TO ERR IS HUMAN, UNLESS YOU ARE A HEALTHCARE PROVIDER

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I. INTRODUCTION

Charlene Murphy was admitted to the Neurological Intensive Care Unit ("Neuro ICU") at Vanderbilt University Medical Center ("VUMC") on December 24, 2017, with an intraparenchymal hematoma. [1] After showing significant improvement, Ms. Murphy was transferred from the Neuro ICU to the Neurological Step-Down Unit.[2] Less than twenty-four hours later, Ms. Murphy was declared dead.[3]

[1] U.S. Dep't of Health and Human Services, Centers for Medicare and Medicaid Services ("CMS"), *Statement of Deficiencies and Plan of Correction*, Vanderbilt University Medical Center (Nov. 8, 2018), at 6-7 [hereinafter "CNS Statement"].
[2] *Id. at* 8.
[3] *Id.* at 52.

Ms. Murphy spent her life in Gallatin, Tennessee, and worked at the local Walmart for twenty-four years.[4] Married for more than fifty-years with two sons, seven grandchildren, and several great-grandchildren, Ms. Murphy's family described her as a "born-again Christian with a friendly smile, a generous spirit and an enthusiastic love of yard sales."[5] Despite experiencing headaches and vision loss, Ms. Murphy was relatively healthy before she went to the hospital on December 24, 2017.[6] Ultimately, Ms. Murphy was diagnosed with a brain bleed, which the doctors suspected was caused by a brain mass.[7] To evaluate the potential mass in Ms. Murphy's brain, Ms. Murphy's physician ordered a Positron Emission Tomography ("PET") scan.[8] On December 26, Ms. Murphy was transported to the Radiology Department, and while there, she complained of claustrophobia and requested anxiety medication, prompting her physician to order her Versed.[9] The Versed administration instructions read, "For PET scan if first milligram is insufficient, can give 1-2 mg additional if needed…."[10] The radiology technician contacted Ms. Murphy's nurse to come and administer the Versed, but the nurse could not leave her other patients.[11] Not wanting Ms. Murphy's scan to be delayed, the nurse asked the help-all nurse, RaDonda Vaught, to go down to the Radiology Department to administer the versed to Ms. Murphy.[12]

Ms. Murphy's physician placed the order for the Versed at 2:47 PM, and the pharmacist verified the Versed at 2:49 PM.[13] While discussing another patient with an orientee, Ms. Vaught searched for Versed under Ms. Murphy's profile in the Automated Dispensing Cabinet ("ADC").[14] Unable to locate the Versed under Ms. Murphy's profile, Ms. Vaught selected the override function, searched "VE," and chose the first medication that appeared on the

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[4] Brett Kelman, *Vanderbilt death: Victim would forgive nurse who mixed up meds, son says*, THE TENNESSEAN (Feb. 6, 2019, 5:05 PM), https://www.tennessean.com/story/news/health/2019/02/04/vanderbilt-deadly-vecuronium-error-victim-would-forgive-nurse-son-says/2774381002/.

[5] *Id.*; *see also* CHARLENE MARIE MURPHY OBITUARY, CRESTVIEW FUNERAL HOME, MEMORY GARDENS & CREMATION, https://www.crestviewfh.com/obit/charlene-marie-murphey/ (last visited Dec. 1, 2020).

[6] *Id.* at 7.

[7] *Id.*

[8] *Id.* at 45.

[9] *Id.* at 7. Midazolam, marketed under the brand name Versed, is a benzodiazepine that is often used for sedation and in the treatment of anxiety and amnesia. *See* Reed T. Drug Label 55154-2883.

[10] CNS Statement, *supra* note 1, at 7, 20.

[11] *Id.* at 22-23.

[12] *Id.* at 23.

[13] *Id.* at 7.

[14] CNS Statement, *supra* note 1, at 23.

list.[15] At 2:59 PM, Ms. Vaught pulled Vecuronium[16] 10 milligrams from the ADC in the Neuro ICU using the override feature.[17]

Ms. Vaught read the reconstitution instructions on the back of the Vecuronium vial; she then collected a handful of flushes, alcohol swabs, and a blunt tip needle, and placed them in a baggie.[18] Ms. Vaught put one of Ms. Murphy's patient labels on the bag and wrote, "PET scan, Versed 1-2mg" and proceeded to the Radiology Department.[19] Ms. Vaught recognized Ms. Murphy on one of the Neuro ICU beds, so she checked Ms. Murphy's armband and told her she was going "to give her something to help her relax."[20] Ms. Vaught reconstituted the Vecuronium based on the instructions on the back of the vial and administered it to Ms. Murphy before going to the Emergency Department to assess another patient.[21]

Approximately thirty minutes later, at 3:29 PM, the patient's family, nurse, and Ms. Vaught were back on the sixth floor of the critical care tower when they heard an overhead page for a rapid response in radiology.[22] Unsure what patient the rapid response was called for, Ms. Vaught rushed to the Radiology Department and found Ms. Murphy intubated.[23] A transporter had found Ms. Murphy unresponsive and pulseless and began chest compressions, prompting the overhead page.[24]

Once back in the Neuro ICU, Ms. Vaught discovered that she mistakenly administered Vecuronium to Ms. Murphy instead of Versed.[25] Ms. Vaught immediately went to Ms. Murphy's room, where several physicians and a nurse practitioner were discussing Ms. Murphy's condition.[26] Ms. Vaught admitted that she had inadvertently given Ms. Murphy Vecuronium.[27] At that moment, everyone in the room knew what happened.[28] Before leaving the room, the nurse practitioner told Ms. Vaught, "I'm so sorry."[29] Ms.

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[15] *Id.* at 23-24.
[16] Reed T. Drug Label 23360-160 (Vecuronium is a paralytic agent "indicated as an adjunct to general anesthesia, to facilitate endotracheal intubation and to provide skeletal muscle relaxation during surgery or mechanical violation." It has no "known effect on consciousness, the pain threshold or cerebration.").
[17] CNS Statement, *supra* note 1, at 7.
[18] *Id.* at 9.
[19] *Id.*
[20] *Id.*
[21] *Id.* at 10.
[22] *Id.* at 10.
[23] CNS Statement, *supra* note 1, at 10.
[24] *Id.* at 21.
[25] *Id.* at 24.
[26] *Id.*
[27] *Id.*
[28] CNS Statement, *supra* note 1, at 24.
[29] *Id.*

Vaught spoke to management and filled out a Veritas report before leaving the hospital after 8:00 PM.[30]

In the early morning of December 27, 2017, after showing signs of "progression towards but not complete brain death," and a "very low likelihood of neurological recovery," Ms. Murphy's family chose to pursue comfort care measures.[31] Ms. Murphy's resuscitation order was changed from Full Code to Do Not Resuscitate ("DNR"), and she was extubated. At 1:07 AM, Ms. Murphy was declared dead.[32]

Ms. Vaught did not return to VUMC until January 3, 2018, when she was terminated.[33] More than a year later, on February 1, 2019, Ms. Vaught was indicted for reckless homicide and impaired adult abuse.[34] She faces up to twelve years in prison for her mistake.[35]

Almost twenty-years before Ms. Murphy was the victim of a fatal medication error, the Institute of Medicine ("IOM") released a report entitled, *To Err Is Human: Building a Safer Health System*. In this report, the IOM revealed that between 44,000 and 98,000 Americans die each year due to medical error.[36] More recently, in May of 2016, John Hopkins published a study that listed medical errors as the third leading cause of death in the United States, claiming 251,000 lives every year.[37] The 1999 IOM Report laid out a plan to improve quality of care by reducing errors and improving patient safety.[38] The Report explained that for that plan to be met, the culture of blame needed to be broken down because blaming an individual does not change the underlying factors which contribute to an error, so the same error is likely to recur.[39] The Report emphasized that to prevent errors and improve patient safety, there

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[30] *Id.* at 25.
[31] *Id.* at 8.
[32] *Id.* at 8.
[33] *Id*. at 11.
[34] Tennessee Bureau of Investigation, *Middle Tennessee Nurse Charged with Patient Abuse, Reckless Homicide*, TBINEWSROOM (Feb. 4, 2019), https://tbinewsroom.com/2019/02/04/middle-tennessee-nurse-charged-with-patient-abuse-reckless-homicide/.
[35] *See* Tenn. Code Ann. § 39-13-215 (Lexis Advance through the 2019 Regular Session); and Tenn. Code Ann. § 40-35-111 (Lexis Advance through the 2019 Regular Session).
[36] Committee on Quality Health Care in America, Institute of Medicine, TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 1 (Linda T. Kohn et al., eds., 2000) [hereinafter "To Err is Human"].
[37] Makary, M. A., & Daniel, M., *Medical error - the third leading cause of death,* BMJ (2016).
[38] To Err is Human, *supra* note 36, at 5.
[39] To Err is Human, *supra* note 36, at 49.

needs to be a shift in focus to a systems approach to modify the conditions that contribute to errors.[40]

Despite the IOM's 1999 Report, the number of criminal prosecutions of health care providers is on the rise.[41] The first criminal prosecution for a medical act dates back to 1809.[42] Over the next 172 years, appellate courts would hear roughly fifteen similar cases.[43] However, from 1981 to 2001, approximately twenty-four cases of criminally prosecuting health care providers were heard by lower courts alone.[44] This number continues to rise, leading to a heightened concern amongst the medical community, which may lead to dire effects on patient safety.[45]

This note will explore the rise of criminal prosecutions of health care providers for medical errors, absent any intent to harm.[46] This note will demonstrate that in the interest of patient safety and error prevention, there are alternative forms of punishment, other than criminal prosecution, that are better suited to address medical errors when there is no intent to do harm. Part II of this note lays out mechanisms currently in place to address medical errors. Part III attempts to address why some cases are criminally prosecuted by analyzing specific cases. Next, Part IV explores arguments for and against criminal penalties for medical errors. Finally, Part V concludes with the recommendation to improve upon the mechanisms currently in place to address medical errors rather than relying on criminal prosecution.

II. MECHANISMS FOR ADDRESSING MEDICAL ERRORS

Extra-judicial oversight activities carried out by entities such as state licensure and discipline boards, hospital peer review committees, national regulations such as the Health Care Quality Improvement Act of 1986, and civil actions constitute fundamental quality control mechanisms in place to address medical errors.[47] While no one suggests that the current system is perfect, many

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[40] *Id.*
[41] Christopher J. Kim, *The Trial of Conrad Murray: Prosecuting Physicians for Criminally Negligent Over-Prescription*, 51 AM. CRIM. L. REV. 517, 519 (2014).
[42] E. Monico et al., *The Criminal Prosecution of Medical Negligence*, 5 THE INTERNET J. OF LAW, HEALTHCARE AND ETHICS 1, 3 (2006); *See* Com. v. Thompson, 6 Mass. 134, 134 (1809).
[43] *Id.*
[44] *Id.*
[45] Alexander McCall Smith, *Criminal or Merely Human?: The Prosecution of Negligent Doctors*, 12 J. CONTEMP. HEALTH L. & POL'Y 131 (1995).
[46] For purposes of this note, an intent to do harm includes impaired healthcare providers.
[47] Robert B Leflar & Futoshi Iwata, *Medical Error as a Reportable Error, as Tort, as Crime: a Transpacific Comparison*, 12 WIDENER L. REV. 189, 191 (2005).

experts recognize that errors result from systems failures.[48] Therefore, to improve patient safety and prevent error, we must unqualifiedly embrace an approach of complete disclosure and transparency.[49] Critics suggest that these mechanisms are inefficient in protecting consumers.[50] These critics point to cases like the notorious Dallas neurosurgeon Christopher Duntsch, who injured almost every patient he treated in the roughly two years that he practiced medicine in Dallas, Texas.[51] Dr. Duntsch operated on thirty-eight patients, thirty-five of which were injured during or after these procedures, "suffering almost unheard-of complications" from nerve damage, to paralysis, and death.[52] Critics use the case of Christopher Duntsch to highlight the inadequacies of the current system, including state licensure, peer review, the National Practitioner Data Bank, and civil actions.

A. **STATE LICENSURE**

Every state has licensing boards tasked with protecting the public health and welfare by enforcing various state practice acts (e.g., nurse practice act, medical practice act, dental practice act, etc.).[53] Historically, a state licensing board was made up of almost all members of that given profession.[54] Today, practically every state requires some lay members "on the theory that they are more likely to hold errant [members] accountable."[55] For example, "[t]he typical medical board today has ten to fifteen members and usually covers osteopathic physicians. . . and no state has a majority of non-physicians."[56] State governors appoint board members to a term of three to eight years depending on the state and are typically funded from licensure fees.[57]

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[48] Joanna C. Schwartz, Note, *Systems Failures in Policing*, 51 SUFFOLK U. L. REV. 535, 544 (2018).
[49] *Id.*
[50] Kara M. McCarthy, Note, *Doing Time for Clinical Crime: The Prosecution of Incompetent Physicians as an Additional Mechanism to Assure Quality Health Care*, 28 SETON HALL L. REV. 569, 614 (1997).
[51] Lauren Beil, *A Surgeon So Bad it was Criminal,* PROPUBLICA (Oct. 2, 2018, 5:00 AM), https://www.propublica.org/article/dr-death-christopher-duntsch-a-surgeon-so-bad-it-was-criminal.
[52] *Id.*
[53] Pablo Aligathe & Randall R. Bovbjerg, *State discipline of physicians: assessing state medical boards through case studies ASPE*, THE URBAN INSTITUTE, HEALTH POLICY CENTER (2006) https://aspe.hhs.gov/basic-report/state-discipline-physicians-assessing-state-medical-boards-thruogh-case-studies [hereinafter "Assessing State Medical Boards"].
[54] *Id.* at 11.
[55] *Id.*
[56] *Id.*
[57] *Id.* at 12, 15.

The two main regulatory functions of state licensing boards are licensure and discipline.[58] Meeting these regulatory functions, state licensing boards license health care professionals, investigate complaints, discipline providers who violate their practice act, and refer providers for evaluation and rehabilitation when appropriate.[59] Licensure requires a demonstration that a member of a given profession has met the minimum education requirements and can demonstrate their knowledge. [60] Licensure boards stipulate "minimum education, training requirements, and certification, among other criteria, for those who seek to acquire or maintain a license to practice a given profession or provide certain services"[61] In summary, licensure ensures the competence of the member of the profession at the time they join the profession.[62]

In contrast, discipline oversees the ongoing practice in a state. [63] Members of a profession can be disciplined for misbehaviors, from business offenses to quality care problems.[64] Disciplinary actions range from non-public warning letters to public reprimand and suspension of license to practice.[65] "The theory is that discipline protects the public directly by removing some problem [members] from practice, restricting their scope of practice, or improving their practice."[66] The threat of discipline also acts to deter members of a profession from practicing beyond their capabilities.[67]

Several factors are impediments or barriers to effective discipline.[68] These factors include low funding and staffing, the capture of boards by medical interests, insufficient legal framework, high costs of investigation and formal legal processes, and fear of litigation by aggrieved members. [69] The disciplinary process typically involves five stages: intake, investigation, pre-hearing process, hearing, and action, with most complaints originating from the public. [70] Three-quarters of investigations end with closure

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[58] *Id.* at 55.
[59] TENNESSEE DEP'T OF HEALTH, HEALTH RELATED BOARDS, https://www.tn.gov/health/health-program-areas/health-professional-boards.html (last visited January 28, 2021).
[60] Assessing State Medical Boards, *supra* note 53, at 8.
[61] *See Joint Hearing on Health Care and Competition Law and Policy Before the FTC and Department of Justice*, 33-34 (Jun. 10, 2003) (statement of Dr. Morris Kleiner).
[62] Assessing State Medical Boards, *supra* note 53, at 8.
[63] *Id.*
[64] *Id.*
[65] *Id.*
[66] *Id.* at 8-9.
[67] *Id*. at 9.
[68] *Id.*
[69] *Id.* at 9-10.
[70] *Id.* at 20.

during the investigation because of insufficient evidence to support board action, and only 1.5% of complaints reach a formal hearing.[71] Overall, about 10% of initial complaints result in some level of sanction. A consistent problem all state licensing boards face is backlogging.[72] When a board fails to take prompt action to a report of a member not practicing safely, the board fails to protect the public.[73] This problem was demonstrated in California in the 1990s when a large backlog of uninvestigated complaints resulted in controversial administrative closure of cases without investigations.[74] Similarly, in 2004, an Iowa backlog reached approximately two years' worth of investigations leading to substantial changes in procedures.[75] Massachusetts' large backlog of cases in 1999 led to bad publicity, a crash program of catch-up and review, and a change in leadership.[76] The amount of time it takes to resolve a case depends greatly on how far the case proceeds through the disciplinary process.[77] "Nationally, cases resolved before or during investigation averaged 180 days from intake to closure, 425 days for cases closed after investigation but before hearing, and 675 days to reach a hearing."[78]

Skeptics of state licensing boards believe the boards are ineffective in weeding out incompetent members of a profession, pointing to understaffing, underfunding, and the failure of a self-policing system.[79] While critics often recognize that state licensing boards may offer some protection, they claim that protection is limited by requiring minimum qualifications rather than optimal qualifications. Additionally, these critics believe that once a member of a profession is granted a license, state licensing boards are ineffective at removing members who fail to retain these minimum qualifications.[80] They believe state licensing boards do little to maintain optimal levels of care and protection for patients.[81] However, state licensing boards play an essential role in health care safety and quality assurance because these boards are the only entities with the power to stop members from practicing beyond their scope of practice.[82] If a board can overcome understaffing,

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[71] *Id.* at 26.
[72] *Id.* at 29.
[73] *Id.* at 31.
[74] *Id.*
[75] *Id.*
[76] *Id.*
[77] *Id.* at 32.
[78] *Id.*
[79] McCarthy, *supra* note 50, at 585.
[80] *Id.* at 588.
[81] *Id. at* 588-589.
[82] Assessing State Medical Boards, *supra* note 53, at 63.

underfunding, and outside interests, then it can be successful in protecting the public by moving cases quickly through the disciplinary process to impose appropriate sanctions.[83]

B. **PEER REVIEW**

Attempting to improve the nationwide quality of health care, Congress passed the Health Care Quality Improvement Act of 1986. Congress encouraged good faith peer review by granting immunity to participants in the peer review process.[84] A peer review system is necessary for a hospital's participation in Medicare and accreditation by the Joint Commission.[85] Peer review committees, made up of practicing providers who have specialized knowledge, analyze providers' training, qualifications, and experience upon initial employment, every two years thereafter, and anytime a health care entity has reason to believe quality concerns exist.[86] The peer review committee then recommends whether the provider shall receive or retain medical staff privileges and whether that physician shall have any limitations placed on that privilege.[87] This process is used to evaluate and improve provider quality while preventing providers from practicing substandard medicine.[88]

However, peer review is not without limitations.[89] A peer review system inherently forces providers to pass judgment on their colleagues' professional conduct, but generally, no one wants to speak up.[90] One expert recognized, "[d]octors know who the outliers are. Nurses know. They will know before anyone else knows. You know who you would and would not send your loved one to. But physicians do not want to point fingers. Clearly, anyone can make a mistake, but typically these are not just mistakes, these are violations of standards of care."[91]

Additionally, experts contend that the immunity granted to the peer review process has "the paradoxical effect of undermining

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[83] *Id.* at 64.
[84] Anthony W. Rodgers, Comment, *Procedural Protections During Medical Peer Review: A Reinterpretation of the Health Care Quality Improvement Act of 1986*, 111 PENN ST. L. REV. 1047, 1047 (2007).
[85] Michael Benson et al., *Hospital Quality Improvement: Are peer reviewed immunity, privilege, and confidentiality in the public interest?,* 11 NW. J. L. & SOC. POL'Y. 1, 3 (2016).
[86] Susan O. Scheutzow, *State Medical Peer Review: High Cost but No Benefit-Is It Time for A Change?,* 25 AM. J.L. & MED. 7, 21 (1999).
[87] Rodgers, *supra* note 84, at 1049.
[88] Scheutzow, *supra* note 86, at 14.
[89] McCarthy, *supra* note 50, at 591.
[90] *Id.*
[91] Michael J. Lee, *On Patient Safety: How well do we police ourselves?*, 473 CLINICAL ORTHOPEDICS AND RELATED RESEARCH 1552, 1553 (Jan. 31, 2015).

the quality assurance function of peer review."[92] On the one hand, critics point to bad-faith or a "sham" peer review, and on the other hand, to improper motives for leniency.[93] In some cases, hospitals have used the peer review process to retaliate against doctors. In effect, "the wide perception among doctors that whistleblowers may be punished with sham peer review has an in terrorem effect, discouraging doctors from challenging hospital administrators on issues of healthcare quality."[94] Thus, contributing to a provider's unwillingness to speak up.[95] On the other end of the spectrum, there are often improper motives for leniency at play in the peer review process, including friendships and collaborative relationships.[96] However, because the peer review process is confidential, it would be challenging to discover that a justifiable punishment was withheld due to improper motivations.[97]

While the immunity granted to the peer review process has its setbacks, it also encourages physicians to participate in peer review by protecting them from lawsuits by disciplined physicians.[98] "[D]octors are the most familiar with the relevant standard of care, and hence are best able to judge their fellow physicians, but the fear of litigation discourages them from participating."[99] Further, the peer review process allows hospitals to learn from their mistakes and appropriately address affected parties.[100] Ideally, the protections in place would encourage self-reporting, which would enable peer review committees "to investigate the situation, attempt to settle grievances with the patient, and provide education to other health care providers to reduce the occurrence of such mistakes in the future."[101] Thus, peer review can serve as a pillar of quality assurance in healthcare despite its limitations.[102]

C. NATIONAL PRACTITIONER DATA BANK

In addition to granting immunity to participants in the peer review process, the Health Care Quality Improvement Act of 1986

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[92] Benson, *supra* note 85, at 8.
[93] *Id.* at 10.
[94] *Id.* at 9.
[95] *Id.*
[96] *Id.* at 10.
[97] *Id.*
[98] *Id.* at 7.
[99] *Id.*
[100] *Id.* at 8.
[101] *Id.*
[102] McCarthy, *supra* note 50, at 576.

established the National Practitioner Data Bank ("NPDB").[103] To increase support for the peer review immunity provision, the NPDB serves as a quid pro quo provision, compiling certain disciplinary information about health care providers, particularly physicians.[104] The NPDB "is a web-based repository that provides confidential information that employers may query in order to review whether a license is encumbered by a regulatory board action as well as review any reports of malpractice payments or other credentialing results."[105] The NPDB helps prevent providers who have had their privileges revoked by a health care institution from simply switching institutions to gain privileges and continue their practice.[106]

The NPDB includes two basic provisions, reporting and querying. Hospitals are required to report certain disciplinary matters to the NPDB.[107] Generally, matters that affect clinical privileges for over thirty days and are based on competence or professional conduct that could adversely affect the health or welfare of a patient must be reported.[108] While health centers are only required to report clinical privilege actions taken against physicians and dentists, they may report similar actions taken against other licensed health care professionals.[109] In fact, nursing is the most commonly reported profession to the data bank.[110] In addition, medical malpractice payors must also report any payments resulting from a final judgment in, or written settlement of, a medical malpractice claim.[111] The NPDB also serves as a check for hospitals, as hospitals are required to query the NPDB.[112] This query must occur when any licensed health care practitioner seeks

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[103] Yann H.H. Van Geertruyden, *The Fox Guarding the Henhouse: How the Health Care Quality Improvement Act of 1986 and State Peer Review Protection Statutes Have Helped Protect Bad Faith Peer Review in the Medical Community*, 18 J. CONTEMP. HEALTH L. & POL'Y 239, 246 (2001).
[104] Ilene N. Moore, MD, JD et. al., *Rethinking Peer Review: Detecting and Addressing Medical Malpractice Claims Risk*, 59 VAND. L. REV. 1175, 1180 (2006).
[105] Kathleen Russell, *Reporting of Nurse Discipline to the National Practitioner Data Bank,* 9 J. NURSING REG. 21, 21 (2018).
[106] Van Geertruyden, *supra* note 103, at 247.
[107] *See* 42 U.S.C.A. § 11133(a)(1).
[108] U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *NPDB Guidebook* (2018), https://www.npdb.hrsa.gov/resources/NPDBGuidebook.pdf (last visited Jan. 28, 2021).
[109] *Can health care centers report or query on health care practioners who are not physicians or dentists?*, NPDB, https://www.npdb.hrsa.gov/qa/hc3.jsp (last visited Jan. 28, 2021).
[110] *Id.*
[111] 42 U.S.C.A. § 11133(a).
[112] William O. Quirey Jr. & Jeannie Adams, *National Practitioner Date Bank Revisited - The Lessons of Michael Swango, M.D.* 1, 3, https://www.vsb.org/sections/hl/bank.pdf (last visited Jan. 28, 2021).

admission to the medical staff or applies for clinical privileges and every two years thereafter.[113]

The NPDB can be a useful tool in quality assurance if appropriately used.[114] However, that is not always the case.[115] According to numbers from the Health Resources and Services Administration, "[i]n 2017, 30 state medical boards in the U.S. backgrounded a physician using the database fewer than 100 times. . . [t]hirteen boards didn't even check it once."[116] In addition, one investigation "identified more than 500 physicians who have had problems in one jurisdiction but were allowed to practice with clean licenses in another."[117] Health care providers also raise the concern that the data bank is being misused.[118] The Association of American Physicians and Surgeons recognized the purpose of the data bank is "to prevent so called bad doctors from moving state to state," however, "damaging information is being entered into this data bank with no regard to accuracy" and "good physicians are being reported to the data bank for reasons totally unrelated to patient care."[119] An additional limitation to the NPDB is that the general public cannot obtain access to the information.[120] As a result, consumers are at the mercy of the health care facilities and the state licensing boards to protect them.[121] This limitation is further emphasized by the wide variation in the character of the events being reported and substantial underreporting.[122]

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[113] *Id.*
[114] Matt Wynn & John Fauber, *NPDB Records Often Ignored in Docs' Licensing -Most Medical Boards Rarely Look at Practitioner Data Bak,* MEDPAGE TODAY (Mar. 7, 2018), https://www.medpagetoday.com/special-reports/states-of-disgrace/71600.
[115] *Id.*
[116] *Id.*
[117] *Id.*
[118] *AAPS Tells Congress: NPDB is Flawed and Should Be Abolished,* AM. ASS'N OF PHARM. SCIENTISTS (Feb. 20, 2018), https://aapsonline.org/aaps-tells-congress-npdb-flawed/.
[119] *Id.*
[120] McCarthy, *supra* note 50, 597-598.
[121] *Id.* at 598.
[122] Haavi Morreim, *Malpractice, Mediation, and Moral Hazard: The Virtues of Dodging the Data Bank*, 27 OHIO ST. J. ON DISP. RESOL. 109, 112 (2012).

D. CIVIL ACTIONS

Derived from English common law and developed by rulings in state courts, in the United States medical malpractice lawsuits are a relatively common occurrence.[123] To succeed in a medical malpractice action, an injured patient must show that the provider acted negligently in rendering care and that such negligence resulted in the patient's injury.[124] Medical malpractice actions include four essential elements: a professional duty owed to the patient, a breach of such duty, injury caused by the breach, and resulting damages.[125] These actions require comparing a provider wrongdoer's conduct with the conduct of a reasonable provider with similar skill, training, and knowledge under the same or similar conditions.[126] If the provider's conduct falls below this established standard of care, then the provider is liable.[127] The focus is on an individual provider's medical errors that result in harm, relies on a judge or a jury to evaluate that medical error, and imposes monetary damages if the provider is liable.[128]

While deterring health care professionals from practicing negligently and committing medical errors, the four principal objectives of medical malpractice actions are to achieve justice, compensate those injured, quality improvement via deterrence, and sometimes punishment.[129] As a result, patients might expect medical malpractice actions to act as a deterrent to the improper practice of medicine and to compensate victims.[130] However, only a small number of harmed patients receive compensation.[131]

Ideally, the threat of medical malpractice would force health care professionals to take remedial steps to improve the quality of care they provide.[132] However, experts suggest that in reality, the threat leads to defensive medicine, impairs providers' quality of performance, and inhibits communication.[133] Perceived threats of medical malpractice force physicians to order tests and procedures

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[123] B. Sonny Bal, *An Introduction to Medical Malpractice in the United States,* 467 CLINICAL ORTHOPEDICS AND RELATED RES. 339, 339 (2012).
[124] *Id.*
[125] *Id.* at 342.
[126] McCarthy, *supra* note 50, at 577.
[127] *Id.*
[128] *Id.* at 575-576.
[129] Morreim, *supra* note 122, at 113.
[130] Joseph S. Kass & Rachel V. Rose, *Medical Malpractice Reform: Historical Approaches, Alternative Models, and Communication and Resolution Programs,* 18 AMA. J. ETHICS 299, 300 (2016).
[131] *Id.*
[132] Scheutzow, *supra* note 86, at 15.
[133] Morreim, *supra* note 122, at 115-116.

to reduce the perceived risk of litigation. These unnecessary tests can result in billions of dollars annually and can cascade further testing and injury.[134] In addition, "evidence suggests that physicians named in a lawsuit tend to suffer a marked increase in symptoms of depression, including fatigue, insomnia, difficulty concentrating, decreased self-confidence, or a loss of nerve in clinical activities."[135] Medical malpractice actions focus on pinpointing blame resulting in the inhibition of essential communication and system-level quality improvement.[136] Experts recognize that while individuals should be responsible for the quality of their work, a "'bad apple' approach of the tort system focuses on outliers rather than on more pervasive influences."[137] To improve quality, we must understand the problem in detail through ongoing communication and problem-solving.[138] Nonetheless, many experts still view medical malpractice as "a critical component of a comprehensive patient safety solution" and should be viewed as a "productive patient safety tool, one with sharp edges that help increase attention to medical error that cause death or permanent harm to patients."[139]

E. INADEQUACIES OF THE CURRENT SYSTEM

Dr. Christopher Duntsch, made infamous in part by the hit podcast "Dr. Death," was a Texas neurosurgeon whose incompetence led to two patient deaths and more than two dozen other patients maimed or paralyzed.[140] In June 2011, Dr. Duntsch began practicing with Minimally Invasive Spine Institute in Dallas and had surgical privileges at Baylor Regional Medical Center in Plano, Texas.[141] In Fall 2011, Dr. Duntsch performed multiple procedures at Baylor that resulted in lawsuits and permanent injuries to three patients.[142] Then, in February 2012, Dr. Duntsch operated on his close friend, leaving him paralyzed from the neck down and

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[134] *Id.* at 115.
[135] *Id.*
[136] *Id.* at 117.
[137] *Id.*
[138] *Id.*
[139] Barry R. Furrow, *The Patient Injury Epidemic: Medical Malpractice Litigation as a Curative Tool,* 4 DREXEL L. REV. 41, 49-50 (2011).
[140] Tanya Eiserer & Mark Smith, *'Dr. Death' highlights loopholes putting patients at risk* (Feb. 10, 2020, 10:23 PM), https://www.wfaa.com/article/news/local/investigates/two-thirds-of-texas-hospitals-have-never-reported-a-bad-doctor-to-national-practitioner-data-bank-records-show/287-13d9f229-43e1-4c0c-8261-4933b09c55e8.
[141] Alan Condon, *Dr. Death to hit TV screens: A timeline of the former neurosurgeon's case,* BECKER'S SPINE REVIEW (Aug. 27, 2019), https://www.beckersspine.com/spine/item/46730-dr-death-to-hit-tv-screens-a-timeline-of-the-former-neurosurgeon-s-case.html.
[142] *Id.*

resulting in his temporary suspension from Baylor.[143] In Spring 2012, after his suspension was lifted, Dr. Duntsch botched another surgery by cutting a patient's major blood vessel, resulting in the patient's death.[144] Dr. Duntsch was ordered to take a drug test following the incident; the first came back diluted with water, but the second came back clean.[145] Dr. Duntsch resigned from Baylor in April 2012.[146] He left with a recommendation letter that said he had "no restrictions or suspensions" on his clinical privileges during his employment.[147] Baylor did not report Dr. Duntsch to the medical board or the National Practitioner Data Bank.[148]

Following his resignation from Baylor, Dr. Duntsch was granted temporary surgical privileges at Dallas Medical Center.[149] His privileges were revoked after two of his three surgeries resulted in a patient's death and another patient permanently disabled.[150] Dr. Robert Henderson, a fellow neurosurgeon, filed a complaint with the Texas Medical Board.[151] However, while the board investigated, Dr. Duntsch was able to keep operating.[152] In May 2013, Dr. Duntsch performed another operation, leaving that patient with permanent brain damage.[153] It was not until June 2013, after numerous complaints, that the Texas Medical Board suspended Dr. Duntsch's license.[154] In February 2017, Dr. Duntsch was charged with five counts of aggravated assault and one count of injury to an elderly person.[155] Ultimately, Dr. Duntsch was convicted and sentenced to life in prison.[156]

The safeguards implemented to protect patients failed when Dr. Duntsch, an incompetent and dangerous physician, was able to continue practicing.[157] As of February 2020, two out of three Texas hospitals had never reported a doctor to the NPDB.[158] Dr. Duntsch was able to move from hospital to hospital without anyone reporting

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[143] *Id.*
[144] *Id.*
[145] Hannah Gilham, *How Dr. Death Managed To Operate In Plain Site for So Long* (May 2, 2019), https://www.ranker.com/list/christopher-duntsch-timeline/hannah-gilham.
[146] Condon, *supra* note 141.
[147] *Id.*
[148] Gilham, *supra* note 145.
[149] *Id.*
[150] Condon, *supra* note 141.
[151] *Id.*
[152] Beil, *supra* note 51.
[153]Condon, *supra* note 141.
[154] *Id.*
[155] *Id.*
[156] *Id.*
[157] Beil, *supra* note 51.
[158] Eiserer & Smith, *supra* note 140.

him.[159] A former Texas Medical Board member recognized, "We failed as a profession to try to acknowledge, recognize and try to stop somebody who was harming the public."[160] It took more than six months and multiple catastrophic surgeries before anyone reported Dr. Duntsch to the state medical board.[161] When someone did report, it took the board another year to investigate, all while Dr. Duntsch was still operating.[162]

The case of Dr. Duntsch demonstrates that the mechanisms in place to address medical errors need to be improved upon, but it does not mean that if implemented correctly, they cannot be successful. Nonetheless, the criminal prosecution of Dr. Duntsch was appropriate because of his active drug and alcohol use in addition to his possible intent to harm his patients.

III. WHY SOME HEALTHCARE PROVIDERS ARE CRIMINALLY PROSECUTED

The perceived inadequacies of the mechanisms currently in place to address medical errors may explain the increase of criminal charges against health care providers. Some experts argue that the current safeguards are insufficient to adequately punish health care professionals who consciously disregard a substantial and unjustifiable risk.[163] However, the effect of criminal charges on improving the quality of care and preventing medical errors is largely debatable and may have dire consequences.[164] Criminal prosecution for medical errors focuses on the health care provider involved, even though most errors result from system failures and several factors that culminate in individual error.[165] Further, it is unclear why one case mandates criminal charges, and another does not.

A sentinel event is "an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof… including any process variation for which a recurrence

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[159] Condon, *supra* note 141.
[160] Eiserer & Smith, *supra* note 140.
[161] Beil, *supra* note 51.
[162] *Id.*
[163] McCarthy, *supra* note 50, at 618-619.
[164] *See generally Position Paper on Criminal Prosecution of Health Care Providers for Unintentional Human Error,* TANA.ORG, (Aug. 12, 2011, 5:30 PM), https://taana.org/resource/papers/8859161; Alan Fuchsberg, *When Do Doctor Medical Errors Become Criminal Medical Negligence?*, FUSCHSBERG.COM: BLOG (July 20, 2016), https://www.fuchsberg.com/blog/medical-errors-become-criminal-negligence/.
[165] *See generally* E. Bussey, *Medical Errors Are Result of Systems Failure Medical Errors in U.S. Hospitals Usually Result from Systems Failure,* 9 MEDICO-LEGAL WATCH 96 (2000).

would carry a significant chance of a serious adverse outcome."[166] While sentinel events and medical errors are not synonymous, many sentinel events are the result of preventable medical errors.[167] The Joint Commission reported a total of 824, 804, and 801 sentinel events in 2016, 2017, and 2018 respectively.[168] While the criminal prosecution of medical errors is on the rise, the number of medical errors that result in criminal charges is nominal and disproportional compared to the hundreds of sentinel events and reported 250,000 yearly deaths resulting from medical error. It is unclear at what point a medical error is so egregious to mandate criminal charges, but medical errors that rise to the level of criminal culpability typically tend to involve nurses rather than physicians[169] and involve one or more of the following factors: (1) a highly publicized case, (2) death or serious injury, (3) a failure to self-police, and (4) failure to follow established patient safety measures.

A. **JULIE THAO, RN**

In September 1990, the Wisconsin Board of Nursing licensed Julie Thao as a registered nurse.[170] Starting in 1993, Ms. Thao worked on the labor and delivery unit at St. Mary's Hospital in Madison, Wisconsin.[171] After working two consecutive eight-hour shifts on July 4, 2006, the latter of which ended at midnight, Ms. Thao slept at the hospital before having to report to another eight-hour shift scheduled for 7:00 AM on July 5, 2006.[172] Ms. Thao was assigned two patients; a mother admitted at nineteen-weeks gestation because her membranes had ruptured, and a sixteen-year-

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[166] Jointcommission.org, *Sentinel Events (SE)* (Jan. 2013), https://www.jointcommission.org/-/media/deprecated-unorganized/imported-assets/tjc/system-folders/topics-library/camh_2012_update2_24_sepdf.pdf?db=web&hash=FD320B7BAF3E08EC28B44AA51CB21ABE.

[167] *See generally* Paul R. VanOstenberg & Paul Reis, *Understanding and Preventing Sentinel and Adverse Events*, 8 ICU MANAGEMENT & PRACTICE (2013), https://healthmanagement.org/c/icu/issuearticle/understanding-and-preventing-sentinel-and-adverse-events.

[168] Jointcommission.org, *Summary Data of Sentinel Events Reviewed by the Joint Commission* (July 1, 2019), https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/sentinel-event/summary-2q-2019.pdf.

[169] Mara Gordon, *When a Nurse is Prosecuted for a Fatal Medical Mistake, Does it Make Medicine Safer?*, NAT'L PUBLIC RADIO (Apr. 10, 2019, 9:44 AM), https://www.npr.org/sections/health-shots/2019/04/10/709971677/when-a-nurse-is-prosecuted-for-a-fatal-medical-mistake-does-it-make-medicine-saf.

[170] State of Wisconsin v. Julie Thao, 200606NUR247 (Nov. 2, 2006) (Final Decision and Order at 1).

[171] *Id.* (Final Decision and Order at 3).

[172] *Id.* (Final Decision and Order at 4).

old mother, Jasmine Gant,[173] admitted for induction of labor because she was past due.[174] Ms. Grant received prenatal care at her local public health clinic and planned to have a natural birth.[175] During her prenatal care, she also tested positive for beta streptococcus, group B, which "resulted in a prophylaxis order of IV penicillin during labor."[176]

Ms. Grant arrived at the hospital on July 5 with her mother, aunt, and brother.[177] The unit secretary prepared Ms. Grant's identification wristband and placed it in her medical chart, and according to hospital policy, Ms. Thao as the primary nurse was responsible for verifying the wrist band and fastening it "to the patient's wrist as soon as possible."[178] However, Ms. Thao would never fasten a wrist band to Ms. Grant's wrist.[179]

Ms. Thao spent an hour educating Ms. Grant on what she could expect during the birthing process and answering questions while also trying to relieve Ms. Grant's anxiety, as this was Ms. Grant's first pregnancy.[180] Ms. Thao examined Ms. Grant's cervix at 10:49 AM, at which time her cervix was "dilated 2 cm and effaced 80%."[181] Ms. Thao then discussed Ms. Grant's birthing plan, "Ms. Grant's mother recalls saying that [her daughter] wanted an epidural only as a last resort."[182] However, Ms. Thao's recollection was that Ms. Grant and her mother wanted an epidural "as early as possible," to which Ms. Thao explained that the epidural could be given when Ms. Grant's cervix was dilated 3-5 centimeters.[183]

Ms. Thao began receiving orders for Ms. Grant at 11:00 AM.[184] First, the order for "Penicillin G, 5 million units IV, may add 1ml Lidocaine 1% PRN.," which Ms. Thao ordered from the pharmacy.[185] Next, "the labor admission orders, which included: starting a one-liter IV bag of lactated ringers to provide water and electrolytes, oxytocin (brand name Pitocin) to be used during labor

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[173] David Wahlberg, *Living, or Wanting to Die, After A Mistake*, MADISON.COM, (June 24, 2007), https://madison.com/news/living-or-wanting-to-die-after-a-mistake/article_446d8639-9b0a-5161-945c-ccaf67d261af.html (Ms. Gant's name was anonyms in Ms. Thao's final decision and order but was publicized in numerous news outlets).
[174] Wisconsin v. Thao, *supra* note 170 (Final Decision and Order at 6).
[175] *Id.* (Final Decision and Order at 6a).
[176] *Id.* (Final Decision and Order at 6b).
[177] *Id.* (Final Decision and Order at 7).
[178] *Id.* (Final Decision and Order at 8).
[179] *Id.*
[180] *Id.* (Final Decision and Order at 10).
[181] *Id.*
[182] *Id.*
[183] *Id.*
[184] *Id.* (Final Decision and Order at 11).
[185] *Id.*

to initiate or improve contractions and oral and IV analgesics for pain as needed."[186] At "around 11:30 AM, the obstetrician ruptured [Ms. Grant's] membranes to begin labor. The obstetrician did not order an epidural." [187] Ms. Thao then went to the medication dispensing cabinet (Pyxis) and entered Ms. Grant's identification before removing several ordered medications and the epidural medications, although it was not ordered.[188] She then took all of the medications and placed them on a counter in the anteroom to Ms. Grant's birthing room. [189] Another nurse received Ms. Grant's penicillin from the pharmacy and added it to the counter in the anteroom before informing Ms. Thao of its location.[190]

The penicillin and the epidural were in 250 cc of liquid in a clear plastic mini-bag of the same size and shape. [191] While the penicillin is given intravenously and the epidural is given into the spine, "the outlets and connections were the same."[192] However, the two bags did have "visible differences between the[ir] appearances."[193] Each of the bags had a print out of their distinctive drug names, the epidural included "a bright pink label approximately three inches square which read 'Epidural Medication.'"[194] Each bag contained a portal, but the epidural portal had an unremovable dark cap, and the penicillin portal had a smaller light-colored removable cap.[195]

Ms. Grant's room had a computer with a monitor, keyboard, and scanner.[196] According to hospital policy, before a nurse can give any medication to a patient, the nurse must scan the patient armband, the nurse ID card to identify who was administering the medication, and then scan it.[197] A little before noon, Ms. Thao hung the IV bag of lactated ringers then added what she thought was the penicillin.[198] However, Ms. Thao hung the epidural, which can only be administered into the spine rather than intravenously.[199] Ms. Thao failed to use the scanning mechanism in place or to read the label.[200] Also, while the penicillin order did not specify the infusion rate, the

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[186] *Id.* (Final Decision and Order at 12).
[187] *Id.* (Final Decision and Order at 13).
[188] *Id.* (Final Decision and Order at 14).
[189] *Id.*
[190] *Id.* (Final Decision and Order at 15).
[191] *Id.* (Final Decision and Order at 16).
[192] *Id.*
[193] *Id.*
[194] *Id.*
[195] *Id.* at (Final Decision and Order at 16c).
[196] *Id.* at (Final Decision and Order at 17).
[197] *Id.* at (Final Decision and Order at 17b).
[198] *Id.* at (Final Decision and Order at 18).
[199] *Id.*
[200] *Id.* (Final Decision and Order at 19).

hospital recommends an infusion rate at 180ml/hr, which was printed on the medication bag.[201] However, Ms. Thao infused what she thought was penicillin at 250ml/hr.[202] Almost immediately after beginning the infusion, Ms. Grant experienced a severe adverse reaction and appeared to be seizing.[203] The infusion was stopped, a code blue was called, and advanced cardiopulmonary life support (ACLS) was initiated, but proved unsuccessful.[204] An emergency cesarean section was completed, and the baby was delivered at 12:20 p.m.[205]

After discovering her mistake Ms. Thao "collapsed and was admitted to the hospital as a psychiatric patient" before being fired a few weeks later.[206] Despite the support from the Wisconsin Nurses Association, the Institute for Safe Medication Practices, and the Wisconsin Hospital Association, Ms. Thao was charged with a felony, "criminal neglect of a patient causing great bodily harm."[207] Ms. Thao faced a $25,000 fine and up to six years in prison.[208] In exchange for dropping the felony charge, Ms. Thao entered a "no contest" plea to two misdemeanor counts of "illegally administering prescription drugs."[209] In addition, Ms. Thao's nursing license was suspended for nine months, plus a three year probation period in which she could not work in critical care settings or birthing units.[210] Another condition of the plea agreement, Ms. Thao could not work more than twelve hours in a twenty-four hour period or more than sixty hours per week for two years. Additionally, Ms. Thao had to take classes on preventing medication and health care errors and make three presentations to nurses or nursing students on the topic.[211]

As a result of Ms. Thao's fatal error, there was a formal investigation and report. [212] This report found that systemic

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[201] *Id.* (Final Decision and Order at 21).
[202] *Id.*
[203] *Id.* (Final Decision and Order at 22).
[204] *Id.*
[205] *Id.*
[206] Wahlberg, *supra* note 173.
[207] Diana J. Mason, *Good Nurse-Bad Burse: Is it an Error or a Crime?*, 107 AM. J. NURSING 11 (2007).
[208] Cheryl L. Mee*, Should human error be a crime?*, 37 NURSING2007 6, 6 (February 2007).
[209] *Criminal Case Against Nurse Ends,* 37 NURSING2007 34, 34 (2007).
[210] *Id.*
[211] *Id.*
[212] David Wahlberg, *Report: Systemic problems at St. Mary's set stage for fatal drug error*, WISCONSIN STATE JOURNAL (Mar. 15, 2010), *available at* https://madison.com/wsj/news/local/health_med_fit/report-systemic-problems-at-st-marys-set-stage-for-nurses-fatal-drug-error/article_73b1055e-2fee-11df-9f7a-001cc4c002e0.html.

problems at St. Mary's Hospital contributed to Ms. Thao's fatal mistake.[213] These problems included pressure to prepare epidurals in advance to minimize physician waiting time, ineffective labeling, and sporadic use of patient wristbands and scanners.[214] As a result, St. Mary's Hospital now requires orders for epidurals signed by doctors, warning labels on tubes, not just bags, and has increased the use of wristbands and scanners.[215]

B. **ERIC CROPP, MD**

Eric Cropp was the lead pharmacist at Cleveland's Rainbow Babies and Children's Hospital on February 26, 2006.[216] That day, the computer system was down, resulting in a backlog of orders, the pharmacy was under-staffed, and there was no time for routine work or meal breaks.[217] When a nurse called the pharmacy for a patient's chemotherapy, Dr. Cropp "felt rushed to check the solution so it could be dispensed."[218] That patient, Emily Jerry, was a two-year-old girl battling a tumor on the base of her spine and was undergoing her last round of chemotherapy.[219]

The chemotherapy needed to be prepared by the pharmacy using 0.9% sodium chloride.[220] Working with Dr. Cropp, Ms. Dudash, an experienced pharmacy technician, prepared Emily's chemotherapy with a 23.4% sodium chloride solution, twenty-six times the 0.9% solution required.[221] Dr. Cropp then checked off on the solution, believing it to be the correct 0.9% solution, and the chemotherapy was delivered to the floor where it would be administered to Emily.[222] On March 1, 2006, Emily Jerry died as a result of the error.[223]

After learning about the error, the Ohio Board of Pharmacy investigated the error and permanently revoked Dr. Cropp's

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[213] *Id.*
[214] *Id.*
[215] *Id.*
[216] Kevin McKoy & Erik Brady, Rx for Errors: Drug Error Killed Their Little Girl, USA Today (Feb. 2, 2009), https://usatoday30.usatoday.com/money/industries/health/2008-02-24-emily_N.htm.
[217] Ohio Government Plays Whack-a-Mole with Pharmacist, ISMP.org, (Aug. 27, 2009), https://www.ismp.org/resources/ohio-government-plays-whack-mole-pharmacist.
[218] *Id.*
[219] McKoy & Brady, *supra* note 216.
[220] Bob Watcher, *Jail Time for Medical Error, Redux: The Case of Eric Cropp,* THE HOSPITALLEADER.ORG (Nov. 26, 2009), http://thehospitalleader.org/jail-time-for-a-medical-error-redux-the-case-of-eric-cropp/.
[221] McKoy & Brady, *supra* note 216.
[222] Watcher, *supra* note 220.
[223] McKoy & Brady, *supra* note 216.

license.[224] After Dr. Cropp's license was revoked, a grand jury indicted Dr. Cropp for reckless homicide and involuntary manslaughter, punishable by up to five years in prison.[225] Ms. Dudash did not face any disciplinary action.[226] Emily's mom supported the punishment believing, "Eric Cropp's incompetence goes far beyond conducting one reckless act… he consciously disregarded any and every set standard of protocol regarding patient safety."[227] Emily's father felt sorry for Dr. Cropp, recognizing, "This guy is facing a prison sentence, and I know it was an accident."[228] Dr. Cropp plead guilty to involuntary manslaughter and was sentenced to "six months imprisonment, six months of home confinement, three years of probation, four-hundred hours of community service, and a five thousand dollar fine."[229] As a result of the fatal error, the Ohio legislature passed and implemented Emily's Law. Emily's law requires all pharmacy technicians to be trained, tested, and certified.[230]

C. **KIMBERLY HIATT, RN**

After working at Seattle Children's Hospital for almost twenty-five years, Kimberly Hiatt would make the only medication error of her career.[231] While caring for a critically ill infant in the pediatric intensive care unit, Ms. Hiatt administered 1.4 grams of calcium chloride ("CaCI") instead of the intended 140 milligrams, a ten-fold overdose.[232] On September 14, 2010, Ms. Hiatt self-reported, "I messed up. I've been giving CaCl for years. I was talking to someone while drawing it up. Miscalculated in my head the correct mLs according to the mg/mL. First med error in 25 years working here. I am simply sick about it. Will be more careful in the future."[233]

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[224] *Eric Cropp Weighs in on the Error that Sent Him to Prison*, Inst. for Safe Medicine Practices, (Dec. 3, 2009), https://www.ismp.org/resources/eric-cropp-weighs-error-sent-him-prison [hereinafter "Weighs In"].
[225] Damon Sims, *Eric Cropp, Ex-Pharmacist in Case in Which Emily Jerry Died, Is Ready to Plead No Contest,* CLEVELAND.COM, (Apr. 19, 2009), *https://www.cleveland.com/metro/2009/04/eric_cropp_expharmacist_in_cas.html.*
[226] McKoy & Brady, *supra* note 216.
[227] Watcher, *supra* note 220.
[228] *Id.*
[229] Weighs In, *supra* note 224.
[230] Ohio Bill Analysis, 2008 S.B. 229; *See* Ohio Rev. Code Ann. §4729 (West 2020).
[231] Alexandra Robbins, THE NURSES: A YEAR OF SECRETS, DRAMA, AND MIRACLES WITH THE HEROES OF THE HOSPITAL, 170 (2016).
[232] *Id.*
[233] *Id.*

After reporting her medical error, Ms. Hiatt was escorted from the hospital.[234] Five days later, the critically ill infant would die.[235] However, it is unclear to what extent the medication error contributed to the infant's death.[236] After being placed on administrative leave, Ms. Hiatt was fired several weeks later.[237] As a result of the medical error, the state nursing board put Ms. Hiatt on a four-year probation period during which the board of nursing mandated supervised medication dispensing in addition to a fine.[238] No criminal charges were filed, but on April 3, 2011, Ms. Hiatt committed suicide.[239] In response to the fatal medical error, Seattle Children's Hospital changed its policy to allow only pharmacists and anesthesiologists to access calcium chloride in non-emergency situations.[240]

D. **GERALD EINAUGLER, MD**

On Friday, May 18, 1990, Alida Lamour returned to her nursing home after being treated at Interfaith Hospital for renal disease.[241] While at the nursing home, Dr. Einaugler mistakenly ordered a feeding solution to be administered through Ms. Lamour's dialysis catheter.[242] Two days after the feeding solution had been administered, on Sunday, May 20, 1990, Ms. Lamour was having difficulty breathing, her abdomen was distended, and she vomited.[243] A nurse noticed the error and attempted to drain the remaining feeding solution and notified Dr. Einaugler. Dr. Einaugler then contacted the Chief of Nephrology at Interfaith Hospital, Dr. Irving Dunn.[244] While Dr. Einaugler contends that Dr. Dunn advised him that Ms. Lamour just needed to go to the hospital on Monday for treatment, Dr. Dunn remembers advising Dr. Einaugler to hospitalize Ms. Lamour, although it is unclear if Dr. Dunn advised

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[234] JoNel Allecia, *Nurse's Suicide Highlights Twin Tragedies of Medical Errors*, MSNBC (June 27, 2011), https://www.nbcnews.com/health/health-news/nurses-suicide-highlights-twin-tragedies-medical-errors-flna1C9452213 [hereinafter "Twin Tragedies of Medical Errors"].
[235] *Id.*
[236] *Id.*
[237] *Id.*
[238] Robbins, *supra* note 231, at 170.
[239] Twin Tragedies of Medical Errors*, supra* note 234.
[240] *Medical Error Nurse Suicide,* CHIPSO.ORG, https://www.chpso.org/newsletter/medical-error-nurse-suicide (last visited January 28, 2021).
[241] Einaugler v. Supreme Court*,* 109 F.3d 836, 838 (2d Cir. 1997).
[242] *Id.*
[243] *Id.*
[244] *Id.*

Dr. Einaugler of the importance of hospitalizing Ms. Lamour immediately.[245]

Later that day, between 11:00 AM and 2:00 PM, Dr. Einaugler reported the mistake to the nursing home supervising physician, Dr. Khaski, and informed him that Ms. Lamour's condition was not thought to be an emergency and could wait until Monday for hospitalization.[246] It is debated whether Dr. Khaski agreed that this was not an emergency.[247] By 4:30 PM, Ms. Lamour was "less responsive, unable to take food by mouth, and looked weak," prompting Dr. Einaugler to transfer Ms. Lamour to the hospital.[248] Ms. Lamour died four days later. Subsequently, Dr. Einaugler was "charged and convicted of reckless endangerment and willful neglect for delaying hospitalization once he knew that to do so would create a serious risk of physical injury."[249] He was sentenced to incarceration for fifty-two weekends. However, Dr. Einaugler was unanimously found innocent of any misconduct by the state licensing board.[250]

E. **DIONNE COOPER, RN**

Ms. Plass was a stay-at-home mother of three and an avid jogger.[251] However, after she ran out of her anti-anxiety drug Klonopin, Ms. Plass had a seizure and was rushed to Broward General Medical Center on April 23, 2006.[252] While there, Ms. Plass was ordered 800 milligrams of the anti-seizure drug Dilantin.[253] A nine-year veteran nurse, Ms. Cooper, worked in the emergency department that day and was Ms. Plass's nurse.[254] After receiving the order for the 800 milligrams of Dilantin, Ms. Cooper obtained thirty-two vials, and because it did not fit in one intravenous bag, Ms. Cooper hooked up two, one in each arm.[255] Ms. Plass's heart stopped, and she died shortly thereafter.[256]

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[245] *Id.* at 839.
[246] Einaugler, 109 F.3d at 839.
[247] *Id.*
[248] *Id.*
[249] *Id.*
[250] Gerald Einaugler, *Innocence is Irrelevant – The Einaugler Case*, 3 *MEDICAL SENTINEL 136, 138 (1998).*
[251] Bob LaMendola, *Overdose kills patient, officials say,* SUN SENTINEL (Jan. 24, 2007), https://www.sun-sentinel.com/news/fl-xpm-2007-01-24-0701230455-story.html.
[252] *Id.*
[253] *Id.*
[254] *Id.*
[255] *Id.*
[256] *Id.*

Ms. Cooper failed to double-check or question the amount of Dilantin she obtained, and instead of administering 800 milligrams, she administered 8000 milligrams or eight grams.[257] The correct dose required 3.2 vials of the drug, not 32 vials.[258] The state Department of Health filed an action to revoke Ms. Cooper's nursing license or discipline her for "gross negligence" due to the error.[259] No criminal charges were filed.[260]

F. **GREGORY HOGLE, DO**

An ear, nose, and throat specialist, Dr. Hogle, failed to review a patient's medical record before deciding, based on his exam, to remove her tracheostomy tube.[261] On April 8, 2005, Dr. Hogle examined Khusni Yusupova for the first and only time and decided to remove her breathing tube.[262] Shortly after. Ms. Yusupova went into cardiac arrest. She died two days later after being removed from life support.[263] Dr. Hogle had access to information relating to Ms. Yusupova's condition, which showed that she had a blockage that likely needed surgery.[264] Dr. Hogle admitted that he made a "serious mistake." The Assistant District Attorney "decided criminal charges were warranted because '… Dr. Hogle had access to information relating to Ms. Yusupova's condition, which he refused to review.'"[265] However, after Dr. Hogle was arrested for manslaughter, the investigation continued, and the decision was finally made not to follow through with criminal charges.[266] Dr. Hogle remains practicing medicine and received no known licensing sanctions as a result of his error.[267]

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[257] *Id.*
[258] *Id.*
[259] *Id.*
[260] *Id.*
[261] Kirk Mitchell, *Doctor is arrested in breathing-tube fatality,* THE DENVER POST (Dec. 3, 2005), https://www.denverpost.com/2005/12/03/doctor-is-arrested-in-breathing-tube-fatality/.
[262] *Charges Declined Against Doctor*, DENVER DA (May 11, 2006), https://www.denverda.org/wp-content/uploads/news-release/2006/Hogle-decision.pdf [hereinafter "Charges Declined"].
[263] *Id.*
[264] Mitchell, *supra* note 261.
[265] *Id.*
[266] Charges Declined, *supra* note 262.
[267] Webite of Gregory A. Hogle, DO, http://www.entcolorado.com (last visited Jan. 29, 2021).

G. **RADONDA VAUGHT, RN**

Though Ms. Murphey's family stated that Ms. Murphy would be upset if she knew Ms. Vaught was going to prison for her mistake, the Nashville District Attorney's office[268] indicted Ms. Vaught for reckless homicide and impaired adult abuse.[269] Ms. Vaught is currently awaiting her trial, which is scheduled for February 2021.[270] While the Tennessee Department of Health previously decided that Ms. Vaught's mistake did not warrant professional discipline as memorialized in an official letter, the department rescinded this decision and filed charges against Ms. Vaught before the Tennessee Board of Nursing.[271] As a result of the fatal mistake, Vanderbilt University Medical Center did a comprehensive review of their medication override list and removed some drugs, updated hospital policies, and procedures regarding patient monitoring, and implemented scanners in the radiology department.[272]

IV. ARGUMENTS FOR AND AGAINST THE CRIMINAL PROSECUTION OF HEALTHCARE PROVIDERS

Adverse medical events are as old as medicine itself.[273] As medicine becomes more complex, the risk of adverse events is even higher.[274] Mark Chassin, president of the Joint Commission, and Jerod Loeb, executive vice president for healthcare quality evaluation at the Joint Commission note, "Hospitals house patients who are increasingly vulnerable to harm due to error, and the

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[268] *See Vanderbilt's Role in The Death of A Patient*, HOSPITAL WATCHDOG, May 22, 2019, https://hospitalwatchdog.org/vanderbilts-role-in-the-death-of-patient-charlene-murphey/ [hereinafter "Vanderbilt's Role"] (Allegations have been made that District Attorney, Glenn Funk, has a conflict of interest due to his multiple professional and personal relationships with Vanderbilt. People now question whether other healthcare providers, including doctors, should fear prosecution.).
[269] *Id.*
[270] Tennessee Bureau of Investigation, *supra* note 35.
[271] Brett Kelman, *RaDonda Vaught: Health officials reverse decision not to punish ex-Vanderbilt nurse for fatal error,* THE TENNESSEAN (Oct. 17, 2019, 11:35 AM), https://www.tennessean.com/story/news/health/2019/10/17/radonda-vaught-vanderbilt-nurse-medication-swap-versed-vecuronium-fatal-error-reckless-homicide/3975427002/.
[272] Vanderbilt's Role, *supra* note 268.
[273] Symposium, *On the Table: An Examination of Medical Malpractice, Litigation, and Methods of Reform: Adverse Events and Patient Injury: Coupling Detection, Disclosure, and Compensation*, 46 NEW ENG. L. REV. 437, 440 (2012).
[274] *Id.* at 439.

complexity of the care hospitals now provide increases the likelihood of those errors."[275]

Traced back to two pioneers in patient safety data collection, Florence Nightingale and Dr. Ernest Codeman, the patient safety movement attempts to define and identify sources of patient injury.[276] In the 1850s, Florence Nightingale, the mother of nursing, determined the role poor living conditions played in soldiers' deaths at army hospitals.[277] The statistical approach she used to show the effects of poor living conditions laid the groundwork for standard statistical approaches for hospitals.[278] In the 1920s, Dr. Codeman, a Boston physician, studied hospital patients' data to learn what worked and what did not and how doctors contributed to bad outcomes.[279] By the 1960s, a seismic shift focused on the problem of patient harm in hospitals.[280] One of the first sophisticated looks at safety in hospital practice, E.M. Schimmel of Yale Medical School, examined adverse outcomes caused by acceptable diagnostic or therapeutic measures.[281] Dr. Schimmel "found that twenty percent of the patients admitted to the medical wards at Yale experienced one or more adverse episodes – some severe – with sixteen out of 240 episodes resulting in death."[282] As a result, Dr. Schimmel called for physicians to better balance benefits and harms in treatment approaches.[283]

Human error is impossible to avoid, and it is more productive to address systems contributors to error than human contributors to error.[284] A profound transformation in the approach to medical errors can be linked to the 1999 IOM Report.[285] The focus shifted from individual human contributions to error to a focus on systemic weaknesses, addressing "system-wide weaknesses in policy, organization, equipment, and technology."[286] The long embraced "'perfectibility' model which assumes that if health-care workers care enough, work hard enough, and are well trained errors will be avoided" was replaced by a culture that "seeks to optimize

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[275] Mark R. Chassin & Jerod M. Loeb, *The Ongoing Quality Improvement Journey: Next Stop, High Reliability,* 30 HEALTH AFFAIRS (April 2011), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2011.0076.
[276] Symposium, *supra* note 273, at 441.
[277] *Id.*
[278] *Id.* at 441-442.
[279] *Id.* at 442.
[280] *Id.*
[281] *Id.*
[282] *Id.*
[283] *Id.*
[284] The Joint Commission, *Human Factor Analysis in Patient Safety Systems*, 13 THE SOURCE 7, 8 (2015).
[285] Schwartz, *supra* note 48, at 542.
[286] *Id.*

the relationship between technology and human, applying information about human behavior, abilities, limitations, and other characteristics to the design of tools, machines, systems, tasks, jobs and environments for effective, productive, safe and comfortable human use."[287] The focus is on "recognizing the potential for error, and developing systems and strategies to learn from mistakes, so as to minimize their occurrence and effects."[288] Under this approach, it is imperative to minimize and learn from errors and near misses, which can only be achieved by reporting adverse events.[289]

The reporting and investigation of medical errors is crucial to prevent the recurrence of error.[290] As humans are not infallible and actions rarely occur in isolation, addressing system error focuses on the "blame" more fairly and is more effective in preventing future errors.[291] The practical implementation of a systemic approach to medical errors can be traced to the prevention of wrong site and wrong patient procedures, the reduction of anoxic brain injury while under anesthesia, the significant decline in central-line associated bloodstream infection ("CLABSI") rates, and the decrease in medication errors. [292] Two decades of patient safety research confirms the characterization of medical error as complex and multifactorial, so any intervention to error must incorporate the wide range of causal factors.[293]

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[287] World Health Organization, *Why applying human factors is important for patient safety* (2012), https://www.who.int/patientsafety/education/curriculum/course2_handout.pdf?ua=1.
[288] *Id.*
[289] *Id.*
[290] *See generally* Bussey, *supra* note 165.
[291] *Id.*
[292] *See* P.F. Stahel *et al,. The 5th Anniversary of the "Universal Protocol": pitfalls and pearls revisited*, 3 PATIENT SAF SURG 14, 18 (2009) (The implication of the Universal Protocol which includes a pre-procedure verification process and surgical site marking and a "time out" in the OR are steps mandated to ensure correct patient, procedure, and site); R. Botney, *Improving Patient Safety in Anesthesia: A Success Story?*, 71 INT. J. RADIATION ONCOLOGY BIOL. PHYS., 182, 185 (2007) (After the highlight of medical mishaps that resulted in serious injury or death the Anesthesia Patient Safety Foundation was created. The Foundation is responsible for implementing standard practices, including the use of pulse oximentry and capnography, that prevent anoxic brain injuries.); P.J. Pronovost et al., *Fifteen years after To Err Is Human: a success story to learn from*, 25 BMJ QUAL SAF. 396 (2015) (Through a systems analysis, five distinct elements were used to effectively reduce CLABSI rates by over eighty percent in the fifteen years after the 1999 IOM report); A. Agrawal, *Medication errors: prevention using information technology* systems, 67 BR. J. CLIN. PHARMACOL. 681, 683 (2009) (IT systems including computerized physician order entry, automated dispensing, barcode medication administration, electronic medication reconciliation, and personal health records are key components in the prevention of medical errors.).
[293] David M. Studdert & Michelle M. Mello, *In from the Cold? Law's Evolving Role in Patient Safety*, 68 DEPAUL L. REV. 421, 432 (2019).

Quality improvement is better served by constructing system-level safeguards to reduce the chances of error, as opposed to punitive responses.[294] The lesson to be learned in medical errors "is that quality is not optimally improved by simply demanding that inherently fallible human beings be ever more obsessively attentive. People become fatigued, distracted, or inattentive, and safety systems must plan for this."[295] A response to mistakes, which emphasizes individual culprits, presumes that errors are the product of individual persons' failings, and recommends making those individuals pay a personal price so that they will not make a mistake next time, is out of touch with contemporary realities of quality and safety improvement in complex systems.[296] Addressing mistakes solely through punishment acts to inhibit communication when robust communication is most urgently needed.[297]

Nonetheless, those in support of the criminal prosecution of health care providers look to the current self-governance of health care providers as inadequate and see criminal sanctions as a legitimate quality assurance mechanism.[298] Supporters contend that "current forms of professional discipline cannot serve as an adequate replacement for the prosecutions of criminally negligent medical conduct."[299] These advocates reason that logistical difficulties and accountability issues are insurmountable to self-governing medical institutions that lack the preventative tools to stand alone.[300] As a practical matter, criminal prosecution retains a force of censure that its private and civil equivalents cannot match.[301] Experts point to the inadequacies of state licensing boards, peer review committees, the NPDB, and civil actions and conclude that "the current mechanisms of civil sanctions and disciplinary actions are insufficient to punish adequately health care professionals who intentionally harm patients or consciously disregard a substantial and unjustifiable risk."[302]

On the other hand, Medical associations and physician groups have unanimously taken a position against the criminal prosecution of health care providers absent any intent to harm, as it sets a dangerous precedent.[303] Criminalizing a mistake sends the

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[294] Morreim, *supra* note 122, at 119.
[295] *Id.*
[296] *Id.*
[297] *Id.*
[298] Kim, *supra* note 41, at 538.
[299] *Id.*
[300] *Id.*
[301] *Id.*
[302] McCarthy, *supra* note 50, at 618-619.
[303] *Id.* at 617.

message that mistakes are "something professionally embarrassing, something to be avoided, and if that is not possible, to be denied, muffled and hidden."[304] Evidence shows that the sheer threat of criminal prosecution can halt the reporting of incidents and prevent individuals from coming forward with safety-critical information.[305] "Judicial proceedings, or their possibility, can create a climate of fear about sharing information. It can hamper an organization's ability to learn from its incidents."[306]

Additionally, professional opinion is united behind the idea that criminal prosecution fails to deter medical errors.[307] The American Nurses Association fears that the criminalization of medical errors could "have a chilling effect on reporting and process improvement."[308] While nurses should be held accountable for their practice, errors are best addressed by correction or remediation, and disciplinary action should only be taken if warranted.[309] Harvard physician and professor Lucian Leape observed:

> Physicians and nurses need to accept the notion that error is an inevitable accompaniment of the human condition, even among conscientious professionals with high standards. Errors must be accepted as evidence of systems flaws not character flaws. Until and unless that happens, it is unlikely that substantial progress will be made in reducing medical errors.[310]

Criminal prosecution for a medical mistake conflicts with the principle "that the morally innocent should not be convicted of serious crimes."[311] While providers who make errors should be held accountable and pay for the injuries they cause, those providers do not deserve to lose their liberty and be stigmatized for their mistakes.[312] One expert goes so far to assert:

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[304] Sidney W. A. Dekker, *Criminalization of Medical Errors*, 77 ANZ J. SURG. 831, 835 (2007).
[305] *Id.*
[306] *Id.*
[307] *Id.*
[308] *ANA Responds to Vanderbilt Nurse Incident,* AM. NURSES ASS'N (Feb. 19, 2019), https://www.nursingworld.org/news/news-releases/2019-news-releases/ana-responds-to-vanderbilt-nurse-incident/.
[309] *Id.*
[310] James M. Doyle, *Learning from Error in American Criminal Justice*, 100 J. CRIM. L. & CRIMINOLOGY 109, 147 (2010).
[311] Kim, *supra* note 41, at 536.
[312] McCarthy, *supra* note 50, at 617.

> The long-term consequence for society turning medical mistakes into crimes or culpable malpractice could be less safe health care. If they become the main purveyor of accountability, legal systems could help create a climate in which freely telling accounts of what happened (and what to do about it) becomes difficult. There is risk of a vicious cycle. We may end up turning increasingly to the legal system because the legal system has increasingly created a climate in which telling each other accounts openly is less and less possible. If they take over the dispensing of accountability, legal systems will slowly strangle it.[313]

In addition to siphoning communication, criminal prosecution may make doctors more reluctant to take on difficult cases.[314] The fear of criminal prosecution drives defensive medicine, leading to increased costs and unnecessary tests and treatment.[315] "[D]octors working under a criminal malpractice regime would routinely settle for the most conventional, predictable, and uncontroversial methods in order to shield themselves from the catastrophic professional consequences of a criminal prosecution."[316] In return, stifling the advancement of medicine and causing harm to patients that could benefit from high-risk or experimental treatment.[317] In summary, criminal charges against healthcare providers, absent any intent to harm, are neither required nor beneficial.[318] Ultimately, criminal charges "inhibit error reporting, contribute to a culture of blame, undermine the creation of a culture of safety, accelerate the exodus of practitioners from clinical practice, exacerbate the shortage of healthcare providers, perpetuate the myth that perfect performance is achievable, and impede system improvements."[319]

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[313] Dekker, *supra* note 304, at 836-37.
[314] Kim, *supra* note 41, at 536.
[315] *Id.* at 536-537
[316] *Id.* at 536.
[317] *Id.*
[318] Inst. for Safe Medical Practices, *Criminal Prosecution of Human Error Will Likely have Dangerous Long-Term Consequences* (Mar. 8, 2007), https://www.ismp.org/resources/criminal-prosecution-human-error-will-likely-have-dangerous-long-term-consequences [hereinafter "Inst. for Safe Medical Practices Criminal"].
[319] Inst. for Safe Medical Practices, *Another Round of the Blame Game: A Paralyzing Criminal Indictment that Recklessly Overrides Just Culture,* (Feb. 14, 2019), https://www.ismp.org/resources/another-round-blame-game-paralyzing-criminal-indictment-recklessly-overrides-just-culture [hereinafter "Inst. for Safe Medical Practices Blame"].

V. CONCLUSION

Better processes, not greater individual efforts, produce the greatest enhancements of quality and productivity.[320] The IOM's publication of "To err is human" in 1999 marked "a seismic shift in medicine's approach to error," shifting perspectives about the frequency and causes of medical error and the importance of focusing on systems to make human error less likely.[321] This shift in addressing medical errors has "reduced medical errors not because health care providers got any better at their jobs, but because technologies, checklists, and protocols made it more difficult for them to make mistakes."[322] However, to improve the systems that are essential to making it more difficult for human error to occur, medicine must unqualifiedly embrace an approach of complete disclosure and transparency.[323]

The criminal prosecution of health care providers directly interferes with the ability of providers to openly disclose errors to the detriment of patient safety because absent disclosure, there is no opportunity to benefit from lessons derived from past medical errors and near misses due to a provider's fear of repercussion.[324] When the focus shifts from understanding mistakes to assigning blame, mistakes are driven underground, making them harder to detect and correct.[325] Rather than providing a scapegoat, the true goal of addressing medical error is preventing another error and improved patient safety.[326] Focusing on system error allows for the "free-flowing" of communication and makes it more likely "misses" and "near misses" will be reported, leading to improved safety overall.[327]

While the law clearly allows for the criminal prosecution of healthcare providers who make errors that result in patient harm, despite the lack of intent to cause harm, this course of action is neither required nor beneficial.[328] The mechanisms currently in

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[320] Bill Bornstein, *Medical Mistakes: Human Error or System Failure?,* http://www.whsc.emory.edu/_pubs/momentum/2000fall/onpoint.html (last visited January 28, 2021).
[321] Schwartz, *supra* note 48, at 542.
[322] *Id.* at 544.
[323] *Id.*
[324] Zachary R. Paterick et. al., *The Challenges to Transparency in Reporting Medical Errors*, 5 J. PATIENT SAF. 205, 207 (2009).
[325] U.S. DEP'T OF JUSTICE, *Mending Justice: Sentinel Event Reviews* (Sept. 2014), https://www.ncjrs.gov/pdffiles1/nij/247141.pdf [hereinafter "U.S. DEP'T OF JUSTICE MENDING"].
[326] Bussey*, supra* note 165.
[327] *Id.*
[328] Criminal Prosecution of Human Error, *supra* note 318.

place to address medical errors have some problems, but criminal prosecution is not the answer."[329] The case of Dr. Duntsch clearly demonstrates the inadequacies of the current system, but if implemented correctly and adequately enforced, the existing safeguards can be successful.

Criminal charges for medical errors have an enormous impact on patient safety, sending the wrong message to healthcare providers about the importance of reporting and analyzing errors.[330] If the influx of criminal charges continues, it likely will have a chilling effect on the recruitment and retention of an already depleted workforce. [331] When prosecutors disregard the long-established precedent of relying on licensure, peer review, and civil actions and choose to bring criminal charges against a healthcare provider for an inadvertent error, one must ask whether there will be an influx of charges against other providers or if this is an isolated event prompted by inappropriate motives.[332] Using Glenn Funk's "threshold for reckless homicide," healthcare providers should be uneasy about whether they are next, and society should be apprehensive about how this will affect patient safety.[333] As Dr. Zubin Damania asks:

> For those of us who take care of patients all the time, I ask the question who hasn't made a mistake that's harmed a patient? I'm not raising my hand. I've made those mistakes. If nurses and doctors are afraid of going to jail, what do you think will happen to the reporting of errors from now on.[334]

In the end, the criminal justice system lacks what medicine has found essential to detecting and addressing organizational errors: "a [non-blaming], all-stakeholder, forward-leaning mechanism through which we can learn from error and make systemwide improvements that go beyond disciplining rulebreakers and render similar errors less likely in the future."[335] Therefore, absent any intent, the criminal prosecution of health care providers is inappropriate and will have a dire effect on patient safety.

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[329] Blame Game, *supra* note 319.
[330] *Id.*
[331] *Id.*
[332] Vanderbilt's Role*, supra* note 268.
[333] *Id.*
[334] *Id.*
[335] Sentinel event Review, *supra* note 325.