When is a Medical Error a Crime?

by BOB WACHTER on NOVEMBER 5, 2007 in HEALTH POLICY, HOSPITAL CARE, NURSES/NURSING, PATIENT SAFETY/MEDICAL ERRORS

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The first commandment of the modern patient safety movement was "Thou Shalt Not Blame." *Old-Think:* errors are screw-ups by "bad apples," and can only be prevented by some combination of shaming and suing the doctor or nurse holding the smoking gun. *New-Think:* errors represent "system problems;" any attempt to assess blame will drive providers underground, inhibiting the free-flow of information so crucial to error prevention.

Like most complicated issues in life, the truth lives somewhere between these polar views. In the main, the "no blame" view is right – most errors *are* committed by good, hardworking docs and nurses, and finger-pointing simply distracts us from the systems fixes that can prevent the next fallible human being from killing someone.

Yet, taken to extremes, the no blame argument has always struck me as both naive and more than a little PC. Anyone who has practiced for more than a month can name docs and nurses who they would never want caring for their loved ones. And what about the substance-abusing nurse, the internist who doesn't keep up with the literature, the retractor-throwing surgeon, or the provider who refuses to follow reasonable safety rules. If nobody is ever to blame, who is accountable?

This debate reached a fine point last year with the case of Julie Thao, a Labor and Delivery nurse at St. Mary's Hospital in Madison, Wisconsin. On July 5, 2006, Thao, working a double shift, was caring for Jasmine Gant, a pregnant 16-year-old high school student. Gant appeared to be infected, and Thao intended to give her a dose of IV antibiotics, as well as an epidural anesthetic. By report, Gant was anxious about the epidural, and the nurse removed the anesthetic, bupivacaine, from the Pyxis machine to show it to her patient. The bupivacaine had a label warning against intravenous administration, and the hospital had a bar code medication administration system. Thao apparently missed the former and bypassed the latter (we don't know how often other St. Mary's nurses did the same thing, but many bar coding systems are bypassed 20-30% of the time), ultimately mistaking the bupivacaine for the antibiotic and infusing the anesthetic intravenously. Gant died soon afterwards; her baby was saved by an emergency C-section. The hospital apologized to Gant's family, Thao's license was suspended by state regulators, and St. Mary's agreed to tighten its policies and its educational programs for nurses.

This case would have been but one more terrible tragedy in the sea of fatal medical errors but for an aggressive Wisconsin district attorney, who chose to charge Thao with patient neglect and causing great bodily harm, a felony that carries a penalty of up to six years in prison and a fine of $25,000. Thao eventually pled no-contest to two misdemeanors, after which the prosecutor dropped the felony count. The case became a cause célèbre in the blogosphere, with most bloggers noting the chilling effect that criminal prosecution would have both on reporting and on nursing recruitment and retention.

Which errors really should be handled with "no blame" and a focus on shoring up faulty systems, and which

are indeed blameworthy? The current issue of AHRQ WebM&M, the patient safety journal I edit for the Agency of Healthcare Research and Quality, features two articles on "Just Culture," the concept that tries to answer this question.

The first is my interview with David Marx, the engineer-attorney who first described the application of Just Culture to healthcare and now runs the "Just Culture Community." According to the Just Culture paradigm, three kinds of behaviors can lead to errors:

- Human error – inadvertently doing other than what should have been done; a slip, lapse, or mistake.
- At-risk behavior – a behavior that either increases risk where that risk is not recognized or is mistakenly believed to be justified.
- Reckless behavior – a behavioral choice to consciously disregard a substantial and unjustifiable risk.

Marx argues that most errors are due to *at-risk behaviors* – shortcuts and workarounds that normal people use to get their work done – and should be dealt with by examining why the system pushed them to make these choices. On the other hand, reckless behavior *is* blameworthy, and should be handled accordingly. A companion article by Alison Page, Chief Safety Officer of the Fairview system in Minneapolis, describes how her terrific organization has made these concepts real. Both pieces are well worth reading.

Where did Julie Thao's behavior fit in? Marx, though clearly sympathetic, has argued that the fact that she bypassed a number of safety systems makes her behavior more reckless than simply at-risk. I agree: although Thao was apparently a good, hardworking, and compassionate nurse (and a highly sympathetic figure – a divorced mother of four, with one child serving in Iraq), the number of safety system shortcuts she took (working a double shift, removing the epidural from the locked box, neglecting the warning label, bypassing the bar code system) make it difficult to look the other way, even if there was no intent to harm (as there clearly wasn't). But, like Marx, I think the criminal justice system has no role in such cases unless the healthcare regulatory system (such as her own organization's HR department and the state licensing board) cannot manage the problem effectively. I see no evidence of that in this case.

So, from what I know of the case, I think that Thao should have been counseled, suspended, and, arguably, fired. But criminally prosecuted? No way.

A few years ago, I heard Aetna's then-CEO Dr. Jack Rowe speak. "I have three boxes on my desk," he quipped. "The Inbox, the Outbox, and the 'Too Hard Box.'" For too long, we have filed this issue of "no blame" vs. "accountability" in the "Too Hard Box." The Just Culture concept doesn't answer every question or address every situation, but I like it for being a thoughtful attempt to place this crucial issue in the Inbox, where it rightly belongs.

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15 Responses to “When is a Medical Error a Crime?”

dale November 7, 2007 at 11:17 am #

Having traveled through the devastation of the discovery process, following the death of our child, I too, am quite concerned and frustrated that this topic hasn’t been forced into the spotlight or “Inbox” for healthcare leaders and others to initiate immediate action and mandate change. The system is cruel and inhumane. We all deserve a just culture that embraces the patient with the same fortitude that it embraces the caregiver while learning from the behaviors that change so many lives forever. Laziness and lack of courage are no longer accepted as excuses for doing the right thing.

elliott gorelick November 11, 2007 at 10:58 pm #

So everyone in healthcare has a personal list of colleagues they do not trust. That list is not available to the public and is only shared, in private, with those you most trust. Now these professionals may be 10X more likely to do something wrong, but given the checks and balances in the system, as imperfect as it might be, that still means a relatively low frequency of problems. How do you weed out, retrain, or minimize the risk of this set of incompetent providers? I know from personal experience that vague complaints of practice either cannot or will not be acted upon and invite retaliation. The only thing that seems to ever result in changes in such a situation is an action that rises to the level of malpractice.

michael November 18, 2007 at 9:12 pm #

While this posting does a good job of highlighting the difficulty involved in how to deal with someone that commits serious preventable medical error, little is stated about the devastation caused by this nurse’s negligence.

How can anyone all but ignore that a 16 year-old lost her life, a mother and a father lost a child and a baby lost a mother that he/she never knew and will never know? Judging nurse Thao’s multiple negligent acts must include the manifold tragedies that she directly caused. Retelling this story without appropriately focusing on the consequences of what appears to be clear, avoidable, and egregious negligence is biased at best and adds to an atmosphere of

injustice. Any sympathy that I have for nurse Thao, who may appropriately suffer because of her negligence, is dwarfed in comparison to my sympathy for an entire family of at least three generations of victims.

If you are to use this terrible case as a model to learn from, which I assume is the point of your posting, you must complete the picture.

REPLY

GaggedByOrder November 19, 2007 at 2:58 am #

I appreciate the comment about how chilling it would be for caregivers to worry about criminal prosecution for that kind of neglect. Is it possible that that is what is necessary to get the system and the people in it to worry about the consequences of circumventing safeguards? If concern for the safety of the patients was enough, this would not be an issue.

The absolute least a patient should be able to expect is to be protected from crime in medicine. Yet there is no mechanism to offer that before hand or to offer remedy afterwards.

If you want to understand how a system operates, see how it handles its worst moment. Caregivers committing crimes against their patients probably is their worst moment. But almost no one in medicine reports crimes. According to JCAHO the least likely of all people to report a crime in medicine is anyone working in medicine. Those are covered up. Documents are forged. Witnesses “forget.” Victims are sued into silence. The example in this posting might be criminal neglect, but not the commission of an act with intent to harm. If it were that, you would not have heard about it.

Crimes get redefined and called other things because that is the only way the victims can get their complaints to fit into anyone’s box. The police usually won’t criminalize medicine. Lawyers defend criminals, not prosecute them. The provider’s insurance does not cover criminal acts. State medical boards are not authorized to investigate crime. Etc. So victims have to pretend it was something else.

The medical community is unwilling to acknowledge even that crime is a problem, often dismissing it as though it is so rare that it is not worth considering, like if the police did not enforce rape laws because rape happens so rarely.

Crime in medicine might be the rock bottom issue of patient safety, but so far it really isn’t part of the discussion. We can make only marginal progress in reducing the amount of unnecessary death and injury in medicine without addressing the fundamental issues, like crime. I’m glad something at least on the periphery of it has surfaced in your blog.

REPLY

JVicktwin November 19, 2007 at 4:27 am #

My twin-sister died after a coronary artery was punctured. The surgeon has shown remorse and I have truly forgiven him…but the doctor "on call" that night was called when her blood pressure was 0 and she was tachacardic. He waited over an hour after the call to arrive at the hospital…I learned that he lived 3 minutes away. In depositions…his response concerning, why he did not come immediately, was "I did not feel that it was important ENOUGH for me to come at that time". In my opinion, he should be held accountable and charged with involuntary manslaughter. My sister's life depended on his response. How can you be a doctor, take an oath, and then let a human being die…because it was an inconvenience. There needs to be disciplinary measures in place…when doctors just decide NOT to respond…when they are on call.

REPLY

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justapatient November 19, 2007 at 11:09 pm #

Hi, Bob. Glad to happen upon your website. I have registered and urge all our mutual friends of Helen H. to do so. Helen emailed your article on medical error being a crime. You, God and the rest of us know how virtually impossible it is to get a healthcare professionals to report any error. Risk managers advice not withstanding, if they convict the nurse in your state of criminal charges, the task may become even harder. Not even TJC will find any reports on Sentinel Events on its website. Firstly, we all have to acknowledge that "reckless endangering" is a crime, when committed with malicious intent. Other than that, we need to be diligent in our insistence that medical errors be reported to some higher healthcare authority.

REPLY

Timothy January 10, 2009 at 4:45 pm #

Dr. Wachter while I respect your work over the years I have to disagree with you and Mr. Marxx Just Cause. Having been in the VA system 20 years and moonlighting 20 years in the community it is clear JC is a retread of same ole way. Problem with JC is who will deteremine when deviation is worthy of blame. The Madison easy is and easy case unfortunately healthcare is very complex and politically driven. Until we can fund and implement a truly objective governing body those deciding if "blame" is necessary will be no different than today's professional licensing board, juries, or judges. It has taken the VA several years to reduce the system "issues" with our EMR to where now the system issues are at a manageable level. Our bar coding medications is still not "there yet". Wireless interfaces

in older buildings not designed for wireless technology and limits of the bar coding technology itself make it impossible to objective say this error is worthy of blame and that error is not. The VA has reached a reasonable medium – if a provider violates the law (substance abuse, patient abuse) then blame is administered via a specific due process disciplinary system other wise we consider EVERYTHING else to have a system component. Today JC is like the 5 Rights of Medication Administration (30 years ago) – it is a great concept but it is not an operating procedure (bar coding meds being an operating procedure for the 5 Rights).
I would very much like your view,
Timothy

REPLY

John October 7, 2009 at 7:16 pm #

Criminal prosecution for healthcare providers in cases like these or cases with 'no intent to harm' is unfair in my opinion. The system issues are many. Many healthcare providers use work-arounds not by choice but by perceived necessity. There are constant pressures to do things faster, and better with fewer resources and even the most conscientious hcp can be affected by these influences. I know that this loss of life is a tragedy, but for providers to feel like every time they go to work they are at risk doing something that can lead to their imprisonment is very sad to me. Many of these bad habits that can lead to this sort of incident are pervasive in our healthcare system and in my opinion also the product of our healthcare system. It has to change from the top down; providers need to be given the proper resources to do their jobs safely. Persecuting the individuals that happen to commit an error that leads to serious harm when many others are engaging in the same unsafe practices to great extent because of the system they work in will only lead to cover-ups and ultimately providers leaving healthcare.

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REPLY

Gail November 28, 2009 at 12:58 pm #

I've always felt there are a few simple actions that would prevent such tragedies, as the potential for mix-ups is obvious. The bags used for antibiotic administration and epidural administration are often the same size (for ex., 50mls) and appear identical (i.e. clear plastic, similar font, color, and size of writing). Until my hospital installed small, wall-mounted epidural pumps, the bags were placed on an I.V. pole and strung into the same IVAC pumps as IV fluid bags and tubings. The only difference in the tubing appearance is epidural tubing has a pale yellow line imbedded in it. Finally, the worst bit; two IVAC pumps were often placed on the same pole one above the other – one with the usual IV bags and the other carrying the potentially fatal epidural solution. Can anyone not see the potential for disaster? This has worried me for years. Epidural infusions need to be placed in red bags; bags trimmed in red; bags printed in red – something!

This nurse apparently took out the bupivicaine bag to 'show the patient.' She didn't 'disregard' the warning that it was not for intravenous use – she already knew that! She probably took it out of Pyxis in preparation for the doctor coming to insert the epidural, and was showing it to the patient beforehand. She would have then put it down while waiting for said doctor.

Then it was time to hang the antibiotic – in one horrible moment, she thought she picked up the plastic bag with antibiotics in it (which she would have previously prepared or removed properly from Pyxis)…but it was actually the nearly identical bupivicaine bag, instead. Absolutely yes, she should have looked closely that one final time to check the 'Rights.' But I can also see how this happened because it's concerned me for as long as I can remember – you're at the bedside of the right patient with the right medication, properly prepared. But a distraction happens of some sort, and you've just attached the tubing to the wrong pump.

It's never happened to me, but then again, I was in the habit of placing brightly colored stickers to differentiate the two sets of tubings and pumps, as it was always on my mind, anyway. There but for the grace of God, etc…

(My condolences go to all concerned parties, including Ms. Thao who must be devastated, too.)

REPLY

Gail November 28, 2009 at 1:42 pm #

Addendum to my comments, above…

Here's an interesting follow-up article:
http://host.madison.com/news/local/health_med_fit/article_bc888491-1f7d-5008-be21-31009a4b253a.html

Though, in this case, different connectors would not have helped. I imagine the nurse picked up the wrong bag and inserted the (distal) sharp end of the IV tubing into the bag's receptor; then commenced the infusion, with the remaining tubing already strung through the IVAC pump (proximal), as usual.

Dog supplements September 10, 2010 at 2:06 am #

I think is a very grey area. I think when negligence comes in to play i think its a crime then. But other then that i think each circumstance has to be dealt with individually. Very good interesting post. Really got me thinking

canterberr July 22, 2011 at 5:40 pm #

I agree wholeheartedly with the poster who pointed out how many lives have been ruined by this nurse's act/mistake. It is really important to add those details when reporting on stories such as this one. I find the clue in this case lies in the patient's request to look at the medications prescribed. The culture is such that if a patient or layman asks to double check a nurse or doctor's decision they are in line for some "i'll-show-you." The category "intentional" should be added to the list of hospital mishaps. Medical people much like other razzle-dazzle workers are trained to think they are elite and are very touchy about civilian autonomy. Narcissism is born from this kind of training as is psychopathy. The reason why no measures are taken to correct this state of affairs is that narcissists and psychopaths are needed to fuel the staffing style of modern hospitals. Take them out and who has the stomach to follow orders. There is a lot of political interference as well as profiteering going on. The type of person working in a hospital is the concern when thinking of going there. In fact, don't go…! You'll probably live longer.