AMERICAN HEALTH CONSULTANTS®

ED Legal Letter™

The Essential Monthly Guide to Emergency Medicine Malpractice Prevention and Risk Management

From the publishers of *Emergency Medicine Reports* and *ED Management*

American Health Consultants Home Page—http://www.ahcpub.com For more information, call (800) 688-2421. CME for Physicians—http://www.cmeweb.com

When does malpractice become a criminal act?

By **Douglas A. Blair, JD, LLM** (Health Law), Staff Attorney, BJC Health System, St. Louis

"The thought of malpractice . . . you can live with it . . . But the thought of going to jail for 15 years to life: That is very, very scary."[1]

In 1998, Dr. C. Douglas Wood was indicted on a charge of first-degree murder following the death of one of his patients after he administered 40 mEq of potassium chloride (KCL) directly into the patient's vein for the purpose of treating the patient's hypokalemia. Dr. Wood later was tried before a jury and was convicted of involuntary manslaughter. The U.S. District Court for the Eastern District of Oklahoma sentenced Dr. Wood to five months in prison, 36 months of supervised release, and a $25,000 fine. The court could have sentenced Dr. Wood to up to six years in prison and fined him as much as $250,000.

Cases such as Dr. Wood's undoubtedly send a chill up the spine of any physician practicing today in a legal environment that, at times, seems increasingly hostile toward the medical profession. Because some readers might be tempted to dismiss Dr. Wood's criminal conviction as a unique event (i.e., "it could never happen to me"), one of the purposes of this article will be to convince those skeptics that this is not the case. Not only are physicians not immune from prosecution for what they might conceive of as merely "clinical errors," such prosecutions, while certainly uncommon, are increasing. In this article, we will examine some of the major cases involving the criminal prosecution of physicians for alleged medical errors and the reasons underlying this emerging trend. We will focus solely on physicians who have been criminally charged for a patient's death as a result of an alleged clinical error. We will not include cases involving euthanasia in our discussion.

Case No. 1: *People v. Schug.*

Editor's note: *Most emergency physicians have at least some familiarity*

with the Schug *case, perhaps more in the EMTALA (Emergency Medical Treatment and Active Labor Act) context than as a case of a physician charged with murder. In this article, the author discusses the criminal case brought against Dr. Schug. The subsequent civil case is interesting from an EMTALA perspective and is quite significant because the federal district court judge ruled in that case that California's peer review statute, which protects peer review records from discovery, was inapplicable because the case was brought in federal court. The Ninth Circuit Court of Appeals refused to review the judge's decision, as did the U.S. Supreme Court. The applicability of state peer review statutes in federal courts is a hot topic, with some split among the federal circuits. While most malpractice cases are brought in state court, if the plaintiff can get into federal court on the basis of diversity of citizenship or a federal question (e.g., EMTALA), in at least some federal circuits, the plaintiff will be able to avoid state peer review protection.*

Dr. Wolfgang Schug, an emergency physician, was practicing at a rural hospital in Clearlake, CA, at the time of the incident that led to his criminal prosecution. In February 1996, Rhoda Thomas brought her 11-month-old son, Cody Burrows, to the emergency department (ED) at Redbud Community Hospital (Redbud), a 40-bed facility, where he was initially treated by Dr. Schug. Within three days of this visit, Cody was dead. Later, Dr. Schug would be charged with second-degree murder and involuntary manslaughter.[2]

When Ms. Thomas first brought her son into the ED at Redbud, Dr. Schug diagnosed an ear infection, for which he prescribed amoxicillin. Cody seemed to improve the next day, but he subsequently became gradually worse, which prompted his parents to return with him to the ED. During this second visit, Cody was seen by a different physician who performed a blood test, diagnosed a gastrointestinal ailment, and advised the parents to give him Pedialyte to prevent dehydration. The physician also instructed Cody's parents to return to the ED if he did not improve. The newspaper account did not specify how long Dr. Schug instructed the parents to wait for improvement before returning to the ED. Later that same day, the parents returned to the ED because they were alarmed that their son's eyes appeared to be "sinking in."[3] By that time, Cody had been experiencing a high fever, vomiting, and diarrhea for three days.

Dr. Schug, who was again on duty at the time of Cody's third ED visit, ordered a tepid bath and a chest X-ray, and he observed that Cody appeared to be vomiting blood. While in the tepid bath, Cody reportedly splashed around and placed his mouth under the running faucet. Dr. Schug would note in Cody's medical record that he appeared playful, but a prosecution witness would later assert that this behavior (drinking from the faucet) indicated that Cody was dehydrated and was instinctively acting to save his own life. Dr. Schug, though, claimed that he did not initially believe that Cody was dehydrated. In fact, it was not until almost five hours later that Dr. Schug attempted to start an IV. However, efforts to start an IV at that time were futile (for reasons that are not clear, although the prosecution would later argue that it was because Cody's veins had collapsed from dehydration). Nonetheless, Dr. Schug was able to draw enough blood to run laboratory tests that later revealed that three results were at "panic" levels. The newspaper account did not

ED Legal Letter™, ISSN 0744-6470, is published monthly by American Health Consultants, 3525 Piedmont Rd., NE, Bldg. 6, Suite 400, Atlanta, GA 30305.

Vice President/Publisher: Brenda Mooney
Editorial Group Head: Valerie Loner
Managing Editor: Joy Daughtery Dickinson
Production Editor: Nancy McCreary

GST Registration Number: R128870672. Periodical postage paid at Atlanta GA 30304. **POSTMASTER:** Send address changes to ***ED Legal Letter,*** P.O. Box 740059, Atlanta, GA 30374.

Back issues: $67. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue's date.

AMERICAN HEALTH CONSULTANTS™
THOMSON HEALTHCARE

Subscriber Information

Customer Service: 1-800-688-2421
Customer Service E-Mail Address: customerservice@ahcpub.com
Editorial E-Mail Address: joy.dickinson@ahcpub.com
World-Wide Web: http://www.ahcpub.com

Subscription Prices

United States: $399 per year
With CME: $449 per year
Multiple Copies:
2-9 additional copies: $319 each.
10+ copies: $239 each.
Canada: $429 per year plus GST
Elsewhere: $429 per year

Accreditation

American Health Consultants is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide CME for physicians. American Health Consultants designates this CME activity for 12 credit hours of Category 1 of the Physician's Recognition Award of the AMA. ***ED Legal Letter™*** is also approved by the American College of Emergency Physicians for 12 hours of ACEP Category 1 credit. This CME activity was planned and produced in accordance with the ACCME Essentials.

Questions & Comments

Please call **Joy Daughtery Dickinson,** Managing Editor, at (912) 377-8044 between 8:30 a.m. and 4:30 p.m. ET, Monday-Friday.

Now available on-line at www.ahcpub.com/online.html

Statement of Financial Disclosure

In order to reveal any potential bias in this publication, and in accordance with Accreditation Council for Continuing Medical Education guidelines, we disclose that Dr. Freedman (peer reviewer) discloses no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. Dr. Henry (advisory board member) is a stockholder in Emergency Physician Medical Group, Medical Practice Risk Assessment, and American Physicians Assurance Society, Ltd.

specify what those laboratory tests were.

Dr. Schug contacted a pediatrician at Santa Rosa Community Hospital (Santa Rosa), a facility located 55 miles from Redbud, regarding transfer of Cody. In his telephone conversation with the pediatrician at Santa Rosa, Dr. Schug described Cody as being able to sit up and drink from a bottle, a description that the prosecution would subsequently portray as an intentional mischaracterization of Cody's condition. Dr. Schug then instructed Cody's parents to take him by family car to Santa Rosa, even though later testimony would disclose that an ambulance could have been at Redbud within five minutes. The trip took Cody's parents 80 minutes and, unfortunately, by the time they reached Santa Rosa, Cody had stopped breathing. Doctors at Santa Rosa tried unsuccessfully to resuscitate Cody, and the cause of death ultimately was attributed to anoxic encephalopathy. Cody was determined to have died because of overwhelming sepsis and severe dehydration, due to his underlying otitis media.[4]

Although it is unclear from the newspaper accounts exactly why the prosecutor brought charges against Dr. Schug, it appears that the charges might have been instigated by a complaint filed by Cody's parents with the state department of health services. Interestingly, at the time that Dr. Schug's case was attracting attention, two other California physicians were being charged with murder in unrelated cases involving the deaths of their patients.[5] It was the prosecution's theory that Dr. Schug's recognition that his conduct was inappropriate was evidenced by his drafting of a four-page, after-the-fact addendum to Cody's medical record explaining his actions. Dr. Schug allegedly drafted this addendum shortly after he learned of the child's death. In the addendum, Dr. Schug repeatedly asserted that Cody had not been lethargic when he left the ED at Rosebud, although this fact was disputed by the government's expert witnesses at trial.

The prosecution argued that Dr. Schug "panicked" when he realized that he had inappropriately treated Cody and consequently failed to stabilize him before sending him to Santa Rosa with his parents. According to the prosecution, the addendum was merely an attempted "cover-up."[6] As viewed by the prosecution: "We're not saying he intended harm, but he didn't care either . . . He was trying to protect his reputation and protect himself."[7] In response, Dr. Schug maintained that he did not believe Cody's condition to be as critical as it was portrayed by the prosecution. The reasonableness of this belief was supported by Dr. Schug's expert witnesses, including a medical expert in pediatric infectious disease who testified that Dr. Schug had acted appropriately in caring for Cody.

Given the inconclusive evidence, it is not surprising that shortly into the trial, the court dismissed the charges against Dr. Schug. The court ruled that the prosecution had failed to present substantial evidence of criminal conduct to support the charges. Even though the American Medical Association (AMA) and the California Medical Association hailed that ruling as a victory for the medical profession, members of which those organizations and others maintain should not be held criminally liable for medical "mistakes." This decision was not the end of Dr. Schug's legal battles. As of the time this article was written, Dr. Schug was still facing an inquiry from the state medical board, and Dr. Schug, along with Redbud and a pediatrician at Santa Rosa, have been named in a civil suit by Cody's parents.[8]

Editor's note: *There is no published opinion from Dr. Schug's criminal trial. Therefore, the "facts" of the case have been primarily obtained from newspaper accounts. The difference between a court's written opinion and a newspaper's account of a case should always be kept in mind. That is, those "facts" have not come directly from the court. At this time, we know that Dr. Schug was not guilty of any criminal conduct. In fact, the judge ruled that there was insufficient evidence produced by the prosecution for the case to even be sent to the jury. Other legal actions, to the best of our knowledge, are still pending at the time this article was written.*

Homicide Charges

It should be emphasized from the outset that historically, physicians have rarely been charged, let alone convicted, of homicide when a patient dies as a result of alleged medical error. With that said, in order to understand the decision in *United States v. Wood,* discussed in detail below, as well as the government's decision to prosecute in the first place, one must first appreciate the differences between the three crimes with which Dr. Wood was charged: first-degree murder, second-degree murder, and involuntary manslaughter.

All three crimes involve the unlawful killing of

another human being. The difference between them is the requisite *mens rea. Mens rea* refers to an individual's mental state at the time he or she engaged in the prohibited conduct (i.e., the defendant's level of intent in committing the criminal act). In order for an individual to be convicted of a criminal offense, he or she must not only have committed a wrongful act, but must have done so with the required level of intent *(mens rea).* There are a few criminal offenses where this is not the case, and the defendant's *mens rea* is irrelevant (e.g., statutory rape). In those "strict liability" offenses, the prosecution need only prove that the defendant committed the unlawful act.

The *mens rea* required for a first-degree murder conviction requires proof of both "malice aforethought" and the specific intent to commit an unlawful killing. Under federal law, "[a] killing is committed with the requisite specific intent if it is 'willful, deliberate, malicious, and premeditated.'"[9] In contrast to first-degree murder, second-degree murder only requires that the government prove that the defendant acted with malice aforethought; specific intent to commit an unlawful killing is not required. Malice aforethought, for purposes of second-degree murder, may be satisfied by any one of the following:

- an intent to kill without the added ingredients of premeditation and deliberation;
- intent to do serious bodily injury;
- reckless indifference to an unjustifiably high risk to human life ("abandoned and malignant heart");
- intent to commit certain felonies.

The third basis listed, or a variation thereof, is the one that thus far has been relied upon by prosecutors when charging physicians with second-degree murder due to alleged medical error. Some courts also have held that malice aforethought "may be established by evidence of conduct which is reckless and wanton, and a gross deviation from a reasonable standard of care, of such a nature that a jury is warranted in inferring that [the] defendant was aware of a serious risk of death or serious bodily harm."[10]

Involuntary manslaughter, or negligent homicide, is the unlawful killing of a human being <u>without malice</u> in the commission of a <u>lawful act</u> that might produce death.[11] The defendant's act must amount to "gross negligence" ("criminal negligence") defined as a "wanton or reckless disregard for human life."[12] There are two important points to be made concerning this standard. First, "gross" or "criminal" negligence refers to a degree of culpability far more serious than tort negligence (i.e., the degree of negligence required to support a plaintiff's malpractice claim). Thus, the minimal level of negligence sufficient for the imposition of liability in a medical malpractice case (conduct that fails to meet the relevant standard of care) is not sufficient to sustain a conviction for involuntary manslaughter. As explained by one court:

> [I]t is important to note that criminal negligence differs substantially from ordinary civil negligence. Indeed, . . . evidence of civil negligence is insufficient to convict a person of negligent homicide. In situations where it is alleged that a medical doctor was negligent in the treatment of a patient, that doctor may be held civilly liable if the evidence establishes that it is more likely than not that the doctor's treatment fell below the appropriate standard of care. In contrast, a doctor may be held criminally liable only when the evidence establishes beyond a reasonable doubt that the doctor's treatment created a substantial and unjustifiable risk that the patient would die, that the doctor should have but failed to perceive this risk, and that the risk is of such a nature and degree that the failure to perceive it constitutes a gross deviation from the standard of care. *Given the high showing required for negligent homicide, doctors' negligence in the treatment of patients will rarely precipitate criminal liability.* It is also true, however, that if doctors act with criminal negligence, they should not escape criminal liability merely because the negligence occurred in a professional setting.[13]

After reading the above description of involuntary manslaughter, the reader might still be confused as to the distinction between second-degree murder and involuntary manslaughter, because cases involving both offenses are sometimes referred to as conduct that is "wanton or reckless." If you are puzzled by this similar use of terminology, you are not alone; it often creates confusion among jurors and jurists alike. A prime example of this confusion is exemplified by a statement made by an alternate juror in the *Wood* case to a reporter: "He [Dr. Wood] was aiming to help him [the patient]. He was just *negligent* in

the way he went about doing it."[14] If the jury convicted on the basis of this degree of culpability, it was simply wrong.

The *Wood* court pointed out that "[t]he substantive distinction [between second-degree murder and involuntary manslaughter] is the severity of the reckless and wanton behavior: Second-degree murder involves reckless and wanton disregard for human life that is extreme in nature, while involuntary manslaughter involves reckless and wanton disregard that is not extreme in nature."[15] The difference between second-degree murder and manslaughter is therefore "one of degree rather than of kind."[16]

Case No. 2: *United States v. Wood.*[17]

Bearing in mind this general framework of the various homicide charges available to prosecutors, we will take a look at the facts involved in *Wood*. On Feb. 5, 1994, Virgil Dykes, an 86-year-old man, arrived at the Veterans Affairs (VA) hospital in Muskogee, OK, with a complaint of severe abdominal pain. Dr. C. Douglas Wood was the attending physician on duty at the hospital when Mr. Dykes arrived. Dr. Wood examined Mr. Dykes and then operated on him "to repair a perforation in the proximal duodenum which had led to diffuse peritonitis."[18] Mr. Dykes remained in the ICU for the next eight days under the care of Dr. Wood.

On the eighth postoperative day, the chief of surgery, as well as a fifth-year resident and a first-year intern, examined Mr. Dykes when making hospital rounds. A blood test taken that morning showed that Dykes' potassium level was slightly less than normal (3.2 mEq per liter). Based upon those results, the resident ordered that 40 mEq of KCl be administered to Mr. Dykes via a nasogastric tube to increase his potassium level. In addition, the intern, after discussion with the resident, prescribed furosemide, a diuretic, which has a common side effect of reducing potassium levels. Soon after giving the KCl, one of the nurses aspirated 170 cc of fluid from Mr. Dykes' stomach, indicating that he was probably not absorbing the potassium.

Later that morning, Dr. Wood evaluated Mr. Dykes and concluded that he had pulmonary edema. Based upon the facts as recounted in the court's opinion, the following events then took place:

> Dr. Wood . . . ordered Nurse Kinsey to prepare 40 mg of Lasix and an IV bag with 40 mEq of KCl in 100 ccs of saline solution. When Nurse Kinsey informed Dr. Wood that the most rapid rate at which she could administer the KCl solution was over the course of an hour, he ordered her to draw up a syringe of 40 mEq of KCl in 30 to 50 ccs of saline. Nurse Kinsey prepared the KCl solution in a 60 cc syringe, but refused to administer it, believing it to be dangerous. Nurse Martha Hardesty, who was also present, told Dr. Wood that hospital policies permitted a maximum dosage of 40 mEqs of KCl over one hour. Dr. Wood then took the syringe from Nurse Kinsey and administered the KCl himself. *Dr. Bass [the intern], Nurse Kinsey, Nurse Hardesty, and Dr. Wood gave conflicting testimony regarding how much KCl was administered how quickly*.
>
> During the injection, the heart monitor flat-lined and patient Dykes stopped breathing. Dr. Wood stopped injecting [the KCl] and made one or two precordial thumps … in an effort to restart Dykes' heart. Dr. Bass and Nurse Kinsey also engaged in resuscitation efforts, including chest compressions. After two to four minutes, Dr. Wood pronounced Dykes dead.[19]

Because of the questionable circumstances surrounding Dykes' death, the federal government conducted an investigation into the matter. The end result of the government's investigation was an indictment charging Dr. Wood with first-degree murder. Although a criminal investigation into a wrongful death is usually conducted by the local district attorney's office as a potential crime under state law, the fact that Dykes' death occurred on federal property (a VA hospital) made it a possible federal criminal offense.

At Dr. Wood's trial, the jury was instructed as to first-degree murder, as well as second-degree murder and involuntary manslaughter. At trial, Dr. Wood claimed that an acquittal on the charges of first- and second-degree murder was warranted because the evidence was insufficient to prove that he acted with either premeditation or malice aforethought. Similarly, he claimed that an acquittal as to the charge of involuntary manslaughter was appropriate because the evidence was insufficient to support a finding of "gross negligence," the required *mens rea* for that offense. At the end of the trial, the jury found Dr. Wood guilty of involuntary manslaughter. Dr. Wood then appealed the verdict to the U.S. Court of

Appeals for the 10th Circuit.

On March 29, 2000, the 10th Circuit delivered its opinion. The appellate court reversed Dr. Wood's conviction on the involuntary manslaughter count. The court held that it was prejudicial error for the trial court to have:

- denied Dr. Wood's motion for an acquittal as to the first- and second-degree murder charges prior to sending the case to the jury, because the government had failed to introduce sufficient evidence to prove that Dr. Wood had killed Mr. Dykes with premeditation or malice aforethought;
- admitted certain prejudicial evidence over the defense's objection (e.g., that intravenous KCl is used to execute criminals).

However, the court also held that the evidence presented at trial was sufficient to send the case to the jury on the charge of involuntary manslaughter. As a result, the court remanded the case for a new trial on the sole charge of involuntary manslaughter. (As of the date that this article was written, Dr. Wood's case had not yet been retried.)

In its written opinion, the 10th Circuit analyzed the circumstances surrounding Mr. Dykes' treatment in detail. The court summarized the facts that were undisputed at trial, as well as those upon which there was substantial disagreement. Ultimately, the 10th Circuit held that "[t]he government [had] presented no direct evidence of a specific intent to kill," and a rational juror could not have inferred from the circumstantial evidence that Dr. Wood had "acted with premeditation or in a manner that was *extremely* reckless, wanton, and a gross deviation from the reasonable standard of care when he injected Mr. Dykes with potassium chloride"[20] (i.e., Dr. Wood could not be convicted of murder). The 10th Circuit found that there was conflicting testimony at trial as to how much KCl was administered and how fast it was given. According to the testimony, Dr. Wood had admitted to an FBI agent that he had given 10 mEq of KCl intravenously over seven minutes.[21] Other witnesses testified that the amount was larger and the rate of administration faster. The court found the testimony regarding the amount and rate of administration of the KCl to be sufficient to support a jury conclusion that Dr. Wood's action was reckless enough to constitute a lack of "due caution and circumspection," which was sufficient to support a conviction for involuntary manslaughter.[22] The evidence was insufficient, however, for the jury to conclude that Dr. Wood's conduct was "extreme" enough to support a second-degree murder conviction.

Additionally, and arguably the most important point made by the 10th Circuit, was that "[w]ell-intentioned but inappropriate medical care, standing alone, does not raise an inference that a killing was deliberate, willful, and premeditated."[23] Moreover, the specific intent for first-degree murder is only properly inferred if the apparent purpose of the lethal act was to cause the victim's death.[24] No such intent by Dr. Wood was apparent from the evidence presented in his case. Rather, according to the 10th Circuit, Dr. Wood "acted in good faith with the intent to save or prolong Mr. Dykes' life in what he believed to be an emergency situation."[25]

Not only did Dr. Wood not act with a premeditated intent to kill Mr. Dykes, he did not act with malice aforethought either. Although the 10th Circuit believed that the quantity of intravenous KCl administered to Mr. Dykes was unusual and presented a serious risk of death or serious bodily harm, the administration of KCl in *some manner* was nonetheless medically indicated.[26] In the court's view,

> Dr. Wood's treatment of Mr. Dykes involved a choice between several courses of action, some of which were more risky, but perhaps more efficacious, than others. *A physician cannot be convicted of murder simply for adopting, in an emergency setting, a risky course of action intended to prolong life that, when carried out, fails to forestall or even hastens death*. Instead, to permit a charge of murder with malice aforethought to go to the jury, that choice [of conduct by the physician] must be not only a gross deviation from a reasonable standard of care, but also extremely reckless and wanton. Dr. Wood's good-faith efforts at treatment simply [did] not rise to the "extreme" disregard for human life necessary to satisfy the malice aforethought standard.[27]

The 10th Circuit also distinguished the facts in *Wood* from those in *Einaugler*[28] and *Klvana*,[29] two widely cited cases involving criminal charges against physicians, because both of those cases "involved treatment that had no conceivable clinical benefit and was entirely outside the proper standard of care. By contrast, Dr. Wood gave a medically indicated drug

to a very ill man, but . . . gave an inappropriate dosage. When it became apparent that his chosen course-of-treatment had failed, he then took [medically appropriate] measures [in contrast to Drs. Einaugler and Klvana]."[30] Consequently, in comparing Dr. Wood's conduct to that of the physicians in *Einaugler* and *Klvana*, as well as another federal case in which a physician was charged with second-degree murder,[31] the 10th Circuit concluded that Dr. Wood's actions fell far short of the "extremely" reckless disregard for human life necessary to sustain such a second-degree murder conviction.[32]

Case No. 3: *State v. Warden.*[33]

In February 1988, Dr. David Warden was convicted of negligent homicide by a Utah jury. He had been practicing family medicine in that state since 1968. As part of his practice, Dr. Warden provided obstetrical care to his patients. One such patient, Joanne Young, consulted Dr. Warden in September 1986. Ms. Young was an unwed expectant mother who told Dr. Warden that she wished to deliver her baby at home to avoid having "people know" of her pregnancy. Dr. Warden evaluated Ms. Young for home delivery and concluded that her pregnancy was low risk; that her mother (Ivy Young), who would be the primary caregiver after birth, had given birth to several of her own children at home; and that adequate medical facilities were nearby. Consequently, Dr. Warden deemed Ms. Young to be a suitable candidate for home delivery and agreed to attend the birth. He also obtained Ms. Young's medical records from her previous physician and, based upon his own examination, calculated her delivery date to be in December.

On the morning of Nov. 7, Ms. Young began experiencing cramps and vaginal bleeding, whereupon her mother contacted Dr. Warden. Warden told Ivy Young that her daughter was "in labor and not to worry" and to call back at 1 p.m.[34] At 1 p.m., Ivy Young called Dr. Warden back and was told that "it was not necessary to bring her daughter to the clinic."[35] She called again at 4 p.m. and told Dr. Warden that her daughter was "having contractions and 'losing blood clots.'"[36] She was told to "stop fussing" and call back when the contractions were 3-5 minutes apart.[37] At 10:15 p.m., Ivy Young phoned Dr. Warden to tell him that her daughter was in the last stage of labor. At no time during this interval did Dr. Warden examine Ms. Young to make a determination as to whether this would be a premature birth and, if so, what precautions should be taken to minimize the likelihood of a premature birth.

Shortly after Dr. Warden arrived at the Youngs' house (approximately 10:30 p.m.), Ms. Young gave birth to a baby boy weighing approximately 4 pounds. Soon after birth, the infant began experiencing respiratory problems and was "purplish-blue" in color. "Warden recognized that the infant was premature and showing symptoms of respiratory distress syndrome," yet "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."[38] When asked by Young's older sister whether the baby needed to be hospitalized, "Warden told her that hospitalization was not indicated and that the type of breathing exhibited was normal in premature babies."[39] When Warden left the house at approximately 11:40 p.m., he told Ivy Young to watch the baby but "did not tell her or anyone else in the household specifically what to watch for, nor did he tell anyone that the baby was suffering from a condition that could result in death."[40]

The child's condition deteriorated through the night, and Ivy Young was unable to reach Dr. Warden. In the morning she was still unable to reach Dr. Warden but reached her clergyman who came to the house with a pediatrician, Dr. Kramer. The infant "appeared to Dr. Kramer to be near death," and was immediately taken to a nearby hospital where he was pronounced dead shortly after arrival.[41]

Oddly, "[Dr.] Warden's house was only five blocks and his office was only six to eight blocks from the Youngs' home. He was up at 6 the following morning; nevertheless, he made no attempt to contact his patients until noon that day, when, for the first time, he phoned the Youngs and was informed of the infant's death."[42]

Dr. Warden was charged and convicted of negligent homicide (i.e., involuntary manslaughter). At trial, the state called several expert witnesses who testified that the infant died of respiratory distress syndrome due to prematurity, weighed approximately 4 pounds, and had a gestational age of approximately 33-34 weeks. The Utah Court of Appeals curiously reversed his conviction on the ground that there was insufficient evidence to establish that Dr. Warden's conduct deviated significantly from the applicable standard of care. The state then petitioned the Supreme Court of Utah to review the Court of Appeals' decision.

The Supreme Court of Utah reversed the Court of Appeals' decision and upheld the jury's verdict convicting Dr. Warden of negligent homicide. The court first reviewed the definition of negligent homicide in Utah: "Negligent homicide is committed when a person 'acting with criminal negligence, causes the death of another.'"[43]

Under Utah law, a person acts "with 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 such 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."[44] The court noted the difference between ordinary civil negligence and criminal negligence, stating that "a doctor may be held criminally liable only when the evidence establishes beyond a reasonable doubt that the doctor's treatment created a substantial and unjustifiable risk that the patient would die, that the doctor should have but failed to perceive this risk, and that the risk is of such a nature and degree that the failure to perceive it constitutes a gross deviation from the standard of care."[45]

In reaching its decision, the Utah Supreme Court held that there was sufficient evidence of Dr. Warden's criminal negligence, i.e., the required elements listed in the previous paragraph were satisfied. Specifically, the prosecution established that Dr. Warden:

- should have examined Ms. Young in the early stages of labor and diagnosed her premature labor;
- should have taken measures to stop the labor or hospitalize her;
- knew the infant had signs of respiratory distress syndrome and should have placed the newborn in a neonatal intensive care unit;
- told the Youngs that "an obvious sign of disease was a normal condition," and that the infant did not need medical attention;
- "positioned the infant in a manner which masked the symptoms of the disorder";
- "did not see fit to check on the baby's condition until noon the next day."[46]

Additionally, the court noted that, because Dr. Warden did not have malpractice insurance, he did not have hospital admitting privileges. As a result, he would have had to call another physician to admit Ms. Young and/or her baby. Based upon this fact, the court found that "[t]he jury could have reasonably inferred that this could cause Warden embarrassment, and that this embarrassment could have influenced his decision not to hospitalize the baby."[47]

The court summarized as follows: "[T]here was evidence of repeated deviations from the standard of care, a wide divergence between the appropriate level of care and the care actually received, a significant chance of death that could have been alleviated by hospitalizing the infant, as well as other evidence of the degree of negligence and evidence that inappropriate factors could have influenced Dr. Warden's decisions. Given this evidence, the jury could well have believed, beyond a reasonable doubt, that Dr. Warden should have perceived the risk created by his treatment and that his failure to perceive the risk constituted a gross deviation from the appropriate standard of care."[48] That is, there was ample evidence for the jury to convict Dr. Warden of negligent homicide.

Case No. 4: *Commonwealth v. Youngkin.*[49]

Dr. James Youngkin was convicted of involuntary manslaughter by a Pennsylvania jury in 1977, sentenced to a term of imprisonment of one to three years, and fined $5,000.[50] The relevant facts were summarized by the appellate court as follows:

Barbara Fedder, a 17-year-old patient, lapsed into a state of unconsciousness while attending a party on the night of July 23, 1976. Attempts at cardiopulmonary resuscitation proved unsuccessful, and she was pronounced dead during the early morning hours of July 24. The cause of death was determined to be asphyxiation from aspiration of the contents of her stomach due to depression of her gag reflex. Simply stated, Ms. Fedder suffocated when the contents of her stomach entered her lungs. Normally, one's gag reflex would expel the regurgitated material. However, in Ms. Fedder's case, her gag reflex was depressed.

Post-mortem laboratory analyses revealed the presence of the drugs amobarbital and secobarbital, components of a chemical compound known as Tuinal, a barbiturate prescribed as a hypnotic or sleeping pill. Medical and toxicological experts for the prosecution testified that the depression of Ms. Fedder's gag reflex was caused by ingestion of the barbiturate. Further (prosecution) evidence revealed that in the seven weeks preceding Ms. Fedder's

death, Dr. Youngkin prescribed numerous drugs for her, including seven prescriptions for Tuinal, the last of which was written July 23, 1976.[51]

The state of Pennsylvania charged Dr. Youngkin with involuntary manslaughter because it proclaimed that "the reckless and grossly negligent manner in which he prescribed the drug Tuinal" caused Ms. Fedder's death.[52] Involuntary manslaughter is defined in Pennsylvania as follows: "A person is guilty of involuntary manslaughter when as a direct result of the doing of an unlawful act in a reckless or grossly negligent manner, or the doing of a lawful act in a reckless or grossly negligent manner, he causes the death of another person."[53]

The appellate court noted that the "tort concepts of causation are inapplicable in criminal homicide prosecutions, and thus a conviction requires a more direct causal connection."[54] However, the court also points out that: "[A] defendant's acts need not be the direct cause of death for criminal responsibility to be imposed. If the [defendant's] acts contributed in producing the ultimate result of death, they may be considered the legal cause of the victim's death."[55]

So, what exactly did Dr. Youngkin do that was "reckless and grossly negligent?" The *Youngkin* court recognized that the mere fact that a patient dies from a controlled substance prescribed to him or her is, of course, insufficient to sustain a charge of involuntary manslaughter.[56] Rather, the prosecution had to prove that Dr. Youngkin's act (i.e., prescribing a controlled substance) was conducted in a reckless or grossly negligent manner, *and* that this act was a legal cause of Ms. Fedder's death.[57] This task did not prove to be very difficult for the state in Dr. Youngkin's case.

First, the prosecution's pathology and toxicology experts testified that the depression of Ms. Fedder's gag reflex, which caused her death, was in turn caused by high levels of barbiturates in her body. Then the state introduced evidence that Dr. Youngkin had written seven separate Tuinal prescriptions for Ms. Fedder within a two-month period, as well as additional prescriptions for diazepam, flurazepam, and desamyl. Moreover, expert testimony at trial revealed that the Tuinal prescription was for more than twice the normal dosage and that it was a "questionable practice" to even prescribe it at all on an outpatient basis.[58] One expert even referred to the practice as being "dangerous, with fatal results a possibility."[59]

The state introduced testimony from nine pharmacists who described the dozens of prescriptions for controlled substances that Dr. Youngkin had written for Ms. Fedder in the months preceding her death. The most convincing evidence of recklessness was undoubtedly the testimony of a pharmacist who testified that Ms. Fedder came into his pharmacy on one occasion, about a month before her death, in such a dazed and stuporous condition that she had to hold onto the cash register to maintain her balance. Reluctant to sell Ms. Fedder a prescription that would increase her stuporous state, the pharmacist telephoned Dr. Youngkin, described to him Ms. Fedder's condition, and asked whether it was advisable to fill the prescription in those circumstances. Dr. Youngkin's reply was: "Fill the damn thing."[60]

In affirming the jury's conviction, the appellate court declared that:

> [T]he evidence indicates that [Dr. Youngkin] prescribed Tuinal to [Ms. Fedder] in quantities and frequencies termed irresponsible and totally inappropriate in the circumstances. The frequency with which the prescriptions were written should have suggested that [Ms. Fedder] was abusing Tuinal. Moreover, this fact was specifically brought to [Dr. Youngkin's] attention by a pharmacist who called [him] alarmed over [Ms. Fedder's] physical condition. However, [Dr. Youngkin] chose to ignore these indications of abuse and continued to prescribe the drug to [Ms. Fedder]. In these circumstances, the record supports and justifies the jury's conclusion that [Dr. Youngkin] consciously disregarded a substantial and unjustifiable risk, which disregard involved a gross deviation from the standard of conduct a reasonable person would have observed.[61]

Reaction to the Criminalization of Malpractice

Not surprisingly, cases such as those discussed in this article have led to growing concern among physicians and other health care providers. This concern has not gone unnoticed by the AMA, which passed a policy in 1997 stating that it "will continue to take all reasonable and necessary steps to ensure that medical decision making, exercised in good faith, does not become a violation of criminal law."[62] The AMA has expressed its determination to oppose the "attempted criminalization of health care decision making,

especially as represented by the current trend toward criminalization of malpractice."[63] After Dr. Wood was convicted in 1998, then AMA president-elect, Dr. Nancy Dickey, commented: "The move recently to criminalize health care decision making, particularly if it appears that the physician has the best interests of the patient at heart, is extraordinarily bothersome" because it can destroy the physician-patient relationship.[64] Dr. Dickey's statement indicates that she advocates a good-faith exception to a charge of homicide. But what Dr. Dickey fails to recognize is that a physician could be criminally negligent or even reckless while at the same time believing that he or she is acting in the patients' best interests. In addition, Dr. Dickey stated her belief that such intervention by the criminal justice system places a chilling effect on doctors' willingness to handle the more difficult cases, a claim which is open to debate.[65]

Nonetheless, Dr. Dickey is obviously not alone in her opinion.[66] Others, though, would support criminal liability for physicians in certain limited circumstances. A source within the AMA, who requested not to be identified, said: "There are some situations where the facts are so beyond the pale that perhaps criminal prosecution is appropriate."[67]

There is a growing concern among the public that the various other mechanisms that serve to regulate the conduct of medical professionals are inadequate. As characterized by one commentator: "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."[68]

Dr. Dickey also seems to misunderstand the basis for criminal liability. She claims that "if the simple measure of a bad outcome is what leads to at least the accusation and the need to defend oneself, then physicians will have to think twice before they take on the care of those kinds of patients."[69] However, a "bad outcome" alone is not sufficient to sustain a criminal charge. Recall from above that a criminal offense requires both a *mens rea* element, as well as the act (the *actus reus*).

Confusion as to the basis of criminal liability is also reflected by the "friend-of-the-court" brief filed in the *Einaugler* case by the AMA and other professional medical societies that argued that "[i]t is as inappropriate to criminalize a doctor's clinical judgment as it would to criminalize a lawyer's tactical judgment."[70] This statement, however, oversimplifies the issue for several reasons. First, and most obviously, when a lawyer makes an error in "tactical judgment," his or her client does not die (except potentially in a capital murder case) as a result. Second, claiming that cases such as those discussed in this article are indicative of a widespread effort to "criminalize a doctor's clinical judgment" ignores the reality that, in order to successfully convict an individual of involuntary manslaughter (the least serious of the homicide crimes), the prosecution must prove at least gross negligence. Instead, this statement suggests that even simple negligence, such as that required for a medical malpractice case, is somehow evolving into a basis for criminal liability. Such is not the case. For a health care provider to be convicted of any form of a homicide, he or she must have been at least grossly negligent in treating the patient, and that gross negligence must have caused the patient to die.

In response to Dr. Wood's conviction, one journalist covering the case opined that "[t]he idea that doctors could face criminal charges as a result of doing their jobs is troubling."[71] If acting in a grossly negligent manner, as the jury concluded Dr. Wood had, and which the 10th Circuit agreed was supported by the evidence, is an example of "physicians doing their jobs," then perhaps those cases should be creating more of a concern for the public than for the medical profession. As the prosecutor in Dr. Schug's case remarked: "There's nothing . . . that says that an MD degree at the end of your name says that somehow, you're above the law."[72]

Editor's note: *Criminal charges against physicians as a result of alleged medical error should be kept in context. Although it is unfortunate that physicians are often sued merely because there has been a bad outcome, and cases are sometimes settled or even lost without clear evidence that the standard of care was breached, there is no evidence that mere bad outcomes have led to successful criminal convictions of physicians. Although there is often confusion as to what constitutes a breach of the standard of care for*

medical malpractice purposes, there is no significant evidence that this confusion extends to determinations of criminal liability.

Conclusion

The number of homicide cases against physicians and other health care providers continues to grow. Even at the time of the writing of this article, the U.S. Army is considering whether to proceed with a charge of involuntary manslaughter against Capt. Michael Hamner, an anesthesiology resident at Walter Reed Hospital.[73] Capt. Hamner is alleged to have given an overdose of an antibiotic, clindamycin, to Katie Tyra, the 16-year-old daughter of a Marine colonel. Dr. Hamner allegedly gave her 900 mg of the drug over a one- to two-minute period, despite having been instructed by her surgeon to give her 600 mg over a period of 15 minutes. What makes Capt. Hamner's situation even worse is that, allegedly, he failed to promptly request help in the wake of Tyra's cardiac arrest and then, once other physicians were able to respond, he lied to them as to the short duration during which he administered the drug as well as the overall quantity given.[74] In addition, Capt. Hamner, according to one of the surgeons, administered "way too much" anesthesia to Ms. Tyra during her surgery. If Capt. Hamner is convicted of involuntary manslaughter and the other related charges, he could be sentenced to over 30 years imprisonment pursuant to the Military Code of Justice.

Thus, the trend of prosecuting physicians for the types of fatal errors discussed in this article continues. The point of this article has been to emphasize that, during the past 10 years, there has been a noticeable increase in the willingness of prosecutors to bring criminal charges against physicians when patients die due to apparent medical error. The medical profession would be wise to recognize that trend and not respond by simply arguing that it is always inappropriate to bring criminal charges against a physician. Rather, the medical profession should take measures to ensure that other methods of professional regulation (e.g., medical licensing boards) take a more proactive role in investigating such matters and disciplining errant physicians appropriately, rather than leaving the responsibility to prosecuting attorneys. Unless such a reformation occurs, it is likely that the trend of prosecuting physicians for medical errors that cause the death of a patient will continue.

Endnotes

1. Dolan M. A medical mistake or murder? *LA Times* 1998; Jan. 7:A1.
2. *Id*.
3. *Id*.
4. *Id*.
5. *Id*.; *See also* Smith R. Doctors on trial. *Press-Enterprise* (Riverside County, San Bernardino County, and Los Angeles County) 1998; Feb. 1:A1.
6. Dolan M. Doctor's trial begins in baby's death. *L.A. Times* 1998; Feb. 4:A3.
7. Dolan M. A medical mistake or murder? *L.A. Times* 1998; Jan. 7: A1.
8. Grinfeld MJ. A growing trend? Criminalization of medical decisions. *Medicine & Behavior.* Web site: www.cmea.com/mb/mb980420.html.
9. 18 USC § 1111(a).
10. *United States v. Soundingsides*, 820 F.2d 1232, 1237 (10th Cir. 1987), citing *United States v. Black Elk*, 579 F.2d 49, 51 (8th Cir. 1978).
11. 18 USC § 1112.
12. *United States v. Wood,* 2000 U.S. App. LEXIS 5475, *10 (10th Cir. 2000).
13. *State v. Warden*, 813 P.2d 1146, 1151 (Utah 1991) (emphasis added).
14. Espinosa R. Jury convicts doctor. *The Tulsa World* 1998; May 12 (emphasis added).
15. *United States v. Wood*, 2000 U.S. App. LEXIS 5475 (10th Cir. 2000).
16. *United States v. Fleming*, 739 F.2d 945, 948 (4th Cir. 1984).
17. *United States v. Wood*, 2000 U.S. App. LEXIS 5475, at *10-11 (10th Cir. 2000), citing *United States v. Houser*, 130 F.3d 867, 872 (9th Cir. 1997).
18. *Id*. at *2.
19. *Id*. at *4-5 (emphasis added).
20. *Id*. at *13 (emphasis added).
21. *Id*. at *14.
22. *Id*. at *28.
23. *Id*. at *14.
24. *Id*.
25. *Id*. at *22.
26. *Id*. at *22-23.
27. *Id*. at *23 (citations omitted) (emphasis added).
28. *Einaugler v. Supreme Court*, 918 F.Supp. 619 (1996).
29. *People v. Klvana*, 15 Cal.Rptr.2d 512 (1992).
30. *United States v. Wood*, 2000 U.S. App. LEXIS 5475, at *25.
31. See *United States v. Millen*, 594 F.2d 1085 (6th Cir. 1979).
32. *United States v. Wood*, 2000 U.S. App. LEXIS 5475, at *27.
33. 813 P.2d 1146 (Utah 1991).
34. *Id*. at 1148.
35. *Id*.
36. *Id*.

37. *Id*.
38. *Id*. at 1152.
39. *Id*. at 1148.
40. *Id*. at 1149.
41. *Id*.
42. *Id*.
43. *Id*. at 1150-1151, citing Utah Code Ann. § 76-5-206(1) (Supp. 1988).
44. *Id*. at 1151, citing Utah Code Ann. § 76-2-103 (Supp. 1988).
45. *Id*. at 11151.
46. *Id*. at 1152.
47. *Id*.
48. *Id*.
49. 427 A.2d 1356 (Pa. Super. Ct. 1981).
50. *Id*. at 1358.
51. *Id*. at 1359.
52. *Id*.
53. 18 Pa.C.S. § 2504.
54. 427 A.2d at 1359.
55. *Id*.
56. *Id*. at 1360.
57. *Id*.
58. *Id*. at 1361.
59. *Id*.
60. *Id*.
61. *Id*.
62. Espinosa R. Doctor's verdict concerns physicians. *The Tulsa World* 1998; May 17.
63. *Id*. *See also*, Dolan, supra note 1, at A1.
64. Espinosa, supra note 49.
65. *Id*.
66. *See* Crane M. Malpractice is not criminal; mistake is? *National Law Journal* 1997; July 28: A17. Smith R. Doctors on trial *Press-Enterprise* 1998; Feb. 1:A1.
67. Grinfeld, supra note 7.
68. Van Grunsven PR. Medical malpractice or criminal mistake? An analysis of past and current criminal prosecutions for clinical mistakes and fatal errors. *DePaul J Health Care L* 1997; 2:51.
69. Espinosa, supra note 49.
70. *Id*.
71. Criminal case? Federal trial raises troubling issues. *The Tulsa World* 1998; May 19.
72. Dolan M. Judge acquits rural doctor of murder of infant patient, *LA Times* 1998; Feb. 21:A1.
73. See Army doctor charged in girl's death; antibiotic treatment, truthfulness at issue. *The Washington Post* 2000; March 22:B1.
74. *Id*.

Physician CME Questions

17. Gross negligence is the minimum *mens rea* for which of the following offense?
    a. First-degree murder
    b. Second-degree murder
    c. Involuntary manslaughter
    d. None of the above

18. Negligence in the context of a medical malpractice case (i.e., breach of the standard of care) is the same as criminal negligence in an involuntary manslaughter prosecution.
    a. True
    b. False

19. Which of the following statements is true, according to the 10th Circuit Court of Appeals, regarding the direct intravenous injection of KCl by Dr. Wood?
    a. The direct intravenous injection of KCl, although it might have been reckless, was not evidence of an intent to kill.
    b. Direct intravenous injection of KCl is routinely within the standard of care.
    c. Inappropriate medical care resulting in a patient's death, however well-intentioned it might have been standing alone, allows an inference that a killing was deliberate.
    d. None of the above

20. In proving a homicide charge, the prosecution must prove beyond a reasonable doubt that the defendant had the requisite state of mind (*mens rea*) when the victim was killed. If the defendant is charged with first-degree murder, the prosecution must prove that the defendant acted with:
    a. Malice aforethought
    b. Specific intent to commit an unlawful killing
    c. Both of the above
    d. Neither of the above

In Future Issues:

Abdominal Aortic Aneurysm