No. 05-4474

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

UNITED STATES OF AMERICA,
Plaintiff-Appellee

v.

WILLIAM ELIOT HURWITZ,
Defendant-Appellant

APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA

BRIEF OF APPELLANT WILLIAM ELIOT HURWITZ

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TABLE OF CONTENTS

Page

TABLE OF CONTENTS — cont'd

Page

TABLE OF CONTENTS — cont'd

Page

TABLE OF AUTHORITIES

Page(s)

Cases:

TABLE OF AUTHORITIES – cont'd

Page(s)

TABLE OF AUTHORITIES – cont'd

Page(s)

TABLE OF AUTHORITIES – cont'd

Page(s)

TABLE OF AUTHORITIES – cont'd

Page(s)

Statutes and Regulations:

TABLE OF AUTHORITIES – cont'd

Page(s)

Miscellaneous:

INTRODUCTION

Dr. William Hurwitz was sentenced to 25 years imprisonment after he was convicted on 50 counts of distributing and conspiring to distribute controlled substances. The charges arose from opioid prescriptions that he wrote while operating a clinic to treat patients for pain.

The government has portrayed this as just another case in which a doctor pretended to treat patients but was in fact pushing drugs for financial gain. As DEA Administrator Karen Tandy proclaimed, "Dr. Hurwitz was no different from a cocaine or heroin dealer peddling poison on the street corner." *Washington Post*, B1 (April 15, 2005). But the government was unwilling to put its rhetoric to the only true test – a fair trial, under settled legal principles, before a fully informed jury. Instead, the government managed to persuade the district court (Wexler, J., sitting by designation) that:

- Whether a physician has prescribed a controlled substance in "good faith" is legally irrelevant under the Controlled Substances Act ("CSA"), 21 U.S.C. 841, et. seq., and a jury should be instructed *not* to consider any "good faith" defense;

- The only "knowledge" the government must prove under the CSA is that the physician "knowingly distributed and dispensed" the controlled substance – a standard met by any sentient being; and

- Because a physician's good faith is irrelevant, crucial evidence bearing directly on Dr. Hurwitz's subjective intent should be excluded.

These errors – which stripped the CSA of its *mens rea* component – turned Dr. Hurwitz's trial into little more than a species of malpractice litigation. To make matters worse, the district court declined to explain the few (highly technical) elements on which it *did* decide to instruct the jury. Even when the jury asked for clarification, the court merely repeated the same, unilluminating information. Those errors alone require reversal.

But there is more. The instructional and evidentiary errors were bookended by two other, equally serious derelictions, one at the outset of the trial, the other near the end. To commence the case, government agents conducted a search of Dr. Hurwitz's medical office based on a warrant *that completely omitted any description of the items to be seized*. For precisely the reasons articulated by the Supreme Court in *Groh* v. *Ramirez*, 540 U.S. 551 (2004), the search was invalid, and its fruits – which constituted the overwhelming majority of the government's evidence – should have been suppressed. Then, at the conclusion of the case, the district court dismissed a deliberating juror who reported that his daughter's dog was ill and needed to be put to sleep. We use the word "reported" loosely, however, because the court never met with the juror, sent his communications only through a clerk who made no contemporaneous record, never notified the defendant or his attorneys until after the juror had been dismissed, and never inquired whether the juror's dog-related absence

would consume more than the four hours that remained before the weekend recess.

For all these reasons, defendant's convictions should be set aside.

JURISDICTIONAL STATEMENT

William Hurwitz appeals from a judgment of conviction entered on April 21, 2005, in the United States District Court for the Eastern District of Virginia. A timely notice of appeal was filed on April 25, 2005. This Court has jurisdiction under 28 U.S.C. § 1291.

STATEMENT OF THE ISSUES

1. Whether the search of defendant's medical office was unlawful where the warrant did not identify the items to be seized, in violation of *Groh* v. *Ramirez*, 540 U.S. 551 (2004), and the search itself was overbroad.

2. Whether the instructions under the CSA were defective where they (a) told the jury that defendant's "good faith" is not relevant, (b) failed to define key elements of the offense, and (c) failed to respond to the jury's request for supplemental guidance.

3. Whether crucial evidence bearing on defendant's state of mind was erroneously excluded on the premise that a physician's good faith is not relevant to a CSA violation.

4. Whether the dismissal of a juror during deliberations was error where (a)

there was no "good cause" for such dismissal, and the judge did not meet with or inquire of the juror before dismissing him, (b) the court ordered the dismissal outside the presence of the defendant and his lawyer, and (c) no record was created of the juror's colloquy with the clerk.

STATEMENT OF THE CASE

Dr. Hurwitz was charged with violating 21 U.S.C. § 846 by conspiring to distribute controlled substances (count 1 of the indictment); violating 21 U.S.C. § 841(a) by distributing controlled substances (counts 2-59); violating 21 U.S.C. § 848 by engaging in a continuing criminal enterprise (count 60); and violating 18 U.S.C. § 1347 by aiding and abetting schemes to defraud healthcare benefit programs (counts 61 and 62). Counts 2 and 3 alleged distribution resulting in death and counts 4-6 alleged distribution resulting in serious bodily injury.

After a jury trial, Dr. Hurwitz was acquitted on six distribution charges (counts 26, 27, 33, 36, 37, and 38); the continuing criminal enterprise charge (count 60); and the charges of defrauding healthcare benefit programs (counts 61 and 62). The jury was unable to reach a verdict on counts 3 (distribution resulting in death), 4 (distribution resulting in serious bodily injury), and 7 (distribution). Dr. Hurwitz was convicted on the remaining 50 counts, sentenced to 25 years imprisonment, and fined $1,000,000.

STATEMENT OF FACTS

A. The CSA And Medical Practice

The CSA provides that "[e]xcept as authorized * * * it shall be unlawful for any person knowingly or intentionally (1) to * * * distribute or dispense * * * a controlled substance." 21 U.S.C. § 841(a). As a licensed physician registered by DEA, Dr. Hurwitz was authorized to distribute (by prescribing) controlled substances. See 21 U.S.C. § 802(21) (defining "practitioner"); 21 U.S.C. § 823(f) (registration of "practitioners"); 21 U.S.C. § 822(b) (authorizing prescriptions by registered practitioners). A prescription is lawful if issued "for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice" and if issued "in the usual course of professional treatment." 21 C.F.R. § 1306.04(a). A doctor may not, however, prescribe controlled substances if he knows that his patient intends to resell the prescribed drugs, nor may he prescribe drugs merely to satisfy a patient's addiction, unless the doctor is specially registered to administer such treatment. See *United States v. Moore*, 423 U.S. 122, 125-126 (1975).

These principles are more easily stated than applied. Most patients who sell their prescription drugs actively conceal such conduct from their doctors, so proof that a patient engaged in illegal diversion does not mean that the prescribing doctor acted illegally. Difficult judgments are also required when a doctor prescribes

medication to a patient who suffers both from pain (for which a doctor may lawfully prescribe medication) and from drug addiction (for which, absent special authorization, a doctor may not prescribe drugs). To begin with, diagnosis is difficult. There are no objective medical tests that detect or measure pain or addiction. Instead, doctors must interpret symptoms and behavior (usually based on the patient's own reports). Signs of addiction often are ambiguous, frequently indicating only that the patient has developed tolerance or physical dependence. See AMERICAN MEDICAL ASS'N, PAIN MANAGEMENT: ASSESSING AND TREATING PAIN IN PATIENTS WITH SUBSTANCE ABUSE CONCERNS 10 (http://www.ama-cmeonline.com/pain_mgmt/module04/pdf/ama_painmgmt_04.pdf).

Even when addiction is clear, the doctor must make the difficult judgment how best to treat the patient's pain. Sometimes doctors choose to terminate opioid medications. In other cases, a doctor may continue opioid therapy, because "[s]ome individuals with addictive disorders identify pain as a major contributor to their addiction, and pain can be an obstacle to withdrawal of alcohol or other drugs." *Id.* at 9. Because the "right" diagnosis and treatment is often unclear, and because it is *sometimes* medically appropriate to treat the pain of drug addicts with opioid medication, it can be difficult to determine whether a doctor who has prescribed medication to a known or suspected drug addict has done so in the course of *bona*

fide medical practice, or whether he has departed from medical practice and has, in effect, sold drugs for profit to addicts.

Recognizing that the CSA was not meant to interfere with the practice of medicine, but also that some doctors *claim* to be practicing medicine when they are really drug dealers, courts have articulated several principles to help juries apply the CSA to doctors. First, doctors are not immune *per se* from prosecution under the CSA, and a jury need not acquit merely because a doctor prescribes in accordance with standards that he, alone, deems appropriate. "One person's treatment methods do not alone constitute a medical practice." *United States v. Norris*, 780 F.2d 1207, 1209 (5th Cir. 1986). Second, the jury must decide whether the doctor acted, as 21 C.F.R. §1306.04(a) requires, "for a legitimate medical purpose * * * in the course of his medical practice" – *not* whether the doctor made mistakes in diagnosis or treatment, even if those mistakes rise to the level of malpractice. *United States v. Tran Trong Cuong*, 18 F.3d 1132, 1137 (4th Cir. 1994). Third, because application of the "legitimate medical purpose" standard must often rest on inferences drawn from ambiguous evidence, juries should hear all of the evidence required to reach an informed and reasoned judgment. Evidence that the defendant *failed* to follow appropriate medical practices is admissible, not because malpractice is a crime, but because such evidence may shed light on whether the doctor acted for legitimate

medical purposes and in the course of medical practice. Evidence that the defendant's practices are *supported* by *bona fide* medical opinion is admissible for the same reason.

B. The Case Against Dr. Hurwitz

Timothy Urbani, Robert Woodson, Peter Grant, Bret McCarter, and Cindy Horn – participants in an illegal conspiracy to sell Oxycontin and other controlled substances – were arrested at various times in early 2002. They told the authorities they obtained drugs through prescriptions written by Dr. Hurwitz. Based on their allegations, the government secured a warrant to search Dr. Hurwitz's office, seized all of his patient records, and indicted Hurwitz on 62 felony charges.

At trial, the prosecution presented detailed evidence showing that Dr. Hurwitz prescribed opioids to patients who, in some instances, were abusing or illegally selling their medications, or both. (In other cases the government alleged, not that the patient was a drug diverter or abuser, but that Dr. Hurwitz prescribed dosages that were too large.) The addicts and diverters often requested and received large quantities of opioids that increased over time; some repeatedly asked for early refills of prescriptions; drug tests indicated that some had used cocaine or other illicit drugs; some had "track marks" on their arms indicating that they were "shooting up"; some had skin rashes caused by cocaine use; some made secret tape recordings of

conversations with Dr. Hurwitz from which the government argued that defendant knew or suspected drug diversion. See, *e.g.*, JA1481-1544 (Horn); JA1629-88 (Tyskowski); JA3085-3133 (T. Urbani).

Taken as a whole, however, the trial evidence also permitted an inference that Dr. Hurwitz prescribed, both to the drug dealers and to the drug abusers, in good faith for the legitimate medical purpose of treating their pain. Dr. Hurwitz explained (and the prosecution's evidence confirmed) that the dealers and abusers came to him with complaints (in most cases, genuine) of severe and persistent pain. See, *e.g.*, JA1636, JA1667-69 (Tyskowki); JA2793 (McCarter). Dr. Hurwitz watched for drug abuse (though sometimes he failed to detect it). He asked patients about their drug use, conducted drug tests, looked for track marks, monitored the dosages prescribed and used, documented requests for early prescription refills, talked to family members, and then recorded evidence of these red flags in his medical records. See, *e.g.*, JA2516-17 (Santmyer), JA2565-68 (Grant), JA2582-89 (Mullins). He did so, knowing that those records were subject to review by law enforcement authorities. JA4299-302; JA4342-43.

When Dr. Hurwitz detected signs of drug abuse, his responses varied depending on his assessment of the individual patient. Sometimes he terminated treatment. JA4446. Sometimes he threatened to terminate treatment, hoping the

threat would induce better behavior; sometimes he prescribed different medications less susceptible to abuse, or "tapered" (*i.e.*, gradually reduced) medications. See, *e.g.*, JA4364 (Nye), JA4382 (Carlin), JA4396 (Fuller). As defendant freely admitted, however, he did not invariably and immediately stop prescribing opioids whenever he learned about – or suspected – drug abuse, because he believed that approach was inconsistent with his obligation to address his patients' medical needs. See, *e.g.*, JA4271-73, JA4445-46; JA1940.

Dr. Hurwitz also explained that he did not know that any patient intended to divert drugs that he prescribed. The drug dealers constituted a small fraction of the patients (roughly 400) that Dr. Hurwitz treated. They paid the same fees that other – indisputably legitimate – patients paid, and those fees were entirely unrelated to the number of prescriptions written, the medication prescribed, or the quantity of drugs prescribed. JA4332-33. The dealers' own testimony confirmed that they consistently lied to Dr. Hurwitz to obtain prescriptions. See, *e.g.*, JA2797; JA1904-05. By their own admission, they successfully deceived him. See, *e.g.*, JA3245-46; JA1463-64; JA1936. As for the patients who were *not* alleged to be diverters or addicts at all – assuming that merely prescribing excessive doses can *ever* constitute a felony violation of the CSA – there was testimony that Hurwitz prescribed excessive doses, but also testimony that the doses prescribed were reasonable. See, *e.g.*, JA2596-98;

JA4228-29.

The government proffered its view chiefly through an expert, Dr. Michael Ashburn. With respect to the drug abusers, Ashburn opined that Dr. Hurwitz should have stopped treating any patient at the first sign of drug abuse, even if the patient suffered from serious pain. See, *e.g.*, JA2683; JA2482, JA2483, JA2487. With respect to the non-abusing patients – such as Linda Lalmond, whose treatment was the subject of a "resulting in death" count – Ashburn opined that defendant's dosages were simply too high. JA2596-98. There was no evidence that Lalmond abused or diverted drugs.

The defense countered with expert testimony from Dr. James Campbell, Director of the Blaustein Pain Center at Johns Hopkins Hospital, who testified that the dosages prescribed by Dr. Hurwitz were medically appropriate. JA4201-36. Another of defendant's experts, Dr. Steven Passik – Director of Symptom Management Studies at Sloan-Kettering Memorial Hospital – emphatically rejected Ashburn's view that a doctor must terminate treatment to drug-abusing patients:

> [T]here are no, to my knowledge, guidelines that would suggest that that was a mandatory reaction to those behaviors. * * * These people have two diseases, and there is no particular reason to say that you have to stop treating one because the other one is becoming a little bit more clinically obvious.

JA3986.

On a level playing field, the question whether Dr. Hurwitz intentionally violated the CSA is precisely the kind of factual issue that should be resolved by a jury. As we show below, however, the prosecution was unwilling to take that chance.

SUMMARY OF ARGUMENT

I. The search of Dr. Hurwitz's medical office was fatally flawed in two respects. First, the seizing agents made the *identical* error that caused the Supreme Court to hold the search illegal in *Groh* v. *Ramirez*, 540 U.S. 551 (2004) – they *completely omitted to identify* in the warrant the "person or property" to be seized. The search itself was also hopelessly overbroad. The affidavit related allegations from a tiny fraction of Dr. Hurwitz's patients – five admitted drug dealers. Yet, based on these isolated statements, the government seized the private medical records for *every patient treated by Dr. Hurwitz*.

II. Over defendant's objection, the district court instructed the jury that it could not consider Dr. Hurwitz's good faith in deciding whether he violated the CSA. The instructions contravene dispositive case law holding that good faith is not only *relevant*, but *determinative*, in deciding whether a licensed physician is actually a drug dealer. To make matters worse, the district court declined to explain what it means to prescribe "not for a legitimate medical purpose" or "beyond the bounds of medical practice." Even when the jury specifically asked for such guidance, the

district court failed to provide it.

III. Having concluded that good faith is irrelevant, the district court excluded three crucial pieces of evidence that bore directly on defendant's state of mind: a consent decree that required Hurwitz to report his prescriptions to DEA on a regular basis; a finding by the Virginia Medical Board that defendant had prescribed in good faith; and a set of Frequently Asked Questions ("FAQs") – formulated after long-term study by DEA and other professionals – that strongly supported the reasonableness of defendant's conduct. Even if the defendant's subjective intent *were* irrelevant – and it is not – this evidence was relevant to show the "bounds of medical practice" and should have been admitted.

IV. During jury deliberations, the district court – outside the presence of the defendant and his attorneys, and without even inquiring of the juror – dismissed one of the deliberating jurors because his daughter's dog needed to be put to sleep. The court had nothing close to "good cause" within the meaning of Fed. R. Crim. P. 23 and 24. Moreover, dismissing the juror outside the presence of the defendant and his counsel was a violation of Rule 43, as well as the Fifth and Sixth Amendments.

ARGUMENT

I. THE EVIDENCE SEIZED FROM DEFENDANT'S OFFICE SHOULD HAVE BEEN SUPPRESSED

A. Standard of Review

Factual findings on a suppression motion are reviewed for clear error; legal conclusions are reviewed *de novo*. *United States v. Brookins*, 345 F.3d. 231, 234 (4th Cir. 2003).

B. The Search Violated The Rule in *Groh*

The warrant to search Dr. Hurwitz's medical office contained no description of the "person or property" to be seized. All it said was "see attachment" – *but there was no attachment to the warrant*. While there was an attachment to the affidavit in support of the warrant, the affidavit was sealed, on the government's motion, the same day the warrant was issued. JA97-98.

Under *Groh* v. *Ramirez*, 540 U.S. 551 (2004), the evidence seized from Dr. Hurwitz's office should have been suppressed. *Groh* was an action under *Bivens* v. *Six Unknown Fed. Narcotics Agents*, 403 U.S. 388 (1971), arising from the execution of a search warrant. In support of the warrant, federal agents presented an application specifying the items to be seized; the warrant itself, however, "failed to identify any of the items that [the agents] intended to seize." 540 U.S. at 554. The Court held not

only that the search violated the Fourth Amendment, but that the seizure lacked good faith under *United States* v. *Leon*, 468 U.S. 897 (1984), foreclosing a qualified immunity defense.

The Court noted that "[t]he warrant was plainly invalid." 540 U.S. at 557. "The fact that the *application* adequately described the 'things to be seized' does not save the *warrant* from its facial invalidity. The Fourth Amendment by its terms requires particularity in the warrant, not in the supporting documents." *Ibid.* (emphasis added). A warrant may cross-reference other documents *only* if it "uses appropriate words of incorporation" *and* "the supporting document accompanies the warrant," neither of which occurred in *Groh*. *Id.* at 558.

The Court next held that the seizing officer could not assert a qualified immunity defense. The Court noted that the question whether a constitutional right is "clearly established" for purposes of qualified immunity involves "the same standard of objective reasonableness that [the Court has] applied in the context of a suppression hearing in *Leon*." 540 U.S. at 565 n.8. Applying that standard, the Court explained that "a warrant may be so facially deficient – *i.e.*, in failing to particularize the place to be searched or the things to be seized – that the executing officers cannot reasonably presume it to be valid.' * * * This is such a case." *Id*. at 565.

This, too, is such a case. As in *Groh*, the government successfully moved to

seal the affidavit in support of the warrant, and it was that affidavit – not the warrant itself – that particularized the property to be seized. As in *Groh*, the sealed affidavit did not accompany the warrant at the time of the search, as court records showing the return on the warrant confirm. JA99-100. On this ground alone, the evidence should have been suppressed. See also *United States* v. *Grubbs*, 377 F.3d 1072, 1077 (9th Cir. 2004) (citing *Groh* in holding that, "[w]hen officers fail to attach the affidavit to a general warrant, the search is rendered illegal because the warrant neither limits their discretion nor gives the homeowner the required information.")

C. The Search Was Fatally Overbroad

Even if the attachment to the affidavit *had* been attached to the warrant, suppression would still be required. The agents seized every single patient file from defendant's office, and downloaded everything from his computers. The "attachment" listing the items to be seized did not, however, authorize such a wholesale seizure. The agents were authorized to seize only those records "constitut[ing] evidence of violations of Title 21, United States Code, Sections 841(a)(1), 848(e) and (n), and Title 18, United States Code, Section 1956(a)(1)." JA94.

The question whether a particular patient file is "evidence" of a "violation" of the CSA depends on a complex array of medical judgments. Indeed, at trial the

government addressed that question through testimony by Dr. Ashburn that lasted two days and consumed nearly 250 transcript pages. And Dr. Ashburn had to review "several thousand pages" of records in minute detail, a task that took him the better part of 200 hours, to form his opinion. JA2620, 2681.

By contrast, the agents who searched Dr. Hurwitz's office had *no experience* interpreting medical records; they were entirely incapable of making case-by-case judgments about which patient files reflected illegal activity. The affiant was a deputy sheriff who had "conducted numerous criminal drug trafficking investigations and executed a multitude of drug-related search and arrest warrants." JA74, ¶ 1. From this experience the affiant doubtless understood how drugs are commonly distributed and abused (JA78, ¶ 9), but notably missing is any experience investigating doctors who allegedly prescribed medications improperly. Nor does it matter that the affiant conducted "preliminary consultation with experts in the Medical field of pain management." JA88, ¶ 23. The affidavit contained absolutely no information about the purported experts – not their names, their professions, their credentials, their experience, their understanding of the case, or indeed what they actually said.

Lacking either the experience or training necessary to make fine distinctions, the agents did the only thing they could – they seized everything in sight. JA1100.

Such a top-to-bottom seizure was permissible if, but only if, there was probable cause to believe that Dr. Hurwitz's practice was so "pervaded by fraud" that *every piece of paper and computer file* "constituted evidence of violations" of the federal narcotics laws. See, *e.g.*, *United States* v. *Brien*, 617 F.2d 299 (1st Cir. 1986). But the underlying affidavit came nowhere close to showing "pervasive" illegality.

To the contrary, the affidavit contained statements from only five – approximately 1% – of Dr. Hurwitz's 400 patients. With the exception of one source whose wife was also a patient, none of the five claimed to have information that Dr. Hurwitz was prescribing drugs to others involved in illegal drug sales.

- CS-1 became a patient in January 2000. There is no suggestion that CS-1 knew of other patients who sold drugs. JA82-84, ¶¶ 14-16.

- CS-2 became a patient in April 2001. Although he implicated "another patient" – his wife – CS-2 said nothing about drug sales by other patients. JA84-85, ¶¶ 17-18.

- CS-3 became a patient in November 1998. CS-3 professed no knowledge of Dr. Hurwitz's other patients. JA85-86 ¶ 19.

- CS-4 became a patient in 1998. CS-4, like the others, professed no knowledge of drug sales by other patients. JA86-87, ¶¶ 20-21.

- CS-5 became a patient 2001. Like the others, CS-5 described only his own experience with Dr. Hurwitz. JA87-88 ¶ 22.

This paltry foundation comes nowhere close to satisfying the "pervaded by fraud" standard. Under such circumstances, courts have not hesitated to suppress. In

United States v. *Abrams*, 615 F.2d 541 (1st Cir. 1980), for example, agents searched a physician's office for evidence of Medicare fraud, but they

> made no attempt to distinguish bona fide records from fraudulent ones so they seized all of them in order that a detailed examination could be made later. This is exactly the kind of investigatory dragnet that the fourth amendment was designed to prevent.

Id. at 543. Accord, *In re Lafayette Academy, Inc.*, 610 F.2d 1 (1st Cir. 1979); *United States* v. *Stubbs*, 873 F.2d 210 (9th Cir. 1989) (no probable cause to seize all documents in office where affidavit detailed only certain aspects of business that were used to evade taxes); *In re Grand Jury Proceedings*, 716 F.2d 493 (8th Cir. 1983) (warrant allowing seizure of all records over seven-year period outruns probable cause showing that defendant defrauded only two customers).

Finally, the seizure from defendant's medical office cannot be saved by the "good faith" rule in *Leon*, 468 U.S. at 897. As the courts of appeals have uniformly held, *Leon* does not apply when warrants are so facially overbroad that they amount to general warrants, or when officers fail to take every reasonable step to narrow the scope of the warrant.[1] Although the search could (and should) have been confined

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[1]See *e.g.*, *United States* v. *Fuccillo*, 808 F.2d 173, 177-78 (1st Cir. 1987), cert. denied, 482 U.S. 905 (1987) (suppression required where agents "removed the entire contents of the * * * warehouse," and the warrant was "so facially deficient * * * that the executing officers cannot reasonably presume it to be valid"); *United States* v. *Leary*, 846 F.2d 592, 602 (10th Cir. 1988) (although affidavit in support of warrant described only one transaction,"[t]he warrant encompassed virtually every document

to specific patients files for which there was (at least arguably) probable cause, the government adopted no such limitation. The agents simply took everything and let Dr. Ashburn attempt to separate the wheat from the chaff.

D. Without The Evidence Seized From Dr. Hurwitz's Office, His Convictions Cannot Be Sustained.

The prosecution in this case was critically dependent on the medical records to support the testimony of the patients and of Dr. Ashburn, whose opinion rested on his review of those records. JA2492-94. Without that testimony, the government could not have obtained convictions, as the trial court acknowledged. JA2518-19 ("In order for them to prove beyond a reasonable doubt, they need a medical expert to say it's beyond the bounds").

II. THE JURY INSTRUCTIONS WERE FLAWED IN MULTIPLE RESPECTS

All of defendant's convictions arose under 21 U.S.C. § 841(a), which provides in pertinent part that, "[e]xcept as authorized * * * it shall be unlawful for any person knowingly or intentionally (1) to * * * distribute or dispense * * * a controlled substance."[2] The district court instructed the jury that this offense required two

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that one might expect to find in a modern export company's office").

[2] Count 1 alleged a conspiracy to distribute a controlled substance, in violation of 21 U.S.C. § 846. The governing legal principles are the same.

findings:

> One, that the defendant knowingly distributed and dispensed, or caused to be distributed and dispensed, a controlled substance.
>
> And, two, that the substance was distributed and dispensed, not for a legitimate medical purpose or beyond the bounds of medical practice.

JA4905. For the second element, the only guidance the court provided was that "[i]f you find that the defendant was negligent or made mistakes, that is not sufficient to find the defendant guilty." JA4908.

As we show below, the instructions were marred by two, independently reversible flaws: They stripped the CSA of any *mens rea* requirement, and they failed to define two crucial elements – "beyond the bounds of medical practice" and "legitimate medical purpose."

A. Standard of Review

A legal error in a jury instruction is subject to *de novo* review. *United States* v. *Hsu*, 364 F.3d 192, 204 (4th Cir. 2004). The failure to give a requested jury instruction is reversible error if "the instruction (1) was correct; (2) was not substantially covered by the court's charge to the jury; and (3) dealt with some point in the trial so important, that failure to give the requested instruction seriously impaired the defendant's ability to conduct his defense." *United States v. Lewis*, 53 F.3d 29, 32 (4th Cir. 1995).

B. The Instructions Stripped The CSA Of Its *Mens Rea* Requirement

Over defendant's objection (JA4837), the district court refused to instruct the jury that Dr. Hurwitz's "good faith" constituted a defense to the CSA counts.[3] Indeed, the court told the jury that it *could not* consider Dr. Hurwitz's good faith in connection with the CSA counts. "[W]hether [the] defendant acted in good faith," the court told the jury, "applies only to Counts 61 and 62," which charged a scheme to defraud healthcare benefit programs by prescribing to patients Nye and Santmyer. JA4909. The jury acquitted Hurwitz on the two fraud counts, but convicted on illegal distribution counts involving the same patients, Nye and Santmyer, where the instructions foreclosed a good faith defense.

The district court then stripped the statute even further of any *mens rea* requirement. The court told the jury that, to convict under the CSA, it need only find that (i) defendant "*knowingly* distributed and dispensed" a controlled substance and (ii) the distribution was not for a "legitimate medical purpose" or was "beyond the

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[3] Defendant submitted the following proposed instruction on "good faith": "If a doctor dispenses a drug in good faith to medically treat a patient, then the doctor has dispensed the drug for a legitimate medical purpose and in the course of medical practice. That is, he has dispensed the drug lawfully. 'Good faith' in this context means good intentions in the honest exercise of best professional judgment as to a patient's needs. It means the doctor acted according to what he believed to be proper medical practice." JA719. The government disputed only the relevance, not the text, of the proposed instruction. The instruction was taken from the good faith instruction quoted with approval in *Tran Trong Cuong*, 18 F.3d at 1138.

bounds of medical practice." JA4905. The court used the word "knowingly" to modify *only* the phrase "distributed and dispensed." The instructions thus authorized the jury to convict Hurwitz so long as (i) he "realized" and was "aware" (JA4907) that he was "distribut[ing] or dispens[ing]" a controlled substance – a standard satisfied by any prescribing physician, and (ii) the prescriptions fell outside the bounds of medical practice.[4]

These instructions reflected the government's fundamental view that Dr. Hurwitz's subjective intent or good faith simply was not relevant. When the defense protested that "there has to be some way for the jury to consider what was the intent in issuing the prescription" (JA4852), the prosecutor's response was adamant: "I will not agree." JA4853. That is just plain wrong. In an unbroken line of decisions, the Supreme Court and this Court have held that doctors cannot be convicted of unlawful distribution if they prescribe in good faith.

The earliest cases arose under the Harrison Anti-Narcotic Law, 38 Stat. 785, "the predecessor of the CSA" (*United States* v. *Moore*, 423 U.S. 122, 132 (1975)). In *Linder v. United States*, 268 U.S. 5 (1925), a physician was charged with

[4] To be sure, the requirement of "not for a legitimate medical purpose" would seem to presuppose a *mens rea* finding. But at the government's request (JA4842-43), and over the defendant's objection (JA4842), the district court instructed the jury that it could convict if it found that Hurwitz prescribed *either* without a legitimate medical purpose *or* "beyond the bounds of medical practice." JA4904.

prescribing excessive quantities of narcotics to an addict. The Court explained that a physician does not "act[] improperly or unwisely or for other than medical purposes solely because he has dispensed to [an addicted patient] in the ordinary course and in good faith . . . ." *Id*. at 18. Applying that standard, the Court held that the evidence was insufficient. Among other things, the Court stated, "[t]he facts disclosed indicate no conscious design to violate the law," and the charges "did not question the doctor's good faith." *Id*. at 17.[5]

One year later, in *Boyd v. United States*, 271 U.S. 104 (1926), a physician contended that a jury instruction permitted conviction even if he had prescribed in good faith. *Id.* at 107. The Supreme Court agreed that, if that were true, the instruction would conflict with *Linder*. *Ibid*. The Court affirmed the conviction, however, because the instructions made clear that good faith was a complete defense:

> In its charge to the jury the court said that the determinative question was whether the defendant issued the prescriptions in good faith 'as a physician to his patients in the course of his professional practice only'; that, if they were issued in good faith, 'for the purpose of curing disease or relieving suffering,' he should be acquitted; and that if, on the evidence, that question was left in reasonable doubt, he should be given the benefit of the doubt and acquitted.

Id. at 106-107. See also *id*. at 108 ("regardless of whether the course of treatment

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[5] Significantly, the jury in *Linder* was instructed that it should acquit the defendant if it found that he "believed in good faith" that he was prescribing the narcotics to his patient, not for the purpose of "catering to her appetite," but "for the purpose of relieving her pain." 268 U.S. at 16.

given by this defendant is a cure, the question is: Was he honestly and in good faith in the course of his professional practice and in an effort to cure disease issuing these prescriptions.").

As the Supreme Court's decision in *Moore* confirms, the CSA and its implementing regulations preserved the same "good faith" principle. In sustaining a physician's conviction under Section 841(a)(1), the Court explained that the trial court instructed the jury that it could convict only if the defendant acted "other than in good faith" and did not make "'an honest effort' to prescribe . . . in compliance with an accepted standard of medical practice." *Moore*, 423 U.S. at 139, 142 n.20.

In view of this dispositive Supreme Court case law, it is hardly surprising that this Court's decisions have likewise held that juries may not convict a doctor who practices medicine in good faith. In *Tran Trong Cuong*, the jury was given the very "good faith" instruction that Hurwitz sought in this case:

> [If a] doctor dispenses a drug in good faith in medically treating a patient, then the doctor has dispensed the drug for a legitimate medical purpose in the usual course of medical practice. That is, he has dispensed the drug lawfully. Good faith in this context means good intentions in the honest exercise of best professional judgment as to a patient's need. It means the doctor acted in accordance with what he believed to be proper medical practice. If you find the defendant acted in good faith in dispensing the drug, then you must find him not guilty.

18 F.3d at 1138. That instruction, this Court held, provides "a satisfactory definition

of the actions of a physician which are outside the course of professional medical practice." *Ibid.* Moreover, when it evaluated the sufficiency of the evidence, this Court repeatedly emphasized that the defendant *knew* his prescriptions were unauthorized. The defendant "knew he was doing something outside the professional practice." *Id.* at 1139. "[H]e knowingly prescribed these drugs in an unlawful manner" and "knew that he was prescribing drugs improperly." *Id.* at 1140. The evidence showed "intentional misconduct." *Ibid.* Accord, *United States v. Singh*, 54 F.3d 1182, 1187 (4th Cir. 1995) (evidence was sufficient because it showed that the defendant "'did not act in good faith in the honest exercise of his best professional judgment as to these patients' needs'").

In this case, the prosecutors convinced the district court that "good faith" is *legally irrelevant*, even though the Supreme Court squarely held in *Boyd* that a good faith defense *must* be available, and even though *the specific language* in the defense's proposed instruction was unambiguously endorsed in *Tran Trong Cuong*. To make matters worse, the trial court told the jury that the only act defendant had to have "knowingly" performed was "distributing or dispensing" a controlled substance. Under these instructions, the jury was free to convict Dr. Hurwitz even if he acted for a legitimate medical purpose and in good faith.

In addition to contravening eighty years of settled precedent, the instructions

violated two basic principles of our criminal justice system. First, they ignored the principle that "[t]he existence of a *mens rea* is the rule of, rather than the exception to, the principles of Anglo-American criminal jurisprudence." *United States v. United States Gypsum Co.*, 438 U.S. 422, 436 (1978). That rule is "universal and persistent in mature systems of law." *Morissette v. United States*, 342 U.S 246, 250 (1952). Its application is especially critical "where the act underlying the conviction" – here, a doctor prescribing medicine – "is by itself innocuous." *Arthur Andersen LLP v. United States*, 125 S.Ct. 2129, 2134 (2005). The Supreme Court has emphasized this principle repeatedly. "*Morissette*, reinforced by *Staples* [*v. United States*, 511 U.S. 60 (1994)], instructs that the presumption in favor of a scienter requirement should apply to each of the statutory elements that criminalize otherwise innocent conduct." *United States v. X-Citement Video, Inc*. 513 U.S. 64, 72 (1994).

Second, by making a physician's criminal liability turn on nothing more than whether he performed "outside the bounds of medical practice," the instructions transformed the CSA into a species of super-malpractice statute, in derogation of important federalism principles. Doctors who prescribe narcotics inappropriately are a danger to the public; so are incompetent surgeons, anesthesiologists, and cardiologists, not to mention arsonists and felons carrying firearms. But states – not the federal government – have primary (if not exclusive) authority to protect the

public from these dangers. See *Jones v. United States*, 529 U.S. 848 (2000) (refusing to construe federal statute to encompass traditional state-law crime of arson); *United States v. Bass*, 404 U.S. 336 (1971) (refusing to construe federal statute dealing with felon's possession of a firearm to effect significant change in the relationship between state and federal criminal jurisdiction). "Unless Congress conveys its purpose clearly, it will not be deemed to have significantly changed the federal-state balance" in matters traditionally addressed by state law and regulation. *Id*. at 349.

Federal prosecutions are an especially blunt instrument for policing malpractice, even gross malpractice, by physicians. In this case, for example, the government's principal expert described the "bounds of medicine" as a series of concentric circles, the smallest circle representing "ideal" medical practice, a larger circle representing "malpractice," and the largest circle representing practices "outside the bounds of what's appropriate medical care." JA2601. But Dr. Ashburn offered no objective medical criteria for defining (and confining) these metaphors. His testimony was replete with explanations of what he did in his own practice, untethered from any documented professional standard. See, *e.g*., JA2471-72; 2480; 2484-85; 2491-92. On the central issue of appropriate dosages, he opined that "there's virtually no data in the medical literature to support the use of high-dose opioids" – which he defined as approximately 195 mg. per day – because "there's

only been 16 *well-controlled* trials." JA2456 (emphasis added). But he offered no testimony that prescriptions above that dosage would violate any professional norm or medical guideline, and for good reason: many highly-respected experts disagree strongly with Dr. Ashburn's definition of a "high" dose,[6] just as many respected experts (and DEA) disagree with his opinion that it is always inappropriate to prescribe opioids to patients suffering from addiction. See Section IIIB3, *infra*. If draconian prison sentences can be imposed whenever a lay jury credits one expert's opinion on complex medical issues rather than another's, doctors inevitably will be discouraged from exercising their best *medical* judgment when prescribing opioids. Thirty-two State attorneys general have expressed concern that federal narcotics prosecutions will have such a chilling effect, because "many physicians fear investigations and enforcement actions if they prescribe adequate levels of opioids or have many patients with prescriptions for pain medications." Letter from Attorneys General to Deputy Administrator of DEA 1 (March 21, 2005) (http://www.naag.org/issues/pdf/20050321-Final-DEA-Comment.pdf).

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[6] Six former presidents of the American Pain Society have written that Dr. Ashburn's definition of "high dose" opioid therapy is "without foundation in the medical literature and we believe that it is, on its face, absurd." JA752. Indeed, a medical text edited by Dr. Ashburn himself states that "doses of opioids should be escalated until pain relief occurs or side effects intervene. There is no predetermined maximum dose of an opioid." ASHBURN & RICE, THE MANAGEMENT OF PAIN 132 (1998).

By contrast, State medical boards have ample legal authority to regulate the practice of medicine, and they have the requisite expertise to draw distinctions between malpractice, even gross malpractice, and conduct that cannot reasonably be described as medical care at all. The Virginia Medical Board exercised such authority here, expressing its expert judgment that Dr. Hurwitz, though he practiced medicine poorly, was nonetheless practicing medicine in good faith and for medical purposes. JA285.[7] An expert State agency such as the VMB, using procedures and evidentiary standards specifically formulated for that purpose, is a better judge of a doctor's quality of care than is a lay jury in a federal criminal prosecution. And because a medical board is less likely to *wrongly* condemn a doctor's practices, its oversight is less likely to chill legitimate medical prescriptions.

In any event, authority to regulate medical practice has rested with the States, not federal criminal prosecutors, for centuries. If the federal government is to displace – or "supplement" – the efforts of local officials, its actions should be confined to the traditional province of federal law enforcement. That traditional balance between state and federal authority (and the fundamental principle that criminal convictions require *mens rea*) is preserved by a natural reading of the CSA's

[7] Virginia law specifically permits doctors who act "in good faith for accepted medicinal or therapeutic purposes" to treat pain by prescribing dosages of opioids in excess of the recommended dosage. Va. St. § 54.1-3408.1.

language[8] to require proof that the physician "knowingly or intentionally" exceeded the scope of his authorization to prescribe medication. The Supreme Court construed similar statutory language in *Liparota v. United States*, 471 U.S. 419 (1985), where the defendant knowingly acquired food stamps and where the acquisition was "not authorized." *Liparota* rejected the argument – parallel to the government's argument here – that the statute permitted conviction even if the defendant did not know his actions were unauthorized.[9]

C. The Instructions Failed To Explain The Meaning Of "Beyond The Bounds Of Medical Practice" And "Not For A Legitimate Medical Purpose"

1. The initial instructions were worse than merely unhelpful

The district court instructed the jury that it could convict Dr. Hurwitz if he prescribed a controlled substance "not for a legitimate medical purpose or beyond the

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[8] "Except as authorized * * * it shall be unlawful for any person knowingly or intentionally (1) to * * * distribute or dispense * * * a controlled substance." 21 U.S.C. § 841(a).

[9] Even if the CSA's language were somehow ambiguous on this point (*i.e.*, if the words "knowingly or intentionally" could be read *either* to modify all elements of the offense *or* to modify only the element of "distribut[ing] * * * a controlled substance"), the ambiguity *must* be resolved by requiring *mens rea* for all elements of the crime under the rule of lenity. *Ratzlaff v. United States*, 510 U.S. 135, 148 (1994) (citing cases); *X-Citement Video,* 513 U.S. at 72 ("scienter requirement should apply to each of the statutory elements that criminalize otherwise innocent conduct."). See also *Andersen,* 125 S.Ct. at 2135 (construing statute to require proof that defendant "knowingly * * * corruptly persuad[ed]").

bounds of medical practice." JA4903. The court declined to tell the jury, however, what those terms meant. Although Hurwitz submitted proposed definitions,[10] the court refused to give them or any other explanation of these terms of art. JA4841-43.

That alone requires reversal. "Discharge of the jury's responsibility for drawing appropriate conclusions from the testimony depend[s] on discharge of the judge's responsibility to give the jury the required guidance by a lucid statement of the relevant legal criteria." *Bollenbach v. United States*, 326 U.S. 607, 612 (1946). For that reason, "[i]f an instruction uses a term of legal significance, its meaning must be explained." 2A WRIGHT & MILLER, FEDERAL PRACTICE AND PROCEDURE § 485 (3d ed. 2000); *United States v. Anderton*, 629 F.2d 1044, 1049 (5th Cir. 1980). The initial instructions provided virtually no guidance on the legal standard the jury was supposed to apply.

We say "virtually" because the court *did* provide *some* guidance – but it was worse than no guidance at all. The court told the jury that, in deciding whether Dr. Hurwitz acted "outside the bounds" of his profession,"[i]f you find that the defendant

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[10] The defense requested that "outside the bounds of medical practice" be defined as "outside the course of the defendant's professional medical practice" (JA720) and requested that the instructions refer to conduct outside the bounds of "his" medical practice. JA4841. It requested that "not for a legitimate medical purpose" be defined as "a doctor us[ing] his authority to prescribe controlled substances not for the treatment of * * * a patient, but for some other purpose." JA720.

was *negligent* or *made mistakes*, that is not sufficient to find the defendant guilty." JA4907-08 (emphases added). The natural implication of *that* instruction is that anything the slightest bit worse than mere negligence would be sufficient for conviction. Worse yet, the court not only rejected the defense's request for a definition of "negligent" (JA4857), but it also coupled that term with the phrase "or made mistakes." The jury easily could have understood this formulation to mean that "made mistakes" is a synonym for "was negligent." So understood, the instructions permitted the jury to convict for malpractice, or even something less, because a doctor who "makes mistakes" does not necessarily commit malpractice. See, e.g., *Franklin v. Toal*, 19 P.3d 834 (Okla. 2001) ("The question in professional malpractice suits is not whether a physician has made a mistake, but whether he has used 'ordinary care.'")*; DiLieto v. County Obstetrics and Gynecology Group*, No. CV 9701504355, 2000 WL 157538, at *15 (Conn. Super. Jan. 31, 2000) ("Doctors' mistakes are not actionable as malpractice unless they constitute deviations from the standard of care."); *Schaffner v. Cumberland County Hospital System, Inc.*, 336 S.E.2d 116 (N.C. App. 1985) (quoting HERZOG, MEDICAL JURISPRUDENCE, sec. 187, pp. 162-163 (1931) ("[M]ere proof of a mistake * * * does not itself prove malpractice."). And an instruction that permits a jury to convict under such a standard cannot stand under *Tran Trong Cuong*, which holds that malpractice does not violate the CSA. 18 F.3d

at 1137.

The district court's *uber*-negligence standard for "outside the bounds" is especially pernicious here because, at the government's request and over defendant's objection (JA4841-43), the court told the jury that it could convict if it found *either* that Dr. Hurwitz lacked a legitimate medical purpose *or* that his prescriptions fell "outside the bounds of medical practice."[11] The government resolutely maintained throughout the trial that these are different inquiries, with the latter focused on "the bounds of what's appropriate medical care." See, *e.g.*, JA2601. That gloss on the statute, alone, is erroneous; the two inquiries are *not* substantively different.[12] But to

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[11] The district court evidently believed, mistakenly, that an unpublished (and, therefore, non-precedential) decision by this Court required such an instruction. See JA727.

[12] The Solicitor General, citing numerous decisions from other circuits, has told the Supreme Court that the two phrases "reflect essentially the same standard." Brief For Petitioners 17 n.6, *Gonzales v. Oregon*, No. 04-623 (May 2005), http://www.usdoj.gov/osg/briefs/2004/3mer/2004-0623.mer.aa.pdf. See *United States v. Kirk*, 584 F.2d 773, 784 (6th Cir.) ("there is no difference in the meanings"), cert. denied, 439 U.S. 1048 (1978); *United States v. Plesons*, 560 F.2d 890, 897 n.6 (8th Cir. 1977) (same); *United States v. Rosenberg*, 515 F.2d 190, 197 (9th Cir.) (same), cert. denied, 423 U.S. 1031 (1975); *United States v. Nelson*, 383 F.3d 1227, 1231 (10th Cir. 2004); ("[I]t is difficult to imagine circumstances in which a practitioner could have prescribed controlled substances with a legitimate medical purpose and yet be outside the usual course of medical practice."); *United States v. Boettjer*, 569 F.2d 1078, 1082 (9th Cir. 1978) (disjunctive instruction "would theoretically permit a conviction where a practitioner had merely fallen below the standards 'generally recognized and accepted in the medical profession,' *i.e.*, merely upon a showing of malpractice. Such a result would clearly be contrary to the letter and spirit of the

then invite the jury to convict on *either* ground – while telling the jury that "outside the bounds" means anything worse than simple "negligence" or "making mistakes" – authorizes conviction of doctors who prescribe in complete good faith for a lawful medical purpose, but who (according to some paid expert) have simply made a sufficiently bad mistake.

2. The district court compounded matters by failing to respond to a confused jury's request for supplemental instructions

The deficiencies in the initial instructions soon became apparent. Jury deliberations began at mid-day, December 9. That afternoon, the jury requested more guidance on the law. The jury asked "Is it illegal to prescribe opioids to somebody you (a) suspect (b) think (c) know is addicted to illicit drugs? Is there a definition in federal law of (a) legitimate medical purpose (b) beyond the bounds of medical practice that can be provided? If not, can you provide us with definitions or criteria for those terms?" JA734.

The defense asked again for definitions of those critical concepts, and pointed out that "[i]t is perfectly legal to treat an addict for pain." JA4925. But the court refused, and merely told the jury:

> Whether the physician thinks, suspects or knows that the patient is addicted to illicit drugs is a circumstance you may consider * * * For example, if the

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statute.").

> physician knew * * * that the addicted patient would be distributing the prescribed substance to others or that the patient would be abusing the prescribed substance by taking contrary to the directions for use, then it would be prescribed not for a legitimate medical purpose and beyond the bounds of medical practice.

JA4927-28. The court then repeated the definition of "knowingly" but did not modify its original instruction that required only a finding that the defendant knowingly prescribed a controlled substance. JA4928-29.

Even if initial instructions are adequate, a jury's request for more guidance on critical issues triggers an obligation to provide it. The judge "has a 'duty of special care" when responding to a request for "'further light on a vital issue.'" *United States v. Duncan*, 850 F.2d 1104, 1115 (6th Cir. 1988) (quoting *Bollenbach*, 326 U.S. at 612 (1946)). He must provide answers to the jury's questions that will "clear them away with concrete accuracy." *Bollenbach*, 326 U.S. at 612-13. Here, the supplemental instructions aggravated confusion, rather than clearing it away.

The supplemental instructions were deficient in three different respects. First, although the jury asked for guidance on the *law*, the supplemental instruction addressed the *evidence* the jury could consider. JA4928. That non-answer was, in substance, indistinguishable from the non-answer that led to reversal in *United States v. Anderton*, 629 F.2d 1044 (5th Cir. 1980). There, when a jury considering an entrapment defense asked if a private citizen could be considered an "agent" of the

government, the judge answered "this is a factual issue to be decided by the jury under the facts heard in court and the Court's instructions as to the law." Id. at 1046. "The error" in this non-responsive answer "was failure 'to instruct the jurors as to the principles of law which they are to apply in deciding the factual issues.'" *Id*. at 1049 (quoting *United States v. Gilbreath*, 452 F.2d 992, 994 (5th Cir. 1971)).

Second, the supplemental instruction was non-responsive in failing to explain the difference, if any, between "beyond the bounds of medical practice" and "not for a legitimate medical purpose." The prosecution insisted that these phrases mean different things, but the instructions failed to explain the meaning of either concept or the difference between them, even when the jury specifically requested definitions. The court's only response was to describe two examples of findings that would permit conviction under both standards – "if the physician knew * * * that the addicted patient would be distributing the prescribed substance to others or that the patient would be abusing the prescribed substance by taking contrary to the directions for use." Each of these examples, the court told the jury, would permit a finding that a prescription "would be prescribed not for a legitimate medical purpose *and* beyond the bounds of medical practice." JA4928 (emphasis added). But examples that violate *both* standards provide no guidance on the difference *between* the standards or on the kinds of conduct that violate one standard (*e.g.*, "beyond the bounds of

medical practice") but not the other ("not for a legitimate medical purpose"). *Bollenbach* imposes an "obligation" to "clarif[y] questions of law" in response to jury confusion. *United States v. Ellis*, 121 F.3d 908, 925 n.23 (4th Cir. 1997). The trial court failed to meet that obligation.

Third, by telling the jury that a patient's drug addiction is "a circumstance you may consider" but without offering further guidance on the legal standard that the jury was to apply, the supplemental instructions invited the jury to convict if it found that Dr. Hurwitz did nothing more than prescribe opioids to treat the pain of patients who were drug addicts. That, after all, was the opinion of the government's principal expert. And that opinion, as we have shown, contradicts an unbroken line of precedent beginning with the Harrison Act, *Linder*, and *Boyd*, and continuing to the present.

* * *

Taken as a whole, the instructions in this case invited the jury to convict based on nothing more than which expert more persuasively opined on "the bounds of medical practice." It is bad enough that *civil malpractice* cases often come down to such warring expert testimony. But where a *criminal conviction* turns on little else, bad has taken a turn for the worst. Dr. Hurwitz's jury was told to ignore his good faith when considering the principal charges in this case – and it *acquitted* him on the

only two counts where the instructions permitted consideration of good faith. Moreover, the only guidance the jury received on what it means to be "beyond the bounds of medical practice" was worse than useless. The instructions alone require that defendant's convictions be reversed.

III. THE DISTRICT COURT ERRONEOUSLY EXCLUDED CRUCIAL EVIDENCE

A. Standard Of Review

Evidentiary rulings are reviewed for abuse of discretion. *United States v. Queen*, 132 F.3d 991, 995 (4th Cir. 1997). Legal errors, however, constitute an abuse of discretion. *United States* v. *DeBeir*, 186 F.3d 561, 566-67 (4th Cir. 1999).

B. Three Crucial Pieces Of Evidence Were Improperly Excluded

Persuaded by the government's erroneous reading of the CSA, the district court excluded three crucial pieces of evidence tending to prove that Dr. Hurwitz prescribed in good faith and for legitimate medical purposes. Each of those evidentiary decisions warrants reversal. Indeed, the exclusion of this evidence is reversible error even if, as the government insisted, good faith were *not* an available defense.

1. Evidence That Dr. Hurwitz Sent His Records To DEA

The Virginia Medical Board ("VMB") reviewed Dr. Hurwitz's practices in two

proceedings, in 1996-1998 and in 2003. The first proceeding, which was carefully monitored by DEA, resulted in a temporary suspension of defendant's medical privileges and a consent agreement that required Dr. Hurwitz to send quarterly reports to DEA identifying each of his patients and the prescriptions he wrote for them. The defense sought to admit that agreement because it bore on Dr. Hurwitz's intent. A doctor trying in good faith to treat a patient would record evidence of red flags in his medical records, as Dr. Hurwitz did; a doctor conspiring in illicit drug sales would *conceal* such evidence, especially if he *knew* his prescriptions to drug dealers would be sent to DEA. As defendant explained, the evidence of DEA monitoring was "part of his state of mind." JA4305.

The government did not dispute that the evidence was relevant to show defendant's state of mind. According to the prosecutors, however, the only "state of mind" that mattered was whether defendant "knowingly and willfully issued a prescription. He can be – he can be outside the bounds of medicine and still be in complete good faith and still be in violation of this Title 21 U.S.C. 841." JA4306-07. On that basis, the trial court excluded the evidence. JA4307.

For the reasons set out in Point II, Dr. Hurwitz's good faith plainly *is* an available defense. The exclusion of the DEA evidence, based on a contrary premise, was therefore mistaken. What is worse, the district court applied that mistaken

premise *only* when it prejudiced Hurwitz; by contrast, much of the government's evidence in this case was admitted on the *contrary* premise – that the defendant's state of mind *was* an issue. For example, the trial court permitted the prosecutors to cross-examine Dr. Hurwitz extensively about VMB's findings, in the 1996-1998 proceedings, that defendant had provided inadequate medical care to several patients *other* than those named in this case. JA4453-70. The district court recognized that evidence of these "other wrongs" was inadmissible as direct evidence of the charges against Dr. Hurwitz and that it was potentially prejudicial. JA4473-74. The court admitted the evidence, however, based on the prosecution's argument that the evidence was "directly relevant to the defendant's knowledge" of appropriate prescribing practices. JA273; see also JA4473-74. That, of course, is the very theory the court *rejected* when it was invoked by Hurwitz.[13]

2. VMB's Finding That Dr. Hurwitz Acted In Good Faith

The 2003 VMB proceeding examined Dr. Hurwitz's treatment of patients

[13] Similarly, Dr. Vilensky testified that he taught Dr. Hurwitz about "red flags" and how physicians can identify drug-seeking patients. JA2810-11. Evidence bearing on defendant's ability to detect drug abusers is relevant *only* if his state of mind is material. The same is true of the testimony of the government's principal expert, Dr. Ashburn, who opined that Hurwitz prescribed opioids to patients he *knew* were abusers or diverters. What defendant knew or believed about his prescriptions was deemed relevant when it came to admitting the *government's* evidence. Dr. Hurwitz was entitled to the same rule of law in his defense.

whose prescriptions were the subject of his criminal indictment. VMB found that Hurwitz had provided deficient medical care; but after carefully examining the circumstances, it also found that Hurwitz "believed he was practicing pain medicine in good faith, and for recognized and accepted medicinal or therapeutic purposes." JA285.

The prosecution moved to exclude VMB's finding of good faith, on the usual ground that good faith is irrelevant. JA274-75. The trial court granted the government's motion. JA499. The court offered no explanation to reconcile its *exclusion* of the 2003 VMB findings – offered by the defense to show that Dr. Hurwitz *did not* know or believe that he was prescribing inappropriately – with its *admission* of the 1996-1998 VMB findings, offered by the prosecution to show that Dr. Hurwitz *did* know he was prescribing inappropriately. JA4460-75.

3. The FAQs

In 2004, DEA, Last Acts Partnership, and the Pain & Policy Studies Group at the University of Wisconsin published "Prescription Pain Medications: Frequently Asked Questions and Answers for Health Care Professionals and Law Enforcement Personnel" ("FAQs"). JA329-76. The document was the product of intensive collaboration among leading pain experts and DEA representatives. JA330. It was carefully reviewed by twelve other leading experts from the fields of nursing,

neurology, psychiatry, pharmacology, pharmacy and addiction medicine. *Ibid.* The document represented "a consensus, supported by the available literature and by the laws and regulations that govern the use of controlled prescription drugs." JA331. It was announced at a DEA press conference and posted on DEA's website. And virtually every page of this 48-page document contained statements that supported critical aspects of Dr. Hurwitz's defense. Among other things, the FAQs explained that pain is a severe and under-treated medical problem (JA338); that opioid medication is often the most effective treatment for pain (JA343); that "red flags" may indicate inadequate treatment for pain, rather than addiction (JA361-62); and that it is both lawful and medically appropriate to prescribe opioid medications to treat the pain of addicts. JA364.

On September 22, 2004, the defense filed a motion that made reference to the FAQs. Two weeks later, DEA removed the FAQs from its website, saying the FAQs "contained misstatements." The prosecution then moved to bar the defense from using the document at trial. JA322-28. The trial court initially denied the motion, then granted it in the midst of trial after the government requested reconsideration. JA499 (denying motion); JA2427 (granting motion for reconsideration).

Whereas the government usually blocked defendant's proffered evidence on the ground that his subjective state of mind was irrelevant, this time the government

changed rationales. The prosecution conceded the FAQs would be relevant if the document "were in place at the time Dr. Hurwitz was practicing and he relied on it." JA456. But because the document was published *after* the events in the indictment, Dr. Hurwitz could not have relied on it. Moreover, the government argued, the FAQs were not admissible as evidence of the objective reasonableness of Dr. Hurwitz's practices because the document contained "misstatements" and was never approved as an official DEA policy.

Those arguments are simply preposterous – and the district court's exclusion of the FAQs was, without more, reversible error. For one thing, the FAQs bore directly on the (legally available) defense of good faith. A jury is more likely to conclude that a physician holds his views in good faith if those views are shown to be widely accepted within the medical profession. See, *e.g.*, *Cheek v. United States*, 498 U.S. 192, 203-204 (1991) ("the more unreasonable the asserted beliefs or misunderstandings * * * the more likely the jury * * * will find the government has carried its burden"); *United States* v. *Garber*, 607 F.2d 92, 99 (5th Cir. 1979) (*en banc*) (finding error in exclusion of testimony about a recognized, though disputed, theory that would have shown defendant's views were reasonable).

But even on the government's view – that good faith doesn't matter – exclusion of the FAQs makes no sense. The FAQs directly addressed "the bounds of medical

practice" – a subject that cannot possibly be off-limits when the government is prosecuting a physician for straying "beyond" those bounds. The FAQs, like the VMB's finding of good faith and Dr. Hurwitz's belief that DEA was reviewing his prescribing practices, were also relevant – indeed central – to the question whether Dr. Hurwitz had a legitimate medical purpose in prescribing as he did. The defendant surely was entitled to rebut the government's contention that he acted "beyond the bounds" or without a "legitimate purpose." With or without the defense of good faith, it was highly prejudicial error to exclude this evidence.

Nor does it matter that DEA did not formally adopt the FAQs. A document that purports to reflect "a consensus" of medical experts, and which is "supported by the available literature," is plainly relevant in a case like this, even if, perhaps for tactical reasons, DEA has declined to adopt the statement as formal policy. Dr. Hurwitz was not, after all, mounting a challenge to "agency action" under the Administrative Procedure Act; he was defending a criminal case in which the gravamen of the indictment was that his medical practices fell outside of professional norms. To defend that charge, he was entitled – obligated – to establish that professional norms were soundly in his corner.[14]

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[14] Compounding the error, the district court permitted the government to present evidence on the governing professional norms, while excluding defense evidence on precisely the same issues. See *United States v. Sellers*, 566 F.2d 884,

In any event, the government's suggestion that DEA somehow disavowed the content of the FAQs is quite wrong: The statements contained in the FAQs that were most significant to the defense *were then and still are accurate statements of DEA policy*. DEA confirmed that fact on November 16 – the day after the government's motion to exclude the FAQs was granted and the day that Dr. Ashburn testified – when it published (69 Fed.Reg. 67170 (Nov. 16, 2004)) an Interim Policy Statement ("IPS") to explain its abrupt withdrawal of the FAQs.[15]

One frequently-asked-question was, "If a patient receiving opioid therapy engages in an episode of drug abuse, is the physician required by law to discontinue therapy * * * ?" After noting that some state laws may require discontinuation [Virginia state law does not] the FAQs stated, "In states with no specific legal requirements on this subject, if continued opioid therapy makes medical sense, *then the therapy may be continued, even if drug abuse has occurred*. Additional monitoring and oversight of patients who have experienced such an episode is recommended * * * *It is within the scope of current federal law to prescribe opioids*

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886 (4th Cir. 1977) (trial court abused discretion by excluding defense evidence while admitting government's evidence on the same point); *United States v. Gaskell*, 985 F.2d 1056, 1063 (11th Cir. 1993) (same).

[15] The prosecution did not inform the trial court or the defense of the issuance of the IPS.

for pain to patients with a history of substance abuse or addiction." JA364 (emphasis added).

The IPS confirms the correctness of that answer. It states that the FAQs "understated the degree of caution that a physician must exercise to minimize the likelihood of diversion *when dispensing controlled substances to known or suspected addicts*" – confirming that such dispensation is not *per se* illegal. 69 Fed.Reg. 67171. The IPS also states, "If a physician is aware that a patient is a drug addict and/or has resold prescription narcotics, it is not merely 'recommended' that the physician engage in additional monitoring * * * [T]he physician has a responsibility *to exercise a much greater degree of oversight*." *Ibid*. (emphasis added). This oversight, of course, can be exercised *only if the physician continues to treat the patient*. Remarkably, on the very day the IPS was published, Dr. Ashburn testified repeatedly that such treatment was beyond the bounds of medical practice. See p. 11, *supra*.

Patients' requests for more medication, requests for specific pain medications, acquiring similar medications from other providers, unsanctioned dose escalations, and nonadherence to other recommendations for pain therapy – all of which Dr. Ashburn identified as "red flags" that should have caused Dr. Hurwitz to discontinue treatment – are described in the FAQs as behaviors that "cannot be perceived to be an immediate reflection of addiction. Rather, the assessment may reveal other

potential explanations, including the possible effects of unrelieved pain." JA361-62. According to the FAQs, expressions of concern about opioid treatment from friends and family members (another red flag highlighted by the prosecution) may reflect poor understanding of the therapy. JA352.

The IPS does not dispute these statements, either. The IPS describes the "red flags" as "indicators of *possible* diversion" (69 Fed.Reg. 67171 (emphasis added)), not as behavior that requires immediate termination of opioid prescriptions. And the IPS acknowledges that "it is true that concerns of family members are not always determinative of whether the patient is engaged in drug abuse." *Ibid*.

* * *

The jury should have been allowed to hear both sides of the story. Because it heard only one side, the prosecution could argue that Dr. Hurwitz's prescriptions to drug addicts were outside the bounds of medicine, and that his explanations of his practices (and the opinions of experts supporting those practices) lacked credibility. JA4760-64. The excluded evidence was not irrelevant. The problem for the prosecution was that the evidence was *too* relevant – it easily could have persuaded the jury to acquit.

IV. THE TRIAL COURT IMPROPERLY DISMISSED A JUROR DURING DELIBERATIONS

A. Standard of Review

The decision to excuse a juror for cause is reviewed for abuse of discretion. *United States* v. *Acker*, 52 F.3d 509, 515 (4th Cir. 1995). But a legal error constitutes abuse of discretion. *DeBeir*, 186 F.3d at 566-67.

B. The Dismemberment Of The Jury

The jury began deliberations on December 9, 2004. As deliberations continued the next morning (a Friday), Juror 12 received a message that his daughter's dog was ill. Shortly thereafter, at approximately 11:00, the daughter called again. Deliberations stopped. Juror 12 spoke with his daughter, then apparently told the clerk that the dog was going to be put to sleep and that his daughter was very upset.[16] On that basis, the juror asked to be excused. JA4934.

The trial judge – without ever speaking to the juror about the situation and without any additional inquiries – excused Juror 12 from further service. This dismissal occurred in the absence of, and without notice to, Dr. Hurwitz or his counsel. By the time they arrived in court and learned of the dismissal, Juror 12 had

[16] There is no direct account of these events. Neither the juror nor the court clerk with whom he was apparently communicating spoke on the record. JA4934. As a result, the only information about their communications comes from the double hearsay version offered by the district court.

departed, never again to return. *Ibid.*

Upon hearing (after the fact) what had happened, Dr. Hurwitz made a "strong objection" to the removal of the juror, objecting both to the reasons for removal and the way in which it was handled:

> We should have been present when it happened. We would have wanted to be present when it happened. There were alternatives to excusing him in the way it happened. The jury could have been put in recess. He could have come back. The jury could have been continued until Monday, so our objection is based on that.

JA4936. Defense counsel specifically requested that Juror 12 be required to return on Monday, when the situation with his daughter's dog would presumably have been resolved. The court refused: "I excused him. He said he didn't want to – he requested not to come back." JA4937.

The court then replaced Juror 12 with Alternate Juror 1, who was recalled to the courthouse. The court made no inquiry whether the replacement juror had read about or discussed the case in the intervening time.[17] The newly-constituted jury deliberated from 12:47 to 4:25, then recessed until the following Monday. JA4942-45.

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[17] A district court "may retain alternate jurors after the jury retires to deliberate" and use an alternate to replace an excused juror. The court "must ensure that a retained alternate does not discuss the case with anyone until that alternate replaces a juror or is discharged." FED. R. CRIM. P. 24(c).

C. The Dismissal of Juror 12 Lacked Good Cause

Once deliberations begin, a juror may be excused only for "good cause." FED. R. CRIM. P. 23(b)(3); see also FED. R. CRIM. P. 24(c); *United States* v. *Nelson*, 102 F.3d 1344, 1349 (4th Cir. 1996) ("The trial judge is not at liberty to interfere with the jury selected unless it has adequate cause."). It is never "good cause," however, to remove a juror during deliberations because of a problem that would justify, at most, a brief delay in deliberations. Juror 12's concerns – however much they may resonate with dog lovers everywhere – do not meet that standard.

United States v. *Patterson*, 26 F.3d 1127 (D.C. Cir. 1994), illustrates the point. There, an elderly juror experienced chest pains and called the court clerk to say that her doctor wished to see her immediately. On the judge's authorization, the clerk told the juror to go to the doctor. A few hours later, the judge, having heard nothing further from the juror, announced – over the defendant's objection – that deliberations would continue without her. Observing that "the judge below made no attempt to learn the precise circumstances or likely duration of the twelfth juror's absence," the court of appeals ordered a new trial. *Id* at 1129.

> [T]he juror's age and the nature of her complaint do not by themselves support the inference that she would be unable to complete her service. She might have been able to return to court in short order or she might have had a serious medical problem precluding further participation in the trial. We have no way of knowing because the trial judge made no effort to find out. "Since (1) the

> record is silent, and (2) the court must 'find' just cause on the record, and (3) the case must be affirmed or reversed on the record, and (4) there is nothing in the record to support the court's action, the case must be reversed."

Ibid. (quoting *United States* v. *Essex*, 734 F.2d 832, 842 (D.C. Cir. 1984)).

The Seventh Circuit applied this reasoning in *United States* v. *Araujo*, 62 F.3d 930 (7th Cir. 1995). After deliberations had begun, the district court dismissed a juror who had car trouble and could not get to the courthouse. The conviction was reversed. Before a deliberating juror can be dismissed, "the district court *must* render a finding that it is necessary to do so for just cause; and if the record does not already make clear the *precise* nature or likely duration of the juror's inability to serve, the court bears an affirmative duty to inquire further into those circumstances." *Id.* at 934 (emphases added).

> When the record is unclear as to the juror's inability to serve, and when the facts that are known leave open the possibility that the juror might have been able to resume her service after a reasonably brief delay, just cause for dismissal most likely is lacking.

Id. at 935.

United States v. *Tabacca*, 924 F.2d 906 (9th Cir. 1991), provides another illustration. A juror was dismissed during deliberations after reporting that he could not come to the courthouse that day because his wife had taken his car keys. Those circumstances did not provide adequate cause for dismissal. "[T]he absent juror was

certain to be available the next day. The only reason he was out was because his wife had his car keys." *Id.* at 915. Waiting a single day "is unlikely to induce dulled memories on the part of the jurors." *Ibid.* The dismissal of the juror was therefore reversible error.

United States v. *Spence*, 163 F.3d 1280 (11th Cir. 1998), involved a juror who was dismissed after suffering an allergic reaction. The district court excused the juror over the objection of the defendant, who argued that the juror might be well enough the next morning to return. Reversing, the Eleventh Circuit held that the district judge had not conducted a "sufficient inquiry" to find good cause. "[E]verything that the district court knew in this case indicated that the juror would be able to return in the morning." *Id.* at 1283-84.

Here, the record is utterly silent concerning the "precise" nature and duration of Juror 12's absence, and the district court made no effort to learn more. Quite the contrary, the court dismissed Juror 12 on the basis of nothing more than a second-hand report that his daughter's dog was sick. Even if that was sufficient reason for a *temporary* excusal (which is far from obvious), there was no reason to think that the juror could not return the next Monday.[18] Certainly, the district court took *no*

[18] A recess in the jury's deliberations, rather than the dismissal of Juror 12, would have cost *at most* four hours' delay in the jury's deliberations, and quite possibly no delay at all. By the time the alternate juror was empaneled at 12:45

"affirmative" action to "clarify the record" or to discover any information that might have suggested otherwise. *Araujo*, 62 F.3d at 934-35. Indeed, the trial judge did not meet or speak with the juror at all. The "few facts" known to the district court "simply do not reveal how long [Juror 12] would [have been] unable to participate in the deliberations; thus, the record lacks the requisite support for the district court's determination that he should be dismissed for just cause." *Id.* at 934.

This error, *in and of itself*, requires reversal. In *Araujo*, the improper dismissal required reversal – *without any determination of prejudice*. 62 F.3d at 937 ("Because the district court lacked just cause to excuse the twelfth juror pursuant to Rule 23(b), we reverse the defendants' convictions and remand for a new trial."). Similarly, in *Patterson*, the D.C. Circuit eschewed a harmless error analysis and held that where the existing record did not justify dismissal, "the case must be reversed." 26 F.3d at 1129. So, too, both *Spence* and *Tabacca* held – without a harmless error analysis – that the unwarranted dismissal of a juror during deliberations required a new trial. *Spence*, 163 F.3d at 1284; *Tabacca*, 924 F.2d at 915.

(JA4942) the newly constituted jury had less than four hours to deliberate until it recessed for the weekend (JA4953). Because the reconstituted jury was instructed to begin its deliberations anew, and because the alternate juror had not been present for the supplemental instructions the previous day, a significant portion of that four-hour period – if not all of it – presumably was spent re-plowing ground for the benefit of the jury's new member.

This Court has expressly held that similar errors related to the dismissal of jurors are structural errors that require reversal "without any showing of prejudice." *United States* v. *Curbelo*, 343 F.3d 273, 280 (4th Cir. 2003); see also *id.* at 284 ("[A] violation of Rule 23(b) entitles a defendant to a new trial, without regard to whether the error was actually prejudicial."). *Curbelo* involved a violation of Fed R. Crim. P. 23(b) where the district court, midway through trial, excused a juror and continued with an 11-person jury. Favorably citing *Araujo*, *Patterson*, and *Tabacca*, the Court concluded that "the court's decision to excuse the twelfth juror prior to deliberations and absent the defendant's consent falls into the special category of errors that 'defy analysis by harmless-error standard' and require automatic reversal because they are 'necessarily unquantifiable and indeterminate.'" 343 F.3d at 285 (quoting *Sullivan* v. *Louisiana*, 508 U.S. 275, 281-82 (1993)). The same result is required here.

D. The District Court Violated Rule 43 And The Constitution By Dismissing Juror 12 Outside The Presence Of Dr. Hurwitz And His Counsel

The district court committed yet another error by dismissing the juror outside the presence of Dr. Hurwitz and his lawyers. In doing so, the district court violated both the Constitution and Rule 43 of the Federal Rules of Criminal Procedure. Rule 43(a)(2) requires that the defendant be present at "every trial stage, including jury impanelment and the return of the verdict."

In *United States* v. *Hanno*, 21 F.3d 42, 45 (4th Cir. 1994), the trial court removed six jurors previously selected for defendant's trial and moved them – in the absence of, and without notice to, either the defendant or his lawyer – to another trial. Identifying several errors, all of which are present here, the Court ordered a new trial. *First*, the Court held that dismembering a duly-selected jury "without giving notice to and in the absence of the defendant" violated both Rule 43 and the Due Process Clause. *Id.* at 46. Noting that "an accused has the constitutional right to be present at his jury selection," the Court concluded that "he has the same right to be present at the dismemberment of a jury which previously had been selected in his absence." *Id*. at 47. *Second*, the dismemberment occurred "in the absence of the defendant's attorney." *Ibid*. Under *United States* v. *Cronic*, 466 U.S. 648, 659 (1984), a trial is deemed unfair in violation of the Sixth Amendment "if the accused is denied counsel at a critical stage of his trial." Applying that rule, *Hanno* held that jury dismemberment, like jury selection, is a critical stage that requires the presence of counsel. 21 F.3d at 47-48.

Third, the Court held that "the district court erred in not recording the proceedings in which Hanno's jurors were removed." *Id.* at 48. A federal statute (28 U.S.C. § 753(b)) requires such recording, and the Court noted that "'non-compliance seems fraught with potential for mistake and possible prejudice.'" *Ibid.* (quoting

United States v. *Snead*, 527 F.2d 590, 591 (4th Cir. 1975)). The Court then determined that these errors were prejudicial and required a new trial. *Hanno*, 21 F.3d at 48 ("Hanno was prejudiced because both he and his attorney were prevented by lack of notice from participating in the decision as to whether their selected jurors should be removed.").

In reaching this conclusion, the Court relied heavily (21 F.3d at 47) on *United States* v. *Gay*, 522 F.2d 429 (6th Cir. 1975), where the trial court excused two jurors and replaced them with alternates outside the presence of the defendant and his lawyer. That error necessitated a new trial:

> We hold that it was error for the District Judge to engage in discussions with members of the jury after it was empaneled and to consider requests for excuses out of the presence of the defendant and without giving notice to defense counsel. * * * The defendant should have an opportunity to object to requests for excuses from the jury and to make a record of the proceedings.

Id. at 435. In reversing the conviction, the court added that "the total absence of a record of the proceedings in which the changes in the makeup of the jury occurred requires us to assume prejudice." *Ibid.*

The same errors that required reversal in *Hanno* and *Gay* infected this case. The district court dismembered Dr. Hurwitz's duly constituted jury by dismissing Juror 12 outside the presence of the defendant and his lawyers. This is an obvious violation of Rule 43, as well as a deprivation of Dr. Hurwitz's Fifth and Sixth

Amendment rights. Neither the defendant nor his counsel had any warning that the composition of the jury would be permanently changed. The district court acted without the defendant's input and without giving him a timely opportunity to object, and compounded this error by failing to ensure that communications with Juror 12 were transcribed. As a result, there is no record of exactly what the juror said. As in *Hanno* and *Gay*, this series of obvious errors cannot be deemed harmless and requires the reversal of Dr. Hurwitz's conviction.[19]

CONCLUSION

The judgments of conviction should be reversed.

ORAL ARGUMENT REQUESTED

Appellant respectfully requests oral argument, and submits that the issues in the case are sufficiently complex, and sufficiently important to Appellant and the public, that 30 minutes per side of oral argument time is warranted.

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[19] In *Hanno* the defendant failed to object to the errors, and this Court reversed under a plain-error analysis. *Hanno*, 21 F.3d at 45 & n.2; see also *id.* at 48. Here, Dr. Hurwitz *did* object at the first opportunity; his appeal, therefore, is *not* governed by the more stringent plain-error standard set forth in *United States* v. *Olano*, 507 U.S. 725 (1993), but (at best for the government) by a harmless error standard in which the burden is on the government to prove the error harmless beyond a reasonable doubt. See *United States* v. *Lovern*, 293 F.3d 695, 701 (4th Cir. 2002). The finding of plain error in *Hanno* means *a fortiori* that the same errors require a new trial here.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

I, Damon W. Taaffe, hereby certify that this brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B): it is proportionally spaced, has a typeface of 14 points, and contains 13,904 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii).

Date: August 30, 2005

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Damon W. Taaffe

CERTIFICATE OF SERVICE

I, Damon W. Taaffe, hereby certify that two copies of the Brief for Appellant William Eliot Hurwitz, and one copy of the related Appendix, were hand-delivered this 30th day of August, 2005, to:

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