

Risk Rx

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Medical Malpractice- When Does it Become a Crime? A Historical Review

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In November 2011, Dr. Conrad Murray was tried and convicted of involuntary manslaughter for providing Michael Jackson with propofol; he is serving a four year sentence in prison. A year before, Dr. Sandeep Kapoor, physician to Anna Nicole Smith, was tried and acquitted of involuntary manslaughter charges for providing her with numerous prescriptions for opiates and sedatives found in her system at the time of her death. In 2006, Julie Thao, an RN in Wisconsin, pled guilty to two misdemeanors after being charged with criminal neglect in the death of a 16 year old patient after mistaking an anesthetic for an antibiotic. Ms. Thao administered the wrong drug after working 2 eight hour shifts, sleeping 7 hours at the hospital, and then starting another 8 hour shift. In the aftermath of Katrina, Dr. Anna Pou, faculty at the Louisiana State University Health Sciences Center in New Orleans, was charged with murder for allegedly injecting critically ill patients with a lethal combination of drugs; in 2007 a grand jury refused to indict her. Do these high profile cases indicate a new or growing trend to criminalize medical malpractice? Have the standards changed?

The concern regarding an increase in criminal prosecution for medical malpractice is not new. In 1993, concerned about the trend, the AMA adopted a resolution, which has since been reaffirmed mul-

iple times, to “insure that medical decision-making, exercised in good faith, does not become a violation of criminal law...”¹ In 1995 the AMA stated that it opposed “the attempted criminalization of health care decision-making especially as represented by the current trend toward criminalization of malpractice...”² In a 1997 review of the issue, Paul R. Van Grunsven pondered “[w]hy does there seem to be [an] increase in criminal prosecution of health care providers for clinical mistakes and fatal errors?”³ In 1998, the AMA again addressed the issue -- committing to “educate physicians regarding the continuing threat posed by the criminalization of healthcare decision-making...”⁴

While there is no definitive source of comprehensive data, the most frequently cited evidence supporting the view that the incidence of criminal charges against healthcare providers for alleged negligence is increasing, is a review published by James A. Filkins, *The Criminal Prosecution of Physicians for Medical Negligence “With No Evil Intent.”*⁵ In his review of the court cases, Filkins found only about 15 reported appellate cases in the 172 years between 1809 and 1981. In the 20 years after that (1981-2001), Filkins found at least 9 reported appellate cases; additionally he found 12 other cases which were discussed in newspapers or television, but which did not result in reported cases. In the ensuing decade (2001-2011) another researcher using Filkins’ methodology found around 37 reported criminal cases.⁶ Even if this data does in fact indicate an increase, it is clear that such prosecutions nevertheless remain fairly uncommon,⁷ and they certainly are not new. Furthermore, the standard for a conviction seems to be fairly consistent over time. That is, it typically takes more than “mere” negligence to attract the attention of a

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prosecutor, and to ultimately get a conviction. Generally, for negligence – medical or otherwise – to rise to the level of a criminal act, behavior that reflects “gross negligence” or “recklessness” is required.

The earliest reported case in American jurisprudence appears to be a Massachusetts Supreme Court case, *Commonwealth v Samuel Thompson*.⁸ (Mr./Dr.) Thompson

“came into *Beverly*, where the deceased then lived, announced himself as a physician, and professed an ability to cure all fevers, whether black, gray, green or yellow; declaring that the country was much imposed upon by physicians, who were all wrong, if he was right. He possessed several drugs, which he used as medicines, and to which he gave singular names. One he called *coffee*; another, *well-my-gristle*; and a third, *ramcats*. He had several patients in *Beverly* and in *Salem* ... when the deceased, having been for several days confined to his house by a cold, requested that the prisoner might be sent for as a physician.

He accordingly came, and ordered a large fire to be kindled to heat the room. He then placed the feet of the deceased, with his shoes off, on a stove of hot coals, and wrapped him in a thick blanket, covering his head. In this situation he gave him a powder in water, which immediately puked him. Three minutes after, he repeated the dose, which in about two minutes operated violently. He again repeated the dose, which in a short time operated with more violence. These doses were all given

within the space of half an hour, the patient in the mean time drinking copiously of a warm decoction, called by the prisoner his *coffee*. The deceased, after puking, in which he brought up phlegm, but no food, was ordered to a warm bed, where he lay in a profuse sweat all night.”⁹

Thompson treated the patient, Ezra Lovett, with his emetic powders and ‘coffee’ for a week, during which he “appeared to be comfortable [after repeatedly puking], although complaining of increase debility.” On the last day, Dr. Thompson

“administered another of his emetic powders, and in about twenty minutes repeated the dose. This last dose did not operate. The prisoner then administered pearlsh mixed with water, and afterwards repeated his emetic potions. The deceased appeared to be in great distress, and said he was dying.... [That] evening, the deceased lost his reason, and was seized with convulsion fits; [after which] the prisoner got down his throat one or two doses more of his emetic powders; and remarked to the father of the deceased, that his son had got the hyps like the devil, but that his medicines would fetch him down; meaning, as the witness understood, would compose him. The next morning, the regular physicians of the town were sent for, but the patient was so completely exhausted, that no relief could be given.”¹⁰

The prosecutor accused Thompson of murder, a conviction which the court rejected finding there was no evidence that he intended to kill or injure his patient. Alternatively, the prosecutor argued

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that Thompson was guilty of manslaughter, because he “rashly and presumptuously administered ... a deleterious medicine, which, in his hands, by reason of his gross ignorance, became a deadly poison.”¹¹ Rejecting the manslaughter charge as well, the Court found that, although Thompson’s

“ignorance [was] in this case very apparent ... notwithstanding this ignorance ... if [he] acted with an honest intention and expectation of curing the deceased by [the] treatment, although death, unexpected by him, was the consequence, he was not guilty of manslaughter. **** [I]f a physician, whether licensed or not, gives a person a potion, without any intent of doing him any bodily hurt, but with intent to cure, or prevent a disease, and contrary to the expectation of the physician, it kills him, he is not guilty of murder or manslaughter.”¹²

Nevertheless, the Court stated that had it been shown that Thompson had previous experience with the deleterious effects of his treatment, one might then presume that the death had occurred due to “obstinate rashness and foolhardy presumption, although he might not have intended any bodily harm to his patient.”¹³ Such behavior (established knowledge of ill effects), the Court said, could form a reasonable basis for a manslaughter conviction. Although the Court’s emphasis on “honest intentions” did, by its own analysis, seem to provide a substantial barrier to conviction on a criminal charge,¹⁴ this latter language appears to be the precursor to current standards for establishing criminal negligence. Roughly three quarters of a century later, the Massachusetts

Supreme Court slightly changed its own opinion.

In 1883, Dr. Franklin Pierce was tried based on allegations that:

“on the seventh day of January, in the year eighteen hundred and eighty-three, and on divers other days and times between that day and the ninth day of January, in said year eighteen hundred and eighty-three, in and upon one Mary A. Bemis ... wilfully and feloniously, did make divers assaults, and ... wilfully, feloniously, ignorantly, rashly, injuriously, and improperly, put, pour, and place, and cause and procure to be put, poured, and placed, on and upon the body, arms, legs, and feet of her, the said Mary A. Bemis, certain large quantities, to wit, two gallons of kerosene oil, and that the said Franklin Pierce, by the means and in the manner aforesaid, did then, and at the several times aforesaid, there feloniously cause her, the said Mary A. Bemis, to be and become mortally sick, weak, shocked, diseased, and disordered in her body aforesaid, of which said mortal sickness, weakness, shock, disease, and disorder of her body, occasioned and brought on by the means and in the manner aforesaid, ... she ... did languish and languishing did live, [and on the] fourteenth day of January, in the year aforesaid, ... the said Mary A. Bemis, of the said mortal sickness, weakness, shock, disease, and disorder, occasioned and brought on as aforesaid, died.”¹⁵

Apparently, Dr. Pierce had treated other patients similarly with positive results, but at least in one

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case, the treatment had resulted in blistering and burning of the skin, as with Mrs. Bemis. Relying on the 1809 *Thompson* opinion, Dr. Pierce argued that to be found guilty of manslaughter he would have to show “so much [actual] knowledge or probable information of the fatal tendency of the prescription that [death could] be reasonably presumed by the jury to be the effect of obstinate willful rashness, and not of an honest intent and expectation to cure.”¹⁶ In this case however, the Massachusetts Supreme Court rejected the ‘good intentions’ argument, stating “[s]uch may once have been the law, but for a long time it has been ... recognized that a man may commit murder or manslaughter by doing otherwise lawful acts recklessly....”¹⁷ The Court defined recklessness to be “a certain state of consciousness with reference to the consequences of one’s acts, [regardless of] whether [a result of] indifference to what those consequences may be, or ... a failure to consider their nature or probability as fully as the [the prudent person].”¹⁸ In adopting a recklessness standard -- rejecting the *Thompson* well-intended standard -- the Court states that “where [there is no] sudden emergency, and no exceptional circumstances are shown ... we cannot recognize a privilege to do acts manifestly endangering human life, on the ground of good intentions alone.”¹⁹ In *Pierce*, it is interesting to note that the Court addressed the issue of a patient’s consent to the disputed treatment (a factor in the *Murray* case), stating “seriously and unreasonably endangering life according to common experience, [the physician took actions that] his patient could not justify by her consent, and which therefore was an assault notwithstanding that consent.”²⁰

Two decades later (1905) in Florida, a Hillsborough prosecutor alleged that surgeon Hiram Hampton

“took and had the charge and care of ... Luvenia Evans and that ... [he] ... did then and there on the second day of May, in the year our Lord one thousand nine hundred and four, with force and arms ... unlawfully, feloniously, wilfully and by unskillful acts and procurement and culpable negligence and the exercise of gross ignorance and the lack of ordinary knowledge and skill in surgery and with utter disregard for the health, safety and life of the said Luvenia Evans in the performance of a certain surgical operation upon her ... did then and there insert, thrust and strike a certain instrument, a further description of which is to the [prosecutor] unknown, which said instrument he ... had and held in his hands, up and into the womb, abdomen and body of the said Luvenia Evans and did then and there in an unskillful, culpable, felonious and negligent manner aforesaid plunge and force an entrance through the womb of the said Luvenia Evans into the abdomen of the said Luvenia Evans then and there in the manner aforesaid producing a large rent in and through the womb of the said Luvenia Evans and membranes in the regions of the womb of the said Luvenia Evans and did then and there in the manner aforesaid pull out the intestines of the said Luvenia Evans and did thereby then and there unlawfully, feloniously, by his acts, procurement and culpable negligence inflict upon the said Luvenia Evans in and about her womb, abdomen and other internal parts certain mortal bruises, wounds and lacerations and created in the said Luvenia Evans a

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mortal sickness and feebleness of body, of which ... she ... did languish and languishing did live until the third day of May ... on which ... of the mortal bruises, wounds, lacerations, sickness and feebleness of body she ... did then and there die, and ... so that said Hiram J. Hampton ... did then and there in the manner and form aforesaid unlawfully, feloniously, by and through [his] acts, procurement and culpable negligence kill and slay the said Luvenia Evans, against the form of the statute in such cases made and provided and to the evil example of all others in like cases offending, and against the peace and dignity of the State of Florida.”²¹

At that time, Florida law provided that a physician could be found guilty of manslaughter if he was intoxicated at the time of the performance of the acts causing the death of a patient. Dr. Hampton argued that the statute furnished the exclusive circumstances under which a physician could be convicted of manslaughter for medical malpractice, and propounded the good intentions argument recognized by the *Thompson* court governed any other circumstance. The Florida Supreme Court disagreed on both counts. First, the Court found that the intoxication statute did not supersede the general manslaughter statute providing that “[t]he killing of a human being by the act, procurement or culpable negligence of another, in cases where such killing shall not be justifiable or excusable homicide nor murder ... shall be deemed manslaughter.”²² (The language of the current statute, F.S. §787.07, is almost identical. Additionally, Florida has a statute addressing “culpable negligence” F.S. §784.05.) Further, the Court declared that

[t]he law seems ... fairly well settled ... that where the death of a person results from the criminal negligence of [a treating physician, he] is guilty of manslaughter, and [such] criminal liability ... is not dependent on whether or not the party undertaking the treatment ... is a duly licensed practitioner, or merely assumes to act as such, acted with good intent ... and did so with the expectation that the result would prove beneficial. ... [The] real question upon which the criminal liability depends in such cases is whether there was criminal negligence. ... That criminal negligence exists where the physician or surgeon ... exhibits *gross lack of competency*, or *gross inattention*, or *criminal indifference* to the patients safety, and that this may arise from his *gross ignorance* of the science of medicine or surgery, and of the effect of the remedies employed, through his *gross negligence* in the application and selection of remedies, his lack of proper skill in the use of instruments, or through his failure to give proper instructions to the patient as to the use of the medicines; *that where the person treating the case does nothing that a skilled person might not do, and death results merely from an error of judgment on his part, or an inadvertent mistake, he is not criminally liable.* (Emphases added.)²³

In the case of Mrs. Evans, testimony at trial indicated that Dr. Hampton drew out four or five feet of bowel through Mrs. Evans’ uterus and vagina, mistaking it apparently for the “bag of waters” of an unborn child. The jury found him guilty of manslaughter, and the Supreme Court upheld the verdict.

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Citing to the decision of the Florida Supreme Court in *Hampton*, in addressing the indictment of chiropractor Charles Lester for culpable negligence (under a statute similar to Florida's) for the death of a patient due to burns caused by his use of an x-ray machine, the Minnesota Supreme Court stated that "[g]ross as ... used [in the *Hampton* opinion] is intended to convey the idea of recklessness with regard to the safety of others, or, [as expressed by the *Pierce* Court] 'foolhardy presumption'."²⁴ (Emphasis added.)

In 1940, the Florida Supreme Court 'clarified' that the rule articulated in *Hampton* applied to passive acts as well. In *State v. R.L. Heines*²⁵, the Court upheld the indictment of a chiropractor who advised a diabetic patient with an infected foot to stop taking his insulin; as a result the patient died. The Court held that "[i]f a person undertakes to cure those who search for health and who are, because of their plight, more or less susceptible of following the advice of any one who claims the knowledge and means to heal, [the physician] cannot escape the consequence of his gross ignorance of accepted and established remedies and methods for the treatment of diseases from which he knows his patients suffer and if his wrongful acts, positive or negative, reach the degree of grossness he will be answerable to the State."²⁶ (Emphasis added.)

The gross ignorance and "answerable to the State" concepts were well expressed by the New Jersey Supreme Court in its review of Dr. Weiner's conviction for involuntary manslaughter. Dr. Weiner, a neuropsychiatrist, was convicted based on his nurse's negligence, which allegedly caused 15 of his patients to be infected with, and die from, hepatitis. In distinguishing a criminal practitioner

negligence case from a civil one, the Weiner Court stated that in the former,

"[t]he 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 '[n]egligence 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.'"²⁷ (Emphasis added.)

The Supreme Court overturned Dr. Weiner's conviction, finding the concept of *respondet superior* inapplicable in a criminal context. More recent cases continue to similarly articulate the need to establish something more than 'ordinary' negligence to rise to a criminal level. For example, in considering the case of Dr. Wood, the United States Court of Appeals for the 10th Circuit stated "[i]nvoluntary manslaughter... is the unlawful killing of a human being without malice in the commission, without due caution and circumspection, of a lawful act which might produce death. [citation omitted] The defendant's acts must amount to 'gross negligence,' defined as 'wanton or reckless disregard for human life.' 'Gross negligence' describes a degree of culpability far more serious than tort negligence. [citations omitted]"²⁸ In *United States v. Donal Billig*, the military court expressed its "distaste for holding a physician criminally liable for simple negligence" and stated

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“[p]eople 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 the medical personnel occurred – or if some negligent act did occur, that anyone is criminally responsible therefore. Given the critical 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.”²⁹

As noted at the beginning of this article, there have never been many reported cases. In addition to those, one can find several cases reported in newspapers and journals. While the overall number of cases is not large, some reports indicate that there does appear to be increased prosecutorial activity based on controlled substance prescribing practices. Florida in particular is seen as a hotbed of such activity. According to a report by Reuters, Florida Attorney General Pam Bondi views Florida as an “epicenter” of prescription drug abuse, and dozens of doctors and clinic operators have been indicted for unnecessarily prescribing pills.³⁰ Some have been convicted. In 2002, Dr. James Graves of Pensacola was convicted of manslaughter for the overdose deaths of four of his patients for prescribing OxyContin and other narcotics.³¹ In 2003, Dr. George Kubski, a Palm Beach psychiatrist, pled guilty to manslaughter by culpable negligence for causing the death of a patient who was prescribed

almost 20,000 doses of painkillers, anti-anxiety drugs and sleeping pills during a short time period.³²

While pain management prescribing practices may be under close scrutiny these days, there is no reason to conclude that the standard in those cases is any different than that indicated by the cases reviewed herein. Those clearly establish that even where a prosecutor may be overzealous in bringing a case, generally, courts will not find health care practitioners guilty for acts of “simple” negligence. Generally, only acts rising to the level of gross negligence or reckless disregard for life are subject to conviction.³³ (In his review of cases, Filkins suggests that a critical question that seems to affect whether medical malpractice will be viewed as criminally liable is did the accused “Give a Damn?”³⁴ What I call the “Rhett Butler standard.”)

In conclusion, even if it is true that there has been a slight up-tick in the criminalization of medical malpractice in the last decade or two, it would appear that it continues to be reserved for cases that indicate a gross deviation from the standard of care, indicating “reckless disregard” for the consequences of the treatment being offered. Consequently, continuing to strive to practice as would any other prudent practitioner in the same or similar circumstances, not only should protect against “ordinary” medical malpractice, but against a criminal action as well. Moreover, even “honest mistakes” that are the subject of medical malpractice lawsuits are highly unlikely to be targeted for criminal prosecution. With regard to the more risky area of pain management, following the recent Florida State legislative and regulatory parameters for practice where applicable, careful and complete documen-

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tation of the rational for prescriptions, and careful monitoring of patient drug use (to the extent reasonably feasible) should significantly reduce if not eliminate the risk of any criminal actions. Just like you do to reduce the risk of 'regular' negligence actions – focus on the delivery of quality medical care – and be the best practitioner you can be.

¹AMA Policy H-160.954, *Criminalization of Medical Judgment*.

²AMA Policy D-160.999, *Opposition to Criminalizing Health Care Decisions*.

³Paul R. Van Grunsven, *Medical Malpractice or Criminal Mistake? – An analysis of Past and Current Criminal Prosecutions for Clinical Mistakes and Fatal Errors*, 2 DePaul Journal of Health Care Law 1, 1997.

⁴AMA Policy H-160.946, *The Criminalization of Health Care Decisionmaking*.

⁵James A. Filkins, *The Criminal Prosecution of Physicians for Medical Negligence "With No Evil Intent."* Journal of Legal Medicine Vol. 22 pp. 467-499, December 2001.

⁶Terry Baynes, Thomson Reuters News&Insight, *Michael Jackson's doc represents rise in criminal prosecutions*, <http://newsandinsight.thomsonreuters.com/Legal/News/2011/09 - SeptemberMichael Jackson s doc represents rise in criminal prosecutions/>, accessed 3/21/2012.

⁷It should be noted that these numbers do not reflect criminal prosecutions for violations of state and/or federal controlled substances laws, which are estimated to be much higher. At least 335 such criminal cases were brought by state and federal authorities against physicians from 1998-2006. Judy McKee, *Perception Versus Reality: The Facts Regarding Prosecutions and Disciplining of Doctors for Abuses Involving Controlled Substances*, National Association of Attorneys General NAA Gazette Volume 2, Number 8 September 24, 2008. Such prosecutions are beyond the scope of this article.

⁸*Commonwealth v. Samuel Thompson*, 6 Mass. 134 (Mass. 1809)

⁹*Id.* at 134

¹⁰*Id.* at 134-135

¹¹*Id.* at 139

¹²*Id.* at 140-141

¹³*Id.* at 141

¹⁴In closing, the Court muses that "[i]t is to be exceedingly lamented, that people are so easily persuaded to put confidence in these itinerant quacks, and to trust their lives to strangers without knowledge or experience. If this astonishing infatuation should continue, and men are found to yield to the impudent

pretensions of ignorant empiricism, there seems to be no adequate remedy by a criminal prosecution, without the interference of the legislature, if the quack, however weak and presumptuous, should prescribe, with honest intentions and expectations of relieving his patients." *Id.* at p. 142

¹⁵*Commonwealth v. Franklin Pierce*, 138 Mass.165 (Mass. 1884) at 165.

¹⁶*Id.* at 174, quoting *Thompson*.

¹⁷*Id.* at 175

¹⁸*Id.* at 176

¹⁹It is interesting to note the clear exception for emergency circumstances. Under Florida law, the standard for establishing a civil suit for "negligence" in an emergency department situation is "gross negligence."

²⁰*Pierce*, 138 Mass.165 at 180

²¹*Hiram J Hampton v. State of Florida*, 50 Fla. 55 (Fla 1905)

²²*Id.* at 63

²³*Id.* at 63-64

²⁴*State v. Charles A. Lester*, 127 Minn. 282, 285 (Minn. 1914)

²⁵*State v. R.L. Heines*, 144 Fla. 272 (Fla. 1940)

²⁶*Id.* at 275.

²⁷*State of New Jersey v. Albert L. Weiner*, 41 N.J. 21, 25-26 (N.J. Sup. Ct. 1963)

²⁸*United States v. Wood* 207 F.3d 1222, 1228 (10th Cir. 2000)

²⁹*United States v. Donal M. Billig*, 26 M.J. 744, 760-761 (1988)

³⁰More U.S. doctors facing charges over drug abuse, Terry Baynes, Reuters Sept. 14, 2011; www.reuters.com/article/2011/09/14/us-jackson-malpractice-idUSTRE78D3P620110914, accessed Mar 28, 2012.

³²Monica Scandlen, *Landmark Oxycontin Case*, Pensacola News Journal Feb 20, 2002

³³John Pacenti and Antigone Barton, *Psychiatrist Gets Year for Patient's Pill Death*, Palm Beach Post Feb.1 ,2003.

³³As in other criminal cases, conviction for the involuntary manslaughter based on medical malpractice is not immune to error. See e.g., *New York v. Einaugler*, 618 N.Y.S.2d 414 (App. Div. 1994) in which the New York appellate court upheld the conviction of Dr. Gerald Einaugler for reckless endangerment for allegedly delaying the transfer of a nursing home patient to the hospital after causing the patient to be fed Isocal through the dialysis catheter. Dr. Einaugler had his sentence commuted by Governor Pataki of New York; even though convicted by a jury, a review by the State Office of Professional and Medical Conduct reviewed the case and decided he did not deserve to be sanctioned. See Esther B. Fein, *Doctor in Negligence Case Gets His Sentence Eased*, New York Times June 28, 1997 <http://www.nytimes.com/1997/06/28/nyregion/doctor-in-negligence-case-gets-his-sentence-eased.html>, last accessed March 29, 2012.

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Filkins, *supra*, 479, citing Paul Monks, Frankly My Dear, I don't
³⁴Give a Damn. 36 Med., Sci. & Law 185 (Oct. 1999).



Operating Room Or Concert Hall?

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Senior surgeons remember the days when an operation began with the surgical resident helping the anesthesiologist induce the depth of slumber that would enable effective operative intervention. The “help” usually involved keeping a finger on the patient’s pulse to assure it stayed there! Much has changed since those days of open drop ether and explosive anesthetics. Anesthesiologists correctly believed that good surgeons deserved good anesthesia, and less talented surgeons required it. Thus, the process of induction, which was the real start of a surgical procedure, was invariably conducted in a quiet, calming, confident environment designed to focus wholly and completely on the patient and assure safe passage to “surgical” anesthesia. This same focus carried over to actual performance of the procedure which demanded intense concentration, anticipation of findings, and complete environmental control. Since those days, surgical science has advanced, technology has evolved, and miniaturization has com-

pressed what used to require a room full of computer storage onto a microchip half the size of a postage stamp, and probably half the cost! It would have been outlandish to bring the Beatles’ White Album into the OR, key up the needle, and operate to the tunes of “Hey Jude”. Yet today a surgeon can bring the entire compendium of the Beatles’ career into the OR in his or her scrub suit pocket. In fact, sometimes it seems that more time is spent devising the playlist than preparing the surgical site. On top of all of this a debate has emerged about the role of music in the OR. Does it soothe the savage beast and facilitate cognitive function? Does it lower operative stress, for both patient and surgeon? Can the patient actually hear what is being played, as some anecdotal data would suggest? In other words, is all this symphonic support an enhancement or a distraction?

If 99.9% of the time it was an enhancement, would the other 0.1% be a problem? According to some, that missing 0.1% would translate to 500 incorrect surgical procedures *per day*.¹ Most of us would consider that a problem, especially if we or our family were among the unlucky five hundred. Back in the days of the surgical resident keeping a finger on the pulse, operative surgery was complex. Today it is even more so, especially with the addition of limited access and robotic technology. This is the primary reason the OR has adopted the checklist strategy from the aviation industry. None of us would willingly get on an airplane captained by a sleep-deprived pilot who was working on the

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in-flight music selections while the flight attendants were out checking the hydraulics and tire pressures. Yet, in many operating rooms, that is exactly what goes on, as the nurse struggles to get everybody's attention to confirm that the guy lying on the table in the middle of the room actually belongs there, and for the right reason!

The take home message is very simple. Whether you are an advocate of an intra-operative symphony or not, the operative clinical mission is among the most complex in history and deserves the surgeon's undivided attention and leadership, from point of preparation, through execution, and for immediate review thereafter. By definition, the complexity of the modern operating room is a forest of distractions. Checklists enable the surgeon to traverse the forest safely and effectively. Whether the surgeon is humming a tune or listening to rap is immaterial, as long as the music's presence is accounted along with all the other potential distractions, and the team's focus stays on the patient and procedure, where it is supposed to be. Who is responsible for leading this process of safety assurance? Who is the navigator that assures that all distractions are accounted and controlled? That would be the same person to whom the patient has entrusted confidence and hope for efficacious surgical care. Spending at least as much time assuring that all real and potential distractions are controlled as is consumed by picking a playlist is not an option. It is a mandate that has been part of our culture since the days of Hippocrates.

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