THE CRIMINALIZATION OF HEALTHCARE WORKERS BEING CRUEL & UNUSUAL

Trinh N. Chow*

Abstract: The term scapegoat has come to mean a person who bears the blame for others. RaDonda Vaught was designated as the scapegoat for the medication error that resulted in the death of Charlene Murphey on Dec. 26, 2017. Ms. Vaught mistakenly administered vecuronium bromide, a paralytic medication, instead of midazolam (Versed®). Vanderbilt University Medical Center (VUMC) did not report the patient's death to state or federal officials, as required by law. However, Ms. Vaught was terminated by VUMC, and Vanderbilt negotiated a confidential out-of-court settlement with Ms. Murphey's family. The Tennessee Board of Nursing revoked Ms. Vaught's license indefinitely. On Feb. 4, 2019, Ms. Vaught was arrested and criminally charged with reckless homicide and impaired adult abuse. On May 13, 2022, Ms. Vaught was convicted of negligent homicide and of gross neglect of an impaired adult. The judge sentenced Ms. Vaught to three years of probation, instead of prison time. Catapulting from the facts and reasoning of this case, the article will lay out what is considered the duty of care for nurses. Then the current systems used to combat medication errors will be discussed. The remainder of the article will focus on the criminalization of healthcare workers, address the liability of healthcare institutions, and evaluate new models to assess negligence versus culpable homicide. Lastly, healthcare reform in the form of new legislation will be explored.

Keywords: Medication Error; Charlene Murphey; Vanderbilt University; Reckless Homicide; Nurses; Nursing; Healthcare Workers; Healthcare Institutions; Healthcare Reform

* University of La Verne College of Law and Public Service, US.

Table of Contents

Introduction 85

I. Nurses' Duty of Care 86

A. Challenges of Medication Administration Using the Five Rights 86

B. Heavy Workload Contributing to Medication Error 87

C. Negative Impact of Workload on Patient Outcomes 88

II. Addressing Medication Errors 89

A. Issues Contributing to Medication Errors 89

B. Failure to Report Medical Errors 90

C. Plan for Reducing Medication Errors 90

III. Criminalization 91

A. First-Time Offender Versus Repeat Offender 91

B. Not Criminalizing Healthcare Workers 92

IV. Liability 92

A. The Norm for Disciplining Licensed Nurses 93

B. Malpractice Nursing Claims 94

C. The Role of Healthcare Institutions 94

D. Criminal Liability of Hospitals 95

V. New Models for Negligence & Medical Errors 96

A. Deciding When Negligent Conduct Becomes Culpable 96

B. The Sliding Scale of Negligence 97

C. Unified Approach to Tackling Medical Errors 98

VI. Need for Healthcare Reform 99

A. Nursing Shortages After the Pandemic 99

B. Interventions by Healthcare Organizations to Assist Nurses 100

C. Credentialing & Oversight Programs at Healthcare Institutions 101

D. Legislation by Congress for Nursing Reform 102

Conclusion 103

INTRODUCTION

"I think RaDonda Vaught is…the scapegoat in the Old Testament...."

- Peter Strianse, Esq., RaDonda Vaught's Defense Attorney[1]

The term scapegoat has come to mean a person who bares the blame for others.[2] The origins of word "scapegoat" originates from the Old Testament, in which a goat was released into the wilderness to atone for all of Israel's sins.[3] RaDonda Vaught was designated as the scapegoat for the medication error that resulted in the death of Charlene Murphey on Dec. 26, 2017.[4] Ms. Vaught mistakenly administered vecuronium bromide, a paralytic medication, instead of midazolam (Versed®). Vanderbilt University Medical Center (VUMC) did not report the patient's death to state or federal officials, as required by law.[5] However, Ms. Vaught was terminated by VUMC, and Vanderbilt negotiated a confidential out-of-court settlement with Ms. Murphey's family. The Tennessee Board of Nursing revoked Ms. Vaught's license indefinitely.[6] On Feb. 4, 2019, Ms. Vaught was arrested and criminally charged with reckless homicide and impaired adult abuse.[7] Ms. Vaught was convicted of negligent homicide, instead of reckless homicide, and of gross neglect of an impaired adult. On May 13, 2022, the judge sentenced Ms. Vaught to three years of probation, instead of eight years of prison time.[8]

Returning to Ms. Vaught being the "scapegoat," Ms. Vaught's attorney, during his closing arguments reminded the jury of the absence at the trial of Vanderbilt University Medical Center, the physician who wrote the medication order, and the healthcare workers who cared for Ms. Murphey in the Neurology Intensive Care Unit (NICU) and in positron emission tomography (PET) scan.[9] His point was a team of healthcare workers managed the care of Ms. Murphey. However, at the homicide trial of RaDonda Vaught, "the scapegoat" was the only one to bear the mistake and consequences of Ms. Murphey's death. Ms. Vaught's sensational trial brings to mind several questions. What is the standard of care expected of a nurse? Were there other factors that could have contributed to the medication error? Should the liability of Ms.

---

[1] WKRN News 2, *RaDonda Vaught Trial: Defense's Closing Arguments*, YOUTUBE (Mar. 25, 2022), https://www.youtube.com/watch?v=tAjZrGsnB2o&list=PLEuNc TRksDr4-D3hSCkL Xeowc_FWXWQ1Z&index=2&t=1s.

[2] Merriam-Webster Dictionary, Scapegoat Noun, https://www.merriam-webster.com/dictionary/scapegoat (last visited Feb. 17, 2023).

[3] *Leviticus 15-16: The Day of Atonement*, THE CHURCH OF JESUS CHRIST OF LATTER-DAY SAINTS (last visited Feb. 17, 2023, 2:50 PM), https://www.churchofjesuschrist.org/manual/old-testament-seminary-student-study-guide/the-book-of-leviticus/leviticus-15-16-the-day-of-atonement?lang=eng.

[4] WKRN News 2, *supra* note 1.

[5] Donna J. Craig RN, JD, *The Case of Nurse RaDonda Vaught: How Administering the Wrong Medication Resulted in a Criminal Conviction*, THE IOWA NURSE REP. 12 (2022).

[6] State of Tennessee v. RaDonda L. Vaught, No. 2019-A-76 (D. Tenn. May 13, 2022).

[7] *TN Board of Nursing's Unjust Decision to Revoke Nurse's License: Travesty on Top of Tragedy*, INST. For SAFE MEDICATION PRACTICES (ISMP) Aug. 12, 2021, https://www.ismp.org/resources/tn-board-nursings-unjust-decision-revoke-nurses-license-travesty-top-tragedy.

[8] Gabriel Cripe, *Analyzing Abuse of Prosecutorial Discretion in the RaDonda Vaught Verdict*, UNIV. OF CINCINNATI L. REV. (2022), https://uclawreview.org/2022/05/12/analyzing-abuse-of-prosecutorial-discretion-in-the-radonda-vaught-verdict/.

[9] *Supra* note 1.

Murphey's death rest on just her and/or the hospital for Ms. Murphey's death? In other words was RaDonda Vaught's criminalization as a healthcare worker cruel and unusual? Lastly, should healthcare workers in the future be concerned if they will be arrested and criminally charged for medication errors that result in the death of a patient?

Part I of this Article will lay out what is considered the duty of care for nurses. Part II will discuss the current systems used to combat medication errors. Part III will consider the criminalization of healthcare workers. Part IV will address the liability of healthcare institutions. Part V will evaluate new models to assess negligence versus culpable homicide. Lastly, Part VI will explore future healthcare reform.

I. NURSES' DUTY OF CARE

Nurses in California administer medications necessary to treat, prevent, or rehabilitate patients.[10] In doing so, nurses are to observe signs and symptoms of illness and reactions to treatments, to determine whether the signs, symptoms, reactions, behavior, or general appearances are abnormal. Standardized procedures should be based on policies and protocols developed by the health facility where a nurse practices.[11] The standardized procedures are approved by the Medical Board of California, or by the Board of Registered Nursing.[12] In addition to the duties, nurses have the responsibility of direct patient care and collective patient care.[13] Direct patient care is the care related to one patient, such as assisting with bathing, eating, or changing bed linen. Collective patient care includes tasks that are not necessarily done for one patient, such as preparation of medications, handover of the patients to the next shift nurse, and bringing a collection of samples to the laboratory.[14] As the challenges nurses face to administer medications via the "five rights" is discussed, it will become evident how nurses struggle to fulfill their duties, negatively impacting their patients' care.

A. Challenges of Medication Administration Using the Five Rights

A core responsibility of registered nurses is medication administration.[15] In the RaDonda Vaught case, the prosecutor repeatedly mentioned that Ms. Vaught failed to utilize the "Five Rights" in fulfilling her duty of medication administration.[16] The framework known as the "five rights" refers to giving, "the right patient the right drug at the right time in the right dose and by the right route." The right patient means identifying the patient before administration, either by asking the patient identification questions or reading identity bracelets and medication chart labels. Checking for the right drug entails reading the medication chart and medication packaging to match the

---

[10] California Nursing Practice Act, Bus. & Prof. Code § 2725, State of California, Department of Consumer Affairs (DCA), https://www.rn.ca.gov/pdfs/regulations/npr-i-15.pdf.
[11] *Id.*
[12] *Id.*
[13] WFJM van den Oetelaar, et al., *Balancing nurses' workload in hospital wards; study protocol of developing a method to manage workload*, BMJ OPEN 5 (2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5129129/.
[14] *Id.*
[15] Julie-Anne Martyn et al., *The safe administration of medication: Nursing behaviors beyond the five-rights*, NURSE EDUC. IN PRACTICE 109-112 (2019), https://pubmed.ncbi.nlm.nih.gov/ 31132586/.
[16] WKRN News 2, *RaDonda Vaught Trial: State's Rebuttal Following Defense's Closing Arguments*, YOUTUBE (last visited Mar. 25, 2022), https://www.youtube.com/watch?v= KG4bNuNJYJ g&list= PLEuNcTRksDr4-D3hSCkLXeowc_FWXWQ1Z&index=2.

drug name. The right dose includes looking at the medication chart, and calculating the right dose is given. The right route involves crosschecking with the prescriber order and the medication form before administration. Lastly, the right time suggests facilitating timely medication administration when it is due to be given.[17] Clinical competence can be measured and audited for errors by assessing all five steps.[18]

Even with the "five rights" framework, safe medication administration is a challenge. In an observational study of 176 nurses, medication administration was rarely straightforward.[19] For example, in trying to identify the right patient, patients in the emergency department did not have identification bracelets, or the bracelet details were incorrect. Other times, the patient chart label was wrong. In addition, patients either displayed cognitive impairment, hearing impairment, or reduced levels of consciousness when asked identification questions about themselves by the nursing staff. The study found that nurses had to go beyond the five rights framework by applying their clinical judgment to administer medication safely.[20] With the "five rights" being held as the standard for administering medications, the framework needs to be reevaluated to account for variables.

B. Heavy Workload Contributing to Medication Error

Nurses often report heavy workload as a reason for medication errors.[21] Heavy workload consists of the ratio of demands to available resources.[22] In an observational one-month study involving a 267-bed Swiss hospital and 110 nurses, the study concluded a correlation between workload and medication errors.[23] Nurses were asked to report workload as follows: no workload, low workload, medium workload, high workload, and very high workload. An increase in workload by one unit leads to a rise in making medication errors by approximately two times more.[24] The three main reasons provided by the nurses for high or very high workload included large numbers of patients for nurses to monitor, caring for complex multimorbid patients, and being responsible for patients with complications post-surgery.[25] The study confirmed a relationship exists between reported workload and frequency of medication errors.

In a second study involving a 25-bed hospital and 23 nurses over two months, the focus was on "near misses," meaning errors that were caught before the injury occurred to a patient.[26] Workload as a variable significantly contributed to "near misses." The study evaluated the following workload factors: patient count (nurse-to-

---

[17] Martyn, *supra* note 15.
[18] Martyn, *supra* note 15.
[19] Martyn, *supra* note 15.
[20] Martyn, *supra* note 15.
[21] Benjamin D. Rapphold et al., *Medication Errors Caused by Nurses and Physicians in a Swiss Acute Care Community Hospital: Frequency and Correlation to Nurse's Reported Workload*, INT'L J. OF HEALTH PROFESSIONS 14-17 (2018), https://sciendo.com/article/ 10.2478/ijhp-2018-0002.
[22] Rapphold et al., *supra* note 21.
[23] Rapphold et al., *supra* note 21.
[24] Benjamin D. Rapphold et al., *Medication Errors Caused by Nurses and Physicians in a Swiss Acute Care Community Hospital: Frequency and Correlation to Nurse's Reported Workload*, INT'L J. OF HEALTH PROFESSIONS 20 (2018), https://sciendo.com/article/ 10.2478/ijhp-2018-0002.
[25] *Id.*
[26] Amy A. Campbell et al., *Nurse's Achilles Heel: Using Big Data to Determine Workload Factors That Impact Near Misses*, J. OF NURSING SCHOLARSHIP 337-339 (2021), https://pubmed.ncbi.nlm.nih.gov/33786985/.

patient ratio), medication count, task count, call light count, average sepsis score, and 2-hr periods worked. The first five factors were shown to be statistically significant during the 2-hr periods in which "near misses" occurred ($p < .0001$). Medication count was the most effective prediction of "near misses," referring to the overall volume of medications a nurse must administer within a shift.[27] The study concluded that systematic and organizational changes need to address more than one workload factor to have an impact on reducing medication-related errors, along with recognizing the strengths and weaknesses of the individual nurses. Heavy workload contributes to medication errors and needs to be addressed to reduce the possibility of medication errors.

C. Negative Impact of Workload on Patient Outcomes

The nursing workload can be broken up into direct patient care, indirect patient care, and nonpatient care.[28] Nonpatient-focused workload is the time spent waiting for a returned page, troubleshooting, task switching, interruptions, tracking down equipment, or finding a policy needed for a care decision. In acute care, the nursing workload is used to determine staffing needs.[29] Therefore, the connection between workload and patient outcomes is straightforward because the ability to provide quality care relies on enough staff to complete all the required work. However, current workload measurement systems do not consider patient characteristics, provider capabilities, and unit or facility factors that impact workload.[30]

To illustrate, in a cross-sectional correlational study of 472 acute care nurses, heavy workloads resulted in nurses leaving essential tasks undone, and negative nurse and patient outcomes.[31] Nurse outcomes were emotional exhaustion and job satisfaction. Patient outcomes were nurse-reported frequencies of medication errors, patient falls, and urinary tract infections. Specifically, higher patient acuity was associated with medication errors and patient falls. Patient acuity refers to characteristics such as complexity and unpredictability that require nurse surveillance and intervention of a patient.[32] Nurses who experienced heavy workloads daily were six times more likely to report patient falls than nurses who experienced heavy workloads less frequently. Similarly, nurses who experienced daily interruptions were three times more likely to report patient falls on a weekly basis. Interruptions can cause a lack of focus, a delay in treatment, and an increase in the amount of time it takes to complete a task.[33] Compromised professional nursing standards on a daily basis were a strong predictor of job satisfaction. For nurses to carry out their duty of care, nursing leadership needs to identify better ways to manage nurse workload rather than leaving it to the individual nurse to fix the problems.[34] In summary, nurses face numerous challenges while administering medications following the "five rights" framework,

---

[27] *Id.*
[28] Swiger et al., *Nursing workload in the acute-care setting: A concept analysis of nursing workload*, NURSING OUTLOOK 247-49 (Feb. 2016), https://pubmed.ncbi.nlm.nih.gov/26944266/.
[29] *Id.*
[30] MacPhee et al., *The Impact of Heavy Perceived Nurse Workloads on Patient and Nurse Outcomes*, ADM. SCI. 1-4 (2017), https://www.mdpi.com/2076-3387/7/1/7.
[31] *Id.*
[32] *Id.*
[33] Swiger et al., *supra* note 28.
[34] Swiger et al., *Nursing workload in the acute-care setting: A concept analysis of nursing workload*, NURSING OUTLOOK 252 (Feb. 2016), https://pubmed.ncbi.nlm.nih.gov/26944266/.

resulting in medication errors, compromised nursing standards, and adverse effects on patient outcomes.

II. ADDRESSING MEDICATION ERRORS

Medical errors are the third leading cause of death in the United States after heart disease and cancer. A 2008 report reviewed that medical errors cost the healthcare system more than seventeen billion dollars.[35] A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is controlled by the healthcare professional.[36] The U.S. Food & Drug Administration (FDA) receives over 100,000 reports each year regarding suspected medication errors. Several ways the FDA prevents medication errors include reviewing the package and product design of all new drugs, reducing similar names of old drugs with new drugs names, differentiating labels for multiple strengths of the same medication, and creating barcode technology for healthcare professionals to scan the medications that will be administered. The FDA collaborates with patient safety organizations, such as the Institute for Safe Medication Practices (ISMP).[37] In trying to apply the goals set by safety organizations such as the FDA and ISMP, the issues contributing to medication errors need to be understood. In addition, the failure to report medication errors needs to be examined. With the failure to report medication errors, there needs to be interventions to help reduce errors, and improve patient outcomes. The goal is to create a safety culture that encourage nurses to report errors and to stay in the profession.

A. Issues Contributing to Medication Errors

The most common medication errors (MEs) are wrong patient, wrong medication, wrong time, wrong dosage, and wrong route; factors are discussed above of the "five rights" framework of drug administration.[38] Issues contributing to MEs include physicians' intelligible handwriting, employees' fatigue, carelessness and distraction, inadequate pharmacological knowledge, and similarity in the names, shapes, and packaging of medications.[39] Based on a cross- sectional study of twelve hospitals and the review of 366 nurses' questionnaires, the total average of MEs for each nurse was 6.27 ± 11.95 per month. In addition, nurses with second jobs had more MEs, probably due to fatigue. Also, there was a significant correlation (p-value 0.001) between lack of work experience and several night shifts with total MEs. The increase in MEs seemed logical for night shifts due to the unconventional time of work and the tiredness of personnel.[40] By understanding the reasons contributing to MEs, institutions

---

[35] Salim Aljabari & Zuhal Kadhim, *Common Barriers to Reporting Medical Errors*, HINDAWI THE SCI. WORLD J. 5 (2021), https://doi.org/10.1155/2021/6494889.
[36] *Id.*
[37] FDA, *Working to Reduce Medication Errors*, U.S. FOOD & DRUG ADMIN.,https://www.fda.gov/drugs/information- consumers-and-patients-drugs/working-reduce-medication-errors (last visited Aug. 23, 2019).
[38] Martyn, *supra* note 15.
[39] Bakhtiar Piroozi et al., *Frequency and potential causes of medication errors from nurses' viewpoint in hospitals affiliated to a medical sciences University in Iran*, INT'L J. OF HUM. RTS. IN HEALTHCARE 268-69 (2019).
[40] *Id.*

can try to implement interventions to assist nurses in reducing and preventing these errors.

B. Failure to Report Medical Errors

The most reported reason for underreporting medication errors (MEs) is fear of consequences, which includes fear of being blamed, losing one's job, legal matters, and losing the respect of coworkers.[41] Another critical reason for failure to report medication errors is administrative or organizational.[42] The administrators' responses to medication errors determines if there is an unsupportive atmosphere and a culture of blame and shame, which does not encourage incident reporting.[43] Additional reasons MEs are not reported include failure to recognize that an error occurred, or the error was not necessary to report.[44] Lastly, barriers to reporting include nurses' perception that reporting takes too much time from direct patient care or that contacting the physician to fix the error takes too long.[45] If medication errors continue to be unreported, the exact rate will remain concealed, and the leading causes of these errors will not be discovered.[46] Alternatively, some hospitals are utilizing voluntary incident reporting. Voluntary incident reporting could serve as a valuable tool to not only alert of one-time incidents but also identify and solve the causes of ongoing medication related problems.[47]

C. Plan for Reducing Medication Errors

Since 2002, the California Department of Public Health has required every acute care hospital to establish a Medication Error Reduction Plan (MERP).[48] The framework includes maintaining a medication error reporting system, creating interdisciplinary teams to analyze medication risks and errors, and annually reviewing strategic plans to reduce medication errors. The interdisciplinary medication safety committees should include pharmacists, nurses, physicians, and administrators. Past interventions have included replacing physician-written orders with computerized physician order entry (CPOE) systems, using bar-coding technology to scan for the right medication before administration, and completing medication reconciliation by nurses. Lastly, a

---

[41] Baraa M. Hammoudi et al., *Factors associated with medication administration errors and why nurses fail to report them*, SCAN. J. CARING SCI. 1039-44 (2018). *See also* Salim Aljabari & Zuhal Kadhim, *Common Barriers to Reporting Medical Errors*, HINDAWI THE SCI. WORLD J. 5-6 (2021), https://doi.org/10.1155/2021/6494889.

[42] Aljabari, *supra* note 35.

[43] Aljabari, *supra* note 35.

[44] Aljabari, *supra* note 35.

[45] Aljabari, *supra* note 35.

[46] Aljabari, *supra* note 35.

[47] Gillian F. Cavell & Deepal Mandaliya, *Magnitude of error: a review of wrong dose medication incidents reported to a UK hospital voluntary incident reporting system*, EUROPE ASS'N. HOSPITAL PHARMACISTS 260-61 (Aug 2019), https://ejhp.bmj.com/content/28/5/260.

[48] Institute for Safe Medication Practice (ISMP), *ISMP Encourages Adoption of Medication Error Reduction Plans,* YAHOO! (Nov. 30, 2022), https://www.ismp.org/news/ismp-encourages-adoption-medication-error-reduction-plans.Harmeet S. Rehan & Shashikant Bhargava, *Medication Errors Are Preventable*, PHARMACOVIGILANCE (2015), https://www.walshmedicalmedia.com/open-access/medication-errors-are-preventable-2329-6887-S2-005.pdf.

medication error reporting system should provide clear information on how to report a medication error, followed by feedback.[49]

In addition, a Comprehensive Unit-based Safety Program (CUSP) encourages a local safety culture. Safety culture is the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to an organization's health safety management.[50] Strategies of CUSP include educating staff members about patient safety, empowering staff to address patient safety problems on their unit, building relationships between executive leadership and unit staff, and providing tools to investigate errors.[51] The goal is to provide nurses with more education and encouragement to report medication errors. With establishing a safety culture, nurses will be encouraged to report errors. In addition, healthcare organizations will better understand the root cause of medical errors to make improvements that will decrease medication errors as a whole, improve patient outcome, and lower healthcare system costs.

III. CRIMINALIZATION

American law requires "beyond a reasonable doubt" in criminal cases to convict, "preponderance of the evidence" in most civil litigation, and "clear and convincing evidence" in a few civil matters.[52] In *Tenn. v. RaDonda Vaught*, the defendant was charged with a criminal proceeding, in which the prosecutor had the burden to prove "beyond a reasonable doubt" that Ms. Vaught was guilty of reckless homicide and gross neglect of an impaired adult.[53] The evidence must be so strong that the judge or jury is nearly certain the defendant is guilty.[54] When it comes to healthcare professionals, judges should consider first-time offenders versus repeat offenders when deciding on a judgment. In addition, courts should not be so quick to criminalize healthcare workers, keeping in mind the intent or lack thereof.

A. First-Time Offender Versus Repeat Offender

Ms. Vaught was a first-time offender with no prior criminal record.[55] The judge, considering this being her first-time offense, ordered a judicial diversion instead of a prison sentence.[56] Judicial diversion is a lesser consequence for first-time offenders, available by judicial discretion.[57] After the prosecution argued against diversion, probation was granted with the possibility of Ms. Vaught's record being expunged after

---

[49] Julius Cuong Pham et al., *Reducing Medical Errors and Adverse Events*, ANNU. REV. MED. 448-56 (2012), https://pubmed.ncbi.nlm.nih.gov/22053736/.
[50] *Id.*
[51] JOHN E.B. MYERS, CALIFORNIA CRIMINAL LAW: CASES, PROBLEMS, AND MATERIALS 33 (3d ed. 2019).
[52] MYERS, *supra* note 51.
[53] Nashville.gov., *Radonda Vaught - Davidson County Criminal Court Clerk*, Nashville, Davidson County (2023), https://sci.ccc.nashville.gov/Search/CriminalHistory?P_CASE_IDENTIFIER=RADONDA%5EVAUGHT%5E01251984%5E586540.
[54] Tennessean, *RaDonda Vaught sentenced to three years probation on a diverted sentence could wipe record clean*, YOUTUBE, https://www.youtube.com/watch?v=C9fdh17EK0s (last visited Mar. 25, 2022).
[55] Vincent Maher & Mark Cwiek, *Criminal Liability for Nursing and Medical Harm*, HOSPITAL TOPICS 3-5 (2022), https://doi.org/10.1080/00185868.2022.210157.
[56] *Id.*
[57] Tennessean, *supra* note 54.

the successful completion of probation.[58] During her judgment, the judge emphasized more than once the fact that Ms. Vaught took responsibility for her actions immediately after she realized her mistake and never intended to break a law.[59]

In contrast, consider the track record of Christopher Duntsch, also known as Dr. Death.[60] From the period of 2011 to 2013, Dr. Duntsch operated on thirty-eight patients, thirty-three of which resulted in two deaths and neurologic severe injuries to the others. Dr. Duntsch clearly displayed a reckless indifference to the outcome of his surgeries. Beyond a reasonable doubt, Dr. Duntsch was found guilty of being reckless and was sentenced to life imprisonment. Thus, it is necessary for the courts to look at the facts of whether a defendant is a first-time offender or has a track record when deciding on the punishment in a criminal case.

B. Not Criminalizing Healthcare Workers

Criminal liability occurs when there is a violation of statutory criminal law, and a demonstration of mens rea, the "malice aforethought" state of mind of intent to engage in a criminal act and the actual commission of a criminal act.[61] According to the facts in Ms. Vaught's case, a routine situation became emergent when an order for versed was delayed by both the doctor who entered the orders and the first nurse who could not give the medication.[62]

Then Ms. Vaught, training another nurse, was asked to go to the positron emission tomography (PET) scan area to administer the medication. Not only was Ms. Vaught unfamiliar to where the PET scan area was, but the medication room also needed a scanner for Ms. Vaught to verify the proper medication pulled was versed, instead of vecuronium. One variable after another contributed to Ms. Vaught pulling the wrong medication. Ms. Vaught's attorney importantly pointed out the lack of "malice aforethought," when he stated, "how could a person that has no idea that they had the wrong medication when they administered it be acting with conscious disregard."[63] Yet, the prosecutor tried to convince both the jury and the judge to evaluate the facts of Ms. Vaught's case, despite no intent to harm her patient, the same as a criminal who had "malice aforethought." In the future, prosecutors should not be so quick to criminalize healthcare workers without proving intent. Allowing the precedence of the criminalization of medical errors would undermine the goal of building safety culture and non-punitive environments in hospitals.[64]

IV. LIABILITY

Malpractice claims occur when a medical provider has failed to follow a reasonable standard of care, causing patient harm. Civil malpractice cases are brought

---

[58] Tennessean, *supra* note 54.
[59] Maher, *supra* note 55.
[60] Maher, *supra* note 55.
[61] Maher, *supra* note 55.
[62] WKRN News 2, *supra* note 1.
[63] WKRN News 2, *supra* note 1.
[64] Eli Y. Adashi & Glen Cohen, *Criminalizing medical errors will undermine patient safety*, NATURE MED. 2241(2022), https://doi.org/10.1038/s41591-022-01982-149.

by individuals to be awarded damages.[65] Criminal medical malpractice cases are brought before the court by government prosecutors to punish with incarceration.[66] In response, medical providers may obtain malpractice insurance, but the healthcare system bears the costs.[67] During the late 70s, mid-eighties, and early 21st century, the increase in medical malpractice suits resulted in insurance premiums going up, sometimes causing the unavailability of malpractice liability insurance.[68] In response to the "medical malpractice crisis," many states passed legislation for changes to limit the amount which could be received for pain and suffering or the total amount that could be recovered in the malpractice action, to reduce limitation periods, and to require arbitration.[69] To explore liability, it is worth learning how licensed nurses are disciplined by the board for medical errors, the type of nurse encouraging malpractice claims, and how healthcare institutions contribute.

A. The Norm for Disciplining Licensed Nurses

The California Board of Registered Nursing has the authority to discipline California- licensed nurses who are in violation of the Nursing Practice Act, under Business and Professions Code § 2750.[70] The Board of Registered Nursing looks at several factors before deciding on a disciplinary penalty: severity and recency of offense, rehabilitation evidence, current ability to practice safely, mitigating factors, and past disciplinary history.[71] An accusation must be filed to formally charge a registered nurse (RN) and to notify the public that a corrective action is pending against that nurse. Reasons to file an accusation can be for crimes ranging from embezzlement, child abuse, battery, theft from a patient, and failure to report abuse. The board applies the standard of "gross negligence," the repeated failure, to provide the required nursing care or failure to provide care or exercise precaution in a single situation in which the nurse knew or should have known, could result in patient harm.[72]

Under California Penal Code § 23, during a criminal proceeding, a judge may order that a licensee be suspended from practice as a registered nurse or be restricted in how they may practice. If probation is ordered, a RN may practice under certain restrictions for a set period of time. A suspension results in the licensee being unable to practice as a registered nurse for a set or indefinite period. Harsher actions include revoking a license temporarily until successful completion of probation or revoking or surrendering the license in which the licensee no longer has the right to practice as an RN. Licensees may file an appeal in Superior Court, requesting the Board to overturn disciplinary action.[73] In the case of Ms. Vaught, The Tennessee Board of Nursing filed

---

[65] James S. Barry et al., *Is medical error a crime? The impact of the State v. Vaught on patient safety?,* J. OF PERINATOLOGY (2002), https://doi.org/10.1038/s41372-022-01481-8.
[66] PROQUEST, *Malpractice Nursing Claims Rise with Experience*, HEALTHCARE RISK MGMT. (Oct. 2018), https://www.proquest.com/docview/2114567475/AEBF7FDFAAE0489BPQ /1?Account id=14749.
[67] SCHWARTZ ET AL., PROSSER, WADE, AND SCHWARTZ'S TORTS CASES AND MATERIALS, (14th ed. 2020).
[68] *Id.*
[69] CA.Gov. *Disciplinary Actions and Reinstatements*, CA. BOARD OF NURSING (2022), https:// www.rn.ca.gov/enforcement/dispaction.shtml.
[70] *Id.*
[71] *Id.*
[72] *Id.*
[73] *Id.*

a disciplinary action against her on Sep. 27, 2019 for three violations: 1) unprofessional conduct related to nursing practice and the five rights of medication administration, 2) abandoning or neglecting a patient requiring nursing care, and 3) failure to maintain a record of interventions.[74] Ultimately, the nursing board chose to discipline Ms. Vaught by revoking her nursing license indefinitely.[75] The norm for disciplining nurses ranges from probation to revoking a nurse's license permanently.

B. Malpractice Nursing Claims

Contrary to intuition, one would think a new nurse would be more likely to be sued since they would not be familiar with policies and procedures, or take longer with patients and not recognize signs of distress compared to a more experienced nurse.[76] Research by the Nurses Service Organization (NSO) shows "the more experienced a nurse is, the more likely he or she is to have malpractice claims." Several factors contribute to this finding: experienced nurses become too comfortable in their environment and let their guard down, take on more complicated cases, or become vulnerable while mentoring younger nurses.[77] Not only is there an increased likelihood for a claim to result from the negligence of an experienced nurse, the payment made to the injured third party also increases. Regarding Ms. Vaught, she had been a nurse for fourteen years. She pulled and mixed the medication without asking for a second nurse to check her. Lastly, she was training a new hire.[78] All of these factors contributed to Ms. Vaught's fatal medication error. However, NSO's research also shows that nurses who take continuing education and risk management courses have a lower incidence of malpractice lawsuits, and the payouts on claims are lower. This last finding reiterates the need for institutions to provide continuing education for both new and experienced nurses to ensure fewer malpractice nursing claims.[79]

C. The Role of Healthcare Institutions

Along with the Board of Nursing's role in disciplining nurses, healthcare institutions have a role in how they deal with the liability of healthcare professionals that cause injury to patients. Healthcare institutions vary on how they decide to handle an injury to a patient due to a practitioner's error. While one healthcare institution may provide settlements to the injured party without disciplining the healthcare professional, another hospital may only fire the practitioner or report them to the appropriate medical boards. With lack of consistency in how liability is dealt with, healthcare professionals are encouraged to carry their own malpractice insurance.[80]

Even if liability is shifted to the healthcare professional, healthcare institutions should acknowledge and take responsibility in their role, especially when they have failed to act against a negligent healthcare provider. Referring again to Dr. Duntsch, Baylor Regional Medical Center allowed Dr. Duntsch to continue operating on patients,

---

[74] Craig RN, JD, *supra* note 5.
[75] Craig RN, JD, *supra* note 5.
[76] PROQUEST, *supra* note 66.
[77] PROQUEST, *supra* note 66.
[78] PROQUEST, *supra* note 66.
[79] PROQUEST, *supra* note 66.
[80] PROQUEST, *EPs, Hospitals Face Liability for ED Nurse Practitioners*, ED LEGAL LETTER (Apr. 2019), https://www.reliasmedia.com/articles/144142-eps-hospitals-face-liability-for-ed-nurse-practitioners-negligence.

despite having received warnings about his lack of competence, questionable mental stability, alcoholism, and possible drug addiction.[81] To illustrate the harm done to his patients, Jerry Summers, 2012 woke up with no movement in his limbs after Dr. Duntsch sliced an artery while performing a spinal fusion. That same year, Kellie Martin died during a laminectomy, normally usually a simple 45-minute procedure, but Dr. Duntsch sliced one of the arteries along her spine. After Ms. Martin's incident, Dr. Duntsch resigned from Baylor with full clinical privileges. Duntsch went on to operate at other facilities in the area until the Texas Medical Board suspended his license on June 26, 2013.[82] With this example, a strong argument could be made that healthcare institutions should be obligated to inform other hospitals about reckless practitioners.[83]

In Ms. Vaught's case, she continued to work at Vanderbilt University Medical Center after the death of Ms. Murphey. The hospital did not require Ms. Vaught to participate in additional education. Only when an anonymous tipster reported the institution did the institution fire Ms. Vaught.[84] In the criminal proceeding, the institution not prosecuted for their role was not reporting the sentinel event when it occurred and not disciplining Ms. Vaught immediately after the medical error. In his closing statement, Ms. Vaught's defense attorney reminded the jury of the lack of VUMC's shared liability with Ms. Vaught, the "scapegoat," the only defendant in the criminal trial.[85] Ultimately, the lesson here is for hospital credentialing and peer review committees to take a comprehensive and serious approach to review errors of healthcare professionals and to take appropriate action immediately, along with additional training for healthcare providers when sentinel events occur.

D. Criminal Liability of Hospitals

At this point, the question is to what extent are hospitals, and legal persons, responsible for the fault of a healthcare professional who injures a patient?[86] Modern criminal jurisprudence recommends establishing the criminal responsibility of legal persons by stipulating that responsibility and determining the procedure of the trial and penalties of the legal persons. Both public and private hospitals need to be responsible for the doctor's fault. Hospitals may be held criminally accountable for the crimes of the healthcare professional by means of fines and preventive measures, i.e., dissolution and suspension. The judiciary would determine the ability to pay and the return from the violation. Also, the publication of the conviction would be a way to affect the hospital's reputation. In extreme incidences, hospitals may be asked to temporarily or permanently close.[87] Lastly, healthcare institutions that do not report negligence do not deserve to have their credentials renewed or to receive government funding, i.e., Medicaid, and Medicare.

---

[81] HCPro, *Malpractice lawsuits against Baylor neurosurgeon implicate hospital,* CREDENTIALING & PEER REV. LEGAL INSIDER (Jun. 2014).
[82] *Id.*
[83] *Id.*
[84] Bob Aller, *Vanderbilt Failed to Report Unnatural Patient Death*, HOSPITAL WATCHDOG (2019), https://hospitalwatchdog.org/vanderbilt-med-center-cover-up/.
[85] WKRN News 2, *supra* note 1.
[86] Dr. Khalid sabri hasani, *Criminal Liability of Hospital for Physician Error*, 19; 6 WEBOLOGY 926-31 (2022).
[87] *Id.*

In the case of Ms. Vaught, VUMC did not notify the family of the medical error or report the incident to the state for ten months, despite being legally required by the Tennessee Department of Health to report within seven days of an incident of "neglect," according to T.C.A. 68-11-211.[88] After being reported to the Centers for Medicare and Medicaid Services (CMS), VUMC cooperated in the federal investigation. According to recent updates, Vanderbilt submitted a corrective plan to CMS to address the prevention of future medication errors, but the plan has not been made public.[89] VUMC continues to receive federal funding from CMS. To this date, VUMC has not been held criminally liable, fined as a legal person, or temporarily closed. Lastly, despite nurses' letters against renewing VUMC's Magnate designation, the institution again received the credentialing last year.[90] The significance of the Magnate status is to recognize hospitals for their excellence in nursing. In conclusion, liability should not rest solely on the nurses and nursing boards. Healthcare institutions also need to be liable for their role in the rising incidence of malpractice cases.

V. NEW MODELS FOR NEGLIGENCE & MEDICAL ERRORS

Institutions abroad are implementing new models to assess negligence versus culpable homicide. Negligence implies ignorance. Thus, a negligent doctor should not be criminally liable for a lapse of concentration or error of judgment. In colloquial terms, one tries to do the right thing but actually does the wrong thing. The same cannot be said for a doctor who disregards the safety of others and is guilty of a violation.[91] New models may provide further guidance for the judicial process to evaluate whether the negligence of healthcare professionals is sufficiently gross to be adjudged criminally.

A. Deciding When Negligent Conduct Becomes Culpable

Older models examine whether death occurs and assigns blame in medical settings. Newer models consider the context in which negative events occur, assessing for both harm and culpability. For negligent conduct to be culpable, three factors must be considered: awareness, choice, and control.[92] Awareness describes when a defendant is aware of a risk and elects to omit to act or to act in a certain way. There must be an awareness of a risk of harm to others, willful blindness, or dissonance in respect of such risk. The awareness can be at the time of the event or before the incident, such as the motorist who drives at an excessive speed. Next, choice deals with when the defendant exercises a conscious choice to act or omit to act. For example, a healthcare worker makes a choice to run an unnecessary risk or has the capacity to

---

[88] Craig RN, JD, *supra* note 5.
[89] Mackenzie Bean, *Vanderbilt should lose Magnet status over RaDonda Vaught's treatment, nurses say*, BECKER'S HOSPITAL REV. (Aug. 5, 2022), https://www.beckershospitalreview. com/nursing/vanderbilt-should-lose-magnet-status-over-radonda-vaught-s-treatment-nurses-say.html.
[90] *Id.*
[91] Robson et al., *Doctors Are Aggrieved - Should They Be? Gross Negligence Manslaughter and the Culpable Doctor*, THE J. OF CRIM. L. 313 (2020), https://journals.sagepub.com/doi/full/10.1177/0022018320946498.
[92] *Id.*

refuse to work. The last factor is control. Control is present when a person can alter the chain of events.[93]

In looking at culpability in the RaDonda case, the prosecutor accused Ms. Vaught of being aware when her willful blindness resulted in her pulling vecuronium, instead of versed.[94] In regard to choice, Ms. Vaught made a choice to ignore the warning messages from the medication cabinet. Lastly, the prosecutor stated that Ms. Vaught could have refused to pull the medication for her co-worker. However, the element of control was missing because she had no control over the lack of staff coverage. Hence, Ms. Vaught's actions were negligible, and not culpable. To conclude, the justification of criminal liability should not depend on if the patient dies but on whether the conduct should be judged.[95]

B. The Sliding Scale of Negligence

In New Zealand, criminal prosecution for medical manslaughter has been abandoned.[96] Criminal law is only applied to healthcare settings in cases of deliberate harm or recklessness. To summarize, the grossness of the negligence per se should be the necessary mens rea, instead of the defendant's state of mind. Their "sliding scale of negligence" test focuses on the defendant's conduct. The point of the "sliding scale of negligence" test is to evaluate how far below an endpoint of the scale is reached. If the defendant's behavior is illogical, the negligence should be adjudged as gross and culpable.[97]

The first point on the scale is the Bolam test, which defines the standard of care for a professional, meaning "the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill…it is sufficient if he exercises the 'ordinary skill of an ordinary competent man' exercising that particular art." [98]The next point is whether the defendant's actions are illogical or grossly unreasonable, "[w]here a judge can be satisfied that the body of expert opinion 'cannot be logically supported at all' that such opinion will not provide the benchmark by reference to which the defendant's conduct falls to be assessed." A grossly negligent doctor is considered to have behaved "illogically" where there has been a blatant disregard for accepted practice or adherence to an outdated practice. Essentially, they have failed to recognize the risks in their approach which could cause the death of a patient.[99] Once the illogical marker is met, culpability is considered.

The "sliding scale of negligence" test has four categories of culpability and one level of harm. At the most serious end, the offender shows a blatant disregard for a very high risk of death resulting from the negligent conduct, whereas the lower end includes

---

[93] Robson et al., *Doctors Are Aggrieved - Should They Be? Gross Negligence Manslaughter and the Culpable Doctor*, THE J. OF CRIM. L. 326-29 (2020), https://journals.sagepub.com/doi/full/10.1177/0022018320946498.
[94] WKRN News 2, *supra* note 15.
[95] Robson, *supra* note 93.
[96] Robson, *supra* note 93.
[97] Robson, *supra* note 93.
[98] Robson, *supra* note 93.
[99] Robson, *supra* note 93.

the offender's actions as a 'lapse' in an otherwise satisfactory standard of care.[100] In addition, the approach reduces the seriousness of the offense with mitigating circumstances, such as the offender lacking the necessary expertise which contributed to the negligent conduct, the offender being subject to stress or pressure, the negligent conduct occurring in circumstances where there was reduced scope for exercising usual care and competence, and the negligent conduct was compounded by the actions or omissions of others.[101] In deciding Ms. Vaught's judgment, the judge looked at mitigating factors under TCA 40-35-113, in which the defendant committed the offense under such unusual circumstances that it is unlikely that a sustained intent to violate the law motivated the criminal conduct.[102] To reiterate, the "sliding scale of negligence" model focuses on the conduct itself to determine culpability, instead of trying to determine the mens rea.

C. Unified Approach to Tackling Medical Errors

In looking at both Ukrainian and participating countries of the European Court of Human Rights (ECHR) practice, the lack of a unified approach to understanding and tackling medical errors were believed to be a factor in the failure to establish leading legal practices of national courts.[103] The Convention for the Protection of Human Rights and Fundamental Freedoms established Article 2, which is the right to life, which implies both negative and positive obligations of the state. In an attempt to comply with Art. 2, ECHR's suggested three approaches in understanding medical error. First, a medical error is seen objectively, as an unlawful action with negative social consequences. Second, a medical error is understood as a result of good faith deceit and a result of the committed negligence. Third, any departure from medical standards, including protocols, is a medical error.[104]

The ECHR's position on medical error and carelessness of healthcare workers is as follows: 1) errors of judgment of a healthcare worker, meaning the negligence in coordinating the actions of such workers during the treatment of a patient, are not sufficient to hold the state liable for the fulfillment of positive obligations under Art. 2 of the Convention, 2) the national system of law, to prevent medical negligence, should provide for remedies for victims in criminal courts and/or in civil courts, 3) medical errors should be evaluated in disciplinary bodies.[105] Medical error is defined as the innocent action (act or omission) of a healthcare professional that has caused or could cause potential harm to a patient's health and which results from a deliberate deception.[106] Medical negligence is the failure to perform or improper performance of professional duties by a healthcare professional as a result of a negligent or dishonest

---

[100] Robson et al., *Doctors Are Aggrieved - Should They Be? Gross Negligence Manslaughter and the Culpable Doctor*, THE J. OF CRIM. L. 337 (2020), https://journals.sagepub.com/doi/full/10.1177/0022018320946498.
[101] *Id.*
[102] Tennessean, *supra* note 54. *See also* TENN. CODE *§ 40-35-113* (JUSTIA 2019), 2019 *Tennessee Code Title 40 - Criminal Procedure Chapter 35 - Tennessee Criminal sentencing Reform Act of 1989 Part.*
[103] Liudmyla Dobroboh et al., *Medical Illegality and Errors in the Leading Legal Practice*, ADVANCES IN SOC. SCI., EDUC., AND HUMAN. RSCH. 55-58 (2020), http://creative commons.org/licenses/by-nc/4.0/.
[104] *Id.*
[105] *Id.*
[106] *Id.*

attitude that has caused or could cause harm to a patient's health.[107] Due to the difference in medical error and medical negligence, events involving either that result in an injury to a patient's health should be recognized differently and dealt with differently.[108] In establishing a unified approach, national courts can have a consistent standard for evaluating medical errors.

VI. NEED FOR HEALTHCARE REFORM

Reform is needed to aid the current nurses in the healthcare system before more nurses leave the profession. Over two years of fighting the pandemic have resulted in an all-time high of burnout and a mass exodus of nurses.[109] According to the U.S. Bureau of Labor Statistics, in just 2022, 1.7 million people quit healthcare. In a recent survey of 1,000 healthcare professionals, the reason cited for quitting was burnout.[110] Nurses are either quitting to take higher paying traveling positions or choosing to retire early.[111] As mentioned before, patient outcomes and medical errors are affected by a shortage in staffing.[112] The effect of nursing shortages on the future of healthcare will be discussed. The interventions on how to improve the current situation for nurses will be listed. In regard to healthcare institutions, oversight needs to be provided with clear policies and protocols. Lastly, recent changes in legislation will predict where the profession of nursing and nursing reform is headed.

A. Nursing Shortages After the Pandemic

A perfect example of the nursing shortage after the pandemic occurred in the Northeast Hospital Corporation (NHC), a health system in Massachusetts.[113] Starting in 2020, their nurses were quitting in the masses. Unsafe staffing due to high patient acuity and low wages were issues long before the pandemic. However, with NHC prioritizing its profit margins over nurse and patient safety, even during the pandemic, the existing situation became worse. Nurses were placed in danger of providing compromised patient care during the public health crisis of COVID-19. Hospital administrators understaffed the hospitals to generate greater operating margins. In 2020, NHC had a profit margin of 12.8%, five times more than the state average. As a result,

---

[107] *Id.*
[108] Dobroboh et al., *supra* note 103.
[109] Deb Gordon, *Amid Healthcare's Great Resignation, Burned Out Workers Are Pursuing Flexibility and Passion*, FORBES (May 2022), https://www.forbes.com/sites/debgordon/ 2022/05/17/amid-healthcares-great-resignation-burned-out-workers-are-pursuing-flexibility-and-passion/?sh=5339afd57fda.
[110] *Id.*
[111] Hailey Mensik, *Third of nurses plan to quit their jobs by end of 2022, survey shows,* HEALTHCAREDIVE (Mar. 2022), https://www.healthcaredive.com/news/nurse-burnout-covid-quit-travel-incredible-health/620488/; *See* MacPhee *supra* note 30.
[112] *Id.*
[113] David Schildmeier, *MNA: Years of Understaffing Exacerbated by Pandemic Drives 40% Loss of Nursing Staff at Northeast Hospital Corporation (Beverly Hospital & Addison Gilbert Hospital in Goucester) in the Last Three Years: Mass Resignation of North Shore nurses is the Latest Manifestation of a Statewide Crisis in Nursing Care as Hospital Corporations Like Northeast Hospital Corp Sacrifice Nursing and Patient Safety to Boost Profit Margins,* PR NEWSWIRE ASSOC. LLC., 2022.

the organization experienced an unprecedented loss of 322 nurses in 2022, 40% of the hospital's nursing staff.[114]

Commenting on the nursing profession as a whole, the American Nurses Association (AMA) notes that nursing shortages were already a problem before the pandemic. Factors included retiring nurses outpacing new entrants, an increase in demand for healthcare from aging and chronic disease populations, and an inadequate workforce.[115] These existing factors, combined with a surge in demand for nurses during the pandemic, worsened the nursing shortage and exposed the challenges nurses face in the workplace. As a result, the U.S. Bureau of Labor Statistics projects over 200,000 openings for registered nurses over the decade.[116] Also, high turnover of nursing staff translates to higher costs for training new nurses or using temporary staff.[117] With the aging population, healthcare cannot afford to have a shortage of nurses.

B. Interventions by Healthcare Organizations to Assist Nurses

Referring back to the findings by the Nurses Service Organization (NSO), research indicates that nurses who take continuing education and risk management courses have a lower incidence of malpractice lawsuits.[118] Thus, healthcare organizations clearly need to invest in training for both new and experienced nurses. Not only should risk managers encourage nurses to keep up with trends in healthcare, but they also should implement a peer review process for all the nurses to ensure continued compliance with policies and procedures, as well as best practices and clinical standards.[119]

Also, burnout in nurses decreases with interventions that improve work organization. Improvements in work organization consist of work pace and work shifts based on staff preferences.[120] The organization can influence job satisfaction by increasing support with greater teamwork and improving relationships with managers. With a decrease in workload, nurses can focus on recording medical history, which facilitates the transmission of information without errors and omissions.[121] In addition, another staff member can handle the responsibility to admit, discharge, and transfer patients. Lastly, organizations can employ teams to handle the transport of patients, initiate intravenous therapy, and transport laboratory specimens. Thus, the nurses can spend more time on tasks which require skilled nursing knowledge and assessment.[122]

---

[114] *Id.*
[115] ANA, *Nurses in the Workforce*, AM. NURSES ASS'N., https://www. nursingworld.org/practice-policy/workforce/ (last visited Apr. 3, 2023).
[116] Occupational Outlook Handbook, *Registered Nurses*, U.S. BUREAU OF LAB. STAT. (last visited Apr. 4, 2023), https://www.bls.gov/ooh /healthcare/registered-nurses.htm.
[117] WFJM van den Oetelaar, et al., *supra* note 13.
[118] PROQUEST, *supra* note 66.
[119] PROQUEST, *supra* note 66.
[120] Perez-Francisco et al., *Influence of Workload on Primary Care Nurses' Health and Burnout, Patients' Safety, and Quality of Care: Integrative Review*, HEALTHCARE 8-10 (2020), https://pubmed. ncbi.nlm.nih.gov/31947761/.
[121] *Id.*
[122] Swiger, *supra* note 28.

Speaking of alternatives, telenursing through telephone calls or video conferencing is a viable option.[123] Benefits of telecare for the healthcare system include fewer readmissions, better therapeutic control, improvements in diseases, and fewer in-person consultations. By having virtual nursing programs, the burden on bedside nurses is eased with virtual nurses performing tasks that do not require physical proximity, such as handling admissions interviews, discharge instructions, and medication instructions. The virtual nurses can be assigned a group of patients for whom they provide care for their shift duration.[124] With more nursing staff to monitor each patient, detection of rapid changes in patient condition is improved because staff will know early to respond before a patient's condition worsens. In addition, nurse managers can better optimize nurse-to-patient ratio and patient acuity due to added support of the telecare nurses.[125]

Finally, good workload management helps to keep employees healthy as a high workload is a predictor for burnout and absenteeism.[126] In developing a nursing workload management method, it needs to be easy to interpret, be applicable to different types of hospital wards, and cover all activities of nurses, both direct and indirect patient care. Direct patient care may include activities from assisting patients with bathing or eating, handing out medication, changing bed linen, or helping with wound care. Indirect patient care may include activities that facilitate patient turnover, mandatory registrations, communication with family, etc.[127] A well-developed nursing workload management method will provide both guidance and consistency in patient care. Overall, the various interventions discussed creates a collective responsibility between nursing leadership and direct care nurses in better managing nurse workload, which in turn ensures delivery of nurse satisfaction and high-quality patient care.

C. Credentialing & Oversight Programs at Healthcare Institutions

External organizations exist whose function is to audit healthcare institutions, such as The Joint Commission (TJC).[128] TJC is an independent, not-for-profit organization that accredits more than 20,000 US healthcare programs and organizations. TJC provides unbiased assessments of the organization's achievement in patient care and safety. TJC looks at factors such as multitasking, interruptions, worker fatigue, etc., with the aim of avoiding medical errors and identify non-compliance. With successful certification, hospitals are awarded accreditation. Accreditation assists hospitals in obtaining liability insurance and receiving support from the state and federal government for Medicare and Medicaid. However, TJC only reviews each hospital every two to three years to reevaluate patient care and safety.[129]

Hence, healthcare institutions need to develop their own oversight programs to regularly evaluate patient care and safety. To illustrate, in developing a plan to optimize

---

[123] Perez-Francisco, *supra* note 120.
[124] AHA, "5 Imperatives to Scale a Virtual Nursing Program, AM. HOSP. ASS'N. (last visited Apr. 4, 2023), https://www.aha.org/aha-center-health-innovation-market-scan/2023-02-28-5-imperatives-scale-virtual-nursing-program.
[125] *Id.*
[126] WFJM van den Oetelaar, et al., *supra* note 13.
[127] Swiger, *supra* note 28.
[128] Roopma Wadhwa & Annie P. Boehning, *The Joint Commission*, STATSPEARLS PUBLISHING LLC. (Mar. 16, 2023).
[129] *Id.*

in-hospital stroke care, an in-hospital stroke quality oversight program is recommended to provide data-driven performance feedback and drive targeted quality improvement efforts.[130] The board would consist of various healthcare professionals who set clear and measurable goals for improvement.[131] Participating disciplines for stroke quality could include neurology, internal medicine, neurocritical care, neurosurgery, neuro-interventional radiology, and nursing. Also, an oversight board would aid in translating complex therapies, often dictated by current treatment guidelines, to treating patients in an easy-to-understand process and in standardizing protocols. Without standardized protocols and quality benchmarks, diagnosis and management may be delayed.[132]

Effective protocols for in-patient stroke treatment include staff education, a simplified assessment method, a defined in-hospital alert activation system, and a dedicated team to respond to code stroke alerts.[133] Education may include pocket cards, posters, in-service lectures, grand rounds, and case simulations. Feedback should be provided after each code and reviewed at least semiannually in a nonpunitive and constructive manner. Written protocols should be used to expedite treatment and to ensure consistency. Developing written checklists to use on the floors would solve the issue of lack of familiarity with the protocol or inconsistent adherence. The last task is for the board to review and track their performance through the collection and analysis of internally generated data, which in turn gives feedback on how to reach national benchmarks. In the end, high-performing hospitals, with accreditation and oversight, tend to have better outcomes in regard to quality than hospitals that do not.[134]

D. Legislation by Congress for Nursing Reform

Safe nursing staff legislation is necessary and has caught the attention of Congress. In May of 2021, Congress introduced S.1567: Nurse Staffing Standards for Hospital Patient Safety and Quality Act.[135] The bill was referred to the United States Senate Committee on Health, Education, Labor, and Pensions. The committee is currently made up of twenty-one members. Public health falls under the jurisdiction of the Committee. The makeup of the committee varies from past and present politicians from various parties, i.e., Bernie Sanders of the Independent Party as majority leader to minority members such as Mitt Romney of the Republican Party.[136] The Nurse Staffing Standards for Hospital Patient Safety and Quality Act aims to amend the Public Health Service Act and create a federal standard for safe nursing staffing ratios. The impotence of the bill was the decrease in healthcare employment seen in 2020. The bill hopes to reduce the negative impact low staffing can have on the health of nurses and their patients. The Committee recognizes that improper staffing can lead to more mistakes and less patient satisfaction, as well as burnout for nurses and the impotence to leave

---

[130] Nouh, et al., *Identifying Best Practices to Improve Evaluation and Management of In-Hospital Stroke: A Scientific Statement from the American Heart Association*, STROKE 165-72 (Apr. 2022).
[131] *Id.*
[132] *Id.*
[133] *Id.*
[134] Ross Millar, et al., *Hospital Board Oversight of Quality and Patient Safety: A Narrative Review and Synthesis of Recent Empirical Research*, THE MILBANK QUARTERLY 738 (2013).
[135] Whitney Sandoval, *Updates on Safe Staffing Legislation in the U.S.*, BC BEST COLLEGES (Aug. 2022), https://www.bestcolleges.com/nursing/safe-staffing-legislation/.
[136] U.S. Senate Committee on Health, Education, Labor, and Pensions, https://www. help.senate.gov (last visited Apr. 3, 2023).

the profession.[137] As of March 2022, sixteen states have laws or regulations to address nurse staffing in hospitals.[138] At present, there is no federal standard.

Instead of assigning nurses to a general number of patients, the bill categorizes the number per department.[139] The ratio is broken down to account for various departments within a hospital. The ratio factors in the demand nurses will most likely encounter with patients in each unit, i.e., one nurse for one patient in a trauma emergency unit, one nurse for two patients in critical care, etc.[140] In addition, a nurse will have federal protection against employer retaliation if staffing ratios are not followed. Also, the legislation accounts for the demonstration of unit-specific competence, meaning the direct care registered nurse must demonstrate current competence. Employers will be mandated to have a staffing plan for the nurse staffing ratios that must be posted ahead of time, and must be updated annually.[141] Once the bill passes, hospitals will have two years to comply. By being mindful of safe staff-to-patient ratios, healthcare facilities can increase positive patient outcomes and decrease mistakes, which will decrease nursing burnout.[142] With federal legislation, consistent application of nurse-to-patient ratio will have a consistent application across all the states and have the federal government's power behind it.

CONCLUSION

RaDonda Vaught's case was not the first time a healthcare professional has been charged in criminal court and may not be the less. However, her case was unique because the media publicly brought a nurse's negligence to light and sensationalized her. Healthcare workers from across the nation rallied outside her trial because RaDonda Vaught's criminalization as a healthcare worker was considered cruel and unusual. As discussed in length, all the factors which possibly led to her medication error have long been building up in the nursing profession. The prosecutor focused on Ms. Vaught's individual conduct while her defense lawyer emphasized how the healthcare system has failed his client. The healthcare system made Ms. Vaught the "scapegoat" for all the problems that had escalated at the healthcare institution to which she was employed at, as if only one person is responsible for the care of a patient.

Before society is quick to criminalize healthcare professionals, the legal profession must consider the difficulty nurses have in carrying out their duty of care with the "five rights." Nurses administer medications in unsafe settings exacerbated by the healthcare institutions that employ them. Healthcare institutions should strive to improve systems to combat medication errors. In addition, hospitals need to encourage a safety culture to report errors, which will provide lessons on how to avoid the same mistake in the future. Otherwise, medication errors will continue to be made and be underreported.

---

[137] Library of Congress, *S.1567 - Nurse Staffing Standards for Hospital Patient Safety and Quality Care Act of 2021,* CONGRESS.GOV, https://www.congress.gov/bill/117th-congress/ senate-bill/1567/text.
[138] Sandoval, *supra* note 135.
[139] Library of Congress, *supra* note 137.
[140] Library of Congress, *supra* note 137.
[141] Library of Congress, *supra* note 137.
[142] Library of Congress, *supra* note 137.

Traditionally, liability in a criminal case has relied on the defendant's mens rea. Except for extreme cases of culpable and reckless practitioners, medical errors by healthcare professionals lack the intent to harm. New models account for the context in which healthcare professionals must make decisions before determining if the level of negligence is culpable. With new models and a unified approach to tackling medical errors, courts will have guidance on deciding the appropriate judgment, instead of using the current model and convicting healthcare professionals as we would criminals who have the intent to break the law.

Instead of putting all our resources into criminalizing healthcare workers in the future for medication errors, let's focus instead on providing the support the nurses need to carry out their duties, including sharing liability amongst healthcare managers and healthcare organizations. Healthcare organizations need to be held accountable for how they proceed in disciplining negligent or reckless healthcare staff. In addition, the management of these healthcare institutions needs to work on improving workload management. Lastly, healthcare institutions need to be regulated, not only by external organizations but also by internal oversight boards to regularly ensure patient safety and care improvement. As seen, the healthcare system has not supported its nurses, especially during the pandemic, resulting in massive numbers of nurses either retiring early or resigning when we need them the most. Essentially, Ms. Vaught's case was a wake-up call to Congress that reform is necessary in the form of federal legislation consistent amongst all the states. Otherwise, our country will face an uncertain future with insufficient nursing staff to handle the increasing, aging population.