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ISMP Opposes Criminal Charges for Ohio Pharmacist Involved in Medication Error

Horsham, Pa.—Recent news reports indicate that a former Ohio pharmacist plans to plead no contest next month to the charge of involuntary manslaughter for his role in a 2006 fatal medication error that occurred while preparing the final dose of chemotherapy for a two-year-old child. The Institute for Safe Medication Practices (ISMP) staff members, like so many healthcare professionals and organizations around the country, were deeply saddened by the loss of life in this case and extend their condolences to the patient's family. This incident was tragic for everyone involved, and ISMP takes the stance that criminal prosecution of a healthcare professional for an unintentional error is inappropriate and unwarranted.

Unfortunately, when a fatal medication error occurs, there often is considerable pressure from the public and the legal system to blame and discipline individuals for mistakes. However, criminal prosecution sends the false message that clinical perfection is an attainable goal, and that "good" healthcare practitioners never make errors and should be criminally punished if they are involved in an error.

Practitioners begin to fear disciplinary action if they make a mistake, and reporting of errors decreases, making it more difficult to determine the true cause of the errors. In this case, the pharmacy board revoked the pharmacist's license, and an Ohio grand jury indicted the pharmacist on charges of reckless homicide and involuntary manslaughter. The pharmacist now faces up to 5 years in prison.

Prosecutors hold the pharmacist responsible for the toddler's death because he oversaw the mixing of the chemotherapy. A pharmacy technician mistakenly prepared the infusion using too much 23.4% sodium chloride, and the pharmacist failed to notice the error. Though we cannot shed more light on the root causes of the error, our experiences with analyzing similar situations strongly suggest that underlying vulnerabilities in the healthcare organization's medication use systems may have played a role.

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Without minimizing the tragic loss of life in this case, we continue to be deeply concerned about the criminalization of human errors in healthcare. Safety experts such as ISMP advocate for a more fair and just path for individuals involved in adverse events, arguing that punishment because the patient was harmed does not serve the public interest. Its potential impact on patient safety is enormous, sending the wrong message to healthcare professionals about the importance of reporting and analyzing errors.

It could also have a chilling effect on the recruitment and retention of an already depleted workforce of healthcare professionals, who are fallible human beings destined to make mistakes along the way. It is human nature to drift away from safe behaviors as perceptions of risk fade when trying to do more in resource-strapped professions. Most individuals would not knowingly put themselves at risk for criminal indictments to enter the medical profession. If warranted, in cases of truly reckless or incompetent actions, licensing boards can act to protect patients by limiting or revoking his or her license.

The greater public good is better served by focusing on the system-based issues that allow tragedies like this to happen then in punishing only the "easy targets." ISMP hopes that all hospitals will be able to learn from this horrible episode, and adjust their own medication-use systems to ensure that the same type of error cannot happen again.

For a copy of the April 23, 2009 *ISMP Medication Safety Alert!* newsletter cover story on this issue, visit http://www.ismp.org/Newsletters/acutecare/articles/20090423.asp.

About ISMP: The Institute for Safe Medication Practices (ISMP) is an independent, nonprofit organization that works closely with healthcare practitioners and institutions, regulatory agencies, consumers, and professional organizations to provide education about medication errors and their prevention. ISMP represents more than 35 years of experience in helping healthcare practitioners keep patients safe, and continues to lead efforts to improve the medication use process. ISMP is a federally certified patient safety organization (PSO), providing healthcare practitioners and organizations with the highest level of legal protection and confidentiality for patient safety data and error reports they submit to the Institute. For more information on ISMP, or its medication safety alert newsletters and other tools for healthcare professionals and consumers, visit www.ismp.org.

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