The American Association of Nurse Attorneys

3416 Primm Lane ❖ Birmingham, AL 35216 ❖ 205/824-7615 ❖ taana@primemanagement.net

Criminal Prosecution of Health Care Providers for Unintentional Human Error

Preamble

The American Association of Nurse Attorneys (TAANA) and the American Association of Legal Nurse Consultants (AALNC) are not for profit membership organizations dedicated to:

- Serving as resources for the healthcare and legal communities;
- Professional enhancement and growth of registered nurses practicing in the specialty areas of nurse attorneys and legal nurse consulting respectively; and
- Advancing these nursing specialties.

TAANA and AALNC believe patient harm can only be prevented when modern safety theory is employed in response to adverse events. Errors must be reported and analyzed, examining contributing factors and system flaws. The root cause analysis and/or failure mode and effects analysis required to do so cannot occur in a culture of fear or a culture of blame. Because punitive approaches deter error-reporting and endanger patients by allowing latent failures to continue, the criminal prosecution of health care providers for unintentional error creates worrisome implications for patient safety (Plum, 1997).

Unintentional human errors occur in clinical practice and are inevitable. (Joint Commission, 2006). The vast majority of errors reflect system problems that need to be addressed. The fear of criminal charges undermines an organization's attempts to create a culture of safety and improve those dangerous systems. The criminal prosecution of an unintentional human mistake undermines error reporting and the creation of a culture of safety, demoralizes providers, accelerates the exodus from clinical practice, exacerbates the shortage of health care providers, contributes to a culture of blame, and perpetuates the unachievable expectation of perfection in practice. (ISMP, 2006) (ISMP, 2007) (Richardson, 2006). When investigating clinical error, emphasis should be placed on problem-solving rather than on blame (Joint Commission, 2007).

Errors need to be recognized as inevitable and viewed as opportunities to improve the systems in which providers work. The legislatures have created professional licensing boards with the intent that they have exclusive authority over the practice of licensees. The public is protected from unsafe providers by the professional licensing board authority to restrict or revoke licensure. Criminal prosecution of a health care provider for clinical error may undermine that exclusive board authority. As such, the criminal system should only be invoked in those cases involving an element of intentionality.

Position Statement

- TAANA and AALNC join the safety experts and regulatory bodies who believe patient safety depends upon a systems approach to analyzing adverse events and clinical error and that this can only occur in a non-punitive environment.
- The criminal prosecution of health care providers for unintentional error endangers patients, demoralizes providers, accelerates their exodus from clinical practice, exacerbates the shortage of health care providers, contributes to a culture of blame, and perpetuates the unachievable expectation of perfection in practice.

- The criminal justice system should be invoked only in situations in which there is an actual intent to cause harm.
- The determination as to the appropriateness of disciplinary action should be within the exclusive purview of employers and professional licensing boards.
- TAANA and AALNC oppose the criminal prosecution of health care providers for unintentional error and support other organizations in similar opposition.

References

1. Institute of Medicine. (2006). To err is human: Building a safer health system. Washington, DC: National Academy Press. Retrieved from http://www.nap.edu/catalog.php?record_id=9728.

2. "[W]hen a fatal medication error occurs, there often is considerable pressure from the public and the legal system to blame and discipline individuals for mistakes. However, criminal prosecution sends the false message that clinical perfection is an attainable goal, and that 'good' health care practitioners never make errors. Practitioners begin to fear disciplinary action if they make a mistake, and reporting of errors decreases, making it more difficult to determine root causes. The belief that a medication error could lead to felony charges, steep fines, and a jail sentence also can have a chilling effect on recruitment and retention of health care providers-particularly nurses, who are already in short supply. . . . While there is considerable pressure from the public and the legal system to blame and punish individuals who make fatal errors, filing criminal charges against a health care provider who is involved in a medication error is unquestionably egregious and may only serve to drive the reporting of errors underground."

3. Institute for Safe Medication Practices. (2007, March 7). Criminal prosecution of human error will likely have dangerous long-term consequences. Retrieved from http://www.ismp.org/Newsletters/acutecare/articles/20070308.asp.

4. "[T]he most recent wave of criminal investigations into errors made by healthcare practitioners is cause for concern. The law clearly allows for the criminal indictment of healthcare professionals who make errors that harm patients, despite the lack of intent to cause harm. But it will long be debated whether this course of action is required or beneficial. Its potential impact on patient safety is enormous, sending the wrong message to healthcare professionals about the importance of reporting and analyzing errors. Further, if this is just the beginning of an upward trend of criminal investigations and indictments in the wake of medical errors, it could also have a chilling effect on the recruitment and retention of an already depleted workforce of healthcare professionals."

5. Joint Commission. (2006). Strategies for building a hospitalwide culture of safety. Safety Initiatives. Oakbrook Terrace, IL: Joint Commission Resources.
6. "[E]veryone needs to understand that human error is inevitable-we need to avoid blaming individuals and begin to develop solutions that will make our systems better able to defend against mistakes, preventing them from reaching our patients."

7. Joint Commission. (2007). Front line of defense: The role of nurses in preventing sentinel events. Oakbrook Terrace, IL: Joint Commission Resources.
8. "Organizations that continue to harbor cultures of blame, on the other hand, view error as individual failures and respond punitively, rather than constructively. Such cultures breed fear, undermine error reporting, and do not reduce patient risk. The Joint Commission has stated that when investigating, emphasis should be placed on problem-solving rather than on blame."

9. Plum, S. (1997). Nurses indicted: Three nurses may face prison in a case that bodes ill for the profession. Nursing, 97. Retrieved from http://findarticles.com/p/articles/mi_qa3689/is_199707/ai_n8766289.

10. Flight Safety Foundation's Kenneth Quinn:, "[T]here is a tremendous chilling effect that criminal prosecutions can have on getting people to come forward and admit mistakes. We need to focus not on putting people behind bars, but rather on finding out what went wrong and why, and then to prevent its reoccurrence." Michael R. Cohen, RPh, MS, FASHP, past president of the ISMP: "Prosecuting these nurses accomplishes nothing. The real error is blaming the people instead of the process."

11. Richardson, D. (2006). Hospital association statement regarding legal actions against nurse. Wisconsin Hospital Association. Retrieved from http://www.wha.org/newsCenter/pdf/nr11-2-06Crimchargestmt.pdf. "By setting a precedent that the DOJ

will pursue criminal charges against healthcare professionals who make unintentional human errors, the DOJ sends a chilling message to healthcare professionals now in the state, and to those considering practicing here."

Resources

1. Agency for Healthcare Research & Quality. (2007). 10 patient safety tips for hospitals. Retrieved from http://www.ahrq.gov/qual/10tips.htm.
2. American Nurses Association. (2006). ANA comments on criminal charges filed against WI RN. Retrieved from http://www.okcnursingtimes.com/newsletter/newsletter_view.aspnewsid=3217&catid=296&active=0&mode=current.
3. Gordon, S. (2005). Nursing against the odds: How health care cost cutting, media stereotypes, and medical hubris undermine nurses and patient care. New York: Cornell University Press.
4. Institute of Medicine. (2004). Keeping patients safe: Transforming the work environment of nurses. Washington, DC: National Academy Press. Retrieved from http://www.nap.edu/catalog.php?record_id=10851.
5. Institute of Medicine. (2005). Crossing the quality chasm: A new health system for the 21st century. Washington, DC: National Academy Press. Retrieved from http://www.nap.edu/html/quality_chasm/reportbrief.pdf.
6. Institute for Safe Medication Practices. (2006). Since when is it a crime to be human. White paper. Retrieved from http://www.ismp.org/pressroom/viewpoints/julie.asp.
7. Joint Commission. (1998). Medication use: A systems approach to reducing errors. Oakbrook Terrace, IL: Joint Commission Resources.
8. Joint Commission. (2002). Health care at the crossroads: Strategies for addressing the evolving nursing crisis. Retrieved from http://www.aacn.nche.edu/media/pdf/JCAHO8-02.pdf.
9. Joint Commission. (2003). Staffing effectiveness in hospitals. White paper. Oakbrook Terrace, IL: Joint Commission Resources.
10. Joint Commission. (2005). Contracted staff and patient safety. Oakbrook Terrace, IL: Joint Commission Resources.
11. Joint Commission. (2006a). Patient safety: Essentials for health care. Guidelines. Oakbrook Terrace, IL: Joint Commission Resources.
12. Just Culture Community. (2007). Professionals facing criminal charges: A threat to system safety? Retrieved from http://www.justculture.org/newsletters/pdf/newsletter_janfeb07.pdf.
13. Mason, D. (2007). Good nurse bad nurse: Is it an error or a crime? American Journal of Nursing, 107 (3), 11.
14. National Institute for Occupational Safety and Health. (2004). CDC workplace: Overtime and extended work shifts: Recent findings on illnesses, injuries, and health behaviors. Retrieved from http://www.cdc.gov/niosh/docs/2004-143/references.html.
15. Shalo, S. (2007). To err is human but for some nurses a crime. American Journal of Nursing, 107 (3), 20-21. Retrieved from http://journals.lww.com/ajnonline/Abstract/2007/03000/To_Err_Is_Human_But_for_Some_Nurses,_a_Crime.10.aspx.
16. Smetzer, J. (1998). Lesson from Colorado. Beyond blaming individuals. Nursing, 28 (5), 48-51.
17. Smetzer, J., & Cohen, M. (1998). Lessons from the Denver medication error/criminal negligence case: Look beyond blaming individuals. Hospital Pharmacy, 33, 640-657.
18. State of Wisconsin v. Julie Thao, Circuit Court, Dane County, Criminal Complaint, Case Number 2006 CF 2512. Retrieved from http://www.thedailypage.com/media/2006/11/22/ThaoComplaint.pdf.
19. Wahlberg, D., & Trevelen, E. (2006). Nurse is charged in death of patient: Legal action upsets staff at St. Mary's. Wisconsin State Journal, November 3, 2006. Retrieved from http://host.madison.com/news/article_1e495798-ed4f-5f8d-971d-3eb3effdd43d.html.