BETWEEN A ROCK AND A HARD PLACE:
THE PROPRIETY AND CONSEQUENCE OF PHARMACISTS’ EXPANDING LIABILITY AND DUTY TO WARN

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INTRODUCTION

During the last decade, the volume of prescriptions written and dispensed in the United States reached staggering proportions.1 Studies illustrate that retail sales of prescription drugs almost doubled during this time while prescription spending reached an astounding $112.1 billion annually.2 Unfortunately, an increase in the use of prescriptions inevitably increases the potential for medication errors.3 In 1999, the Institute of Medicine published an eye-opening report entitled To Err is Human: Building a Safer Health System, bringing national attention to the growing frequency and cost of medical errors.4 Numerous studies, including the highly publicized investigation Danger at the Drug Store by U.S. News & World

1 J.D., University of Houston Law Center Class of 2002; B.A., Campbell University. The author wishes to thank Glenn and Janice Smith for inspiring the topic and depth of this comment and offering an enlightening look at the pharmacy profession.


3 Id. at 17 (citing a rise in prescription drug expenses from $50.6 billion in 1993 to a projected amount of $185.2 billion in 2005).

4 ID. at 33 (stating that “medication errors result from improper prescribing, dispensing, and use of medications.”).
Report, reveal the importance of pharmacists’ identification and prevention of medication errors and adverse drug events. Pharmacist now represent the nation’s third largest group of health professionals. Working in one of the most trusted professions, pharmacists occupy a crucial position in health care. Although traditionally viewed as mere dispensers of medication, pharmacists have expanded their roles beyond the pharmacy setting and have forged a new path towards better patient care and drug therapy outcomes. Proclaiming “pharmaceutical care” as their mission and standard, pharmacists have successfully transcended dispensing boundaries and have proven themselves to be valuable key players in the health care system. Recognizing this value, Congress passed the Omnibus Budget Reconciliation Act of 1990 (hereinafter OBRA 90), which codified the minimum standard of care and required pharmacists to carry out drug utilization reviews and counsel patients. OBRA 90 acknowledges pharmacists’ ability and duty to improve the quality of patient care and reduce the number of adverse drug events.

Historically, courts have declined to hold pharmacists liable for anything more than simple dispensing accuracy. Many courts continue to refer to the learned intermediary doctrine, physician-patient relationship interference, and public policy theories when analyzing pharmacist duty to warn cases. Despite the expanding roles of pharmacists and the OBRA 90 requirements, pharmacists remain shielded from duty to warn liability. Nonetheless, an increasing number of courts are slowly beginning to recognize the contemporary expanded role of pharmacists and are finding that the pharmacy profession’s standard of care encompasses the duty to warn. As a result, the traditional limits on pharmacist liability are lifting.

However, at alarming problem currently looms large over the pharmacy profession with no clear solution in sight. Due to the dramatic increase in prescription use and third-party coverage, pharmacists face unprecedented demands for pharmaceutical care services. Burdened with an exhausting workload and encumbered by the growing pharmacist shortage, pharmacists have become bogged down by dispensing demands, leaving little time to fulfill more substantive patient care duties.

Arguably, the expansion of pharmacists’ liability through OBRA 90 requirements, the adoption of pharmaceutical care stan-

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5 Susan Headen et al., Danger at the Drugs, U.S. News & World Report, Aug. 26, 1996, at 40 (discussing the roles of pharmacists in reducing medication error and noting that due to specialized training, most pharmacists have more expertise in pharmaceutical matters than physicians); see also THE PHARMACIST WORKFORCE, supra note 1, at 23-31 (discussing how medication errors arise in pharmacy).
6 THE PHARMACIST WORKFORCE, supra note 1, at 1 (stating that there were about 186,000 active pharmacists in 2000).
7 See Darren K. Carlson, Nurses Remark at Top of Honesty and Ethics Poll, GALLUP, Nov. 27, 2000 (noting that pharmacists consistently finished first in the poll, yet fell to second place when nurses were added in 1999, available at http://www.gallup.com/poll/10217.asp).
8 THE PHARMACIST WORKFORCE, supra note 1, at 33-41 (discussing pharmacists’ expanding roles in community pharmacies, clinical settings, disease management programs, health care systems, cost containment, managed care, quality of care in hospitals, long-term care facilities, new drug development, the changing use of prescription drugs, use of one- versus non-traditional therapeutics, and prevention of medication errors).
9 See David R. Brashaw, The Professional Capabilities and Legal Responsibilities of Pharmacists Should “Carry” (Reply “Ought” 7, 4 DIANE L. REV. 435, 457-58 (1996) (noting that pharmacists have taken on advisory role regarding patient’s appropriate use, adjustment, or enhancement of prescribed drug therapy).
11 71, § 1396a-8(g)(1)(A) (stating that the goals of OBRA 90 are to identify and reduce numerous types of adverse drug events.)
any expansion in liability will have on the quality of patient care and the frequency of adverse drug events. Finally, Part V concludes that although the no duty to warn rule can no longer be justified, any increase in liability in light of pharmacists’ demanding working conditions can have dangerous consequences on the quality of patient care and drug therapy outcomes.

II. THE TRADITIONAL ROLE AND LIABILITY OF PHARMACISTS

Historically, the underlying function of the traditional pharmacist is to fill and dispense drugs with accuracy. A pharmacist’s primary responsibility is to correctly process prescriptions according to the specific terms and instructions given by the prescribing physician. Viewed as merely occupying a dispensing role, pharmacists owe a duty only to practice error-free when filling prescriptions, exercising neither independent judgment regarding the physician’s drug therapy choices nor assisting the patient with drug therapy in any way. Under this paradigm, pharmacists are only required to pull the correct medication from the shelf, compound the appropriate dose, label the medication properly, and dispense it to the patient. The mid-century Code of Ethics of the American Pharmaceutical Association viewed pharmacists as silent intermediaries between the patient and physician who should not discuss the effects or composition of a prescription with any patient.

20 See Bredenbeek, supra note 9, at 443 ("Pharmacists have always been responsible for the accurate processing of prescription orders..."), see also Allen G. Myhre, The Pharmacist’s Duty to Warn in Texas, 18 Rev. L. & Soc. 27, 33 (1999) (defining accuracy in dispensing as the “bedrock function” of the pharmacist).

21 David J. Marchetti, Annotation, Liability of Pharmacists Who Accurately Fill Prescriptions for New Resulting in Error, 44 A.B.A. J. 301, 412 (1956) ("Central to a pharmacist’s responsibilities is the duty to fill accurately and accurately fill prescriptions according to the terms and instructions of the author.

22 See Myhre, supra note 23, at 34 (stating that under the traditional view, a pharmacist has no duty to make therapeutic determinations or to exercise judgment); see also Asbury, supra note 19, at 930 (referring to the lack of independent judgment of a pharmacist by holding that he is only liable for accurate processing of prescriptions).

23 Myhre, supra note 23, at 35-34 (stating that the primary duty of a pharmacist is on the mechanical processes of delivering medications).

24 See id. at 34; see also Lauren Fleischer, Few New Courts enticing to Patient Care: Pharmacists’ Standard of Care in Negligence Laws, 80 FORDHAM L. REV. 827, 168 (1999) (citing the 1992 Code of Ethics of the American Pharmaceutical Association which discouraged the pharmacist from discussing the therapeutic effects or composition of a prescription with a patient, even when asked).
As a result, courts held pharmacists liable only for errors made during the mechanical processing of prescriptions. Thus, an accurately filled prescription grants pharmacists immunity from further liability.

Beyond the traditional duty of accuracy, courts face the question of when and to what extent a pharmacist owes a duty to warn patients of the dangers involved with a particular drug therapy. Following the traditional restricted role of a pharmacist, many courts approach the issue of the pharmacist’s duty to warn with a conventional eye and skeptical attitude.

The legal concept of a duty is the first element analyzed by a court in a common law action of negligence. A duty is any obligation one person owes to another to refrain from negligent conduct. Pharmacists are generally recognized as having a duty to act with due care and diligence when dispensing drugs. Once a duty is found to exist, the court must then analyze what standard of care is required to uphold that duty. Courts typically hold the standard of care for pharmacists to be the degree of care that an ordinary and prudent pharmacist would exercise under the same or similar circumstances.

63 Braddock, supra note 9, at 44 (stating that a pharmacist would not be found liable if the prescription was accurately processed), see also Lentine v. Cannon Drugs, 291 N.W.2d 103, 105 (Mich. Ct. App. 1980) ("Pharmacists are not liable for correctly filling a prescription."); Intermountain Drug Co. v. Rapson, 662 P.2d 234, 236 (Utah Ct. App. 1983) (recognizing that a pharmacist has a duty to create instructions and suggesting that a pharmacist has a duty to create instructions and suggest the number of dispensing errors.

64 Fletcher, supra note 27, at 179-83 (discussing the different approaches that courts have taken to the pharmacist’s duty to warn).

65 Id. (indicating that some courts take a very active role in imposing a duty to warn on pharmacists, while others adopt a more conservative role of imposing liability only on obviously inadequate prescriptions).

66 Lasky v. Shetek’s Country Club Pharmacy, Inc., 480 P.2d 1129, 1131 (Ariz. Ct. App. 1974) (noting that if there were negligence, the court must first determine whether defendant owed “a duty to conform to a particular standard of conduct to protect [the plaintiff] against unreasonable risk of harm.”)


69 Hoke SuperX, Inc. v. McLaughlin, 842 N.E.2d 514, 519 (Ind. 1994).

70 Lasky v. Shetek’s Country Club Pharmacy, Inc., 480 P.2d 1129, 1131 (Ariz. Ct. App. 1974) (noting that if there were negligence, the court must first determine whether defendant owed “a duty to conform to a particular standard of conduct to protect [the plaintiff] against unreasonable risk of harm.”)

71 Supra v. Ball, 532 N.W.2d 442, 446 (Mich. 1995).


73 Hoke SuperX, Inc. v. McLaughlin, 842 N.E.2d 514, 519 (Ind. 1994).

74 Hoke SuperX, Inc. v. McLaughlin, 842 N.E.2d 514, 519 (Ind. 1994).

75 However, until recently, many courts have refused to find the existence of a pharmacist’s duty to warn.

76 The cases dealing with the pharmacist’s duty to warn reveal three theories generally relied upon to support the view that the pharmacists have no such duty. Most cases cite one or more of the following three theories, arguing that imposing a duty to warn: (1) interferes with the physician-patient relationship; (2) violates the learned intermediary doctrine, and/or (3) contradicts public policy.

77 Courts frequently state that imposing a duty to warn injects the physician into the physician-patient relationship. Such interference in the patient-physician relationship can only do more harm than good. Arguably, this harm can occur because the pharmacist...
is presumed to have neither the medical training nor the intimate knowledge of the patient’s medical history to make a proper judgment regarding drug therapy.61 The physician is the only person with complete knowledge of the patient’s medical history; thus, he is uniquely qualified to weigh the risks and benefits of the proposed drug therapy and to determine what facts to tell the patient.62 With such knowledge comes an understanding of which risks are material enough to require disclosure to the patient.63 Disclosure, if made with a lack of such knowledge, could adversely interfere with treatment and limit the effectiveness of the physician-patient relationship.64

Additionally, courts advocating the no-duty-to-warn rule argue that implementing such a duty on pharmacists violates the learned intermediary doctrine.65 This doctrine holds that a manufacturer’s duty to provide an adequate warning of the dangers associated with a drug runs only to the physician.66 The manufacturer’s duty to warn the patient is effectively shifted to the physician who becomes the “learned intermediary” between the manufacturer and the patient.67 The rationale behind the learned intermediary doctrine is that the physician has a duty to inform himself of the qualities of a drug.68 He then exercises his individual judgment based on the character of the drug and his knowledge of the patient to prescribe a course of treatment.69 Based on this knowledge, the physician decides what facts should be disclosed to the patient.70 As a result, the patient is expected to rely primarily on the physician’s judgment.71 Because the pharmacist cannot determine when and how much information should be divulged to the patient, any warnings provided by the pharmacist would violate this doctrine.72 Thus, the learned intermediary doctrine virtually becomes a protective barrier between pharmacists and liability, prohibiting the imposition of any duty to warn.73

Courts also rely on several public policy reasons to uphold the no duty-to-warn rule.74 The primary reason offered to justify the rule is that such a requirement would compel pharmacists to second-guess the accuracy and propriety of every prescription filled.75 According to the court in McKee, this would place quite a burden on the profession and would lead to antagonistic relationships between physicians and pharmacists.76 Furthermore, a patient faced with numerous or serious warnings may decide not to take the prescribed medication due to fear or confusion, thus endangering his health.77 McKee specifically notes that direct warnings to a patient without

61 Young v. Key Pharm., Inc., 770 P.2d 582, 190 (Wash. 1989) (arguing that unlike physicians, pharmacists are not licensed to prescribe medication due to their lack of training in diagnosis and treatment).
62 McKee, 782 P.2d at 1053 (arguing that knowledge of the patient’s medical condition is necessary to determine what information to tell the patient).
63 Id. (noting that there may even be circumstances justifying the nondisclosure of material risks).
64 Id. ("Requiring the pharmacist to warn patients of risks associated with a drug would inject the pharmacist into the physician-patient relationship and interfere with ongoing treatment.")
66 McKee, 782 P.2d at 1049-50 (noting that the reasons for adopting the learned intermediary doctrine are in part based on the physician’s "knowledge of the patient’s medical condition").
67 See Tenbroeck v. A. H. Robins Co., 577 P.2d 975 (Wash. 1978) (explaining that as the learned intermediary, it is the physician’s duty to inform himself of the qualities and characteristics of the medication that he prescribes for the patient).
68 McKee, 782 P.2d at 1049.
physician interaction can be counterproductive to the rationale behind the learned intermediary doctrine.\textsuperscript{50} 

A. Judicial Interpretation of Pharmacists’ Traditional Role and Liability

1. The McKee Case

In 1989, the Washington Supreme Court decided the case of McKee v. American Home Products Corp.,\textsuperscript{51} now considered to be one of the leading cases advocating the no duty to warn rule.\textsuperscript{52} In this case, plaintiff McKee became physically and psychologically addicted to Pregnate, an appetite suppressant prescribed to her over a period of ten years.\textsuperscript{53} McKee brought an action against the dispensing pharmacists for negligently selling her the drug over an extended length of time without warning of its adverse effects and without giving her the manufacturer’s package insert.\textsuperscript{54}

The court chose, however, to follow the majority of jurisdictions previously addressing the same issue and held that a pharmacist has no duty to warn.\textsuperscript{55} Citing the learned intermediary doctrine as its foundational basis, the court took the position that pharmacists have no duty to warn of a drug’s dangerous side effects.

The court stated that it is the physician’s duty alone to be aware of a drug’s harmful effects and to use his knowledge to determine how and when to inform the patient of the risks of a particular treatment.\textsuperscript{56} To impose a duty to warn on the pharmacist would also intrude on the physician-patient relationship.\textsuperscript{57} Such an intrusion “[c]ould only do more harm than good.”\textsuperscript{58} Furthermore, the court declined to impose a duty on pharmacists to provide patients with the drug manufacturer’s package insert for public policy reasons.\textsuperscript{59} Thus, a pharmacist’s duty only extended to filling the prescription accurately and remaining alert for clear errors in the prescription.\textsuperscript{60}

2. The Kasin Case

Recently, in Kasin v. Osco Drugs, Inc.,\textsuperscript{61} an Illinois court examined the issue of a pharmacist’s duty to warn.\textsuperscript{62} In this case, plaintiff Kasin had a prescription filled for Daypro at Osco Drugs.\textsuperscript{63} Upon dispensing the medication, the pharmacist did not discuss the side effects of the drug with Kasin, but rather provided him with an information sheet listing several unlikely side effects.\textsuperscript{64} After taking the drug over a ten-day period, Kasin was diagnosed with renal failure, ultimately necessitating a kidney transplant.\textsuperscript{65} Kasin subsequently brought a claim of negligence against the pharmacy arguing that the learned intermediary doctrine does not shield a pharmacy or pharmacist from liability when there is a voluntary undertaking to warn of dangerous side effects.\textsuperscript{66} Kasin further argued that be-

\textsuperscript{50} See McKee, 782 P.2d at 1055 (discussing the risks associated with providing the patient with a drug manufacturer’s package insert, which may contain detailed, technical, or disturbing material).
\textsuperscript{51} 782 P.2d at 1045.
\textsuperscript{52} See Myres, supra note 23, at 44 n.73 (distinguishing McKee as the leading case due to the volume of scholarly treatment it has received).
\textsuperscript{53} McKee, 782 P.2d at 1046-47 (noting that the defendant pharmacists accurately filled the prescription pursuant to the physician’s authorization).
\textsuperscript{54} Id. at 1047 (noting that McKee also alleged breach of implied express warranties).
\textsuperscript{55} Id. at 1048-49 (relaying briefly on Pyzyk v. Henry’s Drug Store, 457 So. 2d 501 (Fla. Dist. Ct. App. 1984), an almost factually identical case in which the court held that pharmacists have no duty to warn patients of dangerous side effects or to warn treating physicians of a patient’s known addiction).
\textsuperscript{56} Id. at 1049 (placing the duty to warn solely on physicians rather than on manufacturers or pharmacists).
\textsuperscript{57} Id. at 1050-51 (adapting the view that the physician is in the best position to decide a patient’s drug therapy and to disclose any harmful side effects).
\textsuperscript{59} McKee, 782 P.2d at 1054-55 (stating that the insert is directed towards physicians, not pharmacists; imposing a duty to provide the insert to the patient violates the learned intermediary doctrine and creates the risk of frightening or confusing the patient).
\textsuperscript{60} Id. at 1055-56 (holding specifically that the pharmacist does not have a duty to question a physician’s judgment or to warn patients of the dangerous effects of a drug either orally or by way of the package insert).
\textsuperscript{61} 728 N.E.2d 77 (Ill. App. Ct. 2000).
\textsuperscript{62} Id. at 81 (affirming the finding that a pharmacist does not have a duty to warn patients of all potential medication side effects).
\textsuperscript{63} Id. at 78 (noting that the plaintiff was previously healthy and had no history of any illness in the past twenty-five years).
\textsuperscript{64} Id. (listing the side effects as "eye/color problems, change in urine color, bloody stools, difficulty breathing, and mental changes").
\textsuperscript{65} Id. (noting that Kasin’s diagnosis revealed he had been born with only one functioning kidney).
\textsuperscript{66} Kasin, 728 N.E.2d at 78-79 (discussing the plaintiff’s claim that voluntarily providing an information sheet removes the pharmacy from the protection of the learned intermediary doctrine).
cause the pharmacy voluntarily undertook to warn of certain side effects of the drug, it was obligated to warn of all side effects.79

The court rejected these arguments, relying instead on the reasoning used in Frye v. Medicare-Glaser Corp.77 to hold that once a pharmacist voluntarily attempts to warn a patient of side effects, the duty the pharmacist assumes is limited to the extent of the undertaking.80 Because the side effects listed on the information sheet constituted the extent of the pharmacy’s undertaking, the pharmacy and pharmacist were only liable for the accuracy of these particular warnings.79 As a result, the pharmacy had no duty to warn Kasin of further possible side effects.80

3. The Morgan Case

In the case of Morgan v. Wal-Mart Stores, Inc.,81 the Texas Court of Appeals reversed a lower court’s ruling that a pharmacist had a duty to warn of a drug’s dangerous side effects.82 In this case, Morgan’s son was diagnosed with Attention Deficit Hyperactivity Disorder for which the drug Desipramine was prescribed.83 The prescription for Desipramine was filled at a Wal-Mart pharmacy.84 Morgan testified that no Wal-Mart pharmacist ever offered to counsel her or give her any information concerning the side effects of the

68 Id. at 457-58 (noting that although Morgan denied receipt of any oral or written counseling from the pharmacist, it was the Wal-Mart pharmacy’s common practice to staple a written information sheet onto the bag containing the drug).
69 Morgan, 30 S.W.3d at 457-60 (stating that upon her son’s death from hyperosmosophic syndrome, Morgan authorized an autopsy to be performed which concluded that the syndrome was the result of taking Desipramine).
70 Id. at 460 (arguing that Wal-Mart was negligent “by failing to properly warn intended users of the hazards and harms associated with the use of the product”).
71 Id. at 461 (recognizing that pharmacists may have a duty to warn if the physician or manufacturer requires a warning).
72 Id. at 466 (stating that “courts holding that pharmacists owe their customers a duty beyond accurately filling prescriptions do so based on the presence of additional factors, such as known contradictions, that would alert a reasonably prudent pharmacist to a potential problem,” cf. Stubbins v. Concord Wrigley Drugs, Inc., 416 N.W.2d 381, 388 (Mich. Ct. App. 1987) (specifically reserving consideration of pharmacists’ liability in situations “where the pharmacist knows of a particular patient’s unique problems or . . . fills two incompatible prescriptions”).
73 Morgan, 30 SW.3d at 467 (discussing several reasons for not imposing a general duty to warn, including interference with the physician-patient relationship).
74 Id. (concluding that Wal-Mart did not breach their duty of care when filling the prescription).
76 Id. at 792 (affirming the judgment of the trial court in favor of the hospital, the nurse, the pharmacy, and the physician).
Silves, who was prescribed two interacting drugs and developed a pulmonary hemorrhage. Silves alleged that the hospital pharmacist was negligent in failing to warn both him and the prescribing physician of the potential drug interactions and contraindications. The court concluded that the pharmacist did not have a duty to warn either Silves or his physician. Relying on McKe, the court stated that the physician is in the best position to determine drug therapy and to decide when to warn a patient; therefore, the pharmacist has no duty to question the physician’s judgment. Specifically, the court reasoned that, according to the Physician’s Desk Reference, there are no “absolute contraindications” to prescribing the two drugs. Thus, Silves’ prescription contained no clear error for which the pharmacist was required to either warn or to inquire to the physician about.

III. THE CONTEMPORARY ROLE AND LIABILITY OF PHARMACISTS

Although the historical foundation of the pharmaceutical profession is rooted in the accurate compounding and dispensing of medication, much can be said about the ever-increasing role pharmacists will play in twenty-first century health care. As one study commented, “Pharmacists will transcend their traditional roles of compounding and dispensing drugs to deliver knowledge about health care therapy and monitoring the usage of drugs.” The expanded form of practice known as “pharmaceutical care” now defines the pharmacy profession. The pharmaceutical care concept embraces the professionalism of pharmacists by expanding their role beyond dispensing to include drug therapy, disease management, patient counseling, and an overall outcome-oriented approach. As a result of pharmaceutical care, pharmacists are now viewed by many as “playing an important role in counseling patients, reducing medication errors, and providing assistance with clinical disease management programs. The role of pharmacists is thus far greater than simply filling and dispensing prescription medications.”

State legislative expansion of pharmacist authority in community pharmacy settings gives evidence of the significant expansion of pharmacists’ roles. By early 2000, over half the states had passed regulations designating some form of prescriptive authority to pharmacists. Florida pharmacists have enjoyed prescriptive authority for over fifteen years, allowing pharmacists to “prescribe from a formulary following a strict protocol.” The benefits of al-
lowing pharmacists prescriptive authority include more effective treatment of patients and saved time for doctors who are relieved of maintenance therapy responsibilities. Also, prescriptive authority “brings into the health-care system patients who might not otherwise seek help” due to the accessibility of pharmacists.

Many states have also passed legislation that expands drug therapy management responsibilities for pharmacists. A new law in Arkansas now allows pharmacists to administer immunizations and form collaborative care agreements with physicians. This law permits pharmacists to modify drug therapy with the physician’s consent in case of complications. Pennsylvania has also proposed an amendment to its pharmacy act to “expand the scope of practice” and allow pharmacists to manage drug therapy. However, the state medical society and pharmaceutical industry oppose the collaborative care agreement provision of the law. Legislation to expand pharmacists’ interaction in drug therapy has also been proposed in Ohio. The local point of this proposal is the consult agreement between physicians and pharmacists. Such an agreement would allow pharmacists to initiate or modify a patient’s drug therapy in order to take better care of that patient’s needs.

Beyond the local community pharmacy setting, pharmacists are now allowed, even encouraged, to branch out into areas where

106 Id. (indicating that despite the uniqueness of Florida’s law, patients there enjoy the same benefits as in other states with prescriptive authority laws).
107 Id. (citing the opinion of Michael Jackson, RPh, executive vice president of the Florida Pharmacy Association).
108 Ukens, Drug Therapy Management, supra note 105 at 44 (detailing different state approaches and opponent viewpoints).
109 Id. (noting that the legislation is a contemporary approach that “recognizes the changing role of pharmacists who must work as partners on the health-care provider team to achieve positive patient outcomes”).
110 Id. (explaining that the last revision to the 1961 practice act occurred in 1985 and indicating that this change is supposed to be a “pro-patient” change).
111 Id. (relating that the proposal would allow doctors and pharmacists to enter into agreements where pharmacists perform services under protocol).
112 Id. (indicating that this proposal may provide pharmacists with more definitive agreements such as in group practice situations, rather than allowing agreements on only a patient-by-patient basis).
113 Ukens, Drug Therapy Management, supra note 105, at 44 (explaining that as part of the consult agreements, pharmacists could, among other things, order lab tests).
114 Id. (noting that the consult agreement differs from the collaborative care agreements adopted by other states).

their knowledge and training will be increasingly useful. The Department of Health and Human Services, in a study concerning the shortage of pharmacists, listed new roles pharmacists must assume within the health care industry. The employment opportunities for pharmacists now include: pharmaceutical research and sales, pharmacoconomics, managed care administration, pharmacy benefit managing (PBMs), online telehealth services, long-term and ambulatory care, cognitive services, and alternative/herbal therapy counseling. Pharmacists are also moving towards the performance of more clinical duties, including the screening, diagnosis, education, and monitoring of diseases such as diabetes, asthma, and cardiovascular disease. Effectively, “Pharmacists are now where nurses were ten years ago. In many places, nurses are primary care givers, a position almost unthinkable a decade ago.” Furthermore, pharmacists are beginning to receive reimbursement for their clinical services. Although most reimbursement comes through traditional commercial insurance companies, nonprofit organizations such as Blue Cross, and managed care organizations are also beginning to consider reimbursing pharmacists for performing clinical services. In several states, pharmacists receive reimbursement through Medicare as certified diabetic educators. 124

127 See THE PHARMACIST WORKFORCE, supra note 1, at 33 (noting that pharmacists can serve as consultants to physicians who have questions about new drugs and may participate in clinical care teams).
128 See id. at 12, 79 (detailing the survey responses of various pharmaceutical groups regarding the future of the pharmacy profession and suggesting that expanded patient care, more than prescription volume, will determine future manpower needs in pharmaceutical care).
129 See id. For a discussion with members of the National Association of Chain Drug Stores (NACDS) pharmacy department about the new roles of pharmacists, see Advancing the Cause of Community Pharmacy, CHAIN DRUG REV., July 17, 2000, at 69.
130 See Larry Husten, How Do You Bill for $180 an Hour? One Expert’s Advice, DRUG TOPICS, June 2, 1997, at 61 (citing a lecture by Gene A. Mansell, RPh, on reimbursement for cognitive services and noting that pharmacists will also be involved in drug monitoring and diagnosis).
131 Id.
132 Id. (conceding to the difficulty of obtaining reimbursement and noting that the process is becoming easier as innovative companies are becoming more open to reimbursing for these services).
133 Id. (noting that an appropriate fee for clinical services for a pharmacist falls between $60 and $100, a sum that should include the hourly wage of the pharmacist, 15% for benefits, and 15% to 25% for clinical support).
134 See id. at 61 (stating that pharmacists are seeking full legislative recognition under Medicare Part A).
Through the implementation of pharmaceutical care, state legislation, and expansion of employment opportunities, pharmacists have clearly evolved into much more than mechanical dispensers of medication. Pharmacists are an integral part of the health care system and are increasingly recognized as such. Unfortunately, although many individuals and entities embrace the contemporary role of pharmacists, judiciary acceptance has not been as forthcoming. However, a number of courts are demonstrating a willingness to recognize the contemporary role of the pharmacy profession when addressing the issue of a pharmacist’s duty to warn.

A. Judicial Interpretation of the Contemporary Role and Liability of Pharmacists

1. The Dooley Case

In the often cited case of Dooley v. Ezerett, a Tennessee appellate court recognized that pharmacists may have a duty to warn patients of potential drug interactions. Dooley suffered cerebral seizures after two of his prescribed drugs adversely interacted with one another. At the time Dooley’s prescription was filled, the Rexall pharmacist warned neither Dooley nor the prescribing physician of the possibility of a drug interaction. Discussing the pharmacist’s duty to patients, the court stated that “the pharmacist has a duty to act with due, ordinary, care and diligence in compounding and selling drugs.” However, the question the court sought to answer was whether the scope of that duty included a duty to warn the patient. After rejecting the learned intermediary doctrine because it did not involve either the drug manufacturer and patient, or the physician and patient, but rather involved the pharmacist and patient, the court acknowledged the possibility that a pharmacist’s duties could include the duty to warn patients of possible drug interactions. The court based its finding on the testimony of a Tennessee pharmacist who stated that although the accepted standard of care includes a pharmacist warning patients of possible drug interactions. Thus, the importance of Dooley lies in the fact that the court’s analysis shifted from the pharmacist’s duty to the pharmacist’s standard of care.

2. The Hooks Case

In Hooks SuperX, Inc. v. McLaughlin, the Supreme Court of Indiana decided to impose a duty upon pharmacists to cease refilling prescriptions at an unreasonably faster rate than that prescribed. Over a period of five years, McLaughlin became addicted to propanolol, consuming the drug much faster than the normal consumption rate. McLaughlin claimed that the pharmacy breached its duty of care by continuing to refill the prescription at such a fast rate, thereby endangering his health. The court ad-

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125 Cary C. Cacciatore, Computers, OBRA 90 and the Pharmacist’s Duty to Warn, 5 J. PHARMACY & L. 103 (1996) (noting the historical reluctance of courts to recognize the expanded role of pharmacists).
126 For additional information on the evolution of the pharmacy profession and an in-depth discussion of the various new roles pharmacists are accepting in the health care arena, see THE PHARMACY WORKFORCE, supra note 1, at 23-39. The various new areas include ambulatory settings, disease management programs, health care systems, and others. Id.
127 Cacciatore, supra note 125, at 103 (speculating that the state implementation of OBRA 90 may persuade courts to recognize the expanded role of pharmacists).
128 Id. (conjecturing that the implementation of OBRA 90 could have spurred judicial reevaluation of the role of pharmacists).
130 Id. at 385-386 (explaining that in a dispute as to whether pharmacists have a duty to warn which prevents the granting of summary judgment).
131 Id. at 382 (stating that the two interacting drugs were Erythromycin and Theophylline).
132 Id. (noting that the pharmacist was not aware of the possible interaction, even though the package insert for Erythromycin warned that dosage levels of Theophylline should be reduced when taking Erythromycin because Erythromycin may elevate levels of Theophylline in the serum and cause illness).
dressed whether a pharmacist is legally obligated to stop filling a valid prescription, holding that pharmacists owe a duty to cease filling prescriptions in circumstances such as this. Its reasoning relied upon the relationship between pharmacists and patients, the reasonable foreseeability of the addictive harm, and the public policy concerns involving drug abuse. The court also held that the standard of care for pharmacists is "that degree of care that an ordinarily prudent pharmacist would [exercise] under the same or similar circumstances."

Although Hooks is not a "duty to warn" case, but rather a "duty to stop dispensing" case, the court's rejection of the argument that such a duty might interfere with the physician-patient relationship marks an important shift in the analysis of the liability of pharmacists. The court states that within the physician-patient relationship, recognition of a duty "will encourage pharmacists and physicians to work together . . ." rather than create adversaries. Thus, this court rejects one of the main theories relied upon by other courts to limit pharmacists' liability.

3. The Baker Case

Baker v. Arbor Drugs, Inc., presents a slightly different case when examining a pharmacist's duty to warn. In this case, Arbor drugs filled plaintiff Baker's prescription for Tavist-D where a drug three days. McLaughlin argues that Hooks knew or should have known of his addiction, and is thus liable to him for breach of duty. Id.

14 Id. at 516, 519 (noting that pharmacists must use their professional judgment to determine whether the refill rate is unreasonable on a case by case basis).

153 See Hooks SuperX, Inc., 642 N.E.2d at S17-19. According to the court, recovery requires a finding that an individual had a duty. The court concluded that there was a relationship between the pharmacist and patient that justified imposing a duty; that McLaughlin's risk was foreseeable to Hooks; and that a legal duty will further the best interests of the patient by urging pharmacists and physicians to work together. Id.

144 Id. at 519 (suggesting that under this standard, "filling prescriptions faster than prescribed is not necessarily a breach of the duty owed"). The court indicated that what constitutes a prescription at a faster rate for the first few days after surgery would be acceptable. Id.

15 Id. at 518-19; see also Gonzalez, supra note 49, at 70-71 (revealing the court's rejection of the pharmacists' "interference rationale").

155 hooks SuperX, Inc., 642 N.E.2d at 519 (indicating the ultimate responsibility of proper prescription of medication remains with physicians).

156 See Gonzalez, supra note 49, at 70 (noting the court's "recognition of the team approach to patient care").


interaction detection system known as "Arbortech Plus" detected an interaction between it and Parnate, a prior prescription filled for Baker. However, a pharmacy technician likely overrode the interaction and it remained hidden. Baker later suffered a stroke as a result of taking both drugs. The court examined previous Michigan cases, noting that pharmacists do not generally owe a duty to warn of side effects when the prescription is proper on its face. However, the court also stated that a duty is imposed "where a defendant voluntarily assumes[] a function that it [is] under no legal obligation to assume." Arbor Drugs and its pharmacists voluntarily assumed a duty to use the Arbortech system with due care when it advertised the system as a means to monitor for drug interactions. Due care was not followed when the pharmacist failed to warn Baker of a possible drug interaction.

4. The Lasley Case

In Lasley v. Shrock's Country Club Pharmacy, Inc., the Arizona Court of Appeals rejected the traditional no duty to warn argument. In this case, the pharmacist dispensed two addictive drugs to plaintiff Lasley for more than ten years without warning him of

158 Id. at 729, 731 (explaining that the Arbortech Plus computer system was designed to detect drug interactions and was advertised to the public as such). The system functioned correctly, as evidenced by an "F" appearing on the bottle label to denote the potential interaction. Id.

159 Id. at 729 (noting that the pharmacist who filled Baker's prescription personally knew that Parnate and Tavist-D should not be taken simultaneously).

160 Id. (stating that Baker later committed suicide due to an inability to cope with the condition the stroke had left him in).

161 Id. at 730 (emphasizing that courts will hold pharmacists to a very high standard of care to fill prescriptions accurately).

162 Baker, 544 N.W.2d at 730 (implying that pharmacists in Michigan do not have a legal obligation to use Arbortech Plus or similar programs to warn of potentially harmful drug interactions).

163 Id. (quoting the advertisement, "How can you avoid harmful drug interactions? Simple. Get your prescription filled at Arbor Drugs . . .").


166 Id. at 1133-34 (stating that the decisions embracing the no duty to warn argument use "details of the standard of conduct to determine whether a duty exists").
the drugs’ addictive nature. Lasley required hospitalization and treatment for his addiction and brought a claim against the pharmacy stating it had breached its duty of care towards him. The court found that the pharmacy owed a duty of reasonable care to patients. It also stated the appropriate standard of care necessary to meet that duty is based on the usual conduct of other pharmacists in the same or similar position. The court rejected the physician-patient relationship and public policy theories used by other courts to uphold the no duty to warn rule. Instead, the court found that the pharmacy did owe a duty of care to patients and that it may have breached its duty to Lasley.

B. OBRA 90: A Legislatively Created Standard of Care

Courts rejecting the traditional no duty to warn rule primarily base their decisions on the pharmacy profession’s applicable standard of care. The shift in focus from duty of care to standard of care seems to be the primary reason behind the increasing judicial recognition of pharmacists’ duty to warn. As the Dooley court noted, “[I]n negligence cases, the duty is always the same—to conform to the legal standard of reasonable conduct . . . . What the [pharmacist] must do or must not do, is a question of the standard of conduct required to satisfy the duty.” Courts have defined pharmacists’ standard of care as “that degree of care that an ordinary prudent pharmacist would [exercise] under the same or similar circumstances.” Thus, pharmacists clearly have a duty to conform to the appropriate standard of care. However, the question remains as to whether providing a warning to patients is a type of conduct the pharmacist’s standard of care encompasses. In 1990, Congress passed groundbreaking legislation helping to set the minimum standard of care for pharmacists and bringing courts closer to answering this question.

The Omnibus Budget Reconciliation Act of 1990, also known as OBRA 90, significantly impacts the expansion of the types of services pharmacists are required to provide to patients. OBRA 90 arose due to Congress’ growing concern over the rising costs of Medicaid and through the efforts of the pharmacy profession itself. Recognizing a need to enhance their professional recognition and earning power, pharmacy leaders rallied their support behind the introduction of expanded service requirements. Although the requirements of OBRA 90 apply only to those pharmacy services provided to Medicaid beneficiaries, most states have passed legislation extending the requirements to all patients.

The stated goals of OBRA 90 focus on the appropriateness of prescriptions and drug therapy and the reduction of error, fraud, overuse, abuse, drug interactions, and medically unnecessary care. In order to reach these goals, OBRA 90 requires pharmacists

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168 Hooks SuperX, Inc. v. McLaughlin, 642 N.E.2d 514, 519 (Ind 1994) (stating that the traditional negligence standard should apply to pharmacists). 169 Id. (noting that “What constitutes due care in a particular case will depend upon the circumstances . . . . and will usually be a question of fact.”).

170 See OBRA 90, 42 U.S.C. § 1396d-8ig (requiring pharmacists to perform a drug use review and counsel patients for each dispensed prescription).

171 Id. For a detailed discussion of the impact OBRA 90 has had on the duties of the pharmacy profession, see Baker, supra note 137, at 510-18.

172 Baker, supra note 137, at 503 (noting that the pharmacy profession supplied Congress with many of the ideas implemented in OBRA 90).

173 See id. at 503-04 (commenting that many pharmacists had seen a decrease in profits due to the utilization of only their dispensing function).


175 See Baker, supra note 137, at 503 (stating that as of 1994, at least forty states had extended the OBRA 90 requirements to all patients); see also Cacciatore, supra note 125, at 111 (arguing otherwise would create two standards of practice for pharmacists, the higher standard applying only to Medicaid patients). Id.
to take a more active role in drug therapy by mandating the use of a prospective drug use review program and establishing patient counseling and patient profiling requirements.\textsuperscript{176}

The drug use review (DUR) provision of OBRA 90 requires pharmacists to make a reasonable effort to "obtain, record, and maintain" the following patient information: (1) the patient’s name, address, phone number, age, and gender; (2) the patient’s individual history, disease state, allergies, drug reactions, and list of medications; and (3) the pharmacist’s comments about the drug therapy.\textsuperscript{177} Once the patient profile information has been obtained, the pharmacist is required to screen patients for potential drug therapy problems caused by duplications, contraindications, interactions, incorrect dosage or duration, drug allergies, and clinical misuse/abuse.\textsuperscript{178} Afterwards, the pharmacist must offer to complete what might be considered his most significant and recognizable DUR function: counseling the patient.\textsuperscript{179} If the customer accepts counseling, OBRA 90 requires the pharmacist to counsel the patient on matters that, in the pharmacist’s professional opinion, are deemed to be significant.\textsuperscript{180} However, OBRA 90 does not require a pharmacist to counsel any patient who refuses consultation.\textsuperscript{181}

The requirements of OBRA 90 impose a duty on pharmacists to counsel and to check for prescription errors, interactions, overdoses, and misuse.\textsuperscript{182} Nevertheless, the requirements "do not impose a duty on the pharmacist to prescribe or second guess the physician."\textsuperscript{183} Pharmacists do not have to perform a risk–benefit analysis to decide which medication is most appropriate for a patient.\textsuperscript{184} OBRA 90 limits the pharmacist’s duty to the determination of how medication should be taken to reach the best outcome for the patient.\textsuperscript{185} Thus, "the physician performs risk assessment [while] the pharmacist performs risk management."\textsuperscript{186}

IV. Analysis

A. Invalidating the Theories Behind the No Duty to Warn Rule

1. The Physician–Patient Relationship.

Courts often argue that imposing a duty to warn on pharmacists interferes with the physician–patient relationship.\textsuperscript{187} Arguably, such interference can be harmful because the pharmacist lacks the education and the intimate knowledge of the patient’s medical history to competently advise him or her of possible drug side effects or interactions.\textsuperscript{188} However, after analyzing the contemporary phar-

\textsuperscript{176} Id. at § 1396e–8(g)(2)(A)(iii)(II) (indicating that the pharmacist is only required to offer to consult with the patient).

\textsuperscript{177} See id. at § 1396e–8(g)(2)(A)(ii)(II).


\textsuperscript{179} The statute lists the minimum information the pharmacist is required to offer to counsel the patient as being:

(a) the name and description of the medication;

(b) the route, dosage form, dosage, route of administration, and duration of drug therapy;

(c) special directions and precautions for preparation, administration, and use by the patient;

(d) common adverse effects or adverse drug reactions and therapeutic contraindications that may be encountered, including their avoidance, and the action required if they occur;

(e) techniques for self monitoring drug therapy;

(f) proper storage;

(g) prescription refill information; and

(h) action to be taken in the event of a missed dose.

\textsuperscript{180} Smith, supra note 137, at 516–17 (arguing that it is important for courts to realize only a limited duty is placed on pharmacists by the OBRA 90 requirements).
macy profession, it becomes apparent that the above argument should fail. Pharmacy education underwent quite a change during the last thirty years, moving from a product/chemical-oriented approach to the modern patient/outcome-oriented approach. A wider range of courses are now offered to pharmacy students focusing on topics such as the therapeutics of medication, the social and administrative issues of health care, and communication with the patient and provider. Students are also required to participate in clinical rotations and make drug therapy recommendations to the prescriber. Furthermore, many pharmacy students obtain a Doctor of Pharmacy degree (PharmD) rather than the standard Bachelor of Science (BS) in Pharmacy degree. In 1992, the House of Delegates of the American Association of Colleges and Pharmacy (AACP) adopted the PharmD as the entry-level degree, and the BS in Pharmacy is set to be phased out.

Thus, as the education of pharmacists greatly improves and moves toward a more patient-oriented approach, the gap between the physician’s knowledge of drug therapy and the pharmacist’s knowledge of drug therapy will steadily close. As one pharmacist has stated, “the students coming out of pharmacy school today probably know just as much, if not more, about certain drugs and types of drug therapy than some physicians do.” As a result, courts must recognize the depth of knowledge that contemporary pharmacists possess and hold them accountable as professionals to use that knowledge effectively. Furthermore, courts must realize that imposing a duty to warn on pharmacists does not confer on them the power to prescribe or choose a particular course of drug therapy. The duty merely grants pharmacists the power to evaluate the effectiveness, accuracy, and safety of the prescribed drug therapy.

With the advent of the OBRA 90 requirements and the use of reliable computer technology, pharmacists have also become increasingly knowledgeable about patients’ medical histories. OBRA 90 specifically states that a pharmacist should obtain and record each patient’s individual history regarding his disease state, drug reactions, current medications, and any other significant medical information. This is the minimum standard of care a pharmacist must comply with for each patient. The information is then entered and maintained within a computer database, enabling the pharmacist to retrieve a patient’s medical profile quickly and easily. Each time a prescription is filled, the pharmacist can review and build upon a patient’s medical history. Although a patient’s profile is unlikely to be as detailed or as thorough as the information a physician has access to, the pharmacist can still make accurate judgments based on the information given. The pharmacist continues to have the ability to discover and alert patients to possible drug interactions, allergies, addictiveness, and side effects.

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189 See The Pharmacist Workforce, supra note 1, at 58-59 (describing the expanded educational requirements for pharmacists).
190 See Cacciarelli, supra note 125, at 104 (explaining that in the past, pharmacists were taught to refer questions about medication to the physician).
191 See The Pharmacist Workforce, supra note 1, at 58-59; Cacciarelli, supra note 125, at 104 (noting that pharmacy students now have access to a wider range of courses).
192 Cacciarelli, supra note 125, at 104 (describing the expanded curriculum in pharmacy education); see also The Pharmacist Workforce, supra note 1, at 58-59 (noting that clinical rotations usually take place in both community and institutional settings).
193 See The Pharmacist Workforce, supra note 1, at 58-59 (discussing the gradual transition to the PharmD).
194 See id. (noting that the American Council of Pharmaceutical Education will only accredit PharmD programs after 2003). The transition to the PharmD as the entry-level degree has gradually taken place in all eighty-one schools and colleges of pharmacy. Id. at 45.
195 Telephone interview with E. Glenn Smith, Owner and Head Pharmacist, Glenn’s Pharmacy (Jan. 9, 2001) (speculating that pharmacist’s knowledge of drugs may exceed that of physicians).
196 Id. (responding to the question “Do you feel that pharmacists know more than doctors about some types of drugs?”).
197 See Baker, supra note 137, at 516-17 (emphasizing that OBRA requirements do not give pharmacists the authority to prescribe medication or impose a duty to second guess physicians).
201 See id. (stating that the pharmacist’s knowledge “at least” obtain the patient information listed in the statute).
202 See Cacciarelli, supra note 125, at 103, 112-14 (describing the expanded use of and reliance on computers within the pharmacy industry to manage the abundance of available drug and patient information).
203 See id.
204 See id. (explaining that computer technology has allowed pharmacists to screen for drug allergy interactions, print patient education materials, and monitor drug usage).
Moreover, there are some warnings that pharmacists can provide without any knowledge of a patient’s medical history. Such warnings are based on the particular drug itself and usually involve avoiding alcohol, possible drowsiness, and potential drug interactions with common over-the-counter drugs.

The McKee court also argues that the pharmacist’s duty to warn will interfere with the physician-patient relationship, creating “antagonistic relations between pharmacists and physicians.” However, the Hooks court states, “We believe recognition of a legal duty will encourage pharmacists and physicians to work together in considering the best interests of their customers and patients.” Furthermore, patients may become more attentive to their drug therapy when pharmacists warn. This increased awareness and interest can actually improve the physician-patient relationship.

In light of pharmacists’ increased education, drug therapy knowledge, and access to patients’ medical history, the criticism of pharmacists’ interference with the physician-patient relationship is no longer valid. The argument that pharmacists lack the adequate education and knowledge of patients’ medical history is unpersuasive when applied to the contemporary pharmacist. Furthermore, imposing a duty to warn on pharmacists does not harm the physician-patient relationship, but rather strengthens it. Therefore, the theory of physician-patient relationship interference can no longer support the no duty to warn rule.


207 See id. (noting that the relationship between pharmacist and customer can be independent of the physician-patient relationship); see Cacioppo, supra note 125, at 107 (stating that there are drug specific warnings that can be provided without knowing a patient’s medical history).

208 McKee v. American Home Products Corp., 725 P.2d 1045, 1053 (Wash. 1989) (pointing that such antagonism would result from pharmacists questioning every prescription they fill).


210 See Cammisa, supra note 205, at 444-45 (citing the view of the Illinois Pharmacists Association).

211 See id. (arguing that the pharmacist’s duty to warn complements the physician-patient relationship).

212 See infra pp. 126-29.

213 See also Riff v. Morgan Pharmacy, 508 A.2d 1247, 1251 (Pa. Super. Ct. 1986) (arguing that the physician patient interference rationale makes a pharmacist “no more than a shipping clerk who must dutifully and unquestionably obey the written orders of omnipotent physicians”).

2. The Learned Intermediary Doctrine.

Courts often cite the learned intermediary doctrine as grounds for limiting the liability of pharmacists. This doctrine holds that a drug manufacturer owes a duty to warn the physician of a particular drug’s danger and the physician, in turn, owes a duty to warn the patient. The doctrine implies that pharmacists should not attempt to warn patients of potential dangers because only the physician has adequate knowledge of the patient’s condition and drug therapy to determine what dangers to disclose. As a result, patients are expected and encouraged to rely only on the information given by their physician.

The learned intermediary doctrine has been misapplied to pharmacist duty to warn cases because it was a defense conceived to limit the liability of drug manufacturers. Thus, the doctrine should not be used by courts to determine if liability exists for pharmacists. In addition, the logic behind the learned intermediary doctrine is that physicians’ close relationships to their patients allow them to better warn of potential drug dangers. This rationale, however, should extend a duty to warn to the pharmacist because the pharmacist is arguably more proximate to the patient than the physician.

The National Association of Boards of Pharmacy (NABP) also advocates the doctrine’s overthrow, arguing that “by virtue of their education and licensure . . . R.Ph.’s do have a duty to warn their

206 See infra p. 194 and accompanying notes (recognizing that courts use the learned intermediary doctrine to prohibit the imposition of a duty to warn upon pharmacists).

214 Terhune v. A. H. Robins Co., 577 P.2d 975, 980 (Wash. 1978) (holding that a drug manufacturer’s duty to warn runs only to the physician); McKee v. American Home Products Corp., 782 P.2d 1045, 1049 (Wash. 1989) (stating that it is the physician’s duty to be informed about the characteristics of the medication he prescribes to patients).

215 See id. at 1005-51 ("Neither manufacturer nor pharmacist has the medical education or knowledge of the medical history of the patient . . . .").

216 See id. at 1125 (stating that the patient is to rely on the expertise of the physician, rather than the pharmacist).


218 Id.

219 RICHARD R. ARCEO & DAVID B. BRUSHWOOD, PHARMACY PRACTICE AND THE LAW 230 (Ruth Bloom ed., 1994) ("The learned intermediary doctrine rests on the fact that the physician is chosen in the sense that the pharmacist is not."").

220 See Cammisa, supra note 205, at 446.
patients."222 Ultimately, the learned intermediary doctrine is no longer compatible with the contemporary pharmacy profession and has merely become "a defense that's been twisted by some states."222

In essence, courts use the doctrine as a crutch, uplifted by the no duty to warn rule in the face of obvious incompatibility with the pharmacists' profession. Furthermore, courts fail to realize the extent to which patients and others rely on pharmacists' ability to provide information and warnings about drugs.223

Patients' reliance on pharmacists as a source for drug information and warnings is a result of several factors. The development and expanded use of computerized drug interaction-detection systems is one factor.224 The pharmacy in Baker v. Arbor Drugs advertised its "ArborTech Plus" system as a way for patients to be confident that their prescriptions were being properly monitored for drug interactions.225 The utilization of such systems and advertisements invite patients to rely on pharmacists beyond their mere dispensing function.226 Furthermore, when a pharmacist complies with OBRA 90 and inquires about a patient's general medical history, the patient logically believes that the pharmacist uses the information to ensure there are no present and future drug interactions or complications.227 Arguably, the pharmacist does not procure such information simply for the sake of having it. Rather, the pharmacist obtains the information in furtherance of the prescription safety goals set forth in OBRA 90.228

Additionally, an upsurge in the production of new prescription medication has led to an increased reliance on pharmacists' drug therapy knowledge.229 According to a 1998 survey, 61% of patients stated they had complete confidence in their pharmacist, while 46% noted that they respected the advice of pharmacists as much as the advice of physicians.230 "Patients and health care professionals expect pharmacists to stay current on the safe use, doses and suspected adverse reactions of new drugs and to advise both physicians and patients on the medication and its use."231 Likewise, the expanding availability and use of over-the-counter (OTC) medications and herbal/dietary supplements serves to reinforce patients' reliance on pharmacists' knowledge.232 Serious medical problems can result from the simultaneous use of prescription medication and OTC or herbal/supplemental products.233 Many patients, purchasing these products without the help, advice, or presence of a physician, must rely on the pharmacist's knowledge about such products and ability to adequately warn about possible side effects and drug interactions.234

Finally, the health care industry as a whole is beginning to place greater reliance on pharmacists' expanding knowledge of drugs and drug therapy.235 This is evident in the new roles pharma-

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222 Carol Ukeles, Illinois Lawuit Testing Pharmacists' Duty to Warn, DRUG TOOLS, Aug. 7, 2000, at 19 (hereinafter Ukeles, Illinois Lawuit) (quoting a friend-of-the-court brief written by the NABP regarding Illinois case Happel v. Wal-Mart, in which the court found that a pharmacist did not have a duty to warn).
223 Id. (citing a comment made by David B. Brushwood, R.Ph., J.D., and pharmacy law expert).
224 Nicholas J. Lynn, Avoiding Malpractice in Today's Litigious Society, On-Line Continuing Education for Pharmacists (June 1998) (explaining the pharmacist profession has become patient-oriented and patients request counseling from the pharmacist because they want to know more about the drugs they have been prescribed), at http://www.npsn.org/CONTINUING/medmatters.html.
225 See Cacioppo, supra note 125, at 113 (noting that a survey found that 96.3% of retail pharmacies use a computer system to check for drug interactions).
227 See id. at 731 (asserting that advertising the ArborTech Plus system as a way to detect drug interactions was a voluntary assumption of care that patients could rely upon).
228 See Addo & Brushwood, supra note 219, at 160-61 (discussing the requirements of OBRA '90 to screen prescriptions, discuss drug therapy, and to counsel patients regarding their prescribed medication).
229 See SMITH, supra note 1, at 38 (asserting that the increase in production of new prescription drugs has a significant impact on the role of the pharmacist).
230 Report Examines the Roles of Players in the Health Care System, supra note 101, at 69 (noting that 62% of pharmacists also believe patients respect their opinions as much as they respect a physician's).
231 THE PHARMACY WORKFORCE, supra note 1, at 38 (asserting that due to the increase of prescription drugs on the market, pharmacists will have to constantly educate themselves in order to stay current).
232 See id. at 39 (stating that there are currently more than 100,000 OTC products on the market).
233 Id. (opining that because one in three Americans use non-traditional therapies, pharmacists must become more knowledgeable about their use).
235 See id. (indicating that physicians and patients both rely on pharmacists to manage medications).
cists are taking on in areas such as pharmaceutical research and sales, managed care administration, long-term and ambulatory care, and alternative therapy counseling. State legislators are also placing more reliance on pharmacists' knowledge, granting them the authority to prescribe medication in limited circumstances and to administer immunizations. Likewise, insurance companies now reimburse pharmacists for performing patient clinical duties, acknowledging that patients are relying on pharmacists for such services. It follows that if the health care industry, legislators, and insurance companies all rely on pharmacists' knowledge in performing certain duties, courts cannot continue to expect patients to rely only on the physician's knowledge and ability to provide appropriate warnings.

As pharmacy law expert David B. Brushwood, R.Ph., J.D., commented, "Learned intermediary is one of the red herrings of pharmacy law, and I don't think it ever fits well with pharmacists."

Pharmacists have greater access to information concerning new drugs and have extensive knowledge of OTC medication and supplemental products. As a result, patients and many others in the health care industry increasingly rely on pharmacists' knowledge and ability to provide proper information and warnings about drugs. Thus, when applied to contemporary pharmacists, the learned intermediary doctrine is no longer a valid theory for upholding the no duty to warn rule.

3. Public Policy.

Courts justify the no duty to warn rule because of two prevailing public policy reasons. The first states that a duty to warn would

258 See infra pp. 203-204 and accompanying notes (discussing the various employment opportunities now available for pharmacists due to their knowledge and training).
259 See infra pp. 202-203 and accompanying notes (declaring that over half of states have given prescriptive authority to pharmacists).
260 See infra note 120 (citing Larry Huston, How Do You Bill for $180 an Hour? One Expert's Advice, DRUG TOPICS, June 2, 1997, at 61).
261 See Hoelsa SuperX, Inc. v. McLaughlin, 642 N.E.2d 514, 517 (Ind. 1994) ("It is a matter of common expectation as well as statute that pharmacists possess expertise regarding the dispensing of prescription drugs... and that customers rely upon pharmacists for that expertise.").
262 Ukena, Illinois Lawsuit, supra note 221, at 19 (responding to an Illinois court ruling that found a pharmacist did not have a duty to warn because of the learned intermediary doctrine).
263 See THE PHARMACY WORKFORCE, supra note 1, at 58-59 (discussing the educational process of pharmacists).

compel pharmacists to second-guess the correctness of every prescription filled. The second states that numerous or serious warnings provided by the pharmacist may frighten and confuse patients, causing them to refrain from taking the medication as prescribed. While these policy considerations are certainly relevant, a more significant and pressing policy consideration exists to justify imposing a duty to warn on pharmacists: the reduction of medical errors and adverse drug events.

As medication has become increasingly complex and diverse, the potential for misuse and error has reached startling proportions. According to a 1993 study, an estimated 7,000 deaths result each year from medication errors. The overall cost of these errors range between $76.6 billion and $136 billion annually. Numerous studies show that pharmacists play an important role in the reduction of medical errors and health care costs. A 1999 study reported that adverse drug events decreased by 66% when pharmacists participated in medical rounds in an Intensive Care Unit. Another study of nineteen community pharmacies found that 59% of pharmacist interventions resulted in the avoidance of potential medical errors through the clarification, modification, or withholding of the prescription. A 2000 study found that more than half of retail and hospital pharmacists “often” correct medication directions and more

264 Morgan v. Wal-Mart Stores, Inc., 30 S.W.3d 455, 467 (Tex. Ct. App—Austin 2000, no pet. h.) (stating that in order to escape liability, pharmacists would question every prescription they fill); McKee v. American Home Products, Corp., 782 F.2d 1045, 1053 (Wash. 1989) (stating that pharmacists' would be required to question the prescribing physician's judgment).
265 Morgan, 30 S.W.3d at 467 (arguing that patients might be overwhelmed by warnings given by a pharmacist and thus, not take the medication prescribed by their doctors).
266 See THE PHARMACY WORKFORCE, supra note 1, at 39-41 (discussing the prevalence of medical errors and pharmacists' role in reducing the number of such errors).
267 THE PHARMACY WORKFORCE, supra note 1, at 39 (citing a 1999 study that found an unacceptable high level of health care errors, including errors associated with medication).
268 Id. at 40 (citing one of several studies highlighting the adverse outcomes resulting from mistakes in prescribing, dispensing, and using medications).
269 Id. (citing a 1995 study).
270 Id. at 39-41 (citing various studies identifying pharmacists' ability to reduce medical errors).
271 Id. at 41 (reasoning that the presence of a pharmacist helps to lower the rate of adverse drug events).
272 See THE PHARMACY WORKFORCE, supra note 1 (citing a 1995 study where, over a four week period, pharmacists documented over 712 interventions).
than 40% “often” take measures to prevent drug interactions.\textsuperscript{231} Results such as these clearly reveal that pharmacists have the ability to intercept prescribing errors and interactions before the patient is harmed.

The enactment of the patient counseling and drug utilization review (DUR) requirements of OBRA 90 illustrates the growing national concern over the frequency and prevention of drug errors and misuse.\textsuperscript{252} Because of their specialized drug knowledge, pharmacists are uniquely qualified to identify and prevent medical errors and adverse drug reactions before they happen.\textsuperscript{250} Thus, public policy demands that pharmacists owe a duty to warn to their patients.

B. Recognizing the Pharmacy Profession’s Own Standard of Care

The standard of care for professionals is based on the conduct of other members of the profession acting in the same or similar circumstances.\textsuperscript{284} As health care professionals, pharmacists are held to a higher standard of care\textsuperscript{266} that must be set by the pharmacy profession itself.\textsuperscript{256} Thus, “the pharmacist is a professional who has a duty to his customer to exercise the standard of care required by the pharmacy profession in the same or similar communities as the community in which he practices his profession.”\textsuperscript{257} To determine exactly what duties the pharmacy profession’s standard of care entails, pharmaceutical care and its relation to OBRA 90 must be analyzed.

\textsuperscript{231} Michael F. Cordian, The Watchful Eye, DRUG TOPICS, Sept. 4, 2000, at 28, 29 [hereinafter Cordian, Watchful Eye] (listing the type of intervention and the percentage of time pharmacists said such an intervention was called for, using the terms “often,” “sometimes,” and “never”).


\textsuperscript{256} THE PHARMACIST WORKFORCE, supra note 1, at 41 (citing a 1990 study showing that pharmacists’ interventions prevented potential harm to patients).

\textsuperscript{257} See Lesley v. Shackle’s Country Club Pharmacy, 880 P.2d 1129, 1132 (Ariz. Ct. App. 1994) (citing the earlier case of Raab v. American Home Products, Corp., 782 F.2d 1045, 1048 (Wash. 1989) (“The duty of physicians must be set forth by a physician, the duty of structural engineers by a structural engineer and that of any expert must be proven by one practicing in the same field—by one’s peer.”)).

\textsuperscript{258} See id. at 1122-33 (indicating that the standard of care for a pharmacist is that of a reasonable, prudent pharmacist).

\textsuperscript{259} See id. at 1125 (noting the concern of a pharmacy that patients “are not being advised of the value of pharmaceutical care”).

\textsuperscript{250} Id. at 855-86 (discussing the scope of a pharmacist’s duty in exercising the standard of care).

Throughout the last decade, the pharmacy profession willingly embraced pharmaceutical care as its mission.\textsuperscript{260} As one study shows, pharmacists overwhelmingly supported the advent of pharmaceutical care and were confident that it was the “right direction for the profession as a whole.”\textsuperscript{260} Furthermore, pharmacists reported that pharmaceutical care is much more rewarding and ultimately brings higher job satisfaction than simply dispensing drugs with no further involvement.\textsuperscript{260} In 1999, the American Pharmaceutical Association (APhA) adopted pharmaceutical care as the standard for pharmacists and stated that its vision of improved health care services would be achieved “by making the provision of pharmaceutical care a standard of pharmacy practice that is accepted by the citizenry and for which pharmacists are paid.”\textsuperscript{261} These observations indicate that the pharmacy profession regarded pharmaceutical care to be the defining standard of care to which pharmacists should aspire.\textsuperscript{262} Yet, the question remained as to what types of duties pharmaceutical care endorses.

Pharmaceutical care is defined as “the responsible provision of drug therapy for the purpose of achieving definite outcomes that improve a patient’s quality of life.”\textsuperscript{263} Much like OBRA 90 and the DUR process, the goal of pharmaceutical care is to identify, resolve, and prevent drug related problems.\textsuperscript{264} These problems include “untreated indications, improper drug selection, subtherapeutic dosage,

\textsuperscript{260} See Brushwood, supra note 9, at 456-58 (revealing that the concept of pharmaceutical care was accepted as the mission of the pharmacy profession in the early 1990s in an effort to further meet health care needs).

\textsuperscript{263} Helen Anne Richards, R.Ph: Agree: Pharmaceutical Care is the Way to Go, DRUG TOPICS, Nov. 4, 1996, at 44 (detailing the results of a survey released at a recent Pharmaceutical Care Outcomes Research Conference which indicated that pharmacists support the expansion of their duties, but also believe they should be paid for the new services).

\textsuperscript{264} Id. at 44-45 (citing Jeffrey Kortzan, professor and head of the University of Georgia’s department of pharmacy care administration).

\textsuperscript{266} APhA Mission, supra note 19.

\textsuperscript{267} Id. (confirming the trend toward the standard of pharmaceutical care by adoption of viral infection and medication statements that incorporate that standard); see also Richards, supra note 259, at 46, 48 (noting that the survey results “serve as a validation to those in the profession who have been advocating a move toward pharmaceutical care”).


\textsuperscript{261} See id. at 68-69; see generally American Pharmaceutical Association, Principles of Practice for implement a pharmaceutical care pharmacy practice at http://www.aphanet.org/apha.
The current standard of care requires the imposition of a duty to warn. 271

C. The Consequence of Pharmacists’ Expanding Liability

When analyzing the possible effects an increase in pharmacists’ liability would pose, the logical conclusion is that such an increase would lead to better patient care and positive drug therapy outcomes. 274 In fact, these effects are precisely what legislators and the pharmacy profession intended when passing OBRA 90 and adopting the concept of pharmaceutical care. 275 Requiring the maintenance of patient profiles produces a more knowledgeable pharmacist who can provide patients with information individually tailored to their needs. 276 Likewise, requiring pharmacists to counsel patients about drug therapy produces a more knowledgeable patient who can use the prescribed medication correctly and effectively. 277 Most importantly, requiring pharmacists to warn patients of adverse drug interactions and side effects reduces the number of medical errors and complications patients face. 278 Therefore, increasing the liability of pharmacists will have an overall positive effect for consumers. 279 Such reasoning, however, fails to take into account an alarming failure to receive drugs, overdose, adverse drug reactions, drug interactions, and drug use without indication. 268 Inherent in this goal is a duty to warn; failure to do so could cause serious drug therapy complications, 269 Allowing pharmacists to ignore their duty to warn patients is in direct violation of the pharmaceutical care concept. 270 This, in turn, leads to a direct violation of the pharmacy profession’s standard of care.

Furthermore, pharmacists who reject the use of pharmaceutical care “place themselves at risk for enforcement action.” 268 Failure to implement pharmaceutical care will likely signal a failure to comply with some or all of the requirements of OBRA 90. 269 Consequently, a strong argument can be made that a failure to comply with the pharmaceutical care standard is tantamount to a failure to comply with the OBRA 90 standard of care. 270 Such a circumstance opens to liability those pharmacists who do not practice pharmaceutical care because they would be violating both the profession’s accepted standard of care and OBRA 90’s standard of care. 271 Therefore, pharmaceutical care and OBRA 90 both serve to establish that a duty to warn is part of the standard of care for the pharmacy profession. Courts continuing to ignore this duty are denying pharmacists their professional status by holding them to a lower standard of care. 272

268 Fitzgerald, Pharmaceutical Care, supra note 263, at 69 (noting that OBRA 90 identifies similar problems that are addressed by the DUR process). The major difference between pharmaceutical care and OBRA 90 is that adherence to the former is voluntary while adherence to the latter is mandated by law. Id. at 68. See also 42 U.S.C. § 1396s-b(l)(3)(A) (stating that the DUR program is designed to identify and reduce the following: drug abuse, adverse drug reactions, incorrect dosage, drug interactions, and therapeutic duplication).

269 See id. at p. 219 and accompanying notes (citing studies that illustrate pharmacists’ ability to prevent medication errors).

270 See Coffey, supra note 234 (stating that a goal pharmacists and physicians share is helping patients get the outcome intended from their prescribed medications).

267 Fitzgerald, Pharmaceutical Care, supra note 263, at 68.

271 Id. (comparing the differences and similarities between OBRA 90 and the concept of pharmaceutical care).

272 Id.

273 See id. at 69-70 (contending that judicial decisions forthcoming will reinforce the notion that all pharmacists comply with OBRA 90 and the concept of pharmaceutical care).

274 See Fred Gebhart, Five Years Later Is OBRA 90 Working?, DRUG TOPICS, July 22, 1996, at 42 (noting that a national duty to warn is developing as state courts in Arizona, Illinois, Louisiana, North Carolina, and Tennessee hold pharmacists owe a duty to warn, and that “the pharmacy profession itself is clamoring for more accountability”).

275 See Fred Gebhart, Off the Hook: OTC Switches May Be Reducing R.Pl. Liability, DRUG TOPICS, July 22, 1996, at 42 (noting that a national duty to warn is developing as state courts in Arizona, Illinois, Louisiana, North Carolina, and Tennessee hold pharmacists owe a duty to warn, and that “the pharmacy profession itself is clamoring for more accountability”).

276 Fitzgerald, supra note 263, at 68 (stating that pharmacists are being told why they are taking each medication (84%), how to take it (94%), what to do if they miss a dose (76%), how to score the product (76%), potential drug-drug interactions (79%), drug-food interactions (79%), drug-alcohol interactions (87%), and side effects (90%).

277 See id. at 58 (citing a multi-year, 11,000-patient study at Kaiser Permanente that found pharmacist counseling reduced hospital admissions and treatment costs by up to 31%).

278 See id. at 219 and accompanying notes (citing studies that indicate pharmacists’ ability to prevent medication errors).

279 See Gebhart, Five Years Later, supra note 276, at 65 (“Counseling is a public health and safety issue. If the public is aware of what they’re entitled to, they will demand more of...”)
problem growing within the pharmacy profession: pharmacists are overworked and dissatisfied. Combine these factors with increasing liability and the result is a nasty brew of adverse drug events, slapdash counseling, and neglected patients.

1. Pharmacists' Current Working Conditions

The working conditions of pharmacists today are a far cry from the working conditions enjoyed just a few decades ago. Pharmacists no longer work in the relaxed atmosphere of yesterday's local pharmacy where each patient was called by name and there was always time for a quick chat. Instead, pharmacists now operate primarily in a community/retail or hospital setting, working an average of 44.2 demanding hours each week. According to a recent Drug Topics/Hospital Pharmacist Report time/workload study, 84% of retail pharmacists believed their workload could improve, with 52% classifying the workload as heavy and 17% classifying the workload as extremely heavy.

According to the study, a typical day for a community/retail pharmacist is predominantly spent fulfilling dispensing duties. Overall, an average of 182 prescriptions are filled each day at various retailers, with independent pharmacists averaging 151 prescriptions per day.

281 Harris Fleming, Jr., No Rest for the Weary, Drug Topics, June 21, 1999, at 50 (citing a Drug Topics/Hospital Pharmacist Report Time/Workload Study that indicates that 84% of pharmacists believe they are overworked, and that some innovations created to make their jobs easier have actually made their jobs more difficult).

282 See Carol Ukena, Dually Dispensing, Drug Topics, Mar. 3, 1997, at 100, 104 (citing a study that found that 5% of pharmacists' surveyed admitted to making drug errors in the previous sixty days due to prescription volume, similar drug names and packaging, confusing labels, physician mistrust, time limit requirements, and too few pharmacists on the job).

283 Id. at 111 ("The era of managed care has forced pharmacists to face the fact that economic survival has now taken precedence over minimizing medication errors. The result is a prescription for disaster") (citing many pharmacists who say their workload is "too much", and that they are underpaid and overworked).

284 See Fleming supra note 280, at 50 (citing a study that shows pharmacists work an average of 10 hours per day, much of that time spent contacting patients due to prescriptions that are inaccurate, incomplete, or create potential drug interactions).

285 See THE PHARMACIST WORKFORCE, supra note 1, at 53, 55-56 (indicating that full-time pharmacists work 48.7 weeks per year with 63% working in a community/retail setting and 24.2% working in a hospital setting); generally id. at 49-58 for additional demographic data concerning the pharmacist workforce.

286 Fleming, supra note 280, at 50 (revealing that the report's findings are based on responses to a 1996 questionnaire mailed to 917 independent and chain pharmacists on the Drug Topics/Hospital Pharmacist Report Council of Pharmacists).

287 Id. (indicating that more than half of pharmacists' time is spent filling prescriptions).

288 Smith, supra note 280, at 56.

289 Id. at 58-59 (citing many pharmacists who say they spend more than 10% of their time as a "go-between for patients and their managed care organizations"); see also THE PHARMACIST WORKFORCE, supra note 1, at 72, 86.

290 Fleming, supra note 280, at 56.

291 Id.; see also Carol Ukena, New York Pharmacists Feel Put Off and Put Down, Drug Topics, Nov. 2, 1998, at 39 (hereinafter Ukena, New York) (reporting that a survey of New York forty percent can take rest or bathrooms breaks when needed).

292 Id. at 59 (referring to one new pharmacist who equates his job to working at Burger King).

293 Id. (citing workload and managed care hassles as two reasons pharmacists would choose a different career path).

294 See id. (noting that PSSNY had received numerous unsolicited comments discussing the possibility of pharmacy unions in order to relieve the "sweatshop working conditions").

295 Id.; see generally THE PHARMACIST WORKFORCE, supra note 1, at 8-9 (commenting that the pharmacist shortage creates job stress and inadequate working conditions, among other
 Prescription Use.

The volume of prescriptions written and dispensed in the United States has skyrocketed during the last several years. Studies show that between 1992 and 1999, retail sales of prescription drugs grew by 44%, from 1.9 billion to 2.8 billion prescriptions. Likewise, spending on prescription drugs more than doubled between 1993 and 2000, increasing from $50.6 billion to $112.1 billion. Such unprecedented growth is due to a number of factors, such as population growth, economic prosperity, and increased third party prescription coverage.

A very visible factor affecting prescription use is the United States' roaring economy. As the economy grows and incomes rise, the demand for health care goods and services also intensifies. In addition, the baby boomers are aging and there are now an estimated 80 million Americans aged 50 and over, consuming 74% of prescriptions and 51% of OTC products. Furthermore, the introduction of new and innovative drugs increased the number of treatable medical conditions. From 1984 to 1991, the Food and Drug Administration (FDA) approved 189 new drugs. A subsequent change in the FDA review process accelerated the approval rate and 277 new drugs were approved between 1992 and July 2000. Inevitably, as more drugs enter the marketplace and more conditions are found treatable, prescription use will rise. To illustrate this fact, new drugs constituted almost one-third of retail drug expenditures in 1998.

Direct-to-consumer marketing is another factor that is increasing prescription use. With greater flexibility to advertise, pharmaceutical companies are now marketing to consumers directly, spending approximately $1.9 billion in 1999 alone. The result is that consumer demand for specific brands increases while both physicians and pharmacists spend increasing amounts of time discussing marketing materials with patients.

Perhaps the most influential factor affecting prescription use is the increase in third-party prescription coverage. In 1992, only 44% of all prescriptions were covered by third parties. However, due to an increase in such benefits by managed care and health insurance plans, almost 80% of prescriptions were paid for by third parties in 1999. Such a dramatic increase in prescription coverage gave patients greater access to medication and drug therapy. Patients eagerly utilized these benefits and prescription use soared. Consequently, increases in prescription volume ultimately result in an increase in related pharmacy functions, "including the number of prescriptions filled by others that must be checked, the number of occasions on which patient counseling is called for, the number of......"
occasions on which third party payment issues must be resolved, and so on.\textsuperscript{314}

b. Managed Care and Third Parties Issues.

The growth of managed care and third party prescription coverage enormously impacts pharmacists’ workload.\textsuperscript{315} Aside from the burden of prescription issue, managed care has placed a tremendous administrative burden on pharmacists.\textsuperscript{316} Pharmacists are now the intermediaries between patients and their managed care organizations.\textsuperscript{317} As one study found, 81\% of pharmacists said “they spend more time explaining drug benefits to patients today than they did a year ago.”\textsuperscript{318} Another study found that on an average day, pharmacists spend 20\% of their time dealing with third party issues and conflicts.\textsuperscript{319} Consequently, the word most commonly used by pharmacists to describe the impact managed care has had on the pharmacy profession is “frustration.”\textsuperscript{320} The middle of third party red tape and slow implementation of a standardized prescription card has forced pharmacists to spend more time dealing with managed care problems, leaving much less time to counsel patients and attend to other duties.\textsuperscript{321}

Realizing the burden managed care and third party issues place on pharmacists, North Carolina has passed a rule to shield pharmacists from third-party hassles.\textsuperscript{322} This rule states that “in filling or refilling prescription orders, the pharmacist shall not be required to deal with parties, including managed care companies and insurance providers, outside the practitioner-pharmacist-patient relationship.”\textsuperscript{323} Although such a rule is in the right direction, it remains to be seen how effective it will be in easing pharmacists’ workload or whether other states will adopt similar rules.\textsuperscript{324}

In addition to the administrative burden, managed care and third-party prescription coverage has narrowed the profit margins of pharmacies.\textsuperscript{325} In an attempt to quell the rising costs of health care, prescription reimbursement rates decreased.\textsuperscript{326} To make up for the loss in profits, pharmacies began to strongly emphasize increasing the volume of prescriptions filled.\textsuperscript{327} As a result, pharmacists are stuck with the task of filling as many prescriptions as possible as fast as possible to improve the pharmacy’s bottom line.\textsuperscript{328}

c. The Pharmacist Shortage.

Pharmacists’ working conditions have worsened as a result of the national pharmacist shortage.\textsuperscript{329} A comprehensive study launched in 2000 by the Department of Health and Human Services

\textsuperscript{314} Id. at 16 (arguing that any increase in the number of medication prescriptions that a pharmacyfills will naturally increase the amount of other pharmacy activities that contribute to filling a prescription).

\textsuperscript{315} See Fleming, supra note 280, at 36 (noting that much of a pharmacist’s time is spent dealing with managed care concerns).

\textsuperscript{316} See The Pharmacist Workforce, supra note 1, at 72 (noting that the types of administrative duties pharmacists have assumed in dealing with managed care).

\textsuperscript{317} See Fleming, supra note 280, at 36 (noting that pharmacists spend increasing amounts of time dealing with managed care plans and patients).

\textsuperscript{318} Id. (noting that pharmacists now assume the steadily increasing burden of explaining to patients the scope and contours of the patients’ drug benefits as dictated by the patients’ managed care plans).

\textsuperscript{319} See The Pharmacist Workforce, supra note 1, at 22, 72 (citing a study performed by Arthur Anderson L.L.P.); see also Fleming, supra note 280, at 51 (finding that pharmacists spend 10% of their time dealing with third party issues and spend 17% answering patients’ third party related questions).

\textsuperscript{320} Gerona M. Tarlach, Managed Care Putting Depend on R.Ph. Practiz, Drug Topics, Mar. 16, 1998, at 38 (describing a study performed by the Pharmacy Marketing Group, Inc. in Waverly, Iowa involving both hospital and chain pharmacists).

\textsuperscript{321} See id.; see also The Pharmacist Workforce, supra note 1, at 22 (noting that the use of a standardized prescription card would ease the third-party burden on pharmacists).

\textsuperscript{322} See Carol Ukena, North Carolina Shields R.Ph.s from Third-Party Hassles, Drug Topics, Aug. 21, 2000, at 27 (reporting that a regulatory change in North Carolina now shields R.Ph.s from third-party difficulties by effectively saying that employers cannot require pharmacists to manage third-party issues such as prior authorizations, medication changes, and formulary problems).

\textsuperscript{323} Id. (indicating that North Carolina has broken new ground by placing that shield between pharmacists and managed care companies).

\textsuperscript{324} See id. (noting that pharmacy officials in Connecticut, Maine, New York, and Oklahoma will present the North Carolina rule to their own boards for consideration).

\textsuperscript{325} See The Pharmacist Workforce, supra note 1, at 73 (noting that under third-party systems, prescription reimbursement is often provided at a level below cost).

\textsuperscript{326} See id.

\textsuperscript{327} See S. Craig Smith & Thomas William Arent, Prescription for Error: In Pharmacies, the Quest for Profit Can Triumph over the Concerns for Safety, Oct. Tit. 66, at 67 (1999) (noting that busy pharmacies often value speed over caution). Shortcuts are often utilized, such as an expert problem because a technician takes care of it without notifying the pharmacist. Id.

\textsuperscript{328} See The Pharmacist Workforce, supra note 1, at 73-74 (discussing several views on the impact a Medicare drug benefit might have on pharmacists’ workloads); see also Telephone file with the Health, J. Health Law & Pol’y).

\textsuperscript{329} See The Pharmacist Workforce, supra note 1, at 9 (indicating that the pharmacist shortage has, among other things, led to longer working hours, less flexibility, increased stress, and inadequate time to counsel patients).
found “there is currently an acute shortage of pharmacists in the United States.” According to a report, entitled *The Pharmacist Workforce: A Study of the Supply and Demand for Pharmacists*, a sharp increase in the demand for pharmacists and pharmaceutical care services increases the number of pharmacists needed to deliver quality health care. As evidence of the shortage, the report cites a study performed by the National Association of Chain Drug Stores (NACDS) analyzing the vacancy rates and hiring success among retail pharmacies. The report showed that between February 1998 and February 2000, the number of unfilled full and part-time pharmacist positions rose dramatically from 2,670 to almost 7,000 unfilled positions. Walgreens, a participant in the NACDS study, reported it currently had 900 full-time and 200 part-time pharmacist openings vs. 650 full-time and 166 part-time pharmacist openings at the same time last year. Consequently, pharmacists face increasing job stress, longer working hours, and reduced professional satisfaction.

2. The Effect of Increasing Liability.

As pharmacists’ liability expands under the pharmaceutical care standard and OBRA 90 requirements, the number of duties pharmacists must perform also increases. Unfortunately, “[y]ou can’t expand the role of the pharmacist effectively if your pharma-

330 Id. at 4 (noting that the shortage is recent, unexpected, and severe, and is evidenced by increased vacancy rates and hardships in hiring pharmacy workers).

331 Id. (noting that the number of active pharmacists increased from 1991 to 2000, but this increase in supply was more than offset by an unprecedented increase in the demand for pharmacists).

332 See id. at 5 (citing another study performed by the American Society of Health-System Pharmacists reporting that in the year 2000, 70% of respondents called the shortage of experienced pharmacist practitioners “severe” as opposed to 48% in 1999).

333 Id.

334 THE PHARMACIST WORKFORCE, supra note 1, at 68 (stating that one primary indicator that a shortage exists is increased job vacancy rates).

335 Id. at 8-9 (noting that some of the beneficial consequences of the shortage include salary increases, bonuses, and expanded opportunities for continuing education); See also id. at 69-70 for a discussion of some of the steps pharmacists and other employers have taken to alleviate the shortage problem, including reducing store hours, increasing recruiting efforts, substitution, and hiring incentives.

336 See Role of Pharmacy Law Groups, CHAIN DRUG REV., Dec. 6, 1993, at XX16 (stating that the Omnibus Budget Reconciliation Act of 1990 mandates that pharmacists assume a larger role in patient counseling, and that such expansion of duties increases pharmacists’ legal liability).

337 Id. at 4 (noting that the shortage is recent, unexpected, and severe, and is evidenced by increased vacancy rates and hardships in hiring pharmacy workers).

338 See THE PHARMACIST WORKFORCE, supra note 1, at 9 (noting that increasing demands on pharmacists are associated with increased risk for medication errors).

339 See id. at 73 (reporting that understaffed pharmacists may increase medication errors and that “staffing levels of pharmacists in acute care hospitals are inversely correlated with patient mortality.”).

340 See id. (noting the NAPHI/PHPC/UHC coalition findings).

341 See id. at 40.

342 See id.

343 Small & Azken, supra note 327, at 67.

344 See Advancing the Cause of Community Pharmacy, supra note 119, at 69 (noting that educating patients—those types of things”).

345 See id.

346 See id.
macists found that 63% do not feel they have enough time to meet OBA 90 duties and 60% cannot counsel patients on OTC products due to time constraints. As one CVS Corporation pharmacist commented, "With the way working conditions are for pharmacists today, the idea of counseling is a joke." In fact, the increasing fear of liability and time constraints have forced pharmacists to find ways to fulfill their counseling duties without actually counseling the patient. This is usually done through two procedures. First, the pharmacist distributes a drug information sheet to the patient at the time of prescription pick-up. The patient must then read and understand the information on his or her own. Second, the pharmacist requests the patient to sign a waiver stating he does not wish to be counseled, thus freeing the pharmacist of responsibility. The problem with using such procedures is that they transfer from pharmacist to patient the authority to decide when and on what issues to receive counseling. Such methods allow patients to determine...

scripts is a critical factor in being able to free their time for more and more of these patient care services.

Ukens, New York, supra note 290, at 39 (reporting that pharmacists feel their workload is too oppressive to allow for compliance with regulations and counseling patients).

Telephone Interview with Janice W. Smith, supra note 328 (noting that pharmacists' workloads often require the pharmacists to focus on completing only the most basic duties such as actually filling the prescription—while allowing the more involved, patient-care duties to go unsatisfied).

See Role of Pharmacy Law Groups, supra note 336, at RX16 (quoting Alan Pope, corporate counsel for Longs Drug Stores, as stating: "It puts [pharmacists] in a position where they say, 'I don't need to counsel. I need to get people to refuse counseling.'").

See Smith & Arbon, supra note 327, at 67 (noting that pharmacists often use written "drug sheet information" handouts); see also Role of Pharmacy Law Groups, supra note 336, at RX16 (noting that pharmacists often resort to using written instructions); see also Telephone Interview with Janice W. Smith, supra note 328.

See generally Smith & Arbon, supra note 327, at 67 (noting that counseling sessions between pharmacists and patients offer patients an opportunity to educate and clarify the prescription with patients and thus avoid errors; when such sessions are omitted, the patient must meet these needs on his or her own).

See Role of Pharmacy Law Groups, supra note 336, at RX16; see also Telephone Interview with Janice W. Smith, supra note 328.

At CVS, each patient is required to sign under a column stating either "Yes, I would like counseling" or "No, I do not want counseling." Almost everyone signs under the 'No' column. After waiting an eternity to get their prescription, they do not want to wait around to speak to the pharmacist. They also sign under 'No' because the pharmacy tech points to that column and tells them to sign there—they don't even realize what they are signing for.

Id.

See Telephone Interview with Janice W. Smith, supra note 328 (noting that to save time, most pharmacists simply provide the patient with written information; once given the written information, it is left to the patient to decide if he wants to ask the pharmacist for more information).

See id.

See Smith & Arbon, supra note 327, at 67 (noting that pharmacists require five years of education just to meet the basic degree requirements).

See THE PHARMACIST WORKFORCE, supra note 1, at 8-9 (listing the "potential for increased tient counseling and/or check for errors" as one consequence of the working conditions that if the duty to counsel is ignored or treated as a formality, the pharmacist misses his last chance to prevent any error).

THE PHARMACIST WORKFORCE, supra note 1, at 18 (discussing the large growth in prescription volume from 1992 to 1996 (48%) and noting that the population growth during the same time was comparatively small (7%)).

Id.

Id. at 21.

See id. at 8-9 (noting that because of the pharmacist shortage and the resulting shortage of time available for patient counseling and checking for prescription errors, there is an increased risk for medical error).

See Smith & Arbon, supra note 327, at 67 (discussing the expanding use of pharmacy technicians); see also THE PHARMACIST WORKFORCE, supra note 1, at 94-95 (discussing the expanding use and importance of pharmacy technicians); see also Advancing the Cause of Community Pharmacy, supra note 119, at 69 (discussing the importance of pharmacy techni-
Pharmacy technicians work under the supervision of a licensed pharmacist and assist in numerous pharmacy-related activities. Because of the increasing demands on pharmacists, pharmacy technicians play a vital role in the pharmacy workplace. Some of the most common tasks assigned to community pharmacy technicians include the following: cashier duties, stocking shelves, counting and pouring medication into prescription containers, preparing and labeling prescription containers, and entering patient and prescription information into a computer system. Yet, most state regulations prohibit technicians from counseling patients or performing drug utilization reviews. The pharmacist is ultimately held responsible for the accuracy of a dispensed prescription.

As reliance on pharmacy technicians increases, pharmacists have time to fulfill more substantive patient care duties. One study reports that 79% of pharmacists surveyed agree that counseling is more effective if there are more technicians who can help as the demand for prescriptions continues to increase. Likewise, 69% agree more technicians would enhance DUR effectiveness. As a result, many pharmacists support the idea of increasing the role and use of pharmacy technicians. However, when this reliance goes

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361 The Pharmacists' Workforce, supra note 1, at 64 (indicating that licensed pharmacists oversee pharmacy technicians while the technicians contribute to the pharmacy activities).

362 See Smith & Arbon, supra note 327, at 67.

363 Michael F. Conlan, Tech's Time, Drug Topics, Nov. 15, 1999, at 52 (hereinafter Conlan, Tech) (discussing the duties that pharmacy technicians typically perform; see also The Pharmacists' Workforce, supra note 1, at 65 (outlining the breadth of pharmacy-related activities in which pharmacy technicians engage)).

364 Smith & Arbon, supra note 327, at 67 (indicating that while pharmacists have experienced significant role expansion, that expansion has not included patient counseling or drug utilization review).

365 Id. (noting that despite the fact that technician roles have expanded, it is still the pharmacist's duty to assure that a prescription is filled properly and that the patient is appropriately counseled).

366 Carol Ulmer, More Techs, More Efficiency, New NAPS Survey Concludes, Drug Topics, May 1, 2000, at 36 (indicating that as technician support increases, pharmacists believe that DUR and counseling effectiveness are improved).

367 Id.

368 Id.

369 See Conlan, Tech, supra note 363, at 60 (listing numerous responses by pharmacists speaking of the importance of pharmacy technicians). But see Fleming, supra note 280, at 56 (stating that only 49% of pharmacists surveyed agreed that hiring more technicians would make their jobs easier while 12% of those questioned stated that more technicians would actually make their jobs harder).

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too far, serious adverse drug events can occur and patients may suffer from poorer quality care. A primary reason such errors occur is that pharmacy technicians lack the proper pharmaceutical training.

Unlike pharmacists, who must complete a five to six year degree program, pharmacy technicians are usually required to have only a high school diploma or its equivalent. Twenty-three states require some type of general instruction, most commonly through an on-the-job training program. In addition to training, pharmacy technicians now have the option to attain national certification.

The Pharmacy Technician Certification Board (PTCB) was established in 1995, creating a standardized certification examination for technicians. Currently, more than 86,000 pharmacy technicians since 1995. Many pharmacies offer incentives to becoming certified such as pay raises and increased responsibilities. Despite such incentives, however, noncertification remains typical of many technicians, with 60% of independent and 64% of chain pharmacies reporting no certified technicians on staff. As a result, pharmacists rely more on inadequately trained pharmacy technicians to perform their traditional dispensing duties. Because pharmacists remain liable for dispensing prescriptions correctly, incompetent technicians

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370 See Smith & Arbon, supra note 327, at 67 (noting that in some instances, technicians are taught to override computer medicine alerts, which results in errors).

371 See id. (stating that most technicians only need a high school diploma or equivalent, while pharmacists must complete a five-year degree program).

372 Id.

373 The Pharmacists' Workforce, supra note 1, at 65 (noting that pharmacy technician training varies from state to state).


376 See id.

377 See Conlan, Tech, supra note 363, at 60 (stating that 46% of community pharmacists offer a certified technician both a raise and an increase in responsibility). But see id. at 59-60 (noting that only 35% of hospital pharmacy technicians are certified).

378 See Smith & Arbon, supra note 327, at 67.
can become more of a hindrance than a help when pharmacists have to supervise each individual. As one survey found, 40% of pharmacists feel hiring additional technicians does not alleviate job duties and 12% believe their jobs actually become tougher with more technicians. One pharmacist commented, "With the shortage of pharmacists and the increased RX load, I'm afraid someone is going to come up with the idea of . . . forcing R.Ph.s to supervise more techs." Thus, more technicians do not necessarily result in better patient care when the pharmacist is stuck behind the counter performing supervisory duties. Moreover, if pharmacists neglect their supervising duties because of time constraints or general indifference, technicians are left to perform most of the dispensing duties, relying on their own limited knowledge of prescriptive drugs. In the end, requiring pharmacists to perform increased patient care duties may harm patients if the pharmacists must rely on inadequately trained pharmacy technicians.

Of further significance is the availability of qualified technicians. Even though many pharmacists support the use of additional technicians, recruiting is increasingly difficult, especially for certified technicians. It has been reported that there is currently a shortage of technicians that parallels the shortage of pharmacists.

More than 60% of chain pharmacies report that hiring technicians has gotten tougher over the past two years. As a result, less than 20% of community pharmacies advertise for certified technicians.

An additional problem that surfaces when analyzing pharmacists' reliance on technicians relates to the use of unsafe time savers. In an effort to keep up with sales volume, many pharmacies allow pharmacy technicians to employ shortcuts when filling prescriptions. One such shortcut is used in connection with the drug interaction software utilized by many pharmacies to identify possible drug interactions. Pharmacists report that on any given day, 35% of prescriptions trigger a drug utilization check (DUR) system alert for a drug interaction. Nonetheless, these alerts are overridden 56% of the time by the technicians. According to another report, DUR alerts are overridden an astonishing 88.1% of the time. The report considers the number unsurprising considering the "hectic environment" of most pharmacies. Pharmacists report that the primary reason for so many overrides is that most systems catch too many insignificant alerts. Some technicians are trained to override DUR alerts without the pharmacist's knowledge by entering a special code into the system. This technique allows them to proceed

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386 See Fleming, supra note 280, at 55-56 (indicating that pharmacists feel stretched to supervise a large number of technicians and some pharmacists report that having more technicians would make their job more difficult).

387 Id. (discussing the idea that an increased number of pharmacy technicians does not necessarily equate to an easier job for pharmacists).

388 Conlan, Tech, supra note 363, at 53 (quoting a supermarket pharmacist from the Midwest).

389 See Advancing the Cause of Community Pharmacy, supra note 119, at 69 (indicating that pharmacists should be focused on patient care, drug interactions, patient education, and clinical judgments, as opposed to just supervising technicians); see also Smith & Arbon, supra note 327, at 67 (noting that as pharmacy technicians assume larger roles, the chance of a supervising pharmacist never being made aware of a potential danger increases, as does the risk for harmful error to patients).

390 See Smith & Arbon, supra note 327, at 67 (noting that as the pharmacist's role expands, technicians with limited formal education also experience expanding duties as the technicians essentially become dispensers of medicine).

391 See id.

392 Conlan, Tech, supra note 363, at 59 (indicating that recruiting certified technicians is difficult that many employers do not even advertise for certified technicians).

393 THE PHARMACIST WORKFORCE, supra note 1, at 64.

394 Conlan, Tech, supra note 363, at 59 (indicating that because recruiting is so difficult, a majority of employers do not advertise for certified pharmacy technician).

395 Id. at 59 (stating that "because recruiting is so difficult, a majority of employers do not advertise for certified technician").

396 See Smith & Arbon, supra note 327, at 67 (discussing the fact that many pharmacists rely on technicians to respond to computer drug alerts and instruct technicians to override such alerts without first notifying the pharmacist).

397 Id. (noting that technicians often bypass computer drug interaction alerts).

398 See id., (noting that technicians often are given a code that they can use to override computer drug alerts and continue filling prescriptions).

399 Fleming, supra note 280, at 55 (discussing the high rate of medication alerts noted by pharmacy computer programs and the high frequency with which the alerts are overridden).

400 Id.

401 Elena P. Beyzaeev, Staying on Top of DUR Alerts: Problems and Solutions, DRUG TRENDS, Mar. 6, 2000, at 38 (citing a recent study published in the Journal of Managed Care Pharmacy that focused on Indiana community pharmacies).

402 Id.

403 Fleming, supra note 280, at 55; see also Beyzaeev, supra note 395, at 38 (warning that numerous DUR alerts may be "desensitizing busy pharmacists by causing a cry-wolf effect").

404 Smith & Arbon, supra note 327, at 67.
with filling what may be a dangerous prescription.\textsuperscript{396} Other technicians call the doctor’s office to discuss the DUR alert.\textsuperscript{400} However, because the technician usually speaks only to a nurse, both the physician and the pharmacist remain unaware of the possible interaction.\textsuperscript{401} Either way, dangerous shortcuts increase the likelihood that patients will encounter an adverse drug event.\textsuperscript{402}

As can be seen, pharmacists are finding themselves in a perilous predicament.\textsuperscript{403} In an effort to meet pharmacy workplace demands and avoid liability, they are forced to turn to inferior and sometimes dangerous methods to fulfill patient care and dispensing duties.\textsuperscript{404} The result is a decline in the quality of patient care and a rise in adverse drug events.\textsuperscript{405} It naturally follows that as long as pharmacists continue to face such demanding working conditions, any expansion in pharmacist liability will only exacerbate this problem.\textsuperscript{406} The only solution may be to transfer nearly all of pharmacists’ dispensing duties to the pharmacy technician so that more pharmaceutical and patient care duties can be fulfilled.\textsuperscript{407} However, pharmacists will not be able to safely relinquish these dispensing duties until pharmacy technicians are properly trained and certified.\textsuperscript{408}

\textsuperscript{396} See id. (noting that the flagged prescriptions are supposed to be set aside by the technician so that the pharmacist can later review them).

\textsuperscript{400} Id. (noting that some companies allow technicians to call doctor’s offices and ask questions about prescriptions).

\textsuperscript{401} Id. (reporting that even if the pharmacy technician calls the doctor’s office to discuss a DUR alert, the technician often only talks to a nurse, thus leaving the doctor unaware of the situation).

\textsuperscript{402} Id. (stating that when technicians are allowed to override DURs, increased errors may result).

\textsuperscript{403} See Role of Pharmacy Law Greens, supra note 336, at RX16 (reporting that as the role of professional pharmacists expands, so too does their legal liability).

\textsuperscript{404} Smith & Arbon, supra note 327, at 67.

\textsuperscript{405} See id. (reporting that the busy pharmacy environment drives the increased use of technicians, which may result in increased errors).

\textsuperscript{406} See Role of Pharmacy Law Greens, supra note 336, at RX16 (noting that expanding pharmacist roles also expand pharmacist liability).

\textsuperscript{407} See Conlan, Tech, supra note 363, at 52 (noting that the use of technicians allows pharmacists more time to perform clinical functions, as opposed to dispensing duties).

\textsuperscript{408} See Smith & Arbon, supra note 327, at 67 (noting the potential risks involved when pharmacy technicians are improperly trained, for example, to override computer DUR alerts).

\textsuperscript{409} See Advancing the Cause of Community Pharmacy, supra note 119, at 69 (noting that the pharmacist role should be concentrated on making clinical judgments, patient education, patient care and drug interactions issues).

\textsuperscript{410} See Fleming, supra note 280, at 51 (indicating that pharmacists spend significant amounts of time both contacting doctors to clarify prescription issues, and explaining prescription issues to patients so that the pharmacist can later review them).

\textsuperscript{411} See The Pharmacist Workforce, supra note 1, at 18 (reporting the 44% increase in the number of prescriptions filled from 1992 to 1999; see also Fleming, supra note 280, at 51 (indicating that pharmacists play crucial roles in communicating with doctors, patients, and managed care companies)).

\textsuperscript{412} See Smith & Arbon, supra note 327, at 67 (reporting that pharmacists have advanced education, and that they bring this education to their counseling sessions with patients, thus improving care by minimizing the opportunities for medication errors).

\textsuperscript{413} See generally id. (suggesting that ideally, pharmacists provide patients with a counseling session in which the pharmacist explains what the medication is, what it treats and how to take it; this session also offers patients an opportunity to ask questions about medications, and thus provides the pharmacist with a chance to clarify misunderstandings, address concerns, and prevent potential errors).

\textsuperscript{414} See Fleming, supra note 280, at 50 (noting that Gallup studies rank pharmacists as members of the most trusted profession).

\textsuperscript{415} See Role of Pharmacy Law Greens, supra note 336, at RX16 (noting that the Omnibus Budget Reconciliation Act of 1990 mandates that pharmacists assume a larger role in patient counseling, a pharmaceutical care model that is more emphasis on duties such as computer drug checking and counseling patients on prescriptions and over-the-counter medications).
impose this duty do so with complete disregard for a legislatively and professionally established standard of care.\(^{416}\) Relying instead on unpersuasive and unsuitable theories, courts are effectively denying pharmacists their rightful professional status when upholding the no duty to warn rule. Moreover, due to growing prescription use, increasing drug errors, and mounting health care costs, public policy dictates that pharmacists use their expanded roles and knowledge to full potential.\(^{417}\) This requires pharmacists to be held accountable for failing to warn patients about potential adverse drug events.\(^{418}\)

Theoretically, the expansion of pharmacists’ liability is a step in the right direction, recognizing the professional status of pharmacists and leading to better patient care and drug therapy outcomes. Unfortunately, however, current working conditions have forced pharmacists to take a step back from quality patient care activities, negating any positive effects expanding liability might bring. As pharmacists struggle under high dispensing volumes and exhausting work conditions, little time is left to meet even the bare minimum in patient care requirements.\(^{419}\) As a result, pharmacists have resorted to utilizing unsafe and inadequate methods in order to meet workplace demands and simultaneously avoid any liability to fulfill their duties.\(^{420}\) Thus, although the no duty to warn rule is no longer compatible with the contemporary pharmacy profession, any increase in liability without a corresponding decrease in other workplace demands can have dangerous consequences. It remains to be seen whether the pharmacy profession will be able to find the proper means to successfully remove itself from such a precarious position.

\(^{416}\) See Omnibus Budget Reconciliation Act of 1990, 42 U.S.C. § 1396e(h) (mandating that the minimum standard of care for pharmacists requires that pharmacists perform drug utilization reviews);

\(^{417}\) See generally THE PHARMACIST WORKBOOK, supra note 1, at 35 (discussing the increased importance and expanded role of pharmacists in medicine becomes more complex, the risk for errors increases, and cost containment intensifies).

\(^{418}\) See Gonzales, supra note 49, at 53, 76 (noting that the complexity of current drug therapy combined with the ORBS mandates and various state statutes, creates an environment in which pharmacists must warn patients about the potential risks of drug therapy).

\(^{419}\) See Uretz, New York, supra note 293, at 39 (suggesting that pharmacists’ workload requires that they perform only their basic duties, often resulting higher-level functions such as patient counseling).

\(^{420}\) See Smith & Aron, supra note 327, at 67.

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**Erecting Women: Contracting Parentenhood From Marriage To Divorce**

Rachel Pollinger-Hyman

The sex impulse was dangerous to the Party, and the Party had turned it to account. They had played a similar trick with the instincts of parenthood. The family could not actually be abolished, and, indeed, people were encouraged to be fond of their children in almost the old-fashioned way. The children, on the other hand, were systematically turned against their parents and taught to say on them and report their denials. The device by means of which everyone could be surrounded night and day by informers who knew him intimately.\(^{1}\)

—George Orwell, 1984

**INTRODUCTION**

The disposition of frozen embryos in divorce proceedings presents an opportunity to explore how our judicial system accommodates advances in assisted reproductive technologies with contractual freedoms.\(^{2}\) Recent case law and advancements in reproductive technology give rise to ethical and moral dilemmas...

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