A COSTLY TRANSCRIPTION ERROR

Many people relying on critical medical care are injured or killed because of mistakes made in writing down or transcribing their medical information. In a complicated case that took more than four years to prepare for trial, plaintiff's attorneys revealed the circumstances that led to the needless death of a former patient of a hospital in Alabama.

The woman was discharged from the hospital and was to be transferred to a rehabilitation facility. Unbeknownst to her treating physician, the discharge summary he dictated was outsourced by the hospital and ultimately transcribed in another country. The transcript contained three critical errors, including the dosage of Levemir insulin, which was written incorrectly as 80 units rather than eight (10 times the prescribed dose).

The plaintiff's attorneys alleged the hospital violated its own procedures and multiple national patient safety standards by using the unreviewed, unsigned discharge summary to write the patient's new rehab facility admission and medication orders. Shortly after her admission to the rehab facility, the patient was given a fatal dosage of insulin based on the paperwork the hospital had sent to the rehab facility. The medication caused an irreparable brain injury that resulted in cardiopulmonary arrest. The woman never regained consciousness and died.

The hospital had authorized its U.S.-based transcription service to use overseas transcription to save 2 cents per line. Testimony at trial revealed that employees of the U.S.-based transcription company were highly critical of the poor accuracy of the transcription work performed overseas. But, instead of instituting better quality control procedures, these employees were replaced with overseas reviewers. Consequently, no one in the United States reviewed the transcripts for critical errors before they were provided to the hospital. Even after the patient's death, the hospital continued its relationship with the transcription company for two more years.

The jury was clearly outraged by the circumstances that led to the patient's death. Jurors deliberated only one hour and returned a huge verdict of twice what the plaintiff had asked for –

an extremely rare occurrence.

As the population ages, and the landscape of U.S. healthcare continues to change, many challenges lie ahead. As exemplified in this case, medical facilities will have to figure out ways to communicate better with one another about the care and condition of transferred patients. Medical facilities will also continue to face the challenges of keeping their costs down to keep healthcare affordable for patients, while also ensuring patients receive high-quality care. Clearly, this quality control must include assurances that doctors' orders are accurately transcribed – regardless of where the transcription occurs.

Be alert if you or one of your loved ones is being transferred from one medical facility to another. It is a situation that comes with some inherent risks. Ask if the patient is being transported by skilled and experienced personnel with medical training. Ask if the new facility has received the patient's complete medical chart from the transferring facility before any care is implemented. Ask whether the doctor's orders have been transcribed *and verified* before the new facility begins any treatment. Errors occur – it is a fact of life. But, advocating for yourself or someone else by asking questions is one way to help catch critical errors before the consequences become disastrous.

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Nothing in this article should be construed as legal advice. You must consult with an attorney for the application of the law to your specific circumstances.

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