IN THE SUPREME COURT FOR THE STATE OF MONTANA

No. DA 18-0268

STATE OF MONTANA,

Plaintiff/Appellee,

v.

CHRIS ARTHUR CHRISTENSEN,

Defendant/Appellant

OPENING BRIEF OF APPELLANT

On appeal from the 21st Judicial District Court, Ravalli County
Cause No. DC-15-177
Court of the Honorable Jeffrey Langton

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INTRODUCTION

In August 2014, Dr. Chris Christensen was a physician, licensed under Montana law to practice medicine, certified by the DEA to prescribe scheduled drugs, operating his own small general practice in the Bitterroot Valley, seeing a wide variety of patients. He employed several other professionals, including a Physician's Assistant. He conducted exams on patients, kept records of their visits, billed reasonable rates for his services, (possibly largely because he did not accept insurance and thus needed far fewer employees), and purchased or leased a number of pieces of equipment to help diagnose and treat his patients.

Among the patients he saw and treated were patients who suffered chronic pain. He used a variety of methods with them to control their pain, including using prolotherapy, recommending visits to his in-house physical therapist (his wife), and providing an extensive written protocol for learning how to "rewire" one's brain through exercises to reduce pain. For some patients he also prescribed opiates. In order to make sure he was doing so correctly, he attended conferences on pain management, belonged to professional societies dedicated to pain management, and stayed abreast of the literature. He was also aware of, and followed the guidelines promulgated by the Montana Department of Public Health and Human Services and published in its "Guidelines for the Use of Controlled Substances for the Treatment of Pain." (Tab A). Those guidelines reflected the

scientific understanding that no quantity of opiates is *per se* dangerous or too much, and instructed physicians that "the inappropriate treatment of pain includes "nontreatment and undertreatment" in addition to "overtreatment and the continued use of ineffective treatments." (Tab B at 1-2). The guidelines also advised that "Fear of investigation or sanction by federal, state and local agencies may also result in inappropriate treatment of pain," and urged physicians not to be afraid of action from the Board of Medical Examiners as long as they were prescribing "for a legitimate medical purpose and in the course of professional practice." (Tab B at 2).

This is a case which tests the limits of how far the criminal law can be stretched. The opiate crisis is much in the news, and for good reason. Record numbers of people are dying through their consumption of opiate drugs. And the public is clamoring for action. The ultimate question in this case is whether that crisis is grounds for departing from established law to criminally punish physicians for that crisis.

STATEMENT OF ISSUES

I. As a Matter of Law, Can a Properly Licensed Physician, Operating a Professional Medical Practice, Be Convicted under MCA §45-9-101, Criminal Distribution of Dangerous Drugs, Because He Prescribed Dangerous Drugs?

II. Is Montana's Criminal Endangerment Statute Unconstitutionally Vague As Applied to a Physician Prescribing Medication, Which By

Its Very Nature Creates a Potential Risk of Death Or Serious Bodily Injury if Misused?

III. Did the Court Err as a Matter of Law by Using Ninth Circuit Jury Instructions to Instruct the Jury on the Montana Law?

IV. Did the District Court Err by Failing to Conduct a Hearing Before Allowing the State to Introduce Evidence Under Rule 404(b)?

V. Did the District Court Err in Refusing to Permit Dr. Christensen to Present a Complete Defense?

VI. Did the State Present Enough Evidence to Convict Dr. Christensen?

VII. Did the District Court Err in Ordering Dr. Christensen to Pay a Fine When Dr. Christensen Is Effectively Bankrupt and Has Only Social Security Income?

STATEMENT OF THE CASE

On August 19, 2015, the State filed an Information charging Dr. Chris Christensen with 302 counts of criminal distribution of dangerous drugs, in violation of MCA § 45-9-101(2), 82 counts of criminal distribution of dangerous drugs, in violation of MCA § 45-9-101(4), one count of criminal possession of dangerous drugs, in violation of MCA § 45-9-102(6) , nine counts of criminal endangerment in violation of MCA § 45-5-207, and two counts of negligent homicide, in violation of MCA § 45-5-104. D.C. Doc. 4.

The Defendant filed motions to dismiss the drug distribution charges, the criminal endangerment charges and the negligent homicide charges on January 19, 2017. D.C. Docs. 111, 112, 113.

On October 19, 2017, the charges were amended without objection to eleven counts of criminal distribution of dangerous drugs, nine counts of criminal endangerment, and two counts of negligent homicide. D.C. Doc. 214. Trial began the same day. The trial ended on November 20, 2017 with conviction on all counts. On February 2, 2018, Dr. Christensen was sentenced to twenty years in Montana State Prison, with ten of those years suspended. D.C. Doc 284.

STATEMENT OF FACTS

In 2012, Dr. Chris Arthur Christensen was a physician with a small practice located in Florence, Montana called Big Creek Medicine. In Florence, Dr. Christensen practiced general medicine as he always had in a career that stretched back to the 1970s, though in Florence he was determined to extricate himself from the unending bureaucratic burden of modern medicine, and did not accept insurance payments in return for his services. Instead, he expected his patients to pay him for his services and they could seek reimbursement from their insurance companies if they wanted. By refusing insurance Dr. Christensen was able to avoid hiring several additional administrative positions, and therefore was able to lower

the prices he charged his patients. Because of that structure, Dr. Christensen attracted a lot of patients who were not financially well-off. Trial TR 2042-2045.

Doctor Christensen treated patients for a host of ailments as general practice doctors do, and referred patients out to specialists when necessary. He also treated a number of patients for chronic pain issues. Dr. Christensen knew from the personal experience of his father that pain can be absolutely debilitating, and can even lead a person to take his own life. Trial Tr. 2326-2330. Indeed, according to the Montana Department of Health and Human Services, chronic pain sufferers are three times more likely than the general population to commit suicide. https://dphhs.mt.gov/Portals/85/suicideprevention/SuicideinMontana.pdf, page 2. (*See also*, https://www.mtpr.org/post/pain-helped-him-pull-trigger, detailing the suicide of a Montanan who had been denied pain medication.).[1] While Dr.

[1] While the cited guidelines were operative during the time Dr. Christensen was practicing, it appears the Board has withdrawn the previous guidance, or at least it no longer appears on its website. In general, the "standard of care" in the area of opiate prescribing continues to evolve. In 2016, for instance, two years after Dr. Christensen's involuntary retirement (though he is of retirement age), the United States Centers for Disease Control issued new guidelines which strongly recommended that physicians not prescribe at a rate higher than 90 milligram of morphine equivalent (MME). https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fmmwr%2Fvolumes%2F65%2Frr%2Frr6501e1er.htm. In 2019, however, the CDC endorsed a commentary appearing in the New England Journal of Medicine by the authors of its 2016 guidelines that the limits endorsed in the guidelines were not actually "hard limits" and higher dosages are

Christensen's father did not commit suicide, he was an alcoholic and he was abusive toward his wife and children, behavior Dr. Christensen understood in later years to be related to the pain his father had suffered following the crash of his B-17 over Germany in World War II. Trial Tr. 2326-27. Dr. Christensen's father had been badly beaten when he was taken prisoner after the crash, spent the rest of the war starving in a prisoner of war camp as the Germans continued to lose the war, and ultimately returned home, there becoming an alcoholic, sometimes spending a week in bed when not verbally and emotionally abusing his family. Trial Tr. 2327-2328.

With medical training, Dr. Christensen began to put his resentment aside as he came to understand his father was in constant pain because of his war experiences. Trial Tr. 2328. That prompted a professional interest in the management of chronic pain. He began to pursue additional training in the management of pain, went to conferences on pain management and joined professional organizations dedicated to the study of pain and pain management. Trial Tr. 2329, 2337-2344. At that time, the 1990's, more and more practitioners were interested in pain, which had largely been ignored or undertreated previously. Trial Tr. 2329-2930. Dr. Christensen began following studies showing that opiates,

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called for in appropriate cases. https://www.cdc.gov/media/releases/2019/s0424-advises-misapplication-guideline-prescribing-opioids.html

while creating a physical dependence, did not create addiction in people suffering pain, a distinction also found in the Montana guidelines on pain management. Trial Tr. 2334-2335; Exhibit at 2: "Physicians should recognize that tolerance and physical dependence are normal consequences of sustained use of opioid analgesics and are not the same as addiction."

In general terms, Dr. Christensen summed up the learning he received by referring to one of the leaders in the movement to promote pain management, Dr. Kathleen Foley: "be willing to bring anything to the table that can facilitate increased functionality and improved quality of life. That include opiates." Trial Tr. 2341. At trial, Dr. Forest Tennant, a pain expert called by Dr. Christensen, affirmed that the encouragement to opioid prescribing Dr. Christensen received in his training was common:

> "after 1996 --and if you go back and look at the label indication by FDA on OxyContin, for example, the labeling said these drugs have less abuse potential than the old opioids because they are put into a hard tablet that can't -- that's long acting and will not get into the system very fast and cause either addiction or abuse or overdoses. Now, that was the belief."

Trial Tr. 2180. Dr. Tennant went to describe how long the attitude prevailed: "So up until 2016, we still had a few thousand doctors in the country in every state still following the party line that opioids were acceptable at a high dose and as first line treatment." Trial Tr. 2185. Dr. Tennant noted that until recently many of the other methods for alleviating pain had fallen by the wayside during that 1996-2016

period: “ultrasound treatments and physical therapy and massages and topical medicines, psychiatric therapy, massages; a whole host of nonmedical treatments. But frankly, treatment rooms started to disappear after 1996. Nobody used TENS units anymore.” Trial Tr. 2180.

Despite having been an acolyte of the teachers of opiate prescribing, Dr. Christensen employed a variety of non-opiate pain remedies in his clinic, including those mentioned by Dr. Tennant and others besides. These included prolotherapy and other “regenerative injection therapies” (a method of stimulating the body’s own immune system), a physical therapist on staff, topical treatments and other herbal approaches, a workbook on neuroplasticity (a program designed to essentially re-wire to brain to react less vigorously to pain stimuli), dietary supplements, a THOR (a cold-laser device designed to stimulate mitochondria for tissue healing) a particularly sophisticated TENS unit called a Synexus, and finally just plain old time and attention from the doctor, a form of counseling. Trial Exhibits A, B, C; Trial Tr. 2352-2371. Dr. Christensen was clear about his goal: “It became the focus of the efforts that we were making at the time the practice was closed to begin to take opioids, which were the primary therapy of every patient, and make it secondary or just eliminate it altogether.” Trial Tr. 2371.

For its case, the State chose from Dr. Christensen’s approximately 5000 patients, the following eleven patients:

Kara Philbrick had been in pain for years, if not decades, wracked by pain resulting from a back injury from childhood when she had fallen from a horse. Trial Tr. 937. She had been successfully treated for years in California and later in Kalispell (she drove there from Missoula every month) with 80 milligrams of methadone a day, but was kicked out of the Kalispell program after a test showed she had been smoking marijuana. After she was kicked out she tried to treat herself with alcohol, but the methadone, for obvious reasons, worked better. Trial Tr. 938-942. She went to Dr. Ravitz in Missoula, but he would only prescribe 40 milligrams a day, and that was not relieving her pain. Trial Tr. 942. Dr. Ravitz then put her a fentanyl patch, but that also was insufficient. *Id.* Dr. Ravitz still would not prescribe the relieving amount—her common law husband described the fentanyl as a "disaster"—but approved her going to Dr. Christensen for the larger amount of methadone. Trial Tr. 947.

Dr. Christensen examined her, took her history, and diagnosed a fracture that Dr. Ravitz had misdiagnosed. Trial Tr. 952; 2430-2432. He also prescribed her the methadone quantity that had worked for years, but because it was Dr. Christensen, she had trouble filling the prescription. Trial Tr. 956-959. Two days later she was dead by her own hand, having used her prescription drugs, and others of unknown origin to end her life. Her common-law husband, Jerry, opined that she committed suicide, and noted that she had previously discussed committing suicide because of

the pain. Trial Tr. 963-963. The State blocked or successfully objected to Jerry expounding on the difficulties of actually getting the prescription filled (Trial Tr. 958-959), testifying about her fears about being able to get the prescription filled in the future (Trial Tr. 994-995), or offering his opinion about the reasons she would commit suicide (Trial Tr. 996).

Gregg Griffin had suffered a series of injuries from working in construction, including breaking his ankle in a bad fall, shooting a nail through the one of the main nerves in the arm, and back pain and knee pain from hauling drywall and working concrete. Trial Tr. 359-360; 2462. He was in a lot of pain, but was also an addict. He had been on a Suboxone program but could not afford it. He had no insurance coverage, not even Medicaid. He and Dr. Christensen discussed managing both the pain and the addiction out of the Suboxone program. Ultimately Dr. Christensen prescribed him methadone because, "It was affordable. It had the best balance of potential to help his pain without exacerbating his opioid misuse/substance use disorder slash addiction; and it served a -- it fit into the financial profile that he was capable of handling." Trial Tr. 2463.

Dr. Christensen saw him two weeks later, and again two weeks after that, at which time "he reported that this was working better than anything he had been on in recent memory and he was happy with it and he wanted to go forward." Trial Tr. 2464. Not long after, Mr. Griffin died of a drug overdose. Like Ms. Philbrick, Mr.

Griffin had a variety of drugs in his system, not all of them prescribed by Dr. Christensen. Trial Tr. 421. Additionally, judging by the missing pills, it appeared Mr. Griffin took 60 too many Methadone pills, 9 too many Xanax, and between 10 and 20 doxepin. Trial Tr. 394-395, 402.

Ryan Marchand had suffered a severe neck injury, damaging several vertebrae, in a fall while rock climbing. Trial Tr. 2377. The damage was severe enough that he had a disc replacement surgery, and he regularly took hydrocodone for it. Trial Tr. 1953, 2379. The surgery was unsuccessful, perhaps because the replacement disc itself was faulty. Trial Tr. 2385. Mr. Marchand reported he could handle mild to moderate pain, but his pain was more severe than that. Trial Tr. 2379. Dr. Christensen prescribed methadone to Mr. Marchand since the hydrocodone wasn't working, and Mr. Marchand continued to see Dr. Christensen for approximately two years. Trial Tr. 1943, 1959. Mr. Marchand was then hurt in an accident at work, and went to Dr. Christensen to be checked. Later, Mr. Marchand asked Dr. Christensen to complete a report to Worker's Comp so he could be covered. He claimed Dr. Christensen failed to follow up. Dr. Christensen maintained that he did as Mr. Marchand requested, despite his not normally taking Work Comp cases. Trial Tr. 1962-1965, 2414-2419.

Paul Peterson was a patient originally seen in Dr. Christensen's clinic by Robin Rice, a Physician's Assistant employed in the clinic who wrote his first

prescriptions for opiates. Trial Tr. 2425-2426. Mr. Peterson was a semi-professional golfer who had pain in his knee, in his lower back and pelvis, and also had pain in his upper back from an automobile accident. Trial Tr. 2427. While receiving treatment from Dr. Christensen he had his best year ever as a professional golfer. Trial Tr. 1319. He blamed Dr. Christensen for causing him to become an addict, but also failed to reveal to Dr. Christensen that he had in fact taken methadone previously and had even been to drug addiction treatment previously. Trial Tr. 1378-1381. He also lied to that doctor. Trial Tr. 1380. At the time of the trial he had been a friend of the lead detective in the case for 20 years. Trial Tr. 1336-1337. He lied to the detective and the DEA agent assigned to the case. Trial Tr. 1339-1348.

Jackie Golden initially lied to Dr. Christensen that she had sciatic nerve pain, after being coached by a friend on how to lie to him. She had been addicted to opiates for years and was practiced at obtaining them from doctors. Trial Tr. 1431-36. She did have genuine pain in her hands, caused by rheumatoid arthritis and carpal tunnel syndrome. Trial Tr. 1438.

Ms. Golden's mother, Jennifer Hiscoe, described her own medical problems as follows: "I have degenerative bone disease, and I've had, like, a neck fusion, and I had a bad shoulder, and I have a lot of arthritis and such in my back." Trial Tr. 1456.

Michelle Jessop had been nearly decapitated when she rode an ATV through a barbed wire fence—the wire cutting through her trachea to her spine—and had chronic pain resulting from it. Trial Tr. 2436, 1705, 1722. Her scarring and physical appearance were consistent with the story of her accident. Trial Tr. 2436. By her own estimate she had been drug addict for 15 years before going to see Dr. Christensen. Trial Tr. 1712. She was a casual user of methamphetamine and heroin during that period, though not an addict in her estimation. Trial Tr. 1713. Her neck injury caused her a great deal of pain originally, and off and on in the ensuing years. Trial Tr.1722. She went to many doctors during that time and received opiates for the pain, though she rejected the pain relief alternatives they offered. Trial Tr. 1723. When she went to Dr. Christensen she was not in pain but lied and said she was. Trial Tr. 1722. She judged herself to be a good liar, but she faulted Dr. Christensen for not being "caring" enough to see through her lies. Trial Tr. 1714-1715, 1717.

She ultimately stole a prescription pad from Dr. Christensen, used it to forge prescriptions, and was prosecuted by the same prosecutor prosecuting Dr. Christensen. Trial Tr. 1702. She did not like the prosecutor at first, but when asked by him on direct if he had required her to testify, or made promises to him, asserted that he had not. Trial Tr. 1702-1703.

Dan Lieberg had fallen down the stairs at his home and suffered paralysis for a time from it. He had also had injuries from riding bulls and had had in excess of 40 motorcycle accidents. Trial Tr. 2451. Because of the pain he was able to work only sporadically and could not participate in his regular activities. He tried other therapies for the pain, including injections in his back. Trial Tr. 1491. He also had been addicted to drugs since he was 16 years old—twenty years at the time of trial. Trial Tr. 1474, 1488. Dr. Christensen diagnosed him with chronic pain, put him on pain medication, and proceeded to provide prolotherapy to him to relieve his pain. Trial Tr. 1479. The medications helped, but Mr. Lieberg became dependent, and even addicted to them. Trial Tr. 1485.

Mr. Lieberg's mother, a nurse, intervened and agreed to hold his drugs and provide only a proper dose to him. Mr. Lieberg ended the arrangement, however, and Ms. Lieberg did not notify Dr. Christensen of that fact. Trial Tr. 1524-1526. She reasoned that he was an adult, and if that was his choice, that was his issue. Trial Tr. 1526.

Erica Cummings had had a degenerative back issue for which she had two failed operations. Trial Tr. 1466-1467. She came to Dr. Christensen with chronic pain issues and he prescribed opiates for her. Trial Tr. 2470. Prior to his treatment, Ms. Cummings was not able to function, not able to hold a job or parent her children. With his treatment she was able to do those things. Trial Tr. 2470-2471.

In exchange for her testimony Ms. Cummings received amended charges of her own, including the dismissal of a negligent homicide charge and the attendant potential sentence of 20 years. Testimony about that deal was restricted by the Court, however. Trial Tr. 1080. She was also on probation at the time of trial and had also been prosecuted by the same prosecutor. Trial Tr. 1015.

Todd Gore was also a criminal, having been convicted of federal drug trafficking crimes. Trial Tr. 1727. He had been running a drug trafficking ring to the Bakken and he lied and acted hurt to get Dr. Christensen to prescribe to him. Trial Tr. 1732. That he was in pain was completely believable, though, as he had had several major surgeries while he was in the Marines, and he brought the past records to prove it. Trial Tr. 1727. Upon reviewing the records and examining him, Dr. Christensen prescribed him opiates. Trial Tr. 1736.

Heather Sutherland had a severe chronic pain problem, with a long history of serious orthopedic problems, including Perthes disease in her hip, requiring multiple surgeries since childhood. Trial Tr. 1678-82. The State's expert, Dr. Wasan, acknowledged this history when he commented: "This person is suffering terribly." Trial Tr. 1856.

SUMMARY OF ARGUMENT

A host of problems infected this case. Legally the case should not have been brought in the first place. Dr. Christensen was charged with 11 counts of drug

distribution based on his prescribing practices, despite a statutory provision that literally says doctors can't be prosecuted: "Practitioners, as defined in 50-32-101, and agents under their supervision acting in the course of a professional practice are exempt from this section." MCA §45-9-101(6). Dr. Christensen wrote his prescriptions in the course of the medical practice he owned, during business hours, in the presence of staff, with records maintained. The statute appears designed to stop the criminal justice system from second-guessing a doctor's decision, and by its plain language should have prevented these charges from going forward.

The State advanced an argument that federal law should apply, however, adopting reasoning from federal courts' interpretation of the federal prohibition on selling controlled substances. The federal and Montana statutes are significantly different from one another, however. It should be axiomatic that one cannot be prosecuted in Montana courts for a violation of federal law. Moreover, the Montana statute, which prohibits selling, bartering, or giving away dangerous drugs, has no prohibition on "prescribing" them. And no mix of definitions gets to that conclusion. There is nothing about the Montana statute that permits prosecutors in Montana to use the criminal law to pursue physicians for the prescribing decisions they make as part of treating their patients.

The District Court accepted the State's theory, though, and instructed the jury on how to decide the case using federal law. However, the District Court failed to include in its instructions a scienter element which the Ninth Circuit said was necessary to ensure that the defendant possessed the classic "black heart" before being convicted. Because the jury was not properly instructed on mental state, Dr. Christensen was essentially given a prison sentence for what at worst was medical malpractice.

Similarly, the charges of criminal endangerment, brought against a physician for his prescribing practices, are unique. And they present a unique problem of constitutional legitimacy. Statutes which are too vague to offer clear guidance and citizens are not constitutional. In this case, as applied to doctors in the course of prescribing the statute is unconstitutionally vague. Because the very act of prescribing allows a patient to obtain a substance which can create a "substantial risk of death or serious bodily injury," no doctor or law enforcement officer can know whether any particular prescription will constitute a felony crime.

The Court also erred by failing to hold a hearing on the admission of 404 evidence, and thus allowed into evidence a host of testimony that violated Rule 403. Additionally, Dr. Christensen was denied an opportunity to present witnesses who would discuss his practice generally, and a number of patients who would testify about their good treatment from Dr. Christensen. These witnesses were

necessary to demonstrate the "good faith" of Dr. Christensen's charged conduct, as well as whether he was operating "in the course of a professional practice." One cannot know if Dr. Christensen is operating within a "professional practice" if one does not hear about the practice other than hearing from .2% of his patients, all chosen by the prosecutor.

Finally, even with all the errors above, the State did not meet its burden of proving the charges against Dr. Christensen. Dr. Christensen was not the cause of the deaths of Ms. Philbrick or Mr. Griffin, both of whom misused their prescriptions and took drugs prescribed by other doctors. The State presented no expert testimony that Dr. Christensen's prescriptions were the "but for" cause of their deaths, which were attributed to "mixed drug toxicity." With respect to criminal endangerment, the State's expert witness would only testify that the risk of death or serious bodily injury was much less than 10% and agreed that there is no upper limit on the prescribing of opiates. On the drug sale counts, "prescribing" is not selling, giving or bartering, and Dr. Christensen followed the guidelines that were in place during his practice. Moreover, the only witness who even addressed the elements offered by the State was the defense expert who opined that Dr. Christensen met the standard established by those (incorrect) elements.

ARGUMENT

I. As a Matter of Law, Can a Properly Licensed Physician, Operating a Professional Medical Practice Be Convicted under MCA §45-9-101, Criminal Distribution of Dangerous Drugs, Because He Prescribed Dangerous Drugs?

A. Standard of Review

This Court reviews the denial of a motion to dismiss in a criminal case de novo. *State de Updegraff*, 2011 MT 321, ¶ 24, 363 Mont. 123, 267 P.3d 28. A district court's statutory interpretation constitutes a conclusion of law, which this Court reviews for correctness. *State v. Shively*, 2009 MT 252, ¶ 13, 351 Mont. 513, 216 P.3d 732.

B. The Court Should Reverse the Drug Distribution Counts as a Matter of Law Because MCA §45-9-101 Does Not Prohibit "Prescribing" Of Dangerous Drugs.

1. The plain meaning of "sell" does not include "prescribe" or "dispense" and broadening its meaning violates Dr. Christensen's due process rights under the U.S. and Montana Constitutions (Amend. VI and Art. II, § 17).

Montana's criminal drug distribution statute penalizes the actions of a person who "sells, barters, exchanges or gives away…any dangerous drug." MCA § 45-9-101. Yet, the State did not charge Dr. Christensen with any of those actions (no doubt because he did not do any of those) and instead appeared to allege that "prescribing" somehow counts as "selling, bartering, exchanging or giving away." This Court has interpreted the meaning of "sell" in MCA §45-9-101 as follows:

"To sell [drugs] means to knowingly and intentionally transfer possession or ownership of the [drugs] to another for money or other valuable consideration." *State v. Brown*, 232 Mont. 1, 5, 755 P.2d 1364, 1367 (1988). "Barter" is defined by Webster's as "to trade by exchanging one commodity for another," or "to trade goods and services for other goods and services." www.merriam-webster.com/dictionary/barter. Similarly, the plain meaning of "give away" or "exchange" requires that a person have possession of the thing first. "Give away" in the context of the statute's list of verbs refers to a "free transaction," not to the broad act of "giving."

While the legislature did not include "prescribe" as one of the illegal acts of distribution, it did use and define the word "prescribe" in a separate statutory provision. Montana's Controlled Substances Act defines "prescribing" as a subset of "dispensing" drugs.

> "Dispense" means to deliver a dangerous drug to an ultimate user or research subject by or pursuant to the lawful order of a practitioner, including the prescribing, administering, packaging, labeling, or compounding necessary to prepare the drug for that delivery.
>
> "Prescription" means 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 and bearing the name and address of the prescriber, the prescriber's license classification, the name of the patient, the name and quantity of the drug or drugs prescribed, the directions for use, and the date of its issue.

MCA §50-32-101(10) (25). The criminal distribution statute—section 45-9-101—also does not prohibit "dispensing."

Plainly the legislature could have included "prescribing," or "dispensing" in the list of prohibited activity, and thereby included doctors among the people restricted by the general drug distribution statute. Just as plainly, however, the legislature has not chosen to do this. Indeed, the one mention the statute makes with respect to doctors is to specifically exclude them from the provisions of the statute. "[Physicians]…acting in the course of a professional practice are exempt from this section." MCA § 45-5-101(6).

"Absent statutory definitions, the plain meaning of the words used controls." *City of Great Falls v. Mont. Dept. of Pub. Serv. Regulation*, 2011 MT 144, ¶ 18, 361 Mont. 69, 254 P.3d 595; *Northwestern Corp. v. Mont. Dep't of Pub. Serv. Regulation*, 2016 MT 239, ¶ 33, 385 Mont. 33, 380 P.3d 787. The Montana Supreme Court "look[s] first to the plain language of the statute to determine legislative intent." *In re K.M.G.*, 2010 MT 81, ¶ 26, 356 Mont. 91, 229 P.3d 1227. When the plain language of the statute is clear, no other means of interpretation are necessary or proper. *City of Missoula v. Cox*, 2008 MT 364, ¶ 9, 346 Mont. 422, 196 P.3d 452. The Court does "not insert that which the legislature omitted, nor [does it] omit that which the legislature has inserted." MCA § 1-2-101; *In re*

K.M.G., ¶ 26. Only when the language of the statute is ambiguous [does the Court] resort to the statute's legislative history. *State v. Merry*, 2008 MT 288, ¶ 17, 345 Mont. 390, 191 P.3d 428.

In this case, Dr. Christensen was charged with violating MCA §45-9-101 by "prescribing" controlled substances to his patients. The plain meaning of "sell" cannot encompass the verb "prescribe," because by any definition selling requires that the seller first possess and own the goods and then exchange them for money. Dr. Christensen did not possess or own the controlled substances that he prescribed. He only issued written prescriptions which patients then took to pharmacies to be filled.

This Court has previously held that it will reverse convictions under MCA § 45-9-101 if they are based on acts that do not constitute distribution. The Court reversed a conviction of a defendant who had "cultivated" marijuana because the act of cultivation did not necessarily bear a rational relationship to distribution or sale of drugs. It was a violation of the defendant's constitutional right to due process to convict him of distributing marijuana when the State had proved only that he had cultivated marijuana, which did not necessarily lead to distribution. "The conviction offends the 'due process' clause of our State Constitution," the Court concluded, citing Article II, section 17. *State ex rel. Zander v. District Court of Fourth Judicial Dist.*, 180 Mont. 548, 559, 591 P.2d 656, 662 (1979).

2. Other State Courts Have Held That Physicians Could Not Be Prosecuted Under The Language of Their States' Criminal Drug Distribution Statutes.

In other states with statutory schemes similar to Montana's, courts have held that their state law did not apply to physicians who were prescribing drugs. The Supreme Court of Arkansas reversed a physician's conviction for illegally "delivering" dangerous drugs, because it held that "deliver" did not include the act of "prescribing." The Court reasoned, "If the General Assembly had intended for 'prescribing' to come within the definition of 'delivery' it would have said so. It certainly knows how to do so. For example, 'prescribing' is specifically included in the definition of 'dispense' in the Act. Since the Federal Act prohibits 'dispensing,' which by definition includes prescribing, it is clear that it can be applied to physicians. Our legislature, on the other hand, chose to prohibit the 'delivery' rather than the 'dispensing' of controlled substances." *Hales v. State*, 299 Ark. 93, 94, 771 S.W.2d 285 (Ark. 1989).

Similarly, a physician convicted of "selling" controlled substances was held not to have violated Alabama's drug distribution statute because the act of "prescribing" was not proscribed by that law. *Ex Parte Evers*, 434 So. 2d 813, 816 (Ala. 1983). "Had the Legislature intended that the statute proscribe the writing of a prescription by a physician for other than a legitimate medical purpose, it would have used a more descriptive word such as 'dispense' or 'prescribe' to

define the prohibited act." *Cf. McLean v. State*, 527 S.W.2d 76 (Tenn. 1975) (reversing conviction of pharmacist for "selling" controlled substances because "selling" did not encompass "prescribing.")

The Supreme Court of North Carolina also reversed a doctor's conviction for "sale or delivery" of a controlled substance because the act of "prescribing" did not constitute a "sale or delivery." *State v. Best*, 292 N.C. 294, 233 S.E.2d 544 (N.C. 1977). The New York Court of Appeals also held that the criminal statute prohibiting the "sale" of dangerous drugs did not encompass the act of "prescribing" by a physician. *State v. Lipton*, 54 N.Y.2d 340, 429 N.E.2d 1059 (N.Y. 1981). The Texas Court of Criminal Appeals also overturned a conviction of a physician for unlawfully "dispensing drugs" because the state's statute did not specify that failure to conduct an examination made the act of writing a prescription unlawful. *Haney v. State*, 544 S.W.2d 384 (Tex. 1976).

Texas, North Carolina, Tennessee, Arkansas have since added "prescribing" to its definition of "dispensing." (Texas Health & Safety Code, §§481.112, 481.002; North Carolina Controlled Substances Act, Article 5, §90-87.8; Tenn. Code §39-17-402; Ark. Code Ann. § 5-64-101(7).) New York added "prescribe" to its list of proscribed acts. New York Public Health Law §3304. This Court should follow the lead of those states and require that Montana County Attorneys act only within their authority as actually enacted by the Montana legislature.

C. MCA §§45-9-101(6) Prohibits the Exact Kind of Prosecution Undertaken Here, by Specifically Exempting the Actions of Physicians Acting in the Course of Their Professional Practice From Prosecution for Distribution of Dangerous Drugs.

1. The plain language of Montana's exemption statute requires the reversal of the drug distribution and possession convictions.

Montana's statute prohibiting criminal drug distribution clearly and specifically exempts physicians acting within their practice from being prosecuted: **"**Practitioners, as defined in 50-32-101, and agents under their supervision acting in the course of a professional practice are exempt from this section." MCA § 45-9-101(6). "Practitioner" is defined as "a physician… licensed, registered, or otherwise permitted to distribute, dispense, or conduct research with respect to or to administer a dangerous drug in the course of professional practice or research in this state." MCA §50-32-101(24).

Dr. Christensen was licensed by the State, approved by the DEA, operating in an established office with staff including other professionals, keeping records, invested in additional medical equipment, engaged in continuing education, referring patients to specialists, and caring for some 5000 patients. And every allegation arose from prescriptions written from that established office, during business hours, with other staff present. By any measure Dr. Christensen

prescribed in the course of a professional practice and therefore, by the plain language of the statute should be exempt from prosecution.

There is no definition of "in the course of a professional practice" in the Montana statute, but Merriam-Webster defines "professional" as "engaged in one of the learned 'professions,' with professions defined as "a calling requiring specialized knowledge and often long and intensive academic preparation." https://www.merriam-webster.com/dictionary/professional, and /profession. Dr. Christensen graduated from the UCLA school of Medicine, was at all times licensed by the State of Montana. He was at all times registered with the DEA and permitted by them to prescribe narcotics, both indicating that he was engaged as a professional. "Practice" is defined by Merriam-Webster as "the continuous exercise of a profession." https://www.merriam-webster.com/dictionary/practice.

It makes sense that doctors need to be exempt from a law that prohibits providing controlled substances to others. Doctors administer medicines and give away samples regularly. Doing so is what doctors are trained to do, and second-guessing those decisions is not a role for which law enforcement is trained. At the same time, merely being a doctor should not constitute a free pass to do whatever one wants with a controlled substance. Whether one was acting as part of a professional practice is a good line to draw for the application of criminal law

which protects the public, but does not risk depriving patients of the medical care they need.

The exemption should apply in this case. Dr. Christensen was not in the street trading drugs for sex, was not at a tavern sliding samples across the bar, was not in the street trying to make an extra buck. His medical practice operated in a fixed location, kept regular hours, advertised its presence, had over 5000 patients, employed staff, kept records, purchased and used equipment and supplies, and did all the things one would expect in a professional practice. All the evidence demonstrates that Dr. Christensen was "operating in the course of a professional practice." The exemption should therefore apply and the drug distribution counts should be reversed.

2. The body of law offered by the State to support its theory of prosecution and accepted by the court interprets a federal statute which is substantially different from Montana's statute, and therefore is inapposite.

The State announced its intention to ignore Montana law generally, and the exemption against prosecuting physicians particularly, in note 2 of the original Information, where it cited *United States v. Rosen*, 582 F.2d 1032 (5th Cir. 1978) for the proposition that a series of actions, all undertaken quite literally within the course of professional practice, could nevertheless result in a conclusion that the physician was not in fact acting within the course of his professional practice. The State's theory suffers from a long series of problems, beginning with the most

glaring – that the federal statute *Rosen* interprets does not have the same language the Montana statute does, most notably that it does not include any exemption for physicians – and continuing to the merely difficult, that rulings from the Fifth Circuit, or any court engaged in the interpretation of federal or non-Montana law, are not binding on this Court.

The United States Supreme Court has considered whether, despite there being no explicit exemption, physicians should be nevertheless be exempt from the federal statute and why. In *United States v. Moore*, 423 U.S. 122, 129 (1975), the Supreme Court held that physicians were subject to the maximum criminal federal statute, 21 U.S.C. § 841, criminalizing the "…distribu[tion] or dispens[ation]" of controlled substances. Moore was a doctor who in 1971 claimed to be treating addicts with enormous quantities of methadone. The DEA had revoked his authorization to prescribe, however. *Moore* at 126. Moore admitted his "treatment" (he claimed he was "saturating" patients so they would be overwhelmed and want to detoxify) was outside any accepted medical practice. *Id.* He did little to no examination of patients, and gave no instructions or warnings about use, other than to say follow the instructions on the label, which itself said to "take as directed for detoxification." *Id.* at 126-127. He charged patients on a "sliding fee" scale depending on how much methadone the patient was prescribed. *Id.*

But the federal statute, 21 U.S.C. §841, which prohibited the distribution of controlled substances, also had the phrase, "except as authorized by this subchapter…." Moore argued that because he was a physician, he was authorized to prescribe and therefore could not be prosecuted under the statute. *Moore* at 131. The *Moore* court, however, noted that the statute authorizing doctors to prescribe had a number of requirements to qualify for authorization, including registration, and ultimately approved the jury instruction the district court formulated, which introduced the idea of "good faith" and "the usual course of a professional practice." *Id*. at 138-139. In order to reach that conclusion, the *Moore* court analyzed and interpreted the interplay between §841 and host of other federal statutes. The Court also reviewed and relied upon Congressional history and its prior cases interpreting the *Harrison Act*, the federal statutory scheme which preceded the *Controlled Substances Act*. There are countless differences between the Montana statute and the federal statute. The conclusion is inescapable: if the State of Montana was not able to prosecute Dr. Christensen under Montana law, it should not be able to prosecute him using non-Montana law.

Other states which have prosecuted physicians on similar theories also contained broader language than Montana's criminal drug distribution act, including prohibitions on the "dispensing" or "delivering" of dangerous drugs, provisions not present in Montana's statute, and specific references to "good faith"

or "the course of professional practice." In Michigan, a conviction of a physician for prescribing was upheld because the state statute prohibited the "delivery" of dangerous drugs. *State v. Alford*, 405 Mich. 570, 581-85, 275 N.W. 2d 484 (Mich. 1979). *See also Alarcon v. State*, 573 N.E.2d 477 (Ind. App. 1991) (statute prohibiting "delivery" of controlled substances could be used to convict physician for prescribing); *People v. Cliche*, 111 Ill. App. 3d 593, 444 N.E.2d 649 (Ill. App. 1982) (statute prohibiting "delivery" of controlled substances could be used to convict physician for prescribing); *State v. Young*, 185 W. Va. 327, 406 S.E.2d 758 (W.Va. 1991) (statute prohibited "delivery"; collecting cases). Some states have convicted physicians under statutes that prohibited "sale *or* delivery." *Cilento v. State*, 377 So. 2d 663 (Fla. 1979) (statute prohibits "sale *or* delivery"); *State v. Sway*, 15 Ohio St. 3d 112, 472 N.E.2d 1065 (Ohio 1984) (legislature defined "sell" as "deliver").

Other states also have modernized their laws so that the crime of dispensing drugs outside the norms of accepted practice is expressly defined and criminalized. For example, Pennsylvania's general controlled substances act has a subsection that prohibits "the administration, dispensing, delivery, gift or prescription of any controlled substance by any practitioner or professional assistant under the practitioner's direction and supervision unless done (i) in good faith in the course of his professional practice; (ii) within the scope of the patient relationship; (iii) in

accordance with treatment principles accepted by a responsible segment of the medical profession." 35 Pa. Cons. Stat. §780-113 (14). Florida's general criminal drug distribution statute expressly prohibits the act of "[writing] a prescription for a controlled substance for a patient, other person, or an animal if the sole purpose of writing such prescription is to provide a monetary benefit to, or obtain a monetary benefit for, the prescribing practitioner." Fla. Stat. §893.13(8)(a).

If the Montana legislature wished to authorize prosecution of physicians for allegedly prescribing for a non-legitimate purpose, it could have passed legislation expressly defining the crime. It did not make any of those changes, however, instead choosing to exempt physicians.

The State's theory—essentially that medical malpractice is criminal behavior—is also illogical in face of the plain language of the statute, and runs counter to public policy. By the State's theory, any physician whose patient errs in taking his or her medication could be subject to criminal penalties. Such a result would be crazy. A more logical interpretation is that physicians are exempted, except for the times in their lives they are not acting as physicians. Thus, a doctor having a drink at the bar cannot give away (or sell or barter) drugs to the bar patrons. Or a doctor who continues to distribute drugs despite having lost his license would be subject to the law. The logical reading of the exemption, though,

is that unless they are way out of line, unless the doctor is not actually acting as a doctor, doctors are protected from prosecution, even in the event they err.

In this case Dr. Christensen was acting "in the course of a professional practice." MCA § 45-9-101(6). Notably, not only does the Montana exemption not appear in the federal law the State advanced, the particular language the Montana statutes uses, "in the course of a professional practice," differs in meaningful ways from the "exemption" fashioned by federal courts, which is predicated on both acting outside the course of professional practice (and sometimes outside the course of "usual" professional practice), and requiring that the prescription be for no medical purpose. *United States v. Feingold*, 454 F.3d 1001, 1008 (2006). The *Feingold* court emphasized that "the jury [must] look into [a practitioner's] mind to determine whether he prescribed the pills for what he thought was a medical purpose or whether he was passing out the pills to anyone who asked for them." *Id.* (citations omitted).

That federal standard, even if it had been followed in this case (see Issue III below), still leads to a difficult intertwining of civil medical malpractice and criminal liability, an intertwining which can easily lead to false convictions. Montana's statute seeks to avoid that injustice, and instead focuses solely on whether the doctor is in the process of being a doctor—is he operating in the course of a professional practice? Is he licensed to practice medicine, does he have

prescription-writing privileges, is he in an actual doctor's office, employed as a doctor or as the doctor/owner, are patient records kept? Is the office staffed with other professionals, has there been an investment in medical equipment, does the doctor have professional relationships, go to conferences, confer with other doctors, or refer cases out? All of those factors indicate Dr. Christensen was indeed acting the course of a professional practice.

Another good way to analyze the phrase is to consider its opposite—what is it to operate outside a professional practice? The phrase "outside a professional practice" by its plain meaning suggests literally that—outside the office. On the street, in a bar, hidden in the shadows. To operate outside the practice is to operate outside the view of other professionals—both doctors and non-doctor professionals—or outside the view of regulators. Outside the professional practice is to operate without equipment, without help from other professionals, without a license without records. Only by reading the Montana statute literally can the law be understood to differentiate between a civil and criminal case. And like a lot of Montana wisdom, reading the statute literally is easier, and works better to ensure the purpose of the clause—to protect physicians from a prosecution which seeks to second-guess the physician's professional decisions.

By the plain meaning of the statute, Dr. Christensen's drug distribution convictions must be dismissed as matter of law, and should have been at the

beginning of the case. Even the State cannot dispute that all of Dr. Christensen's prescribing was quite literally done in the course of a professional practice.

II. Is Montana's Criminal Endangerment Statute Unconstitutionally Vague As Applied to a Physician Prescribing Medication, Which By Its Very Nature Creates a Potential Risk of Death Or Serious Bodily Injury If Misused?

A. Standard of Review

The constitutionality of a statute is a question of law, which this Court reviews for correctness. *State v. Knudson*, 2007 MT 324, ¶ 12, 340 Mont. 167, 174 P.3d 469. When reviewing a question of constitutional law, including the issue of whether a defendant's due process rights were violated, this Court reviews the district court's conclusion to determine whether its interpretation of the law was correct. *State v. Michaud*, 2008 MT 88, ¶15 342 Mont. 244, 180 P.3d 636.

B. The District Court Erred in Refusing to Dismiss the Criminal Endangerment Convictions Because MCA §45-5-207 Is Unconstitutionally Vague As Applied In This Case.

1. Montana's criminal endangerment statute uses broad, undefined terms and provides no guidelines about its application in the medical context.

MCA §45-5-207 provides: "A person who knowingly engages in conduct that creates a substantial risk of death or serious bodily injury to another commits the offense of criminal endangerment." "Conduct" is broadly defined to mean "an act or series of acts and the accompanying mental state." MCA §45-2-101(15). The

phrase "substantial risk" is not defined in the Montana Code. *State v. Crisp*, 249 Mont. 199, 204, 814 P. 2d 981 (1991). That case explained that "substantial" is defined as "not imaginary or illusory: real, true" and that "risk" is defined as "possibility of loss or injury: peril." *Id*. Thus, the criminal endangerment statute criminalizes the actions of a physician who creates any amount of risk so long as it is a "true" or "real" risk of serious bodily injury or death.

Labeling the amount of risk to be "true" or "real" does little to help a physician know when her prescribing might constitute good medicine and when it might be a felony crime. As anyone who has ever received medication, or even watched television commercials for drugs knows, there are risks associated with taking medication, some of them very serious.

2. Statutes are unconstitutionally "vague as applied" when they fail to provide notice of the prohibited conduct and/ or when they lack minimal guidelines to govern law enforcement.

When courts examine a statute for constitutional vagueness, they analyze it under a two-pronged test. First, the statute must "define the criminal offense with sufficient definitiveness that ordinary people can understand what conduct is prohibited." *Kolender v. Lawson*, 461 U.S. 352, 357 (1983). Second, the statute must "establish minimal guidelines to govern law enforcement." *Id.* at 358.

Montana has followed the *Kolender* test. *State v. Knudson*, 2007 MT 324, ¶ 19, 340 Mont. 167, 174 P.3d 469 (2007).

"It is a basic principle of due process that an enactment is void for vagueness if its prohibitions are not clearly defined." *Grayned v. City of Rockford,* 408 U.S. 104, 108 (1972). That principle also applies to the enforcement. Laws must contain explicit standards for those who apply them. *Grayned*, 408 U.S. at 108. A vague law impermissibly delegates basic policy matters to policemen, judges, and juries for resolution on an ad hoc and subjective basis, with the attendant dangers of arbitrary and discriminatory application. *Grayned,* 408 U.S. at 108-09. Where the legislature fails to provide minimal guidelines, a criminal statute may unconstitutionally permit "a standardless sweep [that] allows policemen, prosecutors, and juries to pursue their personal predilections." *Smith v. Goguen,* 414 U.S. 566, 574-75. (1974).

3. The Criminal Endangerment Statute Is Unconstitutionally Vague as Applied in the Context of Medical Prescribing Because In Failing to Distinguish Legal from Illegal Prescribing of Controlled Substances, It Fails the *Kolender/Knutson test*.

One of the very reasons a drug requires a prescription at all is, "**because of its toxicity or other potentiality for harmful effect**, the method of its use, or the collateral measures necessary to its use, is not safe for use except under the supervision of a practitioner licensed by law to administer or prescribe the drug."

MCA §50-31-307(2)(b) (emphasis added). A law which penalizes creating that very potentiality for harm, while another law approves such action, cannot be constitutional.

The U.S. Supreme Court opinion in *Gonzalez v. Carhart*, 550 U.S. 124 (2007) is illustrative. In that case, the Supreme Court held that the federal law banning "partial birth abortions" was not unconstitutionally vague on its face because it required a "deliberate overt act" by the physician separate from the act of delivery of a fetus. *Id*. at 149-54. The federal law also contained specific anatomical landmarks and objective standards for physicians to follow. The law was also not unconstitutionally vague because it required a deliberate act rather than an accidental or unintentional act by the physician. The majority noted that the law could be vague as applied to certain cases. *Id*. at 168.

Here, by contrast, Montana's criminal endangerment statute, which consists of only twenty words, provides no guidelines as to the type of medical practices that it prohibits. It also requires only that the physician create a "risk of death or substantial bodily injury," without requiring that any injury actually occur. The *scienter* requirement in Montana's statute—that the physician be aware of both his conduct and be aware of the risks of that conduct[2]—does not limit the overbreadth

[2] *See State v. Lambert*, 280 Mont. 231, 929 P.2d 846 (1991) (State must prove defendant was both aware of his conduct and aware of the substantial risk of death or serious bodily injury in criminal endangerment case).

of the law, because even the most meticulous prescriber could be proven to know that the drug he prescribed posed a substantial risk of death or serious bodily injury. The law is impermissibly vague as applied in the prescribing context because it does not specify a quantifiable, or even understandable, amount of risk.

The swirling smoke in the physician's crystal ball only increases when handed to the law enforcement officer. The most prescribed drug in the United States by some measures is *Humira*, a drug used to treat Rheumatoid Arthritis and Crohn's disease.[3] Its manufacturer warns on the opening page of its website, however, that "you should discuss the potential benefits and risks of Humira with your doctor" because it could cause serious infection or cancer. https://www.humira.com/. The site also warns, as is so common as to be axiomatic, that risk factors may rise depending on individual circumstances. A doctor is equipped to work with patients to make such decisions. It is absurd to think a law enforcement officer is equipped to make such a decision, especially given the fact that law enforcement officers do not usually make arrest and charging decisions in conjunction with the people they are arresting and charging. That relationship is indispensable to a physicians' ability to weigh risk, however.

[3] *See*, https://www.webmd.com/drug-medication/news/20150508/most-prescribed-top-selling-drugs

There are many ways to regulate and manage prescribing. The criminal law is not well suited to the purpose, and the criminal endangerment statute especially is too blunt an instrument. The statute could be used to criminalize any prescription depending on the whim of the policeman or prosecutor. That is exactly what the principle of void-for-vagueness is designed to prevent. This Court should reverse the lower court and reverse the convictions for criminal endangerment as overly vague as applied to physician prescribing practices.

III. Did the Court Err as a Matter of Law by Using Ninth Circuit Jury Instructions to Instruct the Jury on the Montana Law?

A. Standard of Review

The standard of review for jury instructions in criminal cases is "whether the instructions, as a whole, fully and fairly instruct the jury on the law applicable to the case." *State v. Ilk*, 2018 MT 186, ¶15, 392 Mont. 201, 422 P. 2d 1219. When a jury instruction is based on a district court's conclusion of law, this Court applies a plenary review standard. *W. Sec. Bank v. Eide Bailly LLP*, 2010 MT 291, ¶ 18, 359 Mont. 32, 249 P. 3d 35. The Ninth Circuit reviews jury instructions for abuse of discretion overall, but reviews instructions explaining the elements of a crime *de novo* to determine if the elements given accurately reflect the law. *United States. v. Feingold*, 454 F. 3d 1001, 1007 (9th Cir. 2006).

B. Having Opted for Instructions From the Ninth Circuit, the District Court Erred by Not Giving Instructions on *Mens Rea,* which the Ninth Circuit Requires to Ensure the Conviction is Based on Criminal Rather than Civil Malpractice Standards.

Because no physician has ever before been prosecuted in Montana for criminal drug distribution based on his prescribing decisions, the State had to look outside of Montana for any kind of jury instruction. The State turned to *United States v. Feingold*, 454 F.3d 1001 (9th Cir. 2006), a case which discusses exactly what the instructions should be under federal law (or, presumably, for any non-federal court following federal law). The State, however, did not include the *mens rea* requirements specified in *Feingold* in its proffered instruction. Instead, the State insisted that the *mens rea* requirement should merely be "purposely and knowingly," the ordinary *mens rea* for criminal drug distribution in Montana. D.C. Doc. 233; Trial Tr. 2143.

Dr. Christensen, maintaining his objection to the use of federal law at all, offered instructions which covered the complex *mens rea* requirement outlined in *Feingold*. (D.C. Doc. 232 at 67). The District Court erred in accepting the State's instruction, which did not accurately represent federal law, let alone Montana law.

In accepting the State's instruction, the Court erroneously followed the State's lead in ignoring the very issue that the *Feingold* struggles with—how to

ensure that the jury is making a decision based criminal liability rather than mere negligence. The *Feingold* court noted:

> If a practitioner's distribution of controlled substances becomes illegal only by virtue of the fact that his actions are "outside the usual course of professional practice," it follows that the practitioner must have deliberately acted in this fashion in order for him to be convicted of a crime.
>
> *Feingold, supra* at 1007-1008 (citations omitted).

The Ninth Circuit, quoting *Morissette v. United States*, 342 U.S. 246, 250 (1952), went on to emphasize that "The contention that an injury can amount to a crime only when inflicted by intention is no provincial or transient notion. It is as universal and persistent in mature systems of law as belief in freedom of the human will and a consequent ability and duty of the normal individual to choose between good and evil." *Id. at* 1008. The intent to break the law, in other words, is the very thing that makes the act criminal at all.

Feingold explained further that "an instruction is improper if it allows a jury to convict a licensed practitioner under §841(a) *solely on a finding that he has committed malpractice, intentional or otherwise*. Rather, the district court must ensure that the benchmark for criminal liability is the higher showing that the practitioner intentionally has distributed controlled substances for no legitimate medical purpose and outside the usual course of professional practice." *Feingold*, 454 F. 3d at 1010.

The *Feingold* court then went on to say exactly what the elements under the federal criminal drug distribution statute need to be when prosecuting a physician for prescription-writing practices:

> Simply put, to convict a practitioner under §841(a), 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*. In other words, the jury must make a finding of intent not merely with respect to distribution, but also with respect to the doctor's intent to act as a pusher rather than a medical professional.

Feingold, 454 F. 3d at 1008. The district court had not given that instruction at the trial, however—an error that might have resulted in reversal but for the rest of the instructions which were given in *Feingold*.

The *Feingold* court approved the following jury instruction regarding the third element, "with intent to distribute outside the course of professional practice," which the district court in *Feingold* did give:

> A practitioner may not be convicted of unlawful distribution of controlled substances when he distributes controlled substances in good faith to patients in the regular course of professional practice. Only the lawful acts of a practitioner, however, are exempted from prosecution under the law. **A controlled substance is distributed by a practitioner in the usual course of his professional practice if the substance is distributed by**

> **him in good faith in medically treating a patient. Good faith is not merely a practitioner's sincere intention towards the people who come to see him, but, rather, it involves his sincerity in attempting to conduct himself in accordance with a standard of medical practice generally recognized and accepted in the country.** Thus, good faith in this context means an honest effort to prescribe for a patient's condition in accordance with the standard of medical practice generally recognized and accepted in the country. However, 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.

Feingold, 454 F. 3d at 1012. Because the district court gave this "good faith" instruction, the Feingold court held that the instructions overall covered the necessary heighted *mens* rea, and the case was affirmed.

Other federal circuits have also approved the same or similar good faith instructions as one way to ensure a defendant is not convicted of a crime using a civil, medical malpractice standard. There is a consensus among federal appellate decisions that "a physician's departure from the standard of care, without more, is not enough to sustain a conviction under Section 841(a)." *United States. v. Sabean*, 885 F.3d 27, 44 (1st Cir. 2018), citing *United States v. Wexler*, 522 F.3d 194, 204 (2d Cir. 2008) (violation of standard of care alone insufficient to support criminal conviction of licensed practitioner under 841(a)) and *United States v. Feingold*, 454 F.3d 1001, 1007 (9th Cir. 2006) (same).

Federal appellate courts have also agreed that jury instructions regarding a "good faith" defense must be given in these prosecutions of physicians under the Controlled Substances Act. *Sabean*, 883 F.3d at 44, citing *United States v. McIver*, 470 F.3d 550, 559-60 (4th Cir. 2006) (upholding conviction of physician because district court instructed jury on criminal standard of proof as compared with civil standard and instructed jury on good faith defense). Appellate courts have reversed convictions of a physician under the Controlled Substances Act because the jury instructions failed to offer a "good faith" defense to the defendant physicians. *See United States. v. Hurwitz*, 459 F.3d 463, 482 (4th Cir. 2006) (reversing conviction of physician because district court did not instruct jury on good faith defense). Similarly, in *United States v. Carroll*, the trial court did not advise the jury that physicians are exempt from the provisions of the drug abuse statute when they dispense or prescribe controlled substances in good faith to patients in the regular course of professional practice. 518 F. 2d 187, 189-90 (6th Cir. 1975).

Here the district court also did not give a good faith instruction, even though *Feingold*'s instructions had emphasized that point. *See* D.C. Doc. 233.

These instructions omitted the heightened *mens rea* requirement for prosecution of licensed physicians for drug distribution. Under that requirement, the State would have had to prove that the physician not only knew that he was distributing, but also that he intended to do so "outside the course of a professional

practice," that is, for the purpose of being a "pusher" and not for a "legitimate medical purpose." Instead, the State had only to prove that Dr. Christensen "purposely and knowingly" distributed dangerous drugs. Notably, the final instructions in this case also did not instruct the jury on the difference between civil and criminal liability. They also omitted any reference to a "good faith" defense.

In choosing not to follow *Feingold*, the district court took a different path not only from the Ninth Circuit, but from other federal appellate courts. Most federal circuits have approved jury instructions similar to those in *Feingold* for prosecutions of physicians accused of violating the Controlled Substances Act, and all have insisted on some way to distinguish between a negligent state of mind and a criminal one. Dr. Christensen was afforded no such opportunity.

The *Feingold* case could not be clearer, using strong language in requiring that a doctor be proven not merely negligent or even "intentionally negligent," but that it be proven he committed "the significantly greater offense of acting as a drug `pusher.'" *Feingold* at 1010. In order to convict a physician of the Federal Offense of Distribution of a Controlled Substance, the United States government must prove not merely "that the doctor had committed malpractice, or even intentional malpractice, but rather on the fact that his actions completely betrayed any

semblance of legitimate medical treatment." And in order ensure that, the court must give instructions that reflect that standard.

IV. Did the District Court Err by Failing to Conduct a Hearing Before Allowing the State to Introduce Evidence Under Rule 404(b)?

A. Standard of Review

The abuse of discretion standard applies in reviewing a trial court's decision whether to admit evidence of other crimes, wrongs or acts. *State v. Crosley*, 2009 MT 126, ¶ 26, 350 Mont. 233, 206 P. 3d 932; *State v. Aakre*, 2002 MT 101, ¶ 8, 309 Mont. 403, 46 P.3d 648. A district court abuses its discretion when it acts arbitrarily, without conscientious judgment, or exceeds the bounds of reason. *State v. Hernandez*, 2009 MT 341, ¶ 7, 353 Mont. 111, 220 P. 3d 25. To the extent the court's ruling is based on a rule of evidence, a statute, or a constitutional right, this Court's review is de novo. *State v. Given*, 2015 MT 273, ¶ 23, 381 Mont. 115, 359 P.3d 90.

B. The Admission of Evidence and Argument Regarding A Dismissed "Overdose Death," Uncharged "Overdose Deaths," Acquitted Conduct, And Reputation Evidence Involving Other Patients Combined to Deny Dr. Christensen a Fair Trial.

1. Throughout the trial, the State introduced improper character evidence about other patients, in violation of Rules 404 and 403, as well as the court's pretrial order.

At trial, the district court opened the floodgates to a torrent of character evidence about patients other than the eleven on whom the charges were based. An Idaho Board of Medicine prosecutor testified that Dr. Christensen had overprescribed opiates and other prescription drugs to 54 patients between 1997 and 2001, and that "at least" five of these patients overdosed and six others were hospitalized. Trial Tr. 531-45. Another Idaho Board of Medicine employee (a nurse) described, over defense objection, hearsay autopsy reports and law enforcement reports for the five Idaho patients who had overdosed. Trial Tr. 2671-76.

The Ravalli County prosecutors emphasized these uncharged overdose deaths in opening and closing arguments. Only at sentencing did they admit that the Defendant had not been convicted of those deaths. Sentencing Tr. 13-14. No effort was made before trial to determine whether there was any overlap between the patients listed in the Idaho Board administrative case and the patients in the Idaho criminal trial at which Dr. Christensen had been acquitted and at which charges had been dismissed.

In fact, the Idaho criminal charges did overlap with the civil allegations described by the Idaho Board witnesses. Thus, these witnesses' testimony violated the district court's order barring reference to underlying conduct from the Idaho criminal trial. D.C. Doc. 211 at 2. In the Idaho criminal case, several counts were

dismissed and the remaining counts were acquitted at trial, with none of the twenty charges resulting in convictions.

In particular, the Board witnesses repeatedly referred to the allegation that Dr. Christensen caused the overdose death of C.M. in February, 2001. *See United States v. Christensen*, 2008 U.S. Dist. LEXIS 102370 (D. Idaho 2008) (denying motion to dismiss); *cf.* Ms. Uranga's testimony at the Montana trial. Trial Tr. 543-45. Neither of the Idaho witnesses mentioned to the jury that this charge ultimately had been dismissed with prejudice. They also summarized Board petition allegations that involved patients who were also part of the Idaho criminal trial (in the distribution charges), even though all of those charges were ultimately acquitted or dismissed.

In addition to presenting the allegations about uncharged Idaho deaths, the lead Ravalli County detective also testified that Dr. Christensen was associated with "a large number of our [Montana] overdose deaths," and that "70 percent of my pill cases would come back to him." Trial Tr. 145. The Montana prosecutor elicited testimony from four of the patient witnesses that Dr. Christensen had a reputation with other patients of being an easy source of opiates. Trial Tr. 1025, 1411, 1703,1730-31. The State also asked Dr. Christensen why "eighty-five percent of pharmacies in the area refused to fill his prescriptions." Trial Tr. 2508-09.

The Ravalli County prosecutor told the jury in closing argument that a task force had to be assembled because "everyone" was reporting on Dr. Christensen's overprescribing of controlled substances. "Multiple agencies in multiple counties throughout the state were getting reports, to the point where they finally had to band together and say, okay -- in other words, it's silly for us to do this all independently, because we are all getting the same reports; Mineral County, Missoula County, Missoula City, Ravalli County, Hamilton City, the DEA, and they finally said let's stop doing this independently…. ***everybody*** that reported to them said these came from Dr. Christensen." Trial Tr. 2781.

This character evidence and argument were presented in the context of a month-long, medically complex trial in which the jury was asked to evaluate the medical treatment of eleven patients with differing medical conditions, who had received prescriptions of multiple types of drugs from different physicians, all in the course of reaching a verdict on twenty-two different charges for three different types of crimes.

C. Rule 404(b) Prohibits Admission of Evidence Offered To Prove Bad Character.

Rule 404(b) states that evidence of other crimes, wrongs, or acts is not admissible "to prove the character of a person in order to show action in conformity therewith" but may be admissible for various other purposes, "such as proof of motive, opportunity, intent, preparation, plan, knowledge, identity, or

absence of mistake or accident." Essentially, the rule disallows the inference from bad act to bad person to guilty person. *State v. Stewart*, 2012 MT 317, ¶ 61, 367 Mont. 503, 291 P.3d 1187.

As a general rule, evidence of other crimes, wrongs, or acts must be excluded because "'prior acts or crimes are highly prejudicial to the defendant, and usually irrelevant for purposes of the charged crime.'" *State v. Derbyshire*, 2009 MT 27, ¶51, 349 Mont. 114, 201 P.3d 811. Proof that the "accused committed other crimes, even if they were of like nature to that charged, is not admissible to show his depravity or criminal propensities, or the resultant likelihood of his committing the offense charged[.]"

This rule barring proof of other crimes "'should be strictly enforced in all cases where applicable, because of the prejudicial effect and injustice of such evidence, and should not be departed from except under conditions which clearly justify such a departure.'" *Derbyshire*, ¶ 22. One of the dangers in admitting evidence of a defendant's prior misconduct is that the jury will convict him not for the offense charged, but for his past misdeeds. *Derbyshire*, ¶ 51. This Court has applied this rule to ensure that a defendant is not convicted "'merely because he is an unsavory person' or on the rationale that because he committed a crime in the past, he has a defect of character that makes him more likely than people generally to have committed the charged offense." *Derbyshire*, ¶ 22.

D. The District Court Failed In Its Gatekeeper Role Because It Did Not Conduct the Required Hearing On 404(b) Evidence.

In Montana, the district court is required to conduct a pretrial hearing on 404(b) issues. *State v. Eighteenth Judicial District Court*, 2010 MT 263, ¶ 49, 385 Mont. 325, 246 P. 3d 415 (describing procedure to be followed and noting that after motions in limine have been filed, the district court "should conduct a hearing and issue a written decision with appropriate findings of fact and conclusions of law").

In this case, the district court failed to conduct the required hearing and did not issue "findings of fact and conclusions of law." A hearing should have been held because the quantity and complexity of improper character evidence the State wanted to present made it cumbersome to analyze in written documents.

Had the court conducted the required hearing, it could have weighed more carefully the probative value of the Idaho prosecutor's "thumbnail sketch" of the 54 Idaho medical cases, and could have compared it with the risk of unfair prejudice. The district court could have determined whether there was any overlap between these medical cases and the medical cases in the Idaho criminal trial at which Dr. Christensen was acquitted.

Because there was no hearing, the district court never evaluated whether or not it was unfair for the prosecutors to insinuate at trial that Dr. Christensen had

"caused" the Idaho overdose deaths. No expert medical evidence was offered regarding the suitability of the Defendant's medical treatment in the 54 Idaho cases. Instead, an Idaho prosecutor and an Idaho nurse were permitted to testify that Dr. Christensen had overprescribed and wrongly prescribed, and that he had caused hospitalization and deaths. The fact that one of the deaths had been dismissed with prejudice in the criminal trial, and the fact that other charges based on some of the 54 patients were acquitted or dismissed, was never mentioned to the jury.

None of the State's physician experts reviewed the Idaho records. Despite the lack of expert foundation, the Ravalli County prosecutors were permitted to argue to the jury that Dr. Christensen was responsible for overdose deaths in Idaho. The district court should have required expert testimony on the medical reliability of the Idaho witnesses' allegations.

At a 404(b) hearing, the district court also could have issued findings of fact on whether the Idaho incidents were sufficiently similar to the Montana cases. In the past, this Court has held that the 404(b) acts involving other victims, in other periods of time, are not necessarily probative for 404(b) purposes. See *State v. Aakre*, 2002 MT 101, ¶ 22, 309 Mont. 403, 46 P.3d 638 (citations omitted).

A hearing might have revealed that the State's purported reason for offering the Idaho evidence—to "prove the doctor was on notice that prescribing opiates is

dangerous and can cause deaths"—was really just a pretext for getting into evidence as much bad character evidence as possible. The State did not need this evidence to prove this point. It had several physicians testify that it was well-known that prescribing opiates carries a risk of death or serious bodily injury. And the defendant never argued that he was not aware of the risks. The probative value of the Idaho "bad acts" evidence was greatly outweighed by its prejudicial effects.

The motions practice before trial also did not provide the defense with sufficient notice about the State's planned improper use of such evidence. The State's *Response* brief did not inform the defense that it intended to use other character evidence concerning other patients—specifically, the Defendant's reputation as an "easy source of drugs." The State merely claimed in its motion that it needed to have victims testify about how they had learned about Dr. Christensen. D.C. Doc. 193.

The State's *Response* also did not disclose the extent or specifics of the evidence regarding what it regarded as contextual information about "how Dr. Christensen came to be charged." There was no mention of the planned testimony that law enforcement in five counties wanted to stop Dr. Christensen, or that Detective Basnaw would testify that Christensen was responsible for "70 percent of my pill cases" and "a large number of overdose deaths." D.C. Doc. 193.

The prosecutor's *Response* brief did not offer a 404(b) purpose for any of this evidence, merely arguing that it was "necessary to provide context." D.C. Doc. 193. Had the court conducted a hearing, it would have been forced to weigh the minimal probative value of this "transaction evidence" against the risk of unfair prejudice.

E. The District Court Should Have Barred the Evidence of the Dismissed "Overdose Death," Uncharged "Overdose Deaths," Acquitted Conduct, And Reputation Evidence Concerning Other Patients, Because It Was Unfairly Prejudicial Under Rule 403.

Rule 403 provides: "Although relevant, evidence may be excluded if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or misleading the jury, or by considerations of undue delay, waste of time, or needless presentation of cumulative evidence." Evidence is unfairly prejudicial if it tempts the jury to decide the case on an improper basis. *State v. Franks*, 2014 MT 273, ¶ 15, 376 Mon. 431, 335 P 3d. 725. Unfair prejudice may arise from evidence that arouses the jury's hostility or sympathy for one side, confuses or misleads the trier of fact, or unduly distracts the jury from the main issues. *State v. Bieber*, 2007 MT 262, ¶ 59, 339 Mont. 309, 170 P.3d 444.

1. The prosecution used the dismissed and uncharged Idaho overdose deaths to urge the jury to decide the case on an improper basis.

In closing argument, Mr. Fulbright implied that the Idaho overdose deaths had been proven to be caused by Dr. Christensen, when in fact only allegations had been made. His closing argument was particularly misleading in the case of the death of CM, which had been charged in the Idaho criminal case and dismissed with prejudice. He then invited the jury to convict the Defendant because "people had died" in Idaho and because he should not get away with it again in Montana.

> Why are we hearing about Idaho?....He was put on notice, if you do this, people die. He did nothing to change. He did it again. People died. It's that simple….
>
> What I'm asking you is to say to Dr. Christensen you cannot do that in Idaho, put your blinders on, come over here in Montana, ignore everything you should have learned and do the same thing here. Tell him that is criminal. It fits every definition. That is criminal.

Trial Tr. 2784, 2792.

The prosecutor misled the jury when he suggested that Dr. Christensen had in fact been responsible for killing people in Idaho. He then inflamed the jury by suggesting that Dr. Christensen had gotten away with causing overdose deaths in the past, providing a motive for the jury to convict him of the charges in this case.

This Court has reversed at least three cases after the prosecution made improper argument regarding prior bad acts for which the defendant had been acquitted. Mr. Fulbright's argument may be compared to the improper comments made by the prosecutor in *State v. Franks*, who implied to the jury that Franks

"was a serial child molester who had simply gotten away with it" when he had been previously acquitted. *Franks*, ¶ 19. *See also State v. Rogers*, 2013 MT 221, ¶ 44, 371 Mont. 239, 306 P.3d 348. In *Rogers*, this Court noted that the prosecutor's comments on Rogers' overturned prior convictions for rape and felony assault with a weapon "invited… the jury to make sure Rogers would be punished when it deliberated on the crimes charged." In this case, the prosecutor's message to the jury was: Dr. Christensen should have been convicted in Idaho, and the jury should not pass up the chance to convict him in Montana. The prosecutor created a risk that the jury convicted Dr. Christensen in part because of what he had done in Idaho, rather than based on the charges in Montana.

In her concurrence in *State v. Franks*, Justice McKinnon explained how and why prosecutorial argument about acquitted conduct may be grounds for reversal. *Franks*, ¶¶ 43-44. She criticized the *Franks* prosecutor for inviting the jury to hold Franks accountable for an offense for which he had already been tried and acquitted, and explained that admission of prior "acquitted conduct" may violate the Double Jeopardy clause.

> One of the protections guaranteed by the Double Jeopardy Clauses of the Fifth Amendment to the United States Constitution and Article II, Section 25 of the Montana Constitution is the protection against a separate prosecution for the same offense after acquittal. *Ashe v. Swenson*, 397 U.S. 436, 445-46 (1970); *State v. Barron*, 2008 MT 69, ¶ 14, 342 Mont. 100, 179 P.2d 519. One of the dangers in admitting evidence of a defendant's prior misconduct is that the jury will convict him not for the offense charged, but for his past misdeeds. *Old*

> *Chief*, 519 U.S. at 180-81; *Derbyshire*, ¶ 51… "These dangers . . . strike at the heart of the protections embodied in the Double Jeopardy Clause." *State v. Mundon*, 129 Haw. 1, 292 P.3d 205, 222 (Haw. 2012).

Franks, ¶ 43**.** Justice McKinnon further noted that "[s]ome courts have held that evidence of a prior offense is not admissible if the defendant has been acquitted of that offense." *Franks*, ¶ 44. *See Mundon*, 292 P.3d at 221-23*; State v. Wakefield*, 278 N.W. 2d 307, 308-09 (Minn. 1979); Christopher Bello, Annotation, *Admissibility of Evidence as to Other Offense as Affected by Defendant's Acquittal of that Offense*, 25 A.L.R.4th 934, §§ 3-4 (1983 & Supp. 2014); *see also State v. Hopkins*, 68 Mont. 504, 517, 219 P. 1106, 1110 (1923).

The district court's admission of this evidence and the prosecutor's improper argument about it violated Dr. Christensen's constitutional rights under Article II, section 25 and under the Double Jeopardy clause of the Fifth Amendment of the U.S. Constitution.

2. Evidence of uncharged "overdose deaths" was also unfairly prejudicial because it was confusing and the Defendant did not have a fair opportunity to respond to the barrage of unproven accusations.

The evidence of uncharged "overdose deaths" and hospitalizations from Idaho and other "overdose deaths" in Montana also should have been barred under Rule 403 because it was confusing and cumulative. It was unfair to introduce these

allegations in this complex medical trial because they distracted the jury from its task of considering the 22 charges in the case itself.

The admission of this evidence on other uncharged deaths was unfairly prejudicial because the Defendant did not have a fair opportunity to defend against the alleged other bad acts. The prosecution did not have to prove beyond a reasonable doubt that the Defendant caused the uncharged Idaho deaths, but could insinuate that he had caused them. The prosecution could introduce the allegations via shorthand testimony, or via hearsay, such as autopsy reports or law enforcement reports, in violation of the rules of evidence and the Defendant's Confrontation Clause rights. (Defense counsel objected on hearsay grounds to the introduction of some of this evidence, commenting "We've opened up a whole new case." Trial Tr. 506.)

The evidence of "uncharged deaths" deprived the Defendant of a fair trial, because he had no meaningful opportunity to rebut such a large number of undeveloped allegations. This evidence was confusing and cumulative in the context of a long, complex trial in which he was already responding to 22 charges involving eleven other patients. The evidence encouraged the jury to throw up its hands, give up evaluating each of the eleven patients' medical cases separately, and find the defendant guilty on all counts.

3. Federal courts have determined that evidence of "uncharged deaths" is unduly prejudicial in prosecutions of physicians for illegal prescribing.

The Eleventh Circuit reversed a conviction of a physician in an improper prescribing case because the government had introduced hearsay evidence of five other uncharged "overdose deaths" at a trial on two charged "overdose deaths." *See U.S. v. Ignasiak*, 667 F.3d 1217, 1233, 1237 (11th Cir. 2012) (introduction of autopsy reports of uncharged deaths under Rule 404(b) was reversible error because it violated the doctor's Confrontation Clause Rights and because this information on five uncharged deaths may have "contributed to the verdict.") The government in *Ignasiak* had argued in closing, as did Mr. Fulbright in this case, that "the deaths of uncharged patients 'put [Ignasiak] on notice that his prescribing habits could be killing people,' and 'that at the very least should have served as notice to Dr. Ignasiak that perhaps there was something wrong with the way that he was prescribing [controlled substances].'"

Other federal courts have followed *Ignasiak* in refusing to admit evidence of uncharged deaths in physician prosecutions. *See, e.g., United States v. Kostenko*, 2017 U.S. Dist. LEXIS 57975, 2017 WL 1395500, at 2 (S.D.W. Va. April 17, 2017) (district court grants defense motion in limine to exclude uncharged deaths in physician prosecution under 841(a), because evidence of other, uncharged

overdose deaths "has the potential to be both unfairly prejudicial and confusing to the jury").

4. The "pattern evidence" regarding Christensen's reputation among other patients and pharmacies should have been barred as more prejudicial than probative because it was not offered for a 404(b) purpose and did not prove any element of the charged crimes.

The evidence that Dr. Christensen was known to other addicts as an easy source of prescription opiates, the testimony that Dr. Christensen was named in 70% of Detective Basnaw's pill cases and was responsible for "a large number of [Montana] overdose deaths" was not evidence of any of the facts in dispute. Nor was the information that "85% of pharmacies would not fill his prescriptions" relevant to prove any element in the case.

Given the highly prejudicial nature of this evidence, the District Court erred in admitting this "pattern" evidence under the transaction rule, solely for the purpose of "providing context" for the charges in this case. *See State v. Sage*, 2010 MT 156, 357 Mont. 99, 235 P.3d 1284 (reversing conviction because highly prejudicial "context" evidence was admitted).

Several federal appellate courts have reversed convictions of a physician under 21 U.S.C. 841(a) because of introduction of this kind of broad "pattern evidence." *See U.S. v. Tran Cuong Cong*, 18 F.3d 1132 (4th Cir. 1994) (reversing conviction of physician under 841(a)). In *Tran Cuong Cong*, the Fourth Circuit

criticized the trial judge for allowing "the prosecution to ask a defense witness 'is it fair to say that Dr. Tran had a reputation in the community for being an easy source of drugs?' The witness answered that Tran "had a reputation for being an easy source of drugs, which is the answer the prosecution obviously wanted." *Id*. at 1136.

This is the same question that Mr. Geist asked four of the patient witnesses, and that he discussed in his opening statement. For example, he asked Michelle Jessop:

Mr. Geist:	How did you first hear about Dr. Christensen?
Ms. Jessop:	Just on the streets, word of mouth.
Mr. Geist:	What was the word of mouth?
Ms. Jessop:	To go to him because you could basically get anything.

Trial Tr. 1703.

See also U.S. v. Greenfield, 554 F.2d 179, 185-86 (5th Cir. 1977) (reversing conviction of physician accused of improperly prescribing and noting that evidence that other patients were addicts or drug abusers was more prejudicial than probative).

In *Tran Cuong Cong*, the Fourth Circuit further explained that it had been "substantial error" in a prior case to allow the government to introduce "testimony concerning [the defendant's] reputation as a 'liquor law violator ***on a large scale***.'"

It was similarly substantial error to introduce that kind of reputation evidence in a prosecution of a physician under 841(a). *Id.* at 1136-37. The court explained that the jury might have convicted the defendant based on the "pattern" described by the State, rather than deliberating on each individual count.

The district court erred by admitting this contextual "pattern" evidence that did not prove any of the elements of any of the crimes charged in this trial.

V. Did the District Court Err in Refusing to Permit Dr. Christensen to Present a Complete Defense?

A. Standard of Review

The abuse of discretion standard applies in reviewing a trial court's evidentiary decisions. *State v. Colburn*, 2016 MT 41, ¶6, 382 Mont. 223, 366 P.2d 358. To the extent the court's ruling is based on a rule of evidence, a statute, or a constitutional right, this Court's review is de novo. *State v. Given*, 2015 MT 273, ¶ 23, 381 Mont. 115, 359 P.3d 90.

B. The Defendant's Constitutional Right to Present A Complete Defense Was Violated by the District Court's Exclusion of Testimony From His Former Patient Witnesses And By the Court's Restriction On Cross-Examination.

1. Criminal defendants have a right to present a complete defense.

A defendant has a constitutional right to present evidence in his defense. *State v. Colburn*, 2016 MT 41, ¶ 24, 382 Mont. 223, 366 P.3d 258. "Whether

rooted directly in the Due Process Clause of the Fourteenth Amendment, or in the Compulsory Process or Confrontation Clauses of the Sixth Amendment, the Constitution guarantees criminal defendants 'a meaningful opportunity to present a complete defense.'" *Crane v. Kentucky*, 476 U.S. 683, 690 (1986) (citations omitted). This includes "the right to put before a jury evidence that might influence the determination of guilt." *Taylor v. Illinois*, 484 U.S. 400, 409 (1988). "We break no new ground in observing that an essential component of procedural fairness is an opportunity to be heard." *Crane*, 476 U.S. at 690 (citations omitted). "That opportunity would be an empty one if the State were permitted to exclude competent, reliable evidence bearing on the credibility of a confession when such evidence is central to the defendant's claim of innocence. In the absence of any valid state justification, exclusion of this kind of exculpatory evidence deprives a defendant of the basic right to have the prosecutor's case encounter and 'survive the crucible of meaningful adversarial testing.'" *Crane*, 476 U.S. at 691 (citations omitted).

2. The district court erred in excluding twenty-eight former patient witnesses, who would have provided a corrective impression of the Defendant's "professional practice" as a whole, including the absence of a criminal scheme to distribute controlled substances without a legitimate medical purpose.

At trial, the Dr. Christensen sought to introduce favorable testimony from other patients from his medical practice. These witnesses were twenty-eight former patients from the time period involving the eleven patient witnesses who had been cherry-picked by the State. They included twenty-one patients who had received treatment for chronic pain syndrome and had received prescriptions for controlled substances, including pain-killers, and seven patients who had received treatments for various non-pain conditions including pregnancy, hyperthyroidism, and hypertension. D.C. Doc. 180.

These patients would have testified that they a) received alternative medical treatments for pain, other than prescription opiates, in the course of Dr. Christensen's professional practice; b) received prescription opiates, followed the prescriptions, and found that this treatment benefited them without side effects; c) were denied prescription opiates by Dr. Christensen; or d) had no issues with pain and did not have pain medication pushed on them. Order, re: State's Motion *in limine*, D.C. Doc. 204.

Some of the patients whose testimony the Defendant had wanted to introduce submitted letters at Dr. Christensen's sentencing. *See* D.C. Docs 271, 272, 273, 277. Ms. Edith Valenzano wrote:

> I, Edith Valenzano, was a patient of Dr. Christensen's for five or more visits, three or four years ago. My husband, Cliff, was always in the room during those doctor

> procedures in which Dr. Christensen never suggested or prescribed excessive pain medication for my condition. When I couldn't find or call Dr. Christensen, I lost all hope of relieving the pain. I have had and currently have debilitating neck, middle, and lower back pain which may never go away. After X-rays and MRIs, two neurosurgeons in Missoula have said it is too dangerous to operate on my back to give me relief…..We believe Dr. Christensen is a good, fair, and honest physician.

D.C. Doc. 271.

At sentencing, the district court judge commented that he had received a completely different impression of the defendant after hearing this testimony:

> And in this case, as much or more as any other I've had, I've been presented with two competing pictures of the Defendant that are at odds with one another. That's not uncommon in these cases, but it's probably more stark here than most. I have literally dozens of letters here from satisfied patients talking about a -- describing a doctor who is knowledgeable, caring, compassionate, unselfish, unconcerned with financial compensation to some extent; and then we have, at the same time, the doctor described at trial, who was careless in the extreme with, at least certain patients...

Sent. Tr. 28-29.

The defense wanted to introduce the former patients' testimony and records to rebut the State's evidence and argument contending that Dr. Christensen distributed prescription drugs "outside the course of professional practice," and not "for a legitimate medical purpose." The defense evidence was relevant to the statutory element of the crime—specifically, the exclusion for "practitioners in the

course of professional practice." MCA § 45-9-101(6). It was also relevant to the "good faith" element which should have been introduced pursuant to *Feingold.*

The former patients' testimony would have supported the defense argument that even if Dr. Christensen behaved negligently with the eleven patients cherry-picked by the State, this negligence constituted only specific instances of medical malpractice that occurred within the "course of a professional practice." Trial Tr. 2017, 2029. The testimony would have demonstrated that the Defendant was not engaged in a broad-based criminal scheme to distribute drugs "outside the course of a professional practice."

Near the end of the case, counsel argued again that the defense wanted to introduce favorable evidence regarding Dr. Christensen's professional practice in general because it was relevant to the element of "course of professional practice," and because it was relevant to showing the doctor's intent—that is, his intention not to be a criminal drug-dealer. These arguments came up in the course of the State's successful efforts to limit the testimony of two other defense witnesses, Mrs. Christensen (office manager and wife) and Frances Paddock (office employees) concerning the doctor's day-to-day practices in the office). Trial Tr. 2028. Defense counsel told the court that the rulings barring this kind of evidence had "gutted" his defense. Trial Tr. 2028.

3. The district court erred in excluding the defense witnesses' testimony, which addressed a statutory element—the defense that Dr. Christensen was engaged in a "professional practice."

Before trial, in its motion in limine, the State had asked the court to exclude these former patient witnesses. The district court granted the State's motion *in limine*, reasoning that that the defense witnesses' testimony was inadmissible under Rule 406, habit, because evidence of habit is admissible only "to prove that conduct on a particular occasion was in conformity with the habit or routine practice." The court also stated that the testimony was irrelevant. D.C. Doc. 204 at 4.

The district court's reasoning failed to consider the relevance of such testimony to an element of the drug distribution crime—specifically, the practitioner exemption of section 45-9-101(6). Testimony from these other patients was relevant to show that Dr. Christensen's medical practice did not consist solely or even mostly of overprescribing opiates to addicts.

In addition, the court should have realized that testimony from other patients was relevant to Dr. Christensen's intent—specifically, whether or not he had the "intent" to act as a "drug pusher," rather than as a physician, when he prescribed controlled substances in the "course of his professional practice." The testimony also would have allowed the defense to show that the eleven patients at issue could be considered examples of negligent medical malpractice, occurring within a

broader professional practice that was not functioning solely as a "pill mill." Finally, the testimony was relevant to rebut the State's repeated insinuation that Dr. Christensen prescribed dangerous drugs solely because he wished to feed the addictions of patients.

4. The State exploited the absence of these defense witnesses in arguing to the jury that the Defendant acted "outside the course of a professional practice."

Even as the district court barred Dr. Christensen from presenting evidence regarding his "professional practice" generally, the State was permitted to present extensive evidence and argument regarding other patients outside the eleven charged cases and about Dr. Christensen's practice as a whole. (*See* argument regarding improper character evidence in section IV above.)

In the State's motion in limine to exclude the defense former patient witnesses, the State had claimed that "neither side should have it both ways." D.C. Doc. 180. But at trial, the State was permitted to have it both ways, presenting testimony about the defendant's general reputation among pharmacies, among law enforcement, and among patients other than the eleven named in the charges.

The State also exploited the absence of this rebuttal evidence in closing argument. For example, the State argued to the jury that "**The only ones who went to him** because others wouldn't -- or they didn't want to keep going to the others, **are the addicts**, because the people doing it right made it too tough." Trial Tr.

2791. The State's claim went unchallenged because the defense had been barred from presenting testimony from other chronic pain patients who were not addicts and who went to Dr. Christensen because he had helped them.

In his closing, the prosecutor also exploited the absence of the defense evidence by claiming sarcastically that Dr. Christensen's only evidence that he was acting in the course of a "professional practice" was that he had a building. "Of course, he has a professional practice, because he has a building. It's not about a physical building. It's about are you conducting yourself as a part of the professional practice." Trial Tr. 2788. The State also made other general allegations about Dr. Christensen's practice as a whole. It told the jury that Dr. Christensen was not acting like the other doctors who testified at trial regarding their practices. The prosecutor argued that Dr. Christensen was not like these "good doctors" whose practice was "not opiates on the first visit ***every time***." Trial Tr. 2792. The State could make this argument, with its inference that Dr. Christensen offered opiates "on the first visit, ***every*** time" to ***all*** his patients, because the district court had barred Dr. Christensen from presenting testimony from former patients. Those patients would have testified that Dr. Christensen did not offer them opiates "the first time" and for some never offered them opiates.

Because the State's "general reputation" evidence about the defendant's professional practice as a whole went unrebutted, the exclusion of the Defendant's

evidence was highly prejudicial and his constitutional right to present a complete defense was violated.

5. This Court has reversed convictions when the defendant's constitutional right to present a complete defense was violated.

This Court has reversed convictions in which the district court's exclusion of defense witnesses impermissibly interfered with a defendant's constitutional right to present a defense. In *Colburn*, this Court reversed a conviction in an incest case because the district court barred a defense expert witness from testifying and blocked the defense from presenting evidence that the victim had been abused by another person. *State v. Colburn*, 2016 MT 41, 382 Mont. 223, 366 P.3d 258. *See also State v. Cunningham*, 2018 MT 56, ¶ 15, 390 Mont. 408, 414 P.3d 289 (conviction reversed because district court erred in excluding statements by victim, which were offered to show defendant's state of mind as part of justifiable use of force defense).

Here, the district court did not give consideration to the Defendant's constitutional rights when making its evidentiary decisions. The district court overlooked defendants' constitutional right to present a defense, which has been upheld in landmark cases such as *Chambers v. Mississippi*, 410 U.S. 284 (1973) (holding that trial court violated defendant's Fourteenth Amendment rights when it excluded as hearsay confessions by someone other than defendant). Whatever

evidentiary objections the State might have raised were greatly outweighed by the Defendant's constitutional right to present a complete defense.

"A court's discretion in evidentiary rulings is circumscribed by the rules of evidence *and* the defendant's constitutional right to present a defense." *People v. Carroll*, 95 N.Y.2d 375 (2000)(citations omitted). Given that "[f]ew rights are more fundamental than that of an accused to present witnesses in his own defense" (*Chambers v. Mississippi*, 410 U.S. at 302), the exclusion of evidence on the grounds of state evidentiary rules such as the rule against hearsay must be necessary to satisfy a compelling state interest. *See Patrick v. State*, 295 Ark. 473, 750 S.W.2d 391 (1988); *People v. Young*, 59 A.D.2d 920, 399 N.Y.S.2d 156 (2d Dept. 1977); *People v. Torre*, 42 N.Y.2d 1036, 399 N.Y.S.2d 203 (1977).

Here, the Rule 406 "habit" argument cited by the district court was not a justifiable reason for exclusion of the defense evidence. Moreover, the excluded testimony was directly relevant to a statutory defense provided by the legislature—the exemption for practitioners distributed drugs "in the course of a professional practice." The district court erred by excluding the defense witnesses.

C. The Defendant's Constitutional Right to Present Evidence and His Confrontation Clause Rights Were Also Violated By the District Court's Restriction of His Cross-Examination of Erica Cummings.

A defendant has a constitutional right to present a complete defense and to confront his accusers, including to "demonstrate the bias or motive of prosecution

witnesses . . . .” *State v. Gommenginger,* 242 Mont. 265, 272, 790 P.2d 455,460 (1990), citing U.S. Const. amend. VI; M. R. Evid. 608(b)).

The State’s first patient witness was Erica Cummings, who had been charged with negligent homicide for distributing some of her prescriptions from Dr. Christensen to a man who died. As part of her plea deal with the State, she agreed to testify against Dr. Christensen, in exchange for concurrent, partially suspended 8-year sentences for drug distribution and criminal endangerment. At trial, the defense sought to examine her on the benefits she received under this plea agreement, in an effort to show bias. The State objected when she was asked what her sentence would have been had she been convicted of negligent homicide. The Court sustained the State’s objection, barring counsel from exploring how great the benefit was that she received. Trial Tr. 1080. The jury did not hear that Ms. Cummings plea deal had saved her from a potential sentence of twenty years.

The district court’s ruling was contrary to a recent holding of this Court. In *State v. Flowers*, 2018 MT 96, 391 Mont. 237, this Court reversed a conviction because of a similar restriction on cross-examination regarding the benefits of a plea agreement extended to a State’s witness. Flowers was a drug possession case in which the State’s key witness received a beneficial plea deal in exchange for testimony against Flowers. The district court barred the defense from questioning the State’s witness about how he was spared a potential 147-year sentence in

exchange for his testimony. This Court stated: "But to prohibit any questioning to show that Hill had faced a potential 147-year sentence and got an agreement from the State for seven years with two suspended deprived Flowers of valuable impeachment evidence." *Flowers*, ¶ 22.

Here, Ms. Cumming's testimony was central to Dr. Christensen's convictions on one count of drug distribution to her and one count of criminal endangerment. The convictions on those counts should therefore be reversed.

VI. Did the State Present Enough Evidence to Convict Dr. Christensen?

A. Standard of Review

This Court reviews de novo a district court's denial of defendant's motion to dismiss for insufficient evidence. *State v. Eisenzimer*, 2014 MT 208, ¶ 5, 376 Mont. 157, 330 P.3d 1166. Denial of a motion brought under MCA § 46-16-403 is reviewed to determine whether, in viewing the evidence in the light most favorable to the prosecution, any rational trier of fact could have found the essential elements of the crime beyond a reasonable doubt; the appellate courts review a district court's conclusions of law to determine whether those conclusions are correct. *State v. McCarthy*, 1999 MT 99, 294 Mont. 270, 980 P. 2d 629.

B. The District Court Erred in Denying Defendant's Motion to Dismiss the Negligent Homicide Charges For Insufficient Evidence.

Prior to trial, the defense moved to dismiss the negligent homicide charges because the State's charging affidavit on its face stated facts that did not establish probable cause to charge the Defendant with the deaths of Gregg Griffin and Kara Philbrick. D.C. Doc. 111. Defense counsel also moved to dismiss the negligent homicide charges for insufficient evidence at the close of the State's case at trial and at the end of trial, pursuant to MCA § 46-16-403. Trial Tr. 1999, 2681.

1. The State failed to present expert testimony that the drugs prescribed by the Defendant were the "cause-in-fact" of the patients' deaths.

In proving the charge of negligent homicide, the State was required to prove the element of causation beyond a reasonable doubt—specifically, that Dr. Christensen negligently "caused" the deaths of Gregg Griffin and the death of Kara Philbrick. MCA § 45-5-104.

Cause-in-fact is required for a conviction of negligent homicide. *State v. Bowen*, 2015 MT 246, ¶33, 380 Mont. 433, 356 P.3d 449, citing *State v. Schipman*, 2000 MT 102, 299 Mont. 273, 2 P.3d 223. In addition, "where a crime is based on some form of negligence, the State must show not only that defendant's negligent conduct was the 'cause in fact' of the victim's death, but also that the victim was foreseeably endangered, in a manner which was foreseeable and to a degree of

harm which was foreseeable." *State v. Bier*, 181 Mont. 27, 32-33, 591 P.2d 1115, 1118 (1979).

A party's conduct is a cause-in-fact of an event if the event would not have occurred but for that conduct. *State ex rel. Kuntz v. Mont. Thirteenth Judicial Dist. Court*, 2000 MT 22, ¶ 37, 298 Mont. 146, 995 P.2d 951. Further, the defendant's conduct is not a cause of the event, if the event would have occurred without the conduct. *Kuntz*, ¶ 37.

Negligent homicide cases require expert testimony on causation when the cause of death is drug consumption. *State v. Bieber*, 2007 MT 262, ¶ 44, 339 Mont. 309, 170 P.3d 444, citing *State v. Nobach*, 2002 MT 91, ¶ 17, 209 Mont. 342, 46 P.3d 618. In *Nobach*, this Court held that testimony on symptoms of drug consumption or the effect of drug consumption must be given by experts.

In the criminal context, courts in other jurisdictions have held that the medical examiner's testimony regarding causation should be stated in terms of a "reasonable medical certainty." *See, e.g.*, *Perkins v. State*, 920 A.2d 391, 394-95 (Del. 2007) (holding that medical examiner must testify to either a "reasonable medical probability" or a "reasonable medical certainty" as to the cause of death in a homicide case).

a. In *Burrage*, the U.S. Supreme Court held that the government's experts must testify that a defendant's drugs were more than a "contributory factor" in causing an overdose death.

Recently, the U.S. Supreme Court considered the requirements for expert testimony offered by the government to prove that a defendant "caused" a death, in cases in which the victim dies of "mixed drug toxicity." *Burrage v. United States*, 571 U.S. 204, 134 S.Ct. 881 (2014). In *Burrage*, the defendant sold heroin to a person, who used the heroin in combination with other dangerous drugs (not provided by the defendant) and died the next day.

The Supreme Court held that in order for Burrage to receive a 20-year penalty enhancement for causing death by drug distribution, the government had to prove that the drug distributed by the defendant was "an independently sufficient cause of the victim's death." The Court reversed the 20-year sentencing enhancement jury verdict because "no expert was prepared to say that the victim would have died from the heroin use alone." Moreover, the government's experts also were not willing to testify that the heroin was required for the victim to have died, i.e., that the heroin was a "but for" factor. They were only willing to testify that the "heroin was a contributing factor," and that testimony was insufficient.

Justice Scalia explained why the language government experts used was insufficient to prove causation beyond a reasonable doubt:

> One of the experts in this case, for example, testified that Banka's death would have been "[v]ery less likely" had he not used the heroin that Burrage provided. App. 171. Is it sufficient that use of a drug made the victim's death 50 percent more likely? Fifteen percent? Five? Who

> knows. Uncertainty of that kind cannot be squared with the beyond-a-reasonable-doubt standard applicable in criminal trials or with the need to express criminal laws in terms ordinary persons can comprehend.

Id. at 892.

The Supreme Court held that "at least where use of the drug distributed by the defendant is not an independently sufficient cause of the victim's death or serious bodily injury, a defendant cannot be liable for penalty enhancement under §841(b)(1)(C) unless such use is a but-for cause of death." *Id*. at 892.

Applying *Burrage*, one state appeals court has reversed a conviction for involuntary manslaughter based on distribution of heroin leading to death. *See State v. Kosto*, 2018 Ohio 1925, 2018 Ohio App. LEXIS 2064. "Just as in *Burrage*, "'[n]o expert was prepared to say that [the victim] would have died from the heroin use alone.'" *Id*. at 23, quoting *Burrage* at 890. That exact situation is also present in this case. *See also United States v. MacKay*, 20 F. Supp.3d 1287, 1294 (D. Idaho 2014) (applying *Burrage* in physician prescribing case).

b. No evidence was presented to support the element that Dr. Christensen was the cause of death.

At trial, two coroners with law enforcement training (Officer Dicken and Detective Seibert) testified that the patients died due to "mixed drug toxicity." Trial Tr. 389, 734. Both coroners agreed that the "cause of death" in both cases was "self-cause." Trial Tr. 404, 747. Moreover, Mr. Dicken stated, "I'm not a

medical professional. So, we defer to the state crime lab and the forensic pathologist to help us with the medical side of things." Trial Tr. 391.

Mr. Schlueter, a forensic toxicologist who does not possess a medical degree, testified regarding the presence of certain drugs in the blood and urine of each patient. He did not make any statements regarding causation, let alone a statement that the drugs prescribed by the Defendant were a "but-for" cause of the patients' deaths.

With respect to Gregg Griffin, Mr. Schlueter stated that Griffin's blood contained numerous controlled substances, including methadone, Xanax, doxepin, and marijuana. Trial Tr. 414-19. The doxepin was prescribed by Dr. Furrow. State's Ex. 26. Propanolol, a different morphine metabolite, and a different benzodiazepine metabolite were detected in his urine. Trial Tr. 420-21. The autopsy report listed death due to "mixed drug toxicity" and listed methadone, alprazolam and doxepin. State's Ex. 28. Mr. Schlueter did not testify as to which of the many substances caused Griffin's death, or what their role was in relationship to each other. On cross-examination, he conceded that he could not testify that the methadone alone caused Griffin's death.

Defense counsel:	So are you able to say whether or not the methadone could have killed Gregg Griffin by itself?
Mr. Schlueter:	So toxicology cannot be interpreted on its own, and that is so important for everyone to

> understand, that we are part of an investigation.

Trial Tr. 427. Mr. Schlueter also did not testify that the methadone prescribed by the defendant in combination with Xanax prescribed by the defendant caused Griffin's death. He only testified that in general reference literature, "there are citations" that opiates and benzodiazepines taken together can "you can have some respiratory depression." Trial Tr. 416. He did not rule out the possibility that the doxepin, marijuana, morphine, propranolol, or the other benzodiazepine (all not prescribed by Dr. Christensen) which were also in Griffin's body could have played a role in Griffin's death in combination with the methadone and Xanax.

Even if the evidence could have allowed Mr. Schlueter to testify that the two drugs prescribed by Dr. Christensen were a "but-for cause" of Griffin's death, the point here is that he did not. Nor did he testify that "to a reasonable degree of medical certainty or probability" that those drugs "caused" Griffin's death.

With respect to Kara Philbrick, Mr. Schlueter testified that the samples obtained from the hospital and the funeral home were inadequate for quantifying the levels of the drugs in her system. "The samples that we received from the hospital are traditional clinical type samples, so it's traditional that the samples that the hospital uses are just fractions of the amount that would be required for our

analysis. They're drawing their samples for their testing. They're really not thinking about me." Trial Tr. 752.

He testified that the following substances were detected in Ms. Philbrick's blood and/or urine: methadone (prescribed by Dr. Christensen); Fentanyl (prescribed by Dr. Ravitz); Valium/diazepam (prescribed by Dr. Ravitz); Zoloft (prescribed by another doctor); Dilaudid (prescribed by the Defendant); tramadol (an opiate) (prescriber unknown); and marijuana. Trial Tr. 753-761. He noted that in the case of the tramadol, "we were unable to finalize the test because of lack of sample." Trial Tr. 762.

Quantification of levels of drugs is necessary to determine the dose-response relationship and to determine the causative role of certain drugs in bringing about death. Mr. Schlueter did not testify regarding cause of death, or about the relative role or importance of any of these drugs in causing death. The coroner's report did not identify which specific drugs caused the death.

None of the physician experts, including Dr. Wasan, testified on the element of causation. They testified only that Dr. Christensen's prescribing was negligent. Proof of negligence alone does not establish the element of "causation" required to prove negligent homicide. This point was explained by this Court in *State v. Schipman, supra* ¶ 16 (reversing negligent homicide conviction because "cause in fact was not established" even though this Court assumed he was negligent).

If the State had brought a civil suit for wrongful death with these medical cases, and had relied on these witnesses, the lawsuit would have been dismissed on summary judgment for failing to prove causation. There is a reason no expert testified that Dr. Christensen was not the cause-in-fact of the deaths of Kara Philbrick and Gregg Griffin: he was not the cause of their deaths. Gregg Griffin had been taking the drugs Dr. Christensen for a month before he died and was not just fine, but doing well. He died only when he abused his prescriptions and took other drugs as well, against instructions. Kara Philbrick had previously taken the exact prescription Dr. Christensen provided, and had been successful on it for years. She also died only when she took additional drugs, against Dr. Christensen's orders. Her partner believed she took additional drugs intentionally to end her life. Dr. Christensen did not cause their deaths, and even the State's experts were unable to say otherwise.

3. The State failed to meet its burden of proving causation because the patients' intentional misuse of the prescribed drugs was an intervening cause of their deaths.

In proving the charge of negligent homicide, "the State must show not only that defendant's negligent conduct was the 'cause in fact' of the victim's death, but also that the victim was foreseeably endangered, in a manner which was foreseeable and to a degree of harm which was foreseeable." *State v. Bier*, 181 Mont. 27, 32-33, 591 P.2d 1115, 1118 (1979). In addition to failing to prove cause-

in-fact, the State failed to prove beyond a reasonable doubt that Dr. Christensen proximately caused the deaths of Griffin and Philbrick.

a. In negligence cases, an intentional or grossly negligent act severs the chain of causation, cutting off defendants' liability in both civil and criminal cases.

An intentional act or a grossly negligent act by another person may serve as an intervening cause that cuts off liability for the person charged with causing death. This Court has explained that intervening acts may, in some cases, as a matter of law, sever the chain of causation, if the acts are unforeseeable to the defendant. *Estate of Strever v. Cline*, 278 Mont. 165, 178, 924 P.2d 666 (1995) (upholding summary judgment for defendant gun owners who were sued after a child was killed by gun stolen from defendants' unlocked car). This Court noted that "a grossly negligent act on the part of a plaintiff may be considered unforeseeable" and that "the criminal or intentional actions of a third person may not be foreseeable." *Id*. at 177, citing *Sizemore v. Montana Power Co*., 246 Mont. 37, 47 (1990). Failure of proof of causation can be determined as a matter of law. *Estate of Strever* at 175.

Numerous states have held that intervening cause is an affirmative defense in criminal cases, particularly those in which the defendant is charged with negligent homicide, often in the form of vehicular homicide. *See, e.g. State v. Robinett*, 2004 Ida. App. Lexis 2, (collecting cases in note 4) and citing and citing

People v. Saavedra-Rodriguez, 971 P. 2d 223, 225-26 (Colo. 1998); *State v. Pelham*, 176 N.J. 448, 824 A.2d 1082 (N.J. Super. Ct. App. Div. 2003; Black's Law Dictionary, p. 221 (6th ed. 1990).

At a minimum, the district court in this case should have offered a jury instruction on intervening cause, particularly given the fact that the defense raised the issue of intervening cause in a pretrial motion and the defense argued this theory to the jury.[4] This Court has endorsed the use of intervening cause jury instructions on behalf of civil defendants. *See Goodnough v. State*, 199 Mont. 9, 647 P.2d 364 (upholding defense verdict after intervening cause instruction given on behalf of government defendant).

Even without a jury instruction, however, the overwhelming evidence that the two patients did not take the prescriptions as directed by the Defendant was never rebutted by the State. The State therefore did not prove beyond a reasonable doubt that Dr. Christensen caused their deaths.

b. Griffin and Philbrick intentionally misused their prescription drugs, not taking them as directed by Dr. Christensen and not heeding warnings provided with the prescriptions.

In this case, evidence offered by the State established that Gregg Griffin and Kara Philbrick intentionally misused the controlled substances prescribed to them

[4] Because the defense did not offer an intervening cause jury instruction, this is a plain error claim.

by Dr. Christensen. They misused them by consuming them in amounts far greater than he had directed them to take them, by consuming them in combination with other drugs that they also misused, and by consuming them in combination with drugs for which they did not have a legal prescription.

Their misuse rose far above the level of negligence or accident. Coroner Jace Dicken testified that 60 methadone pills were missing from the prescription bottles possessed by Mr. Griffin. Trial Tr. 394. Mr. Griffin did not follow the prescription, which directed him to take two pills every eight hours as needed, and no more than six per day. Trial Tr. 402. Mr. Griffin also appeared to have taken nine additional Xanax pills, not following the prescription given, and ten to twenty doxepin pills were missing. Trial Tr. 395. According to the forensic toxicologist, Griffin's urine testing showed that he had also taken additional substances from an unknown source, including another morphine substance and another benzodiazepine. Trial Tr. 421.

In the case of Ms. Philbrick, twelve methadone pills were missing in her prescription bottles, and one Fentanyl patch (prescribed by Dr. Ravitz) was missing. Two Dilaudid pills were unaccounted for. Trial Tr. 742-43. Her body also contained tramadol, an opiate that wasn't prescribed by Dr. Christensen or by Dr. Ravitz. It was difficult to determine what amount had been consumed because of the inadequate samples provided to the toxicologist.

These intervening acts of misuse by the patients themselves were intentional or grossly negligent, and as such, cut off the chain of causation. In fact, their misuse amounted to an intervening criminal act—criminal possession of dangerous drugs. *See State v. Temple*, 2016 MT 284, 385 Mont. 287, 384 P.3d 54 (ultimate user's misuse of prescription drugs constitutes criminal possession of dangerous drugs). The State failed to meet its burden of proving that these intentional acts were not the proximate cause of Griffin's death and Philbrick's death.

c. The State also did not meet its burden of proving that the patients did not commit suicide.

In a wrongful death case, suicide is a special intervening cause that almost always cuts off the liability of the defendant. This Court adopted this rule in *Kreig v. Massey*, 239 Mont. 469, 781 P.2d 277 (1989), explaining that "the general rule, as relied upon by the District Court, in the area of civil liability for suicide is that "[n]egligence actions for the suicide of another will generally not lie since the act or suicide is considered a deliberate, intervening act exonerating the defendant from legal responsibility . . ." *Prosser and Keeton on Torts* § 44 at 280-81 (4th ed. 1971); *McPeake v. Cannon Esquire, P.C.*, 381 Pa. Super. 227 (1989); *McLaughlin v. Sullivan*, 123 N.H. 335 (1983). *See also Pretty on Top v. City of Hardin*, 182 Mont. 311 (1979) (summary judgment affirmed for defendant jail because plaintiff widow could not show that jail policy caused decedent's suicide, which was intentional act cutting off liability for jail). The criminal standard should be no less.

At trial, Kara Philbrick's partner, Jerry Price, testified repeatedly that he believed Kara had committed suicide. Price said that she had been talking about suicide a lot, that she had previously talked about giving away her possessions, that she had behaved oddly just before death in the way in which she arranged her water bottles in the refrigerator. He told the jury,

> She was talking about suicide a lot **because she was suffering a lot with her pain**. And she had told me that she wanted do not resuscitate tattooed across her chest in case something did happen. She didn't want to come back and have to suffer anymore.

Trial Tr. 962-63. (emphasis added).

There was no such evidence that Mr. Griffin intentionally ended his own life, rather than having been grossly negligent. It is difficult to believe, however, that he could have taken the quantity of additional medication he did without deliberate intent. Both Mr. Griffin and Ms. Philbrick lived lives filled with pain. Dr. Christensen tried to alleviate that pain. In the end, however, both took actions that ended their lives. Dr. Christensen did not take those actions, did not condone them, and in fact cautioned against them.

C. The State Presented Insufficient Evidence That Dr. Christensen's Conduct Amounted to "Criminal Endangerment" As Defined in the Montana Code.

Dr. Christensen was charged with criminally endangering nine patients. "A person commits the offense of criminal endangerment if the person knowingly

engages in conduct that creates a substantial risk of death or serious bodily injury to another." MCA § 45-5-207. In the context of criminal endangerment, "[a] person acts knowingly when the person is aware there exists the high probability that the person's conduct with cause a specific result." D.C. Doc. 233. This definition and jury instruction come from this Court's holding in *State v. Lambert*, 280 Mont. 231, 237, 929 P.2d 846 (1996). *Lambert* held that to prove criminal endangerment, the State must do more than merely prove that a defendant was aware of his conduct; the State has to prove that the defendant is aware of the *high probability* of the risk of death or serious bodily injury that could result from his conduct. "To prove that a defendant was aware of his conduct is one thing; to prove that he was aware of the high probability of the risks posed by his conduct is quite another." *Id*.

The phrase "high probability" is defined in *Burton's Legal Thesaurus*: "almost certainly, favorable prospect, in all likelihood, in most instances, with a high degree of certainty." This definition suggests percentages like ninety percent, 99 percent, or, at the very least, greater than fifty percent. The State therefore had to prove not just that Dr. Christensen knew he was prescribing, but that he knew that there was a high risk of death or serious bodily injury created by his prescribing. There is no proof Dr. Christensen knew of high risk, or even that there was in fact a high risk.

1. Dr. Wasan did not testify that Dr. Christensen's prescribing posed a "high probability" of overdose or death.

The State's leading expert, Dr. Wasan, opined that the Defendant's medical care fell "far below the standard of care" in the case of the nine "criminally endangered" patients. In his criticism of Dr. Christensen's medical treatment of these patients, Wasan identified three types of risks created by Dr. Christensen in prescribing controlled substances to these patients: 1) the risk of death or overdose associated with combining benzodiazepines and high dose opiates; 2) the risk of death or overdose from prescribing high dose opiates alone; and 3) the risk of prescribing controlled substances to patients who had a history of addiction that Dr. Christensen should have found about based on "red flags." (Trial Tr. 1836-1871). Because all nine of the patients had a prior history of addiction, this third risk was a risk that would exacerbate, not create, their pre-existing addiction to drugs.

Here, the State failed to prove that the first two risks created by Dr. Christensen in prescribing opiates posed a "high probability" of death or serious bodily injury. Dr. Wasan conceded on cross-examination that the actual risk of death or overdose associated with concurrent prescription of opiates and benzodiazepines was very low.

Defense counsel:	What is the risk of treating -- And what I mean by that is, how high is the risk of prescribing opiates and benzodiazepines at the same time?
Dr. Wasan:	Well, what literature shows is that if you have concurrent prescribing of opioids and benzodiazepines you have at least twice--and it depends on the dose of those meds--at least twice the chance of an accidental overdose or death.
Defense counsel:	That's sort of a deception with statistics, though, isn't it?
Dr. Wasan:	I don't know what you mean.
Defense counsel:	Well, if the risk in the first place is, say, one in 100,000 and the risk goes up by twice, what's now the risk?
Dr. Wasan:	Correct, it's twice in 100,000.
Defense counsel:	It's now two in 100,000; right?
Dr. Wasan:	Uh-huh.
Defense counsel:	And that's still really low; right?
Dr. Wasan:	Yes.
Defense counsel:	So, when you say that the risk doubles, you really haven't said anything; right?

Trial Tr. 1902. Dr. Wasan refused, in fact, to identify a percentage of risk. Trial Tr. 1915-16. When pressed, he admitted that the overall risk of the combined prescriptions was "much lower" than ten percent. *Id*. He also noted that the risk of overdose and death from the prescription of opiates alone was half that of prescription of the combination of opiates and benzodiazepines. In the end, Dr. Wasan failed to offer any testimony that prescribing high doses of opiates or

combined prescriptions of opiates and benzodiazepines poses a "high probability" risk of death or serious bodily injury.

This testimony was legally insufficient to establish that Dr. Christensen was aware that his prescribing created a "high probability of a risk of death or serious bodily injury."

2. The State did not prove that Dr. Christensen knowingly created a risk of "exacerbated addiction," because most of the patients admitted they lied extensively to Christensen about their addiction and also admitted that they did not take the prescriptions as directed.

In the case of the third "risk" suggested by Dr. Wasan—exacerbating the nine patients' pre-existing addiction to drugs—the State did not prove that Dr. Christensen "knowingly" endangered the majority of these nine patients, because most of these patients admitted that they had lied extensively to him about their prior addiction history, their pain needs, and their current addictive behaviors. (See section VI.D.3. below on insufficient evidence for drug distribution charges.) Moreover, the State presented no evidence that a history of addiction creates a "high probability" of death or serious bodily injury when being treated for pain with opiates. At most, the State proved that Christensen negligently endangered these patients by failing to sufficiently consider the possible risk that they might be addicts.

The following patients in particular admitted extensive dishonesty about their addiction history and current addiction: Erica Cummings, Todd Gore, Michelle Jessop, Jackie Golden, Heather Sutherland, and Paul Petersen. The State did not prove that Dr. Christensen "knowingly" endangered these addicts by prescribing them controlled substances, because they admitted that they lied to him.

In denying defendant's pretrial motion to dismiss the criminal endangerment charges, the district court erroneously concluded that "contributory negligence" is not a defense in criminal cases. D.C. Doc. 127 at 16. On the contrary, "intervening cause" is a defense in criminal cases based on tort-like crimes, such as vehicular homicide. See *State v. Imokawa*, 4 Wn. App. 2d 545, 422 P.3d 502 (2019) (reversing conviction for vehicular homicide because due process required the State to have to prove absence of superseding cause)*; see also State v. Robinett*, 2004 Ida. App. Lexis 2 (collecting cases in note 4).

The State failed to prove that Dr. Christensen's medical treatment "endangered" these patients. Dr. Christensen did not "create" or "cause" the risks of death or serious bodily injury for patients who misused his prescriptions.

D. The State Presented Insufficient Evidence That Dr. Christensen Was Outside the Statutory Exception, Even By the Inapplicable Ninth Circuit Standard.

1. Every patient had a legitimate medical condition that caused him or her chronic pain.

The evidence produced at trial demonstrated that Dr. Christensen had a legitimate medical purpose in prescribing opiates to every one of the eleven patients at issue. Every patient had a legitimate medical condition for which opiates or painkillers or other controlled substances was a legitimate medical treatment. *See* Statement of Facts. All of the patients had received opiates from other physicians for their medical conditions, some of them at the same doses prescribed by Dr. Christensen. While other physicians criticized Dr. Christensen's dosages, his lack of regular monitoring, his record-keeping, and his failure to fully explore other non-opiate treatments, no physician testified that opiates were not a legitimate medical treatment for these medical conditions. While these failures might constitute medical malpractice, they do not prove Dr. Christensen lacked a "legitimate medical purpose."

2. No State's expert testified that Dr. Christensen's treatment was "without a legitimate medical purpose" and that he prescribed "outside the course of professional practice."

The convictions for criminal distribution should be dismissed for insufficient evidence because no rational trier of fact could find that Dr. Christensen distributed the drugs "without a legitimate medical purpose." The State did not present expert testimony that Dr. Christensen's prescribing was "not for a legitimate medical purpose."

The State presented only expert testimony that Dr. Christensen's treatment "fell far below the standard of care." While such evidence—a medical malpractice opinion—is relevant to whether or not the defendant prescribed drugs "outside the course of professional practice," it is not sufficient for purposes of proving that the defendant had criminal intent, that he intended to "act as a pusher." Even expert testimony that the medical malpractice reached a "grossly negligent" level—i.e. "far below the standard of care"—never has been upheld as sufficient by itself for proving criminal intent to distribute drugs outside the course of a professional practice.

Instead, in federal prosecutions of physicians for prescribing, the government has introduced expert testimony that the defendant prescribed "without a legitimate medical purpose" and "outside the course of professional practice." *See U.S. v. Diaz*, 876 F.3d 1194 (9th Cir. 2017) (collecting cases in which federal appellate courts upheld admission of government expert testimony that defendant prescribed "outside the course of professional practice" and "without a legitimate medical purpose."); *United States v. Feingold*, 454 F.3d 1001, 1005 (9th Cir. 2006) ("both experts consistently and unambiguously testified that Dr. Feingold's conduct was outside the course of usual professional practice and that there was no legitimate medical purpose for the 185 prescriptions identified in the indictment.")

Failure to present expert testimony that there was no legitimate medical purpose for the defendant's prescribing decisions has led at least two courts to grant physician defendants' motion for acquittal. *U.S. v. Binder*, 26 F.Supp. 3d 656, 662 (E.D. Mich. 2014), noting that "No physician testified at trial that Dr. Binder's prescribing practices exceeded the bounds of legitimacy" and that "none of the government's experts testified that they categorically would have refused to fill a particular prescription, or that any particular combination of drugs and dosages prescribed could not have been given for any legitimate medical purpose."

See also United States v. Martinez, 2008 U.S. Dist. LEXIS 120940 (E.D. Wash) at 9, in which the district court granted the defense motion for acquittal on distribution counts, noting that "the record contains no evidence that would support the inference that Dr. Martinez intended "to act as a pusher rather than a medical professional." "While [government expert] Dr. Irving disagreed with the Defendant's practices, he did not attempt to speak to her state of mind. Nor has the Government cited to any other evidence in the record from which a rational jury could infer that Dr. Martinez intended to engage a medically illegitimate practice."

Several state appellate courts have dismissed verdicts obtained against physicians for prescribing because the prosecution failed to prove the doctor prescribed without a legitimate medical purpose or "in bad faith." *See People v. Downes*, 168 Mich. App. 484, 425 N.W.2d 102 (1987); *People v. Albano*, 216 Ill.

App. 3d 247, 576 N.E. 2d 998 (1991); *People v. Pal*, 56 App. Div. 2d 640, 391 N.Y.S. 3d 702 (1977).

In this trial, the State repeatedly tried to question Dr. Wasan in a way that conflated both medical malpractice negligence and the legal requirement in a criminal case that the State prove the prescribing was "outside the course of professional practice." For example:

Mr. Fulbright:	Doctor, having reviewed Gregg Griffin's medical file, do you have an opinion as to whether Dr. Christensen's prescriptions of opioids in Gregg Griffin's case is ***within the standard of medical practice*** generally recognized and accepted in the United States?"
Dr. Wasan:	Yes.
Mr. Fulbright:	And what is your opinion?
Dr. Wasan:	That the care is ***far below*** standard medical practice that's acceptable.

Trial Tr. 1826. Dr. Wasan repeatedly answered using the language of medical malpractice and the language of negligence, not echoing the "within" language proffered by the State.

While Dr. Wasan testified in a way that would have enabled a jury to find that Dr. Christensen was "grossly negligent" in a medical malpractice case, he failed to testify that Dr Christensen had no medical purpose whatsoever. Dr. Wasan never once stated that Dr. Christensen's medical treatment of the eleven patients was "not for any legitimate medical purpose." He never once stated that the only purpose for such medical decision-making was to act as a pusher or a drug

dealer. *See Feingold,* 454 F.3d at 1007 (noting that violation of standard of care alone is insufficient to support criminal conviction of licensed practitioner under 841(a)).

Astonishingly, in prosecuting Dr. Christensen for violating the standards of care for his prescribing of controlled substances for the treatment of pain, the State of Montana barely mentioned the "Guidelines for the Use of Controlled Substances for the Treatment of Pain," promulgated by the State of Montana, which encourages the treatment of pain with opioids and disapproves of undertreatment. Tab A, pages 1-2. Nor did the State seek to ask its experts about the Ninth Circuit standard it sought to apply, focusing instead on the civil standard, "standard of care." The defense expert, Dr. Forrest Tennant, was the only witness who testified about the applicable standard at all:

Defense counsel:	Dr. Tennant, have you had a chance to review the 11 files or charts that are at issue in this case?
Dr. Tennant:	Yes, I have.
Defense counsel:	And have you had a chance to consider those charts against the Montana standards?
Dr. Tennant:	Yes, I have.
Defense counsel:	And in your evaluation of those charts, do you find – or in your opinion, has Dr. Christensen been prescribing to patients for a legitimate medical purpose?
Dr. Tennant:	Yes.

Defense counsel: And is that across the board for all 11 of them?

Dr. Tennant: Yes.

Defense counsel: And in your opinion, has he acted within the course of a professional practice in his prescribing?

Dr. Tennant: Yes.

Trial Tr. 2220. The only evidence addressing the actual elements of the crime as the Ninth Circuit created them was addressed in favor of Dr. Christensen and never rebutted or otherwise contradicted.

3. The State failed to prove that Dr. Christensen "knowingly" prescribed drugs "outside the course of a professional practice" because most of the patients testified that they lied to Dr. Christensen about their addictions.

The drug distribution charges should also be dismissed for insufficient evidence because evidence was uncontroverted at trial that the nine patients lied to Dr. Christensen and did not reveal to him their full addiction history. Nor did they reveal their current levels of addiction.

Thus, the State failed to prove that Dr. Christensen "knowingly" prescribed drugs "outside the course of a professional practice"—that is, to feed an addiction. The State did not seek to prove that Dr. Christensen prescribed drugs inappropriately to make money—feeding an addiction was the alternative. The point is he did not knowingly prescribe inappropriately if the patients lied to him. The State had to prove that Dr. Christensen "knowingly" prescribed, or purposely

and knowingly endangered, not that he "should have known" or "should have seen red flags" indicating that the patient was an addict.

The most egregiously dishonest patient was Todd Gore, a drug dealer from the Bakken oil fields, who admitted that he engaged in an elaborate series of ruses to obtain prescriptions for opiates form Dr. Christensen. He admitted that for his first visit, he wore a back brace and carried a crutch that he did not need. Trial Tr. 1744. Later, when he was told his urine would be tested, he brought in a fake urine sample from a friend who was not using drugs. Trial Tr. 1747-48. Mr. Gore also admitted that he lied to Ryan Marchand when he was evaluated for addiction risk. Trial Tr. 1749. Ironically, Mr. Gore had in fact had major surgeries on his back and had the medical records to prove it. It was not difficult to believe, given his medical history, that he suffered chronic pain.

Michelle Jessop also admitted that she lied to Dr. Christensen about why she was there, and that she did not disclose her addiction history, including not telling him that she was a regular use of methamphetamine.

Defense counsel:	Did you lie to Dr. Christensen about why you were there?
Ms. Jessop:	Yeah.
Defense counsel:	Did you tell him you were a drug addict?
Ms. Jessop:	No.

Defense counsel: Were you a drug addict?

Ms. Jessop: In the past.

Trial Tr. 1714-15. Jackie Golden admitted she lied deliberately about having sciatic nerve pain the first time she visited. Trial Tr. 1432-33. When she knew there would be a pill count, she gathered pills from fellow addicts so that she would have the correct number to present to Dr. Christensen. Trial Tr. 1445-46. She never told Dr. Christensen subsequently that she had lied to him. Erica Cummings admitted that she lied about the level of pain she was experiencing in her medical forms, in order to receive a higher prescription from Dr. Christensen. Trial Tr. 1059-1060. She also testified that she also supplemented her supply in anticipation of a pill count by borrowing pills from fellow addicts. Trial Tr. 1075.

Heather Sutherland did not initially tell Dr. Christensen that she had previously been on Suboxone, which would have indicated she had a long history of addiction. Trial Tr. 1697-98. She did not tell him she was taking more methadone than he was prescribing and that she was taking additional benzodiazepines not prescribed by him. Trial Tr. 1698.

Paul Peterson admitted that he had never informed Dr. Christensen that he had previously been treated by another physician for withdrawal from methadone, nor did he tell the Defendant that he was struggling with addiction while being treated by Christensen and that he had decided to go to rehab. Trial Tr. 1384-85.

Jennifer Hiscoe never reported incidents to Dr. Christensen in which her children found her lying on the ground, because she was afraid her pills would get cut off. Trial Tr. 1463.

Dan Lieberg did not tell Dr. Christensen about how bad his addiction had gotten or about his suicide attempts. Trial Tr. 1505-07. After Dr. Christensen took him off the pain medications and arranged to have his mother provide Fentanyl patches to him, he moved out of his mother's home and into a home with other addicts. Trial Tr. 1525-26.

On the other side of the coin, Dr. Christensen did not hesitate to contact law enforcement if he learned that a patient was lying to him and abusing or diverting prescriptions. On one occasion, after a call by Dr. Christensen to police, a patient was arrested in the parking lot of his clinic. Dr. Christensen also contacted law enforcement officials to ask them to help him identify which of his patients, if any, were abusing or diverting drugs. Law enforcement refused to help him, however.

Federal appeals courts have recognized that a physician who is lied to by patients or government agents posing as patients may not be convicted of prescribing without a legitimate medical purpose if his patients or government agents pretending to be patients are lying to him. A "good faith" defense was relevant to Dr. Christensen's case in part because one of the defense theories was that some or all Dr. Christensen's patients lied to him about being drug addicts. As

one court determined, a physician is not guilty when a patient, through lies and deception, convinces a physician of a legitimate medical purpose. *U.S. v. Greenfield*, 554 F.2d 179, 183 (5th Cir. 1977) (conviction reversed because it was based on entrapment by undercover agents lying about non-existent medical conditions). The Fifth Circuit explained that the physician was entitled to an entrapment defense on retrial because "If the government agent through lies and deception convinces a physician that a legitimate medical need exists for the drugs, the physician is simply not guilty of a crime."

See also United States. v. Henry, 749 F.2d 203 (5th Cir. 1984) (pharmacist conviction under 841(a) reversed because undercover government agents lied in telling him they had legitimate medical need, and prescribing physicians were instructed by government to lie to pharmacist about legitimate medical need).

Appellate courts have reversed convictions of a physician under the Controlled Substances Act because the jury instructions failed to offer a "good faith" defense to the defendant physicians. *See United States v. Hurwitz*, 459 F.3d 463, 482 (4th Cir. 2006) (reversing conviction of physician because district court did not jury on good faith defense).

But at this trial, the prosecutors and their experts contended that Dr. Christensen was criminally liable for prescribing drugs to addicts, even when they lied to him. They urged the jury to find that Dr. Christensen's medical care was

"far below the standard of care" because he failed to realize that some of his patients were lying to him about their addictive behavior. The prosecution then asked the jury to convict Dr. Christensen even though some of his patients were lying to him. Mr. Fulbright argued in closing: "[S]ome people have said, but they lied to their doctor….It's his responsibility to determine if there's legitimate medical need, **regardless of whether they are lying**, every patient, every time." Trial Tr. 2724 (emphasis added). He misstated the *mens rea* standard for the crime, which is "knowingly."

This evidence is insufficient to prove that Dr. Christensen "knowingly" prescribed drugs "outside the course of a professional practice."

VII. Did the District Court Err in Ordering Dr. Christensen to Pay a Fine When Dr. Christensen Is Effectively Bankrupt and Has Only Social Security Income?

A fine may be not be imposed on a convicted criminal "unless the offender is or will be able to pay the fine." MCA § 46-18-231(3). In this case, Dr. Christensen presented evidence to the District Court that he has far more debts than assets and is effectively bankrupt. Moreover, his income is limited to Social Security Retirement income. Sent. Tr. 28. No evidence contradicts those findings. Therefore, the fine imposed on Dr. Christensen should be overturned.

CONCLUSION

This Court should reverse and dismiss all the counts of the Amended Information. The Negligent Homicide counts should be dismissed because as a matter of law the State failed to prove Dr. Christensen had violated the statute for all the reasons listed. The Criminal Endangerment counts should all be dismissed because the statute is unconstitutionally broad as applied to physicians writing prescriptions, and even if not, because the State failed to prove Dr. Christensen violated the statute. The Criminal Sale of Dangerous Drug counts should be dismissed because the statute exempts physicians from prosecution. But even if the federal standard applied, the counts should be dismissed because Dr. Christensen was operating within the course of a professional practice, was prescribing for a legitimate medical purpose, and was acting in good faith.

Alternatively, the case should remanded for retrial with the proper jury instructions, a hearing and complete consideration of the 404, 403 issues, and the opportunity for Dr. Christensen to present a defense.

The requirement that Dr. Christensen pay a fine should be reversed and the fine vacated.

Respectfully submitted this 17th day of July, 2019.

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By: /s/ Joshua S. Van de Wetering
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CERTIFICATE OF COMPLIANCE

Pursuant to Rule 11 of the Montana Rules of Appellate Procedure, I certify that this principal brief is printed with a proportionately Times New Roman text typeface of 14 points; is double-spaced except for footnotes and for quoted and indented material; and the word count calculated by Microsoft Word for Windows is 24,326, excluding Table of Contents, Table of Authorities, Certificate of Service, Certificate of Compliance, and Appendices. This over-length word count was permitted by the Court in its July 2, 2019 order.

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I, Joshua Schorr Van de Wetering, hereby certify that I have served true and accurate copies of the foregoing Brief - Appellant's Opening to the following on 07-17-2019:

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