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The Doctor Will See You Now: How the Opioid Crisis Changed the Standard of Care for Physicians in Medical Malpractice Suits

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I. INTRODUCTION

"Every time I take my oxy, as soon as I swallow the water and pills there's this anxiety that just completely dissipates from my mind and body . . . there's this instantaneous relief."[1] This is not a unique reaction: pharmaceutical companies designed drugs like OxyContin to have this effect on patients.[2] These

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1. Feedagoat2169, *Opiates*, REDDIT (Oct. 21, 2019), https://www.reddit.com/r/opiates/comments/dkxbjb/anybody_else_get_this_instantaneous_feeling_of/ (on file with the *University of the Pacific Law Review*).

2. *See* Barry Meier, *Origins of an Epidemic: Purdue Pharma Knew Its Opioids Were Widely Abused*, N.Y. TIMES (May 29, 2018), https://www.nytimes.com/2018/05/29/health/purdue-opioids-oxycontin.html (on

same companies then simultaneously marketed the drugs as safe and effective, with low potentials for abuse.[3] Yet over the past twenty years, these drugs took hold of American society and led to one of the greatest health crises in the nation's history.[4]

Recently, massive lawsuits put the pharmaceutical companies and their actions in the spotlight.[5] Maura Healey, Massachusetts Attorney General, highlighted the national sentiment when she said, "[w]e owe it to families in Massachusetts and across the country to hold Purdue and the Sacklers accountable, ensure the evidence of what they did is made public, and make them pay for the damage they have caused."[6] After years of fraudulent and deceitful behavior, pharmaceutical companies finally are facing their day in court.[7]

When looking at the opioid crisis, many parties potentially warrant blame: big pharma for making the drugs, the government for lacking oversight, and individuals themselves for abusing the drugs.[8] Yet the conversation seemingly ignores one party that might have more fault in perpetuating the epidemic than any other single actor.[9]

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file with the *University of the Pacific Law Review*) (explaining how Purdue Pharma designed OxyContin to have far higher narcotic levels than standard, increasing its pain-killing ability).

3. *See* SAM QUINONES, DREAMLAND 127 (2015) ("One question [that sales reps for Purdue] addressed concerned the risk of addiction to pain patients when treated with narcotics. 'The correct answer was 'less than one percent.'"); *see also* Meier, *supra* note 2 (reflecting on how Purdue Pharma "trained sales representatives to tell doctors that OxyContin was less addictive and prone to abuse than competing opioids").

4. *See* Patrick McGrath, *Legal Strategies Unfold as Opioid Lawsuits Rise*, 16 MASS TORTS LITIG. 15, 16 (2018) (quoting President Trump when he weighed in on the opioid epidemic, calling it the worst public health crisis in American history); *see also* Meier, *supra* note 2 (numbering the death toll from overdoses involving prescription opioids over the past two decades to more than 200,000 people).

5. Nick Castle, Colin Dwyer & Brian Mann, *Not Just Purdue: Big Drug Companies Considering Settlements to Resolve Opioid Suits*, NPR (Aug. 28, 2019, 12:10 PM), https://www.npr.org/2019/08/28/755007841/several-big-drug-companies-considering-massive-settlements-to-resolve-opioid-sui (on file with the *University of the Pacific Law Review*); *see* Nuala Sawyer Bishari, *S.F. Files Lawsuit Against Big Pharma Over Opioid Crisis*, SF WEEKLY (Dec. 20, 2018, 1:16 PM), http://www.sfweekly.com/news/s-f-files-lawsuit-against-big-pharma-over-opioid-crisis/ (on file with the *University of the Pacific Law Review*) (noting that San Francisco joined 1,200 other cities and counties across America that are suing Purdue, McKesson, and other drug manufacturers for their role in the nationwide opioid crisis).

6. Castle, Dwyer & Mann, *supra* note 5.

7. *See id.* (examining the numerous lawsuits big pharmaceutical companies face, including the state case Johnson & Johnson lost in Oklahoma).

8. *See generally* Meier, *supra* note 2 (exploring Purdue Pharma's role in perpetrating the opioid crisis); *see* Jacey Fortin, *D.E.A. Let Opioid Production Surge as Crisis Grew, Justice Dept. Says*, N.Y. TIMES (Oct. 1, 2019), https://www.nytimes.com/2019/10/01/us/dea-opioid-crisis.html (on file with the *University of the Pacific Law Review*) (uncovering how the Drug Enforcement Administration ("D.E.A.") authorized large increases in opioid painkiller production despite the growing number of opioid-related deaths in the United States); *see also* Anna Edney & Lauren Etter, *Quicktake: The Opioid Crisis*, BLOOMBERG (Aug. 26, 2019, 1:28 PM), https://www.bloomberg.com/quicktake/heroin (on file with the *University of the Pacific Law Review*) (explaining how some prescription painkiller addicts turned to heroin, thereby increasing heroin and other synthetic opioid use).

9. *See* Ronald Hirsch, *The Opioid Epidemic: It's Time to Place Blame Where It Belongs*, 114 MO. MED.

Physicians play a unique role in the opioid crisis due to their control over dispensing and prescribing opioid-based drugs to patients.[10] Opioids became popular in pain management for a reason: they treat pain in ways other drugs cannot.[11] For many years, prescribing opioids was more than just the norm; it was essentially a requirement.[12] Yet despite the pervasiveness of the drugs, only a few cases of physicians facing individual liability for prescribing opioids exist.[13]

Rarely is a physician's prescription of opioids negligent.[14] Of course, there are many legitimate circumstances where opioids are the best—and sometimes only—option to treat a patient's pain.[15] However, patients should have the opportunity to hold bad acting physicians liable for their negligent conduct.[16]

Medical malpractice is the most common avenue where patients can recover against physicians for harmful treatment.[17] However, uncertainty remains if medical malpractice law can currently provide the proper remedy to patients in this new and complex age of opioid addiction.[18]

This Comment examines how the opioid crisis changed the standard of care

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82, 82 (2017) (describing physicians as "innocent bystanders" within the opioid crisis).

10. Hirsch, *supra* note 9, at 82; *see* Joanne Finnegan, *Major Chains Including CVS, Walmart Say Physicians–Not Pharmacists–Responsible for Fueling Opioid Crisis*, FIERCEHEALTHCARE (Jan. 8, 2020, 1:24 PM), https://www.fiercehealthcare.com/practices/major-pharmacy-chains-file-lawsuits-saying-physicians-not-pharmacists-are-responsible (on file with the *University of the Pacific Law Review*) ("A prescription for a controlled substance is an order for a medication that may be issued only be a physician or other authorized healthcare practitioner.").

11. *See* Marilyn Serafini, *The Physicians' Quandry with Opioids: Pain Versus Addiction*, NEJM CATALYST (Apr. 26, 2018), https://catalyst.nejm.org/quandary-opioids-chronic-pain-addiction/ (on file with the *University of the Pacific Law Review*) (highlighting a patient's success story of using opioids to treat her chronic pain that other non-opioid prescription drugs could not treat).

12. Sarah Kliff, *The Opioid Crisis Changed How Doctors Think About Pain*, VOX (June 5, 2017, 6:30 AM), https://www.vox.com/2017/6/5/15111936/opioid-crisis-pain-west-virginia (on file with the *University of the Pacific Law Review*).

13. *See generally* Koon v. Walden, 539 S.W.3d 752 (Mo. Ct. App. 2017) (finding a physician liable for his negligent prescribing patterns); *see generally* County Com'n of McDowell County v. McKesson Corp., 362 F. Supp. 3d 639 (S.D.W. Va. 2017) (alleging that a doctor provided written opioids prescriptions for patients, despite knowing that the drugs were likely abused, diverted, or misused).

14. *See* David Studdert, et al., *Changes in Practice Among Physicians with Malpractice Claims*, 380 NEW ENG. J. MED. 1247, 1248 (2019) ("A small group of physicians accounts for a disproportionately large share of all malpractice claims and patient complaints.").

15. *See* Will Stone, *Patients with Chronic Pain Feel Caught in an Opioid-Prescribing Debate*, HEALTHLEADERS (Aug. 1, 2018), https://www.healthleadersmedia.com/clinical-care/patients-chronic-pain-feel-caught-opioid-prescribing-debate (on file with the *University of the Pacific Law Review*) (explaining how Arizona's law on opioid prescribing limits exempts cancer, trauma, end-of-life, and other serious cases from the prescribing limits because of the necessity of these drugs for those situations).

16. *Infra* Part IV.

17. *See What is Medical Malpractice?*, AM. BOARD OF PROF. LIABILITY ATT'YS, https://www.abpla.org/what-is-malpractice (last visited Jan. 7, 2020) (on file with the *University of the Pacific Law Review*) (listing the different types of physician malpractice that can lead to patient recovery, including "failure to diagnose or misdiagnosis", "improper medication or dosage", "poor follow-up or aftercare", "failure to recognize symptoms", or "disregarding or not taking appropriate patient history.").

18. Telephone Interview with Kellen Galster, Emergency Room Physician, Kaiser Permanente (Jan. 7, 2020) (notes on file with the *University of the Pacific Law Review*).

in medical malpractice cases and ultimately proposes a new standard that courts should apply.[19] Because of the drugs' unique background and role in the medical community, using the initial physician prescription of opioids as the only metric to determine physician liability is deficient.[20] Only considering the prescription as the liability producing conduct fails to account for the inherent complexity of these cases.[21] Instead, when determining potential medical malpractice liability for treating a patient with opioids, this new standard of care considers the physician's conduct during the entirety of the physician–patient interaction.[22] Examining the interaction as a whole promotes both better physician conduct and patient well-being because it allows for advantageous use of opioids and ensures certain patients have access to opioid treatments they need.[23]

This Comment begins by providing an overview of the opioid crisis in America from its background to why physicians still treat patients with opioids.[24] It then examines physician liability in general and what the traditional medical malpractice case entails.[25] Next, it explores what should make up the relevant standard of care in a case involving physician misconduct in connection with opioids.[26] Finally, it proposes a new standard of care based on the relevant information available to a physician and best practices of prescribing opioids for courts to utilize in these cases.[27] Such decisions based on this information and context of the opioid crisis can promote conscious prescribing and safer patient treatment.[28]

II. OPIOIDS IN AMERICA

The story of opioids in America is one of pain and how Americans tried to treat it.[29] Since their modern introduction into the medical community roughly thirty years ago, opioids have become one of the deadliest parts of American society.[30] Section A explains the basics behind the unique scientific makeup of

19. *Infra* Part IV.
20. *Infra* Part IV.
21. *Infra* Part IV.
22. *Infra* Part IV.
23. *Infra* Part IV.
24. *Infra* Part II.
25. *Infra* Part III.
26. *Infra* Part IV.
27. *Infra* Part IV.
28. *Infra* Part IV.
29. EJ Dickson, *How the Opioid Epidemic Became a Uniquely American Problem*, THE ROLLING STONE (Apr. 4, 2019, 3:50 PM), https://www.rollingstone.com/culture/culture-features/opioid-epidemic-american-problem-817756/ (on file with the *University of the Pacific Law Review*).
30. *See* Lilly Dancyger, *Americans Now More Likely to Die From Opioids Than Car Crashes*, THE ROLLING STONE (Jan. 15, 2019, 3:57 PM), https://www.rollingstone.com/culture/culture-news/opioid-od-kill-more-than-car-accidents-779489/ (on file with the *University of the Pacific Law Review*) (summarizing a report

opioid drugs.[31] Section B provides insight on the history of opioids and the current opioid epidemic in America.[32] Section C explores how and why physicians use opioids to treat patients.[33]

A. What are opioids?

English physician Thomas Sydenham noted in 1680 that "[a]mong the remedies which it has pleased almighty God to give to man to relieve his sufferings, none is so universal and so efficacious as opium."[34] Opium comes directly from the inner bulb of a mature poppy plant.[35] For centuries, civilizations hailed opium's immense power to soothe pain and induce sleepiness.[36] From this opium, scientists developed the opioid-based medications.[37]

Opioids are "seductively powerful."[38] The drugs' seductiveness relates to how they chemically react once in the body.[39] Opioid medications work by binding to receptors located in the brain and spinal cord.[40] These receptors produce pleasure sensations when they interact with endorphins.[41] David Juurlink, a specialist with the Sunnybrook Research Institute, compared opioids to "the key" and the receptors in the brain to "a lock."[42] "The key enters the lock and changes it."[43]

Prescription opioid medications contain potency similar to heroin.[44] Over time, patients can develop a tolerance to opioid-based medications and require higher dosages to achieve the same amount of pain relief.[45] Such tolerance—combined with dependence—can lead prescription opioid users to begin using

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from the National Safety Council, which found that "Americans are more likely to die from an opioid overdose than in a car accident.").

31. *Infra* Section II.A.

32. *Infra* Section II.B.

33. *Infra* Section II.C.

34. Tuan Trang, et al., *Pain and Poppies: The Good, the Bad, and the Ugly of Opioids Analgesics*, 35 J. OF NEUROSCIENCE 13879, 13885 (2015).

35. QUINONES, *supra* note 3, at 38.

36. *See* QUINONES, *supra* note 3, at 52 (listing the various civilizations that cultivated poppies and extracted opium from them, including the Sumerians the ancient Egyptians, Greeks, and Venetians).

37. *What are Opioids?*, JOHNS HOPKINS MED., https://www.hopkinsmedicine.org/opioids/what-are-opioids.html (last visited Dec. 28, 2019) (on file with the *University of the Pacific Law Review*); James Hamblin, *The Opioid Reckoning Will Not Be Just*, THE ATLANTIC (Aug. 29, 2019), https://www.theatlantic.com/health/archive/2019/08/opioid-justice/597064/ (on file with the *University of the Pacific Law Review*).

38. Kliff, *supra* note 12.

39. *Id.*

40. *Id.*

41. QUINONES, *supra* note 3, at 38.

42. Kliff, *supra* note 12.

43. *Id.*

44. *See* QUINONES, *supra* note 3, at 124 ("Molecularly, oxycodone is similar to heroin."); Hamblin, *supra* note 37.

45. Kliff, *supra* note 12; JOHNS HOPKINS MED., *supra* note 37.

heroin.[46] A National Institute of Drug Abuse study revealed that between 2008 and 2009, 86% of heroin users once used opioid pain relievers before using heroin.[47] Thus, many question why medical professionals employ such toxic and addictive drugs in their treatments.[48]

B. Opioids: From Past to Present

Commentators agree that "[t]he scale of America's opioid epidemic is shocking."[49] Physicians knew of the extreme power these drugs had to treat pain since the early 1900s.[50] Yet it was not until the 1990s that the use of opioid medications drastically increased.[51] Two primary factors drove this increase: the medical profession's campaign to treat patient pain and the vigorous marketing of OxyContin by Purdue Pharma.[52] In roughly the decade following the emergence of these factors, the Centers for Disease Control and Prevention ("CDC") noted a fourfold rise in prescription-related opioid overdose fatalities.[53]

Beginning with the campaign to treat patient pain, physicians learned that pain was "the fifth vital sign," and that they had to keep pain "well controlled."[54]

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46. *See* QUINONES, *supra* note 3, at 192 (describing the cycle of how addicts turn to cheaper street drugs like heroin after their tolerance to prescription opioids such as OxyContin builds up and such prescription drugs can no longer provide the relief they seek); *Prescription Opioids and Heroin*, NAT'L INST. OF DRUG ABUSE, https://d14rmgtrwzf5a.cloudfront.net/sites/default/files/rx_and_heroin_rrs_layout_final.pdf (last visited Dec. 29, 2019) (on file with the *University of the Pacific Law Review*).

47. NAT'L INST. OF DRUG ABUSE, *supra* note 46.

48. *See* QUINONES, *supra* note 3, at 125 ("[N]o one had imagined that a pill containing a drug similar to heroin would be marketed almost like an over-the-counter drug."); *see also* Dave Chase, *Industry Voices – We Still Need to Convince Doctors to Stop Prescribing So Many Opioids*, FIERCE HEALTHCARE (Sept. 14, 2018, 12:15 AM), https://www.fiercehealthcare.com/hospitals-health-systems/industry-voices-we-still-need-to-convince-doctors-to-stop-prescribing-so (on file with the *University of the Pacific Law Review*) ("So why is the country still facing epidemic proportions of opioid addiction and death?").

49. *See* THE NAT'L ACADS. OF SCIENCES, ENG'G, AND MED., PAIN MANAGEMENT AND THE OPIOID EPIDEMIC: BALANCING SOCIETAL AND INDIVIDUAL BENEFITS AND RISKS OF PRESCRIPTION OPIOID USE 17 (2017) ("Drug overdose, driven primarily by opioids, is now the leading cause of unintentional injury death in the United States."); *see also* Lawrence Lewis, et al., *The Opioid Crisis in Missouri: A Call to Action for Physicians, Legislators, and Society*, 114 MO. MED. 440, 440 (2017) (noting that deaths due to opioid overdose increased in the past 15 years over 400%); German Lopez, *How to Stop the Deadliest Drug Overdose Crisis in American History*, VOX (Dec. 21, 2017, 10:00 AM), https://www.vox.com/science-and-health/2017/8/1/15746780/opioid-epidemic-end (on file with the *University of the Pacific Law Review*).

50. *See* Dickson, *supra* note 29 (noting how physicians in the early 1900s recognized the deadliness of opium after patients died from morphine overdoses).

51. Salley Satel, *The Truth About Painkiller Addiction*, THE ATLANTIC (Aug. 4, 2019), https://www.theatlantic.com/ideas/archive/2019/08/what-america-got-wrong-about-opioid-crisis/595090/ (on file with the *University of the Pacific Law Review*).

52. *Id.*

53. *Id.*

54. Hamblin, *supra* note 37; *see* Kliff, *supra* note 12 (noting that neurosurgeon James Campbell argued for a change in pain management at the 1996 American Pain Society annual conference, saying that "[i]f pain were assessed with the same zeal as other vital signs are, it would have a much better chance of being treated properly . . . [w]e need to train doctors and nurses to treat pain as a vital sign.").

There was a stigma in the medical community that if a physician did not treat patients with opioids, the physician did something wrong.[55] Physicians had to do more than just treat pain—they had to cure it.[56] This focused their treatment solely on pain, while ignoring the potential for a patient to develop a tolerance or addiction to the drugs.[57]

Powerful commercial opioid painkillers emerged as the medical profession's focus on pain increased.[58] The drugs offered the level of relief both patients in severe pain and physicians sought.[59] Drug manufacturers took note, and, as the medical community pursued more aggressive pain treatment, companies like Purdue Pharma released drugs such as OxyContin into the market.[60]

The timing of the confluence of these two factors led to a perfect storm of over-prescription.[61] In an effort to fully treat pain, physicians gradually prescribed patients more opioid medications.[62] Treating patients with opioid medications "was no longer a controversial opinion in America."[63] Physicians could treat patient pain like they never could before, and patients now had hope they could live pain free.[64]

C. Physicians and Opioids

Physicians, at their most basic level, have an obligation to treat patient pain, and opioids remain one of the most effective medications physicians can use to fulfill this obligation.[65] Opioids relieve pain almost like no other drug—so much so that they inherited the name the "medicine of the gods."[66] Section 1 looks to the medical uses for opioid drugs.[67] Section 2 then examines the modern trends in

55. Hamblin, *supra* note 37; Kliff, *supra* note 12.

56. Kliff, *supra* note 12.

57. Hamblin, *supra* note 37.

58. *See* QUINONES, *supra* note 3, at 84 ("In 1984 Purdue Frederick . . . released MS Contin . . . for cancer and postoperative patients."); Kliff, *supra* note 12.

59. *See* Kliff, *supra* note 12 ("There was a push that we had to get pain to zero . . . Hydrocodone worked well at that – too well, because patients became addicted, and kept needing more and more to control their pain.").

60. *Id.*

61. *See* Mark R. Jones, et al., *A Brief History of the Opioid Epidemic and Strategies for Pain Medicine*, 7 PAIN AND THERAPY 13, 15–16 (2018) (describing the confluence of the influential "pain as the fifth vital sign" campaign and the massive push from companies like Purdue Pharma about the benefits of these drugs).

62. *See* QUINONES, *supra* note 3, at 84–85 (highlighting how physicians responded to these drugs by using them to treat almost any ailment they came across and "began treating more patients with this kind of pain control."); *see also* Jones, et al., *supra* note 61, at 16 (listing the climbing numbers of opioid consumption in the United States from 46,946 kg in 2000 to 165,525 kg in 2012).

63. QUINONES, *supra* note 3, at 85.

64. *Id.*

65. Kelly K. Dineen & James M. DuBois, *Between a Rock and a Hard Place: Can Physicians Prescribe Opioids to Treat Pain Adequately While Avoiding Legal Sanction?*, 42 AM. J. LAW MED. 7, 8 (2016).

66. Walter Ling, *Prescription Opioid Addiction and Chronic Pain: More than a Feeling*, 173 DRUG AND ALCOHOL DEPENDENCE 73, 74 (2017).

67. *Infra* Section II.C.1.

prescribing an opioid-based treatment.[68]

1. Medicinal Benefits of Opioids

Physicians traditionally prescribe opioids to patients with chronic pain, which is pain lasting more than three to six months.[69] Non-cancer chronic pain is one of the most prevalent and incapacitating medical conditions in the United States.[70] For patients suffering with diseases such as multiple sclerosis, arthritis, or chronic migraines, opioids offer real relief from debilitating pain.[71]

Physicians also commonly prescribe opioids for severe, acute pain, occurring, for example, after surgery.[72] Depending on the severity of the pain and its inception, the actual drug prescribed and its respective dosage can vary.[73] In either situation, opioids remain "quintessential drugs in a physician's pharmacological toolbox."[74]

Addiction is a risk among all patients, regardless of whether the treatment is short or long term.[75] Most patients, though, do not form a physical dependence or an addiction from exposure to opioids.[76] This health risk is of low frequency, but high danger.[77] Yet even despite the low frequency of opioid addiction, addiction

68. *Infra* Section II.C.2.

69. Ling, *supra* note 66, at 74.

70. Nora Volkow & Thomas McLellan, *Opioid Abuse in Chronic Pain – Misconceptions and Mitigation Strategies*, 374 NEW ENG. J. MED. 1253, 1253 (2016).

71. *See* Martha Cornell & Anthony Guarino, *Opioids as a Treatment for MS Patients with Chronic Pain*, 7 INT'L J. OF MS CARE 10, 10 (2005) (explaining how opioids can be "powerful and potentially effective pain" treatment for patients suffering from multiple sclerosis); Trang, et al., *supra* note 34, at 13879–80.

72. *See* THE NAT'L ACADS. OF SCI., ENG'G, AND MED., *supra* note 49, at 53 ("Opioids have long been used successfully to treat acute postsurgical and postprocedural pain."); Harvard Women's Health Watch, *When Are Opioids Safe to Take?*, HARVARD HEALTH PUBLISHING (Mar. 2015), https://www.health.harvard.edu/pain/when-are-opioids-safe-to-take (on file with the *University of the Pacific Law Review*).

73. *See* Harvard Women's Health Watch, *supra* note 72 (describing how patients "may need the drugs only for two or three days" or longer, depending on the operation and pain level).

74. Trang, et al., *supra* note 34, at 13879.

75. *See* THE NAT'L ACADS. OF SCI., ENG'G, AND MED., *supra* note 49, at 55 (examining how studies show tolerance can build up in both patients on short-and long-term treatments).

76. *See* THE NAT'L ACADS. OF SCI., ENG'G, AND MED., *supra* note 49, at 210 ("It is important to acknowledge that an overwhelming majority of people who use prescription opioids do not continue to use them chronically."); *see also* Volkow & McLellan, *supra* note 70, at 1255–57 (defining physical dependence as an individual's repeated administration of opioid drugs that will "inevitably" result in development of tolerance and physical dependence through the body getting used to the drug's effects; and defining addiction as something that develops slowly over a period of months of exposure that produce such effects as "prolonged craving for the drug, obsessive thinking about the drug, erosion of inhibitory control over efforts to refrain from drug use, and compulsive drug taking.").

77. *See* QUINONES, *supra* note 3, at 191 (totaling OxyContin abusers to 6.1 million people, which is roughly 2.4% of the American population); Volkow & McLellan, *supra* note 70, at 1256; *see also* Greg Amer, *Why Some People Become Addicted to Opioids While Others Don't*, FAIRVIEW (Dec. 21, 2017), https://www.fairview.org/Blog/Why-Some-People-Become-Addicted-to-Opioids-While-Others-Dont (on file

will always remain a risk because of the chemical nature of opioids, and it is unlikely that any single behavior change can alleviate that risk.[78]

Opioids are unique in the narcotics world.[79] Unlike street drugs, the government supervises and controls opioid distribution under the veil of the prescribing medical professionals.[80] The pills do not originate on the street but rather come from a doctor's hands by way of a prescription.[81] This puts physicians in a unique position to fight the opioid crisis on a more personal level.[82]

2. Modern Trends in Opioid Treatment

Medical professionals are moving away from emphasizing the prominent role pain management had in the early 2000s.[83] In November 2015, two physicians reiterated this trend, stating that "[i]f you focus on just pain intensity, the tendency is just to use opioids, because opioids are the only thing that will reduce pain so immediately."[84] The measure of good patient treatment is not whether pain disappears, but rather it is getting people back to the activities that pain once prevented.[85]

This was a controversial viewpoint at the time, especially because it potentially created the risk of improper treatment.[86] Eventually the viewpoint caught on and the American Medical Association voted to denounce the use of pain as a vital sign, significantly altering the profession's focus.[87] The CDC

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with the *University of the Pacific Law Review*) (explaining how someone's genetic makeup likely explains how addiction impacts humans differently, which helps explain why only 10–15% of the American population struggles with addiction issues).

78. Volkow & McLellan, *supra* note 70, at 1257.

79. Hamblin, *supra* note 37.

80. *See* THE NAT'L ACADS. OF SCI., ENG'G, AND MED., *supra* note 49, at 25 ("[M]ost other prescription opioids are not regulated under the Controlled Substances Act (CSA) of 1970 as Schedule II drugs–those with a 'high potential for abuse which may lead to severe psychological or physical dependence.'"); Hamblin, *supra* note 37.

81. Hamblin, *supra* note 37.

82. *See* QUINONES, *supra* note 3, at 189 (speaking to all the ailments physicians used to prescribe opioids for and could potentially refrain from prescribing opioids for in the future).

83. *See* Kliff, *supra* note 12 (describing how doctors are now concerned with overtreating pain).

84. *Id.*

85. Jane Ballantyne & Mark Sullivan, *Intensity of Chronic Pain–The Wrong Metric?*, 373 NEW ENG. J. MED. 2098, 2099 (2015).

86. *See* Kliff, *supra* note 12 (listing the criticism the physicians received from this article, including one commentator arguing that "thinking about pain in this way would 'result in human misery on a massive scale.'").

87. Joyce Frieden, *Remove Pain as 5th Vital Sign, AMA Urged*, MEDPAGE TODAY (June 13, 2016), https://www.medpagetoday.com/meetingcoverage/ama/58486 (on file with the *University of the Pacific Law Review*); *see Vital Signs (Body Temperature, Pulse Rate, Respiration Rate, Blood Pressure)*, JOHNS HOPKINS MED., https://www.hopkinsmedicine.org/health/conditions-and-diseases/vital-signs-body-temperature-pulse-rate-respiration-rate-blood-pressure (last visited Dec. 29, 2019) (on file with the *University of the Pacific Law Review*) (defining vital signs as "measurements of the body's most basic functions", including body temperature, pulse, breathing rate, and blood pressure); *see also* Kliff, *supra* note 12 ("the notion of 'pain as the

followed suit shortly afterwards, issuing conservative guidelines for prescribing opioids to patients with chronic pain.[88]

Overall, prescribing numbers are down, causing some to think the tide is turning on the country's battle against opioid addiction.[89] Yet this move away from emphasizing pain management presents a troubling situation for those with chronic pain who potentially cannot obtain the treatment they need.[90]

Opioids are "the most rapidly effective drugs for relieving pain."[91] In addition to not providing patients with potentially life-saving drugs, ending opioid treatment or rapidly decreasing dosages can have dangerous consequences.[92] In April 2019, the CDC and the U.S. Food and Drug Administration ("FDA") clarified that stopping opioid treatment altogether "can result in severe opioid withdrawal symptoms" and can lead patients to "seek other sources of opioids."[93] Reducing access to prescription medication could lead a patient to use other drugs, such as heroin or fentanyl, to achieve the pain relief he or she seeks.[94] Not focusing on providing other forms of treatment and simply cutting off access to opioid painkillers does not solve America's opioid crisis.[95]

Imposing potential liability for merely prescribing opioids leaves certain patients without any options for relief at all because it could cut off access to the drugs altogether.[96] Completely eliminating opioid painkillers is not the answer as they still provide a plethora of medicinal benefits.[97] The answer lies in taking this information and creating a legal standard to encourage better practices and safer use of the drugs as a whole.[98]

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fifth vital sign' . . . although intended to promote pain assessment and effective treatment, in general contributed to an increase in opioid prescribing.").

88. THE NAT'L ACADS. OF SCI., ENG'G, AND MED., *supra* note 49, at 35–36.

89. *See* THE NAT'L ACADS. OF SCI., ENG'G, AND MED., *supra* note 49, at 51 ("There are indications that opioid prescribing is decreasing."); Satel, *supra* note 51.

90. *See* Kliff, *supra* note 12 (noting one patient's comment on the article: "Why, with chronic pain disease, would we not treat the pain??").

91. Ballantyne & Sullivan, *supra* note 85, at 2098.

92. Keith A. Reynolds, *Opioid Crisis Fallout: Physicians Increasingly Avoid Treating Chronic Pain Patients, Survey Finds*, MED. ECON. (Nov. 6, 2019), https://www.medicaleconomics.com/news/opioid-crisis-fallout-physicians-increasingly-avoid-treating-chronic-pain-patients-survey-finds (on file with the *University of the Pacific Law Review*).

93. *Id.*

94. *See* QUINONES, *supra* note 3, at 269 (recalling how all of the addicts a physician working in a drug treatment center sees started using OxyContin before moving to heroin or other drugs); Stephen Gelfand, *The Perils of Pain Meds Revisited*, THE RHEUMATOLOGIST (Dec. 18, 2018), https://www.the-rheumatologist.org/article/the-perils-of-pain-meds-revisited/?singlepage=1&theme=print-friendly (on file with the *University of the Pacific Law Review*).

95. Gelfand, *supra* note 94.

96. *See* Trang, et al., *supra* note 34, at 13879 (mentioning the powerful treatment powers that opioids have for those patients with chronic pain or severe, acute pain).

97. Telephone Interview with Kellen Galster, *supra* note 18.

98. Telephone Interview with Kellen Galster, *supra* note 18; *see Infra* Section IV.C (identifying the

III. MEDICAL MALPRACTICE LIABILITY

Due to the inherent risks of their profession, physicians face various types of liability.[99] The most traditional form of liability physicians face is medical malpractice—when a physician, hospital, or medical professional's negligent act or omission causes patient injury.[100] Medical malpractice liability theoretically promotes good acting physicians while deterring bad actors.[101] However, such liability can also increase the risk that well-intentioned physicians will compromise patient well-being to reduce their own risk of liability.[102] Section A looks to the elements of a medical malpractice case.[103] Section B then examines the potential issues with medical malpractice liability.[104]

A. Medical Malpractice: The Claim

To establish a prima facie case for medical malpractice, the plaintiff must meet certain elements.[105] First, the plaintiff must show the physician owed the patient a duty.[106] This duty is intrinsic in the nature of the relationship that begins when a physician examines and treats a patient.[107] A physician has the duty to provide "competent, compassionate, and economically prudent care" that is in the best interest of the patient.[108] "Mutual trust" is the foundation of the patient–

optimal standard of care to address liability during the opioid crisis).

99. *See generally* Rebeccha L. Haffajee, Marc R. Larochelle & Y. Tony Yang, *Managing Increasing Liability Risks Related to Opioid Prescribing*, 130 AM. J. OF MED. 249 (2017) (describing the different types of liabilities physicians face, including civil, criminal, and administrative liability from respective state medical boards).

100. Haffajee, Larochelle & Yang, *supra* note 99, at 249; AM. BOARD OF PROF. LIABILITY ATT'YS, *supra* note 17.

101. *See* Daniel P. Kessler, *The Effects of Liability Rules on Medical Malpractice*, THE NAT'L BUREAU OF ECON. RES., https://www.nber.org/reporter/winter00/kessler.html (last visited Mar. 5, 2020) (on file with the *University of the Pacific Law Review*) (listing deterrence of bad faith physician conduct as one of the social goals of medical malpractice liability).

102. Haffajee, Larochelle & Yang, *supra* note 99, at 249.

103. *Infra* Section III.A.

104. *Infra* Section III.B.

105. *See* Guerra v. Advanced Pain Ctrs. S.C., 122 N.E.3d 345, 351 (Ill. App. Ct. 2018) ("To succeed on a medical malpractice claim, the plaintiff must prove (i) the standard of care a medical provider should have followed, (ii) the defendant failed to meet the standard of care, and (iii) the plaintiff's injuries were proximately caused by the defendant's failure to meet the standard of care.").

106. Sonny Bal, *An Introduction to Medical Malpractice in the United States*, 467 CLINICAL ORTHOPAEDICS RELATED RES. 339, 339 (2009).

107. *See* Valarie Blake, *When Is a Patient-Physician Relationship Established?*, AMA J. OF ETHICS (May 2012), https://journalofethics.ama-assn.org/article/when-patient-physician-relationship-established/2012-05 (on file with the *University of the Pacific Law Review*) ("Once the physician consensually enters into a relationship with a patient in any of these ways, a legal contract is formed in which the physician owes a duty to that patient to continue to treat or properly terminate the relationship.").

108. *The Physician-Patient Relationship*, N.C. MED. BOARD (July 1995), https://www.ncmedboard.org/resources-information/professional-resources/laws-rules-position-statements/position-statements/print/the_physician-patient_relationship (on file with the *University of the*

physician relationship.[109] A patient likely can prove this element with ease by simply showing that the physician treated the patient.[110]

Second, the plaintiff must show the standard level of care that reasonably prudent physicians in good standing in the relevant medical community would provide.[111] Evidence as to the degree of care and skill the medical community requires of the physician comes mainly from expert testimony that establishes the relevant standard of care.[112]

Courts require a member of the profession that either practices in that medical field or is sufficiently familiar with it to explain what a physician should do or refrain from doing under the particular circumstances.[113] This testimony ultimately aids the fact-finder in determining whether the physician's conduct constitutes negligence, i.e., if the physician's conduct falls below the professional standard of care.[114] To help the fact-finder better make this decision, expert witnesses describe complicated medical terms and concepts.[115] States almost universally require expert witness testimony to set the standard of care because of the complexity associated with these cases.[116]

Courts also look to a second basis for the standard of care when deciding whether the physician-defendant conformed with the customary practices of the profession.[117] This approach looks to the actual practices within the medical profession instead of hypothetical practices that the reasonably prudent physician standard looks to.[118] If there are multiple acceptable customary practices, physicians need to only follow one to stay within the standard of care.[119]

While this rule may allow for more real-world consideration, it fails to account for experimental treatments or situations where a physician's best

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Pacific Law Review).

109. *Id.*

110. Bal, *supra* note 106, at 342.

111. Winkjer v. Herr, 277 N.W.2d 579, 583–84 (N.D. 1979); *see* Bal, *supra* note 106, at 342 ("[T]he standard of care generally refers to that care which a reasonable, similarly situated professional would have provided to that patient.").

112. Winkjer, 277 N.W.2d at 585.

113. Sonny Bal, *The Expert Witness in Medical Malpractice Litigation*, 467 CLINICAL ORTHOPAEDICS RELATED RES. 383, 383 (2009).

114. *Id.*

115. Anjelica Cappellino, *The Standard of Care for Medical Malpractice: What You Need to Know*, THE EXPERT INST. (Feb. 8, 2018), https://www.theexpertinstitute.com/standard-care-medical-malpractice-need-know/ (on file with the *University of the Pacific Law Review*).

116. Bal, *supra* note 113, at 383; *see* Cappellino, *supra* note 115 (describing how in New York, attorneys must consult with an expert physician witness in order to bring a medical malpractice action); Heather Morton, *Medical Liability/Malpractice Merit Affidavits and Expert Witnesses*, NAT'L CONF. OF ST. LEGIS. (June 24, 2014), https://www.ncsl.org/research/financial-services-and-commerce/medical-liability-malpractice-merit-affidavits-and-expert-witnesses.aspx (on file with the *University of the Pacific Law Review*).

117. Philip G. Peters, Jr., *The Quiet Demise of Deference to Custom: Malpractice Law at the Millennium*, 57 WASH. AND LEE L. REV. 163, 165 (2000).

118. *Id.* at 166.

119. *Id.*

judgment falls outside the custom.[120] It also might not promote the best physician conduct because medically accepted practices do not always equate to medically preferred practices.[121] In areas where there are multiple accepted customs, injured plaintiffs must then prove the defendant's conduct fell outside all customary practices, which plaintiffs potentially could not do.[122] Many states are moving away from the customs-based approach because of the uncertainty it presents in every medical malpractice situation.[123]

Third, the plaintiff must establish that the physician's conduct breached the duty of care by falling below the relevant standard of care.[124] A breach of the physician's duty can take many forms: injuries from a misdiagnosis, errors in choice or execution of medical procedures, or improper administration of medications.[125] Courts judge the physician's actual conduct against the relevant standard of care to determine if the conduct fell below that level of acceptable care.[126]

Fourth, the plaintiff must prove two forms of causation: but-for causation and legal, or proximate, causation.[127] When proving but-for causation, the plaintiff must establish a direct relationship between the alleged misconduct and the subsequent injury.[128] The common legal way of phrasing this is but for the misconduct, there would be no patient injury.[129]

The other form of causation—proximate causation—is a question of legal sufficiency.[130] "Legal cause is a question of foreseeability and whether the injury is of a type that a reasonable person would see as a likely result of his or her conduct."[131] Proximate causation ensures that defendants are not liable for acts or

120. *Id.* at 166–67.

121. *See generally* Helling v. Carey, 83 Wash. 2d 514 (1974) (finding a physician-defendant negligent in not performing glaucoma test because it was the reasonable and most medically prudent course of conduct even though performing such tests was not a customary practice in the relevant community); Peters, Jr., *supra* note 117, at 168.

122. Peters, Jr., *supra* note 117, at 168.

123. *Id.* at 170.

124. Joseph Kass & Rachel Rose, *Medical Malpractice Reform: Historical Approaches, Alternative Models, and Communication and Resolution Programs*, 18 AMA J. OF ETHICS 299, 299 (2016).

125. *Id.*

126. Bal, *supra* note 106, at 342.

127. Bal, *supra* note 106, at 342; *But-for Test*, CORNELL L. SCH. LEGAL INFO. INST., https://www.law.cornell.edu/wex/but-for_test (last visited Jan. 20, 2020) (on file with the *University of the Pacific Law Review*).

128. Bal, *supra* note 106, at 342.

129. CORNELL L. SCH. LEGAL INFO. INST., *supra* note 127; *see Proximate Causation (Medical Malpractice)*, CHAPMAN L. GROUP, https://www.chapmanlawgroup.com/practice_areas/proximatecause/ (last visited Jan. 24, 2020) (on file with the *University of the Pacific Law Review*) ("But for the fact that you turned off the oxygen, the patient would not have died. This is a cause and effect way of saying your action of turning off the oxygen caused the death.").

130. CHAPMAN L. GROUP, *supra* note 129.

131. Martinelli v. City of Chicago, 989 N.E.2d 702, 710 (Ill. App. Ct. 2013); *see* James M. Varga, *Pitfalls in Proving Proximate Cause*, 105 ILL. B.J. 44, 46 (2017) ("Essentially, 'legal cause' is a question of foreseeability: whether the injury is one a reasonable person would see as a likely result of his or her conduct

omissions they should not have reasonably thought would cause harm.[132] To establish a prima facie case for medical malpractice, the plaintiff must show both forms of causation.[133]

Finally, the prior elements must culminate in actual harm to the patient measured through a calculation and showing of damages.[134] Even if the plaintiff can meet the other elements of the claim, without a showing of actual patient harm and subsequent damages, "a plaintiff cannot maintain a cause of action for medical negligence."[135]

B. Medical Malpractice: The Good, the Bad, and the Ugly

A bad result itself does not allow a finding of malpractice.[136] If the physician's treatment of the patient meets the applicable standards of care and skill, there is no medical malpractice liability on part of the physician.[137] This is because courts do not judge the medical result itself, but rather the physician's conduct and the methodology employed during treatment.[138] If courts just looked at patient injury, medical malpractice would be a strict liability standard, only considering one aspect of an overall claim without considering any underlying fault.[139]

Applying this to treatment with opioid-based medications, if the patient's treatment satisfies the applicable standard of care, even an injurious result cannot warrant a liability finding.[140] This uncertainty highlights the importance of creating a legal standard that protects physicians who act in their patient's best interest even when an injury results from the treatment.[141]

. . . whether the defendant reasonably could have seen the injury as a likely result of his or her conduct.").

132. *Proximate Cause*, N.Y. CITY B. LEGAL REFERRAL SERV., https://www.nycbar.org/get-legal-help/article/personal-injury-and-accidents/proximate-cause/ (last visited Jan. 21, 2020) (on file with the *University of the Pacific Law Review*).

133. CHAPMAN L. GROUP, *supra* note 129.

134. Bal, *supra* note 106, at 342.

135. *Id.*

136. Winkjer v. Herr, 277 N.W.2d 579, 586 (N.D. 1979).

137. *Id.*

138. Cappellino, *supra* note 115; *see First Steps to Sue a Doctor*, ALLLAW, https://www.alllaw.com/articles/nolo/medical-malpractice/first-steps-sue-doctor.html (last visited on Apr. 7, 2020) (on file with the *University of the Pacific Law Review*) (noting how many states do not let patients bring forward medical malpractice claims without first proving their case "is at least arguably a legitimate medical malpractice case" through an Offer of Proof or a Certificate of Merit which is many times reviewed by physicians who write a report if in support of the claim).

139. *Strict Liability*, JUSTIA, https://www.justia.com/injury/negligence-theory/strict-liability/ (last updated Apr. 2018) (on file with the *University of the Pacific Law Review*).

140. *See* Cappellino, *supra* note 115 ("A physician does not guarantee recovery. . . A competent physician is not liable per se for a mere error of judgment, mistaken diagnosis or the occurrence of an undesirable result.").

141. *Infra* Part IV.

Medical malpractice litigation has benefits and drawbacks.[142] "There are three social goals of malpractice litigation: to deter unsafe practices, to compensate persons injured through negligence, and to exact corrective justice."[143] Theoretically, the threat of litigation and its attendant costs—both professional and financial—promote better physician performance.[144]

However, the threat of litigation can also lead to what some physicians call "defensive medicine."[145] Defensive medicine happens when a physician performs procedures predominantly to reduce the risk of litigation.[146] This is problematic because it shifts the focus of the medical care from the patient's best interest to the physician's best interest.[147] Defensive medicine can lead to a level of care that is not only unproductive but potentially harmful.[148]

Ideally, medical malpractice liability should both promote physician accountability and prioritize the patient's best interest and well-being.[149] To uphold the viability of using medical malpractice as an avenue for recovery, the legal standard itself should adequately protect all parties involved.[150] One way to ensure this is to alter the standard of care reasonably prudent physicians should employ to factor in these concerns.[151] Deterring defensive medicine by creating a different, more comprehensive standard of care would work to insulate physicians acting appropriately while holding accountable those who are not.[152]

IV. WHAT IS THE STANDARD OF CARE IN THE AGE OF OPIOIDS?

The opioid crisis generated a heavy caseload for courts across America: from large class action suits against big pharma to criminal charges for certain physicians whose patients died from overdoses to liability for physicians running "pill mills."[153] However, whether the standard of care in medical malpractice

142. *See* Kass & Rose, *supra* note 124, at 300 (discussing the benefit of potential physician negligence deterrence, but also the downfall of pressure from malpractice litigation leading to changes in physician performance solely in an effort to avoid litigation).

143. David Studdert, et al., *Medical Malpractice*, 350 NEW ENG. J. MED. 283, 283 (2004).

144. *Id.*

145. Kass & Rose, *supra* note 124, at 300.

146. *Id.*

147. *Id.*

148. *Id.*

149. *See* Serafini, *supra* note 11 ("Many frontline physicians and clinical leaders feel caught in the middle – acknowledging the national crisis of opioid addiction and wanting to adhere to the new guidelines, but also wanting to decrease patients' pain.").

150. *Infra* Part IV.

151. *Infra* Part IV.

152. *Infra* Part IV.

153. *See* Bobby Allyn, *Purdue Pharma, Accused of Fueling Opioid Crisis, Files for Chapter 11*, NPR (Sept. 16, 2019, 2:01 AM), https://www.npr.org/2019/09/16/761107097/purdue-pharma-accused-of-fueling-opioid-crisis-files-for-chapter-11 (on file with the *University of the Pacific Law Review*) (highlighting how Purdue Pharma's settlement with more than 2,000 local governments over its alleged role in creating and sustaining the deadly opioid crisis lead it to file Chapter 11 bankruptcy protection); *see also* Erin Allday, *Doctor*

cases can account for the complexities of the medical profession's relationship with opioids remains unanswered.[154]

Determining ultimate liability remains a case-by-case decision.[155] While there are many elements that make up a medical malpractice case, this Comment only focuses on the standard of care reasonably prudent physicians should adhere to.[156] In cases involving the use of opioids, factors exist that establish a physician's rationality in making a decision to treat a patient with opioid-based drugs.[157] The new standard of care in the age of opioids should not look to a simple prescription of the drugs.[158] Rather, this new standard would encompass these factors and consider the interaction in its entirety because that better reflects the considerations physicians prescribing opioids must face.[159]

Section A examines how a court's decision finding a physician negligent for his treatment of his patient with opioids provides an example for a new future standard of care.[160] Section B examines how societal and medical knowledge about the opioid crisis should help set the standard of care for physicians' prescribing practices.[161] Section C then proposes a new standard of care courts should use that reflects the information physicians possess and how that should shape their course of conduct.[162]

A. Koon v. Walden

In 2017, the Missouri Court of Appeals upheld a lower court decision finding physician Dr. Henry Walden negligent for his conduct involving the treatment of his patient, Brian Koon.[163] Koon alleged that Dr. Walden's overprescribing of opioid medications resulted in Koon's opioid addiction and subsequent

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Facing Murder Charges in Opioid Cases Was Already Under Investigation, S.F. CHRONICLE (Aug. 15, 2019, 8:31 PM), https://www.sfchronicle.com/bayarea/article/Santa-Rosa-doctor-facing-murder-charges-was-under-14308285.php (on file with the *University of the Pacific Law Review*) (explaining how a Santa Rosa, California physician is facing murder charges after the death of five patients who suffered opioid overdoses); *e.g.* Del Quentin Wilber, *12 Million Pills and 700 Deaths: How a Few Pill Mills Helped Fan the U.S. Opioid Inferno*, L.A. TIMES (June 14, 2019, 4:00 AM), https://www.latimes.com/nation/la-na-pol-pill-mills-linked-to-hundreds-of-deaths-20190614-story.html (on file with the *University of the Pacific Law Review*) (exploring how federal authorities investigated and raided an illicit pill mill, which resulted in criminal charges against 140 people).

154. Telephone Interview with Kellen Galster, *supra* note 18.

155. Telephone Interview with Tim Cronin, Medical Malpractice Attorney, The Simon Law Firm, P.C. (Jan. 14, 2020) (notes on file with the *University of the Pacific Law Review*).

156. *Infra* Section IV.C.

157. Telephone Interview with Tim Cronin, *supra* note 155; *Infra* Section IV.C.

158. *Infra* Section IV.C.

159. *Infra* Section IV.C.

160. *Infra* Section IV.A.

161. *Infra* Section IV.B.

162. *Infra* Section IV.C.

163. Koon v. Walden, 539 S.W.3d 752, 752 (Mo. Ct. App. 2017).

injuries.[164]

Koon sought treatment from Dr. Walden after suffering a lower back injury in 2008.[165] Initially, Dr. Walden ordered x-rays and told Koon to use a muscle relaxer and "ibuprofen as needed."[166] However, Koon returned about a week later complaining of continued discomfort.[167] In response to this visit, Dr. Walden prescribed Koon thirty pills of hydrocodone with one refill.[168]

From there, Dr. Walden increased the prescription from six pills a day to almost forty pills a day, using three different prescriptions.[169] Over this time period, Dr. Walden repeatedly ignored Koon's phone calls, requests for visits, and pleas for help with a growing addiction.[170] Dr. Walden instead refilled the prescriptions without even speaking with Koon about his addiction issues.[171]

The prescribing patterns were so unusual that in July 2012, the pharmacy called Dr. Walden and expressed concern about the large amount of prescription opioids Koon tried to refill and ultimately refused to refill the prescriptions altogether.[172] The medications interfered with his ability to work, his relationships, and eventually his "everything revolved around the opioids."[173] Only then did Dr. Walden acknowledge Koon's severe opioid misuse problem.[174]

The plaintiff's expert witness described Dr. Walden's behavior as "excessive," "colossal," "reckless," "extraordinary," and "astronomical," exposing Koon to a very high risk of injury and addiction.[175] The court noted that this was "the very pattern of prescribing that state licensure boards and the DEA are trying to protect patients from because it 'exposes a patient to a very high risk of dying for backache.'"[176] Plaintiff's expert testified that these deviations from the standard of care for treating patients with opioids led to Koon's injuries.[177] It was not Dr. Walden's initial prescription that led to the negligence finding.[178] Instead, it was "Dr. Walden's complete indifference to Koon's safety" after the initial prescription that breached the standard of care.[179]

This case provides essential insight into future like-kind cases: prescribing

164. *Id.*

165. *Id.* at 757.

166. *Id.*

167. *Id.*

168. *Id.*

169. *See id.* at 759 (explaining how beginning with the initial prescription in 2008, Dr. Walden increased Koon's daily dosage roughly six times the initial dosage).

170. *Id.* at 757–59.

171. *Id.*

172. *Id.* at 759.

173. *Id.*

174. *Id.*

175. *Id.*

176. *Id.*

177. *Id.*

178. *Id.* at 773.

179. *Id.*

opioids is not a per se deviation from the standard of care.[180] Rather, it is the failure to properly treat and monitor a patient that creates liability.[181]

The expert testimony inferred that the standard of care is consistent monitoring of the patient, not the initial prescription itself.[182] Dr. Walden's failure was not his prescription to Koon of the opioid-based pain medications for his back injury.[183] Dr. Walden's negligence rested on the failure to take care of Koon after that initial prescription.[184] It was his failure to recognize Koon's warning signs of addiction that raised his conduct to negligent levels.[185]

This case provides an important example of how a court could make a negligence finding based on the entire physician–patient interaction through expert testimony evidence.[186] The court in *Koon* opened an important door for employing similar metrics in future cases.[187]

B. How to set the standard of care in the age of opioids

In setting the standard of care, courts must determine the acceptable conduct of physicians in good standing in the relevant community.[188] To determine this, plaintiffs need to provide evidence of what most physicians would or actually do in a particular situation.[189]

Prescribing numbers alone are a poor measure of physician competency because such numbers do not accurately account for the reason behind the prescriptions.[190] Courts should not opine that lower prescription rates means better conduct without considering the reasons for such prescriptions or the actual patient treatment.[191] Even though individualized prescription rates might be probative in individual cases, national statistics do little to speak to the actual level of care physicians provide patients.[192] Looking at the prescription rates

180. Telephone Interview with Tim Cronin, *supra* note 155.

181. Telephone Interview with Kellen Galster, *supra* note 18.

182. Walden, 539 S.W.3d at 773.

183. *Id.* at 759, 768.

184. *Id.* at 773.

185. *Id.*

186. *Id.*

187. *Id.* at 777.

188. AM. BOARD OF PROF. LIABILITY ATT'YS, *supra* note 17.

189. AM. BOARD OF PROF. LIABILITY ATT'YS, *supra* note 17; Coulter Boeschen, *Medical Malpractice: Using Expert Witnesses*, NOLO, https://www.nolo.com/legal-encyclopedia/medical-malpractice-using-expert-witnesses-30087.html (last visited Jan. 7, 2020) (on file with the *University of the Pacific Law Review*).

190. Dineen & DuBois, *supra* note 65, at 23.

191. Telephone Interview with Kellen Galster, *supra* note 18; *see* Reynolds, *supra* note 92 (noting how the CDC and FDA altered prescribing guidelines to stop physicians from "abruptly ceasing opioid treatment or rapid tapering" in certain cases because of the potentially deadly consequences from opioid withdrawals).

192. *See* Andrea Finney, *Growing Number of Doctors No Longer Prescribing Opioids*, CBS LOCAL 21 NEWS (Feb. 10, 2020), https://local21news.com/news/the-opioid-crisis-finding-hope/growing-number-of-doctors-no-longer-prescribing-opioids (on file with the *University of the Pacific Law Review*) (talking about

without considering the underlying cause of the prescription and reason for its use discounts and distorts the view of the physician's conduct.[193]

There are widely available opioid-prescribing state and federal government guidelines that can help determine what a reasonably prudent physician would do in the same situation.[194] In 2016, the CDC released comprehensive guidelines regarding how physicians can help curb the opioid epidemic.[195] The CDC wants "to improve communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy."[196] However, there are inherent problems with using only agency guidelines as a standard of care.[197]

There has yet to emerge a clear or consistent pattern courts follow when considering medical guidelines.[198] Even the CDC's guidelines do not apply to all patients and therefore would not be useful in every case.[199] Agencies like the CDC continue to change the proper guidelines as more information about the drugs and addiction continues to come out, making it even harder to follow only those guidelines.[200]

Agency guidelines might not best reflect what the law considers the traditional "standard of care" for physicians.[201] The agency guidelines often represent best practices, something the standard of care may not reflect because it typically measures common practices which might not equate to best practices.[202] While the CDC and individual states might hope all physicians follow their

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how a proposed bill in Pennsylvania addressing faulty opioid prescribing led physicians to potentially provide worse care to patients because of less time spent with them and greater strain on the medical system).

193. Telephone Interview with Kellen Galster, *supra* note 18; Telephone Interview with Tim Cronin, *supra* note 155.

194. *See generally* Koon v. Walden, 539 S.W.3d 752 (Mo. Ct. App. 2017) (determining that a combination of information about the known risks associated with prescribing opioids from state medical boards and the DEA and expert testimony established negligent prescribing from Dr. Walden that caused Brian Koon's opioid addiction); *see also* THE NAT'L ACADS. OF SCI., ENG'G, AND MED., *supra* note 49, at 304 (examining different treatment practices state medical boards address with their guidelines); Haffajee, Larochelle & Yang, *supra* note 99, at 249.

195. CENTERS FOR DISEASE CONTROL AND PREVENTION, GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN 1 (2016).

196. *Id.*

197. *See* Ben Rich & Lynn Webster, *A Review of Forensic Implications of Opioid Prescribing with Examples from Malpractice Cases Involving Opioid-Related Overdose*, 12 PAIN MED. 59, 62 (2011) (questioning the applicability of agency guidelines to the standard of care because of legal ambiguity about their effectiveness).

198. *Id.*

199. *See* CENTERS FOR DISEASE CONTROL AND PREVENTION, *supra* note 195, at 1 (distinguishing how these guidelines are only applicable to those patients with chronic pain, and not for patients who are in "active cancer treatment, palliative care, or end-of-life care.").

200. *See* Reynolds, *supra* note 92 (explaining the new CDC and FDA guidelines the agencies released in April 2019 that clarify their 2016 prescribing guidelines because of new information about stopping opioid treatment to patients suffering with dependence).

201. Rich & Webster, *supra* note 197, at 62.

202. *Id.*

prescription opioid guidelines, most physicians likely do not.[203]

It is almost impossible to think that such guidelines would apply to every situation, injury, and patient.[204] There is no one medically accepted way of treating a patient.[205] Simply failing to follow medical board or agency recommendations will likely not result in liability because such deviations from the norm might not always result in harm or damage to the patient.[206] Yet the guidelines can and do offer real evidence as to the level of treatment the medical profession should strive to achieve in that area of practice.[207]

The guidelines could potentially supplement the expert testimony that establishes the acceptable physician conduct.[208] Having a concrete set of rules might help a jury better analyze conduct that could be abstract and confusing for non-medical professionals.[209] Such established and agreed upon rules in the field allow a jury to point to something and compare the defendant-physician's conduct to the established rules.[210]

Precedent exists in California that supports using agency guidelines in addition to expert testimony to set the standard of care.[211] In *Bergman v. Chin*, the plaintiff introduced into evidence two administrative policy guidelines to show acceptable medical practices.[212] First, the plaintiffs introduced the Agency for Health Care Policy and Research clinical practice guidelines for management of pain care.[213] Second, they introduced the policy of the California Medical Board that prioritized effective pain management in patient care.[214] This evidence helped show that the physician acted so outside the bounds of acceptable medical practice that such conduct constituted negligence.[215] This case is an important example of how agency guidelines helped set the standard of care.[216]

Expert testimony will always remain a necessity in medical malpractice cases

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203. *Id.*

204. *Id.* at 63.

205. Dineen & DuBois, *supra* note 65, at 22–23.

206. *See id.* at 23 ("For example, courts have held that failing to follow every recommendation of a state medical board prescribing policy is insufficient to establish a failure to meet the standard of care.").

207. *See* CENTERS FOR DISEASE CONTROL AND PREVENTION, *supra* note 195, at 1–2 (providing physicians with recommendations on opioid selection, dosage, duration, follow-up, and discontinuation).

208. *See* Rich & Webster, *supra* note 197, at 62 (talking about the ambiguity within the legal field over how agency guidelines should factor into an applicable standard of care); Telephone Interview with Tim Cronin, *supra* note 155.

209. Telephone Interview with Tim Cronin, *supra* note 155.

210. *Id.*

211. *See* Rich & Webster, *supra* note 197, at 62 (highlighting the case of *Bergman v. Chin* and how plaintiffs used agency guidelines to show Dr. Chin acted negligently in the course of his patient treatment).

212. *Id.*

213. *Id.*

214. *Id.*

215. *Id.*

216. *Id.*

because of the complexity such cases present.[217] Guidelines alone will not determine the standard of care, but courts should consider employing the guidelines in addition to expert testimony.[218] This combination of information can help the jury understand the risks inherent with prescribing opioids and how a physician should act when treating a patient with these drugs.[219] Ultimately, this can better show whether a physician's conduct fell within the relevant standard of care.[220]

C. What is the new standard of care in the age of opioids?

When considering what the standard of care is in these types of cases, courts should examine a number of relevant factors and not just point to one of the physician's acts, such as the initial prescription.[221] These factors can include anything from the examination of the patients themselves and dosing to patient education and referrals.[222] At the initial consultation, physicians and patients should mutually set reasonable expectations for treatment with the opioid drugs.[223] From there, physicians should consider prescribing in the context of the patient's entire medical history.[224]

Hypothetically, if the physician considered these factors, courts would defer to their medical judgment.[225] The hope of employing this approach is twofold: to insulate good acting physicians while protecting patients from potentially dangerous conduct.[226] In many of the cases where physicians faced liability for their conduct, the physician failed to consider a full range of ramifications from opioid treatment.[227]

The Louisiana State Medical Board disciplined a physician for an extended

217. Cappellino, *supra* note 115.

218. Telephone Interview with Kellen Galster, *supra* note 18; Telephone Interview with Tim Cronin, *supra* note 155.

219. Telephone Interview with Tim Cronin, *supra* note 155.

220. *Id.*

221. Telephone Interview with Kellen Galster, *supra* note 18.

222. Dineen & DuBois, *supra* note 65, at 23.

223. *See* THE NAT'L ACADS. OF SCI., ENG'G, AND MED., *supra* note 49, at 64 ("[E]mphasis is increasing on setting reasonable expectations and establishing mutually agreed-upon goals for the control of chronic pain, with an emphasis on communication and safety.").

224. Dineen & DuBois, *supra* note 65, at 23.

225. Telephone Interview with Tim Cronin, *supra* note 155.

226. Telephone Interview with Kellen Galster, *supra* note 18.

227. *See* Koon v. Walden, 539 S.W.3d 752, 773 (Mo. Ct. App. 2017) (noting Dr. Walden's "decision to prescribe increasingly higher doses over several years–without adequate discussions with Koon about the risks, without any monitoring system in place and despite warning signs that Koon was dependent and possibly addicted" greatly increased the risk of addiction and demonstrated Dr. Walden's negligence); *see also* Dineen & DuBois, *supra* note 65, at 40–41 (describing the conduct of Dr. Jarrot, who prescribed opioids "without consulting the patient's other doctors, previous records, or hospital records" in addition to multiple prescription refills, all leading to administrative discipline in Louisiana by the state medical board).

pattern of mis-prescribing in the late 1990s and early 2000s.[228] The physician repeatedly increased doses of opioids without adequately documenting any patient history or any continued evaluation of the drugs' impacts.[229] The physician prescribed the drugs without checking other patient records that showed the patient's history of opioid abuse documented by other hospitals.[230] While the initial prescribing did not create liability, the continued neglect and failure to account for the full circumstances of the individual patient did.[231] This suggests that the liability turns on the entirety of the treatment and not on just one specific act.[232] This is the conduct a court needs to consider in the standard of care—not just the simple prescribing itself.[233]

The true risk of addiction increases over time, further suggesting that continued monitoring and patient surveillance is key to conscious prescribing.[234] Many times, patients show signs of intolerance or addiction that a trained and astute physician should pick up on.[235] A court in Illinois elaborated on the "red flags" a physician should look for in a patient.[236] "[R]unning out of medication early, . . . requesting early medication refills, taking more medication than is prescribed, . . . seeking medication from other doctors, requesting stronger doses of medication, claiming pharmacy errors in filling a prescription" all were signs the physician did not recognize, but arguably should have.[237] The plaintiff's expert noted a prudent physician would notice these, and the failure to do so resulted in a breach of the standard of care.[238]

This idea of fully accounting for all the circumstances is not novel.[239] The CDC guidelines promoted the very same concept of conscious monitoring.[240] "[E]valuation of risks prior to opioid initiation, careful ongoing evaluation of those risks, and regular assessment of response to therapy" are all things physicians should think about during opioid treatment.[241]

The key to prescribing the drugs even in situations where the ailments

228. Dineen & DuBois, *supra* note 65, at 40.

229. *Id.* at 40–41.

230. *Id.* at 41.

231. *Id.*

232. *See* Walden, 539 S.W.3d at 773 (explaining how Dr. Walden's continual ignorance of signs that Koon developed opioid addiction displayed his "complete indifference" to his patient, leading to the negligence finding); Dineen & DuBois, *supra* note 65, at 41.

233. Telephone Interview with Tim Cronin, *supra* note 155.

234. *See* QUINONES, *supra* note 3, at 191–92 (describing how "OxyContin often served as an addict's bridge between the milder opiate painkillers and heroin.").

235. Guerra v. Advanced Pain Centers S.C., 122 N.E.3d 345, 349 (Ill. App. Ct. 2018).

236. *Id.*

237. *Id.*

238. *Id.*

239. THE NAT'L ACADS. OF SCI., ENG'G, AND MED., *supra* note 49, at 35–36.

240. *Id.*

241. *Id.*

warrant the use of opioids is the manner and precision in which physicians employ them.[242] "A thorough understanding of the potential consequences and methods of monitoring patients for these consequences is essential prior to prescribing opioids."[243] Such consequences include physical dependence and tolerance that can eventually lead to addiction.[244]

However, physicians should not let these consequences stop them from prescribing the drugs altogether.[245] Physicians need not forget that opioids still have legitimate and important medical uses.[246] Prescribing opioids for patients with moderate and severe pain is likely still the best course of action.[247] For some chronic pain patients, such as those suffering from multiple sclerosis, opioids are still vital for treatment.[248]

Opioids remain an important tool in a physician's toolbox for treating patients.[249] However, it is the physician's job to monitor the patient and continue to treat that person based on the individual's reaction to the drugs.[250] The question of what action the reasonably prudent, well-trained physician would take must consider the inexact nature of medical practice and the complexity of individual patients.[251] Therefore, the standard of care should include all of the approaches physicians employ to treat patients and reflect common mitigation strategies.[252]

Individual states set their own laws about medical malpractice liability—so it is a state's job to determine the appropriate way of implementing this standard.[253] When considering how exactly states can implement this new standard of care, two potential options emerge: statutory implementation or court-imposed jury instructions.[254]

State legislatures should not enact this standard through a statute because it

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242. Cornell & Guarino, *supra* note 71, at 11.

243. *Id.*

244. *Id.*

245. *See id.* at 12 (describing certain steps a physician should take when treating a patient with opioids).

246. *Id.* at 10.

247. *Id.* at 11.

248. *See id.* at 10 (describing how multiple sclerosis "damages the central nervous system, including the brain, spinal cord, and optic nerves" and likely requires constant pain management, which opioids are a treatment option).

249. *Id.*

250. *See* Koon v. Walden, 539 S.W.3d 752, 773 (Mo. Ct. App. 2017) (describing how Dr. Walden was aware of the risks of his prescribing patterns to Koon, but continued to prescribe anyway without taking any other precautions, contributing to the finding of his negligence); *see also* Cornell & Guarino, *supra* note 71, at 15 ("Judicious use of opioids should include evaluation of patients in advance for potential addiction and an ongoing agreement with the patient to follow mutual guidelines.").

251. Rich & Webster, *supra* note 197, at 63.

252. Volkow & McLellan, *supra* note 70, at 1257–58.

253. Bal, *supra* note 106, at 340.

254. Paul Yowell, *Judicial Discretion in Adopting Legislative Standards: Texas's Solution to Negligence Per Se?*, 49 BAYLOR L. REV. 109, 110–11 (1997); Elizabeth G. Thornburg, *The Power and the Process: Instructions and the Civil Jury*, 66 FORDHAM L. REV. 1837, 1840 (1998).

would turn the negligence finding into a negligence per se standard.[255] In negligence per se cases, the applicable statute turns into the standard of care and juries base their breach of duty finding on a violation of that statute.[256] Therefore, the liability rests on the statute's scope and specific language.[257] Likely, a statute cannot adequately capture the intricacies of the opioid-based treatments this Comment explores.[258] The inherent nature of these cases is fact specific and broad application of a standard likely does not adequately measure all cases and situations.[259] Negligence per se standards inherently cannot appropriately account for that due to their inflexible nature, and therefore, passing a statute is not the answer.[260]

Rather, courts should enforce this new standard through jury instructions at the time of trial.[261] Jury instructions are likely the best way to account for the fact specific complexities of each case while still following relevant legal requirements.[262] While jury instructions are not as legally enforceable as statutes, they would allow jurors to consider the facts and complexities facing these cases.[263]

Incorporating this into a jury instruction would afford the judge the opportunity to clarify the applicable standard of care and any evidentiary questions.[264] Instructions about the standard of care the jurors should judge the physician-defendant on would remind the jury to consider all of the aforementioned circumstances in their decision.[265] Applying this standard through a jury instruction could also allow courts the discretion to employ this in other medical malpractices cases outside of the narrow realm this Comment addresses.[266]

Courts can and should use the standard of care as an opportunity to promote better physician treatment overall.[267] Prescribing opioids is not inherently a liability-producing event, and patients would likely need to prove something more to recover against their physicians for injuries resulting from prescribed

255. Yowell, *supra* note 254, at 110–11.

256. *Id.*

257. *Id.*

258. *See id.* at 115 ("[N]egligence per se 'places all responsibilities on a legislature that could not possibly conceive of all cases to which its proscription might apply and that has not provided for civil liability, and that, therefore, surely has not considered proper limitations and excuses.'").

259. *Id.*

260. *Id.*

261. *Jury Instructions*, 63 GEO. L. J. 544, 546 (1974).

262. Thornburg, *supra* note 254, at 1840.

263. *Id.*

264. *Id.*

265. *Jury Instructions*, *supra* note 261, at 546–47.

266. *See* Thornburg, *supra* note 254, at 1840 (talking about the discretion courts have in framing jury charges).

267. Telephone Interview with Kellen Galster, *supra* note 18.

opioids.[268] However, failing to prescribe opioids altogether and eliminating that class of narcotics as a possible life saving pain treatment should not become another casualty of the opioid addiction crisis.[269]

V. CONCLUSION

Physicians are in a unique position to help end America's opioid epidemic.[270] Unlike big pharma or law enforcement agencies, "[p]hysicians typically interact with an individual with a goal of improving the individual's well-being through a continuing relationship. One patient at a time, the physician hopes to meet a secondary goal of improving the public health and safety."[271]

Despite their medically acceptable uses, there is no question that opioid-based medications permanently changed the medical profession.[272] It is dangerous to ignore current information about the nature of these medications.[273] "Opioids are not panaceas for pain management."[274] With all the evidence circulating about the toxicity of the drugs, physicians should take precautionary steps when using opioid-based medications.[275]

Dr. Kellen Galster, an emergency room physician in Vallejo, California, a community ravaged by drug abuse, highlighted the tough legal position opioids

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268. *See* Koon v. Walden, 539 S.W.3d 752, 774 (Mo. Ct. App. 2017) (describing how it was the post-prescription conduct from Dr. Walden that shocked the court, stating that "[h]is decision to prescribe these amounts for this length of time was done in conscious disregard of, and with complete indifference to, Koon's safety and the safety of other.").

269. *See* THE NAT'L ACADS. OF SCI., ENG'G, AND MED., *supra* note 49, at 38 ("[R]egulations restricting access to opioids may be objectionable because they are perceived as unduly constraining the options available to physicians seeking to alleviate the suffering of each patient under their care."); Trang, et al., *supra* note 34, at 13885; *see also* Reynolds, *supra* note 92 (looking at a study that found that "81 percent of responding physicians are reluctant to take on new patients currently prescribed opioids" and 83 percent of physicians admit that "it has become increasingly difficult to treat patients suffering from chronic pain.").

270. Dineen & DuBois, *supra* note 65, at 8; *see* Joanne Finnegan, *Who Is to Blame for the Opioid Crisis? In Florida, Walgreens and CVS Point Fingers at Physicians*, FIERCEHEALTHCARE (Feb. 13, 2020, 10:22 AM), https://www.fiercehealthcare.com/practices/laying-blame-for-opioid-crisis-florida-walgreens-and-cvs-point-finger-at-physicians (on file with the *University of the Pacific Law Review*) (examining the difference between the pharmacists' role in the opioid crisis versus the physicians' role: "Pharmacists do not write prescriptions and do not decide for doctors which medications are appropriate to treat their patients . . . [w]hile pharmacists are highly trained and licensed professionals, they did not attend medical school and are not trained as physicians. They do not examine or diagnose patients. They do not write prescriptions.").

271. Dineen & DuBois, *supra* note 65, at 26.

272. *See* QUINONES, *supra* note 3, at 126 (describing how OxyContin changed how physicians could treat patient pain).

273. *See Physicians' Opioid Prescribing Pattern Linked to Patients' Risk for Long-Term Drug Abuse*, HARV. T.H. CHAN SCH. OF PUB. HEALTH (Feb. 15, 2017), https://www.hsph.harvard.edu/news/press-releases/opioids-addiction-physicians/ (on file with the *University of the Pacific Law Review*) ("A physician who prescribes an opioid needs to be conscious that there is a significant risk that the patient could continue to be on an opioid for the long term, even from a single, short, initial prescription.").

274. Cornell & Guarino, *supra* note 71, at 15.

275. *See* THE NAT'L ACADS. OF SCI., ENG'G, AND MED., *supra* note 49, at 38–39 (speaking to the physician's ethical duty of making individualized treatment decisions based on that respective patient's need).

put physicians in: "[t]o limit physicians for how they care for patients based on a legal standard would be a huge shortcoming."[276] Creating a blanket liability for employing opioid-based treatment neither curbs the epidemic nor promotes better care.[277]

No one practice or standard can alleviate all the risks associated with these drugs, and physicians are not the only party that needs to change their tactics to address the crisis.[278] Further, this Comment only addresses the risks associated with controlled, medicinal uses of opioid drugs, which is by no means the only contributor to America's drug crisis.[279] Additionally, physicians do not control the flow of heroin—a drug that caused potentially more societal harm than prescription opioids.[280]

However, physicians can and should use their specific role as a bridge between patients and pharmaceutical companies to encourage safe and responsible use of opioids.[281] In addition to administrative and criminal liability, courts should employ a standard of care in medical malpractice liability that promotes best physician practices.[282] Acting on this information by continually monitoring patients provides a better answer for all parties involved.[283]

No one solution can end America's opioid addiction crisis because that takes a coordinated societal effort.[284] However, physicians can "one patient at a time" do their part to help curb America's opioid epidemic.[285]

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276. Telephone Interview with Kellen Galster, *supra* note 18.

277. *Id.*

278. *See* THE NAT'L ACADS. OF SCI., ENG'G, AND MED., *supra* note 49, at 19 (speaking to how the FDA addressed its shortcomings in previous opioid regulatory schemes that helped fuel the crisis and the need for future changes to help curb future issues); *see also* Stephie Grob Plante, *Walmart and CVS Are Among the Retailers Being Sued for Aiding the Spread of Opioids*, VOX (July 23, 2019, 2:10 PM), https://www.vox.com/the-goods/2019/7/23/20707179/walmart-cvs-walgreens-opioid-crisis-lawsuit-trial (on file with the *University of the Pacific Law Review*) (highlighting recent lawsuits filed against retail chains such as Walmart and CVS for their "corporate complicity in the opioid epidemic.").

279. *See* THE NAT'L ACADS. OF SCI., ENG'G, AND MED., *supra* note 49, at 37 (talking about the risk associated with prescription drugs ending up on the streets and in black market drug trades).

280. *Id.* at 206.

281. *See* Finnegan, *supra* note 270 (noting the difference between pharmacists and physicians, saying that physicians directly examine, diagnose, and write prescriptions for patients).

282. *See* Kessler, *supra* note 101 (examining the goals of medical malpractice liability, including deterrence for negligent practices).

283. Telephone Interview with Kellen Galster, *supra* note 18.

284. *See* Jay Bhatt, *Together, We Can Prevent Further Addiction and End the Opioid Epidemic*, AM. HOSP. ASS'N (Oct. 24, 2018, 2:51 PM), https://www.aha.org/news/blog/2018-10-24-together-we-can-prevent-further-addiction-and-end-opioid-epidemic (on file with the *University of the Pacific Law Review*) ("[W]e all have a part to play in ending the opioid epidemic.").

285. Dineen & DuBois, *supra* note 65, at 26.

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