

## PROSECUTING DOCTORS FOR TRUSTING PATIENTS

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“[T]o have great pain is to have certainty; to hear that another person has pain is to have doubt.”<sup>†</sup>

### INTRODUCTION

Prosecutions of physicians under drug trafficking laws in connection with their prescribing controlled substances are on the rise.<sup>1</sup> Yet these prosecutions are increasingly questionable, and the legal standard used to convict these doctors puts undue pressure on the physician’s professional obligation to trust her patients. Two high profile prosecutions exemplify this disturbing trend: the case of William Hurwitz in Virginia, who was re-convicted in 2007 after a “successful” appeal to the Fourth Circuit,<sup>2</sup> and the case of Ronald McIver of South Carolina, whose appeal to the Fourth Circuit was denied in 2006.<sup>3</sup> Both men were sentenced to federal prison, with Dr. Hurwitz receiving a sentence of fifty-seven months<sup>4</sup> and McIver receiving a sentence of thirty years.<sup>5</sup> In each case, the court instructed the jury that it could convict the doctor under a statute that prohibits *knowingly* prescribing to patients who resell drugs if the jury found merely that the physician was *willfully blind* to this fact.<sup>6</sup>

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<sup>†</sup> ELAINE SCARRY, *THE BODY IN PAIN: THE MAKING AND UNMAKING OF THE WORLD* 7 (1985).

<sup>1</sup> See Amy J. Dilcher, *Damned if They Do, Damned if They Don’t: The Need for a Comprehensive Public Policy to Address the Inadequate Management of Pain*, 13 *ANNALS HEALTH L.* 81, 92 (2004) (“[T]he number of DEA actions against health care providers is increasing.”).

<sup>2</sup> Jerry Markon, *Pain Doctor Is Guilty of Drug Trafficking*, *WASH. POST*, Apr. 28, 2007, at B5.

<sup>3</sup> *United States v. McIver*, 470 F.3d 550, 552 (4th Cir. 2006), *cert denied*, 127 S. Ct. 2276 (2007).

<sup>4</sup> Transcript of Sentencing at 44-45, *United States v. Hurwitz*, No. 1:03CR467 (E.D. Va. July 13, 2007) (on file with author). Dr. Hurwitz was released early, in January 2009.

<sup>5</sup> Tina Rosenberg, *When Is a Pain Doctor a Drug Pusher?*, *N.Y. TIMES MAG.*, June 17, 2007, at 48, 50, available at 2007 WLNR 11328293.

<sup>6</sup> *McIver*, 470 F.3d at 563; Jury Instructions at 45, 48, *United States v. Hurwitz*, No. 1:03CR467 (E.D. Va. Apr. 17, 2007) (on file with author).

This Article focuses on whether the use of the doctrine of willful blindness is appropriate in these cases. This issue is important because it provides a window into the central issue that these cases pose: whether the physician's professional obligations provide a defense to the charges at issue. Prosecuting doctors for being willfully blind to a patient's wrongful reselling of drugs criminalizes physicians' trust in their patients. Criminalizing such trust is bad policy, as it will likely lead doctors to restrict access to needed medication for legitimate suffering patients and might also decrease the already insufficient supply of pain management doctors.<sup>7</sup> The focus of this Article, however, is not on these policy concerns. Instead, this Article argues that doctors treating patients in pain act rightly in trusting their patients, and thus the law erroneously imposes criminal sanctions on actions that are morally justified. In fleshing out this argument, this Article contributes to debates within criminal theory about whether and when willful blindness *is* morally and legally equivalent to knowledge.

Clearly, the fact that a person is a physician should not insulate her from criminal liability for drug trafficking. Just because she has a medical degree, wears a white coat, and writes a prescription rather than distributing the drug itself does not immunize the doctor against criminal drug trafficking charges. When a doctor sells prescriptions in return for money or something else of value, this *is* rightly equated with ordinary drug selling. But when the prescription of drugs occurs during an office visit under the pretense of treatment for real pain, the doctor only receives the routine fee-for-service or other normal reimbursement. In these situations, the question becomes what precisely defines the prohibited conduct? Two recent developments make the resolution of this issue especially pressing. First, the medical community and the public have become increasingly aware of the dramatic under-treatment of pain, particularly chronic, non-malignant pain.<sup>8</sup> Doctors are thus being encouraged to recognize and treat patients who are in pain. Second, the abuse of opium-based prescription pain medications is increasingly seen as an important public health problem.<sup>9</sup> In the wake of the May 2007 judgment against the makers of the drug OxyContin<sup>10</sup> for \$600 million on federal criminal charges relating to the misbranding of the drug, stories of communities ravaged by the abuse of this drug and others like it

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<sup>7</sup> Ronald T. Libby, *Treating Doctors as Drug Dealers: The DEA's War on Prescription Painkillers*, POL'Y ANALYSIS, June 6, 2005, at 21, available at <http://www.cato.org/pubs/pas/pa545.pdf>.

<sup>8</sup> See, e.g., Dilcher, *supra* note 1, at 83-84; Aaron M. Gilson et al., *State Policy Affecting Pain Management: Recent Improvements and the Positive Impact of Regulatory Health Policies*, 74 HEALTH POL'Y 192, 194 (2005); Margo McCaffery & Chris Pasero, *Pain Control*, AM. J. NURSING, Aug. 1999, at 18, 18; Elizabeth H. Winslow, *Effective Pain Management*, AM. J. NURSING, July 1998, at 16HH, 16HH.

<sup>9</sup> Opium-based drugs include, among others, Morphine, Methadone, OxyContin (Oxycodone), and Dilaudid.

<sup>10</sup> OxyContin is a time-release form of Oxycodone, an opium-based drug.

fill the media.<sup>11</sup> This combination, more doctors treating chronic pain and the simultaneous increase in abuse of opium-based drugs often used to treat this pain, has made the doctor's office the new target for our country's war on drugs.

The *Hurwitz* and *McIver* cases have both attracted a significant amount of attention. John Tierney of *The New York Times* made the case of Virginia pain doctor William Hurwitz his cause célèbre in 2007.<sup>12</sup> Similarly, in June 2007, *The New York Times Magazine* featured a cover article on the trial of South Carolina pain doctor Ronald McIver.<sup>13</sup> Interestingly, both of these doctors were in the vanguard in the fast-evolving field of pain management, both committed to the view that the amount of narcotic pain medication prescribed to pain patients should be limited only when the side effects begin to outweigh the benefits of increasing the dose of pain medication.<sup>14</sup> While controversial at the time, this view has now been adopted by experts in the medical community who agree that there is no upper limit of acceptable dosage for opium-based drugs.<sup>15</sup> This distinguishes this class of drugs from other pain medications, such as non-steroidal anti-inflammatory drugs like aspirin and ibuprofen, which become toxic at high doses.<sup>16</sup> This

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<sup>11</sup> The company settled a criminal prosecution for "misbranding" of the drug for this amount. Barry Meier, *Narcotic Maker Guilty of Deceit Over Marketing*, N.Y. TIMES, May 11, 2007, at A1, available at 2007 WLNR 8928498. Three executives of the company also pleaded guilty to misdemeanor charges and agreed to pay fines totaling \$34.5 million. *Id.* The company also settled claims with twenty-six states and the District of Columbia related to charges that it encouraged doctors to overprescribe OxyContin for \$19.5 million. *Id.* In October 2007, Kentucky brought suit against the company for an unspecified amount alleging that Purdue Pharma had misled doctors, pharmacists, patients, and others about the addictive qualities of the drug. Stephenie Steitzer, *Kentucky Sues OxyContin Maker: Addictive Painkiller Is Often Abused*, COURIER-JOURNAL (Louisville, Ky.), Oct. 5, 2007, at 1A. A previous suit by West Virginia settled for \$10 million. *Id.*

<sup>12</sup> See, e.g., John Tierney, *Juggling Figures, and Justice, in a Doctor's Trial*, N.Y. TIMES, July 3, 2007, at F1, available at 2007 WLNR 12517328; John Tierney, *At Trial, Pain Has a Witness*, N.Y. TIMES, Apr. 24, 2007, at F1, available at 2007 WLNR 7685792; John Tierney, *Trafficker or Healer? And Who's the Victim?*, N.Y. TIMES, Mar. 27, 2007, at F1 [hereinafter Tierney, *Trafficker or Healer?*], available at 2007 WLNR 5747254.

<sup>13</sup> See generally Rosenberg, *supra* note 5.

<sup>14</sup> In an article written in the *Journal of American Physicians and Surgeons* in 2003, Dr. Hurwitz argued for a principle called "titration to effect," which requires that treatment with opioids be "individualized according to patient response, with upward titration of dose until adequate relief is provided or intolerable side effects develop." William E. Hurwitz, *Pain Control in the Police State of Medicine (Part II)*, 8 J. AM. PHYSICIANS & SURGEONS 13, 14 (2003). *The New York Times* reported that Dr. Ronald McIver's goal in treating pain patients was to reduce their pain to a "2" on a scale from 1 to 10, as contrasted with a "5," which many doctors treat as adequate. Rosenberg, *supra* note 5, at 50.

<sup>15</sup> SEDDON SAVAGE ET AL., AM. PAIN SOC'Y, DEFINITIONS RELATED TO THE USE OF OPIOIDS FOR THE TREATMENT OF PAIN (2009), <http://www.ampainsoc.org/advocacy/opioids2.htm> ("Tolerance to the analgesic effects of opioids is variable in occurrence but is never absolute; thus, no upper limit to dosage of pure opioid agonists can be established.")

<sup>16</sup> See, e.g., Pamela E. Windle, *The Challenges of Pain Management: Adverse Effects of Analgesics*, 19 J. PERIANESTHESIA NURSING 212, 212-14 (2004).

medical fact makes these cases especially difficult, as the amount of narcotic prescribed is no longer a reliable indicator of misuse. High doses of narcotic analgesics are safe and may be necessary to provide relief and enable an otherwise bed-ridden or house-bound individual to rejoin the workforce and social world.

In the legal literature, the prosecutions of doctors for drug trafficking have garnered less attention. Diane Hoffmann, however, has forcefully criticized these prosecutions as overzealous and bad policy on several grounds. Hoffmann suggests that a person has a constitutional right to palliative care that is threatened by the prosecution of pain doctors.<sup>17</sup> She further argues that prosecutions of physicians do not give enough weight to the costs of over-prosecution in chilling appropriate treatment of pain patients as compared to the risks of under-prosecution in failing to stop doctors who are acting as “pill-mills.”<sup>18</sup> Lastly, Hoffmann argues that the standard for prosecuting doctors amounts to holding doctors criminally liable for a violation of the civil standard of negligence.<sup>19</sup> Each of these arguments provides a sufficient reason to rethink the justifiability of prosecuting pain doctors for drug trafficking in all but the most extreme and limited circumstances.

This Article also criticizes these prosecutions, but from an importantly different perspective. It focuses on the professional obligations of doctors and argues that these prosecutions force doctors to choose between professional duty and fear of criminal sanction. Citizens and policymakers are likely to continue to disagree about how best to balance the harms of over-prosecution as compared to under-prosecution in this context. Should we worry more about legitimate patients unable to get relief from pain or drug abuse facilitated by the diversion of drugs? There is another factor to consider however. The problem with criminalizing physicians’ willful blindness is that in doing so we impinge on the professional obligations of physicians and criminalize morally justified conduct.

The Article proceeds as follows. Part I introduces recent prosecutions of physicians for drug trafficking and notes that courts increasingly allow juries to convict when they find the defendant was “willfully blind” to whether his patient was reselling the prescribed drugs. Part II describes the willful blindness doctrine, explaining the debate within criminal law theory about the use of willful blindness as a substitute for knowledge. Participants in this debate aim to answer the following question: when and why is willful blindness an apt substitute for knowledge? Finding these accounts to be inadequate, Part II uses the example of the physician-prescribing cases to

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<sup>17</sup> Diane E. Hoffmann, *Treating Pain v. Reducing Drug Diversion and Abuse: Recalibrating the Balance in Our Drug Control Laws and Policies*, 1 ST. LOUIS U. J. HEALTH L. & POL’Y 231, 291-94 (2008).

<sup>18</sup> *Id.* at 294-95.

<sup>19</sup> *Id.* at 286-89.

point the way to a new approach. Part II concludes by offering a theory of willful blindness that requires looking at the justification for the blindness itself. Where an actor has a good reason to opt for blindness, he should not be prosecuted under a statute requiring knowledge. This account has two important virtues. First, it accords with widely shared moral intuitions about when contrived ignorance constitutes culpable blindness. Second, it provides a way to make sense of the actual defense offered by doctors in these cases: I trusted my patient.<sup>20</sup>

In a painfully revealing statement at the sentencing hearing following his retrial, Dr. William Hurwitz “accept[ed] responsibility for my failure of judgment” in not recognizing that many of his patients were reselling or abusing drugs and added “the course I have followed has been tragic, tragic because those qualities that are the soul of medicine, compassion and trust, grew into the flaws that led to my failure.”<sup>21</sup> While he is surely right that his compassion and trust led, in part, to his conviction, is his *mea culpa*—that his compassion and trust constitute both a failure of judgment and a professional failing—appropriate? In other words, implicit in the appeal to trust common in these cases is the following claim: a good pain doctor trusts her patients. Is this right? Part III addresses this question and argues that the extreme vulnerability of the patient in pain requires doctors to balance the physician-patient relationship with ethical obligations that respond to that vulnerability. Just as the duty of confidentiality responds to the vulnerability that derives from patients’ revealing private and sensitive information, so too a duty of trust is necessary to respond to the unique vulnerability that derives from pain and the inherent difficulties in effectively communicating and verifying that pain to others.

## I. THE LEGAL STANDARD

### A. *Can Prescribing Constitute Drug Trafficking?*

The physicians prosecuted for the federal crime of drug trafficking<sup>22</sup> are prosecuted under the Controlled Substances Act (“CSA” or “the Act”).<sup>23</sup>

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<sup>20</sup> See, e.g., Hurwitz, *supra* note 14, at 14 (“The policy of targeting physicians based on patient misbehavior establishes a standard of perfection in selecting patients that no doctor could meet. It forces doctors who try to treat pain to act like police, reinforcing a perverse medical paternalism that subverts the ethical imperatives designed to protect patient autonomy and dignity. This distortion of the patient–physician relationship stigmatizes patients and erodes their trust. At the same time, it assigns doctors a function that they are ill-qualified to perform.”).

<sup>21</sup> Transcript of Sentencing, *supra* note 4, at 35.

<sup>22</sup> Some doctors are prosecuted under state law as well. See, e.g., *State v. Schwarm*, 21 P.3d 990, 991, 997 (Kan. 2001) (affirming a conviction of ten counts of distributing a controlled substance “other than for a medical purpose”); *State v. Moody*, 393 So. 2d 1212, 1212-13 (La. 1981) (affirming a conviction of six counts of unlawful distribution of controlled substances).

The CSA provides, in section 841, that “[e]xcept as authorized by this subchapter, it shall be unlawful for any person knowingly or intentionally (1) to manufacture, distribute, or dispense, or possess with intent to manufacture, distribute, or dispense, a controlled substance . . . .”<sup>24</sup> Physicians who are registered under the Act may, however, write prescriptions for controlled drugs as long as they do so in the manner required by other provisions of the Act. Violations of these provisions, which apply only to registrants, carry far lesser penalties than those that attend violations of section 841.<sup>25</sup>

This distinction raises the predicate question of whether physicians registered under the Act can ever be prosecuted for the offense of drug trafficking for dispensing or distributing controlled substances in violation of section 841, or if they are only liable under the more lenient provisions pertaining to registrants. In 1975, the United States Supreme Court resolved this issue in *United States v. Moore*,<sup>26</sup> interpreting section 841’s reference to “any person” to mean that physicians registered under the Act could be prosecuted under its prohibition on dispensing controlled substances in a manner not authorized by law.<sup>27</sup> This answer is reasonable on substantive as well as statutory interpretation grounds. The mere fact that someone is a physician registered to write prescriptions for controlled substances does not mean that the physician is incapable of selling drugs illegally. A registered physician selling drugs or prescriptions for drugs out of his office constitutes normal drug trafficking notwithstanding his authorization to write prescriptions for such drugs under proper circumstances.

The logic of this conclusion follows a familiar path. When the soldier kills an enemy, he does not *murder* him. Rather the soldier’s conduct might instead be described as “fighting a war.” When the lawyer marshals a vigorous defense for a client she believes is guilty of the crime charged, she does not “wrongfully help a guilty person evade punishment,” rather she “defends her client.” Roles, and the actions undertaken within them, change the moral evaluation of the actions. Some might even argue that the roles change the appropriate descriptions of the actions themselves, and not just the correct evaluation of those actions, but we need not go that far here.<sup>28</sup> It

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<sup>23</sup> Controlled Substances Act, 21 U.S.C. §§ 801-904 (2006).

<sup>24</sup> *Id.* § 841(a)(1) (emphasis added).

<sup>25</sup> Compare *id.* § 842(c), and *id.* § 843(d), with *id.* § 841(b).

<sup>26</sup> 423 U.S. 122 (1975).

<sup>27</sup> *Id.* at 124 (“[R]egistered physicians can be prosecuted under § 841 when their activities fall outside the usual course of professional practice.”); *United States v. Feingold*, 454 F.3d 1001, 1004 (9th Cir. 2006) (“Thus, a physician remains criminally liable when he ceases to distribute or dispense controlled substances as a medical professional, and acts instead as a ‘pusher.’” (citing *Moore*, 423 U.S. at 138, 143)).

<sup>28</sup> See ARTHUR ISAK APPLBAUM, *ETHICS FOR ADVERSARIES: THE MORALITY OF ROLES IN PUBLIC AND PROFESSIONAL LIFE* 76-109 (1999), for an excellent discussion of this argument for redescription. Applbaum rejects the claim that roles can succeed in redescrbing the actions of actors because the

is enough to recognize that when the doctor writes a prescription for a patient in pain and is paid a fee for this service, he is legitimately dispensing drugs—not trafficking drugs. But there are limits. Just as the soldier can commit murder, the doctor can traffic in drugs. The difficulty comes in differentiating one type of conduct from the other. As a general principle, actions that are outside the scope of a particular role no longer get the benefit of the role-dependent evaluation.

The CSA takes precisely this approach. Physicians can be prosecuted for violations of section 841 for distributing or dispensing a controlled substance “[e]xcept as authorized by this subchapter.”<sup>29</sup> The regulations then provide the parameters by which a physician may prescribe controlled substances in his capacity as a doctor. Specifically, section 1306.04(a) of the Code of Federal Regulations provides that “[a] prescription for a controlled substance must be issued for a *legitimate medical purpose* by an individual practitioner acting in *the usual course of his professional practice*.”<sup>30</sup> While this approach seems sensible—providing that medical practice is doctoring and non-medical practice is trafficking—these regulations prove problematic in application because of the failure to provide clear standards to determine when a doctor is practicing medicine and when he is not.

#### B. *Legitimate Medical Practice Is Not Trafficking*

The two italicized phrases above often guide the inquiry into whether a physician has violated the law. Unfortunately, the language of “a legitimate medical purpose” and “the usual course of his professional practice” is open to different interpretations—some more subjective in emphasis, others more objective in emphasis. For example, the combination of the words “usual” and “his professional” exemplify the confusion. While “usual” suggests that the physician must comply with objective standards of medical practice, the use of the possessive “his” in front of “professional” suggests that the doctor acts permissibly so long as he exercises his own professional judgment

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redescription (the lawyer is defending his client) does not supplant the non-role-based description (the lawyer is lying, for example). *Id.* at 89-90. He provides the following example:

Consider children throwing a small white leather sphere, swinging a wooden stick, and running about on a neighbor’s freshly seeded lawn. When the neighbor scolds them, one child (are his parents lawyers?) replies, “You don’t understand. We are not crushing the seedlings, we are playing baseball.” What are we to make of this defense? Though it is true that baseball is a practice in which X, the brute facts of throwing a ball and running about on grass, count as institutional fact Y, playing the game of baseball, and though baseball is still baseball even when the neighbor is angry (since permission to use the field is not part of the specified context C), the description “playing baseball” does not supplant the description “crushing the seedlings.” The children are doing both. Though there is collective agreement that brute facts count as institutional facts, the brute description does not disappear.

*Id.* at 91-92. For Applbaum, the role is relevant to the moral evaluation of the action. *Id.* at 96-97.

<sup>29</sup> 21 U.S.C. § 841(a) (2006).

<sup>30</sup> 21 C.F.R. § 1306.04(a) (2006) (emphasis added).

in prescribing the drugs, even if this manner of practice departs from a generally accepted standard.

The conflict between these two different interpretations becomes apparent when we consider their different answers to the question of whether a physician who believes he is properly treating his patients can violate the statute. If the physician has a legitimate purpose, such as providing palliation to a patient in pain, then the physician's subjective belief that he is furthering that end should be exculpatory. If instead, "the usual course of his professional practice" is defined with regard to generally accepted standards of care in medicine, then a physician's honest belief that he is providing proper treatment may not be enough to exonerate him. There is, of course, a middle ground between a purely subjective and purely objective reading of this provision. The regulations may require that the physician honestly attempt to conform his practice to what he believes are generally accepted standards of practice. Alternatively, they may require him to conform his practice to what he *reasonably* believes are generally accepted standards of practice. We thus have four possible readings of the regulations governing physicians prescribing under the Act. Each of these formulations represents a plausible reading of the regulations, yet they differ in how much leeway the physician is accorded to follow his own judgment about appropriate care. The cases struggle to find the appropriate reading of section 1306.04(a), failing to establish any clear rule among the circuits or even within a single case.<sup>31</sup>

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<sup>31</sup> For example, in *United States v. Williams*, the Eleventh Circuit held that the trial court correctly refused to give the defendant's proposed jury instruction, which provided:

If a doctor dispenses a drug in good faith in medically treating a patient, then the doctor has dispensed the drug for a legitimate medical purpose in the usual course of medical practice; that is, he has dispensed the drug lawfully. Good faith in this context means good intentions and the honest exercise of best professional judgment as to a patient's needs. It means that the doctor acted in accordance with what he reasonably believed to be proper medical practice. If you find that the defendant acted in good faith in dispensing the drugs, then you must find him not guilty.

445 F.3d 1302, 1309 (11th Cir. 2006), *abrogated on other grounds by* *United States v. Lewis*, 492 F.3d 1219 (11th Cir. 2007). This standard is one that is predominantly subjective, in that it emphasizes the doctor's good intentions and the honest exercise of his own professional judgment. But it is not without an objective check, as the doctor must act in accord with what he "reasonably believed to be proper medical practice." *Id.* The Eleventh Circuit affirmed the trial court's refusal to give this instruction based on its reading of the Supreme Court's opinion in *United States v. Moore*, which seemingly approved the need for some limits on what may count as "medical practice." *Id.* According to the *Williams* court, the defendant's proposed instruction could not be given because it "fail[ed] to introduce any objective standard by which a physician's prescribing behavior [could] be judged." *Id.* In particular, the court worried that "[u]nder *Williams*'s proposed instruction, if it is a physician's subjective belief that he is meeting a patient's medical needs by prescribing that patient a controlled substance, then that physician cannot be convicted of violating the Controlled Substances Act even if he acts outside all accepted standards of medical practice." *Id.* This conclusion is somewhat of an overstatement because *Williams*'s proposed instruction did require that the physician's belief that he was acting in accord with legitimate medical practice be *reasonable*. Nevertheless, the *Williams* court pronounced that "[t]he instruction given by the court afforded *Williams* an opportunity to defend himself by arguing at trial, as

C. *Objective Good Faith: An Oxymoronic Solution*

The definition of “good faith” in this context and its relevance to a doctor’s defense to a drug trafficking charge under the CSA is addressed directly by the Fourth Circuit in the 2006 case *United States v. Hurwitz*.<sup>32</sup> In *Hurwitz*, the Fourth Circuit reversed the conviction of Dr. William Hurwitz on multiple counts of drug trafficking and conspiracy to traffic for prescribing narcotic pain medication in violation of the CSA because the trial judge erroneously refused to allow the jury to consider whether the doctor had acted in good faith.<sup>33</sup> In this case, the court was “squarely presented with the question of whether, in a [section] 841 prosecution against a doctor, the inquiry into the doctor’s good faith in treating his patients is a subjective or objective one” and concluded that “the inquiry must be an objective one . . . .”<sup>34</sup> It is far from clear, however, what the court means by “objective” good faith and whether this is a helpful standard. This confusion is created in part by the Fourth Circuit’s agreement with the government that the trial court properly refused to give the jury instructions offered by Hurwitz.<sup>35</sup> Those instructions proposed that: “‘Good faith’ in this context means good intentions in the honest exercise of best professional judgment as to a patient’s needs. It means the doctor acted according to what *he believed to be proper medical practice*.”<sup>36</sup> The problem with this approach, according to the court, was that it “allow[ed] . . . criminal liability to turn on whether the defendant-doctor complied with his own idiosyncratic view of proper medical practices . . . .”<sup>37</sup> In this way, the Fourth Circuit gave with one hand, holding that the defendant must be able to offer the defense that he acted in good faith, and took away with the other, interpreting that good faith objectively. This resolution is not helpful. Objective good faith is inherently self-

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he actually did, that all the prescriptions he wrote were written *in good faith, as a part of his legitimate practice of medicine*.” *Id.* at 1310 (emphasis added). If Williams’s good faith is not established by showing his honest and reasonable belief that he was meeting his patients’ needs, it is not at all clear what “good faith” is supposed to consist of. Thus, we look to the jury instructions actually given by the trial court and approved by the Eleventh Circuit for guidance. The jury instructions given by the trial court in *Williams* provided that:

A controlled substance is prescribed by a physician in the usual course of a professional practice and, therefore, lawfully, if the substance is prescribed by him in good faith as part of his medical treatment of a patient in accordance with the standard of medical practice generally recognized and accepted in the United States.

*Williams*, 445 F.3d at 1309. This combination of allowing the defense of “good faith” along with the requirement that physicians treat patients in accord with accepted standards of medical practice is confusing at best and self-contradictory at worst.

<sup>32</sup> 459 F.3d 463 (4th Cir. 2006).

<sup>33</sup> *Id.* at 482.

<sup>34</sup> *Id.* at 479.

<sup>35</sup> *Id.* at 477-78.

<sup>36</sup> *Id.* at 478.

<sup>37</sup> *Id.*

contradictory. To act “in good faith” is to do what one honestly believes is right.<sup>38</sup> By its nature, it connotes a subjective approach. As long as a doctor honestly believes his conduct is appropriate, he acts in good faith. What then does “objective good faith” require? If it requires that one conform one’s conduct to objective standards of acceptable practice, it is hard to see what the invocation of good faith has added.

The nonsensical nature of the concept of objective good faith was replayed in the jury instructions of U.S. District Judge Leonie Brinkema in the 2007 retrial of William Hurwitz. The jury instruction on “Good Faith” first provided a mostly subjective approach: “‘good faith’ is not merely a doctor’s sincere intention towards the people who come to see him, but rather involves his sincerity in attempting to conduct himself in accordance with a standard of medical practice generally recognized and accepted in the country.”<sup>39</sup> On this view, as long as a doctor honestly attempts to conform his practice to what he sincerely believes are the generally accepted standards of medical practice, he is not guilty of drug trafficking under the statute, even if he makes a mistake about what is generally accepted and even if that mistake is unreasonable. Two sentences later, however, these same instructions provide a more objective standard that “[good faith] connotes an observance of conduct in accordance with what the physician should reasonably believe to be proper medical practice.”<sup>40</sup>

The difference between these two standards is especially important in this case, and others like it, where what constitutes standard or accepted practice in the treatment of patients in chronic pain is evolving at great speed. Judge Brinkema herself admitted at Dr. Hurwitz’s sentencing hearing that “in the few years since this case was originally prosecuted, the level of expertise in pain medicine has improved”<sup>41</sup> and in particular that, as of the re-sentencing in the summer of 2007, “there’s an increasing body of respectable medical literature and expertise that supports those types of high quantities of opioid medication in the correct case where people suffer from legitimate pain issues.”<sup>42</sup> A subjective approach would criminalize only the conduct of the doctor who himself believes that what he is doing is not within the scope of medical practice or would require a doctor to aim at conforming his practice to generally recognized standards in order to fall within the practice of medicine. The rapid evolution of what is considered “accepted practice” would not pose a problem under this standard. However, by raising the bar and requiring a doctor to aim at conforming to what he *reasonably* believes is accepted medical practice, doctors at the forefront

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<sup>38</sup> BLACK’S LAW DICTIONARY 713 (8th ed. 2004).

<sup>39</sup> Jury Instructions, *supra* note 6, at 49.

<sup>40</sup> *Id.* The jury instructions also specifically provided that “[i]n deciding whether the defendant acted in ‘good faith,’ the jury must use an objective standard.” *Id.*

<sup>41</sup> Transcript of Sentencing, *supra* note 4, at 4.

<sup>42</sup> *Id.* at 6.

of a changing practice may face criminal prosecution for their failure to recognize that their practices are not merely on the edge, but instead are regarded by others in their field as beyond the realm of accepted practice.

D. *Objective Good Faith as Applied: Is Trusting Patients Legitimate Medical Practice?*

The difference between these two standards also makes a difference if we focus on the question whether medical practice allows or requires a doctor to trust his patient. After all, what counts as acting with a “legitimate medical purpose” or in “the usual course of his professional practice” could relate both to specific issues of treatment, such as whether providing high doses of opium-based drugs is ever legitimate, as well as to more qualitative questions, such as whether the doctor-patient relationship requires the doctor to trust his patient. A pain doctor might believe that the practice of medicine requires or allows him to adopt an attitude of trust toward his patients’ reports of pain, even in the face of evidence that undermines their veracity. If the legal standard exonerates the doctor as long as he sincerely believes his conduct conforms to generally accepted standards, then the doctor may continue to trust his patients. If this belief must be objectively *reasonable*, however, then the jury may evaluate the physician’s conduct to decide for itself whether or not such trust was reasonable in light of “accepted medical practice.” This judgment should focus on the question of whether the belief that medical practice allows or requires such trust is reasonable. Yet this inquiry might easily devolve into an *ex post* judgment about whether a particular instance of trust is reasonable in light of facts suggesting reasons to doubt a patient’s sincerity.

Interestingly, the more subjective of the two standards seemingly in play (that the doctor acts non-criminally as long as he in good faith attempts to conform his conduct to generally accepted standards) and the most subjective possible alternative that has been squarely rejected by the courts (that the doctor acts non-criminally as long as he in good faith attempts to conform his conduct to what *he believes* are appropriate standards of medical practice) could arguably amount to the same thing depending on how one conceives of what constitutes medical practice. This could occur in two ways. First, the contours of what counts as medical practice may themselves be contested. In other words, if there are no clear rules governing whether pain doctors ought to trust their patients or whether they may prescribe to patients whom they suspect are diverting drugs, then the doctor’s personal beliefs regarding what medical practice ought to be may be all that is available.<sup>43</sup> Secondly, medical practice itself may be the sort of profes-

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<sup>43</sup> Arthur Applbaum made this point more generally:

sion that allows practitioners some leeway in determining for themselves what counts as the “practice of medicine.” As Arthur Applbaum explained, “[a] practice may recognize its practitioners as authoritative shapers and interpreters of the practice.”<sup>44</sup> This claim need not entail that medical practice is *anything* a doctor says it is. Rather, it is plausible to argue that medical practice is “incompletely specified,”<sup>45</sup> meaning that some clear rules exist regarding what does constitute medical practice while other areas are far from settled.<sup>46</sup> For example, sleeping with a patient is not medical practice even if the physician believes it is beneficial.<sup>47</sup> The obligation of a physician to trust her patient in pain, however, might fall into the category of unsettled practices. After all, “a capacity for self-reflection and self-criticism is part of what distinguishes professions from games and other sorts of rule-governed practices.”<sup>48</sup> If so, the pain doctor’s professional judgment that medical practice allows or requires that he trust his patient’s report of pain arguably constitutes both his subjective view about what medical practice ought to be and his good faith belief about what are the generally accepted standards of medical practice. Thus, the two different subjective approaches collapse into one when the doctor rightly believes that generally accepted standards allow him to exercise independent professional judgment about what an incompletely specified practice requires.

#### E. *Bringing the Standard Home: What Is the Mens Rea of the Offense?*

This debate regarding how subjectively or objectively to interpret the standard for criminal liability imposed by the CSA is most salient to the issue of the mens rea required for the offense. The statute provides that a person is guilty of drug trafficking if he *knowingly or intentionally* distrib-

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When constituted descriptions [of practices which define roles within them] are contested, criticism of particular practice-defined actions is possible in this special sense: critical practitioners can claim that others are making particular mistakes about what the constitutive conventions of the practice are. Challenges to orthodoxies in artistic practices often take this form. The originality of Joyce, Picasso, and Stravinsky can be understood as new claims about what their art forms already were and already meant, rather than as revolts against the existing meanings.

APPLBAUM, *supra* note 28, at 102. This account gives a special meaning to the idea of good faith—here it means the honest exercise of judgment about best practices in the face of an accurate assessment that the practice is contested. As Applbaum emphasized, “genuine contestation is a claim in good faith about what shared meanings actually are, not a proposal for what they should be.” *Id.* at 103.

<sup>44</sup> *Id.*

<sup>45</sup> This term comes from Applbaum. *Id.*

<sup>46</sup> See APPLBAUM, *supra* note 28. Here medical practice is contrasted with conduct that is not medical practice rather than with conduct that is poor medical practice or malpractice.

<sup>47</sup> See, e.g., COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, AM. MED. ASS’N, CODE OF MEDICAL ETHICS OF THE AMERICAN MEDICAL ASSOCIATION 8.14, at 255 (2006) (“Sexual contact that occurs concurrent with the physician-patient relationship constitutes sexual misconduct.”).

<sup>48</sup> APPLBAUM, *supra* note 28, at 103.

utes or dispenses a controlled substance, unless he is authorized to do so by the statute.<sup>49</sup> This formulation leaves unresolved the question of whether an actor must intend or know that he is acting in a manner that is not authorized. Though they rarely address this question directly, most courts seem to require the prosecutor to show that the defendant knew something beyond merely the fact that he was dispensing a controlled substance.<sup>50</sup> This is particularly crucial because in all of the cases of physician prescribing, the doctor intends to prescribe what he knows is a controlled substance.<sup>51</sup> Courts require knowledge about more than merely the dispensing of a controlled substance by one of two interpretive moves. Some courts find that the mens rea requirement of “knowingly or intentionally” for the “distributing” and “controlled substance” elements also applies to the fact that distribution in that context is unauthorized.<sup>52</sup> Alternatively, other courts read the mens rea requirement into their interpretation of what constitutes a “legitimate medical purpose.”<sup>53</sup> Prescribing is only authorized if it is for a legitimate medical purpose.<sup>54</sup> To show that a defendant prescribed for an illegitimate medical purpose requires, according to this view, that the defendant intended or knew that he was prescribing in an illegitimate manner.<sup>55</sup>

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<sup>49</sup> 21 U.S.C. § 841(a)(1) (2006).

<sup>50</sup> See, e.g., *United States v. Feingold*, 454 F.3d 1001, 1008 (9th Cir. 2006) (“[T]he jury must make a finding of intent not merely with respect to distribution, but also with respect to the doctor’s intent to act as a pusher rather than a medical professional.”).

<sup>51</sup> Case law has clearly held that writing prescriptions is a method of dispensing or distributing the controlled substance. See, e.g., *United States v. Tran Trong Cuong*, 18 F.3d 1132, 1140 (4th Cir. 1994) (“Improperly issuing a prescription for a controlled substance is sufficient to warrant a conviction under the Controlled Substances Act even though the doctor does not himself actually distribute the drugs and even though the prescription is not subsequently filled.” (quoting *United States v. Stump*, 735 F.2d 273, 275-76 (7th Cir. 1984))).

<sup>52</sup> *Feingold*, 454 F.3d at 1007 (“[A] practitioner who acts outside the usual course of professional practice may be convicted under § 841(a) only if he does so intentionally.”).

<sup>53</sup> See *infra* note 55.

<sup>54</sup> 21 C.F.R. § 1306.04(a) (2006) (“A prescription for a controlled substance to be effective must be issued for a legitimate medical purpose . . .”).

<sup>55</sup> For example, in *Hurwitz*, the court of appeals did not hold that the prosecutor must show that a person “knowingly and intentionally” prescribed in a manner not authorized by law (i.e., that the mens rea of knowledge or intention applies to the third element of the offense as well). See *United States v. Hurwitz*, 459 F.3d 463, 475 (4th Cir. 2006). According to the Fourth Circuit, conviction of a doctor for violation of the Controlled Substances Act requires “(1) ‘that the defendant distributed or dispensed a controlled substance’; (2) that the defendant ‘acted knowingly and intentionally’; and (3) ‘that the defendant’s actions were not for legitimate medical purposes in the usual course of his professional medical practice or were beyond the bounds of medical practice.’” *Id.* (quoting *United States v. Singh*, 54 F.3d 1182, 1187 (4th Cir. 1995)). One of the issues raised by *Hurwitz* on appeal was that the jury instructions “required the jury to apply the knowledge requirement only to *Hurwitz*’s act of writing a prescription, and that the instructions therefore permitted the jury to convict even if it concluded that *Hurwitz* did not know that any given prescription was not for a legitimate medical purpose or was beyond the bounds of medical practice.” *Id.*

In fact, the discussion in the cases is often more focused and specific. Rather than asking whether the defendant intended or knew that he was prescribing in an illegitimate manner, the prosecutor attempts to show that the defendant intended or knew that he was prescribing to a person who was reselling or abusing drugs.<sup>56</sup> One could, of course, raise a question about whether knowingly prescribing to someone who abuses or resells drugs is, in fact, prescribing for an illegitimate medical purpose or outside the bounds of usual professional practice. But that question is outside the scope of the inquiry here.<sup>57</sup> Instead, the focus here is on the impact of the chosen legal standard on the physician's ability to trust his patient.

In many recent cases, the courts have disturbingly instructed juries that they may find the doctors guilty of knowingly dispensing a controlled substance in a manner not authorized when the doctor is *willfully blind* to the fact that his patients are diverting or abusing the drugs.<sup>58</sup> The use of willful

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The court did not reach this issue, however, because it found that the trial court erred in failing to give a good faith instruction. *Id.* at 476. Given that the court went on to hold that good faith is objectively determined, *id.* at 477-80, the court's neglect of this question leaves unresolved the issue of whether the physician must knowingly or intentionally prescribe in a manner that is not for a legitimate medical purpose in the usual course of a professional practice. Rather, the court read the doctor's good or bad faith as relevant to the content of those actions themselves. As the court explained, "we agree with Hurwitz that a doctor's good faith generally is relevant to a jury's determination of whether the doctor acted outside the bounds of medical practice or with a legitimate medical purpose when prescribing narcotics." *Id.* at 476.

<sup>56</sup> In framing the issue in this way, the relevant knowledge clearly relates to a fact (that the patient was reselling the drugs) rather than to a legal or quasi-legal issue (whether dispensing to a patient who is reselling is unauthorized). See Kenneth W. Simons, *Should The Model Penal Code's Mens Rea Provisions Be Amended?*, 1 OHIO ST. J. CRIM. L. 179, 184-85 (2003), for a discussion of the complexity of treating knowledge about law versus fact.

<sup>57</sup> The medical community appears to accept the view that prescribing to an addict or former addict *is* permissible, as an addict may still be in pain. See American Academy of Pain Medicine and American Pain Society, *The Use of Opioids for the Treatment of Chronic Pain: A consensus statement*, <http://www.ampainsoc.org/advocacy/opioids.htm> ("[E]xperience has shown that known addicts can benefit from carefully supervised, judicious use of opioids for the treatment of pain due to cancer, surgery, or recurrent painful illnesses such as sickle cell disease."). Prescribing to a patient who is diverting drugs, even if the patient is also in pain, is more controversial. The most subjective of the potential readings of the statute would permit this interpretation. If the statute forbids knowingly prescribing in a manner that the physician honestly believes is actually illegitimate (as compared with what she believes or reasonably believes is viewed as legitimate by doctors generally), then a doctor could permissibly prescribe controlled substances to a patient who she believes is in pain and believes is reselling some of those drugs. If the physician honestly believes that good medical practice allows her to do so, then the most subjective reading of the statute (which courts largely reject) would allow this practice.

<sup>58</sup> In the instructions themselves, the courts do not direct the jury with regard to what specifically the defendant is allegedly willfully blind. Rather the instructions say something more general, such as: "The government may prove that the defendant acted 'knowingly,' as used throughout these instructions, by proving, beyond a reasonable doubt, by proving that the defendant deliberately closed his eyes to what would otherwise have been obvious to him at the time he acted." Jury Instructions, *supra* note 6, at 48. But one natural home for this inquiry is with regard to the question of whether a physician *knows*

blindness as a substitute for knowledge in these cases is troubling. Unlike other situations in which a willful blindness instruction may be appropriate, doctors prescribing drugs often are morally justified in trusting their patients. This argument, further discussed in Part II, suggests that not all willful blindness is equally culpable. Rather, willful blindness may substitute for knowledge only when the person is willfully blind to the fact at issue and has no good reason to be so.<sup>59</sup> This formulation departs from both the traditional understanding of willful blindness and recent suggestions for reconceiving the doctrine.

In summary, federal case law from around the country exhibits no clear standard for criminal liability in the context of doctors prescribing controlled narcotics. In particular, judges vacillate between more subjective standards—in which a doctor's good faith attempt to conform his conduct to what he believes is a generally accepted standard of medical practice is sufficient—and more objective standards in which the doctor's conduct in this regard must also be reasonable. This tension is well illustrated by the oxymoronic "objective good faith." At issue here is a choice about when and whether a doctor's professional judgment deserves deference. Part and parcel of this professional judgment is the physician's decision to trust his patients. By allowing juries to convict doctors for being willfully blind to the fact that their patients are reselling the prescribed drugs, the legal system restricts such trust and thus intrudes on a vitally important aspect of medical practice.

## II. PROSECUTING DOCTORS FOR TRUSTING PATIENTS

The fact that willful blindness acts as a substitute for knowledge in holding physicians criminally liable for *knowingly* prescribing to a patient who resells drugs puts pressure on the doctor's ability to trust her patient. This Part begins with a short description of courts' use and interpretation of willful blindness. Next, it describes the controversies surrounding the doctrine. Using the example of the trusting pain doctor, this Part then argues that current accounts of willful blindness are inadequate and proposes an alternative. The central claim is this: if the pain doctor is morally justified in trusting his patients, then his willful blindness is not culpable.

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he is prescribing to someone reselling the drugs (which we will assume, for our purposes here, would be unauthorized by law).

<sup>59</sup> See *infra* Part II.B.

A. *The Willful Blindness Standard in Case Law*

Assume that a doctor violates the CSA if he knowingly prescribes a controlled substance to a patient who the doctor knows is reselling the drugs.<sup>60</sup> Where the evidence of knowledge is circumstantial (e.g., patients “lose” their prescriptions, fail urine tests, request particular drugs, are seen by pharmacists handing drugs to someone else, etc.), the prosecution may want to argue that the facts show either that the physician knew the patient was reselling, or that if he did not actually know, this lack of knowledge was due to his willful blindness. For example, in the retrial of William Hurwitz, the government argued that a willful blindness instruction was appropriate because the defendant “repeatedly, and deliberately, ignored the obvious implications of what he learned about his patients—their inability to afford the drugs he was prescribing, their numerous positive drug tests, their track marks, their brushes with the law, and on and on.”<sup>61</sup> Similarly, in reviewing the appropriateness of the willful blindness instruction with regard to a conspiracy to engage in drug trafficking charge in *United States v. McIver*,<sup>62</sup> the court found that evidence of “warning signs that [the doctor’s] patients were not using their medications as prescribed, were seeking his treatment specifically to obtain drugs, or were drug addicts” was sufficient to support “either of two alternate conclusions: that Appellant had actual knowledge that he was prescribing drugs for non-medical purposes or that he was willfully blind to his patient’s true motives in seeking his care.”<sup>63</sup> In the Eighth Circuit’s 2006 opinion in *United States v. Katz*,<sup>64</sup> the court approved the trial court’s willful blindness instruction because “the government adduced ample evidence . . . including testimony from several pa-

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<sup>60</sup> Actually even this may not be quite right. The DEA’s FAQ (which were published August 11, 2004 and taken down October 6, 2004) instructed that “[i]ncontrovertible evidence of criminal activity, such as diversion, is grounds for termination of the doctor-patient relationship.” Drug Enforcement Agency, Prescription Pain Medications: Frequently Asked Questions and Answers for Health Care Professionals and Law Enforcement Personnel (2004), <http://www.cpmission.com/main/painpolitics/deapulls.html>. One could surely know that the patient is diverting drugs without having “incontrovertible evidence” of that fact. For further analysis, see *DEA Pulls Prescription Pain Medicine FAQs Without Explanation*, DRUG WAR CHRON. (Drug Reform Coordination Network), Oct. 8, 2004, <http://stopthedrugwar.org/chronicle-old/357/deapain.shtml>; *Now You See It, Now You Don’t: The Amazing Vanishing DEA Pain FAQ*, DRUG WAR CHRON. (Drug Reform Coordination Network), Oct. 15, 2004, <http://stopthedrugwar.org/chronicle-old/358/thefaq.shtml>.

<sup>61</sup> Government’s Memorandum Concerning Willful Blindness and Theory-of-Defense Instructions at 1, *United States v. Hurwitz*, No. 1:03CR467 (E.D. Va. Mar. 26, 2007) [hereinafter Government’s Willful Blindness Brief].

<sup>62</sup> 470 F.3d 550 (4th Cir. 2006), *cert denied*, 127 S. Ct. 2276 (2007).

<sup>63</sup> *Id.* at 564.

<sup>64</sup> 445 F.3d 1023 (8th Cir. 2006).

tient/witnesses that they obtained 30-day prescriptions for controlled substances every two weeks for several years.”<sup>65</sup>

### 1. Traditional Willful Blindness

In these cases, there are two different conceptions of willful blindness in play. First, there is what might be called “traditional” willful blindness. As the drug courier presents the paradigm case of willful blindness, the mental state of the drug courier who chooses not to investigate the contents of the package he carries in order to avoid criminal liability represents “traditional willful blindness.” Analogously, traditional willful blindness is alleged in physician prescribing cases in which the physician suspects that the patient is diverting drugs, could investigate further, and deliberately decides not to investigate.

The Ninth Circuit’s opinion in *United States v. Jewell*<sup>66</sup> defines the characteristics of willful blindness and still serves as a model for appropriate jury instructions on the doctrine. In *Jewell*, the defendant was convicted for knowingly attempting to bring drugs across the border when he drove a car carrying 110 pounds of marijuana contained in a secret compartment.<sup>67</sup> In that case, there was good reason for Jewell to suspect that his cargo was illegal drugs.<sup>68</sup> Jewell himself testified at trial that a stranger approached him in Mexico and had asked him if he wanted to buy marijuana.<sup>69</sup> When he declined, the stranger asked if he wanted to drive a car to Los Angeles for \$100, and Jewell agreed.<sup>70</sup> Jewell looked the car over and noted that the visible trunk space was smaller than it should have been, suggesting a secret compartment, yet did not investigate.<sup>71</sup> Presumably, if he had, he would have found the drugs.<sup>72</sup> The jury instructions given by the trial court and approved by the appellate court provided:

The Government can complete their burden of proof by proving, beyond a reasonable doubt, that if the defendant was not actually aware that there was marijuana in the vehicle he was driving when he entered the United States his ignorance in that regard was solely and entirely

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<sup>65</sup> *Id.* at 1031; *see also* *United States v. Neville*, 82 F.3d 750, 760 (7th Cir. 1996); *United States v. Shultice*, No. CR 98-54 MJM, 2000 WL 34030842 at \*9-10 (N.D. Iowa Apr. 4, 2000).

<sup>66</sup> 532 F.2d 697 (9th Cir. 1976) (en banc).

<sup>67</sup> *Id.* at 698.

<sup>68</sup> *Id.*

<sup>69</sup> *Id.* at 699 n.1.

<sup>70</sup> *Id.* at 699 n.2.

<sup>71</sup> *Id.*

<sup>72</sup> *Jewell*, 532 F.2d at 698.

a result of his having made a conscious purpose to disregard the nature of that which was in the vehicle, with a conscious purpose to avoid learning the truth.<sup>73</sup>

Under the traditional model of willful blindness then, the defendant lacks knowledge only because he deliberately chooses not to do something that would confirm or disconfirm his suspicions.<sup>74</sup>

## 2. Inferential Willful Blindness

There is a second, somewhat deviant, species of willful blindness at work in the physician-drug cases as well. In such a case, it is alleged that the physician lacks the relevant knowledge not because he fails to investigate but instead because he fails to draw the obvious or reasonable inference from the facts that are known to him. Call this “inferential willful blindness.” William Hurwitz’s case provides a good example of this variety. In that case, the government argued that the willful blindness instruction was appropriate because Hurwitz “repeatedly, and deliberately, *ignored the obvious implications of what he learned about his patients.*”<sup>75</sup> The government did not, however, claim that Hurwitz lacked knowledge that his patients were reselling drugs because he failed to take simple steps to confirm or deny such suspicions by doing things such as looking in a suitcase or a trunk. Rather the government argued that Hurwitz’s knowledge of specific facts involving his patients’ “inability to afford the drugs he was prescribing, their numerous positive drug tests, their track marks, their brushes with the law, and on and on,”<sup>76</sup> would have led him *to believe* that these patients were diverting or abusing the drugs, but for his deliberate steps to block this chain of inference.<sup>77</sup> If the metaphor for the willfully blind defendant is the ostrich that puts its head in the sand, then what is lacking in the inferential conception of willful blindness is the action of putting one’s

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<sup>73</sup> *Id.* at 700.

<sup>74</sup> This conception meets two of the three criteria for willful blindness identified by Husak and Callender in their important article critiquing the use of willful blindness instructions in the context of offenses requiring knowledge. See Douglas N. Husak & Craig A. Callender, *Willful Ignorance, Knowledge, and the “Equal Culpability” Thesis: A Study of the Deeper Significance of the Principle of Legality*, 1994 WIS. L. REV. 29, 39-40. Husak and Callender argue that a willfully blind actor must meet three nonmental criteria: warranted suspicion, availability (the actor is easily able to learn the truth), and motivation (the actor avoids doing so to avoid criminal liability). *Id.* at 40-41.

<sup>75</sup> Government’s Willful Blindness Brief, *supra* note 61 (emphasis added).

<sup>76</sup> *Id.*

<sup>77</sup> This inferential conception of willful blindness is explicitly approved in another doctor-prescribing case in which a willful blindness instruction is given. See *United States v. Neville*, 82 F.3d 750, 760 (7th Cir. 1996) (holding that “[e]vidence of purely psychological avoidance, a cutting off of one’s normal curiosity by an effort of will’ is enough” to raise an inference of willful blindness (quoting *United States v. Stone*, 987 F.2d 469, 472 (7th Cir. 1993))).

head in the sand. Instead, in a case of inferential willful blindness, the ostrich sees what is occurring and ignores its obvious implications.

Hurwitz's lawyers argued to the trial court that this divergence from the classical notion of willful blindness made giving such instructions inappropriate: "[w]illful blindness requires affirmative steps to *avoid* knowledge—here, knowledge of patients' abuse and diversion—not merely the defendant's failure to see that which is 'obvious.'"<sup>78</sup> They argued that this inferential conception of willful blindness "would allow the jury to convict based on nothing more than a conclusion that the defendant failed to draw an inference he *should have* drawn, *i.e.*, that he was mistaken, negligent, or foolish for failing to infer that patients were abusing or diverting."<sup>79</sup> The judge, however, rejected this argument and the willful blindness instruction was given to the jury.<sup>80</sup> There is yet a third way to think about what is going on in cases where a physician ignores signs that his patient is diverting drugs. It may be that the doctor does not decide to trust his patients at all. Rather, the doctor's habits and professional self-conception may make him predisposed to trust his patients.<sup>81</sup> Such an analysis only further complicates the question of how the courts ought to think about these cases.

#### B. *Debates About the Definition of Willful Blindness and When It May Substitute for Knowledge*

Why is it that willful blindness may serve as a substitute for knowledge? There are two common answers to this question: (1) because "knowledge" as the term is used in the criminal law is something less than knowledge as we ordinarily conceive of it, or (2) because the actor purposely avoids knowledge.<sup>82</sup> The Model Penal Code ("MPC") adopts the first approach. According to the MPC, a person knows something when he is "aware of a high probability of its existence, unless he actually believes that it does not exist."<sup>83</sup> While this formulation does not appear to include willful blindness, it is commonly understood to accommodate such cases.<sup>84</sup>

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<sup>78</sup> Defendant's Reply Memorandum Concerning Willful-Blindness and Theory-of-Defense Instructions at 2, No. 1:03CR467 (E.D. Va. Mar. 26, 2007) [hereinafter Hurwitz's Willful Blindness Brief].

<sup>79</sup> *Id.* at 3.

<sup>80</sup> See Jury Instructions, *supra* note 6, at 48.

<sup>81</sup> How the criminal law ought to treat dispositions to act is itself controversial—and will not be addressed here.

<sup>82</sup> Husak and Callender frame the question a bit differently, asking whether willful blindness is a form of knowledge or instead whether it is the moral equivalent of knowledge, and concluding that it is neither. See Husak & Callender, *supra* note 74, at 41-58.

<sup>83</sup> MODEL PENAL CODE § 2.02(7) (1962).

<sup>84</sup> See, e.g., Ira P. Robbins, *The Ostrich Instruction: Deliberate Ignorance as a Criminal Mens Rea*, 81 J. CRIM. L. & CRIMINOLOGY 191, 193 (1990) ("Deeming deliberate ignorance to be a culpable

Consider again the classic example of the drug courier where the defendant is aware of the high probability that he is carrying drugs and does not actually believe to the contrary. In such a case, the MPC would conclude that the defendant knows he carries drugs. Alternatively, some argue that the courier's deliberate decision to avoid knowledge is the relevant factor.<sup>85</sup>

Something important, however, is missing from both of these accounts as well as the recently proposed alternatives. This Article argues that courts must also look at whether the actor has a good reason<sup>86</sup> for his blindness in order to determine when willful blindness instructions are appropriate. Where the actor is justified in not investigating further, the willfully blind actor is not equally culpable as the knowing actor.

Each of the common approaches has garnered criticism, the Model Penal Code's approach most thoroughly. Douglas Husak and Craig Callender argue that the willfully blind actor need not be aware of a high probability of the relevant fact.<sup>87</sup> Moreover, David Luban argues that in the organizational setting (for which the willful blindness framework also seems apt), the MPC approach may not work.<sup>88</sup> The manager who has successfully structured the organization to produce deniability of actual knowledge of wrongdoing may not be aware of the high probability of wrongdoing about any particular event or transaction.<sup>89</sup> Some commentators argue instead that willful blindness is really a sort of recklessness and the fact that it is sometimes as culpable as knowledge shows us that recklessness is not always less culpable than knowledge generally.<sup>90</sup>

In response to critiques of the willful blindness doctrine, scholars either attempt to rehabilitate the doctrine through reconstruction or challenge the legal and moral equivalence of willful blindness with knowledge.<sup>91</sup> One interesting reconstruction of the willful blindness doctrines is that proposed

attempt to cheat justice, the federal courts have sought to eliminate the defense by expanding the definition of knowledge." (footnote omitted); Simons, *supra* note 56, at 187 (describing section 202(7) as "[t]he MPC's version of the willful blindness doctrine").

<sup>85</sup> *E.g.*, David Luban, *Contrived Ignorance*, 87 GEO. L.J. 957, 962 (1999) ("The focus in a willful ignorance case is on whether the actor deliberately avoided guilty knowledge.").

<sup>86</sup> The term "good reason" is deliberately open-ended. Clearly application of this view would require specifying what constitutes a morally good reason to opt for blindness. This Article does not attempt to provide a complete account here. However, in Part III, *infra*, I argue that the physician treating a patient who claims to be in pain is morally justified in choosing blindness.

<sup>87</sup> Husak & Callender, *supra* note 74, at 37.

<sup>88</sup> *See* Luban, *supra* note 85, at 964 ("[T]he Model Penal Code standard . . . is also too weak for organizational settings.").

<sup>89</sup> *See id.* at 970 (arguing that in the corporate setting, "[t]he actor lacks awareness of the high probability of guilty facts, so by the lights of the Model Penal Code she is off the hook—precisely because her willful ignorance succeeded so well!").

<sup>90</sup> LARRY ALEXANDER ET AL., *CRIME AND CULPABILITY: A THEORY OF CRIMINAL LAW* 31-35 (2009).

<sup>91</sup> *See, e.g.*, LEO KATZ, *ILL-GOTTEN GAINS: EVASION, BLACKMAIL, FRAUD, AND KINDRED PUZZLES OF THE LAW* 38-44 (1996).

by Alan Michaels. In “Acceptance: The Missing Mental State,” Michaels proposes adding the mental state of acceptance to the MPC’s current list of intention, knowledge, recklessness, and negligence.<sup>92</sup> According to Michaels, a person acts “acceptingly” if he would have so acted even if he had known the relevant fact at issue.<sup>93</sup> Thus, “[a]cceptance defines a particular level of indifference towards a result or a circumstance—a particular level of not caring.”<sup>94</sup> Michaels argues that we ought to substitute the mental state of acceptance for the knowledge-via-willful blindness approach, as it better captures our moral intuitions about what makes the action culpable.<sup>95</sup> Michaels explains:

If knowledge of an attendant circumstance is particularly culpable because it shows the actor’s willingness to engage in the relevant conduct in spite of the general certainty that such attendant circumstance exists, the same particular culpability would exist when, and only when, that willingness to engage in the relevant conduct despite the presence of the attendant circumstance is also present. That is the very definition of acceptance.<sup>96</sup>

Michaels offers an intriguing theory, but it is ultimately unsuccessful in adequately accounting for our moral intuitions about willful blindness cases for a variety of reasons. First, it rests on the controversial claim that, from the perspective of the actor, there is no moral difference between *doing* and *allowing*. Consider the case of an actor who does not act acceptingly—a courier who would not carry the pouch into the country if he knew that it contained illegal drugs but who is willing to do it when he suspects but does not know that it does. On Michaels’s account, the courier is not culpable because he would not carry the pouch if he knew that it contained drugs. Thus, Michaels assumes that the courier cares somewhat about the event or circumstance itself—in this case, about whether drugs are coming into the country. For Michaels, “[a]cceptance defines a particular level of indifference toward a result or a circumstance—a particular level of not caring.”<sup>97</sup> But it might be the case that the courier’s refusal to knowingly import drugs arises not because he cares about the result or circumstance—whether drugs are carried into the country—but instead because he cares about whether he would be knowingly transporting drugs. Admittedly, this objection sounds somewhat circular, but we cannot ignore, without begging the question of the significance of willful ignorance, the fact that it might

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<sup>92</sup> Alan C. Michaels, *Acceptance: The Missing Mental State*, 71 S. CAL. L. REV. 953, 958-63 (1998).

<sup>93</sup> *Id.* at 961.

<sup>94</sup> *Id.* at 962.

<sup>95</sup> *Id.* at 995 (“Courts and commentators argue that the goal of a wilful [sic] blindness doctrine should be to capture those, but only those, whose culpability matches the knowing actor’s. Acceptance does this.” (footnote omitted)).

<sup>96</sup> *Id.* at 996.

<sup>97</sup> *Id.* at 962 (emphasis added).

matter whether one acts knowingly. If it matters to the actor, then he might not be willing to act where he knows but be willing to act when he does not, without this reflecting any different level of concern about the event or circumstance itself. Ignorance, though contrived, may be relevant. Leo Katz thinks so.<sup>98</sup> Michaels's approach, however, seems to ignore this possibility by assuming that a person's willingness to act depends entirely upon his level of concern about the event or circumstance that he suspects but does not know.

In defense of the idea that there is a moral difference between knowledge and willful blindness, Katz offers the case of Albert Speer as an example. Speer was the Nazi who famously claimed both that he did not know of the death camps and that this fact was morally irrelevant, as he was as culpable as if he had actual knowledge.<sup>99</sup> Katz thinks Speer "was being coy, was playing Marc Anthony by saying he was not seeking to excuse himself while going to such extraordinary pains to establish his willful ignorance."<sup>100</sup> Nonetheless, Katz goes on to explore the question of whether Speer's actual knowledge has moral significance and concludes that it does.<sup>101</sup> According to Katz, the structure of morality is such that it matters what route one takes to a given end.<sup>102</sup> If creating the conditions of one's own ignorance is not itself wrongful, doing something under these conditions of contrived ignorance is not wrongful and therefore should not be illegal.<sup>103</sup> This is not an endorsement of Katz's views on willful blindness but rather shows that Michaels's courier might refuse the packet only because he, like Katz, believes that actual knowledge does make a difference. If this is correct, Michaels cannot assume that the non-acceptor actually cares about allowing drugs to come into the country for he may only be concerned about knowingly doing an illegal act.

There is a second problem with Michaels's suggestion that we substitute the mental state of acceptance for the doctrine of willful blindness—professionals and possibly others can choose blindness for reasons that are morally justified. David Luban, who offers an account of willful blindness that is similar to Michaels's, recognizes this problem but sees no real way to avoid it.<sup>104</sup> According to Luban, the relevant moral question is: "What was the actor's state of mind toward the unwitting misdeed at the moment

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<sup>98</sup> See KATZ, *supra* note 91, at 95 ("[T]he nature of the causal chain [is] crucial in determining the fairness of blaming someone.").

<sup>99</sup> *Id.* at 39-41.

<sup>100</sup> *Id.* at 41.

<sup>101</sup> *Id.* at 41-44.

<sup>102</sup> See *id.* at 43-44.

<sup>103</sup> Katz recognizes that the upshot of this view will trouble many people—in fact, he quotes Michael Moore as having this to say about his (Katz's) view: "'You're making Kant look like Machiavelli.'" *Id.* at 131.

<sup>104</sup> Luban, *supra* note 85, at 978-80.

she opted for ignorance?”<sup>105</sup> Yet Luban is unable to accept the consequences of this view in the context of a lawyer and her client.<sup>106</sup> The case that troubles Luban is the example of the lawyer who suspects but does not know that her client will lie on the stand.<sup>107</sup> If the lawyer intentionally avoids knowing in order to escape the ethics rules prohibiting lawyers from knowingly putting on perjured testimony,<sup>108</sup> then the lawyer is culpable according to Luban’s view. This approach, however, departs from the ethics rules governing lawyers, and Luban himself would not countenance such a departure.<sup>109</sup> As he acknowledges, this leaves Luban in a difficult place, as his theory “counsels that such willful blindness [in the case of the lawyer-client relationship] is morally indistinguishable from knowing deception—but every instinct screams that the theory is wrong.”<sup>110</sup> Finding “no easy way out of this dilemma,” Luban has “come to accept the willful blindness alternative.”<sup>111</sup>

There is, however, an answer to this dilemma. Under the account of culpable blindness presented here, an actor might be charged with knowledge only when he lacks a good reason for his blindness. Thus, the reasons for blindness matter. An actor may have a morally relevant reason to deliberately avoid learning facts which, if known, would make her actions culpable.

### C. *The Lawyer and the Drug Courier*

Luban’s lawyer example illustrates that an actor who has a good reason to deliberately avoid learning a legally relevant fact, though deliberately ignorant, is not as blameworthy as the knowing actor and perhaps is not blameworthy at all. Compare the case of a criminal defense lawyer who suspects but does not know that her client may perjure himself when he testifies in his trial with the case of a drug courier who suspects but does not know that the package he has been asked to carry contains illegal drugs. In both, relevant law forbids knowingly doing some act—putting on perjured testimony or carrying illegal drugs into the county.<sup>112</sup> And in both

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<sup>105</sup> *Id.* at 973.

<sup>106</sup> *See id.* at 976-78 (expressing “grave doubts” about amending the Model Rules of Professional Conduct to include willful ignorance).

<sup>107</sup> *See id.* at 976.

<sup>108</sup> MODEL RULES OF PROF’L CONDUCT R. 3.3(a)(3) (2003) (“A lawyer shall not knowingly . . . offer evidence that the lawyer knows to be false.”).

<sup>109</sup> Luban, *supra* note 85, at 976.

<sup>110</sup> *Id.* at 978.

<sup>111</sup> *Id.*

<sup>112</sup> MODEL RULES OF PROF’L CONDUCT R. 3.3(a)(3) (2003).

cases, doing the act without such knowledge is not punishable.<sup>113</sup> Knowledge is therefore crucial. If “willful blindness” is to substitute for the mens rea of knowledge, acting with willful blindness should be as blameworthy as acting with knowledge.<sup>114</sup> Is it?

Commentators suggest that willful blindness instructions are appropriate where an actor is aware of a high probability of the relevant fact or deliberately acts to avoid knowledge of the relevant fact.<sup>115</sup> Do these factors help to assess the culpability of the lawyer Luban describes? Suppose the client tells his lawyer that he intends to testify that he did not commit the crime. The lawyer might believe there is a high probability that this testimony is untrue—perhaps the client has told the lawyer several inconsistent stories or the lawyer might have other evidence that strongly suggests that the story is a lie. The lawyer, aware of this high probability of falsehood, may counsel the client not to lie. Yet the lawyer may decide to go no further. She does not investigate the truth of her client’s claims, even when doing so would be relatively easy. In this situation, the lawyer satisfies the above criteria for willful blindness, yet the lawyer’s action seems justifiable.

Now, compare the lawyer’s decision to put her client on the stand without investigating further with the drug courier’s decision to import a suitcase without opening it. The lawyer’s professional duty of loyalty requires her to act in her client’s interest unless some other ethical rule directs otherwise.<sup>116</sup> But, the drug courier faces no similar constraint on his free-

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<sup>113</sup> *Id.* cmt. (“The prohibition against offering false evidence only applies if the lawyer knows that the evidence is false.”). The term “punishable” is used because the lawyer is subject to professional discipline rather than to criminal prosecution for putting a client on the stand whom she knows will lie.

<sup>114</sup> Husak and Callender argue that even equal culpability is not enough, as punishing someone just because he is equally culpable as the person who does the legally prohibited act violates the principle of legality. *See* Husak & Callender, *supra* note 74, at 56 (“Using the equal culpability thesis to justify punishing the wilfully ignorant defendant under a statute requiring that he act knowingly is to employ the very kind of analogical reasoning condemned by the principle of legality.”).

<sup>115</sup> *See supra* notes 86-88 and accompanying text.

<sup>116</sup> While no specific Model Rule of Professional Conduct specifies that a lawyer owes a duty of loyalty to her client, the rules prohibiting conflicts of interest of various kinds are justified on the ground that the lawyer owes a general duty of loyalty to her client. For example, Comment [1] to Rule 1.7 lays out the following “general principle:” “Loyalty and independent judgment are essential elements in the lawyer’s relationship to a client.” MODEL RULES OF PROF’L CONDUCT R. 1.7 cmt. (2003). Similarly, Comment [6] provides that “[l]oyalty to a current client prohibits undertaking representation directly adverse to that client without that client’s informed consent.” *Id.* The Model Code of Professional Responsibility was clearer still. Canon 7 provided that “[a] lawyer should represent a client zealously within the bounds of the law.” MODEL CODE OF PROF’L RESPONSIBILITY Canon 7 (1980); *see also* MODEL RULES OF PROF’L CONDUCT pmb1. 9 (2003) (“[T]he basic principles underlying the Rules . . . include the lawyer’s obligation zealously to protect and pursue a client’s legitimate interests, within the bounds of the law . . .”). Further, the “ethical considerations” emphasize that the lawyer is to “resolve reasonable doubts in favor of his client” when “developing evidence relevant to the state of mind of the client at a particular time.” MODEL CODE OF PROF’L RESPONSIBILITY EC 7-6 (1969).

dom of investigation. The lawyer, therefore, has a good reason not to investigate further while the courier does not. The presence or absence of a justification for failing to act is the critical distinction between the two cases.

Husak's and Callender's account of willful blindness most closely reflects the view proposed here but still differs in important respects. Using what they consider to be the paradigm case, *United States v. Jewell*, Husak and Callender explain the elements of willful blindness.<sup>117</sup> According to their view, the willfully ignorant defendant must first be suspicious regarding the relevant fact.<sup>118</sup> Second, the defendant's suspicion must be warranted (the "warranted suspicion" criterion).<sup>119</sup> Third, the defendant must be easily able to learn the truth (the "availability condition").<sup>120</sup> And finally, the defendant "must consciously desire to preserve a possible defense from blame or liability in the event that he is apprehended" (the "motivational condition").<sup>121</sup>

Husak's and Callender's account differs from the account proposed here in that the former focuses on a subjective element while the latter rests on an objective element. For Husak and Callendar, willful blindness consists of actual suspicion by the defendant of the relevant fact at issue plus three non-mental elements: warranted suspicion, availability, and the desire to avoid punishment. Yet what distinguishes the lawyer from the drug courier is not a difference in motivation, as Husak and Callender propose, but a difference in justification for choosing ignorance. Some lawyers may be motivated by a desire to preserve a defense from blame or professional discipline for knowingly suborning perjury. Others may be motivated by the desire to provide their clients with a vigorous defense or to avoid disloyalty to clients by investigating the truth of their stories. Under Husak's and Callender's approach, a willful blindness instruction would be appropriate in the first case, where a lawyer acts in self-interest to preserve his own defense, but it would not be appropriate in the second case, where a lawyer acts to further his client's interest. This seems an odd result.

It is important to note that the account proposed here asks whether the actor is morally justified in choosing blindness, not whether the actor believes that she is morally justified or is otherwise motivated by appropriate concerns. After all, the drug courier might think he has a good reason for blindness too. Nor is an appeal to professional role sufficient. The drug courier might also try that route. For example, a good drug courier is surely one who refrains from investigating the packages his employer gives him to carry. Yet an appeal to this role surely would not mean that willful blind-

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<sup>117</sup> Husak & Callender, *supra* note 74, at 34-40. However, Husak and Callendar do not think that a willfully blind actor, so defined, is always equally culpable as a knowing actor. *Id.* at 54-55.

<sup>118</sup> *Id.* at 41.

<sup>119</sup> *Id.* at 39-40.

<sup>120</sup> *Id.* at 40.

<sup>121</sup> *Id.*

ness instructions are inappropriate for this reason. While it might be a stretch to characterize drug carrying as a “profession,” there are professional roles that involve morally problematic activities and thus the role-based obligations they give rise to are not capable of providing good reasons for action. Arthur Applbaum provided such an example when he investigated the profession of executioner in pre- and post-revolutionary France.<sup>122</sup> While the state executioner was a recognized professional and that role was understood to carry important obligations (to kill the condemned person as painlessly as possible, not to inquire into the justice of the execution itself, etc.), the fact that these role obligations were derived from a professional practice is not sufficient to show that the executioner acts rightly in carrying out these role obligations. The role must be good in itself or serve some important end. The public executioner in an unjust regime fails in both respects.<sup>123</sup> If the reason appealed to derives from professional role, one must not only appeal to the professional role that guides her actions but also provide a defense of the role and of the importance of the particular obligation to the professional role.<sup>124</sup> Clearly a defense of the adversarial system and the lawyer’s role within it is beyond the scope of this Article. Nonetheless, the claim that the lawyer has a good reason not to investigate her client’s story, if she believes it would not be in her client’s interest to do so, is sufficiently plausible to provide support for the argument presented here. In those instances where it is less clear that the lawyer’s professional role allows particular conduct, then the claim that contrived ignorance is not culpable becomes more tenuous. Consider, for example, the controversy surrounding the criminal defense lawyer who gives her client “the speech.”<sup>125</sup> Before eliciting any information from her client,

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<sup>122</sup> See Arthur Isak Applbaum, *Professional Detachment: The Executioner of Paris*, 109 HARV. L. REV. 458, 473-86 (1995). Adopting the role of the executioner Charles-Henri Sanson himself, Applbaum provided the following argument for professional detachment: “But if law is to rule, the executioner must obey a division of labor between his office and the office of the tribunal. To allow personal views about the sentences I execute to interfere with my duty is to substitute arbitrariness for the rule of law.” *Id.* at 476.

<sup>123</sup> I do not attempt to provide a full account of the moral relevance of professional roles here. See *id.*; LUBAN, *infra* note 124. The point here is simply that some roles will fail to provide any justification for acts that would, absent role, clearly be wrong.

<sup>124</sup> See generally DAVID LUBAN, *LAWYERS AND JUSTICE: AN ETHICAL STUDY* (1988), for an account of how one might sketch such an argument.

<sup>125</sup> The controversial nature of the so-called “speech” derives from the fact that the Model Rules seem to require the lawyer to encourage the client to reveal all relevant information. Model Rule 1.6, which requires the lawyer to keep client confidences, is understood to aim at this end. See MODEL RULES OF PROF’L CONDUCT R. 1.6 cmt. (2003) (“The client is thereby encouraged to seek legal assistance and to communicate fully and frankly with the lawyer even as to embarrassing or legally damaging subject matter.”). However, Model Rule 3.3 prohibits the lawyer from putting on evidence at trial that the lawyer “knows” is false. *Id.* R. 3.3(a)(3). But the Rule explicitly allows the lawyer, especially a criminal defense lawyer, to put on testimony that he “reasonably believes is false.” See *id.* (“A lawyer may refuse to offer evidence . . . that the lawyer reasonably believes is false.” (emphasis added)). The

the criminal defense lawyer informs the client that she, as a lawyer, is ethically obligated not to allow the client to testify if she knows that the client will lie. If the lawyer delivers this speech with a wink or other nonverbal indication of its hidden meaning, the client will undoubtedly understand that he is being asked not to tell his lawyer if he plans to lie. Accordingly, the speech looks like quintessential willful blindness—a deliberate attempt to contrive ignorance. The difficult question is whether the lawyer here has a good reason to choose blindness. It is because the answer to this question is not straightforward that giving “the speech” is controversial. According to the view proposed in this Article, willful blindness instructions are inapt in this case if the zealous defense lawyer is right that the lawyer’s role permits her to give the speech and that, if she is right, this conception of the lawyer’s role is itself morally justified. If she is wrong about either of these claims, then the lawyer lacks a good reason for her willful blindness and thus she is equally culpable as the actor who acts knowingly.

The lawyer’s contrived ignorance about the fact that her client’s testimony may be a lie is different from the courier’s contrived ignorance that the pouch he has just been paid a significant amount of money to carry into the country may contain drugs. Distinguishing these two cases is the fact that the lawyer has a good reason to deliberately avoid knowledge while the drug courier does not. The lawyer-client relationship is defined by obligations of trust and loyalty that permit and arguably require a lawyer not to inquire into the truth or falsity of a client’s statement, unless doing so would further the client’s interests. The courier, in contrast, has no such obligations.

This account of when contrived ignorance constitutes culpable blindness explains why cases such as *Jewell* (in which the defendant is paid a sum of money to drive a car into the U.S.) are seen as paradigm cases. In such a case, it is hard to imagine what good reason the driver might have for shielding himself from knowing what the car contains. In *Jewell*, the court vacillated between a subjective reading of this element, like Husak and Callender proposed, and the more objective view endorsed in this Article.<sup>126</sup> First, quoting from Glanville Williams, the court explained:

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importance of the distinction between what the lawyer *knows* and what she *reasonably believes* seems to invite the sort of willful blindness inherent in the so-called “speech.” Moreover, the ethical defensibility of this approach is supported by the fact that some states even allow criminal defense lawyers to put clients on the stand to testify, even when they know such testimony will be false or presented in a narrative fashion. *Id.* R. 3.3 cmt. The fact that the Model Rules acknowledge this practice, *see id.*, demonstrates that as between the duty to encourage client disclosure to the lawyer and the duty to zealously defend the client, the resolution should be struck on the side of zealous representation. After all, loyalty underlies both these duties. The speech, by preserving both loyalty and candor to the tribunal, may represent the best course.

<sup>126</sup> United States v. Jewell, 532 F.2d 697 (9th Cir. 1976) (en banc).

The rule that wilful blindness is equivalent to knowledge is essential, and is found throughout the criminal law. It is, at the same time, an unstable rule, because judges are apt to forget its very limited scope. A court can properly find wilful blindness only where it can almost be said that the defendant actually knew. He suspected the fact; he realised [sic] its probability; but he refrained from obtaining the final confirmation *because he wanted in the event to be able to deny knowledge*. This, and this alone, is wilful blindness. It requires in effect a finding that the defendant *intended to cheat the administration of justice*. Any wider definition would make the doctrine of wilful blindness indistinguishable from the civil doctrine of negligence in not obtaining knowledge.<sup>127</sup>

Williams and the court found it important that a defendant willfully or purposefully avoided knowledge with the intent to “cheat . . . justice.”<sup>128</sup> Yet, later, the court stressed that “[n]o legitimate interest of an accused is prejudiced by such a standard . . . .”<sup>129</sup> The fact that the court emphasized this factor suggests that if a legitimate interest of the defendant were compromised by allowing wilful blindness to substitute for knowledge, then wilful blindness instructions would not be appropriate. If this is indeed the court’s view, then, notwithstanding what the court says, the court would be adopting an objective test for when wilful blindness instructions should be given.

A professional whose role permits or requires blindness often differs significantly with respect to whether he has a legitimate interest that is compromised by holding him responsible for choosing blindness. While cheating justice is not a good reason to choose blindness, complying with morally sound professional obligations is.<sup>130</sup> Moreover, in the case of the lawyer, a “legitimate interest of the accused [i.e., the lawyer] is prejudiced” by not allowing a professional to choose blindness. The lawyer has an important interest in maintaining a professional relationship marked by trust in and loyalty to her clients. The lawyer could be motivated by a desire either to avoid professional discipline or by a desire to comply with her professional role. This motivation does not matter. Rather, the lawyer is distinguished from the courier in the above examples because she acts rightly, even if her motivation is to avoid discipline, because a morally justified conception of her professional role permits and may even require her to avoid investigations that might prove damaging to her client.

Before proceeding, it is important to recognize that where an actor risks great harm in choosing blindness, the justification provided by professional obligations may not be sufficient. Wilful blindness may be morally equivalent to knowledge where the actor’s reason for shielding herself from

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<sup>127</sup> *Id.* at 700 n.7 (emphases added) (quoting GLANVILLE WILLIAMS, CRIMINAL LAW: THE GENERAL PART § 57, at 159 (2d ed. 1961)).

<sup>128</sup> *Id.*

<sup>129</sup> *Id.* at 704.

<sup>130</sup> Note that this factor has been transposed so that it is in objective rather than subjective terms. Evading the law does not justify choosing blindness. It does not matter, however, whether the actor is in fact motivated by that aim.

knowledge is outweighed by the risk she runs of doing a great wrong or causing a significant harm. Thus, there is a limit on the justification that a good reason for blindness may provide. The earlier mentioned case of the Nazi, Albert Speer, demonstrates this point well. One could argue that, as an army officer, Speer had good reasons to trust his superiors and to follow orders without questioning or investigating their actions. Deference to commanding officers is an obligation of a soldier. Recognizing obedience as part of the soldier's professional role, Speer could have argued that his willful blindness was not culpable. But given the nature of his wrongdoing and the harm it caused, this defense would clearly have been inadequate. His professional role provided some shield but not the protection of full armor—given the magnitude of the harm, Speer was culpable for his blindness and could not find protection in his professional role as a soldier.

#### D. *The Friend and the Drug Courier*

William Hurwitz and other pain doctors prosecuted for drug trafficking ground their defense, at least in part, on the fact that they trusted their patients.<sup>131</sup> This argument calls into question the moral relevance of how an actor forms his beliefs and opinions. Unlikely as it may seem under the circumstances of particular cases, some physicians claim they did not believe that their patients were likely to resell the prescribed drugs, even though in hindsight the risk may seem obvious. Some scholars criticize this inferential form of willful blindness, claiming that a failure to draw a seemingly obvious inference cannot constitute willful blindness, which requires at least a suspicion of wrongdoing.<sup>132</sup>

This section begins from the premise that the inferential form of willful blindness is an acceptable variant. The section supplements the main argument of the previous section with a possible additional argument. If an actor is partial or biased, rather than simply incompetent or negligent, in the way he forms his beliefs, then his failure to draw the reasonable inference from a known set of facts is a form of willful blindness. An actor seeking truth may do a poor job of judging the significance of relevant factors, and this is merely incompetence or negligence. But if the actor is not motivated by truth-seeking, this is epistemic partiality.<sup>133</sup> Such bias or partiality may, at times, be justified by professional role or other special relationship. In

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<sup>131</sup> See, e.g., Tierney, *At Trial, Pain Has a Witness*, *supra* note 12 (reporting that Dr. Hurwitz testified that “pain is what the patient says it is”); Tierney, *Trafficker or Healer?*, *supra* note 12 (“When treating people with chronic pain, doctors have to rely on what patients tell them because there is no proven way to diagnose or measure it.”).

<sup>132</sup> See *supra* Part II.A.2.

<sup>133</sup> Epistemology is the study of knowledge. “Epistemic” means related to knowledge; thus “epistemic partiality” is partiality or bias in the search for knowledge.

those cases, it should be judged differently than other deviations from proper epistemic practice. This argument may sound esoteric and surely responds to an already questionable form of willful blindness. However, because this deviant form of willful blindness is used by courts, it is important to explore. Moreover, we would do well to be open to the idea that belief-formation processes ought not to be immune from moral criticism.

William Hurwitz argued that the special relationship between doctors treating pain and their patients should permit doctors to be biased in favor of trusting their patients.<sup>134</sup> If such trust is justified, this is an argument for the moral relevance of belief-formation processes. The doctor argues that his actions are not culpable because he is justified in believing his patients.<sup>135</sup> From this perspective, the issue then is whether his belief-formation process is justified. Compare the case of a courier being paid money to carry a package that he is aware may contain drugs, with a friend carrying a package for another friend and the carrying-friend is aware it may contain drugs. We may well judge the courier to be culpable for bringing the package into the country without checking its contents based on the elements of willful blindness described in the previous section. The carrying friend, however, is likely to be judged differently. Perhaps the situations differ because the former is a business transaction while the latter is an agreement between friends. Helping a friend may provide more reason to risk carrying drugs than does financial gain, but this is a weak argument, especially if there is no special reason why the asking-friend needs the carrying-friend's help. Moreover, if the courier has a family to support, making money may also provide a reason to risk carrying drugs.

Consider the following modified example. Suppose the asking-friend offers to pay the carrying-friend a fee for carrying the package, and the carrying-friend agrees because she needs money. In addition, suppose that the asking-friend tells the carrying-friend that she does not need her to carry the package, and so no demands of friendship press on the carrying-friend to help out a friend in need. Now, neither the courier nor the friend has an obligation to carry the package, and both the courier and the friend do so in order to make money. Should these cases be viewed as morally equivalent? One still might be inclined to judge these cases differently because the carrying-friend had a good reason to see her friend as unlikely to ask her to transport drugs. Here the fact that one is dealing with a friend provides a reason to believe the best of her motives, to discount the possibilities that

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<sup>134</sup> See Dr. William Hurwitz, *The Police State of Medicine: Reflections on a Case of Regulatory Abuse*, Remarks at the Annual Meeting of the Drug Policy Foundation (Oct. 18, 1997) ("A physician must trust that his patient is reporting his circumstances and symptoms accurately."), in 3 *MED. SENTINEL* 131, 133 (1998).

<sup>135</sup> See sources cited *supra* note 131.

cast her actions in a negative light, and to search harder for explanations that show her to be a good person.<sup>136</sup>

The degree of risk perceived by an actor is a decisive factor in evaluating her decision to opt for blindness. For instance, where the doctor believes the risk that his patient will resell drugs is low, less is required to justify his decision to opt for blindness. But this picture is incomplete. Suppose that both the courier and the friend assess the risk that their package contains drugs to be  $x$ , a probability small enough to justify non-investigation of any suspicion. Now suppose that different factors cloud the judgment of each about the level of risk. In the case of the courier, his desire for financial gain inclines him to discount indications that the package contains drugs and to search for alternative explanations for the high carrying payment. Rather than assess the situation with an orientation toward truth, his approach is biased and partial, inclining to see things as permissible unless directly contradicted by the facts. The friend too approaches the situation in a biased fashion; she also is not oriented toward the truth. Friendship clouds her judgment just as the courier's desire to make money clouds his. But there is a moral distinction between the reasons for which the friend and the courier each come to believe the requestor. The epistemic partiality of friendship leads the friend to the (perhaps unreasonable) belief that it is unlikely she is carrying drugs. By contrast, it is the courier's desire to make money that clouds his judgment and leads him to a similarly unreasonable belief. These cases are distinguishable because the friend departs from good epistemic practice for a good reason while the courier does not. Thus, just as the moral justifiability of the reason to choose blindness is relevant in assessing whether willful blindness instructions are appropriate in the traditional case, the moral justifiability of the reason for epistemic partiality is relevant to assessing whether willful blindness instructions are appropriate in the deviant case.

#### E. *Is this Really a Recklessness Account?*

Some scholars have proposed that willful blindness might be reduced to a form of recklessness. While the view proposed in this Article has some similarities to a recklessness account, it differs in an important way.<sup>137</sup> While both recklessness and the account proposed here emphasize objective

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<sup>136</sup> See Simon Keller, *Friendship and Belief*, 33 PHIL. PAPERS 329, 339 (2004) and Sarah Stroud, *Epistemic Partiality in Friendship*, 116 ETHICS 498, 512 (2006), for accounts of friendship and its import for belief-formation processes.

<sup>137</sup> ALEXANDER ET AL., *supra* note 90, at 25, 40-43 (proposing a "unified conception of criminal culpability" that sees all criminal culpability in terms of recklessness and arguing that the best way to think about the drug courier in the willful blindness scenario is as a reckless actor); Robbins, *supra* note 84, at 233 (proposing that deliberate ignorance be treated as recklessness or that drug statutes in particular identify the specific culpable mental state at issue, which he describes as a form of recklessness).

components of the mens rea element, they inject this evaluative standard at different points in the analysis. An actor is reckless according to the MPC “with respect to a material element of an offense when he consciously disregards a substantial and unjustifiable risk that the material element exists or will result from his conduct.”<sup>138</sup> In the account proposed here, an actor is culpably blind with respect to a material element of an offense if he is unjustified in choosing blindness. It is the decision to choose blindness that must be justified rather than the decision to act. Thus, rather than ask if the doctor is reckless in continuing to prescribe drugs to a patient he suspects may be reselling them, we would ask instead whether the doctor is reckless in adopting a posture of deliberate ignorance about his patient’s conduct.<sup>139</sup>

#### F. *The Value of Ignorance*

Deliberate ignorance, in and of itself, is not necessarily a bad thing. For example, the deliberate ignorance of friends towards each others’ faults is to be commended. Indeed, ignorance can be a virtue. Julia Driver argues that the virtues of modesty and “blind charity” both require ignorance—the first of one’s true worth and the second of the faults of others.<sup>140</sup> A person might wonder then if being deliberately ignorant about whether he is doing something that would be prohibited if done knowingly is even prima facie wrong. One possible answer is grounded in recklessness—a person ought not risk doing a prohibited act. But there is no reason to assume that risking doing the deed is wrong just because the law prohibits knowingly doing the deed. The fact that the law prohibits a doctor from writing prescriptions for a patient he knows is reselling drugs does not necessarily mean that a doctor ought not to risk writing prescriptions for a patient who might resell drugs. The legislative choice to prohibit knowing conduct only and not also recklessness may reflect judgments about what makes the conduct wrongful and how best to balance various costs and benefits.

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<sup>138</sup> MODEL PENAL CODE § 2.02(2)(c) (1962). The MPC further provides: “The risk must be of such a nature and degree that, considering the nature and purpose of the actor’s conduct and the circumstances known to him, its disregard involves a gross deviation from the standard of conduct that a law-abiding person would observe in the actor’s situation.” *Id.*

<sup>139</sup> This approach is in line with Paul Robinson’s view on how best to think about instances of creating the conditions of one’s own defense more generally. See Paul H. Robinson, *Causing the Conditions of One’s Own Defense: A Study in the Limits of Theory in Criminal Law Doctrine*, 71 VA. L. REV. 1, 30-36 (1985). For Robinson, however, contrived defenses—such as willful blindness—subject the actor to sanction when the actor contrives the defense with the same mental state required for the underlying offense. *Id.* at 50. On this view, recklessly blinding oneself would not make one culpable for knowingly prescribing drugs to a diverting patient.

<sup>140</sup> Julia Driver, *The Virtues of Ignorance*, 86 J. PHIL. 373, 382 (1989). Driver questions, however, whether these virtues can be adopted deliberately. See *id.*

In most cases where willful blindness instructions are contemplated, the actor has no good reason to choose blindness. Perhaps this is the reason that deliberately maintaining ignorance about whether one is doing an act that would be prohibited if done knowingly seems to be *prima facie* wrong. But the physician-prescribing cases described in this Article, in which courts increasingly allow willful blindness to substitute for knowledge, expose the flaw in that approach. Where a defendant has a morally sound reason to choose ignorance, willful blindness instructions are not appropriate. Sometimes there is value and virtue in choosing ignorance.

### III. DOES THE DOCTOR HAVE A GOOD REASON TO TRUST?

Thus far, this Article has argued that if the doctor is morally justified in trusting his patient, then his willful blindness is not culpable and ought not be treated as the moral or legal equivalent of knowingly prescribing drugs to a diverting patient. This argument rests on the assumption that all doctors, or at least all pain doctors, are morally justified in trusting their patients. The primary goal of this Article is to show that a physician is only culpable for willful blindness regarding the fact that his patient is reselling drugs if the physician lacks a good reason for blindness. This argument exonerates the physicians in the cases discussed in Part I if these doctors have such a reason. This final Part offers several possible ways to defend that claim and presents a preliminary argument for one view about why such blindness is justified.<sup>141</sup>

#### A. *Trust and the Doctor-Patient Relationship*

While trust is indisputably an important component of the doctor-patient relationship, what we usually have in mind is that the doctor must be trustworthy rather than that he must be trusting. The patient must be able to trust her doctor and have confidence that the doctor will keep information about her health confidential and that the doctor will put the patient's interests first, with some modest limitations.

This obligation to be trustworthy is threatened by legal obligations that prohibit willful blindness. For example, a physician who suspects that his patient is diverting drugs might be able to confirm or disconfirm that suspicion by speaking with the patient's family or by consulting with the pharmacist. Family members might know whether the patient is taking the

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<sup>141</sup> There are, however, two important caveats to this argument. First, I do not attempt to address the general question of which reasons justify choosing willful blindness. Rather, this Part simply argues for one particular reason. Second, the argument I present for why a doctor ought to trust his patient's report of pain is itself offered as a preliminary sketch.

medication and the pharmacist could provide information about who calls in and picks up the drugs. But a physician's obligation of confidentiality—even about the fact that the patient is taking drugs—prohibits divulging such information and thus precludes an inquiry to the family. Similarly, obligations of loyalty preclude a physician from questioning the pharmacist in any way that may make it more difficult for a patient to fill her prescriptions.

Alternatively, the physician could try to take actions in his office that would help him to determine whether or not his patient is indeed diverting the prescribed drugs—urine screens, for example. The purpose of a urine screen is to make sure that the patient is taking the prescribed medication. While such a test may not seem overly invasive or damaging to the doctor-patient relationship, much more would be required in order to effectively identify dishonest patients. Those determined to deceive their doctor may bring in another person's urine. An observed urine test might cure this potential problem, but not without significantly undermining the relationship between doctor and patient. One doctor reports that he calls his patients at random times and requires them to report within two hours to a pharmacy for a pill count or to the doctor's office for a urine screen in order to effectively monitor whether the patients are diverting drugs.<sup>142</sup> For patients in pain who may be unable to appear within twenty-four hours at the pharmacy or doctor's office without great hardship, such practices have a significant cost, sacrificing the patient's health and thus compromising the physician's obligation of loyalty to his patient's interests. In so doing, these practices undermine the quality of the doctor-patient relationship.

As an alternative to investigation, a physician could merely terminate his relationship with patients whom he suspects are not honest. In fact, this is the more likely scenario, as most doctors are unlikely to be willing to engage in investigative actions. But if the doctor is not certain that a patient is reselling the drugs, then this action risks terminating a relationship with a patient who might be legitimately in need of pain medication, arguably a gross deviation from his obligation of loyalty to his patient.

#### B. *The Trusting Doctor*

The more controversial conception of the physician's role requires him not merely to be trustworthy but also trusting. It is not clear that this view of the doctor's role, particularly in the context of the pain doctor, is widely

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<sup>142</sup> See Walter A. Brown, *Finessing the Fine Line Between Pain Management and Opioid Addiction*, APPLIED NEUROLOGY, Feb. 1, 2007, at 39, 40.

accepted.<sup>143</sup> On the one hand, a plethora of recent articles and various interest groups have urged medical professionals to trust patients' reports of pain.<sup>144</sup> On the other hand, the fact that pain is so often under-treated indicates that current professional practice has either not accepted or not incorporated this mandate. Sandra Johnson reports, for example, that emergency room physicians often distrust their patients' reports of pain because (1) they see pain as a diagnostic indicator rather than something to be treated; (2) they fear being duped by a patient; and (3) physicians usually have no prior relationship with their patients in an emergency treatment setting.<sup>145</sup> This Article takes the view that doctors treating those who report to be in pain ought to trust their patients. While this argument is preliminary in nature, its purpose is to make plausible the claim that doctors are morally justified in trusting their patients' reports of pain, and this trust thus provides the good reason needed to escape criminal liability for willful blindness to patient diversion of drugs.

Two types of arguments support the proposition that a good physician ought to trust her patients' reports of pain: consequentialist and non-consequentialist. Both offer strong reasons in favor of the claim that physicians ought to trust patients' reports of pain. But because a consequentialist argument is by nature empirical and thus depends on evidence that is beyond the scope of this Article, its discussion is brief. The focus will instead be on the non-consequentialist arguments for the trusting pain doctor.

### 1. Consequentialist Argument

Pain patients often have difficulty finding a physician who is knowledgeable about pain and available treatments.<sup>146</sup> It is also common for pain patients to be doubted and ill-treated by family members, coworkers, and

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<sup>143</sup> In separating what the role is from what it ought to be, I adopt a positivism about roles that follows the account of Arthur Applbaum. See APPLBAUM, *supra* note 28, at 58 (“[A] role simply is what it is, and not what it ought to be.”).

<sup>144</sup> See, e.g., W.A. Rogers, *Is There a Moral Duty for Doctors to Trust Patients?*, 28 J. MED. ETHICS 77, 80 (2002) (“[D]octors should consciously direct their attention towards trusting patients . . .”).

<sup>145</sup> See Sandra H. Johnson, *The Social, Professional, and Legal Framework for the Problem of Pain Management in Emergency Medicine*, 33 J.L. MED. & ETHICS 741, 741 (2005) (“What really appears to be operating is a complex ecosystem that supports ambivalence, denial, and even suspicion of the circumstance of patients in pain and efforts to treat them.”).

<sup>146</sup> See Rosenberg, *supra* note 5, at 51 (“[M]ost doctors have received virtually no training in medical school about managing pain: many hold the same misconceptions about addiction and dosage as the general public.”).

friends.<sup>147</sup> If the doctor to whom a patient finally turns for treatment also treats her with skepticism, the patient may suffer emotionally.<sup>148</sup>

Chronic pain often has no visible or verifiable underlying cause.<sup>149</sup> In such cases, the only way to learn about and thereby diagnose and treat the problem is to listen to the patient's report of pain.<sup>150</sup> What the physician must treat is the patient's pain. Because opioid medications are safe even at high doses, the appropriate level of such medication is the amount needed to alleviate the patient's pain without causing debilitating side effects.<sup>151</sup> Thus, the way to treat a pain patient and to provide the appropriate dosage must be with deference to the patient's report of pain. As William Hurwitz himself argued in a journal article before his arrest, "doctors must rely upon their patients' reports of pain, relief, and side effects, to provide effective treatment."<sup>152</sup>

In fact, using precisely this method of trust, doctors have made advances in the understanding and treatment of pain. Ronald Melzack, who discovered the "gate control theory of pain," also invented a diagnostic method by which pain patients could communicate about their pain more effectively.<sup>153</sup> By listening to the words patients used to describe their pain and grouping them together, Melzack was able to uncover previously unrecognized dimensions of pain.<sup>154</sup> For example, he discovered that words like "flickering," "quivering," "pulsing," "throbbing," and "beating" together represent escalating degrees of the "temporal dimension" of pain.<sup>155</sup> Similarly, by grouping the patients' reports of "hot pain," "burning pain," "scalding pain," and "searing pain," Melzack identified a thermal dimension to pain.<sup>156</sup> Because different pain dimensions or combinations of pain dimensions are characteristic of certain conditions or might respond better to specific therapies, the vocabulary increases the ability of physicians to diagnose and treat pain. It was Melzack's belief in his patients' self-assessment of their pain that enabled him to develop this influential diag-

<sup>147</sup> See *id.* at 52 ("[P]ain patients . . . often have long experience of being treated like criminals or hysterics.").

<sup>148</sup> See Tierney, *At Trial, Pain Has a Witness*, *supra* note 12 (reporting the story of Kathleen Lohrey, one of Dr. Hurwitz's patients).

<sup>149</sup> Tierney, *Trafficker or Healer?*, *supra* note 12 ("When treating people with chronic pain, doctors have to rely on what patients tell them because there is no proven way to diagnose or measure it.").

<sup>150</sup> Rosenberg, *supra* note 5, at 50 ("Pain can be measured only by how patients say they feel . . ."); Tierney, *Trafficker or Healer?*, *supra* note 12 ("When treating people with chronic pain, doctors have to rely on what patients tell them because there is no proven way to diagnose or measure it.").

<sup>151</sup> See Rosenberg, *supra* note 5, at 51 ("All modern pain-management textbooks advocate 'titration to effect'—in other words, in cases where opioids are helping, gradually increasing the dosage until either the pain is acceptably controlled or the side effects begin to outweigh the pain-relief benefits.").

<sup>152</sup> Hurwitz, *supra* note 14, at 14.

<sup>153</sup> RONALD MELZACK & PATRICK D. WALL, *THE CHALLENGE OF PAIN* 62 fig.4 (1982).

<sup>154</sup> See *id.* at 60-61.

<sup>155</sup> *Id.* at 58-59 fig.3.

<sup>156</sup> *Id.*

nostic tool,<sup>157</sup> which highlights again the importance of the trust relationship between doctor and patient in this developing area of medicine.

Consequentialist arguments can also be made for the view that physicians should not trust their patient's report of pain. Perhaps a healthy dose of skepticism will better allow physicians to detect when patients are abusing drugs and thereby help avoid further addiction. Some patients may have psychological problems that lead them to exaggerate their pain. A skeptical physician might be better equipped to identify such patients and help them find psychological treatment. While by no means comprehensive, the above arguments for and against trusting physicians present the type of consequentialist claims that would bear on the question of whether doctors ought to trust their patients' reports of pain.

## 2. Non-Consequentialist Argument

Should doctors acting in their professional capacity trust their patients? The patient—especially one who is in pain—exposes an extreme vulnerability to her doctor. It is a vulnerability born of her suffering, her inability to help herself, her distance from others who doubt her pain, her inability to show others why and how much she suffers, and her distance from the world of healthy people. The appropriate way for the physician to respect the patient's vulnerability is to meet it with trust.

Imagine if the doctor had no obligation to trust her patients. Under these circumstances, the pain patient would be entirely at the physician's mercy and would expose her vulnerability to the doctor under conditions where the doctor may or may not believe her. In light of his patient's extreme pain and vulnerability, the doctor would have a moral obligation to balance the relationship, to some degree. This view comports with one way of understanding the doctor's other, uncontroversial, professional duties. A doctor has obligations of confidentiality and loyalty that arise, at least in part, from the fact that the patient is vulnerable vis-à-vis the doctor. Similarly, a person who holds money for another has fiduciary obligations to invest it wisely and those obligations arise, in part, from the beneficiary's vulnerability. The more vulnerable one party is, the greater the obligations of the other. Moreover, different types of vulnerability call for different ethical obligations from the more powerful party in order to treat the vulnerable party with due respect. The doctor who listens to sensitive information from a patient who becomes vulnerable by the sharing of such information has an obligation to respect that vulnerability by keeping the patient's confidences. The doctor who treats a patient made vulnerable by illness and lack of medical knowledge also owes an obligation of loyalty to the patient,

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<sup>157</sup> See *id.* at 63 (“Because pain is a private, personal experience, it is impossible for us to know precisely what someone else’s pain feels like.”).

often stated in terms of beneficence, to do her best to cure the patient or alleviate her suffering. Similarly, a doctor who listens to a patient's report of pain and sees the vulnerability created by that pain has a duty to trust her patient even when the patient is unable to demonstrate or verify the presence or source of that pain to her doctor. The duties of confidentiality, loyalty, and trust all serve to further the common purpose of putting the patient and the doctor on more even footing, which is required by the duty to treat the patient with respect.

The parent-child relationship provides an apt analogy. Children are extremely vulnerable, as they are unable to care for themselves, depend on the love and support of their parents, and are legally required to stay with the parent except in cases of abuse or neglect. Given the extreme vulnerability of a child, a parent has several obligations. First, a parent must care for the child, providing emotional and financial support. This duty is largely uncontroversial and parallels the physician's obligation to be trustworthy and to use her best efforts to care for the patient's health. But the parent may also have an obligation to believe in the child and to meet her incapacity with faith in her ability to succeed. This too is a form of trust. And just as the good parent should trust in the child's potential to develop into a capable and moral adult, so too should the good physician trust in the veracity of his patient's report of pain.

The physician's obligation to trust her pain patient is certainly not unique. As seen above, other relationships impose similar duties. Friendship is yet another example of a relationship where the duties of belief and trust play an important role. This sort of trust includes both being more likely to believe that a friend is being truthful as well as being more likely to doubt reports that disparage friends and to believe in their capacity to achieve their goals. Lady Randolph Churchill, Winston's Churchill's mother, allegedly quipped: "Treat your friends as you do your pictures, and place them in their best light."<sup>158</sup>

In an important article analyzing the demands of friendship, Sarah Stroud argues that the obligations of friendship not only include doing certain things for friends, such as helping them, standing up for them, and being there to support them.<sup>159</sup> But, according to Stroud, obligations of friendship also require that we form beliefs about our friends in a certain way.<sup>160</sup> First, we process new information about our friends differently than new information about others.<sup>161</sup> When information involves friends, "we tend to devote more energy to defeating or minimizing the impact of unfavorable

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<sup>158</sup> 2 RALPH G. MARTIN, *JENNIE: THE LIFE OF LADY RANDOLPH CHURCHILL: THE DRAMATIC YEARS, 1895-1921*, at 376 (1969).

<sup>159</sup> See Stroud, *supra* note 136, at 503 ("It is commonly accepted that loyalty is one of the constitutive elements of friendship.").

<sup>160</sup> *Id.* at 499.

<sup>161</sup> *Id.* at 504.

data than we otherwise would. . . . [W]e are more liable to scrutinize and to question the evidence being presented than we otherwise would be; we spend more time and energy doing this than we otherwise would.”<sup>162</sup> Second, we are likely to draw different inferences than we would if the information concerned non-friends. In particular, we seriously entertain alternative explanations.<sup>163</sup> Third, when confronted with evidence that shows a friend in a bad light, we look for ways to interpret what we have heard in a way that is more charitable to the friend.<sup>164</sup> According to Stroud, the good friend is an internal “spin doctor”—“the bias of the good friend will normally take the form of casting what she sees or hears in a different light, shading it differently, placing it in a different optic, embedding it in a different overall portrait of her friend.”<sup>165</sup>

Stroud offers this picture of friendship not merely as a descriptive account of how friends in fact act but rather as a normative account of what being a good friend entails. In her view, friendship involves a sort of epistemic partiality similar to the kind discussed in Part II.<sup>166</sup> The obligation of physicians to trust their patients is importantly similar to the epistemic obligations created by other special relationships, such as friendship and parenthood. At his sentencing hearing, William Hurwitz rejected his earlier trusting attitude and suggested that he was morally wrong to adopt the epistemic partiality to patients in pain argued for here.

As I reviewed the records of my care of the patients who exploited my good will, I was appalled at the signs that I missed, at my misplaced trust, and at my predisposition to place the most benign and optimistic construction on the worrisome facts of which I was apprised.<sup>167</sup>

By this point, Hurwitz was a beaten man. He had already been in prison for over two years, had been retried and reconvicted and was awaiting his sentence following reconviction. He had given up his previously strident defense of his trust in his patients, his tendency to “place the most benign and optimistic construction on the worrisome facts.”<sup>168</sup> But should he have? In cases such as Hurwitz’s, the use of the willful blindness instruction threatens the ability of doctors to trust their patients and to have the epistemic partiality of a friend toward the patient in pain. If a good pain doctor trusts his patient’s assessment of her pain, then the use of willful blindness instructions in these cases is truly a miscarriage of justice and an important incursion into good professional practice.

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<sup>162</sup> *Id.* at 505.

<sup>163</sup> *Id.* at 506.

<sup>164</sup> *Id.* at 506-09.

<sup>165</sup> Stroud, *supra* note 136, at 508.

<sup>166</sup> *See supra* Part II.D.

<sup>167</sup> Transcript of Sentencing, *supra* note 4, at 34.

<sup>168</sup> *Id.*

### C. *Objections to Trusting Patients*

Having asserted that a good doctor ought to trust his pain patients, three objections to that claim must now be addressed. First, the obligation to trust may conflict with good epistemic practice, which requires beliefs to be formed with an aim toward discovering truth. Second, trusting pain patients may not be good for patients. In such a case, the ethical obligation to trust will conflict with the physician's obligations to do what is best for her patient. Finally, even if trusting the patient is best for the patient, it may not be good for society if it facilitates easy diversion of dangerous prescription drugs. The following sections discuss each of these three arguments in turn.

#### 1. Epistemic Partiality

In an article exploring the relationship between friendship and belief, Simon Keller highlights the tension he sees between obligations of friendship and more general duties to form true beliefs.<sup>169</sup> Keller uses an episode of the sitcom "Friends" to make his point. Here is the scene, as Keller reports it:

Joey and Chandler are driving from New York to Las Vegas, where Joey has landed an acting job that he hopes will be his big break into show business. They are playing a game, which involves Joey asking questions and Chandler giving immediate, unreflective replies. (Example: Whom would you rather sleep with, Rachel or Monica?) One of Joey's questions is, 'Is this job going to be my big break?', and Chandler, before he can catch himself, answers 'No'. A crisis in the friendship ensues; Joey feels betrayed, and Chandler feels like a betrayer. Joey expels the remorseful Chandler from the car, and drives to Las Vegas alone.<sup>170</sup>

Analyzing this situation, Keller illuminates a dilemma of friendship in that "as Joey's friend . . . Chandler should believe that Joey's big break is imminent, but as an agent who aims to have true beliefs, he should not."<sup>171</sup>

Stroud too sees the epistemic partiality of friendship as creating a real tension with epistemic theories about the proper way to form beliefs.<sup>172</sup> People trying to arrive at true beliefs should treat information about friends no differently than other information.<sup>173</sup> But a good friend should be a spin

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<sup>169</sup> Keller, *supra* note 136, at 329 ("[I]t is not always possible to be both a good friend and a diligent believer.").

<sup>170</sup> *Id.* at 329.

<sup>171</sup> *Id.* at 330.

<sup>172</sup> Stroud, *supra* note 136, at 512 ("[S]tandard epistemological theories would indeed give the good friend's differential epistemic practices an unfavorable rating . . .").

<sup>173</sup> *Id.* at 513 ("[T]hat someone is your friend is not itself a relevant epistemic reason . . . to form different beliefs about him than you would about anyone else.").

doctor, spending time challenging unflattering reports about friends and envisioning alternative explanations.<sup>174</sup> Similarly, a doctor's obligation to trust his pain patient may turn him into a spin doctor of sorts. When the pharmacist calls him to report that she saw the patient handing a package of medication to someone in a parking lot, the pain doctor imagines legitimate reasons for the patient's actions. When his patient tells him she lost her medication, the pain doctor credits that report more than another might be inclined to do. This does not mean the doctor will ignore incontrovertible evidence of a patient diverting drugs or even that cumulative evidence of such conduct cannot convince her of such illegal activity. What it does mean, however, is that it will take more evidence to convince the doctor that his patient is lying or diverting drugs than it would take to convince him that a non-patient is doing so. The pain doctor has a thumb on the scale in favor of interpretations that cast his patient in the best light. In that sense, there is a real conflict between the demands of the doctor's role and the demands of good epistemic practice.

The different interpretation of the friend or doctor is attributable, in part, to the special information possessed by both actors. Knowing her friend better than others do, a person might be right to believe that there is an explanation for what appears to be very bad behavior. The pain specialist also often brings special knowledge to bear that rightly allows him to conclude that behavior, which raises a red flag to others, is actually typical behavior for a patient legitimately in pain and unsuccessful in prior treatment.<sup>175</sup> In fact, specialists in pain medicine use the term "pseudoaddiction" to refer to behaviors that seem to indicate that a patient is addicted to opioid drugs, but which in fact may simply indicate that the patient's pain is not being adequately treated.<sup>176</sup> In part then, the tendencies of both the friend and the doctor to see things differently than others can be justified as good epistemic practice based on special information. However, this account cannot explain away the dilemma altogether.<sup>177</sup> Sometimes the doctor's credulity exceeds the justification provided by his expertise, just as a person's faith in her friend can go beyond what is justified by her special knowledge.

There is thus a genuine conflict between the demands of the ethical role and the requirement that we form beliefs in an epistemologically responsible manner. Stroud is genuinely uncertain about which demand

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<sup>174</sup> *Id.* at 506-09.

<sup>175</sup> SAVAGE ET AL., *supra* note 15.

<sup>176</sup> *Id.* ("[P]atients with unrelieved pain may become focused on obtaining medications, may 'clock watch,' and may otherwise seem inappropriately 'drug seeking.' Even such behaviors as illicit drug use and deception can occur in the patient's effort to obtain relief.")

<sup>177</sup> Stroud agrees in the case of friendship. Stroud, *supra* note 136, at 518 ("I don't think we will be able to mount a complete evidentialist vindication of our differential epistemic practices concerning our friends.").

should take precedence,<sup>178</sup> while Keller believes that in some cases friendship should prevail and in others the search for true belief.<sup>179</sup> In their discussion of this issue, both offer some intriguing ideas that may create a way out of the dilemma in cases where the physician is biased in the manner in which he forms beliefs about his patients. Keller believes that the demands of certain situations require that the agent take care to have true beliefs.<sup>180</sup> For example, when choosing someone for a job from a pool of applicants that includes a friend, having true beliefs about the friend's ability should take precedence.<sup>181</sup> In other situations, however, having true beliefs matters less. For example, Chandler's biased view that Joey's new job will be his big break would be unlikely to cause harm or violate other duties. Where having true beliefs is important, seeking truth should prevail over friendship; but where it is not, the demands of friendship should take precedence.<sup>182</sup> Stroud suggests that adopting a systemic perspective might justify friends having biased beliefs about each other.<sup>183</sup> Intriguingly, she explains this idea by drawing an analogy to the familiar justification for the role of the lawyer in an adversarial system:

Like a defense lawyer, the friend who consistently advocates the more charitable hypothesis serves an important social epistemic function: without her input, negative views (which propagate rapidly through gossip) might become entrenched with little resistance, leading to a decrease in the overall accuracy of the social set of beliefs about her friend.<sup>184</sup>

Combining the insights of Keller and Stroud yields a promising approach. Keller emphasizes that truth-finding must trump friendship when there are important reasons to know the truth. Thus, a doctor should aim at acquiring true beliefs when there is some indication that the patient herself is addicted. Where there is no indication of abuse, the doctor's obligation to care for this patient makes knowing the truth about whether the patient is taking or diverting the drugs less important. In such a case, the demands of the relationship should take precedence over the obligation to form true beliefs. Following Stroud, the doctor could defend this approach by noting that the doctor's role is to care for her patient, not to act as a police officer.

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<sup>178</sup> See *id.* at 518-24 ("I have not advocated any one response to the present predicament over others . . .").

<sup>179</sup> Keller, *supra* note 136, at 346-47.

<sup>180</sup> *Id.* at 347 ("It seems to me that some fairly fine-grained details of the particular cases will matter . . . including the facts about how much the believer values having true beliefs about the subject matter at hand.")

<sup>181</sup> See *id.* at 348.

<sup>182</sup> *Id.* at 347. Keller of course recognizes that we cannot simply decide to believe something. *Id.* However, if we recognize the ways in which friendships incline us to bias, we can try to neutralize that bias by examining our beliefs more closely, asking others for their opinions, etc.

<sup>183</sup> See Stroud, *supra* note 136, at 522-23.

<sup>184</sup> *Id.* at 523.

The investigative function belongs with the DEA or police and not to the doctor.<sup>185</sup>

## 2. Conflict with Loyalty

The obligation of the physician to trust her pain patient clearly has limits. In some situations, the doctor's skepticism can actually benefit the patient. If there are signs that the patient may be abusing the pain drugs, then the physician's duty of loyalty to this patient counsels some skepticism. The physician must balance the harm to the patient caused by drug abuse against his obligation to meet the patient's vulnerability with trust. As these are both duties owed to patients as individuals, the physician must balance these duties in light of the particular facts of the specific case. The patient needs to be trusted and the patient needs to be treated for addiction if she indeed has a drug abuse problem. The doctor's inclination to trust her patient must, therefore, be moderated to take into consideration this possibility of abuse. This scenario fits Keller's category of cases where the actor has important reasons to aim at truth. Where alerted that there is a possibility that the patient may be abusing her medication, the doctor ought to do whatever is in his power to distance himself from his epistemic partiality in order to make a true assessment of whether his patient is abusing drugs.

## 3. Conflict with Public Good

In addition, the physician's obligation to trust is further limited by the obligations she has to the community. Where her role obligations conflict with her general moral obligations, the physician must balance the two duties. While a discussion of how to balance role-based obligations that conflict with general moral obligations is beyond the scope of this Article, it is enough here to note that sometimes the former must give way to the latter.<sup>186</sup> The California Supreme Court's 1976 ruling in *Tarasoff v. Regents of the University of California*<sup>187</sup> can be read as staking out the limits of therapist-patient confidentiality in precisely this way.<sup>188</sup> Where the potential harm to a third party is great, the duty of confidentiality that the therapist

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<sup>185</sup> Interestingly, Hurwitz made this same argument in his *Journal of American Physicians and Surgeons* article in 2003, arguing that "[p]olice should do the policing, doctors should do the doctoring, and professional regulators should develop and review professional standards, while each should cooperate with the others." Hurwitz, *supra* note 14, at 15.

<sup>186</sup> See generally APPLBAUM, *supra* note 28, at 43-110 and LUBAN, *supra* note 124, at 104-47, for a comprehensive account.

<sup>187</sup> 551 P.2d 334 (Cal. 1976), *superseded by statute*, CAL. CIV. CODE § 43.92 (West 2007).

<sup>188</sup> *See id.* at 342-48 (holding that tort liability could be imposed on a therapist for failing to warn a patient's girlfriend that he was planning to kill her).

owes the patient must give way. It is difficult to say what magnitude of potential harm, other than a high likelihood of death, could justify limits on the duties inherent in the doctor-patient relationship. Surely other public policy concerns would and do warrant such incursions into professional duties.<sup>189</sup> But are the harms to society caused by drug diversion great enough to justify invading the doctor's obligations to trust his pain patient?

This question is partially empirical in nature, requiring an assessment of the quantity of harm caused by drug diversion. It is important to note that this question is not about the harm caused by addiction to OxyContin, the most well-known and controversial of the opium-based drugs at issue in these prosecutions, or other opioid drugs. There are other avenues for dealers to get these drugs. Rather, the question asks for a measure of the increase in drug availability due to doctors' trust of pain patients as contrasted with the amount of drugs that would circulate were doctors not to trust their patients. This measure must take into account the fact that even if doctors did not trust their patients, some very crafty pseudo-patients would still fool their doctors and continue to divert drugs. In fact, studies of physicians demonstrate that they are not good at detecting deception by patients.<sup>190</sup> Determining whether directing physicians not to trust patients' report of pain would in fact provide benefits (in terms of curbing drug diversion) that would outweigh its costs (in terms of cutting off access to pain medications for legitimate patients) is a question that is nearly impossible to answer.

Part of the cost analysis would necessarily involve looking at the harms caused by abandoning trust. If doctors adopted a more truth-seeking attitude and thus were more likely to be skeptical, they would probably cut off legitimate patients more often,<sup>191</sup> which itself would cause harm. It is possible that the harms of drug diversion even discounted by the benefits of trust could be so great as to outweigh the doctor's obligation to trust. Nonetheless, given the benefits of trust and the fact that drug diversion is only one source of illicit drugs, this seems unlikely.

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<sup>189</sup> See Ronald Bayer & Amy L. Fairchild, *Surveillance and Privacy*, 290 *SCIENCE* 1898, 1898-99 (2000) (discussing name-based reporting requirements for public health surveillance). Several states have enacted statutes imposing reporting requirements on doctors. See, e.g., Child Abuse and Neglect Reporting Act, CAL. PENAL CODE §§ 11164-11174.3 (West 2000); FLA. STAT. ANN. § 790.24 (West 2007) (requiring health care workers to report gunshot wounds); N.J. STAT. ANN. § 2C:58-8(a) (West 2005) (requiring health care providers to report wounds, burns, or injuries caused by firearms); N.Y. SOC. SERV. LAW §§ 411-28 (McKinney 2003).

<sup>190</sup> In one study, doctors were told that some patients coming to see them were actors (so-called "standardized patients" used in training and evaluating doctors). Beth Jung & Marcus M. Reidenberg, *Physicians Being Deceived*, 8 *PAIN MED.* 433, 434 (2007). When asked to identify which were the standardized patients, physicians were mostly unable to do so. *Id.* at 436 ("[T]he data [show] how easily a doctor can be deceived by a standardized patient into thinking the standardized patient was a bona fide patient.").

<sup>191</sup> *Id.* at 435 ("Patients can get . . . insufficient medical care when the doctor fears deception (disbelieving reports of pain when it exits).").

Because the costs and benefits are nearly impossible to measure objectively, there is also the question of who ought to determine whether the harms of drug diversion outweigh the benefits provided by physicians' trust of patients. The public can decide to impose limitations on professional roles through legislative action. Action through the legislature gives medical professionals a chance to respond and explain the value of maintaining a conception of the professional role, which includes protecting the doctor-patient trust relationship.<sup>192</sup> Independent decisions by prosecutors and judges via their adoption of willful blindness instructions, however, require doctors to depart from traditional understandings of their professional role without providing them with a forum to explain the importance of preserving doctor-patient trust. A criminal trial of an individual doctor is not the place for a full and informed debate of the appropriate contours of the doctor-patient relationship.

#### CONCLUSION

Recent prosecutions of doctors in connection with their prescribing opium-based drugs have allowed juries to convict based on a theory of willful blindness. If the jury finds that the physician was willfully blind to the fact that his patient was diverting drugs, he is guilty of drug trafficking—a serious federal crime, often carrying a lengthy prison sentence. Using willful blindness as a substitute for the knowledge required by the CSA is a serious mistake. Doctors have good reasons to trust their patients with chronic non-malignant pain, as these patients often have no way to demonstrate or verify for their physicians the fact or severity of their pain. The vulnerability that these patients experience, arising from both the pain itself and from their difficulty in communicating it to others, should be met with trust by their physicians.

Doctors who trust their pain patients are thus willfully blind for good reason. This distinguishes them from other willfully blind actors. In assessing whether a willfully blind actor is equally culpable as a knowing actor—and thus whether the substitution of willful blindness for knowledge is justified—we must look at the reasons for this blindness. Where blindness is morally justified, this factor ought to be considered when assessing the actor's culpability for an unwitting misdeed.

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<sup>192</sup> A similar question was raised in connection with the obligations of corporate lawyers to report the misconduct of their corporate clients in the wake of corporate scandals. The result—the Sarbanes-Oxley Act of 2002—imposes very moderate obligations on lawyers. While corporate lawyers have an obligation to report wrongdoing “up the ladder,” they have no obligation to disclose it outside of the corporation itself. See, e.g., Roger C. Cramton et al., *Legal and Ethical Duties of Lawyers after Sarbanes-Oxley*, 49 VILL. L. REV. 725, 740-41 (2004).