

Legal Aspects of SIDS

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My remarks today focus on four legal aspects of SIDS; the first three are problems of long standing and the fourth is less well recognized, an immediate problem to some but more of a cloud on the horizon to others.

At the outset, I want to emphasize that I bring you no certain solutions. Rather, my more modest objective is to provide a focus and framework for further discussions.

The first legal aspect of SIDS I want to discuss is the capacity of the legal system to distinguish between SIDS and criminally actionable infant death caused by neglect, abuse or worse. Great progress has been made on this problem since 1933 when in England, for example, SIDS was thought to result from inadvertent suffocation of the infant while sleeping with its mother. Acting on this myth, Parliament passed a law stating that sleeping with infants was a criminal offense under certain circumstances. Of course, that is no longer the law there or here and this, I suppose, helps to illustrate that substantial progress has been made in distinguishing between SIDS and criminally actionable homicide. Still, some relatively recent examples illustrate that the problems our legal system has in making this distinction may not be entirely behind us.

The first situation is particularly unfortunate. In 1973, a young couple in the Bronx lost an infant to SIDS. The infant was a second child and delivered by Caesarian section. At the time of death, the mother was undergoing psychiatric care for postpartum depression and the father was caring for both children at home. The infant had a cold during the last week of life. On discovering that the infant had died, the parents were understandably distraught and for this and a number of other reasons, delayed three hours before calling the authorities. An autopsy was performed and the diagnosis was listed as "congestion of the viscera." The cause of death was noted as "pending further study."

The parents were taken to a precinct station and questioned by a detective. Inexplicably, the detective misunderstood the father to say that the child had not been fed for three days. The autopsy, however, made no mention of dehydration, malnutrition, bruises on the body or abnormal findings in the liver or thymus. After the interrogation, though, the medical examiner noted on the autopsy report that the cause of death was "abandonment and neglect."

On the basis of the detective's conclusion and the medical examiner's report, the couple was indicted and then jailed because they were unable to post a \$1,000 bond. Lamentably, the father remained in jail for eight months and the mother for six months before bail was posted. During this period, the older child was placed with grandparents. Ultimately, the parents were exonerated.

By any standard, this is an aggravated case and I must say that I know of no similar documented incidents since 1973. Still, the potential for recurrence of a similar incident remains in those states where the death investigation laws are inadequately sensitive to SIDS as an identifiable disease entity. The potential also remains because large segments of the public, particularly the authorities in some states and cities, remain relatively ignorant about SIDS.

The second case I shall describe illustrates the opposite facet of failing to distinguish adequately between SIDS and criminally actionable infant death. This case comes to us through a published decision of the Court of Appeals for the Fourth Circuit in Richmond.* The decision reveals essentially the following facts: A foster parent was charged with first-degree murder and a number of other charges of assault with intent to murder, attempt to murder,

* See *United States v. Woods*, 484 F.2d 127 (1973).

and mistreatment and neglect of an eight-month-old, pre-adoptive foster son. The evidence showed, among other things, that the infant spent the first five months of his life in a foster home and that his physical well-being and health during this period were uneventful and unremarkable. At the end of the five-month period, the infant was placed in the defendant's home. Thereafter, a bizarre series of events occurred. On at least six occasions, the infant suffered episodes of gasping for breath and turning blue from lack of oxygen. On all but one of these occasions, the infant responded well to mouth-to-mouth resuscitation. On the final occasion, the infant lapsed into a coma and died. During the hospitalization, no cause for cyanosis could be discovered and at the trial on the criminal charges, the state forensic pathologist expressed the view that he was 75% sure that the infant's death was homicide. He explained, however, that he was 25% uncertain because the infant could have died from a poorly-understood disease referred to as "natural crib death."

On that evidence alone, the defendant might well have escaped conviction. Recognizing this, the government lawyers went on to attempt to introduce other incriminating evidence. This evidence showed that beginning in 1945, the defendant had had custody or access to nine children who, collectively, had experienced a minimum of twenty episodes of cyanosis. Seven of these children died, while five had multiple incidents or episodes of cyanosis. Three of the children were her own natural-born children, two were children she had adopted, one was a niece, one was a nephew, and two were children of friends. On one previous occasion, the defendant had been charged with assault and attempted murder, but had been acquitted.

On the basis of this and the other evidence in the case, the defendant was convicted. On appeal, an important issue was whether the evidence of the other incidents should have been admitted at the trial. This issue, long debated by legal scholars, is not important to our discussion today. What is important is the near failure of the legal system in this instance to distinguish SIDS from homicide. For those of you who are curious, though, let me say that the evidence was held admissible and the conviction affirmed. Significantly, though,

one judge dissented, relying in part on the medical examiner's equivocal testimony to the effect that the diagnosis of suffocation was no more consistent with the facts than a diagnosis of crib death.*

What do these cases reflect? The first reflects that the tragedy of SIDS is cruelly compounded when the legal system confuses SIDS parents with criminals. By the same token, of course, the second case reflects that those guilty of abuse, neglect or worse should not be permitted to masquerade as SIDS parents.

The capacity of the legal system to distinguish properly between SIDS and homicide depends, at least, upon the following basic requirements:

1. Full legal recognition of SIDS as a disease entity that results in natural death and not culpable death;

2. Provision for prompt, *expert* and thorough postmortem examination; and

3. Well defined and generally accepted postmortem findings for SIDS that distinguish this disease entity clearly from various deaths by homicide.

Whether a legal system satisfies these three requirements depends upon the details of the autopsy or death investigation laws. As many of you know, the manner in which a death is handled by a medical examiner or coroner is largely a matter of state law and varies widely. Only a few states, not including Virginia, have death investigation laws that are explicitly "SIDS sensitive." That is, only a few states have statutes specifically recognizing or dealing with SIDS.* Many states do not have death investigation laws that satisfy the three criteria I just mentioned. Notwithstanding the absence of SIDS-sensitive legislation, Virginia has achieved substantial success in dealing with the problem. This success, it seems to me, is attributable to the special sensitivity and competence medical examiners in Virginia have with respect to SIDS.

The second legal aspect of SIDS is closely

*For another court decision involving this issue, see *People v. Nyberg*, 24 Ill. App. 3d 41, 320 A.2d 546 (1974), *reversed*, 356 A.2d 80 (1976).

*For an informative study of the state death investigation laws, see *Death Investigation: An Analysis of Laws and Policies of the United States, Each State and Jurisdiction [as of January 31, 1977]*, DHEW Pub. No. 78-5252 (1978).

related to the first; it is, simply, the obligation of, or necessity for, the legal system to aid or at least not hinder the families of SIDS victims in recovering from the psychological trauma of the experience. The example I discussed of SIDS parents in the Bronx jailed for six months underscores how insensitive some legal systems can be to this problem.

The insensitivity of death investigation laws to the trauma suffered by SIDS parents has been studied—in 1975 by Allan Cleveland, a New Hampshire lawyer,^{**} and in separate findings conducted under the direction of Dr. Bergman in 1972.^{***} In essence, both investigators concluded that the death investigation laws were largely inadequate in this respect.

Both studies show that the problem is most likely to arise where the death investigation system of a particular state fails to make adequate provision for an autopsy conducted by an expert pathologist familiar with SIDS. A necessary first step in helping a family to recover is an immediate autopsy. In many instances only an autopsy can furnish the evidence necessary to identify a SIDS death. Armed with this knowledge, the family's physician and other counselors can reassure the parents, and the authorities can make unmistakably clear that the child's death is one wholly attributable to natural causes.

Notwithstanding this obvious need, Dr. Bergman's studies reveal that not only were autopsies rarely done routinely but they were performed in only 25% of all cases of sudden unexplained death of an infant. In an additional 20% of the cases, only deaths involving suspicion of a crime were investigated by autopsy. In the remaining 55%, autopsies were occasionally performed depending upon the inclination of the coroner or medical examiner, availability of funds and other factors.

Dr. Bergman's study also indicates that autopsies were frequently performed by persons unfamiliar with SIDS and that death certificates were signed by pathologists in only 27% of the cases, by physicians not trained in pathology in 30% of the cases, and by non-physicians in 43% of the cases.

^{**}Cleveland, *Sudden Infant Death Syndrome (SIDS): A Burgeoning Medicolegal Problem*, 1 Am J Law & Med. 55 (1975).

^{***}A. Bergman, *A Study in the Management of Syndrome Death in the United States* (1972).

Other exacerbating factors revealed in the Bergman study include the failure to make autopsy results available to parents and the use of a bewildering variety of scientific terminology to describe the cause of death. For example, Dr. Bergman found that pneumonia and suffocation were sometimes listed as incorrect diagnoses of SIDS. He also found that SIDS was the diagnosis in only 52% of the cases of sudden, unexpected, clinically unexplained infant death. On the other hand, SIDS was the diagnosis in 85% of the sudden infant deaths where autopsies were performed by expert pathologists. That is a telling contrast.

Finally, both Bergman and Cleveland noted and decried the lack of any legislative provision for counseling aggrieved parents. While the value of counseling is generally conceded,^{*} public funding for this service presents a difficult political question. Why, for example, should public money be spent for counseling SIDS parents and not for those parents whose children died from cancer, accidents or other causes?

In summary, the two legal aspects of SIDS I have discussed so far underscore that the capacity of the legal system to deal effectively with SIDS depends on full recognition, preferably in statutory form, of SIDS as a disease entity that results in natural death. Additionally, there is compelling evidence that there should be a provision for prompt, expert and thorough post-mortem examination with well-defined and generally accepted postmortem findings for SIDS that distinguish the disease from homicide. Legislation should also provide for the cost of the autopsy to be borne by the state and for prompt disclosure of the results to parents and to counseling personnel.

In Virginia, we are fortunate to have an enlightened death investigation system.^{*} Problems seem to arise in states that elect local coroners and permit them to operate with broad discretion and little supervision. We have a state-wide medical examiner system and while there is no explicit statutory recognition of SIDS, we are fortunate to have physicians and coun-

^{*}Hoekelman, *The Physician's Responsibility in the Management of Sudden Infant Death Syndrome*, 128 Am. J. Dis. Child 16 (1974); Nakushian, *Restoring Parents' Equilibrium After Sudden Infant Death*, Am J Nursing (October 1976).

^{*}See Virginia Code §§ 32-31.9, *et seq.*

selors who are sensitive to the problem and who use their discretion under the statute to the fullest and most beneficial extent in the SIDS context.

But even states with specific SIDS legislation sometimes fall far short of the mark. Massachusetts, Maine and California, for example, leave unclear the parents' right to receive autopsy results. Oregon has an administrative program that seems to be the most SIDS-sensitive of all.

The passage of SIDS-sensitive legislation in Virginia and other states may also be important to the third SIDS problem I want to discuss today, a medicolegal problem that involves the effect of the legal system on the ability of the medical community to conduct epidemiological studies. Extensive, reliable and uniform data are essential to an epidemiological approach to studying the nature, causes and cure for SIDS. At present, 33 private groups collect SIDS data that are neither uniform nor mutually coherent. Surprisingly, there is, to date, no central or uniform data collection organization or entity. This long-standing need will not be met until at least 1980 when, pursuant to a 1978 amendment to the 1974 SIDS Act,* the US Department of Health, Education and Welfare plans to establish a national uniform collection system. Under this system, HEW will also establish a national clearinghouse to disseminate educational materials if Congress provides the funding.

The HEW data collection plan is a welcome addition to the fight against SIDS, but the national system will be an effective epidemiological tool only to the extent that the state death investigation systems are adequately SIDS-sensitive or otherwise equal to the challenge of collecting reliable data.

We come now to the final legal aspect of SIDS I want to discuss with you today. This is the one I described as being of immediate concern to some and as a cloud on the horizon to others. The problem I am referring to is civil malpractice liability risks for physicians, hospitals and nurses in the SIDS context. Before I review the analytical framework needed to consider the problem, let me give you a hypothetical situation to put things into perspective.

You are a physician, an internist or gen-

eral practitioner, or perhaps a pediatrician in a relatively small community in Virginia. A couple comes to you who has just moved to the community. They have an infant child two months old. They tell you that this is their second child and that their first child was found dead in his crib at three months for reasons they have never understood. They may show you a death certificate in which the cause of death is noted as "crib death" or SIDS. They further tell you that their first child was premature as was their second. Next, they tell you they are consulting you because on four occasions they have noticed that their child has had difficulty breathing and on two of these occasions the child apparently stopped breathing altogether. On these occasions, the child seemed to turn ashen or gray before starting to breathe again after frantic efforts by the parents to blow in the baby's face and shake the baby. They are concerned that this child is in the same danger as their first child and they seek your advice. You examine the child and find him normal in all respects. What do you do and what do you advise the parents?

To answer these questions, you should refer to two sources. The first is the standards of excellence in medical care that you set for yourself personally because of your commitment to medicine as a physician. These standards are personal and not relevant to our discussion. The second source is the standard of care expected of you under the law, a violation of which could subject you to substantial legal liability.

What is the standard of care the law expects and requires of physicians? The definition of this standard of care, like the death investigation laws I spoke of earlier, is generally defined by state law. Three or four decades ago, the definition was fairly uniform around the country. It was defined simply as the action or failure to act by a physician in contravention of the standard of care observed by a reasonably prudent physician in the same locality. In order to prevail, an injured party had to produce an expert physician witness who could testify as to the appropriate standard of care for the locality and as to the defendant physician's failure to meet that standard. Further, the expert had to be prepared to testify that the defendant physician's failure to meet the local standard of care proximately caused the injury.

In response to a number of pressures, this

*42 U.S.C. § 300c-11.

standard was generally modified to include the notion that a physician had to meet the standard of care in the same *or similar* locality. This modification meant that an expert witness could be brought in to testify who, though not familiar with the standard of care in the specific locality, was nonetheless qualified to testify by virtue of familiarity with the standard of care in a similar locality. Whether localities were similar for this purpose frequently depended upon the number of hospitals, hospital beds, similarity in hospital equipment available and the number of practitioners and specialists.

Until July 1, 1979, the foregoing standard generally described the law in Virginia. The last session of the General Assembly, however, amended the statute to provide for a new definition.* In essence, as of July 1, 1979, the standard of care applicable to physicians, nurses, hospitals or other health care providers in Virginia is that degree of skill and diligence practiced by a reasonably prudent practitioner in the particular field of practice or specialty in this Commonwealth. Thus, in the first instance, the standard is a state-wide standard. Note, though, that a local standard of care may still govern if any party proves by a preponderance of the evidence that the health care services or health care facilities available in the locality give rise to the standard of care which is more appropriate than the state-wide standard. The decision maker is the jury or the judge trying the case without a jury.

Unlike Virginia, some states like California have nation-wide standards of care so that a pediatrician from New York or Virginia might well qualify to testify in a California case.

Now, what sources do we refer to in order to determine the standard of care? In general, these include at least the following:

1. The practice and procedures actually being followed in Virginia at the time;

2. The content and teachings contained in current widely distributed literature such as *Pediatrics*, *Journal of Pediatrics* and the *New England Journal of Medicine*. Particularly pertinent here would be the statement of the American Academy of Pediatrics, 61 *Pediatrics* 651-52 (April 1978);

3. The training of the physician involved may be important. Thus, a board-certified neo-

natologist may well be held to a higher standard than a non-board-certified general practitioner;

4. The extent to which the subject matter, in this case SIDS, is treated in continuing medical education programs and other seminars throughout the state; and

5. The general state of the art in monitoring equipment.

Now, with this analytical framework as background, let us return to the hypothetical situation I described at the outset. Obviously, it is intended to raise the question of a physician's duty with respect to identifying high-risk SIDS infants and prescribing monitoring or other treatment for them. What, then, should the physician do in order to comply with the standard of care in Virginia? No definitive answer is available to this question, in part because no Virginia court has specifically addressed the question and in part because the state of the medical art is evolving in this area. Despite this, a few tentative observations seem warranted.

To me, it appears that the state of the art has reached the point where many believe it is feasible to identify high-risk SIDS infants, particularly in cases involving siblings of SIDS victims and survivors of near-miss episodes. This, of course, was the point of my hypothetical situation. The work of Drs. Kelly and Steinschneider certainly supports the notion that a reasonable standard of care requires identification of high-risk SIDS infants. Whether such a standard should apply to practitioners in rural or remote areas is less clear, though I think these practitioners would be imprudent to conclude otherwise.

Identifying the high-risk SIDS infant is only part of the problem. Once high-risk SIDS candidates are identified, what steps should a physician take or recommend? Again, while no definitive legal answer is available, the literature suggests that monitoring and surveillance are indicated. Thus, the statement of the American Academy of Pediatrics is instructive in noting that apart from specific treatment of any underlying disorder, "twenty-four-hour surveillance is critical to the management of prolonged apnea." As the Academy's statement notes, this may require electronic or other monitors, and the setting for the observation may include properly staffed acute care hospitals or the infant's home. Of course, it is not enough to place the infant on a monitor at home if the per-

* See Virginia Code § 8.01.

sons charged with surveillance are not skilled and trained in infant cardiopulmonary resuscitation and other pertinent matters. Nurses and nurse practitioners and other health care providers in the SIDS context risk incurring civil liability unless they are adequately trained to take the proper action in the event of an episode. Physicians in rural areas should consider sending the infant to an appropriate hospital if facilities are not available locally. But home monitoring may be appropriate* where the persons involved in the surveillance are adequately trained.

*The question whether to prescribe an electronic monitor in appropriate situations is sometimes complicated unfortunately by the question whether such a monitor is covered by the pertinent insurance carrier. This is frequently a matter of insurance contract law and beyond the scope of my remarks here. Some suggest coverage turns on whether a specific expense is treatment of a condition or prophylactic care. I find this distinction unhelpful in the SIDS context.

The physician's duty in this context seems to me to have been summed up succinctly by Dr. Kelly, et al., in a recent article.

We conclude that infants who have experienced near-miss SIDS are at great risk of recurrent apnea, hypoxia, and sudden death. Most deaths can be prevented by supervised home monitoring of respirations and appropriate intervention by parents trained in resuscitation.*

In closing, I must say I do not know whether the civil liability problem in the SIDS context is an immediate one or merely a cloud on the horizon. It could be neither and the problem can be avoided permanently by continuing medical education programs such as this to ensure that physicians and other health care providers in Virginia remain abreast of the latest developments in medicine.

Thank you.

*61 *Pediatrics* at 514 (April 1978).

The Grief Reaction

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For most parents the death of their infant is the first serious crisis in their lives. This event is regarded by all young parents as more stressful than previous deaths in the family, divorce, separation, alcoholism, or suicide. The infant death may be the first death in the family. The grief reaction is not stereotyped; it is as varied as the individuals experiencing it and the families of which they are a part. Several patterns of grief will be treated here.

One of the features of the grief reaction is reminiscing. Old people who die have a history. There are photographs, objects that are meaningful, shoes, dresses, suits and ties are left be-

hind. There are memories. A 3-month-old infant doesn't have a lot of memories associated with it. It may have a little toy or blanket. The process of internal bargaining is lost in the SIDS death. There are limited experiences and a lack of time associated with the death. Rationalization of the death is difficult because there was no recognizable cause. There is no opportunity to speculate or predict what might have been.

This leads us to the subject of guilt which has been mentioned before many times; the guilt of the parents and let us not neglect the physician. I would like to introduce the thought