closely with this person on important, stressful matters. If your personalities or work styles clash, you're only asking for trouble.

2. Is the lawyer willing and able to work within your litigation management guidelines? There's no point in choosing a lawyer who is experienced and highly skilled if he or she won't abide by the guidelines you must follow when settling or litigating cases.

3. Is the lawyer accessible? Don't fall into the trap of choosing an extremely qualified lawyer who is so busy that you can't ever have a phone conversation or a meeting. All the talent in the world is no good if you can't talk to the lawyer when you have a question.

4. Does the lawyer understand your organization's needs? Does he or she express an interest in hearing more about your organization and your particular needs, or are you seen as just another client? It is far better for the lawyer to be familiar with your organization before handling the first case, instead of trying to play catch-up later.

5. Is the lawyer experienced in health care and particularly in the area in which you need help? Not all lawyers are the same. Even the best in one field may not be adequate in another, so look for lawyers — not just law firms — who have experience in medical malpractice, workers' compensation, credentialing, or whatever area you're seeking help with.

6. What results has the lawyer obtained for other hospitals? Results are important. Ask for specific examples of how the lawyer has helped other health care providers in the same area in which you ask him or her to work.

7. What are the lawyer's professional credentials? Look for membership in legal organizations that suggest the lawyer has achieved a certain degree of success in the field. ■

One key point to keep in mind is that you're selecting people you want to work with, not just a set of credentials for the law firm, says **John Metcalfe**, JD, vice president of risk management services at Memorial Health Services in Long Beach, CA.

"I deal with people, not law firms, so when I recommend putting someone on our panel of lawyers, I will name the lawyer but not necessarily the law firm," he says. "I try to do business by dealing with a lawyer I like working with, not an entire law firm."

Experience is always an asset when choosing an attorney, but Metcalfe points out that there is nothing wrong with choosing a younger attorney with a solid start and a promising future. A young lawyer with more experience in health care litigation, especially big wins, or one with experience in a particular area that is useful to you could be a good bet, Metcalfe explains. One benefit of selecting a younger lawyer is that you nurture a long relationship and reap the benefits as that person becomes more seasoned and experienced, he says.

Metcalfe notes that to entice the best defense counsel and ensure the relationship continues, you must be willing to send them enough business to make it worth their while. At Memorial Health Services, Metcalfe has put together a five-lawyer panel from five law firms, and he makes sure that each one gets some business.

"I give one of those lawyers about 30% of the business, and then I divide the remainder of the business among the other four," he explains. "The one who receives 30% is a little more visible than the others and sits on some hospital boards. It's OK to favor one more than the others as long as you have enough business to keep them all satisfied."

Metcalfe also bases his decisions on the associates at the firm who will do some of the work. He makes it clear when choosing an attorney that he will need to approve the associate designated for the work and that he must approve that person's work.

"I want to make sure that the majority of my work is going to be done by the lawyer I hire and not handed off to an associate," he says. "That can be a real danger, especially if you don't have enough rapport with the lawyer and don't communicate clearly and often. You don't want to find out when it's too late that your important case was handled by an associate with far less experience than the lawyer you thought was doing the job."

The lawyer you choose should be willing to act as a resource for you and other hospital leaders, not just a hired gun for specific legal matters, suggests **Dwight Scott**, JD, an attorney with the

law firm of McGlinchey Stafford in Houston.

"If you look at legal counsel as just someone to go to when things go bad, you're missing the opportunity to get a lot more out of that relationship," he says. "I'd advise risk managers to look for a lawyer who is willing to be a resource you can call on to help you navigate through legal and regulatory issues before anything bad happens."

Andria Lure Ryan, JD, a partner with the law firm of Fisher & Phillips in Atlanta, advises risk managers to select counsel who can handle more than just one narrow area of health care legal concerns. Though it is beneficial to have lawyers on call who are highly experienced in one area, such as medical malpractice defense, Ryan says it also can be good to have other counsel who are experienced more broadly in health care issues.

"It is not uncommon for one incident to lead to a number of different concerns for the risk manager, maybe a malpractice suit from the patient, regulatory issues, and employment issues from the employee you fired," she explains. "As outside counsel, we often have to dig around for information about peripheral cases, so it can be to your advantage to have counsel that is knowledgeable about all those issues and willing to address them all." **(For more information on working with outside counsel, see *Healthcare Risk Management*, October 2006, p. 115.)** ■

Patients' idea of med errors affects satisfaction

All of the emphasis on reducing medical errors has not escaped your patients' attention, and they may be defining the term so broadly that they will never be satisfied with your care, according to the results of a recent study from the Joint Commission.

The research suggests that hospital patients define medical errors much more broadly than the traditional clinical definitions of medical errors. The patient definition of medical errors includes communication problems, responsiveness, and falls, according to the study.[1] **Thomas E. Burroughs**, PhD, a researcher with the St. Louis University Center for Outcomes Research in Missouri and lead author of the study, says the findings point out the need for physicians and other health care professionals to clarify what patients mean when they talk about an "error" or "mistake."

The study of more than 1,600 patients at 12 Midwestern hospitals also shows the importance of explaining exactly what is meant by the term "medical error" if patients are to be effectively engaged in programs to prevent them. Burroughs and his colleagues conclude that most patients felt a high level of medical safety, but 39% experienced concern about at least a single type of medical error during their hospitalizations. Certain groups of patients were more likely to be concerned about medical errors, such as middle-aged patients, parents of pediatric patients, and blacks.

In addition, patients who experience longer lengths of stay, more severe illnesses, or were admitted through the emergency department were likely to have more concerns. Patients who received care in small and rural hospitals reported the fewest types of concerns, regardless of the severity of illness. The authors of the study note that programs to educate patients to play a more active role in preventing errors may need to be tailored to effectively address the fears and concerns of each patient.

"The study underscores that patients and clinicians can have different views of the things that constitute a medical error," Burroughs says. "For patients, clear communication and responsiveness are particularly important. If these are lacking, patients may view this as a medical error. It is important that clinicians recognize these differences and the importance of communication and responsiveness."

Burroughs says the research showed a strong link exists between a patient's concerns about medical errors and his or her satisfaction with the entire hospital experience. A single concern was tied to a significantly reduced likelihood of recommending and returning to the hospital for future care. It is important to note that these are "concerns," not necessarily actual errors.

"For patients, it appears that error-related concerns alone, even if not linked to an actual error, are enough to significantly affect their perceptions

SOURCE

For more information on the study regarding medical errors, contact:

- **Thomas E. Burroughs**, PhD, St. Louis University Center for Outcomes Research, Salus Center, Second Floor, 3545 Lafayette Ave., St. Louis, MO 63104. Telephone: (314) 977-9300. E-mail: burroute@slu.edu.

of the entire experience, which could alter adherence and willingness to return for care," he says.

Reference

1. Burroughs TE. Patients' concerns about medical errors during hospitalization. *Jt Comm J Qual Saf* 2007; 33:12-16. ■

Safety progress called 'abysmal' by Leapfrog

Progress toward meeting key patient safety goals is "abysmal" at most hospitals, according to The Leapfrog Group, a patient safety advocacy organization in Washington, DC.

The group recently released a report that said the use of practices to protect patients from harm still is very bad at most hospitals, citing these examples:

- Ninety percent of hospitals have not implemented computer physician order entry to Leapfrog's standard.
- Ninety percent fail to meet the standards for performing two high-risk procedures: coronary artery bypass graft surgery (90%) and abdominal aortic aneurysm repair (96%).
- Seventy percent do not enlist intensivists (intensive care specialists) to oversee patient care in the intensive care unit according to Leapfrog's standard.
- Fifty percent do not have an explicit protocol to ensure adequate nursing staff or a policy to check with patients to make sure they understand the risks of their procedures.
- Thirty percent lack procedures for preventing malnutrition in patients and do not vaccinate their health care workers against the flu.

The statistics come from the Leapfrog Hospital Quality and Safety Survey, which the group says is the only national survey that provides a full assessment of hospital quality and safety. (The Leapfrog web site at www.leapfroggroup.org displays the results of each participating hospital. On the home page, click on the link that says "Click here for our hospital quality ratings." The data can be viewed by anyone at no charge, and it is updated each month with data from additional hospitals.)

The survey results from more than 1,200 hospitals do show some progress toward meeting the 30 "Safe Practices for Better Healthcare" endorsed by the National Quality Forum. For instance, 90% of the hospitals have implemented procedures to avoid wrong-site surgeries, and 80% require a pharmacist to review all medication orders before medication is given to patients.

Only 7% have fully implemented computerized physician order entry (CPOE), and another 7% have plans for implementing it soon. The group reports that this represents "little progress since Leapfrog began tracking implementation in 2002, when the figure was 3%." ■

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CE objectives

After reading this issue of *Healthcare Risk Management*, the CE participant should be able to:

- **Describe** legal, clinical, financial, and managerial issues pertinent to risk management in health care.
- **Explain** how these issues affect nurses, doctors, legal counsel, management, and patients.
- **Identify** solutions, including programs used by government agencies and other hospitals, for hospital personnel to use in overcoming risk management challenges they encounter in daily practice. ■

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- Introducing rapid response teams

innovation and change for The Joint Commission and the facilities it accredits. This special paper is written specifically to explain the new standards so that you can plan appropriately.

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CNE Questions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with the **June** issue, you must complete the evaluation form provided and return it in the reply envelope provided in that issue in order to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you.

5. What does Mary Anne Hilliard, JD, BSN, CPHRM, recommend regarding the equipment necessary for covert video surveillance (CVS)?
A. One camera always is sufficient.
B. One camera usually is sufficient except in especially challenging cases.
C. Two cameras always will be enough.
D. Most cases will require multiple cameras, as many as six or seven, to cover all parts of the room.

6. According to Andrew R. Rogoff, JD, how does the Electronic Communications Privacy Act of 1986 apply to the use of CVS in health care settings?
A. The act prohibits the interception of communication by any electronic means, but it provides exceptions with regard to employees.
B. The act prohibits all secret videotaping of employees with no exceptions.
C. The act applies to patients but makes no mention of employees.
D. The act explicitly allows the employer to videotape employees at will, with no requirement to forewarn employees.

7. According to Susan A. Abookire, MD, MPH, what is the hospital's policy regarding leaving messages about critical test results?
A. Critical results are never released to an answering service or voice mail. Instead, the lab requests that the doctor call back immediately.
B. It is acceptable to leave messages with test results if the physician is not available.
C. Messages with test results may be left only with nurses.
D. It is up to the judgment of the staff making the call as to whether it is acceptable to leave a message with the test results.

8. What does John Metcalfe, JD, recommend when selecting outside counsel?
A. Focus on the individual attorney, not the credentials of the law firm.
B. Focus on the overall qualifications of the law firm, not individual attorneys.
C. Never select young attorneys.
D. Select only attorneys from the top 25 largest law firms.

Answers: 5. D; 6. A; 7. A; 8. A.

Healthcare Risk Management's
Legal Review & Commentary™
A Monthly Supplement

Improper use of forceps results in large federal tort verdict

By **Blake J. Delaney**, Esq.
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Tampa, FL

News: During a delivery, a contract OB/GYN improperly used forceps. The infant's skull was crushed in the process, which left the child severely brain damaged. The judge awarded $33 million to the child and parents for pain, suffering, and lifetime medical expenses.

Background: A military couple based in Texas was expecting the birth of their first child. The woman was receiving care through Army facilities and providers, and the Army hospital had a contract with civilian obstetricians for OB/GYN services. After a normal and healthy pregnancy, the woman went into labor. At the hospital, the delivering physician was an OB/GYN who had been hired under a personal services contract and whom the family had not met before. While attempting to use forceps to aid in the delivery by applying traction to the fetal head, the physician used them in such a manner that they crushed the baby's skull, which caused massive global and focal brain damage. The infant's hearing complex and right eye socket were destroyed, resulting in permanent hearing loss and partial blindness. The child's injuries were severe and permanent, which led to cerebral palsy. She is physically and mentally handicapped and will require 24-hour care for the balance of her normal life expectancy.

At the time of delivery, the military medical personnel had described the girl's condition as "seizures" instead of making the parents aware of the true extent of their daughter's injuries. It was not until they requested a copy of the medical record that they learned that the improper use of forceps had caused such severe medical problems.

The distraught parents brought suit under the Federal Tort Claims Act against the U.S. government, which admitted that the physician was an employee acting within the course and scope of his employment. The government also admitted liability and causation, which left the amount of damages as the only issue for trial. During the pretrial period, the parents discovered the obstetrician had an extensive history of substance abuse involving alcohol and codeine compounds. They also discovered that within months after the delivery of the plaintiff's child, the obstetrician was cited by the state's Board of Medical Examiners for failure to practice medicine in an acceptable manner consistent with public health and welfare and for prescribing or administering a treatment that is nontherapeutic in nature or nontherapeutic in the manner the treatment is administered or prescribed.

Prior to trial, the government offered $1.6 million to settle the case, but the parents countered with $7 million. The government increased their offer during the bench trial to $4 million, but the counteroffer became $10 million. The judge ultimately awarded nearly $33 million, the second-largest medical malpractice verdict ever against the federal government. The government appealed

the case, and the appellate court ordered that the amount of the judgment be reduced. Following the appeal, the parties settled the case for the reduced amount plus post-judgment interest, totaling $25.5 million.

What this means to you: It is always sad that in the course of an event that is supposed to be a happy time for a family, such as the much-anticipated birth of a first child, an unfortunate, and possibly preventable, outcome occurs. As an initial matter, this case demonstrates that a hospital can be held liable for the acts of the personnel working at the facility, to include doctors. In this case, the doctor who committed the professional malpractice was a contracted employee of the hospital, which is not an infrequent relationship between government hospitals and civilian physicians who provide certain obstetrical care. "But even outside of the government hospital context, this case is evidence that risk managers should be intimately involved in the review of all contracts," recommends **Leilani Kicklighter**, RN, ARM, MBA, CPRHM, LHRM, consultant/principal at The Kicklighter Group in Tamarac, FL, and past president of the American Society of Health Care Risk Management.

A risk manager should assess the risk exposure, risk assumption, and insurance provisions found in any such document and also should review the language in the contract regarding "agency." Agency — a concept under which an entity will be deemed to be vicariously liable for the acts of an individual — is a concept that plays a significant role in the legal aspects of claims. In this case, the government facility admitted that the physician was an employee, meaning "agency" did not become an issue. But even if a contract does not specifically state that the contracted party is an employee, a court still can find the party to be an agent, thereby exposing the facility to liability.

Kicklighter advises that there are certain conditions, such as assignment of work, control of work, and how the contracted person is paid, that will factor into a court's decision regarding whether the contracted person is an agent. "Risk mangers should become familiar with the 'tests' applied in their states in order to recognize and assess the level of risk exposure in a contract for the provision of services," she says.

This case also emphasizes the importance of the initial appointment, reappointment, and delineation of privileges of doctors. "The use of mid- and high-forceps should be used only by those physicians who request — and are granted — privileges to do so. And, as in all procedures requested, approval should be given only based on demonstrated education and competency," advises Kicklighter. This case is particularly interesting because the use of high forceps is not that common nowadays. Nevertheless, when forceps are used, the doctor should follow the published guidelines of the American College of Obstetrics and Gynecology (ACOG) and provide notice that he or she will be using forceps to the chief of the obstetrical service for peer review, as well as to risk management for investigation and possibly a root-cause analysis.

If this physician were granted privileges to use mid- or high-forceps without a good foundation of experience or training in this modality, Kicklighter notes that the issue of corporate liability exposure could rear its ugly head. "On the other hand," she continues, "if the physician had not been granted such privileges and used the forceps without requesting an emergency consult from the chief of service, other liability exposures in addition to being reportable to the state board of medicine would be raised."

As part of the initial appointment process, a facility should conduct background checks on all physicians, especially those who are contracted. Kicklighter suggests that as part of the medical staff rules and regulations, processes should be included to address suspected substance abuse and disruptive behavior, including interventions. Staff also should be educated to report aberrant and unusual behavior exhibited by physicians and other staff members. She further notes that many facilities have "drug-free" workplace programs, which tend to focus on preventing work-related accidents.

"Rank-and-file employees are often hesitant to intervene or to report physicians who exhibit symptoms of substance abuse or unusual behavior," says Kicklighter. "Yet studies reflect that a significant percentage of health care staff, including physicians, are substance abusers. It is a serious problem that many facilities do not have programs to reinforce the process and to give employees comfort that they will be supported if they make such a report." She suggests that the risk management department become an integral component of this initiative as a loss prevention effort.

Every risk manager should be immediately involved in untoward events, especially ones

with such devastating injuries as those found in this case. Kicklighter is alarmed by the fact that the hospital in this case did not immediately inform the parents of the extent of the baby's injuries, as disclosure of untoward outcomes is a standard from The Joint Commission. In many states, in fact, such disclosure now is a statutory requirement, Kicklighter adds. Not only is withholding the condition of the newborn problematic from an ethical and moral standpoint, but disclosure of untoward outcomes and the lending of support to the family often can mitigate or prevent the assertion of a claim. In cases like these, risk management should orchestrate the disclosure meeting with the family and the subsequent status meetings, including a review of the medical record. Kicklighter contends that to withhold information as to the event, to describe the infant's condition as "seizures," and to withhold the medical record from the family are all fodder for inflaming a jury and could be considered fraud in some situations.

One final point raised by this case is the fact that this facility is a U.S. military hospital. "State-based governmental health care facilities may be entitled to sovereign immunity, which is a consideration that will affect every risk manager's mindset when faced with potential litigation." Nevertheless, Kicklighter stresses, the patient care issues detailed in this case should be of considerable concern to any risk manager considering that governmental health care facilities and providers are *not* exempt from complying with applicable standards of care.

Reference

• Case No. A-99-CA-316 JN (U.S. District Court, Western District of Texas at Austin). ■

$340,000 verdict follows Alzheimer's patient's case

News: An elderly man suffering from Alzheimer's disease was taken to the hospital for treatment of cough and body aches. When hospital staff completed their treatment of the patient and cleared him for discharge, the man learned that his ride home had left the facility. The man subsequently spent the night at the hospital. The man was wandering through the hospital's hallways during the night and ultimately wandered off the hospital's premises early the next morning. He was found several hours later by the side of a highway, and he had been caught in a brush fire. The man died the next day. The patient's surviving wife sued the hospital for negligently failing to monitor her husband, and a jury returned a verdict against the hospital for $340,000.

Background: A 73-year-old nursing home resident suffering from Alzheimer's disease was taken to the emergency department following complaints of coughing and body aches. By 1 a.m., the man was cleared for discharge. However, because his caregiver had left the hospital, the patient stayed the night in the emergency department. Social services personnel were scheduled to take the man back to his assisted living facility the next morning.

In the middle of the night, the hospital's nursing staff found the man wandering the hallways. Consequently, nurses moved the patient to an area where he could have the assistance of a technician outside his room. At 8 a.m. the next morning, however, the hospital's security surveillance video showed the man leaving the facility's premises. He was found several hours later by local fire department personnel in a gully off an interstate, where he had been caught in brush fire.

The man was transported by helicopter to another hospital for treatment of burn injuries to nearly 90% of his body, more than half of which were third-degree burns. Hospital staff attempted to save the man's life by removing nonliving tissue from his burns; administering full life support and full burn protocol treatment; intubating him; and cutting holes in the thick, rigid barrier of burn tissue from his ankles to his armpits to release swelling — a procedure known as an escharotomy. Nevertheless, the man died within 24 hours.

The man's surviving spouse sued the first hospital and alleged negligence for its failure to monitor her husband. She alleged that her husband should have been directly observed because he was an Alzheimer's patient who required a caregiver and because he was in a strange environment. She further contended that had her husband been appropriately monitored, he would have been seen trying to leave the hospital and brought back for safekeeping. As a result, he would have avoided the horrific massive burns and subsequent death. The wife brought claims for her husband's pain and suffering and economic damages as well as on her own behalf for loss of companionship.

The hospital disputed liability and claimed that its nurses were not required to monitor the man very closely, given that he had been cleared for discharge and was merely awaiting transportation back to his assisted living facility. After trial and four hours of deliberation, a jury returned a verdict of $340,000 for the plaintiff, awarding $300,000 to the man's estate and $40,000 to his wife.

What this means to you: "Upon admission, a hospital legally accepts responsibility for its patients until they are returned safely to their usual caregivers," says **Lynn Rosenblatt**, CRRN, LHRM, risk manager at HealthSouth Sea Pines Rehabilitation Hospital in Melbourne, FL. And the undisputed tenet of hospital care that "discharge planning begins at admission" applies to all services, including the emergency department and ambulatory surgery. This includes an affirmative duty to safely transition every patient to the next level of care, regardless of whether the transition is internal after being admitted as an inpatient or external to a subsequent discharge. Indeed, Rosenblatt notes, it is a requirement of the Centers for Medicare & Medicaid Services and is a long-held standard of The Joint Commission that once a patient is admitted, the facility has an undeniable obligation to ensure a safe discharge.

In this case, the staff were well aware that the patient resided in an assisted living facility and was cognitively impaired. As such, the patient could not get himself home safely and was likely incapable of understanding post-discharge instructions. "His Alzheimer's disease placed him in the same category of a minor child, requiring a health care surrogate to give consent, supervision to ensure he did not wander off, and a discharge plan to ensure someone assumed responsibility for his person," says Rosenblatt.

Upon the man's admission, the case manager should have entered into a dialogue with the patient's representative as to what supervision the hospital could provide and what was expected of the caregiver. When the hospital learned that the caregiver would be unable to remain in attendance, the hospital was required to find a suitable alternative. Although the hospital apparently argued that it had no responsibility for monitoring the man once it cleared him for discharge, Rosenblatt notes that the hospital's conduct actually constitutes patient abandonment.

Rosenblatt advises risk managers to implement a policy whereby patients, upon admission, are assigned a staff member who is responsible for developing a plan of care that includes a safe and executable discharge plan based on the patient's presentation and current medical condition. "In situations such as the [emergency department], a nurse case manager is the likely role to assume such responsibility. This individual would be responsible for overseeing the patient's movement through the various aspects of the emergency evaluation process and plan for the patient's ultimate disposition when the evaluation is complete and the patient ready to move on."

In this case, because the hospital failed to assign someone to be directly responsible for the patient, he would not have received any assistance unless he had affirmatively asked for it. The problem here also might have been exacerbated by the fact that a shift change likely occurred overnight, and no one informed the new shift that a patient was waiting for his ride and still required monitoring. "This hospital failed to realize that discharge actually occurs when a patient is deemed to be able to safely leave the premises and has the capability of assuming full responsibility for himself or having another do so. Had this rather simple but effective safeguard been in place, this patient would not have suffered as he did and would have been returned safely to his home."

Reference

• Baltimore County (MD) Circuit Court, Case No. 03-C-03-013966. ■

HIPAA Regulatory Alert

Supplement to *Healthcare Risk Management* and *Hospital Access Management*

Realities of disclosure: When docs violate patient privacy

Study shows while providers often violate HIPAA requirements, the intent is good

While patients assume their doctors will work to maintain trust and privacy in their relationships with patients, research has shown that health care providers often disclose personal information to patients' family members. The reasons they give for breaking confidentiality requirements generally involve concern for their patients' welfare and the belief that they know better than lawmakers and regulation writers what those patients need.

A study by West Virginia University communications studies professor **Maria Brann** found that health care providers share confidential health information daily, frequently with patients' relatives. And, while providers maintained that Health Insurance Portability and Accountability Act (HIPAA) privacy regulations theoretically are good ideas, they said they follow their own ideas for their patients, even if that means violating HIPAA.

"Through personal observations of the lack of confidentiality maintenance in various health care organizations, I began to research what types of confidentiality disclosures occur and, more importantly, why they are occurring," Brann, who has studied confidentiality practices in the health care setting for nearly 10 years, tells *HIPAA Regulatory Alert*.

"In previous research, physicians routinely commented on their willingness to share patients' personal information with relatives of patients. They commonly spoke about this practice of communicating with family members without receiving permission from patients, and they felt that they were justified in doing this," she says.

"Then, with the implementation of HIPAA, more people became aware of the salience of this topic, and obviously many health care providers needed to respond to this new legislation. As clearly illustrated by the physicians in this study, they understand and respect the theoretical ideology behind HIPAA; but, practically, they felt it was too cumbersome and hindered patient care, which leads them to continue to disclose information to relatives of patients . . . Many of them feel that politicians, people not in medicine, are telling them how to practice medicine."

She says confidentiality of patient information is vital to positive interaction between patients and health care providers. "Patients expect that their information will be kept confidential," she says, "and based on this expectation, patients disclose personal and sometimes sensitive information to their health care providers."

Is it really an emergency?

HIPAA allows disclosure of information to specific third parties in emergency situations. But Brann found many instances in the study, published in the September 2006 issue of *Communication Studies,* were not truly emergency situations, such as a diagnosis of mild dementia or lower IQ.

"As a health care consumer, I have always been interested in confidentiality maintenance or lack thereof," she says. "I have witnessed first hand how easily patients' confidential information is disclosed. Many times, physicians freely give information to relatives of patients simply because they are relatives; but we know that this may actually be harmful to a patient."

Brann writes that while ethical principles exist for health care providers, confidentiality of private information is one of the most basic human rights for patients in a health care setting and the

study of confidentiality in the health care context "represents [one of] the more fundamental problems of the relative rights of the individual in the social system."

HIPAA is the first federal law to try to codify a privacy requirement in health care. It describes maintaining confidentiality as restricting dissemination of private information. Brann says health care organizations abide by HIPAA and sometimes impose even stricter rules regarding patients' confidential health information.

All in the family

One reason the issue is arising with physicians, she notes, is shifting emphasis in the United States from institutional care to more communal care, which means that families are more involved with the care of relatives. "This assistance with health care raises the issue of who should have access to confidential health information," she writes. "A noticeable tension emerges because relatives who become informal caregivers for the patient need information, coping skills, and support in order to adequately assist their loved ones.

"But at the same time, they are not always legally entitled to that information," she adds. "Relatives claim that they do not receive enough information from physicians, but studies have shown that physicians are more likely to disclose confidential health information to relatives than to other individuals."

In interviewing 22 internists for periods ranging from 35 to 150 minutes, Brann found that several illness factors, such as a patient's prognosis or diagnosis, can play an important role in information disclosure. She found that sometimes physicians disclose information because they empathize with relatives, want to encourage relatives to be advocates for the patient, or, more commonly, believe the diagnosis is severe.

When physicians disclose information to families about a poor prognosis or when they believe the family could be emotionally or instrumentally supportive of a diagnosis, Brann says, the intent obviously is not malicious. "They just thought it was best for [the patient]."

Physicians cited mental impairments most often, but also discussed how patients' emotional issues and physical limitations influenced their decision to disclose information. Brann says the physicians she interviewed chose to share information with patients' relatives regardless of consent or even possible conflict that could arise between the patients and their relatives.

"The physicians felt they knew what was best for the patient (i.e., informing relatives) and would continue to share information to improve the physical health of the patient, even if conflict between patients and relatives resulted," she wrote.

She also found that when physicians determined a serious diagnosis or poor prognosis, relatives sometimes were told before the patient was told. Seeking direction from relatives when a patient has a bad diagnosis or prognosis was reiterated by several of the interviewees, she says.

The type and age of patients whose HIPAA rights are violated often varies, according to Brann. Fully competent and cognitive patients also experience privacy violations, she adds, reporting that physicians sometimes disclosed information to family members who were in the room with the patient because they thought it would be alright.

Physicians said they would knowingly take steps that are contrary to HIPAA regulations because patients need to be cared for in the context of their family. "This theme suggests that physicians include relatives because they feel it is in the patient's best interests," Brann says. "Especially when relatives take on the role of caregiver, physicians share information with them. They encouraged patients to talk with their relatives, and when physicians chose to talk with relatives on their own, they began to communicate with the relative as if they were speaking to the patient . . . Physicians constantly reiterated the importance of assessing the individual within the context of the patient's family.

"I don't agree with it, but they really feel they're doing what is best," she says. "Sometimes they look to the family to help them. It's really disheartening that they had to put a law into effect to protect patient confidentiality and physicians continue to disclose information."

Early communication might lead to compliance

Knowing why physicians disclose confidential health information to patients' relatives provides a better understanding of the phenomenon, which may offer insights into managing physician

communication, Brann says. If physicians are concerned about possible impairments, they may be able to communicate with patients about health care surrogacy before a situation arises in which they want to disclose confidential information with a relative of a patient, she suggests.

"Much like preventive health care, communication before a potential problem occurs could improve the health and care of a patient," she says. "When physicians have the opportunity to discuss potential sharing of information with patients before engaging in such actions, they should be able to abide by the HIPAA regulations . . . In many instances, physicians should be able to determine and follow the requests of the patients. This practice coincides with a patient-centered approach to health care, affording patients freedom of choice in numerous aspects regarding their health care."

Educate physicians rather than change HIPAA

She tells *HRA* she is not sure that changing HIPAA requirements would lead to a desirable change in physician communication behavior.

"Ultimately, I believe the goal of most people involved in patient care is to provide quality care and respect for the patient," she says. "The problem is that each party sees a different way to do this. I agree that allowing physicians more autonomy in caring for their patients may lead to HIPAA violations, but as the physicians in this study explained, regardless of the legislation, they are still going to practice medicine the best way they know how, and that is often involving relatives in patient care.

"I think the biggest change needs to occur in educating physicians about possible negative consequences for the patient in disclosing the patient's personal information," she continues, "and then teaching physicians how to communicate with patients and family members while still maintaining patient confidentiality."

Brann recommends that additional research of confidentiality and HIPAA implications be conducted before any changes to the law are considered. Her article suggests it could be useful to look into patient reactions and wishes with regard to disclosure of confidential health information. While physicians say disclosure of information to relatives is in patients' best interests, Brann says scholars should determine if patients agree. She says it would also be beneficial to discuss the issue with patients' relatives to find out why they want information, not just why physicians think they want information; it may be that relatives are not actually looking out for patients' best interests.

Future research also could look into comparisons among health care providers and organizations, which may provide valuable information into who is more likely to disclose information, why they are disclosing information, and whether disclosures are consistent across different types of health care providers and organizations.

Brann suggests that since physicians didn't have to deal with HIPAA's legal ramifications until 2003, it may be that they are just now feeling its effects and once patients are more aware of their rights, they may make their physicians more aware of what needs to be done, either through their own communication with their physicians or through lawsuits related to information breeches. "This may have a bigger impact on physicians than what they are willing to admit at this time," she concludes.

(Editor's note: You can contact Maria Brann at maria.brann@mail.wvu.edu.) ■

Few privacy complaints are investigated further

Analysis raises more questions than it answers

The Department of Health and Human Services found that less than 25% of the total medical privacy complaints lodged with the agency merited further federal investigation of the health care organizations involved, according to an analysis of HHS' Office of Civil Rights (OCR) statistics by Melamedia LLC President **Dennis Melamed**.

Of the 22,664 complaints received by OCR between April 2003, when the complaint system started, and September 30, 2006, some 5,400 (23.8%) were given further investigation or action, according to agency statistics.

Of the 5,400 complaints that were pursued, OCR took informal action in 3,700 cases, while it found that in the remaining 1,700, the health care organization named in the complaint had not violated the HIPAA privacy rule.

"These statistics raise a lot more questions than

they answer," Melamed says. "For example, does this mean that concerns over medical privacy are overblown? Or does it mean that the HIPAA privacy rule doesn't cover everyone it should? Or does it mean that the country got lucky and that the health care community has been protecting patient confidentiality but just didn't have a way to prove it until HIPAA came along? We just don't know."

While Melamed cautions against reading too much into the statistics, he says they do indicate that we still don't have a grasp on how well we protect patient confidentiality. "And that, by itself, is important to know as the United States pursues a national system of electronic health records and personal health records," he says.

Saying OCR understood the statistics would raise more questions than they answer, Melamed praised the agency for issuing its report, saying it is a "step in the right direction in helping policy makers and citizens understand some of the strengths and weaknesses in the systems the government has created to protect patient confidentiality."

More information is available at http://www.melamedia.com. ■

Wellness program final rule issued for employers

The federal Departments of Health and Human Services, Labor, and Treasury have issued final rules to guide employers in complying with HIPAA nondiscrimination provisions and implementation of wellness programs.

The final rules generally do not change interim rules issued by the three agencies in 2001. The rules allow employers to provide incentives of up to 20% of the cost of coverage to encourage participants to participate in wellness programs. They clarify some issues under the HIPAA nondiscrimination provisions and give examples of wellness programs that are not subject to additional standards.

Analysts say the HIPAA nondiscrimination provisions generally prohibit group health plans from charging similarly situated individuals different premiums or contributions, or imposing different deductibles, copayments, or other cost-sharing requirements based on a health factor. But they do allow plans to offer wellness incentives to encourage program participation as long as none of the conditions for obtaining a reward are based on an individual satisfying a standard related to a health factor.

If the reward is based on satisfying a standard related to a health factor, the wellness program, among other requirements, must offer rewards equal to no more than 20% of the cost of coverage, be reasonably designed to promote health and prevent disease, and allow individuals at least one year to qualify for the reward.

The final rules give, for the first time, examples of wellness programs complying with HIPAA's nondiscrimination requirements without having to satisfy the additional standards. They include:

- programs that reimburse all or part of the cost for a fitness center membership;
- diagnostic testing programs that provide a reward for participation and don't base any part of the reward on outcomes;
- programs that encourage preventive care through waiving copayments or deductibles under group health plans for the costs of prenatal care or well baby visits, among other things;
- programs that reimburse employees for costs of smoking cessation programs without regard to whether the employee quits smoking; and
- programs that reward employees for attending monthly health education seminars.

The final rules also clarify some other issues under the HIPAA nondiscrimination provisions, and give an example of how the provisions apply to the carryover of unused employer contributions in health reimbursement arrangements.

Because the maximum reimbursement under a group health plan to any employee in any single period may vary based on the employee's claims experience, concerns have arisen about the application of HIPAA's nondiscrimination rules, the three agencies said. According to the regulations, an employer does not violate HIPAA if the maximum annual reimbursement to an employee is a uniform amount.

The final regulations were published in the Dec. 13, 2006, *Federal Register*, and are effective Feb. 12, 2007.

(Editor's note: Final rules can be downloaded at www.dol.gov/ebsa/regs/fedreg/final/2006009557.pdf.) ■