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**MEDICAL MALPRACTICE OR CRIMINAL
MISTAKE? - AN ANALYSIS OF PAST
AND CURRENT CRIMINAL PROSECUTIONS
FOR CLINICAL MISTAKES AND
FATAL ERRORS**

Paul R. Van Grunsven *

INTRODUCTION

On the evening of March 29, 1992, Nelson Yamamoto, a twenty-six-year-old deputy with the Los Angeles County Sheriff's Department, became involved in a shootout with a criminal suspect. Yamamoto was hit four times by the bullets of his assailant, who days later would be killed by police in New York.¹ Wounded in the abdomen, thigh, shoulder and toe, Yamamoto was rushed by ambulance to Martin Luther King Jr./Drew Medical Center (King), a 334-bed county teaching hospital near Watts. King hospital is renown for its heavy load of trauma patients and a medical staff that is skilled at treating multiple gunshot wounds. The reputation of King in treating gunshot wounds is so well known, the United States Army once sent physicians to train at this hospital because the wounds treated there were so similar to combat injuries.²

Newspaper reports indicate that Yamamoto was conscious and alert when he arrived at King.³ Surgeons worked nearly eight hours in two consecutive operations to repair his colon and intestine, and to tie off blood vessels in his pelvic area and thigh. Yamamoto died about thirty-

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¹Claire Spiegel, *Hospital's Care Of Deputy Probed*, L.A. TIMES, Nov. 15, 1993, Part B, at 1, col. 2.

²*Id.*

³Ralph Frammolino & Virginia Ellis, *Gross Negligence In Case At King Hospital Alleged*, L.A. TIMES, July 21, 1995, Part A, at 1.

two hours after surgery and a coroner later ruled that Yamamoto had died from massive bleeding, shock, and lung damage caused by his wounds.⁴

Yamamoto was buried in April, 1992 with a hero's funeral that drew nearly 4,000 uniformed officers from all over Southern California.⁵ In May, 1992, the Los Angeles County District Attorney's Office and California Medical Board began an investigation after informants alleged that other factors led to Yamamoto's death.⁶ Newspaper reports suggest this investigation was launched after the Sheriff's Department received complaints about Yamamoto's treatment.⁷ The matter was also brought to the attention of the state medical board who asked King hospital in May, 1992 to turn over Yamamoto's medical records.⁸

Deputy District Attorney Brian Kelberg, head of the office's medicolegal division, launched an investigation into Yamamoto's death. Working with investigators from the California Medical Board and the Sheriff's homicide division, Kelberg interviewed eight physicians in addition to various nurses and paramedics.⁹ The first few physicians interviewed by Kelberg "came back really shaken" and expressed concern about being there without legal representation. Newspapers reported that the former medical director at King asked Los Angeles County counsel's office to represent the King physicians at subsequent interviews by Kelberg, but this request was initially refused.¹⁰ The physicians were, therefore, forced to hire a private attorney. After the physicians' private attorney objected to the interviews, Kelberg resorted to the use of a county grand jury summons to continue his investigation.

One of the King physicians brought before the grand jury to testify was Dr. Rosalyn Sterling Scott. Dr. Scott was highly regarded in medical circles as being the first black woman in the country certified as a thoracic surgeon.¹¹ Dr. Scott was no stranger to high profile cases: She operated on a senator who'd been shot, a SWAT team member who accidentally

⁴*Id.*

⁵*See* Spiegel, *supra*, note 1.

⁶*See* Frammolino & Ellis, *supra*, note 3.

⁷*See* Spiegel, *supra*, note 1.

⁸*Id.*

⁹*Id.*

¹⁰*Id.*

¹¹Julie Marquis, *Vindication Came Hard For Doctor In Deputy's Death*, L.A. TIMES, Dec. 8, 1997, Part A, at 1.

shot himself, and a little girl gunned down in a schoolyard.¹² Newspaper reports indicate that Scott and others were questioned before the grand jury. These reports indicate that on the advice of her attorney, Scott invoked her Fifth Amendment rights.¹³

Kelberg told newspapers he was examining the amount of time Dr. Scott, the attending physician in charge, was present during Yamamoto's treatment.¹⁴ Records provided to the medical board reportedly indicated that Dr. Scott signed several medical prescriptions for Yamamoto, but he entered virtually no patient care notes.¹⁵ In addition, newspaper reports indicate Kelberg was also focusing on the administration of two cardiac drugs -- Verapamil and Labetalol -- shortly before Yamamoto's death. Kelberg reportedly questioned whether the administration of these drugs by Dr. Jonathan Heard was appropriate.¹⁶ Also under investigation, was whether Yamamoto was over-transfused with blood and overloaded with fluids prior to his death.¹⁷ Although Kelberg allegedly admitted to newspapers that the surgeons did a "first class job" in repairing Yamamoto's colon and intestine and tying off blood vessels in his pelvic area and thigh, he added he was concerned about the amount of blood and fluid Yamamoto received during and after surgery.¹⁸

In the summer of 1995, the results of the two and one-half year joint investigation by the District Attorneys' office and the California Medical Board into Yamamoto's death were released in a 160-page report.¹⁹ The report criticized the physicians at King for pumping so much blood into Yamamoto during surgery that some had to be drained afterward.²⁰ The report also criticized the physicians for what one of the medical experts said was the "ridiculous" mistake of mixing the heart drugs -- a deadly error that could have been avoided by reading the standard physician's reference manual.²¹ Newspapers reporting on this case obtained a copy of the report and quoted the report as stating, "The evidence ... clearly

¹²*Id.*

¹³*Id.*

¹⁴Spiegel, *supra*, note 1.

¹⁵*Id.*

¹⁶*Id.*

¹⁷*Id.*

¹⁸*Id.*

¹⁹See Frammolino & Ellis, *supra*, at note 3.

²⁰*Id.*

²¹*Id.*

established that an immediate cause of Deputy Yamamoto's death was the inappropriate administration of two cardiac drugs, Verapamil and Labetalol, by Dr. Jonathan Heard, compounded by the overall mismanagement of Deputy Yamamoto's postoperative condition ... by Dr. Sterling Scott and Dr. Heard."²² These same newspaper reports indicated that Los Angeles County District Attorney Gil Garcetti decided not to file criminal charges in this case.²³ Reportedly, Garcetti determined that, although there was enough to charge Heard with involuntary manslaughter, he decided not to file a case primarily because juries are reluctant to send physicians to jail for mistakes made in good faith, no matter how grievous.²⁴

Undaunted by the District Attorney's decision not to file criminal charges, the California Medical Board, in July, 1995, filed administrative charges against four of the physicians who treated Yamamoto.²⁵ The medical board sought to strip the licenses of these four physicians and among those charged by the board was King's vice chairwoman of surgery, Dr. Rosalyn Sterling Scott. Following the release of the report and the issuance of charges by the Medical Board, the county abruptly pulled Scott from clinical practice.²⁶ Newspaper reports quoted Scott as stating she felt branded as "a murderer,"²⁷ and that she "decided not to go quietly."²⁸

Outrage within the medical community quickly followed the Medical Board's actions in the Yamamoto case. Many highly regarded physicians stepped up to defend Dr. Scott and the other physicians subjected to charges by the Medical Board. Newspapers reported Dr. Robert Replegle, former president of the Society of Thoracic Surgeons, as stating "[i]f this happens, when patients come in filled full of bullets, physicians are going to lock the doors This one had to be stopped."²⁹ Dr. Brian Johnston, former president of the Los Angeles County Medical Association,

²²*Id.*

²³*Id.*

²⁴*Id.*

²⁵*Id.*

²⁶*See* Marquis, *supra*, note 11.

²⁷*Id.*

²⁸*Id.*

²⁹*Id.*

described the investigation as “a search for a scapegoat and that turned out to be Dr. Scott.”³⁰

Newspaper reports provided ammunition for defenders of Dr. Scott. These reports cited to the April, 1992 autopsy report which stated that Yamamoto died from his gunshot wounds, the type that can cause death “even with excellent medical and surgical attention.”³¹ These newspaper reports also stated early reviews of the Yamamoto case by local physicians -- both inside and outside King -- found the care met medical standards as well.³² The newspaper reports went on to suggest the Medical Board’s actions against Scott and the other physicians were politically motivated by recent bad press.³³ At the beginning of 1993, an investigative report concluded the Board had disposed of hundreds of complaints against physicians in 1990 to clear a growing backlog.³⁴

Committees of both the Society of Thoracic Surgeons and the Los Angeles County Medical Association independently reviewed the medical records, and concluded the care met medical muster.³⁵ In 1997, after the Medical Board consulted with a wider array of experts and had a physician interview Scott, it dropped the accusations against Scott and Heard.³⁶ The Board, however, tried to force the two physicians to take competency examinations and both refused.³⁷ Ultimately, Heard took the exam and passed.³⁸ In August, 1997, the board notified Scott she would not be required to take the test after all.³⁹

As of December, 1997 Scott had yet to be restored to her clinical duties. In an interview with the *Los Angeles Times*, Scott provided insight into her resolve to defend herself stating, “most physicians when they get into a situation like this, they try to settle, they want it to go away I was not going to allow the D.A. and the Medical Board to push me into taking any position that would represent anything short of complete

³⁰*Id.*

³¹*Id.*

³²*Id.*

³³*Id.*

³⁴*Id.*

³⁵*Id.*

³⁶*Id.*

³⁷*Id.*

³⁸*Id.*

³⁹*Id.*

vindication.”⁴⁰ Whether complete vindication was in fact achieved is questionable as this case likely left permanent “scars,” both professional and emotional, on Dr. Scott and others whose care was the focus of the Yamamoto investigation.

Media fascination with criminal prosecutions of health care providers for negligence which causes injury or death appears to be at an all time high. These cases are typically viewed as “high-profile” cases as they involve criminal sanctions against health care professionals, rather than the payment of damages. The prospect of a physician, nurse, lab technician, or other health care professional being convicted of “criminal activity” and facing possible imprisonment captures the curiosity of the public and makes for “good copy.” At the outset, this Article will explore the history of criminal prosecutions of health care providers for “negligent” conduct that causes injury or death. The Article will also highlight some of the more recent cases which resulted in criminal prosecutions against health care providers in relation to patient care.

PEOPLE v. MILOS KLVANA

The criminal prosecution of physicians for negligence which causes death or serious injury can be traced back to the case brought against Milos Klvana and his conviction on nine counts of second-degree murder.⁴¹ Interestingly, Klvana was prosecuted and convicted by the same unit of the Los Angeles County District Attorney’s Office that was subsequently responsible for the investigation into the death of Officer Yamamoto. Newspapers, in fact, noted that the same unit of the District Attorneys’ office investigating the Yamamoto case also prosecuted Klvana and was the first in the country to convict a physician of murder due to poor care.⁴²

⁴⁰*Id.*

⁴¹*People v. Klvana*, 11 Cal. App. 4th 1679, 15 Cal. Rptr. 2d 512 (Cal. App. 2 Dist. 1992). In addition to being convicted of second-degree murder (PEN. CODE § 187, subd. (a)), Klvana was also convicted of five counts of aiding and abetting the practice of medicine without a license (BUS. & PROF. CODE § 2053), one count of conspiracy to practice medicine without a license (Sec. 182/BUS. & PROF. CODE § 2053), nineteen counts of preparing false insurance claims (INS. CODE § 556, subd. (a)(3)), ten counts of presenting false insurance claims (INS. CODE § 556, subd. (a)(1)), two counts of grand theft (PEN. CODE § 487, subd. (1)) and two counts of perjury (PEN. CODE § 118).

⁴²*See Marquis, supra* note 11.

Klvana attended medical school in Czechoslovakia and obtained a degree in 1967.⁴³ In July, 1972, he began a four-year residency program in New York, but resigned when he failed to become Chief Resident.⁴⁴ Klvana applied for and was granted a California medical license and was accepted into a two-year anesthesiology residency at Loma Linda University Hospital (Loma Linda).⁴⁵ In late 1976, Loma Linda's reviewing faculty concluded that Klvana was responsible for a patient's death due to his failure to closely monitor the effects of drugs administered and to detect early signs of depression and inadequate breathing which resulted in cardiac arrest.⁴⁶ After Klvana was informed that he would not be reappointed to Loma Linda's residency program, he resigned on December 16, 1976.⁴⁷ Between 1977 and 1982, a pattern emerged where Klvana applied for privileges at various hospitals, many times failing to disclose his Loma Linda residency or his probationary status,⁴⁸ and misrepresenting his board eligibility.⁴⁹ On December 20, 1980 Klvana purchased the Diet-Rite Medical Clinic, and it was at this clinic where he came in contact with patients whose care ultimately became the subject of his arrest and criminal conviction.

The Johnson Death

When Kathleen Johnson became pregnant in 1982, she sought a physician who would agree to a vaginal delivery because she had been displeased with the manner in which a previous Cesarean section delivery had been handled.⁵⁰ Johnson responded to Klvana's advertisement in the Yellow Pages.⁵¹ Klvana did not inform Johnson of any risks associated with a

⁴³*Klvana*, 15 Cal. Rptr. 2d at 515.

⁴⁴*Id.*

⁴⁵*Id.*

⁴⁶*Klvana*, 15 Cal. Rptr. 2d at 515.

⁴⁷*Id.*

⁴⁸On March 14, 1980, following Klvana's misdemeanor conviction of 26 counts of prescribing controlled substances without a good faith examination, Klvana's license was placed on probation for five years by the Board of Medical Quality Assurance (BMQA). In his applications for privileges at Hollywood Presbyterian and Valley Vista, and for permission to supervise a physician's assistant filed with the California Physician's Assistant Examination Committee, Klvana misrepresented that his medical license had never been limited, suspended, revoked or otherwise disciplined. *Id.*

⁴⁹*Id.* at 516.

⁵⁰*Id.*

⁵¹*Klvana*, 15 Cal. Rptr. 2d at 516.

vaginal delivery following two Cesarean section deliveries, and assigned a December 10, 1982 due date.⁵² Johnson later inquired into the availability of an alternative birthing center and Klvana informed her he was preparing a birthing room in his office since he was concerned about the influence and pressure other practitioners might exert on Johnson regarding a Cesarean section.⁵³ On December 14, 1982, Johnson had an office visit with Klvana. Already past her due date, Klvana told Johnson he miscalculated her due date and not to worry about not yet delivering.⁵⁴

Johnson began labor on December 23, 1982 and went to Klvana's office. After declining Klvana's suggestion that she have her membranes ruptured in order to hasten delivery, Johnson was sent home with instructions to call when her labor progressed.⁵⁵ Johnson returned to Klvana's office the next morning and he determined she was only dilated three centimeters.⁵⁶ Klvana administered Pitocin to Johnson, but failed to use an infusion pump or electronic fetal monitor during the drug's administration.⁵⁷ With Johnson's husband holding the bag of intravenous Pitocin solution in the air, she began to have intense contractions.⁵⁸ Klvana occasionally checked the fetus's heart rate, took Johnson's blood pressure and pulse only once, and never adjusted the infusion rate of the Pitocin.⁵⁹ After the delivery of a baby girl, in response to Johnson's concern that her baby did not seem responsive, Klvana stated the baby was breathing normally.⁶⁰ Klvana indicated the Johnson baby was fine and did not make an appointment for the baby to see a pediatrician the following day.⁶¹

Later that night, the baby girl cried and refused to eat.⁶² The following morning, she developed seizures and labored breathing.⁶³ Klvana suggested the problem was low blood sugar and that "it was probably better [for the baby] not to go to the hospital because

⁵²*Id.* at 516.

⁵³*Id.*

⁵⁴*Id.* at 517.

⁵⁵*Id.*

⁵⁶*Id.*

⁵⁷*Klvana*, 15 Cal. Rptr. 2d at 517.

⁵⁸*Id.*

⁵⁹*Id.*

⁶⁰*Id.*

⁶¹*Klvana*, 15 Cal. Rptr. 2d at 517.

⁶²*Id.*

⁶³*Id.*

[hospitalization] would probably result in unnecessary intervention."⁶⁴ Klvana recommended the baby be given sugar water, which the baby refused.⁶⁵ The baby's breathing continued to be labored until she stopped breathing.⁶⁶ Efforts at CPR were unsuccessful and the baby was pronounced dead at the hospital.

An autopsy determined the baby girl's cause of death was respiratory distress syndrome and hyaline membrane disease.⁶⁷ A pediatric pathology expert subsequently concluded that perinatal asphyxia was the most likely cause of death.⁶⁸

The Fava Death

Joanne Fava became pregnant in 1983 and visited Dr. Klvana's office in March of that year.⁶⁹ Klvana estimated a due date between August 10, and 25, 1983.⁷⁰ On August 24, 1983, after Fava's water broke, Fava and her family met Klvana at his office.⁷¹ After examining Fava, Klvana indicated she was not ready to deliver and stated she should return home.⁷² Later that evening, Fava's contractions grew stronger and she and her family returned to Klvana's office.⁷³ Klvana examined Fava while one of Fava's relatives (who worked for Klvana) monitored the fetus's heartbeat with a stethoscope.⁷⁴ After several hours, Fava repeatedly requested Klvana to perform a Cesarean section delivery.⁷⁵ Klvana said it would take up to two hours to set up the surgery, and he would instead induce labor.⁷⁶ Klvana administered a drug intravenously and sometime later added something to the intravenous line which he indicated was to induce labor.⁷⁷ Fava's relative notified Klvana that the fetus's heartbeat was very

⁶⁴*Id.*

⁶⁵*Id.*

⁶⁶*Klvana*, 15 Cal. Rptr. 2d at 517

⁶⁷*Id.*

⁶⁸*Id.*

⁶⁹*Id.*

⁷⁰*Id.*

⁷¹*Klvana*, 15 Cal. Rptr. 2d at 518.

⁷²*Id.*

⁷³*Id.*

⁷⁴*Id.*

⁷⁵*Id.*

⁷⁶*Klvana*, 15 Cal. Rptr. 2d at 518.

⁷⁷*Id.*

faint, yet Klvana did not send Fava to a hospital.⁷⁸ Klvana thereafter examined Fava and determined the fetus had died.⁷⁹ Klvana informed Fava of the fetus's death and, along with Fava's family members, pushed on Fava's abdomen; the dead body of a six pound, thirteen ounce fetus was delivered.⁸⁰

In June, 1985, when Fava asked Klvana for birth and death certificates, Klvana indicated that he was being investigated and did not prepare either document.⁸¹ Klvana allegedly requested that Fava not tell anyone that she gave birth.⁸²

The James Death

In August 1983, Julie James began seeing Dr. Klvana for management of her pregnancy. On October 10, 1983, James visited Klvana's office and was dilated three or four centimeters.⁸³ Klvana administered Pitocin and James began to have harder contractions.⁸⁴ James was never connected to an electronic fetal monitor and Klvana moved her to the waiting room so he could attend to another patient in the birthing room.⁸⁵ When Klvana was through with the other patient, he stopped administering Pitocin to James and told her to return to the office the following day.⁸⁶

When James returned, the receptionist allegedly told her Klvana was too busy with other patients to attempt to induce labor.⁸⁷ Later, when Klvana examined James she was dilated four centimeters and he broke her water.⁸⁸ James, was told to call Klvana when she went into labor.⁸⁹ James called Klvana when the contractions were fifteen to twenty minutes apart.⁹⁰ Pursuant to Klvana's instructions, she again called when the contractions were five, four, and three minutes apart.⁹¹ Klvana met James

⁷⁸*Id.*

⁷⁹*Id.*

⁸⁰*Id.*

⁸¹*Klvana*, 15 Cal. Rptr. 2d at 518.

⁸²*Id.*

⁸³*Id.*

⁸⁴*Id.*

⁸⁵*Id.*

⁸⁶*Klvana*, 15 Cal. Rptr. 2d at 518

⁸⁷*Id.*

⁸⁸*Id.*

⁸⁹*Id.*

⁹⁰*Id.*

⁹¹*Klvana*, 15 Cal. Rptr. 2d at 518.

at his office; she was dilated nine centimeters and Klvana administered Pitocin.⁹² At approximately 11 o'clock in the morning, Klvana and the baby's father began physically pushing on James' abdomen.⁹³ During the last hour of James' labor, Klvana monitored the fetus's heart rate with a stethoscope.⁹⁴

Upon delivery of a baby girl, Klvana took the baby to a small bathtub, flushed her with water, and massaged her chest.⁹⁵ He left the room with the baby, leaving James, who was bleeding heavily, on the bed.⁹⁶ Klvana thereafter informed the parents the baby had died and made two injections into James' uterus, telling her the injections would stop the bleeding, but this was not successful.⁹⁷

James inquired about an autopsy and was told by Klvana that an autopsy would cost \$1,500.⁹⁸ Klvana allegedly recommended James bury the baby in her backyard, not tell anyone about the death, and take a vacation to Hawaii.⁹⁹ An autopsy was conducted, which found swelling and bleeding under the scalp and concluded the cause of death was a lack of oxygen at the time of birth.¹⁰⁰ The autopsy revealed no evidence of *Id.* hypoplasia of the lung, the cause of death listed by Klvana on the death certificate.¹⁰¹

The foregoing represents only three of the several cases summarized in the decision of the California Court of Appeals which affirmed the conviction of Dr. Klvana.¹⁰² The appellate court, in affirming the conviction of Klvana, made note of the expert testimony introduced at trial to support the verdict against him. A board certified obstetrician and gynecologist testified that continuous electronic fetal monitoring and administration by an infusion pump are necessary when Pitocin is used to induce or augment labor.¹⁰³ Another expert, a board certified obstetrician

⁹²*Id.*

⁹³*Id.*

⁹⁴*Id.*

⁹⁵*Id.*

⁹⁶*Klvana*, 15 Cal. Rptr. 2d at 519.

⁹⁷*Id.* at 518. A footnote to this opinion indicates that James continued to bleed for six weeks.

⁹⁸*Id.*

⁹⁹*Id.*

¹⁰⁰*Id.*

¹⁰¹*Klvana*, 15 Cal. Rptr. 2d at 519.

¹⁰²*Id.*

¹⁰³*Id.* at 525.

and gynecologist with a subcertification in high risk obstetrics, testified his review of the deliveries at issue revealed the following recurring events: use of Pitocin without adequate fetal monitoring, unmanaged signs of fetal distress, failure to adequately perform neonatal resuscitation, failure to transfer sick babies to the hospital, and failure to transfer high risk mothers for hospital deliveries.¹⁰⁴ This expert also testified Klvana's history in his residencies, his repeated loss of hospital privileges,¹⁰⁵ and

¹⁰⁴*Id.*

¹⁰⁵Klvana's hospital privilege history is as follows:

Granada Hills Hospital, California

Applied: November, 1976

Granted: May 24, 1977

Reappointed: 1982 and 1983

Resigned: October 18, 1983

Northridge Hospital, California

Provisional: February 14, 1977

Associate: November 28, 1978

Provisional reappointment granted: March 19, 1979

Reapplication granted: November 28, 1979

Reapplication granted: August 1981

Resigned: January 31, 1983

Henry Mayo Hospital, California

Applied: April 25, 1977

Granted: September 19, 1977

Revoked: December 18, 1980

Reapplication: August 21, 1981

Delivered baby without privileges: October 9, 1981

Application denied: February 11, 1982

Reapplication: May 10, 1983 (denied)

Hollywood Presbyterian Hospital, California

Applied: March 17, 1980

No action taken due to BMQA probation

Valley Vista Hospital, California

Temporary admitting/clinical privileges: January 15, 1982

Applied: February 20, 1982

Denied: April 22, 1982

Temporary admitting/clinical privileges suspended: May 7, 1982

East Los Angeles Hospital, California

Applied: May 31, 1982

Granted: June 16, 1982

Letter regarding unacceptable quality: April 18, 1984

Letter regarding ineffectual tubal ligation/privileges

Revoked: February 7, 1985

Revoked: February 27, 1985

Letter regarding below standard of care: March 19, 1985

Removed from medical staff: April 10, 1985.

repeated warnings by other physicians served notice on Klvana that "he had difficulty in judgment making, particularly regarding the management of obstetric patients."¹⁰⁶ Based on the evidence, this expert concluded it was impossible to believe Klvana was not aware of the risks he was disregarding.¹⁰⁷

Following his conviction of nine counts of second degree murder and other related charges, Klvana appealed the jury verdict, challenging the sufficiency of the evidence to support the jury's verdict, and claiming error with regard to various evidentiary rulings. The California Court of Appeals rejected all of Klvana's arguments and affirmed the judgment against him. In its decision, the Court stated after reviewing the evidence, "we conclude sufficient evidence was presented from which the jury could reasonably infer that Klvana was subjectively aware his methods of home and office deliveries were life-endangering, but consciously and deliberately disregarded these risks."¹⁰⁸

The Court analyzed applicable statutes and noted "[s]econd degree murder based on implied malice is committed when the defendant does not intend to kill, but engages in conduct which endangers the life of another, and acts deliberately with conscious disregard for life."¹⁰⁹ An essential distinction between second degree murder based on implied malice and involuntary manslaughter based on criminal negligence is that in the former, the defendant subjectively realizes the risk to human life created by his conduct, whereas in the latter the defendant's conduct objectively endangers life, but he does not subjectively realize the risk.¹¹⁰ Implied malice, like all other elements of a crime, may be proven by circumstantial evidence.¹¹¹ Whether the evidence presented at trial is direct or circumstantial, the relevant inquiry on appeal remains whether any reasonable trier of fact could have found the defendant guilty beyond

See id. at 516-17.

¹⁰⁶*Klvana*, 15 Cal. Rptr. 2d at 525.

¹⁰⁷*Id.*

¹⁰⁸*Id.* at 526.

¹⁰⁹*Id.*; *see also* WEST'S ANN. CAL. PENAL CODE § 187(a).

¹¹⁰*Klvana*, 15 Cal. Rptr. 2d at 526 (citing *People v. Brito*, 232 Cal. App. 3d 316, 321 fn. 4 (1991)).

¹¹¹*Id.* (citing *People v. Bloyd*, 43 Cal. 3d 333, 346-347, 233 Cal. Rptr. 368, 729 P. 2d. 802 (1987)).

a reasonable doubt.¹¹² The Court of Appeals then concluded the jury was presented with overwhelming evidence from which it could conclude beyond a reasonable doubt that implied malice existed when Klvana performed each delivery which formed the basis of the second degree murder conviction.¹¹³ Klvana was sentenced to forty-five years to life for three counts of second degree murder and the Court of Appeals upheld the sentence of the trial court.¹¹⁴

UNITED STATES v. DONAL M. BILLIG

Commander Donal Billig was a cardiothoracic surgeon and the head of the Cardiothoracic Surgery Department at Naval Hospital, Bethesda, Maryland (Bethesda) from June, 1983 to March, 1985.¹¹⁵ Dr. Billig was charged with twenty-four specifications of willful dereliction of duty arising out of his alleged failure to have a supervisory surgeon present during various open heart surgeries performed during the summer of 1983.¹¹⁶ He was also charged with five specifications alleging involuntary manslaughter arising out of coronary artery bypass surgeries performed at Bethesda between March, 1983 and November, 1984.¹¹⁷ This section will focus on several instances of care that were the subject of charges brought against Dr. Billig.

The Kas Operation

On October 29, 1984, Drs. Billig and Haggerson operated on Lieutenant Colonel Kas (Kas). Kas was sixty-seven years old and had coronary artery disease and aortic stenosis.¹¹⁸ The surgery performed on Kas involved replacing his aortic valve and installing two coronary artery bypass grafts. Dr. Haggerson was the primary surgeon and Dr. Billig was

¹¹²*Klvana*, 15 Cal. Rptr. 2d at 526 (citing *People v. Towler*, 31 Cal. 3d. 105, 118-119, 181 Cal. Rptr. 391, 641 P. 2d 1253 (1982)).

¹¹³*Id.*

¹¹⁴*Id.* at 531.

¹¹⁵*United States v. Donal M. Billig*, 26 M.J. 744 (1988).

¹¹⁶*Id.*

¹¹⁷*Id.*

¹¹⁸*Id.* at 749. Aortic stenosis is a narrowing of the aortic valve which impedes the flow of blood from the left ventricle into the aorta.

the first assistant and supervisor.¹¹⁹ During the course of the operation, a number of difficulties were encountered.¹²⁰

The first problem involved the inadvertent initial grafting of a saphenous vein to a coronary vein rather than to a coronary artery.¹²¹ The mistake was discovered and the bypass was then properly grafted to a coronary artery.¹²² This misidentification of a vein as an artery, however, added about thirty minutes to the limited time that can be safely spent on the cardiopulmonary bypass machine.¹²³

The surgeons then preceded to replace the aortic valve. Difficulty was encountered in getting the new valve seated properly in the aorta because blood blocked the surgeons' field of vision.¹²⁴ Ultimately, the surgeons successfully seated and tied down the new valve.¹²⁵ The aorta was closed and the surgeons began to wean the patient off the bypass machine.¹²⁶ In the process of coming off the bypass, the vent was removed and the wound was closed by pulling the purse-string sutures together.¹²⁷ During this procedure, however, some of the sutures tore through the heart tissue and bleeding ensued.¹²⁸ Kas was placed back onto the bypass machine and the appropriate repairs were accomplished.¹²⁹ As the surgeons prepared to close the chest, the tear redeveloped.¹³⁰ Dr. Billig elected to repair the bleeding site without putting the patient back onto the bypass machine and he placed another pledgeted suture onto the area of bleeding by lifting the heart to expose the apex and accomplish the repair.¹³¹ The lifting of the heart, however, caused a drop in blood pressure and damaged the myocardium (heart muscle), which became

¹¹⁹*Id.*

¹²⁰*United States v. Donal M. Billig*, 26 M.J. 744, 749 (1988).

¹²¹*Id.* A saphenous vein is described as a large, superficial blood vessel removed from the leg and grafted onto the heart during bypass surgery to deliver blood around blocked coronary arteries.

¹²²*Id.*

¹²³*Id.* Blood is circulated through a cardiopulmonary bypass machine during that portion of the operation when the heart is stopped.

¹²⁴*United States v. Donal M. Billig*, 26 M.J. 744, 750-51 (1988).

¹²⁵*Id.* at 751.

¹²⁶*Id.*

¹²⁷*Id.*

¹²⁸*Id.*

¹²⁹*Billig*, 26 M.J. at 750.

¹³⁰*Id.* at 751.

¹³¹*Id.*

edematous (swollen).¹³² Because of the swelling, the patient's chest could not be closed after repairs to the apex were completed.¹³³ The surgeons decided to pack the chest with sterile dressing and bring the patient into the intensive care unit to allow the cardiac function to stabilize and the swelling to reduce.¹³⁴ It was anticipated that the swelling would dissipate within forty-eight to seventy-two hours, at which time the chest could be safely closed.¹³⁵

As Kas was being positioned for a chest x-ray, around 19:00 (7:00 p.m.), heavy bleeding from Kas's chest was discovered by a unit nurse.¹³⁶ At 19:30 Dr. Haggerson unpacked the chest and began replacing the soaked dressings with new ones.¹³⁷ Dr. Billig arrived at 20:14 and initiated attempts to stop the bleeding by suturing the apex of the heart.¹³⁸ When Dr. Billig began the suturing, however, Kas went into cardiac arrest, requiring Dr. Haggerson to begin open heart massage.¹³⁹ After about fifteen minutes of heart massage, Dr. Haggerson's thumb went through the right ventricle and the patient exsanguinated.¹⁴⁰

The Estep Case

Mr. Estep was a sixty-six-year-old retired United States Navy Petty Officer with a long history of coronary artery disease which included two previous heart attacks, the most recent of which occurred two months prior to surgery.¹⁴¹ He was referred to surgery because of "significant triple artery disease and impaired ventricular function."¹⁴² Tests performed prior to surgery revealed a severely damaged left ventricle with total occlusion of at least two major coronary arteries.¹⁴³ He underwent quadruple bypass surgery on October 18, 1994 with Dr. Haggerson as the primary surgeon and Dr. Billig as the first assistant and supervisor.¹⁴⁴

¹³²*Id.*

¹³³*Id.*

¹³⁴*Billig*, 26 M.J. at 751.

¹³⁵*Id.*

¹³⁶*Id.*

¹³⁷*Id.*

¹³⁸*Id.*

¹³⁹*Billig*, 26 M.J. at 751.

¹⁴⁰*Id.*

¹⁴¹*Id.* at 753.

¹⁴²*Id.*

¹⁴³*Id.*

¹⁴⁴*Billig*, 26 M.J. at 753.

The initial surgical plan was to fashion a bridge graft (one saphenous vein feeding two coronary arteries) from the aorta to the left anterior descending artery (LAD) and then to the left diagonal artery.¹⁴⁵ Separate bypass grafts were also planned from the aorta to the right coronary artery and circumflex coronary artery.¹⁴⁶ After grafting the first saphenous vein to the left diagonal artery, the surgeons prepared to graft onto the LAD; however, during preparation, they discovered the artery was too small to properly accept a graft, and thus decided not to graft onto that artery.¹⁴⁷ The opening was sewn shut, but bleeding continued.¹⁴⁸ Dr. Billig then decided to ligate (tie off) the LAD altogether.¹⁴⁹ The remaining bypasses were grafted apparently without incident, using saphenous veins with a lumen (hollow opening) of approximately six millimeters grafted to coronary arteries with lumens ranging between 1.3 and 2 millimeters.¹⁵⁰

Estep was cared for in the intensive care unit (ICU) for four days after surgery without serious complications.¹⁵¹ On the fifth day, however, he went into cardiac arrest.¹⁵² Dr. Haggerson began resuscitation efforts by reopening the chest and starting open heart massage.¹⁵³ After about forty five minutes of massage, the patient's right ventricle eroded to the point that Haggerson's thumb ruptured through the heart wall and the patient died.¹⁵⁴

The Grubb Surgery

Major Grubb was a seventy-three-year-old retired United States Army officer with a history of coronary artery disease and a previous heart attack.¹⁵⁵ Upon admission to Bethesda, he was suffering from severe angina (chest pain) and tests performed prior to surgery revealed partial occlusions of both the LAD and the diagonal artery, as well as the

¹⁴⁵*Id.*

¹⁴⁶*Id.*

¹⁴⁷*Id.*

¹⁴⁸*Id.*

¹⁴⁹*Billig*, 26 M.J. at 753.

¹⁵⁰*Id.* at 753-54.

¹⁵¹*Id.* at 754.

¹⁵²*Id.*

¹⁵³*Id.*

¹⁵⁴*Billig*, 26 M.J. at 754.

¹⁵⁵*Id.* at 755.

complete occlusion of the right coronary artery.¹⁵⁶ Grubb underwent bypass surgery on August 8, 1984.¹⁵⁷

The operation, like the others, was performed by Dr. Haggerson as the primary surgeon and Dr. Billig as the first assistant and supervisor.¹⁵⁸ Prior to surgery, two grafts were planned -- a single graft from the aorta to the posterior descending branch of the right coronary artery, and a bridge graft going sequentially to the LAD and to the left diagonal artery.¹⁵⁹ During surgery it was decided instead to connect the single graft from the right coronary artery to the LAD bridge graft, thereby creating a "Y" graft and leaving one saphenous vein feeding the three bypasses.¹⁶⁰ After grafts were completed, the patient was successfully weaned off the bypass machine.¹⁶¹ In short, the operation proceeded well and was completed without significant incident.¹⁶²

Grubb entered the ICU at 15:00 (3:00 p.m.) and nurses' notes reflected his condition was relatively stable until approximately 19:30 when his blood pressure started to drop.¹⁶³ Attempts initiated to increase this pressure were largely unsuccessful and, at 20:50, Grubb went into heart block and cardiac arrest occurred.¹⁶⁴ His pacemaker, which had not been activated, was immediately turned on and his heart was restarted.¹⁶⁵ Approximately one hour later, however, Grubb's heart arrested again and he died despite resuscitation efforts.¹⁶⁶

In the *Kas* case, Dr. Billig was charged with and convicted of involuntary manslaughter.¹⁶⁷ The Government alleged three main acts or

¹⁵⁶*Id.* at 755-756.

¹⁵⁷*Id.* at 756.

¹⁵⁸*Id.*

¹⁵⁹*Billig*, 26 M.J. at 756.

¹⁶⁰*Id.* There was conflicting testimony as to why the decision was made to use the "Y" graft instead of the planned dual graft bypass. Dr. Haggerson testified that the "Y" graft was used because the surgeons cut the saphenous vein too short, and thus the vein was not able to reach from the coronary artery to the aorta. Dr. Billig testified, however, that the "Y" graft was used because the aorta was discovered to be "tortuous and friable," that is, very brittle. Using the "Y" graft, according to Dr. Billig, was necessary because he did not want to place two holes in the fragile aorta.

¹⁶¹*Id.*

¹⁶²*Id.*

¹⁶³*Id.*

¹⁶⁴*Billig*, 26 M.J. at 756.

¹⁶⁵*Id.*

¹⁶⁶*Id.*

¹⁶⁷*Id.* at 751.

omissions by Dr. Billig constituted culpable negligence.¹⁶³ First, was his “improper placing and repairing” of the left apex vent.¹⁶⁹ Second, was his “improperly identifying and grafting a saphenous vein graft to a coronary vein rather than the posterior descending coronary artery.”¹⁷⁰ The third was his “improperly overmanipulating or improperly allowing to be overmanipulated, the tissue of the heart, thereby wrongfully causing inadequate myocardial protection, excessive cardiac strain, edema, and hemorrhage.”¹⁷¹

In the *Estep* case, Dr. Billig was charged with and convicted of the culpably negligent killing of Estep by “improperly selecting or allowing to be selected, saphenous vein conduits and coronary arterial connection sites, improperly sewing or allowing to be improperly sewn, saphenous vein connections, and improperly damaging or allowing to be improperly damaged, the left anterior descending artery, thereby creating impeded coronary artery perfusion.”¹⁷² The bulk of the prosecution’s case centered on two allegedly culpable acts -- Dr. Billig’s decision to ligate the LAD, and the improper sewing of the saphenous vein grafts to the coronary arteries (the saphenous veins being too large in comparison to the arteries), thus causing blood clotting, inadequate blood flow to the heart and, ultimately, death.¹⁷³

In the *Grubb* case, Dr. Billig was charged with involuntary manslaughter by “wrongfully fashioning or allowing to be wrongfully fashioned, saphenous vein bypass conduits in such a manner that a small conduit with an inadequate lumen was the only conduit connected to his aorta.”¹⁷⁴ He was found guilty of the lesser included offense of negligent homicide.¹⁷⁵

In addition to the foregoing, Billig’s general court-martial proceedings resulted in his being found guilty of twelve specifications of willful dereliction of duty, four specifications of negligent dereliction of duty and two specifications of dereliction of duty through culpable

¹⁶³*Id.*

¹⁶⁹*Billig*, 26 M.J. at 751.

¹⁷⁰*Id.* at 751-52.

¹⁷¹*Id.* This over manipulation refers to the lifting of the heart during surgery, not the heart massage in the ICU.

¹⁷²*Id.* at 754.

¹⁷³*Id.*

¹⁷⁴*Billig*, 26 M.J. at 756.

¹⁷⁵*Id.*

inefficiency.¹⁷⁶ He was sentenced to confinement for four years, total forfeiture of pay and allowances, and dismissal from the Naval Service.¹⁷⁷

Billig appealed his conviction and the reviewing court set aside the findings of guilt and the sentence against him. All charges and specifications against him were dismissed and all rights, privileges, and property taken from Billig by the verdict against him were restored.¹⁷⁸ In overturning Billig's conviction, the reviewing court analyzed the evidence against Billig and found it failed to support the verdict against him.

In the *Kas* case, the court rejected the notion that Billig's use of the apex vent was *per se* improper stating:

Testimony from defense and government experts alike indicates that the apex vent is an acceptable means of venting blood from the heart, although it is not used extensively because of the risk of uncontrollable bleeding and because of other less hazardous means of achieving the same result. Simply because this vent has risks inherent in its use, however, does not make its use improper In short, Dr. Billig made an informed decision to use a vent which he thought would do the best job with which he felt the most comfortable under the circumstances. In such a situation, we decline to substitute our judgment for that of a surgeon choosing a medically acceptable surgical technique.¹⁷⁹

In a footnote to this portion of its decision, the court adamantly voiced its reluctance to "second guess" medical judgments made by physicians intimately familiar with a patient's care stating:

Our refusal to second guess reasonable medical decisions made by physicians in the course of surgery is closely analogous to our refusal to question judgment calls made by attorneys during the course of providing legal representation. We will not evaluate strategic professional choices from hindsight, but from the

¹⁷⁶*Id.* at 746. Billig was found not guilty in the deaths of Lt. Colonel Harold Coplan and Lois Parent. *Navy Surgeon Is Convicted In Deaths Of 3 Patients*, N.Y. TIMES, Feb. 27, 1986, Sec. A, at 1.

¹⁷⁷*Id.* at 746.

¹⁷⁸*Id.* at 761.

¹⁷⁹*Billig*, 26 M.J. at 752.

perspective of the professional at the time such choices are made, with the presumption that the conduct was reasonable.¹⁸⁰

The court likewise found the evidence in the *Estep* case to be insufficient to support the verdict against Billig. The court bluntly stated it “simply [found] no negligence, gross or simple, on the part of Billig [in this case].”¹⁸¹ Like the *Kas* case, the court analyzed the evidence and concluded:

Both government and defense experts agree that the decision not to graft onto the LAD was proper because if the graft had been accomplished the blood flow to the left diagonal artery could have been severely compromised. What is really in issue here is the decision to ligate the artery after having chosen not to use it as part of the bridge graft. It is important to note two critical factors in this regard. First, the surgeons were faced with a bleeding artery that was irreparable. Second, the LAD was completely occluded above the sight of the incision and, therefore, there was no direct blood flow feeding the left ventricular wall of the heart In fact, the evidence shows that the surgeons acted properly throughout the operation and that ligating the artery, under these circumstances, was the only reasonable course of action.¹⁸²

The court also analyzed the evidence regarding the suturing of the saphenous veins in the *Estep* surgery, and likewise rejected the contention that the vein grafting in this case was criminally negligent.¹⁸³ The court disagreed with the Government’s contention that the bypass connections were narrowed by poor suturing techniques and noted that the saphenous veins were in fact tested by Dr. Haggerson during surgery and found to be acceptable.¹⁸⁴

Finally, the court analyzed the evidence presented in the *Grubb* case and concluded, “we do not know for certain what caused this patient’s death.”¹⁸⁵ The autopsy performed on Major Grubb listed the probable

¹⁸⁰*Id.* (citing *United States v. Scott*, 24 M.J. 186 (C.M.A. 1987), *United State v. DiCupz*, 21 M.J. 440 (C.M.A. 1986)).

¹⁸¹*Billig*, 26 M.J. at 754.

¹⁸²*Id.*

¹⁸³*Id.* at 755.

¹⁸⁴*Id.*

¹⁸⁵*Id.* at 756.

cause of death as being “attributed to a possible arrhythmia or metabolic imbalance,” and it stated that the saphenous vein grafts “were intact and patent,” or in other words, were adequately sutured and open for blood flow.¹⁸⁶ The court thereafter stated:

Given the confused and often conflicting nature of the evidence presented at trial, we find it difficult, if not impossible, to determine to any precise extent the cause of Major Grubb’s death except to say that it occurred after an operation that was supervised by Dr. Billig. Criminal liability cannot flow from such a tenuous relationship.¹⁸⁷

The court went on to note that Dr. Haggerson, and not Dr. Billig, was the primary surgeon and actually performed the suturing complained of by the Government as being the cause of Major Grubb’s death.¹⁸⁸ Nonetheless, the record reflected the saphenous vein selected for the bypass, while somewhat phlebosclerotic, was checked for adequate lumen and judged to be acceptable, and that the grafts sutured by Dr. Haggerson were tested prior to closure by means of both inserting probes into the graft and by flushing cardioplegia solution throughout the newly constructed bypass with good results.¹⁸⁹ The court therefore dismissed this case stating it “simply saw no negligent act on Dr. Billig’s part that had anything to do with the death of the patient.”¹⁹⁰

A total of seven assignments of error were raised by Billig’s attorneys with regard to the trial and verdict rendered in this case.¹⁹¹ As

¹⁸⁶*Billig*, 26 M.J. at 757.

¹⁸⁷*Id.*

¹⁸⁸*Id.*

¹⁸⁹*Id.*

¹⁹⁰*Id.*

¹⁹¹It is worth noting that one issue raised on appeal was what the appellate court labelled the “bad burgeon” theory of evidence. The court stated that the prosecution was permitted, over timely objection, to introduce evidence from numerous witnesses and documents which essentially amounted to a smear campaign to portray Dr. Billig as a bungling, one-eyed surgeon who should have known better than even to enter an operating room because of his past mistakes and poor eyesight. The court stated this tactic should not have been permitted by the military judge and went on to state:

The appellant was forced not only to defend against the charges, but also to explain and account for virtually all of his mistakes, professional setbacks, or surgical misadventures during the previous 20 years. Although some of this evidence may have been admissible to establish awareness of his surgical

stated previously, the findings of guilty and the sentence were set aside. In this regard, the court concluded its opinion by stating, "we are not convinced beyond a reasonable doubt that the deaths that formed the basis of the appellant's conviction were due to any negligence, simple or otherwise, on his part."¹⁹²

Newspaper reports provided insight into the impact Dr. Billig's conviction had on his professional career. These reports indicated that Billig lost his medical licenses in New York, Texas, Massachusetts, and Pennsylvania as a result of his 1986 conviction.¹⁹³ Billig's statements following his release from a military prison are likewise insightful:

It's my belief I've been precluded from any further clinical care just by the nature of what's happened," Billig told a Washington Post reporter several weeks after he was released from a military prison at Fort Leavenworth, Kansas, where he had served twenty-five months of a four-year sentence. "There's no way I can make a decision on a patient, knowing you have to take risks."¹⁹⁴

In 1993, newspapers reported that Billig had his medical licenses restored and had also obtained new unrestricted licenses in Maryland, Virginia, and the District of Columbia.¹⁹⁵ This same story indicated that Billig was seeing patients six days a week as a partner in a seven-member group practice in Virginia.¹⁹⁶ Billig's attorney indicated he was practicing internal medicine and is not performing surgery because he "elected not

The appellant was forced not only to defend against the charges, but also to explain and account for virtually all of his mistakes, professional setbacks, or surgical misadventures during the previous 20 years. Although some of this evidence may have been admissible to establish awareness of his surgical limitations, we are of the general opinion that as to much of this evidence, Military Rules of Evidence 401, 402, 403 and 404 were either incorrectly applied or were ignored altogether. This "bad surgeon" theory permeated the trial proceedings and undoubtedly influenced the court members' decisions — especially in light of the absence of a properly tailored limiting instruction by the military judge. *Billig*, 26 M.J. at 758.

¹⁹²*Id.* at 761.

¹⁹³Sandra G. Boodman, *Former Navy Surgeon Donal Billig Now Practices In Virginia*, WASH. POST, Sept. 14, 1993, at Z15.

¹⁹⁴*Id.*

¹⁹⁵*Id.*

¹⁹⁶*Id.*

to do it."¹⁹⁷ He had also received an honorable discharge and \$120,000 in back pay from the Navy.¹⁹⁸

STATE OF UTAH v. DAVID R. WARDEN

David Warden was a licensed and board certified physician who had been practicing family medicine in Kaysville, Utah, since 1968.¹⁹⁹ He also provided obstetrical care and had attended approximately 2,500 births, 300 of which have been home deliveries.²⁰⁰ At all times relevant to this case, Warden lacked malpractice insurance, and therefore, did not have hospital privileges and only delivered babies in home settings.²⁰¹

In September, 1986, Warden was visited by Joanne Young, an eighteen-year-old pregnant woman.²⁰² In connection with her pregnancy, she had previously seen Dr. Bitner, who had given her a complete obstetric exam and estimated the date of delivery to be December 20, 1986.²⁰³ Dr. Bitner had scheduled Young for an ultrasound examination in order to firmly establish the delivery date.²⁰⁴ Prior to the examination, however, Young changed physicians because she wished to have a home delivery.²⁰⁵ Warden, based on his examination of Young and medical records received from Dr. Bitner, estimated the date of delivery to be December 17, 1986.²⁰⁶ He did not perform an ultrasound to confirm this date.²⁰⁷ Warden also decided Young was a suitable candidate for home delivery.²⁰⁸

On the morning of November 7, 1986, approximately six weeks before her delivery date, Young developed cramps and vaginal bleeding. Ivy Young (Joanne's mother) phoned Warden and informed him of

¹⁹⁷*Id.*

¹⁹⁸*Id.* This same story also states that, according to a Pentagon spokeswoman, the Navy paid slightly more than \$3 million to settle 18 malpractice claims brought by families of his patients. His attorney is thereafter quoted as saying the Navy did not defend those claims properly.

¹⁹⁹*State v. Warden*, 813 P.2d 1146 (Utah 1991).

²⁰⁰*Id.*

²⁰¹*Id.*

²⁰²*Id.*

²⁰³*Id.*

²⁰⁴*Warden*, 813 P.2d at 1146.

²⁰⁵*Id.*

²⁰⁶*Id.*

²⁰⁷*Id.*

²⁰⁸*Id.*

Joanne's condition.²⁰⁹ Warden told Ivy Young that her daughter was in labor, not to worry,²¹⁰ and to call back at 1:00 p.m.²¹¹ Ivy Young called again at 1:00 p.m. and was told that it was not necessary to bring her daughter to the clinic.²¹² She called again at 4:00 p.m. and told Warden that her daughter was having contractions and "losing blood clots."²¹³ She was then told to "stop fussing" and call back when the contractions were three to five minutes apart.²¹⁴ At 10:15 p.m., Ivy Young phoned Dr. Warden to inform him that her daughter was in the last stage of labor.²¹⁵ At no time during this interval did Warden examine Young to determine if premature birth was likely and, if so, what precautions should be taken to minimize the likelihood of a premature birth.²¹⁶

Warden arrived at the Youngs' house at approximately 10:30 p.m. that evening. Shortly thereafter, Young gave birth to a male infant.²¹⁷ The infant was weighed on a bathroom scale and his weight was estimated to be approximately four pounds.²¹⁸ Soon after the birth, the newborn began experiencing respiratory problems, as evidenced by a periodic grunting sound the infant made while breathing and his purplish-blue color.²¹⁹ Warden recognized that the infant was premature and showing symptoms of respiratory distress syndrome -- a disease that Warden knew was progressive, linked to premature births, and could result in death.²²⁰ Warden, however, did not inform the Youngs of the baby's condition and positioned the infant in a way that would mask the symptoms, but would not affect the condition itself.²²¹ When asked if the baby needed to be hospitalized, Warden said hospitalization was not indicated and that such breathing patterns were normal in premature babies.²²² Ivy Young was also concerned about the infant and repeatedly asked Warden whether the

²⁰⁹ *Warden*, 813 P.2d at 1146.

²¹⁰ *Id.*

²¹¹ *Id.*

²¹² *Id.*

²¹³ *Id.*

²¹⁴ *Warden*, 813 P.2d at 1146.

²¹⁵ *Id.*

²¹⁶ *Id.*

²¹⁷ *Id.*

²¹⁸ *Id.*

²¹⁹ *Warden*, 813 P.2d at 1149.

²²⁰ *Id.*

²²¹ *Id.*

²²² *Id.*

baby needed “to be checked or [given] any other attention.”²²³ Warden’s only reply was “[N]o grandma, watch the baby.”²²⁴

At 11:40 p.m., approximately forty minutes after the birth, Warden left the home.²²⁵ In instructing Ivy Young to watch the baby, Warden allegedly did not tell her or anyone else in the household specifically what to watch for, nor did he tell anyone the baby was suffering from a condition that could result in death.²²⁶

During the night, the infant’s condition appeared to remain virtually unchanged.²²⁷ The only perceivable difference was that his hands and feet had turned a deeper shade of blue.²²⁸ At 8:00 a.m., however, the period of silent breathing between the episodes of grunting respirations increased, and Ivy Young became concerned that he may have stopped breathing.²²⁹ Although she was not positive that the baby was no longer breathing, she nonetheless attempted to revive him by gently rubbing his chest and breathing into his face.²³⁰ After a period of time, the infant let out a cry and began a grunting respiration.²³¹ She immediately attempted to call Warden at his home and later at his office, without success.²³² She succeeded, however, in contacting her clergyman, who came to her home accompanied by a pediatrician, Dr. Kramer. The infant appeared to Dr. Kramer to be near death.²³³ The newborn was immediately transferred to a nearby hospital, and was pronounced dead shortly after arrival.²³⁴ Ivy Young did not take the baby to a hospital herself because she expected Warden to arrive at any time and did not realize the seriousness of the baby’s condition.²³⁵

Both Warden’s house and office were less than eight blocks from the Young’s home.²³⁶ Although, he awakened at 6:00 a.m. the

²²³*Id.* at 1149.

²²⁴*Warden*, 813 P.2d at 1149.

²²⁵*Id.*

²²⁶*Id.*

²²⁷*Id.*

²²⁸*Id.*

²²⁹*Id.*

²³⁰*Warden*, 813 P.2d at 1149.

²³¹*Id.*

²³²*Id.*

²³³*Id.*

²³⁴*Id.*

²³⁵*Warden*, 813 P.2d at 1149.

²³⁶*Id.*

following morning, he made no attempt to contact his patients until noon when, for the first time, he phoned the Youngs and was informed of the infant's death.²³⁷ A postmortem examination revealed the infant was born approximately six to seven weeks premature and had died from respiratory distress caused by prematurity of the lungs (hyaline membrane disease).²³⁸

Warden was charged with one count of negligent homicide.²³⁹ Utah's Annotated Code establishes that negligent homicide is committed when a person "acting with criminal negligence, causes the death of another."²⁴⁰ Specifically, section 76-2-103 provides that a person acts:

[w]ith criminal negligence or is criminally negligent with respect to circumstances surrounding his conduct when he ought to be aware of a substantial and unjustifiable risk that the circumstances exist or the result will occur. The risk must be of a nature and degree that the failure to perceive it constitutes a gross deviation from the standard of care that the ordinary person would exercise in all the circumstances as viewed by the actor's standpoint.²⁴¹

An initial jury trial ended in a mistrial prior to the rendition of a verdict.²⁴² A second jury trial was held in February 1988, and Warden was convicted as charged.²⁴³ Warden appealed and the Court of Appeals of Utah reversed his conviction. In doing so, the Court of Appeals concluded the evidence failed to establish criminal negligence.²⁴⁴ The State challenged the decision of the Court of Appeals and the Utah Supreme Court reversed and upheld the jury verdict and criminal conviction of Dr. Warden.²⁴⁵

²³⁷*Id.*

²³⁸*State of Utah v. Warden*, 784 P.2d. 1204 (Utah App. 1989).

²³⁹*Id.*

²⁴⁰*Warden*, 813 P. 2d. at 1150-51.

²⁴¹*Id.* at 1151.

²⁴²*Warden*, 784 P. 2d. at 1206.

²⁴³*Id.*

²⁴⁴*Id.* at 1209. Since it concluded that the evidence failed to establish criminal negligence, the Court of Appeals did not reach the issue raised as to whether defendant's acts or omissions were the legal cause of death.

²⁴⁵*Warden*, 813 P. 2d. at 1146.

STATE OF NEW YORK v. GERALD EINAUGLER, M.D.

One of the most widely reported cases is that of New York internist, Gerald Einaugler.²⁴⁶ Dr. Einaugler was caring for a woman, Alida LaMour, who had been admitted to a nursing home in May, 1990. Ms. LaMour was terminally ill, suffering from kidney failure, when she was transferred from a Brooklyn hospital to an adjacent nursing home. Dr. Einaugler mistakenly identified Ms. LaMour's peritoneal dialysis catheter for a gastrostomy feeding tube and directed that Ms. LaMour be fed through the peritoneal dialysis catheter.²⁴⁷ Ms. LaMour received numerous feedings through the dialysis catheter before the mistake was discovered by a nurse approximately thirty-six hours later.²⁴⁸ The feeding solution was drained off and Ms. LaMour was reportedly stable when the nurses notified Dr. Einaugler of the mistake.²⁴⁹ It has also been reported that Dr. Einaugler examined Ms. LaMour three times that day.²⁵⁰ Dr. Einaugler also called the chief nephrologist at the hospital where Ms. LaMour received dialysis.²⁵¹ Appellate decisions on this case state the nephrologist advised Dr. Einaugler to "get the patient into the hospital."²⁵² The same nephrologist later "clarified" his testimony, saying he told Dr. Einaugler only to monitor the patient and that Dr. Einaugler followed his advice responsibly.²⁵³ The evidence also suggested that although Dr. Einaugler knew that peritonitis could be fatal if untreated, he did not order Ms. LaMour's transfer to the hospital for more than ten hours after his conversation with the nephrologist.²⁵⁴ Upon admission to the hospital, Ms. LaMour was diagnosed with peritonitis and she died four days later.²⁵⁵ Interestingly, no autopsy was performed and no official cause of death was stated.²⁵⁶

²⁴⁶People v. Einaugler, 618 N.Y.S.2d 424, 208 A.D. 2d 946 (N.Y. App. Div. 1994).

²⁴⁷*Id.* at 946-7.

²⁴⁸*Id.*

²⁴⁹*Id.*

²⁵⁰*Id.*

²⁵¹Einaugler, 208 A.D.2d at 947.

²⁵²*Id.*

²⁵³Mark Crane, *Malpractice Is Not Criminal; Mistake Is?*, NAT'L L.J., July 28, 1997, at

A17.

²⁵⁴Einaugler, 208 A.D.2d at 947.

²⁵⁵*Id.*

²⁵⁶*Id.*

A New York State Medical-Conduct Board reviewed this case and cleared Dr. Einaugler.²⁵⁷ The State Medical-Conduct Board found that although Dr. Einaugler mistook the dialysis catheter as a feeding tube, its resemblance to a feeding tube led to his mistake.²⁵⁸ The Medical-Conduct Board also found the hospital had failed to send crucial paperwork to the nursing facility at the time of Ms. LaMour's admission.²⁵⁹

Prosecutors were not satisfied with this result. Charges were filed against Dr. Einaugler and he was convicted of a misdemeanor for willful violation of the New York health laws which prohibit the commission of "an act of neglect."²⁶⁰ The term "neglect" is defined by the New York State Department of Health Regulations as:

Failure to provide timely, consistent, safe, adequate and appropriate services, treatment and/or care to a patient or resident of a residential healthcare facility while such patient or resident is under the supervision of the facility, including, but not limited to: nutrition, medication, therapies, sanitary clothing and surroundings, and activities of daily living.²⁶¹

The jury also convicted Dr. Einaugler of reckless endangerment in the second degree.²⁶² Dr. Einaugler appealed the jury's verdict, and a divided appellate court upheld Dr. Einaugler's conviction.²⁶³ As a result of his conviction, Dr. Einaugler was sentenced and ordered to spend fifty two weekends in jail at Rikers Island.²⁶⁴

In the summer of 1997, Governor George Pataki commuted the sentence of Dr. Einaugler.²⁶⁵ The Governor ordered that instead of the fifty two weekends in jail, Dr. Einaugler should serve fifty two days of community service as a physician.²⁶⁶

²⁵⁷See, e.g., Esther B. Fein, *Doctor In Negligence Case Gets His Sentence Eased*, N.Y. TIMES, June 28, 1997, Sec. 1, at 25.

²⁵⁸*Id.*

²⁵⁹*Id.*

²⁶⁰N.Y. PUBLIC HEALTH LAW § 2803-d(7) (McKinney 1995); *Einaugler*, 208 A.D.2d at 947.

²⁶¹N.Y. COMP. CODES RULES & REGS. tit. 10 § 81.1[c] (YEAR).

²⁶²*Einaugler*, 208 A.D.2d at 946-7.

²⁶³*Id.* at 946.

²⁶⁴See Fein, *supra* note 257.

²⁶⁵*Id.*

²⁶⁶*Id.*

STATE OF WISCONSIN v. CHEM-BIO CORPORATION

In March, 1995, at the age of twenty-nine, Karen Smith died of cervical cancer. Her death and the death of another Milwaukee woman resulted in criminal charges being brought against Chem-Bio Corporation. In 1987, Karen Smith began experiencing mild postcoital bleeding,²⁶⁷ and went to her health maintenance organization (HMO) physician for an exam. A physician's assistant took a pap smear and sent it off to Chem-Bio Laboratory and, several days later, the results came back as normal.²⁶⁸ Karen's symptoms persisted and, a year later, another pap smear came back normal.²⁶⁹ The HMO referred Karen to a gynecologist who did a biopsy of Karen's cervix to test it for cancer.²⁷⁰ At that time, a diagnosis of hyperplasia was made.²⁷¹ Four months later, the bleeding returned.²⁷² Karen's physicians took a second biopsy.²⁷³ Like the others, this test was sent to Chem-Bio and was interpreted as negative.²⁷⁴ Physicians suggested Karen stop using birth control pills as they might be irritating her cervix.²⁷⁵

Over the next twelve months, Karen's bleeding grew more frequent and heavier, sometimes lasting for weeks.²⁷⁶ In June, Karen passed out twice after a volleyball game.²⁷⁷ She had been bleeding continuously for twenty-one days.²⁷⁸ Karen went to her clinic where they recommended another pap smear and biopsy, her third in two years.²⁷⁹ The gynecologist stated he had seen her negative lab tests and assured her she did not have cancer.²⁸⁰ Karen's symptoms persisted and she again went to see the

²⁶⁷See Jan DeBlieu, *It's A Crime. Misread Pap Smears Led To Death*, HEALTH, July 1996, at 82.

²⁶⁸*Id.*

²⁶⁹*Id.*

²⁷⁰*Id.*

²⁷¹*Id.*

²⁷²*Id.*

²⁷³*Id.*

²⁷⁴*Id.*

²⁷⁵*Id.*

²⁷⁶*Id.*

²⁷⁷*Id.*

²⁷⁸*Id.*

²⁷⁹*Id.*

²⁸⁰*Id.*

gynecologist who tried repeatedly to stop the bleeding by cauterizing the cervical tissue.²⁸¹

After four years of bleeding, three pap smears and three biopsies, Karen Smith went to see a different gynecologist not affiliated with her HMO.²⁸² Another biopsy was done and sent out to a lab other than Chem-Bio.²⁸³ The results were unquestionable: cancer.²⁸⁴

With the help of a medical malpractice attorney, Karen and her husband settled a lawsuit for 6.3 million dollars.²⁸⁵ In the fall of 1994, Karen asked the Milwaukee District Attorney to investigate potential criminal charges.²⁸⁶ News reports of this case provide details of facts leading up to the criminal charges being filed.²⁸⁷ One such story begins by identifying Betty Setum, a woman who began supervising work at Chem-Bio in 1990.²⁸⁸ This story stated:

Reading a Pap smear accurately is difficult even for the best cytotechnologists, as technicians trained to read Pap smears are called. Each slide may contain as many as 300,000 cells; when cancer is present, only a few may have the darkened center or malformed shape indicating the disease. It's like searching for a few odd blossoms in a roomful of flowered wallpaper.

For that reason, cytotechnologists need about five minutes to check a Pap smear slide, according to the College of American Pathologists. The work is so painstaking that professional guidelines have long recommended cytotechnologists read no more than 100 slides a day. In 1990, federal law set the limit at 120 slides, but concerns about accuracy caused the government to cut the limit to 100 slides a day in 1992.

A few days after Setum began work at the lab, June Fricano, a freelance cytotechnologist, told her to be especially careful with slides that had case numbers ending in 2; those were the ones that would be rescreened for quality control. "My jaw hit the floor,"

²⁸¹*Id.*

²⁸²*Id.*

²⁸³*Id.*

²⁸⁴*Id.*

²⁸⁵*Id.*

²⁸⁶*Id.*

²⁸⁷*Id.*

²⁸⁸*Id.*

Setum says. "Quality control is supposed to be random. If its not, there's no point in doing it."

Then, in January 1991, Setum noticed a stack of 160 slides in Fricano's work area. Half had been marked with the next day's date, making it appear that she hadn't exceeded the legal limit. Setum had the slides rescreened. One, which Fricano had marked as normal, showed clumps of ominous dark cells. Fricano was fired that week.

A month later, Setum took a phone call from the medical secretary at a nearby hospital. Physicians performing a hysterectomy on a thirty-nine-year-old woman had discovered advanced cervical cancer. Could they check her previous Pap smears? Setum pulled a 1987 Pap smear from the files and had it examined. "There were almost no normal cells on it," she says quietly. "Cancer's ugly. It's black and horrible. It was the worst thing I've ever seen."

That Pap smear belonged to Dolores Geary, a physical therapy aide and mother of three who also belonged to Family Health Plan Cooperative. She would become the second homicide victim in Michael McCann's criminal case. The slide had been read, and reported as normal, by June Fricano.

Fricano, it turned out, had screened more than 48,000 Pap smears in a year -- four times the safe caseload. For her speedy work, she was paid \$2 a slide, earning \$96,000 at a time when top staff cytotechnologists made \$33,000. Her mistakes were never detected, perhaps because she knew which slides would be rescreened for quality control.²⁸⁹

On April 7, 1995, District Attorney Michael McCann took his evidence of reckless homicide to a Milwaukee inquest jury.²⁹⁰ The inquest jury came back with an unprecedented recommendation: charge Chem-Bio, June Fricano, and Robert Lippo, the head of the laboratory, with reckless homicide.²⁹¹ McCann decided against prosecuting Fricano and Lippo.²⁹² "There was no criminal intent on any individual's part," McCann stated,²⁹³ however, McCann charged Chem-Bio with two counts

²⁸⁹*Id.*

²⁹⁰*Id.*

²⁹¹*Id.*

²⁹²*Id.*

²⁹³*Id.*

of reckless homicide.²⁹⁴ In December, 1995, Chem-Bio pleaded no contest to the charges and paid the maximum legally allowable fine of \$20,000.00.²⁹⁵

STATE OF COLORADO v. JOSEPH VERBRUGGE, M.D.

On July 8, 1993, an eight-year-old boy, Richard Leonard, underwent minor ear surgery at a Denver hospital. The anesthesiologist during this operation was Dr. Joseph Verbrugge. During surgery, Richard's vital signs indicated serious trouble: his heart rate and temperature soared and the carbon dioxide level in his blood was dangerously high. Verbrugge, fifty-six, was accused of falling asleep during the operation²⁹⁶ and failing to notice drastic changes in the boy's condition that led to a fatal heart attack.²⁹⁷ When he died, Richard Leonard's had a temperature of 107 degrees, and he had four times the normal amount of carbon dioxide in his blood.²⁹⁸ Shortly after Richard's death, prosecutors in Denver filed criminal charges against Verbrugge.

A jury found Dr. Verbrugge guilty of "grossly negligent medical care."²⁹⁹ In so doing, the jury found Verbrugge's conduct to be "an extreme deviation from generally accepted standards of practice."³⁰⁰ Grossly negligent medical care in Colorado is a class 2 misdemeanor with a maximum penalty of twelve months in jail and a \$1,000.00 fine.³⁰¹ The jury, however, deadlocked 10-2 for conviction on a count of criminally negligent homicide.³⁰² The Denver district judge declared a mistrial on that charge.³⁰³

While Dr. Verbrugge awaited retrial on the count of criminally negligent homicide, he moved from the state of Colorado and sought a

²⁹⁴*Id.*

²⁹⁵*Id.*

²⁹⁶Sue Lindsay, *Doctor Faces Second Trial In Boy's Death*, ROCKY MTN. NEWS, Nov. 13, 1996, at 4A.

²⁹⁷*Id.*

²⁹⁸*Id.*

²⁹⁹Howard Pankratz, *Verbrugge 'Negligent' Mistrial Declared On More-Serious Counts*, DENVER POST, Oct. 23, 1996, Sec. A, at A1.

³⁰⁰*Id.*

³⁰¹*Id.*

³⁰²*Id.*

³⁰³*Id.*

medical license in New Mexico.³⁰⁴ Newspaper reports indicate he withdrew his application in December, 1995 after it garnered widespread news coverage.³⁰⁵ These same news reports indicate an official with the Colorado Board of Medical Examiners told the newspaper that, even if VerBrugge were convicted on the more serious charge (criminally negligent homicide), it wouldn't automatically result in a revocation of his license, although it would be considered.³⁰⁶

THE CASE OF THE COLORADO NURSES

In 1997, three nurses in Colorado were charged with criminally negligent homicide in relation to a death last year of a day-old baby at a Denver hospital.³⁰⁷ Reports of this case indicate the charges were brought against all three nurses despite the fact that two of the three nurses had already been disciplined by the board of nursing.³⁰⁸

In April, 1997, an Adams County grand jury issued the indictments of the 3 nurses who were accused of causing the death of Miguel Angel Sanchez on October 16, 1996.³⁰⁹ Miguel was allegedly born healthy on October 15, but died the next day shortly after being injected with an oil-based penicillin,³¹⁰ given as a precaution against an infection his mother had.³¹¹ The drug, at ten times the physician's prescribed dosage, was allegedly injected into the baby's vein instead of into his hip muscle.³¹² A hospital pharmacist misinterpreted and improperly dispensed the order, however, she did affix a label indicating it was to be injected into the muscle.³¹³ One of the nurses allegedly consulted with another of the defendant nurses who changed the route of administration to intravenous.³¹⁴

³⁰⁴Shonda Novak, *Denver Anesthesiologist Ponders Future After Conviction*, ALBUQUERQUE TRIB., Oct. 23, 1996, at A8.

³⁰⁵*Id.*

³⁰⁶*Id.*

³⁰⁷Ann Schrader and Marilyn Robinson, *Baby's Nurses Face Homicide Charges*, DENVER POST, Apr. 29, 1997, Sec. A, at A1.

³⁰⁸Nursing Management, Vol. 28, No. 7, pp. 7-8 (July 1997).

³⁰⁹Schrader and Robinson, *supra* note 307.

³¹⁰*Id.*

³¹¹*Id.*

³¹²*Id.*

³¹³*Id.*

³¹⁴*Id.*

Under Colorado law, criminally negligent homicide is defined as a gross deviation from the standard of care that causes the death of another person.³¹⁵ In Colorado, punishment for the class 5 felony usually ranges from one to three years in jail.³¹⁶ The minimum sentence under mitigating circumstances is six months and the maximum sentence under aggravating circumstances is six years.³¹⁷ Also there is a fine of up to \$100,000.00.³¹⁸ The attorney for one of the nurses reportedly called the indictments a public relations stunt by the Adams County District Attorney who decided to present the case to the grand jury.³¹⁹

On January 30, 1998, a jury exonerated nurse Kathy King by finding her not guilty of criminally negligent homicide in relation to the death of Miguel Angel Sanchez.³²⁰ The two other nurses involved in the incident had previously pleaded guilty to criminally negligent homicide.³²¹ Newspaper reports indicate that the two nurses will not face any jail time and will receive a deferred judgment when sentenced, meaning the case will be wiped off their records if they successfully complete probation and public service requirements.³²²

THE CASE OF THE NEW JERSEY NURSES

A New Jersey judge has intervened in a case involving attempts to have criminal charges brought against five Middlesex County nurses accused of endangering the welfare of a stroke patient who died.³²³ According to the indictment, statements by Prosecutor Robert Gluck, and evidence in the record of the civil case, the nurses allegedly waited too long during the early morning of October 22, 1996, to call a physician to treat Isaac Baron; a seventy-four-year-old stroke patient whose condition was deteriorating.³²⁴ Baron was a stroke patient at Warren Hospital in

³¹⁵*Id.*

³¹⁶*Id.*

³¹⁷*Id.*

³¹⁸*Id.*

³¹⁹Michael Romano, *Nurses Fear Indictments Put Profession On Trial - Charges In Infant's Accidental Death Are A First In Colorado*, ROCKY MTN. NEWS, Apr. 30, 1997, at 28A.

³²⁰THE ROCKY MOUNTAIN NEWS, Jan. 31, 1998, p. 38A.

³²¹*Id.*

³²²*Id.*

³²³Henry Gottlieb, *Nurses In Death Case Offered PTI*, 149 N.J.L.J. 337 (1997).

³²⁴*Id.*

Phillipsburg until he was transferred to Roosevelt Care Center on October 1, 1996.³²⁵ Upon the transfer, he was still in very ill health, and his discharge summary from Warren Hospital put Roosevelt on notice to be careful about Baron's sensitivity to one of his drugs, Coumadin, a blood thinner.³²⁶ Coumadin prevents life-threatening clotting in stroke patients, but there is danger that the drug will work too well, causing the blood to become unable to clot rendering even the the slightest bruise to cause possible internal bleeding.³²⁷ A blood test that shows a high "prothrombin time," or PT, means the blood is taking too long to clot and that Coumadin should be held or replaced with other drugs.³²⁸

According to the nurses' notes for October 19 through 21, Baron was alert and responsive, as he had been throughout his stay in Roosevelt.³²⁹ But his condition worsened when he returned from a brief visit to JFK Medical Center for a barium swallow x-ray.³³⁰ First, according to a note by charge nurse Mary Ann Hoyda at 5:30 p.m., a physician ordered a hold on Coumadin until further notice because Baron's PT was 31.8 seconds.³³¹ Further, tests were to be done the next day, the nurse noted.³³² Then came the damaging notes, from midnight to 6:45 a.m., by the next shift's charge nurse, Rose Tubens.³³³ The notes included such comments as, "resident found unresponsive and lethargic, color pale, skin warm and dry, respiration labored, oxygen applied ... small amount of brownish mucus noted from mouth ... incontinence of bowel and bladder."³³⁴ The notes say Baron was cleaned, changed, tube fed, and his blood pressure was charted as eighty over fifty, which is extremely low.³³⁵ Finally, the notes show that at 6:45 a.m., at the direction of another physician, an emergency call was made and Baron was taken to JFK Medical Center at 7:25 a.m.³³⁶ He

³²⁵Henry Gottlieb, *Making Malpractice A Crime, New Jersey Joins Other States In A Trend Toward Criminalization Of Medical Wrongdoing*, 147 N.J.L.J. 1 (1997).

³²⁶*Id.*

³²⁷*Id.*

³²⁸*Id.*

³²⁹*Id.*

³³⁰*Id.*

³³¹*Id.*

³³²*Id.*

³³³*Id.*

³³⁴*Id.*

³³⁵*Id.*

³³⁶*Id.*

died at 10:30 a.m., and according to an autopsy, he bled to death.³³⁷ The pathologist found 2,000 to 3,000 cubic centimeters of blood in his abdominal cavity.³³⁸

On March 25, 1997, the nurses were indicted on charges of endangering the welfare of an elderly person in their care, a fourth-degree crime with a potential penalty of eighteen months in jail and a \$7,500.00 fine.³³⁹ Superior Court Judge Robert Figarotta decided that the nurses qualified for PTI, the "go-and-sin-no-more" dismissal of charges against normally law-abiding people who make one mistake and are not likely to transgress again.³⁴⁰ The lawyer for the Baron family reportedly said the family of Isaac Baron was upset, not so much about the PTI offer, but about the particular deal with the nurses.³⁴¹ The nurses' defense attorneys state there will be no admission of guilt or other conditions, just a requirement that the nurses stay out of trouble for a year.³⁴² According to published reports, the civil case involving this death was still going forward and the state ombudsman was urging the state Board of Nursing to discipline the nurses.³⁴³

PEOPLE v. WOLFGANG SCHUG, M.D.

On February 23, 1996, Rhoda Thomas walked into the emergency room of Redbud Community Hospital carrying Cody Burrows, her eleven-month-old son. Cody had been vomiting and Rhonda and her husband, Cody's parents, were worried. Dr. Wolfgang Schug examined Cody, diagnosed an ear infection, and prescribed amoxicillin, an antibiotic.³⁴⁴ Cody initially improved, and his parents even took him to watch a cousin play basketball the next day, a Saturday.³⁴⁵ But later that night, he grew sicker, prompting his parents to return to the emergency room before dawn on Sunday.³⁴⁶ A physician on duty performed a blood test,

³³⁷*Id.*

³³⁸*Id.*

³³⁹Gottlieb, *supra* note 323.

³⁴⁰*Id.*

³⁴¹*Id.*

³⁴²*Id.*

³⁴³*Id.*

³⁴⁴Maura Dolan, *A Medical Mistake Or Murder?*, L.A. TIMES, Jan. 7, 1998, Part A, at 1.

³⁴⁵*Id.*

³⁴⁶*Id.*

diagnosed a gastrointestinal ailment, advised the parents to give him Pedialyte, an electrolyte solution to prevent dehydration, and told them to return if the baby did not improve.³⁴⁷ All sides agreed the blood test results were not alarming.³⁴⁸

Shortly before noon on Sunday, the exhausted family rushed back to the emergency room after Cody's mother noticed her son's eyes appeared to be "sinking in."³⁴⁹ For almost three days, Cody had been vomiting, had diarrhea, and could not hold food down.³⁵⁰ Schug again was on duty.³⁵¹ Cody had a high fever and Schug ordered a tepid bath and a chest x-ray.³⁵² The baby also was vomiting something that looked like dried coffee grounds -- blood, according to the medical records and grand jury transcripts.³⁵³

The emergency room was busy; Schug said he probably saw twenty-seven patients during the eight and one-half hours Cody was there.³⁵⁴ While in the bath, Cody put his mouth under the running faucet to drink the water.³⁵⁵ Schug recalled that a nurse called him over to see how cute the splashing child looked.³⁵⁶ Schug would write in the records that the baby had been "playful" in the bath.³⁵⁷

Delbert Thomas, Cody's grandfather, told Schug his grandson needed "some kind of intravenous or something."³⁵⁸ Schug told him to look at Cody's tongue;³⁵⁹ it was wet, so he wasn't dehydrated, according to Schug.³⁶⁰ Medical records show, five hours after the baby arrived, Schug and the nurses began looking for a vein to draw blood and insert an IV.³⁶¹ "Everybody and his brother looked at him to try and start an IV," Michael Hegele, a hospital laboratory technician, testified.³⁶²

³⁴⁷*Id.*

³⁴⁸*Id.*

³⁴⁹*Id.*

³⁵⁰*Id.*

³⁵¹*Id.*

³⁵²*Id.*

³⁵³*Id.*

³⁵⁴*Id.*

³⁵⁵*Id.*

³⁵⁶*Id.*

³⁵⁷*Id.*

³⁵⁸*Id.*

³⁵⁹*Id.*

³⁶⁰*Id.*

³⁶¹*Id.*

³⁶²*Id.*

Finally Schug obtained blood, but no one could get an IV into Cody, witnesses said.³⁶³ Schug briefly consulted by phone with a Redbud pediatrician, who later said he had no idea how ill the baby was.³⁶⁴

Cody by now appeared "totally lethargic, not conscious very much ... zonked," recalled Hegele.³⁶⁵ "I mean his head was rolling ..."³⁶⁶ The blood test revealed three measurements that the technician called "panic" levels, a huge unexplained deterioration from fourteen hours earlier.³⁶⁷ A physician who later examined the records said Cody's kidneys had shut down.³⁶⁸ "The lab values were way out of line and were hard to believe," Schug recalled, noting that some textbooks say such changes cannot occur so rapidly.³⁶⁹ He said he knew the baby needed hospitalization and called a pediatrician at Santa Rosa Community Hospital, fifty-five miles away.³⁷⁰ Redbud has no pediatric ward.³⁷¹

"How does the baby look?" the pediatrician asked.³⁷² "He can sit up and drink from a bottle," the pediatrician said Schug told him.³⁷³ The baby had just ingested three ounces in the emergency room.³⁷⁴ "Then there must be something wrong with your lab," the pediatrician suggested, according to the grand jury transcripts.³⁷⁵ They decided Cody should go to Santa Rosa by car.³⁷⁶

Schug did not ask for an ambulance or helicopter because he said he thought a private car would be fastest.³⁷⁷ During the prior three months, transfers had been delayed an average of seventy-five minutes each in waiting for ambulances, and helicopters were used only in extreme cases, Schug said.³⁷⁸ "He certainly didn't look critical or lethargic in the medical

³⁶³ *Id.*

³⁶⁴ *Id.*

³⁶⁵ *Id.*

³⁶⁶ *Id.*

³⁶⁷ *Id.*

³⁶⁸ *Id.*

³⁶⁹ *Id.*

³⁷⁰ *Id.*

³⁷¹ *Id.*

³⁷² *Id.*

³⁷³ *Id.*

³⁷⁴ *Id.*

³⁷⁵ *Id.*

³⁷⁶ *Id.*

³⁷⁷ *Id.*

³⁷⁸ *Id.*

sense,” said Schug, “or like he was going downhill so rapidly that he didn’t even have an hour or two.”³⁷⁹

Cody still had a fever and was breathing rapidly, medical records show.³⁸⁰ The emergency room nurse allegedly testified she so feared for Cody that she considered telling the parents to lie to Schug and claim they had no car.³⁸¹ On the transfer form, the nurse described Cody as lethargic and “mottled to the extremities,” evidence of extreme dehydration.³⁸² “M.D. aware,” she added.³⁸³

Schug handed the parents a map and a bottle of Pedialyte for their journey.³⁸⁴ Cody’s father drove quickly over the mountain roads -- but not fast enough to save his son.³⁸⁵ The drive took an hour and twenty minutes.³⁸⁶ As Cody’s mother handed him to a nurse, she suddenly realized her baby was not breathing.³⁸⁷ Physicians at two hospitals tried to save the boy, but his condition had deteriorated beyond all hope.³⁸⁸ Cody was taken off life support the following day.³⁸⁹

A coroner attributed the cause of death to “anoxic encephalopathy.”³⁹⁰ The brain had succumbed because of lack of oxygen “due to sepsis,” a massive infection and severe dehydration “due to otitis media,” the ear infection.³⁹¹

Eighteen months later, Schug received a call from his wife while he was in the emergency room.³⁹² Investigators had been at the house and were en route to the hospital.³⁹³ Schug, the only physician on duty, opened a back door and let them in.³⁹⁴ A nurse listening in an adjoining room said she felt she “was in a dream” when she overheard an officer read Schug his rights and tell him the charge: a grand jury had indicted

³⁷⁹*Id.*

³⁸⁰*Id.*

³⁸¹*Id.*

³⁸²*Id.*

³⁸³*Id.*

³⁸⁴*Id.*

³⁸⁵*Id.*

³⁸⁶*Id.*

³⁸⁷*Id.*

³⁸⁸*Id.*

³⁸⁹*Id.*

³⁹⁰*Id.*

³⁹¹*Id.*

³⁹²*Id.*

³⁹³*Id.*

³⁹⁴*Id.*

him for second-degree murder.³⁹⁵ Schug also was charged with involuntary manslaughter and child endangerment.³⁹⁶ "I can't leave here," the stunned physician told the officers.³⁹⁷ "I have to take care of my patients."³⁹⁸ Still clad in his blue scrubs, the physician was handcuffed and placed in a patrol car.³⁹⁹

The criminal case against Dr. Schug went to trial in February, 1998. Newspapers covering this trial reported that in opening statements, Deputy Attorney General Vernon Pierson told the jury that Schug, after keeping Cody in the emergency room about eight hours, finally realized the baby was seriously ill, and out of concern for his professional reputation tried to conceal it.⁴⁰⁰ Pierson reportedly said the baby desperately needed fluids, but Schug waited too long to try to insert an IV and refused to summon help from an on-call surgeon because he did not want to admit he had misjudged the boy's condition.⁴⁰¹

This same newspaper article noted statements by Schug's attorneys that defense medical experts would testify that Cody was probably suffering from a "rotovirus," a type of intestinal infection that strikes 500,000 children a year in the United States and causes 300 to 400 deaths.⁴⁰² Schug's lawyer also reportedly stated that experts would testify that Cody suffered from kidney failure, and if Schug had tried to give him fluids intravenously at Redbud, the baby probably would have died there.⁴⁰³

On February 20, 1998, Lake County Superior Court Judge Robert Crone acquitted Schug on a defense motion and dismissed the jury after ruling that the prosecution had not presented substantial evidence of criminal conduct to support the charges.⁴⁰⁴ This same newspaper story

³⁹⁵ *Id.*

³⁹⁶ *Id.*

³⁹⁷ *Id.*

³⁹⁸ *Id.*

³⁹⁹ *Id.*

⁴⁰⁰ Maura Dolan, *Doctor's Trial Begins In Baby's Death*, L.A. TIMES, Feb. 4, 1998, Part A, at 3.

⁴⁰¹ *Id.*

⁴⁰² *Id.*

⁴⁰³ *Id.*

⁴⁰⁴ Maura Dolan, *Judge Acquits Rural Doctor Of Murder Of Infant Patient*, L.A. TIMES, Feb. 21, 1998, Part A, at 1.

reported that Schug faced fifteen years to life if convicted and had borrowed heavily to pay for his defense, which has cost about \$140,000.⁴⁰⁵

OTHER RECENT PROSECUTIONS

Dr. Bruce Saul Steir

On December 13, 1996, Sharon Hampton of Barstow, California, was five months pregnant when she went to A Lady's Choice Women's Medical Center in Moreno Valley, California, for an abortion.⁴⁰⁶ Dr. Bruce Saul Steir completed the procedure and Hampton left the clinic at approximately 5:45 p.m.⁴⁰⁷ Hampton's mother drove her home, but could not wake her when they arrived in Barstow around eight o'clock that evening.⁴⁰⁸ The family called paramedics, but Hampton was dead before she reached Barstow Community Hospital.⁴⁰⁹ An autopsy determined she bled to death after her uterus was perforated during the abortion.⁴¹⁰ Newspapers reported Steir was scheduled to appear on February 3, 1998 for a preliminary hearing in Riverside County Superior Court on charges of murder.⁴¹¹ These same newspaper reports indicate Steir's license was revoked by the California Medical Board in March of 1998.⁴¹² When Hampton died, Steir was on probation because of a string of problems in previous abortions and was practicing without a mentor physician, as required under the terms of probation.

Dr. Patrick Chavis

In Los Angeles County, California, Dr. Patrick Chavis is reportedly accused of botching a liposuction procedure, killing a forty-three-year-old woman.⁴¹³ The physician left his office to check on another patient who suffered complications after a liposuction the previous day, said Deputy District Attorney Brian Kelberg, who is prosecuting the case.⁴¹⁴

⁴⁰⁵ *Id.*

⁴⁰⁶ Raymond Smith, *Doctors On Trial*, PRESS-ENTERPRISE, Feb. 1, 1998, Sec. A, at A1.

⁴⁰⁷ *Id.*

⁴⁰⁸ *Id.*

⁴⁰⁹ *Id.*

⁴¹⁰ *Id.*

⁴¹¹ *Id.*

⁴¹² *Id.*

⁴¹³ *Id.*

⁴¹⁴ *Id.*

Dr. Guillermo Falconi

In San Bernardino County, California, an unlicensed physician was charged with murder after a Rancho Cucamonga, California woman died in June from a liposuction procedure Falconi performed in her home.⁴¹⁵

U.S.A. v. C. Douglas Wood, M.D.

Nearly four years after the death of an elderly patient at a Veterans Hospital in Oklahoma, his physician has been indicted on charges of intentionally killing the man with a fatal injection.⁴¹⁶ Dr. C. Douglas Wood, former chief of surgery at the Muskogee, Oklahoma Veterans Hospital, was charged with first-degree murder on January 13, 1998 for the February, 1994 death of Virgil Dykes.⁴¹⁷ The federal grand jury indictment says that Wood "willfully" and "deliberately" killed Dykes by injecting him with potassium chloride.⁴¹⁸ Dykes was eighty-six years old; Wood, who is sixty-years old, worked at the hospital since 1980.⁴¹⁹ In May, 1998, a United States District Court jury found Dr. Wood guilty of involuntary manslaughter. Motions after verdict are pending.⁴²⁰

FOREIGN PROSECUTIONS

One should not conclude that the criminal prosecution of health care providers for "negligent" acts is a phenomenon unique to the United States. Other countries have had similar cases brought against health care providers thereby introducing an "international" element to this controversial topic.

New Zealand

*Regina v. Yogasakaran*⁴²¹ involved criminal charges being brought against a physician for a fatal error. Dr. Yogasakaran was an anaesthetist who noticed his patient was experiencing difficulty breathing and decided to

⁴¹⁵*Id.*⁴¹⁶David Dahl, *VA Doctor Is Charged With Murder*, ST. PETERSBURG TIMES, Jan. 15, 1998, at 1A.⁴¹⁷*Id.*⁴¹⁸*Id.*⁴¹⁹*Id.*⁴²⁰THE DAILY OKLAHOMAN, May 12, 1998, Sec. 1, col. 1, atA-1.⁴²¹[1990] 1 N.Z.L.R. 399 (1989).

inject her with the drug, Dopram.⁴²² He opened the right drawer of the anesthetics trolley and extracted an ampoule of a drug from the section marked with the name "Dopram."⁴²³ Unknown to the physician, another member of the staff had inserted the wrong drug into this section of the anesthetics trolley.⁴²⁴ As a result, the patient was injected with Dopamine which caused her death.⁴²⁵ Dr. Yogasakaran did not read the label of the drug he was injecting, assuming that it was correct because it had come from the right place in the anesthetics trolley.⁴²⁶ Expert evidence at trial led to the conclusion that an anesthetist should read the label of every drug before it is injected, even in an emergency.⁴²⁷ On this basis, Dr. Yogasakaran was held to have been negligent and was subsequently convicted of manslaughter.⁴²⁸

Saudi Arabia

In Saudi Arabia, newspapers reported on a criminal case involving a physician and the death of his patient. This newspaper story indicates that in 1996, a medical commission inquiring into the death of a woman after her discharge from Shaqra hospital accused the treating physician of negligent homicide and ordered him to pay SR50,000 in blood money plus other fines.⁴²⁹ Ministry of Health officials said the blood money was paid to relatives of the deceased woman, and the erring physician has been suspended.⁴³⁰

ANALYSIS

This Article provides detailed examples of cases in the past and present involving criminal charges brought against health care providers for alleged fatal mistakes and clinical negligence. What is becoming obvious is that medicine, previously thought to being immune from criminal

⁴²²Alexander McCall Smith, *Criminal Or Merely Human?: The Prosecution Of Negligent Doctors*, 12 J. CONTEMP. HEALTH & POL'Y 131, 143 (1995).

⁴²³*Id.*

⁴²⁴*Id.*

⁴²⁵*Id.*

⁴²⁶*Id.*

⁴²⁷*Id.*

⁴²⁸*Id.*

⁴²⁹*Errant Doctor Fined*, SAUDI GAZETTE, May 25, 1996.

⁴³⁰*Id.*

prosecution, is now becoming increasingly subject to scrutiny by district attorneys and prosecution in criminal courts.

A FAILURE OF THE MEDICAL PROFESSION TO "POLICE" ITS OWN?

Why is there is this increase of criminal prosecution of health care providers for clinical mistakes and fatal errors? Some have pointed to the failure of state medical licensing boards, peer review panels, and other watchdog agencies to police the medical profession and mete out harsh discipline when a case calls for it. For example, a study in New Jersey found that 3 to 10 percent of the 26,965 physicians licensed to practice medicine in that state were either incompetent or impaired; but just a handful, about one-half of one percent, ever get disciplined. This study also found that even fewer physicians lose their medical license. For example, as mentioned previously, the Colorado State Medical Board indicated it was not certain what disciplinary measures, if any, would be taken with regard to Dr. Joseph VerBrugge.⁴³¹

Some have pointed to the murder case brought against Dr. David Benjamin as proof that medical self-policing is inadequate. Dr. Benjamin was found guilty of second degree murder, and sentenced to the maximum of twenty-five years to life, after a patient bled to death following a botched second trimester abortion.⁴³² According to the proof at the trial, the patient suffered a three and one-half inch tear in her cervix and vagina and was left on an operating table in the clinic.⁴³³ Documents showed Dr. Benjamin had formerly practiced upstate under the name of Dr. Elyas Bonrouhi, where he had been disciplined for five other bungled medical procedures in the mid-1980s.⁴³⁴ He changed his name and moved to the New York area during the state Medical Board's investigation.⁴³⁵ Dr. Benjamin's license had been revoked by the Board one month before his 1993 arrest, but because the revocation was on appeal, he was allowed to

⁴³¹See Novak, *supra* note 304.

⁴³²See *25 Years To Life For Doctor In Woman's Death After A Bungled Abortion*, N.Y. TIMES, Sept. 13, 1995, at B3.

⁴³³*Id.*

⁴³⁴Thomas Maier, *More Doctors Face Prosecution; Crimes Charged In Cases Of Deadly Error*, NEWSDAY, Apr. 18, 1995, at A35.

⁴³⁵*Id.*

continue to practice medicine and performed the abortion that led to murder charges.⁴³⁶

These types of incidences and statistics provide ammunition for interested citizens and consumer groups to call for the continued criminal prosecution of health care providers. An Illinois medical-consumer advocacy group reportedly cited statistics suggesting the Illinois Department of Professional Regulation (DPR) was failing in its efforts to "police" physicians in that state. Families Advocating Injury Reduction (FAIR) was quoted as stating that since 1985, the amount DPR has spent on medical oversight has grown by 512 percent, but the agency has disciplined fewer and fewer physicians each year for "quality-of-care" violations such as gross negligence, violations of confidentiality, and unethical conduct.⁴³⁷ According to FAIR (between 1990 and 1993), the number of quality-of-care complaints DPR received grew from 622 to 801, while citations dropped from sixty-two to eight during the same period.⁴³⁸ These statistics led FAIR to call for a complete program audit of DPR by the state auditor general to look at the timeliness of investigations and the adequacy of procedures.⁴³⁹ Concerns were also raised as to Illinois' system of having only physicians decide the fate of wayward members of their own profession.⁴⁴⁰ This Illinois system of allowing two non-voting public members to sit in on meetings was described as "fairly unusual" when compared with other states, such as New York, which has a five-member review board, two members of which are "consumer representatives" with full voting power.⁴⁴¹

The medical profession has responded to this criticism. It contends that disciplinary proceedings are on the rise. A report issued by the Federation of State Medical Boards indicated that in 1994, there was an 11.8 percent increase over 1993 in the number of physicians who had their licenses revoked or suspended, and the total number of disciplinary actions increased by 38 percent.⁴⁴² A more recent report of the Federation

⁴³⁶*Id.*

⁴³⁷Bill Bush, *Critics: Regulation Of Illinois Doctors Needs Closer Look*, STATE JOURNAL-REGISTER, Jan. 14, 1996, at 4.

⁴³⁸*Id.*

⁴³⁹*Id.*

⁴⁴⁰*Id.*

⁴⁴¹*Id.*

⁴⁴²Francis P. Bensel and Barbara Decrow Goldberg, *Prosecutions and Punitives For Malpractice Rise Slowly*, N.L.J., Jan. 22, 1996 at B7.

of State Medical Boards concluded that state medical boards took 4,432 disciplinary actions against 3,880 physicians in 1996.⁴⁴³ The disciplinary actions were divided into two types -- prejudicial and nonprejudicial.⁴⁴⁴ Prejudicial actions, in turn, were divided into three categories:

- (A) loss of licensure or loss of licensed privilege,
- (B) restriction of license or licensed privilege, and
- (C) other prejudicial actions.⁴⁴⁵

In 1996, there were 1,607 category A violations, 1,261 category B violations, and 953 category C violations for a total of 3,821 prejudicial actions.⁴⁴⁶ State medical boards also took 611 non-prejudicial, or administrative, actions.⁴⁴⁷ The Federation president stated state medical boards have taken more disciplinary action since 1991 and noted there was a 4.5 percent increase from 1995 to 1996 in serious prejudicial actions involving revocation, suspension, or restriction of medical licenses.⁴⁴⁸

The State of New York has also taken steps to improve its method of disciplining physicians. Under new legislation, a physician whose license has been revoked or suspended is not allowed to continue practicing medicine while appealing the ruling, and the disciplinary action is made public.⁴⁴⁹ In addition, the legislation seeks to speed up the lengthy process of taking disciplinary action against a physician who has been convicted of a felony or had a license suspended or revoked in another state.⁴⁵⁰ The

⁴⁴³Kelly McMurry, *Discipline Against Physicians By State Medical Boards Increased In 1996*, TRIAL, June 1997, at 80-82.

⁴⁴⁴See The Federation of State Medical Boards of the United State, Inc. - Summary of 1996 Board Actions (on file with Author).

⁴⁴⁵See McMurry, *supra* note 443. The latter category, Category (C), refers to Board recommendations for continuing medical education or for fines for improper charting as a result of prejudicial behavior.

⁴⁴⁶*Id.*

⁴⁴⁷*Id.* These actions typically were license denials based on inadequate qualifications or denials of reinstatements following disciplinary action.

⁴⁴⁸*Id.* Included in the Federation's summary is a statistical calculation used to assess each board's disciplinary activity. Computed since 1991, this statistic - the Composite Action Index (CAI) - averages four activity ratios that measure disciplinary activity. The 1996 CAI increased 17.4 percent from 1995. Based on the 61 licensing jurisdictions that supplied data for both years, 36 boards improved their CAI's by an average of about 64 percent in 1996, while 25 boards saw a decrease averaging 21 percent from 1995.

⁴⁴⁹Harvy Lipman, *Pataki Seeks Rules For Doctors*, TIMES UNION, June 6, 1996, at B2.

⁴⁵⁰*Id.*

legislation also streamlines the disciplinary process by allowing additional charges of physician misconduct to be brought during an ongoing investigation.⁴⁵¹ Previously, new charges could only be raised in a separate disciplinary action.⁴⁵²

CRITICISMS OF CRIMINAL PROSECUTIONS OF HEALTH CARE PROVIDERS

Representatives of the medical profession and other commentators have blasted the manifest unfairness which accompanies the criminal prosecution of health care providers for their clinical mistakes and fatal errors.⁴⁵³ In the *Einaugler* case, an amicus brief was filed with the appellate court on behalf of various medical societies and the American Medical Association.⁴⁵⁴ In this brief, the medical societies argued that in criminalizing the abuse, neglect, and mistreatment of nursing home residents, the New York legislature never intended a special prosecutor to inject himself into medical decisions that are purely a matter of physicians' professional judgment.⁴⁵⁵ The medical societies made clear that their position on this issue was not to endorse physicians being able to "get away with murder."⁴⁵⁶ They stated that physicians who recklessly and wantonly cause patient injury or death, illegally sell prescription drugs, or commit other criminal acts are subject to the penal law.⁴⁵⁷ The *Einaugler* case, however, was based more on a disagreement with his clinical judgment than the violation of any criminal statutes.⁴⁵⁸ In their view, Dr. Einaugler was convicted of having chosen to hospitalize an elderly nursing home patient later, rather than earlier, in the day.⁴⁵⁹

The medical societies argued it is as inappropriate to criminalize a physician's clinical judgment as it would be to criminalize a lawyer's

⁴⁵¹ *Id.*

⁴⁵² *Id.*

⁴⁵³ See, e.g., Crane, *supra* note 253, at A17; Smith, *supra* note 406.

⁴⁵⁴ See Brief of Amici Curiae, *People v. Einaugler*, 618 N.Y.S.2d 414, 208 A.D.2d 946 (N.Y. App.Div. 1994) (No. 93-04865) (on behalf of the Medical Society of the State of New York, The New York State Society of Internal Medicine, the Medical Society of the County of Kings, and the American Medical Association).

⁴⁵⁵ *Id.* at 2.

⁴⁵⁶ *Id.*

⁴⁵⁷ *Id.*

⁴⁵⁸ *Id.*

⁴⁵⁹ *Id.*

tactical judgment.⁴⁶⁰ On occasion, wrong decisions are made. Physicians and lawyers are human and capable of mistake.⁴⁶¹ These mistakes of judgment, however, have historically been redressed through civil malpractice litigation, and professional misconduct and licensing proceedings.⁴⁶²

The medical societies went on to argue that if Dr. Einaugler's conviction is upheld, the practice of medicine in New York will be irreparably chilled.⁴⁶³ No professional -- much less a professional engaged in the constant risk assessment of life and death situations -- can function efficiently with the Damoclean sword of criminal liability looming over his head.⁴⁶⁴ The medical societies argued that affirmance of this conviction will result in physicians either declining to treat patients at all, or tailoring their treatment of such patients, in order to play it safe and avoid the risk of criminal prosecution, rather than responsibly choosing among alternatives that would better serve the patients' best interests.⁴⁶⁵

THE PROBLEM OF VAGUE AND GENERAL CRIMINAL STATUTES

Why does there seem to be this increase in criminal prosecution of health care providers for clinical mistakes and fatal errors? In a previous Article I authored on this topic, I pointed to the circumstance where vague and general criminal statutes are used by district attorneys to prosecute these cases.⁴⁶⁶ It could be argued that these criminal statutes were never intended to be used to prosecute physicians for mistakes in judgment; but the foregoing cases make clear that they are being used for just that purpose.

In Colorado, one of the criminal statutes used to prosecute Dr. Verbrugge for criminally negligent homicide states:

⁴⁶⁰*Id.*

⁴⁶¹*Id.*

⁴⁶²*Id.*

⁴⁶³*Id.* at 3.

⁴⁶⁴*Id.*

⁴⁶⁵*Id.*

⁴⁶⁶See Paul R. Van Grunsven, *Criminal Prosecution Of Health Care Providers For Clinical Mistakes And Fatal Errors: Is 'Bad Medicine' A Crime?*, 29 J. HEALTH & HOSP. L. 2 (1995).

Sec. 18-3-105. Criminally negligent homicide.

Any person who causes the death of another person by conduct amounting to criminal negligence commits criminally negligent homicide which is a class 5 felony.

In New York, the criminal statute used to prosecute Dr. Einaugler for reckless endangerment in the second degree states:

Sec. 120.20. Reckless endangerment in the second degree. A person is guilty of reckless endangerment in the second degree when he recklessly engages in conduct which creates a substantial risk of serious physical injury to another person.

Reckless endangerment in the second degree is a class A misdemeanor.

What is evident is that very general criminal statutes are being used to criminally prosecute health care providers in addition to any potential civil liability and/or disciplinary sanctions that may be brought against a physician. Is this fair? Is this just? Legal commentators have argued that it is not.⁴⁶⁷ These commentators have argued these criminal statutes were never intended to criminalize mistakes in medical judgment or care.⁴⁶⁸ They have argued that prosecutors are wrong in using these statutes to indict and try health care providers in the criminal arena.⁴⁶⁹ However, as long as these statutes exist, and as long as prosecutors are allowed to use the general language of these criminal statutes to gain headlines in prosecutions against physicians, this trend is going to continue.

CONCLUSION

This Article has presented a detailed factual analysis of past and pending cases in which criminal charges have been filed against health care providers for clinical mistakes and fatal errors. It has also identified the controversy surrounding such criminal prosecutions. If one kept a scorecard of the results of the United States cases cited herein, it would suggest that Prosecutors (5 Convictions/Plea Bargains) are losing to the

⁴⁶⁷See, e.g., Smith, *supra* note 406.

⁴⁶⁸*Id.*

⁴⁶⁹*Id.*

Health Care Providers (6 Acquittals/Reversals/Dismissed Charges/Reduced Sentences). Is there an appropriate response to this controversy? This Author is prepared to offer his suggestions.

First, I believe the medical community needs to address a perceived inability of the medical profession to "police its own." As long as there are reports of cases of gross negligence by physicians which go unpunished or which result in what is perceived to be minimal discipline, prosecutors will continue to be able to argue that these cases are necessary to punish conduct which the medical profession itself is unwilling, or unable to punish. Medical licensing boards, peer review panels and other agencies vested with the responsibility of "policing" the medical profession need to be more vigilant in identifying and promptly taking action in those cases deserving of disciplinary measures. If this can be done, strong arguments can be made to let the medical profession take care of its own. The medical profession is the most appropriate body to evaluate and discipline care which is found to be inappropriate and these "medical judgments" should arguably not be left to the whim of district attorneys.

To provide a greater level of certainty to the issue of criminal prosecution of health care providers for clinical mistakes and fatal errors, I also advocate that the medical community involve itself in working with state and federal legislatures in drafting laws which specifically address this situation.

The medical societies and the AMA, in their legal brief filed in the *Einaugler* case, admitted that physicians who recklessly and wantonly cause a patient injury or death should be subject to the penal law. If that is a position which the medical community still endorses, then legislation could be drafted, with the advice and input of the medical profession, which would limit criminal prosecutions of physicians for clinical mistakes to only those cases where it can be shown that the physician "recklessly and wantonly caused a patient injury or death." The medical profession could even go further with such legislation to actually define what is "reckless or wanton" care and thereby further eliminate uncertainty as to what type of conduct would subject a physician to criminal prosecution for clinical mistakes and fatal errors.

This position is not without precedential authority and, interestingly, legal authority which can be traced back to 1963. In *State v. Weiner*,⁴⁷⁰ the Supreme Court of New Jersey was faced with an appeal of a physician who was convicted on twelve counts of involuntary manslaughter because of deaths of patients from hepatitis after having received intravenous injections. In reversing the judgments of conviction and remanding the case for a new trial, the New Jersey Supreme Court eloquently reminded us of the necessary distinction between a civil tort action and a criminal prosecution, stating:

We of course must keep in mind that this is a criminal case. In a civil action for damages, the question is whether a loss shall remain where it fell or be shifted to him whose act brought it about. The test there is ordinary negligence - the failure to behave as would a reasonable man in such circumstances. The issue being only whether the victim or the actor shall bear the dollar impact, the law goes far in permitting the trier of the facts to "infer" both fault and causal connection between the fault and the loss. Indeed, if the total circumstances bespeak a likelihood of fault upon the part of a defendant, the law, for civil purposes, permits a jury to infer negligence even though the precise respect in which there was fault cannot be identified. So here, if the suit were for damages, it could be urged (we of course have no occasion here to pass upon it) that the total picture breathes the probability that defendant was careless somewhere and that his unidentifiable carelessness brought about these deaths. And in that connection, we would not be troubled by the possibility that one of defendant's nurses may have been the careless actor, since for the purposes of civil liability, defendant, as the employer of a nurse, must answer for her fault even though he was personally blameless.

But a criminal case is another matter. The injury to be vindicated is not the personal wrong suffered by the victim but rather an outrage to the State. And the question is not whether a defendant should absorb the dollar loss of his victim but whether his conduct justifies stamping him a criminal and sending him to State Prison. In that inquiry, the test is not ordinary negligence - behavior of which men of the highest character are capable. Rather, as phrased in 1 Warren, *Homicide* (perm. ed. 1938), Sec.

⁴⁷⁰*State v. Weiner*, 194 A.2d 467, 41 N.J. 21 (1963).

86, p. 424: "Negligence, to be criminal, must be reckless and wanton and of such character as shows an utter disregard for the safety of others under circumstances likely to cause death."⁴⁷¹

The foregoing portion of the *Weiner* decision was cited with approval by the United States Navy-Marine Corps Court of Military Review in the case of *United States v. Donal M. Billig*.⁴⁷² The *Billig* Court however went further and provided the following dissertation with regard to, not only Dr. Billig's criminal prosecution, but criminal prosecutions of health care providers in general for mistakes that occur in rendering care to patients:

In Dr. Billig's case, perhaps those making prosecutorial decisions lost sight of the fact that coronary artery bypass surgery is an inherently risky business, performed only within approximately the last thirty years, and that those patients who agree to this elective surgery are quite ill in the first place, many of them gravely so. Even when all goes well, there is a substantial risk of dying from nothing more than the traumatic ordeal the body is subjected to in this attempt to improve or sustain their life. People die from complicated surgeries, and the fact that there are complications and resultant death does not necessarily mean that any negligent act on the part of medical personnel occurred -- or if some negligent act did occur, that anyone is criminally responsible therefor. Given the nature of the work and its complexity, these surgeons face a difficult enough task without having to worry about the spectre of the criminal prosecutor -- waiting to reduce to a charge sheet honest mistakes which fall far short of the gross, wanton, and deliberate misconduct, with an accompanying *mens rea*, that truly deserves punishment.⁴⁷³

In this era of ever changing treatment alternatives for a given disease or condition, physicians do not need the specter of criminal prosecution clouding their medical judgments and decision making. Admittedly, negligent medical care which causes serious injury or death can ruin the lives of "victims" of that care. The foregoing also makes clear, however,

⁴⁷¹*Id.* at 469-70.

⁴⁷²*United States v. Donal M. Billig*, 26 M.J. 744 (1988).

⁴⁷³*Id.* at 760-61.

that cases of improvidently filed criminal charges brought against health care providers for negligent acts also risk ruin to the lives and professional reputations of health care providers who are the subject of such criminal charges. By taking steps to enact legislation which provides some certainty on this issue, physicians will be better able to focus on their patients needs without the concern that one injurious or fatal mistake may and him or her in jail.