PHARMACISTS, PHYSICIAN-ASSISTED SUICIDE, AND PAIN CONTROL

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INTRODUCTION

A revolution is underway in end-of-life care. Just what it is and where it is going, like most revolutions, will only become clear with the benefit of hindsight. Perhaps it will lead to the legalization of actively hastening death — what is commonly referred to as physician-assisted suicide, or even to mercy killing — and if not, it may lead to an increased willingness on the part of some physicians to engage in these practices covertly, though still illegally.

It is definitely heading toward new medical practices, new laws, and new societal attitudes in end-of-life care, and one of the most notable areas in which this is happening is pain control.[1] In clinical medical practice, there is more of it, and its quality is improving.[2] In law, there is increasing statutory and judicial activity to remove barriers to effective pain control.[3] There are also increasing efforts to make hospice care more readily available.[4] There is diminished tolerance by terminally ill patients and their families for dying in pain.[5] And there is improved education of doctors and medical students about ways to improve the quality of end-of-life care.[6] Nonetheless,

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1. *See generally* INSTITUTE OF MEDICINE, APPROACHING DEATH: IMPROVING CARE AT THE END-OF-LIFE (Marilyn J. Field & Christine K. Cassel eds., National Academy Press 1997); Phebe Saunders Haugen, *Pain Relief for the Dying: The Unwelcome Intervention of the Criminal Law*, 23 WM. MITCHELL L. REV. 325 (1997).

2. *See* discussion of physician assisted suicide *infra* notes 61-74 and accompanying text.

3. *See* discussion of states which have enacted palliative care statutes *infra* notes 25-26 and accompanying text.

4. *See Quality Hospice Care*, COURIER J., June 1, 1998, at 6A.

5. A National Hospice Organization-Gallup Survey found that one of the greatest fears people have when thinking about dying is pain. *See Hospice Is Alternative to Doctor-Assisted Suicide*, THE COLUMBUS DISPATCH, July 29, 1998, at 10A.

6. *See AMA to Educate U.S. Physicians on Caring for Dying Patients*, U.S. NEWS WIRE, March 16, 1997. *See also* Mary Chris Jaklevic, *End of Life Training; N.Y. Med. Schools to Join on Improving Palliative Care*, MODERN HEALTH CARE, Aug. 18, 1997, at 32.

complaints about undertreated severe pain in the terminally ill persist.[7]

An important focus, if not the central focus, in the debate about the changing nature of end-of-life care has been the role of physicians.[8] This is ironic; the focus should be patients, but that is emblematic of the problem — that we have not been practicing patient-centered end-of-life care. Physicians are not the only health care professionals that have played or will play a role in end-of-life care. Nurses, visiting nurses, inhalation therapists, nutritionists, clinical pharmacists in tertiary care settings, and retail pharmacists also have important roles to play — often more important than physicians do. This article discusses the legal concerns of pharmacists in end-of-life care. Specifically, the article focuses on the role of pharmacists in the prescription of medication to control pain in terminally ill patients and to carry out physician-assisted suicide.

BACKGROUND

The beginning of public debates about end-of-life care could be marked by many events, though all would be arbitrary to some degree. I usually prefer to begin with the Karen Quinlan case in 1976,[9] but one could just as logically begin with the debate about brain death in the mid- to late-1960s,[10] or the debate about letting handicapped newborn infants die,[11] or a number of other events having to do with end-of-life decisionmaking, but for present purposes, even the *Quinlan* case may be too far back.

In December 1989, the United States Supreme Court heard oral arguments in the case of *Cruzan v. Director, Missouri Department of Health.*[12] Despite the proliferation of similar cases around the country

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7. Studies and accounts of undertreated pain are legion. Two of the more significant are The SUPPORT Principal Investigators, *A Controlled Trial to Improve Care For Seriously Ill Hospitalized Patients*, 274 JAMA 1591 (1995); AD HOC COMMITTEE ON PAIN MANAGEMENT, BREAKING DOWN THE BARRIERS TO EFFECTIVE PAIN MANAGEMENT: RECOMMENDATIONS TO IMPROVE THE ASSESSMENT AND TREATMENT OF PAIN IN NEW YORK STATE: REPORT TO THE COMMISSIONER OF HEALTH (January 1998).

8. *See generally* Haugen, *supra* note 1.

9. *See In re* Quinlan, 355 A.2d 647 (N.J. 1976) (holding that a decision by a young woman to terminate by natural forces her noncognitive, vegetative existence was a part of her right to privacy which could be asserted on her behalf by her guardian).

10. *See A Definition of Irreversible Coma: Report of the Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death*, 205 JAMA 85 (1968).

11. *See* Anthony Shaw, *Dilemmas of "Informed Consent" in Children*, 289 NEW ENG. J. MED. 885 (1973); *see also* Raymond S. Duff & A.G. Campbell, *Moral and Ethical Dilemmas in the Special-Care Nursery*, 289 NEW ENG. J. MED. 890 (1973).

12. 497 U.S. 261 (1990).

in the 15 years since *Quinlan*, this was the first case the Court had agreed to review.[13] Months passed, and still the Court had not handed down a decision. *Cruzan* was one of the longest-pending cases on the Court's docket. And then along came a Michigan pathologist, whom few had ever heard of except those who watched the Donahue show, Jack Kevorkian, who stole the Court's thunder by assisting a woman in ending her life with his suicide machine.[14] Suddenly, the terms of the debate about end-of-life care took a quantum leap from *Cruzan's* focus on the legal niceties of terminating medically provided artificial nutrition and hydration to the morality and legality of physician-assisted suicide.[15]

Although Kevorkian refocused our attention on physician-assisted suicide, he did not introduce this debate; there had been a number of precursors over the preceding decade or more.[16] What he did was to

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13. The Supreme Court had previously denied certiorari in five right-to-die cases. *See* Drabick v. Drabick, 245 Cal. Rptr.2d 840 (Ct. App.), *cert. denied*, 488 U.S. 958 (1988), *reh'g denied*, 488 U.S. 1024 (1989); *In re* Estate of Prange, 520 N.E.2d 946 (Ill. App. Ct.), *vacated sub nom.* Murphy v. Chicago Volunteer Legal Serv. Found., 527 N.E.2d 303 (Ill.), *cert. denied sub nom.* Murphy v. Benson, 488 U.S. 892 (1988); *In re* Jobes, 529 A.2d 434 (N.J. 1987), *reconsideration and stay denied*, 531 A.2d 1360 (N.J. 1987), *stay denied sub nom.* Lincoln Park Nursing and Convalescent Home v. Kahn, 483 U.S. 1036 (1987); *In re* Quinlan, 355 A.2d 647 (N.J. 1976); *In re* Storar, 420 N.E.2d 64 (N.Y. 1981), *cert denied*, 454 U.S. 858 (1981), and in a larger number of related cases. *See also In re* Phillip B., 156 Cal. Rptr. 48 (Ct. App. 1979), *cert. denied*, 445 U.S. 949 (1980); *In re* Infant Doe, No. GU8204-00 (Ind. Cir. Ct. Monroe County, Apr. 12, 1982), *writ of mandamus dismissed sub nom.* State *ex rel.* Infant Doe v. Baker, No. 482 S. 140 (Ind. May 27, 1982), *cert. denied*, 464 U.S. 961 (1983); Weber v. Stony Brook Hosp., 467 N.Y.S.2d 685 (App. Div.) (per curiam), *aff'd*, 456 N.E.2d 1186 (N.Y. 1983), *cert. denied*, 464 U.S. 1026 (1983); *In re* Milton, 505 N.E.2d 255 (Ohio 1987), *cert. denied*, 484 U.S. 820 (1987).

14. *See* Laura Mansnerus, *The Suicide and the Doctor*, THE N.Y. TIMES, June 10, 1990, § 4, at 7.

15. *See, e.g.*, Annette Clark, *Autonomy and Death*, 71 TUL. L. REV. 45 (1996).

16. *See, e.g.*, *It's Over Debbie*, 249 JAMA 272 (1988) (physician anonymously claimed to have administered lethal overdose to terminally ill patient at her request); Timothy E. Quill, *A Case of Individualized Decision Making*, 324 NEW ENG. J. MED. 691 (1991) (physician admitted to having provided terminally ill patient with lethal overdose).

Voluntary active euthanasia of the terminally ill has been an increasingly accepted medical practice in the Netherlands since 1973, though increasingly subject to legal regulation. Debates about the Dutch experience have spilled over into the American and international press and professional and scholarly journals. *See, e.g.*, CARLOS GOMEZ, REGULATING DEATH: EUTHANASIA AND THE CASE OF THE NETHERLANDS (1991); Peter Admiraal, *Euthanasia in the Netherlands—Justifiable Euthanasia*, 3 ISSUES L. & MED. 361 (1988); Margaret Battin, *Voluntary Euthanasia and the Risks of Abuse: Can We Learn Anything from the Netherlands?*, 20 L. MED. & HEALTH CARE 133 (1992); M. deWachter, *Active Euthanasia in the Netherlands*, 262 JAMA 3316 (1989); Final Report of the Netherlands State Commission on Euthanasia: An English Summary, 1 BIOETHICS 163 (1987).

Public debate about actively hastening death in the United States dates back to the turn of the last century. *See* Ezekiel Emanuel, *Euthanasia—Historical, Ethical, and Empiric Perspectives*, 154 ARCHIVES INTERNAL MED. 1890, 1892 (1994) (Physician-assisted suicide and

move the discussion of physician-assisted suicide from the fringe to center-stage. This has subsequently led to a mountain of academic, popular, and professional writing and debate.[17] Yet, despite the extensive public discussion about assisted suicide for almost a decade, there has been very little discussion about the role that health care professionals — other than physicians — would play if assisted suicide were legalized.

One group of health care professionals — besides physicians — that is likely to be involved in legalized assisted suicide is pharmacists, who would dispense lethal substances prescribed by physicians.[18] The debate about the legalization of assisted suicide has also served as an important catalyst to less drastic alternatives, most notably pain control.[19] This, too, implicates pharmacists because an important, if not the predominant, mechanism of pain control is prescription medications.[20]

Any barriers that are placed in the way of pharmacists dispensing medications in accordance with a physician's legitimate prescription for pain control undermines the rights that patients might have to receive such medication and interferes with good end-of-life care. In addition, legal barriers to terminally ill patients receiving adequate medications for pain control undermine the Supreme Court's reasoning about the constitutionality of state statutes making assisted suicide a crime and could lead the Court to reconsider its decisions. Finally, legal barriers to the dispensing of medications for patients to use in physician-assisted suicide, where it is legal, interferes with this right as well.[21]

I. THE RIGHT TO PAIN CONTROL

Over the past few years, a concrete right of terminally ill patients to adequate pain control has gradually begun to emerge, first from state legislation and later from decisions of the United States Supreme

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active euthanasia have been debated throughout history, and as recently as the end of the nineteenth century, "had become a topic of speeches at medical meetings and editorials in British and American medical journals.").

17. *See supra* note 16.

18. *See generally* William Allen & David Brushwood, *Pharmaceutically Assisted Death and the Pharmacists' Right of Conscience*, 5 J. PHARMACY & L. 1 (1996).

19. *See id.*

20. *See id.*

21. Currently, Oregon is the only state that has legalized physician assisted suicide. *See* OR. REV. STAT. § 127.800-897 (1998).

Court.[22] Previously, there were no express prohibitions on physicians providing adequate pain control to patients — terminally ill or otherwise suffering from pain — but many physicians, whether reasonably or not, feared possible adverse legal consequences that might ensue from the prescription of the kinds of medications — not just analgesics, but sedatives and tranquilizers — often needed by terminally ill patients or by nonterminally ill patients in chronic pain.

In fact, not just physicians but *pharmacists* — and other health care professionals who prescribe or administer prescription medications — are potentially subject to a variety of criminal, civil, and administrative penalties. Pharmacists are subject to professional discipline, including revocation or suspension of their license, for improperly dispensing such medications; they can lose their registration with the federal Drug Enforcement Administration to dispense controlled substances,[23] which include most of the medications used for the treatment of severe pain and related conditions; they are subject to criminal liability for violation of the federal Controlled Substances Act;[24] and because the medications used for the treatment of severe pain have the potential for causing the patient's death, they may be subject to criminal, civil, and administrative proceedings if a patient dies or is injured from taking a prescription medication.

A. State Palliative Care Statutes

A gradually increasing number — now about 40 percent — of states have enacted statutes[25] intended to assist patients in receiving

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22. This is most recently evidenced by Justice O'Connor's concurrence in *Washington v. Glucksberg*, 521 U.S. 702, 702 (1997).

23. *See* 21 U.S.C. §824 (1999). For a thorough description of the registration process by which physicians become entitled to prescribe and pharmacists to dispense controlled substances, *see* Douglas J. Behr, *Prescription Drug Control Under the Federal Controlled Substances Act: A Web of Administrative, Civil, and Criminal Law Controls*, 45 WASH. U. J. URBAN & CONTEMP. L. 41, 53-58 (1994). *See also* Douglas J. Pisano, *Controlled Substances and Pain Management: Regulatory, Oversight, Formularies, and Cost Decisions*, 24 J. L. MED. & ETHICS 310 *passim* (1996).

24. *See* 21 U.S.C. §841(a)(1) (1999). *See generally* Behr, *supra* note 23, at 66-117.

25. In addition, some other states have adopted administrative rules or guidelines. *See, e.g.*, LA. REV. STAT. ANN. §37:1285.2 (1998) (establishing state Board of Medicine Advisory Committee on Pain to make recommendations to board on law reform about the use of prescription medications for treatment of pain); WASH. REV. STAT. ANN. §18.130.340 (1999) (directing state Secretary of Health to work with health professional regulatory boards and commissions to develop opiate therapy guidelines for treatment of terminal and intractable conditions). *See* Ann M. Martino, *In Search of a New Ethic for Treating Patients with Chronic Pain: What Can Medical Boards Do?*, 26 J.L. MED. & ETHICS 332, 332 (1998) ("Between 1997 and 1998, thirty states enacted laws adopting administrative rules, and/or established guidelines for the use of narcotic analgesics for the treatment of chronic pain.") (citing D.E. Joranson & A.M. Gilston, *State Intractable Pain Policy: Current Status*, 7

adequate palliative care, including adequate doses of appropriate medications for pain control.[26] These statutes were enacted to overcome physicians' reluctance to use powerful medications to treat pain because of their fear that the medications might hasten or cause the patient's death, thereby subjecting the prescribing physician to legal liability.[27]

There are actually two different kinds of statutory provisions. One type is usually labeled an "intractable pain act." These statutes authorize physicians to use medications to treat intractable pain, and they confer immunity from disciplinary action by state licensing authorities if the medication hastens or causes the patient's death.[28] The second type is an amendment to the state's statute making aiding suicide a crime,[29] which confers immunity from criminal prosecution

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APS Bulletin 7-9 (no. 2, 1997)). *See also* CHOICE IN DYING, RIGHT TO DIE LAW DIGEST, *State Laws Regarding Intractable Pain* (Sept. 1998).

26. *See* CAL. BUS. & PROF. CODE §2241.5 (West 1998); CAL. HEALTH & SAFETY CODE §§124960, 124961 (West 1998); COLO. REV. STAT. ANN. §12-36-117(1.5) (West 1998); FLA. STAT. ANN. §458.326(3) (West 1998); IND. CODE. ANN. §35-42-1-2.5 (West 1998); IOWA CODE ANN. §707A.3; KY. REV. STAT. ANN. §216.304 (Michie 1998); MICH. COMP. LAWS ANN. §§752.1027, 333.5658; MINN. STAT. ANN. §609.215(3)(a) (West 1998); MO. ANN. STAT. §§334.105-.107 (West 1998); NEV. REV. STAT. ANN. §§630.3066, 633.521 (Michie 1996); N.D. CENT. CODE §§19-01.3-01-06; OHIO REV. CODE ANN. §§2133.11, 2133.12 (Anderson 1998); OHIO REV. CODE ANN. §4731.052 (Anderson 1997); OKLA. STAT. ANN. tit. 63, §3141.4; OR. REV. STAT. §§677.470-.485 (1997); R.I. GEN. LAWS §11-60-4 (1998); R.I. GEN. LAWS §§5-37.4-1-.4-3; S.D. CODIFIED LAWS §22-16-37.1 (Michie 1998); TENN. CODE ANN. §39-13-216(b)(2) (Michie 1997); TEX. REV. CIV. STAT. ANN. ART. 4495(c) (West 1999); VA. CODE ANN. §54.1-3408.1 (Michie 1998); VA. CODE ANN. §8.01-622.1(E) (Michie 1998); WASH. REV. CODE ANN. §69.50.308; W. VA. CODE §§30-3A-1-3 (1999). *See generally* Sandra H. Johnson, *Disciplinary Actions and Pain Relief: Analysis of the Pain Relief Act*, 24 J.L. MED. & ETHICS 319 (1996).

27. *See generally* Johnson, *supra* note 26. *See also* Ann Alpers, *Criminal Act or Palliative Care? Prosecutions Involving the Care of the Dying*, 26 J. LAW MED. & ETHICS 308 (1998).

28. *See, e.g.*, CAL. BUS. & PROF. CODE § 2241.5; COLO. REV. STAT. ANN. § 12-36-117 (1.5); MICH. COMP. LAWS ANN. §§752.1027, 333.5658; MINN. STAT. ANN. §609.215(3)(a); MO. ANN. STAT. §§334.105-.107; NEV. REV. STAT. ANN. §§630.3066, 633.521; N.D. CENT. CODE §§19-03.3-01-06; OHIO REV. CODE ANN. §§2133.11(A)(6), 2133.12(E)(1), 4731.052; OR. REV. STAT. ANN. §§677.470- .485; R.I. GEN. LAWS §§5-37.4-1-3; TEX. REV. CIV. STAT. ANN. ART. 4495(C); W. VA. STAT. ANN. §30-3A-2.

29. *See, e.g.*, IND. STAT. ANN. §35-42-1-2.5; IOWA CODE ANN. §707A.3; KY. REV. STAT. ANN. §216.304; MICH. COMP. LAWS ANN. §§752.1027, 333.5658; MINN. STAT. ANN. §609.215(3)(a); OHIO REV. CODE ANN. §§2133.11(A)(6), 2133.12(E)(1); OKLA. STAT. ANN. tit. 63, §3141.4; R.I. GEN. LAWS §11-60-2; S.D. CODIFIED LAWS ANN. §22-16-37.1; TENN. CODE ANN. §39-13-216; W. VA. STAT. ANN. §§30-3A-2.

Virginia has a provision of its Drug Control Act dealing with this issue. *See* VA. CODE ANN. §54.1-3408.1. This provision states that a physician who in good faith prescribes an "excess dosage" of a pain relieving agent for the treatment of intractable pain is not in violation of the act. *Id.* However, it continues, "[n]othing in this section shall be construed to grant any person immunity from investigatory or disciplinary action based on the prescription, dispensing or administration of an excess dosage in violation of this title." *Id.*

if, as a result of the treatment of intractable pain, the physician hastens or causes the patient's death — what I refer to as "double effect" provisions. For convenience, I will refer to both types of statutes collectively as "palliative care statutes."

The enactment of palliative care statutes constitutes legislative recognition of the principle of double effect in end-of-life medical care. That is, these statutes recognize that if the intended effect of providing palliative care is the legitimate one of treating a patient's symptoms, but an unintended (though foreseeable) effect also occurs — namely, the palliative care causes the patient's death — the actor is exempt from legal consequences.[30]

1. Scope of Protection

One problem with the palliative care statutes is that they confer significantly different protections on physicians.[31] The intractable pain statutes provide immunity from state licensing board disciplinary action.[32] Theoretically, the physician is still subject to prosecution for assisted suicide in states in which assisted suicide is a criminal offense — which is most states — or for homicide.[33] The physician may also be subject to tort liability for wrongful death.

The double effect provisions exempt physicians from criminal liability if the patient dies as a result of being treated for intractable pain.[34] However, in theory, the physician is still subject to disciplinary action by state licensing authorities and to wrongful death actions.[35] The West Virginia statute provides protection against both criminal prosecution and administrative proceedings,[36] and four other states

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Thus, it appears to provide only immunity from prosecution for drug offenses but expressly not for disciplinary actions nor implicitly for other criminal offenses or civil actions. Virginia also has a statute intended to prevent suicide by creating a statutory basis for obtaining injunctive relief against any person who is believed to be about to aid another in committing suicide, but it does not apply to licensed health care practitioners who prescribe or dispense medications to relieve pain. *See* VA. CODE ANN. §8.01-622.1(E).

Aiding suicide is a distinct crime in most states. *See* ALAN MEISEL, THE RIGHT TO DIE, §18.17, at 344-45 (Supp. 1999) (Tbl. 18-1).

30. *See* 1 ALAN MEISEL, THE RIGHT TO DIE, §8.7 (2d ed. 1995).

31. *See* Martino, *supra* note 25.

32. *See* Chris Stern Hyman, *Pain Management and Disciplinary Action: How Medical Boards Can Remove Barriers to Effective Treatment*, 24 J. LAW MED. & ETHICS 338, 340 (1996) (noting that six states have enacted statutes that offer protection from disciplinary action with language, such as California's, that no physician and surgeon shall be subject to disciplinary action by the board for prescribing or administering controlled substances in the course of treatment of a person for intractable pain).

33. *See* MEISEL, *supra* note 29, at 344-45 (Tbl. 18-1).

34. *See* Alpers, *supra* note 27, at 318-20.

35. *See id.*

36. *See* W. VA. STAT. ANN. §§30-3A-2(a).

do so because they have both types of statutes.[37] Only two states also provide protection against civil liability.[38] Of course, none of the statutes do or could confer liability against violations of federal law, and thus physicians are still subject to criminal and administrative penalties for violation of the federal Controlled Substances Act.[39]

It is difficult to know what is the magnitude of risk of investigation or prosecution of a physician for homicide when a patient dies who has been prescribed large doses of pain control medications. Most instances of investigation or prosecution do not result in a reported appellate case, and thus obtaining accurate data is virtually impossible.[40] However, this is an area where perception probably

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37. *See* MICH. COMP. LAWS ANN. §§752.1027, 333.5658; MINN. STAT. ANN. §609.215(3)(a); OHIO REV. CODE ANN. §§2133.11(A)(6), 2133.12(E)(1), 4731.052; R.I. GEN. LAWS §§5-37.4-1 -3.

38. *See* MICH. COMP. LAWS ANN. §§752.1027, 333.5658; OHIO REV. CODE ANN. §§2133.11(A)(6), 2133.12(E)(1), 4731.052.

39. 21 U.S.C.A. §801 *et seq.* (1998). *See, e.g.*, W. VA. STAT. ANN. §30-3A-2(c) ("Nothing in this article shall prohibit disciplinary action or criminal prosecution of a . . . pharmacist for: (1) Administering or dispensing a controlled substance in violation of the provisions of the federal Comprehensive Drug Abuse Prevention and Control Act of 1970 . . .").

There are other problems with the protection purportedly conferred by palliative care statutes. The Institute of Medicine identified the following:

1. [These statutes] do not, in all cases, mark a clear area of medical practice in which physicians feel free to manage their patients' pain. The more specific laws, for example those that set out detailed prescription practices, may actually afford physicians less leeway in the practice of medicine. Additionally, by carving out an area of pain treatment that is immune from medical board discipline, there may be an implication that other forms of pain treatment should be subject to disciplinary review.
2. Even the strongest intractable pain law is still limited by the term intractable. Many cases are ambiguous, and physicians may believe that they must delay opioid treatment until pain is far enough along to be called intractable.
3. An additional problem arises when state laws define addition without regard to pain management. As noted earlier, California defines addicts as "habitual users," which might include patients taking opioids for chronic pain. Such confusing definitions . . . expose physicians to the threat of medical board discipline.
4. Finally, the legal affirmations in these laws of the importance of pain control do not, in themselves, correct practice patterns or improve physician training. Laws could, however, encourage patients to expect diligence in pain relief, including use of generally effective medications. Medical boards could consider disciplining physicians who fail to apply proven methods of pain control.

INSTITUTE OF MEDICINE, APPROACHING DEATH: IMPROVING CARE AT THE END-OF-LIFE 197 (M.J. FIELD & C.K. CASSEL eds., 1997).

40. *See generally* Alpers, *supra* note 27, at 308 (Tbl. 1, at 312-13, reporting criminal investigations of physicians; Tbl. 2, at 313-14, reporting criminal trials of physicians). *But see* Haugen, *supra* note 1, at 353 ("[N]o physician in the United States has ever been convicted of murder or assisted suicide for providing a patient with high doses of medication for pain relief." (citing Melissa L. Buchan & Susan W. Tolle, *Pain Relief for Dying Persons: Dealing with*

matters more than reality.[41] An occasional news report of an investigation or prosecution of a physician — or a pharmacist or a nurse — may have a strong impact on other health care professionals, with the lasting message that it is better to err on the side of being conservative in the prescribing and dispensing of pain control medications.[42] In addition, even if physicians are not subject to criminal prosecutions in such situations, they may be cited for violations of state licensing laws and regulations and federal drug control laws.[43] Even if violations of such laws are ultimately not proved, in the meantime, a physician can incur substantial financial costs, embarrassment and bad publicity, and possible temporary suspension of a license to practice medicine or registration to prescribe controlled substances.[44]

2. Applicability to Pharmacists

Palliative care statutes were enacted largely to allay physicians' fears of incurring adverse legal consequences from the use of medications intended to treat severe pain. In most instances in which physicians prescribe medications for legitimate palliative purposes, a pharmacist will dispense the medication, and thus the question arises of whether or not palliative care statutes provide protection to pharmacists too.[45]

At the threshold, we must ask what it is for which pharmacists might need protection. A pharmacist could conceivably be subject to liability for assisted suicide (or possibly homicide) if a patient committed suicide using a medication prescribed by a physician for pain control and dispensed by the pharmacist. However, the possibility of criminal liability seems extremely remote. For there to be liability for

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Physicians' Fears and Concerns, 6 J. CLINICAL ETHICS 53, 53 (1995)); Leonard H. Glantz, *Withholding and Withdrawing Treatment: The Role of the Criminal Law*, 15 LAW MED. & HEALTH CARE 231, 238-40 (1987); Sidney H. Wanzer et al., *The Physician's Responsibility to Hopelessly Ill Patients*, 310 NEW ENG. J. MED. 955, 956 (1984).

41. *See generally* Martino, *supra* note 25.

42. *See id.*

43. *See generally* RICHARD R. ABOOD & DAVID B. BRUSHWOOD, PHARMACY PRACTICE AND THE LAW chs. 3 & 6 (1994).

44. *See* 21 U.S.C.A. §823(b), (e) (West 1998); Johnson, *supra* note 26. *See generally* Martino, *supra* note 25.

45. A model pain relief act specifically includes pharmacists within its definition of health care provider. *See* Project on Legal Constraints on Access to Effective Pain Relief, *The Pain Relief Act*, 24 J. LAW, MED. & ETHICS 317, 317 (1996). The National Legal Center for the Medically Dependent & Disabled, Inc., drafted model legislation stating that "[a] licensed pharmacist . . . may dispense medical means of suicide to a person who the pharmacist reasonably believes presents a valid prescription for such means." *See* National Center for the Medically Dependent and Disabled, Inc., *A Model State Act to Authorize and Regulate Physician-Assisted Suicide*, 13 ISSUES IN LAW & MED. 219, 223 (1997).

assisted suicide under the Model Penal Code, among other things, the actor must "purposely aid[ ] . . . another to commit suicide . . . ."[46] Rare would be the pharmacist who possesses sufficient facts about the patient to meet this scienter requirement.[47]

In a jurisdiction in which physician-assisted suicide is not legal, it is likely that if a physician is going to aid the patient in ending his life, the physician will take considerable pains to be sure that his complicity will not be apparent. For example, the physician may insinuate that the patient could gradually build up a lethal supply of a prescribed medication. Although the pharmacist plays a role in the patient's death by dispensing the medication, it is an altogether unwitting one if the prescription, on its face, gives no hint of the fact that the patient intends eventually to use it to kill himself. In other cases of patient suicide, the physician will not even be aware of the patient's intent to use medications prescribed for pain control to end his life. This would make criminal liability on the part of the pharmacist an even more remote possibility. The same is true of tort liability for intentionally causing the patient's death. In addition, in such cases, courts have usually concluded that the patient's conduct in committing suicide is a superseding cause that cuts off any liability the pharmacist might otherwise have had.[48]

A pharmacist could also conceivably be subject to criminal or tort liability for negligently causing the death of a patient being treated for intractable pain if the pain medication accidentally caused the patient's death. Proof of negligence would be far simpler than proof of intent. However, establishing that a pharmacist owes a duty, the breach of which is actionable, to warn patients of the lethality of a drug taken in excess of what is prescribed is highly problematic.[49]

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46. MODEL PENAL CODE §210.5(2)(1980).

47. Under the Model Penal Code:

> A person acts purposely with respect to a material element of an offense:
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> (i) if the element involves the nature of his conduct or a result thereof, it is his conscious objective to engage in conduct of that nature or to cause such a result; and
>
> (ii) if the element involves the attendant circumstances, he is aware of the existence of such circumstances or he believes or hopes that they exist.

MODEL PENAL CODE §2.02 (1980).

48. *See, e.g.*, Speer v. United States, 512 F. Supp. 670, 679 (N.D. Tex. 1981) (finding pharmacist negligent for failure to monitor patient's prescriptions which patient hoarded and used to commit suicide, but holding that this negligence was not a proximate cause of harm to the patient). *See generally* W.E. Shipley, Annotation, *Druggist's Civil Liability for Suicide Consummated with Drugs Furnished by Him*, 58 A.L.R.3d 828 (1975).

49. *See, e.g.*, Kampe v. Howard Stark Prof'l Pharmacy, Inc., 841 S.W.2d 223, 226 (Mo. Ct. App. 1992) (holding the pharmacist's responsibility applies to dispensing controlled

Pharmacists may also be subject to administrative proceedings, resulting in suspension or revocation of their license to practice pharmacy, if a patient dies or is injured as a result of an excessive dosage of medication. Pharmacists generally are subject to professional discipline for a conviction of a felony,[50] so in the unlikely event that a pharmacist is convicted of intentional or accidental criminal homicide or aiding suicide from an excessive dose of pain medication, this could also form the basis for disciplinary proceedings. Even in the absence of a criminal conviction, pharmacists are subject to professional discipline for unprofessional conduct as a result of dispensing practices.[51] Finally, pharmacists might be subject to criminal or civil penalties for the violation of federal or state statutes regulating controlled substances.[52]

We can only begin to answer the question of whether palliative care statutes provide protection to pharmacists against these myriad possible sanctions by looking at the exact language of the statutes, and of course we find that they are worded in various ways and that some are clearer than others in this regard. Only the West Virginia statute specifically addresses applicability to pharmacists.[53] It provides that "[a] registered pharmacist shall not be subject to disciplinary sanctions by a licensing board or criminal punishment by the state for dispensing a prescription for a pain-relieving controlled substance to alleviate or control intractable pain, if dispensed in accordance with the orders of a licensed physician."[54] A few palliative care statutes ex-

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substances, not providing advice on their use). *See generally* Mitchell Waldman, 25 AM. JUR. 2D Drugs and Controlled Substances §236 (1996).

50. *See* ABOOD & BRUSHWOOD, *supra* note 43. Furthermore,

> [n]early all pharmacy practice acts contain catchall phrases that can snare unsuspecting pharmacists who follow the letter, but not the spirit, of the law. Terms such as 'unprofessional conduct' and 'moral turpitude' can serve as the basis for a successful disciplinary proceeding, even if the pharmacist involved has disobeyed no specific legal requirement.

Id. at 176.

51. *See generally* Vitauts M. Gulbis, Annotation, *Wrongful or Excessive Prescription of Drugs as Grounds for Revocation or Suspension of Physician's or Dentist's License to Practice*, 22 A.L.R.4th 668 (1981). Minnesota has enacted a statute specifically providing that a pharmacist's license may be denied, suspended, or revoked if he or she is found to have aided or attempted to aid in a suicide in violation of the state's assisted suicide statute. *See* MINN. STAT. §151.06(7)(xiii) (1998).

52. *See, e.g.*, 21 U.S.C. §841(a)(1) (West 1998). *See generally* Behr, *supra* note 23, at 66-117.

53. *See* W. VA. STAT. ANN. § 30-3A-3(b)(1).

54. *Id.* However, the statute also states that "[n]othing in this article shall prohibit disciplinary action or criminal prosecution of a . . . pharmacist for: (1) Administering or dispensing a controlled substance in violation of the provisions of the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970." *Id.*

pressly provide protection to "health care professionals" or a "licensed health care provider" and then define that term to include pharmacists.[55] Others, such as Indiana's, contain no definition of health care provider.[56] However, it is reasonable to assume that the statutory term "health care provider" includes pharmacists.[57]

Other statutes might cover pharmacists but do not do so expressly. For example, the provision in a few palliative care statutes that any "person" "who prescribes, dispenses or administers an excess dosage in accordance with this section shall not be in violation of the provisions of this title" certainly includes pharmacists.[58] Some statutes include dispensing medications within the scope of a physician's statutorily protected activities,[59] and these might also support a claim for the inclusion of pharmacists among those who are protected by the statutes.

Finally, even in the absence of express or tacit statutory language, a claim can be made on the basis of policy that pharmacists should be protected under the remainder of the statutes because pharmacists are an ordinary, and often necessary,[60] part of the process of dispensing medication, and the primary interest sought to be protected by the statute — assuring adequate analgesia and sedation for terminally ill patients — would be undermined if only physicians were accorded statutory protection but not pharmacists and all other necessary persons in the chain of prescribing, dispensing, and administering the medications.

In sum, current state legislation provides uneven and incomplete protection to pharmacists. One of the most obvious shortcomings is that it does not — and cannot — confer protection against federal offenses.

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55. *See, e.g.*, IOWA CODE ANN. §707A.1 (West 1998); IND. CODE ANN. §35-42-1-2.5 (Michie 1998); KY. REV. STAT. ANN. §216.300 (Michie 1998); MINN. STAT. ANN. §609.215 (3)(a) (West 1998); R.I. GEN. LAWS §11-60-2 (1997); S.D. CODIFIED LAWS ANN. §22-16-37.7 (Michie 1998).

56. *See* IND. CODE ANN. §35-42-1-2.5 (Michie 1998).

57. Some of the statutes that do define health care professionals specifically include pharmacists. *See, e.g.*, KY. REV. STAT. ANN. §216.300 (Michie 1998); MINN. STAT. ANN. §609.215(3)(a) (West 1998); R.I. GEN. LAWS §11-60-2 (1997); S.D. CODIFIED LAWS ANN. §22-16-37.7 (Michie 1998).

58. *See* VA. CODE ANN. §54.1-3408.1. *Accord* MICH. COMP. LAWS ANN. §752.1027; TENN. CODE ANN. §39-13-216.

59. *See* MO. ANN. STAT. §334.106(1); OHIO REV. CODE ANN. §§2133.11-.12; R.I. GEN. LAWS §5-37.4-3; VA. CODE ANN. §54.1-3408.1.

60. *But see* discussion of pharmacist dispensing *infra* notes 103-07 and accompanying text.

B. United States Supreme Court Decisions

Two United States Supreme Court cases, having little on their face to do with palliative care, may turn out to be critically important to the development of the law in this area. *Washington v. Glucksberg*[61] and *Vacco v. Quill*[62] commenced as actions to declare unconstitutional and enjoin the further enforcement of, respectively, the Washington and New York state statutes making aiding suicide a criminal offense, at least when the person doing the aiding was a licensed physician and the person receiving the aid was terminally ill.[63] The Supreme Court's narrow holdings in these cases are that neither the Fourteenth Amendment's due process clause nor the equal protection clause invalidate these state statutes.[64] However, the cases do much more. They might establish a constitutional right to palliative care; they recognize the legitimacy of the principle of double effect; and they seemingly recognize that states are constitutionally permitted to legalize physician-assisted suicide.

1. Constitutional Right to Palliative Care

If state palliative care statutes do not cover the waterfront — and there are still many states that do not have one, and in others it is unclear whether they apply to pharmacists — then the Supreme Court's decisions in the physician-assisted suicide cases should assure a right to palliative care. The *Glucksberg* and *Vacco* decisions are strongly grounded in the assumption that physician-assisted suicide is not needed because there are no legal barriers to obtaining adequate palliative care. Although the Court did not hold, or even state, that states are constitutionally prohibited from constructing barriers to obtaining medication for pain relief,[65] if such barriers did exist, this might be one of the situations in which the Chief Justice's majority

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61. 521 U.S. 702 (1997).

62. 521 U.S. 793 (1997).

63. *See Glucksberg*, 521 U.S. at 702; *Vacco*, 521 U.S. at 793.

64. *See Glucksberg*, 521 U.S. at 706; *Vacco*, 521 U.S. at 797.

65. However, Justice Breyer in concurrence was more specific:

> [T]he laws before us do not force a dying person to undergo that kind of pain . . . . Were the legal circumstances different–for example, were state law to prevent the provision of palliative care, including the administration of drugs as needed to avoid pain at the end of life–then the law's impact upon serious and otherwise unavoidable physical pain (accompanying death) would be more directly at issue. And as Justice O'Connor suggests, the Court might have to revisit its conclusions in these cases.

Vacco, 521 U.S. at 791-92 (Breyer, J., concurring).

opinions stated that the Court would have to revisit the question of the constitutionality of state laws that criminalize assisted suicide.[66]

Second, a majority of the Justices — especially Justices O'Connor, Ginsburg, and Breyer, but also Justices Stevens and Souter – issued concurring opinions that went significantly beyond the Chief Justice's narrow opinion for the Court. As Professor Robert Burt has observed, all, in their own way, can be viewed as providing substantial support for the existence of a constitutional right to palliative care.[67] This should also create a strong incentive for opponents of the legalization of physician-assisted suicide to work to be certain that legal barriers to obtaining adequate palliative care do not exist, for if they do, one of the foundations of the Court's holdings will crumble.

2. Supreme Court's Recognition of Principle of Double Effect

One need not go as far as Professor Burt does, for it is certain that Supreme Court decisions recognize the legitimacy of the doctrine of double effect.[68] In *Vacco*, the Court lumped death resulting from

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66. That is, such barriers to palliative care might be what the Court envisioned in the last footnote of each case that would cause the Court to reconsider the constitutionality of state prohibitions on physician-assisted suicide. *See Glucksburg*, 521 U.S. at 735 n.24; *Vacco*, 521 U.S. at 809 n.13.

67. *See* Robert A. Burt, *The Supreme Court Speaks - Not Assisted Suicide But a Constitutional Right to Palliative Care*, 337 NEW ENG. J. MED. 1234, 1235 (1997). He states that:

> [T]hree Justices (O'Connor, Ginsburg, and Breyer) specifically concluded that judicial intervention would become necessary, as Justice Breyer put it, "were state law to prevent the provision of palliative care, including the administration of drugs as needed to avoid pain at the end of life." An additional two justices (Souter and Stevens) mentioned this issue as one among other problems afflicting terminally ill people that, if not adequately addressed by state legislatures, would require future judicial intervention.

Id.

68. *See* Vacco v. Quill, 521 U.S. 793, 802-03 (1997).

> The law has long used actor's intent or purpose to distinguish between two acts that may have the same purpose or result. The law distinguishes between actions taken "because of" their intended end and actions taken "in spite of" their unintended but foreseen consequences.

Id. See also John D. Arras et al., *Introduction* to JOHN D. ARRAS & BONNIE STEINBOCK, ETHICAL ISSUES IN MODERN MEDICINE 21 (John D. Arras & Bonnie Steinbock eds., Mayfield Publishing Company 1993).

> The doctrine of double effect (DDE) was formulated in response to the recognition that an act may have both a good and a bad effect . . . For example administering morphine to a dying cancer patient may be necessary to relieve his or her pain, but it may also depress respiration and hasten death. Must a doctor refrain from using the most effective pain medication because it might also kill the patient? Would this count as doing evil (causing death) that good (relieving pain) may come? . . . The physician's purpose is not to kill, but rather easing pain, although he or she foresees that death is a possible, or even likely, result. Giving drugs for pain relief is not intrinsically wrong; indeed it is a central function of

an unintentional overdose of pain relief medication with the acceptable practices of withholding and withdrawing treatment, and distinguished them from actively hastening death:

> [A] physician who withdraws, or honors a patient's refusal to begin, life-sustaining medical treatment purposefully intends, or may so intend, only to respect his patient's wishes and "to cease doing useless and futile or degrading things to the patient when [the patient] no longer stands to benefit from them." [Citation omitted]. The same is true when a doctor provides aggressive palliative care; in some cases, painkilling drugs may hasten a patient's death, but the physician's purpose and intent is, or may be, only to ease his patient's pain. A doctor who assists a suicide, however, "must, necessarily and indubitably, intend primarily that the patient be made dead."[69]

And in *Glucksberg*, the Court more pointedly stated that:

> The purpose of requesting and giving the medication is presumably not to cause death but to relieve the pain so that the State's interest in preserving life is not unequivocally implicated by the practice; and the importance of pain relief is so clear that there is less likelihood that relieving pain would run counter to what a responsible patient would choose, even with the consequences for life expectancy.[70]

These are clear statements of the Supreme Court's acceptance of the legitimacy of double effect and its imprimatur on the use of adequate medications for pain control even if they inadvertently accelerate or even cause death.

3. Supreme Court's Recognition That States May Legalize Physician-Assisted Suicide

The Supreme Court also recognized, though obliquely, that the Constitution does not bar physician-assisted suicide, and thus a state may choose to legalize it, as has been done in Oregon[71] and unsuc-

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> the physician. The good effect-the relief of pain-is produced by the bad effect, namely the patient's death. And lastly when a patient is both terminally ill and suffering, the desirability of relieving suffering compensates for the shortening of his or her life. Thus, DDE can be a useful tool for justifying an action that has a bad effect.

Id.

69. *Vacco*, 521 U.S. at 802 (quoting *Assisted Suicide in the United States, Before the Subcomm. On the Constitution of the House Comm. on the Judiciary*, 104th Cong., 2d Sess., 368 (1996) (testimony of Dr. Leon R. Kass)).

70. *Glucksberg*, 521 U.S. at 784 n.16 (Souter, J., concurring).

71. *See* OR. REV. STAT. §§127.800-.897 (1997).

cessfully attempted in other states.[72] Thus, the Supreme Court probably granted Oregon a right to legalize physician-assisted suicide, a conclusion supported by the Court's denial of certiorari in *Lee v. Harcleroad*, the case dismissing the injunction against the implementation of Oregon's voter initiative legalizing physician-assisted suicide.[73] If states may legalize the use of medications for the purpose of intentionally hastening a patient's death, certainly physicians should not be prohibited from using legitimate prescription medications for the less drastic purpose of pain control merely because their use risks causing death.

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72. *See Glucksberg*, 521 U.S. at 735 (stating that "[t]hroughout the Nation, Americans are engaged in an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society."). *See also id.* at 788-89 (Souter, J., concurring); *id.* at 738-52 (Stevens, J., concurring). The consensus among scholars is that the Court did leave it up to each state to decide for itself how to address the concerns over physician-assisted suicide. *See, e.g.*, Benjamin C. Zipursky, *Physician-Assisted Suicide: Right and Risk to Vulnerable Community*, 24 FORDHAM URB. L. J. 777, 777 (1997); Susan Frelich Appleton, *Assisted Suicide and Reproductive Freedom: Exploring Some Connections*, 76 WASH. U. L. Q. 15, 31 (1998).

73. 118 S. Ct. 328 (1997), *denying cert. to* Lee v. Oregon, 107 F.3d 1382 (9th Cir. 1997), *rev'g* Lee v. Oregon, 891 F. Supp. 1429 (D. Or. 1995). A provision of the Oregon statute provides that:

> No health care provider shall be under any duty, whether by contract, by statute or by any other legal requirement to participate in the provision to a qualified patient of medication to end his or her life in a humane and dignified manner. If a health care provider is unable or unwilling to carry out a patient's request under ORS 127.800 to 127.897, and the patient transfers his or her care to a new health care provider, the prior health care provider shall transfer, upon request, a copy of the patient's relevant medical records to the new health care provider.

ORE. REV. STAT. §§127.885(2), (4).

The applicability of this provision to pharmacists is unclear. The threshold question is whether a pharmacist is a "health care provider" as that term is used with the statute. The Death with Dignity act defines "health care provider" as:

> a person licensed, certified, or otherwise authorized or permitted by the law of this State to administer health care in the ordinary course of business or practice of a profession, and includes a health care facility.

Id. §127.800(5), thereby begging the question.

The provisions of the Oregon statutes dealing with the licensing of pharmacists do not make it clear whether or not pharmacists are to be considered "health care providers" or whether the practice of pharmacy is "health care." However, it is certainly a reasonable assumption that they do. *See, e.g.*, ORE. REV. STAT. §689.025(2) (1997) (stating that the purpose of the act is to promote the public's health and welfare through the regulation of drugs "used in the diagnosis and treatment of injury, illness and disease.").

Second, the second sentence of § 127.885(4) dealing with the transfer of medical records makes it seem as if the entire subsection is intended to apply to physicians and health care institutions such as hospitals, nursing homes, and hospices but not necessarily to pharmacists.

II. PHARMACISTS' CONCERNS ABOUT THE LEGALIZATION OF PHYSICIAN-ASSISTED SUICIDE

If pharmacists could be subjected to legal penalties — criminal, civil, or administrative — based on their dispensing medications in accordance with a physician's legitimate prescription for palliative care, it would render a patient's right to adequate palliative care a nullity. Logic dictates that if it is legal for a physician to prescribe medication for palliative care, it must be legitimate for a pharmacist to dispense it. Thus, state palliative care statutes must be construed by courts and administrative agencies — and probably should be clarified by legislatures — to apply to pharmacists' dispensing of medications prescribed by physicians as well as to physicians' prescription practices. Similarly, to the extent that the United States Supreme Court's decisions rejecting a constitutional right to physician-assisted suicide can be viewed as creating a constitutional right to palliative care, this right must also extend to pharmacists' dispensing as well as physicians' prescribing.

That much ought to be uncontroversial. What is more controversial are the concerns of pharmacists arising from the legalization of physician-assisted suicide. The right to physician-assisted suicide, where it has been legalized, would be undermined if pharmacists could be penalized for filling a legal prescription for a medication intended for such use. Thus, as with the dispensing of medications for palliative care, logic again dictates that if it is legal for a physician to prescribe medication for physician-assisted suicide, it must be legal for a pharmacist to dispense it. As a starting point, that might be correct, but as with most things, it's more complicated than that.

Oregon is the only state to have legalized physician-assisted suicide, although similar efforts have been made in other states, both before and after Oregon's actions.[74] It did so through a voter initiative in 1994, leading to the enactment of the Oregon Death with Dignity Act[75] by a margin of 51 to 49 percent.[76] The implementation of this act was promptly enjoined by a federal district court.[77] The injunction remained in place for almost three years.[78] It was not lifted

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74. *See generally* Arthur A. Povelones, Jr., *When the Majority Says You May Die: Aid-in-Dying Initiatives*, 9 NOTRE DAME J.L. ETHICS & PUB. POL'Y 537 (1995).

75. *See* OR. REV. STAT. §127.800 *et seq.* (1996).

76. *See* Povelones, *supra* note 74, at 550 n.65.

77. *See* Lee v. Oregon, 891 F. Supp. 1429 (D. Or. 1995), *vacated and remanded for lack of standing*, 107 F.3d 1382 (9th Cir. 1997), *cert. denied sub. nom.* Lee v. Harcleroad, 118 S. Ct. 328 (1997).

78. *See Lee*, 107 F.3d at 1386.

until after the United States Supreme Court had ruled in the two physician-assisted suicide cases.[79] By that time, efforts were underway in Oregon to repeal the original initiative through a second initiative.[80] However, this effort failed by a margin of 60 to 40 percent in the November 1997 election.[81] As of the end of 1998, Oregon officials reported that physicians had prescribed a lethal dose of medication to terminally ill patients on 23 occasions, and 15 patients actually died from the prescribed overdose, six died naturally before being able to take the medications, and two were still alive at the time of the report.[82]

Although failing at the state level to repeal the legalization of physician-assisted suicide, opponents still hold out hope at the federal level. Shortly after Oregon voters reaffirmed their commitment to the legalization of physician-assisted suicide in the November 1997 election, the director of the United States Drug Enforcement Administration (DEA) ruled that it would be a violation of the federal Controlled Substances Act for any physician, including those in Oregon, to dispense controlled substances for the purpose of aiding a patient in ending his own life.[83] However, the DEA director neglected to consult with his superior, Attorney General Reno, who commenced a study of the action and concluded that the DEA director had not acted in keeping with the Congressional purpose in enacting the Controlled Substances Act — to prevent trafficking in illegal drugs and abuse of legitimate drugs.[84] She then concluded that the Controlled Substances Act did not support the ban on the use of legitimate drugs for an approved medical purpose.[85]

In reaction to the Attorney General's decision, legislation known as the Lethal Drug Abuse Prevention Act was introduced in the House and the Senate to block the use of controlled substances for use in

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79. *See id.*

80. *See* Timothy Egan, *In Oregon, Opening a New Front in the World of Medicine*, N.Y. TIMES, Nov. 6, 1997, at A26.

81. *See id.*; Gail Kinsey Hill, *Suicide Law Stands*, PORTLAND OREGONIAN, Nov. 5, 1997, at A1.

82. *See* Arthur E. Chin et al., *Legalized Physician-Assisted Suicide in Oregon – The First Year's Experience*, 340 NEW ENG. J. MED. 577 (1999); Oregon Health Division, *Oregon's Death with Dignity Act: The First Year's Experience* (visited Feb. 18, 1999) <http://www.ohd.hr.state.or.us/cdpe/chs/pas/ar-index.htm>.

83. *See DEA Could Take Action Against Oregon Physicians, Constantine Says*, BNA HEALTH CARE DAILY, Nov. 13, 1997, at D6.

84. *See DEA Won't Sanction Oregon Physicians Who Participate in Lawful Assisted Suicides*, 7 BNA's HEALTH LAW REP. No. 24, at 958-59 (1998).

85. *See id.*

physician-assisted suicide, euthanasia, or mercy killing.[86] The Senate version of the bill states that "the dispensing or distribution of controlled substances to assist suicide is not a legitimate medical purpose and should not be construed to be permissible under the Controlled Substances Act."[87] However, prominent opponents of physician-assisted suicide, including Oregon's Governor Kitzhaber and Senator Wyden, opposed federal intervention to impede the Oregon statute, whether by the DEA or by federal legislation.[88]

Although the bills acknowledge that use of controlled substances for the treatment of pain is a legitimate use under the Controlled Substances Act,[89] even some opponents of physician-assisted suicide fear that the legislation will seriously harm the efforts to make pain control medications available to those who legitimately need them.[90] The principal objection to the proposed legislation is that it would deter physicians from aggressively prescribing pain medication for terminally ill patients because of their fear that inadvertent patient deaths could cost doctors their DEA registration, needed for prescribing controlled substances.[91] The American Medical Association, one of the most outspoken and influential organizations on record as opposing the legalization of physician-assisted suicide, concurred in the opposition to federal intervention.[92]

The proposed legislation would also burden pharmacists, who would be forced to distinguish between prescriptions intended for pain relief and prescriptions intended for use in physician-assisted sui-

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86. *See* S. 2151, 105th Cong. (1998); H.R. 4006, 105th Cong. (1998).

87. S. 2151, at §2.

88. *See* Erin Hoover Barnett, *Congress to Open up Debate on Assisted Suicide*, PORTLAND OREGONIAN, July 9, 1998, at B1; Jim Barnett, *Utah Senator Vows to Fight Oregon's Law*, PORTLAND OREGONIAN, Nov. 10, 1997, at A1.

89. *See* S. 2151, §2(a)(4); H.R. 4006, §2(b)(i)(B).

90. *See AMA, Pharmacists Blast Bill to Block Physician-Assisted Suicide*, MED. & HEALTH, July 20, 1998 (reporting over 30 organizations expressed opposition to the measure, including the American Pharmaceutical Association and American Society of Health Systems Pharmacists).

91. *See* Dave Hogan & Jim Barnett, *House Panel Votes to Block Suicide Law*, PORTLAND OREGONIAN, Aug. 5, 1998, at A1; *see also* Johnson, *supra* note 26, at 320:

> Doctors' fears of disciplinary action and criminal prosecution are justified. There is no evidence that the large numbers of physicians are sanctioned for their treatment of patients in pain, but the impact of the process on those physicians who are only investigated, or only charged but not disciplined, or only warned or cautioned but not penalized is severe.

Id.

92. *See* Diane M. Gianelli, *Aid Suicide, Lose DEA License*, AM. MED. NEWS, July 27, 1998, at 1.

cide cases.[93] This, and the burden placed on physicians, would ultimately redound to the disadvantage not merely of patients seeking controlled substances for physician-assisted suicide but the much larger group of patients — both terminally ill and nonterminally ill — who need these medications for the relief of serious pain.[94]

A. Pharmacists' Need to Know the Purpose of a Prescription

In November 1997, after the second referendum to legalize physician-assisted suicide, the Oregon Board of Pharmacy adopted a temporary rule stating that:

> a prescription issued pursuant to the Oregon Death with Dignity Act shall be in writing and signed by the physician with the words 'This prescription is pursuant to ORS 127.800 - 127.897' on the face of the prescription.[95]

Why the Board did so is not entirely clear. It might have been a legitimate effort to provide pharmacists with information they believed they needed to appropriately fill prescriptions, or it might have been an attempted end run by the Pharmacy Board around the Death with Dignity Act.

Although this rule has been withdrawn, some pharmacists still contend that they need to know if a prescription is intended to be used for physician-assisted suicide.[96] Further, enactment of legislation like the federal Lethal Drug Abuse Prevention Act[97] would also create a need for physicians to have this information. There are a number of arguably legitimate reasons why pharmacists need to know that a par-

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93. *See Physician-Assisted Suicide Bill Would Require Pharmacies to "Guess" Intended Use of Substances, Risking Pharmacies' DEA Registration If Guess is Wrong, NHO Says*, HEALTH NEWS DAILY, Aug. 21, 1998, *available in* 1998 WL 9315046.

94. *See id.*

95. OR. ADMIN R. 855-041-0065 (Nov. 14, 1997). A few months later, a lawsuit commenced by the Oregon Medical Association challenging the validity of this rule. *See* Patrick O'Neill, *Physicians Appeal Rule on Suicide Medicines*, PORTLAND OREGONIAN, Jan. 9. 1998, at D1. This suit was settled, and the Pharmacy Board's rule was replaced by a Board of Medical Examiners' rule requiring that physicians who prescribe medications pursuant to the Death with Dignity Act either dispense the medications themselves if the physician is registered as a dispensing physician with the Board, or "with the patient's consent" inform the pharmacist of the purpose of the prescription. OR. ADMIN R. 847-015-0035 (final review, July 17, 1998) (on file with *Journal of Health Care Law & Policy*). The rule does not state what is to occur if the patient refuses consent to release of this information to the pharmacist.

96. *See* Michael T. Rupp & Holly L. Isenhower, *Pharmacists' Attitudes Toward Physician-Assisted Suicide*, 51 AM. J. HOSP. PHARM. 69, 73 (1994).

97. S. 2151, 105th Cong. (1998); H.R. 4006, 105th Cong. (1998).

ticular prescription is intended to be used by a patient pursuant to the physician-assisted suicide statute.[98]

1. Counseling Patients

One such reason is so that the pharmacist can properly dispense and label the prescription and properly counsel the patient (or the patient's caregiver) about the prescription's use, whether the medication is intended for the relief of pain or for physician-assisted suicide. Because many medications can be used for either purpose, pharmacists need to be able to protect patients who are using the medication for some medical purpose other than committing suicide. A physician might prescribe a medication for a patient for pain control that could also be used for assisted suicide. If the physician were to make an error in the dosage that inadvertently made the prescription lethal, the pharmacist would only be able to alert the physician or the patient to the error if he knew the prescription's purpose. If the pharmacist incorrectly assumed that the prescription was intended for hastening the patient's death and filled the prescription, a tragic error could occur. In other words, the pharmacist can only know if the prescription is correct if he knows the prescription's intended purpose. On the other hand, if the purpose of the prescription is to end the patient's life, pharmacists may need to know that too in order to give proper counsel as to how to use the medication.[99]

Pharmacists have legal obligations to counsel patients.[100] The traditional common-law obligation is somewhat attenuated, uncertain, and even conflicting,[101] but in the last two decades it has begun to develop into a more robust obligation to warn patients of a variety of kinds of things that can go wrong from the medications dispensed by a pharmacist.[102] Furthermore, there are federal statutory obligations

98. Fifty-four percent of pharmacists would want to know if a prescription was intended for assisted suicide. *See* Rupp & Isenhower, *supra* note 96, at 71.

99. *See* O'Neill, *Pharmacy Board Requires Notification*, PORTLAND OREGONIAN, Nov. 7, 1997, at A14 ("Pharmacists who want to help with suicides say notification will let them better counsel patients on how to use the medication.").

100. *See infra* notes 103-04 and accompanying text.

101. *See, e.g.*, Jones v. Irvin, 602 F. Supp. 399, 402 (S.D. Ill. 1985) (holding pharmacist has no duty to warn patient or notify physician that patient is being over-medicated or that drugs could cause adverse reactions, placing duty on physician to ascertain correct dosages and combinations of drugs). *See generally* David J. Marchitelli, Annotation, *Liability of Pharmacist Who Accurately Fills Prescription for Harm Resulting to User*, 44 A.L.R. 5th 393, 393 (1996) ("In most cases, courts have taken a position . . . that a pharmacist has no duty to warn a customer of the risk of harm that might be encouraged from drugs which are accurately dispensed upon a valid and legal prescription.").

102. *See* Allen & Brushwood, *supra* note 18, at 4.

to counsel patients,[103] and some states have similar statutory obligations.[104] In the context of physician-assisted suicide, this obligation means, as one Oregon Pharmacy Board member explained, "if they're going to take a large dose of barbiturates, they need to take it very rapidly because of the possibility that they'd fall asleep before they finished it."[105]

2. Avoiding Liability

Closely related to the first reason for wishing to know if the purpose of a prescription is for assisted suicide is pharmacists' and pharmacy owners' fears that they will incur civil liability if a prescription for assisted suicide fails and injures the patient.[106] This concern is probably without substantial legal basis. Although there is not a great deal of law on the subject, what there is suggests that pharmacists do not have a duty to warn a patient that a medication is inappropriate or ineffective.[107]

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103. *See* Pharmaceutical Access and Prudent Purchasing Act of 1990, 42 U.S.C. §1396r-8 (g)(2)(A)(ii)(I) (1991). The Act requires pharmacists to "offer to discuss" matters that in the pharmacist's professional judgement are significant, including:

- The name and description of the medication.
- The route, dosage form, dosage, route of administration, and duration of drug therapy.
- Special directions and precautions for preparation, administration and use by the patient.
- Common severe side or adverse effects, or interactions and therapeutic contraindications that may be encountered, including their avoidance, and the action required if they occur.

Id. §1396r-8(g)(2)(A)(ii)(I)(aa)-(dd). *See generally* Michael J. Holleran, *The Pharmaceutical Access and Prudent Purchase Act of 1990: Federal Law Shifts the Duty to Warn from the Physician to the Pharmacist*, 26 AKRON L. REV. 77 (1992). This legislative mandate has been furthered through the efforts of the Food and Drug Administration. *See* Allen & Brushwood, *supra* note 18, at 4 n.5 (citing David A. Kessler, *A Challenge for American Pharmacists: The FDA Commissioner Challenges Pharmacists to Renew Their Commitment to Patient Education*, 23 AM. PHARM. 33 (1992)).

104. *See* CONN. GEN. STAT. ANN. §20-620 (West 1998) (applying only to Medicare patients); GA. CODE ANN. §26-4-85 (Harrison 1998); IDAHO CODE §54-179 (1998); ME. REV. STAT. ANN. tit. 32 §13784 (West 1998); NEB. REV. STAT. ANN. §71-1, 147.35(2)(a) (Michie 1998); N.D. CENT. CODE §43-15-31.2 (1998); S.C. CODE ANN. §40-43-86(L)(1) (Law Co-op 1998); S.D. CODIFIED LAWS §36-11-68 (Michie 1998); UTAH CODE ANN. §58-17a-612 (1998). *Cf.* W. VA. CODE §30-5-5a (1998) (creating profession of licensed pharmacy technician to enable pharmacists to counsel patients).

105. O'Neill, *supra* note 99, at A14.

106. *See* Michael Slevak, *Suicide Law Divides Oregon R.Phs.*, 215 AM. DRUGGIST 11, 19 (1998) (reporting that both moral and legal concerns would prevent pharmacists from filling such prescriptions).

107. *See, e.g.*, Wimm v. Jack Eckerd Corp., 3 F.3d 137 (5th Cir. 1993) (affirming a district court ruling that pharmacist has no duty to warn where drug prescribed for patient is inappropriate for patient's condition); Speer v. United States, 512 F. Supp. 670 (N.D. Tex. 1981) (finding pharmacist negligent for failure to monitor patient's prescriptions which

Pharmacists may also be concerned about incurring liability to patients for whom controlled substances are prescribed for the treatment of serious pain rather than for physician-assisted suicide, but who die from the ingestion of the medication. As previously discussed, there is little risk of liability if the patient intentionally commits suicide or if the patient accidentally dies from an overdose of the medication.[108]

3. Conscientious Objection

Some pharmacists wish to know whether a prescription is intended to be used in physician-assisted suicide because of their conscientiously held objections to participating in — even legalized — assisted suicide.[109] Although conscientious objection to participation in the provision of health care services is a well-accepted concept, especially in the area of reproductive services (abortion, contraception, and sterilization) and to a somewhat lesser extent in the forgoing (withholding or withdrawing) of life-sustaining treatment, the full extent of its legal status and scope are uncertain.

The concept of conscientious objection to providing certain types of medical treatment achieved prominence and acceptance during the bitter abortion debate beginning with *Roe v. Wade*,[110] a topic at least equal in terms of the level of controversy it engenders to physician-assisted suicide. A majority of the states have adopted conscience clause legislation covering abortion.[111] These statutes provide that the refusal to participate in abortion services — and sometimes in providing other reproductive services — does not, as New Jersey's statute states, "constitute grounds for civil or criminal liability, disciplinary action or discriminatory treatment."[112]

The vast majority of state conscience clause statutes apply only to abortion (or other reproductive services) and thus do not include persons who choose to exercise this right in the context of physician-as-

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patient hoarded and used to commit suicide, but holding that this negligence was not the proximate cause of harm to the patient); Marchitelli, *supra* note 101, at 393.

108. *See supra* notes 23 and 24 and accompanying text.

109. *See* Michael F. Conlan, *Pharmacists Share Divergent Views on Assisted Suicide Issue*, 141 DRUG TOPICS 86 (1997). According to 1995 Survey of Oregon State Pharmacists Association by Oregon State University College of Pharmacy, "49% of responding pharmacists said they would not participate professionally in physician-assisted suicide, while 36% of pharmacists said they would." *Id.*

110. 410 U.S. 113 (1973).

111. *See* Lynn D. Wardle, *Protecting the Rights of Conscience of Health Care Providers*, 14 J. LEGAL MED. 177, 178 (1993).

112. N.J. STAT. ANN. §2A: 65A-3 (West 1998).

sisted suicide.[113] However, a small number of states have statutes that provide a general right of conscientious objection to health care personnel that could be construed to include physician-assisted suicide.[114] And at least one statute specifically includes euthanasia.[115] However, this statute only applies to health care personnel working in hospitals, and then only if the opposition to performing euthanasia or another specified health service is based on "the dogmatic or moral beliefs of any well established religious body or denomination."[116]

Most conscience clauses for abortion do not specifically apply to pharmacists.[117] This results from the fact that when enacted, most abortions were surgically performed, and thus applied only to those who would be called upon to participate in surgery.[118] To date, only South Dakota has enacted legislation conferring a right of conscientious objection for pharmacists faced with a prescription to actively hasten a patient's death.[119] The driving force behind this legislation was the lobbying of pro-life advocates opposed to physician-assisted suicide.[120] The South Dakota statute states that "[n]o pharmacist may be required to dispense medication if there is reason to believe that the medication would be used to . . . [c]ause the death of any person by means of an assisted suicide, euthanasia, or mercy killing."[121] The statute further provides that "[n]o such refusal to dispense medication pursuant to this section may be the basis for any claim for damages against the pharmacist or the pharmacy of the pharmacist or the basis for any disciplinary, recriminatory, or discriminatory action against the pharmacist."[122]

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113. *See* Wardle, *supra* note 111, at 179.

114. *See, e.g.*, ILL. COMP. STAT. ANN. ch. 745 §70/4 (West 1998) (providing immunity from liability to "health care personnel" who refuse to participate in "any particular form of health care service which is contrary to the conscience"); N.Y. EDUC. LAW §6527(4)(c) (McKinney 1998) (permitting physicians to refuse to perform any professional service to which they are conscientiously opposed); WASH. REV. CODE ANN. §48.43.065(2) (a) (West 1998) (providing protection from discrimination in employment or professional privileges to any individual health care provider who refrains from providing service by reason of conscience).

115. *See* N.J. STAT. ANN. §30:11-9 (West 1998).

116. *Id.*; *see also* Wardle, *supra* note 111, at 177; Allen & Brushwood, *supra* note 18, at 13.

117. *See* Wardle, *supra* note 111, at 184.

118. *See* David B. Brushwood, *Conscientious Objection and Abortifacient Drugs*, 15 CLINICAL THERAPEUTICS 204, 208 (1993).

119. *See* S.D. CODIFIED LAWS §36-11-70 (Michie 1998).

120. *See* Julie Brienza, *State Law Protects 'Conscientious Objector' Druggists*, TRIAL, Aug. 1998, at 86 (summarizing the provisions of the new South Dakota law) (interview with Terri McEntaffer, executive director of the South Dakota Pharmacists Association).

121. S.D. CODIFIED LAWS §36-11-70.

122. *Id.*

Oregon's Death with Dignity Act contains a general conscience clause stating that "[n]o professional organization or association, or health care provider, may subject a person to censure, discipline, suspension, loss of license, loss of privileges, loss of membership or other penalty for participating or refusing to participate in good faith compliance with ORS 127.800 to 127.897."[123] Pharmacists are undoubtedly covered by this clause with respect to the designated types of organizations that might seek to penalize them for their refusal to dispense a prescription for physician-assisted suicide. However, it is unclear whether retail pharmacies are subsumed within the term "health care provider," the only statutory term that could conceivably apply.[124]

The official position of the American Pharmaceutical Association (APhA) "recognizes the individual pharmacist's right to exercise conscientious refusal and supports the establishment of systems to ensure patient access to legally prescribed therapy without compromising the pharmacist's right of conscientious refusal."[125] The APhA resolution also recognizes the right of patients to have legal prescriptions filled by pharmacists who are willing to do so.[126] In other words, the APhA's position tries to strike a balance between competing interests,[127]

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123. OR. REV. STAT. §127.885(2) (1996).

124. The scope of protection in other state conscientious objection statutes is sometimes far less clear than that of the state of Oregon. For example, the Illinois statutes provide immunity from civil and criminal liability, but not from administrative proceedings. *See* 745 ILL. COMP. STAT. ANN. §70/4 (West 1998). Also, it almost certainly does not provide protection against discharge from employers. *See id.*

By contrast, the South Dakota statute recognizing a right of conscientious objection to assisted suicide provides far broader protection than merely against liability and seemingly protects actions taken by employers against employees or even independent contractors. *See* S.D. CODIFIED LAWS §36-11-70 (Michie 1998). ("No such refusal to dispense medication pursuant to this section may be the basis for any claim for damages against the pharmacist or the pharmacy or the basis for any disciplinary, recriminatory, or discriminatory action against the pharmacist.").

125. *See* Michael F. Conlan, *'I Object': APhA Endorses Refusal to Dispense on Moral Grounds*, 142 DRUG TOPICS 83, 83 (1998); Diane M. Gianelli, *Pharmacists Wary of Assisted Suicide Measure*, AM. MED. NEWS, Oct. 24, 1994, at 17.

126. *See* Erin Hoover, *Pharmacists Accept Right to Legal Lethal Dose*, PORTLAND OREGONIAN, Apr. 18, 1998, at E1.

127. *See* American Pharmaceutical Association, *1997-98 Policy Committee Report: Pharmacist Conscience Clauses* (visited June 2, 1998) <http:/ww2.aphanet.org/APhA/rontest/committee2.html>:

> The Association's policy committee concurred with previous discussion by the APhA House of Delegates, where the Delegates chose to support the decisions of individual pharmacists in such situations, rather than prescribing a specific course of behavior. Such a stand supports the professions' responsibility to the patient, including respecting the decisions that the patient has made, without requiring the pharmacist to participate in activities they find objectionable.

not unlike what courts have tried to do in end-of-life decision-making.[128]

APhA's efforts to support those pharmacists who have conscientiously held beliefs that they should not participate in physician-assisted suicide, as well as those whose beliefs dictate that they should, may run into a very practical obstacle posed by the contemporary structure of the retail pharmacy business. Many, if not most, pharmacies are owned by large pharmacy chains, and pharmacists are employees.[129] Even in smaller chains of pharmacies or individual-pharmacist owned pharmacies, there are still likely to be pharmacists who are employees.[130] Under these circumstances, there is ample opportunity for disagreement between owners and individual pharmacists about what is the morally proper course of action.

Owners may not only disagree with employees but seek to dictate whether they may or may not fill a prescription for physician-assisted suicide.[131] The scope of coverage of conscientious objection provisions, such as Oregon's, will play a determinative role in resolving these conflicts. If the statute provides pharmacists with protection against efforts by employers to pressure them to conform their actions to the employers' views, they will be able to exercise their right of conscience. Otherwise, they will probably have to choose between their conscience and their job.[132]

Id.

128. Eleven state advance directive statutes expressly permit health care providers to refuse to implement a living will, health care power of attorney, or both on the basis of conscience. *See* ARIZ. REV. STAT. ANN. §36-3205 (West 1998); DEL. CODE ANN. tit. 16 §2508 (1998); HAW. REV. STAT. ANN. §327D-11 (1995); ILL. COMP. STAT. ANN. ch. 755 §§35/6, 45/4-8 (West 1998); ME. REV. STAT. ANN. tit. 18-A §5-807 (West 1998); MISS. CODE ANN. §41-41-215 (1998); N.H. REV. STAT. ANN. §§137-H:6, 137-J:8 (1998); N.M. STAT. ANN. §24-7A-7 (Michie 1998); OHIO REV. CODE ANN. §§1337.16, 2133.02 (Anderson 1998); PA. STAT. ANN. tit. 20, §5409 (West 1998); TENN. CODE ANN. §§24-6-214, 32-11-108 (1998). *See generally* MEISEL, supra note 30, at 422-26. However, most state advance directive statutes permit health care professionals to decline to comply with the provisions of an advance directive. *See Noncompliance Provisions in Statutes, Authorizing Health Care Agents, Noncompliance Provisions in Living Will Statutes*, RIGHT-TO-DIE LAW DIGEST (March 1998).

129. *See generally Manpower Shortage Lifts Pharmacists' Wages*, CHEMIST & DRUGGIST, Apr. 11, 1998, at 31.

130. *See, e.g.*, Melissa Montealagre, *Small Pharmacies Fill the Bill*, MONTGOMERY ADVERTISER, Feb. 16, 1998, at 6B.

131. *See, e.g.*, Elaine Lafferty, *Beware the Counterpunch — What Happens When a Prescription Offends Pharmacist's Beliefs?*, TIME, Apr. 28, 1997, at 66 (reporting drug store reprimanded pharmacist who refused to fill prescription for abortifacient and store's policy is that "a pharmacist, if he has moral objections, should refer the prescription to another on-duty pharmacist, . . . or to a competing pharmacy, if necessary.").

132. *See* Allen & Brushwood, *supra* note 18, at 6-9. In the field of end-of-life decision-making, there have been a small number of cases in which nurses — who, like pharmacists, are employees — have objected to following a physician's order, allegedly on grounds of

If the experience with abortion is any guide, pharmacies, as institutions, will be able to opt out of filling prescriptions for physician-assisted suicide. The courts have generally held that there is no obligation on the part of hospitals, unless they are public hospitals, to offer abortion services.[133]

Pharmacists who do follow the dictates of their consciences against dispensing prescriptions intended for physician-assisted suicide are likely to create considerable hardship for some patients, especially those living in nonurban areas where pharmacists and pharmacies might not be plentiful. In the case of abortion, finding an abortion provider can be very difficult, but in most cases patients are at least mobile.[134] By contrast, patients seeking medications for physician-assisted suicide are far more likely to be totally dependent on their caretakers to obtain their medications for them, and taking care of a dying person at home can be an extremely onerous process, even with the support of a hospice program.[135] In many cases, having to locate and travel to a pharmacy that will dispense a lethal medication may turn out to be a practical impossibility for either the patient or the caretaker.[136]

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conscience. *See* Warthen v. Toms River Community Mem'l. Hosp., 488 A.2d 229 (N.J. Sup. Ct. App. Div. 1985); Farnam v. CRISTA Ministries, 807 P.2d 830 (Wash. 1991); Free v. Holy Cross Hosp., 505 N.E. 2d 1188 (Ill. App. Ct. 1987). The courts upheld the dismissals of these nurses. *See Warthen*, 488 A.2d at 233; *Farnam*, 807 P.2d at 843; *Free*, 505 N.E.2d at 1191. However, the facts of these cases are different enough from each other and, possibly, from the scenarios that might result in the assertion of conscientious objection by pharmacists, to draw any conclusions applicable to the instant issue.

With respect to abortion:

> [m]any states require objecting pharmacists to notify their employers of their objection before such a situation arises. The language in conscience clauses varies greatly from state to state, and the language differences may alter the applicability of the clauses to pharmacists. In some states, pharmacists may not be included within the protection of the clause at all. In other states, pharmacists are clearly included, but the clause applies only in hospitals or clinics.

ABOOD & BRUSHWOOD, *supra* note 43, at 307.

133. *See, e.g.*, Wolfe v. Schroering, 541 F.2d 523 (6th Cir. 1976).

134. *See generally* Verena Dobnik, *Study Finds Number of U.S. Abortions at Lowest Level in 20 Years: Surveyors Say Number of Providers Also Falls, and Violence by Protestors May Be a Reason*, STAR-LEDGER, Dec. 11, 1998, at O23 (reporting a nationwide drop in the number of abortion providers and, of cities surveyed, one-third have no abortion providers available).

135. *See* Susan M. Wolf, *Pragmatism in the Face of Death: The Role of the Facts in the Assisted Suicide Debate*, 82 MINN. L. REV. 1063, 1076-77 (describing terminal patients as profoundly dependent on health care professionals for everything from toileting to life-saving care).

136. Hospice programs generally supply patients under their care with medications from the hospice pharmacy, and thus neither patients nor their caretakers need to bear the burden of finding a pharmacy that stocks necessary medications or of traveling to the pharmacist. However, this is not likely to be the case with medications intended to be used for physician-assisted suicide, which is generally anathema to the philosophy of hospice care.

A possible solution is the development of a program to direct patients who receive prescriptions pursuant to statutes like Oregon's Death with Dignity Act to pharmacists who would be willing to fill these prescriptions.[137] Another possibility is increased reliance on physician dispensing of medications.[138]

The problem, in practice, is that permitting pharmacists not to participate might have the same result in physician-assisted suicide that permitting physicians and hospitals not to participate has had in the realm of abortion: there is a right in theory but a very attenuated one in practice because so many choose not to participate, whether for reasons of conscience or convenience.

4. Reprisals

A more practical concern of some pharmacists than conscientious objection is that if they dispense prescriptions for medications intended to be used in physician-assisted suicide and it becomes known publicly that they do so, they might be subject to reprisals in the form of harassment, boycotts, picketing, and even violence by opponents of physician-assisted suicide.[139] These are not fanciful concerns given the history of the actions of opponents to the equally controversial topic of abortion.[140]

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137. *See* Gianelli, *supra* note 125, at 17 (interview with Susan Winckler, policy and legislative director of the APhA). Pharmacists for Death with Dignity formed in Oregon in January of 1998, likely in response to the potential need for a program to link pharmacists with patients. *See* Hoover, *supra* note 126, at E1.

138. The federal Controlled Substances Act permits physicians to dispense controlled substances. *See* 21 U.S.C.S. §802(10) (defining "dispense"); 21 U.S.C.S. §802(21) (defining "practitioner" to include physicians) (West 1998); 21 C.F.R. §1304.02(d) (defining "individual practitioner" to include physicians). Most states also permit physician dispensing, though often with limitations. *See* Richard Abood, *Physician Dispensing: Issues of Law, Legislation and Social Policy*, 14 AM. J. L. & MED. 307, 318-20 (1989); *Nat'l Ass'n of Board of Pharmacy, Survey of Pharmacy Law* (visited Jan. 30, 1999) <http://www.nabp.net/whoweare/publications.asp>. In general, physicians have the right to dispense medications to patients. *See* 28 C.J.S. DRUG AND NARCOTICS §39 (1996). The specifics vary and are ordinarily governed by individual state statutes. *See id.*

139. *See* Derek Humphry, Euthanasia Research & Guidance Organization (ERGO), <right_to_die@efn.org>, Nov. 19, 1997 (electronic news listserve) (on file with author).

> [O]wners of pharmacies are afraid . . . [t]hat militant right to life groups will target them in a vociferous and perhaps violent manner. Geoff Sugerman, political consultant to Oregon Right to Die, sponsors of the new law, which took effect October 27, said the Tiffany's owner was well within his rights as a health provider to refuse to participate under the Act.

Id.

140. *See, e.g.*, O'Neill, *Pharmacy Panel Affirms Suicide Disclosure*, PORTLAND OREGONIAN, Nov. 19, 1997 at E10 ("Doctors are worried that their participation in an assisted suicide might become public. That it could make them the target of protests by assisted-suicide

As is the case with conscientious objection, individual pharmacists and pharmacy owners may have different views about the risks that they wish to take, resulting in conflicts that, in this case, will make it necessary for pharmacists to choose not between their conscience and their job but between their personal security and their job.

B. Reasons for Withholding Information from Pharmacists

There are a number of countervailing considerations to pharmacists' wishes to know whether a prescription is intended to be used for physician-assisted suicide. As previously mentioned, the most fundamental one is that such knowledge could significantly impede — if not entirely thwart — patients' access to needed medications, thus undermining their right to assisted suicide.

There are a number of other reasons for not providing pharmacists with information about the fact that a prescription is intended to be used for physician-assisted suicide. Although at first glance, some of these reasons appear to protect physicians' interests, in fact some also protect patients' interests in access to medications needed for physician-assisted suicide because deterrents to physician participation ultimately redound to the disadvantage of patients who wish a physician's assistance in ending their lives.

1. Identification of Physicians by the DEA

If prescriptions intended to be used for physician-assisted suicide were so labeled, it would make it simple for the federal Drug Enforcement Administration (DEA) to identify physicians who participate in assisted suicide.[141] If the DEA is hostile to physician-assisted suicide, it can use this information to scrutinize more thoroughly the controlled-substances prescribing practices of physicians who participate in assisted suicide, subjecting them to investigations, prosecutions, and the fear that they will lose their DEA registration to prescribe controlled substances.[142] If such information comes into the hands of state regulatory authorities, doctors may also be subject to state investigation, with the possibility of having sanctions imposed on their license to

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opponents, much in the same was that doctors who perform abortions are targeted by anti-abortion groups.").

141. *See* 21 U.S.C.A. §822(a)-(b) (West 1998) (requiring every person who manufactures, distributes, or dispenses any controlled substance to register with the U.S. Attorney General); 21 U.S.C.A. §829 (West 1998) (requiring physicians to write prescriptions for all controlled substances).

142. *See* 21 U.S.C.A. §824 (West 1998) (authorizing Attorney General to deny, revoke, or suspend registration required for distribution of controlled substances); 21 U.S.C.A. §822 (f) (authorizing Attorney General to inspect the establishment of a registrant).

practice medicine or being subject to criminal prosecution for drug offenses.[143]

Although the current director of the DEA is hostile to legalized physician-assisted suicide,[144] he has been curbed by a ruling by the Attorney General that it is not a violation of the federal Controlled Substances Act for Oregon physicians to prescribe controlled substances for use in physician-assisted suicide pursuant to the Oregon statute.[145] Future administrations may take a different position on this issue — assuming that federal legislation governing the use of controlled substances for use in physician-assisted suicide is not enacted[146] — thereby putting physicians in jeopardy at some later time.

2. Physicians' Privacy and Security

Physicians are not only concerned that their involvement in physician-assisted suicide could become known to federal and state regulators, they are also concerned that it could become known to virulent opponents of assisted suicide.[147] Taking a lesson from the abortion wars, like pharmacists, they are concerned about the possibility of harassment, boycotts, picketing, and even violence by opponents of physician-assisted suicide.[148] Thus, those physicians who choose to participate in physician-assisted suicide may still have a strong interest in concealing it.

3. Patient Confidentiality

Indicating on a prescription that it is intended to be used for physician-assisted suicide violates patient confidentiality. In the case of many prescriptions, pharmacists are able to determine, or to guess with a fair degree of accuracy, a prescription's intended use. Stating the intended use on a prescription, however, leaves no room for doubt. On the other hand, pharmacists' ethics require that they keep

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143. *See, e.g.*, MD. REGS. CODE tit. 10, §.03 (requiring registration of manufacturers, distributors, and dispensers of controlled substances); MD. REGS. CODE tit. 10, §.09 (delineating states administrative functions, practices, and procedures regarding controlled substances); MD. ANN. CODE art. 27, §287 (1998) (criminalizing possession or administration of controlled substance unless obtained pursuant to a "valid" prescription subject to four years imprisonment and $25,000 fine upon conviction).

144. *See DEA Could Take Action Against Oregon Physicians, Constantine Says, supra* note 83, at D6.

145. *See DEA Won't Sanction Oregon Physicians Who Participate in Lawful Assisted Suicides, supra* note 84, at 958.

146. *See generally* Lethal Drug Abuse Prevention Act, S. 2151, 105th Cong. (1998).

147. *See Assisted Suicide Foes Invade Hemlock Offices*, AM. MED. NEWS, Feb. 9, 1998, at 3.

148. *See* O'Neill, *supra* note 140, at E10.

such information confidential,[149] and a breach of this obligation is grounds for professional discipline by the state regulatory board.[150] Yet, information about prescriptions is potentially available to persons other than pharmacists, persons who are not subject to the same professional requirements of confidentiality as pharmacists are.[151]

CONCLUSION

The legalization of physician-assisted suicide in Oregon and efforts to legalize it elsewhere will have profound implications for many health care professionals. Although the focus to date has been on the implications for physicians, pharmacists also have serious concerns. Where physician-assisted suicide is legal, the threshold question for pharmacists will be whether they will dispense a physician's prescription for a lethal medication intended to be used by a patient for assisted suicide. Individual pharmacists whose conscience or other concerns leads them to refuse to do so will potentially face reprisals from employers and will possibly jeopardize a patient's right to choose. Pharmacist who do dispense such prescriptions may also come into conflict with employers who hold opposing views and may also be subject to conflict with vocal opponents of physician-assisted suicide. They may also risk liability if a lethal prescription injures a patient, rather than ending his life.

The movement to legalize physician-assisted suicide has given added urgency to the already existing concerns of health care professionals about improving the quality of palliative care — especially the use of pain control medications — for the terminally ill. This has spawned another set of concerns for pharmacists. As long as physician-assisted suicide remains illegal in most jurisdictions, these matters will be of far more concern to the overwhelming majority of pharmacists than those that arise where physician-assisted suicide is legal. Despite the enactment in many jurisdictions of statutes intended to permit physicians to prescribe and pharmacists to dispense adequate medications for palliative care, and despite the Supreme Court's decisions strongly supporting the right of terminally ill patients to have adequate medication for the relief of pain, physicians and pharmacists will continue to be wary of the potential regulatory and criminal pit-

149. *See* American Pharmaceutical Association, *supra* note 127, at §II.

150. "Unprofessional conduct" is generally a basis in state law for professional discipline of pharmacists. *See* ABOOD & BRUSHWOOD, *supra* note 43, at 175.

151. *See* Allen & Brushwood, *supra* note 18, at 15 ("The setting in which pharmacy is typically practiced, however, may raise some legitimate apprehensions on the part of persons attempting to acquire a prescription for pharmaceutically assisted death.").

falls of prescribing such medication caused by state and federal controlled substances legislation.

If terminally ill patients are to receive the medications they need so that they may die peacefully, without preventable suffering, courts, legislatures, and administrative agencies will need to give pharmacists as well as physicians sufficient latitude to practice their professions in accordance with the intent of the palliative care statutes and the Supreme Court decisions.