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occupation tax authorized by L.B. 701 violates the constitutional prohibition against commutation.

V. CONCLUSION

For the reasons discussed, we conclude that the landowners have not overcome the presumption of constitutionality with respect to the challenged statutes, and we therefore affirm the judgment of the district court.

AFFIRMED.

CONNOLLY, J., not participating.

ROBERT MURRAY, SPECIAL ADMINISTRATOR OF THE ESTATE OF MARY K. MURRAY, AND ROBERT MURRAY, INDIVIDUALLY, APPELLEES, V. UNMC PHYSICIANS, FORMERLY KNOWN AS UNIVERSITY MEDICAL ASSOCIATES, A CORPORATION, APPELLANT.

806 N.W.2d 118

Filed September 16, 2011. No. S-10-455.

1. **Motions for New Trial: Appeal and Error.** A motion for new trial is addressed to the discretion of the trial court, whose decision will be upheld in the absence of an abuse of that discretion.
2. **Motions for New Trial.** The discretion of a trial court in ruling on a motion for new trial is only the power to apply the statutes and legal principles to all facts of the case; a new trial may be granted only where legal cause exists.
3. **Negligence: Evidence: Tort-feasors.** While the identification of the applicable standard of care is a question of law, the ultimate determination of whether a party deviated from the standard of care and was therefore negligent is a question of fact. To resolve the issue, a finder of fact must determine what conduct the standard of care would require under the particular circumstances presented by the evidence and whether the conduct of the alleged tort-feasor conformed with that standard.

Appeal from the District Court for Douglas County: JAMES T. GLEASON, Judge. Reversed.

Jeffrey A. Nix, Thomas J. Shomaker, and Mary M. Schott, of Sodoro, Daly & Sodoro, P.C., for appellant.

Christopher P. Welsh and James R. Welsh, of Welsh & Welsh, P.C., L.L.O., for appellees.

HEAVICAN, C.J., CONNOLLY, GERRARD, MCCORMACK, and MILLER-LERMAN, JJ.

GERRARD, J.

This case involves a failure to provide medical treatment. The treatment at issue is a very expensive drug that must be administered indefinitely. But it also may cause serious and even deadly symptoms if its administration is interrupted. In this case, the patient's treating physicians, wary of those health risks, decided not to administer the drug until the patient's insurer approved it or another source of payment could be found. But, regrettably, the patient died before either happened. The question presented in this appeal is whether under such circumstances, an expert medical witness is permitted to opine that under the customary standard of care, a physician should consider the health risks to a patient who may be unable to pay for continued treatment. We conclude that such testimony is admissible and, therefore, reverse the district court's order granting a new trial.

BACKGROUND

This is a medical malpractice case in which Robert Murray, individually and as special administrator of the estate of his wife, Mary K. Murray, alleges that the defendants caused the death of Mary by negligently failing to administer Flolan therapy to treat her pulmonary arterial hypertension. The defendants were the Nebraska Medical Center, the Board of Regents of the University of Nebraska, UNMC Physicians (UNMC), and several associated individual employees, although UNMC was the only defendant remaining by the time of trial.

Pulmonary arterial hypertension is a chronic medical condition in which the blood vessels in the lungs constrict, and the resulting pressure on the heart leads to heart failure. Flolan is a vasodilator that relaxes blood vessels and prevents blood clotting. It is administered by a pump, connected to a port and catheter usually inserted above the collarbone. Flolan is very expensive and shortacting, so patients on Flolan treatment need a constant supply of the drug, because if its administration stops, pulmonary blood pressure rebounds and can be life

threatening. And because Flolan is a chronic treatment, patients who begin Flolan need to remain on it, essentially, for the rest of their lives—it must be administered 24 hours a day and costs approximately $100,000 a year. The parties do not seem to disagree that generally, Flolan therapy is the appropriate course of treatment for chronic pulmonary arterial hypertension. Nor do the parties seem to dispute that there are significant and potentially deadly risks associated with interrupting Flolan treatment.[1]

The course of treatment relevant to this case began in late June 2006, as Mary's treating physician, Austin Thompson, M.D., was preparing to treat Mary's pulmonary arterial hypertension with Flolan. On June 29, Mary underwent a heart catheterization to confirm her diagnosis and eligibility for Flolan; in fact, Thompson had already written the Flolan order before the catheterization, pending the results of the catheterization and insurance approval. The catheterization showed pulmonary arterial hypertension, significant heart failure, and reduced blood flow.

On July 4, 2006, Mary reported to the medical center with swollen legs and fluid around her heart. She was given diuretics and hospitalized until July 8. She was discharged and was supposed to begin Flolan after port placement the following week. But on July 10, she reported to the emergency room with a rapid heartbeat and shortness of breath. She began to seize, then her heartbeat stopped, and medical efforts failed to resuscitate her.

At trial, the parties disputed both the cause of Mary's death and whether UNMC had breached the standard of care. Robert presented expert medical testimony that the proximate cause of Mary's death was pulmonary arterial hypertension. UNMC, on the other hand, presented expert medical testimony that myocarditis, an inflammation of the heart usually caused by viral or bacterial infection, was a contributing factor to Mary's death—a conclusion with which Robert's experts disagreed. And Robert presented expert medical testimony that immediate Flolan administration, even a day or two before Mary's death,

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[1] See Physicians' Desk Reference 1181-82 (54th ed. 2000).

would have prevented her death; UNMC, on the other hand, presented expert medical testimony that Flolan would have made no difference.

Specifically, Robert's experts testified that Mary's pulmonary arterial hypertension was acute by June 29, 2006, based on the results of her heart catheterization, and that Flolan can be administered as an emergent treatment for acute pulmonary arterial hypertension. Robert adduced expert medical testimony that UNMC's treatment of Mary fell below the relevant standard of care after June 29, because the medical center should have paid for and provided Flolan by July 4 or 5—in other words, that the standard of care for a patient as sick as Mary was to start Flolan and obtain insurance approval afterward.

UNMC's witnesses, on the other hand, testified that Flolan was not effective as an emergent treatment, because it did not work immediately. And they testified that their practice was to wait for insurance approval before beginning Flolan, because most patients are not able to pay for the drug without insurance and it can be more dangerous if treatment is started and then stopped.

The UNMC attending physician during Mary's July 2006 hospitalization, James Murphy, M.D., explained that because Flolan treatment can last for years and require hundreds of thousands of dollars, it was important to make sure the treatment was sustainable before commencing. Thompson testified to "horror stories" about patients who had been forced to discontinue treatment, and he said it would be "irresponsible" not to have lifelong financial support for the drug, because it could be "devastating" if discontinued. Thompson said that the standard of care required such a process. And another of UNMC's experts, William Johnson, M.D., explained that the standard of care required finding some source of payment for a patient, but that if insurance was unavailable, it was still usually possible to find some other payment on a "compassionate need basis" within the 12-week timeframe that Johnson opined was appropriate for treatment of chronic pulmonary arterial hypertension.

Robert moved for a directed verdict on the standard of care, arguing that as a matter of law, insurance coverage cannot

dictate what doctors do. UNMC replied that according to its experts, a continuing source for treatment is something that doctors should consider in determining how treatment is to be administered. Robert's motion was overruled. Robert also asked that the jury be instructed that if the standard of care requires prescription of a drug, it is not a defense to a claim the standard of care has been violated that the drug would not be provided until approved by an insurance carrier. That instruction was refused.

The jury returned a general verdict for UNMC. But Robert filed a motion for new trial that the district court granted. The court explained:

> The evidence offered by [Robert's] expert on the issue of standard of care indicated that after the confirmation of [pulmonary arterial hypertension] by a right heart catheterization, the standard of care required the commencement of FLOLAN therapy. The evidence offered by [UNMC's] expert was basically the same with one major difference. [UNMC's] expert opined that the standard of care required the commencement of FLOLAN therapy after payment approval by the patient's insurance carrier. On cross-examination, [UNMC's] expert conceded that if no outside funds were available to subsidize the treatment to a patient who needed it, then treatment would be provided on a "humanitarian" basis. The substance of this concession was that the treatment was required by the standard of care regardless of how it was to be paid for.
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> This Court is of the opinion that, as a matter of law, a medical standard of care cannot be tied to or controlled by an insurance company or the need for payment. The "bean counters" in an insurance office are not physicians. Medicine cannot reach the point where an insurance company determines the medical standard of care for the treatment of a patient. Nor, can we live in a society where the medical care required is not controlled by the physicians treating the patient. The position advanced by [UNMC's] expert tells us that the standard of care is different for those with money than for those without. This is neither moral nor just. It is wrong.

> This Court cannot determine the basis upon which the jury found in favor of [UNMC]. It could have been on the standard of care issue and it could have been on the causation issue. This Court erred in not directing the jury that the standard of care had not been met by [UNMC]. This error taints the entire verdict of the jury and requires a new trial.

UNMC appeals from the order granting Robert's motion for new trial.[2]

ASSIGNMENT OF ERROR

UNMC assigns that the court erred in granting Robert's motion for new trial.

STANDARD OF REVIEW

[1,2] A motion for new trial is addressed to the discretion of the trial court, whose decision will be upheld in the absence of an abuse of that discretion.[3] But the discretion of a trial court in ruling on a motion for new trial is only the power to apply the statutes and legal principles to all facts of the case; a new trial may be granted only where legal cause exists.[4]

ANALYSIS

It is important, from the outset, to carefully note what issues this appeal does *not* present. This appeal arises against a backdrop of increasing concern about the costs of health care, among health care providers, insurers, government officials, and consumers. That concern has prompted a great deal of discussion, among commentators and in the public arena, about what should be done to control health care costs or to allocate potentially limited resources. As we will explain below, the question presented in this appeal is narrow and does not require us to address the more sweeping issues that are the subject of greater public policy debate. But some discussion of the broader picture will help us clarify what this case is about—or, more precisely, what it is not about.

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[2] See Neb. Rev. Stat. § 25-1315.03 (Reissue 2008).

[3] *Robinson v. Dustrol, Inc.*, 281 Neb. 45, 793 N.W.2d 338 (2011).

[4] *Kant v. Altayar*, 270 Neb. 501, 704 N.W.2d 537 (2005).

In Nebraska, in cases arising (like this one) under the Nebraska Hospital-Medical Liability Act,[5] the standard of reasonable and ordinary care is defined as "that which health care providers, in the same community or in similar communities and engaged in the same or similar lines of work, would ordinarily exercise and devote to the benefit of their patients under like circumstances."[6] That standard is consistent with the general common-law rule and is a so-called unitary, or wealth-blind, standard of care.[7] In other words, the standard of care is found in the customary practices prevailing among reasonable and prudent physicians and must not be compromised simply because the patient cannot afford to pay.[8] That standard of care, however, developed in a world of fee-for-service medicine and persisted while health insurance still primarily provided first-dollar unlimited coverage.[9] Today,

> [h]ealth plans and self-insured corporations are placing increasingly stringent controls on health care resources, thereby limiting physicians' freedom to practice medicine as they see fit. Clinical guidelines have proliferated from a wide variety of sources: managed care organizations, medical subspecialty societies, malpractice insurers, entrepreneurial guideline-writing firms, and others. Each guideline purports to tell physicians the best way to practice. Yet often they conflict with each other, with traditional practice patterns, and with patients' expectations.[10]

But "[b]ecause tort law expects physicians to provide the same standard of care regardless of patients' ability to pay,

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[5] See Neb. Rev. Stat. §§ 44-2801 to 44-2855 (Reissue 2010).

[6] § 44-2810.

[7] See E. Haavi Morreim, *Cost Containment and the Standard of Medical Care*, 75 Cal. L. Rev. 1719 (1987).

[8] See *id*. See, also, John A. Siliciano, *Wealth, Equity, and the Unitary Medical Malpractice Standard*, 77 Va. L. Rev. 439 (1991).

[9] See E. Haavi Morreim, *Stratified Scarcity: Redefining the Standard of Care*, 17 L. Med. & Health Care 356 (1989).

[10] E. Haavi Morreim, *Medicine Meets Resource Limits: Restructuring the Legal Standard of Care*, 59 U. Pitt. L. Rev. 1, 5 (1997).

and because this standard sometimes encompasses costly technologies no longer readily available for the poorest citizens," physicians are "caught in a bind between legal expectations and economic realities."[11] Courts have been accused of being "oblivious to the costs of care, essentially requiring physicians to commandeer resources that may belong to other parties, regardless of whether those other parties owe the patient these resources."[12]

It has been suggested that at a fundamental level, a unitary, wealth-blind standard of care cannot be reconciled with the growth of technology and the stratification of available health care. Custom is increasingly difficult to identify in today's medical marketplace, as resource distinctions produce fragmentation and disintegration.[13] It has also been suggested that maintaining a unitary standard of care disadvantages those who may not be able to pay for health care. Physicians remain free, for the most part, to decline to treat those who cannot pay, and "an outright refusal to treat an indigent patient, in contrast to a decision to treat in a manner inconsistent with the unitary malpractice standard, rarely creates the threat of liability."[14] So, it has been argued that rather than assume the burden of paying for a patient's treatment, or the potential liability of providing some but not all possible care, the unitary standard makes it more likely that "providers will now sidestep the entire problem simply by refusing to accept some, or all, of such patients for treatment."[15]

On the other hand, it has been argued that permitting physicians to make medical decisions based on resource scarcity would compromise the fiduciary relationship between patient and physician, creating a conflict of interest because the

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[11] *Id.* at 4-5.

[12] *Id.* at 4.

[13] See James A. Henderson, Jr. & John A. Siliciano, *Universal Health Care and the Continued Reliance on Custom in Determining Medical Malpractice*, 79 Cornell L. Rev. 1382 (1994).

[14] Siliciano, *supra* note 8 at 457.

[15] *Id.*

patient's well-being would no longer be the physician's focus.[16] The question is how the value judgments inherent in the development of the standard of care might evolve in response to a societal interest in controlling health care costs.[17] It has been explained that a physician's initial value judgment, in treating a patient,

> is made in light of conclusions reached about the likely benefits that services would have had for the plaintiff patient. It involves an evaluation as to whether the services should have been provided given their likely benefits, the risk of iatrogenic harm, and the gravity of the problem experienced by the patient. Normally the value judgment does not involve an explicit consideration of the costs of caring for a patient, although economics are implicitly considered. Physicians do not do everything conceivably possible in caring for a patient—they draw what they consider to be reasonable boundary lines. For example, physicians do not order every diagnostic test available for a patient that requests a physical examination, even though doing so might reveal interesting information. Instead, they order tests which are indicated given the age and physical characteristics of the patient.[18]

A physician's initial value judgment, in other words, is constrained by reason but does not include a societal interest in conserving costs or resources, and certainly does not include weighing the physician's own economic interests.[19]

In short, the traditional ethical norms of the medical profession and the legal demands of the customary standard of care impose significant restrictions on a physician's ability to consider the costs of treatment, despite significant and increasing

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[16] See, Maxwell J. Mehlman, *The Patient-Physician Relationship in an Era of Scarce Resources: Is There a Duty to Treat?*, 25 Conn. L. Rev. 349 (1993); Edward B. Hirshfeld, *Should Ethical and Legal Standards for Physicians Be Changed to Accommodate New Models for Rationing Health Care?*, 140 U. Pa. L. Rev. 1809 (1992).

[17] Hirshfeld, *supra* note 16.

[18] *Id.* at 1835.

[19] See *id.* See, also, Morreim, *supra* note 10.

pressure to contain those costs. Whether the legal standard of care should change to alleviate that conflict, and how it might change, has been the subject of considerable discussion. It has been suggested that the customary standard of care could evolve to permit the denial of marginally beneficial treatment—in other words, when high costs would not be justified by minor expected benefits.[20] Others have suggested that the standard of care should evolve to consider two separate components: (1) a skill component, addressing the skill with which diagnoses are made and treatment is rendered, that would not vary by a patient's financial circumstances and (2) a resource component, addressing deliberate decisions about how much treatment to give a patient, that would vary so as to not demand more of physicians than is reasonable.[21] It has been suggested that physicians should be permitted to rebut the presumption of a unitary standard of care when diminution of care arises by economic necessity instead of negligence.[22] And many have suggested that custom should no longer be the benchmark for the standard of care;[23] instead, practice standards or guidelines could be promulgated that would settle issues of resource allocation.[24]

All of the concerns discussed above are serious, and they present difficult questions that courts will be required to confront in the future. But we do not confront them here, because under the unique facts of this case, they are not presented. Contrary to the district court's belief, this is not a case in

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[20] See Mark A. Hall, *Rationing Health Care at the Bedside*, 69 N.Y.U. L. Rev. 693 (1994).

[21] See, Mark A. Hall, *Paying for What You Get and Getting What You Pay For: Legal Responses to Consumer-Driven Health Care*, 69 Law & Contemp. Probs. 159 (2006); Morreim, *supra* note 10; Morreim, *supra* note 9.

[22] Morreim, *supra* note 7.

[23] See Morreim, *supra* note 10.

[24] See, Daniel W. Shuman, *The Standard of Care in Medical Malpractice Claims, Clinical Practice Guidelines, and Managed Care: Towards a Therapeutic Harmony?*, 34 Cal. W. L. Rev. 99 (1997); Hirshfeld, *supra* note 16; Peter H. Schuck, *Malpractice Liability and the Rationing of Care*, 59 Tex. L. Rev. 1421 (1981). But see Siliciano, *supra* note 8.

which insurance company "bean counters" overrode the medical judgment of a patient's physicians[25] or in which those physicians allowed their medical judgment to be subordinated to a patient's ability to pay for treatment.[26] Nor is this a case in which the parties disputed the cost-effectiveness of the treatment at issue.[27] Rather, UNMC's evidence was that its decision to wait to begin Flolan treatment was not economic—it was a medical decision, based on the health consequences to the patient if the treatment is interrupted.

[3] Whether a medical standard of care can appropriately be premised on such a consideration is a matter of first impression in Nebraska, and the parties have not directed us to (nor are we aware of) any other authority speaking directly to that issue. But as a general matter, we have said that while the identification of the applicable standard of care is a question of law, the ultimate determination of whether a party deviated from the standard of care and was therefore negligent is a question of fact.[28] And it is for the finder of fact to resolve that issue by determining what conduct the standard of care would require under the particular circumstances presented by the evidence and whether the conduct of the alleged tort-feasor conformed with that standard.[29]

Malpractice, as alluded to above, is defined as a health care provider's failure to use the ordinary and reasonable care, skill, and knowledge ordinarily possessed and used under like circumstances by members of his or her profession engaged in a similar practice in his or her or in similar localities.[30] The district court granted a new trial based on its conclusion that UNMC's expert testimony was inconsistent with the standard of care. So the question is whether, as a matter of law, UNMC's

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[25] Compare *Long v. Great West Life & Annuity Ins.*, 957 P.2d 823 (Wyo. 1998).

[26] Compare *Wickline v. State*, 192 Cal. App. 3d 1630, 239 Cal. Rptr. 810 (1986).

[27] Compare *Helling v. Carey*, 83 Wash. 2d 514, 519 P.2d 981 (1974).

[28] *Wilke v. Woodhouse Ford*, 278 Neb. 800, 774 N.W.2d 370 (2009).

[29] *Id.*

[30] § 44-2810.

expert opinion testimony was inconsistent with the standard of care as defined above.

The district court determined that it was. But the district court's reasoning was erroneous in three respects. First, the district court understood Johnson's testimony to concede that "if no outside funds were available to subsidize the treatment to a patient who needed it, then treatment would be provided on a 'humanitarian' basis." The "substance of this concession," the court reasoned, "was that the treatment was required by the standard of care regardless of how it was to be paid for."

But that is not exactly what Johnson said. The import of Johnson's testimony, as revealed by the record, was that if a patient was unable to obtain insurance coverage for Flolan, it was Johnson's practice to try to work with the patient to find another way for the patient to get the drug on a "compassionate need" basis. Johnson's testimony in that regard was about his practice, not the general standard of care. Nor did Johnson testify that the drug would be started regardless—he simply said that if insurance was unavailable, he would try to find another way for the patient to obtain the medication. Nothing in Johnson's testimony is contrary to his basic opinion that the standard of care requires a doctor to make sure that a payment source is in place before beginning Flolan treatment, because of the risks associated with interruption of treatment.

Second, the customary standard of care in this case is defined by statute, and it is not a court's place to contradict the Legislature on a matter of public policy.[31] UNMC's witnesses testified that UNMC's treatment of Mary was consistent with the statutory standard of care—in other words, that health care providers in the same community or in similar communities and engaged in the same or similar lines of work would ordinarily defer Flolan treatment until payment for a continuous supply had been secured. We cannot depart from the customary standard of care on policy grounds, even if it is subject to criticism, because the standard of care is defined by statute and public policy is declared by the Legislature.[32] Robert was, of course,

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[31] See *Wilke, supra* note 28.

[32] See *id.*

free to argue and present evidence that UNMC's experts were wrong when they opined about customary practice. But that was a jury question.

Finally, and more fundamentally, the district court's concerns about health care policy, while understandable, are misplaced in a situation in which the patient's ability to continue to pay for treatment is still a *medical* consideration. In other words, even when the standard of care is limited to medical considerations relevant to the welfare of the patient, and not economic considerations relevant to the welfare of the health care provider,[33] the standard of care articulated by UNMC's witnesses in this case was still consistent with a medical standard of care.

This case does not involve a conflict of interest between the physician and patient—there was no evidence, for instance, of a financial incentive for UNMC's physicians to control costs.[34] As explained by UNMC's witnesses, the decision to defer Flolan treatment was not based on its financial effect on UNMC, or subordinating Mary's well-being to the interests of other patients, or even considering Mary's own financial interest. Instead, when making its initial value judgment regarding Mary's treatment,[35] UNMC's physicians were not weighing the risk to Mary's health against the risk to her pocketbook, or UNMC's budget, or even a general social interest in controlling health care costs. UNMC's physicians were weighing the *risk to Mary's health* of delaying treatment against the *risk to Mary's health* of potentially interrupted treatment. Stated another way, this was not a case in which a physician refused to provide beneficial care—it was a case in which the physicians determined that the care *would not be beneficial* if it was later interrupted. In fact, it could be deadly.

As explained by Murphy, Thompson, and Johnson, the reason for waiting to begin Flolan until after insurance approval

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[33] See, e.g., *Thompson v. Sun City Community Hosp., Inc.*, 141 Ariz. 597, 688 P.2d 605 (1984); *Wilmington Gen. Hospital v. Manlove*, 54 Del. 15, 174 A.2d 135 (1961). Cf. *Creighton-Omaha Regional Health Care Corp. v. Douglas County*, 202 Neb. 686, 277 N.W.2d 64 (1979).

[34] Compare *Shea v. Esensten*, 622 N.W.2d 130 (Minn. App. 2001).

[35] See Hirshfeld, *supra* note 16.

had been obtained was out of concern for the health of the patient. That was not meaningfully different from any number of other circumstances in which a health care provider might have to base a treatment decision upon the individual circumstances of a patient. For instance, a physician with concerns about a particular patient's ability to follow instructions, or report for appropriate followup care, might treat the patient's condition differently in the first instance. And a health care provider who is told that a patient cannot afford a particular treatment may recommend a less expensive but still effective treatment, reasoning that a treatment that is actually used is better than one that is not. These are difficult decisions, and there may be room to disagree, but it is hard to say they are unreasonable as a matter of law, or that an expert cannot testify that such considerations are consistent with the customary standard of care.

And as noted above, Robert's witnesses were free to disagree with UNMC's witnesses; Robert could (and did) argue that the standard of care required more than UNMC's witnesses said it did. And the evidence might have supported the conclusion that given Mary's deteriorating condition, there was little risk in beginning Flolan even without a payment source in place. (Although we note, for the sake of completeness, that Johnson also testified that Mary's weakening condition militated against beginning Flolan on an emergent basis, because its side effects could have been deadly.)

In other words, the jury *could* have found that in this case, given the facts and testimony, the standard of care required Flolan to be administered immediately. But it was a question for the jury, and there was also competent evidence supporting a conclusion that the standard of care had not been breached. The court erred in concluding that it should have directed a verdict on the standard of care. And for that reason, the court abused its discretion in granting Robert's motion for new trial. UNMC's assignment of error has merit.

UNMC's evidence and opinion testimony reflect difficult medical decisions—but still *medical* decisions. Therefore, the scope of our holding is limited. We need not and do not decide whether the standard of care can or should incorporate

considerations such as cost control or allocation of limited resources. Although the decision (or lack thereof) of a third-party payor contributed to the circumstances of this case, UNMC's decisions were still (according to its evidence) premised entirely upon the medical well-being of its patient. In a perfect world, difficult medical decisions like the one at issue in this case would be unnecessary. But we do not live in a perfect world, and we cannot say as a matter of law that UNMC's decisions in this case violated the standard of care.

CONCLUSION

For the foregoing reasons, the district court's order granting Robert's motion for new trial is reversed.

REVERSED.

WRIGHT and STEPHAN, JJ., not participating.

STATE OF NEBRASKA, APPELLEE, V.
ARMON M. DIXON, APPELLANT.
802 N.W.2d 866

Filed September 16, 2011. No. S-10-476.

1. **Venue: Appeal and Error.** An appellate court reviews the denial of a motion to change venue for abuse of discretion.
2. **Venue.** Under Neb. Rev. Stat. § 29-1301 (Reissue 2008), a change of venue is mandated when a defendant cannot receive a fair and impartial trial in the county where the offense was committed.
3. **Venue: Proof.** Unless a defendant claims that the pretrial publicity has been so pervasive and prejudicial that a court should presume the partiality of prospective jurors, a change in venue is evaluated under the following factors: These factors are (1) the nature of the publicity, (2) the degree to which the publicity has circulated throughout the community, (3) the degree to which the publicity circulated in areas to which venue could be changed, (4) the length of time between the dissemination of the publicity complained of and the date of the trial, (5) the care exercised and ease encountered in the selection of the jury, (6) the number of challenges exercised during voir dire, (7) the severity of the offenses charged, and (8) the size of the area from which the venire was drawn.
4. **Venue: Due Process.** Mere exposure to news accounts of a crime does not presumptively deprive a defendant of due process.
5. **Venue: Due Process: Proof.** To warrant a change of venue, a defendant must show the existence of pervasive misleading pretrial publicity. A defendant must show that publicity has made it impossible to secure a fair and impartial jury.