

CORRECTIONAL HEALTH CARE REPORT

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Electronic Medical Records: Moving Jails Forward

Darrelle Knight

It is obvious that we live in the Age of Technology. Nevertheless, technology for health information has evolved slowly over the past three decades, compared to systems for other industries. The importance of concise, assessable medical records continues to be a goal for the health care industry, in theory best accomplished through the use of an electronic medical records (EMRs) system.

The usefulness of such a system has been emphasized in the political arena. Both of the 2008 presidential candidates talked about the importance of electronic medical records. John McCain praised the Cleveland Clinic's electronic medical records system, noting that "technologies like this could reduce errors, alert doctors to best practices and might even lower medical malpractice insurance premiums" (Vanac, 2008). As part of his initiative to reform health care, Barack Obama said his administration would invest \$10 billion dollars over the next five years to help transition U.S. healthcare to a standards-based electronic health information system, which includes electronic health records (Obama, 2008).

Health information technology has also created new employment opportunities. As the United States moves forward to implement electronic medical records, the ever-evolving fields of health care and information technology are merging to offer exciting new jobs. According to the U.S. Department of Labor, employment of medical records

and health information technicians is expected to increase 18% a year through 2016—faster than the growth for all other occupations—because of the rising number of medical tests, treatments, and procedures that will be increasingly scrutinized by health insurance companies, regulators, courts, and consumers (Bureau of Labor Statistics, 2008).

A benchmark study, conducted by researchers from the RAND Health Corporation and published in *Health Affairs* in 2005, is widely referred to within health economics literature to support the need for electronic medical records. Overall, the authors of the study found that EMRs could save money by reducing redundant care, speeding patient treatment, improving safety, and keeping patients healthier (RAND, 2005). In a separate study by RAND published in the same issue, authors stated that incentives from federal officials could encourage medical providers to adopt more advanced drug prescription systems (RAND, 2005).

In July 2008, the House of Representatives and Senate overrode President Bush's veto of H.R. 6331: Medicare Improvement for Patients and Providers Act of 2008. This law will raise Medicare payments to physicians who "e-prescribe." The increased payments will take effect in 2009 and taper off by 2013. It will also enforce Medicare payment penalties beginning 2012

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Substance Abuse Awareness Program

David Gillert and Susan J. Dean

It is well recognized that abuse of drugs and alcohol is often at the root of criminal activity, affecting the safety and quality of life of citizens everywhere. It is also widely accepted that 80% or more of all offenders are substance abusers. Recovery from addiction or endless incarceration—the choice seems simple. However, the addicted offender continues on the vicious cycle of substance abuse, crime, and incarceration.

Stopping the cycle is the goal of the Palm Beach County Sheriff's Office's Substance Abuse Awareness Program (SAAP). SAAP is a unique, collaborative effort among the Palm Beach County Sheriff's Office, State Attorney's Office, Public Defender's Office, the Judiciary, Clerk's Office, and the Florida Department of Corrections' Probation and Parole Division, among others. Beginning with the original programming concepts in 1990, these key criminal justice agencies worked cooperatively in the development of the SAAP consortium.

The roots of SAAP go back to 1991, when the Palm Beach County Sheriff's Office opened the Sheriff's Drug Farm. In an intense therapeutic community, incarcerated substance-abuse offenders were (and still are) managed under strict military discipline. Starting with 15 male offenders, the Drug Farm has grown to treat up to 96 males and 18 females who suffer from substance-abuse addiction.

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for physicians who do not e-prescribe (Dunham, 2008).

Through the Medicare Modernization Act of 2003, Congress mandated the Institute of Medicine "to carry out a comprehensive study of drug safety and quality issues in order to provide a blueprint for system-wide change."

Illegible handwriting is one of the most common problems pharmacists encounter.

The study, released July 2006, revealed that at least 1.5 million preventable, adverse drug events occur in the United States each year (IOM, 2006).

The overwhelming number of documented medical errors are from hospitals and other inpatient settings, not necessarily because they make more mistakes but because their errors are easier to track. It is considerably more difficult to conduct such studies in outpatient centers. In one notable study, researchers reviewed death certificates over a 10-year span and concluded that the number of deaths because of medication errors increased 2.57-fold from 1983 to 1993. The number of deaths resulting from outpatient mistakes increased 8.48-fold (Phillips, 1998).

Illegible handwriting is one of the most common problems pharmacists

encounter. Physicians' handwriting is often a source of laughter; however, statistics reveal no humor in prescriptions and other physicians' orders that are sloppily written. In 2000, the increasing number of medication errors prompted the Institute for Safe Medication Practices to encourage the elimination of handwritten prescriptions within three years. Eight years later, the organiza-

tion continues to push for electronic prescribing.

According to the Institute for Safe Medication Practices, pharmacists make more than 150 million calls a year to physicians to clarify prescriptions (ISMP, 2000). This is a time-consuming process that takes physicians away from their patients and delays the moment at which patients receive medication. Illegible handwriting can also lead to obvious mistakes, such as a patient receiving an incorrect dose or dosing frequency.

Cost Containment

Every medical error can be potentially fatal and create expenses that may be preventable. With EMRs, health care providers use centralized patient information. The fact that most electronic

software allows providers to access information onsite or from remote locations enables these providers to make improved health care decisions (Haas 2007). And because physicians, nurses, pharmacists, lab technicians, and other allied healthcare professionals can access the same information, they can better communicate among each other to optimize patient care. Streamlining such information also leads to more efficient care, cost containment, and a possible reduction in liability.

Advertisements for attorneys representing clients who have had adverse reactions to medications or have been harmed by medication errors have become just as prevalent as commercials for cars. Reducing liability is always a concern in health care systems, but correctional facilities must be particularly vigilant about this because they have a particularly high risk for litigation. Each patient in a correctional institution is already linked to an attorney.

Failure to document can be the deciding factor in a lawsuit, and lost documents can be particularly detrimental. Every day, hundreds of health care workers simply place lab orders, results, and other important health information in patients' charts without securing them. This practice increases the risk of putting the information in the wrong patient's chart, of orders falling out of the chart, or of orders being overlooked. EMRs ensure that patients' information

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processes to do so. Instead, 37% of them reported using informal processes, like officer observation or inmate self-reports. Only 41% reported that the intake processes, including IDD screenings, took place in private. They pointed out that inmates are reluctant to disclose their IDD publically, due to the victimization that can follow if their weakness is exposed to other inmates.

Seventy-nine percent reported that intake procedures were performed by jail officers. Among the jails that required screenings, 83% of them were conducted by jail officers. This is an important point because the officer training was typically limited to the state's detention-officer-certification course, which only includes two sections on IDD-related issues. Only 35% of the respondents indicated that their jail staff received any additional training on mental disorder or disability.

Additional analysis revealed that participants with medical backgrounds were significantly less likely to report no IDD than participants without medical backgrounds. Also, participants that conducted IDD screenings were significantly more likely to have medical backgrounds. Finally, participants from smaller jails were significantly more likely to report no IDD than participants from larger jails.

Conclusion

Participants seemed to have severely underreported IDDs, judging from data found in the literature. This underreporting may indicate that screening processes, if conducted at all, are not conducted consistently or reliably. The training of jail personnel should be enhanced to give them additional experience with identifying and handling cases of IDD. Moreover, better training to differentiate IDD from mental illness is needed; in fact, the authors should have provided a few distinguishing

facts and explanations in their article, following the criticism that most personnel cannot distinguish between the two.

In sum, the authors suggest that a bridge between research and practice be built with regard to IDD screening processes. Much research suggests which tools and procedures are most effective for IDD screening in various settings. However, the information on best practices does not appear to be heavily utilized among this particular sample of jail personnel. Of course, this study of 80 individuals in North Carolina is limited in its generalizability to other geographic locations, though the results are useful towards developing training and policies regarding jail administration in that state. Enhancing the screening procedures will help better identify inmates with IDD and will therefore allow additional measures of protection, aid, and treatment to be provided for this vulnerable population. ■

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is centrally located and readily accessible.

Physicians often write orders requesting that patient charts be "thinned." The electronic system stores all of the patients' data on servers, therefore, eliminating the tedious and time-consuming task of rummaging through binders several inches thick to find one document. This system not only gives health care workers an opportunity to provide a continuum of care, it may also be instrumental in preventing a case from ever reaching litigation.

In any health care organization, the pharmacy plays a large role in controlling costs, directly and indirectly. For the purpose of this article, direct costs will be described in terms of concrete costs a facility spends on drug purchasing. These costs are fully quantitative, tangible costs that directly affect budget control. Indirect costs will be described as qualitative, intangible costs that can be prevented by pharmaceutical staff and other health care personnel.

A formulary is one of an organization's most helpful tools for control-

ling costs. Using generic drugs is an obvious way to cut costs, though some medications that lie outside of the formulary will always be required. Careful consideration must be taken during the compilation of a formulary. Size, drug variations, new drugs entering the market, and therapeutic substitutions must all be considered, but in such a way that does not interfere with health care practitioners' medical judgment. Formularies often vary widely, according the type of services an organization offers. They are meant to ensure excellent patient care while maximizing an organization's budget. A drug database loaded with restrictions on nonformulary options can remind physicians to try formulary options before moving on to nonformulary drugs that are often more costly.

Pharmaceutical staff can help facilities avoid costs and improve care by reviewing patient profiles. No reliable indicators exist for predicting which patients will have an adverse drug reaction or what their severity will be, but preventive measures can help reduce the likelihood of such events. All medications have side effects and the potential to cause

adverse reactions; however, certain therapeutic classes of drugs command more attention.

In 2003, Wenchen Wu and Nicholas Pantaleo published data they collected on outpatient adverse drug reactions that required hospitalization. They found that the average length of stay for these patients was about 8 to 10 days and

Table 1: Summary of Data From Wu and Pantaleo's Study

Therapeutic Class	Percent of Occurrences
Antidiabetic Agents	28
Anticoagulants	15
Anticonvulsants	10
Beta-Blockers	8
ACE Inhibitors	8
Analgesics	6
Cardiac Glycosides	6

Source: Adapted from *Am J Health-Syst Pharm* 60(3): 253-259, 2003.

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that the average charge per patient was \$9,491, with room and board accounting for 50% of the total charges. It is also interesting to note that 45% of the patients were 75 years or older. Of the 24 therapeutic classes involved, seven accounted for over 80% of the reported adverse drug reactions. The results are summarized in Table 1 (Wu, 2003).

The Agency for Healthcare Research and Quality (AHRQ) summarized data from several studies on adverse reactions and ways to reduce the associated hospital costs. The AHRQ found several target classes were often involved in adverse reactions: antibiotics, analgesics, electrolyte concentrates, cardiovascular drugs, sedatives, antineoplastics, and anticoagulants. The agency also identified several common, preventable medical errors. Illegible orders, duplicate therapy, drug-drug interactions, and inadequate monitoring respectively accounted for 6%, 5%, 3-5%, and 1% of medical errors (AHRQ, 2001).

According to the AHRQ, one hospital estimated that it could reduce its costs by \$270,000 by relying on pharmacists to assist physicians with prescribing and by educating other health care providers on medication use and safety (AHRQ, 2001).

An integrated computer system that connects pharmaceutical, lab, and other patient information completes the continuum of health care and maximizes efficiency of the organization's personnel. An AHRQ-funded study at the LDS Hospital in Salt Lake City found that when pharmacists notified physicians of patient allergies, the physician changed to a different drug 99% of the time. This monitoring resulted in only eight Adverse drug events (ADEs) from allergic reactions. The study also suggests that pharmacists can help prevent ADEs from excessive or incorrect doses by monitoring patient doses and drug levels (AHRQ, 2001).

Observation of Private Data

Data collected from a private organization that provides health care to correctional facilities nationwide suggests that monitoring by pharmaceutical staff and restrictions to formulary drugs helped a facility with an average daily population of 3,300 reduce its total drug costs by over \$219,000 from October 2005 to September 2008. Pharmaceutical staff reduced the cost of nonformulary drugs, which were 29.8% of the total cost in 2005, to 18% by 2008. This saved the facility \$226,888 in nonformulary drugs over the three-year period. The data is summarized in Table 2.

From a remote location, pharmacists with this health care organization examined all the facility's pharmaceutical records electronically. They examined the profiles of all inmates who reported a list of medications during the booking process. Whenever a profile was modified (e.g., a new medication is added), the change was transmitted to the pharmacist queue, which was reviewed for duplicate therapies, allergies, drug interactions, dosing irregularities, and adherence to the formulary standards approved by the facility's Pharmacy and Therapeutics Committee. Pharmacists also monitored for medications that are just as effective when they are given twice daily as when they are three times daily and for extended release dosing or patches that can be used instead of immediate-release dosing. The organization's pharmacists reviewed an average of 4,700 profiles and make an average of 95 recommendations each month for this facility.

Because the recommendations by pharmacists like those in this study are not part of inmates' medical record, physicians readily accept of them. At one facility, the average charge per patient hospitalized with an ADE was \$9,491 (Wu, 2003). If 10 of the pharmacists' recommendations were accepted by the physician at this facility—and prevented an inmate's subsequent hospital admission—the facility could save over \$90,000 a month in averted costs. Of course, this is not a concrete estimate because each patient and outcome is highly variable. This estimate also excludes the costs associated with possible legal liabilities that can result from ADEs.

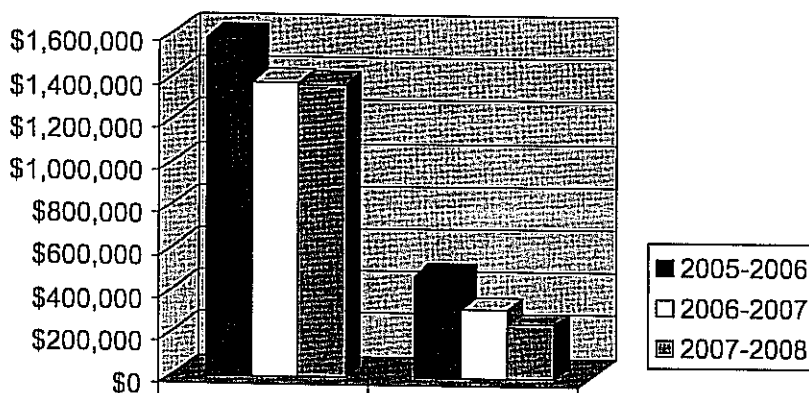
National Commission on Correctional Health Care (NCCHC) Standards

The NCCHC has promulgated several standards for health records. Among the *essential* ones are standards for their recording, format, and confidentiality. Access to custody information and management of health records are among the standards NCCHC categorizes as *important*. As the world moves forward with the speed of technology, health care must move along with it. EMRs are not only helpful for streamlining health care, they support a "green" initiative, because less paper means less waste.

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Table 2: Drug Cost Comparison

Drug Cost Comparison 2005-2008



	Total Drug Costs	Cost of Nonformulary
■ 2005-2006	\$1,590,758	\$474,192
□ 2006-2007	\$1,382,178	\$320,560
▒ 2007-2008	\$1,375,962	\$247,308

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The NCCHC has a minimum of compliance indicators that each inmate's health record must meet. Identifying information, laboratory reports, medical administration records, medical diagnoses, consent and refusal forms, and known allergies are just a few of them (NCCHC, 2008). If each medical discipline's records are kept separate (e.g., mental and dental records), a process must ensure collaborative care. Pertinent patient information must be accessible to each health care giver caring for the inmate. With EMRs a provider (or designee) can enter medication orders, progress notes, lab reports, and other pertinent information at the point of care, creating a collective record that ensures improved patient care and that is preferred by the NCCHC. Caregivers can also have immediate access to information, without transferring charts to several locations and risking losing orders. EMRs should be restricted so two users cannot enter orders at once, but they should allow several users to view patient information simultaneously.

The NCCHC accepts electronic signatures for documentation. It also recommends that all health records be standardized to fit a homogenous structure. All staff must be trained to provide records in this form, and this training can be time consuming and costly as new employees are hired. EMRs are typically loaded into a database and structured so that all orders follow the same format.

Another optional recommendation from the NCCHC is to place an inmate's problem list at the beginning of his or her chart. EMRs allow prominent information to be put in clear, organized displays. Dashboards, tabs, drop-down lists are just a few methods that can ease navigation through an electronic chart. It is also simple to track inmate's transfers throughout facilities and to court by a few simple clicks.

The US Department of Health and Human Services created the Privacy Rule to establish the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as a requirement to protect patient medical information while allowing flexibility in transmitting it. Repercussions for noncompliance with HIPAA regulations may include civil

monetary penalties and criminal penalties. The NCCHC requires complete compliance with HIPAA regulations because this is an *essential* standard.

The NCCHC suggests that health care providers use passwords to protect inmates' medical records because passwords allow more thorough monitoring and control. Facilities must also prove that staff members have been educated about maintaining inmates' confidentiality (NCCHC, 2004). Records of this education can be easily accessed if the facility's software is programmed to instantly construct a database based on the as staff's electronic signature as they complete HIPAA education requirements.

Because hard copies of inmates' health records may be accessed by unauthorized personnel, failing to secure these

If an inmate returns to a given correctional system, timely reactivation of his or her previous medical records can give clinicians a comprehensive account of the patients' previous problem list. The NCCHC also suggests that patients with known critical or chronic conditions be flagged to expedite their immediate referral to a health care provider (NCCHC, 2004). This can be accomplished with EMRs by sending profiles of these patients directly to a "critical queue" that immediately prompts health care staff that the inmates needs urgent care.

The NCCHC's 2008 Standards for Health Services addresses 20 *significant* changes pertaining to health care; however, only four are paraphrased in this article. Standard B-02 is intended to motivate facilities to implement systems

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records may violate federal laws protecting patients' rights. Therefore, medical records must be maintained under secure conditions and kept separate from inmates' correctional records. This can be accomplished by using only one software program to assign user privileges and limiting access to those privileges. Using a single program can avoid the training, costs, and maintenance associated with using several such systems within a facility. It can also benefit health care professionals who must access search inmates' arrest and custody records for information about their violent behaviors, drug and alcohol abuse at time of their arrest, and mental conditions.

Another standard characterized as *important* by the NCCHC is the Management of Health Records, which indicates that health records and summaries may accompany inmates when they transfer to other correctional facilities. Record retention must be followed according to the jurisdiction's legal requirements, and reactivated records must be provided in a timely manner when a health care provider requests them (NCCHC, 2004).

The NCCHC recognizes that readily accessible health records from collaborative clinicians improve patient outcomes.

that improve clinical outcomes. Systems that refer inmates requiring immediate attention to clinicians, the prevention of medication errors, and error-reporting mechanisms are examples.

Standard E-04 is considered a *significant* change. It allows two options for conforming to health assessments of inmates. The first is to perform a health assessment on all inmates. The second allows the responsible health authority to perform individual health assessments on inmates when there is a clinical indication. These options are available for sites with 24/7 onsite health staff. Clinical indications can be discovered during intake screening or as clinical changes develop during the inmate's tenure in custody.

Standard E-12 addresses continuity of care during incarceration and includes periodic screenings, clinical chart reviews as a requirement, and episodic illness. Standard G-01 requires comprehensive treatment for patients who need chronic care. These requirements should be in accordance with nationally and clinically accepted guidelines for treating condition and preventing further complications. Conditions include

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diabetes, hypertension, HIV, epileptic disorders, and mental illness.

The transition of all of the aforementioned changes to standards can be implemented with EMRs. Paper charts can make the transition process for the required changes cumbersome and tedious. Electronic systems can reduce human error by preventing medication errors. For example, hard copy of inmates' appointments for medical attention can be carelessly misplaced—EMRs reduce this possibility by adding the appointment date to the clinicians' calendars and queues for scheduled dates. They can also flag patients with chronic conditions and those who need health assessments. Once these patients are categorized by condition, it is simple to track data within the facility and contribute to community health statistics as inmates are released.

Author's Note

Overall, EMRs should be simple to use, unified, uniform, and easily accessible by authorized personnel. They should produce hard copies upon request. In case of power or system failure, a backup source in a remote location should provide health records in a timely manner. EMRs also give medical staff prompt access to previous booking records so they can have a complete picture of inmates' previous conditions and medications. The software should also be designed to reduce human error and enhance clinical outcomes.

There is limited research or subsequent data suggesting that computerized

medical records would be beneficial within correctional facilities. Most of the literature reviewed for the purpose of this article was based on data collected from hospitals, large health care facilities, and physicians' offices. It should be noted that it is not the author's intent to insinuate that any of the benefits mentioned within the course of this article will be realized by correctional facilities providing health care to inmates. Rather, this represents the author's attempt to open discussion about possible advantages and rewarding outcomes that could result from correctional facilities implementing an EMR system.

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did indicate a preference for deliberate indifference claims to be supported by expert testimony, the concurring opinion noted that Bias' "obvious and emergent condition" placed this case outside of the general rule.

Circuit Judge Owen filed a vigorous dissent from the majority and concurring opinions, asserting that there was "absolutely no evidence that Dr. Sabater was negligent in her diagnosis and treatment of Michael Bias, much less evidence that Sabater was deliberately indifferent

to a substantial risk of serious harm to Bias." While acknowledging that expert testimony is not required in every case, the dissent pointed out that Bias was the only witness at trial and that he was not qualified to judge the appropriateness of his transfer, "nor are federal judges, learned though they may be."

This judge was quite troubled by the fact that the lower court apparently based its finding of deliberate indifference "largely, if not entirely" upon what was observed on the videotape." She maintained that the seriousness of Bias' condition and the risks in transferring him to

another facility "were not matters about which a layperson has knowledge" and a layperson should not make such determinations. Thus, the case under consideration was, as described in *Estelle v. Gamble*, "a classic example of a matter for medical judgment." In conclusion, the dissent stated: "This is not a close case, and I must say that I am mystified by the reaction the videotape in this case has engendered."

Comment: Upon further appeal, the U.S. Supreme Court in Sabater v. Bias, 2990 U.S. LEXIS 416 (January 12, 2009) declined to hear the case. ■