

AORN Position Statement on Criminalization of Human Errors in the Perioperative Setting

POSITION STATEMENT

AORN believes:

- That all acts resulting in harm or potential harm to patients require thorough review and action.
- Acts intended to cause patient harm that are committed by persons licensed as nurses are appropriately addressed by the criminal justice system. This statement should not be interpreted to seek immunity for such persons.
- That in the health care setting, all unintentional errors are appropriately addressed initially within the health care organization quality/risk management program, using causative models to assess unsafe acts. Furthermore, after a systematic investigation, if indicated, the facility will take appropriate next steps in concert with the current state and federal regulatory requirements with respect to individual health care professional licensure and mandatory reporting.
- Criminalization of errors may result in health care professionals refraining from timely and open disclosure of key error-related information.
- All perioperative nurses and health care organizations should strive to create a culture of patient safety that provides an atmosphere where perioperative team members can openly discuss errors, process improvements, or system issues without fear of reprisal.¹⁻⁵

RATIONALE

AORN and perioperative registered nurses have created a strong clinical tradition and literary legacy of protecting patients from harm, avoiding error, and promoting safe operative practices.⁶ AORN is aware that nurses have been criminally charged for committing unintentional errors that resulted in patient harm.⁷⁻⁹ Any such attempts to criminalize unintentional nursing errors will provide the ultimate fear of reprisal, hampering future error-reduction efforts. A leading scholar in the patient safety literature states that the greatest impediment to error prevention is that "we punish people for making mistakes."^{10(p4)}

The perioperative nurse's role in advocating for and providing protection to patients undergoing invasive procedures requires trust in an environment of early, full, and frank disclosure followed by systematic examination of all errors and near misses regardless of patient outcome.¹¹ Health care-related errors cannot be solely attributed to "bad people; the problem is that the system needs to be made safer."^{12(p49)}

Bringing criminal charges upon those who commit unintentional errors in the health care setting has a broad impact on the entire surgical team, creating obstacles to open communication. The mere possibility of criminal charges may have a detrimental effect on the ability to freely disclose, examine, and address errors. Criminal prosecution interferes with perioperative nurses' ability to fulfill their professional responsibilities. Additionally, criminalization will continue to erode the patient's sense of safety. AORN opposes attempts to criminalize unintended errors and joins many nursing and other professional health care associations in resisting such actions.

Glossary

Error: The failure of a planned action to be completed as intended, or the use of a wrong plan to achieve an aim. This includes problems in practice, products, procedures, and systems.⁸

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