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Lawyers Track Electronic Health Data

By Emma Gallegos

When an Oakland doctor prescribed a blood thinner to a patient in Highland Hospital's emergency room in October 2007, he did something that's increasingly common: he ordered it electronically.

But the doctor hit the wrong button and prescribed the right dose to the wrong patient. Because of the mix-up, Ronald Enskip, the patient who mistakenly received the medication, ended up with permanent brain damage, according to Bruce Fagel, an attorney who represented him in a malpractice suit settled for undisclosed terms last year.

Dosage mix-ups aren't new to emergency rooms, but the electronic systems at play in cases like this are slowly changing the face of medical liability and malpractice litigation.

Problems stemming from electronic health records are becoming so common that lawyers in medical malpractice cases now have a ready-made defense for it: "inputting error."

Fagel said part of the reason that no one caught the error in the Oakland ER is that health care workers, even well-trained emergency physicians and surgeons, are still learning the limits of the technology their profession is incorporating.

"People have a tendency to rely on [computers] when they shouldn't yet," Fagel said, adding that viewing a prescription on a screen gives the false security that it's been double-checked. "The problem is that the people using it don't know when not to trust it."

Some technology firms and medical liability insurers are trying to remedy that by setting up websites to track the trends of errors and near-misses caused by electronic health records.

Digitizing health records has been hailed as the surest way to make the nation's health care system more efficient and to reduce medical errors. Lawmakers built it into the federal health care reform legislation. As a result, a wave of high-tech firms have hammered out new software programs with a push from federal dollars.

Proponents said the simple act of trading in a pen for a keyboard will help cut down on errors caused by sloppy handwriting and inexact notes, and be a much more efficient way of sharing data.

But these new systems could cause a spike in medical errors initially, as doctors learn to adapt to these systems, liability insurers warn.

Alan Lembitz, the vice president of medical liability insurer COPIC, said there likely will be a period of adjustment because even something as simple as knowing whether a file is complete becomes trickier with digital records.

"We use paper in a fairly standard way," Lembitz said. "It's something that's been done for decades, but it's not as easy in the electronic world."

Insurers noted that most doctors nationwide still aren't using electronic medical records, and it will take some time for any trend to be seen in malpractice cases wending through the courts.

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California could be an important testing ground for those concerns, because doctors are ahead of the curve when it comes to electronic records. According to the California Association of Physician Groups, one out of every four of its member groups uses electronic records. The groups that tend to adopt first are larger ones with more infrastructure, like Kaiser Permanente, which recently completed its transition to electronic records.

Bill Spooner, the chief information officer at Sharp HealthCare, which operates seven hospitals in San Diego, described the switch as a long process. Sharp provided its doctors live on-the-job training.

"One of the biggest areas of concern is making sure that providers have the right training so that they understand the limits of their new systems," Spooner said. "Some providers have higher expectations for computer systems than they do for pen-and-paper records, luring them into a false sense of security."

PDR Network is a risk management firm focused on making drug warnings from the Food and Drug Administration easy to integrate into physicians' systems.

According to CEO Edward Fotsch, his group worked with medical liability carriers to launch the website EHRevent.org, which was approved by the FDA to take reports of faulty design systems without worrying about legal action.

"Liability carriers are strong proponents of [electronic health records] adoption, but like any new system there's a learning curve," Fotsch said.

Plaintiffs' attorneys said some electronic health records systems harbor design flaws that could cause serious medical errors if left uncorrected.

For example, instead of leaving space for a doctor to take notes during an office visit, some software programs provide checklists that lead doctors through a template, according to Philip Michels, a plaintiffs' attorney with the Law Offices of Michels & Watkins.

"Even though it's easier to read words or boxes, you have what feels like inadequate descriptions of the problems," Michels said.

Some software doesn't include patient names on every page printed out, which means that records could easily get mixed up. Others make it easy for a doctor to take shortcuts that lead to mistakes - like copying and pasting the notes from a previous patient with a similar case and forgetting to change the relevant details.

Electronic records also are expected to change the way malpractice attorneys try cases. Because the records are less descriptive, it's harder to get a sense of what caused an error, which can hurt a doctor's case, Michels said.

But computerized systems can show a record's legitimacy. If someone tries to change records after the fact, those changes' dates will be noted in a computer system.

As for the growing "input error" defense, attorneys said it is an attempt to shift blame away.

Dr. Bradford S. Davis, an in-house medical director at Michels & Watkins, said he doubts juries will be sympathetic to this explanation if it causes a serious error.

"Once a jury sees that they're sloppy, and spending less time with patients and more time clicking on a computer, I think it helps us and hurts doctors," Davis said.

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