Joint Statement Against Criminalization of Medical Errors

Monday, May 2, 2022

Like all members of the medical community, we at the American College of Medical Toxicology, American Academy of Emergency Medicine, and American Academy of Clinical Toxicology were saddened to learn of the tragic death of a patient in Tennessee due to a medical error. A nurse at Vanderbilt University Medical Center mistakenly administered a drug that paralyzes muscles- including those needed for breathing-instead of a sedative, directly contributing to a patient's death.

As physicians and toxicologists with expertise in pharmacology, medication safety, and public health, we were disturbed when this nurse was convicted of criminally negligent homicide and gross neglect of an impaired adult [1]. As a result, the nurse faces a criminal record and the possibility of time in prison. Medical errors have been addressed with loss of employment, license suspension from nursing and medical boards, and malpractice charges in civil court, but the use of criminal charges sets a dangerous precedent. Since the 1999 IOM report "To Err is Human," it has been clear that patient injury and deaths from medical errors are all too common and medication errors are the most common cause [2]. Errors are systemic failures; usually with multiple factors contributing to the event. Although individuals should be responsible for their own actions, errors are rarely the fault of one person. Although in this case the nurse had overridden warnings that she was withdrawing the incorrect medication, a "cabinet override," the practice of bypassing a pharmacist's review of the prescription to rapidly withdraw a medication from a drug cabinet, may be indicated in an emergency to help a patient. We support an approach that addresses medical errors from a systems perspective, recognizing that they are rarely an intentional act or the failure of one person.

An approach that focuses on punishing individuals does not improve patient safety because it does not address the underlying system factors that led to the error. To prevent errors, we need to empower individuals to report errors, unsafe conditions, and "near misses" in order

to improve processes. Addressing problems before they reach the patient decreases error and reduces harm. In fact, an emphasis on blame and punishment for errors stands in opposition to safety efforts because individuals may avoid reporting errors out of fear of retaliation. Electronic charting systems have tools to facilitate easy reporting. When team members feel that errors place them at risk of punitive measures such as losing their job -or worse consequences- they do not disclose them. We learn from errors when team members feel safe to report them.

We support systems of accountability that address errors punitively only when behavior is truly reckless- when employees make a conscious choice to disregard substantial risks. This “Just Culture” approach recognizes that most errors are system(s) issues and can usually be corrected by coaching and engaging members of the health care team for solutions and consoling them when human error occurs [3].

Further, we are concerned that perpetuating a punitive culture will discourage individuals from choosing careers in health care. Experts forecast a shortage of primary care physicians [4]. There are currently not enough people entering nursing to meet demand. We know that the lack of qualified nurses is associated with increased infection, hospital stays, and even death [5]. By driving people away from the health professions, criminal punishment of care providers will discourage individuals from pursuing these careers, causing harm to patients.

We recognize that medical errors are common and largely preventable, although some are inevitable. The American College of Medical Toxicology, American Academy of Emergency Medicine, and American Academy of Clinical Toxicology condemn the criminalization of medical errors. We join the American Association of Critical-Care Nurses, American Nurses Association, Tennessee Nurses Association, American Hospital Association, American Organization for Nursing Leadership, Academy of Medical-Surgical Nurses, American Society of Health-System Pharmacists, American College of Emergency Physicians, and others who have issued statements in opposition to this practice [6-11].

We support an approach to patient safety that supports continuous surveillance and quality improvement along with the ability for team members to disclose near misses and errors. In most cases, errors are prevented by fixing systems and fostering a culture of collective responsibility rather than individual responsibility. Individual errors can usually be addressed by coaching and team member engagement. A culture that coaches and encourages team members will make health careers desirable and ensure that there are sufficient health care professionals. Civil courts play a role in addressing errors when there is a breach in the standard of care and a need to recover damages, but criminal punishment should be a last resort for rare instances of intentional recklessness.

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