We All Make Mistakes So Why Can't They?

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In 2017, a nurse from Vanderbilt Hospital accidentally administered a muscle relaxant drug (Vecuronium) instead of a sedative (Versed) to a patient after having overridden the medication cabinet. The override function allows the nurse to get the medication without needing a pharmacist to review the order. Typically, that specific medication would have a warning label, but since the nurse overrode the cabinet, the label did not print. The patient passed away within a couple of hours, and the toxicology report came in. Once the nurse realized her mistake, she immediately reported it. Following the incident, the nurse was fired and had to wait five years for her trial. When it was time, she was criminally charged with criminally negligent homicide and had her license revoked. Reading this story, many would immediately point the blame at the nurse; however, there is more to the story that is rarely ever discussed. Each day, healthcare workers around the U.S. work in fear of the repercussions that may ensue if they make a medical error. According to the severity of those mistakes, one may face punishments like being fired, suspended, getting their license revoked, and/or even jail time. Society often harshly scrutinizes healthcare workers who make these mistakes before they ever question why these errors are made. Despite how many years of school goes into becoming a healthcare worker, they are still human, and they will make mistakes. Society tends to put healthcare professionals on a higher pedestal than everyone else, which is both good and bad. The belief is that since they are a health professional, they are exceptionally smart which, in some way, means that they don't, or can't, make mistakes. When accidents do occur, the public is quick to point the blame at the worker. This does not go to say that medical professionals who commit acts that blatantly show intentional harm should not reap the consequences. However, there are so many other factors that go into why these mistakes occur and they should not be criminalized for it. Medical professionals are overworked, sleep-deprived, and understaffed, which are big contributors to

why medical errors happen. Technology also plays a big role in why they happen; technical errors are a common trend seen in health institutions. Not to mention, with all the chaos that regularly occurs in hospitals and clinics, there is always the probability that miscommunication will occur.

People tend to point the blame at healthcare workers whenever they make a medical error. However, medical errors result from many underlying systematic issues that are rarely taken into account when examining why they occur. One contributing factor is medical professionals' work schedules; many of them are severely overworked. In the U.S. we are seeing a constant wave of physician and nurse burnout. Many are leaving the profession after devoting many years to it because of the unreasonable responsibilities they are being tasked with. Others who were once interested in entering the career field are now backing away from further pursuing it. According to Salazar, Sullivan, and Jasionowski (2023), some nurses "are now being expected to care for up to seven patients […] previously the patient-to-nurse ratio was two-to-one." In addition, this article also highlights that these nurses are being put to work for long hours "without going to lunch or even being able to go to the restroom." When we apply all this pressure onto our healthcare workers, they become more susceptible to making mistakes. Many nurses will also feel they need to rush to attend to their next patient. With this profound sense of urgency, they may make silly mistakes that, had they not been in a rush, they would not have made in the first place. Having these workers work long shifts with many patients and not providing them with time to rest contributes heavily to why we see many health professionals make preventable mistakes and ultimately leave the profession. A possible solution to this would

In any profession, success directly reflects how well a team works together to delegate roles and execute them. A major benefit of having more people on a work team is how efficiently work can get done and how it provides everyone with equal responsibility. In many parts of the healthcare field, this depiction of teamwork rarely comes around. With the increase in people leaving the profession, the recent pandemic, and other variables, medical institutions are noticing how understaffed they are. With fewer staff available to delegate tasks, the remaining nurses and physicians are left to take on extra work. As a result, many errors can occur such as administering the wrong medication, underdiagnosis, and failure to monitor patients. In one article by Cohen and Jaffe (2022), it mentioned that nurses can administer the wrong medication due to being in a hurry "To get to the next patient." It continues to discuss how healthcare workers' main goal is to help as many people as possible, but due to understaffing many may "Quickly diagnose a patient without carefully considering their symptoms." This can ultimately lead to a patient undergoing unnecessary treatment. This was especially apparent during the height of the pandemic when everyone who came into the hospital seemed to be diagnosed with COVID. Even common symptoms of other infections were likely to be diagnosed with the disease. Although one may argue that this is an example of individual malpractice, there is a reason why many nurses/physicians must rush through their examinations with their patients. Upon closer examination of why this occurs, it is clear to see that it all points back to the system. Healthcare workers wouldn't have to rush and risk misdiagnosing an individual if they weren't so understaffed. If more workers were hired, nurses and physicians would have more comfort in taking their time examining their patients because they wouldn't have to worry that they are neglecting the several other patients waiting for them. However, this cannot happen until hospitals and clinics begin to hire an adequate number of workers.

With the strenuous work schedules health professionals are dealt with, it is no wonder that many come into work heavily sleep-deprived. This lack of sleep can contribute to even the most skilled professionals making preventable medical errors. An article by Pauline Anderson (2020) noted how "Sleep deprivation in physicians is linked to serious medical errors that result in patient harm." Pauline goes on to state that "Even moderate sleep loss raises the risk by 53%." These statistics especially reign true for trainee physicians who, when compared to attending physicians, had higher levels of sleep-related impairment. (Anderson, 2020) There is this pattern that doctors/nurses are having to work, overbearingly, long hours. Likely, the reason behind this is that it makes the staffing administration's job easier. It is much easier for them to hire one person to work a long shift than to find several people to work an average shift length. Hiring staff doesn't consider the toll this lack of sleep has on both the worker as well as the patient. Nancy Redfern, an anesthetist from Newcastle Hospital, described what happens when you have a team of sleep-deprived healthcare workers, stating, "' We in the medical and nursing team are less empathetic with patients and colleagues, vigilance becomes more variable, and logical reasoning is affected, making it hard for us to calculate, for example, the correct dose of drugs a patient might need.'" (McKie, 2022) Typically, cases where a medical professional is criminally charged are a result of the patient getting harmed or killed under their supervision. However, when a healthcare provider is working on two hours of sleep it is not reasonable to blame them for making a mistake; because they were not in the headspace to work in the first place. The healthcare system fails to prioritize the health of its workers and innocent patients are paying the price. Providing an adequate work schedule could help many workers get the much-needed rest they require, without it, we are left with sleepwalking nurses and doctors.

Technology is becoming more and more advanced, and as a result, many varying professional fields are beginning to adapt to the gradual advancements. From stores introducing the tap feature to pay, to robots, like Starship, who are completely revolutionizing the food delivery industry. It is no doubt that technology is moving fast, and professions everywhere are trying to keep up. The healthcare field is no different and has seen many new technologies being added to their facilities. A specific add-on to the field that has led to some medical errors, is the automated dispensing cabinet. This dispenser is responsible for providing medications to the nurses so they can administer them. With any technological device, we always have to be wary of the probability that it will malfunction. Oftentimes these problems are resolved within a few days by a technology professional. But what happens when something as vital as a medicine dispenser begins to malfunction in an emergency situation? According to Julie Dickinson (2022), several medical error cases are a result of faulty systems that nurses and physicians are forced to work with. Many are forced to "Compensate by creating workarounds/safety bypasses to complete their tasks." A bypass that is commonly performed when the dispenser system malfunctions is manually overriding the medication; this is the same thing RaDonda had to do back in 2017. Leaving healthcare workers with equipment that isn't regularly updated increases the risk that it will malfunction. Additionally, when they are left with no tech support for quite some time, they must do what is necessary for their patient or else it would be considered neglect. The healthcare system leaves its workers with no other options but to do whatever is necessary to provide medication to their patients. Oftentimes that means overriding the medicine cabinet when errors occur. It is unfair to require workers to tend to their patients efficiently, but then turn around and reprimand them for creating bypasses that sometimes lead to errors.

As previously emphasized, healthcare workers are human, and they will make mistakes. These errors, unfortunately, can sometimes result in a patient getting harmed or even killed. Despite these unfortunate outcomes it is still important to not immediately point the blame on the health professional. It is understandable that as a victim's family member, this would be difficult to consider. However, if we were to always identify the root of the issue instead of immediately pointing the blame at the doctor then it may become easier for families to not initially direct their anger to the healthcare worker. Oftentimes these mistakes occur due to underlying systematic issues, but other times they may happen because of human errors, like miscommunication. After long shifts at work, many are fortunate enough to clock out and head home. However, the same is not true for medical professionals. Commonly, before a nurse/physician clocks out they must go over every important detail about their patients to the incoming nurse/physician that will be taking over for them. At this point in their shift, many of them are tired and hungry, which can lead to them reporting ambiguous or inaccurate information. The HIPPA Journal (2022) highlights the effects that can occur when miscommunication happens stating, "Poor communication could lead to patients receiving the wrong treatment or procedure, being given incorrect medication, or could result in delays to essential tests and treatments." Although miscommunication at work may seem like something that can only be blamed on one person, that's not always the case. Miscommunication can happen because of many reasons, and as mentioned previously, there are several underlying problems that healthcare workers deal with that increase the probability of miscommunication. As stated, these workers are left working many hours with not enough time to sleep, and on top of that they are being handed an unreasonable number of patients to tend to. This doesn't mean that healthcare workers who make mistakes because of personal carelessness should not receive a punishment. It is a reminder to

everyone that health professionals are not always at fault for medical errors caused by miscommunication.

Medical errors are an unfortunate risk that we all take whenever we seek medical treatment. There are few cases where these errors occur solely because of a medical professional's failure, however, many of these issues arise because of the underlying systematic problems that are rarely discussed. Many health professionals are left with poorly updated technology that requires them to create safety bypasses, others are overworked with barely any time to use the restroom or eat, and some hospitals and clinics are severely understaffed leaving the rest to take on an extra load of work, and their work schedule is overly packed making them heavily sleep deprived. All this in addition to the already chaotic environment of hospitals/clinics, there is no wonder why there are many miscommunication occurrences. As more and more health professionals begin to face criminal charges for crimes that wouldn't have been committed had the underlying issues been addressed. It begs the question, how long until we begin to hold administrators and government officials accountable for pushing these professionals to make such mistakes? As an aspiring physician, reading about the lack of support we are given by the administration to address these issues is disheartening. As a black woman wanting to go into medicine, I already know I will face racism, microaggressions, and more. Now knowing that in addition to those things I will also have to fear the possibility of jail time, it makes it hard for me to want to pursue this career field. I want to go into a field where if I make a mistake, I don't have to worry that I will face jail time, instead, they will prioritize the steps necessary to prevent that from happening again. It is crucial to address the systematic issues in our healthcare system because if we don't the only outcome that results from criminally charging medical workers is inflicting more fear for them to speak out. It is stated that "Just the fear of that outcome could

make people hesitant to speak freely." (Freeman, 2022) This fear of reporting can lead to several serious mistakes being swept under the rug. By criminally charging these professionals we are not creating a safe medical environment for our community, we are simply applying a band-aid to a broken bone.

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