

A Watchful Eye in Hospitals

By TIM LAHEY FEB. 16, 2014



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HANOVER, N.H. — DESPITE the intensely personal moments that happen in hospitals, patient privacy can be elusive. Hospitals are multimillion-dollar corporations that look like shopping malls and function like factories. Doctors knock on exam room doors to signal they are about to enter — not to ask permission. The curtain that encircles the hospital bed always lets in a crack of light.

Yet we do expect some degree of privacy in hospitals. We trust doctors with our secrets in part because they take a 2,000-year-old Hippocratic oath to respect our privacy, an oath enforced by laws like the [Health Insurance Portability and Accountability Act](#). But sometimes, doctors have to weigh patients' privacy against their health and safety, and that's when things get complicated.

The use of video monitoring — covert or disclosed, of patients or providers — has proliferated as high-quality, inexpensive technology has become increasingly accessible. The possibilities range from watching elderly patients at risk of falling in their rooms to recording doctors and nurses at sinks to make sure they're washing their hands.

My hospital, where I am chairman of the bioethics committee, recently wrestled with the question of where patient and family privacy ends. Nurses in the neonatal intensive care unit (N.I.C.U.) worried that a premature infant, whom I'll call Rickie to protect his identity, was being harmed by his parents.

Rickie had been released a week earlier from our hospital to a penniless couple in their early 20s whom Child Protection Services was already investigating on charges of neglecting their other children. Days later, Rickie's mother brought him to the emergency room, telling the nurse that the baby couldn't breathe.

In the N.I.C.U., Rickie improved quickly, and a medical evaluation found no cause for his difficulty in breathing. But the next day, alerted by the squawking of an oxygen monitor, nurses and doctors ran in to find Rickie spluttering and blue. His mother was leaning over him. "See, it happened again," she said.

A pattern emerged. Each time arrangements were made for his discharge, the alarms would ring in Rickie's room and he would be found gasping for air. Nurses noticed Rickie's breathing problems occurred only when Rickie was alone with his mother, and never in the presence of a nurse.

Concerned about child abuse, the N.I.C.U. doctor proposed mounting a small digital camera in an unobtrusive corner of Rickie's room. "I don't like snooping," she said, "but we have a duty to protect that little boy." Not everybody agreed. A senior nurse worried, "How can patients trust us if they realize we are spying on them?"

Patients admitted to our hospital, like other hospitals, receive a written privacy policy stating that personal health information may be shared for medical reasons and "to report abuse or neglect to the appropriate state agencies." Our privacy policy does not, however, warn patients about the use of video or any other specific monitoring technology.

Some uses of surveillance in hospitals are clearly controversial. Nurses in a Los Angeles hospital protested in 2004 that their privacy was violated when hospital officials installed hidden security cameras, including in nursing locker rooms, after a spate of burglaries. In this case, covert videotaping did not seem justified, especially if other means of ensuring security were available.

After doctors in a Veterans Affairs hospital in Tampa, Fla., secretly monitored the family of a brain-damaged patient, the decision was condemned by the chairman of the House Committee on Veterans Affairs, Representative Jeff Miller, Republican of Florida. He subsequently proposed legislation that would "protect the sacred trust" between providers, patients and families from covert video.

Other uses of monitoring are less contentious. Greenwich Hospital in Connecticut conducts video monitoring for patients deemed at risk of falling. Nebraska Medical Center developed an unrecorded video-monitoring system for high-risk patients, such as those on suicide watch. Rhode Island Hospital was required to install recording equipment in operating rooms after multiple mistakes in surgery. And one company, [Arrowsight](#), has developed video-auditing technology to monitor clinician hand-hygiene practices at sinks and safety and cleanliness in operating rooms. These all seem like thoughtful uses.

Protecting children is a well-established justification for video surveillance. In a 2000 [study](#), Georgia physicians reported that covert video monitoring diagnosed far more cases of Munchausen syndrome by proxy — in which parents fake illness in their children — than usual diagnostic testing.

At my hospital, the ethics team decided it would be acceptable to secretly monitor Rickie's room if other methods, like confronting the parents, failed to ensure Rickie's safety. A few days later, Rickie's mother confessed to neglect, and to holding a pillow over his face to keep him from returning home. We never had to videotape Rickie's room, and he now awaits placement in a safer home.

Hidden cameras should be a last resort. Hospitals should notify patients that covert video monitoring may be used in unusual circumstances, and only with the oversight of a hospital ethics committee. Institutions should then track the use of covert video monitoring to ensure that it remains rare and appropriate, while letting hospitals marshal technology to protect our most vulnerable patients.

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