
The Criminal Prosecution of Medical Negligence

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Abstract

Historically, the medical malpractice lawsuit stood alone within the four corners of any description of liability arising out of the practice of medicine. Now, criminal sanctions against medical personnel for medical acts that result in harm to patients represent a new page in the book on professional liability. This paper discusses traditional medical malpractice jurisprudence, reviews criminal counts against medical personnel and discusses arguments for and against criminal charges resulting from medical acts.

INTRODUCTION

In Waukegan, Illinois, 49 year old Beatrice Vance died of a heart attack after waiting two hours in a hospital waiting room.¹ A Lake County coroner's jury had declared her death a homicide. Over the past two decades, medical personnel have faced criminal charges for medical acts that resulted in harm to patients. Angst within the medical community, turmoil among legal scholars, and shock within the lay press followed each occasion. This paper discusses traditional medical malpractice jurisprudence, reviews criminal counts against medical personnel and discusses arguments for and against criminal charges resulting from medical acts.

MEDICAL MALPRACTICE AND CIVIL COURTS

Traditionally, redress for patients harmed during the course of medical therapy has been sought in civil court. "Civil" in the legal sense refers to private rights and remedies that are sought by action or suit.² Civil cases, therefore, involve individuals and organizations seeking to resolve legal disputes. In a civil case the victim brings the suit. Persons found liable in a civil case may only have to give up property or pay money.

Negligence law offers plaintiffs the legal framework upon which to build their civil suit. A plaintiff in a medical malpractice action must satisfy four elements—duty, breach, causation and damage— in order to prevail.³ In a negligence case, the wrongdoer's actions are compared to what would be expected of a reasonable and prudent person in the same or similar circumstance.⁴

In the majority of negligence cases, this reasonable standard

of care determines whether liability attaches.⁵ However, the standard of care in a medical malpractice case is not derived from a reasonable person.⁶ Medical malpractice cases differ from the typical negligence case in that the plaintiff in a medical malpractice case is required to establish affirmatively the applicable standard of care through expert testimony—other health care professionals.⁷ As a result, the legal profession has allowed healthcare professionals to determine their own standard of care in negligence cases.⁸

The two principle objectives civil litigation brings to medical malpractice are to reimburse injured patients and to monitor the quality of health care. How effective medical malpractice litigation is at achieving either of these objectives is at the heart of the criminal prosecution of health care professionals.⁹ The disproportionately low numbers of injured people who actually file claims against health care professionals demonstrates that malpractice litigation falls short of compensating injured victims.¹⁰ Some claim that even the successful claimant is not fully compensated for the economic losses incurred through the litigation process.¹⁰

Furthermore, the notion that medical malpractice suits control the quality of health care by forcing physicians to take the necessary safety precautions in an effort to avoid compensating negligently injured patients has recently been challenged.¹¹ One reason cited is the simple fact that insurance companies, not physicians, pay malpractice claims.⁹ Although physicians pay insurance premiums, these premiums are typically influenced more by specialty than individual physician performance.⁹

THE FAILURE OF ALTERNATIVE SAFEGUARDS

The efficacy of other modes of quality oversight has also been called into question. Through their policing power, state licensing boards have the authority to regulate the quality of medicine.¹² These boards may revoke a physician's license to practice medicine for gross negligence,¹³ professional incompetence,¹⁴ or similar acts.¹⁵ Despite this power, state licensing boards rarely revoke a health care provider's license for incompetence.⁹ This may be, in part, because these boards are under-staffed and under-funded, receive incomplete information, and usually forego disciplinary actions in return for the physician's promise never to practice in the state again. In the past, this allowed incompetent physicians to simply continue their practices in another state.

In theory, peer review provides oversight of the care rendered by medical professionals and should be well situated to monitor the quality of health care. However, lack of compensation for peer review committee members, and a perceived prohibition against passing judgment against one's colleagues,⁹ limits the usefulness of these committees. Also, despite the immunity provided to peer review committee members by the Health Care Quality Improvement Act (HCQIA), fear of litigation continues to dissuade physicians from serving on peer review committees.⁹ Whether real or perceived, these failures have stimulated a search for an alternative way to ensure the quality of health care. As a result, the general public remains skeptical of this form of internal policing and views peer review as having only a limited role in weeding out incompetent health care providers.

CRIMINAL LAW

Criminal law defines offenses against the community at large, regulates how suspects are investigated, charged, and tried, and establishes punishments for convicted offenders. In a criminal case, the state, through a prosecutor, initiates the suit. Persons convicted of a crime may be incarcerated, fined or both. Criminal law has the added objective of seeking to achieve deterrence and retribution through punishment.¹⁷

Generally, the basic elements of a crime include a voluntary act coupled with the appropriate mental state.¹⁸ Usually, the criminal law punishes only affirmative harm the offender inflicts. However, failure to act may be a crime if the defendant had a legal duty to act or the inaction rises above civil negligence to include a level of risk taking indifferent

to the attendant risk of harm.¹⁹

A legal duty to act may arise out of other laws such as statutes (a law passed by a legislative body),² or contract (a binding agreement between two or more bodies enforceable by law).² Health care providers are subject to both. For instance, physicians are legally prohibited from refusing to treat patients because the patients are seropositive for the human immunodeficiency virus (HIV).²⁰ Similarly, hospitals, HMO's and nursing facilities have physician employment contracts creating a legal obligation to treat all patients admitted to the facility.

Prosecutors who cannot rely on statute or contract can still prevail if a health care provider's indifference to the risk of harm amounts to either criminal negligence or recklessness.²¹ If it could be shown that a physician's negligence rose to the level of gross inattention, gross lack of competency, or criminal indifference to the patient's well-being, criminal negligence could attach.²² In legal parlance, for recklessness to apply, an actor must be aware of a substantial or unjustified risk inherent in the conduct, but proceeds in the face of such risk.¹⁹

Despite this explanation, what medical acts transform tort negligence into criminal negligence remains anybody's guess. Courts and common law have not been helpful in clarifying how criminal negligence applies to the practice of medicine. However, current definitions do seem to contemplate that criminal negligence is more than a mistake in judgment.²³ That notion can be found in the following definitions: "That degree of negligence or carelessness which is denominated as gross, and which constitutes such a departure from what would be the conduct of an ordinarily careful and prudent man... as to furnish evidence of that indifference to consequences which in some offenses takes the place of criminal intent."²⁴ or "Negligence, to be criminal, must be reckless and wanton."²⁵ In the end, what will tip the criminal vs. civil balance might be whether justice would be better served if a medical act or omission requires the defendant to pay the victim for the loss or whether the defendant should pay society for the loss.²⁵

CRIMINAL PROSECUTIONS OVERSEAS

Criminal prosecution of health care providers for medical errors is not novel to American jurisprudence. Courts in Japan, New Zealand, Saudi Arabia, and India also see their health care providers on trial as criminal defendants for medical acts. Although no single answer adequately explains

what drives criminal prosecution for medical mistakes in other countries, culture and lack of alternative forms of redress probably have a hand on the wheel.

For instance, Japan relies heavily on criminal prosecution to carry out the social function of public accountability for medical mistakes.²⁶ American entities such as Medicare Quality Improvement Organizations, state licensure and discipline boards, and quasi-public accrediting organizations such as the Joint Commission for Accreditation of Healthcare Organizations (JCAHO) and the National Committee for Quality Assurance (NCQA) are without effective overseas counterparts.²⁷ One reason for this is that hospitals in Japan need not be accredited by a JCAHO-like organization to obtain payment for services rendered.²⁸ When the Japan Council for Quality Health Care (JCQHC), JCAHO's overseas brethren, does offer accreditation, it focuses on structure and process, not on patient safety related-outcomes.²⁶

CRIMINAL PROSECUTION IN THE UNITED STATES

To describe the criminal prosecution of health care providers in the United States as a trend might be asking too much from the term when you compare the flurry of criminal cases to the blizzard of civil litigation providers face when they are accused of medical malpractice. None-the-less criminal prosecution for medical acts is on the rise.²⁹ Between the time of the first such criminal case in 1809, *Commonwealth of Massachusetts v. Thompson*,³⁰ and 1981, appellate courts heard approximately 15 similar cases. Over the next twenty years, approximately two dozen cases found their way into the lower courts.³¹

The overwhelming predominance of civil liability cases makes head-to-head comparison difficult. However, enough criminal cases have surfaced over the last twenty years to make some observations possible. For instance, two distinct layers of behavior settle out of the emulsion of criminal cases arising from medical acts. One layer contains cases which so closely resonate with the mens rea or guilty mind embodied in criminal statutes that no controversy can legitimately exist. These include attempts to defraud the Medicare program³² and illegally prescribing medication.³³ The other layer involves purely medical acts and is more difficult to rationalize. The following case is used to exemplify the difference between these layers.

PEOPLE V. MILOS KLVANA

On December 18, 1989, Milos Klvana was convicted on nine counts of second degree murder.³⁴ Klvana obtained his medical degree in 1967 in Czechoslovakia.³⁵ After failing, due to poor performance, to complete a residency in obstetrics and gynecology in New York, and after being forced to resign a residency in anesthesiology at Loma Linda University upon the discovery that he was responsible for a patient's death, Klvana embarked on a private practice in the Los Angeles area.³⁵ While on probationary status with the California Medical Board for misdemeanor convictions of 26 counts of prescribing controlled substances without a good faith examination, Klvana applied for staff privileges at various hospitals, often failing to disclose his probationary status and misrepresenting himself as "board eligible" in obstetrics and gynecology.³⁵

During his six-month trial, experts revealed the way Klvana's conduct fell egregiously below the standard of care.³⁴ This testimony included his failure to monitor the conditions of the mothers during delivery, his disregard of signs of infant stress, including the presence of meconium, his absence during delivery, and his disregard of infants' exhibitions of obvious danger signs, including difficulty breathing, as well as his failure to perform high-risk deliveries in the hospital.³⁴

Through the lens of Dr. Klvana's conviction, it becomes easier to distinguish his level of culpability from the culpability of a nurse who failed to notify a physician with a change in a patient's condition in a timely manner,³⁶ or a physician who confused sepsis with dehydration in an eleven month old child.³⁷

ARGUMENTS FOR AND AGAINST PROSECUTING MEDICAL PROFESSIONALS

Several theories exist to explain the rise in criminal prosecutions. Some cite an increasing acceptance to view medical negligence as a white collar crime with its hybrid civil/criminal nature.³⁸ Others cite the failure of state and federal regulatory agencies such as state licensing boards to adequately "police" the medical profession.⁹

Proponents of criminal prosecution rely on utilitarian and retributive theories of justice to rationalize their position. Utilitarians believe criminal sanctions are appropriate when punishing negligent conduct because prosecution encourages all individuals to conduct themselves with more caution.¹⁹ Utilitarian theory applied to health care supports

the notion that the threat of criminal sanctions would force physicians to monitor their own practices.¹⁹ Retributive justice, a theory centered on the notion that punishment is justified on the grounds that the criminal has created an imbalance in the social order, also supports criminal sanctions for medical acts.²² A physician's inadvertent risk taking may be viewed as a "fault in social interaction" that should be punished through criminal sanctions.²²

Those who oppose criminally punishing negligent medical conduct argue that a just criminal system should only punish those who have voluntarily committed a wrong.¹⁹ Based on this theory, it would be unjust to punish an actor for risk taking that is inadvertent or when the actor is unaware that the conduct creates a risk of danger.¹⁹ In addition, a negligent actor who fails to identify her dangerous conduct, would also fail to comprehend the potential threat of sanctions for such conduct.³⁹ Therefore, it would be unjust for such a defendant to lose her liberty and be stigmatized.⁴⁰

Medical associations and physician specialty groups add that criminal prosecution for clinical errors would set a dangerous precedent.⁴¹ They argue such a precedent will drive physicians away from taking hard cases or experimenting in new areas.⁴² Others argue that such a precedent will encourage the practice of defensive medicine and further drive up the cost of health care.⁸ There may come a day when only the bravest or most foolhardy clinician will opt for anything but the least controversial option.⁴³

CONCLUSION

It may be too early to tell if criminal prosecution of health care professionals for medical acts represents a new legal threat to health care for the coming decade. The fear emerging from these cases is that the general public may grow to expect criminal charges should follow every bad outcome or medical misadventure.⁴⁴ Before this happens, those making prosecutorial decisions should keep two things in mind.

First, emergency medicine is inherently risky business. Emergency care is frequently delivered through understaffed, overcrowded, antiquated facilities straining to accommodate the nation's sickest, and impoverished patients. Second, emergency patients are frequently gravely ill. Bad outcomes do not necessarily mean that care was negligent.⁴⁵ When mistakes do happen, health care providers are not necessarily criminally at fault.⁴⁵ Given the nature of the work and its complexity, physicians 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 of well-intentioned medical professionals.⁴⁵

One way to reduce this treat is to draft legislation reserving criminal prosecution for acts possessing the gross, wanton, and deliberate misconduct, with an accompanying mens rea, that truly deserves punishment. Another is for regulatory agencies and peer review boards to be more proactive in uncovering negligent practices and weeding out incompetent physicians. Only when these mechanisms are exhausted or when the negligent act amounts to more than human mistake should criminal sanctions be sought.

Criminal sanctions against health care personnel should be an extraordinarily rare event in clinical medicine. Although cases are sparse, the number of medical professionals facing criminal prosecution is increasing. Clearly, the time to address this problem is now. Complacency might be all it takes to transform aberrant behavior into common occurrence.

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