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Geri Amori: Hello, everyone, and welcome to *Healthcare Perspectives 360*, a series dedicated to exploring contemporary healthcare issues from multiple perspectives.

I am your host, Geri Amori, and I'm talking with emergency medicine physician Dr. Megan Ranney, hospital administrator Pierre Monice, and customer experience expert Jake Poore. Thanks for joining in the conversation today.

The prosecution of a nurse for a medication error sent shockwaves through the medical community earlier this year. Today, we are discussing the criminalization of healthcare.

Let's start with Dr. Ranney. Dr. Ranney, if patients were all allowed to bring criminal charges for perceived medical errors, how would that affect your job?

Megan Ranney, MD: Thank you, Geri, and please call me Megan. So in answering this question, I'm going to leave aside discussions about the recent Dobbs Supreme Court decision which is dramatically altering concerns and fears among healthcare providers across the country right now.

So leaving that aside and focusing on this question around kind of criminalization of medical error, misdiagnosis, or poor outcomes, I want to say that there is a huge difference in my mind between a criminal act in healthcare and medical error. Now, medical error should not happen, we should do everything we can to root it out, to identify its root causes, and to mitigate it, and patients who have been hurt do deserve compensation.

But fearing that you are going to be put in jail because of what we know sometimes these errors happen because of circumstances outside of our control, particularly right now during COVID where we're understaffed and undersupplied, that's just strikes fear at the heart of healthcare providers and is going to drive more folks out of this profession. The idea that you may be jailed for something that you don't have any control over is not a tenable way to be able to work.

Again, very different from actual criminal behavior which should be treated as a criminal matter.

Amori: Okay. So it's have a chilling effect on the way people felt about doing their jobs.

Ranney: That's right.

Amori: Because an error would then become a criminal act. Pierre, what has been the discussion in the C suite?

Pierre Monice: As you can imagine, it's been a hot topic. And I'll take the avenue of what I felt has been the most productive conversation around this has been how do we provide a safe environment for our colleagues. How do we ensure that we're listening, and we're ensuring that they're working in an environment where they feel safe, and if there are mistakes they're an opportunity to learn from them?

Because that has not always been the case. We've known that over years that healthcare has opportunities to improve, and from a burnout perspective, from a safety of environment of care, from supply. And, honestly, our clinicians, the heroes on the frontline, they've been trying to always make things happen with very little.

So from an administrator's standpoint, we've got to listen to our frontline colleagues and provide a safe environment for them to do the very difficult job they do every single day.

Amori: That makes a lot of sense. Jake, have you had any experiences with discussions about this?

Jake Poore: Yeah. Listen, how this is not headline news of every newspaper for the past 6 months is crazy to me. A quarter million people die every year of medical mistakes or infections, we're the third leading cause of death in America—not cancer, not heart disease, medical errors. Why are we not talking about this more?

Now, was she set up to fail? Of course she was. She was a preceptor from the emergency department covering someone else's shift. She was trying to train someone else who she wasn't even assigned to while she was trying to do the Pyxis machine for the medical error that happened. Then nobody double checked it before she administered it. Of course she was set up to fail.

Well, how come we're the only industry in the world that doesn't criminalize an act of death? Listen, I want to have empathy all day long, but my dad died of a medical mistake in an open heart surgery in Michigan, while on a fishing trip he had a heart attack. Medical error. Now, did I sue them, did I want money? People don't just want money. And by the way, no, I didn't sue them and want money.

But just like Dennis Quaid when his wife had twins and one of his twins got 10,000 cc extra of heparin instead of the right amount that somebody miss hand wrote back in the days when we hand wrote notes, he asked for a $30 million endowment so that he could use that endowment to teach more safety in healthcare.

So on one hand, we all have loved ones. My sister who is mentally disabled, Down syndrome, died recently in a coma in Upstate New York, and I came in 2 days later after she was in a coma, and nobody had brushed her teeth. I was upset. Now, imagine if they had caused the coma.

There's huge emotion in healthcare. And I'm trying to have empathy from the caregiver because I know they're short staffed and they're stressed, but I'm trying to give you the patient's perspective as well.

Ranney: So I totally get that, Jake, but I want to say that criminalizing things that are not someone's fault, that creates an environment where more medical errors are going to happen. When you take something, the series of events that you just repeated, that's this place where the organization failed.

What many of us in healthcare have been working towards for decades is this idea of just culture. The idea that you have a system where you recognize that mistakes are generally a result of that Swiss cheese of holes is a faulty organizational culture, and just culture is one where you feel free to report errors or near errors, allowing us to go back, look at what caused it, and then prevent it going forwards. There has been study after study showing that when you have a culture of blame and criminalization, that you actually worsen safety.

So I think that if we criminalize these types of mistakes—again, different from intentionally going around and shooting up a bunch of patients with extra insulin to kill them, different from intentionally giving a bunch of patients extra potassium in order to kill them. That's horrible and does deserve to be criminalized when there's an intentionality. But this unintentional stuff, we need to keep it in that malpractice realm, and fund and go deeper on creating that just culture instead of making it something that people fear that they're going to have to go to jail for.

Poore: I would agree with that.

Amori: I'm going out of character here a minute and talk a little about my experience as a healthcare risk management professional, and also as working as a patient advocate, and just want to share that I have dealt with many, many family members who have lost other family members due to medical error. And even after pursing litigation, tort litigation and getting millions of dollars, they have come back to me later and said the money just doesn't do it, it's not what I wanted.

And when we sit and we chat about what is it that would have made you really feel better about what happened, it was humility. What they were angry about was the lack of humility on the part of the healthcare facility, and that if someone had just taken their hand and sincerely said this was our fault, and we'll make you whole, but we can never bring your family member back.

I've actually had people tell me they never would have pursued litigation much less criminal action, it is anger that leads to litigation, and a wanting to know what happened. And that's been my experience. So I'm going to side with Megan on this, that I don't think criminalization personally would actually influence or help the situation.

Pierre, you've been silent for a few minutes here, you want to jump in on this?

Monice: Oh, definitely, great point being brought up. And I think it reminds us of the fact that in healthcare we're dealing with people on both sides, we're dealing with the patients and we're dealing with caregivers.

And, yes, we've known for the longest time healthcare is broken and we want to find creative solutions to do that, but at the core of it we've got to make sure we provide an environment where we're protecting our clinicians.

We could talk about prior to COVID and now staffing has been an issue, supplies have been an issue, and just culture has not been always consistent. But we want to continue, especially from

an administrator's standpoint, I want to do my best and encourage others. We have to listen to our colleagues. You go to most departments in a healthcare facility, they'll tell you what the top issues are, or they'll tell you we haven't brought it up because nobody wants to pay for that, or we know administration isn't going to listen to us.

But we have to reverse that, it's not okay, everything cannot be about the bottom line. That's important, but we've got to make some tough decisions to ensure that our physicians and our clinicians feel supported, and patient safety is number one.

Ranney: Yes. There are 2 things that I want to say going off of that, Pierre. The first is I don't want to give folks the sense that we shouldn't be disciplining folks who do make errors, and I think that in that nurse's case her losing her license was warranted. So there is a difference between brushing things under the rug and criminalization, there's a huge space in between those two.

The other thing, Pierre, going off of your point, is to point out when you talk about fixing systems' issues, one of the things that comes up over and over in discussions and was certainly a factor in this case was the electronic medical record.

We know that the electronic medical record was created with the intention of avoiding errors, like that error with Dennis Quaid's twin, but it has created a whole host of spaces for new errors, and is frequently identified by healthcare providers as a major source of both burnout, frustration, and mistakes either because you order something on the wrong patient, you order the wrong amount, or like in this case, the way the system is set up forces you to ignore alarms, to override things that are supposedly safety procedures, that it's created in a way that ignores your workflow and actually puts you and the patient at greater risk.

Amori: Jake.

Poore: Yeah, Dr. Ranney, I think those workarounds that have become the norm in healthcare are what hospital healthcare administration needs to be held accountable for, because those workarounds happen because systems go down, updates need to be happening, and those workarounds have become the norm. And now nurses are basically putting their foot down and saying no. From the patient's perspective, that creates a huge amount of anxiety.

Let's go back to the root cause. I've been doing this now for 21 years just in healthcare. I know I spent my first 18 years at Disney, but in healthcare I've been working exclusively in healthcare for the past 21 years. And I will say 9 out of 10 healthcare organizations, when a conflict happens, when a complaint is made to a caregiver or a frontline person, they don't deal with it, they hand it to their nurse, charge nurse, their boss, their boss' boss, and it sits, and it festers, and then finally gets dealt with, and it's exacerbated, the magnifying glass is now on it.

And worst-case scenario, a death happens. To Geri's point, I'm going to sue your pants, off, I'm going to make this public. Versus if you had just admitted the problem at the outset—you're human, I'm human, we made a mistake—we would probably settle out of court, we would probably keep it private and confidential. But because you hid it or perceived didn't handle it,

you tried to protect or put it under the rug, I'm going to take it to the nth degree. Doesn't matter who I am, my 84-year-old grandmother.

So I think it's important that if you go back to basics, and we've got to be brilliant on the basics, that every care team member can't skip orientation, they can't do it virtually, we've got to do some conflict resolution scenarios just like we do in evidence-based medicine in the OR room when things happen. Let's practice it, let's practice service recovery and actually make it part of our processes and not just a program with a little kit in the corner.

Amori: So, Jake, you're actually leading into my next question, which is what are some of our solutions, what can we do to improve this so that we don't have to have this conversation about criminalization? And you just mentioned one about improving the way we handle situations when they occur. Pierre, what would you like to say?

Monice: The word that pops up in the head on that question is accountability. I don't know the perfect solution, but we have to all be accountable. So like Jake's point, we can't keep passing the buck, someone has to take ownership. Let's have the direct conversation with family members, let's own up when we make a mistake. It's not going to fix everything, but it's going to go so much further than just ignoring it. And then how can we learn from it? So I think accountability is the biggest step we could take in the right direction.

Amori: So do you think that would work, Megan?

Ranney: I think it is a really important step. I do think that we have to acknowledge that errors happen, and then we have to take the step to fix the problem. These are not new problems that we're talking about, these are things that keep coming up over and over. So we have to commit to having adequate staffing, to having stable teams, to having electronic medical records that actually work the way that they're supposed to, to having access to the medications that we expect to have access to so that we're not recalculating doses or double checking things.

How many of us in the last 2 years that are healthcare providers listening to this podcast have had to use a substitute or a different formulation from what we're used to? That creates a space where errors are prone to happen.

So if we're going to take accountability, we then need the system to take accountability on the other side, and to create a place where we can move forwards together.

Amori: So as we bring this episode to a close, I'm going to ask each of you what is the one thing you would like our listeners to take away from your perspective. And I'm going to start with Jake today.

Poore: Well, I'll give you the voice of the patient. If I bring you a complaint, a concern, an issue, a worry, I'll give you the quote that we put in place at Penn Medicine. If you hear it, see it, or smell it, you own it. But we can't just have accountability without tools. Teach me how to handle tough situations. If it's a Band-Aid situation, that's different from a dead battery, that's different

from a dead patient. We can't do a one-size-fits-all coffee coupon at Starbucks. That's a Band-Aid on a tumor, that's not going to work.

So to say to anybody in the hallway with blue scrubs on do you work here? Yes. I have a situation. You can't say well that's not my job, or I don't know. If you hear it, see it, or smell it, you own it, and follow it through.

And if we take that level of ownership, I think to Pierre's point we'll have that level of accountability, because now if I own it you've got to teach me how to deal with it.

Amori: Alright. Thank you so much, Jake. Pierre, what would be the one thing you'd like people to take from this?

Monice: As we look at the generations in healthcare, our clinicians are getting younger and younger, and I think what we need to remember is education is not just an orientation for 45 minutes or a book, it has to be continual, and it has to be interactive. We can't sit people down in a room and say this is what it is, but let it be interactive, and let's keep teaching our clinicians to get better. And also as administrators, we also have to be part of that learning process.

Amori: Excellent point, thank you so much. Megan?

Ranney: My takeaway would be that it's on us to create a culture of safety, which includes creating a space where folks can speak up if they see things that are going wrong without fear of being punished.

Amori: Thank you very much for that. Well, this has been a really exciting conversation and an enlightening conversation, and I'd like to thank all of our panelists for being here today as well as our listening audience.

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Thank you, and see everyone next time.