SUPREME COURT OF ARIZONA

CVS PHARMACY, INC. and CVS ARIZONA, LLC,

Petitioners,

v.

HON. JANET C. BOSTWICK, Judge of the SUPERIOR COURT OF THE STATE OF ARIZONA, in and for the County of PIMA,

Respondent Judge,

TUCSON MEDICAL CENTER,

Real Party in Interest.

Arizona Supreme Court No. CV-20-0120-PR

Court of Appeals
Division Two
No. 2 CA-SA 20-0012

Pima County
Superior Court
No. C20184991

BRIEF OF AMICI CURIAE KINGMAN HOSPITAL, INC.; ARIZONA SPINE AND JOINT HOSPITAL LLC; BULLHEAD CITY HOSPITAL CORPORATION; CARONDELET ST. JOSEPH'S HOSPITAL; HOLY CROSS HOSPITAL, INC.; HOSPITAL DEVELOPMENT OF WEST PHOENIX, INC.; NORTHWEST HOSPITAL, LLC; OASIS HOSPITAL; ORO VALLEY HOSPITAL, LLC; ORTHOPEDIC AND SURGICAL SPECIALTY COMPANY, LLC; ST. MARY'S HOSPITAL OF TUCSON; VHS ACQUISITION SUBSIDIARY NUMBER 1, INC.; VHS OF ARROWHEAD, INC.; AND YUMA REGIONAL MEDICAL CENTER IN SUPPORT OF REAL PARTY IN INTEREST

(Filed with consent of all parties)

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INTRODUCTION*

The Court should dismiss the petition for review as improvidently granted because CVS misrepresented what could be gained from this Court's early intervention. This case does not present discrete legal questions that can be easily and fully resolved on the existing record. CVS's request thus invites the Court to render an advisory opinion in a legal and evidentiary vacuum. The best course of action is to dismiss review as improvidently granted.

If the Court does reach the merits, it should reject CVS's request to prevent hospitals from recovering in tort for their direct, systemic injuries. The hospitals assert personal and direct harms, not indirect claims for the personal injuries of patients. Moreover, adopting a blanket rule of nonliability for pharmacies, no matter how negligent their conduct, does not serve any community benefit and conflicts with public policy, as reflected in legislative enactments and settled Arizona law recognizing tortfeasors' liability to innocent third parties.

INTEREST OF AMICI CURIAE

Amici curiae are regional hospitals that operate in the State of Arizona, and the plaintiffs in *Kingman Hospital, Inc., et al. v. Purdue Pharma L.P, et al.*, No. S8015CV201900563 (Mohave Cty. Super. Ct.) (referenced at page 4 of CVS's

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* "APP" refers to the appendix to CVS's Petition for Special Action. "PRAPP" refers to the appendix to CVS's Petition for Review. Amici curiae's trial counsel provided the financial resources for preparation of this brief.

supplemental brief). As the healthcare providers on the front lines of the opioid crisis, these hospitals have a strong interest in ensuring that the legal issues in this lawsuit are both well understood and correctly decided.

ARGUMENT

I. This Court should dismiss the petition as improvidently granted because CVS sought review prematurely.

With the benefit of the full record and supplemental briefing, the Court should dismiss the petition for review as improvidently granted. This case does not squarely raise the issues identified for review, does not involve discrete legal issues that will be dispositive in numerous pending cases, and is not (at this stage) a good vehicle for the Court's review.

A. The post-petition briefing shows that CVS misrepresented the issues for review.

The Court relies on the parties to inform it of the issues presented. *See* ARCAP 23(d)(1). Sometimes, however, the issues described do not match the reality of the case. In those circumstances, this Court regularly dismisses or denies review as improvidently granted. *See, e.g.*, *Cullen v. Auto-Owners Ins. Co.*, 218 Ariz. 417, 419, ¶ 5 n.2 (2008) (dismissing review as improvidently granted after concluding upon "further review of the record" that the case did not present the issue); *Valerie M. v. Ariz. Dep't of Econ. Sec.*, 219 Ariz. 331, 334, ¶ 8 (2009) (dismissing review of an issue as improvidently granted "upon further consideration"); *Champlin v. Sargeant*, 192 Ariz. 371, 372, ¶ 1 n.1 (1998) (denying review "as having been improvidently

granted" after "review[ing] the entire record"); *see also* 5 Am. Jur. 2d *Appellate Review* § 347 ("A writ of certiorari will be dismissed as improvidently granted where examination of the case on the merits . . . brings into proper focus a consideration which, although present in the record at the time of the granting of the writ, only later indicates that the grant of certiorari was improvident.").

This is one of those circumstances. Based on CVS's petition, the Court granted review of two issues: (1) "Whether a hospital may assert a direct claim against a third party it contends caused personal injuries to its patient, even if the patient is covered by Medicaid," and (2) "[w]hether a pharmacy that self-distributes prescription opioids to its affiliated pharmacies owes a duty to the hospital." Order re Review at 1. But an examination of the full record and the parties' subsequent supplemental briefing confirms that this case squarely presents neither issue.

Consider the first issue for review. CVS framed the question as: "Whether a hospital may bypass Arizona's lien statute and assert a direct claim against a third party it contends caused personal injuries to its patient, even if the patient is covered by Medicaid." Pet. for Review at 2. But TMC's supplemental brief unequivocally states that it is "*not seeking recovery for the cost of treating Medicaid patients*." TMC Supp. Br. at 3 (emphasis added); *accord id.* at 7 ("TMC is ***not*** seeking the costs of un-reimbursed care provided to Medicaid patients"). In fact, TMC does not seek to recover for the personal injuries of its patients *at all*. (*See* Arg. § II.A, below.)

Consequently, this case does not present the question of "[w]hether a hospital may assert a direct claim against a third party it contends caused personal injuries to its patient, even if the patient is covered by Medicaid." Order re Review at 1.

The supplemental briefs also illustrate why neither issue is ready for this Court's review because the underlying claims and legal theories are still developing. Special-action review is warranted only when "[t]he facts are not contested, and the legal issues can properly be decided on the present record." *Piner v. Super. Ct.*, 192 Ariz. 182, 185, ¶ 10 (1998). Yet CVS's supplemental brief "advise[s] the Court of . . . *new developments* [i.e., post-petition] in this litigation." CVS Supp. Br. at 1 (emphasis added). Specifically, CVS focuses on the hospital's recently disclosed *expert reports*. But neither the hospital's damages calculations nor its nuisance claim are before this Court. *See* Pet. for Review at 15 (referencing nuisance claim in a single sentence, without argument or supporting citations).

CVS's attempt to refashion and expand the issues for review based on recent discovery disclosures underscores that the claims in the case are not yet fully developed. Expert reports should have no bearing on a motion to dismiss, and especially not on an interlocutory appeal taken from the denial of a motion to dismiss. Relying on post-petition expert reports when the case is at the Supreme Court confirms that all of this is premature. If CVS thinks that the expert reports show that TMC has no valid claim, then it should present those arguments to the trial

court at summary judgment, not to this Court in the first instance. A case that requires consideration of expert reports filed *after* the Supreme Court grants review is not one that can be resolved at the pleading stage on an interlocutory appeal.

B. This appeal does not present discrete legal issues that will be dispositive in numerous pending suits.

A bystander reading the two supplemental briefs may question whether they come from the same lawsuit. That disconnect drives home that this case does not involve a discrete issue of law—such as interpretation of a statute—the resolution of which will decide a key issue in multiple pending cases.

Contrary to what CVS told this Court when petitioning for review, the subsequent briefing shows that the issues are neither case-dispositive nor identical across opioid lawsuits. For example, both parties' supplemental briefs acknowledge that answering the "duty" question won't resolve the numerous non-negligence tort claims against CVS. *See* TMC Supp. Br. at 11 n.7 (duty is not an element of intentional torts under Arizona law); CVS Supp. Br. at 8 (conceding that Arizona courts have not held duty to be a formal element of a public nuisance claim). Unlike negligence, hospitals' intentional tort claims "do not require proof of a predicate duty of care." *See Gipson v. Kasey*, 214 Ariz. 141, 144, ¶ 11 n.2 (2007). In other words, there is little to be gained from early intervention in this case. Ruling now will not resolve all the claims against CVS, in this case or others.

Similarly, it is not true that deciding the "direct claims" issue in CVS's favor and excluding all treatment costs associated with Medicaid patients will gut hospitals' recoveries and thus effectively "resolve" these cases. *See* Pet. for Spec. Action at 25 (claiming that the hospital's non-derivative damages "will likely pale in comparison to the unreimbursed health care" damages). Uninsured patients alone accounted for an estimated $7.575 billion in opioid-related healthcare costs in 2018. Soc'y of Actuaries, *Economic Impact of Non-Medical Opioid Use in the U.S.* 9 (2019), https://www.soa.org/globalassets/assets/files/resources/research-report/2019/econ-impact-non-medical-opioid-use.pdf ("Actuaries Rpt.") (table of uninsured healthcare expenses across three patient categories).

Moreover, the legal issues here are still abstract and amorphous because the litigation—in this case and other pending opioid cases in Arizona—is still in its early stages. And unlike cases involving pure legal issues, the tort claims in these cases are inherently fact-bound. *Summerfield v. Super. Ct.*, 144 Ariz. 467, 469 (1985) (accepting special action review to decide whether "person" in wrongful death statute encompassed stillborn fetus); *Blake v. Schwartz*, 202 Ariz. 120, 121, ¶ 7 (App. 2002) (accepting special action review to decide whether statute unconstitutionally imposed mandatory confinement). CVS concedes as much by devoting its entire supplemental brief to new arguments based on additional discovery.

Consequently, CVS's request for review invites an advisory opinion. And given the early stage of the litigation, the Court would be forced to rule without the benefit of a developed record or analysis by a lower court—risking not only an advisory opinion, but an incorrect one. *See League of Ariz. Cities & Towns v. Brewer*, 213 Ariz. 557, 561, ¶¶ 21-22 (2006) (choosing to exercise judicial restraint given prudential concerns about rendering advisory opinions and having to rule based on "only limited briefing by the parties and without a court of appeals decision or a full record").

C. Because CVS sought review prematurely, this case is a bad vehicle for reviewing these important questions.

This case comes before the Court on special-action review of the superior court's denial of a motion to dismiss for failure to state a claim. The superior court has not even issued a definitive ruling. It held only that "TMC has sufficiently shown a public policy-based *potential* duty," PRAPP082-83 (emphasis added), while cautioning that TMC's claims may not have any merit beyond the pleading stage, *id.* ("I find there is enough evidence and enough law to create a duty from the pharmacy to TMC, for purposes of this case and the showing required at a 12(b)(6) level. *This is not my saying that there may be nothing later and no other law and no other facts that could ever come before the Court that would change my decision.*" (emphasis added)). In other words, the superior court is not done with this issue yet.

As the superior court suggested, CVS will have ample opportunities to prevail in full or in part, whether on summary judgment, on a Rule 50 motion for judgment as a matter of law, at trial, or even after trial. If CVS prevails, it may never need this Court's review. If CVS prevails in part, then the superior court could articulate a narrow duty, informed by thorough analysis, that would survive this Court's review. And if CVS ultimately loses, it could seek review from the court of appeals and from this Court, but with the benefit of a fully developed record and multiple rounds of lower-court legal analysis. It makes sense to wait until at least one court has addressed these issues on the merits before this Court takes them up, rather than deciding them in an evidentiary and legal vacuum.

* * *

CVS misled the Court about what could be gained from early intervention in this litigation. It framed the issues as if they could be cleanly resolved on the existing record. After the Court granted review, it dodged the issues as phrased by the Court and instead refashioned them to try to salvage its premature interlocutory appeal. Reviewing this case now carries the risks of all premature decisions, including the risk that the incomplete record may lead to an incorrect result. The parties' supplemental briefing has confirmed that this case is not ripe for review. The best course of action is to dismiss review as improvidently granted. If any issues remain after a ruling on the merits, CVS may seek review via a direct appeal.

II. If the Court does reach the merits, it should affirm the superior court's ruling.

If the Court does reach the merits, it should affirm because CVS's two key contentions—that hospitals are trying to circumvent the medical lien statute by asserting direct claims for patients' personal injuries and that Arizona law does not allow injured third parties to recover in tort absent a prior relationship—are wrong.

A. The wrongful conduct of opioid manufacturers and distributors harms hospitals directly.

Let us be clear: the hospitals suing opioid manufacturers and distributors do not seek to recover for the personal injuries of their patients, whether covered by Medicaid or otherwise.[1] Rather, these hospitals assert distinct injuries that are unique to them as healthcare providers legally required to treat all comers, regardless of their ability to pay. *See* APP740, ¶ 938 ("Defendants' misconduct alleged in this case does not concern a discrete event or a discrete emergency of the sort a hospital would reasonably expect to occur and is not part of the normal and expected costs of a hospital's healthcare services."). These injuries include (1) a systemic increase in treatment expenses across the universe of patients that hospitals are legally

[1] Medicaid beneficiaries are a relatively small portion of the overall patient population in the United States (approximately 20%), and only a small subset of those (approximately 12% of adults) have substance abuse disorders. U.S. Dep't of Health & Human Servs., Office of the Surgeon Gen., *Facing Addiction in America* 6-23 (2016), https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf ("Surgeon Gen. Rpt.").

obligated to treat; and (2) new and increased operational costs precipitated by the opioid crisis.

1. Hospitals are suffering from a statistically significant increase in treatment expenses systemwide.

It costs significantly more to treat patients presenting with opioid use disorders than other patients. The average cost of care for patients with opioid use disorders is *eight times higher* than the average cost for patients without such disorders. APP496, ¶ 37; *see also* Meyer, et al., *Prescription Opioid Abuse: A Literature Review of the Clinical and Economic Burden in the U.S.*, 17 Pop. Health Mgmt. 372, 380 (2014) (documenting "$24,193 in total direct health care costs per [opioid] patient; . . . $3,647 in total direct health care costs per [non-opiod] patient, amounting to a mean annual excess of $20,546 in health care costs for opioid abusers."). And those with chronic medical conditions "incur health care costs two to three times higher when they have a comorbid substance use disorder compared with individuals without this comorbidity." Surgeon Gen. Rpt. at 6-18. Excess health care spending for patients impacted by opioid use disorder between 2015 and 2018 was $205 *billion*. Actuaries Rpt. at 4.

Even setting aside the direct costs of treatment for opioid addiction and overdose, patients with addiction issues visit the emergency room more frequently and stay longer in the hospital. In just six years, emergency department visits related to opioid use increased almost 200%, and inpatient stays increased 64%. APP496,

¶ 36. Even newborns exposed to opioids in the womb "stayed in the hospital an average of 16.9 days, more than eight times the number of days other newborns stay in the hospital (2.1 days)." Surgeon Gen. Rpt. at 6-11. These systemic expenses will continue to increase as the number of people addicted to and dying from opioids continues to balloon. Actuaries Rpt. at 5 (projecting a $5 billion increase year-to-year in opioid-related healthcare costs).

The statistics show that hospitals have been saddled with extraordinary, unanticipated treatment expenses for opioid patients that exceed normal and anticipated treatment costs for non-opioid patients. This systemic burden is unique to healthcare providers who must, as a matter of law, provide care to all comers.

2. The opioid crisis imposes new and increased operating costs on hospitals.

The opioid epidemic has also caused hospitals to incur novel and higher operational costs. These costs include things like hiring substance abuse counselors and additional behavioral health professionals, stocking the emergency drug (Narcan) used to reverse overdoses and drugs used in medical-assisted addiction therapy, hiring additional security, and training healthcare providers and staff on dealing with people with opioid use disorders. *See* APP504, ¶¶ 64-65.

Hospitals must also develop new processes, procedures, and protective measures for dealing with opioid-dependent patients in their care because standard operating procedures create additional risks for addicts who, for example, should not

be prescribed opiates after surgery. *See* APP504, ¶ 64 (describing how surgical procedures on opioid-affected patients are more complicated and costly and require special protective measures and alternative prescription drugs on hand); Ariz. Dep't Health & Safety, *Preventing Overdose from a Hospital Setting* 1 (2017) https://azdhs.gov/documents/audiences/clinicians/clinical-guidelines-recommendations/prescribing-guidelines/hospital-discharge-opioids.pdf ("ADHS Draft Guidelines") (recommending that hospitals offer Narcan to patients at risk of an opioid overdose and increase access to Narcan generally).

This includes developing and implementing training and internal processes to identify, diagnose, and treat individuals with opioid addiction who present at hospitals claiming illness and injury to get more drugs. *See* ADHS Draft Guidelines at 4-6 (advising hospitals to implement and update opioid-related policies and procedures, consider establishing in-patient treatment programs for opioid use disorders, and engage in thorough screening and post-discharge follow-up). Again, these harms uniquely affect hospitals and are entirely independent of any injuries suffered by patients themselves.

3. CVS ignores the aggregate, institutional-level harm caused by systemic opioid diversion.

CVS argues that any injuries hospitals suffered necessarily derive from their patients' personal injuries because hospitals are in the business of treating injuries and illness. Not so. As TMC explained, the harm it alleges flows not from discrete

wrongs in the distribution or dispensing of opioids to a particular patient or set of patients, but rather from the defendants' systemic failures. *See, e.g.*, APP508, ¶ 78 ("Defendants systematically and repeatedly" disregarded their obligation to monitor, report, and prevent improper distribution of highly addictive pharmaceutical drugs).

No other private party suffers from this kind of aggregate, institutional-level harm. Indeed, the opioid industry *depends* on hospitals handling the consequences of an addicted population. APP495-96, ¶ 34 ("Defendants depend on hospitals to mitigate the health consequences of their illegal activities . . ."). CVS thus misses the mark by arguing that the "lien procedure is [a] hospital's exclusive remedy *for recovery of patient debt from a third-party tortfeasor*." Pet. for Review at 8 (emphasis added). The lien statute doesn't apply because these hospitals are not trying to recover patient debt. And contrary to CVS's claims, hospitals would not be made whole "if patients paid for their treatment and education" because the aggregate, systemic injury to the healthcare system from CVS's wrongful conduct exists whether or not individual patients pay in full, *see* CVS Supp. Br. at 3, and whether or not hospitals could recoup increased costs through "hospital facility fees or the like," *see* Pet. for Spec. Action at 26. Fundamentally, it is CVS who should bear the consequences of its wrongful conduct—not hospitals, patients, or insurers.

CVS also attempts to equate the harm from opioids and the harm from tobacco. But the two are not the same. For one thing, the medical problems caused

by tobacco use are much more attenuated than the medical problems caused by opioid abuse. Lung cancer and heart disease from tobacco use take years to develop, but a person can become hooked on opioids in just days.

In addition, the opioid epidemic has significantly impacted hospitals' operational costs in ways that tobacco-related illnesses do not. Tobacco-related illnesses do not require increased security measures and additional emergency response and behavioral health services; opioid-related issues do. *See, e.g.*, APP748, ¶ 978 (additional emergency and security services needed to respond to opioid crisis); APP488, ¶ 12 (TMC had to build new annex to neonatal ICU to treat opioid-dependent newborns). These are costs unique to the opioid epidemic and entirely separate from any patient debt covered by the medical lien statute.

B. Tortfeasors can owe a duty to third parties under Arizona law.

CVS is also wrong that pharmacies cannot owe a duty to third-party hospitals as a matter of law, regardless of the circumstances. A duty of care can arise from either (1) the relationship between the parties or (2) public policy. *Gipson*, 214 Ariz. at 144-46, ¶¶ 18-26. CVS incorrectly conflates the two sources of duty, suggesting that the lack of a direct relationship between hospitals and the defendants prevents recognizing a policy-based duty. But "[u]nlike duties based on special relationships, duties based on public policy do not necessarily require preexisting relationships." *Quiroz v. ALCOA Inc.*, 243 Ariz. 560, 565, ¶ 15 (2018). Indeed, "in a country such

as ours with over 300 million people, duties based on public policy are necessary to govern relationships between people who may be legal 'strangers.'" *Id.* ¶ 16.

Under settled Arizona law, public policy can justify imposing a duty owed to third parties, regardless of any preexisting relationship. In *Ontiveros v. Borak*, 136 Ariz. 500, 508, 512 (1983), for example, this Court rejected the common law rule of nonliability for tavern owners as "both bad law and bad social policy" and instead held that dram shops owe a duty to members of the public who are injured by intoxicated patrons. In doing so, it concluded that a statute making it unlawful to serve alcohol to an already intoxicated patron "was intended partly for the safety of others" and thus reflected a public policy justifying the "recognition of a duty which extends to innocent third parties" in the dram shop context. *Id.* at 508-11. *See also Stanley v. McCarver*, 208 Ariz. 219, 223, ¶14 (2004) (doctor hired by third party to review job candidate's x-rays owed duty to the candidate because "public policy is better served by imposing a duty in such circumstances to help prevent future harm, even in the absence of a traditional doctor-patient relationship").

The Court similarly relied on the public interest in *Grimm v. Arizona Board of Pardons & Paroles*, 115 Ariz. 260, 267-68 (1977), when holding that members of the parole board owed "a duty to individual members of the general public when the Board decides to release on parole a prisoner with a history of violent dangerous conduct toward his or her fellow human beings." It reasoned that "[t]he serious

potential for harm in such situations mandates liability for injury to individual members of the public despite the fact that the duty could also logically be viewed as one owed to the public in general." *Id.* at 267. *See also Estate of Hernandez v. Ariz. Bd. of Regents*, 177 Ariz. 244, 256 (1994) ("as to Plaintiffs *and the public in general*, Defendants had a duty of care to avoid furnishing alcohol to underaged consumers" (emphasis added)).

These cases reflect the fundamental principle that tort law is, at bottom, a reflection of community values. "Duty," after all, is merely "an expression of the sum total of those considerations of policy which lead the law to say that the particular plaintiff is entitled to protection." *Ontiveros*, 136 Ariz. at 508 (citation omitted). Thus, tort law's continued vitality "depends upon its ability to reflect contemporary community values and ethics." *Whetzel v. Jess Fisher Mgmt. Co.*, 282 F.2d 943, 946 (D.C. Cir. 1960) (citing Oliver Wendell Holmes); *Estate of Hernandez*, 177 Ariz. at 254 (Arizona's judiciary "has an obligation to participate in the evolution of tort law so that it may reflect societal and technological changes").

As both the President and the Governor of Arizona have formally declared, the opioid crisis is an unprecedented health emergency. APP494, ¶¶ 27-28. The wrongful conduct of opioid manufacturers and distributors, including CVS, in creating and perpetuating that epidemic creates "serious potential for harm." *Grimm*, 115 Ariz. at 267. Like the epidemic of drunk driving courts faced around the time of

Ontiveros, we now face an epidemic of opioid abuse, addiction, and overdose. In addition to the public policy reflected in relevant statutes, *see* TMC Supp. Br. at 11-20, these changing conditions weigh in favor of holding responsible the actors who created the conditions for the epidemic through misleading marketing and failing to control the distribution of these highly addictive drugs.

For these reasons, CVS is simply wrong when it suggests that it owes no duties to third parties like hospitals.

III. A premature ruling in this case could insulate negligent pharmacies from private suit.

Finally, the Court should either decline review or reject CVS's argument on the merits because CVS cannot justify a "no-duty" rule for pharmacies who negligently distribute opioids.

"[T]he burden of proving a no-duty rule rests squarely on the shoulders of the defendant." *Quiroz*, 243 Ariz. at 578, ¶ 83. To meet that burden, CVS "must convince a court that, in [its] cases, a no-duty rule is justified based on 'general social norms of responsibility' and the 'overall social impact' of imposing such a no-duty rule." *Id.* It cannot, because both factors weigh heavily against a "no-duty" rule for pharmacies that hand out opioids like candy.

CVS is not an innocent bystander who merely self-distributes medications and fills prescriptions to order. Rather, CVS and others in the opioid industry have "operated together as a united entity, working together on multiple fronts, to engage

in the unlawful sale of prescription opioids." APP651-52, ¶ 568. They did so with enormous success, too. "Opioid analgesic pain relievers are now the most prescribed class of medications in the United States, with *more than 289 million* prescriptions written each year." Surgeon Gen. Rpt. at 1-14 (emphasis added). And despite multiple government enforcement actions against it in recent years, CVS has continued its wrongful practices. *See, e.g.*, APP675, ¶ 668 (CVS entered into eight settlement agreements in seven years with the DEA). The additional deterrent effect of a private tort action will thus serve the public benefit.

On the other hand, CVS identifies no public interest or policy that would be served by immunizing pharmacies from responsibility for harm caused by their failure to exercise reasonable care in the distribution of prescription opioids. *See Booth v. State*, 207 Ariz. 61, 69, ¶¶ 22-23 (App. 2004) (declining to adopt rule of nonliability absent "any persuasive public policy reason"). Its "slippery slope" arguments about limitless liability cannot overcome the principle that "no person and no group should be given special privileges to negligently injure others without bearing the consequences of such conduct." *Ontiveros*, 136 Ariz. at 512.

Furthermore, as a practical matter, adopting a no-duty rule could effectively insulate pharmacies from private suit entirely. Although CVS repeatedly asserts that patients have direct causes of action against negligent pharmacies, several courts have barred such actions on the basis of the "wrongful conduct" doctrine, which

prevents a plaintiff from recovering for injuries sustained while engaging in, or as a proximate result of, illegal conduct. *See, e.g.*, *Price v. Purdue Pharma Co.*, 920 So. 2d 479, 481 (Miss. 2006) (barring patient's claims against pharmacy under "wrongful conduct" doctrine). Given that CVS's negligence resulted in systemic opioid diversion and that possession and use of diverted opioids is criminal conduct, the wrongful conduct doctrine may prevent patients from holding defendants like CVS accountable. Combine that with a blanket no-duty rule preventing suits by injured hospitals and other third parties, as CVS would like, and negligent pharmacies would be effectively insulated from private suit.

Finally, the risk of prematurely adopting a no-duty rule is enhanced here because the trial court has not yet conducted any factfinding. The Court should not hold that a pharmacy that negligently distributes opioids never owes a duty of care to third-party hospitals without the benefit of any factual findings regarding either the conduct of these defendants or the conduct of opioid manufacturers and distributors more widely. This is critical because CVS blatantly misrepresents the allegations against it. *See* Pet. for Review at 2 (claiming CVS "did not market" prescription opioids). CVS *is* accused of wrongful opioid marketing, and just last month, CVS's marketing partner (Purdue) pled guilty to federal criminal charges relating to opioid marketing. *See, e.g.*, 2d Am. Compl., *Kingman Hospital, Inc., et al. v. Purdue Pharma L.P, et al.*, No. S8015CV201900563, ¶¶ 634-37 (Mohave Cty.

Super. Ct. Oct. 30, 2020). Thus, the best course of action is to wait for an appeal from a final judgment so that the Court has a fully developed record for consideration.

The Court should therefore decline to reach the issue, or, alternatively, decline to adopt a no-duty rule for pharmacies in this case.

CONCLUSION

The Court should dismiss the petition for review as improvidently granted. Or, in the alternative, it should affirm the decision of the court of appeals, which declined to exercise its special-action jurisdiction.

RESPECTFULLY SUBMITTED this 4th day of November, 2020.

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