Just last month, a Registered Nurse, Radonda Vaught, who was employed by Vanderbilt University Medical Center was brought to trial for making a medication error in 2017, that contributed to a patient's death.[i]

She was found guilty.

She was "criminally prosecuted for a ***fatal*** drug error" that occurred "in 2017, was convicted of gross neglect of an impaired adult and negligent homicide."[ii]
"According to sentencing guidelines provided by the Nashville district attorney's office"…
This Nurse "faces three to six years in prison for neglect and one to two years for negligent homicide as a defendant with no prior convictions.
She "is scheduled to be sentenced May 13."[iii] {emphasis added}

Now, to be clear, the Nurse *did* make a medication error.
After typing in the name of the medication she needed into the computerized electronic medication dispensing machine, the machine wouldn't dispense the medication, so she overrode it…a "daily occurrence" by staff at many hospitals, but particularly on those machines at Vanderbilt at that time, as Vanderbilt was having ongoing problems with their machines after "a 2017 upgrade to the hospital's electronic health records system which was causing rampant delays at medication cabinets …and Vanderbilt instructed nurses to use overrides to circumvent delays and get medicine as needed."[iv] [v]
One could say that it was a *serious* system problem.

So after overriding the machine the Nurse then gave the medication to the patient. Turns out it was the wrong medication. The names were similar.
Then after she realized she made the error, she **followed hospital protocol**, to address the error and take responsibility for it.
She reported herself. She reported her mistake to the hospital.

This protocol, of self reporting, is standard among hospitals, and its goal is to help ***reduce*** **medical errors**, by tracking behaviors/systems/designs that may have led to, or contributed to, medical errors, such as
Vanderbilt's ongoing problems with their computerized medication dispensing machines at that time. A *serious* system problem, that Vanderbilt did not initially report.
Placing all the blame on the Nurse. That is until someone tipped off the Tennessee Investigation Bureau. Even still, only the nurse was prosecuted.

Sometimes medical errors are relatively harmless. At other times they can be quite serious, or as was found in Vanderbilt's situation, fatal.

Typically, however, these errors are NOT criminally punished. Sometimes corrections are made, or additional oversight provided. If more serious, staff may lose their medical licenses, as this Nurse did in 2017. But rarely, are they prosecuted criminally…
and there's a good reason for this.

To do so…
To criminally prosecute hospital staff
who are simply trying to do their jobs,
often under unsafe conditions, be that from:

- dangerous patient to staff ratios
- faulty/broken equipment
- mandatory overtime
- sleep deprivation
- the constant grind to do more with less

To criminally prosecute people who are *not* robots, but are human beings, who sometimes make mistakes…
is to cast them as scapegoats
for systems that make **inhuman demands**.

It is to blame them for:

- corporate failures
- things beyond their control
- the systemic abuse of power, and
- insatiable greed

In my work as a hospital chaplain, I cannot begin to count how often nurses have expressed to me their fear of losing their licenses,
or worse,

because of unsafe conditions they are being forced to work within.

Criminally prosecuting hospital staff for their self-reported mistakes has another consequence.
A likely ***unintended*** consequence

It terrorizes staff.

And it discourages them from reporting medical errors… at all.

[PAUSE]

Sometimes removing oneself from reality can be a helpful coping mechanism.
A particular favorite diversion of mine is to read a mystery series by the Québécois novelist, Louise Penny.
Her stories are more than simply thrillers, in that it seems they are as much about her characters' complexity and many facets, including their shadow-side, particularly of her "regulars," as it is about solving a crime.
Of course other authors do this as well, yet Ms. Penny also reminds me of beloved seminary professors, who would offer what appeared to be a casual offhanded question or comment that later crept back into one's thoughts and demanded to be revisited, often with no easy answer.

As a Canadian living in Quebec, Ms. Penny infuses her stories with French phrases placed strategically in the unfolding, which often had me solving mysteries of my own, via Google.

While reading one of her novels, there appeared the French phrase:

L'heure entre chien et loup[vi]

The literal translation is:

"*the time between dog and wolf*"[vii]

It is used to reference a time of day…somewhere around twilight or dusk, when it becomes impossible to tell a dog from a wolf.

Sometimes, it can be hard to suss out our reasons for making the decisions we make. *Sometimes* we may simply not look at the whole picture, or thoughtfully consider the all the ramifications.

Maybe we tell ourselves or others, that we are doing it for:

- someone else's benefit
- or some "greater good"
- perhaps even using the rationale, the end justifies the means…

Take Judas and Peter for example.

It is interesting that they are <u>both</u> highlighted today and elsewhere during Holy Week. They appear to be at opposite ends of the spectrum for disciples.
Peter over here… Judas over there.

From where we sit today and view this unfolding, it's pretty easy to claim that Peter and Judas were clearly wrong.

Yet, we're not talking about a couple of <u>randos</u> here…we're talking *<u>*disciples*</u>.*
So, what happened…?
Something clearly went wrong.

And for our own comfort's sake, we'd like to assume that we would have done better.

But to do so, is to lose sight of how drastic decisions often stem from many "harmless" ones. Like tiny steps along a path. A path that may have seemed clear and simple to follow initially, but then the fog set in, and the trail became obscured.
At some point further along, after the fog lifted,
the clearing we arrived at is not what we anticipated.

Perhaps Judas, earlier on, *was* concerned for the movement they were building…

Perhaps Judas *really did* think the money from that expensive oil that was put on Jesus' feet should have been used for the poor…or even that their movement had become a little cultish in following Jesus. That one person shouldn't be making all the decisions, such a charismatic figure was drawing too much attention, and thus, long-term, they could do better work without him.

I mean, think about it. Judas was **one of the twelve*.*

Not just anybody gets to be **one of the twelve*.*

This means that in the beginning, Judas must have agreed with what Jesus was doing. At some point Judas ***must*** have been excited about Jesus' message and his works. After all, Judas abandoned *his life* to follow Jesus.

And Jesus found Judas to be so devoted and trustworthy that he invited him into his Inner Circle.

Unless Judas was a huckster from the start, Judas must have been an exceptionally *trusted* one of the 12, to have been made responsible for Jesus' and the disciples' finances.

So what happened?

Did Judas just flip overnight?

More likely it was a few, maybe 10… maybe 100, tiny decisions or choices that led him down this path.

And what about Peter… warming himself by that fire,
maybe thinking that he could better protect Jesus from there.

After all, we *did* hear that Peter tried to protect Jesus earlier, when he cut off the ear of the high priest's slave. I mean, in terms of protection, it was a bit tepid if you ask me, as if an ear of a slave was going to stop anyone.
Nonetheless a feeble attempt was made.
Give Peter a B-minus for effort.
Yet still, his ill advised attempt was something.

So maybe remaining outside to learn more about what was happening to Jesus made sense to him. That by remaining outside, and *denying* that he was one of Jesus' disciples, he could increase his ability to lend aid.

Or perhaps Peter's feelings were hurt.
Perhaps he was still smarting
from Jesus' earlier rebuke of him, regarding the whole ear thing.
And thus, in a churlish moment…**or three**, he denied he knew Jesus.

[PAUSE]

It seems we have found ourselves living in
L'heure entre chien et loup - -

the time between dog and wolf.

Not perhaps literally as a time of evening,
rather more as a time of choices.
I guess that's really what the phrase means anyway. Our actions will be different based on what we see…
or what we **think** we see.

Sometimes, we may make decisions that we believe are with the best of intentions, without looking ahead to see clearly for the unintended consequences or long-term impacts.

For example:

~Criminally prosecuting a Nurse, who with the best of intentions, made a mistake.
And thus putting countless numbers of patients at risk in the future…. or

~Denying our affiliation with, or refusing to stand up for, someone or something who is trying to make the world better, albeit through unconventional means or presentations.

What seems to be present in this *time between dog and wolf*,
is the question of
What choice we will make…

When what is on the horizon is unclear.

The Rev. Jakki R. Flanagan
St. Thomas's Episcopal Church
New Haven, Connecticut
April 15, 2022
Good Friday

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[i] "Former nurse found guilty in accidental injection death of 75-year-old patient" March 25, 2022, NPR, https://www.npr.org/sections/health-shots/2022/03/25/1088902487/former-nurse-found-guilty-in-accidental-injection-death-of-75-year-old-patient

[ii] "In nurse's trial, witness says hospital bears 'heavy' responsibility for patient death" March 25, 2022 https://www.npr.org/sections/health-shots/2022/03/24/1088397359/in-nurses-trial-witness-says-hospital-bears-heavy-responsibility-for-patient-dea

[iii] "Former nurse found guilty in accidental injection death of 75-year-old patient" March 25, 2022, NPR, https://www.npr.org/sections/health-shots/2022/03/25/1088902487/former-nurse-found-guilty-in-accidental-injection-death-of-75-year-old-patient

[iv] "In nurse's trial, witness says hospital bears 'heavy' responsibility for patient death" March 25, 2022 https://www.npr.org/sections/health-shots/2022/03/24/1088397359/in-nurses-trial-witness-says-hospital-bears-heavy-responsibility-for-patient-dea

[v] "In nurse's trial, witness says hospital bears 'heavy' responsibility for patient death" March 25, 2022 https://www.npr.org/sections/health-shots/2022/03/24/1088397359/in-nurses-trial-witness-says-hospital-bears-heavy-responsibility-for-patient-dea

[vi] Lawless French, "L'heure entre chien et loup" https://www.lawlessfrench.com/expressions/entre-chien-et-loup/

[vii] Lawless French, "L'heure entre chien et loup" https://www.lawlessfrench.com/expressions/entre-chien-et-loup/