Chapter 18.

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Is Being a Human a Crime?

1. CRIMINALIZING Medical Errors.
2. OVER-LITIGATION of Medical Errors.

INDEX:

(These are selected cuttings from the printed book's full 22 page chapter with 41 references.)

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1. INTRODUCTION

A 2010 British Journal of Anesthesia editor, Hardman, quoted, "To err is human.[1]" Hardman further said anesthesiologists work with highly engineered equipment, technology, and drugs. Anesthesiologists in modern times still make errors, and the foremost dangerous error is with drugs. After a patient anesthesia mishap, examining the case and its circumstances for previously unrecognized latent risk factors (LRFs) is critical. It is then critical to examine those factors and join the report with other error reports, initiating an ITERATIVE LOOP seeking how to avoid similar future events.

In this context, an iterative loop is an *evolving development* design process following serial steps that link back to the start, thus forming the iterative loop. A good design process never misses a step and repeatedly repeats the loop. It identifies problems, then designs solutions, tests the solutions, and finally reassesses what the problems are again. An anesthesia drug starts with (i) data input (the drug error report), which triggers in steps (ii) data quality review, (iii) analysis (propose solutions for future error prevention), and lastly, (iv) feedback to the persons who initiated the cycle with their error report. **Thus, everything must be done to encourage free and open reporting of all anesthesia drug errors, which is the first step of the iterative loop that will prevent similar future errors**.

Dr. Alan Merry[2], a New Zealand expert on anesthesia drug errors, wrote a long editorial about medical mistakes and manslaughter charges against physicians[3]. He tried to answer the question of whether an error made in medical care that ends with the death of a patient should result in a manslaughter charge against the physician. Different laws in different countries will result in different legal outcomes. There are, however, some valid points to be argued. He points out that the *consequences* of very tiny errors can be of

monstrous magnitude. A judge must differentiate between **a violation** by the physician and **an error**. A violation is an act of doing something not allowed by a law or rule, although still with an overall desire to perform optimally and without harm or injury to anyone. Violations of procedural rules are often time-saving shortcuts when under management pressure to work faster. An error is a state or condition of being wrong in **conduct** or **judgment** despite best intentions. Violation requires a decision to oppose the law or rule, but still with good intentions. A person makes an error with the best intentions. A criminal punishment, however, of one person can only serve the purpose of deterring other persons planning to be criminals from choosing to commit that same violation.

- Merry says a "N*o-Blame Culture"* where workers are fully supported and never blamed when they make errors is hard to sustain. Some propose a slightly less soft "*Just Culture*" as better. In a *Just Culture*, blame is restricted to circumstances where it is *morally* appropriate and where most *people view it* as appropriate.
- When a patient is harmed by a medical error, such as an anesthesia drug error, then (1) the priority is giving the patient the best timely medical care at no extra costs, (2) giving open disclosure to explain to the patient what happened, (3) strong consideration be given for **no-fault compensation** if appropriate. New Zealand and Scandinavia have good working systems of medical-error no-fault compensation for medical injuries.
- Medical errors, such as anesthesia drug errors, must never be tolerated. However, the fact of patient harm is not itself a reason alone to punish the erring nurse or physician. More effectively, every effort must be made to make the future safer by improving systems.

After any healthcare worker is caught committing a procedural violation, two things must be determined: (1) review if the protocol or guideline has any merit or *worthy purposes*, and (2) what were the *reasons or factors* contributing to the worker choosing to make a violation (e.g.,) performance time pressures forcing short cuts). Those determinations will influence whether or not the worker is punished.

Merry has much more to say. Criminal punishment of someone for an inadvertent error has no deterrent effect on another person acting with good intentions and who believes they are doing their best. Only drug errors that cause severe harm tend to be criminally prosecuted or earn civil litigation. An identical error that did not result in harm is never prosecuted or litigated. The size of harm becomes the determinant of legal prosecution or litigation. That is illogical because the same error causing no harm triggers no legal prosecution or litigation. Additionally, the money awarded against the erring physician is mostly when the patient survives with disabilities. It has often been said that following a serious medical error of any type is the cheapest option for the physician if the patient does not survive. It is a luck factor that determines whether an error causes harm. Thus, it is a lucky factor to be sued for a medical error or not. The nature of a human error seems irrelevant on its own for the likelihood of being sued.

The inappropriate punishment of human error ultimately creates a price society must pay. Society pays because physicians will prioritize practicing defensive medicine to protect themselves should any medical adverse event occur. Physicians will modify their actions in detrimental ways for society and increase health costs from defensive medical practices

designed to serve the physician's perception of protecting themselves. In countries like the United Kingdom, since 1900, the number of physicians convicted for medical manslaughter due to medical error has increased exponentially every decade. It seems it is a world trend.

The **first** step in defensive medicine is *refusing medical care to high-risk patients* for dying. This is negative defensive medicine; an action is removed. The next two are positive defensive medicine; an action is added to create an illusion of providing the best care. The **second** step in defensive medicine is ordering *excessive, unnecessary laboratory tests and investigations* to create a façade appearance of good healthcare. The **third** defensive medicine action is *overprescribing medications* to support the façade appearance of good medical care. The cost increases in health care have become massive. Merry advises healthcare workers to be altruistic and not to dwell on the fear of conviction for crimes but to remain focused on providing good patient care.

In the USA, in 2023, some states are softening the barriers to suing for wrongful death to someone[4]. The statute of limitations period during which a lawsuit could be opened was also lengthened. For physicians who have a patient die despite their best efforts, apart from having more risk of being sued, they would have the cost of liability insurance increase substantially. It is predicted that this would result in many physicians moving out of that state, severely worsening the current physician shortages in those states.

The Dr. Hadiza Bawa-Garba case in Britain created much emotional, professional, and public debate[5, 6, 7]. She worked an overloaded day in the hospital and managed a sick child who died. The child's illness was complex, and Dr. Hadiza Bawa-Garba did not realize how critically ill the child was. Serial additive aspects of the child's care were short of optimum. Despite having an outstanding record as a post-graduate pediatric trainee and Dr. Hadiza Bawa-Garba doing her best to cope on that day, the child died. The hindsight reviewing of the case could identify multiple steps that may have saved the child's life. The trainee pediatrician was found guilty of manslaughter and lost her medical license, although, after appeal and debate, it was restored a few years later. The summary points in favor of Dr. Hadiza Bawa-Garba were (1) that she had no criminal heart, (2) that the full healthcare system needed to be restructured, (3) that it is wrong and self-destructive to criminalize medical errors that are primarily due to system faults that burdened a well-intended overworked physician.

2. CRIMINALIZING MEDICAL ERRORS.

This book author's maternal grandmother got married in 1910 to a man at the age of 12 and was pregnant in the same age year with the first of her 9 children, who reached adulthood. She was only introduced to her 17-year-old husband-to-be at a joint formal meeting between the two families. Everyone sipped tea while discussing the wedding ceremony arrangements for a month later, in front of the juvenile new couple seeing each for the first time. Her second meeting with her husband was at the wedding ceremony. This represented the tail-end period of a formal Colonial French-European culture on a French-administered island in the Indian Ocean, Mauritius. The same events 100 years later in the US would earn police charges of child trafficking and rape.

This is a poignant example of the fluidity of ever-changing morals and ethics.

(This book's full chapter has 22 pages and 41 references)

8. THE STORY OF RADONDA VAUGHT[36, 37, 38, 39] (Also, read more in Chapter 26)

In Nashville, Tennessee, USA, on 25th March 2022, a nurse, RaDonda Vaught, was found criminally guilty of negligent homicide. Extensive testimony from persons who knew her, with no exceptions, attested to her being a good person, a dedicated and devoted nurse. Negligent homicide was a lesser charge than that of reckless homicide. Hundreds of nurses and an anesthesiologist demonstrated in support of RaDonda outside the Nashville courthouse before her sentencing. **See images number 1 and 3.**

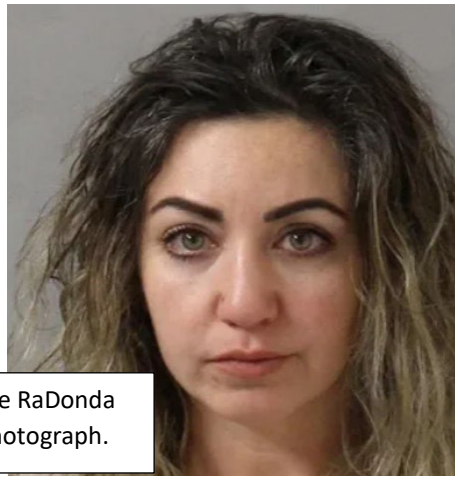

Image no. 1. Nurse RaDonda Vaught's arrest photograph.

RaDonda Vaught additionally lost her nursing License and was fired from her employment. Based on video interviews, she suffered severely from realizing her error and its consequences. She also suffered from her

criminal charges and guilty findings. She is a prime candidate for developing severe PTSD. From the very beginning, she was open, honest, and frank about everything that happened. She freely admitted later that she could retrospectively see she had made the error that caused the patient's death. She realized that from the second she was shown the wrong drug ampule, she had used after the patient's death.

A physician had ordered Radonda to administer a drug he entered into the records as "**Versed**". It was meant to calm the 75-year-old lady patient while undergoing an MRI examination of her head following a spontaneous subdural hematoma that she was recovering from. A muscle relaxant drug, **vecuronium,** was erroneously injected instead and believed to be the lethal event that caused the patient to die soon thereafter.

This occurred at the Tennessee **Vanderbilt University Medical Center** in Nashville. The hospital made a lot of effort to conceal the error from the public and credentialing authorities. Later, the University Health Center reached a private financial settlement with the patient's family, including a clause forcing them to keep the error secret. Some whistle-blowers (anonymous tipsters), however, spoke out. Some systems problems that contributed to the drug error were;

Image no. 2. Versed skin cream.

1) The prescribing physician did not use a generic drug name when prescribing. He used an expired and *discontinued Brand name* for the generic drug midazolam, "Versed," which is the name for a skin cream. That created the first step of confusion. There is no world drug called Versed by brand or generic name. **See image number. 2.**

2) The automated drug dispensing machine Radonda Vaught used to obtain the medication did not recognize the requested drug name, "Versed." The Vanderbilt Hospital admitted in court that their automated medication dispensing system was having defects fixed at that time period[40].

3) Radonda then searched the drug dispensing machine computer drug list. After entering only the first two letters of the prescribed drug name, Versed, "VE," the machine offered the drug "vecuronium," a paralyzing muscle relaxant unfamiliar to the nurse. It was the only drug offered, and RaDonda accepted it as correct.

4) To be time efficient, Radonda had to bypass several steps on the automated drug dispensing cabinet as was feasible in the system and as she nearly typically did daily. All the nurses using these drug dispensing cabinets similarly used the shortcuts. The drug dispensing process shortcuts (bypasses, overrides) were a "n*ormalized"* part of their daily nursing work. The result was that Radonda had no idea the drug was an anesthesia drug to induce muscle relaxation.

5) There was no hotline communication option for Radonda to a pharmacist to assist her at the drug dispensing cabinet. The existence of automated

dispensing machines was to reduce the number of pharmacists needed in hospitals and save money.

6) The hospital was short of nurses who had to work long shifts and comply with time pressures to be more efficient with tasks.
7) RaDonda was distracted by her additional parallel task (multitasking) of mentoring and orientating a new nurse into working in the hospital, standing beside her as she worked.
8) The Tennessee legal system was also pointed out as flawed. The system treated Ms. Vaught's prosecution as legally and ethically justified[41].

Image no. 3. Dr. Robert Raw, with nurses, protesting outside the Nashville law courts against RaDonda Vaught being sentenced to jail for making a drug error. May 13, 2022. Mark Murphy, staff. Associated Press image.

Thousands of American nurses signed petitions in support of RaDonda Vaught. Nearly all nurses had made similar drug administration errors due to improperly designed automated drug dispensing cabinets, although lethal consequences were very rare. Many nurses decided to retire early, fearing similar consequences and serving time in jail.

This case criminalized an unintended nursing error by a well-attested, exemplary role model nurse who had a series of institutional system factors loaded against her and made a human error.

RaDonda said, "*I do not work in a vacuum. I work in a healthcare system*". Of note, none of the university or other hospital employees responsible for the systems RaDonda Vaught had to work with were reprimanded, disciplined, fired, or criminally charged for the patient's death. The university and hospital could have avoided this patient's death in many ways.

Finally, there is a legal argument that RaDonda Vaught should have her conviction overthrown and be given monetary compensation for the suffering and hardships she was subjected to. In the USA, charging a healthcare worker with the threat of jail time for an

unintended medical error is rare. The State Governor of Tennessee has not yet considered granting RaDonda Vaught clemency for her sentence.

Certainly, this case will intensely incentivize American nurses and physicians to try to conceal unintended errors that produce a critical or fatal error to a patient rather than report the error to patient safety improvement systems for analysis.

9. CONCLUSION