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STATE V. CHRISTENSEN: CRIMINALIZING MEDICAL MALPRACTICE

Spencer Pedemonte*

I. INTRODUCTION

The year 2001 began what is known as the "Decade of Pain"—a federally-encouraged movement for physicians to prescribe opioids widely and abundantly in the treatment of pain.[1] During this period, opioids were the first line of defense in treatment, with no diagnosis needed and no maximum limits in what could be prescribed.[2] The results were catastrophic. From 1999 to 2019, drug overdoses quadrupled, with nearly 500,000 Americans dying from opioid-involved overdoses.[3] This period created profound impacts not only upon America's medical system but also the law surrounding it.

In *State v. Christensen*,[4] the Montana Supreme Court established the State's ability to prosecute physicians for overprescribing controlled substances. Although *Christensen* raises several issues, this note focuses solely on how the Court created this newfound precedent by improperly convicting Christensen for the criminal distribution of dangerous drugs. Part II details *Christensen*'s factual and procedural background, and Part III discusses the Court's holdings. Part IV outlines the development of federal criminal prosecution of physicians for overprescribing and Montana's traditional approach—medical malpractice. Part V analyzes the *Christensen* Court's decision. Part VI concludes by discussing the *Christensen* decision's implications on Montana's legal and medical systems.

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1. State v. Christensen, 472 P.3d 622, 643 (Mont. 2020); *see also The Prescription Opioid Epidemic: An Evidence-Based Approach*, JOHNS HOPKINS BLOOMBERG SCH. OF PUB. HEALTH 23, 27 (Nov. 2015), https://perma.cc/7NNL-QL28.

2. *Christensen*, 472 P.3d at 643; *see also* Sarah DeWeerdt, *Tracing the US Opioid Crisis to its Roots*, NATURE (Sept. 11, 2019), https://perma.cc/3T84-C7NX.

3. *Understanding the Epidemic*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://perma.cc/CF63-QZKP (last updated Mar. 17, 2021) (citing Nat'l Ctr. for Health Statistics, *Wide-Ranging Online Data for Epidemiologic Research (WONDER)*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://perma.cc/J9V7-B2TX (last updated Oct. 7, 2021)).

4. 472 P.3d 622 (Mont. 2020).

II. Factual and Procedural Background

In 2005, after practicing medicine in California, Washington, and Idaho,[5] Chris Arthur Christensen opened Big Creek Family Medicine, a general practice clinic in Ravalli County, Montana.[6] On August 26, 2011, Christensen obtained a Drug Enforcement Administration (DEA) license, giving him the ability to prescribe controlled substances.[7] Although Christensen was not a pain management specialist, he took a special interest in it, focusing some of his services on pain management through prescription drugs.[8]

Shortly after Christensen reacquired his ability to prescribe controlled substances, pharmacists in the area noticed a significant increase in opioid prescriptions and notified the Ravalli County Sheriff's Office.[9] On April 1, 2014, after a year of investigative work, a joint task force of local, state, and federal law enforcement officials raided Christensen's clinic and residence, seizing 4,718 medical patient files.[10] The task force focused their investigation on 11 of the nearly 4,700 patients Christensen treated.[11] Two of these patients died from drug overdoses shortly after obtaining prescriptions from Christensen.[12]

After initially charging Christensen with 396 counts of crimes stemming from or relating to drug distribution,[13] on October 19, 2017, the State amended their charges to 11 counts of criminal distribution of dangerous drugs in violation of § 45-9-101, nine counts of criminal endangerment in violation of § 45-5-207, and two counts of negligent homicide in violation of § 45-5-104—all felonies.[14]

On November 20, 2017, the jury found Christensen guilty on all counts.[15] The district court subsequently sentenced Christensen to 20 years in the Montana State Prison with ten years suspended.[16]

On appeal, Christensen raised a myriad of constitutional, procedural, and evidentiary arguments.[17] The Montana Supreme Court, in a highly divi-

5. *Id.* at 630.
6. *Id.* at 631.
7. *Id.*
8. *Id.* at 630.
9. *Id.* at 631.
10. Br. of Appellee at 2, *State v. Christensen*, No. DA 18-0268 (Mont. Jan. 21, 2020).
11. *Christensen*, 472 P.3d at 631.
12. *Id.*
13. Opening Br. of Appellant at 3, *State v. Christensen*, No. DA 18-0268 (Mont. July 17, 2019).
14. *Christensen*, 472 P.3d at 631 (citing Mont. Code Ann. §§ 45-9-101, 45-5-207, 45-5-104 (2019)).
15. *Id.*
16. *Id.*
17. Opening Br. of Appellant, *supra* note 13, at 15–18. **R**

sive holding, affirmed Christensen's convictions for 11 counts of criminal distribution of dangerous drugs and nine counts of criminal endangerment but reversed and vacated the two counts of negligent homicide.[18]

III. HOLDING

A. Majority's Holding

As a matter of original precedent, Chief Justice Mike McGrath, joined by a majority of other Justices, held that a physician defendant could be prosecuted for the distribution of dangerous drugs because he was acting outside the course of his professional practice.[19] First, the majority found that "prescribing" controlled substances fit within the "selling, bartering, exchanging, or giving away" language of § 45-9-101(1).[20] Next, the majority deemed Christensen did not qualify for the "practitioner" exemption under § 45-9-101 because his standard of care for the 11 named patients was outside the course of professional practice.[21] Finally—due to the novel nature of this case in Montana—the majority relied on federal case law to aid in interpreting the Montana statute and determining the proper jury instructions.[22]

The Court affirmed Christensen's convictions for nine counts of criminal endangerment. However, the Court reversed and vacated Christensen's conviction for two counts of negligent homicide, reasoning that the State failed to meet its burden in demonstrating the defendant's conduct was the cause-in-fact of his patients' deaths.[23]

B. Dissent from Criminal Distribution Charges

Justice Ingrid Gustafson rebuked the majority's holding on the 11 counts of criminal distribution of dangerous drugs.[24] She found the majority "strain[ed] logic" to criminally charge a physician in a case that should have been civilly adjudicated.[25] Justice Gustafson argued the Legislature did not intend for § 45-9-101 to be used for criminal prosecution of a licensed physician with DEA prescribing authority; instead, the policing of egregious prescribing should be left for the physician's licensing board and

18. *Christensen*, 472 P.3d at 662.
19. *Id.* at 649.
20. *Id.* at 648 (quoting MONT. CODE ANN. § 45-9-101(1) (2019)).
21. *Id.* at 649 (citing § 45-9-101(6)).
22. *Id.* at 652 (citing United States v. Feingold, 454 F.3d 1001 (9th Cir. 2006)).
23. *Id.* at 662.
24. *Id.* at 662–66 (Gustafson, J., dissenting in part, concurring in part).
25. *Id.* at 663–64.

civil malpractice claims.[26] Further, Justice Gustafson disagreed with how the district court applied prior case law in determining proper jury instructions.[27]

In a separate dissent, Justice Dirk Sandefur voiced concern over how the majority "arbitrarily contort[ed] our existing criminal law beyond its designated and intended bounds to reach a desirable result in an undeniably troublesome case."[28] He feared this decision would have significant implications regarding the quality of medical care and encouraged the Legislature to address the "currently inadequate law" to protect both patients and physicians.[29]

Justice Gustafson[30] and Justice Sandefur both disagreed with the majority in affirming Christensen's criminal endangerment charges but concurred with the reversal of the negligent homicide charges.[31]

C. Concurrence with Criminal Distribution Charges

Justice Laurie McKinnon, joined by Justice Beth Baker and Justice James Rice, concurred with the majority's reasoning in affirming Christensen's criminal distribution charges.[32] She argued that any person who criminally distributes illegal substances should be held accountable for their actions, regardless of their occupation.[33] Justice McKinnon noted the Legislature failed to exempt all physicians from § 45-9-101(6) and instead chose to qualify the exemption for only physicians acting "in the course of professional practice."[34]

Justices McKinnon, Baker, and Rice also concurred with the criminal endangerment charges but dissented to the reversal of the negligent homicide charges.[35]

IV. Background

Prior to the opioid epidemic, legislatures avoided and courts opposed criminalizing overprescribing due to concern that physicians would fear criminal sanctions and, as a result, improperly treat patients who legiti-

26. *Id.* at 664–65.
27. *Id.* at 666–67.
28. *Id.* at 669 (Sandefur, J., concurring in part, dissenting in part).
29. *Id.*
30. *Id.* at 666 (Gustafson, J., dissenting in part, concurring in part).
31. *Id.* at 668 (Sandefur, J., concurring in part, dissenting in part).
32. *Id.* at 669 (McKinnon, J., with Baker and Rice, JJ., concurring in part, dissenting in part).
33. *Id.* at 670.
34. *Id.* at 669.
35. *Id.*

mately needed pain medication.[36] However, as the devastation from the epidemic becomes more apparent, calls for criminal prosecution for over-prescribing physicians are also gaining traction.[37]

A. Federal Law

In 1970, the United States enacted the Controlled Substances Act (CSA) to combat illicit drug use by regulating the manufacturing, distribution, and prescription of controlled substances.[38] Under the CSA, it is unlawful for any person to intentionally "manufacture, distribute, or dispense . . . a controlled substance."[39] The Act grants certain practitioners, like physicians, exemptions from this prohibition as long as they are registered and comply with certain standards.[40]

1. United States v. Moore

In a landmark case, *United States v. Moore*,[41] the United States Supreme Court opened the door for federal criminal prosecution of physicians for improperly prescribing controlled substances.[42] Despite being a licensed physician and registered under the CSA, Thomas Moore was convicted of unlawful distribution after prescribing large quantities of controlled substances without administering physical examinations and charging patients per pill, rather than for the services provided.[43] The Court found Moore could be criminally charged because his actions fell "outside the usual course of professional practice."[44] *Moore* created issues for lower courts because it provided little guidance for how they should decide whether physician conduct falls in or out of the "usual course of professional practice."[45]

36. Michael C. Barnes & Stacey L. Sklaver, *Active Verification and Vigilance: A Method to Avoid Civil and Criminal Liability When Prescribing Controlled Substances*, 15 DePaul J. Health Care L. 93, 95 (2013).

37. *Id.*

38. 21 U.S.C. § 841 (2018); Joanna R. Lampe, The Controlled Substances Act (CSA): A Legal Overview for the 117th Congress, Cong. Rsch. Serv. 1–2 (2021).

39. 21 U.S.C. § 841(a).

40. *Id.* §§ 823(g), 822(b).

41. 423 U.S. 122 (1975).

42. *Id.*

43. *Id.* at 124, 126.

44. *Id.* at 124.

45. Barnes & Sklaver, *supra* note 36, at 122.

2. United States v. Feingold

The Ninth Circuit addressed some of the *Moore* discrepancies in *United States v. Feingold*,[46] where it affirmed the conviction of a physician for 185 counts of illegal distribution of controlled substances.[47] To convict a physician under the CSA, the government must prove

> (1) that the practitioner distributed controlled substances, (2) that the distribution of those controlled substances was outside the usual course of professional practice and without a legitimate medical purpose, and (3) that the practitioner acted with intent to distribute the drugs *and with intent to distribute them outside the course of professional practice*.[48]

Feingold further explained a jury instruction is "improper if it allows a jury to convict a licensed practitioner under § 841(a) [of the CSA] solely on a finding that he has committed malpractice, intentional or otherwise."[49] Instead, the jury instruction must read that "practitioners who act outside the usual course of professional practice and prescribe or distribute controlled substances for no legitimate medical purpose may be guilty of unlawful distribution of controlled substances."[50]

B. Montana Law

Until *Christensen*, Montana lacked precedent for the prosecution of physicians for improperly prescribing controlled substances. Instead, discipline traditionally came from either the Montana Board of Medical Examiners or injured parties pursuing civil action. Use of Montana's criminal distribution of dangerous drugs statute has been reserved for drug traffickers.

Traditionally, causes of actions surrounding physicians in Montana are adjudicated civilly through medical malpractice claims. The plaintiff in a medical malpractice action must establish "(1) the applicable standard of care, (2) the defendant departed from that standard of care, and (3) the departure proximately caused plaintiff's injury."[51] Medical expert testimony is required to establish these elements.[52]

In Montana, a general practice physician is held to the standard of care of a "reasonably competent general practitioner acting in the same or simi-

46. 454 F.3d 1001 (9th Cir. 2006).

47. *Id.* at 1004, 1014.

48. *Id.* at 1008 (emphasis in original).

49. *Id.* at 1010.

50. *Id.* at 1006, 1012.

51. Estate of Wilson v. Addison, 258 P.3d 410, 414 (Mont. 2011) (citing Mont. Deaconess Hosp. v. Gratton, 545 P.2d 670, 672 (Mont. 1976)).

52. Gilkey v. Schweitzer, 983 P.2d 869, 871 (Mont. 1999); *see also Estate of Wilson*, 258 P.3d at 414.

lar community . . . in the same or similar circumstances."[53] If the physician is a board-certified specialist or board-certified general practitioner, "the physician has the duty to possess and exercise the reasonable and ordinary degree of learning, skill, and care possessed and exercised by physicians of good standing in the same school of practice in the same or a similar locality in Montana."[54] A similar locality is based on geographic location, size, and character.[55]

The Montana Medical Legal Panel Act requires a plaintiff to first submit their claim to a panel of three health care providers and three attorneys prior to filing it in a court.[56] One purpose of the Act is to "prevent where possible the filing in court of actions against health care providers and their employees for professional liability in situations where the facts do not permit at least a reasonable inference of malpractice."[57]

To avoid medical malpractice claims for improperly prescribing controlled substances, physicians in Montana must adhere to Montana's Controlled Substances Act[58] and act in accordance with the Montana Board of Medical Examiner's Guidelines for the Use of Controlled Substances in the Treatment of Pain.[59] Additionally, in *Christensen*, physician experts testified that physicians who treat chronic pain patients should adhere to certain guidelines and standards including "(1) comprehensive initial assessments through diagnostic tests and review of medical records to diagnose the underlying cause of pain and identify risk factors of opioid treatment; (2) providing holistic treatment plans; (3) careful patient monitoring; and (4) comprehensive documentation."[60]

V. Analysis

A. The Court's Misuse of Statute Criminalizes Medical Malpractice

The *Christensen* Court unfairly convicted Christensen of criminal distribution of dangerous drugs by using § 45-9-101, a statute not designed for prosecuting physicians for overprescribing controlled substances. A person violates the Montana criminal distribution statute if "the person sells, barters, exchanges, gives away, or offers to sell, barter, exchange, or give

53. Chapel v. Allison, 785 P.2d 204, 210 (Mont. 1990).

54. S. Subcomm. on Med. Liab. Ins., Montana Medical Liability Law, J. Rep., 2003 Reg. Sess. 11 (Mont. 2003) (citing *Chapel*, 785 P.2d at 210), https://perma.cc/LH94-XA3J.

55. *Id.*

56. Mont. Code Ann. §§ 27-6-301, 401 (2019).

57. *Id.* § 27-6-102.

58. *Id.* §§ 50-32-101 to 50-32-611.

59. State v. Christensen, 472 P.3d 622, 634–35 (Mont. 2020).

60. *Id.* at 635.

away any dangerous drug."[61] Practitioners are exempt from this provision.[62] The statute defines a "practitioner" as "a physician . . . or other person licensed, registered, or otherwise permitted to distribute [or] dispense . . . a dangerous drug in the course of professional practice."[63]

First, the Court concluded that Christensen did not qualify for the physician exemption because he acted outside the course of professional practice when he "eschewed the use of appropriate documentation, assessments, tests, follow-ups, [and] referrals" and prescribed drugs in obscene quantities.[64] Notably, these shortfalls are traditionally considered claims for medical malpractice.[65] The Court focused on these shortfalls, downplaying how Christensen always maintained an office space with professional staff, only wrote prescriptions in his office, and maintained current medical and DEA licenses.[66]

Next, the Court conflated critical language from the criminal distribution statute—"sells, barters, exchanges, gives away"[67]—with the common physician practice of "prescribing." Montana Code Annotated defines "prescription" as "an order given individually for the person for whom prescribed, directly from the prescriber to the furnisher or indirectly to the furnisher, by means of an order signed by the prescriber . . . ."[68] The Montana Legislature does not define "exchanges," so the majority opinion used the Black's Law Dictionary definition: "The act of transferring interests, each in consideration for the other."[69] Consequently, the Court concluded that the "prescribing" of dangerous drugs "fits squarely within the definition of exchange."[70] In doing so, the Court not only incorrectly interpreted the intention of the statute, but also confused the role of the physician in American society.[71]

When taken separately, the conclusions the Court reached can be justifiable; however, when taken together, the conclusions are incongruent and cause for concern. The Court found Christensen criminally liable in one

61. MONT. CODE ANN. § 45-9-101(1).

62. *Id.* § 45-9-101(6).

63. *Id.* § 50-32-101(24)(a).

64. *Christensen*, 472 P.3d at 649.

65. Kelly K. Dineen & James M. DuBois, *Between a Rock and a Hard Place: Can Physicians Prescribe Opioids to Treat Pain Adequately While Avoiding Legal Sanction?*, 42 AM. J.L. & MED. 7, 23 (2016).

66. *Christensen*, 472 P.3d at 648.

67. MONT. CODE ANN. § 45-9-101(1).

68. *Id.* § 50-32-101(25).

69. *Christensen*, 472 P.3d at 649 (quoting *Exchanges*, BLACK'S LAW DICTIONARY (11th ed. 2019)).

70. *Id.*

71. A physician's duty to provide care for their patients and society is a long-standing professional obligation, and more than an "exchange" of interests between parties. *See* Ariel R. Schwartz, *Doubtful Duty: Physicians' Legal Obligation to Treat During an Epidemic*, 60 STAN. L. REV. 657, 661–63 (2007) (discussing the American Medical Association's Code of Ethics, first adopted in 1847).

part of the statute because he was not acting in the course of professional practice but also concluded that prescription writing, a professional duty, adequately satisfied another part of the statute.

Further, the *Christensen* Court incorrectly assumed the legislative intent of the criminal distribution statute in its conviction of Christensen. When interpreting a statute, a court's "objective is to implement the objectives the legislature sought to achieve."[72] The judiciary's role involves ascertaining and declaring what is in terms or substance contained within a statute—"not to insert what has been omitted or to omit what has been inserted."[73] The *Christensen* Court focused on how the Montana Legislature chose not to give physicians a blanket exemption for all criminal distribution charges, observing that the Legislature would have included it in the statute rather than creating the practitioner exemption.[74] Yet, the Court failed to question why the Legislature would not have included "prescribe" with the "sells, barters, exchanges, gives away" language necessary to convict the criminals the statute was intended for—drug dealers.

B. The Court's Improper Jury Instruction Criminalizes Medical Malpractice

The *Christensen* Court incorrectly held that the district court did not err in the jury instructions for the criminal distribution of dangerous drugs. The district court improperly instructed the jury because it wrongfully allowed for the criminalization of medical malpractice and incorrectly construed the jury instructions from *Feingold*. To find Christensen guilty of criminal distribution of dangerous drugs, the district court instructed the jury to determine whether the State proved "(1) that the Defendant prescribed a dangerous drug to another; and (2) that the Defendant acted purposely or knowingly; and (3) the professional practice exemption does not apply to the Defendant's conduct."[75] The jury instruction for the professional practice exemption stated that "a practitioner is exempt from prosecution and may not be convicted of criminal distribution of dangerous drugs if he delivers that prescription while acting in the course of a professional practice."[76] It further explained that jurors are to "determine whether the Defendant had a legitimate medical purpose"[77] when prescribing controlled substances and "whether the Defendant made an honest effort to prescribe

72. Bullock v. Fox, 435 P.3d 1187, 1197 (Mont. 2019) (citation omitted).

73. City of Missoula v. Fox, 450 P.3d 898, 903 (Mont. 2019) (quoting MONT. CODE ANN. § 1-2-101).

74. *Christensen*, 472 P.3d at 649.

75. *Id.* at 645.

76. *Id.*

77. *Id.*

for a patient's condition in accordance with the standard of medical practice, if any, that was generally recognized and accepted in the State of Montana."[78]

1. The Court's Improper Adoption of Feingold *Jury Instructions*

While subsections (1) and (2) of the jury instructions are undisputed, subsection (3), the physician exemption, incorrectly criminalizes medical malpractice claims. The district court instructed the jury to determine whether Christensen prescribed a controlled substance in accordance with the physician standard of care—the same element needed for a medical malpractice claim.[79] The district court adopted these jury instructions from *Feingold*; however, *Feingold* explicitly states a jury instruction is "improper if it allows a jury to convict a licensed practitioner . . . solely on a finding that he has committed malpractice."[80] Therefore, the Court erred in permitting jury instructions that criminally convicted Christensen for a medical malpractice claim.

2. The Court's Improper Application of Feingold *Jury Instructions*

While adopting the jury instructions from *Feingold*, the district court erred in applying them because the instructions were incompletely transferred. The third element *Feingold* required for a physician's conviction under the CSA is "that the practitioner acted with intent to distribute the drugs *and with intent to distribute them outside the course of professional practice*."[81] Here, as Justice Gustafson aptly noted in her dissent, while the district court correctly instructed the jury to "determine whether the Defendant had a legitimate medical purpose,"[82] the intent to "act as a pusher rather than a medical professional"[83] was unscrupulously missing from the instruction. Therefore, the Court erred in affirming the district court's unfair application of the jury instructions from *Feingold*.

VI. Conclusion

The *Christensen* Court's decision has profound implications for both Montana's medical and legal systems. By creating an ability to criminally prosecute physicians for criminal distribution of dangerous drugs for their

78. *Id.*
79. *Id.* S*ee generally* Part IV(B).
80. United States v. Feingold, 454 F.3d 1001, 1010 (9th Cir. 2006).
81. *Id.* at 1008 (emphasis in original).
82. *Christensen*, 472 P.3d at 645.
83. *Id.* at 667 (Gustafson, J., dissenting in part, concurring in part) (quoting *Feingold*, 454 F.3d at 1008).

prescribing practices, the Montana Supreme Court effectively changed how physicians will treat patients and how prosecutors will criminalize mistakes in medical judgment.

The outcome for Christensen's patients is undeniably tragic and unfortunate; however, the way the *Christensen* Court contorted the ambiguous statutory language of the criminal distribution statute to fit their desired outcome is cause for concern. General criminal statutes are typically not intended to indict and prosecute physicians for mistakes in judgment, yet prosecutorial use of them is becoming more common.[84] Medical societies argue that prosecutorial use of criminal statutes in this manner is inappropriate and will result in physicians providing a lower standard of care due to fear of criminal prosecution.[85]

As Justice Sandefur urged in his dissent, the Montana Legislature needs to "squarely consider the problem of abusive prescription practices and revise our currently inadequate law to particularly and fairly address the problem in the public interest as deemed appropriate to protect both patients *and* physicians."[86]

84. Paul R. Van Grunsven, *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, 49 (1997).

85. *Id.* at 48–49.

86. *Christensen*, 472 P.3d at 669 (Sandefur, J., concurring in part, dissenting in part) (emphasis in original).

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