

IHI and LLI Statement About the Risks to Patient Safety When Medical Errors are Criminalized

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The Institute for Healthcare Improvement (IHI) and the IHI Lucian Leape Institute (LLI) lament the tragic death of a patient at Vanderbilt University Medical Center in late 2017 after a medication error and extend our sympathies to the family who suffered this loss. This event demonstrates the inherent and serious risks involved in patient care. It also demonstrates the ever-present need for effective, reliable, and resilient systems, and professional accountability for ensuring patient safety. The decision to criminally charge the nurse who administered the wrong medication with reckless homicide and impaired adult abuse is not a remedy.

We know from decades of work in hospitals and other care settings that most medical errors result from flawed systems, not reckless practitioners. We also know that systems can learn from errors and improve, but only when those systems encourage reporting, transparently acknowledge their mistakes, and are held accountable for those errors.

Criminal prosecution over-focuses on the individual and their behavior and diverts needed attention from system-level problems and their solutions. This is not how safety is achieved in health care.

Patient safety improves in organizations with fair and just cultures that value transparency, openness, honesty, learning, and accountability at the system and individual level. Criminalizing medical error creates environments and cultures of fear and blame that are directly counterproductive to patient safety, and reverses the hard-earned progress that has been made by health professionals around the world. Put simply, this prosecution makes patients less safe.

Creating more fear in a health workforce already stretched to its breaking point by the COVID-19 pandemic is the last thing our systems need. All health workers, and especially nurses, need to feel our support right now. They must not be made to fear that a mistake will cost them their livelihood. This will only serve to drive more out of the profession and make it less desirable for the next generation of caregivers.

This case has already damaged patient safety. Were this practice to be repeated in future cases of a serious or fatal error, there will be more damage, less transparency, less accountability, and more lives lost. Instead, this case should be a wake-up call to health system leaders who need to proactively identify system faults and risks and prevent harm to patients and those who care for them.

In the spirit of improvement and based on many years of experience and careful thought, we offer some guidance on how best to respond to a serious clinical adverse event. These recommendations are rooted in the concept of “just culture” and its key emphasis on system-level accountability and learning:

- Minimize further harm to the patient and relieve suffering;
- Transparently report the error to administrative and clinical authorities and the patient’s care team as soon as it is known to have occurred;

- Transparently communicate to the patient and their family about the harm that the patient experienced, including what happened, why it happened, and what's being done to prevent it from happening again;
- Apologize to the family and the community, clearly conveying regret that the incident happened, and determination to prevent similar incidents in the future;
- Provide immediate and long-term support to all staff involved;
- Ensure that the board of trustees and leadership are immediately alerted and are actively engaged in understanding why systems failed and how best to use the event as a learning opportunity to improve safety systems;
- Thoroughly investigate the incident and ground that investigation in organizational values, integrity, and a commitment to doing the right thing;
- Follow through to ensure that the lessons learned are being incorporated to improve the system in a timely and iterative manner; and
- Pay as much attention to near-misses as we do to serious safety incidents that result in harm so that the system anticipates risks proactively instead of remaining in a reactive mode.

Institute for Healthcare Improvement (IHI)

IHI Lucian Leape Institute