# The Criminalization Of Accidental Mistakes in Healthcare: Branding Nurses Who Make Human Errors As Criminals

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## ABSTRACT

*Prosecutors are bringing criminal charges against nurses and other healthcare providers for making accidental medical errors that result in harm to patients. These charges are resulting in convictions. This is a recent phenomenon and one that has disrupted the nursing profession and chagrined patient safety advocates alike. Nurses are losing their licenses to practice, their livelihoods and, in some cases, their freedom while the organizations that place them in harm's way are unscathed. At a time when healthcare has experienced unprecedented pressures, this latest effort to brand those who make human errors as criminals will lead to the implosion of nursing and, therefore, the healthcare industry as we know it.*

*The pursuit of error-free healthcare is a lofty goal. Patient safety advocates and professional organizations are focused on addressing system failures, forthrightly communicating errors, and creating a blameless environment for those that make infrequent accidental errors. The intent of these efforts is to bring light to errors and potential errors and fix the underlying processes that influence them. "Just Culture"[1] is recognized as best practice in the healthcare industry for addressing human errors. The legal community is currently at odds with these principles. Prosecuting nurses for accidental errors is not only detrimental to nursing practice but is the antithesis of efforts to improve patient safety.*

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1. Just Culture is a philosophy that recognizes the human ability to fail and to make errors while addressing those errors in a blame-free environment that focuses on correcting system or process failures that influence those errors. This principle has become the industry standard for driving a culture of safety, particularly in healthcare. David Marx, JD, CEO, is a recognized founder of these principles.

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## I. INTRODUCTION

The 2022 decision in *Tennessee v. Vaught*[2] drew national attention when a well-respected, experienced intensive care nurse was convicted of criminal negligence and abuse of an impaired adult (both felonies) for making an accidental, yet fatal, medication error. The criminal prosecution of this former nurse was unprecedented. For at least two decades, the healthcare industry has promoted a culture of open dialogue surrounding actual and potential errors. The focus has been on identifying the system or process issues that are conducive to errors and correct those issues in the interest of preventing future errors. Impugning the person who made the error does nothing to prevent future errors and, in fact, discourages others from coming forward to report their actual or potential error, thereby eliminating the opportunity to prevent the same error in the future.

**Prosecuting healthcare professionals for making accidental medical errors that result in harm or death is counterproductive and will only forestall patient safety initiatives.**

## II. BACKGROUND

In March 2022, a Tennessee jury convicted RaDonda Vaught for making an unintentional, yet fatal, medication error. The prosecuting attorney claimed that the nurse was "reckless", inter alia,[3] because she had withdrawn a medication from an automated dispensing cabinet by utilizing an "override" function.[4] Vaught was a "float" nurse at Vanderbilt University Medical Center in 2017 when she mistakenly administered Vecuroneum (a paralyzing agent) instead of Versed (a sedative)[5] to a seventy-five-year-old patient. The patient, who was awake and alert, was rendered unable to breathe. She suffocated. She died after being removed from life support.[6]

The patient had been admitted with a brain hemorrhage and was scheduled for a positron emission tomography (PET) scan when the error occurred. She was claustrophobic and requested sedation, which she had had for a previous exam, to reduce her anxiety. Nurse Vaught, who was also orienting a new nurse, was asked to give Versed to the patient. Unable to locate Versed in the patient's profile, Vaught entered

2. State of Tennessee v. Vaught, Case No: 2019-A-76 (Davidson Cty. Crim. Ct. 2022).

3. Brett Kelman, *In Nurse's Trial, Investigator Says Hospital Bears 'Heavy' Responsibility for Patient Death*, KAISER HEALTH NEWS (March 24, 2022), https://khn.org/news/article/radonda-vaught-fatal-drug-error-vanderbilt-hospital-responsibility/.

4. The "override" function allows a nurse to retrieve a medication from the automated dispensing cabinet even though it is not listed on the patient's profile and has not been reviewed by a pharmacist.

5. Versed (Midazolam) is used to help patients feel relaxed or sleepy for surgery or medical procedures. Vecuroneum (Norcuron) is used as part of general anesthesia to provide skeletal muscle relaxation during surgery or mechanical ventilation. https://reference.medscape.com.

6. Brett Kelman, *The RaDonda Vaught trial has ended. This timeline will help with the confusing case*, The Tennessean (March 27, 2022, 2:57 PM), http://www.tennessean.com/story/news/health/2020/03/03/vanderbilt-nurse-radonda-vaught-arrested-reckless-homicide-vecuroneum-error/4826562002/.

the letters VE to search for the medication in the automated dispensing cabinet. Vecuroneum came up first on the search, and Vaught mistakenly chose this medication. She administered it to the patient without ever checking the label to verify that it was the correct medication. She later testified that she was "distracted"[7] by a discussion with the orientee about another patient.

Nurse Vaught admitted her error to colleagues as they were attempting to resuscitate the patient. She also admitted her actions to her managers. Vanderbilt fired Vaught.[8] They reported her to the Tennessee Board of Nursing. Initially, the board cleared Vaught of any wrongdoing but later, after she was arrested, revoked her license.[9] She was indicted on charges of reckless homicide and impaired adult abuse. A jury convicted her of criminally negligent homicide,[10] a lesser charge, and impaired adult abuse. She was sentenced to three years of probation with the opportunity to have her record expunged.[11]

## III. CIVIL LIABILITY

There was a time when hospitals and healthcare providers were immune from civil liability for errors and mistakes, including those errors that caused harm. Prior to the 1950s, hospitals were viewed as charitable organizations not big businesses. As such, hospitals were thought to be providing services gratuitously, and, since they had no funds to pay any judgments, they should be immune from civil liability to protect the public asset. If hospitals exercised due care in selecting their providers, they would not be held responsible for negligent actions even if injury occurred.[12]

The doctrine of immunity was abandoned in *Bing v. Thunig*, where the New York Court of Appeals opined that "[t]he hospital's liability must be governed by the same principles of law as apply to all other employers." Liability should be applied whether the institution was "charitable or profit-making."[13]

Thereafter, the civil justice system and the state licensing boards have been a plaintiff's recourse to address harm suffered because of medical error and malpractice.

## IV. ROLE OF LICENSING BOARDS

The established mechanism for regulating the practice of nursing in all fifty states is a board of nursing. These boards are statutorily delegated the duty to protect the health and safety of the citizens of that state. In Tennessee, the Board of Nursing acted on two occasions to address the errors made by Vaught.

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7. Ramona P. Smith, Tennessee Bureau of Investigation Investigative Report. Interview-Recorded-RADONDA LEANNE VAUGHT, 2 (March 19, 2019), https://ewscripps.brightspotcdn.com/3d/46/feb995d34e9782f9ae33e37391c0/0716-001.pdf.

8. Vanderbilt University Medical Center Termination Letter to RaDonda Vaught (January 3, 2018), *imbedded in* Kelman, *supra* note 6 (stating "you did not validate the five rights of medication administration, per policy, the decision has been made to end your employment").

9. Kelman, *supra* note 6.

10. Tennessee Code §39-11-302(d). "Criminal negligence refers to a person who acts with criminal negligence with respect to the circumstances surrounding that person's conduct or the result of that conduct when the person ought to be aware of a substantial and unjustifiable risk that the circumstances exist or the result will occur The risk must be of such a nature and degree that the failure to perceive it constitutes a gross deviation from the standard of care that an ordinary person would exercise under all the circumstances as viewed from the accused person's standpoint."

11. Brett Kelman, *Tennessee Nurse convicted in lethal drug error sentenced to three years (sic) probation*, KAISER HEALTH NEWS (May 14, 2022, 11:42 AM), https://www.opb.org/article/2022/05/14/tennessee-nurse-convicted-in-lethal-drug-error-sentenced-to-three-years-probation/#:~:text=RaDonda Vaught.

12. McDonald v. Massachusetts General Hospital, 120 Mass. 432, 436 (1876).

13. Bing v. Thunig, 2 N.Y. 2d 656, 666 (1957).

The Tennessee Department of Health operates through the Board of Nursing[14] to regulate and supervise the practice of nursing by promulgating rules and entering orders.[15] As stated in the *Notice of Hearing In The Matter of: RaDonda Vaught*:

> If a licensee violates the Code rules, or an Order, the Board has the power and the duty to: (a) suspend, probate, or revoke a license, Tenn. Code Ann. §§63-7- 115 and 120; (b) assess a civil penalty against the licensee of up to $1,000.00 for each day of each violation, Tenn. Code Ann. §63-1-134(a) and (b) and Tenn. Comp. R. & Regs. 1000-01-.04; (c) assess the costs against the licensee directly related to the prosecution of this case, including the cost of the State's attorney, Tenn. Code Ann. §63-1-144; §63-7-115(d); and Tenn. Comp. R. & Regs. 1000-01-.04(11); or (d) otherwise discipline a licensee.[16]

After an initial investigation in 2018, the Tennessee Department of Health sent a letter to both Vanderbilt and Vaught on October 23, 2018, clearing Vaught of any wrongdoing. The letter to Vaught stated that "[a]fter review by the Board's Consultant and a staff attorney for the Tennessee Department of Health, a decision was made that this matter did not merit further action."[17] Further, "[t]his is not a disciplinary action, and no record of it will appear in your licensure file."[18] The letter to Vanderbilt stated that "[a]s a result of this review, it was their determination that the acts of the practitioner did not constitute a violation of the statutes and/or rules governing the profession. Therefore, the complaint has been closed. . ."[19]

This was not the ultimate action taken by the Board of Nursing. One year later, for unknown reasons, the board reversed itself and charged Vaught with "unprofessional conduct, abandoning or neglecting a patient who required care and failing to maintain a record."[20] Vaught's license to practice nursing was revoked, and she was fined $3,000.00.[21]

The Davidson County prosecuting attorney commented that he had filed charges against Vaught because the Tennessee Board of Nursing had failed to act and that he "needed to protect the community"[22] from Vaught. The board did ultimately act against Vaught, but there were no prosecutorial actions against Vanderbilt despite its failures to report this event, as required by law, to state and federal authorities.

The Commonwealth of Pennsylvania has a similar regulation giving its Board of Nursing the following authority:

> (c) The Board has the right to establish rules and regulations for the practice of nursing.

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14. Tenn. Code Ann. §§63-7-101, *et seq.* (2010).
15. Tenn. Comp. R. & Regs. 1000-01-.01, *et seq.*
16. *In The Matter of: RaDonda Vaught, R. N. License No. 205702*, at 1, Docket #: 17.19-191087A, NOTICE OF HEARING AND CHARGES AND MEMORANDUM FOR ASSESSMENT OF CIVIL PENALTIES (September 27, 2019), https://www.documentcloud.org/documents/6483588-Vaught-RaDonda-NOC-9-27-19.html.
17. Brett Kelman, *RaDonda Vaught: Health officials found no reason to discipline Vanderbilt nurse after deadly error*, The Tennessean (February 25, 2019 7:57 AM), https://www.tennessean.com/story/news/health/2019/02/25/radonda-vaught-after-vanderbilt-nurse-error-health-officials-said-discipline-not-needed/2961464002/.
18. *Id.*
19. Tennessee Department of Health letter to Vanderbilt University Medical Center dated October 23, 2018; Re: Report Filed Against – RADONDA VAUGHT, RN, imbedded in Kelman, *supra* note 6, located at https://www.documentcloud.org/documents/6785898-RaDonda-Vaught-Letters.html.
20. RaDonda Vaught homicide case, Wikipedia, The Free Encyclopedia, https://en.wikipedia.org/wiki/RaDonda_Vaught_homicide_case (last visited February 14, 2023).
21. *Id.*
22. Timothy Bella, *Ex-Nurse convicted of injecting patient with wrong drug gets probation*, WASH. POST, May 14, 2022 (*quoting* Davidson County District Attorney Glen Funk as saying the goal of the conviction was for Vaught never to regain her nursing license).

(d) The Board may impose disciplinary sanctions and assess civil penalties for cause.
(f) The Board will regulate the practice of professional nursing.[23]

State Nursing Boards have the authority to safeguard the community by licensing and regulating nursing practice. They must stay vigilant in this new era of prosecuting nurses so that they remain the final arbiter of nursing practice. Despite the ability to provide remedies for accidental medical errors by utilization of civil courts and professional licensing boards, we are entering an era where nurses are being subjected to criminal charges.[24]

## V. CRIMINAL PROSECUTION OF ACCIDENTAL ERRORS

Human beings are, by definition, fallible and destined to make errors. This fact is inevitable. Sometimes these mistakes cause harm even though the harm was unintentional. People should be held accountable for their actions, and there should be a just remedy for any harm caused. This principle is at the heart of justice. Our legal system has evolved to address certain actions as crimes even when there is no intent to cause harm. The most typical examples include motor vehicle cases when drivers are still held accountable for unintentional accidents that result in fatalities.[25] In the case of accidental medical errors, the evolution from civil to criminal liability has shaken the industry.

Although unintentional, Vaught's actions resulted in a harm that was horrendous (the patient was awake but alone and paralyzed, unable to breathe). Given such an emotion-provoking fact pattern, can a jury distinguish between liability that is criminal in nature versus civil in nature? Arthur Caplan, PhD, founder of the medical ethics division at NYU Grossman School of Medicine, identified the following:

> The distinction between culpable errors or harm and mistakes made because of external forces is critical when considering whether to criminalize medical errors.[26]

Dr. Caplan went on to state that he would not look to criminal charges when there are "external forces" that influence the error. In the *Vaught* case, there were many system flaws that were identified as contributing to the error. In fact, the Tennessee Bureau of Investigation agent is on record as saying that "[in] this case, the review led the (Department of Health) to believe that Vanderbilt Medical Center carried a heavy burden of responsibility in this matter. . ."[27] Dr. Caplan summarized by saying "We tend to pay attention to errors and want to know how to punish them. The correct moral position I think, is [to] prevent error."[28]

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23. State Board of Nursing, 49 Pa. Code §21.2.
24. Kathleen Gaines, *Another Nurse Prosecuted For The Death of a Patient*, https://nurse.org/articles/lpn-guilty-of-neglect/2022 (LPN from Philadelphia pled guilty to misdemeanor neglect of a care-dependent person and tampering with records. Patient died from a subdural hematoma after a fall. Nurse, who had thirty-nine other patients, failed to perform neurological checks). *See also*, Beverly Ann Bratcher, an LPN in Michigan was charged in September 2022 with felonies for failure to report two medication errors. https://www.beckershospitalreview.com/legal-regulatory-issues/nurse-charged-with-felony-over-failure-to-report-medical-error.html.
25. Com. v. Comer, 716 A.2d.593, 597 (Pa. 1998) (citing Commonwealth v. Mayberry, 138 A. 686 (Pa. 1927). *See also* Commonwealth v. Honeycutt, 323 A.2d 775 (Pa. Super. 1974).
26. *"We can't punish our way to safe medical practices": 2 experts on criminalization of medical errors*, in BECKER'S HOSPITAL REVIEW (March 1, 2022), https://www.beckershospitalreview.com/patient-safety-outcomes/we-can-t-punish-our-way-to-safer-medical-practices-2-experts-on-criminalization-of-medical-errors.html.
27. Kelman, *supra* note 3.
28. Becker's, *supra* note 26 at 2.

System error, rather than human error, is a key principle of experts and advocates for a safer health care system. In *Vaught*, there were numerous system errors at Vanderbilt that were identified by the Department of Health. In an article published by the Institute for Healthcare Improvement, the issue of system error is used to argue against criminal prosecution for errors that are not intentional:

> [we] have layered this notion that when a medical error happens, the individual care providers involved can be prosecuted and put in prison for something that was not intentional harm but is, instead, the product of systems unintentionally designed to produce errors. Instead of critically examining those errors, trying to understand their root causes, and creating reliable processes and safer systems, decisions to criminally prosecute individual clinicians for errors place blame in the wrong place. Such choices do not ensure that systems are held accountable.[29]

In *Vaught*, the nurse made numerous procedural errors by bypassing safety measures that were in place. For example, she failed to recognize the warning label on the vial and the automated dispensing cabinet that denoted "WARNING: Paralyzing Agent." Nurse Vaught stated that she was "distracted." The prosecuting attorney stated at trial that, "The patient is dead because RaDonda Vaught couldn't bother to pay attention to what she was doing."[30] How is one to explain how warnings, such as this, can be overlooked? When actions that deviate from established practice cause fatal medical errors how do we distinguish acts that are mere negligence (to be addressed by civil courts and licensing boards) from acts that cross the line to such a significant degree as to be deemed criminal? From a common law perspective, "conduct does not become criminal until it passes the borders of negligence and gross negligence and enters into the domain of wanton or reckless conduct."[31] So although Vaught may have been negligent in the death of her patient, was a crime committed? A close review of the criminal codes that are being utilized to bring criminal charges in these instances is necessary to determine criminal culpability.

## VI. CRIMINAL NEGLIGENCE AND RECKLESSNESS

Vaught was charged with, and convicted of, criminally negligent homicide and gross neglect of an impaired adult when her patient died from an accidental medication error. The primary focus of this article is the charge of criminally negligent homicide.[32] Vaught admitted to making missteps prior to the erroneous administration. A summary of these mistakes, according to Vaught's own statements to a Tennessee Bureau of Investigation Agent, include but are not limited to the following:

1. Vaught used an override function to remove the medication from an automated dispensing cabinet, even though this was not an emergency, thereby bypassing safeguards.
2. She typed in two letter "VE" to search for Versed (the intended sedative) but instead Vecuroneum (the paralyzing agent) popped up on the screen. She chose this medication for dispensing. She never reviewed this medication with a pharmacist. This step is inherent in the automated dispensing cabinet process but requires personal interaction when the override function is used.

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29. Kedar Mate, *The Criminalization of Medical Errors Should Be a Wake-up Call for Health Care Leaders*, INSTITUTE FOR HEALTHCARE IMPROVEMENT (May 5, 2022), https://www.ihi.org/communities/blogs/the-criminalization-of-medical-errors-should-be-a-wake-up-call-for-health-care-leaders-kedar-mate.

30. Smith, *supra* note 7, at 2.

31. Com. v. Lifecare Centers of America, Inc., 926 N.E.2d 206 (Mass. 2010) (citing Commonwealth v. Welansky, 55 N.E. 2d 902, 911 (Mass. 1944).

32. Vaught was also charged with gross neglect because she did not monitor the patient and left the patient alone in radiology after administering the medication.

3. When Vaught removed the medication, she never looked at the front of the vial but only read the back of the vial which directed that the medication be diluted prior to use. Vaught had previous experience with administering Versed but not Vecuroneum. She knew that Versed did not require dilution, but she went ahead and diluted the Vecuroneum as indicated on the vial.
4. She looked for a computer to scan the bar code but was unable to find one, so she went ahead and administered the medication (this technology did not exist in the radiology department).
5. Vaught then returned to her department and left the patient alone in the radiology department where the patient suffered cardiac arrest and subsequently died.[33]

These admissions represent deviations from standard practice. A jury could find that Vaught's behavior is negligent. Without being made aware of how these mistakes are influenced by system flaws, it would be difficult for a jury to see the mitigating factors. Unless there is an understanding of the environment in which nurses work, it may be difficult for a jury to decipher the multi-factorial influences that enable errors to occur. From a criminal law perspective, the focus is simply on proving the elements of the crime beyond a reasonable doubt. The key element of the crimes for which a Davidson County Grand Jury indicted Vaught in February 2019 was "recklessness."

The Tennessee Criminal Code defines Reckless Homicide as follows:

> §39-13-215 Reckless homicide.
> (a) Reckless homicide is the reckless killing of another.
> (b) Reckless homicide is a Class D felony.[34]

The Tennessee Supreme Court defined "recklessly" in *State v. Kimbrough* by declaring:

> A person acts recklessly when he or she is aware of but *consciously disregards a substantial and unjustifiable risk* that the circumstances exist or the result will occur. The risk must be of such a nature and degree that its disregard constitutes a gross deviation from the standard of care that an ordinary person would exercise under all the circumstances as viewed from the accused person's standpoint.[35]

Patient safety advocates would argue that Vaught did not have a "conscious disregard" but rather had an "unconscious disregard" also known as "drift,"[36] a state where her active thinking is paused by distractions or other influences. The conscious brain does not recognize the risk.[37]

Furthermore, it is important to understand that the emphasis is on the reckless act or conduct in question, not the result. The Tennessee Court of Criminal Appeals clarified in *State v. Gillon* that:

> While the defendant may not have intended the disastrous results. . . . , intent is not required to sustain a finding of either recklessness or criminal negligence . . . the risk is of such a nature and degree that injury or death is likely and foreseeable.[38]

As evidence to prove "recklessness," the prosecuting attorney submitted an investigative report that summarized an interview between Vaught and two investigative

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33. Smith, *supra* note 7, at 1-2.
34. TN Code Ann. §39-13-215.
35. 924 S.W.2d 888, 890 (Tenn.1991) (emphasis added).
36. Drift means a gradual deviation from a natural or desirable position or course. RANDOM HOUSE WEBSTER'S COLLEGE DICTIONARY (1991), at 408. *See also* David Marx, *Reckless Homicide at Vanderbilt?* (March 2, 2019, updated March 26, 2022), http://bit.ly/2TflzBbVanderbilt.
37. Marx, *Reckless Homicide at Vanderbilt?*, at 3.
38. 15 S.W. 3d 492, 498 (Tenn. Crim. App. 1997).

agents.[39] During this interview, Vaught stated that she was "not overtired," was "not understaffed," and, although she had a new employee assigned to her, she was "comfortable" with this arrangement.[40] Inadequate numbers of nurses and fatigue are typical reasons for making errors. Vaught could have easily relied on them to justify her conduct, but she did not.

Vaught also stated that she looked "at the back of the vial . . . but never looked at the front of the vial before administering the medication."[41] Although she verbally identified the patient, she was unable to locate a computer to utilize the bar code scanning function. She administered the medication without ever verifying that it was the correct medication.

It is longstanding practice in nursing that the standard of care for medication administration is delivering the: 1) right medication; 2) to the right patient; 3) at the right time; 4) in the correct dose; 5) by the right route, and, more recently: 6) for the right reason. To administer the medication without ever looking at the front label to make sure that it is the correct medication is negligence per se and cannot be excused. But is this conduct negligent from a civil perspective or does it rise to the level of criminal behavior?

Vaught admitted that she "shouldn't have overridden the system though it is common to do so."[42] Vaught also stated that it was "common practice" to use the override function, and, in fact, it was described as the established workaround that was used daily. This workaround was allegedly supported by management. A literature review will reveal that within the nursing community the use of the override function is customary practice.[43]

Use of the override function cannot be customary practice and at the same time meet the definition of recklessness. Failure to look at the front of the vial and verify that Vaught had the correct medication is certainly a deviation from the standard of practice. However, it does not appear to be a willful act that was performed despite a probable or foreseeable harm.[44] Vaught admitted that she was "distracted" by a conversation with an orientee. Being distracted connotes having one's attention diverted and not concentrating.[45] This is different from being reckless.

At her trial, Vaught accepted responsibility for her errors but also described the many broken procedures at Vanderbilt. There were technical problems between the various systems required for medication administration at Vanderbilt, and this was resulting in delays. Vaught stated that the hospital's established workaround was to override the safeguards on the cabinets so that nurses could get drugs quickly as needed.[46]

Most telling are comments that Vaught made to the TBI agents. These include:

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39. Smith, *supra* note 7.
40. *Id.* at 1.
41. *Id.* at 2.
42. *Id.* at 6.
43. ISMP INSTITUTE FOR SAFE MEDICATION PRACTICES, *Another Round of the Blame Game: A Paralyzing Criminal Indictment that Recklessly "Overrides" Just Culture*, ISMP (February 14, 2019), https://www.ismp.org/resources/another-round-blame-game-paralyzing-criminal-indictment-recklessly-overrides-just-culture (explaining that the "override feature is available in basically every hospital that utilizes ADCs and is a function used every day. . .").
44. *See Lifecare, supra* note 31.
45. "Distracted" is defined as 1) having one's thoughts or attention drawn away: unable to concentrate or give attention to something, https://Merriam-Webster.com/dictionary/distracted (last visited February 16, 2023).
46. Kelman, *supra* note 6.

> Vaught admitted that she was thinking, "What kind of life changing things did I just put this patient and her family through?" "It's a horrible situation."[47]

These comments indicate remorse and empathy for the patient and family. They are not indicative of the callous disregard for human life usually associated with criminal behavior. They do not indicate any intent to act in a manner that would cause harm.

It is difficult to understand and discern where the line is between negligence (a civil tort) and reckless homicide or criminal negligence (felonies). A New York appellate court considered this exact issue in a case where it reversed a conviction of a nurse for criminally negligent homicide. The court reasoned:

> Instead of evaluating conduct which is easily recognizable and condemned as morally reprehensible, we are forced to scrutinize conduct which consists of an error in judgment. Therein lies the difficulty for it should be troublesome to even the most casual observer that an error in judgment, though perhaps properly resulting in civil liability, is punishable by criminal sanctions. What is there then to distinguish between the kind of judgmental failure common in civil law and that kind of negligence which makes a qualitative leap into the area of criminal law?[48]

The court concluded by deciding to reverse the conviction of criminally negligent homicide and to dismiss the indictment by stating:

> To stigmatize the defendant with the brand of criminal for an incident, which though tragic, was the result of an error in judgment, would be wholly inappropriate, inconsistent with the purpose of the criminal law, and totally disproportionate to defendant's inadvertent conduct.[49]

*Vaught* was truly a tragic case with a fact pattern that is alarming. Yet, considering what is known about human errors, how distraction can influence errors, how multi-tasking can result in shortcuts that lead to errors—is it reasonable to conclude that we should brand Vaught a "criminal"? The American Nurses Association and the Tennessee Nurses Association stated, "We are deeply distressed by this verdict and the harmful ramifications of criminalizing the honest reporting of mistakes. Health care delivery is highly complex. It is inevitable that mistakes will happen, and systems will fail."[50]

In Pennsylvania, the criminally negligent homicide statute utilizes the key terms "reckless" and "grossly negligent manner."

> **§2504. Involuntary manslaughter.**
> **(a) General rule.**—A person is guilty of involuntary manslaughter when as a direct result of the doing of an unlawful act in a reckless or grossly negligent manner, or the doing of a lawful act in a reckless or grossly negligent manner, he causes the death of another person.
> **(b) Grading.**—Involuntary manslaughter is a misdemeanor of the first degree. Where the victim is under 12 years of age and is in the care, custody or control of the person who caused the death, involuntary manslaughter is a felony of the second degree.[51]

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47. Smith, *supra* note 7 at 2.
48. People v. Futterman, 449 N.Y.S. 2d 108, 109-10, 86 A.D. 2d 70, 73 (1982). This case involved the conviction of a head nurse for the death of a mental health patient who was strangled by the nurse trying to control the patient's violent behavior toward himself and other staff members.
49. *Id.* at 111, 86 A.D.2d at 75.
50. American Nursing Association, Statement in Response to the Conviction of Nurse RaDonda Vaught. March 25, 2022, https://www.nursingworld.org/news/news-releases/2022-news-releases/statement-in-response-to-the-conviction-of-nurse-radonda-vaught/#:~:text=%E2%80%9CWe%20are%20deeply%20distressed%20by,completely%20unrealistic%20to%20think%20otherwise.
51. 18 Pa.C.S.A. §2504 (2021).

"Reckless" or "grossly negligent" are the key elements that must be discerned to arrive at a guilty verdict. How have the courts applied this language in Pennsylvania, and would it apply to the Vaught case? In *Commonwealth v. Polimeni*, the Pennsylvania Supreme Court stated that . . . "involuntary manslaughter is an unintentional killing."[52] Further, the Court discussed the state of mind considered under this crime and the fact that intent is not required:

> [u]nder the Crimes Code it is a killing which requires a state of mind which is in effect simply a gradation on the ascending scale of culpability culminating in malice. The state of mind which characterizes involuntary manslaughter is not malicious; it is referred to as "criminal negligence" and is evidenced by acts, whether lawful or unlawful, done in a "reckless or grossly negligent" manner as those terms are defined.[53]

The Court then cited *Commonwealth v. Aurick* to further define negligence:

> [t]o constitute involuntary manslaughter '(t)he negligence must be such a departure from what would be the conduct of an ordinary prudent or careful man under the circumstance as to evidence a disregard of human life or an indifference to consequences.'[54]

Vaught's actions caused the death of her patient. There is no question about this. Her actions are difficult to understand. However, do they rise to the level of "disregard for human life" or an "indifference to the consequences"? It is hard to reach this conclusion beyond a reasonable doubt. Vaught admitted that she was "distracted"[55] because she was also discussing the care of another patient with the nurse that she was simultaneously training.

Nurses are often expected to multi-task and are often interrupted in their work. It is important to understand this work environment when considering whether Vaught was reckless. She "has been described as a well-liked, respected, and competent nurse who had no previous disciplinary actions against her nursing license."[56] There is no evidence that she had a disregard for the life of her patient or was indifferent to the fact that her patient would die because of her actions. She simply went about her work in a manner that she considered routine. Despite her missteps, her actions do not rise to the level of "conscious disregard." She did not foresee the risk of killing her patient.

## VII. HUMAN ERROR

It is well known that human beings do not have an infinite capacity for processing information. "As the amount of cognitive processing resources needed by a human to solve a problem increases, the greater the likelihood of a mistake. . . The environment also influences the reliability of problem solving. Less than desirable work situations . . . can increase the chance of a mistake."[57] The healthcare environment does not often allow a nurse to solely focus on one action without interruption. Nurses are subjected to acts of violence, inadequate staffing ratios, COVID pandemic

52. 378 A.2d 1189, 1195 (Pa. 1977) (citing Commonwealth v. Jones, 308 A.2d 598 (1973).
53. *Id.*
54. *Id.* (citing Commonwealth v. Aurick, 19 A.2d 920, 923 (Pa. 1941); *see also* Commonwealth v. Root, 170 A.2d 310 (Pa. 1961).
55. Smith, *supra* note 7 at 2.
56. ISMP, *supra* note 43.
57. Sven Ternov, MD, *The Human Side of Medical Mistakes* in ERROR REDUCTION IN HEALTH CARE, A SYSTEMS APPROACH TO IMPROVING PATIENT SAFETY, 99 (Patrice L. Spath 2d ed. 2000).

concerns and other situations that result in a chaotic, stressful work environment.[58] These factors play a role in the ability to focus and concentrate on the quality of work being performed.

The criminal system uses terms such as "knowingly" and "recklessly" when explaining how a nurse can overlook a vial of medication that is labeled "WARNING: Paralyzing Agent." The patient safety industry offers other explanations. The Institute for Safe Medication Practices (ISMP) discusses how Vaught could have "failed to consciously process the warning."[59] It further explains "how reckless conduct differs from our natural tendency to drift into at-risk behavioral choices."[60] At-risk behaviors occur when the "RISK is not seen or mistakenly believed to be insignificant or justified."[61] In other words, it is unconscious. For example, continued use of the override function leads one to adopt a feeling of routineness. Vaught did not consciously think that she was risking the death of a patient by utilizing this function. The ISMP reported that "Charlene Murphey had received almost two dozen medications via override from various nurses in the days prior to her death."[62] This fact further explains the routine nature of using the override function and should negate a criminal finding of recklessness.

## VIII. SYSTEM ERROR

Although they have not received attention in the media, there were system issues at Vanderbilt. According to a statement made by the Institute for Safe Medication Practices (ISMP), there was no evidence produced at trial by defense counsel regarding these "system failures that helped promote this error instead of preventing the individual (nurse) from committing the error."[63] Examples of these system flaws include the following:

> 1) Only two letters (VE) were required to access the medication in the ADC. Vecuroneum was listed first in the nurse's search;
> 2) The ADC defaults to using generic names not brand names for medications. Midazolam is the generic name for Versed (Brand Name), therefore Versed was not listed as a choice;
> 3) Vecuroneum was not within the nurse's scope of practice and should not be stored where she could access it;
> 4) According to Vaught, there were long-standing issues with various computer systems not communicating with each other, and this resulted in delays with accessing medications. Vaught stated that "Vanderbilt instructed nurses to use the overrides to circumvent delays and get medication as needed".[64]

58. It was recently reported that an emergency department nurse called 911 because her department was overrun with patients (allegedly forty-five critically ill patients for five nurses). The 911 center sent emergency personnel to help. Alexis Kayser, *Nurse calls 911 on ER crowding in Washington Hospital*, BECKER'S HOSPITAL REVIEW (October 12, 2022), http://www.beckershospitalreview.com/care-coordination/nurse-calls-911-on-er-crowding-in-washington-hospital.html.

59. ISMP INSTITUTE FOR SAFE MEDICATION PRACTICES, *Criminalization of Human Error and a Guilty Verdict: A Travesty of Justice that Threatens Patient Safety* ISMP (April 7, 2022), https://www.ismp.org/resources/criminalization-human-error-and-guilty-verdict-travesty-justice-threatens-patient-safety.

60. *Id.*

61. *Id.*

62. *Id.*

63. ISMP INSTITUTE FOR SAFE MEDICATION PRACTICES, *Paralyzed by Mistakes-Reassess the Safety of Neuromuscular Blockers in Your Facility* (June 16, 2016), https://www.ismp.org/resources/paralyzed-mistakes-reassess-safety-neuromuscular-blockers-your-facility. *See also*, ISMP 2016-2017 *Targeted Medication Safety Best practices for Hospitals*, https://www.ismp.org/guidelines/best-practices-hospitals.

64. Kelman, *supra* note 3.

These are just four of the system issues identified through various investigations after the fatal error occurred. The Tennessee Department of Health conducted an unannounced survey at Vanderbilt in October 2018. It cited numerous issues and placed Vanderbilt in "Immediate Jeopardy"[65] status which required Vanderbilt to submit and execute a Plan of Correction or risk losing its license and government funding. The Department of Health noted in the Statement of Deficiencies "failure to mitigate risks associated with medication errors and ensure all patients received care in a safe setting to protect their health and safety placed all patients in a SERIOUS and IMMEDIATE THREAT and placed them in IMMEDIATE JEOPARDY and risk of serious injuries or death."[66] The Plan of Correction is one hundred and five (105) pages in length.[67]

According to the ISMP report there was only one defense expert called at trial and there were no expert witnesses presented to testify to system failures or the current science surrounding medication errors and their prevention.[68] ISMP published a feature article about errors with neuromuscular blocking agents in 2016 that it believes held recommendations that "likely would have avoided this error" if implemented at Vanderbilt.[69] Taken as a whole, this plethora of system problems created an environment that was conducive to errors. Blaming one nurse who succumbed to the influences of this environment is not justice.

## IX. CONCLUSIONS

The Davidson County (Tennessee) Attorney's Office brought the criminal charges against Vaught because her "decision to obtain the medication via ADC[70] override was central to the criminal indictment."[71] The District Attorney's Office noted that there were: "... safeguards in place that were overridden" by the nurse, and that the Office felt the "defendant's actions justify the charge" based on the legal definition of "reckless."[72] The fact that use of the override function by Vanderbilt as a "workaround" for system problems and the fact that there was evidence produced at trial that the override function was used "all the time" by nurses as a routine should negate a finding of recklessness. There are numerous citations in the literature that support that use of the override function is customary practice.

Although there was no intent by Vaught to act in a manner likely to cause harm, her actions (such as failure to look at the medication name on the vial) were a deviation from established standards of care. However, the error and harm to this patient should have found their remedy exclusively in the civil courts and with the state licensing board. If the purpose of the criminal legal system is to deter future crimes and to punish, this objective is met by revoking Vaught's license to practice

65. Immediate Jeopardy is "[a] situation in which the provider's noncompliance with one or more requirements, conditions of participation . . . has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident or patient." 42 CFR §489.3.

66. Tennessee Department of Health Statement of Deficiencies, https://hospitalwatchdog.org/wp-content/uploads/VANDERBILT-CMS-PDF.pdf.

67. *Id.* At the beginning of the Plan of Correction there is a notation stating that "Preparation and execution of the Plan of Correction does not constitute admission or agreement by the Hospital of the truth of the facts alleged or conclusions set forth in this statement of deficiencies."

68. ISMP, *supra* note 59.

69. ISMP *supra* note 63.

70. "ADC" is the acronym for automated dispensing cabinet.

71. ISMP, *supra* note 43.

72. *Id.* (citing Kelman, *Vanderbilt Nurse: safeguards were 'overridden' in medication error, prosecutors say*. THE TENNESSEAN (February 6, 2019), https://www.tennessean.com/story/news/health/2019/02/06/vanderbilt-nurse-vecuronium-versed-patient-death-radonda-vaught/2795475002/).

and the out-of-court settlement reached between Vanderbilt and the patient's family.[73] Vaught can no longer practice nursing and, therefore, can no longer cause harm to the public, as noted by the sentencing judge. To imprison Vaught would serve no further purpose and would not provide a remedy for safeguarding future errors.[74]

The system errors in this case are being addressed through the plan of correction submitted by Vanderbilt to the Tennessee Department of Health. The failure of Vanderbilt to report this error to state and federal authorities, as required by law, and the omissions to the medical examiner have not been addressed, leading one to wonder whether, as noted by Vaught's attorney, Vaught was the only "scapegoat" in this case.[75] Vaught did not get the opportunity to submit a plan of correction. Instead, she lost her career and her license, and is now branded a convicted felon.

## X. RECOMMENDATIONS

Unless there is an intent to cause harm, healthcare professionals should not be criminally indicted for unexpected, unintentional, accidental medical errors. An exception to this policy may be made if the error is committed while the professional is truly reckless such as being impaired by drugs or alcohol or other intentional acts of misconduct, including disregard of foreseeable harm. State statutes should be revised to provide limited immunity for errors that are truly accidental in nature even when the errors result in harm. There should be an understanding in the legal community that "recklessness" and the "unconscious disregard" are not the same thing.

In an era where nurses and other professionals are facing a shortage of staff, COVID epidemics, and increasing incidents of violence against healthcare providers, some consideration needs to be given to the environmental factors influencing professional practice and the resultant errors that are inevitable.[76] Nurses who make accidental medication errors are human beings making human mistakes, not criminals. Healthcare leaders need to be held responsible for creating environments that are conducive to safe practice and for flawed systems that inadvertently influence errors.

This is not to say, however, that there should be no punishment for willfully and consciously disregarding established safeguards. This is the mandate for state licensing boards and civil courts, not the criminal courts.

In the interest of due process, nurses and other healthcare professionals should have sufficient warning that they may be charged with crimes for making accidental errors. Mandatory education about these risks should be required for all licensed healthcare professionals.

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73. Kelman, *supra* note 3. *See also* Kelman, *supra* note 6 (stating that "Vanderbilt negotiated an out-of-court settlement with Murphey's family that requires them not to speak publicly about the death or the medication error. The settlement is not publicly known").

74. Judge Smith ordered Vaught to serve supervised probation for three years with the opportunity to have her record expunged. According to Judge Smith "[t]his offense occurred in a medical setting. It was not motivated by any intent to violate the law. She has no criminal record. She's been removed from the healthcare setting. She will never practice nursing again. The situation will never be repeated." Advisory Board Daily Briefing, *RaDonda Vaught will avoid prison time, drawing praise from nurses and experts*, Advisory Board (May 16, 2022), https://www.advisory.com/daily-briefing/2022/05/16/medication-error#:~:text=RaDonda%20Vaught%20will%20avoid%20prison%20time%2C%20drawing%20praise%20from%20nurses%20and%20experts,-Daily%20Briefing&text=RaDonda%20Vaught%2C%20a%20former%20nurse,nurses%20and%20medical%20experts%20praised.

75. Kelman, *supra* note 3.

76. Erica Carbajal, *2 Nurses Assaulted every hour, Press Ganey analysis shows*, BECKER'S HOSPITAL REVIEW (September 8, 2022), https://www.beckershospitalreview.com/nursing/2-nurses-assaulted-every-hour-press-ganey-analysis-shows.html (finding that "[m]ore than 5200 nursing personnel were assaulted in the second quarter of 2022 . . . on average two nurses were assaulted every hour").