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Liability for Prescribing Intravenous Injection Equipment to IV Drug Users

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LIABILITY FOR PRESCRIBING INTRAVENOUS INJECTION EQUIPMENT TO IV DRUG USERS

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IN THE ABSENCE OF WIDESPREAD, publicly sponsored needle exchange programs, the proposal has been made that physicians prescribe syringes and needles to intravenous (IV) drug users in order to reduce the risk of infection from HIV and other diseases that could result from needle sharing. One question is whether physicians who engage in this behavior, as well as pharmacists who fill the prescriptions, face a significant threat of malpractice liability if the IV drug user or someone else, perhaps an innocent bystander, is harmed as a result of the prescribed equipment. No such cases have been reported, perhaps because the practice is not yet frequent. For the reasons explained in the analysis that follows, it is unlikely that any malpractice suits would be brought successfully in the future.

In analyzing this issue, three assumptions are being made: First, it is assumed that no state law is being violated by such a prescribing practice, including state physician and pharmacist licensing laws. (If this were not the case, the courts might deem the behavior of health care professionals to be negligent *per se.*) Second, it is assumed that the health care professional in all other respects has acted in accordance with the applicable standard of care. In other words, the physician has properly examined the patient and taken a complete history, has obtained the patient's informed consent when necessary, and has not made an unreasonable mistake in terms of identifying the patient's IV drug abuse and in terms of prescribing the appropriate injection equipment. Similarly, the pharmacist has exercised due care in filling the prescription. Based on these assumptions, the only potential basis for liability is the fact that the physician has pre-

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scribed the IV equipment or that the pharmacist has filled the prescription. It is *not* being assumed that the person for whom the equipment is prescribed is a patient of the physician's for any purpose other than obtaining the prescription for the equipment, although this certainly might be the case. (Arguably, a physician who had a pre-existing relationship with the person would be even less likely to be sued successfully than a physician who had never seen the person before the visit at which the prescribing took place, since patients are less inclined to sue physicians with whom they have ongoing relationships,[1] and since the physician in such a relationship could more readily establish that she was familiar with the patient's drug abuse and potential for harm from sharing needles.)

Finally, this discussion assumes that the patient is mentally competent and therefore can be reasonably expected to comprehend and follow instructions on the proper use and disposal of the IV equipment. If this is not the case, and it may well not be in the case of some IV drug users, the physician or pharmacist must take special precautions, such as not providing access to the equipment unless the patient is under the care of someone who takes responsibility for the patient, as in a residential treatment program.

One further point at the outset: The physician or pharmacist who chooses *not* to provide access to IV equipment because of fears of malpractice liability also must consider the possibility of being liable if the drug user is harmed by *that* decision, such as by becoming infected with HIV through needle sharing. In other words, the potential liability for providing IV equipment must be compared, not with the absence of liability altogether, but with the risk of liability created by not providing access to the IV equipment. (The only way to avoid any risk of liability whatsoever might be to refrain from creating patient-physician relationships with persons who might be IV drug users, which may be difficult to accomplish for a number of reasons that are beyond the scope of this paper, not the least of which is the limited degree to which physicians in managed care plans can

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[1] *See* Berkeley Rice, *Where Doctors Get Sued the Most*, MED. ECON., Feb. 27, 1995, at 98, 100, 109 (discussing the breakdown of the doctor-patient relationship as a result of increasing litigation); *cf.* Charles Vincent et al., *Why Do People Sue Doctors? A Study of Patients and Relatives Taking Legal Action*, 343 LANCET 1609 (1994) (citing four factors, including poor communication and insensitivity by health professionals, that contributed to the patient's decision to sue).

refuse to take on specific patients from among the pool of enrollees.)

I. POTENTIAL LIABILITY FOR PROVIDING ACCESS TO IV EQUIPMENT

The best way to explain the potential malpractice risks from providing access to IV equipment for patients who are drug users is by discussing in turn each of the elements of a malpractice suit, that is, the points that the patient would have to prove in order to hold a physician or pharmacist liable.

A. Duty

A physician or pharmacist would only be liable as a professional to someone to whom he or she owed a professional duty of care. As noted above, a physician might avoid such a duty by refusing to enter into a patient-physician relationship with someone who was a drug user. Assuming, however, that the physician had agreed to provide professional services to the drug user, the physician would owe that person a professional duty of care.

B. Injury

In order to hold someone liable for malpractice, the plaintiff must demonstrate that he or she has been injured. In the case of a physician or pharmacist who provided access to IV equipment to a drug user, several possible injuries are foreseeable:

The plaintiff might allege that, as a result of being given access to the IV equipment, he or she had continued to abuse IV drugs and, as a result, had been harmed by the effects of the drugs (such as by becoming addicted). (Implicit in this allegation is the questionable causal proposition that, if the person had not been given access to the equipment by the defendant, he or she would not have continued to use the drugs.)

The plaintiff (or a family member) might allege that, as a result of being given access to the IV equipment, the drug user overdosed and was killed or injured. (Implicit in this allegation is the questionable causal proposition that, if the person had not been given access to the equipment, he or she would not have overdosed.)

The plaintiff might allege that he or she had been harmed (such as by becoming infected, continuing to abuse IV drugs, or

overdosing) as a result of using the IV equipment that had been prescribed, although it had not been prescribed for the plaintiff. For example, the plaintiff could have obtained the equipment from the person for whom it had been prescribed. (Again, the plaintiff implicitly would be maintaining that the harm would not have occurred had the IV equipment not been prescribed.)

Finally, the plaintiff could be a non-IV drug user who alleges injury as the result of coming into contact with the equipment, such as becoming infected following a needle stick. Such a plaintiff might be a law enforcement officer, a garbage collector, a health care worker, or an innocent "bystander" like a curious child who finds the paraphernalia lying in the street. Even if the plaintiff had not actually become infected, he or she might seek damages for the fear of becoming infected as a result of the exposure to the risk.

Even though these injuries arguably are foreseeable, a plaintiff would have a difficult time prevailing on the injury issue. For one thing, he or she would have to persuade the judge or jury not only that he or she had been injured, but that the injury resulted from the IV equipment that had been prescribed, rather than from other IV equipment. This may be extremely difficult to prove, since the prescribed equipment is not likely to bear any physical marks that would distinguish it from other IV equipment that was obtained illegally.

In addition, the plaintiff would have to show that the injury sustained was not outweighed by any benefits accruing to him or her as a result of the IV equipment having been prescribed. This is the legal doctrine of "offset."[2] The defendant could argue that, even though the plaintiff had been injured, the injury was offset by the benefit of the reduction in the risk of infection achieved by prescribing the IV equipment. (Even if the court felt that the risks of the injury that occurred were not outweighed completely by the reduction in the risk of infection, the magnitude of the harm that occurred, and hence the damages to be awarded, would be reduced by the value of the benefit that was conferred.[3])

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[2] *See* RESTATEMENT (SECOND) OF TORTS § 920 (1979) (limiting damages when a benefit is conferred upon the plaintiff as a result of the defendant's tortious conduct).

[3] *See id.* §§ 291, 293 (addressing how an unreasonable risk and the magnitude of risk, respectively, are determined).

Finally, most courts refuse to permit damages to be awarded merely for being afraid of becoming infected, unless the individual actually was exposed to an infectious agent, such as HIV.[4]

C. "But-For" Causation

As mentioned in the previous section, the plaintiff not only would have to prove injury as the result of the defendant's actions, but that the injury would not have happened if the defendant had not acted. In other words, the plaintiff would have to prove that he or she would have given up or materially reduced IV drug abuse but-for the prescribed equipment, that he or she would not have overdosed, that he or she would not have obtained IV equipment from some other source, or that he or she would not have been stuck by another contaminated sharp instrument. The element of "but-for" causation is likely to be extremely difficult for the plaintiff to establish. For example, it is likely to be hard to find credible expert witnesses who would testify that someone more probably than not would have stopped using drugs if IV equipment had not been prescribed, or that an addict would not have found equipment from some other source with which to take an overdose or to become infected.

A more plausible argument regarding but-for causation might be made by someone who was injured by a needle stick, and who could identify the IV drug user, and through their testimony, also identify the physician or pharmacist who provided access to the IV drug equipment. This might be the case, for example, when a law enforcement officer is stuck by a sharp or needle in the course of making an arrest. One way for the physician or pharmacist to reduce the risk of liability in these situations is to instruct the IV drug user about proper handling and disposal of the IV equipment. (Arguably, this is required as part of the physician's and the pharmacist's ordinary duty of care, although there are no reported cases in which a health care pro-

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[4] *See* Jeffrey B. Greenstein, Note, *New Jersey's Continuing Expansion of Tort Liability*: Williamson v. Waldman *and the Fear of AIDS Cause of Action*, 30 RUTGERS L. J. 489, 492-493 (1999). For a discussion of this and other restrictions on claims for "mere exposure to risk," see Scott Burris, *Human Immunodeficiency Virus - Infected Health Care Workers: The Restoration of Professional Authority*, 5 ARCH. FAM. MED. 102 (1996).

fessional has been held liable for failing to provide such information, as a result of which someone was injured.[5])

D. Negligence

Even if the plaintiff can prove that the prescribed equipment was the but-for cause of the net injury, the plaintiff must show that the defendant was negligent, that is, failed to meet the applicable standard of care. Physicians and pharmacists are held to a professional standard of care. They are generally expected to act the way a reasonable physician or pharmacist would act in the same circumstances. With a few exceptions not relevant here, judges and juries determine on the basis of the testimony of expert witnesses what behavior meets this standard of care, and whether or not the defendant acted in that manner.

In order to prevail on the issue of negligence, the plaintiff, via expert testimony from physicians or pharmacists, would have to convince the court that a reasonable health care professional would not have prescribed IV equipment in this case. The defendant presumably would introduce expert testimony to the contrary. The judge would apply various legal tests to help determine whether the defendant had behaved reasonably.

One test, reflecting the fact that no behavior is completely free of risk, is basically a comparison of risks and benefits.[6] The defendant would argue that, while prescribing IV equipment perhaps entailed some risk of harm to the patient, the risk of harm was outweighed by the expected benefit in reducing the risk of infection. (Note that this test is similar to, but not the same as, the offset calculation mentioned in the earlier discussion of injury. There, the issue, resolved on the basis of hindsight, is how much actual benefit and harm the plaintiff received as a result of the defendant's action. The risk/benefit test for negligence instead asks how much benefit and harm a rea-

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[5] The closest cases involve efforts to hold needle manufacturers liable for sticks, in part because of the failure to warn health care workers of the risk of infection. *See, e.g.*, Hamley v. Becton Dickinson & Co., 886 F.2d 804 (6th Cir. 1989) (medical assistant contracted hepatitis B virus) and Riley v. Becton Dickinson Vascular Access, Inc., 913 F. Supp. 879 (1995) (nurse contracted HIV infection). In *Hamley*, the court held that the danger of a stick was "open and obvious" and thus no warning was required; however, a warning might be required for the specific risk of contracting hepatitis B. In *Riley*, the plaintiff admitted that she was aware of the danger of infection. Neither case resulted in liability for the needle manufacturer.

[6] *See* RESTATEMENT (SECOND) OF TORTS, *supra* note 2, § 291.

sonable person in the defendant's position should have anticipated when he or she decided to act. A defendant who actually caused net harm to the plaintiff would not be negligent if the benefits reasonably (although ultimately incorrectly) appeared to outweigh the risks.)

Even if the plaintiff's experts persuasively testified that most physicians or pharmacists would not regard providing access to IV equipment to be reasonable, the defendant would still not be negligent if the defendant's experts convinced the court that something akin to a "respectable minority" of physicians or pharmacists would have so acted.[7] In other words, the law recognizes that health care professionals must be allowed, within certain limits, to deviate from the mainstream approach.

One problem that might arise, particularly at the very inception of the practice by physicians and pharmacists of providing access to IV drug equipment, would be that expert witnesses for the defense, although testifying that providing access was reasonable, might admit that no one (except the defendant) actually did it. In determining whether the defendant's behavior conformed to the standard of care, the court would face the disjuncture between how practitioners ought to behave and how they actually behave. In theory, courts should recognize, and instruct juries, that the former is the correct test. (In one celebrated case, a court in effect ruled that the entire profession of ophthalmology was negligent because no one routinely conducted a glaucoma test that plaintiff's experts testified was reasonable.[8]) But there is always a slight risk that the first practitioner to adopt a new approach will be found liable for not following the customary practice of his or her profession. (One way possibly to reduce this risk is to inform the patient and get his or her consent to the fact that, by providing access to IV drug equipment, the practitioner, in the patient's interest, is departing from customary practice. This would make the act of providing the equipment akin to an experiment, with the practitioner obtaining the patient's informed consent to participate.)

Finally, even if the plaintiff established that providing access to IV equipment would be unreasonable in some or even

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[7] *See* 1 BARRY R. FURROW ET AL., HEALTH LAW § 6-5(a), at 382-83 (1995) (explaining that the "respectable minority" defense permits a physician to adopt a mode of treatment that reasonable and prudent medical professionals would adopt under similar circumstances to avoid liability for harm caused to patients).

[8] *See* Helling v. Carey, 519 P.2d 981 (Wash. 1974).

most cases, the defendant could still try to prove that doing so was reasonable in this specific case. For example, the defendant could argue that, while providing access ordinarily might not be reasonable, he or she had taken special care to determine that providing access would be in this patient's best interest and would not be a threat to others. Thus, the defendant could point to the measures taken to educate the patient about proper disposal. Or, in some cases involving an overdose using the prescribed equipment, the defendant might demonstrate that this particular patient was at such an extreme risk of harm from using infected needles that deviating from ordinary practice in the patient's case was justified.

E. Proximate Cause

"Proximate cause" is a confusing doctrine that comes into play when the injury caused by the defendant's negligent behavior is bizarre, highly attenuated, or out of all proportion to what normally would be expected to happen. In these unusual cases, proximate cause permits the defendant to avoid liability on the basis that imposing liability would be unjust. (An example would be a case in which a person negligently tossed a cigarette starting a fire that, when it burned down a theater, caused a dilapidated section of downtown stores finally to go out of business. A suit brought by the owner of one of the stores against the person who threw the cigarette most likely would fail for lack of "proximate cause," even though the defendant was clearly shown to have been the negligent "but-for" cause of the store going out of business.) If the injury caused by providing access to IV equipment was unusual enough, the defendant could avoid liability even though he or she was shown to be negligent. On the other hand, if the plaintiff can show that the occurrence of the injury was not so far-fetched, such as when an IV drug user overdoses or someone is stuck inadvertently, the physician or pharmacist will have to rely on grounds other than proximate cause, such as asserting that there was no negligence on their part, to avoid being liable.

Another type of situation in which the doctrine of proximate cause negates liability is when the defendant's actions have been succeeded by intentional wrongful actions of others

leading to the plaintiff's injury.[9] Thus, a physician or pharmacist who had provided access to IV equipment to person A would not be liable to person B who was injured as a result of being given the equipment for IV drug use by A with A's intent, knowledge, or substantial certainty that injury to B (such as continued use, addiction, or overdosing) would occur.

F. Affirmative Defenses

Even if a physician or pharmacist is deemed to have negligently caused injury by providing access to IV equipment, he or she will not be liable if the plaintiff is found to have assumed the risk of the injury.[10] Assumption of risk requires that the victim be aware of the risk and knowingly and voluntarily agree to accept it. A physician or pharmacist who provided access to IV equipment and who educated the patient about the risks of IV drug use might argue successfully that the patient had been made aware of the risks and had assumed them. The physician or pharmacist even might require the patient to sign a written statement agreeing to refrain from suit if injury should occur, although it is not certain that courts would uphold such a waiver against the patient. Similarly, in the case of injury to a drug user other than the person for whom the equipment was prescribed, the defendant might assert that anyone who uses someone else's equipment thereby accepts the risk of being injured.

The assumption of risk defense (called an "affirmative" defense because, unless it is raised by the defendant, the failure of the plaintiff to address it does not prevent the plaintiff from recovering) has its limitations, however. Courts sometimes are reluctant to shield a person from liability for injuries resulting from negligence even though his or her victim had been warned about the risks ahead of time. Moreover, as noted at the outset of this paper, the physician or pharmacist must be reasonably confident that the IV drug user is competent.

Another affirmative defense is the plaintiff's own negligence. Thus, even if plaintiffs are not deemed to have assumed the risk, they may still be found to have been negligent by be-

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[9] *See* RESTATEMENT (SECOND) OF TORTS, *supra* note 2, § 448 (addressing causal relationship between intentional subsequent wrongdoer and defendant's liability).

[10] *See id.* § 496C (stating that a plaintiff is not entitled to recover when he voluntarily acts with knowledge of the potential risk of harm).

coming drug users in the first place, by taking an overdose, by accepting IV equipment from someone else, or by handling sharps carelessly. In a few states, this affirmative defense, known as "contributory negligence," is a total bar to recovering damages. Most jurisdictions, however, adopt a "comparative negligence" approach, according to which the plaintiff can still recover some damages, but the amount is reduced in proportion to the plaintiff's degree of fault. (In some states, the plaintiff can only recover if he or she is found to be less at fault, or no more at fault, than the defendant.)

Given the degree to which IV drug users are likely to be active participants in the activity which leads to their injury, the affirmative defenses of assumption of risk and contributory or comparative negligence are especially important reasons why their suits against physicians or pharmacists who provide access to IV equipment are unlikely to be very successful. The same defenses may provide protection for physicians and pharmacists when the IV equipment they provide causes a needle stick to a health care worker or law enforcement officer, who arguably should be aware of the risk, and who should take proper precautions to prevent harm to themselves. Only if injury occurs to a truly "innocent bystander," such as a child in an area like a playground, would the defenses of assumption of risk and the victim's own negligence be of no avail.

G. Summary

It is hardly ever possible (and, for a lawyer, rarely advisable) to provide an ironclad assurance against the possibility that a judge or jury somewhere, on some set of facts, will find someone liable for a given act. Nevertheless, the risk of liability for physicians or pharmacists who provide access to IV equipment to drug users seems remote. The victim may not be able to establish that the defendant acted negligently. Even if the plaintiff prevails on the issue of negligence, it will be extremely difficult in most cases to prove that net harm has occurred, or that the net harm was in fact caused by the action of the defendant. Finally, any recovery would be reduced, if not barred altogether, by the victim's own negligence.

II. POTENTIAL LIABILITY FOR FAILING TO PROVIDE ACCESS TO IV EQUIPMENT

As noted at the outset, health care professionals rarely, if ever, confront a choice between a course of action that presents some risk of liability and another that presents no risk at all. Instead, they face a choice between alternative courses of action where each carries some risk of being sued. The professional's goal, therefore, must be to identify the alternative that presents the least, or the most acceptable form of risk.

In deciding whether or not to provide access to IV drug equipment to their patients, the choice is not between the risk of suit from providing access versus no risk, but between the risk of suit from providing access and the risk of suit from not providing access. A decision not to provide access to IV equipment also might cause injury in the form of infection or injuries sustained from obtaining and using equipment illegally.

As in the case of suits complaining of injuries sustained from prescribed equipment, plaintiffs in suits arising from a failure to prescribe would encounter difficulties in attempting to prove but-for causation and injury since they would have to demonstrate that they would have avoided harm if the equipment had been prescribed. This might be hard to prove if the evidence showed, for example, that IV drug users continue to share IV equipment with other users even if their own equipment is provided by a physician or pharmacist. Even if a plaintiff could establish the elements of injury and causation, a judge or jury might decline to regard a refusal to provide access as negligent.

On the other hand, published reports of the success of needle exchange programs in reducing the risk of infection[11] might persuade courts that plaintiffs were entitled at least to a presumption of causation when physicians or pharmacists declined

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[11] *See, e.g.*, Thomas J. Coates et al., *HIV Prevention in Developed Countries*, 348 LANCET 1143 (1996) (finding that cities with low HIV prevalence among injecting drug users made clean syringes available); Don C. Des Jarlais et al., *Continuity and Change Within an HIV Epidemic: Injecting Drug Users in New York City, 1984 Through 1992*, 271 JAMA 121 (1994) (indicating that underground syringe exchange was associated with a significant decline in AIDS risk behaviors) ; Peter Lurie & Ernest Drucker, *An Opportunity Lost: HIV Infections Associated with Lack of a National Needle-Exchange Programme in the USA*, 349 LANCET 604 (1997) (reporting that the lack of a national needle exchange program may have contributed to preventable HIV infection).

to provide them with access to "clean" equipment. As more physicians and pharmacists begin to provide access, the chances increase that those who fail or refuse to do so will be found negligent.

In short, the physician or pharmacist contemplating whether or not to provide access to IV equipment must choose between two (or more) risky courses of action. If reasonable steps are taken to minimize the risks posed by prescribed IV equipment, a good case can be made that refusing to provide access creates at least as much, if not more, risk of liability than providing access to the IV equipment.