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George Clooney's medical records prove irresistible to prying eyes

Privacy lapse shows common weaknesses in security, training

Ensuring the privacy of patients and the security of their medical records is fairly well accepted by staff, and most will not hesitate to pledge their commitment to keeping medical records private. But what happens when one of the world's biggest movie stars shows up at your hospital for a minor emergency, with no opportunity to plan VIP treatment and added security?

Actor George Clooney's recent treatment at Palisades Medical Center in North Bergen, NJ, apparently caused a serious breakdown of some of the most fundamental measures in place to protect patient medical records. After an internal investigation of the actions of as many as 40 employees, the hospital suspended 27 employees for a month without pay for violating the Health Insurance Portability and Accountability Act (HIPAA). **(For more background on the incident, see the story on p. 136.)** Depending on the final determination of what happened and how, the hospital and the individuals involved could face potential fines of up $250,000 and 10

EXECUTIVE SUMMARY

Dozens of hospital employees have been disciplined for accessing actor George Clooney's medical records without a legitimate reason. The security breach illustrates many common weaknesses in how medical records are protected.

- Security experts say the staff were not adequately trained to take health care privacy seriously.
- The celebrity status of the patient may have made the breach larger, but similar breaches may occur with ordinary patients every day.
- The hospital's liability for such a failure could be significant if the patient chose to sue.

years in prison for violating HIPAA.

Many legal and privacy experts point out that the Clooney case is only a sensational example of a problem that happens all the time in health care. The celebrity status made the staff more interested in the patient, so there were dozens of people violating his privacy instead of just one staff member who wants to know about a neighbor or family friend, says **Scott A. Edelstein**, JD, an attorney with Squire Sanders in Washington, DC.

"These types of incidents happen all too frequently and go largely unreported unless a celebrity is involved," he says. "This should serve as a wake-up call to all health care providers to review their HIPAA compliance efforts."

Noncelebrities are the target of similar breaches all the time, says **Maurice A. Ramirez**, DO, BCEM, CNS, CMRO, an emergency physician at Pasco Regional Medical Center and president of the risk management consulting firm High Alert, both in Kissimmee, FL. "The illusion that medical records are secure or private is only punctuated by the disclosure that 27 hospital employees indulged their voyeuristic habits by thumbing through George Clooney's chart," he says. "Every medical professional knows a colleague who regularly checks the chart of a friend or neighbor. The motive may be a desire to 'check-up' on care, a genuine if misguided concern, or just nosiness. Regardless of motive, the practice is rampant and wrong."

Celebrities pose bigger challenge

Celebrity patients pose a special challenge for privacy policies and procedures that might be entirely sufficient for everyday patients, says **Reece Hirsch**, JD, a partner at the law firm Sonnenschein Nath in San Francisco.

"In a struggle between human curiosity and compliance with hospital privacy policies and procedures, curiosity often wins," he says. "A hospital's privacy compliance program is never tested more than when a celebrity or other public figure is a patient."

Hirsch suggests that risk managers have a system in place that ramps up privacy policies and procedures when a celebrity patient is treated. When a celebrity enters a hospital, the hospital's risk manager, privacy officer, and compliance staff should be aware that additional safeguards may be necessary, such as monitoring media access within the facility, controlling public statements, and sharply restricting access to the celebrity's medical record — possibly by requiring that all requests for access to those records go through one person or by requiring a special password to access computerized records.

But if the patient shows up unannounced, as Clooney did, then you have to rely on staff knowing that HIPAA applies even if they are insanely curious about their favorite movie star. An electronic records system also can maintain audit logs that show exactly who accessed the records and when. Those logs can help track down unauthorized users later on and could have been key to Palisades' investigation. "Hospitals must impose real sanctions upon employees that violate privacy

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policies and procedures and send a clear message that protecting the privacy of patients is a priority," Hirsch says. "They should know that you will punish infractions harshly and that you will be able to track them down."

More training needed for staff

The Clooney case demonstrates that the best preventive measures include periodic training for all doctors, staff, and employees to ensure that they understand not only the HIPAA privacy rule and related patient confidentiality laws, but also the purpose and intent of those laws, says **Thomas Taylor**, JD, a health law attorney with the law firm of Johns Flaherty in La Crosse, WI. Taylor has worked with several health care providers and risk managers on medical privacy issues.

"More importantly, doctors, staff, and employees need to understand that their ability to provide optimal patient care can be compromised if patients are unwilling or unable to trust them with highly sensitive medical records and information that could have a stigma if publicly disclosed," he says.

Ramirez says health care employees must understand that peeking at someone's chart without proper authorization is a major violation that will be met with swift punishment. In that respect, he says, Palisades appears to have sent the right message after the violations were discovered. But with the proper staff training and a culture that respects the patient's privacy, staff should realize on their own that reading a patient's chart is wrong.

Securing records from prying eyes is impossible, he says. "The only solution is to re-establish the relationships of mutual respect between health care institutions and their professionals, as well as between patients and providers, so that it is unbearably uncomfortable to unethically invade any patient's privacy."

Clooney not suing, but he could

A patient may be entitled to bring a lawsuit against a hospital alleging an invasion of privacy under applicable state law, Hirsch notes. However, HIPAA does not provide for a private right of action that would permit a patient to sue a hospital for a HIPAA violation. When these sorts of incidents occur, a patient can file a complaint with the Office for Civil Rights in the Department of Health and Human Services, which may choose to conduct an investigation and perhaps impose sanctions if it determines that a violation has occurred, he says.

A patient complaint is not necessary for a HIPAA violation to be found and for sanctions to be imposed, Hirsch explains. Taylor notes that doctors, health care organizations, health insurers, and staff who knowingly obtain or disclose protected health information in violation of HIPAA face a potential fine of $50,000 and one year in prison. People who misuse private medical information under false pretenses face fines of up to $100,000 and up to five years in prison, and people who misuse information with the intent to sell, transfer, or use for commercial gain or malicious harm face fines of up to $250,000 and up to 10 years in prison. Those most severe penalties could apply if authorities determine that any hospital employees sold protected health information about Clooney to the media, Taylor says. In addition to that, there is a growing body of case law across the United States allowing individual patients to pursue civil lawsuits and recover damages from health care organizations and staff who breach patient confidentiality, Taylor says.

Though Clooney has not indicated publicly that he would sue for invasion of privacy, says **Barry Gerald Sands**, JD, a defense lawyer in Los Angeles whose practice encompasses substance abuse and attendant patient confidentiality issues, sometimes including celebrity patients. He says a civil suit is quite possible after such an incident.

"Had anyone taken pictures and sold them for profit, the risk would be higher. Had it been anyone other than the good-natured Mr. Clooney, one might have already been filed by now," Sands says. "Keep in mind that whenever a celebrity is involved, people seem to go a little crazy. Nevertheless, risk managers must emphasize that one picture, one record release is not worth a career." ■

Background on the Clooney medical records breach

This is the background to the medical records breach that led to suspension without pay of 27 employees at Palisades Medical Center in Bergen, NJ:

Actor George Clooney and his companion Sarah Larson were injured while riding Clooney's Harley Davidson motorcycle on Sept. 21 in Weehawken, NJ, according to a local police report. They were taken by ambulance to Palisades Medical Center, where Clooney was treated for a hairline fracture to a rib and abrasions, according to a statement released by **Stan Rosensfeld**, a spokesman for the actor. Larson was treated for multiple foot fractures, Rosenfeld said.

The actor initially planned not to issue any statement to the media regarding his accident, but the media seemed to know immediately. Within three hours of the accident, Rosenfeld received an e-mail from a popular magazine that said, "We have information that George Clooney is in Palisades Medical Center" after a motorcycle accident and is "suffering from road rash," the term commonly used in emergency departments to describe severe abrasions from motorcycle accidents.

Rosenfeld said he was surprised that the message pinpointed exactly where Clooney was and described his injuries accurately. "I figured somebody's been talking to somebody" he said.

On Oct. 10, quoting unnamed hospital employees, the television network CBS 2 HD reported that while doctors were treating Clooney and Larson, employees not involved in their care logged into the hospital computer system to review his medical records.[1] The network reported that a security guard even gave a Clooney family member access to the hospital system to view the actor's records.

Hospital spokesman **Eurice Rojas** issued a statement confirming that 27 employees were suspended without pay for a month for inappropriately accessing Clooney's medical records. "They were severely disciplined," he said. Rojas went on to say the punishment was for inappropriately accessing the records, but the investigation did not determine that any employee had contacted the media.

Jeanne Otersen, a spokeswoman for the Health Professionals and Allied Employees union in Emerson, NJ, which represents seven suspended nurses, says the punishment was overly harsh and that the union would fight to have the suspensions reduced. Otersen says the seven nurses looked at Clooney's records out of curiosity but did not divulge the information to anyone. She also said the real fault lay with the hospital for having such poor records security that a breach of this magnitude was possible.

After the suspensions became public, Clooney released a statement saying, "While I very much believe in a patient's right to privacy, I would hope that this could be settled without suspending medical workers."

Reference

1. "Clooney: Don't suspend hospital workers for medical info leak." CBS 2 HD. Accessed at: wcbstv.com/local/george.clooney.palisades.2.341274.html. ■

SOURCES

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Clooney case shows need for training

The privacy breach with George Clooney's medical records indicates the staff of Palisades Medical Center in North Bergen, NJ, did not truly understand the Health Insurance Portability and Accountability Act (HIPAA), says **Don Thomas**, CEO of SoftLight Development, a health care consulting firm in Dallas, and a certified HIPAA

security consultant.

"HIPAA is quite clear on this type of breach of privacy. Section 1177 clearly identifies this action as a violation with a possible fine of up to $50,000 or one year in prison or both," he says. "If it was one or two accessing the records, it may have been more malicious in nature, but this many people involved shows a clear sign that they did not understand HIPAA and the ramifications of it."

Thomas cautions risk managers not to focus on the fact that the patient was a celebrity. This case is not about how to protect a celebrity's privacy but rather it reveals how all patient records can be compromised, he says. "The real problem is this type of action occurs on a regular basis to the average American and that it is only noticed when a celebrity is involved," he says. "You heard about it, and the leadership at Palisades heard about it because Clooney is a celebrity. But this kind of problem occurs all the time without it making the news."

Hospital's system broke down

The incident signaled a major failure of the hospital's records privacy system, says **James Stewart**, JD, a partner with the law firm of Stewart Stimmel in Dallas.

"This was a system breakdown; and whenever there is a system breakdown, an analysis needs to be performed to find where it failed and then put in additional safeguards to prevent the failure in the future," he says. "In this instance, someone had control over those records and failed to properly exercise that control. When the first person asked to see them, the person in control should have reacted accordingly."

The fact that the patient was a celebrity only escalated the interest in the records, Stewart says. It should not have changed the way the records were protected, he says. The law protects everyone's records equally, and if the law is followed, then nothing special needs to be done for celebrities, Stewart says. "I fully expect that this hospital has appropriate policies for the protection of confidential health care information, and if it is a Joint Commission-accredited hospital, then I am certain it has policies that should work," he says. "You just have to enforce the policies equally across the board."

And that's where things fell apart, says **Barry Gerald Sands**, JD, a defense lawyer in Los Angeles. He says a key lesson from the Clooney incident is that even the best policies and procedures don't work if employees just choose not to follow them one day.

"The lesson learned is vigilance along with a stated, very public enforcement policy should be in place," he says. "Another lesson learned is no matter how many employees attend ongoing HIPAA lectures and seminars, management must continue reminding workers that the privacy rights of patients is always on the mind of personnel as a priority."

Ensuring the policy is implemented is critical to its success, as evidenced by the failure of so many employees to honor federal law in this area, Sands says. He says the scale of the privacy breach, with at least 27 employees casually violating HIPAA, suggests that the hospital's medical records privacy policy had been "extremely lax" prior to the incident, he says. "There had to have been a problem if 27 people felt comfortable to grossly breach HIPAA regulations," he says. "There were problems at intake and at a supervisory level, but perhaps more important was that 27 people seemingly routinely violated HIPAA regulations. How could a hospital claim HIPAA credibility and experience that kind of failure rate?" ■

SOURCES

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Phone calls during surgery can be risky

Suppose you were reviewing a new malpractice claim and a nurse told you that the surgeon happened to be on the phone when the patient made a mistake that injured the patient. Surely the surgeon was talking to another physician or reviewing lab results for the patient, right?

Maybe not. If you probe a little deeper, you may find that the surgeon was on the phone discussing something that had nothing to do with

EXECUTIVE SUMMARY

Surgeons often make phone calls while operating on patients, and the calls sometimes have nothing to do with patient care. Attorneys and risk managers caution that such a revelation could be devastating to the defense in a malpractice case.

- Some phone use in the OR is necessary and poses no exceptional risk.
- It is up to the surgeon to determine how much distraction is acceptable.
- Don't overreact by trying to ban all phone use in surgery.

the surgery at hand, perhaps even something as frivolous as scheduling a round of golf or a dinner date. Risk managers would shudder at the thought of a jury hearing that detail during a malpractice trial, but this scenario may be happening more than you think.

Attorneys say it is difficult to find any documented cases of patients citing cell phone use during surgery as a contributing cause to malpractice, but they also say it is only a matter of time before that occurs. There have been similar cases in other countries, and on Internet sites devoted to reviewing doctors, patients in the United States frequently complain about phone use during surgery. **(See the story on p. 139 for examples of phone use during surgery. See the story on p. 139 for more on the cases from other countries.)**

Would you want plaintiff's attorney to know?

Benjamin W. Glass III, JD, a plaintiff's medical malpractice attorney in Virginia and the author of *Why Most Malpractice Victims Never Recover a Dime, an Insider's Report on Medical Malpractice Claims*, says that if he were representing a medical malpractice plaintiff, he would seize on the revelation that a surgeon was on the phone when a mistake happened. "Most jurors are at least vaguely familiar with the research demonstrating that drivers who talk on the cell phone while driving are as impaired as someone with a 0.08% blood alcohol level," he says. "This research received a fair amount of media attention. Even if they aren't aware of this study at the beginning of a trial, they would be by the end."

Glass also notes that it could be simple to verify that the doctor was on the phone during surgery, and who he or she was talking to. "In most car accident cases today, the cell phone records of the drivers are subpoenaed and examined," he says. "Once the first story of doctors talking on a cell phone during surgery gets out, discovery of the doctors' cell phone records will become standard in surgical malpractice cases."

But people use cell phones so much these days, even while driving, that it may seem jurors would be sympathetic and not see the phone use during surgery so critically. To the contrary, Glass says, he would use that against the doctor by asking the jurors to think about how they are distracted by talking on the phone while driving. If they are honest with themselves, they will admit that the phone distracts the user from other activities. "I cannot imagine a juror not taking this fact as a huge negative against a doctor when a surgery goes awry," he says.

Use discretion about calls

There is nothing inherently wrong with surgeons talking on the phone during surgery, but there should be a good reason for dividing attention between the patient and the phone call, says **Lewis S. Sharps**, MD, FACS, a surgeon and president of Positive Physicians Insurance Exchange, a physician-driven medical malpractice company in Paoli, PA. Sharps says risk managers should encourage surgeons to stay focused, but he also points out that the culture of the operating room has always included distractions.

It is a misconception to think that during surgery the doctors are 100% focused on the patient and what they are doing with their hands, he says. That is an unrealistic, and unnecessary, expectation, Sharps says. There are always distractions in the form of conversations in the room, consultations with other physicians, music playing, and people coming and going from the room, he notes. It is up to the doctor to determine what level of distraction is acceptable and still allows for focusing on the patient, he says. "Physicians routinely get calls in the OR, and it's up to the surgeon to say whether he can take it or not. It's a judgment call," Sharps says. "We certainly would not condone continual use of the phone in the operating room because it can be too much of a distraction. It would not be acceptable to take just any call. It should be related to patient care or otherwise a high priority."

Sharps does caution risk managers about overreacting to the issue and trying to cut back too harshly on phone use in the OR. He is in favor of

SOURCES

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restricting phone use to important calls and focusing on the patient, but he points out that surgeons tend to be masters of dividing their attention without sacrificing performance. "Especially after you've done something a thousand times, a surgeon can have his or her hands totally focused on what they're doing while the mouth is on another topic entirely," he says.

Surgeons understand, jury won't

The American College of Surgeons in Chicago has no policy regarding phone use during surgery according to a spokeswoman. Sharps suggests that risk managers look at phone use during surgery not as a taboo but as just one more distraction in the OR that must be managed and kept to an acceptable level.

"Minimize it, but don't expect people to stop using phones entirely. You wouldn't expect people to stop talking to each other in the OR during surgery, even if they're talking about personal issues, so people are going to see the phone as just one more step from that," he says. "A good surgeon will stay focused and know when a case demands an absolute minimum of distractions, and he or she will make that happen."

Sharps notes, however, that the common usage of phones during surgery may not matter much if the issue comes before a jury. "If the nurses decided to testify that he was on the phone during the surgery, you've got a very big ding in your defense. Your defense is destroyed if that comes up," he says. "A room full of surgeons might understand that using the phone didn't necessarily have anything to do with the alleged malpractice, but a lay jury is going to think, 'Oh my God, he was talking to his wife instead of paying attention to what he was doing.'" ■

Outsiders may know of phone use in OR

In many cases, inappropriate phone calls are more obvious to people other than the patient or the risk manager. For instance, **Bonnie Russell**, owner of 1st-Pick.com, a public relations agency in Del Mar, CA, says she has had several conversations

Foreign cases show phone use cited

Two international cases show how phone use during surgery can be cited as a contributing cause to alleged malpractice. In a case from Israel, a woman underwent hand surgery in Tel Aviv's Sheba Medical Center and then filed a lawsuit claiming malpractice by her surgeon.[1]

The woman remained awake during the procedure and, according to the lawsuit, the surgeon's cell phone rang. He instructed a nurse to answer but eventually took the phone and spoke. According to the complaint, immediately after ending the conversation, the surgeon stated that he had mistakenly cut a nerve. The patient claimed that the doctor then told a nurse, "You see, one shouldn't speak on a phone during surgery." The disposition of the malpractice claim is unknown.

In 2000, the Hong Kong Medical Council banned surgeons from using cell phones while operating.[2] The move followed a week of controversy after the council ruled that Tung Hiu-Ming, MD, who answered his mobile phone during surgery, had not acted unprofessionally. The council ruled in favor of Tung despite records showing that he was on the phone for 14 minutes. He claimed he only was on the phone long enough to speak one sentence and that the other party, by accident, had not hung up.

The patient, however, said he had heard his doctor discussing the purchase of a new car while he was under a local anesthetic to have a polyp removed from his intestines. The patient required a second surgery within hours to repair a punctured colon wall.

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SOURCE

For more on the use of phones during surgery, contact:
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with surgeon clients while they were operating on patients.

"I originally decided to work with one cosmetic surgeon because he regularly made trips to Mexico to help poor kids with cleft palates and things like that, all on his own dime. This impressed me," she says. "However, Dr. Do-Good's darker side very quickly emerged. He repeatedly called me from the operating room to talk about the need for more media exposure. It really kind of freaked me out to think that he was talking to me while operating on a patient. I mean, sure I wanted to talk to him, but not that much."

Russell says she has talked with several surgeons who seemed to think it was fine to take nonmedical calls, such as her calls discussing media exposure, in the middle of an operation. "I also had this one neurologist who bragged to me that he could be reached by phone any time, and he really meant *any* time," she says. "I told him that just wasn't necessary, and I didn't want to talk to him in surgery." (The editor of *Healthcare Risk Management* has had similar experiences in which surgeons took calls, conducted phone interviews while operating, and paused as necessary to give instructions to the rest of the surgical team.) ■

Crew management yields good results

Crew resource management has been the key improvement that led to the significant improvements in patient safety in the obstetrics unit at Beth Israel Deaconess Medical Center (BIDMC) in Boston. The dramatic changes in the obstetrics unit have been recognized with the John M. Eisenberg Patient Safety and Quality Award from the National Quality Forum in Washington, DC, and The Joint Commission.

The award recognizes BIDMC for its adaptation and implementation of military and commercial aviation crew resource management methods. More than 200 staff received training in crew resource management, which resulted in a dramatic reduction in major adverse obstetric events. That reduction cut malpractice liability exposure and improved overall patient safety and the quality of obstetric care, reports **Barbara Lightizer**, CPHRM, director of risk management at BIDMC.

"We did an incredibly thorough root-cause analysis after we had a death in the OB, and the main improvement that resulted was the adoption of crew resource management," Lightizer says. "We also improved staff training, staff hours, and handoffs. The results show that these efforts worked."

Between 1999 and 2005, the department experienced a 35% reduction in adverse events among patients and a 50% decline among high-risk patients, she says. The unit achieved a 25.4% reduction in the Adverse Outcomes Index (a measure developed for the project), and the severity of adverse events was reduced by 13.4% between 1999 and 2005. When the Eisenberg award was announced, Joint Commission president **Dennis S. O'Leary**, MD, noted that BIDMC's experience has prompted other institutions to adopt similar strategies. "Their demonstrated commitment to patient safety and innovative efforts are inspirations to the American health care community," he says.

Blue Cross Blue Cross Blue Shield of Massachusetts (BCBSMA), the state's largest health insurer, also named BIDMC the recipient of its first Health Care Excellence Award for the same effort. BCBSMA has awarded BIDMC a $100,000 prize for its "groundbreaking approach to reducing medical errors." Blue Cross president **Cleve Killingsworth** said in a statement that the hospital "successfully changed its culture and achieved

EXECUTIVE SUMMARY

The obstetrics unit at a Boston hospital has been recognized for a dramatic reduction in major adverse events. Much of the improvement can be attributed to the recent adoption of crew resource management to improve staff communication and performance.
- Malpractice liability exposure also was reduced.
- The hospital committed to significant staff retraining.
- The effort was prompted by the unnecessary stillbirth of a baby.

significant results" through the initiative.

BIDMC used the $100,000 award to pay for obstetrics nurses to attend a national patient safety conference, development of an online continuing medical education course in crew resource management, and research in patient safety. The work was spurred by a stillbirth in the BIDMC obstetrics unit in 2000, Lightizer says. **(See article, bottom right, for more on that incident.)**

Aviation lessons used in OB

Lightizer says the root-cause analysis found two overall causes of the adverse event: communication failures and system failures. The communication failures concerned physicians and staff not adequately addressing their concerns about the patient's condition, so part of the hospital's response was to improve the way clinicians communicate.

The hospital used crew resource management techniques to train the staff in teamwork and conflict resolution, and limited the workloads of obstetricians. **(For more on crew resource management, see *Healthcare Risk Management*, September 2003, p. 103, "Crew resource management a better way to prevent adverse events.")** The Risk Management Foundation, the malpractice insurer for doctors at Harvard teaching hospitals, suggested crew resource management, which has been widely credited with reducing plane crashes by improving how aviation crews interact. BIDMC hired two pilots to train the staff in such skills as the "'two-challenge rule," which calls for a staff member who disagrees with a colleague's decision to politely state his or her concerns twice and then seek a superior if not satisfied.

The department set up three types of teams. The core teams treat patients, while a coordinating team led by a nurse and senior physician oversees the core teams' decisions and workload. A contingency team is activated for emergencies. The unit holds at least two team meetings a day to discuss the plan for all patients. Previously, when doctors and nurses changed shifts, they updated only replacements about their specific patients. Now all staff are responsible for all patients, Lightizer explains.

The obstetrics department also made major changes in the way it monitored patients. Rather than doctors and nurses knowing the medical situations only of patients directly under their care, the entire department now is knowledgeable about all patients.

The hospital prohibits obstetricians from caring for more than three patients in labor at once. The OB unit also encourages doctors to sign up for 12-hour, rather than 24-hour, on-call shifts.

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Trained to work as teams

Lightizer says the crew resource management plan improves care by relying on a layering of staff and physicians so that there are backstops and additional resources if one layer of the team makes an error. Previously, the patient's care was divided more like silos in which there was little opportunity for anyone else to oversee care or resources for a staff member who disagrees with a colleague.

"The training helps everyone in the unit work more as a team, whereas in the past you might not even know everyone in the unit or understand their roles," Lightizer says. "Now people are part of specific teams that work together. Instead of just trying to grab an anesthesiologist when you need one, you know which one is part of your team and he or she should be familiar with your patient."

Since the changes were implemented, legal claims have declined significantly enough that BIDMC's insurer reduced its premium. She says the staff have embraced the new approach to teamwork in the unit.

"People say it's the best thing that ever happened on the unit," she says. "In fact, we have very little turnover on that unit, and when we do have an opening, people jump at the chance to join that unit." ■

Baby's death prompts changes in OB unit

The major improvements in patient safety in the obstetrics unit at Beth Israel Deaconess Medical Center (BIDMC) in Boston were prompted by a

series of tragic errors that led to a stillbirth in 2000.

In August 2005, **Benjamin Sachs**, MD, chief of obstetrics and gynecology at the hospital, published an article that described numerous judgment errors and miscommunications in the baby's case.[1] He said the case was an example of how medical mistakes can be the result of an accumulation of smaller miscues. The case became a "burning platform" that led to a "major reorganization of the way care is provided," he wrote.

Sachs provided this summary of how the adverse event unfolded: A couple arrived at midnight to deliver their first baby. Hospital staff noticed that the mother's blood pressure was high, but blamed pain from her contractions. Later, a resident noticed an unusual fetal heart rate on the monitor. However, she could not get the attention of the attending physician, who had been awake for 21 hours and was running between several patients.

The woman's regular obstetrician was not on call, so the doctor gave her the drug misoprostol, which triggers labor, because she was past her due date, and sent her home. Because of her slightly high blood pressure, she should have been monitored in the hospital, Sachs said in the article. On the way home, she felt contractions and returned.

When she arrived, her blood pressure was higher, which raised the possibility of preeclampsia. Between 4 a.m. and 5 a.m., doctors missed a chance to stop the sequence of miscues when the resident did not go above the attending physician with her concerns about the baby's unusual heart rate. Sachs believes the physician's judgment may have been impaired because he was on duty for so long. He said doctors should have performed a caesarean by 5:30 a.m. "'This would probably have resulted in a live birth without complications," Sachs wrote.

When an emergency caesarean was ordered at 6:45 a.m., they found the placenta had separated from her uterus and her uterus had ruptured. The baby was stillborn. The mother spent three weeks in the hospital.

In the article, Sachs apologized to the family. BIDMC investigated the case immediately, and Sachs urged an immediate settlement before the family sued. The hospital settled in 2001 for an undisclosed amount.

Reference

1. Sachs BP. A 38-year-old woman with fetal loss and hysterectomy. *JAMA* 2005; 294:833-840. ■

Hospital claims fall, thanks to OB, ED efforts

Risk managers are doing something right in the emergency department and obstetrical units, according to new data showing the frequency and severity of hospital claims are at new lows.

The Aon Corp. *2007 Hospital Professional Liability and Physician Liability Benchmark Analysis* is a comprehensive look at liability claims in the U.S. health care industry, published annually by Aon Corp. with the American Society for Healthcare Risk Management (ASHRM), both in Chicago. This year's report is full of kudos for patient safety efforts.

The study measures 65,689 nonzero claims representing more than $7.7 billion of incurred losses. More than 80 health care organizations representing 1,000 facilities and 90,000 licensed beds contributed to the study. The report says hospital claims are at their lowest levels in eight years. Claim severity is increasing at just 3% annually, which is the lowest severity trend in eight years.

Also, for the third straight year, there has been no increase in the frequency of claims. Patient safety initiatives aimed at obstetrics and emergency departments are linked to reductions in the number of claims in those areas, says **Greg Larcher**, director and Actuary Healthcare Practice leader with Aon Global Risk Consulting and author of the analysis.

Facilities that are recognized for their patient safety initiatives exhibit lower liability loss costs, he says. For the third straight year, the industry has seen no increase in the frequency of claims, the data show. Since the last edition of the study, the trend in the severity of claims has been cut in half. Liability losses are projected to be just 3% higher in 2008, down from 6% in the 2007 projection. The resulting loss cost trend is the lowest in the eight-year history of Aon's published advisory benchmarks, Larcher says.

"We continue to recognize improvements in the underlying claims environment and have enhanced our ability to measure the impact of the improvement on claims costs," Larcher says. "I expect many hospitals to realize lower liability expense in 2008 as hospitals adjust to the new cost environment."

The 2007 study introduces benchmark statistics for the obstetrics and emergency departments. More than 800 facilities that experienced about 700,000 births and 16 million emergency department visits provided historical loss information

SOURCES/RESOURCE

For more information on the Aon Corp. study, contact:

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- **Greg Larcher**, Director and Actuary Healthcare Practice Leader, Aon Global Risk Consulting, Aon Corp., 200 E. Randolph St., Chicago, IL 60601. Telephone: (410) 381-2254. E-mail: gregory_larcher@aon.com.

To purchase a copy of the *2007 Hospital Professional Liability and Physician Liability Benchmark Analysis*, call (800) 242-2626 and request item No. 178703. Or you can go to www.aon. com/hpl_study for more information. The cost is $250 for members of the American Society for Healthcare Risk Management (ASHRM) members and $350 for nonmembers.

for these measures, says **Frank Dodero**, senior vice president of Aon Healthcare.

"Since many of the patient safety initiatives being implemented focus on obstetrics and emergency departments, it is important to have industry benchmarks available to measure their effectiveness," he says.

The study found that the number of claims per 10,000 births decreased from 9.4 in 2001 to 6.2 in 2006, while the number of claims per 100,000 emergency department visits dropped from 5.8 to 3.4 in that same period. The report includes a case study of a multistate hospital operator where similar improvements were linked to patient safety initiatives. In obstetrics, fetal heart monitoring and a focus on high-risk deliveries were found to be contributing factors in claim reduction. The assessment of high-risk presentations, such as chest pain in patients over 50 and abdominal pain in all patients, contributed to the reduction of claims in the emergency department.

In addition, the study found that the nation's best hospitals, those recognized for their patient safety environments, exhibit significantly lower liability loss costs compared to the national averages. This is important, Larcher says, because hospitals that emulate the nation's best in terms of their patient safety environment may realize reduced liability costs in the future. ■

Feds asks Mississippi court to clarify med-mal limits

Statutes of limitations can be key in determining whether some malpractice cases move forward or are dead in the water, so a federal appeals panel has asked the Mississippi Supreme Court in Jackson to clarify when the clock starts ticking for medical malpractice claims.

A panel of the Fifth U.S. Circuit Court of Appeals released a statement saying it has asked the court to specify how lower courts should apply the statute of limitations. Specifically, the panel wants to know how Mississippi's statute of limitations applies in circumstances "where the alleged negligence is either the administration of a drug by a physician or the physician's failure to disclose about the risks of a drug, and experts disagree as to whether the drug caused the plaintiff's injuries." The question was prompted by a Fifth Circuit case in which the court overturned a medical malpractice verdict because the statute had run out. The plaintiff disputed how the statute should apply to the circumstances of her case. ■

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 hospitals, for hospital personnel to use in overcoming risk management challenges they encounter in daily practice. ■

COMING IN FUTURE MONTHS

- Improve dystocia drills in OB
- Training staff to speak up
- Time management for risk managers
- Assessing your fall reduction efforts

CNE answers

21. A; 22. D; 23. A; 24. A.

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.**The semester ends with this issue.** You must complete the evaluation form provided and return it in the reply envelope provided in this issue in order to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you.

21. According to Scott A. Edelstein, JD, which of the following is true regarding the incident in which hospital staff improperly accessed actor George Clooney's medical records?
A. These types of incidents happen all too frequently and go largely unreported unless a celebrity is involved.
B. These types of incidents are very rare and usually occur only with celebrities.
C. These types of incidents occur only in the ED.
D. These types of incidents occur only when medical records are not computerized.

22. How did Palisades Medical Center respond to reports that staff improperly accessed Clooney's records?
A. It denied the charges, and there was no investigation.
B. It investigated the charges but did not discipline any employees.
C. After an investigation, only one employee was disciplined.
D. After an investigation, 27 employees were suspended without pay for a month.

23. What does Lewis S. Sharps, MD, FACS, say about surgeons talking on the telephone during surgery?
A. They routinely get calls in the OR, and it's up to the surgeon to say whether he can take it or not. It's a judgment call.
B. They should never take phone calls in the OR under any circumstances.
C. They should take phone calls in the OR only if there is a second surgeon present.
D. They should be allowed to receive only calls directly related to the patient in surgery.

24. Under the new plan that has improved patient safety in the obstetrics unit at Beth Israel Deaconess Medical Center, which of the following is true?
A. The core teams treat patients, while a coordinating team led by a nurse and senior physician oversees the core teams' decisions and workload.
B. The core teams do not treat patients but only provide guidance to the coordinating team.
C. The coordinating team specifically avoids interfering with patient care and only reviews records after treatment is complete.
D. The core teams and coordinating teams provide essentially the same services.

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

Woman suffers bruising on arms after alleged abuse by nursing home director — $825,000 settlement

By **Jon T. Gatto**, Esq.
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News: An elderly woman with Alzheimer's disease suffered severe bruising on her arms while staying at a residential care facility. Although the facility's director initially told the woman's daughter that the bruises were caused when the director had to restrain the woman from attacking her, the daughter subsequently learned that the bruises resulted when the director became angry at the resident and grabbed and twisted her arms while dragging her across the floor. The daughter filed complaints with adult protective services and the police, and she also filed a lawsuit against the facility, its director, and its administrator. The parties settled the case for $825,000 before trial.

Background: A 91-year-old retired schoolteacher suffering from Alzheimer's disease stayed at a residential care facility for two weeks while her caretaker daughter went on an out-of-state trip. The daughter settled on this particular facility after contacting the Alzheimer's Association and making personal visits to several residential care facilities in the area. This facility held itself out as specializing in elders suffering from Alzheimer's disease.

After the first week, the daughter called the facility to speak to her mother, and the facility told the daughter that her mother could not come to the phone but that she was fine. The daughter called again the next day and spoke to her mother. The mother was crying during the conversation, but because she could not express what was wrong, the daughter just assumed that her mother simply missed her.

When the daughter came to the facility the next week to pick up her mother, the facility's director told her that there had been an incident with her mother. The director claimed that the mother had struck the director while the director was assisting a male resident, who had become combative. The mother had apparently believed that the male resident was her father and that the director was hurting the man. In self-defense, the director restrained the mother, which caused bruising to both of the mother's arms. The director told the mother that she had prepared and filed an incident report with the appropriate authorities.

The daughter accepted this version of the incident and brought her mother home. The mother subsequently began complaining of back pain, was despondent and distraught, and was progressively unable to walk, make her bed, or accomplish on her own the other activities of daily living that she had been able to do prior to her stay at the facility. Within a few days of bringing her mother home, the daughter learned that the director's version of the incident at the nursing home was not accurate. Three former employees of the facility (who had witnessed the incident while employed

by the facility) told the daughter that the director had become angry with the mother for constantly entering her office and that the director had grabbed and twisted the mother's arms and dragged her across the floor into the dining area. The director then apparently raised her hand to strike the mother in the face, but she realized that several witnesses were watching the events. She subsequently dragged the mother into the hallway and shoved her into a chair, where she yelled at her to stay put. The former employees told the daughter that even though they reported the incident to an administrator, the complaint was not subsequently reported to any regulatory or law enforcement agency. The daughter also learned that the mother was not provided with any assistance for her injuries from this physical and mental abuse, humiliation, and intimidation.

Alarmed by the true facts underlying the incident, the daughter took her mother for an examination and an MRI, which revealed a spinal compression fracture at the T12 level of very recent origin. The daughter then contacted the state adult protective services agency, which prompted the California Department of Social Services to investigate the facility. It determined that the facility had purported to conduct an internal investigation of the incident but had failed to report these events to any regulatory or law enforcement agency. The daughter also contacted the police, which investigated the matter and brought charges against the director for felony elder abuse. The director ultimately pled no contest to the charges.

The daughter filed suit on behalf of her mother against the nursing home, the director, and the administrators alleging elder abuse. She alleged that the defendants ratified the abuse by failing to report the abuse to the appropriate authorities, assisting in covering up the incident, failing to obtain medical attention for the injuries, lying to the daughter about the incident and the filing of a report with authorities, purporting to conduct an internal investigation of the matter, and allowing the director to continue working at the facility with the full knowledge that this incident had occurred. The plaintiff alleged that she was entitled to a presumption of elder abuse because of the violations of the defendant's statutory and regulatory duties. She sought damages for the spine fracture, ongoing back pain, severe and ongoing cognitive decline, and severe psychological damage manifesting in depression, sleeplessness, fear of strangers, and loss of interest in life.

The nursing home denied any assault and maintained that the mother had become out of control and was resistant to the director's attempts to get her under control. The director specifically claimed that it was the mother who assaulted and battered the director even though the director was making reasonable efforts to restrain the mother. The facility claimed that the former employees were disgruntled and were motivated to claim that an assault occurred because of personal reasons. The defendants also challenged the plaintiff's alleged damages, claiming: a) that the spine fracture was not caused by the incident and that it had fully healed anyway; and b) that any cognitive decline or other physical and psychological impairment was the result of the natural progression of the mother's Alzheimer's disease and not any specific incident.

As the trial neared, the parties prepared for a battle of the experts. The plaintiff retained expert witnesses in the fields of nursing, life care planning, orthopedic surgery, psychology, and geriatrics. The defendant's experts included a life care planner, an orthopedic surgeon, a neurosurgeon, a geriatrician, a psychiatrist, a psychologist, and a nursing expert. Recognizing the negative impact the director's felony no contest plea would have on the trial, the parties reached an $825,000 settlement.

What this means to you: "This case is both a tragedy and an embarrassment to the nursing profession and the long-term care industry," says **Leilani Kicklighter**, RN, ARM, MBA, CPHRM, LHRM, consultant/principal of The Kicklighter Group in Tamarac, FL, which focuses on health care risk management consulting services, and past president of the American Society for Healthcare Risk Management. "This particular resident had been living with her daughter who entrusted her into the care, control, and custody of this facility and staff to care for her on a temporary/respite basis," she says. "What happened to her and the cover-up that followed is unacceptable."

The population of the United States is growing older as each day passes. As that occurs, the number of people living with Alzheimer's disease or dementia increases. Many families are caring for their family members who have these conditions in their homes. People who have no families, or who have families who cannot care for them in their homes, become residents in nursing homes or other facilities that offer care for these conditions. Nursing homes that care for

residents who have Alzheimer's disease, dementia, or other memory/mental impairments are usually equipped with units specifically designed and staffed with personnel who have been trained to care for these residents. Usually these units are locked for protection, as individuals with these conditions are prone to wandering and confusion. Patients exhibiting less severe symptoms of Alzheimer's disease and dementia may or may not be assigned to a locked unit. Exercise and ambulation are encouraged in the nursing home environment to support continued independence.

In the nursing home environment, residents sometimes wander in and out of offices and other areas. Steps should be taken to prevent residents and visitors from having unauthorized access to certain areas of the campus, such as the maintenance area and laundry and kitchen areas. However, Kicklighter indicates that should a resident wander into an office and thereby disrupt an employee's work, there are appropriate ways to redirect the resident, such as by calling a staff member from the residents' unit to retrieve the resident. That step was not done in this situation.

When one encounters a situation such as this, where the facility director or any other staff member acts out in such a violent fashion and inflicts such extensive injuries, it begs the question whether there are other influencing factors. Kicklighter notes that programs focusing on recognition of stress, the effects of stress, and appropriate management of stress are rarely supported in the health care setting. However, as patients and residents in acute care and long-term care facilities get sicker and as staffing shortages grow, staff members are often expected to do more with fewer resources, which leads to increased stress.

"One possible outcome of having overstressed personnel is the potential for errors or loss of control, as was exhibited in this situation," says Kicklighter. Risk management should work with management and the human resources department to develop and support stress management programs. Recognition of the signs and symptoms of stress is the first step in managing it. In particular, personnel who are assigned to work in Alzheimer's locked units, or with patients with Alzheimer's disease or dementia, should be educated as to how to use diversion tactics to redirect agitated residents or wanderers.

Suspected or observed abuse, neglect, or extortion of the elderly or mentally impaired (and children) should be immediately reported to the appropriate state and federal authorities and also to the police. In this case, the staff members who observed the physical abuse of this resident did not make the required reports. Reporting suspected, observed, or confirmed abuse, neglect, or extortion is required under federal law and under the law of most states.

In some states, the consequences for failing to report elder abuse are severe. For example, in a recent Missouri case, the president of a business that operated nursing homes was sentenced to jail for failing to report nursing home abuse. The president of the business received the maximum sentence of one year in prison and a $1,000 fine for a misdemeanor charge of failing to report elder abuse. In that instance, a 78-year-old nursing home patient was beaten by a nurse's aide and died from his injuries. The nursing aide pleaded no contest to elderly abuse and is serving a 15-year prison term. A nurse's assistant testified that she and a co-worker told two supervisors that they suspected that an aide had beaten the patient. A nursing home administrator suggested to the president of the corporation that the incident should be reported to the state. The president responded that it was not an incident of abuse and should not be reported.

Suspected or observed abuse, neglect, or extortion of the elderly or mentally impaired (and children) should be immediately reported to the appropriate state and federal authorities and also to the police.

The jury convicted the president of the corporation for failing to report elder abuse in violation of Missouri law. The judge who heard the criminal case against the president of the corporation said, "I've had rape cases. I've had death penalty cases. This was the maddest, angriest jury I've ever seen." An appellate court ultimately upheld the sentence imposed by the Missouri trial court. The incarceration of the nursing home president serves to underscore the importance of complying with state and federal law regarding reporting of elderly abuse.

It is of supreme importance that nursing homes and long-term care facilities establish an environment in which employees feel comfortable advising their superiors to report instances of elderly abuse. In this Missouri case, the president of the corporation attempted to cover up a situation that was required to be reported to the

state by instructing an employee not to report a clear incident of abuse. The president of the corporation paid the price with a year in jail.

Any nursing home or long-term care facility should have a written policy on how to deal with incidents of elderly abuse, including the reporting of elderly abuse in full compliance with state and federal law. All employees who may be involved in reporting such incidents should be thoroughly trained. It should also be made clear to every employee, through a written policy, that there will never be any action against someone's employment for their good faith efforts to report elderly abuse in compliance with state and federal law. Only by fostering an environment where every employee feels comfortable acting in compliance with the law in cases of elderly abuse can a nursing home or long-term care facility ensure that such compliance will occur.

Additionally, says Kicklighter, whenever an incident occurs that involves a resident, staff members must promptly notify the next of kin or legally responsible party and document the notification. In this case, this was not done promptly and, when it was done, the true sequence of events was not conveyed.

The interaction between the resident and the facility director in this case appeared to be criminal, which calls into question whether the police should be contacted. In this case, it does not appear that the facility even considered contacting the police. Additionally, the facility should have immediately removed and suspended the facility director from duty until a full internal investigation, as well as the investigation from the state adult protection agency, had been completed. "That should be standard practice, and it is unacceptable that it was not done in this case," says Kicklighter.

This incident underscores the importance of the risk manager of a facility establishing an open and trusting relationship with staff, so that the risk manager is the first person staff members will contact when an incident occurs. The risk manager can immediately take control of the situation and protect the resident and minimize the consequences for the facility in full compliance with state and federal law. Had the risk manager been involved early on in this case, it is possible the proper reports would have been made with the correct information. If the risk manager had been advised of the situation and the subsequent cover-up, the risk manager could have dealt with the reporting and other issues that should have been addressed.

One of the roles of the risk manager is to educate staff and administration on their responsibilities and roles in terms of the protection of residents. Such inservice offerings should include responsibilities for reporting; types of incidents to report; to whom to report; and timeliness for reporting suspected or confirmed abuse, neglect, or extortion. In most states, the individual has a legal duty to make the report. In most states, such reports are confidential.

The worldwide patient safety initiative encourages transparency and disclosure, says Kicklighter. The patient safety focus is not restricted to the acute care setting; rather, it applies to the entire continuum of health care delivery, including the long-term care setting.

Because nursing home administrators also are licensed, it is a possibility that the administrator in this case should have been reported to the board of nursing home administrators, as the administrator was apparently part of the cover-up, having been advised of the incident by staff members.

The worldwide patient safety initiative encourages transparency and disclosure, says Kicklighter. The patient safety focus is not restricted to the acute care setting; rather, it applies to the entire continuum of health care delivery, including the long-term care setting. "This is a sad example of one organization that didn't get the message it would seem," laments Kicklighter.

What this should mean to a risk manager, and to senior management of any health care facility or organization, is that honesty is the best policy and that cover-ups rarely stay covered. In this case, staff members were aware of the actual events and ultimately made the daughter aware of what actually happened. "Whistle-blowers, so to speak, are everywhere," notes Kicklighter. If the right questions are asked, the information that facilities are trying to cover-up may, and often do, come to light, which causes the situation to appear even worse than it was due to the cover-up. The way to avoid problems arising from cover-ups is to embrace full, truthful, and prompt disclosure. Risk management should play a significant role in supporting this practice and policy.

Reference

• Los Angeles County (CA) Superior Court, Case No. VC044053. ■

Healthcare Risk Management™

2007 Index

When looking for information on a specific topic, back issues of *Healthcare Risk Management* may be useful. If you haven't already activated your on-line subscription so that you can access the newsletter archives through the company's web site, just click on "Activate Your Subscription" button in the left navigation area of www.ahcmedia.com. Or contact our customer service department at P.O. Box 740060, Atlanta, GA 30374. Phone: (800) 688-2421 or (404) 262-5476. Fax: (800) 284-3291 or (404) 262-5560. E-mail: customerservice@ahcmedia.com.

Healthcare Risk Management

HRM120107TM

CNE Evaluation

Please take a moment to answer the following questions to let us know your thoughts on the CNE program. Fill in the appropriate space and return this page in the envelope provided. **You must return this evaluation to receive your certificate.** Thank you.

CORRECT ● **INCORRECT** ⊘ ✓ ✗ ⚠

1. If you are claiming nursing contact hours, please indicate your highest credential: ○ RN ○ NP ○ Other _____

After participating in this program, I am able to:	**Strongly Disagree**	**Disagree**	**Slightly Disagree**	**Slightly Agree**	**Agree**	**Strongly Agree**
2. Describe legal, clinical, financial, and managerial issues pertaining to risk managers in health care.	○	○	○	○	○	○
3. Explain how these issues affect nurses, doctors, legal counsel, management, and patients.	○	○	○	○	○	○
4. Identify solutions, including programs used by government agencies and hospitals, for hospital personnel to use in overcoming risk management challenges they encounter in daily practice.	○	○	○	○	○	○
5. The test questions were clear and appropriate.	○	○	○	○	○	○
6. I am satisfied with customer service for the CNE program.	○	○	○	○	○	○
9. I detected no commercial bias in this activity.	○	○	○	○	○	○
10. This activity reaffirmed my clinical practice.	○	○	○	○	○	○
11. This activity has changed my clinical practice.	○	○	○	○	○	○

If so, how? _____

12. How many minutes do you estimate it took you to complete this entire semester (6 issues) activity? Please include time for reading, reviewing, answering the questions, and comparing your answers to the correct ones listed. _____ minutes.

13. Do you have any general comments about the effectiveness of this CNE program?

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