**TO ERR**
*Is It Criminal?*

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# TO ERR: IS IT CRIMINAL?

## I. INTRODUCTION*

"Health Officials Label Accused Nurse a 'Threat'."[1]

The nurse who is the subject of this headline had her life and career turned upside down by being accused of a crime for giving a patient vercuronium instead of Versed. She intended to give Versed. She tried to use the hospital's electronic drug dispensing cabinet to obtain Versed. The cabinet failed to dispense. The nurse had to use an override to obtain the medication and typed the first letters of Versed, "VE". A drop down menu of medications was offered. She carelessly selected vercuronium and administered it to the patient without realizing the error. This was an act of professional negligence. However, was it a crime?

Versed, the intended medication, is a sedative. The patient received vercuronium, a paralyzing agent instead of the sedative. The paralyzing agent caused the patient's death. On realizing the wrong medication was administered, the nurse told the physician caring for the patient of the error she had made.

Nurses use the electronic drug dispensing cabinet every day. Had there been no physical consequences to the patient from the nurse's inadvertence, no one most likely would have noticed. She never would have been labeled a criminal, and her career would not have been ruined.

While it is horrible the patient died, the unending damage to this nurse is evident. Investigators with the Tennessee Department of Health claim that the nurse is a "threat to the

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* *This article is submitted with great appreciation to my assigned mentor, Mr. Randall Kinnard, for his enthusiasm, guidance and unending patience over the preceding two years.*

1 Brett Kelman, *Health Officials Label Accused Nurse a Threat,* The Tennessean (Mar. 9, 2020), at 3A.

public" and it is a "scary prospect" that she now has a non-clinical job with another hospital.[2] Two years earlier, the same state agency that now calls the nurse a "threat to the public" found that the nurse had not violated any statutes or standards of nursing and closed its case. That prior finding allowed the nurse to continue to work as a nurse without limitations.[3] Now, she will stand trial as an accused criminal.

The facility did not report the case to the Department of Health as required.[4] The death certificate indicated the death was "of natural causes".[5] For reasons unknown to the public, the same state agency that found no standards of care were violated reversed itself.[6] The nurse has now been indicted on charges for the crimes of reckless homicide and impaired adult abuse.

The Institute for Safe Medication Practices (ISMP) is known and respected as the gold standard for medication safety information. In 1996 in Colorado, at a trial for a nurse indicted on the charge of negligent homicide related to a medication error, the ISMP supported the nurse by providing expert testimony after completing an in-depth analysis of the medication error. Staff from ISMP identified over 50 system failures that contributed to the development of the error, allowed it to remain undetected, and, ultimately, reach the patient.[7] The jury found her not guilty.

In our case under discussion here, the Centers for Medicare and Medicaid Services (CMS)

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2 *Id*.

3 *Id*.

4 Brett Kelman, *Review Details Failures in Vanderbilt Reporting,* The Tennessean (Dec. 15, 2019), at 22A.

5 *Id.*

6 Kelman, *supra* note 1.

7 Judy l. Smeltzer, RN, BSN, *Beyond Blaming Individuals: Lesson From Colorado*, 98 Nursing98 48, 48-51 (1998) (discussing system failures).

required the facility to implement a corrective action plan based on their audit findings. How then in our case is criminal culpability assigned only to a nurse?

## II. NURSING, MEDICATIONS AND QUALITY CONTROL

In 2017, the World Health Organization (WHO) estimated medication errors caused at "least one death every day" and "injured approximately 1.3 million people annually in the United States of America" alone.[8] The Institute of Medicine (IOM) reported in 2011 that total costs of medical errors had risen to an estimated $17-29 billion every year.[9] By 2017, the WHO estimated the cost associated with medication errors at $42 billion annually.[10] It is widely reported that medication errors are the most common and preventable cause of patient injury. Throughout health related publications, medical errors are frequently cited as the third leading cause of death in America. Other leading causes of death are consistently reported to be heart disease, cancer, and other natural causes.[11]

Society in general, and the Tennessee Legislature specifically, want to ensure the delivery of the best medical care possible for the citizens of Tennessee. The Tennessee Department of

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[8] World Health Org., *WHO Launches Global Effort to Halve Medication-Related Errors in 5 Years (Mar. 29,2017)*, https://www.who.int/news-room/detail/29-03-2017-who-launches-global-effort-to-halve-medication-related-errors-in-5-years.

[9] Inst. of Med. 2000. *To Err Is Human: Building a Safer Health System*. Washington, DC: The National Academies Press.

[10] World Health Org., *supra*.

[11] U.S. Dep't of Health & Hum. Res., *Healthy People 2020: Leading Health Indicators* (Feb. 19, 2020), https:www.healthypeople.gov/2020/leading-health-indicators/infographic/injury-and-violence.

Health is the primary state agency responsible for overseeing the health of Tennesseans. The department enforces the Practice Acts of each health profession through the oversight of professional licensing boards.

The Tennessee Board of Nursing was created in 1911. Its mission is to safeguard the health, safety and welfare of Tennesseans by requiring that all who practice nursing within this state are licensed.[12] Tenn. Code Ann. § 63-7 outlines the powers and duties of the Board. Its core responsibilities focus on three broad areas—licensure, education and practice.[13]

The Board specifies the minimum curricular and standards for schools of nursing and for courses of training for licensure.[14] It bears the additional responsibility to approve the nursing schools and courses that meet the requirements, rules and regulations of the Board. Within the role of managing licensure, the Board administers examinations to determine the qualifications and fitness of applicants and issues licenses to applicants who successfully pass the examination for the practice of professional nursing or practical nursing.[15] Other responsibilities of the Board include the planning and oversight of continuing education to assure continuing competence of licensees.

The Board is also responsible for conducting hearings for possible license suspensions or revocations.[16] Any action or ruling by the board is subject to review by the courts of this state.[17]

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[12] Tenn. Dep't of Health, *About the Bd. Of Nursing*, https://www.tn.gov/health/health-program-areas/health-professional-boards/nursing-board/nursing-board/about.html.

[13] *Id*.

[14] *Id*.

[15] *Id.*

[16] Tenn. Code Ann. § 63-7-207(10) (2020).

[17] *Id*.

The Board of Nursing has the power to refer a file for criminal investigation any time the board has a concern regarding the behavior patterns of a nurse.[18]

Tennessee implemented the Health Data Reporting Act of 2002, codified in T.C.A. § 68-11-211 and amended in 2011, which requires the reporting of an unusual medical event to the Tennessee Department of Health.[19] The goal of the reporting requirement is to assist health care providers and the Department of Health to work together.[20] This is designed to facilitate the collection of meaningful health care data used to minimize the frequency and severity of unexpected events and improve the delivery of health care services in Tennessee.[21]

The ISMP is a national nonprofit organization devoted entirely to preventing medication errors.[22] For over 30 years, ISMP has been committed to making a difference in millions of patients' lives and supporting the healthcare professionals who care for them.[23] ISMP maintains the only national voluntary medication error reporting program anyone anywhere can access to report an error.[24] The newsletters they publish report real-time error information, read and trusted by the global healthcare community. ISMP recently joined with the Emergency Care Research Institute (ECRI). In 2008, ECRI was designated a Patient Safety Organization (PSO) by the U.S. Department of Health and Human Services under the Patient Safety and Quality Improvement Act

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18 Tenn. Code Ann. § 63-7-122 (2020).

19 Tenn. Code Ann. § 68-11-211 (2020).

20 Tenn. Code Ann. § 68-11-211(b) (2020).

21 *Id.*

22 Inst. for Safe Medication Practices, https://www.ismp.org/about (last visited Dec. 6, 2019).

23 *Id.*

24 *Id*.

of 2005.[25] Together they form one of the world's largest healthcare quality and safety entities and work closely together for the benefit of all health professionals, patient advocates, governments and patients.[26]

ISMP's advocacy work alone has resulted in many positive changes in clinical practice, public policy and drug labeling and packaging. As a result of our case nurse's error, they included safety recommendations in their publication *2020-2021 ISMP Targeted Medication Safety Best Practices for Hospitals*.[27] These safety recommendations specifically address automated dispensing cabinets (ADC). As a best practice, the recommendation is to limit the types of medications that can be removed from an ADC using the override function.[28] In addition, it is recommended to require a medication order prior to removing any medication, including those removed using the override function.[29]

Like ISMP, many members of the health care community argue that the criminalization of medical mistakes is not only unfair, but also dangerously counterproductive. The American Medical Association and the American Nurses Association (ANA) first released a joint statement in July 2007 regarding their concern about criminalizing decisions concerning patient care. In response to our nurse being indicted, the ANA said, "Health care is highly complex and ever-changing resulting in a high risk and error-prone system. However, the criminalization of medical

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[25] ECRI, https://www.ecri.org/about/ecri-history-trusted-voice-healthcare/ (last visited Dec. 6, 2019).

[26] Inst. for Safe Medication Practices, *supra*.

[27] 2020-2021 ISMP Targeted Medication Safety Best Practices for Hospitals, https://www.ismp.org/sites/default/files/attachments/2020-02/2020-2021%20TMSBP-%20FINAL_1.pdf.

[28] *Id*.

[29] *Id*.

errors could have a chilling effect on reporting and process improvement."[30] How does the punishment of a nurse serve the public? Perhaps it creates a culture of abandonment and isolation of the "second victim", i.e. the nurse.[31] Does potential criminal punishment promote the message, "keep quiet whenever you can?"

Death to any patient as a result of a clinical error is a tragedy. The IOM defines a clinical error in their publication, *To Err Is Human: Building a Safer Health System*, as "the failure of a planned action to be completed as intended or the use of the wrong plan to achieve an aim."[32] Medication administration usually involves other technology, multiple professionals and a series of procedures beyond one nurse completing the task. In our case study, the hospital had a system failure by offering to the nurse "Vecuronium" directly above "Versed." Such close proximity begs for human error by the nurse.

## III. CRIMINAL LAW AND WORKPLACE DEATHS

In 1989, the Tennessee legislature passed the Criminal Code. The code abolished common-law offenses and established that conduct does not equate to a criminal offense unless it is "defined as an offense by statute, municipal ordinance, or a rule authorized by and lawfully adopted under a statute." Tenn. Code Ann § 39-11-102(a)(1991 Repl.). This safeguard is fundamental to two of the objectives of Tennessee's criminal code outlined in Tenn. Code Ann. § 39-11-101(2) and (3).

> (2) Give fair warning of what conduct is prohibited, and guide the

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[30] Steven Porter, *ANA Criticizes* '*Criminalization of Medical Errors' as Vanderbilt Nurse Arraigned*, HealthLeaders (February 20, 2019), https://www.healthleadersmedia.com/nursing/ana-criticizes-criminalization-medical-errors-vanderbilt-nurse-arraigned.

[31] Judy l. Smeltzer, RN, BSN, *Don't Abandon the "Second Victims" of Medical Errors*, 42 Nursing2012 54, 55-58 (2012) (discussing nurses as additional victims).

[32] Inst. of Medicine 2000, *supra*.

> exercise of official discretion in law enforcement, by defining the act and the culpable mental state that together constitute an offense; (3) Give fair warning of the consequences of violation, and guide the exercise of official discretion in punishment, by grading of offenses.[33]

"Thus, our code recognizes the importance of clearly defined criminal offenses."[34] This clear definition is essential for the benefit of the accused and to comply with federal and state constitutional obligations.[35] "If an offense is not defined so as to afford persons of ordinary intelligence fair notice of what conduct is prohibited, it violates due process."[36]

Due process provides that a criminal law may be facially vague if it authorizes and encourages arbitrary and discriminatory enforcement.[37] The 2019 Health Care Liability Claim Report states there were 372 claims filed associated with patient deaths in 2018 alone.[38] With medication errors being the third leading cause of patient deaths, charging one nurse with reckless homicide over the course of the last 3 years would call into question the consistent enforcement of reckless homicide associated with fatal professional errors.

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[33] Tenn. Code Ann. § 39-11-101(2) and (3).

[34] *State v. Boyd*, 925 S.W.2d 237, 245 (Tenn. Crim. App. 1995).

[35] *Id*.

[36] *Id*.

[37] *State v. Burkhart*, 58 S.W.3d 694, 699 (Tenn. 2001).

[38] Dep't of Com. & Ins., *2019 Tenn. Health Care Liab. Claims Report*, https://www.tn.gov/content/dam/tn/commerce/documents/insurance/posts/2019_Report.pdf (Nov. 1, 2019).

According to the Tennessee Department of Labor and Workforce Development, there were 128 workplace fatalities in Tennessee in 2017 and 122 fatalities in 2018.[39] An employee of a multinational delivery service caused the death of a team member unloading a plane, when the employee caused a piece of conveyor equipment to run over the victim.[40] A multinational automobile manufacturer employee was killed when he was struck in the head by a 1,275-pound counterweight that should have been secured by metal mesh.[41] The mesh had been removed by mechanics servicing a conveyor belt and carelessly not replaced.[42] In neither case was a negligent party charged with a crime. Why not? Why would errors made resulting in these deaths not be negligent or reckless homicide? Is the statute so vague that it encourages arbitrary enforcement?

"Since the creation of the federal Occupational Safety and Health Administration (OSHA) 32 years ago, there have been more than 200,000 workplace-related deaths.[43] However, OSHA has referred only 151 cases to the Justice Department for criminal prosecution -- and the maximum penalty companies face for a "willful violation" of OSHA laws is a misdemeanor.[44] Federal prosecutors have declined to pursue two-thirds of these cases, and only eight of them have resulted

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[39] Bureau of L. Stat., U.S. Dep't of L, *Survey of Occupational Injuries and Illnesses*, November 8, 2018.

[40] *Id*.

[41] *Id.*

[42] *Id*.

[43] Frontline, *Crim. Prosecutions of Workplace Fatalities*, https://www.pbs.org/wgbh/pages/frontline/shows/workplace/osha/referrals.html.

[44] *Id.*

in prison sentences for company officials."[45] The eight sentenced were company leaders who willfully violated OSHA standards resulting in the deaths of employees.[46]

Is it possible enforcement is discriminatory due to the highly visible area of health care and the politicized issues surrounding health care? Are prosecutors going to step in and evaluate if every life-threatening injury or death at a place of work was the result of reckless behavior? When a death results, will all occupations be treated impartially, and the negligent party prosecuted? Criminal statutes must apply to everyone in every setting, consistently.

Two elements of an equal protection violation due to selective enforcement of criminal laws are: (1) the government has singled out the claimant for enforcement action while others engaging in similar activity have not been subject to the same action; and (2) the decision to prosecute rests on an impermissible consideration or purpose. Allegations of "selective prosecution in the institution of a prosecution, have constitutional implications that, if proven, may warrant dismissal of the indictment."[47]

Lawmakers in Tennessee have codified the expectation that individuals should not engage in reckless behavior that causes the death of another. "Reckless" is defined as when a person acts thoughtlessly regarding the circumstances surrounding the conduct or the result of the conduct.[48] The person is "aware of, but consciously disregards, a substantial and unjustifiable risk that the

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[45] *Id.*

[46] *Id.*

[47] *State v. Skidmore*, 15 S.W.3d 502, 508 (Tenn. Crim. App. 1999).

[48] Tenn. Code Ann. § 39-11-106(33).

circumstances exist, or the result will occur."[49] This disregard must constitute a glaring departure from the standard of care an ordinary person would use in a similar situation.[50]

In a 19th Century case, a court remarked, "if there was only the kind of forgetfulness which is common to everybody, or a slight want of skill, it would be wrong to proceed against a man criminally."[51] In 1925, a court of appeals emphasized the importance of health care negligence in being gross and showing a "disregard for life and the safety of others to amount to a crime".[52] Perhaps by criminalizing nursing medication errors we are creating a "boutique crime".

## IV. NURSES AS CRIMINALS

The nurse whom Tennessee health officials labeled a threat is charged with a crime in Nashville. This nurse has been charged with reckless homicide and impaired adult abuse following a medication error which occurred in December of 2017. The nurse's role was what the facility designates as a "help all" nurse. The role had no job description. This nurse merely filled in for urgent or emergent needs when other nurses were unable to attend to such needs. At the same time, she was also precepting a new nurse.

As the "help all" nurse, she was asked to go to the radiology area to administer an anti-anxiety medication to a patient who needed to calm down for a scan.[53] She attempted to access the medication in the automated dispensing cabinet using the brand name as stated. When the

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[49] *Id.*

[50] *Id.*

[51] Femi Oyebode, *Clinical Errors and Medical Negligence*, 22 Med. Principles & Prac. 323, 323 (2013).

[52] *Id.*

[53] Working Nurse, *Medication Error or Reckless Homicide,* https://www.workingnurse.com/articles/Medication-Error-or-Reckless-Homicide (2019).

medication wouldn't dispense, the nurse accessed the override feature and typed the first two letters ("VE") of Versed, the medication prescribed. A list of medications was offered on the menu and she inadvertently selected the first medication in the list, vecuronium. She had accidentally dispensed a powerful nerve blocker. From there, she did not adhere to the goals, commonly known among nurses as the Five R's: right patient, right medication, right dosage, right route of administration, at the right time. After the nurse injected the medication, she left the room. The patient was not monitored while her scan was conducted.[54] When it was completed, she was found unresponsive and ultimately was removed from life support and died.

The error was brought to light during a CMS audit. CMS has established minimum standards of care.[55] The agency conducts facility audits to ensure compliance with those standards. CMS defines what they call a "never event" as "an error in medical care that is clearly identifiable, preventable, and serious in its consequences for patients."[56] Another negative finding could be "immediate jeopardy" which indicates the presence of conditions that pose an immediate threat to the lives or safety of patients.[57] In situations with these findings, the hospital can be placed on a timeline for termination from Medicare and Medicaid unless an acceptable corrective action plan is submitted, and a repeat survey validates that the deficiencies have been corrected.[58] CMS finds that many errors are due to process failures rather than unpredictable accidents.

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54 *Id.*

55 Ctrs. for Medicare & Medicaid Servs., https://www.cms.gov (last visited Feb. 10, 2020).

56 *Id.*

57 *Id.*

58 *Id.*

Such was the case with the facility in Tennessee. CMS audit results were released in November 2018.[59] CMS identified system-wide deficiencies at the hospital that existed at the time of the patient's tragic death. "The facility no longer meets the requirements for participation as a provider of services in the Medicare program," the CMS said in a letter to the facility's regulatory officer.[60] The report further noted that the "failure of the hospital to mitigate risks associated with medication errors and ensure all patients' received care in a safe setting to protect their physical and emotional health and safety placed all patients in a SERIOUS and IMMEDIATE THREAT and placed them in IMMEDIATE JEOPARDY for risk of serious injuries and/or death."[61]

The errors made and admitted to by the nurse were included in the report.[62] The report reflected that the patient's death was the result of a combination of human errors and a list of system errors and inadequate systems supporting safe medication practices for both detecting and preventing medication errors and the harm they cause to patients.[63]

These findings are consistent with those of various studies that suggest patient injuries occur as a result of the failure of complex systems rather than the error of a single person. CMS actually cited the hospital for failing to prevent a preventable death.[64] The hospital implemented

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[59] Ctrs. for Medicare & Medicaid Servs., *CMS Report – VUMC* (Nov. 29, 2018), https://bloximages.newyork1.vip.townnews.com/wsmv.com/content/tncms/assets/v3/editorial/a/7e/a7ea6b5e-f41f-11e8-af7b-570ec9f22209/5c005d6899b8d.pdf.pdf.

[60] Modern Healthcare, *CMS Threatens to Revoke Vanderbilt's Medicare Participation After Patient Death*, https://www.modernhealthcare.com/article/20181128/NEWS/181129938/cms-threatens-to-revoke-vanderbilt-s-medicare-participation-after-patient-death (Nov. 28, 2018).

[61] *Supra* at note 59.

[62] *Supra.*

[63] *Supra.*

[64] Hospital Watchdog, *Vanderbilt's Role in The Death of a Patient.* https://hospitalwatchdog.org/vanderbilts-role-in-the-death-of-patient-charlene-murphey/.

several changes in response to CMS's findings that were not in place at the time the incident occurred.[65] The nurse was fired a week after the incident.[66] The Department of Health subsequently completed its investigation and determined action against the nurse was not necessary or appropriate, saying the incident "did not merit further action."[67] The Institute for Safe Medication Practices (ISMP) published their opinion regarding this case stating, "The real issue, in this case, is that there were no effective systems in place to prevent or detect the accidental selection, removal and administration of a neuromuscular blocker that had been obtained via override."[68]

Even with the investigations, recommendations and decisions by expert organizations and entities with vast experience regarding medical and nursing errors and how they occur, the District Attorney's Office deemed it necessary that the nurse be criminally prosecuted in this case. Despite the legislative establishment of medical boards to provide oversight for healthcare licensees, the decision was made to criminalize the error of the nurse. Interestingly, following that decision and after much publicity surrounding the case, eleven months later in September 2019, the Department of Health reversed their decision and elected to also charge the nurse with unprofessional conduct and neglecting a patient, in addition to the State's criminal charges.[69]

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65 Kelman, *supra* at note 4.

66 Working Nurse, *Medication Error or Reckless Homicide?*, https://www.workingnurse.com/articles/Medication-Error-or-Reckless-Homicide.

67 *Id.*

68 ISMP, *Another Round of the Blame Game: A Paralyzing Criminal Indictment That Recklessly "Overrides" Just Culture*, Acute Care Dig. Newsl. (Feb. 14, 2019), https://www.ismp.org/resources/another-round-blame-game-paralyzing-criminal-indictment-recklessly-overrides-just-culture.

69 Kelman, *supra* at note 1.

What responsibility lies with the facility? Retrieval of the neuromuscular blocker was allowed via an override process available for nurses to use. Hospital Watchdog, a nonprofit patient advocacy organization, reviewed the CMS Deficiency Report with the facility's plan of correction. The shared Corrective Action Plan (CAP) contained 330 pages of opportunities for changes within the facility.[70] Two of the medication safety changes instituted by the facility that could have prevented this tragedy were to remove vercuronium from the override mode on the ADC and to now require a nurse to enter "PARA" to obtain a paralytic drug.[71] Had hospital administration provided safe medication practices for its nursing staff, the death in our case could have been prevented. The nurse used a readily available override which has since been removed as a part of the facility's CAP submitted to CMS in response to noted deficiencies. Her use of overrides with the intent to access Versed from the ADC was said to be reckless behavior that contributed to her retrieving vecuronium instead. The use of this commonly used override system resulted in this nurse being charged with reckless homicide.

Healthcare is a complex system in which it is almost impossible to assign blame to a single individual as a criminal. Multiple professionals and processes are associated with each medication administered. A primary argument against criminal prosecution of a nurse is that "medication errors occur frequently, usually without harm to the patient and often due to system factors, that it is unjust to selectively prosecute a nurse whose patient happens to be harmed."[72] To cause a fear of prosecution impairs a culture of safety.[73] The American Association of Nurse Attorneys'

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[70] Hospital Watchdog, *supra*.

[71] Kelman, *supra* at note 4.

[72] PulmCCM, *Former Vanderbilt nurse arrested, charged with homicide for medication error*, https://pulmccm.org/policy-ethics-education-review/former-vanderbilt-nurse-arrested-charged-with-homicide-for-medication-error/alve-medication-related-errors-in-5-years, (Feb. 8, 2019).

[73] *Id*.

position is that the fear of being prosecuted for an unintentional human mistake can undermine reporting of errors and result in an acceleration of nurses leaving clinical practice.[74] Both of which interfere with the provision of quality care to Tennesseans.

## V. PURSUIT OF JUSTICE

At the heart of patient safety, there are two theories of what causes bad outcomes. One involves the errors of individuals and tends to blame an individual for forgetfulness, inattention or disregarding rules or regulations. The other and more common theory is that systems drive inadequate staffing levels, production pressure, hectic schedules, and inhibit communication, all of which can cause bad outcomes.

Most studies in health care systems find that error is not due to the lack of concern for the patient, but the system at large fails to prevent the error. Many are concerned that convicting health care providers of crimes will prevent open reporting of errors for fear of jail time. Failure to report errors only hinders efforts to find and correct the root cause of the problem and achieve the ultimate goal of patient safety. System issues can lie dormant before the perfect storm forms to create an opportunity for a tragedy. We cannot change the human aspect of nurses providing patient care, but we can change the conditions under which the care is provided.

The concern regarding criminalization of health care is not new. In 1993, the American Medical Association adopted a resolution, to "ensure that medical decision-making, exercised in good faith, does not become a violation of criminal law."[75] It has been reaffirmed several times

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[74] The Am. Ass'n of Nurse Attorneys, *Position Paper on Criminal Prosecution of Health Care Providers for Unintentional Human Error*, https://www.taana.org/resource/papers/8859161 (Aug. 12, 2011).

[75] Cristina Palacio, *Medical Malpractice- When Does it Become a Crime? A Historical Review*, Risk Rx, Apr.-June 2012, at 1, 1.

since then.[76] Before the 1990's, it was largely believed that the best way to achieve patient safety was to punish the health care provider for bad conduct.[77] That punitive culture began to breed silence. Nurses were afraid to report near misses or errors and thus the opportunities to identify areas of risk and prevent errors were missed.

Those who are against nurses' having personal or criminal liability for negligence refer to such as "the blame game." The Institute for Safe Medication Practices has gone as far to refer to the criminal indictment of the current case in Tennessee as "shameful", further stating that "any practitioner who did not consciously disregard what they knew in that moment to be a substantial and unjustifiable risk should not be disciplined, let alone charged with reckless homicide."[78] The damaging consequences of criminal prosecution to nurses reporting errors, whether or not they cause harm, far outweigh the negligible impact on improving individual performance.[79]

As healthcare providers attempt to move away from a punitive culture, they have to embrace one that acknowledges "human fallibility and the impossible task of perfect performance."[80] One that accepts shared accountability. In January 2010, the American Nurses Association (ANA) published the following position statement:

> The *Just Culture* concept establishes an organization-wide mindset that positively impacts the work environment and work outcomes in several ways. The concept promotes a process where mistakes or errors do not result in automatic punishment, but rather a process to

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[76] *Id*.

[77] *Id*.

[78] ISMP, *supra* at note 68.

[79] *Supra.*

[80] ISMP, *Our Long Journey Towards a Safety-Minded Culture, Part I: Where We've Been*, Acute Care Dig. Newsl. (Sept. 7, 2006), https://www.ismp.org/resources/our-long-journey-towards-safety-minded-just-culture-part-i-where-weve-been.

> uncover the source of the error. Errors that are not deliberate or malicious result in coaching, counseling and education around the error, ultimately decreasing likelihood of a repeated error. Increased error reporting can lead to revisions in care delivery systems, creating safer environments for patients and individuals to receive services and giving the nurses and other workers a sense of ownership in the process. The work environment improves as nurses and workers deliver services in safer, better functioning systems, and that the culture of the workplace is one that encourages quality and safety over immediate punishment and blame.[81]

These concepts acknowledge that the real reasons nurses drift and lose perception of the risk attached to behaviors is rooted in the overall system. Errors in healthcare need to be viewed as opportunities to improve the system for the greater good of all patients.

In 2005 and again in 2010, two national nursing organizations, the American Association of Critical-Care Nurses and the Association of periOperative Nurses, together released a report entitled *Silence Kills*.[82] They had studied two areas of communication breakdown in nursing, categorized as honest mistakes and undiscussables. Honest mistakes are described as the human equivalent of gravity – they are inevitable. The 2010 study examined three of seven concerns that are "undiscussable."[83] The three explored were dangerous shortcuts, incompetence, and disrespect. The data collected make a strong case against adding to the mix, criminalization of errors.[84] While

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[81] Am. Nurses Ass'n, *Position Statement: Just Culture*, (Jan. 28, 2010), https://www.nursingworld.org/~4afe07/globalassets/practiceandpolicy/health-and-safety/just_culture.pdf.

[82] David Maxfield, Joseph Grenny, Rámon Lavandero & Linda Groah. *The Silent Treatment: Why Safety Tools & Checklists Aren't Enough to Save Lives.* Am. Ass'n of Critical-Care Nurses (AACN), the Ass'n of periOperative Registered Nurses (AORN), VitalSmarts (2011), http://psnet.ahrq.gov/issue/silent-treatment-why-safety-tools-and-checklists-arent-enough-save-lives.

[83] *Id*.

[84] *Id.*

the study revealed that nurses spoke up more in 2010 than in 2005, that rate was still incredibly low at 21-31% of the time.[85] The study showed:

1. More than four out of five nurses have concerns about dangerous shortcuts, incompetence, or disrespect.
2. More than half say shortcuts have led to near misses or harm.
3. More than a third say incompetence has led to near misses or harm.
4. More than half say disrespect has prevented them from getting others to listen to or respect their professional opinion.[86]

In addition, the study found that only 41% of nurse managers reported they had spoken to nurses whose dangerous shortcuts created the most danger for patients.[87]

The study found that by 2010 nurses had greater job demands. Nurses more frequently shared situations where staffing levels were unsafe for the patients' acuity levels, staff not following handwashing protocols, incorrect usage of sterile barriers, necessary items for surgery not being available prior to the patient being put to sleep, among others. A glaring example for potential errors was the facilities' ordering the lowest cost generic medication which resulted in the same medication looking different every time.[88] At one time, one medication on the unit was in four different shaped and colored vials.[89] These types of situations described by the nurses who participated in the study are indicative of the challenges nurses face.

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[85] *Id.*

[86] *Id*.

[87] *Id*.

[88] *Id.*

[89] *Id*.

For healthcare, perhaps it is better to define those who behave recklessly as those who perceive the risk, understand the risk is substantial, behave intentionally knowing that others are not engaging in the same behavior and make a conscious choice to disregard the substantial and unjustifiable risk.[90] After all, it has been decided within Tennessee case law that even to convict someone of homicide by negligence, it is not enough to prove that one was guilty merely of "a want of due care, inadvertence, or inattention."[91] It must be shown that one's negligence was such that they knew or reasonably should have known that it might endanger human life, and that the death charged was the natural and probable result of such negligence.[92]

The intense focus on controlling health care costs, advances in medicine and advances in technology create complex working environments for nurses. That coupled with the continual increase in medical errors and the decreased support for patients and families through tort reform all feed into an atmosphere of mistrust of healthcare professionals in general. Too few staff, long shifts with too many patients, higher acuity patients and ever increasing complex technology are the root cause of most errors, and certainly the one here.

According to the annual Gallup Poll of Honesty and Ethics in Professions, the professionals with a high/very high rating of over 80% for the last 15 years are nurses.[93] No other profession surpasses 70%.[94] Initiating criminal action for reckless or negligent acts of nurses seems somewhat

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[90] ISMP, *Our Long Journey Towards a Safety-Minded Culture, Part II: Where We're Going*, Acute Care Dig. Newsl. (Sept. 21, 2006), https://www.ismp.org/resources/our-long-journey-towards-safety-minded-just-culture-part-ii-where-were-going.

[91] *Roe v. State*, 358 S.W.2d 308, 314 (Tenn. 1962).

[92] *Id*.

[93] Gallup https://news.gallup.com/poll/1654/honesty-ethics-professions.aspx.

[94] *Id.*

barbaric. Hospitals have struggled with the need to move away from blaming individuals for errors since the 1990's. Blame breeds silence, and silence has proven to be deadly.

Pointing a single finger at a nurse like the nurse facing charges in Tennessee, who admitted she made an error, and turning her into a criminal, risks falling backwards into a deeper, unsafe silence. Rather, allowing and encouraging the Department of Health to partner with facilities across the state to look for opportunities to reduce human error and support nurses with safe processes to make good, safe decisions would be far more beneficial for greater patient safety.

Let us not forget the facility's silence. They did not report the fatal error to the Joint Commission, an independent hospital accrediting organization whose policy strongly encourages the facility to do so.[95] The incident was not reported to the Tennessee Department of Health, even though state law requires them to do so.[96] Although there are different explanations why, the medication error is not documented in the patient's hospital record.[97] The facility did negotiate an undisclosed, out-of-court settlement with the family.[98] Perhaps the facility chose to remain silent due to the fear of punishment. The Offices of Health Care Facilities within the Tennessee Department of Health nor the District Attorney have taken any action against the hospital. Is the nurse being protected equally?

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[95] Kelman, *supra* at note 4.

[96] *Id*.

[97] *Id*.

[98] *Id*.

## IV. CONCLUSION

It is unfair to charge a nurse of a criminal act when the nurse is only guilty of unintentional negligence. Charging nurses who are negligent with crimes is counter-productive to our having a sufficient number of nurses to help with medical care in our complex society. To err isn't criminal. To err is human. Criminalizing nurse medication errors sets a dangerous precedent of imposing legal obligations that are unclear and fail to promote the common good. Human error lacks precision. "It usually takes a series of errors to align before an adverse outcome materializes."[99] Merely pointing the finger at a nurse does nothing to prevent the error from happening again.

Dr. Lucian Leape, a professor at Harvard School of Public Health, said it best during testimony before Congress on Health Care Quality Improvement. "The single greatest impediment to error prevention in the medical industry is that we punish people for making mistakes." [100] Focusing punishment on the outcome of an incident creates a culture of no harm, no foul. Instead of learning from "near misses," the threat of punishment prompts them to be kept secret.

One of the criminal justice system's primary goals is to protect the public. But, even the family of this victim stated that criminalizing nurse medication errors is going to "cause people to die, because people won't come forward with their mistakes." [101] The groundwork exists in the Tennessee Board of Nursing Position Statement regarding discipline. However, these statements do not have the force of law.[102] It states that the Board will "judge based on behavior, not the outcome." Opportunity exists for the Department of Justice to collaborate with established

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[99] Edmond Kwok, M.D., *Should We Be Punishing Medical Errors?*, Healthy Debate (Sep. 10, 2012), https://healthydebate.ca/opinions/should-we-be-punishing-medical-errors.

[100] Solveig Dittmann & Susie Weeks, *Just Culture: Still a Powerful Link to Patient Safety*

[101] *Supra* at note 81.

[102] Tenn. Dep't of Health, Bd. of Nursing, https://www.tn.gov/health/health-program-areas/health-professional-boards/nursing-board/nursing-board/policies.html (last visited Mar. 22, 2020).

governmental agencies in the provision of the safest, highest quality healthcare with equal protection for all Tennesseans without choosing to create a new category of criminals. They should do it!