If, as the saying goes, to err is human, then negligence is not an abstract legal concept; it is an everyday event.

Consider this common scenario: Driving to work on a busy street, you are momentarily distracted. Perhaps you are talking to your daughter on your cell phone. Or maybe you are lost and have been looking at the GPS too long. Suddenly, you see a stop sign. By the time you can react, your car has entered the intersection without slowing. You strike another car. Tragically, a child in that car dies from injuries suffered in the collision. An accident? Yes. But could it be more than that? Could you be prosecuted criminally for causing the child’s death, even though it was an accident? In most states, the answer is yes—you could be charged with criminally negligent homicide.

Criminal prosecution for negligent acts is not limited to car accidents. According to the latest pertinent report from the Institute of Medicine (IOM, 2000), between 44,000 and 98,000 medical errors leading to patient deaths occur in the United States every year. A more recent study by Health Grades (2004) reports an average of 195,000 deaths from medical errors annually—nearly double the amount the IOM cited in 2000.

Increasingly, the line between accident and crime is being drawn in retrospect. Where the results are tragic, distinguishing an accident from a crime is not easily accomplished by a medical professional.

In this article, we present two case studies that illustrate how medication errors, as well as systemic medication administration problems, may subject health-care professionals to criminal prosecution and further serious consequences. The cases presented are part of a larger trend of legal cases involving medical professionals.

Case #1: Medication Error Resulting in a Patient’s Death (Madison, Wisconsin)

A 16-year-old patient was admitted for labor induction. Because she had a positive culture for group B streptococcus, an obstetric resident wrote an order for penicillin to be administered. The nurse removed a number of medications that had been ordered for the patient from the Pyxis machine. She also obtained a bag containing an epidural anesthetic (bupivacaine-fentanyl), although it had not yet been ordered by the anesthesiologist. That medication bore a label warning against intravenous administration. In preparation for labor induction, the patient received information on use of an epidural anesthetic. To this end, epidural medication was obtained from the automated medication storage device to show to the patient. Both the antibiotic and epidural bags were at the patient’s bedside. During the medication administration process, the hospital’s bar-code system was not used and the epidural bag was confused with the bag containing the antibiotic. The epidural anesthetic was administered intravenously instead of the antibiotic. The patient’s death resulted; an emergency cesarean section saved the infant (Wisconsin Department of Health Services, 2006, p. 1).

The nurse, who had 16 years of experience, was working her third shift in 24 hours and was assigned to care for two patients. She had worked a double shift the day before, slept at the hospital, and then returned to work. The hospital’s bar-coded medication administration system was new, and the nurse had been on vacation the week before when the system was introduced to her unit.

The hospital suspended the nurse pending an internal investigation. The nurse resigned shortly after the investigation was complete. Four months later, the Attorney General filed criminal charges against her, charging her with negligently abusing a patient and causing great bodily harm—a felony with a maximum penalty of up to 10 years in prison. Investigation revealed she had made at least three errors that, if discovered in time, might have led to a different outcome:

- She obtained the anesthetic from a locked storage system before it was ordered by the anesthesiologist.
- She did not scan the bar code on the epidural bag, which probably would have told her that she had the wrong drug.
- She failed to observe the bright pink label on the bag, which read “For Epidural Administration Only.”

Medication Errors and Criminal Negligence: Lessons from Two Cases

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Health-care professionals who make serious errors may be subject to criminal prosecution for criminal negligence. In recent years, many states have expanded the concept of criminal negligence to the extent that health-care providers may have difficulty fully understanding what conduct could subject them to criminal prosecution. This article presents two cases in which nurses were prosecuted for criminal negligence related to medication errors. It explores the evolving concept of criminal negligence, discusses the role of systemic and interdisciplinary factors in medical errors, and explores the collateral consequences of criminal prosecution.
The criminal complaint alleged that the nurse also failed to verify the “five rights” before giving the drug—right patient, right medication, right administration route, right dose, and right time. These acts and omissions, the Attorney General’s office alleged, constituted a gross breach of medical protocol.

Resolution of the Case

Shortly after the nurse was charged, the Wisconsin Board of Nursing suspended the nurse’s license, commencing retroactively to the date when the event occurred. The board made it clear that the outcome of the criminal matter would not affect what happened to the nurse’s license; i.e., imposition of any additional discipline or modification of the discipline ordered by the board would not be based on how the criminal charges were resolved.

The board’s action was premised on the assumption that the nurse had violated the rule that prohibits misconduct or unprofessional conduct, defined as any practice that violates the minimum standards of the profession necessary to protect the health, safety, or welfare of a patient or the public (Wis. Admin. Code N § 7.04). The board did not require the nurse to make any admission that could have adversely affected her defense to the criminal charges. However, it did put restrictions on her license for a 2-year period. Because she had not engaged in nursing since the incident 6 months earlier, the suspension period was deemed to have been served after the board approved the resolution. Limitations on her license included the condition that she work no more than 12 hours every 24 hours and no more than 60 hours every 7 days. Also, she was required to obtain 54 hours of continuing education within 1 year and to make three presentations to the nursing community on the role of individuals and systems in preventing medication and health-care errors. One day after the board approved the action on her license, the nurse appeared in court to resolve the criminal charges.

The case was resolved short of trial by pleas to amended misdemeanor charges that addressed the fact that the nurse had obtained and administered the anesthetic before it was ordered by a physician. The nurse pleaded no contest to the unlicensed dispensing of prescription medication (she was not legally qualified to administer the anesthetic) and to unlawfully obtaining a prescription medicine. (As stated earlier, the anesthesiologist had not yet written an order for the epidural.)

The court found the nurse guilty. Her sentence was withheld, and she was placed on probation for 2 years. Conditions of her probation forbade her from working as a critical care nurse for 2 years.

Case #2: Medication Error Resulting in a Patient’s Death (Denver, Colorado)

A neonatologist ordered an intramuscular injection of penicillin (150,000 U benzathine penicillin G im) for a day-old infant at risk for syphilis. The pharmacist incorrectly dispensed 10 times the ordered dosage (1,500,000 U). The nurses observed that the medication represented a large volume to administer to an infant by intramuscular injection; however, they did not contact the pharmacist to verify the volume sent. A neonatal nurse practi-

tioner (NP) with 7 years of experience and a nursery nurse with 6 years of experience investigated whether the medication could be given intravenously instead. Although they consulted references, the information they found was unclear, and they misinterpreted it. Neither nurse consulted the neonatologist before altering the administration method. They informed the mother-baby nurse (who had 20 years of experience) that the medication could be given intravenously; all three nurses preferred this route because it required fewer injections. Within minutes of receiving the drug, the infant suffered cardiac arrest, and resuscitation failed (Kowalski & Horner, 1998).

After an internal investigation, the NP was terminated; the nursery nurse was reassigned and her license was suspended. The mother-baby nurse was not disciplined.

The hospital reported the event to the state. The Colorado Board of Nursing suspended the licenses of the NP and the nursery nurse who gave the injection; it dismissed charges against the mother-baby nurse, who was the infant’s primary nurse. The hospital permitted the pharmacist to resign; the Colorado Board of Pharmacy investigated but took no action against the pharmacist’s license.

The board of nursing was authorized to take action against the nurses under the Colorado nurse practice act. This act contains more than two dozen circumstances that give the Board the authority to take action against a nurse’s license. Grounds for discipline are present when a nurse has been found guilty of a felony or has entered a plea of guilty or no contest to a criminal charge, regardless of whether a court made a finding of guilt. Alternatively, a nurse may be disciplined if he or she “willfully or negligently acted in a manner inconsistent with the health or safety of persons under his care” or “negligently or willfully practiced nursing in a manner which fails to meet generally accepted standards for such nursing practice” (C.R.S. § 12-38-117).

Resolution of the Case

The case was presented to the grand jury, which indicted all three nurses for criminally negligent homicide; the pharmacist was not charged. Under then-extant Colorado law, criminally negligent homicide occurs when one negligently causes the death of another person through a “gross deviation from the standard of care that a reasonable person would exercise, or he fails to perceive a substantial and unjustifiable risk that a result will occur” (C.R.S. § 18-3-105). The criminal charge was a felony with a maximum penalty of up to 5 years in prison.

The NP and the nursery nurse pled guilty to the charge. The terms of the plea agreement allowed them to avoid a jail term and a felony conviction provided they did not engage in further criminal conduct. The mother-baby nurse took her case to trial and was acquitted.

Evolution of Criminal Negligence

With the best intentions and often based on tragic facts that garnered much public attention, legislatures have criminalized conduct that historically has not been perceived as criminal. This change in how the criminal law is applied reflects our society’s increasing
intolerance toward accidents. The shift toward criminalizing accidents started with motor vehicle accidents, but the same principles apply to medical mistakes.

Health-care professionals are most familiar with the traditional recourse for negligence through civil lawsuits that seek to provide monetary compensation for mistakes. This paradigm recognizes that as human beings, health-care workers are fallible; damages resulting from their failings are compensable. In extreme cases, to protect the public prospectively, we rely on government agencies that regulate hospitals and license physicians, nurses, pharmacists, and other health-care professionals.

But more recently, the trend (though irregularly applied) has been to make examples of those who commit errors by retrospectively prosecuting these errors as crimes, in addition to providing redress to the harmed parties through civil lawsuits. Historically, the criminal law expressed both a moral and a practical judgment about the societal consequences of certain activities. To commit a crime, the law required that an individual must cause (or attempt to cause) a wrongful injury and must do so with malicious intent. Thus, there must be both a bad act and a guilty mind. Under this formulation, accidents generally were not considered crimes because the actor did not act with the necessary intent. This approach comported with the view that criminal law was directed at conduct that society recognized as inherently wrongful and immoral. Such acts—for instance, rape, murder, and robbery—were wrongs in and of themselves.

This classic understanding of criminal law no longer holds true exclusively. Today, a crime generally is deemed to have been committed if an individual commits some act to further a prohibited end. Criminal law extends to conduct that is intrinsically wrong but also to acts that are codified by a legislature to serve some perceived public good; thus, negligence and even accidents fall within the purview of criminal law. Potentially, then, an individual can be found guilty of a crime for failing to perform an act required by law, without any knowledge of the law’s obligations and with no wrongful intent.

The change in the aim of the criminal law has been political in part. Where a market exists for politicians to be “tough on crime,” legislatures codify more criminal laws with little effective consideration of the countervailing costs to society.

Negligence Examined

According to law, a health-care professional acts negligently when he or she fails to exercise ordinary care—the level of care that a reasonable health-care professional would use in a similar situation. In other words, a nurse who does something a reasonable nurse would recognize as creating an unreasonable risk of patient injury is not exercising reasonable care, even though she intends to do no harm. This is the basis for most medical malpractice actions.

Building on this definition, Wisconsin and many other states define criminal negligence as “ordinary negligence to a high degree, consisting of conduct that the actor should realize creates a substantial and unreasonable risk of death or great bodily harm to another...” (Wis. Stat. § 939.25[1]). It is “something less than willful and wanton conduct which ... is the virtual equivalent of intentional wrong” (State ex rel. Zent v. Yanny, 1943).

To prove criminal negligence, the state “must satisfy jurors beyond a reasonable doubt that the defendant engaged in conduct, which under all of the circumstances present, the defendant should have realized created a substantial and unreasonable risk of death or great bodily harm to another person” (State v. Schutte, 2006). Thus, unlike ordinary negligence, criminal negligence requires serious harm, which means death or great bodily injury, rather than just simple harm, and the risk of such harm must be unreasonable and substantial. Criminal negligence means the creation of a substantial and unreasonable risk of death or great bodily harm to another, of which the actor should be aware (State v. Badoh, 1999).

Distinguishing Ordinary Negligence from Criminal Negligence

The distinction between ordinary negligence and criminal negligence suggests that significantly more severe harm or aggravated conduct must be present before heightened criminal penalties are invoked. But this distinction may be misleading. In reality, both ordinary and criminal negligence is premised on harm to a patient. For example, in a memorandum informing all Wisconsin hospitals of the sentinel event described in the Wisconsin case, the state’s Department of Health Services described a second example of a medication error that caused a patient’s death. That incident involved “the errant intrathecal administration of a ‘not for intrathecal use’ contrast medium. The improper administration of the contrast medium occurred in radiology and led to the patient’s death” (Wisconsin Department of Health Services, 2006). Though the facts underlying both cases showed that the “healthcare provider should have realized that conduct created a substantial or unreasonable risk of death or great bodily harm to patient,” only the death of the 16-year-old was prosecuted as criminal negligence.

To help clarify where ordinary negligence ends and criminal negligence begins, Wisconsin created the felony criminal offense of causing great bodily harm to a patient by neglect. While the statute is aimed primarily at protecting vulnerable adults (such as nursing-home residents), it applies equally to patients in any health-care facility. The statute treats intentional abuse, reckless abuse, intentional neglect, and reckless neglect as equivalents (while begging the question of whether intentional neglect is an oxymoron). Such a broad formulation makes it difficult for health-care providers to fully understand what conduct may subject them to criminal prosecution.

Lessons from the Wisconsin and Colorado Cases

In the cases discussed in this article, the nurses involved had the best intentions. The Wisconsin nurse obtained the anesthetic for the purpose of educating the patient about the epidural. The Colorado nurses sought to avoid injecting the infant multiple times...
and tried to find a better way to administer the medication. In each case, safety systems were bypassed, transforming the nurses’ conduct from mere human error to at-risk behavior that increased the risk to the patient.

The Colorado case teaches that multiple errors can transform negligent care into criminal conduct. The Institute for Safe Medication Practices found more than 50 deficiencies in the medication system that contributed to this medication error and the infant’s death. The nurses’ errors included failure to double-check the unusually large amount of medication prepared by the pharmacist (improperly, as it turned out), failure to follow the “five rights,” and lack of experience in administering this medication. This last error was compounded when the nurses failed to discuss the administration method with the pharmacist or neonatologist, even though the information available to them did not clearly indicate the drug could be given intravenously.

In the Wisconsin case, the numerous errors included human factors such as fatigue. From the prosecutor’s perspective, the potential for patient harm could have been avoided at several points if the nurse had followed the proper protocols. When she sidestepped these protocols, she should have realized that her conduct created a substantial or unreasonable risk of death or great bodily harm. With each safety measure she bypassed, the nurse’s conduct became more reckless and the potential for serious harm increased. This sidestepping transformed her conduct from ordinary negligence to criminal negligence.

The lesson, then, is that no single fact typically transforms ordinary negligence into criminal negligence. Criminal prosecution commonly involves multiple factors. Errors perceived as aggravating, and which are common in criminal prosecutions for criminal negligence, involve the following factors:

- vulnerable patients, including those who are especially old or young
- inattention by the health-care provider (such as overlooking the bright pink warning label), excessive fatigue that affects a nurse’s judgment, bypassing safety systems, and failing to follow the “five rights”
- obtaining medications in anticipation of a physician’s order
- administering or altering the administration method in a manner outside the scope of one’s practice.

Systemic and Interdisciplinary Issues

However, noting these errors does not address some of the systemic forces that may promote these acts. For example, while it may be clear that medication administration is more dangerous when the nurse is excessively fatigued, what responsibility does the hospital bear when it mandates or simply “encourages” overtime due to understaffed units? And what responsibility does the anesthesiologist bear when she regularly requires the obstetric nurse to have all medications and equipment available to start an epidural, even though she has not written an order for the necessary medications (as in the Wisconsin case)? If the lessons of those nurses who have been criminally prosecuted are to lead to procedural change, then it is not only nurses who must examine their practices. Their acts are symptoms of systemic and interdisciplinary issues.

Collateral Consequences

The potential loss of one’s liberty and professional license is not the only dire consequence that can result from a serious error. As the Wisconsin nurse learned, an allegation of criminal conduct (and a subsequent criminal conviction) relating to patient care may lead to a health-care worker being barred from most health care–related employment. An allegation of criminal negligence also may result in a criminal inquiry of the health-care facility for fraud relating to billing of services linked to serious patient harm or death. In addition, because a civil claim against a health-care provider and her insurer is certain to follow, some states exclude criminal acts (sometimes defined as intentional acts) from insurance coverage. The immediate result is that the health-care provider is personally liable for any judgment and must engage a lawyer privately.

Federal statutes regulate health-care professionals’ eligibility to participate in federally financed programs, including Medicare and Medicaid. A professional convicted of a criminal offense relating to patient care may be prohibited (debarred) from being employed by a business (for instance, a hospital) that receives federal funds (42 C.F.R. § 424.535). Also, the professional is not eligible to receive federally insured loans and research grants for at least 5 years. Such a ban may result from state or federal convictions that the Centers for Medicare and Medicaid Services “has determined to be detrimental to the best interest of the program and its beneficiaries” (42 C.F.R. § 424.530[a][3]). Effectively, the federal law means a hospital that receives federal funds may not employ a professional who has been convicted of a health care–related criminal offense during the exclusion period. A facility found to employ such an individual is subject to significant monetary penalties.

Similarly, criminal prosecution for criminal negligence related to patient care may result in a finding that the claim for reimbursement for care provided to the patient who was harmed was fraudulent. Such reimbursement claims may subject the health-care facility to criminal charges.

A final concern for health-care professionals is how a criminal charge related to patient care may affect insurance coverage for negligent acts. Wisconsin, for example, has a state fund whose purpose is to provide secondary occurrence coverage to health-care professionals. However, it excludes intentional criminal conduct:

The fund shall not be liable … for injury or death caused by an intentional crime … committed by a health care provider or an employee of a health care provider, whether or not the criminal conduct is the basis for a medical malpractice claim (Wis. Stat. § 655.27).

Primary insurance policies may have different exclusionary language.
Conclusion

Criminal prosecution of a health-care professional remains an extraordinary event. However, that the number of health-care professionals facing criminal prosecution continues to increase strongly suggests that these professionals should act to address this issue. Such tragedies should not be necessary for health-care professionals and institutions to become proactive in safeguarding patients. Strengthening licensing boards, articulating and following reasonable standards of care, and developing more effective error-prevention programs can benefit both health-care professionals and patients. Failure to adequately address system issues and problems in institutions may lead to serious consequences to the professional and the facility involved.

References

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