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RISK MANAGEMENT PERSPECTIVES

Is It Safe to Send that Text?

The Patient Safety and Liability Risks Associated with Text Messaging

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Is it Safe to Send That Text?

The Patient Safety and Liability Risks Associated with Text Messaging

"If a patient passed a handwritten note containing health information to her physician, there is little doubt that this note would be considered relevant if a medical malpractice lawsuit was filed. Likewise, if the physician wrote a note to her patient as to what to do, it would also be relevant and discoverable. Is text messaging anything different from passing handwritten notes?"[1]

—Matthew P. Keris, Esq.

INTRODUCTION

Text messaging has changed the way we communicate with each other. Like most people, healthcare team members use their cell phones at work,[2,3] and texting about patients is common.[4] Texting with patients and other members of the healthcare team has risks and benefits. Among the benefits: texting is convenient and efficient, and it can enhance patient engagement and team communication. But the benefits must be weighed against patient safety and liability risks, which include:

- Text messaging autocorrection, typos, and text-typical abbreviations can result in inaccuracies.
- Texts may be composed in a manner that is considered unprofessional or too casual for medical record documentation.
- Individuals may assume that deleting incriminating or unprofessional text messages from their phones permanently removes them from existence. However, the data continues to exist in different locations that can be accessed by plaintiffs in malpractice litigation through the legal discovery process. Furthermore, deleting texts, whether intentional or due to deletion settings on one's cell phone, can result in spoliation allegations.
- Texts can be too brief and imprecise when a situation calls for detail typically available during direct communication.
- Texts can be a distraction from patient care, resulting in increased patient injury risk and diminished patient satisfaction.
- Texts often aren't retained in patient records, which can disrupt continuity of care, violate record retention laws, and make it difficult for defendants in malpractice lawsuits to remember what transpired.
- Unsecure messaging platforms can result in federal and state privacy and security law violations and noncompliance with Centers for Medicare & Medicaid Services (CMS) and accrediting organization (e.g., The Joint Commission) requirements for secure text messaging.

Healthcare entities can provide members of the healthcare team with a secure messaging system to facilitate a straightforward way to include text messages in medical records. Administrators can also create and enforce text messaging policies and protocols designed to improve patient safety and reduce professional liability. But ultimately, relative to text messaging, patient safety and liability risk management are up to individuals.

This article presents case studies based on closed claims. They are used to illustrate how text messages may contribute to patient injury and turn into evidence in malpractice litigation. Corresponding strategies are introduced to improve patient safety and reduce liability risks.

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INFORMATION OVERLOAD: Texting and Distraction

Text messaging can be distracting. And distractions, in general, increase the risk of patient injury.[5] Whether work-related or personal, texting usually involves cognitive, visual, or manual tasks. Like phone calls, pages, alarms, and requests from colleagues, patients and patients' families, texts increase the already immense amount of information received and processed during patient care.[6] For example, consider the facts of a case discussed on the Agency for Healthcare Research and Quality's Web M&M website: A physician was using her cell phone to enter an order to stop anticoagulation therapy. Before completing the order, she received a text message about a party. She responded for the party but forgot to finish the patient order. As a result of over-anticoagulation, the patient required emergency open heart surgery.[7] To the extent healthcare team member text messaging shifts the focus of encounters away from the patient, it may depart from reasonable patient expectations.

In malpractice ligation, the decision to settle a case instead of defending it at trial is based on many considerations, including the circumstances surrounding the alleged malpractice. While text messaging associated with the plaintiff's medical care may be excused by a jury, personal text messaging could be expected to reflect poorly on healthcare defendants.[8] The discovery of personal text messaging during or near the plaintiff's injury can nudge a case from one that might be defended to one that needs to be settled.

"Distracted doctoring" aside, cell phones create a barrier between caregiver and patient,[6] and can decrease patient satisfaction.[8] Unless they are told, patients will not know if a cell phone is being used to access decision-making, drug interaction applications (apps), dosing calculators, etc.[6] Patients instead may assume the members of their healthcare team are using their cell phones for personal reasons or entertainment. Take a moment to stand in the shoes of a patient in your treatment environment. If colleagues in hallways, workstations, and elevators are focused on their screens, patients may wonder whether healthcare is being prioritized.[8]

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RISK REDUCTION STRATEGIES

Many healthcare safety improvements can be traced to the aviation industry. The Sterile Cockpit Rule is a set of Federal Aviation Administration regulatory requirements that prohibit pilots from engaging in nonessential activities during critical phases of flight. The rule was specifically amended to prohibit personal cell phone use at any time during the entire flight.[8] With that in mind, consider the following strategies:[5,9]

CLINICIANS AND STAFF

- Turn off cell phone notifications when you are with patients.
  - ► Silent, airplane, and do not disturb modes can decrease the distraction of text messaging during patient care.
- If you must use your cell phone for work-related reasons (e.g., to access a dose calculator app) during patient encounters, be transparent. Tell patients how your cell phone is adding value to their healthcare.
- If you must use your cell phone to avoid missing work-related messages while on shift, select and apply specialized text message tones to work-related telephone numbers and silence the rest.
- Designate times to check cell phone notifications when you are not with patients.
- Leave cell phones outside of the operating room with someone who can triage incoming calls and messages.
  - ► Consider HIPAA compliance when using this strategy.
- Let your family and friends know that you cannot be instantly available while you are providing patient care.

ADMINISTRATORS

- Educate clinicians and staff about the dangers of distracted practice, generally and specifically related to text messaging.
- Create a policy of no personal cell phone use during patient care.
- Use simulation exercises to illustrate how text messaging disrupts medical decision-making.
- Empower members of the healthcare team to comfortably respond to and challenge each other's inappropriate cell phone use.

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CASE ONE:
Unbecoming Text Messages

The medical record is not the forum for blame, personal attacks, or finger pointing.[10] Text messages relating to patient care should be considered part of the medical record (whether they are transferred to it or not), and the same rule about appropriateness of forum should apply. If something about patient care is important enough to be texted, it should be included in the medical record. If it is something that does not belong in the medical record, then it should not be texted. It seems clear that the members of the healthcare team texting each other in the following case study did not expect their text messages to be used against them in the malpractice lawsuit.

> Put yourself in the shoes of the jurors. How might the defendant physicians' text messages change your feelings towards the physicians and hospital?

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A complication occurred during surgery that resulted in the patient's death. Two of the physicians on the surgical team carried on a lengthy text message conversation following the patient's death. The text messages included:

- Admissions of liability
- Considerations of manipulating the facts to deflect fault from themselves
- Ideas about withholding knowledge about the cause of the complication
- Criticisms of the review and handling of the unanticipated outcome and the hospitals likely response to the malpractice claim
- Negative reviews of the peer review committee meeting
- Criticisms of the patient's family
- Name-calling of hospital administrators

The text messages about hospital administrators included: "They are a bunch of bloodsuckers," and "They are so STUPID!" One physician referred to the hospital as "a s**t show."

DISCUSSION

Although the text messages were extensive, the medical record documentation was sparce. The combination of the texts and lack of documentation that could have supported standard of care and lack of causation defenses significantly diminished the defensibility of this claim.

RISK REDUCTION STRATEGIES:

Consider the following strategies:[11]

- Before you send a text message, imagine reading it as a third party. If the message reflects poorly on your character, contains negative comments about a patient, or comes across as unprofessional, do not send it.
  - ► Avoid sarcasm and negative comments when discussing patients or colleagues.
  - ► Do not vent frustrations.
- Do not intersperse personal matters with text messages about patient care.
- Be cautious about how you respond to colleagues' messages. Using a "like" or "laugh" emoji in response to a controversial or inflammatory message may come across as condonation of your colleague's behavior.
- Hold colleagues accountable for unacceptable text messages.

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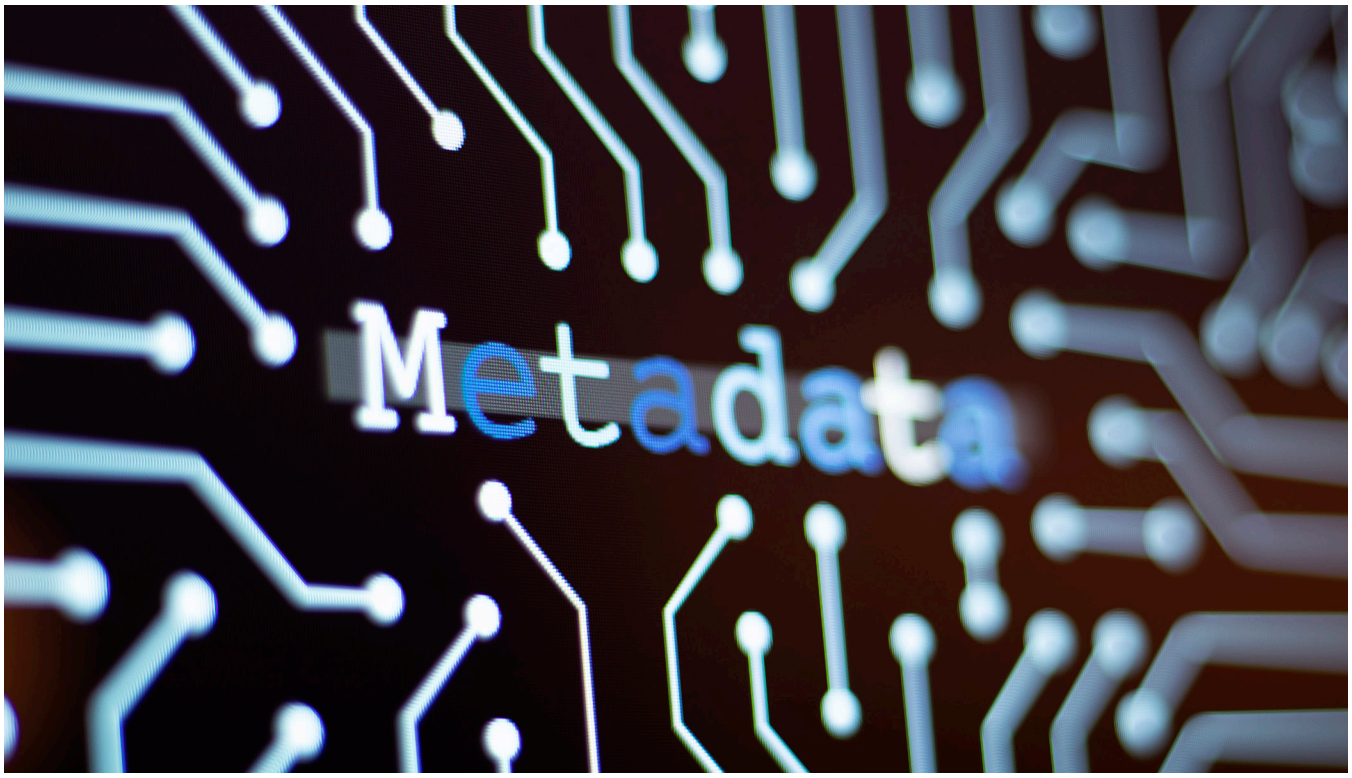

CASE TWO[12]:

Text Messages Used to Impeach Testimony

Some electronic health record (EHR) systems do not offer integrated texting apps, which can lead to the use of texting apps that require a separate process to transfer texts to the patient record. Unfortunately, text messages frequently do not find their way into the record. When text messages about patient treatment are not included in the medical record, there can be gaps in the treatment/progress chronology and absence of justification for treatment decisions.[4] Unlike the days of paper records, where gaps in the records either stayed unfilled or were explained with testimony during malpractice litigation, today, text messages can be resurrected and used as evidence.

> Consider how this case might have resolved if the NP had been truthful with her defense team.

Text messages between colleagues or with patients can be used by plaintiffs to challenge defendants' honesty or otherwise diminish their jury appeal. Deleting offensive text messages from a phone is generally ineffective, since text messages are stored in various places in message sender and receiver devices and on the cloud (i.e., metadata), which makes them usually recoverable. A defendant's deleted text messages can be requested/subpoenaed, printed, and presented as evidence.

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In the following case, the nurse practitioner's (NP's) own text messages were used to challenge the truth of her testimony in deposition. It was clear to the defense team that the text messaging exchanges between the NP and a registered nurse (RN) would be used to impeach the NP if the matter went to trial. Plaintiff's objective in presenting the texts would be to show the jury that the NP did not deserve to be believed, since the text messages indicated she lied under oath in her deposition.

DAY ONE

7:00 a.m.	A patient with multiple comorbidities underwent inpatient right shoulder surgery. The orthopedic surgeon did not note any surgical complications.
12:00 p.m.	The patient complained of numbness and loss of function of her right arm to the RN, who reported it to the orthopedic surgeon's NP. The NP thought the patient's symptoms were being caused by the nerve block given pre-operatively. She continued standard postoperative care.

DAY TWO

8:00 a.m.	The RN documented that the patient had continued complaints of numbness, tingling, tenderness, limited movement, and significant arm pain that was not being relieved with medication. From this point forward in the nursing notes, the patient was noted to be whimpering and moaning in pain, which she reported at 10/10.
8:30 a.m.	The NP documented in the progress notes, "Examined the patient. Mild numbness. Skin normal."
9:00 a.m.	The hospitalist noted right arm pallor, coolness, and paresis. A bedside Doppler showed weak pulses. He ordered a Doppler arterial ultrasound and a neurology consult. Although he did not document it, he asked the RN to share the results of his examination with the orthopedic surgeon, and to call him with the Doppler arterial ultrasound results.
10:00 a.m.	The Doppler arterial ultrasound was completed.
11:00 a.m.	The Doppler arterial ultrasound was available in the picture archiving and communication system (PACS). It showed no radial, ulnar, or brachial pulses, and an injury to the axillary artery.
4:00 p.m.	The radiologist entered his report on the ultrasound in the EHR, but he did not directly contact anyone about the findings.
5:00 p.m.	The hospitalist accessed the ultrasound results in the EHR and realized the patient needed a vascular surgeon. He requested a STAT consultation.
6:00 p.m.	The hospitalist documented that no one brought the results of the Doppler arterial ultrasound to his attention.
7:00 p.m.	The patient was taken to surgery for axillary artery exploration with possible revascularization and fasciotomies as an alternative to amputation. However, the revascularization was unsuccessful, and the patient ultimately underwent an upper arm amputation.

DAY THREE

The hospitalist asked the RN why she had not informed him of the Doppler arterial ultrasound results. She told him she had informed the NP. The hospitalist wanted to know why this wasn't entered in the patient's medical record. To prove the conversation took place, the RN forwarded screen shots of her text messaging exchanges with the NP.

The patient sued all members of the healthcare team for delayed diagnosis and management of the arterial injury resulting in amputation.

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DISCUSSION

The NP's medical record documentation was sparse. She had deleted the text messages from her phone and had not informed her attorney of the text message exchanges that had occurred between her and the RN. When asked about the gaps in her documentation, the NP explained to her defense team that except for slight numbness, she determined the condition of the patient's arm was unremarkable on the morning of Day 2. She did not believe the numbness was significant. When asked to explain why her documentation differed so significantly from the hospitalist's one hour later, she surmised the patient's condition must have declined very quickly. She further explained she did not know anything was wrong until one of her colleagues told her the patient was in surgery. Unbeknownst to the NP or her attorney, during discovery the hospitalist's attorney had provided the plaintiff's attorney with screen shots of text messages between the RN and NP. (The RN had provided the texts to the hospital administrators, who provided them to the hospitalist's attorney.)

Unbeknownst to the NP or her attorney, during discovery the hospitalist's attorney had provided the plaintiff's attorney with screen shots of text messages between the RN and NP.

Combining the text message exchanges, the EHR entries, and the EHR audit logs, the plaintiff's attorney was able to challenge the NP's deposition testimony that the patient's arm and hand were normal except for patient reports of "mild numbness." For example, during the NP's testimony, she denied the patient's hand was cool during her examination at 8:30 a.m. and documented her skin was "normal." However, a text message from the RN to her minutes later stated the patient's hand was cool. And further, at 9:00 a.m., the hospitalist documented he found the hand cool to the touch and feeble pulses in the arm.

Later in her deposition, the NP denied being aware that the hospitalist ordered a Doppler arterial ultrasound. However, she was then shown the RN's text to her at 9:30 a.m., informing her it was ordered. In response to this challenge, the NP changed her testimony, stating she did not remember knowing that the ultrasound was ordered; but if she did, then she would have advised the orthopedic surgeon about it. The orthopedic surgeon denied being advised and there was no documentary evidence of the exchange. Finally, the NP initially denied ever seeing the bedside Doppler report, but after being shown a text message from the nurse with the results, she again claimed to not remember seeing it, and again testified that she would have told the orthopedic surgeon about the weak pulses if she had seen the report. EHR audit logs also indicated she had accessed the bedside Doppler report in the morning of Day 2. When she was shown the audit logs, she suggested someone else in her office logged in as her. The orthopedic surgeon denied being advised of the bedside Doppler findings.

In addition to the text messages impairing the NP's credibility as a witness, in several of the NP/RN exchanges the NP characterized the patient's pain as exaggerated and her complaining as attention-seeking. Based on her belief that the patient was exaggerating her level of pain, the NP discontinued her intravenous pain medications. As the patient's complaints would have been legitimate based on the outcome, the NP's decisions about pain control and mockery surrounding the patient's pain created an additional challenge to the defense team.

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RISK REDUCTION STRATEGIES

Text messages related to patient care, like medical record entries, are documentary evidence, which can carry more weight in litigation than testimony based on memory. Like any other medical record, they should be retained for specific time periods required by law. Just as if portions of the hard copy or electronic medical record were destroyed or lost, the disappearance of relevant text messages can complicate the defense of a medical malpractice claim. Consider the following strategies:

CLINICIANS AND STAFF

- Know and follow your employer's policies on the use of cell phones (personal and company provided), including personal and work-related texting while providing patient care.
- Use a secure system that automatically saves messages in the EHR.
- If the system does not automatically save messages, manually preserve all text messages about the patient's healthcare and treatment in the patients medical record.

ADMINISTRATORS

- Develop a system to ensure that all text messages used for clinical decision-making are automatically preserved in the medical record.
  - ► If a messaging application does not automatically interact with the EHR, develop a policy and system to ensure that texted communications are retained. Consider replacing a system that does not automatically interact with the EHR.

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CASE THREE:

Contradictory Text Messages from Different Members of the Healthcare Team

The brevity and casual nature of text communication that makes it convenient, can also make it inappropriate in a healthcare setting. One key to using text messaging in healthcare is to know when an in-person or telephone conversation is necessary. Discussing a patient during a telephone conversation can facilitate the exchange of important information that may more naturally prompt questions and responses.

> Consider how text messaging increased the risk of patient injury. How could this patient's injury have been avoided?

A patient developed lymphedema in her arms and torso following a mastectomy. Her past surgical history was significant for liposuction of her back. Her physician recommended a compression garment, which was placed at an office visit for the lymphedema. Concerned that the garment provided was not adequately compressing her back, the patient added her own corset to increase compression. She texted her physician's nurse, telling her to advise the physician that she was wearing the corset for additional compression. The nurse texted back that the patient should "remove any compression garment that was not placed by the physician." However, she followed up this text with a forwarded text from the physician: "I want her upper back compressed." Because the patient's corset did compress her upper back, and the other garment did not, the patient disregarded the nurse's direction to remove her corset, believing the physician's comments about upper back compression overrode it. When the patient was seen a week later, the physician noted a large area on her back that had compromised soft tissue and full thickness necrosis. When the wound healed, it left a large, pronounced scar. The patient filed a malpractice lawsuit against the physician and nurse alleging the negligent directions associated with compression caused her injury.

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DISCUSSION

Defense experts believed the patient's injury was caused by the addition of the corset to the physician-placed compression garment. They also believed that the patient's prior liposuction may have predisposed her to the type of injury she sustained. However, the defense team determined the patient's misinterpretation of the text messages was understandable and would resonate with a jury if the matter went to trial.

RISK REDUCTION STRATEGIES

Consider the following strategies:

CLINICIANS AND STAFF

- If your message will require more than a few sentences, use an alternative method of communication.
- When texting, have a low threshold for picking up the telephone and discussing a treatment issue instead of attempting to clarify via additional text messaging.
- Avoid forwarding someone else's text messages.

ADMINISTRATORS

- Establish clear indications and contraindications for text messaging with patients.

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CASE FOUR:
Follow-Up via Texting

Text messaging can provide quick, efficient communication between physicians and patients. In malpractice litigation, it can show physician attentiveness and responsiveness. However, text messages can also complicate the defense of a malpractice claim if they are unprofessional or inconsistent with other documentation.

> Consider differences in the manner of text messaging between the surgeon and patient that could have supported a defense that the postoperative treatment met the standard of care.

On January 5 a patient presented to a podiatric surgeon for a progressively stiffer and more painful big toe. The surgeon diagnosed the patient with hallux rigidus (degenerative arthritis of the first metatarsophalangeal (MTP) joint). Various conservative treatments were not effective, and the patient ultimately underwent a corrective osteotomy on June 10. Antibiotics were prescribed prophylactically for infection control. On June 17 the surgeon noted the wound was healing normally with no cellulitis or streaking redness, just ecchymotic changes consistent with surgery. Antibiotics were continued.

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According to text messages between the surgeon and patient, the patient was seen in the surgeon's office after hours on June 28 for wound drainage and foot swelling. The surgeon did not document this visit in the patient's medical record; however, he later testified that he would have documented something if he suspected infection. On July 5 the patient texted that his physical therapist suspected infection. The surgeon ordered an additional course of antibiotics.

On July 25 the patient texted that his physical therapist removed his stitches and the wound looked almost healed. During the text message exchange, the patient attached a photograph of his toe and the surgeon replied, "Looks good." However, in the beginning of September the patient started texting about increasing pain and stiffness in his toe. He presented to the surgeon's office on September 15. The surgeon determined the first surgery failed, and he scheduled a first MTP joint arthrodesis surgery for September 24. The second surgery was completed without complication. The patient was prescribed antibiotics prophylactically. Postoperative visit notes dated September 29 indicated the patient was healing nicely with no sign of infection.

The patient presented for follow-up on October 5. The surgeon noted increased drainage, but no signs of infection. Antibiotics were continued. On October 12 the patient presented with complaints of pain, warmth, and profuse drainage. The surgeon recommended admission to the hospital for debridement and irrigation. At the hospital, the patient was diagnosed with osteomyelitis and ultimately required an amputation of his toe. He filed a lawsuit against the surgeon alleging his failure to diagnose and treat postoperative infection resulted in osteomyelitis and amputation.

During the text message exchange, the patient attached a photograph of his toe and the surgeon replied, "Looks good."

DISCUSSION

The defense team believed the standard of care criticisms in the case would have been surmountable if the surgeon had documented his interactions with the patient in an appropriate manner. Although the text message exchanges helped the case, as they showed the surgeon was very attentive, there were various issues with the text messaging that tended to outweigh their value. For example:

- Despite the sometimes-daily contact with the patient, there was nothing documented in the patient's medical record from June 17 to September 15.
- The texts were written in text message shorthand (e.g., "2" for "to/too," "B" for "be," "R" for "are," "U" for "you," "Y" for "why," etc.), which appeared unprofessional.
- The physician relied on poor-quality cell phone photographs of the surgical wound for the purpose of diagnosis and follow-up.

Finally, the surgeon had a habit of dictating patient visit notes many weeks after encounters. Even though he believed his excellent memory resulted in accurate documentation despite the time lag, most of the medical record documentation in this case occurred after the patient had been diagnosed with osteomyelitis. This gave the impression that the surgeon was defensively documenting, which the plaintiff's attorney was expected to use to undermine the veracity of the defense evidence. It also appeared that the surgeon did not refer to his text messages when completing the EHR documentation, as the two sources of information were contradictory.

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RISK MANAGEMENT STRATEGIES:

Gaps in a patient's medical record caused by absent text message exchanges can complicate the defense of a medical malpractice claim. When text messages that fill those gaps contain inappropriate abbreviations, typos, and superficial exchanges, similar problems arise. Consider the following strategies:

- When text messages cannot be saved in the EHR, document each encounter as completely as you would document a face-to-face encounter, i.e., dictate, transcribe the text messages, cut and paste the text messages, or print out and scan the text messages into the EHR.
  - ► Indicate that the patient-physician communication occurred by text messaging.
  - ► If dictating or transcribing text messages into the EHR, do not change the original content of the text messages.
- Do not use text shorthand or any other unapproved abbreviations when sending patient care information. Not only does it appear unprofessional, it can result in confusion, for example, "2Day" could mean "today" or "two per day."
- Beware of autocorrect functions. For example, a phone may change "Dilaudid®" to "dilated."
- Review the content of messages before sending them.
- Send a clarification when you notice a mistake after a message has been sent.
- Confirm receipt of texts, for example, by using cell phone read-receipt options.
- Do not attempt to diagnose patient conditions based on poor-quality photographs. If the image quality cannot be adequately improved on the patient side, examine the patient in person.

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CASE FIVE:
Admissions of Liability in Text Messages

Texting can blur traditional patient-physician boundaries. The loosening of social inhibitions in the online environment often allows people to behave differently than they would in person, a phenomenon known as the online disinhibition effect.[13] In the following case, the physician assistant (PA) had a long-standing treatment relationship with the patient. Their text messages to each other interspersed personal and treatment information. Over the years, the text messages took on a casual, conversational tone that reflected the friendship the two women had developed. When the patient's treatment outcome was not as expected, the PA responded as a friend instead of a healthcare professional—this complicated the PA's defense when the patient sued for malpractice.

Consider how the PA's tone and the content in her text messages to the patient complicated her defense.

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The patient presented to a medical spa for various treatments over many years. She requested and was treated by the same PA at each appointment. During a laser hair removal session, she suffered a third-degree burn on her upper lip. Despite treatment at the medical spa, and later by specialists, the patient sustained permanent scarring. The patient and PA communicated almost exclusively by texting before and after the treatment that resulted in her injury. For example, in response to a photograph of the burn the patient sent to her, the PA texted: "I'm so sorry. That looks terrible!" and later that day, "I've never seen a burn that bad."

A month later, in response to the patient's texts about the burn not healing as expected, the PA texted: "This is all my fault. They refunded your money, right?" When the patient indicated she had not yet received a refund, the PA responded that she would write a personal check to cover the amount, if the patient would sign a release of liability. The patient ultimately received a full refund from the medical spa. After the refund, the patient stopped contacting the PA. Instead, she filed a malpractice suit against the PA and her supervising physician, alleging permanent scarring caused by negligent laser treatment.

DISCUSSION

The plaintiff's attorney contended the PA admitted liability on multiple occasions in her text messages to the patient. He further contended the refund of fees in fact and the PA's offer of a refund in the text messages were further evidence of the defendants' acknowledgment of their own negligence.

In addition to the text messaging issues, there was no documentation of the patient's informed consent for the laser procedure. The PA indicated, however, that it was her standard practice to discuss the risks of laser hair removal with patients, and the risks would have included burns and permanent scarring. The patient, predictably, denied that the risks of burns and scarring were discussed with her. If the case went to trial, determination of whether informed consent occurred would essentially depend on who the jury believed on the issue of accepting the risks of burns and scarring—the patient or the PA.

Even though defense experts believed, based on discussions with the PA and the documentation in the medical record, the laser hair removal was conducted in a manner that met the standard of care, settlement of the case was recommended. The combination of compromising text messages and lack of informed consent documentation significantly diminished the defensibility of this claim.

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RISK REDUCTION STRATEGIES:

Consider the following strategies:

- Maintain appropriate clinician-patient boundaries and professional decorum.
  - ► Do not mix professional and personal issues in text messages.
- Take a conservative approach in text messaging with patients and self-check texting disinhibition.
  - ► Avoid humor, sarcasm, slang, and emojis.
    - › The patient may not pick up that a comment is sarcastic without accompanying body language and in-person facial expressions.
    - › The situation may not be humorous from the patient's point of view.
- Do not attempt to manage a refund request via text messaging.
  - ► Because of the potential complexity of a refund demand, it is a good idea to obtain input from the risk management or claims departments when patients demand refunds and reimbursements after an adverse outcome or event.
- Do not attempt to manage and respond to an unanticipated outcome via text messaging.
  - ► Be careful with apologies.
  - ► Do not admit or imply culpability when discussing an unanticipated outcome with a patient.
  - ► Contact the risk management and/or claims department for assistance with responding to an unanticipated outcome.
  - ► Know if your state has an "I'm sorry" law, and if it does, know the extent of its protections.

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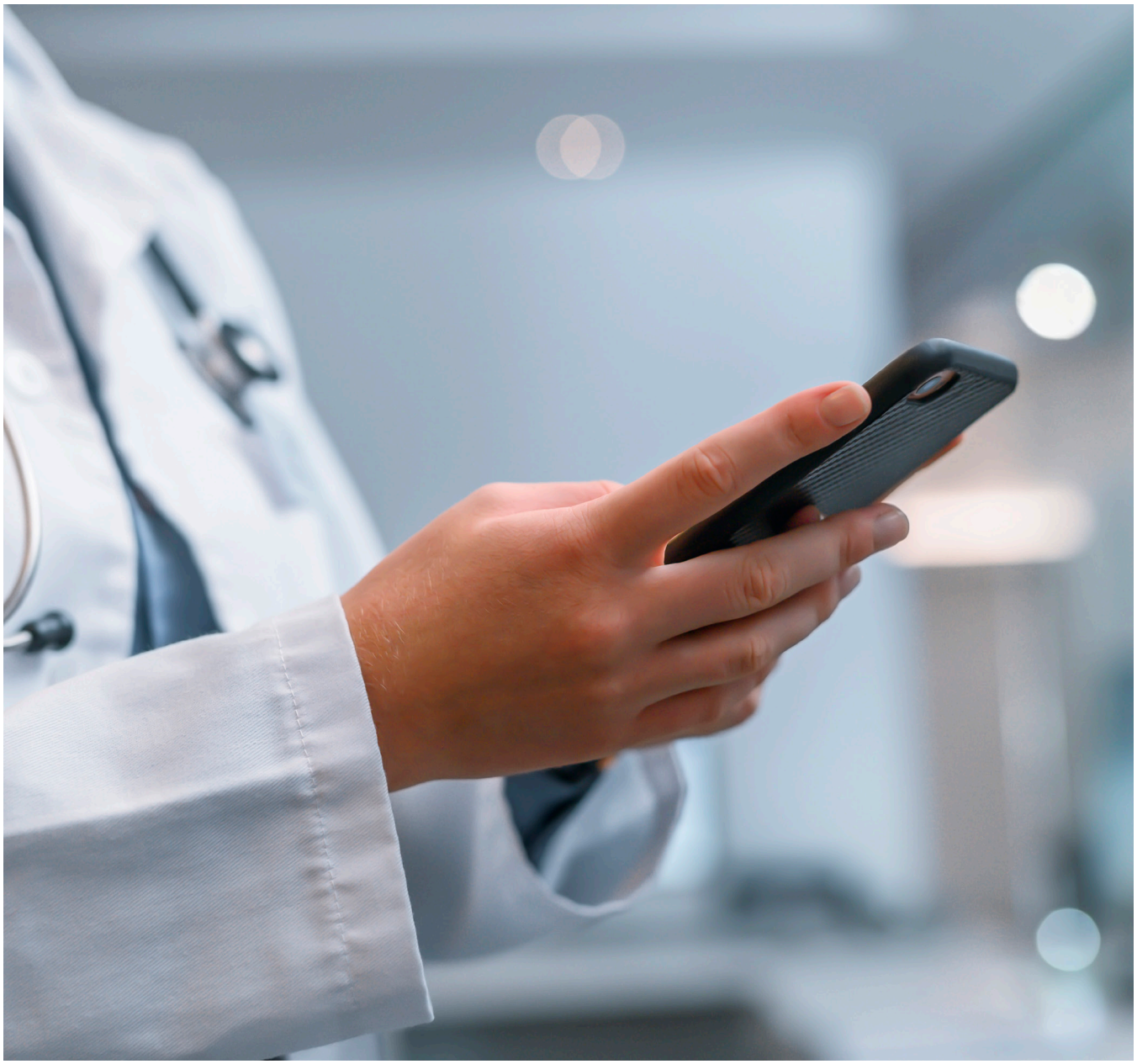

HIPAA, HITECH, AND CONFIDENTIALITY

Texting protected health information (PHI) without proper safety and encryption processes in place could result in HIPAA/HITECH violations, noncompliance with CMS and accreditation requirements for secure text messaging, and violation of state medical information confidentiality laws. Because PHI goes where the phone goes, ensuring the privacy and security of PHI sent by text messaging can be challenging. Cell phones are easy to lose, are frequently stolen, and because they are often a personal device, users may not think of wiping stored text messages containing PHI when disposing of their phone. Messages on phones are also at risk for unauthorized access through eavesdropping and interception, and a sender can never be certain that a message sent in compliance with privacy and security practices will be viewed by the intended recipient.

Although there are compliant text messaging apps, members of healthcare teams continue to send text messages containing PHI using pre-installed messaging apps on their unsecured devices.[14] The success of a text messaging privacy and security plan, therefore, depends in significant part on individual compliance.

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RISK REDUCTION STRATEGIES:

Consider the following strategies:

CLINICIANS AND STAFF

- Double check the recipient of all text messages containing PHI.
- Do not text highly sensitive PHI (e.g., mental health, HIV, substance abuse).
- Only use cell phones or applications that are set up or provided by the facility. If using a personal device, have the facility's information technology (IT) department confirm it meets privacy and security standards.
- Notify appropriate administrators if a device is lost, stolen, or replaced.
- Ensure that misdirected text messages are documented in the HIPAA disclosure log.
- Password protect and set screen lock on devices used for texting PHI.
- Ensure text messages are retained in the EHR.

ADMINISTRATORS

- Implement a secure texting platform that meets the requirements of HIPAA/HITECH, state medical information confidentiality laws, CMS, and accreditation requirements.
- Retain text messages for appropriate time periods, i.e., the same as other medical records.
- Prohibit text messaging of PHI using noncompliant devices and applications.
- Ensure appropriate privacy and security protocols for text messaging are understood and followed.
- Educate healthcare staff on text messaging risks (including the potential for monetary fines) associated with legal and accreditation violations.
- Develop a comprehensive text messaging risk analysis and management strategy that identifies areas of vulnerability, implements "reasonable and appropriate" security measures, and monitors systems in place.
- Address text messaging in medical staff bylaws.
- Require password protection and encryption for all devices that create, receive, or store text messages containing PHI.
- Implement audit controls and reporting processes to review and document any text messages containing PHI.
- Use a system that can authenticate the identity of the text recipient and the sender.
- Require remote erasing of all PHI data from devices that are stolen, lost, or being retired.

ADDITIONAL RESOURCES

Centers for Medicare & Medicaid Services: Texting of Patient Information and Orders for Hospitals and CAHs[15]

The Joint Commission: Texting—Use of Secure Text Messaging for Patient Information and Orders[16]

Is It Safe to Send that Text?

The Patient Safety and Liability Risks Associated with Text Messaging

CONCLUSION

Text messaging has changed the way members of the healthcare team communicate with each other and patients. Using a personal device that does not automatically load text messages into the patient record can result in gaps in the medical record that can be difficult to fill without access to the text messages in the phone. These are frequently deleted prior to litigation. Text messages about patient care should be created with the same skill and professionalism as medical record entries—the text messages are part of the medical record, regardless of where they are being stored. That being the case, text messages between members of the healthcare team and with patients can be used as evidence in malpractice litigation. When engaging in patient care and treatment, it is important to consistently weigh the risks and benefits of using text messaging as a mode of communication. When the benefits outweigh the risks, carefully review messages for accuracy and professionalism before hitting the send button. As the case studies in this article show, careless messages can substantially complicate the defense of malpractice claims.

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ENDNOTES

The ProAssurance documents referenced in this article, along with many other risk management resource documents and past editions of *Claims Rx*, are available on the ProAssurance Risk Management website.

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