



Contents lists available at ScienceDirect

Journal of Radiology Nursing

journal homepage: www.sciencedirect.com/journal/journal-of-radiology-nursing

Legal Awareness

Why Opposition to the Criminalization of Malpractice Is Important to Patient Safety

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In February of this year, a Tennessee nurse was arrested for reckless homicide and patient abuse. Back in 2017, a medication administered by this nurse in error led ultimately to a patient's death. We can all agree that this should not happen to patients. They should be safe from harm in our health care facilities. However, should the sole accountability be on the nurse when there are larger system issues that contribute to medication errors in facilities across the country?

Why should nurses (and all health care clinicians) be in opposition to the recent criminal charges against this nurse even when we are extremely concerned about the death of the patient? These are not mutually exclusive ideas. Nurses and all clinicians work in increasingly complex health care environments. There are distractions, unclear orders or policies, and system processes that allow making errors easier as opposed to harder. Clinicians in many settings are often overworked, overburdened, and working under unrealistic expectations. Errors do occur. They can happen to the most competent and hardworking clinicians. The *just culture* recognizes that humans by nature will make errors and that this does not automatically equate to incompetence or being a sloppy clinician. The health care literature reports that resorting to criminal prosecution is rarely the right answer. It would only be so if the clinician acted willfully or was intoxicated or something extremely egregious and not related to a human factor. Although there may need to be consequences that occur as a result of these types of events at times, criminalizing inadvertent errors is not the appropriate action. There are pathways that can be taken when and if appropriate. The state nursing licensing board can get involved. The hospital/workplace can counsel and follow internal policies and even terminate if it rises to that extreme level. If necessary, the patients and/or families can file a civil malpractice suit if needed.

Clinicians are especially prone to contribute to errors in complicated and fast-paced environments. An error is rarely ever the result of one single human factor. It is typically the result of a system issue that allowed for the error to occur (look-alike sound drugs, culture of overriding drugs being dispense, etc.) (Dolansky &

Moore, 2013). If we criminalize our hardworking clinicians, who will want to enter these professions? We will stifle innovation and better outcomes for our patients in the future and create fear in our clinicians to practice their professions. Many health care systems today practice the *just culture* model. This concept avoids shaming and blaming of individuals and instead promotes open and honest communication among all at the organization. The American Nurses Association (ANA) Position Statement (2010) on *just culture* states that “a *just culture* recognizes that individual practitioners should not be held accountable for system failings over which they have no control” (p. 2). This way, we can ultimately learn from the error and help prevent it from occurring again. When we shame and blame clinicians, we are discouraging the voluntary reporting of events. When punitive measures are taken, we risk less reporting and therefore, more errors as a result.

Should the particular medication that was incorrectly administered (Vecuronium) have even been available in that setting? Should that nurse have been administering the medication if she was not responsible for the patient and would not be there to monitor the patient after administration? Per reports, after being medicated, the patient was then placed in a scanner for an extended period of time without being monitored. The administering nurse was then sent back to the patient unit. Should all of this fall on to that nurse? Did the facility or the department not have a policy for monitoring patients being scanned for extended periods of time or for patients who have been given Versed (the intended medication)? Was the original medication that was ordered (Versed) even an appropriate one for scanning purposes of this patient? These are all questions that need to be answered and considered in the context of investigation and considering criminalization.

The facility must bear responsibility for the systems they did not have in place to protect the patient. All the facts are unknown fully to the public at this point, but holding the nurse solely accountable and potentially criminally responsible is not the proper course of action at this point. In fact, this case was not widely known until after the nurse was arrested. The patient died back in 2017. The arrest occurred after a formal report by the investigating regulatory agency completed its review and released the report. A family member even noted, per one report, that this patient would not have wanted the nurse criminally punished for

Author discloses no conflicts of interest.

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<https://doi.org/10.1016/j.jradnu.2019.04.005>

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an error (Kelman, 2019). *Even the family can find compassion for the nurse.* The facility should show support and compassion for the patient, family, and their employee nurse. They should also be invested in identifying system issues that make the system vulnerable to errors and harm to patients. Blaming one nurse does not acknowledge the system that helped to lead to the error and leaves a facility to risk for future errors. All clinicians should be concerned about this case as it could potentially set a dangerous precedent for criminalizing malpractice.

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