

Pushing Drugs or Pushing the Envelope: The Prosecution of Doctors in Connection with Over-Prescribing of Opium-Based Drugs

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Introduction

On July 13, 2007, Dr. William Hurwitz was sentenced to 57 months in federal prison for drug-trafficking. This result was portrayed by the press as a victory for the defendant as this conviction and sentence resulted from a retrial (his original conviction was overturned by the 4th Circuit) of counts that had originally landed Hurwitz with a 25-year sentence. But while 57 months is surely better for the doctor than 25 years, it is still a troubling sentence for a doctor whom the judge acknowledged was not motivated by financial gain and who arguably did much to help both his individual patients and the cause of pain patients generally.

Dr. Hurwitz is one of a growing number of doctors being prosecuted in federal and state courts for prescribing controlled substances (usually opium-based drugs) in a manner not authorized by their professional licenses or federal law. The doctors are usually charged with drug trafficking, but also sometimes with conspiracy to distribute drugs or even with homicide

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in cases where patients have died. The statute under which most of these prosecutions occur—the Controlled Substances Act (CSA)—allows physicians to prescribe controlled substances (if the physicians are registered to do so) in the course of medical practice but prohibits them from distributing drugs outside of such medical practice. While physician actions that are deemed to be outside the bounds of reasonable med-

ical care are typically the basis for civil liability for malpractice only, the Supreme Court has held (as long ago as 1975) that a medical professional is not immune from normal criminal liability for drug trafficking. Just because a person holds a medical degree does not mean that he can simply sell drugs or sell prescriptions for controlled substances. Such action constitutes drug trafficking. But when the doctor writes prescriptions in his office, following consultation with a patient, and receives no compensation other than the normal fee for service, can this still be drug trafficking? Recent cases have emphatically held “yes.” This result makes a kind of sense as well. After all, an unscrupulous doctor *could* simply be writing any and all prescriptions asked for, while wearing the white coat and doing business in a room that looks like a doctor’s office. While the doctor is only getting a routine fee for an office consultation, if the doctor offers no real medical consultation and merely sees so-called patients one after the other, dispensing scripts to all-comers, then the fee-for-service becomes the method of payment for prescriptions (which enable the “patient” to get access to controlled drugs). Is this not drug-trafficking merely dressed up in medical guise?

After all, what makes actions (here writing prescriptions) *medical practice*? It isn’t just *who* is doing it. The white coat and the office setting don’t ensure that actions constitute medical practice. Perhaps it is whether the person is being paid money (or something else) *for* prescriptions. If so, the actions don’t constitute medical practice. But once we recognize that this payment can be indirect, like in the scenario described above, it is unclear whether this test works or instead devolves into one that focuses on the intentions of the physician him or herself. If she intends to practice medicine (and makes money by way of doing so) then it is medical practice. If she intends to make money by selling drugs, then it isn’t. But this is a tricky path to

walk down. Its very structure is reminiscent of debates about the doctrine of double effect which itself has proved quite controversial.

Before proceeding down this route, let's take a closer look at the legal standard being adopted by courts to delineate permissible (though potentially negligent) actions from criminal behavior by physicians. A violation of the Controlled Substances Act requires that the physician (1) knowingly distribute a controlled substance (2) with knowledge that it is controlled and (3) that he or she do so "outside the usual course of medical practice." It is easy to anticipate the problem this formulation of the legal standard presents. Elements (1) and (2) require knowledge *but* that knowledge is uncontroversial in cases of physician prescribing. The physician knows that she is writing a prescription (distributing) for a controlled substance and she knows that the substance is controlled. The controversy surrounds whether the knowledge requirement also modifies element (3). Must the physician know that her actions are outside the bounds of medical practice? While a straightforward reading of these elements would suggest not, this reading seems untenable as it would criminalize behavior that is merely negligent. It surely cannot be the case that knowingly prescribing controlled substances in a manner that a court later determines is outside the bounds of medical practice turns one into a drug dealer, can it?

Predictably, most of the challenges to convictions of physicians under the CSA have focused on whether the physician is in fact being held criminally responsible for actions that are merely negligent. (Hurwitz himself had his first conviction overruled by the 4th Circuit on the grounds that the trial court erroneously disallowed the jury to consider whether the doctor had acted in good faith.) But the result of these challenges has left a patchwork of standards without adequate analysis of the issues involved and the theories of criminal responsibility that would animate each of the various formulations of the legal standard. In what follows, I will argue that the standards (as different courts are interpreting the requirements of the CSA differently) for criminal liability currently being applied in courts are problematic for four reasons:

- First, there is an unresolved ambiguity about whether in fact doctors are responsible only when they *knowingly* prescribe in a manner that lies outside the bounds of medical practice or if something less than knowledge will suffice. This lowering of the standard (from knowledge to something less) is in part brought about by courts' allowing so-called "willful blindness" to substitute for knowledge.
- But, as I will argue, the use of the willful blindness doctrine in this context is inapt in two ways; these are the second and third problems

with the standard for criminal liability applied in these cases. Willful blindness requires that an actor take some action to avoid knowledge. But in most of the physician prescribing cases, no such action is present. Moreover (third problem), often the reason the doctor doesn't know his patients are abusing or diverting the drugs is because he trusts his patients. Because the good physician-patient relationship is built on trust, the doctor has a good reason to trust his patient and that distinguishes this situation from culpable willful blindness.

- Finally, the doctor also has an ethical obligation to put his patient's needs above those of society. This asymmetry in the way the doctor ought to evaluate the harms and benefits of different

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courses of action may change the assessment of whether some actions are reckless. Because some courts treat willful blindness as a form of extreme recklessness, the fact that actions which would be reckless if done by others are not reckless when done by a physician matters to how courts ought evaluate whether the physician acts culpably in these cases.

Ambiguity about the Standard for Criminal Responsibility

While courts seem to concede that knowledge is the appropriate *mens rea*—the legal term for the mental state of the actor accused of the crime—for the third element (acting outside the bounds of medical practice), they back-peddle in interpreting this requirement in two ways. First, some courts approach this element by asking whether the doctor acted in "good faith." What exactly good faith is and how it should be assessed is notoriously under-analyzed in law generally and therefore especially problematic when used to interpret whether someone has violated criminal law. Some of the courts that see "good faith" as relevant to whether a physician has violated the CSA understand good faith as, at least in part, objectively defined. Indeed, the opinion that reversed Dr. Hurwitz's original conviction held that "good faith" should be viewed objectively. If good faith is understood objectively, the physician can be prosecuted for prescribing in a manner that he should have known exceeds the bounds of medical practice. Requiring what these courts term

“objective good faith” abandons the requirement of knowledge for element (3) and therefore lowers the standard for a finding of criminal conduct.

Other courts do adopt a subjective test of good faith—asking whether the physician believed in good faith that his or her actions exceeded the bounds of medical practice—but back-peddle as well in a different way. Instead, they allow *willful blindness* to indicate that the doctor was prescribing to drug users and dealers to fulfill the knowledge element of the offense.

There is thus an unresolved ambiguity about whether the physician is criminally responsible only for knowingly prescribing in a way that lies outside medical practice or instead whether something less will satisfy the elements of the offense.

Willful Blindness Requires Avoiding Information

Willful blindness is seen as the moral or legal equivalent of knowledge in those instances where one deliberately avoids knowing facts that if known would require (morally or legally) that one desist from one's actions. The drug courier who never looks in the pouch he is paid a large sum of money to carry into the country is willfully blind to the fact that he carries drugs. Here his willful blindness seems culpable because he has reason to believe that the pouch may carry drugs (why else is he offered such a large sum to

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transport it?) and he refrains from investigating in order to reap some gain. Courts see a parallel in the doctor cases. The physician who continues to prescribe drugs to the patient despite numerous “red flags” indicating that the patient may be abusing or selling these drugs is held to be willfully blind to the fact that he is dispensing drugs outside the bounds of medical practice. But this parallel may be inapt.

The drug courier avoids gathering information—his *willful blindness* results from a choice to avoid taking some action which would provide the relevant information. In contrast, Dr. Hurwitz didn't avoid gathering information, rather he failed to make the inferential leap from this information to the conclusion that his patients were dealing or using drugs. He didn't know, not because he didn't have the facts that might suggest such a conclusion. Rather, he didn't know because

he—perhaps naively—didn't see the facts he did know as clearly indicating that his patients were doing these things. Interestingly the court rejected, mistakenly in my view, the argument made by Hurwitz's lawyers against the inclusion of a willful blindness instruction to the jury on the grounds that *willful blindness* requires that the person take some action to shield himself from knowledge—which, they argued, Hurwitz had not done. The failure to draw the reasonable inference from a known set of facts is not the same as shielding oneself from learning facts one suspects may be troubling.

Willful Blindness and Trust

Hurwitz argued that he didn't draw the (perhaps reasonable) inferences from the facts he had because he was disposed to trust his patients. Compare this to the drug courier case. In the drug courier case, willful blindness is culpable because the courier deliberately decides to remain ignorant for reasons that are at best morally ambivalent and at worse devious and wrong. At best, the courier refrains from looking inside the pouch so that he won't be faced with the decision about what to do—knowingly carry the drugs or forgo the money he's been paid for transport. At worst, the courier refrains from looking so that he can carry what he suspects are drugs but can do so in a manner that allows him to escape legal liability for doing so *knowingly*. Hurwitz, by contrast, offers a good reason in support of his actions. He trusted his patients.

Trust is indisputably a cornerstone of the physician-patient relationship. There are both instrumental and non-instrumental justifications for the importance of trust to this relationship. Trust is instrumentally important because it encourages the free flow of information by the patient to the doctor, information that may be critical in accurately diagnosing and treating the patient. The doctor's trust in the patient is also important because this display of trust helps the patient to feel valued and respected. These feelings are especially important in the case of chronic pain patients (who made up Dr. Hurwitz's practice) as such patients are often shunned by other doctors (who don't know how to treat them) or doubted and disbelieved by these other doctors or by co-workers, family and friends because they often have no visible or clearly verifiable injury or disease to point to that accounts for the pain they suffer. Patients often experience significant mental suffering from this skepticism and while not as bad as the physical pain they endure, piles on in a cruel and difficult way.

Perhaps more controversially, trust is important to the doctor-patient relationship for non-instrumental reasons as well. A good doctor trusts his patients. While this account cannot be fully developed here, the

The Economy of the Earth
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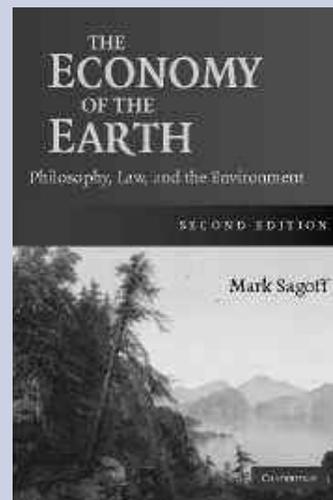
Mark Sagoff

Mark Sagoff draws on the last twenty years of debate over the foundations of environmentalism in this comprehensive revision of *The Economy of the Earth*. Posing questions pertinent to consumption, cost-benefit analysis, the normative implications of neo-Darwinism, the role of the natural in national history, and the centrality of the concept of place in environmental ethics, he analyzes social policy in relation to the environment, pollution, the workplace, and public safety and health. Sagoff distinguishes ethical from economic questions and explains which kinds of concepts, arguments, and processes are appropriate to each.

The second edition incorporates the increasing engagement of mainstream and evangelical religious communities with environmental protection into his argument for a democratic environmentalism not constrained by either economics or science. Sagoff's carefully reasoned and wide ranging arguments will infuriate economists, ecologists and elite environmentalists equally, but the book is essential reading for anyone interested in the future of environmentalism.

—Dan Tarlock, Chicago-Kent College of Law

The Economy of the Earth presents a masterful synthesis of Mark Sagoff's seminal contributions to the theory of environmental policy analysis. Sagoff argues that good policy design requires accommodation between strongly held,



incommensurable moral values. Yet the techniques of policy analysis rest on strong and sometimes naïve ethical assumptions. Sagoff shows how careful philosophical reasoning can reform the practice of policy analysis to better serve the democratic process. This provocative book deserves a central place in the environmental studies literature.

—Richard B. Howarth, Dartmouth College

The first edition of The Economy of the Earth staked out a position that many felt but few had said: the most important reasons for protecting nature are moral and aesthetic, not economic and instrumental. In the second edition, massively revised and updated, Sagoff preaches the same sermon but even more clearly and eloquently. The second edition of The Economy of the Earth is as vital to debates about environmental policy as the first edition was in its time.

—Dale Jamieson, Director of Environmental Studies, New York University

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good doctor does not merely perform a service for the patient, rather she or he enters into a special sort of relationship with the patient. It is an imbalanced relationship in which the patient is vulnerable. The good doctor respects that vulnerability by treating the patient as much as possible as an equal—by respecting her autonomy to make decisions (when adequately informed by the doctor) and by treating her as a person whose word and reports of symptoms are to be trusted. If the doctor's blindness results from his disposition to trust his patients, it is not culpably willfully blind and therefore ought not to subject the doctor to criminal sanction.

Putting the Patient First

Some accounts of willful blindness see it as a form of extreme recklessness. An actor acts recklessly when he takes a substantial and unjustifiable risk of which she is aware. The problem with seeing the doctor's actions as criminal recklessness is that courts fail to pay attention to the fact that the same action that may be reckless if done by an ordinary person may not be reckless when done by a physician.

Courts see these pain doctors as acting recklessly when they prescribe drugs to patients whom the doctor suspects are likely to be abusing or reselling the drugs. This account may be too simplistic however. It isn't reckless to risk a harmful action, even if it is very

likely to occur, if the harm is significantly smaller than the harm that inaction may cause. Suppose the likelihood of X occurring if you do Y is 90%. The likelihood of not-X is thus 10%. If the harm of X is much, much smaller than the harm of not-X, it may well make sense to do Y, notwithstanding the likelihood of X occurring and the harm that X will cause. The definition of recklessness as taking a substantial and *unjustifiable* risk is meant to capture this point. The drug courier recklessly brings drugs into the country when he carries the pouch knowing that is very likely that the pouch contains drugs because if it *does* contain drugs, these will cause significant harm (we assume). But if the pouch *does not* contain drugs (unlikely but possible), failing to bring in the pouch is unlikely to cause significant harm. Without some reason to believe or suspect that there is some great harm his failure to transport a legitimate package will cause, the drug courier's action is reckless.

Now compare this to Hurwitz's action. Suppose that he suspects with a high degree of certainty (90%) that his patient is using or dealing drugs. If he continues to write prescriptions for this patient, he yet may not be reckless. To see why, suppose he is wrong and his

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patient is not using or dealing but legitimately needs the drugs to curb her crushing pain. If so, then failing to prescribe to her will cause terrible harm. Because this harm may be significantly greater (failing to relieve awful suffering) than the harm caused by facilitating access to drugs to users or dealers, the doctor's action may not be reckless. And this is so even when the likelihood that the patient is using or dealing is significantly greater than the likelihood that she is legitimately in need.

Further, the doctor does not approach these harms neutrally. Rather, he is obligated to care more about alleviating the suffering of his patient than he cares about avoiding harm to society. The physician's obligation of loyalty to his patient requires him to help his patient, to care especially about alleviating her suffering, when possible. Special relationships, like parent/child, doctor/patient, friend/friend, allow or even require the participants to value the interests of the related person more than the interests of others. So the physician confronted with the possibility—even a probability—that he may be writing a prescription for a patient who will abuse or sell the drugs prescribed does not simply reason that it would be reckless to

continue because there is a significant likelihood of harm. He must also ask himself what would be the harm of failing to prescribe if his patient is legitimately in need. If that is great, it might outweigh the likelier harm of prescribing to the user even for the neutral observer. For the physician, however, the considerations are not to be weighed neutrally. The physician must care more for his patient's suffering than for the harm to society and this obligation puts an extra thumb on the scale in favor of prescribing despite the risk that the patient is selling the drugs.

Finally, the above discussion overly simplifies the analysis by avoiding the most difficult and troubling sort of case: the patient whom the doctor both believes is in pain and suspects is selling some of his medication (perhaps even in order to make money to afford the pain medication for herself). In one of the tape recordings secretly made of Dr. Hurwitz during the time that he was under investigation, he says "that it was 'not inconceivable' to him that some patients were 'selling part of their medicines so they could buy the rest.'" Whether continuing to prescribe drugs to such a person is "unjustified"—in the way that the Model Penal Code envisions in its definition of recklessness—is far from clear. While the Drug Enforcement Agency appears to take the position that doing so is not permissible, the doctor's professional obligations push in the other direction.

What Is "Medical Practice"?

If we reject the appropriateness of using willful blindness to substitute for the *mens rea* of knowledge in the context of prosecuting doctors for their prescribing practices, where does this leave us? The prosecution must show, in such cases, that the doctor *knowingly* prescribed in a manner "outside the usual course of medical practice." But this formulation raises as many questions as it answers. What *is* it that the doctor must know? That he is prescribing to drug dealers or addicts? That he is prescribing in a way that he believes lies outside the bounds of medical practice? That he is balancing the harms of prescribing to drug users and dealers versus the harms of failing to prescribe to legitimate patients in a vastly different way than how other doctors would balance such harms? Ambiguity abounds. Let me focus on just one of the possible objects of the physician's knowledge and explore its complexities.

When we say that the doctor must knowingly act in a manner that is "outside the usual course of medical practice," do we mean that he knowingly acts in a way that the medical profession considers to be outside the bounds of medical practice (medical practice defined *objectively*), or do we mean that he knowingly acts in a way that he believes is outside the bounds of medical practice rightly conceived (medical practice defined

subjectively)? This question returns us to the inquiry that lies at the heart of this issue and that I flagged at the beginning of this piece: *what is medical practice?* Is medical practice to be defined by what the community of practicing physicians believe is medical practice? Medical malpractice law is built on such an idea. But this doesn't resolve the issue for our purposes here. The focus of medical malpractice is incompetence—which practices of medicine (whatever that is) fall below the standard for how such practices are to be carried out? Our focus is more basic—we are asking what defines or delineates the practice of medicine, rather than what instances of the practice of medicine do it so poorly as to be considered incompetent (though no one disputes they are still the practice of medicine).

In particular, we are asking whether medical practice encompasses practices that push the envelope. Research science is innovative—innovation is an integral part of what it is to be a researcher. But what of medicine? Is innovation a part of the practice of medicine? While it is surely not as central as it is to the research enterprise, it would be odd for the law to define the practice of medicine in such a way that it forbids innovative practice. This conclusion suggests that the practice of medicine cannot simply be defined by what the community of doctors currently think constitutes medical practice. But does such an account allow a rogue physician to do whatever he wants (sell prescriptions for money and call that “medical practice”)? Clearly not. However, it is unlikely such a physician honestly believes *that* constitutes medical practice. Moreover, a jury would still be entitled to assess whether it believes the doctor's claim that he was doing what he honestly believes constitutes practicing medicine. Moreover, medical malpractice (and the civil sanctions it carries) will continue to provide limits to physician action. When patients believe they have been treated in a manner that falls below professional competence, patients can choose to sue. But while failed innovative procedures could constitute medical malpractice, they would not subject the physician to criminal liability for practicing outside the bounds of medicine.

Ironically, US District Judge Leonie M. Brinkema, who presided over the retrial of William Hurwitz, explained before hearing arguments related to his sentencing, that in the years between the first trial and the re-sentencing in the summer of 2007, the level of expertise about the proper way to treat chronic pain patients had advanced considerably. In particular she emphasized that experts now agree that there is no upper limit on the amount of opioids that can safely and appropriately be prescribed to such patients. Dr. Hurwitz's practice was on the vanguard of these changes. And yet, the judge did not find that these facts provided a reason to grant the defendant's motion

for an acquittal. In denying that motion, Brinkema stated that the physician seems to have a “God-complex” rather than to be motivated by financial gain. But as she saw it, this was no reason to find the case not one of drug-trafficking. But having a God-complex is not criminal, one would think. Moreover, one is left wondering what true innovators are free from the kind of arrogance she attributes to Hurwitz. Innovative practice should be viewed as part of the practice of medicine. When done unreasonably, it may constitute medical malpractice but no more. Pushing the envelope is not morally or legally equivalent to pushing drugs.

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Sources: The Supreme Court held that a medical professional is not immune from normal criminal liability for drug trafficking in *United States v. Moore*, 423 US 122 (1975); the requirements for violation of the Controlled Substances Act occurs in *US v. McIver*, 470 F.3d 550, 556; for a case that adopted a subjective test of good faith, see: *US v. Tran Trong Cuong*, 18 F. 3d. 1132, 1138 (1994), and the court that heard the retrial of Hurwitz's case allowed the jury to convict on the basis of willful blindness. The term “red flags” is used both in legal cases and by the Drug Enforcement Agency. David Luban, “Contrived Ignorance,” 87 *Georgetown Law Journal* 957 (1999). According to the Model Penal Code, willful blindness acts as a substitute for knowledge precisely because the actor knows, at the least, that there is a high probability that his actions are illegal: “When knowledge of the existence of a particular fact is an element of an offense, such knowledge is established if a person is aware of a high probability of its existence, unless he actually believes that it does not exist.” *Model Penal Code* § 2.02 (7) (Proposed Official Draft 1962). Commentary to the Code suggests that this expansion of the concept of knowledge is meant to accommodate cases of willful blindness. *Model Penal Code* § 2.02 (2) cmt. 9. The discussion of the tape made of Dr. Hurwitz discussing the possibility that some patients were “selling part of their medicines so they could buy the rest” occurs at *US v. Hurwitz*, 459 F. 3d. 463, 467 (2006).