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Deserving Life: How Judicial Application of Medical Amnesty Laws Perpetuates Substance Use Stigma

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Deserving Life: How Judicial Application of Medical Amnesty Laws Perpetuates Substance Use Stigma

Scott Koven*

Abstract

To combat the continued devastation wrought by the opioid crisis in the United States, forty-eight states have passed medical amnesty (or "Good Samaritan") laws. These laws provide varying forms of protection from criminal punishment for certain individuals if medical assistance is sought at the scene of an overdose. Thus far, the nascent scholarly conversation on medical amnesty has focused on the types of statutory protections available and the effectiveness of these statutes. To summarize, although medical amnesty laws have helped combat drug overdose, the statutes are replete with arbitrary limitations that cabin their life-saving potential.

This Note extends the dialogue on medical amnesty in two ways. First, it examines how judges, in applying these laws, can either frustrate or promote their life-saving purpose. Second, this Note connects the conversation on medical amnesty laws to the broader context they have entered—namely, the United States' troubled history with the criminalization of addiction.

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Medical amnesty laws reflect a legislative interest in health over punishment. Today, substance use disorder is recognized as a medical, neurological issue and the overdose crisis is recognized as a public health phenomenon. This Note argues that, both in statutory language and judicial application, gaps in the medical amnesty response stray from this reality and instead reflect the stigmatizing, racist normative view promoted during the War on Drugs—that substance use is a moral failing, symptomatic of a lack of personal responsibility. This Note's key point is that, as long as legislators and judges fail to acknowledge, interrogate, and learn from the United States' prior failures in responding to addiction, fatal gaps will continue to exist both in medical amnesty laws and in the broader response to the drug overdose crisis.

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INTRODUCTION

Public health experts consider the current opioid crisis to be "one of the most devastating public health catastrophes of our time."[1] Since 1999, over one million people have died from drug overdose in the United States, with the majority of such deaths involving opioids.[2] An even larger number of overdoses are nonfatal, and those who have suffered an overdose before are far more likely to have another.[3] Further, over the last ten years, synthetic opioids, such as fentanyl, have taken over the illicit drug market and greatly exacerbated the harm.[4]

Historically in the United States, substance use has been treated as a criminal problem, a behavior that is symptomatic of a lack of "personal responsibility."[5] Numerous scholars have examined the origins of this punitive response to substance use, beginning usually with the Reagan-and-Clinton-era War on Drugs and its underlying racial intentionality.[6] As part of a targeted political strategy to garner White voters in the 1980s and 90s, Black and Brown communities have been socially and economically depressed by overincarceration, stemming in large

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1. Karen Feldscher, *What Led to the Opioid Crisis—And How to Fix It*, HARV. T.H. CHAN SCH. OF PUB. HEALTH (Feb. 9, 2022), https://perma.cc/BUP3-G427; *see also* U.S. DEP'T HEALTH & HUM. SERVS., DETERMINATION THAT A PUBLIC HEALTH EMERGENCY EXISTS (Oct. 26, 2017), https://perma.cc/SV3N-XD94 (acknowledging that the opioid epidemic is a "public health emergency" in the United States).

2. *Drug Overdose Deaths*, CNTRS. FOR DISEASE CONTROL & PREVENTION, https://perma.cc/7E79-VWMX (last updated Aug. 22, 2023).

3. *Understanding Drug Overdoses and Deaths*, CNTRS. FOR DISEASE CONTROL & PREVENTION (May 8, 2023), https://perma.cc/SUJ9-ETMM.

4. *See id.* ("Deaths involving synthetic opioids (largely illicitly made fentanyl) and stimulants (such as cocaine and methamphetamine) have increased in recent years."); Mbabazi Karisa et al., *Illicitly Manufactured Fentanyl-Involved Overdose Deaths with Detected Xylazine—United States, January 2019–June 2022*, CNTRS. FOR DISEASE CONTROL & PREVENTION (June 30, 2023), https://perma.cc/9N2R-ZASE ("In 2022, provisional data indicated that more than two thirds (68%) of . . . drug overdose deaths in the United States involved synthetic opioids other than methadone, principally illicitly manufactured fentanyls . . . ."); *see also* DRUG ENF'T ADMIN., FENTANYL-RELATED SUBSTANCES (Jan. 2023), https://perma.cc/3PJQ-7A7A (PDF) (acknowledging 2013 as the year in which synthetic opioids entered the illicit market).

5. *See infra* Part I.A.

6. *See infra* notes 34–36 and accompanying text.

part from the policies of the War on Drugs and the purposeful demonization of crack-cocaine use.[7]

In contrast, the opioid crisis, which White people have died from at higher rates than Black people, has been framed in a completely new light.[8] Politicians of all stripes have acknowledged that the opioid epidemic is, in fact, a "health crisis"[9] requiring a public health response,[10] and the media, in stark contrast to the crack-cocaine epidemic, has portrayed victims of opioid use sympathetically.[11] Despite this shift in rhetoric, the zeal with which the War on Drugs was waged has left legislators and judges locked-in to a largely punitive method of addressing the (belatedly acknowledged) physiological nature of substance use. Further, these criminal laws have been counterproductive in addressing the problem of drug overdose because they deter individuals from seeking medical attention within the narrow window available to apply life-saving treatment.[12]

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7. *See* Connor Maxwell & Danyelle Solomon, *Mass Incarceration, Stress, and Black Infant Mortality*, CNTR. FOR AM. PROGRESS (June 5, 2018), https://perma.cc/7MPU-3W4E (connecting mass incarceration to numerous social stressors, including family instability, unemployment, socioeconomic disadvantage, substance use disorder, and mental health problems).

8. *See infra* Part I.B.

9. *Warren, Cummings, and More Than 95 Colleagues in Senate and House Reintroduce Comprehensive CARE Act to Combat Opioid and Substance Use Epidemic*, ELIZABETH WARREN (May 8, 2019), https://perma.cc/3BDA-RQ76 (statements by Democratic senators).

10. *See* U.S. DEP'T HEALTH & HUM. SERVS., *supra* note 1 (acknowledgment of "public health emergency" by Trump administration).

11. *See infra* note 84. Depicting Whites as the primary victims of the opioid epidemic is nowhere near a comprehensive narrative, as the drug overdose mortality is escalating twice as fast among Black populations than among White populations and eclipsed that of Whites in 2020 and 2021. *See* Center for Health Journalism, *The Next Wave of America's Overdose Crisis*, YOUTUBE, at 0:30 (Jan. 31, 2023), https://perma.cc/KX3L-CW4E; *see also* Merianne Rose Spencer et al., *Drug Overdose Deaths in the United States, 2001–2021*, CNTRS. FOR DISEASE CONTROL & PREVENTION (December 2022), https://perma.cc/KNS2-YJNH.

12. *Facts About an Opioid Overdose*, N.Y. DEP'T OF HEALTH, https://perma.cc/2KKG-KKTP (last updated Nov. 2022) ("[Opioid overdose death] usually occurs 1 to 3 hours after injection, rather than suddenly. Overdose is frequently witnessed by someone who does not recognize the danger or does not want to act on it.").

In response to this problem, nearly all state legislatures have adopted medical amnesty laws ("MALs"), or "Good Samaritan" laws,[13] which offer varying forms of protection from criminal punishment for individuals who in good faith seek medical assistance during an overdose event.[14] In general, MALs have had the effect of reducing drug overdose deaths.[15] But many of these laws have "fatal shortcomings" that inhibit their life-saving potential.[16] A few scholars have examined the ways that many MALs expressly limit *who* may receive protection and the *breadth* of protection available, thereby frustrating the statutes' fundamental purpose of encouraging life-saving treatment.[17] This Note extends that conversation by examining, for the first time, issues arising in the judicial application of MALs.[18] In particular, two issues—(1) whether an amnesty-seeker's *subjective belief* of overdose is sufficient to trigger protection or whether belief of overdose must pass an objective test, and (2) whether the amnesty-seeker must litigate and bear the burden of proving their entitlement to protection—have significant implications for a Good Samaritan or overdose victim's prospects of receiving amnesty.[19] In the same way that many MALs offer a narrow scope of protection, judicially-created standards that require an amnesty-seeker to

13. Although scholars and judges use both names, the term "medical amnesty law" likely best encapsulates the nature of these statutes, as they often provide protection to both the victim and the "Good Samaritan." *See infra* Part II.

14. For an overview of medical amnesty laws in each state, see Amy Lieberman & Corey Davis, *Harm Reduction and Overdose Prevention: 50-State Survey*, NETWORK FOR PUB. HEALTH L. (Dec. 2, 2020), https://perma.cc/YT7R-XWEM (PDF). Today, only Kansas and Wyoming do not have MALs in place. *Id.*

15. *See* Christopher McClellan et al., *Opioid-Overdose Laws Association with Opioid Use and Overdose Mortality*, 86 ADDICTIVE BEHAVS. 90, 93 (2018) ("[A]fter states enacted an overdose Good Samaritan law, they had a 15% lower incidence of opioid-overdose deaths, as compared to when states did not have an overdose Good Samaritan law.").

16. The phrase "fatal shortcomings" is pulled from the title of Nicole Schill's fantastic note, *The Fatal Shortcomings of Our Good Samaritan Overdose Statutes and Proposed Model Statute*, 25 CARDOZO J. EQUAL RTS. & SOC. JUST. 123 (2018), which is examined in Parts II and IV.

17. *See infra* Part II.

18. *See infra* Part III.

19. *See infra* Part III.

extensively litigate their position and prove their entitlement to protection fundamentally frustrate the purpose of medical amnesty by creating hurdles—and thus deterrents—to seeking critical aid.

This Note also extends the conversation on MALs by connecting it to the body of scholarship on the particular and devastating harm drug criminalization and the "personal responsibility" narrative have caused to Black and Brown communities. Several scholars have poignantly observed the stark differences between the framing of the opioid epidemic and the framing of drug epidemics in the past.[20] But this scholarship has, until now, not overlapped with conversations on medical amnesty. Specifically, this Note argues that, although widespread adoption of MALs is an important step in the right direction, legal barriers to accessing medical amnesty, whether through heightened judicial standards or through narrow statutory scope, reflect the racist "personal responsibility" narrative of the War on Drugs by effectively presuming that substance use is a criminal issue.[21] MALs are intended to shift substance use disorder from the criminal and normative realm into the sphere of public health.[22] But just as criminal drug laws assume that someone suffering from substance use disorder is *deserving* of punishment, barriers to accessing MALs—such as requiring an overdose victim to litigate and prove their entitlement to protection—reflect a similar normative judgment that an overdosing individual must *deserve* protection from criminal punishment.[23] Thus, barriers to medical amnesty work in the same, misguided direction as traditional drug laws.

Part I begins by examining the historical and social context into which MALs have entered. Because substance use has historically been treated as a moral issue in the United States, Part I necessarily provides an overview of the criminalization of addiction.[24] It then examines the sudden rise of the opioid crisis

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20. *See infra* Part I.B.

21. *See infra* Part IV.

22. *See infra* note 160 and accompanying text.

23. *See* Schill, *supra* note 16, at 155–56 ("[A] major point of contention surrounding this legislation is the fear that it will be over-inclusive and result in criminal amnesty for those who do not deserve such protection.").

24. *See infra* Part I.A.

and the stark shift in social and political discourse that surrounded it.[25]

Part II relies on other scholarship to introduce the varying structures of medical amnesty laws in the United States. Specifically, it examines how statutory language expressly limits the type of protection available and who is covered.

Part III adds to the existing scholarly dialogue on medical amnesty by discussing the issues of whether an objective or merely subjective belief of overdose is necessary to receive protection and the procedural application of MALs. It introduces these issues through the lens of a recent case that was heard twice by the Court of Appeals of Virginia, *Morris v. Commonwealth*,[26] and it goes on to examine how these issues have played out in various other state proceedings.[27] The discussion in Part III illustrates how judges are capable of limiting access to medical amnesty and frustrating the purpose of these laws.

Finally, Part IV connects the examined hurdles to accessing medical amnesty to the broader context of the criminalization of addiction. It argues that legislatures should remove the statutory construction ambiguities discussed in Part III to create a broad, simple protection, with a view toward repairing the damage wrought by the "personal responsibility" narrative and traditional drug laws.[28] Until then, judges should interpret ambiguities in MALs in light of their purpose and historical context.[29] This Note ultimately advocates for treating medical amnesty as a jurisdictional limitation on a court's power to hear the case, removing the deterrent to Good Samaritans and overdose victims of having to work their way through the judicial system to gain protection.[30]

25. *See infra* Part I.B.

26. 876 S.E.2d 182 (Va. Ct. App. 2022), *rev'd en banc on other grounds*, 886 S.E.2d 722 (Va. Ct. App. 2023).

27. *See infra* Part III.B–C.

28. *See infra* Part IV.B.

29. *See infra* Part IV.A.

30. *See infra* Part IV.B.

I. THE UNITED STATES' TROUBLED HISTORY WITH SUBSTANCE USE

Today, substance use disorder is recognized as a medical, neurological condition.[31] But the federal government and state governments continue to criminalize substance use, including opioids, in the same way they have criminalized drug use since the 1980s.[32] To understand the current legal and public health landscape surrounding opioid use and the significance of medical amnesty laws, it is necessary to examine the larger picture of the criminalization of addiction.

A. *The Criminalization of Addiction*

The acknowledgement of a public health crisis by policymakers[33] is a marked shift from attitudes toward drug addiction in the past. Prior to the current opioid epidemic, there were at least two other drug crises—the heroin epidemic of the late 1960s/1970s and the crack-cocaine epidemic of the 1980s[34]—but legislators responded to each by adopting harshly punitive policies.[35] These harsh drug laws of the late-twentieth century, while nominally applicable to all, were disproportionately aimed at Black and Brown communities.[36]

31. *See Is Addiction Really a Disease?*, IND. UNIV. HEALTH (July 13, 2023), https://perma.cc/X7K6-TTJV ("Alcohol or drug addiction, also known as substance use disorder, is a chronic disease of the brain that can happen to anyone.").

32. *See, e.g.*, 21 U.S.C. § 812 (listing as controlled substances various prescription opioids, fentanyl, and heroin alongside non-opioids such as cocaine and marijuana); VA. CODE ANN. § 54.1-3448 (2023) (listing prescription opioids as Schedule II substances); WIS. STAT. § 961.14 (2023) (listing prescription opioids, fentanyl, and heroin as Schedule I substances).

33. *See* U.S. DEP'T OF HEALTH & HUM. SERVS., *supra* note 1.

34. *See* Keturah James & Ayanna Jordan, *The Opioid Crisis in Black Communities*, 46 J.L. MED. & ETHICS 404, 410–11 (2018) (examining the history of the heroin and crack-cocaine epidemics).

35. *See id.* (detailing harsh sentences, including life imprisonment and mandatory sentences, under the "Rockefeller Laws" and "War on Drugs" in response to the heroin and crack-cocaine epidemics, respectively); *see also* Schill, *supra* note 16, at 128 ("Unlike other diseases, addiction is inherently marked by continual law breaking.").

36. *See* Carl L. Hart, *People Are Dying Because of Ignorance, Not Because of Opioids*, SCI. AM. (Nov. 1, 2017), https://perma.cc/NN72-TJMH (arguing that the heroin crisis played out in similar fashion to the opioid crisis but was

Media representation as well as coded language by policymakers reinforced the idea of drug use as a criminal, Black and Brown problem.[37]

The reasons for this phenomenon stem from the broader political shift that occurred in the United States in the wake of the civil rights movement. Conservatives of the 1960s and 70s sought to carve out a new political majority by appealing to the racial sentiments of White southerners who had become disillusioned with the Democratic party's support of the civil rights movement.[38] As the overtly discriminatory policies of the Jim Crow era began to fade away, conservative political leaders saw an opportunity to point to the poverty and destitution experienced by many Black people in urban communities and blame the Black population itself.[39] Whereas poor Whites were portrayed as hard-working and responsible, Blacks were portrayed as "welfare cheats" who were unable to take responsibility for their actions.[40] The alleged "social pathologies" of poor Black individuals, including drug use and street crime, were portrayed not as the result of poverty, but instead as

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acknowledged as a criminal problem because the "face of the heroin addict" was Black); James & Jordan, *supra* note 34, at 410 ("[C]rack is pharmacologically almost identical to powder cocaine; the purported reasons for the differential treatment of crack cocaine and powder cocaine offenses were actually pretext for creation of sentencing regimes that would target poor, Black communities."); MICHELLE ALEXANDER, THE NEW JIM CROW 123–24 (2020) (observing that, although people of all races use and sell illegal drugs at similar rates, Black and Latinx individuals are incarcerated at grossly disproportionate rates).

37. *See* James & Jordan, *supra* note 34, at 410 (describing mainstream media emphasis in the 1980s/90s of drug use in Black communities through the use of coded language such as "urban," "poor," "ghetto," and "inner cities").

38. *See* ALEXANDER, *supra* note 36, at 56–60 (outlining the "Southern Strategy" and the deliberate use of racial sentiments by the Republican party in the 1960s/70s to galvanize White voters).

39. *See id.* at 57 ("Conservatives argued that poverty was not caused by structural factors related to race and class, but rather by culture—particularly black culture.").

40. *See id.* at 60 (describing the concerted effort by conservative leaders to frame welfare "as a contest between hardworking, blue-collar whites and poor blacks who refused to work"); *see also* Kimberlé Crenshaw, *Race, Reform, and Retrenchment: Transformation and Legitimation in Antidiscrimination Law*, 101 HARV. L. REV. 1331, 1371 (1988) (arguing that historically present "racial characterizations and stereotypes about Blacks" serve to reinforce oppositional images of Whites and Blacks and the Black community as the "Other").

"character failings."[41] Thus, conservatives portrayed Black individuals as undeserving of the help of the state and responsible for any disadvantage they faced.[42] By connecting the notion of undeserved welfare to drug use and crime, conservative political leaders were able to create an enemy at which to direct the criminal justice system and galvanize the political support of Whites.[43]

Sadly, using "personal responsibility" as a proxy for race and as justification for the harshly punitive treatment of drug addiction was a remarkably effective political tool.[44] Politicians across the political spectrum feared coming across as "too soft" on crime.[45] The Clinton administration expressly endorsed the "personal responsibility" narrative by spearheading the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.[46] The Act imposed a permanent ban on welfare for anyone convicted of a felony drug offense, including simple

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41. ALEXANDER, *supra* note 36, at 57 (quoting KATHERINE BECKETT, MAKING CRIME PAY: LAW AND ORDER IN CONTEMPORARY AMERICAN POLITICS 32 (1997)); *see also* Crenshaw, *supra* note 40, at 1372–73 (arguing that the laws of the Jim Crow era led to the association of "normatively positive characteristics" with whites and "subordinate, even aberrational characteristics" with Blacks and that this association persisted after the civil rights movement).

42. *See supra* notes 39–40 and accompanying text.

43. *See There Was No Wave of Compassion When Addicts Were Hooked on Crack*, PBS NEWS HOUR (Mar. 29, 2016), https://perma.cc/RZL5-3JZX

> [Ekow Yankah, Law Professor, Yeshiva University]: African-Americans were cast as pathological. Their plight was evidence of collective moral failure, of welfare mothers and rock-slinging thugs and a reason to cut off all help. Blacks would just have to pull themselves out of the crack epidemic. Until then, the only answer lay in cordoning off the wreckage with militarized policing.

see also James & Jordan, *supra* note 34, at 411 ("There was no talk of medical treatment, or of seeing addiction as a disease [during the crack-cocaine epidemic]; in stark contrast with today's approach.").

44. *See* ALEXANDER, *supra* note 36, at 97 (describing how "Presidents George [H.W.] Bush and Bill Clinton enthusiastically embraced the drug war" and made the transfer of resources to local law enforcement contingent on "the willingness of agencies to prioritize drug-law enforcement").

45. *See id.* at 73 ("By the mid-1990's, no serious alternatives to the War on Drugs and 'get-tough' movement were being entertained in mainstream political discourse.").

46. Pub. L. No. 104-193, 110 Stat. 2105.

possession of marijuana.[47] Thus, not only were substance users viewed as worthy of punishment, according to their elected officials, their purported "character failings" made them unworthy of basic human necessities.

Criminalization and the conflation of addiction with morality have not worked to solve drug use. Since the beginning of the War on Drugs, rates of drug use have remained steady while the carceral system has swelled.[48] Tragically, the continued worsening of the opioid crisis only further showcases the ineffectiveness of drug scheduling laws still on the books today.[49] Additionally, disparities in drug convictions between People of Color and Whites do not mirror the rates of drug use.[50]

Far from accomplishing their nominal goal of "cleaning up the streets," these criminal drug policies have in fact contributed to the social conditions that the racist media narrative highlighted in justifying the War on Drugs.[51] The widespread surveillance and control of drug users—for example, through

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47. *See id.* § 115(a) (disqualifying a person for welfare if convicted of a drug felony).

48. *See* Brian Stauffer, *Every 25 Seconds: The Human Toll of Criminalizing Drug Use in the United States*, HUM. RTS. WATCH (Oct. 12, 2016), https://perma.cc/Z6BJ-G95V ("Rates of drug use fluctuate, but they have not declined significantly since the 'war on drugs' was declared more than four decades ago."); *see also Prison Population Over Time*, THE SENT'G PROJECT, https://perma.cc/4NQ9-V833 (last visited Sept. 1, 2023) (showing massive growth of prison populations since the 1980s).

49. *See supra* note 32 and accompanying text.

50. *See* SUBSTANCE ABUSE & MENTAL HEALTH SERV. ADMIN., RACIAL/ETHNIC DIFFERENCES IN SUBSTANCE USE, SUBSTANCE USE DISORDERS, AND SUBSTANCE USE TREATMENT UTILIZATION AMONG PEOPLE AGED 12 OR OLDER (2015-2019) 13 (2021), https://perma.cc/K8FN-WZG7 (PDF) (finding nearly equivalent rates of drug use among White, Black, and Latinx individuals); *see also* Ricky Camplain et al., *Racial/Ethnic Differences in Drug- and Alcohol-Related Arrest Outcomes in a Southwest County from 2009 to 2018*, 110 AM. J. PUB. HEALTH S85, S91 (2020) ("Black and Latino/Latina individuals have more than 2 times the odds of being convicted and serving time for a felony drug-related arrest compared with White persons.").

51. *See supra* note 37 and accompanying text; *see also* Nkech Taifa, *Race, Mass Incarceration, and the Disastrous War on Drugs*, BRENNAN CTR. FOR JUST. (May 10, 2021), https://perma.cc/Z48T-SMYQ ("With the proliferation of mandatory minimum sentences during the height of the War on Drugs, unnecessarily lengthy prison terms were robotically meted out with callous abandon. . . . Traumatizing sentences that snatched parents from children and loved ones, destabilizing families and communities, became commonplace.").

probation, drug testing at work, or simply having a criminal record—have negatively impacted access to housing, education, income, and employment.[52] These "social determinants," in turn, drive health inequities and disparities.[53] The chain of punishment, socioeconomic disparity, and poor health outcomes functions to create a harmful stigma that denigrates drug users and is counterproductive to getting individuals into treatment.[54]

Fifty years and billions of dollars later,[55] the substance use crisis has only worsened.[56] So, the only way to view the War on Drugs as a success is if one views it either as a political strategy designed to exacerbate racial tension and create a reactive

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52. *See* Aliza Cohen et al., *How the War on Drugs Impacts Social Determinants of Health Beyond the Criminal Legal System*, 54 ANNALS MED. 2024, 2026–28 (2022) (examining how compulsory drug testing, background checks, and zero-tolerance policies, among other things, lead to negative outcomes in listed socioeconomic areas).

53. *See id.* at 2024 ("There is a growing recognition in the fields of public health and medicine that [social determinants of health] play a key role in driving health inequities and disparities . . . ."); Feldscher, *supra* note 1 ("In addition to the crushing public health burden of preventable deaths, millions more are affected by related problems involving homelessness, joblessness, truancy, and family disruption, for example."); Mariya Denisenko, Note, *The Impact of Government Sponsored Segregation on Health Inequities: Addressing Death Gaps Through Reparations*, 80 WASH. & LEE L. REV. 1687, 1715–22 (2023) (examining the connection between socioeconomic inequality and health disparities faced by Black Americans).

54. *See* Nora Volkow, *Addressing the Stigma that Surrounds Addiction*, NAT'L INST. ON DRUG ABUSE (Apr. 22, 2020), https://perma.cc/U7EG-XZRX

> People with addiction continue to be blamed for their disease. Even though medicine long ago reached a consensus that addiction is a complex brain disorder with behavioral components, the public and even many in healthcare and the justice system continue to view it as a result of moral weakness and flawed character. . . . People with addiction internalize this stigma, feeling shame and refusing to seek treatment as a result.

Dr. Volkow, who heads the National Institute on Drug Abuse, went on to recount a personal experience she had providing care to a man at an injection site: "His leg was severely infected, and I urged him to visit an emergency room—but he refused. He had been treated horribly on previous occasions, so preferred risking his life, or probable amputation, to the prospect of repeating his humiliation." *Id.*

55. *See Drug War Stats*, DRUG POL'Y ALLIANCE, https://perma.cc/YA3E-DGTN (last visited Sept. 1, 2023) ("$47 billion is the estimated cost to enforce drug prohibition in the U.S. every year.").

56. *See infra* Part I.B.

response by White voters[57] or as an effort to punish without fixing the underlying issue. Today, we remain bound by these harsh criminal laws and expansive law enforcement systems designed to funnel more and more people who suffer from substance use into the criminal justice system. Yet, since the start of the opioid epidemic, we have also seen recognition that addiction is a public health issue. What explains this shift in rhetoric, and what impact has it had on policymakers?

B. *A Crisis for Me but Not for Thee*

The opioid crisis began in 1996, when Purdue Pharma's opioid painkiller, OxyContin, entered the market with the Food and Drug Administration having approved a label stating that addiction was "very rare."[58] Throughout the late 1990s, Purdue Pharma aggressively promoted "the use of opioids generally and OxyContin in particular" to health care providers.[59] OxyContin proved to be extremely addictive; widespread use, caused in large part by Purdue's aggressive campaigning, resulted in a wave of addiction-related deaths.[60] Concurrently, the illicit heroin market expanded to attract those newly addicted to legal prescription opioids, resulting in a second wave of drug-related deaths.[61] In recent years, the introduction of synthetic opioids, particularly fentanyl, into illicit drug markets has further exacerbated the harm.[62] Synthetic opioids are often used in

57. *See supra* notes 43–44 and accompanying text.

58. *See* Art Van Zee, *The Promotion and Marketing of OxyContin: Commercial Triumph, Public Health Tragedy*, 99 AM. J. PUB. HEALTH 221, 221, 224 (2009) (overviewing OxyContin promotion beginning in 1996 and FDA approval of its label); *see also* Feldscher, *supra* note 1 (marking the proliferation of OxyContin as the point at which the opioid crisis began).

59. Van Zee, *supra* note 58, at 221.

60. *See* Feldscher, *supra* note 1. Purdue Pharma was later shown to have fraudulently misrepresented OxyContin's addictiveness. *See* Van Zee, *supra* note 58, at 223 ("A consistent feature in the promotion and marketing of OxyContin was a systematic effort to minimize the risk of addiction in the use of opioids for the treatment of chronic non-cancer-related pain.").

61. Feldscher, *supra* note 1.

62. *See* Spencer et al., *supra* note 11 (showing an exponential increase in deaths involving synthetic opioids since 2013 and that a majority of overdose deaths have involved synthetic opioids); *see also* DRUG ENF'T ADMIN., *supra* note 4 (pointing to 2013 as the year in which synthetic opioids entered the illicit market).

combination with other substances, and they have proven especially deadly.[63]

This startling rise in drug overdose deaths has continued to increase exponentially.[64] As a result, since 1999, over one million people have died from drug overdose in the United States, with the majority of such deaths involving opioids.[65] In 2022, approximately 107,081 people died from drug overdose with an estimated two-thirds involving the use of opioids.[66] Critically, an even larger number of overdoses are nonfatal, and those who have suffered an overdose before are far more likely to have another.[67]

The undeniable nature of this crisis, medical consensus on the physiological nature of substance use,[68] and, as discussed below, a change in who is depicted as the victim of this epidemic[69] have prompted a heretofore unseen response by policymakers of all political affiliations—sympathy. In October of 2018, Congress overwhelmingly passed the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment ("SUPPORT") for Patients and Communities Act[70] across partisan lines, which authorized over $3.3 billion in spending to combat the epidemic over ten years.[71] Numerous

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63. *See Fentanyl Facts*, CNTRS. FOR DISEASE CONTROL & PREVENTION (June 27, 2023), https://perma.cc/4ASB-73DH.

64. Spencer et al., *supra* note 11.

65. *Understanding Drug Overdoses and Deaths*, *supra* note 3.

66. Karisa et al., *supra* note 4.

67. *Understanding Drug Overdoses and Deaths*, *supra* note 3.

68. *See* Volkow, *supra* note 54 ("[M]edicine long ago reached a consensus that addiction is a complex brain disorder with behavioral components.").

69. *See infra* note 84 and accompanying text.

70. Pub. L. No. 115-271, 132 Stat. 3894 (2018).

71. *See* Bill Wynne & Dawn Joyce, *The 660-Page Opioids Bill Is Now the Law. Here's What's in It.*, CAL. HEALTH CARE FOUND. (Nov. 1, 2018), https://perma.cc/4VVZ-THPP (reporting votes of 396-14 in the House and 98-1 in the Senate). Notably, whereas the Republican party of the 1980s spearheaded the push to criminalize addiction, today, many Republican leaders openly talk about personal experiences they have had with suffering people and make the opioid crisis a policy talking point. *See* German Lopez, *When a Drug Epidemic's Victims Are White*, VOX (Apr. 4, 2017), https://perma.cc/FVY3-XH5W (noting instances of Chris Christie, Carly Fiorina, Jeb Bush, and Donald Trump sympathizing with family and friends who suffered from substance use disorder). Still, "personal responsibility" rhetoric in conversations on substance use is hardly absent from political

state legislatures have passed laws providing immunity to persons who administer naloxone, a life-saving drug that can counteract overdose.[72] The subject of this Note, medical amnesty laws, is another obvious example of policymakers emphasizing public health rather than punishment.

Although direct action by legislators seeking to counter overdose deaths is a positive shift, such action begs the question: In light of the harshly criminal response to substance use in the past, why now? What has changed?

A partial explanation is that the opioid crisis is devastating, and the public health community has worked to right the ship away from treating substance use as a moral failing and toward treating it as a medical disorder.[73] While undoubtedly true, this explanation is incomplete because it fails to contemplate that the original response could just as easily have been grounded in public health.[74] The criminal response to addiction originated from, at best, a misguided, racially-undergirded normative view that drug use was the result of character failings, and, at worst, from a desire to galvanize negative racial sentiments into voting

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discourse. Many conservative leaders continue to use messaging evocative of the War on Drugs, treating substance use disorder as a proxy for moral failings and a perceived breakdown in "law-and-order." *See* Lester Duhé, *Sen. Kennedy Suggests Critics of Police "Call a Crackhead" in New Ad; Some Think Line Goes Too Far*, WAFB CHANNEL 9 (Oct. 3, 2022), https://perma.cc/SY67-53U3 (reporting on a television ad Louisiana Republican John Kennedy released in which he stated, "if you hate cops . . . next time you're in trouble, call a crackhead" despite high overdose rates in the Greater Baton Rouge area); Brian Mann, *In Close Races, Republicans Attack Democrats over Fentanyl and the Overdose Crisis*, NPR (Oct. 27, 2022), https://perma.cc/DU3F-N5WE (describing Republicans' recent rhetorical shift away from public health and toward increasingly partisan attacks against Democrats by "linking fentanyl deaths with rising crime and fears about border security").

72. *See* Kelsey Bissonnette, Note, *Anti-Death Legislation: Fighting Overdose Mortality from a Public Health Perspective*, 23 TEMP. POL. & CIV. RTS. L. REV. 451, 470 (2014) (displaying types of immunities).

73. *See* Feldscher, *supra* note 1 (discussing the relationship between the public health community and the criminal justice system); Cohen et al., *supra* note 52, at 2031 (arguing for the need to "extract the drug war from our substance use treatment system").

74. *Cf.* Rick Jones, *From the President: Crack, Opioids, and the Modest Reparation of Clemency*, NAT'L ASS'N OF CRIM. DEF. LAWS. (Nov. 2017), https://perma.cc/4LXJ-JMUP ("As we profess to have adopted a more compassionate response to the latest substance abuse epidemic, we must ensure that we continue to correct the disparities created by the mistakes of our past.").

power.[75] After all, White and Black populations have always used substances at similar rates[76]—the disparity in incarceration was (and is) the result of targeted enforcement tactics.[77] If this is not the first substance use crisis we have experienced,[78] why has the public rhetoric shifted so dramatically?

In addition to the particularly devastating harm caused by opioids,[79] the answer to that question and the explanation for newfound policymaker sympathy lies in another key distinction: the face of the opioid victim is a different color. Between 1999 and 2015, White people died at far higher rates than Black people from opioid overdose while the total number of deaths has continually increased.[80] As one scholar put the issue:

> Substance use disorders and addictions have been a problem plaguing American society for decades. The problem did not become a "crisis," however, until it increasingly affected white people (some of whom were middle class or affluent) who were becoming addicted to a particular class of drugs and dying as a result.[81]

Any loss of life to substance use is obviously and undoubtedly tragic. But aware observers recognize that no such concern was afforded to Black communities during the crack-cocaine epidemic.[82] In the 1980s and 90s, during the War

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75. *See supra* Part I.A.

76. *See supra* note 50 and accompanying text.

77. *See* James & Jordan, *supra* note 34, at 410 ("Law enforcement resources were concentrated in communities of color [during the crack-cocaine epidemic], executing policies like 'stop and frisk' and resulting in increased arrests of Black people."); Camplain et al., *supra* note 50, at S85 ("The War on Drugs has been credited with creating policies that significantly contribute to racial/ethnic and socioeconomic disparities in drug arrests, further embedding racial/ethnic disparities within the criminal justice system.").

78. *See* James & Jordan, *supra* note 34, at 405 ("To say . . . that today's opioid crisis is the likes of which we've never seen before, is only a half-truth. While opioid abuse has undeniably skyrocketed to never-before-seen levels, creating the largest drug epidemic in recorded history, the current crisis is not unprecedented.").

79. *See supra* note 1 and accompanying text.

80. James & Jordan, *supra* note 34, at 406.

81. Mary Crossley, *Opioids and Converging Interests*, 49 SETON HALL L. REV. 1019, 1035 (2019).

82. *See supra* notes 39–41 and accompanying text.

on Drugs, the media perpetuated the "personal responsibility" narrative, thereby creating an oppositional dichotomy between the morality of Whites and Blacks.[83] Media imagery today fleshes out this same oppositional, racially coded message in the opposite direction—it provides a softer, sympathetic, and nuanced depiction of Whites as the primary victims of the opioid crisis.[84]

Conspicuously absent from discourse is a recognition both that substance use has devastated Black communities for decades and that Black people are victims of the opioid crisis as well. In fact, overdose deaths are accelerating twice as fast among Black people than among White people,[85] and, in 2020 and 2021, overdose death rates among American Indian or Alaska Native and Black individuals exceeded that of Whites.[86] Thus, dialogue that decries the opioid crisis through the lens of harm to White people "erases both the past and present experiences of Black people"[87] and other marginalized populations. In so doing, it perpetuates the same oppositional dichotomy surrounding substance use that has always existed in social and political discourse: White people are deserving of help, while Black and Brown people are deserving of punishment.

To be clear, unlike the War on Drugs, which worked affirmatively to strip the rights of those who used substances, the actions taken by legislatures during the opioid epidemic to recognize substance use as a public health issue are a welcome

83. *See supra* note 40 and accompanying text.

84. *See, e.g.*, Michael Shaw, *Photos Reveal Media's Softer Tone on Opioid Crisis*, COLUM. JOURNALISM REV. (July 26, 2017), https://perma.cc/CM7Z-6FTQ (contrasting media images of Black individuals during drug busts with White individuals surrounded by family or emotional support); Charisa Smith, *From Empathy Gap to Reparations: An Analysis of Caregiving, Criminalization, and Family Empowerment*, 90 FORDHAM L. REV. 2621, 2627 (2022) ("Documentaries, television dramas, print media, and educational sources alike propagate dominant, familiar themes and characters such as 'Big Pharma . . . pill mills' and 'Hillbilly Heroin,' as 'gaunt teenagers' (who are white) move 'from Percocet to the needle.'"); James & Jordan, *supra* note 34, at 412 (illustrating media disparity by reference to headlines such as "In Heroin Crisis, White Families Seek Gentler War on Drugs," "A caring lens on the opioid crisis," and "The Addicts Next Door").

85. *See supra* note 11.

86. Spencer et al., *supra* note 11.

87. James & Jordan, *supra* note 34, at 405.

shift. But just as the expansion of criminalization during the crack-cocaine epidemic was facially neutral while targeting specific populations,[88] the steps taken by politicians toward treating substance use as a public health matter are also facially neutral while targeting White people as the primary victims. By failing to give a voice to those most affected by the criminal drug policies of the past, policymakers leave room for gaps in their current response.

This is particularly true in light of the fact these drug laws are still alive, expansive, and operating in full force today.[89] As much as policymakers and media express sympathy for those suffering from substance use disorder, the reality is that our society still treats these individuals as criminals who *deserve* to be punished (i.e., lack "personal responsibility"). As explained, this punishment is not distributed equally,[90] and criminal policies actually *prevent* individuals from getting the help they need by creating a debilitating stigma.[91] Thus, a truly equitable solution to substance use requires not only a rhetorical shift and an expansion of treatment, which currently contemplates a primarily White victim, but also a recognition and dismantling of the counterproductive system of drug criminalization.

Medical amnesty laws exemplify the shift from the traditionally punitive response to substance use to the desire to save lives. MALs offer varying forms of protection from punishment for individuals who seek emergency medical assistance during an overdose event.[92] They thus clearly reflect a policy determination that individuals at the scene of an overdose should seek medical aid rather than fear punishment.[93] Yet, often judicial application or complex statutory structures either create confusion or directly cut out individuals from the scope of applicability, deterring individuals

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88. *See supra* note 77 and accompanying text.

89. *See supra* note 32 and accompanying text.

90. *See supra* note 50 and accompanying text.

91. *See supra* note 54 and accompanying text; *see also* Schill, *supra* note 16, at 131 (describing how stigmatization "leads addicts to avoid treatment . . . while at the same time causing society to dismiss their lives as unworthy of saving").

92. *See infra* Part II.

93. *See infra* note 160 and accompanying text.

from seeking help.[94] As the remainder of this Note examines, every express or judicially created limitation on MALs keeps criminal law rooted in the failed, racist "personal responsibility" approach to substance use and devalues the lives of those suffering from substance use disorder.

II. TYPES OF MEDICAL AMNESTY STATUTES AND LIMITATIONS

Individuals seeking medical amnesty protection face two fundamental hurdles: (1) the statute's structure, meaning their jurisdiction's MAL must cover the amnesty-seeker's situation, and (2) judicial application, meaning the issues that come up if someone must litigate the MALs applicability. Both facets have the potential to deter an individual encountering an overdose event from seeking aid. Part II addresses the first issue, and it relies on the works of several other scholars who have already examined it, namely, *The Fatal Shortcomings of Our Good Samaritan Overdose Statutes and Proposed Model Statute*,[95] by Nicole Schill, and *State-By-State Examination of Overdose Medical Amnesty Laws*,[96] by Thomas Griner, Sheryl Strasser, Catherine Kemp, and Heather Zesiger (hereinafter "Griner"). These pieces primarily address the *type* of protections that the statutes' offer and *who* is covered.

Recall that MALs offer protection from criminal punishment to certain people for certain crimes if medical assistance is sought during an overdose event.[97] The purpose of

94. *Cf.* Samantha Kopf, *Slaying the Dragon: How the Law Can Help Rehab a Country in Crisis*, 35 PACE L. REV. 739, 741 (2014) ("[T]he effort to reduce drug overdose deaths must include the elimination of counterproductive criminal laws that discourage not-completely-innocent bystanders, concerned with their own penal interests, from calling emergency services."); Justin Peters, *When Junkies Deserve a Pass*, SLATE (Aug. 18, 2015), https://perma.cc/DD3X-TXAQ ("In theory, the threat of incarceration is supposed to deter people from using and selling drugs. In practice, it often deters users from seeking treatment or medical assistance for fear of punishment.").

95. Schill, *supra* note 16.

96. Thomas E. Griner et al., *State-By-State Examination of Overdose Medical Amnesty Laws*, 40 J. LEGAL MED. 171 (2020).

97. *See* Schill, *supra* note 16, at 126 ("Good Samaritan Overdose Laws . . . are legislative attempts to solve [overdose fatalities] by granting amnesty from criminal liability for those who summon authorities to the scene of an overdose.").

these laws is to reduce the number of overdose deaths by incentivizing those using substances to call 911.[98] Forty-eight states (all except Wyoming and Kansas) have passed some type of protective law.[99]

As an initial matter, MALs vary with respect to which individuals present at an overdose scene are entitled to protection. Many offer protection to both the bystanders and the victim,[100] but some limit the scope of protection to only the aid-seeker.[101] The issue arising in states that do not protect the victim is the risk that "[t]his lack of immunity . . . may discourage overdose bystanders from contacting authorities, especially if the overdose victim is a friend or loved one," for fear of the substance user being prosecuted.[102] And these MALs nonsensically provide a disincentive for someone experiencing an overdose to seek aid for themselves.

Current MALs also limit the types of crimes to which protection is applicable. Virtually all offer protection for possession and use of a controlled substance.[103] But Schill outlines several problematic examples of MALs that exclude crimes, including West Virginia's, which does not provide protection for any paraphernalia offenses,[104] and Nevada's, which does not provide protection for possession of hypodermic syringes, an extremely common form of injection for opioid users.[105] Schill also notes that most states exclude crimes of

98. *See, e.g.*, ARK. CODE ANN. § 20-13-1702 (2023) ("The State of Arkansas must take steps to combat the increase of drug overdoses in the state and protect the health and safety of its citizens.").

99. *See generally* Lieberman & Davis, *supra* note 14 (outlining protections offered in each state).

100. *See, e.g.*, VA. CODE ANN. § 18.2-251.03(B)(1) (2023) (protecting both overdose victim and aid-seeker); HAW. REV. STAT. ANN. § 329-43.6 (2022) (providing protection to victim, aid-seeker, or an individual "assisting" an aid-seeker).

101. *See, e.g.*, ALA. CODE § 20-2-281(a) (2015) (protecting only an individual "seeking medical assistance for another individual"); OKLA. STA. tit. 63, § 2-413.1 (2023) (protecting a "peace officer" who seeks aid but not an overdose victim).

102. Griner et al., *supra* note 96, at 180.

103. *See generally* Lieberman & Davis, *supra* note 14 (outlining protections offered in each state).

104. W. VA. CODE § 16-47-4 (2022).

105. NEV. REV. STAT. § 453.554(2)(a) (2022) ("The term ['drug paraphernalia'] does not include . . . [a]ny type of hypodermic syringe, needle,

distribution, and she further argues that "by exempting crimes relating to dealing, sharing, and supplying drugs, these Good Samaritan Overdose Statutes are excluding from their protection the exact people who should receive it, those likely to be in the company of [substance users] during the time of the overdose."[106]

With respect to the type of legal protections offered, there are three basic forms: mitigating factor at sentencing, affirmative defense during a prosecution, and immunity from prosecution, arrest, and/or charge.[107] A mitigating factor is by definition not amnesty because it only operates in the context of post-conviction sentencing.[108] Most states offer this type of protection at sentencing *in addition* to another form of amnesty earlier on in the criminal process.[109] Only Indiana appears to offer a mitigating factor without any other form of protection.[110] Thus, in Indiana, the amount of protection from punishment, if any, is left completely up to the discretion of the judge imposing the sentence.[111] Given the uncertainty of whether a judge would choose to consider this factor, and given that a person has already been arrested, charged, prosecuted, and convicted by

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instrument, device or implement intended or capable of being adapted for the purpose of administering drugs by subcutaneous, intramuscular or intravenous injection . . . ."); *cf.* Shuey v. State, No. 0117, 2016 WL 3613391, at *6 (Md. Ct. Spec. App. July 6, 2016) (reasoning that failing to include hypodermic syringes in the definition of "drug paraphernalia" would "lead[] to an absurd result" given the legislative purpose).

106. Schill, *supra* note 16, at 146.

107. *Id.* at 138–39.

108. *Id.* at 139.

109. *See* Lieberman & Davis, *supra* note 14.

110. *See* Schill, *supra* note 16, at 139; IND. CODE ANN. § 35-38-1-7.1(b)(12) (2019)

> The court may consider the following factors as mitigating circumstances . . . [t]he person was convicted of a crime relating to a controlled substance and the person's arrest or prosecution was facilitated in part because the person: (A) requested emergency medical assistance; or (B) acted in concert with another person who requested emergency medical assistance . . . .

111. *See* Schill, *supra* note 16, at 140 ("[S]ince Indiana's statute reads '[t]he court *may* consider' it as a mitigating factor, it leaves open the possibility that the sentencer has the option to disregard as inconsequential that the defendant is only in trouble as a result of calling 911." (emphasis added) (quoting IND. CODE ANN. § 35-38-1-7.1(b))).

the time it is available, it is unlikely that this type of protection in and of itself creates an incentive for an individual to seek medical help during an overdose.[112]

The first type of protection that offers true amnesty from criminal punishment is affirmative defense.[113] As Schill points out, however, "an affirmative defense has its own weaknesses."[114] Utah and Texas are examples of states that expressly limit their MALs to this form of protection,[115] but, as discussed later in Part III, many states functionally treat immunity from arrest or prosecution as an affirmative defense.[116] Utah and states that function similarly do not protect individuals from being arrested or charged, meaning they are treated as criminal defendants until they raise the issue through litigation.[117] The bystander or overdose victim, must admit guilt to the underlying offense and hope that they are able to prove their entitlement to protection, likely weeks or months after the incident.[118] Thus, although a medical amnesty affirmative defense offers more of an incentive to seek medical help than mitigating factor protection, the individual still faces arrest,[119] pre-trial detention, litigation of their claim, and the risk of losing. For an individual who is unsure of whether or not to seek help, fear of the criminal process, particularly in light of

112. *See id.* ("In light of the minor, or even nonexistent, role a mitigating factor plays in criminal punishment, it is hard to see how a mitigating factor could offer any encouragement to addicts to summon authorities.").

113. 21 AM. JUR. 2D *Criminal Law* § 177 (2023) ("[A]n affirmative defense goes beyond the elements of the offense to prove facts which somehow remove the defendant from the statutory threat of criminal liability.").

114. Schill, *supra* note 16, at 140.

115. *See* UTAH CODE ANN. § 58-37-8(16)(a) (West 2022) (providing an affirmative defense to certain offenses if *inter alia* an overdose victim or bystander seeks medical help); TEX. HEALTH & SAFETY CODE ANN. § 481.115(g) (West 2023) (providing "a defense to prosecution").

116. *See infra* notes 148 & 243 and accompanying text.

117. *See* AM. JUR. 2D, *supra* note 113 ("[A] defendant raises an affirmative defense and offers evidence in support thereof . . . .").

118. *See id.* ("[A]n affirmative defense is one that admits the doing of the act charged, but seeks to justify, excuse, or mitigate it."); Schill, *supra* note 16, at 141 ("The clear risk in this type of protection then is that . . . the defendant has in essence, helped to prove their own guilt of the underlying crime . . . .").

119. As discussed in Part IV, this is a weighty risk for certain populations. *See infra* note 279 and accompanying text.

disparities in the system, may very well prevent that person from seeking lifesaving treatment.

The final, and "most effective," form of protection is immunity from criminal liability because it is "most in line with the stated intent of these statutes."[120] Some states offer protection from prosecution only,[121] while many others offer protection from arrest, charge, and prosecution.[122] Prosecution-only jurisdictions create very similar counterbalancing concerns and the same risk of frustrating the statute's purpose as states offering an affirmative defense: fear of arrest and pretrial litigation.[123] Broad immunity from arrest or charging, however, theoretically creates the ideal incentive for a person at the scene of an overdose to seek aid, particularly if the provisions apply to bystanders and victims, and cover a wide range of offenses—the person can focus on calling 911 without fear of arrest and entry into the criminal justice system.

All in all, with respect to the types of MALs, Schill poignantly and effectively argues her central premise: "these statutes offer such limited amnesty and are replete with so many arbitrary restrictions and requirements, that they are simply ineffective at encouraging people to summon help during overdoses."[124] She and Griner accordingly argue for the importance of the broadest type of medical amnesty and for removing restrictions in order to encourage calls for medical assistance.[125] As both works illustrate, inclusive statutory structures theoretically create the ideal incentive for an individual to focus on health rather than punishment at an overdose scene. Unfortunately, notwithstanding this theoretical

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120. Schill, *supra* note 16, at 141.

121. *See, e.g.*, ALASKA STAT. § 11.71.311(a) (2023); N.C. GEN. STAT. § 90-96.2(b) (2022).

122. *See, e.g.*, VA. CODE ANN. § 18.2-251.03(B) (2023); GA. CODE ANN. § 16-13-5(b) (2023).

123. This apparent inconsistency—granting nominal immunity from prosecution while, in practical reality, requiring a party to litigate the issue of immunity—is examined in detail in Part III.C.

124. Schill, *supra* note 16, at 126.

125. *See* Griner et al., *supra* note 96, at 174–75 ("To be most effective, we believe that an [sic] MAL must grant immunity in a broad range of overdose events, convince those affected that its statutory protections will be followed by law enforcement officials, and be readily understood by those seeking to understand its legislative provisions.").

incentive, and as the next Part examines, individuals face numerous additional barriers to accessing medical amnesty: the standards and procedures used by courts and prosecutors to determine if an aid-seeker qualifies for the protection available in their jurisdiction.

III. COURTROOM BARRIERS TO MEDICAL AMNESTY

Like statutory limitations in MALs that restrict the type and breadth of protection available, judicial interpretation and courtroom procedures further complicate the calculus for individuals facing life-or-death overdose situations by creating additional "arbitrary restrictions."[126] Thus far, the judicial application of MALs has received little scholarly attention. In particular, two sets of questions—(1) whether an amnesty-seeker's *subjective belief* of overdose is sufficient to trigger protection or whether belief of overdose must pass an objective test, and (2) whether the amnesty-seeker must litigate and bear the burden of proving their entitlement to protection—have great potential to frustrate the liberal application of MALs. While some medical amnesty statutes are relatively clear,[127] in other jurisdictions, these questions have been considered by courts as matters of both statutory interpretation and policy.[128] In many others, these questions are largely unanswered.

This Part begins by examining a case that recently worked its way up through en banc review in the Court of Appeals of Virginia, *Morris v. Commonwealth*, as a way of framing the issues. With respect to subjective or objective standards, Part III examines different types of jurisdictions and argues that widespread objective standards defeat the purpose of medical amnesty immunity: encouraging calls for medical assistance.[129] A stringent objective standard essentially requires the plaintiff to accurately diagnose themself in the moment, a process that can easily lead to confusion, uncertainty, and loss of life.[130]

126. Schill, *supra* note 16, at 126.

127. *See infra* note 198 and accompanying text.

128. *See, e.g.*, People v. Harrison, 465 P.3d 16, 22–23 (Colo. 2020).

129. *See infra* Part III.B.

130. *See* Griner et al., *supra* note 96, at 192 ("To encourage professional calls for assistance during overdose events, some leeway should exist that

This Part then addresses pretrial proceedings and the question of who bears the burden of proving entitlement to immunity. The answer to this question can greatly influence an aid-seeker's access to amnesty because it can force a defendant, even in a jurisdiction allowing for complete immunity from arrest or prosecution, to effectively litigate their own innocence.[131] As a matter of common sense, it also presumes that a defendant did not seek medical attention in good faith—by potentially requiring an amnesty-seeker-turned-defendant to prove their entitlement to immunity, the judicial system leads with skepticism toward the plight of substance users. Due to the unique, life-and-death health interests at stake, this Note advocates for a jurisdictional approach to medical amnesty that removes from the court the power to hear the case unless the prosecution shows that immunity should not apply.[132]

A. *Framing the Issues:* Morris v. Commonwealth

In *Morris v. Commonwealth*, Virginia's intermediate appellate court had occasion to examine its own MAL on two separate occasions. In the first hearing ("*Morris I*"), the three-judge panel examined the key question of whether, to be granted medical amnesty, an individual in crisis must objectively need medical assistance or whether it is sufficient that the need is only perceived.[133] That court noted ambiguity, but did not decide the issue of burden of proof.[134] Then, earlier this year, an en banc Court of Appeals reheard the case ("*Morris II*").[135] Although the en banc court overturned the three-judge panel on separate grounds, a concurrence by the original *Morris I* majority reemphasized the problems presented in the first hearing.[136] Both *Morris* decisions illustrate the critical role of judicial interpretation for individuals seeking

enables bystanders and overdose victims to contact authorities without having to accurately diagnose an overdose victim's true medical condition.").

131. *See infra* notes 213–214 and accompanying text.

132. *See infra* Parts III.C, IV.B.

133. (*Morris I*), 876 S.E.2d 182, 184 (Va. Ct. App. 2022), *rev'd en banc on other grounds*, 886 S.E.2d 722 (Va. Ct. App. 2023).

134. *Id.* at 188 n.3.

135. *See* (*Morris II*), 886 S.E.2d 722, 723 (Va. Ct. App. 2023).

136. *See id.* at 727–34 (Raphael, J., concurring).

medical amnesty protection. Although it no longer holds precedential value, *Morris I* remains instructive because it is one of the most methodical examples of a court (and vigorous dissent) examining its state's MAL, and it illustrates how judges can work in harmony with the normative goals of these statutes.

Virginia's statute offers one of the broadest forms of medical amnesty—complete immunity from arrest and prosecution for drug possession and possession of controlled paraphernalia offenses.[137] Virginia's MAL states, in relevant part, that an individual is entitled to medical amnesty if "[s]uch individual . . . in good faith, seeks or obtains emergency medical attention . . . for himself, if he is experiencing an overdose."[138] The statute defines "overdose" as "a life-threatening condition resulting from the consumption or use of a controlled substance, alcohol, or any combination of such substances."[139]

At issue in *Morris I* were two aspects of the medical amnesty statutory language: (1) whether the phrase "is experiencing" means a person is entitled to amnesty if they *subjectively believe* they are experiencing a drug overdose, but *in fact* are not; and (2) whether drug-induced suicidal ideation fits into the definition of "overdose" under the statute.[140] The court answered affirmatively to both questions.[141]

The facts of this case are as follows: The appellant-defendant, Jordan Darrell Morris, appealed his drug-possession conviction after the trial court's decision to deny him medical amnesty immunity.[142] Morris attempted to drive himself to the emergency room in Short Pump, Virginia because he was thinking about committing suicide after using numerous narcotic substances in a short period of time.[143] Police officers

137. VA. CODE ANN. § 18.2-251.03(B) (2023). *But see* Schill, *supra* note 16, at 146 (distinguishing statutes, like Virginia's, that fail to cover distribution crimes and arguing that such a restriction "undermines the purpose of these life-saving laws" because "addicts will often resort to selling or trading substances to support their habit").

138. VA. CODE ANN. § 18.2-251.03(B)(1). Immunity also extends to one who calls for emergency medical assistance for an overdosing individual and to one who renders emergency medical assistance to an overdosing individual. *Id.*

139. *Id.* § 18.2-251.03(A).

140. 876 S.E.2d at 184–85.

141. *Id.*

142. *Id.* at 186.

143. *Id.* at 185.

stopped him just before he arrived, and, after he explained his situation, they escorted him to the hospital where he received medical treatment.[144] The court described what unfolded in the hospital as follows:

> As medical personnel drew a blood sample, Morris "made suicidal statements." In response to questions from a third policeman . . . , Morris said that he worked at Food Lion; he had asked to sit in his boss's car to call his mother; he had called his mother "because he was thinking about committing suicide" . . . . When asked whether his mother had told him to "go to the ER," Morris said he "chose to do so himself" because "he was thinking about suicide." When [a policeman] asked, why suicide, Morris responded, "drugs." Morris said that he had used heroin, fentanyl, and cocaine, that he had smoked crack cocaine in his boss's car, and that he "came to the ER to get help for the suicidal thoughts and his drug problem."[145]

At the trial court level, both the prosecution and the defense assumed that the defendant bore the burden of showing that he was entitled to immunity.[146] In denying medical amnesty during pre-trial proceedings, the trial court used an objective standard, requiring Morris to demonstrate that he was, in fact, experiencing drug-induced suicidal ideation, and found that Morris failed to carry his burden.[147]

The Court of Appeals majority, as an initial matter, acknowledged that the question of burden was undecided in Virginia, but it declined to decide the issue given that the parties below had assumed that the defendant bore the burden of showing immunity like an "affirmative defense."[148] The court then moved to the "plain meaning of the text and the clear purpose of the statute" to analyze whether the trial court was correct in using an objective standard to determine whether an overdose occurred.[149]

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144. *Id.*
145. *Id.*
146. *Id.* at 188 n.3.
147. *Id.* at 188.
148. *Id.* at 188 n.3.
149. *Id.* at 188 (internal quotations omitted).

The *Morris I* majority and dissent engaged in a vigorous debate over the "plain meaning" of the statute's text, in particular, the words "is experiencing" and the requirement of "good faith."[150] The majority emphasized that "the phrase 'is experiencing' reflects the personal perspective of the accused" and that "'[e]xperience indicates an actual living through something' or knowing it 'firsthand.'"[151] The court argued that this "inherently subjective viewpoint" is reinforced by the requirement of "good faith," which consists of a "'state of mind consisting in . . . honesty in belief or purpose.'"[152] The majority also argued that the Virginia General Assembly could have created an express objective standard, as other state legislatures had done, if it had intended an objective test.[153]

The dissent, on the other hand, argued that "is experiencing" means that "a defendant *actually* must be experiencing an overdose."[154] Then-Judge Russell[155] insisted that "[t]he plain and ordinary meaning of 'is' leads to the conclusion that the General Assembly intended that whatever fact or condition follows 'is' *actually* existed at the time in question."[156] The dissent argued that the majority's reliance on "in good faith" is misplaced because the phrase "good faith" does not modify "is experiencing," but rather grammatically modifies only the preceding clause: "in good faith, seeks or obtains emergency medical attention."[157] Additionally, the dissent

150. *See id.* at 189–90 ("[The defendant] is entitled to immunity if he is seeking medical attention 'in good faith' because 'he is experiencing' a drug overdose." (quoting VA. CODE ANN. § 18.2-251.03 (2023))); *see also id.* at 197 (Russell, J., dissenting) ("[W]e apply the plain and ordinary meaning of the words.").

151. *Id.* at 189 (majority opinion) (quoting *Experience*, WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY, UNABRIDGED (2002)).

152. *Id.* (quoting *Good Faith*, BLACK'S LAW DICTIONARY (11th ed. 2019)).

153. *Id.* (citing WIS. STAT. § 961.443 (2023)).

154. *Id.* at 198 (Russell, J., dissenting) (emphasis added) (internal quotations omitted).

155. Justice Russell now sits on the Supreme Court of Virginia. *General Assembly Elects Two New Justices to Supreme Court*, VA. STATE BAR (June 22, 2022), https://perma.cc/HPN2-HMSS.

156. Morris I, 876 S.E.2d 182, 198 (Va. Ct. App. 2022) (Russell, J., dissenting) (emphasis added) (internal quotations omitted), *rev'd en banc on other grounds*, 886 S.E.2d 722 (Va. Ct. App. 2023).

157. *Id.* at 199–200.

turned the majority's argument—that other states have adopted express objective standards—around on them, pointing out that the General Assembly could just have easily adopted an express subjective standard.[158]

The point of this overview is not to get into the weeds of statutory interpretation under Virginia's MAL, but rather to emphasize that the majority and the dissent each make colorable arguments with respect to the "plain meaning" of the statute. *There is no clear answer* by examining the "plain meaning," regardless of what each side asserts.[159] This ambiguity is what necessitates the majority's critical next step, which is to examine the *purpose* of Virginia's MAL as a way of confirming beyond any doubt that a subjective standard is needed:

> [A]pplying an objective standard would frustrate the statute's "clear purpose . . . to encourage . . . prompt emergency medical treatment" for overdose victims. . . . The dissent would require Morris to prove through "medical evidence" that "he actually was suicidal" and that his suicidal state "was caused by his use or consumption of drugs." *Such a begrudging standard could cause people to hesitate before seeking emergency care.* It could make them ask questions like, "Am I really overdosing?" "Would a reasonable person be overdosing if they took what I did?" "Do I need a note from my doctor before calling 911?" The deterrent effect of an objective standard might be worse for the good Samaritan who, while using illegal drugs alongside an overdosing victim, would have to decide whether to risk prosecution by calling for help when the victim is "experiencing an overdose." . . . The General Assembly made an obvious policy determination that saving a life is more important than prosecuting the drug-possession charge. A subjective standard better advances that purpose than an objective one.[160]

The court held that this legislative purpose trumped the prosecution's argument that a subjective standard would make

158. *See id.* at 200–01 (citing FLA. STAT. § 893.21(2) (2023)).

159. *See id.* at 198 ("To hold otherwise ignores the plain meaning of the pertinent words that appear in the statute.").

160. *Id.* at 191 (emphasis added) (internal citations omitted).

it "very difficult if not impossible to rebut a defendant's claim."[161]

The *Morris I* majority opinion is a rare example of a court poignantly highlighting the high stakes involved in the application of MALs and the potentially fatal consequences of creating additional obstacles for the accused in seeking medical attention. While the prosecution sought to argue that their own interests may be harmed by a subjective standard, the majority soundly rejected this concern while pointing to the overwhelming weight of the defendant's interest in receiving life-saving medical care.[162] The court, after holding that drug-induced suicidal ideation qualified as an "overdose" under the statute, accordingly vacated Morris's drug conviction and remanded the case to the trial court to apply a subjective standard.[163]

On rehearing en banc, the full Court of Appeals reversed the *Morris I* decision but on wholly separate grounds. The court held that "the trial court reached the right result for a [different reason]."[164] The *Morris II* court did not examine the questions presented in *Morris I* because it found that Morris failed to meet a different statutory requirement: "remain[ing] at the scene of the overdose or at any alternative location to which he . . . ha[d] been transported until a law-enforcement officer respond[ed]."[165] The court engaged in a formalistic analysis, reasoning that under the plain and obvious meaning of the text, because Morris had driven himself to the hospital after the life-threatening condition began, he had neither "remained at the scene" nor "been transported."[166]

161. *See id.* (internal quotations omitted) (pointing to the statute's inapplicability if a lawful search or arrest had already begun as support for the argument that a subjective standard is unlikely to be abused).

162. *See id.* at 191–92 ("We are not persuaded by the Commonwealth's claim at oral argument that a subjective standard would make it 'very difficult' if not 'impossible' to rebut a defendant's claim that he subjectively believed he was contemplating suicide or experiencing an overdose.").

163. *Id.* at 193.

164. Morris II, 886 S.E.2d 722, 725 (Va. Ct. App. 2023) (internal quotation omitted).

165. *Id.* at 723 (quoting VA. CODE ANN. § 18.2-251.03(B)(2) (2023)).

166. *Id.* at 726; *see id.* ("The only rational reading . . . of the word 'remain' is that the individual stay in place—either at the 'scene' where the overdose occurred, or the 'alternative location' to which the person has been

Notably, the *Morris I* majority, comprised of Judges Raphael and Ortiz, joined the *Morris II* opinion in reversing their prior decision, agreeing that the case could be decided on those "narrower grounds."[167] But Judge Raphael, joined again by Judge Ortiz, felt it necessary to reemphasize the issues of *Morris I*, "which may arise in future litigation."[168] The concurrence expanded upon the possible subjective/objective standards, clarifying that an objective standard could take the form of a "scientifically objective standard," which no states have currently adopted, or a "reasonable-person standard," which thirty-five states have adopted.[169] Judge Raphael also devoted greater attention to the burden issue, acknowledging that Virginia's current MAL provides stronger protection—immunity from arrest and prosecution—than an affirmative defense, but stating "[i]t is unclear . . . how that apparently stronger protection works in practice."[170] The remainder of this Part examines both of these issues in depth.

In sum, *Morris I* and the *Morris II* concurrence highlight how, despite Virginia having one of the broadest types of medical amnesty statutes in existence,[171] the substantive

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transported. 'Remain' would be superfluous if the individual need not in fact 'remain' anywhere."). Although it is difficult to argue with the majority's reading of the statute (fifteen of the seventeen Court of Appeals judges joined the opinion), the *Morris II* decision highlights yet another potentially "fatal shortcoming" of MALs, in addition to the problems presented in Part II. Judge Chaney highlighted the issue in her dissent, arguing that the majority's formalistic reading of the statute works against its life-saving purpose: "[T]he majority's unreasonably narrow construction of Code § 18.2-251.03 would eliminate immunity for those who either walk a few blocks to an emergency room or otherwise transport themselves to a hospital after a drug overdose." *Id.* at 738 (Chaney, J., dissenting); *accord id.* at 736 (Callins, J., concurring in the judgment) ("Under the majority's interpretation, a person who overdoses a block away from a hospital would not be able to walk over to the hospital to receive help and still receive protection under the statute.").

167. *Id.* at 727 (Raphael, J., concurring).

168. *Id.*

169. *Id.* at 729.

170. *Id.* at 732. Judge Raphael suggested that, under a separate statutory provision, the burden of proof in Virginia was likely "on the defendant to establish 'any exception, excuse, proviso, or exemption.'" *Id.* (quoting VA. CODE ANN. § 18.2-263 (2023)). As Part III.C examines, that view cyclically begs the exact question posed by Judge Raphael: if the defendant must litigate and prove their immunity, what is the purpose of the stronger statutory language?

171. See *supra* note 137 and accompanying text.

standards, either expressed in the statutes or created by judicial interpretation, can ultimately have as great an impact on the amnesty-seeker's access to immunity—and thus incentive to seek medical help—as the type of amnesty available. The following subparts examine other jurisdictions' approaches to these standards and argue that the approach adopted by Judges Raphael and Ortiz in *Morris I*, viewing statutory ambiguities in light of the overall purpose of medical amnesty, is essential to promoting the life-saving purpose of MALs.

B. *Subjectivity, Objectivity, and "Good Faith"*

Morris I provides a fascinating entry point into the discussion of legal standards in the application of MALs because the court was required to work through ambiguous statutory text, and, ultimately, it had to examine the underlying purpose of MALs in promoting life-saving medical assistance to support its finding of an inclusive subjective standard.[172] As both of the *Morris I* opinions and the *Morris II* concurrence noted, other states' statutes are far clearer on the question of subjectivity or objectivity.[173] The *Morris I* majority also pointed to the statute's "good faith" requirement as support for finding a subjective standard.[174]

As an initial matter, every state but Oregon, Texas, and Wisconsin has a "good faith" requirement in its MAL.[175] Returning to the works examined in Part II, Schill, who did not examine the subjectivity/objectivity question, proposes a model statute that closely tracks what the Virginia General Assembly ultimately adopted in 2021 and was at issue in *Morris*: immunity applies to "[a] person who, in good faith, seeks medical assistance for a person who is experiencing a drug or alcohol overdose."[176] Griner, who similarly discusses MALs only in

172. *See supra* note 160 and accompanying text.

173. *See* Morris I, 876 S.E.2d 182, 189 (Va. Ct. App. 2022) (citing WIS. STAT. § 961.443 (2023)), *rev'd en banc on other grounds*, 886 S.E.2d 722 (Va. Ct. App. 2023); *id.* at 200–01 (Russell, J., dissenting) (citing FLA. STAT. § 893.21(2) (2023)); *Morris II*, 886 S.E.2d at 729–30 (Raphael, J., concurring) (providing an overview of jurisdictions with expressly subjective or objective standards).

174. 876 S.E.2d at 189.

175. *See* OR. REV. STAT. § 475.898 (2023); TEX. HEALTH & SAFETY CODE ANN. § 481.115(g) (West 2023); WIS. STAT. § 961.443 (2023).

176. Schill, *supra* note 16, at 149.

broad strokes and does not examine this question in depth, conflates "good faith and reasonable belief requirements," implying that an objective reasonableness standard accomplishes the same work as a "good faith" requirement.[177] The debate between the *Morris I* majority and dissent highlights why the mere inclusion of "good faith" on its own is insufficient to erase ambiguity and provide the broadest possible coverage.[178] Additionally, the *Morris I* case and other states' MALs show how the "good faith" requirement is conceptually distinct from an objective reasonableness test.[179] As explained below, the "good faith" requirement is usually an additional requirement, relating to seeking medical assistance, on top of language indicating whether a court must view the evidence objectively or from the perspective of the accused.

The *Morris II* concurrence refers to Florida's MAL as one that expressly contemplates a subjective standard.[180] Florida's statute protects a person from arrest, charge, or prosecution if that person "experiences, or has a *good faith belief* that he or she is experiencing, an alcohol-related or drug-related overdose."[181] Florida is the unusual example of a statute that uses the phrase "good faith" in direct reference to the defendant's *belief*, rather than to the process of a person seeking medical assistance.[182]

Some statutes, like Virginia's, are ambiguous on their face but are also not clearly objective.[183] For example, New Jersey's

177. *See* Griner et al., *supra* note 96, at 188.

178. *See supra* notes 152 & 157 and accompanying text.

179. *See supra* note 158 and accompanying text; *e.g.*, FLA. STAT. § 893.21 (2023) (separating seeking medical assistance "in good faith" from the subjective standard of a victim having a "good faith belief that he or she is experiencing" an overdose).

180. *See* 886 S.E.2d 722, 731 (Va. Ct. App. 2023) (Raphael, J., concurring) (quoting FLA. STAT. § 893.21(3) (2023)).

181. FLA. STAT. § 893.21(2) (emphasis added).

182. *Compare id.* § 893.21(3) (protecting a qualified person who "has a good faith belief" that an individual is experiencing an overdose), *with* COL. REV. STAT. § 18-1-711(1)(a) (2023) (providing immunity if "the person reports in good faith an emergency drug or alcohol overdose event"), *and* GA. CODE ANN. § 16-13-5(b) (2023) (providing immunity to "[a]ny person who in good faith seeks medical assistance").

183. *See Morris II*, 886 S.E.2d at 731 n.11 (Raphael, J., concurring) (listing Arizona, Idaho, Ohio, Massachusetts, New Jersey, New Mexico, Rhode Island, and Washington as states that, like Virginia, use the "experiencing an overdose" formulation).

MAL provides immunity to "[a] person who, in good faith, seeks medical assistance for someone experiencing a drug overdose."[184] Such statutes, while ambiguous, at least allow the amnesty-seeking party to argue, as in *Morris*, that the legislature intended a subjective standard in keeping with the underlying purpose of enacting the law.[185] Thus far, however, *Morris I* is the only example of a court addressing this ambiguity head on.[186] Despite the fact that it no longer carries precedential value, amnesty-seekers in "experiencing an overdose" jurisdictions should treat *Morris I* as instructive given that it was reversed on wholly separate grounds and that objective standards, as explained below, remove the ability to argue the issue from the parties entirely.

Oregon's statute, one of only two MALs to not contain a "good faith" requirement, is an example of clear language requiring objectivity: "A person who contacts emergency medical services or a law enforcement agency to obtain medical assistance for another person *who needs* medical assistance due to a drug-related overdose is immune from arrest or prosecution for [the relevant offenses.]"[187] The statute defines "drug-related overdose" as "an acute condition . . . resulting from the consumption or use of a controlled substance . . . that a person would *reasonably believe* to be a condition that requires medical attention."[188] The test is thus plainly one of objective reasonableness, if not actuality, requiring both (1) that a person "need[]" medical assistance and (2) that the court use a reasonableness test in determining whether an overdose occurred.[189]

Colorado similarly bakes reasonableness into the definition of "emergency drug or alcohol overdose event," defining it, in

184. N.J. STAT. ANN. § 2C:35-30a (West 2023).

185. *See supra* Part III.A.

186. *See Morris II*, 886 S.E.2d at 731 (Raphael, J., concurring) ("Courts in those jurisdictions have not yet determined, however, whether such language imposes a subjective standard, a reasonable-person standard, or a scientifically objective standard.").

187. OR. REV. STAT. § 475.898(1) (2023) (emphasis added).

188. *Id.* § 475.898(7)(b) (emphasis added).

189. *Compare id.* § 475.898(1) (providing immunity only if the victim "needs medical assistance"), *with* VA. CODE ANN. § 18.2-251.03(B)(1) (2023) (using the requirement that the victim "is experiencing" an overdose, rather than requiring that the victim "need medical assistance").

part, as a condition "that a layperson would *reasonably believe* to be a drug or alcohol overdose that requires medical assistance."[190] The statute contains a "good faith" requirement, which states, in relevant part, that a person is immune from arrest or prosecution if "[t]he person reports in good faith an emergency drug or alcohol overdose event to [the relevant authorities]."[191] The Colorado Supreme Court in *People v. Harrison*[192] interpreted this "good faith" requirement to mean that a court must consider the "subjective perception of the person making the report," in addition to the requirement that "a layperson must *reasonably believe*" that an overdose occurred.[193] Such a standard, however, does nothing more than impose a subjective "honesty" test on top of the reasonableness test.[194] At bottom, the statute still requires objective evidence of an overdose for the defendant to receive immunity. In fact, in *Harrison*, the court undertook its own examination of the available evidence and affirmed the defendant's conviction in part because she did not "*actually* suffer[]" an overdose.[195]

The District of Columbia is an example of a jurisdiction that, like Colorado and Oregon, bakes the reasonableness component into the definition of "overdose." But, unlike Colorado, an objective test is also used in reference to the defendant's perception. D.C.'s statute states, in relevant part, that a defendant is immune from arrest, charge, or prosecution if the person "[*r*]*easonably believes* that he or she is experiencing a drug or alcohol-related overdose and *in good faith* seeks health care for . . . herself."[196] The definition of "overdose" includes a requirement that the defendant's condition "*is* or *reasonably appears to be* the result of the consumption or use of drugs."[197] D.C.'s standard, like Oregon's, thus seems to be more stringent than Colorado's, as it provides the court two different avenues to interrogate whether the defendant was, in fact, overdosing.

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190. COL. REV. STAT. § 18-1-711(5) (2023) (emphasis added).
191. *Id.* § 18-1-711(1)(a).
192. 465 P.3d 16 (Colo. 2020).
193. *See id.* at 22–23 (emphasis added).
194. *See id.* at 22.
195. *Id.* at 24 (emphasis added).
196. D.C. CODE § 7-403(a)(1)(A) (2023) (emphasis added).
197. *Id.* § 7-403(i)(3) (emphasis added).

Objective standards, like those used in Colorado, Oregon, D.C., and many others,[198] take the subjective perception of the person contemplating medical intervention out of the equation and instead place what happened in the heat of that moment into the hands of the court or factfinder. Regardless of how the user felt at the time, if a court, examining the situation well outside of the circumstances that caused a person to seek help, determines that the individual did not "*actually suffer*[]" an overdose,[199] the defendant is consigned to punishment for their decision to value the life that was at stake. Additionally, such a standard leaves room for shaky, circumstantial evidence based on hindsight—i.e., the fact that the defendant ended up alive—to overcome a defendant's good faith effort to seek medical help. As the *Morris I* court highlighted, such standards could easily cause a person contemplating medical intervention to wonder, "Do I need a note from my doctor before calling 911?"[200]

The basic proposition underlying every medical amnesty statute, regardless of the exact type of procedural protection that it offers, is that we should encourage calls for help at the direct expense of potential punishment when individuals have consumed drugs and are suffering.[201] This proposition implicitly incorporates the medical reality that substance use, for someone suffering from substance use disorder, is usually not within the person's control.[202] In contrast, standards of objectivity and actuality, at their core, reflect a fear that someone may abuse the medical amnesty statute—despite the fact that, in a

198. *See, e.g.*, GA. CODE ANN. § 16-13-5(a)(1) (2023) (defining overdose, in part, as a condition "that a reasonable person would believe to be resulting from the consumption or use of a controlled substance"); TENN. CODE ANN. § 63-1-156(a)(2) (2023) (same); NEB. REV. STAT. § 28-472(6) (2023) (defining overdose, in part, as a condition that "a layperson would reasonably believe requires emergency medical assistance").

199. *Harrison*, 465 P.3d at 25 (emphasis added).

200. Morris I, 876 S.E.2d 182, 191 (Va. Ct. App. 2022), *rev'd en banc on other grounds*, 886 S.E.2d 722 (Va. Ct. App. 2023).

201. *See* Bissonnette, *supra* note 72, at 476; *see also* Leo Beletsky et al., *Prevention of Fatal Opioid Overdose*, 308 JAMA 1863, 1863 (2012) (arguing that Good Samaritan laws encourage "help-seeking").

202. *See Is Addiction Really a Disease?*, *supra* note 31 ("Alcohol or drug addiction, also known as substance use disorder, is a chronic disease of the brain that can happen to anyone.").

subjective jurisdiction, a prosecutor may still bring evidence showing that a person did not act in good faith—by placing the prosecutor and court in charge of deciding whether a defendant was *actually* truthful. By equating MALs to a privilege that must not be abused, the justice system advances an underlying normative judgment that a person is not entitled to medical help unless they *deserve* it.[203]

Clearly, standards of objectivity create an inherent motivational barrier for a victim to seek medical help, and, even if someone does seek assistance, they may find themselves punished for that decision. Both results run counter to the stated purpose of MALs.[204] This issue, and any others that come up in attempting to access medical amnesty protection, becomes even more problematic if an amnesty-seeker bears the burden of proving it. Arguably, in many jurisdictions, the amnesty-seeker should not be in the courtroom at all.

C. *Pretrial Proceedings and Burden*

The question of pretrial procedure under MALs further complicates the complex web of considerations a person must factor in if they are seeking or have already sought medical attention for an overdose. This issue can force an amnesty-seeker, even in a jurisdiction allowing for complete immunity from arrest or prosecution, to effectively litigate their immunity by appearing in pretrial proceedings and forcing them to retain counsel.[205] This may not seem like an issue at all if one views medical amnesty immunity as akin to an affirmative defense—admitting the underlying elements of a crime but otherwise justifying it.[206] But given the fact that immunity provisions theoretically strip the State of the very power to prosecute, arrest, or charge certain offenses,[207] judges should question any assumption that it is the overdose victim or aid-seeker's responsibility to show that the *State* does not have

203. *Cf.* Schill, *supra* note 16, at 156 ("For every one individual who hides under a [MAL] to escape deserved punishment, it is a wholly valid expectation that the law will have saved the lives of countless others.").

204. *See supra* notes 200–201 and accompanying text.

205. *See infra* notes 214–215 and accompanying text.

206. *Cf. infra* note 243 and accompanying text.

207. *See infra* note 251 and accompanying text.

that power.[208] So far, only a handful of state court opinions have addressed this question of pretrial proceedings.

Judge Raphael, in both of his *Morris* opinions, called attention to the issue of burden without resolving it.[209] In the *Morris II* concurrence, he suggested that the amnesty-seeker probably "bears the burden of production" like other exceptions under the Virginia Code's drugs article.[210]

Some states' courts have expressly made the determination. For example, the Wisconsin Court of Appeals in *State v. Williams*[211] determined that burden should rest on the amnesty-seeker.[212] Wisconsin's MAL provides complete immunity from criminal prosecution for certain drug-related offenses.[213] However, in light of *Williams*, if the prosecutor believes it is unclear whether immunity applies, they can charge the individual—turning them into a criminal defendant—despite statutory language that, on its face, seems to prevent exactly that.[214] Now, the criminally charged amnesty-seeker is required to file a motion asserting medical amnesty immunity and to appear in a pretrial proceeding where the trial-level court determines whether immunity applies.[215] The burden is then placed on the amnesty-seeker to prove their entitlement by a preponderance of the evidence.[216] This

208. *See infra* note 259 and accompanying text.

209. *See* Morris I, 876 S.E.2d 182, 188 n.3 (Va. Ct. App. 2022), *rev'd en banc on other grounds*, 886 S.E.2d 722 (Va. Ct. App. 2023); Morris II, 886 S.E.2d 722, 731–33 (Va. Ct. App. 2023) (Raphael, J., concurring).

210. 886 S.E.2d at 731 (Raphael, J., concurring) (citing VA. CODE ANN. § 18.2-263 (2023)).

211. 888 N.W.2d 1 (Wis. Ct. App. 2016).

212. *Id.* at 2.

213. *See* WIS. STAT. § 961.443(2) (2023).

214. *Compare Williams*, 888 N.W.2d at 5 ("[I]f there is uncertainty based upon the particular facts of a case as to whether an individual is entitled to [medical amnesty] immunity, the State may *initiate a prosecution*." (emphasis added)), *with* WIS. STAT. § 961.443(2) ("An aider is *immune from prosecution* under [certain drug-crime statutes]." (emphasis added)).

215. *See Williams*, 888 N.W.2d at 5 ("[A] circuit court should decide pretrial whether a defendant . . . is entitled to [medical amnesty] immunity . . . .").

216. *See id.* at 6 ("[T]he defendant should bear the burden of proving by a preponderance of the evidence his/her entitlement to [medical amnesty] immunity.").

procedure is shared by several other states that also theoretically provide immunity from prosecution.[217]

Courts in these states offer a number of justifications for placing the burden on the amnesty-seeker. In *Williams*, the court worked through a judicially-created balancing test drawn from McCormick's evidence treatise to resolve the issue.[218] Of primary significance were the "natural tendency," fairness, convenience, and public policy considerations.[219]

On the "natural tendency" factor, the court devoted a single sentence; it determined that it was more natural for the defendant to carry the burden because the defendant "seeks to change the existing situation."[220] In considering the fairness and convenience factors, the court reasoned that the amnesty-seeker would "ordinarily be in a much better position" to know the facts surrounding the relevant event and should thus bear the burden as a matter of practicality.[221]

Pausing briefly here—both of these offered justifications are problematic for the same reason: they assume the validity of the proceeding. In stating that the defendant "seeks to change the existing situation," the court did not address the necessary assumption that the "existing situation"[222] should be before the court at all. It arguably should not.[223] The MAL referenced above makes it lawful for a person who has engaged in specific, otherwise illegal behavior to seek medical aid, and it provides

217. *See, e.g.*, State v. W.S.B., 180 A.3d 1168, 1183 (N.J. Super. Ct. App. Div. 2018) (placing the burden on the defendant to show immunity by a preponderance of the evidence but allowing the issue to be raised at any point in the prosecutorial process); People v. O'Malley, 183 N.E.3d 928, 936–38 (Ill. App. Ct. 2021) (placing the burden on the defendant without expressly stating the standard of proof, but holding that the trial court failed to make "a reasonable conclusion" that defendant was entitled to immunity).

218. *Williams*, 888 N.W.2d at 6–7 (citing State v. West, 800 N.W.2d 929, 943 (Wis. 2011) for factors drawn from CHARLES T. MCCORMICK, MCCORMICK ON EVIDENCE § 337 (2d ed. 1972) that are used to determine the burden of proof: the natural tendency to place the burdens on the party desiring change; special policy considerations; convenience; fairness; and the judicial estimate of probabilities).

219. *Id.* at 6.

220. *Id.*

221. *Id.* at 6–7.

222. *Id.*

223. *See infra* notes 247–251 and accompanying text.

complete immunity from prosecution.[224] The government is arguably the party changing the status quo by "initat[ing] a prosecution"—i.e., creating the "existing situation"—despite a defendant who calls for aid comporting with state law.[225] Framing the proceeding in this manner, the court's problematic fairness/convenience reasoning also becomes apparent. The court is correct that the aid-seeker would typically be in a better position to know the facts.[226] But it fails to bridge the gap in its logic by showing why someone who has engaged in lawful behavior—calling for aid—and had a proceeding brought *against them*, despite supposed immunity from prosecution, should be forced to prove that their behavior was lawful.[227]

The Court of Appeals' view on the final factor, public policy considerations, may illuminate the reasons for this logical gap. The court fully recognized that the statute was designed to "remove a disincentive" for individuals to seek out aid.[228] But it confoundingly determined that the "significant public interest in *prosecuting drug crimes*" pushed the public policy factor in favor of burdening the defendant.[229] In other words, the *Williams* court relied on the exact "disincentive" the MAL was designed to eliminate to justify making it more difficult to access immunity. Despite the legislature making a clear policy determination regarding the goals of MALs, the court's reasoning here relies on a simple nonsensical principle: drug crime prosecution outweighs the legislature's determination that drug crime prosecution, in this situation, should not matter. Faced with a medical amnesty statute that suggests the exact opposite, the court takes the opportunity to remove a barrier for the government—having to prove the MAL's inapplicability—to getting past the MAL's protection and into

224. WIS. STAT. § 961.443(1) (2023).

225. *See id.* § 961.443(2) (providing "[i]mmunity from criminal prosecution").

226. State v. Williams, 888 N.W.2d 1, 6–7 (Wis. Ct. App. 2016).

227. *Cf.* People v. Harrison, 465 P.3d 16, 23 (Colo. 2020) (placing heavy "beyond a reasonable doubt" burden on prosecution to show inapplicability of medical amnesty); Morris II, 886 S.E.2d 722, 732 (Va. Ct. App. 2023) (Raphael, J., concurring) (noting uncertainty as to whether "immunity" language makes any "practical difference" to the procedural application of Virginia's MAL as compared to a MAL providing merely an affirmative defense).

228. *Williams*, 888 N.W.2d at 6.

229. *Id.* (emphasis added).

the realm of traditional drug prosecution. In light of the *Williams* court's policy determination, it is easy to see how it could arrive at its cursory fairness, convenience, and "natural tendency" justifications for placing the burden on the defendant.

As a final justification, the Wisconsin Court of Appeals stated that in cases applying "Stand Your Ground" or "Castle Doctrine" immunity, courts typically place the burden on the defendant to prove entitlement at a pretrial hearing.[230] Given that immunity, unlike an affirmative defense, is a relatively rare form of protection from criminal liability, it is worth pausing to examine the relationship between "Stand Your Ground" immunity and medical amnesty immunity in greater depth.

Stand-your-ground ("SYG") laws operate in an entirely different sphere of criminal law. These laws eliminate a duty to retreat in situations of self-defense.[231] Although many SYG laws contain procedural immunity provisions similar to those found in MALs,[232] the *Williams* court's reliance on this type of immunity is misplaced for two reasons.

First, the court's assertion that placing the burden on the defendant "is in accord with cases applying 'Stand Your Ground'/'Castle Doctrine' laws"[233] does not accurately reflect that there are significant discrepancies among states on the question of who bears the burden of showing SYG immunity.[234]

230. *See id.* at 7 n.7 ("We note this conclusion is in accord with cases applying 'Stand Your Ground'/'Castle Doctrine' laws, in which multiple state supreme courts have indicated the defendant bears the burden of proving by a preponderance of the evidence his/her entitlement to immunity from criminal prosecution.").

231. *See* Katryna Santa Cruz, Comment, *The Distraction that Is Stand Your Ground*, 14 FIU L. REV. 149, 154 (2020) ("The majority of states that have adopted stand your ground statutes do not require a defendant to retreat before using deadly force.").

232. *See, e.g.*, KY. REV. STAT. ANN. § 503.085(1) (West 2023) (providing that the defender "is immune from criminal prosecution").

233. *Williams*, 888 N.W.2d at 7 n.7.

234. For an illustration of this point, see Benjamin M. Boylston's comparison of SYG procedures in *Immune Disorder: Uncertainty Regarding the Application of "Stand Your Ground" Laws*, 20 BARRY L. REV. 25, 31–33 (2014). A number of states require the defendant to prove entitlement to SYG immunity by a preponderance of the evidence. *See, e.g.*, State v. Duncan, 709 S.E.2d 662, 665 (S.C. 2011); People v. Guenther, 740 P.2d 971, 980 (Colo. 1987). Other states place the burden on the government. *See, e.g.*, FLA. STAT.

Many jurisdictions either place the burden on the prosecution to disprove SYG immunity or have not addressed the question.[235]

Second, the legislative purposes for these two types of laws are highly distinguishable. SYG laws rest in normative judgments regarding the most ethical and reasonable outcome in a situation where violence is threatened against another person.[236] These laws assume that the social harm of violence will occur, and rather than prevent the violence, they reflect a moral judgment that the innocent defender is justified in engaging in particular conduct.[237] In this way, SYG laws affirmatively increase the likelihood that a defender will use violence against an aggressor in a particular situation.

While admittedly not the subject of this Note, it seems obvious that this normative underpinning differs entirely from that of MALs. SYG laws involve difficult ethical questions of individuals using violence against one another when physical harm is a foregone conclusion. The gravity of the social harm, namely, violence against other persons, makes the application of these laws better suited for pretrial hearing.[238] MALs, on the other hand, are a direct response to a medical crisis and try to prevent a specific social harm from occurring *in the first instance*.[239] They reflect the black-and-white moral determination that a life is obviously better saved than lost when the loss of life is not a foregone conclusion. Unlike in the SYG context, to the extent a court relies on public policy and legislative purpose, which the *Williams* court did expressly,

§ 776.032(4) (2023); KAN. STAT. ANN. § 21-5231(c) (West 2023). One of these states is Florida, whose prior SYG statute the *Williams* court relied on and which has since been amended to cover this specific issue. *See* FLA. STAT. § 776.032(4).

235. *See supra* note 234.

236. *See* Santa Cruz, *supra* note 231, at 158 (summarizing rationales for stand-your-ground laws, including a moral belief that the law should choose "the life of an innocent person" over an unlawful aggressor and the desire to "ensure[] the most reasonable version of events").

237. *See id.* at 159 ("If faced with a . . . choice of choosing between the life of an innocent person and the life of an unlawful aggressor, the law should side with the former and not the latter." (internal quotation omitted)).

238. *See supra* notes 236–237 and accompanying text.

239. *See* Morris I, 876 S.E.2d 182, 191 (Va. Ct. App. 2022) ("The General Assembly made an obvious 'policy determination' that saving a life is more important than prosecuting the drug-possession charge . . . ."), *rev'd en banc on other grounds*, 886 S.E.2d 722 (Va. Ct. App. 2023).

these two types of laws reflect entirely different policy rationales. Thus, in contrast to the Wisconsin Court of Appeals' assertion, SYG laws provide little guidance on the procedural application of MALs.

As another example of a court finding that the burden should rest on the amnesty-seeker, the Appellate Court of Illinois in *People v. O'Malley*[240] relied on a similar justification to the Wisconsin court's convenience argument, asking, "the State is supposed to know that someone is being a good Samaritan *how*?"[241] Like the *Williams* court, the Illinois Appellate Court determined that the defendant "is in the best position to demonstrate their intent,"[242] but it similarly failed to bridge the gap in explaining why someone engaging in lawful conduct should prove that they were behaving lawfully. While the *Williams* court used a substantive factor test and was influenced by policy, the Illinois court arrived at its conclusion on simplified procedural grounds; it viewed immunity as an affirmative defense, and, "along the lines of the other affirmative defenses," it found that the burden rested on the defendant.[243] Similarly, in Missouri, which provides immunity from liability,[244] the Court of Appeals simply relied on the state's possession statute, which states that the defendant has the burden of proving any "exception, excuse, proviso or exemption."[245] Whether via the more complicated process used by the *Williams* court or the analysis of the *O'Malley* court of simply equating statutory immunity to an affirmative defense, the result is the same in both cases: the amnesty-seeker must appear in court and defend themself.

240. 183 N.E.3d 928 (Ill. App. Ct. 2021).

241. *Id.* at 936 (emphasis added) (internal quotation omitted).

242. *Id.*

243. *Id.*; *see also* 29 AM. JUR. 2D *Evidence* § 192 (2022) (noting that the defendant may be required to put an affirmative defense into issue through sufficient evidence or may bear the burden of proof depending on the jurisdiction). *But see* People v. Harrison, 465 P.3d 16, 23 (Colo. 2020) ("The prosecution bears the burden of proving beyond a reasonable doubt that the affirmative defense of [medical amnesty] is inapplicable." (internal quotation omitted)).

244. MO. REV. STAT. § 195.205 (2023).

245. State v. Gill, 642 S.W.3d 356, 361 (Mo. Ct. App. 2022) (citing MO. REV. STAT. §§ 195.205, 579.015); *accord* Morris II, 886 S.E.2d 722, 732 (Va. Ct. App. 2023) (Raphael, J., concurring) (citing VA. CODE ANN. § 18.2-263 (2023)).

The *Williams* and *O'Malley* decisions beg the question suggested by Judge Raphael in the *Morris II* concurrence: what "practical difference" does language conferring immunity from prosecution make if the amnesty-seeker ultimately bears the burden of proving their entitlement to protection?[246] Some judges, highlighting this exact issue, have asked an even more fundamental question: why should someone immune from prosecution be a "defendant" at all?

In *State v. Osborne*,[247] Justice Earls of the Supreme Court of North Carolina took direct aim at the Wisconsin and Illinois view of medical amnesty immunity—i.e., the view that an aid-seeker or overdose victim, despite language nominally preventing prosecution, must litigate the issue of their innocence under the law in a proceeding brought against them.[248] North Carolina's MAL uses similar language to many others conferring immunity, stating that an aider or overdose victim "shall not be prosecuted" for seeking medical assistance.[249] In her concurrence, Justice Earls asked the fundamental question of whether such language "is a *limit on the court's jurisdiction* to prosecute defendant in this case."[250] She suggested that the answer may be unambiguous: "[i]f a person in defendant's circumstances 'shall not' be prosecuted, there is no room for discretion to prosecute them."[251] In support of this view, like the *Morris I* court, she noted that "[t]he goal of statutory construction is to ensure that the purpose of the legislature is accomplished."[252] In the case of this statute,

> [t]he legislature's intent in passing [the MAL] was to ensure that victims of drug overdoses, and those who may be with them or come across them, do not refrain from seeking medical attention out of fear of criminal prosecution. In light of the opioid overdose epidemic in this state, the legislature enacted a policy to sacrifice prosecutions for possession of

246. 886 S.E.2d at 732 (Raphael, J., concurring).

247. 831 S.E.2d 328 (N.C. 2019).

248. *See id.* at 337–41 (Earls, J., concurring).

249. N.C. GEN. STAT. § 90-96.2(b)–(c) (2023).

250. *Osborne*, 831 S.E.2d at 339 (Earls, J., concurring) (emphasis added).

251. *Id.* (quoting N.C. GEN. STAT. § 90-96.2(b)).

252. *Id.* at 340; *see also* Morris I, 876 S.E.2d 182, 187 (Va. Ct. App. 2022) (looking to the "clear purpose of the statute" (internal quotation omitted)), *rev'd en banc on other grounds*, 886 S.E.2d 722 (Va. Ct. App. 2023).

> small amounts of drugs in order to save lives. Treating [this provision] as anything other than a jurisdictional requirement that must be established by the State would severely undercut that policy.[253]

Unlike the *Williams* and *O'Malley* courts, Justice Earls recognized the dangerousness of procedural barriers to accessing immunity, such as the State being freed from its burden of showing that "the immunity did not apply in order to proceed with prosecution."[254] But her concurrence moved beyond the mere issue of burden and poignantly recognized that *any* procedural barrier, including the very power of the court to hear the case, has the potential to "severely undercut" a MAL's goal.[255]

As additional support for the proposition that medical amnesty immunity should not be litigated, Justice Earls cites the Superior Court of Pennsylvania,[256] its intermediate appellate court, which considered the same issue in *Commonwealth v. Markun*.[257] Like both the *Morris I* opinion and Justice Earls's concurrence in *Osborne*, after noting ambiguity in the plain text of the medical amnesty statute, the Pennsylvania Superior Court devoted ample time to reviewing legislative intent within the broader context of the public health crisis.[258] And, like Justice Earls, the court directly connected the legislature's intent in preventing overdoses to the need for fewer procedural hurdles in the aid-seeker or victim's path:

> We find that the Legislature sought to encourage persons, who may be fellow drug users themselves, to report overdoses by guaranteeing that criminal punishments will not normally follow. Moreover, the Legislature intended for prosecutors and police to refrain from filing charges when sorting through the aftermath of the unfortunately all-too-common overdose. *The statute discourages the*

253. *Osborne*, 831 S.E.2d at 340 (Earls, J., concurring).

254. *Id.*

255. *Id.*

256. *Id.* (quoting Commonwealth v. Markun, 185 A.3d 1026, 1035–36 (Pa. Super. Ct. 2018)).

257. 185 A.3d 1026 (Pa. Super. Ct. 2018).

258. *See id.* at 1034–35 (quoting Commonwealth v. Lewis, 180 A.3d 786, 789 (Pa. Super. Ct. 2018) for the history of Pennsylvania's MAL within the context of the "burgeoning humanitarian crisis" of drug overdose deaths).

> *authorities from commencing the criminal justice process*, i.e. by placing a limitation upon the charging power, to provide more incentive for reporters to call. . . . It would significantly undercut the statute's goal to conclude, as the Commonwealth urges, that the Act merely provides a defense, thereby *requiring an overdose victim or a reporter to litigate the issue of immunity*. We find that the statute clearly contemplates that a large number of these cases will never reach the courtroom halls; hence, the prohibition against *charging* a person.[259]

Notably, North Carolina's statute does not contain the same prohibition against charging found in the Pennsylvania statute, which the *Markun* court relied on in part.[260] But the Pennsylvania Superior Court's reasoning does not depend on this distinction. The thrust of its holding is that criminal litigation is contrary to the MAL's legislative purpose.[261] As Justice Earls illustrated in her concurrence, the *Markun* court's reasoning is applicable to virtually any situation in which the language of the statute is ambiguous on the issue of pretrial proceedings (or any other matter of statutory construction),[262] regardless of whether or not it provides for immunity from charging.

In sum, *Markun* and the *Osborne* concurrence illustrate that there is no legal reason to treat medical amnesty immunity as a defense other than that, traditionally, exceptions to criminal behavior are viewed this way.[263] The problem with that viewpoint is that it assumes the argument—that drug use should be treated criminally—which flies past the entire

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259. *Id.* at 1035–36 (emphasis added).

260. *Compare* N.C. GEN. STAT. § 90-96.2 (2023) (providing only that "[a] person shall not be prosecuted"), *with* 35 PA. STAT. AND CONS. STAT. ANN. § 780-113.7(a) (West 2023) (providing that "[a] person may not be charged and shall be immune from prosecution").

261. *See Markun*, 185 A.3d at 1035 n.4 ("As Appellant persuasively states: If the judiciary permits police to criminally charge obviously immune individuals with drug possession, jail them, and force them to later plead and prove their immunity in court, it will effectively reinstate the disincentive against reporting overdose events that the Legislature sought to eliminate . . . ." (internal citation omitted)).

262. No MALs currently address the exact procedures for their application. There is thus ample room for courts to rely on the *Osborne* concurrence and *Markun* opinion.

263. *See supra* notes 230–243 and accompanying text.

purpose of MALs. MALs, at least for the enumerated offenses, are intended to shift substance use from the criminal realm to the public health realm by prioritizing treatment over criminal process. In so doing, and as the final Part will now examine, the law moves away from the failed, racist policies of the War on Drugs and takes a small, reparative step.

IV. CONNECTING MEDICAL AMNESTY TO THE UNITED STATES' TROUBLED HISTORY WITH SUBSTANCE USE

The decision a person faces when determining whether to seek medical help at an overdose scene, either for themself or for another, can be conceived as a weighted scale of disincentives. On one side is a relatively simple consideration: the possibility of death or serious injury if help is not sought. On the other side is the weight of a possible criminal conviction. This consideration is far more complex because it contains a slew of other weighty factors: income loss, family welfare, personal wellbeing, social humiliation, and impact of any prior criminal history, to name just a few.[264] Further, adding to this side of the scale, at the time of an overdosing event, the person must contemplate if they or another are *actually* overdosing and whether they may be arrested, charged, and detained regardless.[265] What if their arrest and detention cause their employer to fire them? What if they have a loved one who is ill? Children? Each minute a person spends weighing this decision, loss of life becomes more likely.[266]

Recall that substance use disorder is a neurological condition over which individuals have little hope of controlling without medical treatment.[267] Substance use has been an issue in the United States for decades, but it was not until White people were viewed as the primary victims, during the opioid

264. *See supra* note 52 and accompanying text.

265. *See supra* Part III.B–C.

266. Only a narrow window of time is available to seek treatment. *See Prevent Overdose*, NYC HEALTH, https://perma.cc/5PZW-2SWC (last visited Sept. 2, 2023) (explaining that "most overdoses occur 1 to 3 hours after the drug is taken" and about one in eight overdoses occurs immediately after drug is taken).

267. *See Is Addiction Really a Disease?*, *supra* note 31 ("Willpower and shaming won't undo the changes in the brain and cure addiction. There is no cure, but treatment helps you manage and successfully live with the disease.").

epidemic, that policymakers and the media responded sympathetically.[268] Our society has historically treated substance use as a moral failure stemming from a lack of "personal responsibility," a deliberately racialized narrative that led to the over-enforcement of drug laws on predominantly Black and Brown communities.[269] In direct response to the new opioid epidemic, however, which has had a greater impact on Whites, medical amnesty laws have been passed in forty-eight states.[270] While a welcome step in the right direction, and theoretically beneficial for all, as the discussions in Parts II and III illustrate, MALs have not accomplished their purpose to the fullest extent possible.

Whether through the discussion begun by Nicole Schill on the overall types of medical amnesty, or this Note's extension of that discussion in examining the judicial application of MALs, it is clear that the complexity of the law has great potential to completely thwart the purpose of MALs.[271] Thus, whether via a conversation on *type* of protection or one on *how* that protection plays out, the argument is the same: when an individual is calculating whether or not to seek aid, there must be no disincentives.

This Note further extends the significance of broad MALs by analyzing them in light of the way those suffering from substance use disorder have historically been treated in this country. As discussed, the criminalization of addiction has not worked.[272] These failed policies have resulted in economic, physiological, and stigmatic harm to those with substance use disorder and, in fact, decrease the likelihood that individuals will seek treatment.[273] While drug laws have been severely detrimental to all suffering from substance use disorder, Black

268. *See supra* Part I.B.

269. *See supra* Part I.A.

270. *See supra* note 99 and accompanying text.

271. *See* Schill, *supra* note 16, at 148 ("Unfortunately, many states seem to have lost sight of the end goal as seen by the degree of complexity and numerous restrictions seen in the various [MALs]."); *see also* State v. Osborne, 831 S.E.2d 328, 340 (N.C. 2019) (Earls, J., concurring) (recognizing that forcing the amnesty-seeker to show their own immunity "severely undercut[s]" the legislature's goals).

272. *See supra* notes 48–50 and accompanying text.

273. *See supra* notes 51–54 and accompanying text.

and Brown communities have been the most impacted by far.[274] Viewed in this light, medical amnesty laws, which remove substance use from the criminal realm, not only save lives, they directly counter the historical oppression by drug laws on Black and Brown communities.

Given that criminal drug laws are still in full force today,[275] their enforcement (and over-enforcement) creates an affirmatively working, constant background norm of oppression and substance use stigma.[276] Medical amnesty laws work affirmatively in the opposite direction to remove this oppressive force from the criminal law. Behavior that otherwise would result in certain targeting by law enforcement and punishment is removed from criminal liability. But with each of the restrictions on the application of MALs—e.g., excluding paraphernalia offenses; requiring a victim to litigate and prove their immunity; requiring a victim to show that an overdose *in fact* occurred; etc.—the needle moves further and further back toward the background norm of "personal responsibility." You may be entitled to life-saving treatment without punishment, but only if you *actually* needed it (i.e., if you *deserved* it) and are willing to hurdle barriers to show it (i.e., if you *earn* it).[277] Thus, these arbitrary barriers to accessing MALs reflect the same justification as the racially-motivated War on Drugs—drug "abusers"[278] suffer from a moral failing, not a medical condition. Further, the concern that those suffering from substance use disorder in historically oppressed communities will be disincentivized to call for help is exacerbated by the fact that Black and Brown populations have special reason to fear contact with law enforcement.[279] Statutes that fail to expressly protect

274. *See supra* notes 50–54 and accompanying text.

275. *See supra* note 32.

276. *See* Schill, *supra* note 16, at 128 ("Unlike other diseases, addiction is inherently marked by continual law breaking.").

277. *See supra* Part III.B–C.

278. For a list of terms to avoid in seeking to reduce substance use stigma, see *Words Matter—Terms to Use and Avoid When Talking About Addiction*, NAT'L INST. ON DRUG ABUSE (Nov. 29, 2021), https://perma.cc/PDF4-9S2F.

279. *See* Devon W. Carbado, *Black-on-Blue Violence: A Provisional Model of Some of the Causes*, 104 GEO. L.J. 1479, 1484–85 (2016) (observing that Black individuals are "vulnerable to repeated police interactions" and that "this frequent police contact exposes African-Americans to the possibility of violence").

from arrest, or jurisdictions that do expressly protect from arrest but effectively eliminate that protection by forcing pretrial litigation, do nothing to alleviate this simple safety concern.

Taken together, in analyzing medical amnesty laws, it is impossible to interrogate their benefits and the dangers posed by restrictions on them without reference to the United States' troubled and oppressive history with substance use. The danger is that a court, legislator, or citizen simply accepts that some medical amnesty is better than no medical amnesty at all and returns to business as usual. As the battle against the deadly opioid crisis rages on, legislators and courts must acknowledge that each arbitrary barrier to accessing amnesty makes it positively more likely that a person will die pointlessly because they feared criminal prosecution. They must also embrace that MALs embody a shift in thinking on the effectiveness of drug criminalization, which has done nothing to stop rates of overdose from increasing each year.[280] Lastly, lawmakers must acknowledge MALs as a small but critical reparative step in rectifying the damage done by drug criminalization, particularly to Black and Brown communities.

A. *The Role of Judges*

Legal scholars have pointed out, in numerous contexts, facially neutral laws carried out by courts perpetuating racial

280. *See* Spencer et al., *supra* note 11 (showing an exponential increase in drug overdose deaths since 2001).

oppression.[281] The War on Drugs is a strong example.[282] The criminalization of addiction "transformed justice systems" not only because it created new punishments for certain behavior, but also because it created funding incentives for the arrest and prosecution of drug offenders.[283] Alongside the resultant swell in criminal prosecutions, the Supreme Court expanded in race-neutral terms the discretionary power available to police and prosecutors.[284] Given the already existing disparities in treatment,[285] the additional power afforded to law enforcement only exacerbated the racist application of drug laws.[286]

In a different manner, medical amnesty statutes and judicial standards that unnecessarily restrict access to immunity fit within this larger oppressive framework. The ostensibly race-neutral search-and-seizure standards adopted by the Supreme Court in the height of the War on Drugs affirmatively increase the likelihood that an individual will encounter law enforcement, be arrested, and be convicted.[287] While burdensome and narrow medical amnesty requirements

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281. *See, e.g.*, James & Jordan, *supra* note 34, at 415 (discussing the critical importance of policymakers avoiding laws that "purport to be colorblind or race-neutral, but, in fact, result in differential treatment"); Crenshaw, *supra* note 40, at 1383 (arguing in the context of antidiscrimination law that "[t]he race neutrality of the legal system creates the illusion that racism is no longer the primary factor responsible for the condition of the Black underclass"); Brandon Hasbrouck, *The Antiracist Constitution*, 102 B.U. L. REV. 87, 107 (2022) (discussing continued existence of public race discrimination via "ostensibly neutral standards that lack regard for the history of oppression that created racial disparities along the lines of those same criteria"); Denisenko, *supra* note 53, at 1700–03 (examining how facially neutral zoning laws were used to racially segregate communities during the twentieth century, leading to still-existing housing and health disparities).

282. *See* Jessica M. Eaglin, *The Drug Court Paradigm*, 53 AM. CRIM. L. REV. 595, 601 (2016) ("[T]he War on Drugs—and mass incarceration—is associated with vast racial inequity . . . .").

283. *Id.* at 600–01; *see also supra* note 44.

284. *See* ALEXANDER, *supra* note 36, at 86–89 (outlining the increase in police and prosecutorial discretion through pretextual stops under the Supreme Court's Fourth Amendment jurisprudence).

285. *See supra* note 36 and accompanying text.

286. *See* ALEXANDER, *supra* note 36, at 163–65 (describing how the Supreme Court's search-and-seizure and equal protection jurisprudence has allowed race to become an express factor in discretionary decision making by law enforcement).

287. *See supra* note 284 and accompanying text.

obviously do not make it more likely that a police officer will initiate a search, such requirements do create a higher likelihood of criminal litigation and potential conviction for someone who has called for help.[288]

Drug arrests are not going anywhere as long as drug scheduling laws remain on the books. Between 2015 and 2020, approximately 1.51 million people on average per year were arrested for drug-related crimes.[289] State trial-level judges thus face a strong likelihood that they will have occasion to consider their state's medical amnesty law at some point.

Some courts will be prevented, in a formalistic manner, from the broadest possible application of MALs by the statutory limitations pointed out by Schill—such as allowing merely for an affirmative defense or not including relevant paraphernalia[290]—and by language requiring objectivity.[291] But, to the extent possible, courts should apply the fullest possible weight to legislative purpose, and they should embrace examination of the historically oppressive context into which MALs have entered.[292] In cases like *Williams*, the court considers public policy up front as part of its burden determination.[293] While, in others, like *Morris I* or *Markun*, public policy and legislative purpose come up in light of ambiguity in the statutory text.[294]

Returning to *Williams*, in Wisconsin, someone who seeks medical assistance at the scene of an overdose, but is later charged for a drug crime, must appear in court, retain counsel, and prove their entitlement to immunity.[295] In holding that the

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288. *See supra* Part III.C.

289. *Drug Related Crime Statistics*, NAT'L CNTR. FOR DRUG ABUSE STATS., https://perma.cc/T8P7-557X (last visited Feb. 17, 2023).

290. *See supra* Part II.

291. *See, e.g.*, OR. REV. STAT. § 475.898(1) (2023) ("A person who contacts emergency medical services or a law enforcement agency to obtain medical assistance for another person *who needs* medical assistance due to a drug-related overdose is immune from arrest or prosecution for [the relevant offenses]." (emphasis added)).

292. *Cf.* Hasbrouck, *supra* note 281, at 107 (highlighting the "lack of regard for the history of oppression" as a driver of racial disparities in the application of facially neutral legal standards).

293. *See supra* note 219 and accompanying text.

294. *See supra* notes 159–160, 258 and accompanying text.

295. *See* State v. Williams, 888 N.W.2d. 1, 4 (Wis. Ct. App 2016).

burden rested on the defendant, the court expressly valued the countervailing "significant public interest in prosecuting drug crimes" over the apparent purpose of the MAL.[296] The court even relied on a case decided in 1988, during the height of the War on Drugs, to suggest that drug *criminalization* was grounded in "public health."[297] When given the opportunity to examine policy, the court not only failed to grasp and provide adequate weight to the purpose of medical amnesty, it failed to note how that purpose would be frustrated by requiring the now-defendant to prove their entitlement.[298] Sadly, despite giving itself the opportunity to directly consider policy, the court went in a diametrically opposite direction to medical amnesty's purpose by expressly valuing the countervailing harm, drug crimes.

In contrast, in the context of determining whether subjective or objective belief of overdose is required, the *Morris I* court properly recognized that "the General Assembly made an obvious policy determination that saving a life is more important than prosecuting the drug-possession charge," and accordingly found that "a subjective standard better advances that purpose than an objective one."[299] The court recognized the real-world impact that a contrary holding would have, reasoning "it could make them ask questions like, 'Am I really overdosing?' 'Would a reasonable person be overdosing if they took what I did?' 'Do I need a note from my doctor before calling 911?'"[300] In other words, when faced with two equally colorable arguments regarding the statute's plain meaning, the original *Morris* majority sensibly emphasized the purpose of MALs and the larger context within which they operate.

While the *Morris I* court dealt with the substantive subjective/objective standard, the *Markun* court and *Osborne*

296. *Id.* at 6.

297. *Id.* (citing State v. Peck, 422 N.W.2d 160, 164 (Wis. Ct. App. 1988)); *see* State v. Peck, 422 N.W.2d 160, 164 (Wis. Ct. App. 1988) ("Preservation of the public health and safety is the obvious purpose underlying Wisconsin's drug laws, and we see a compelling state purpose in the regulation of marijuana and other controlled substances.").

298. *See Williams*, 888 N.W.2d at 6 (factoring in "special policy considerations").

299. 876 S.E.2d 182, 191 (Va. Ct. App. 2022), *rev'd en banc on other grounds*, 886 S.E.2d 722 (Va. Ct. App. 2023).

300. *Id.*

concurrence faced statutory ambiguity on the procedural issue of whether the State was barred from bringing the case in the first instance.[301] Like the *Morris I* court, after looking to the text, both heavily emphasized the life-saving purpose of MALs, with the *Markun* court finding that "[i]t would significantly undercut the statute's goal to conclude . . . that the Act merely provides a defense, thereby requiring an overdose victim or a reporter to litigate the issue of immunity."[302]

Limitations like those placed on amnesty-seekers in Wisconsin, by the admission of its own Court of Appeals,[303] work in the same direction as traditional treatment of drug laws by increasing the likelihood of criminal conviction. By valuing the "interest of prosecuting drug crimes,"[304] the court perpetuates the notion that drug addiction is a "criminal" problem that requires a criminal solution and puts the onus on the person suffering to take "personal responsibility" for their actions.

In contrast, the *Markun* court's analysis sets up future decisions on medical amnesty in Pennsylvania to similarly value the interest in life over punishment. The *Morris I* opinion and the *Osborne* concurrence, although they do not hold precedential value, are similarly instructive. Framed in this way, because of judges who deliberately and sensibly examined MALs within a broader context, Pennsylvania and, likely, Virginia are jurisdictions where MALs work directly against the criminalization of addiction and drug laws' oppressive history.

B. *The Role of Legislatures*

State legislatures are obviously in the best position to amend and clarify their medical amnesty statutes. More importantly, legislatures are responsible for the criminalization of addiction and the resultant funneling of money into the criminal justice system rather than treatment and social

301. *See supra* notes 251–257 and accompanying text.

302. Commonwealth v. Markun, 185 A.3d 1026, 1035 (Pa. Super. Ct. 2018); *see also* State v. Osborne, 831 S.E.2d 328, 340 (N.C. 2019) (Earls, J., concurring) ("[T]he legislature enacted a policy to sacrifice prosecutions for possession of small amounts of drugs in order to save lives. Treating [this MAL] as anything other than a jurisdictional requirement that must be established by the State would severely undercut that policy.").

303. *See infra* note 304 and accompanying text.

304. *Williams*, 888 N.W.2d at 6.

welfare. They have played the starring role in exacerbating the current public health crisis by stigmatizing substance users and pointing them away from treatment.[305] While combatting substance use disorder is a massive problem that is being discussed extensively in both the legal and public health communities, states have already taken the small, but important step of removing certain drug-related offenses from criminal liability though MALs.[306] Now, legislatures must extend that step by simply removing the barriers to accessing these statutes' protections.

In her Note, Schill proposes a model statute designed to encourage calls for assistance.[307] The model statute provides for the broadest type of amnesty, immunity from arrest, charge, and prosecution, and it is applicable to bystanders and victims.[308] It

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305. *See supra* note 54 and accompanying text.

306. *See* McClellan, *supra* note 15, at 93 ("[A]fter states enacted an overdose Good Samaritan law, they had a 15% lower incidence of opioid-overdose deaths, as compared to when states did not have an overdose Good Samaritan law.").

307. *See* Schill, *supra* note 16, at 149

> 1) A person who, in good faith, seeks medical assistance for a person who is experiencing a drug or alcohol overdose or other medical emergency or who seeks such assistance for himself or herself, or who is the subject of a good faith request for such assistance, may not be arrested, charged, prosecuted or convicted, or have his or her property subjected to forfeiture, or be otherwise penalized for violating any and all non-violent offenses in this state's penal code based upon evidence that was obtained as a result of the seeking of assistance.
>
> 2) In the case of the person claiming this immunity being the person who sought assistance for an overdose victim or who sought assistance for his or herself, this immunity will only be available if the person cooperated fully with authorities and provided all requested information. (Nebraska)
>
> 3) For any crime not included under the immunity granted in section (1), evidence of seeking emergency medical assistance for a person who reasonably appears to be experiencing an overdose may be considered by a court or jury as a mitigating factor in the sentencing phase of a criminal proceeding, provided that the conditions of section (2) are met, and the evidence used in the criminal proceeding was obtained as a direct result of the seeking of emergency assistance as described in section (1).

308. *Id.*

also extends protection to amnesty from "any and all non-violent offenses."[309] She explains: "By offering simple immunity from criminal liability for all non-violent offenses and for all parties present at the overdose, the statute is simple, meaning it is easy to make [individuals who use substances] aware of it and easy . . . to understand."[310] Practically speaking, legislatures will likely be reluctant to extend protection to such a wide range of offenses, as such limitations are often the result of compromise efforts in light of competing interests.[311] But, by contemplating the broadest possible protection in terms of the type of immunity, who may be protected, and applicable offenses, Schill's model statute is an excellent starting point.

Turning to the new issues presented in this Note, objectivity and burden, Schill's model statute closely models the language that the Virginia Court of Appeals interpreted in *Morris*, providing amnesty for "[a] person who, in good faith, seeks medical assistance for a person who is experiencing a drug or alcohol overdose."[312] In order to remove the ambiguity that the *Morris I* court had to address, a complete model statute should adopt the language of express subjectivity used in Florida's MAL. For the bystander, Florida's MAL provides: "A person *acting in good faith* who seeks medical assistance for an individual experiencing, or *believed to be* experiencing an alcohol-related or drug-related overdose . . . shall not be arrested, charged, prosecuted, or penalized"; for the victim, it provides immunity if the person "experiences, *or has a good faith belief that he or she is experiencing*, an alcohol-related or drug-related overdose."[313]

On the issue of burden, no MALs directly address this problem, leaving this question completely up to the criminal common law. As *Williams* and *O'Malley* illustrate, judicial

309. *Id.*

310. *Id.* at 155.

311. *Cf.* N.J. STAT. ANN. § 24:6J-2 (West 2023) ("It is not the intent of the Legislature [with respect to overdose prevention] to protect individuals from arrest, prosecution or conviction for other criminal offenses, including engaging in drug trafficking . . . .").

312. Schill, *supra* note 16, at 149; *cf.* VA. CODE ANN. § 18.2-251.03(B)(1) (2023) (providing immunity for an individual if they, "in good faith, seek[] or obtain[] emergency medical attention for" someone who "is experiencing" an overdose).

313. FLA. STAT. § 893.21(1)–(2) (2023) (emphasis added).

application can and does result in frustration of the statute's purpose.[314] In line with *Markun* and Justice Earls's concurrence in *Osborne*, legislatures should treat medical amnesty immunity as a jurisdictional requirement, removing the power of the court to hear the case if the amnesty-seeker asserts that the statute applies to their circumstances.[315] If the government believes that the amnesty-seeker or victim had not acted in good faith, before prosecuting, it would have to prove at a pretrial hearing that immunity did not apply.[316] Thus, legislatures should include a similar jurisdiction-stripping provision to the below in their respective MALs:

> The above immunity provision imposes a duty on a law enforcement officer or prosecuting attorney to neither arrest nor impose charges and deprives a Court of jurisdiction to hear such charges brought under [applicable criminal statutes] if one of the above-listed individuals asserts the applicability of this provision. If a law enforcement officer or prosecuting attorney has a good faith belief[317] that the person seeking protection under this provision has not acted in accordance with the requirements for immunity, the State may initiate a proceeding and submit evidence that this provision does not apply. The Court should only find that this provision does not apply if the State has proven that it is more likely than not that the person seeking immunity has not acted in accordance with the requirements of this provision. If the Court so finds, the State may proceed with prosecution.

The above proposed provisions are in line with Schill's advocacy for the simplest, broadest requirements to access

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314. *See supra* Part III.C.

315. *Cf.* State v. Osborne, 831 S.E.2d 328, 340 (N.C. 2019) (Earls, J., concurring) (suggesting that the statute creates a "jurisdictional requirement").

316. *Cf. id.* ("The application of this immunity . . . is not something that was tacitly waived by defendant here, but rather the State was required to prove that the immunity did not apply in order to proceed with prosecution for this particular offense.").

317. The *Markun* court noted the practical reality that "there will be situations in which the application of the Act will be unclear." 185 A.3d 1026, 1035 (Pa. Super. Ct. 2018). In those situations, the court contemplated that the government's "discretionary power" is not extinguished and "charges will only be filed when law enforcement authorities, acting in good faith, believe that the individual is not entitled to the Act's protections." *Id.*

immunity.[318] A clearly subjective "good faith" requirement without any reasonableness component removes the issue faced by the *Morris I* court of a person having to assess "do I need a note from my doctor before calling 911?"[319] The jurisdiction-stripping provision removes the fear of arrest and pre-trial litigation, which can not only create a deterrent but can also lead to greater social harm.[320] In other words, with these provisions added to and amending Schill's proposed model statute, someone faced with a life-threatening overdose event would be able to call for aid and trust that they will get it with no punitive strings attached. One side of the weighted scale of disincentives is completely removed from the equation.

Lastly, legislatures should include legislative findings that clearly note the purpose of the medical amnesty statute and state the reasons for enacting it.[321] Legislative committees should hold hearings that evaluate not only the critical issue of overdose deaths and the wave of synthetic opioids, but the *entire history* of the stigmatization of substance users in the United States, including discriminatory criminal laws, the oppressive impact on Black and Brown communities, and the unfounded disparities in public perception between past drug epidemics and our current one.[322] By making a clear legislative determination that medical amnesty laws are meant to combat the historic harm of criminalization, the legislature gives clear guidance to courts interpreting any remaining statutory construction issues. In so doing, they would also take a small reparative step, tangibly and rhetorically, toward rectifying the damage caused by criminal drug laws.

CONCLUSION

Medical amnesty laws reflect the principle that saving lives is more important than prosecuting drug offenses. They reflect

318. *See supra* note 310 and accompanying text.

319. 876 S.E.2d 182, 191 (Va. Ct. App. 2022), *rev'd en banc on other grounds*, 886 S.E.2d 722 (Va. Ct. App. 2023).

320. *See supra* note 266 and accompanying text.

321. *Cf.* ARK. CODE ANN. § 20-13-1702 (2023) ("The State of Arkansas must take steps to combat the increase of drug overdoses in the state and protect the health and safety of its citizens.").

322. *See supra* Part I.

an implicit acknowledgement that drug criminalization and militarized enforcement have failed to better the public health.

This failure makes perfect sense in light of the fact that the original impetus behind drug laws was not to right a "moral wrong"—even if public discourse ultimately adopted that position—but instead was intended to galvanize oppositional racial sentiments in White voters. Black and Brown communities have been deeply harmed by discriminatory enforcement and disproportionate incarceration. Now, in addition, prescription and synthetic opioids have proliferated throughout the nation, exacerbating the public health crisis and creating additional opportunities for drug-related punishment.

Legislators owe it to their communities, and particularly to communities of Color, to repair the damage done by drug laws—medical amnesty is one small step. Despite having a crystal-clear purpose, complex and esoteric provisions and needless restrictions in their application prevent the potential benefit of these statutes from being realized. Each limitation creates a greater likelihood of either incarceration for someone needing medical treatment and social stability, or death. As long as these complex provisions remain, courts, in the vein of *Morris I*, *Markun*, and Justice Earls's *Osborne* concurrence, must acknowledge the purpose of these laws and the real-world harm of creating barriers to immunity. Legislators should remove this issue from the realm of the courts, however, and simplify their statutes, conferring broad immunity, trusting in an individual's "good faith" belief, and removing the court's power to hear the case until prosecutors can show the statute's inapplicability. In so doing, legislatures will truly advance the principle that life is more important than punishment.