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Editorial: APSF's Statement About Criminalization of Medical Error and Call to Action Against Preventable Adverse Events

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Almost five years ago, Charlene Murphey, a patient at Vanderbilt Medical Center, died from a series of system failures and errors, a classic "Swiss Cheese" event.[1] The local prosecutor decided to do something extremely rare, to take legal action against the nurse who administered vecuronium in place of midazolam, leading to Ms. Murphey's death.[2] The nurse, who had already lost her job and license, was convicted of gross neglect of an impaired adult and criminally negligent homicide, but ultimately sentenced to three years' probation.[3] Via a position statement that is published in full in this issue of the *Newsletter*, APSF is one of several organizations that is speaking out against the criminalization of errors made by health care providers in the process of delivering care with good intentions. However, APSF believes that the more important action in response to this and many similar adverse events, especially those involving medication errors and failure to monitor, is for all health care systems, professionals, and regulatory bodies to identify and increase activities and interventions that will prevent errors leading to patient harm.

What happened on that fateful day in 2017? According to reports from several media outlets, it is a complicated story that may seem egregious, but on close examination is familiar in tragic, preventable outcomes. Basically, RaDonda Vaught, RN, an experienced ICU nurse, was the resource ("help all") nurse called to the MRI Department that was short-staffed. She was tasked to administer midazolam to Charlene Murphey to reduce anxiety, under the classic trade name "Versed," which was not in the drug list of the medication dispensing system.

Ms. Vaught, who was mentoring a student that day, did not routinely administer midazolam. She did not know that Versed and midazolam are the same medication, and she could not find it in the automated medication dispensing cabinet. She used the override function that led to her picking up a vial of vecuronium, which was the first listed drug and coincidentally had the same first two letters "VE" as Versed. It was common for nurses to override warnings; doing otherwise would often make care impossible, especially in emergency situations. Thus, nurse Vaught retrieved vecuronium and, for whatever

reason, did not read the label and warnings about its paralytic properties. In addition, she did not realize that vecuronium required reconstitution with a solvent and midazolam did not. Because the MRI Department did not yet have bar coding scanning in place, her usual practice of doing so was not executed. Having other assignments in the Emergency Department with her student, she left the patient with a radiology technician who took her to a holding area where she was left unmonitored. The outcome of this action needs no explanation to an anesthesiology audience.[2]

The health care organization privately paid an undisclosed sum to the family as compensation, with agreement that the family remain silent. The organization did not report the event, as required, to regulatory bodies. It was almost a year later, through a whistleblower, that the event became known to regulators, after which action was taken, including the beginning of prosecution of the nurse.[4]

This event came more into the public eye when the prosecution began in 2022. In response, Dan Cole, MD, president of APSF, convened a multidisciplinary task force that was charged to develop an APSF position statement and policy for action for similar future events. The members of the task force included a leader of a patient advocacy organization, health care providers (anesthesiologists, CRNA, pharmacist, and surgeon), risk management professional, lawyer, and biomedical engineer/patient safety leader. Immediately upon starting its work, the task force decided that the focus should be more on prevention of future harm by instituting safer practices immediately as well as developing new ones. As noted in the position paper, this is in the founding spirit of APSF. Under the leadership of its founding President, Ellison C. Pierce, Jr., MD, APSF sought to prevent adverse outcomes as the means to address the crisis in rising malpractice payouts. Given that success, the natural path to obviating prosecution of well-intentioned health care providers, as well as protecting them from becoming second victims, should be to create and implement actions that make it nearly impossible to cause harm to patients from preventable causes.

We, on the task force, recognized that the nurse has culpability and that in such cases, disciplinary and other actions may be warranted. Yet, we explain in the position paper why we feel criminalization of medical error is unjust and counterproductive and why APSF is addressing this issue now. We call health care organizations to act now with specific suggestions to prevent errors and acknowledge those that do occur. We advocate for actions that health care professionals can take now to combat medication error and failure to monitor and improve their organization's safety culture. We hope that health care organizations will support a "Just Culture," where prevention of harm is the focus, and where managers and health care providers are encouraged to design safety

See "Editorial: Criminalization," Next Page

Position Statement on Criminalization of Medical Error (Cont'd)

From "Editorial: Criminalization," Preceding Page

systems and make safe choices for patient care.[4] Lastly, we state what APSF will do to support perioperative professionals should they be prosecuted unjustly and how APSF will foster patient safety prompted by events such as this recent case.

We hope all readers of this *Newsletter* will take the time to learn lessons from this tragedy so that we collectively honor Ms. Murphey and all patients who are harmed by adverse events whether in perioperative care or anywhere during their health care experience. Ask questions of and push your own hospital, department, and yourself to do what is possible to apply best current safety practices and encourage a culture of safety. Please become part of that effort; if you already are, amplify your activities. Collectively, we can make a difference.

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REFERENCES

1. Reason, J. A system approach to organizational error. *Ergonomics*. 1995;38:1708–1721.
2. Kelman B. Former nurse found guilty in accidental injection death of 75-year-old patient. https://www.npr.org/sections/health-shots/2022/03/25/1088902487/former-nurse-found-guilty-in-accidental-injection-death-of-75-year-old-patient. *Health News from NPR*. Accessed May 25, 2022.
3. Kelman B. No prison time for Tennessee nurse convicted of fatal drug error. https://khn.org/news/article/radonda-vaught-nurse-homicide-sentencing-probation-drug-error/. *Kaiser Health News*. Accessed May 25, 2002.
4. Reckless homicide at Vanderbilt? A just culture analysis. https://www.justculture.com/reckless-homicide-at-vanderbilt-a-just-culture-analysis/. *The Just Culture Company*. Accessed May 25, 2022.