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13 hospital workers fired for snooping in Britney Spears' medical records

Oops, they did it again — second breach of singer's privacy

A health provider in Los Angeles that frequently treats celebrities announced recently that it had failed to protect the privacy of singer Britney Spears, and it wasn't the first time. Some risk management experts suggest that the repeated privacy breaches and the wide scale of the snooping suggests a bigger problem at the hospital system.

The University of California, Los Angeles (UCLA) Medical Center, where singer Britney Spears was hospitalized in early 2008 for psychiatric care, is firing 13 employees and suspending six physicians for looking at her medical records without a valid reason. The story was first reported in the *Los Angeles Times*, and then the hospital confirmed the disciplinary action.

The breach occurred even after Carole A. Klove, chief compliance and privacy officer for UCLA Medical Sciences, sent a memo to all staff reminding employees that the Health Insurance Portability and Accountability Act (HIPAA) prohibits accessing medical records without a valid reason. **(See p. 51 for an excerpt from the memo.)**

This was the second breach in the UCLA system involving Spears. The *Los Angeles Times* reports that staff at another UCLA hospital were caught peeking at Spears' records when the singer gave birth to her first son in September

EXECUTIVE SUMMARY

A California hospital acknowledges that staff violated the privacy of singer Britney Spears by perusing her medical records when she was admitted for psychiatric care. At least 13 hospital employees have been fired.

- Six doctors also face disciplinary action.
- The same privacy breach happened at the hospital before.
- The incident could signal a deeper problem at the hospital system.

2005 at Santa Monica — UCLA Medical Center and Orthopaedic Hospital.[1] After the most recent breach, the newspaper quoted **Jeri Simpson**, the Santa Monica hospital's director of human resources who disciplined staff after the first instance, as saying, "It's not only surprising, it's very frustrating and it's very disappointing."

The 13 employees disciplined in the most recent breach include medical and nonmedical employees, the newspaper reports. Unlike a recent privacy breach involving actor George Clooney, there is no suggestion that any UCLA employee leaked information to the media**. (For more on the Clooney privacy breach, see *Healthcare Risk Management*, December 2007, p. 133.)** After the hospital publicly confirmed the privacy breach, the state Department of Public Health announced that it had opened an investigation of the hospital. There is no word yet on whether it will investigate this latest intrusion.

UCLA Health System issued a statement saying it considers patient confidentiality "a critical part of our mission of teaching, research, and patient care. All staff members are required to sign confidentiality agreements as a condition of their employment and complete extensive training on HIPAA-related privacy and security issues. We have stringent policies to protect patient confidentiality and address violations of those policies." A hospital spokesman declined to comment further, citing confidentiality concerns.

Breach could signal bigger problem

The privacy breach causes concern for those who deal with HIPAA security every day, professionals such as **Susan J. Elliott**, JD, MEd, a former emergency services psychiatric clinician and currently an attorney with O'Melveny & Myers in New York City. The repeated breaches of Spears' privacy within the same health system are a red flag that something is wrong with employees' understanding of HIPAA, Elliott says.

"As both a former clinician and an attorney, I find this appalling," she says.

Hospital risk managers must safeguard the records of all patients, but especially patients whose records could be "sold at auction" to the media, Elliott says. Most health systems probably have no special system in place to safeguard high-profile patients, because risk managers subscribe to the theory that all patients deserve equal protection under HIPAA, she says. While that is technically true, the Spears breaches show that some patient records are far more desirable and much more likely to be accessed improperly, Elliott says.

HIPAA calls for civil fines up to $25,000 per violation to be paid by the employer, and criminal fines up to $250,000 to be paid by the employer and/or the individual. Some cases also can result in imprisonment up to one year for a standard violation and imprisonment for up to five years for a violation committed under false pretenses.

Teresa Mosher Beluris, JD, an attorney at the law firm of McDermott Will in Los Angeles, points out that electronic health records increase the risk that a patient's information will not just be viewed by an unauthorized employee but spread to others. "The same mandates that require hospitals to

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store patients' files electronically in order to facilitate patient care also enable any person entitled to access a file to post it on MySpace in an instant," she says. Hospitals already have limited access to essential personnel, but that group is necessarily large, she says. "Would Pentagon-level technology limit the risk? Perhaps," Beluris says. "However, no hospital I know has a Pentagon-sized budget."

Health care providers should be able to demonstrate that they took all reasonable steps to limit access by prohibiting the sharing of passwords, educating personnel on confidentiality obligations and security precautions, periodically auditing electronic file access, and utilizing security cameras in areas where electronic file access is most likely to be abused, she says. Continued high-profile violations could result in more HIPAA cases going to trial, Beluris says. **(See p. 52 for more information on that trend.)**

Another possible safeguard is flagging a celebrity's record for special restrictions, such as requiring a special password known only to a select few caregivers or having one senior employee be the gatekeeper to the records. Some of those restrictions will not be practical when many clinicians need access, Beluris notes. **(See p. 52 for more information on how to respond after a breach.)**

Advance planning can help

The natural curiosity of hospital employees can be compounded by financial inducements offered to them by unscrupulous journalists seeking inside information on the case, says **Leonard Nelson**, JD, a professor at the Cumberland School of Law at Samford University in Birmingham, AL.

In some institutions where such an event is particularly likely to occur, there should be advance planning for the admission of celebrities, he notes. "For example, a special team should already be in place and ready to handle the public relations aspects of this sort of admission," he says. That team should include experts on maintaining the integrity and privacy of the actual records, regardless of whether they are digital or hard copy. "Computer security experts may have to be retained to prepare for this type of event, and of course they should be bonded and hired only from reputable firms," Nelson says.

Nelson also recommends old-fashioned precautions such as moving the celebrity's hard-copy records to a special room, carefully controlling distribution of keys, and posting of additional security guards. "All employees should be explicitly reminded of their duties in regard to preserving patient confidentiality and the sanctions imposed for even minor breaches," he says. "This includes cautions to avoid lunch table, elevator, and restroom conversations concerning the care of the celebrity."

Reference

1. Ornstein C. UCLA workers snooped in Spears' medical records. *Los Angeles Times.* March 15, 2008. Accessed at: www.latimes.com/news/local/la-me-britney15mar15,0,1421107.story. ■

Memorandum warned staff: Don't peek

This is an excerpt from the memorandum sent to all University of California, Los Angeles (UCLA), employees at 9:20 a.m. on Jan. 31, 2008, by chief compliance and privacy officer **Carole A. Klove**:

"Our patients' privacy and the security of their medical information continue to be a top concern for UCLA Health System. Ensuring the confidentiality of patient information is not only a commitment made to our patients but also directly impacts the patient experience as it comforts them to know that they can trust UCLA Health System to keep their medical information and Protected Health Information (PHI) safe. This year, we are implementing additional safeguards for our patients, including a Privacy Code, which will allow patients to designate specific individuals to receive information from their care providers.

"Each member of our work force, which includes our physicians, faculty, employees, volunteers, and students, is responsible to ensure that medical information is only accessed as required for treatment, for facilitating payment of a claim, or for supporting our health care operations, such as quality improvement. . . . Please remember that any unauthorized access by a work force member will be subject to disciplinary action, which could include termination."

Hospital issues stern warning

A similar warning was issued to staff at The University of Texas Medical Branch (UTMB) in Galveston in October 2007 after a privacy breach involving actor George Clooney

More HIPAA cases could go to court

Repeated high-profile violations of the Health Insurance Portability and Accountability Act (HIPAA) such as the recent case involving singer Britney Spears may result in more privacy cases going to court, says **Susan J. Elliott**, JD, MEd, a former emergency services psychiatric clinician and currently an attorney with the law firm O'Melveny & Myers in New York City.

"I have followed with interest the viability of taking HIPAA violation claims to court. While it is not common, I think it might change if these violations continue to occur," she says.

Since HIPAA's origins in 1996, it has been rare that the cases go to court, with most being resolved through fines, she explains. That trend could be changing, Elliott says. Cases in Florida and North Carolina show a new willingness to allow HIPAA breaches to go to trial, she says.

"In North Carolina, a doctor was sued for negligent infliction of emotional distress because [a patient's] medical records were leaked. The doctor moved for summary judgment, believing that the case had no merit. The court granted summary judgment, but the court of appeals reversed it," she says. "The court held that HIPAA is a standard of care and, like other legal standards of care, carries consequences when breached. Therefore a patient's private health information is to be guarded, and failure to do so could result in lawsuits."

While the North Carolina decision is not controlling in other states, it could be used persuasively to convince another court to hold doctors and hospitals to the strict HIPAA standards set out in the law, Elliott says.

"Employees must understand that compliance with HIPAA is not optional," she says. "If high-profile patients come into a facility, the administration must take all measures to protect that person's medical records. If not, these cases could wind up in court." ■

at a New Jersey hospital.

The compliance officer at UTMB took advantage of the publicity surrounding the New Jersey incident to remind the Texas staff about privacy concerns. **Jim Kelso**, privacy officer and associate director for the Office of Institutional Compliance at UTMB, issued a reminder to staff that said, "Patient privacy is serious. The workers at the New Jersey hospital were suspended for a month without pay. At UTMB, disciplinary actions for violations of patient privacy include termination. Violations under HIPAA can also lead to imprisonment and criminal fines if criminal charges are filed."

Kelso reminded staff that any UTMB employee who opens a patient's record, regardless of whether the employee changes the file, can be tracked. He also warned them that the hospital will use "every available resource at UTMB during the investigation, whether it involves conducting an interview, checking the logs in Health Information Management, or accessing the electronic logs found in any information resource."

His memo also cited these examples of inappropriate reasons to access a patient's information:

- You are curious whether a person you know was admitted to the hospital.
- You know the patient and are concerned about his or her health.
- You are involved in a family dispute and want information about the welfare of a family member.
- You need the address or phone number of a patient for a non-UTMB business reason.
- The patient asks you to access the information as a personal favor, which is not part of your job role. ■

Move fast and hard after breach

Once a privacy breach occurs with a patient's medical records, the risk manager must act quickly and decisively, says **Layna Cook**, JD, an attorney specializing in health care risk management with the law firm McGlinchey Stafford in Baton Rouge, LA. The Health Insurance Portability and Accountability Act (HIPAA) requires mitigation when a violation occurs, Cook notes.

It also requires documentation of an unauthorized disclosure of the patient's health information in the patient's record, she says. While the privacy rule does not require a covered entity to report the nonauthorized disclosure to the patient, in many instances it is the best course of action, Cook says. "For instance, there is a strong possibility that unauthorized access to Britney Spears' medical information may result in private health information being provided to the press," she says. "In such a situation, it may be best to notify the patient of the unauthorized disclosure."

Risk managers should be heavily involved in

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the investigation following a breach, says **Steve Gravely**, JD, a partner at the law firm Troutman Sanders in Richmond, VA, and head of its health care practice. The advent of electronic health records in recent years often makes these investigations easier since there is electronic tracking of all who access the medical record, Gravely notes. Maintaining that kind of trail would have been virtually impossible with paper records, he says

"Risk managers are experienced with conducting investigations quickly and efficiently and should certainly be involved with the privacy officers in evaluating what caused the breach and who was involved," he says. "When employees are responsible for the breach of health information, the hospital must take disciplinary action promptly. In serious cases, termination might be the most appropriate response." ■

New strategies help reduce OB errors

Every risk manager worries about the obstetrics unit, where the number of adverse events may be small but the scope of the tragedy and liability can be huge. Health professionals at Yale School of Medicine in New Haven, CT, have addressed the problem head on by instituting a series of patient safety improvements that decreased the rate of adverse events by about 60% over 2.5 years, while improving the staff's own perception of the overall safety climate by 30%.

The effort at Yale was spurred by claims data from the school's insurer that showed obstetrics claims accounted for an inordinately large share of claims dollars and the trend was worsening, says **Edmund F. Funai**, MD, associate professor in the Department of Obstetrics, Gynecology, and Reproductive Sciences at Yale. He notes that an estimated 44,000 to 98,000 Americans die in hospitals each year as a result of errors, and about half of all medical errors are linked to communication errors and system failures. Obstetrics has lagged behind other specialties in attempts to improve safety because perinatal adverse events are relatively uncommon and usually unexpected, because they normally occur in previously healthy patients who are anticipating good outcomes, he says.

Funai and his team designed and implemented clinical patient safety interventions at Yale-New Haven Hospital. These included communication training, standardizing interpretation of fetal monitoring, and creating a novel staff role: the patient safety nurse. The 60% drop in adverse events and the improvement in the staff's perception of safety were determined by tracking and analyzing 14 markers for adverse outcomes and a survey given by a third party.

Funai says Yale put together a team that included obstetricians, risk managers, and several consultants specializing in patient safety and obstetrics. The team soon identified a number of key issues, including management of labor, interpretation of fetal monitoring, and the use of high-risk medications such as oxytocin. However, the common link in most of the threats to patient safety in obstetrics is a breakdown in communication, Funai says. That break usually involves failure to recognize the severity of a given situation or condition, often involving a newborn's status, he says.

Communication issues are only going to increase in response to restrictions on resident work hours, Funai says. Patients are increasingly handed off from shift to shift, and more attending physicians are practicing shift medicine, he says. "There is just more opportunity for errors in

EXECUTIVE SUMMARY

Yale School of Medicine has implemented patient safety enhancements that significantly reduced errors in obstetrics. The strategy includes hiring a dedicated patient safety nurse for the obstetrics unit.
- The staff's perception of safety in the unit improved 30%.
- The rate of adverse events decreased 60% after the changes.
- Many of the improvements relate to better communication.

patient care," Funai says. "Everything we can do to standardize care and facilitate communication will make a big difference."

Improving communication should be a primary focus of any effort to improve obstetrics safety, says **Susan R. Chmieleski**, APRN, FASHRM, JD, vice president of risk management and client services with Darwin Professional Underwriters in Farmington, CT. Darwin has focused on improving patient safety in obstetrics in recent years, and she says that a root-cause analysis of most errors in this specialty will find that a communication breakdown is at least a contributing factor, if not the primary cause.

It's not as easy as saying that everyone should communicate better and therefore there won't be patients harmed by errors, Chmieleski says. "But what we find when we look at the data on obstetrics errors is that no matter what actually went wrong with a medication error, or failure to take notice of a decline in the patient's condition, or failure to take the right action in a timely manner, usually there is a communication failing involved," she says. "If someone had said the right thing in the right way at the right time, a tragedy might have been averted."

Chmieleski also recommends that risk managers conduct patient safety rounds in the obstetrics unit. A systematic check on operations in this critical unit can head off potential problems, she says. **(For more on how to conduct obstetrics safety rounds, see article, right.)**

Patient safety nurse is new

A novel part of the Yale effort was the addition of an obstetrics patient safety nurse whose sole responsibility is to monitor the overall patient care and ensure that all parties are communicating.

This full-time nurse has broad responsibilities that include being present for patient handoffs and overseeing the overall care of patients, but she has no bedside clinical responsibilities, Funai says. The nurse in this role has a clinical background, which is an important qualification, but any hands-on patient care would be a distraction and divide her attention, he says.

The position currently is filled by one person who works full time, so the patient safety nurse is not available 24 hours a day. The hospital had to take on a new full-time equivalent to fill the role, but the hospital's insurer provides funding that covers the cost of the new position.

In addition, the hospital wanted to standardize many of the typical care scenarios in obstetrics, such as the administration of commonly used medications. The medical literature allows a wide range of dosing for some drugs, for instance, so Yale developed 34 new policies and procedures that standardize when and how drugs are to be administered in obstetrics, as well as clearly defining the chain of command and how to communicate concern. **(See p. 55 for more on how to communicate when clinicians are concerned**

OB safety rounds can reduce errors

Patient safety rounds can be a good idea throughout any health care facility, but the obstetrics unit is where you might see a significant impact from this effort, says **Susan R. Chmieleski**, APRN, FASHRM, JD, vice president of risk management and client services with Darwin Professional Underwriters in Farmington, CT.

Chmieleski offers these tips for conducting patient safety rounds in obstetrics:

- **Develop a checklist.** This checklist can include the most important policies and procedures you have instituted for obstetrics, which could be everything from how drug orders are entered to whether the infants have abduction deterrent devices. Remember that you can ask staff about their knowledge of these policies and procedures, in addition to noting what you can observe when you visit.
- **Include other hospital leaders in your rounds.** It is fine, and sometimes desirable, for the risk manager to conduct obstetrics rounds on your own sometimes. But on other occasions, invite other hospital leaders to round with you. Good candidates are the chief of obstetrics, the head of anesthesia, nursing supervisors, and quality improvement leaders.
- **Keep a low profile**. Don't draw a lot of attention to your visit. Your goal is to see the obstetrics unit as it typically operates, not to have everyone shape up because they know you are inspecting them. If others are rounding with you, keep it to just two or maybe three at a time. If more than that are participating, they should go in different groups of two or three at a time.
- **Report back to the unit.** Let the obstetrics unit staff and physicians know what you observed, both the good and the bad. Don't forget to praise the good work you saw and compliment the staff on adhering to policies and procedures. ■

SOURCES

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about an obstetrics patient.)

Getting buy-in from individual physicians was a big task, Funai says, because they naturally will resist any idea of "cookbook medicine." He helped convince his fellow physicians, in part, by reminding them of a fact learned in the airline industry: Most accidents happen when you're extremely busy or when your workload is very light. In the middle, most people perform well, but at the extremes, they can benefit from a set of standardized procedures.

Yale also clarified the steps that staff members should take when they are concerned about a patient but don't agree with the care being provided. The policies and procedure outline in a step-by-step fashion how to proceed up the chain of command. They emphasize that Yale expects staff to do this and that it is not considered troublemaking.

"After taking these surprisingly simple steps to address safety, both patients and staff report that the care is much more seamless and better organized," Funai says. "The staff is more comfortable and empowered to communicate their concerns about a patient. A comfortable staff often leads to more successful patient outcomes." ■

Right words can show your concern

One of the most common threats to patient safety in obstetrics is the inability, or hesitation, of staff to clearly state their concern about a patient's status, says **Edmund F. Funai**, MD, associate professor in the Department of Obstetrics, Gynecology, and Reproductive Sciences at Yale School of Medicine in New Haven, CT. Too often, one clinician is concerned about a patient but does not effectively communicate that concern to others.

Sometimes the problem is that the first staff member or physician is apprehensive about challenging someone else. Other times, the person is trying to express concern but doesn't say it in an effective manner. At Yale, staff and physicians, even the housekeeping staff who work in the obstetrics unit, must undergo four hours of communication training aimed at avoiding those problems.

"We focus on specific techniques that people can use to say they are concerned about a patient, and we teach them how to use specific phrases," Funai says. "They get used to using those phrases, and they get used to hearing them and understanding what they mean."

The hospital uses a system called "CUS" words, derived from the initials of the key words used to escalate communication in a crisis:

- **Concern.** This is the first level of concern. "Doctor, I'm concerned about Mrs. Smith's tracing."
- **Uncomfortable.** This expresses a higher level of concern. "Doctor, I'm uncomfortable with Mrs. Smith's tracing."
- **Scared.** This is the highest level of concern. "Doctor, Mrs. Smith's tracing scares me." At Yale, everyone recognizes that if another team member uses the word "scared," this is a high-priority situation, and you should drop everything you're doing to deal with it immediately.

"These code words perk everyone's ears up," Funai says. "Instead of everyone saying different things and thinking they got their point across, we can use these words and your colleagues know what your level of concern is. If someone says they're scared, that's a slap in the face and gets your attention." ■

Live surgery may not be a great idea

As part of his efforts to educate the public about heart health, **Frederick Meadors**, MD, a cardiothoracic surgeon at St. Vincent Infirmary Medical Center in Little Rock, AR, had planned to perform heart surgery on a patient while 330 people watched the procedure live through a video feed in a hospital auditorium.

However, that plan was scuttled when

EXECUTIVE SUMMARY

Some hospitals and professional organizations are backing away from live surgery broadcasts. Critics cite patient safety concerns and liability risks.

- There is disagreement about whether surgeons are distracted during broadcasts.
- Plaintiffs' attorneys will claim the surgeon's attention was divided.
- Risk managers should be involved in approving surgery broadcasts.

Meadors' professional group, the Society of Thoracic Surgeons, announced recently that such broadcasts are no longer considered acceptable. The hospital had put six months into planning the event, but officials confirm that the plan was changed abruptly in response to the society's move. Instead of watching the surgery live, the group watched a videotape of a surgery as Meadors explained it in person.

Live surgery broadcasts have grown in popularity in recent years, due partly to technological advances that make them relatively easy to produce and also the public's fascination with medical procedures that in previous years might have been considered unpleasant to watch. But some physician leaders, attorneys, and risk managers are expressing concern that having a surgeon perform live for an audience isn't such a great idea.

In 2006, the American College of Surgeons in Chicago banned live surgery broadcasts at its meetings, and the Society of Thoracic Surgeons did the same in January 2008. **(See p. 57 for excerpts from that policy.)** The Society of Thoracic Surgeons went a step further by saying that its members should not perform live surgery broadcasts to the general public because they may be distracted from their primary duty to the patient, explains **Robert A. Wynbrandt**, JD, executive director and general counsel of the society. The society's board of directors is in the process of approving a more extensive policy that addresses a wide range of ways in which surgery may be viewed by others, he says. It includes everything from having residents standing nearby to participating in live television shows. That policy may be published as early as May 2008, he says.

"The tricky thing is that there is no empirical data to base these decisions on. There are no studies that have shown it is risky or not risky to have the surgery broadcast live," Wynbrandt says. "You hear anecdotal evidence about mishaps that people have had during live surgery, but nothing documented. So we have to base our policies on what is good for the patient and where our priorities should be."

Worries about distracted surgeons

The basic concern is that the surgeon's attention will be divided by having to perform for the camera and narrate what he or she is doing, and that this scenario would compromise patient safety, Wynbrandt says. That risk is only theoretical, he notes, and many surgeons argue that they are adept at multitasking. Their attention is divided already, they say, and having a camera in the room does not create any extra risk.

Wynbrandt says the society can't prove otherwise but would rather err on the side of patient safety. There also is considerable concern that live surgery broadcasts can increase the liability risk for surgeons and hospitals, but again Wynbrandt says that still is only a theoretical risk with no cases to show any certain threat.

The potential risk should not be underestimated, says **Stacy Gulick**, JD, an attorney with the law firm of Garfunkel Wild in Great Neck, NY, and a former hospital risk manager. Gulick compares live broadcasts to the more common practice of videotaping surgeries, which causes much concern among risk managers and defense attorneys for similar reasons. The taping or broadcasting creates a public record of the surgery and, in effect, a great many witnesses, she says. Virtually all broadcasts of a surgery will be taped by someone, so all of the videotaping concerns come into play.

"If anything goes wrong, there is a heightened likelihood that a medical malpractice case will be brought because everyone saw it happen," Gulick says. "And then you have this tape to bring into court and show a jury or judge. That can have a pretty dramatic impact, especially when you're showing something bloody that may affect a layperson much more than a clinician."

Explicit contract required

Gulick says she wouldn't necessarily recommend that risk managers forbid surgery broadcasts, but that the educational benefit should be weighed against the potential risks. The risk

Surgeons create broadcast policy

The Society of Thoracic Surgeons recently revised its policy for how member surgeons should deal with the media and whether they should offer live surgery that is broadcast for others to watch. These are some excerpts from the new policy:

- Members should not participate in live broadcasts of surgical procedures to the general public. The society believes a possibility exists wherein participating surgeons might fail to follow proper medical procedures or might be distracted because of the media and, thereby, deprive the patient of the highest-quality care.
- Live broadcasts of surgical procedures are not permitted at the annual meeting sponsored by the society.
- Members should not communicate a patient's medical history or condition to the media without the patient's authorization, except for certain factual information, which is in the public domain.
- Responsibility for what becomes published, televised, or related via radio or electronic media shall lie with the surgeon who releases the information. ■

manager and legal counsel should be involved in the decision-making process, she says.

"I see a lot of tension between public relations and the risk manager on these issues, but your input is necessary," Gulick says. "If you decide to go ahead with the broadcast, your next step is to oversee the arrangements for the actual broadcast. That means working with a reputable company, limiting the broadcast to your intended audience, and obtaining all the necessary consent from the patient and any staff who will participate."

Agreement must be detailed

The risk manager should ensure that the hospital's agreement with the company doing the broadcast is detailed and protects the hospital, Gulick says. Simply granting permission for the crew to come in and set up a broadcast is not enough. **(See Gulick's advice on what that agreement should say, right.)** She points out that the hospital must obtain specific consent from the patient to allow the production crew to witness and broadcast the surgery. That consent is in addition to any consent that the production company obtains for their own purposes.

"There is quite a lot of paperwork involved. It can be a big deal," Gulick says. "I get a lot of calls about this kind of thing on the day they want to do the broadcast or the day before, and it's hard to get all the paperwork in place."

Spell out approval process

Meredith L. Borden, JD, an attorney with the law firm of Venable in Baltimore, says risk managers should have policies on surgery broadcasts that prohibit them or lay out all the steps necessary for a surgeon to obtain approval. One of her concerns about surgery broadcasts is that they may interfere with good clinical decision-making. If a surgeon wants to be the subject of a broadcast or is being pushed to make the broadcast more interesting, there is some risk that he or she will choose a more advanced, more interesting procedure for the patient than what normally would be done, she says.

"Very often they are doing quite advanced, technical surgeries using the latest equipment and techniques that are rarely used," Borden says. "There can be pressures from the manufacturers highlighting the equipment and talking about the equipment they are using; so that can be a distraction to the surgeon who should be focused on patient care, especially if this is a new or advanced procedure." ■

Protect hospital with clear terms

If you allow a live surgery broadcast, you should include some requirements for the company doing the broadcast, says **Stacy Gulick**, JD, an attorney with the law firm of Garfunkel in Great Neck, NY, and a former hospital risk manager.

The agreement with the company should include these points:

- The hospital may ask the production crew to leave the operating room at any point during the surgery, and that they crew must comply immediately even though they are in the middle of a live broadcast. This is a patient safety measure and gives the hospital the ability to terminate the broadcast if there is a crisis.

SOURCES

For more information on live surgery broadcasts, contact:

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• The company will be liable for any damage caused by its crew or equipment.

• The broadcast crew will be restricted to a specified area of the hospital and must be escorted at all times by a hospital representative.

• Only staff and patients specified in the agreement may be filmed.

• Each member of the production crew must sign a confidentiality statement in which he or she agrees not to divulge any patient information they see or hear during the process. ■

Scrubs figure again in baby's abduction

An infant abduction was quickly solved in part because the hospital used an infant alarm that quickly alerted staff to the kidnapping, according to hospital and police officials in Sanford, FL.

However, the incident also underscores how the scrubs worn by many health care workers can provide an easy disguise to criminals who want to blend in on a hospital unit. Police officials in Sanford report that a woman abducted a 1-day-old baby from a secure hospital unit at Central Florida Regional Hospital recently and smuggled the child out in a tote bag.

The infant was wearing a device that triggered an alarm when it passed an exit from the newborn area, and the hospital immediately was locked down as officials searched the grounds, according to statements from **Darrel Presley**, deputy chief of the Sanford Police Department, near Orlando. Hospital officials reported the abduction about 1:45 p.m. on March 28, 2008, and were able to provide a partial vehicle tag number.

Police in Lake Mary, FL, a nearby community, reported that they arrested 39-year-old Jennifer Latham about 3 p.m. the same day. She was pulled over because her vehicle matched a description of the vehicle witnesses described the kidnaper driving. The baby was found inside unharmed and was returned to the hospital and reunited with the parents.

Latham was questioned by police detectives, who determined that Latham apparently has no connection with the child's family, the police reported. On March 31, a judge released Latham with a monitoring device on her ankle until her trial on kidnapping charges, a move that the Lake Mary police criticized as too lenient.

Changed into scrubs after entering

Presley praised the hospital staff for acting quickly when the infant abduction alarm sounded. "But in just those few minutes that it takes to gather the information and disseminate it, she was able to walk from the maternity ward through the exit and then depart the hospital," he said at a press conference.

Hospital officials and the Sanford police initially believed they were looking for two women because a review of the hospital security videos showed what seemed to be two women in different clothes. But court documents filed in the case reveal what the police pieced together after Latham's arrest: According to the police, Latham wore street clothes and followed a maintenance worker into the maternity ward. Police say Latham acted alone. She changed into a hospital scrub shirt or a shirt that looked very much like one. She then convinced a mother to give up the newborn for an eye test. Moments later, she stuffed the baby into a tote bag and walked out of the facility.

Her exit was caught on the hospital's surveillance cameras. When the Lake Mary police stopped Latham, the officer's dash camera caught her trying to convince the officer that the baby belonged to her.

The use of scrubs to facilitate infant abductions has caused concern before. In 2006 and 2007, two hospitals in Lubbock, TX, were hit by separate kidnapers using scrubs to blend in with health care staff on newborn units. Both babies were recovered, and the kidnapers were arrested. After those incidents, some risk managers and security experts noted that scrubs are easily obtained and can be an effective disguise for criminals. **(For**

more on the 2006 incident, see *Healthcare Risk Management*, August 2006, p. 85. For more on the 2007 incident, see *HRM*, May 2007, p. 49.)

The woman arrested in the 2006 Lubbock kidnapping recently pleaded guilty and was sentenced to the maximum 10 years for kidnapping and an additional 10 years, to be served concurrently, for abandoning the baby when police were closing in on her. In the 2007 Lubbock kidnapping, a 22-year-old woman pleaded guilty to kidnapping the baby and was sentenced to 20 years in prison on Nov. 16, 2007. Rayshaun Parson received the minimum sentence allowed under the statute. She could have been sentenced to up to life in prison and a $250,000 fine. ■

Patient data stolen with NIH laptop

A government laptop computer containing sensitive medical information on 2,500 patients enrolled in a National Institutes of Health (NIH) study was stolen in February, according to a recent report in *The Washington Post*.[1]

The newspaper reports that the security breach has the potential to exposing seven years' worth of clinical trial data, including names, medical diagnoses, and details of the patients' heart scans. The information was not encrypted, a violation of the government's data security policy, the newspaper says.

NIH officials made no public comment about the theft and did not send letters notifying the affected patients of the breach until the newspaper revealed the theft almost a month later. They said they hesitated because of concerns that they would provoke undue alarm.

The handling of the incident is reminiscent of a 2006 theft from the home of a Department of Veterans Affairs (VA) employee of a laptop with personal information about veterans and active-duty service members. In that case, VA officials waited 19 days before announcing the theft.

The incident is the latest in several failures by government employees to properly secure personal information. The Government Accountability Office recently found that at least 19 of 24 agencies reviewed had experienced at least one breach that could expose people's personal information to identity theft, according to the newspaper.

NIH officials said the laptop was taken Feb. 23 from the locked trunk of a car driven by an NIH laboratory chief Andrew Arai, who had taken his daughter to a swim meet. Arai oversees the institute's research program on cardiac magnetic resonance imaging (MRI) and signed the letters to those whose data were exposed.

In the letter, Arai told the patients that "some personally identifiable information" was on the stolen computer, including names, birth dates, hospital medical record numbers and MRI information reports, such as measurements and diagnoses. Social Security numbers, phone numbers, addresses, and financial information were not on the laptop, officials said.

Reference

1. Nakashima E, Weiss R. Patients' data on stolen laptop. *The Washington Post*. March 24, 2008. P. A1. Accessed at http://www.washingtonpost.com/wp-dyn/content/article/2008/03/23/AR2008032301753.html. ■

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

- Evaluating your ethics policy
- Unlabeled syringes pose risk
- System reduces staff back injuries
- Proving your department's value

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.

17. What did Carole A. Klove do on the morning that Britney Spears was admitted to the UCLA Medical Center?
A. She warned Spears that the privacy of her records might be breached.
B. She sent a memo to staff reminding them to adhere to privacy rules about access to medical records.
C. She sent a memo to hospital leaders warning them that staff may breach Spears' privacy during her stay.
D. She requested additional police protection to keep staff from accessing Spears' medical records.

18. According to Teresa Mosher Beluris, JD, how does the increased use of electronic health records affect the security of medical records?
A. Electronic records increase the risk that a patient's information will not just be viewed by an unauthorized employee but spread to others.
B. Electronic records make it virtually impossible for any unauthorized person to view the information.
C. Electronic records lower the liability risk because they are not covered by federal privacy laws.
D. Electronic records have little effect because they typically do not contain sensitive data.

19. According to Edmund F. Funai, MD, how does obstetrics safety compare to that of other specialties?
A. It is by far the most advanced in terms of patient safety.
B. It is no different from any other specialty in regard to patient safety.
C. It is significantly better than most other specialties in regard to patient safety.
D. It has lagged behind other specialties in attempts to improve safety because perinatal adverse events are relatively uncommon and usually unexpected.

20. What does Stacy Gulick, JD, recommend regarding live surgery broadcasts?
A. She wouldn't necessarily recommend that risk managers forbid surgery broadcasts, but the educational benefit should be weighed against the potential risks.
B. That live surgery broadcasts be completely forbidden.
C. That all live surgery broadcasts be allowed.
D. That live surgery broadcasts be allowed only for cosmetic procedures.

Answers: 17. B; 18. A; 19. D; 20. A.

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

Physician's failure to come to hospital leads to settlement with physician, defense verdict for hospital

By **Blake J. Delaney**, Esq.
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News: An elderly woman was admitted to the hospital complaining of constipation and suffering from septic shock. She subsequently suffered an interruption in her gastrointestinal (GI) motor activity, after which she was medicated and transferred to a second hospital for further treatment. After a week at the second hospital, the woman's regular physician went on a weekend trip and left the woman in the care of another GI physician at the second hospital. Over the course of the next couple of days, the woman's condition worsened and was characterized by a hard and distended abdomen. The on-call physician continually failed to come to the hospital to physically evaluate her and instead gave orders to the nurses via telephone. The woman's condition did not improve, however, and she ultimately went into respiratory arrest and died. The woman's family sued the second hospital and the on-call physician for negligence. The physician settled with the plaintiffs for a confidential amount. A jury then returned a defense verdict in favor of the hospital and found that the only proximate cause of the woman's death was the on-call physician's negligence.

Background: A 72-year-old woman presented to the hospital complaining of constipation and suffering from low blood pressure and septic shock. She was admitted to the hospital, and a gastrointestinal consult was ordered. The GI physician determined that the woman was exhibiting decreased bowel sounds, that her abdomen was distended, and that she had developed an ileus, which is a disruption of the normal propulsive GI motor activity resulting from non-mechanical mechanisms. A CT scan confirmed the presence of a colonic ileus.

The next day, the woman began to experience regurgitation. The GI physician evaluated the woman again and determined that her abdomen was distended with decreased bowel sounds. The physician ordered a nasogastric (NG) tube to help alleviate the condition. The physician recommended that the woman be given bisacodyl-rectal suppositories and that she continue to use the NG tube. He also recommended that the woman's electrolytes be monitored and, if abnormal, immediately corrected. He recommended that if the suppositories failed, a type of neostigmine should be administered.

That night, another internal medicine physician rounded on the patient, covering for the first doctor. He evaluated the patient and described her abdomen as distended and tympanic with absent bowel sounds. His plan at that time was to continue support, and he indicated that the woman might require total parenteral nutrition (TPN).

The next day, the first GI physician evaluated the woman again and noted that she was suffering from colonic pseudo-obstruction. He ordered that neostigmine be administered intravenously and that the woman's heart rate be monitored

closely. The patient had a liquid bowel movement that night, and her abdomen become soft and less tympanic. The woman's condition continued to improve the next day, when an examination revealed a soft abdomen with positive bowel sounds. The second GI physician evaluated the woman later that day and noted that her abdomen was less distended, the bowel sounds were absent, but that she did pass stool.

Over the next few days, the woman was having spontaneous bowel movements, and her doctors believed that the colonic pseudo-obstruction had resolved for the time being.

The woman was transferred to a second hospital by the first GI physician, where she was given continued medications, engaged in rehabilitation, and was provided with further acute care, including treating the deconditioning that had resulted from her decreased physical activity. The first GI physician, who had privileges at the second hospital as well, continued to monitor her and noted that she was doing well for the first nine days. The GI physician then went out of town for the weekend. The second GI physician from the first hospital, who also had privileges at the second hospital, was asked to cover for the first GI physician.

On that Friday night, the woman began exhibiting abdominal problems. Her temperature spiked, and her abdomen was abnormal in that it was not soft. Nurses attempted to administer the woman a mild narcotic painkiller, but the woman vomited. A nurse paged the second GI physician, but he did not answer. An hour and 15 minutes later, the nurse called the second physician at home, at which point he ordered that blood cultures be taken should her temperature spike again. The nurses apparently did not inform the physician that the woman's abdomen had reverted to being not soft.

The next morning, the woman again complained of abdominal pain, and her abdomen was noted to be hard and distended. The nurse again administered a narcotic painkiller and called for the on-call physician. This time she reminded him that the woman had been diagnosed with an ileus while hospitalized at the first hospital. The on-call physician ordered a milk-and-molasses enema and later, after the woman was unable to eat due to nausea, a second enema was administered.

The woman's pain persisted. She commented to her daughters later that day that it "felt like her stomach was about to explode." In fact, the daughters could not even see their mother's face when they walked into the hospital room due to the massive distention of her abdomen.

At 7 p.m. that day, a new nursing shift took over, and the new nurse noted that the woman's abdomen was hard and distended and that bowel sounds were absent. The nurse called for the charge nurse, who verified the absence of bowel sounds. The nurse called the second physician, telling him that the patient "does not look good" and "I think she needs to be seen." However, the physician did not come to the hospital. Instead, he gave telephone orders that the woman be given an NG tube as well as intravenous (IV) administration of normal saline with potassium chloride.

A few hours later, the woman's heart rate increased, and she became short of breath. The nurse called the second physician again, but he still failed to come to the hospital to physically examine the patient. He gave telephone orders that included telling the nurse to administer an albuterol breathing treatment, a diuretic, and an anticoagulant.

An hour later, the woman went into respiratory arrest. The second physician arrived at the hospital while cardiopulmonary resuscitation (CPR) was in progress, and a code was called. She was pronounced dead 30 minutes later. An autopsy revealed that the woman's recurrence of the colonic pseudo-obstruction, or colonic ileus, caused her colon to massively expand until it reached the point that it ruptured. The contents of her colon subsequently spilled into her abdominal cavity, which led to respiratory arrest, cardiac arrest, and death. The first GI physician returned from out of town the next day, at which point he completed a death certificate that listed the immediate cause of death as a perforated viscus, which is a hole or tear in the wall of the gastrointestinal tract, from colonic pseudo-obstruction.

The woman's family sued the second hospital and the second physician in federal court for medical malpractice and wrongful death. The plaintiffs claimed that the second physician was negligent in, among other things, failing to properly consider and respond to critical details of the woman's recent past medical history, specifically her ileus, failing to physically examine the woman at any time during the last two days of her life, and ordering a milk-and-molasses enema for a patient with a recent history of a colonic pseudo-obstruction who was at high risk of re-obstructing.

As for the hospital, the plaintiffs argued that

the hospital's nurses failed to recognize the symptoms of bowel obstruction and failed to timely report those symptoms to the second physician. They also claimed that the nurses negligently failed to question the second physician's failure or refusal to come to the hospital to physically examine their decedent or take action to obtain an immediate examination or transfer her to the emergency department. The woman's widower asked for damages of $100,000 for past mental anguish and $100,000 for future mental anguish. Each of the woman's children asked for damages of $50,000 for past mental anguish and $50,000 for future mental anguish. The family also sought punitive damages up to $2 million.

Shortly after the lawsuit was filed, the plaintiffs settled with the physician for a confidential amount. The case proceeded against the second hospital, which denied the plaintiffs' allegations and contended that its nurses used ordinary care, called the physician as they should have, received orders, carried them out, and reported the results to the physician. The hospital insisted that it was up to the doctor to decide whether he needed to see the patient personally. The hospital also argued that the woman's preexisting conditions, and the unforeseeable complications resulting from those conditions, caused the unfortunate occurrence, not their negligence. The hospital said the woman had been hospitalized for a month with numerous potentially fatal complications and that there was no proof that she died because of the hospital's negligence.

A jury returned a defense verdict in favor of the second hospital and found that the only proximate cause of the woman's death was the on-call physician.

What this means to you: Even though this scenario did not result in a finding of liability against the hospital, there is plenty that a hospital risk manager can learn from it. "This fact pattern touches on an area of nursing and hospital care that is often not taught in the classroom: that is, how nurses should communicate and interact with physicians to provide the highest level of care possible to patients," says **Trish Calhoun**, JD, of Buchanan Ingersoll in Tampa, FL.

In this case, almost immediately after the care for the patient was transferred to the second GI physician, the nurses felt the need to inform the doctor of the patient's worsening condition. But the physician did not respond to the nurse's initial attempt to contact him by pager.

"It is all too easy for a nurse to give up or question him or herself when faced with a nonresponsive physician," says Calhoun. "Nurses need to be trained to continue to follow up. I give credit to the nurse for being persistent and eventually getting through to the physician, even if it was an hour and 15 minutes later."

A second aspect of the nurse-physician relationship implicated by this fact pattern is how to handle physician orders that are questionable. In this regard, Calhoun points to two telephone orders given by the on-call physician. First, considering that constipation usually is not the cause of an obstructed or pseudo-obstructed colon, the doctor's milk-and-molasses enema order is curious. Second, when the patient's condition clearly was worsening later that night, it is unclear what the physician was thinking when he ordered the albuterol, diuretic, and anticoagulant treatment.

"... the more important point is the training that should be provided to nurses if they find themselves questioning a physician's orders."

"Without more facts, it is difficult to determine what exactly the physician was thinking in terms of diagnosis and treatment," says Calhoun. "But the more important point is the training that should be provided to nurses if they find themselves questioning a physician's orders."

Although the physician is the one who has the medical training and licensure to make such decisions, nurses gain a wealth of knowledge as a result of their day-in-and-day-out work. If a nurse really disagrees with a physician's orders, Calhoun suggests that a procedure be put in place whereby the nurse can report to a supervisor, who then can communicate with the appropriate individual to assess the situation, whether it be the chief of the department or someone in administration.

A third piece of the puzzle in terms of the physician-nurse relationship is the one that presented itself most significantly in this case: the doctor who refuses or fails to come to the hospital to see a patient. "Nurses act as advocates for patients, while at the same time acting as the eyes, ears, and hands of the doctors," says Calhoun. In that regard, nurses are expected to call doctors to inform them of their patients' statuses. The nurses in this case seem to have done a

good job calling the physician and providing him with information to allow him to make orders. But Calhoun recognizes that nurses often find themselves trying to balance the fine line between calling the physician and not wanting to call too often, especially, as in this case, at night. Any time a physician refuses or fails to come to the hospital to see a patient, the nurse is put in a tough spot, says Calhoun. Especially when a physician is nonresponsive, abrupt, mean, or belittling, nurses can become hesitant in continuing to call, she says. However, part of nursing judgment is knowing when a call to the physician is warranted.

"It's a delicate situation when dealing with a physician who will not come into the hospital to see a patient," Calhoun says. "Contrary to the patient's allegations in this case, the nurse does not have the authority or the ability to force the physician to come in to see the patient."

With that being said, risk managers need to ensure their nurses are trained to respond appropriately to such situations so that the patient's well-being is not adversely affected. In this case, the nurse who came on for the 7 p.m. shift on Saturday arrived with a fresh perspective and immediately recognized that the patient needed to be seen by a doctor. She appropriately contacted her charge nurse, and it seems as though the charge nurse recommended calling the physician back for further orders.

Calhoun notes that other options when faced with a nonresponsive physician include calling hospital administration to get the process moving or calling another doctor who has been consulted on the case, assuming of course that that physician specializes in something related to the patient's problem. Although more facts are necessary, it appears that had the day nurse in this case been more aggressive in asking the physician to come in, the NG tube and IV line could have been started earlier, which might have saved this patient's life.

Calhoun points out that it is not always clear how nurses should chart their discussions with a physician who is nonresponsive or who fails to come into the hospital. On the one hand, if the nurse charts the fact the she told the physician that the patient needs to be seen but that the physician refused to come in, the nurse better be prepared to explain what he or she did to follow up. On the other hand, if the conversation is not fully documented, there will be questions regarding exactly what the nurse communicated to the physician. The best practice, Calhoun suggests, is to include chartings such as "informed physician of change in condition" and "informed physician of serious nature of condition," but that it is never wrong to chart verbatim what is said to the physician. In that case, however, the nurse must be prepared to call a supervisor to help get a physician to the hospital, which did not occur in this case.

"Even though the hospital in this scenario was ultimately absolved from any wrongdoing, I can imagine the case would have proceeded differently had the physician not settled with the plaintiff out of court," speculates Calhoun.

If the physician remained as a defendant, it might very well turn out that his recollection of the phone conversations he had with the nurses at the hospital would not corroborate the story told by the nurses. "Especially in situations involving a physician who refuses or fails to come into the hospital to see a patient, the places where the doctor's story could, and I would assume would, diverge would be as to what the nurse said on the phone," says Calhoun.

In these cases, the medical chart becomes the key to determining what actions were taken by the hospital and whether those actions were appropriate. The hospital won this case because the nurses continually called the doctor to inform him of the patient's condition. In that regard, the hospital deserved the defense verdict it received.

Reference

• United States District Court for the Eastern District of Texas. Case No. 5:06-cv-00259. ■