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Medical Legal Forum: Guilty! Safety Implications After Criminal Conviction for a Medical Error

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Guilty! That was the jury verdict on March 25 after former Vanderbilt University Medical Center nurse RaDonda Vaught was criminally charged for a medical error that led to the death of 75-year-old Charlene Murphey. The error, to be clear, was horrendous: On December 26, 2017, Nurse Vaught injected Ms. Murphey with the paralytic vecuronium instead of the sedative versed. She was fired and lost her nursing license after the incident, which was not necessarily unusual. However, what drew national attention was the decision to arrest and charge Nurse Vaught with criminally negligent homicide, gross neglect of an impaired adult, and reckless homicide. She was found not guilty of reckless homicide but guilty of the other two charges, for which she will serve up to 8 years in prison.

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The move to criminally charge a health care professional for a medical error has drawn widespread criticism and condemnation. The American Nurses Association (ANA) released a statement: "We are deeply distressed by this verdict and the harmful ramifications of criminalizing the honest reporting of mistakes." -American Nurses Association

They raise an additional concern about the verdict's impact on nurses who are already facing tremendous job-related stresses, short-staffing, and burnout.

There has always been an aspect of accountability for health care professionals. At the same time, it is also important to recognize that healthcare "is one of the most complex industries in our world." (1) Other complex industries, such as aviation and nuclear power plants, have prioritized safety and reliability for decades. A national focus on patient safety began in 1999 when the Institute of Medicine released a report estimating that medical errors may be responsible for nearly 100,000 deaths/year. (2) A major factor in improving patient safety is creating a culture of safety in which front-line professionals feel comfortable bringing safety concerns to administration without fear of reprisal. This is important because errors in our complex healthcare environment are rarely the result of one individual issue but rather a series of systemic issues. A common analogy developed by James Reason is that barriers to patient harm are like slices of swiss cheese. Each barrier has a weakness, the 'hole' in the cheese, and occasionally those line-up and reach the patient. A culture of safety encourages everyone to work together to close the holes before they reach the patient. When an error does occur, a culture of safety encourages everyone involved to be open and honest about what happened so that measures can be taken to prevent the error from reoccurring in the future.

As noted earlier, Patient safety advocates are rightfully concerned that this prosecution will cause healthcare professionals who commit errors to keep quiet about them to avoid blame and punishment. A culture of silence may increase the risk to patients as reporting errors is crucial to improving the healthcare system. Nurse Vaught reported the error, participated in the investigation, and Vanderbilt did make changes, outlined in a 330-page plan of correction, to prevent this error from occurring in the future. These include taking vecuronium off override, implementing barcode and second nurse verification, and shrink-wrapping paralytic medications. (3) Sentencing is scheduled for May 13. A petition calling for clemency has garnered more than 200,000 signatures.

References:

1. *American College of Healthcare Executives/National Patient Safety Foundation's Lucian Leape Institute. Leading a Culture of Safety: A Blueprint for Success." Accessed at www.osha.gov.*
2. *Institute of Medicine (IOM). 2000. Committee on Quality of Health Care in America; Kohn LT, Corrigan JM, Donaldson MS, eds. To Err Is Human: Building a Safer Health System. Washington, DC: National Academy Press. [Report issued 1999, published 2000].*
3. *Hospital Watchdog. Vanderbilt's Role in the Death of A Patient. Accessed at https://hospitalwatchdog.org/vanderbilts-role-in-the-death-of-patient-charlene-murphey/*

Disclosure: There are no reported conflicts.

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Disclaimer:

This column does not give specific legal advice, but rather is intended to provide general information on medicolegal issues. As always, it is important to recognize that laws vary state-to-state and legal decisions are dependent on the particular facts at hand. It is important to consult a qualified attorney for legal issues affecting your practice.