

Chapter 51

Criminalization of Medical Negligence

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The Differences Between Civil and Criminal Negligence
The Problem in Prosecuting Criminal Medical Negligence

Patterns of Conduct Associated with Prosecutions for Medical Negligence
Recommendations
Conclusion

Although the criminal prosecution of physicians for medical negligence remains relatively rare, the 1990s saw an increase in the number of doctors appearing as criminal defendants to answer charges arising from medically negligent acts. This tendency prompted the American Medical Association (AMA) in 1995 to adopt a resolution opposing the “attempted criminalization of health care decision-making, especially as represented by the current trend toward criminalization of malpractice. . . .”¹ At the time of the 1995 resolution, the AMA estimated that only about ten physicians nationwide had been prosecuted for medical negligence,² but the organization feared increasing numbers of physician prosecutions.³

While the AMA’s worst fears have not been realized, criminal prosecutions of physicians for medical negligence have nevertheless sparked a degree of controversy which is out of proportion to the actual number of indictments.⁴ In January 2000, AMA spokesperson Nancy Dickey, MD stated that “[t]he matter of accountability for negligent or incompetent actions is already established in our health care and judicial systems. State and Federal courts, state licensing boards, and accrediting bodies all maintain accountability and standards.”⁵ Accountability, however, may not be so well established. Many commentators agree that an increasing number of physicians are being prosecuted for clinical mistakes, but explain the trend by pointing to the medical profession’s failure to police itself by, for example, failing to revoke the licenses of incompetent physicians.⁶ In the opinion of these commentators, public concern about the medical profession’s inability to prevent, or at least reduce, the number of significant medical errors may have encouraged the courts to intervene to protect patient safety.⁷ This explanation is not unanimously accepted: other commentators blame managed care and the loss of more personal physician–patient relationships for increasing prosecutions.⁸ Still others suggest that with the loss of public respect for physicians, there is less reluctance to demand severe penalties when bad outcomes do occur.⁹

* The opinions expressed in this paper are those of the author alone and do not necessarily reflect the opinions of the Department of Law of the City of Chicago or the Office of the Medical Examiner of Cook County, Illinois.

Whatever the explanation, neither the criminal prosecution of physicians for medical negligence nor the legal theories underlying the prosecution of physicians are particularly novel.¹⁰ The prosecution of physicians for medical negligence occurs within a well-settled legal framework that resolves, albeit imperfectly at times, guilt for *all* matters of reckless or negligent criminal acts—without distinguishing *medically* reckless or negligent conduct from other criminally reckless or negligent conduct. To the extent that certain physicians may appear to have been singled out unfairly, the blame lies with the individual prosecutors and not with the laws they seek to enforce.

This chapter identifies the factors that tend to bring about criminal prosecutions for medical negligence and which, in turn, result in convictions following trial. Although a bad outcome is always at the core of any criminal prosecution for medical negligence, even an unconscionably bad outcome is insufficient by itself to explain the successful prosecution of some medically negligent acts. Certain patterns of conduct appear to lead more commonly to criminal prosecutions for medical negligence. By avoiding these patterns of conduct, physicians can reduce the likelihood that they will become defendants in a criminal prosecution.

Avoiding inappropriate patterns of conduct is particularly important for the physician who wishes to stay out of criminal court because—unlike a civil action for medical malpractice—a prosecutor need not establish a deviation from the standard of care and causation to win a criminal conviction. Logically, deviation from the standard of care and causation should first be established much as they would in any civil lawsuit for medical malpractice. If there is no departure from the standard of care or if causation cannot be established, then there should be no *prima facie* criminal case that will satisfy due process.¹¹ Nevertheless, successful criminal prosecutions for medical negligence have occurred in the absence of any clearly defined standard of care or established causation.¹² Accordingly, this chapter recommends that screening panels similar to those employed in civil medical malpractice litigation be used to assure that prosecutors have objective medical advice before bringing an indictment.

THE DIFFERENCES BETWEEN CIVIL AND CRIMINAL NEGLIGENCE

Medical Negligence

Medical negligence is an act or omission by a physician rendered in the course of treating a patient, which is the cause in fact of harm to the patient and which fails to meet the appropriate standard of care, but which is rendered without any deliberate intent to harm the patient.¹³ This definition obviously excludes cases in which a physician uses medical treatment to mask a deliberate injury to the patient.¹⁴ If the physician is to be found liable for a negligent act, causation and a deviation from the standard of care must be proven. Causation, or cause in fact, means the “particular cause which produces an event and without which the event would not have occurred.”¹⁵ Standard of care is “the degree of care which a reasonably prudent person should exercise in same or similar circumstances.”¹⁶

Criminal Medical Negligence

Gross Deviation from the Standard of Care

Criminal negligence requires a more serious deviation from the standard of care than ordinary civil negligence. Typically, criminal negligence requires some gross or flagrant deviation from the standard of care.¹⁷ Whether a physician’s conduct deviated from the standard of care, and if so, whether that deviation amounted to a gross deviation, is determined by reference to an external or objective standard. As the jurist Oliver Wendell Holmes explained, “If a physician is not less liable for reckless conduct than other people, it is clear . . . that the recklessness of the criminal no less than that of the civil law must be tested by what we have called an external standard.”¹⁸ A physician’s failure to foresee consequences contrary to those the physician intended is “immaterial, if, under the circumstances known to him, the court or jury, as the case might be, thought them obvious.”¹⁹ In other words, a jury should look to what it believes a reasonable physician would have done under the same or similar circumstances.²⁰

Culpable State of Mind

A criminally culpable state of mind, that is, *mens rea*, is an element of most criminal acts, including criminal medical negligence.²¹ The physician guilty of criminal medical negligence must not only have committed a gross deviation from the standard of care, but must have done so with a criminally culpable state of mind. Section 2.02 of the Model Penal Code identifies four criminally culpable states of mind: “purposely,” “knowingly,” “recklessly,” and “negligently.”²² The latter two states of mind—recklessly and negligently—are the *mens rea* applicable in the criminal prosecution of medical negligence. Confusion sometimes arises because courts in different jurisdictions use terms such as “criminal negligence,” “gross negligence,” and “recklessness” more or less interchangeably.²³

Although this chapter will use criminal negligence to embrace criminal negligence as well as criminal recklessness, the distinction between the two lies not in the degree of the defendant’s deviation from the standard of care—it is a gross deviation in either case—but in the defendant’s state of mind.²⁴ *Criminal negligence* is the disregard of a substantial and unjustifiable risk of which the defendant *should have been aware*, but was not.²⁵ *Criminal recklessness* is the disregard of a substantial and unjustifiable risk *of which the defendant was aware*.²⁶ Criminal recklessness requires the defendant to be subjectively at fault. The defendant must have known that he or she was taking a substantial and unjustifiable risk, but consciously ignored the risk and continued the dangerous conduct.²⁷ In cases of criminal negligence, the defendant’s risk-taking is merely inadvertent.²⁸ In neither situation does the physician deliberately intend to cause harm to the patient.

The AMA has conceded that recklessness may serve as a basis for criminal liability, along with purposeful misconduct and criminal intent, but not negligence.²⁹ Although the AMA’s position is consistent with the opinions of those commentators who oppose any criminal liability for negligent conduct—medical or otherwise³⁰—the AMA has offered no compelling legal argument why a jurisdiction that has enacted negligence as a basis for criminal liability should create a special exemption for medical professionals.³¹

THE PROBLEM IN PROSECUTING CRIMINAL MEDICAL NEGLIGENCE

The problem in the current approach to prosecuting criminal medical negligence lies in the difficulty in establishing causation and the standard of care, especially when complex medical issues are involved. Often, the accused physician’s intention, his state of mind—rather than causation or the degree of any deviation from the standard of care—becomes the touchstone against which the jury evaluates any acts or omissions in deciding whether the defendant physician’s conduct rises to the level of a criminal offense. It is often easier for the jury in a criminal prosecution for medical negligence to put the cart before the horse and to decide that the negligence in question actually amounted to a criminal act when the jury has first decided that the defendant physician possessed a culpable state of mind. Rather than wrestle with causation and standard of care, the jury may simply adopt the expedient, noted by one British commentator, of asking, in effect: “Did the accused Give a Damn?”³²

This approach may be appropriate in distinguishing criminal recklessness from criminal negligence once a gross deviation from the standard of care has been established because the distinction between the two offenses lies in the defendant’s state of mind. As a means of distinguishing *civil* negligence from *criminal* negligence, this approach risks doing substantial injustice to the accused because the threshold questions of causation and standard of care are bypassed. If the defendant physician’s conduct suggests to

the jury that the accused was irresponsible or indifferent, then the physician may be found guilty even if the prosecution fails to establish causation or the standard of care.³³ Additionally, the acts or omissions that lead the jury to infer criminal intent may be distinct in time or place from the acts or omissions that directly caused the injury to the patient. Sometimes the jury will simply take a broad view of any other acts or omissions relevant to the defendant physician's medical practice to identify a pattern of conduct from which a culpable state of mind may be inferred.

PATTERNS OF CONDUCT ASSOCIATED WITH PROSECUTIONS FOR MEDICAL NEGLIGENCE

Table 51-1 identifies 16 cases since 1976 in which a physician was prosecuted for medical negligence.³⁴ Additionally, there is one case in which a corporation was prosecuted.³⁵ An examination of these cases suggests that certain patterns of conduct may be more likely to provoke criminal prosecutions for medical negligence and to result in convictions. Evidence pointing to any of these patterns of conduct may tempt the jury to skip over the more difficult and more aggressively disputed issues of causation and standard of care and to equate a culpable state of mind with criminal negligence. These patterns are summarized in Table 51-2 and discussed briefly below.

Disregarding Past Experience

In these cases, the jury found that a culpable state of mind existed and convicted the defendant physician because he had ignored *repetitions of the same problem* with the same or

different patients. The jury was able to avoid the complexities of causation or standard of care by concluding that the defendant physician had sufficient knowledge based on his previous experience of the problem to have known the problem would cause danger, but the physician ignored the danger.

Failing to Limit Harm in a Timely Manner

In these examples, the jury concluded that the defendant physician possessed a culpable state of mind and convicted because the physician failed to act in a timely fashion to limit the danger to the patient. The failure to act, not the initial negligence, was the decisive issue.

The Appearance of Improper Motive

Finally, the appearance of any improper motive in the defendant physician's conduct will enable the jury more readily to find a culpable mental state. Practicing medicine in defiance of license restrictions, practicing outside of one's area of expertise, attempting to cover up a clinical mistake, or practicing in a manner that suggests more interest in financial gains than patient well-being are common examples. This is the most commonly encountered pattern associated with criminal prosecutions for medical negligence.

RECOMMENDATIONS

Avoiding a Criminal Prosecution for Medical Negligence

Practice Medicine Conscientiously

The physician who wishes to avoid becoming a defendant in a criminal prosecution for medical negligence should observe the old adage, "first do no harm." Physicians should

| Defendant | Jurisdiction | Charge | Trial Date | Verdict | Appellate Decision |
|-----------|-----------------------------|-------------------------------------|------------|------------------------|--|
| Benjamin | New York | 2nd degree murder | 1995 | Guilty | Upheld |
| Billig | Military | 2nd degree murder | 1985 | Guilty | Reversed |
| Biskind | Arizona | Manslaughter | 2001 | Guilty | Appeal denied |
| Chem-Bio | Wisconsin | Reckless homicide | 1995 | <i>Nolo contendere</i> | N/A |
| Einaugler | New York | Reckless endangerment | 1993 | Guilty | Upheld |
| Grotti | Texas | Criminally negligent homicide | 2004 | Guilty plea | N/A |
| Klvana | California | 2nd degree murder | 1989 | Guilty | Upheld |
| Naramore | Kansas | 1st degree murder; attempted murder | 1996 | Guilty | Reversed |
| Pignataro | New York | Negligent homicide | 1998 | Guilty plea | N/A |
| Schug | California | 2nd degree murder | 1998 | Dismissal by court | N/A |
| Steir | California | 2nd degree murder | 2000 | Guilty plea | N/A |
| Verbrugge | Colorado | Reckless manslaughter | 1995 | Not guilty | N/A |
| Warden | Utah | Negligent Homicide | 1988 | Guilty | Upheld |
| Watt | New York | Criminally negligent homicide | 2002 | Guilty plea | N/A |
| Weitzel | Utah | Manslaughter and negligent homicide | 2000 | Guilty | Motion for new trial granted; not guilty |
| Wood | Oklahoma (<i>federal</i>) | 1st degree murder | 1998 | Guilty | Reversed and remanded; case dismissed |
| Youngkin | Pennsylvania | Involuntary manslaughter | 1977 | Guilty | Upheld |

Table 51-1 Recent prosecutions of medical negligence

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| Defendant | Culpable Act | Patterns of Conduct | | |
|-----------|--|------------------------------|-----------------------|-----------------|
| | | Disregarding Past Experience | Failing to Limit Harm | Improper Motive |
| Benjamin | Perforated uterus | | × | × |
| Billig | Coronary artery bypass | × | | |
| Biskind | Perforated uterus | | × | |
| Chem-Bio | Misread pap smears | | | × |
| Einaugler | Misplaced feeding tube | | × | |
| Grotti | Blocked endotracheal tube | | | × |
| Klvana | Mismanaged deliveries | × | × | × |
| Naramore | Improper administration of medications | | | × |
| Pignataro | Outpatient breast reduction | | × | × |
| Schug | Sent ill patient to another hospital | | × | |
| Steir | Perforated uterus | | × | × |
| Verbrugge | Slept during anesthesia | × | | |
| Warden | Failed to follow up on home delivery | | × | × |
| Watt | CO ₂ inhalation therapy | | | × |
| Weitzel | Improper administration of pain medication | | | × |
| Wood | Improper administration of medications | | | × |
| Youngkin | Barbiturate prescription | × | | |

Table 51-2 Culpable acts

be aware that certain patterns or practices are more likely to lead to criminal prosecutions and convictions for medical negligence. A physician should scrupulously comply with any restrictions that have been imposed on his or her license to practice medicine. Even if a physician has no license restrictions, or complies with any restrictions that have been imposed, the physician must be careful not to exceed his or her expertise, particularly if the work appears to be undertaken more for financial gain than patient welfare. Finally, the physician who fails to follow up conscientiously on his or her patients or who is caught attempting to cover up a clinical mistake risks being viewed as a physician who should be punished when something goes wrong, regardless of issues of causation and standard of care.

Maintain Adequate Resources

Settings in which the available medical resources are inadequate to meet reasonably foreseeable emergencies impose a further hazard. As more physicians perform surgeries or other invasive procedures away from hospitals—ostensibly as a means of reducing health care costs and providing medical care to underserved areas—criminal prosecutions for medical negligence may increase. The physician, whose office or clinic lacks the equipment to handle cardiopulmonary arrest, acute bleeding, or other complications that can precipitously arise during an invasive procedure, risks becoming a defendant in a criminal prosecution should something go wrong. The inadequacy of the resources makes the occurrence of a negligent act more likely, while exposing the physician to blame for having failed to anticipate and to prepare for the problem in the first place. Outpatient abortions or the delivery of infants at home or in a clinic may place the patient at a significant risk of harm

if something goes wrong, although the risk may not become apparent until the problem arises. Outpatient cosmetic surgery is another example of this problem.³⁶

Pre-Indictment Screening Panels

Most states require some form of screening by physicians before a medical malpractice case can be filed in court.³⁷ States also usually require that a claim of medical malpractice be proven through expert medical testimony.³⁸ These mechanisms safeguard the defendant in a civil medical malpractice case from lay juries that are unqualified to evaluate complex issues of patient care. Physicians who are charged with criminal medical negligence should be charged only when there is evidence to support both causation and a gross deviation from the standard of care, as well as the requisite state of mind. Accordingly, requiring prosecutors to present their cases to a medical review panel before seeking an indictment would reduce the likelihood of unmeritorious prosecutions for criminal medical negligence.³⁹ Prosecutors would have to convince the panel of the merits of a particular case and, in turn, would receive the panel's expert medical opinion regarding the potential defendant's deviation from the standard of care and whether the acts in question were the cause in fact of harm to the patient.⁴⁰ Pre-indictment screening panels would also help prevent criticism that certain prosecutions are politically motivated.⁴¹

CONCLUSION

The number of criminal prosecutions of physicians for medical negligence will likely continue to rise. The legal framework underlying the prosecution of criminally

negligent or reckless acts is well established. Logically, there is no reason why physicians or other health care professionals should be exempt from liability for medically reckless or negligent acts. Physicians themselves can do much to reduce their chances of becoming defendants in a criminal prosecution by avoiding certain practices. To ensure that only meritorious prosecutions of physicians for medical negligence are brought, causation and a breach of the standard of care should first be established just as they would in any civil proceeding for medical malpractice. If the physician's actions did not cause the harm to the patient or did not breach the standard of care, then the physician cannot have committed medical negligence, let alone criminal medical negligence. All concerned—prosecutors, defense attorneys, judges, and juries—should pay much greater attention to the fundamental issues of causation and standard of care. To this end, prosecutors should be required to present cases of criminal medical negligence to medical screening panels, similar to those used in civil medical malpractice cases, before seeking an indictment. Only if the defendant physician's actions are shown to be the cause of the patient's harm, and only if the physician's actions in causing that harm breached the standard of care, is an indictment for criminal medical negligence warranted.

Endnotes

1. Criminalization of Health Care Decision-Making, Resolution 202, Proceedings of the American Medical Association (June 1995).
2. *Criminal-Negligence Charges Rarely Filed Against Doctors*, Seattle Times (Jan. 15, 1998) at A14 (citing the AMA).
3. Jodie Snyder, *When Doctors Bury Mistakes, Criminal Charges May Follow*, Ariz. Rep. (Dec. 15 1998) at A1.
4. See, e.g., Alexander McCall Smith, *Criminal or Merely Human? The Prosecution of Negligent Doctors*, 12 J. Contemp. Health L. & Pol'y 131 (Fall 1995); Paul R. Van Grunsvan, *Medical Malpractice or Criminal Mistake? An Analysis of Past and Current Criminal Prosecutions for Clinical Mistakes and Fatal Errors*, 2 DePaul J. Health Care L. 1 (Fall 1997); Kara M. McCarthy, *Doing Time for Clinical Crime: The Prosecution of Incompetent Physicians as an Additional Mechanism to Assure Quality Health Care*, 28 Seton Hall L. Rev. 569 (1997); James A. Filkins, "With No Evil Intent": *The Criminal Prosecution of Physicians for Medical Negligence*, 22 J. Legal Med. 467 (Dec. 2001).
5. Nancy W. Dickey, MD, *Creating a Culture of Patient Safety*, AMA Statement (Jan. 26, 2000).
6. Thomas Maier, *More Doctors Face Prosecution: Crimes Charged in Cases of Deadly Error*, Newsday (Apr. 18, 1995) at A35.
7. Concerns about patient safety are valid. For example, on November 29, 1999, the Institute of Medicine for the National Academy of Sciences issued a report, *To Err Is Human*, estimating that medical errors cause between 44,000 and 98,000 deaths each year. See Robert Pear, *Group Asking U.S. for New Vigilance in Patient Safety*, N.Y. Times (Nov. 30, 1999) at A1. The newspaper *USA Today* put the number in perspective by declaring in a front-page headline "Medical Mistakes 8th Top Killer." *USA Today* (Nov. 30, 1999) at 1.
8. *Malpractice or Homicide?*, Wash. Post (Apr. 18, 1995) at A16.
9. *Id.*
10. The earliest example of a criminal prosecution for medical negligence in the United States identified in the course of research for this chapter was *Massachusetts v. Thompson*, 6 Mass. 134, 1809 WL 1120 (Mass. 1809).
11. *Utah v. Warden*, 813 P. 2d 1146, 1154 (Utah 1991) (Stewart, J. dissenting). If there is competent conflicting expert testimony that the defendant physician's actions were medically appropriate, then arguably there should be reasonable doubt. See also *Kansas v. Naramore*, 965 P. 2d 211, 223–24 (Kans. Ct. App. 1998).
12. See, e.g., *United States v. Billig*, 26 M.J. 744 (1988).
13. See, e.g., *Black's Law Dictionary* 959 (6th ed. 1990) ("Failure of one rendering professional services to exercise that degree of skill and learning commonly applied under all the circumstances in the community by the average prudent reputable member of the profession with the result of injury, loss or damage to the recipient of those services . . .").
14. See, e.g., James B. Stewart, *Blind Eye* (1999) (examining the case of Michael Swango, MD, who allegedly poisoned his patients with arsenic).
15. *Black's Law Dictionary* 221 (6th ed. 1990).
16. *Id.* at 1404–05.
17. *Joshua Dressler, Understanding Criminal Law* 113, 116 (2d ed. 1995).
18. *Massachusetts v. Pierce*, 138 Mass. 165; 1884 WL 6544, at *9 (Mass. 1884).
19. *Id.* at *10.
20. Dressler, *supra* note 17, at 115.
21. See *id.* at 101–03.
22. 1 Model Penal Code & Commentaries §2.02 (1985). See also Dressler, *supra* note 17, at 105–17 *passim*.
23. Dressler, *supra* note 17, at 113.
24. *Id.* at 116.
25. *Id.* at 113, 116.
26. *Id.* at 116.
27. *Id.*
28. *Id.*
29. See Judith Ann Gic, RN, CRNA, JD, FCLM, "The Criminalization of Medical Malpractice," Presentation to the American College of Legal Medicine (Mar. 9, 2002).
30. Dressler, *supra* note 17, at 113–14.
31. Gic, *supra* note 29.
32. Paul Monks, *Frankly My Dear, I Don't Give a Damn*, 36 Med., Sci. & Law 185 (July 1996). The criminal prosecution of physicians for medical negligence is not unique to the United States. See, e.g., *Regina v. Adomako*, 3 All E.R. 79 (H.L. 1994) (a notable case from Great Britain); Richard Dettmeyer et al., *Medical Malpractice Charges in Germany: Role of the Forensic Pathologist in the Preliminary Criminal Proceeding*, 50 J. Forensic Sci. 423 (Mar. 2005).
33. For example, the Court of Military Review in *United States v. Billig* observed that the prosecution "[i]n an attempt to establish the necessary element of culpable negligence in the involuntary manslaughter specifications" introduced "evidence... which essentially amounted to a smear campaign to portray Dr. Billig as a bungling, one-eyed surgeon who should have known better than even to enter an operating room because of his past mistakes and poor eyesight." 26 M.J. at 758. The review court noted, however, that the standard of care controlling Dr. Billig's conduct remained "elusive" and "nebulous." *Id.* at 759.
34. See, e.g., *New York v. Benjamin*, 705 N.Y.S. 2d 386 (N.Y. App. Div. 2000); *United States v. Billig*, 26 M.J. 744 (1988); Susie Steckner & Jodie Snyder, *Biskind Charged with Manslaughter*, Ariz. Rep. (Jan. 13, 1999); *New York v. Einaugler*, 618 N.Y.S. 2d, 414 (N.Y. App. Div. 1994); John Council, *Diagnosis Guilty, Unusual Case Leads to Two-Year Prison Sentence for Former Doctor*, 20 Texas Lawyer (Sept. 6, 2004); Deanna Boyd, *Jury Finds Physician Guilty of Homicide*, Fort Worth Star Telegram (Sept. 1, 2004) at A1 (Grotti); *California v. Klvana*, 15 Cal. Rptr. 512 (Cal. App. 1992); *Kansas v. Naramore*, 965 P. 2d 211 (Kan. App. 1998); Dave Condren, *Buff. News* (Aug. 7, 1998) at C1 (Pignataro);

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- Linda O. Prager, *Keeping Clinical Errors Out of Criminal Courts*, Am. Med. News (Mar. 16, 1998) (Schug); Raymond Smith, *Doctors on Trial*, The Press-Enterprise (Riverside, Cal.) (Feb. 1, 1998) at A1 (Steir); *Colorado v. Verbrugge*, No. 98 CA 0262, 1999 WL 417965 (Colo. App. June 24, 1999); Sharon Lerner, *The Struggle to Bring Bad Doctors to Justice*, The Village Voice (Apr. 2, 2002) at 36 (Watt); *Utah v. Weitzel*, No. 99-1700983, 2001 WL 34048225 (Dist. Ct. Utah Jan. 9, 2001), Lois M. Collins, *Resolution Backs Physicians*, Desert Morning News (Salt Lake City, Ut.) (Oct. 11, 2002) at B1 (Weitzel); *Utah v. Warden*, 813 P. 2d 1146 (Utah 1991); *United States v. Wood*, 207 F. 3d 1222 (10th Cir. 2000); *Pennsylvania v. Youngkin*, 427 A. 2d 1356 (Pa. Super. Ct. 1981).
35. David Doege, *Laboratory to Pay \$20,000 Fine*, Milw. J. Sentinel (Feb. 23, 1996) at 1A (Chem-Bio).
 36. In 1998, Dr. Anthony Pignataro, a Buffalo, New York plastic surgeon, pled guilty to criminally negligent homicide in causing the death of his patient, Sarah Smith. Dave Condren, Buff. News (Aug. 7, 1998) at C1. Mrs. Smith, 26, suffered a fatal heart attack while undergoing breast enlargement surgery in Dr. Pignataro's office. *Id.* The court sentenced Dr. Pignataro to six months in jail, a \$5000 fine, 250 hours of community service, and five years probation. *Id.*
 37. In Illinois, for example, in a civil action for medical negligence, an affidavit must be filed with the complaint certifying the plaintiff or plaintiff's attorney has conferred with a health professional who has reviewed the relevant medical records and has determined in a written report that there is a "reasonable and meritorious cause" for filing the action. 735 ILCS 5/2-622 (2004).
 38. Illinois, for example, has long required standard of care in a medical negligence lawsuit to be established by expert medical testimony. See *Ritchey v. West*, 23 Ill. 329 (1860); and more recently, *Higgins v. House*, 288 Ill. App. 3d. 543 (4th Dist. 1997). The same is true of causation. See *Moline v. Christie*, 180 Ill. App. 334 (1913); *St. Gemme v. Tomlin*, 118 Ill. App. 3d 766 (4th Dist. 1983).
 39. See Gic, *supra* note 29, at 15 (citing Linda O. Prager, *Keeping Clinical Errors Out of Criminal Courts*, Am. Med. News, Mar. 16, 1998).
 40. *Naramore*, 965 P. 2d at 225. (Brazil, C.J. dissenting). This would require a legislative act in most jurisdictions. *Id.*
 41. Gic, *supra* note 29, at 15; see also Lois M. Collins, *Resolution Backs Physicians*, Desert Morning News (Salt Lake City, Ut.) (Oct. 11, 2002) at B1.