

## NOTE

### PREVENTING PRESCRIPTION DRUG OVERDOSE IN THE TWENTY-FIRST CENTURY: IS THE CONTROLLED SUBSTANCES ACT ENOUGH?

#### I. INTRODUCTION

The televisions, radios, computers, iPods, and smartphones of countless people across the world were tuned in to local, national, and international news outlets<sup>1</sup> on June 25, 2009, upon hearing initial conflicting reports that the self-proclaimed “King of Pop” had died.<sup>2</sup> Just months after announcing his largely anticipated return to the stage, scheduled to begin in 2009, and only weeks after turning fifty, Michael Jackson died suddenly of cardiac arrest.<sup>3</sup> His death devastated his family and friends, his devoted fans, and an entire world community.<sup>4</sup>

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1. Linnie Rawlinson & Nick Hunt, *Jackson Dies, Almost Takes Internet with Him*, CNN.COM (June 26, 2009, 3:02 PM EDT), <http://www.cnn.com/2009/TECH/06/26/michael.jackson.internet/index.html>.

2. See Jake Coyle, *News of Jackson's Death First Spread Online*, USA TODAY (June 26, 2009, 8:15 AM), [http://www.usatoday.com/tech/webguide/internetlife/2009-06-26-jackson-online\\_N.htm](http://www.usatoday.com/tech/webguide/internetlife/2009-06-26-jackson-online_N.htm); Rawlinson & Hunt, *supra* note 1 (internal quotation marks omitted).

3. Sheila Marikar & Luchina Fisher, *Michael Jackson Dies After Cardiac Arrest*, ABC NEWS (June 25, 2009), <http://abcnews.go.com/Entertainment/Music/story?id=7931645&page=1>.

4. See Brooks Barnes, *A Star Idolized and Haunted, Michael Jackson Dies at 50*, N.Y. TIMES, June 26, 2009, <http://www.nytimes.com/2009/06/26/arts/music/26jackson.html>.

Unfortunately, prescription drug<sup>5</sup> overdose is common on the celebrity scene. In the past three years, actor Heath Ledger,<sup>6</sup> celebrity deejay Adam “DJ AM” Goldstein,<sup>7</sup> and former Playboy model Anna Nicole Smith,<sup>8</sup> among others,<sup>9</sup> have all lost their lives to prescription

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5. The Food and Drug Administration (“FDA”) has the authority to require that certain drugs be obtained pursuant to a prescription. See DRUG ENFORCEMENT ADMIN., U.S. DEP’T OF JUSTICE, DRUGS OF ABUSE 7 (2005), available at <http://www.justice.gov/dea/pubs/abuse/doa-p.pdf>. Enacted in 1938, the federal Food, Drug and Cosmetic Act (“FDCA”) regulates prescription drugs. See 21 U.S.C. § 301, 353(b) (2006). The Drug Enforcement Administration (“DEA”) can further regulate prescription drugs by placing them into one of five drug classification schedules pursuant to the Controlled Substances Act (“CSA”), outlined in 21 U.S.C. §§ 801–971. See, e.g., *id.* §§ 811–812. Once placed in a schedule, the prescription drug is considered a controlled substance and is regulated as such. *Id.* § 829. The Code of Federal Regulations regulates the issuance, filling, and filing of prescription drugs pursuant to the CSA. 21 C.F.R. § 1306 (2010). Not all prescription drugs are classified as controlled substances subject to additional regulations. See 21 U.S.C. § 811; 21 C.F.R. § 1306. For the purposes of this Note, however, any reference to “prescription drug(s)” is meant to encompass controlled substances unless otherwise noted.

6. According to the New York Medical Examiner’s office, Ledger’s cause of death was “acute intoxication by the combined effects of oxycodone, hydrocodone, diazepam, temazepam, alprazolam, and doxylamine.” CITIZENS COMM’N ON HUMAN RIGHTS INT’L, WHEN PRESCRIBING PSYCHOTROPIC DRUGS BECOMES CRIMINAL NEGLIGENCE: CASES AND CONVICTIONS 1 (2008), [http://www.cchrint.org/pdfs/Criminal\\_Negligence\\_White\\_Paper.pdf](http://www.cchrint.org/pdfs/Criminal_Negligence_White_Paper.pdf) (quoting Lorena Blas, *Ledger Death: Accidental Overdose of Prescription Drugs*, USA TODAY (Feb. 7, 2008, 7:42 AM), [http://www.usatoday.com/life/people/2008-02-06-ledgerreport\\_N.htm](http://www.usatoday.com/life/people/2008-02-06-ledgerreport_N.htm)). Pursuant to the DEA’s drug classification schedule, oxycodone and hydrocodone are found under Schedule II; diazepam (Valium), temazepam, and alprazolam (Xanax) under Schedule IV. U.S. DRUG ENFORCEMENT ADMIN., CONTROLLED SUBSTANCES (2009), [http://www.dea diversion.usdoj.gov/schedules/orange\\_book/e\\_cs\\_sched.pdf](http://www.dea diversion.usdoj.gov/schedules/orange_book/e_cs_sched.pdf). Doxylamine is an antihistamine found in many over-the-counter sleep aids. See *Drugs & Medications—Doxylamine Succinate Oral*, WEBMD, <http://www.webmd.com/drugs/drug-14124-Doxylamine+Succinate+Oral.aspx?drugid=14124&drugname=Doxylamine+Succinate+Oral&source=0> (last visited Oct. 8, 2010).

7. The New York Medical Examiner’s office concluded that Goldstein’s death was accidental and caused by “acute intoxication due to the combined effects of cocaine, OxyContin, Vicodin, Ativan, Klonopin, Xanax, Benadryl, and Levamisole, which is used to cut cocaine.” Oren Yaniv, *DJ AM’s Cause of Death Ruled Accidental; Toxicology Report Shows Cocaine, OxyContin in His System*, DAILY NEWS (Sept. 29, 2009), [http://www.nydailynews.com/gossip/2009/09/29/2009-09-29\\_dj\\_ams\\_cause\\_of\\_death\\_ruled\\_accidental\\_toxicology\\_report\\_shows\\_cocaine\\_oxycontin.html](http://www.nydailynews.com/gossip/2009/09/29/2009-09-29_dj_ams_cause_of_death_ruled_accidental_toxicology_report_shows_cocaine_oxycontin.html) (internal quotation marks omitted). Pursuant to the DEA’s drug classification schedule, cocaine and OxyContin are found under Schedule II; Vicodin is found under Schedule III; and Ativan (lorazepam), Klonopin (clonazepam), and Xanax (alprazolam) are Schedule IV controlled substances. U.S. DRUG ENFORCEMENT ADMIN., *supra* note 6. Both Benadryl and levamisole are not classified under the DEA’s drug schedules. See *id.*

8. Alan Duke, *Affidavits: Anna Nicole Smith Received Many Dangerous Drugs*, CNN.COM (Sept. 22, 2009, 5:59 PM EDT), <http://www.cnn.com/2009/SHOWBIZ/09/22/anna.nicole.probe/index.html?iref=newssearch> [hereinafter Duke, *Smith Affidavits*]; Alan Duke, *New Charges Filed in Investigation of Anna Nicole Smith Death*, CNN.COM (Sept. 23, 2009, 3:54 PM EDT), <http://www.cnn.com/2009/SHOWBIZ/09/23/anna.nicole.case/index.html?iref=newssearch>. An autopsy concluded that Smith died as a result of “acute combined drug intoxication.” Duke, *Smith Affidavits*, *supra*; see *infra* text accompanying notes 217–24.

9. In July 2010, actress Brittany Murphy passed away at the age of thirty-two. Kealan Oliver, *Brittany Murphy Death: Accident Says Coroner, But Role of Rx Drugs Unresolved in Actress’ Demise*, CRIMESIDER (Feb. 5, 2010, 6:30 AM),

drug overdose. Elvis Presley, one of the largest celebrity icons of the twentieth century, also fell victim to prescription drugs, which led to his untimely death.<sup>10</sup> These celebrities obtained prescription drugs from physicians entrusted with their care.<sup>11</sup>

In May 2009, Jackson sought out Dr. Conrad Murray, a cardiologist presently licensed to practice medicine in Nevada, Texas, and California,<sup>12</sup> to assume the role of the pop singer's personal physician.<sup>13</sup> Dr. Murray signed on as Jackson's physician for a six-figure monthly salary.<sup>14</sup> Jackson and Dr. Murray had become acquainted a few years

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504083\_162-6173499-504083.html. According to the Los Angeles County coroner's office, prescription drugs played a role in her death; the coroner determined that "multiple drug intoxication" was a contributing factor. *Id.* (internal quotation marks omitted); see also Emily Friedman, *Star Deaths Raise Questions About 'Pharmacy Shopping,'* ABCNEWS (Dec. 24, 2009), <http://abcnews.go.com/Entertainment/oversight-prescription-medication-needed/story?id=9408999> (indicating that approximately nine prescription medications were found in Ms. Murphy's home, and that those drugs "could have proved . . . fatal had they been combined incorrectly"). In August 1962, international superstar Marilyn Monroe was found dead in her Brentwood, California home at the age of thirty-six. *Marilyn Monroe Dead, Pills Near*, N.Y. TIMES, Aug. 6, 1962, at A1. According to news reports, fourteen medicine bottles were found on the nightstand beside her bed. *Id.* The Los Angeles County coroner determined the cause of death to be "an overdose of barbiturates." Murray Schumach, *Marilyn Monroe's Death Is Called Suicide; Will Is Probated*, N.Y. TIMES, Aug. 18, 1962, at A10.

10. See ELVIS UP CLOSE: IN THE WORDS OF THOSE WHO KNEW HIM BEST 335-36 (Rose Clayton & Dick Heard eds., 1994); ALBERT GOLDMAN, *ELVIS: THE LAST 24 HOURS* 2-8 (1991); Molly Ivins, *Elvis Presley Dies; Rock Singer Was 42*, N.Y. TIMES, Aug. 17, 1977, at A1; Wendell Rawls Jr., *Presley Associates Say Torment and Drugs Marked Final Months*, N.Y. TIMES, Sept. 23, 1979, at A1.

11. See ELVIS UP CLOSE, *supra* note 10, at 340; Rawls, *supra* note 10, at A20; Duke, *Smith Affidavits*, *supra* note 8; *Ledger's Death Caused by Accidental Overdose*, CNN.COM (Feb. 6, 2008, 10:25 PM EST), <http://www.cnn.com/2008/SHOWBIZ/Movies/02/06/heath.ledger/>; see also Friedman, *supra* note 9 (describing the ease with which celebrities could obtain prescription drugs from physicians); Alison Stateman, *Michael Jackson's Health: Why Do Doctors Coddle Celebrities?*, TIME (Feb. 16, 2010), <http://www.time.com/time/nation/article/0,8599,1964321,00.html?xid=rss-topstories> (noting that prescription drug abuse among celebrities and the practice of finding physicians to hand out prescription drugs is "as old as Hollywood itself").

12. Ken Ritter, *Former Michael Jackson Doctor Back in Las Vegas*, ABCNEWS (Feb. 10, 2010), <http://abcnews.go.com/Entertainment/wireStory?id=9801782>. The Texas Medical Board prohibited Dr. Murray from administering propofol on April 9, 2010. *Texas Medical Board Disciplines Dr. Conrad Murray and Houston Town Hall Attendee*, MEDBLOG (Apr. 21, 2010), [http://blogs.chron.com/medblog/archives/2010/04/texas\\_medical\\_b\\_2.html](http://blogs.chron.com/medblog/archives/2010/04/texas_medical_b_2.html). In June 2010, a California judge determined that he did not have the authority to revoke Murray's license to practice medicine in that state. *Judge: Dr. Conrad Murray Will Keep California Medical License*, FOXNews.com (June 14, 2010), <http://www.foxnews.com/entertainment/2010/06/14/judge-dr-conrad-murray-california-medical-license/>.

13. *Dream Job Turns to Tragedy for Jackson Doctor*, MSNBC.COM (July 10, 2009, 6:14 PM EDT), <http://www.msnbc.msn.com/id/31855763/ns/entertainment-music/>. It was reported that Dr. Murray was hired by promoter AEG Live to keep Jackson physically fit during the intense preparation for his upcoming "This Is It" tour. See *Jackson's Death Officially Ruled a Homicide*, MSNBC.COM (Aug. 28, 2009, 6:11 PM EDT), <http://www.msnbc.msn.com/id/32598793>.

14. *Dream Job Turns to Tragedy for Jackson Doctor*, *supra* note 13. Dr. Murray's salary was

earlier in Las Vegas when Dr. Murray treated one of Jackson's children.<sup>15</sup> Dr. Murray was to accompany Jackson on his comeback concert series in London during the summer of 2009.<sup>16</sup>

Dr. Murray told detectives that he had been treating Jackson for insomnia in the six weeks prior to his death.<sup>17</sup> During those six weeks, "he gave Jackson 50 mg of propofol<sup>18</sup> . . . diluted with the anesthetic lidocaine<sup>19</sup> via an intravenous drip" each night.<sup>20</sup> Propofol is a powerful

\$150,000 per month. *See Jackson's Death Officially Ruled a Homicide*, *supra* note 13.

15. *Dream Job Turns to Tragedy for Jackson Doctor*, *supra* note 13.

16. *Id.*

17. *Coroner's Preliminary Finding: Jackson Overdosed on Propofol*, CNN.COM (Aug. 25, 2009, 9:29 AM EDT), <http://www.cnn.com/2009/SHOWBIZ/Music/08/24/michael.jackson.propofol/index.html>. According to reports, Jackson had been suffering from a sleep disorder for years, and traveled with an anesthesiologist, Dr. Neil Ratner, in the mid-1990s during his HIStory world tour. Alan Duke & Saeed Ahmed, *Diprivan Risk Well-Known to Doctors*, CNN.COM (July 3, 2009, 9:08 PM EDT), <http://www.cnn.com/2009/SHOWBIZ/Music/07/03/jackson.diprivan/index.html>. Dr. Ratner regularly helped "'take [Jackson] down' and 'bring him back up'" with medications while on tour. *Id.* Jackson allegedly told Murray that he had been treated for years with propofol for chronic insomnia. Harriet Ryan & Jack Leonard, *Michael Jackson's Doctor's Case May Hinge on His Police Statement*, L.A. TIMES, Feb. 10, 2010, <http://articles.latimes.com/2010/feb/10/local/la-me-jackson-analysis10-2010feb10>.

18. Propofol, also known as Diprivan, is an intravenous sedative-hypnotic agent used in the induction and maintenance of anesthesia or sedation during surgical procedures to take place in a hospital or medical office. *See* SURGERY: BASIC SCIENCE AND CLINICAL EVIDENCE 360-62 (Jeffrey A. Norton et al. eds., 2d ed. 2008); FOOD & DRUG ADMIN., DIPRIVAN 12 (2008), [http://www.accessdata.fda.gov/drugsatfda\\_docs/label/2008/019627s0461bl.pdf](http://www.accessdata.fda.gov/drugsatfda_docs/label/2008/019627s0461bl.pdf); Stateman, *supra* note 11. Propofol is designed to act as a depressant on the respiratory system. Duke & Ahmed, *supra* note 17. After propofol is administered, the heart rate and blood pressure of the patient may drop. *Non-Anesthesiologist Administered Propofol*, SEDATION FACTS, <http://www.sedationfacts.org/sedation-administration/non-anesthesiologist-administered-propofol> (last visited Oct. 8, 2010). A patient can slip from moderate to deep sedation, which imposes a risk of life-threatening respiratory depression. *See id.* The effects of propofol cannot be reversed quickly by administering an antagonistic drug, as propofol has no antagonist. *Id.* A patient who overdoses will require manual ventilation until spontaneous ventilation resumes. *Id.* Propofol does not act to relieve pain. *See id.* Propofol is not scheduled under the CSA. *Drugs and Chemicals of Concern: Propofol (Diprivan)*, U.S. DEP'T OF JUSTICE, DRUG ENFORCEMENT ADMIN.: OFFICE OF DIVERSION CONTROL, [http://www.deadiversion.usdoj.gov/drugs\\_concern/propofol.htm](http://www.deadiversion.usdoj.gov/drugs_concern/propofol.htm) (last visited Oct. 8, 2010); *see* U.S. DRUG ENFORCEMENT ADMIN., *supra* note 6.

An AstraZeneca spokesman, Tony Jewell, noted that propofol is "neither indicated nor approved for use as a sleep aid." Duke & Ahmed, *supra* note 17. Dr. Zeev Kain, the chair of the anesthesiology department at the University of California Irvine, asserted that "'[p]ropofol induces coma, it does not induce sleep.'" *Id.* Another physician, Dr. Rakesh Marwah, of the anesthesiology department at the Stanford University School of Medicine observed that propofol "'can lead to cardiac arrest without proper monitoring'" as it "'slows down the heart rate[,] . . . the respiratory rate[,] and . . . the vital functions of the body.'" *Id.*

19. Lidocaine is an antiarrhythmic drug used to suppress fast rhythms of the heart. *See Lidocaine Injection*, DRUGS.COM, <http://www.drugs.com/pro/lidocaine-injection.html> (last visited Oct. 8, 2010); Richard E. Klabunde, *Antiarrhythmic Drugs*, CARDIOVASCULAR PHARMACOLOGY CONCEPTS, <http://www.cvpharmacology.com/antiarrhy/antiarrhythmic.htm> (last visited Oct. 8, 2010). It is not subject to the DEA's drug schedules. U.S. DRUG ENFORCEMENT ADMIN., *supra* note 6.

surgical anesthetic administered by anesthesiologists.<sup>21</sup> It is commonly used during uncomfortable medical procedures performed in a hospital or doctor's office to sedate a patient or induce a semi-conscious state.<sup>22</sup>

It is no secret that Jackson battled with drug addiction for decades.<sup>23</sup> Worried that Jackson may have become dependent on propofol to sleep and that he may become addicted, Dr. Murray tried to wean him off the drug by administering "combinations of other drugs that succeeded in helping Jackson sleep during the two nights prior to his death."<sup>24</sup> On June 22, 2009, Dr. Murray administered propofol along with the sedatives Ativan (lorazepam) and Versed (midazolam).<sup>25</sup> The

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20. *Coroner's Preliminary Finding*, *supra* note 17.

21. *See supra* note 18. "The U.S. [FDA] says Diprivan should be given only by people trained in the administration of general anesthesia and who are not involved in the conduct of the surgery or diagnostic procedure." Elizabeth Landau, *Diprivan Not Approved for Sleep Disorders*, CNN.COM (July 2, 2009, 2:53 PM EDT), <http://www.cnn.com/2009/HEALTH/07/02/diprivan.propofol.jackson/index.html>; *see* Jeff Gottlieb & Rong-Gong Lin II, *Diprivan, The Drug Found in Michael Jackson's Home, May Be More Tightly Restricted*, L.A. TIMES (July 20, 2009), <http://articles.latimes.com/2009/jul/20/local/me-diprivan20>. According to the FDA, propofol may be used in five situations: initiation and maintenance of monitored anesthesia care, combined sedation and regional anesthesia, induction of general anesthesia, maintenance of general anesthesia, and Intensive Care Unit sedation of intubated or mechanically ventilated patients. *See* FOOD & DRUG ADMIN., *supra* note 18, at 13 tbl.3.

22. Gottlieb & Lin II, *supra* note 21. A University of Colorado anesthesiologist, Dr. Paul Wischmeyer, stated that if he was to administer propofol to a patient at home, he would be "fairly likely to hurt" the patient. *Id.* "You'd need to have a surgery center at your house." *Id.* Dr. Wischmeyer went on to say that propofol is "never use[d]" to treat insomnia. *Id.*

23. "Reports of prescription drug abuse have dogged Michael Jackson for much of his career. . . ." Susan Donaldson James, *Friend Says Michael Jackson Battled Demerol Addiction*, ABCNEWS (June 26, 2009), <http://abcnews.go.com/Health/MichaelJackson/story?id=7938918&page=3>; *accord* Doctor: *Michael Jackson Was an Addict*, CBSNEWS.COM (July 9, 2009), <http://www.cbsnews.com/stories/2009/07/09/entertainment/main5145776.shtml>. "When Michael asked for something, he got it." Geller, *Ex-Bodyguard Tell of Jackson Drug Abuse*, MSNBC.COM (July 2, 2009, 1:17 PM EDT), <http://www.msnbc.msn.com/id/31706977/> (quoting Uri Geller, one of Jackson's former confidantes). Jackson's confidantes would confiscate injection materials from his room and plead with physicians to stop supplying the late singer with medications. *See id.* "[D]ozens of drug vials, including Zoloft, Percocet, Vicodin and Demerol, were found" at Jackson's home years ago when he was under investigation for child molestation. Alison Stateman, *Jackson's Death: How Culpable Are the Doctors?*, TIME (July 14, 2009), <http://www.time.com/time/arts/article/0,8599,1910282-1,00.html>.

24. *Coroner's Preliminary Finding*, *supra* note 17.

25. *Id.* Lorazepam, also known as Ativan, is a member of the benzodiazepine group, which consists of sedative-hypnotic agents used for seizure and anxiety control as well as for procedural sedation in hospitals. *See Lorazepam*, DRUGS.COM, <http://www.drugs.com/lorazepam.html> (last visited Oct. 8, 2010); *Toxicity, Benzodiazepine*, EMEDICINE, <http://emedicine.medscape.com/article/813255-overview> (last visited Oct. 8, 2010). Lorazepam is a Schedule IV controlled substance. *See supra* note 7. Midazolam, also known as Versed, is a Schedule IV controlled substance. U.S. DRUG ENFORCEMENT ADMIN., *supra* note 6. Midazolam should be used only in "hospital or ambulatory care settings," and the administering physician should have resuscitative drugs and equipment immediately available. *Midazolam Injection*, DRUGS.COM, <http://www.drugs.com/pro/midazolam-injection.html> (last visited Oct. 8, 2010).

next night, Dr. Murray administered Ativan and Versed, but did not give Jackson propofol.<sup>26</sup> Jackson was able to sleep.<sup>27</sup>

Dr. Murray admits administering propofol in conjunction with other sedatives to help Jackson fall asleep the night before his death.<sup>28</sup> On the night of June 24 into the morning hours of June 25, 2009, Dr. Murray administered the following series of prescription drugs at various doses to Jackson to try and induce sleep:

- 1:30 a.m.: 10 mg of Valium;<sup>29</sup>
- 2:00 a.m.: 2 mg injection of Ativan;
- 3:00 a.m.: 2 mg of Versed;
- 5:00 a.m.: 2 mg of Ativan; and
- 7:30 a.m.: 2 mg of Versed.<sup>30</sup>

At approximately 10:40 a.m., after Jackson pleaded with his physician for hours, Dr. Murray administered a 25 mg injection of propofol.<sup>31</sup> Jackson fell asleep shortly thereafter.<sup>32</sup> Around 11:00 a.m., when Jackson was found not breathing, Dr. Murray began CPR and administered flumazenil, a drug described as “antidote” for certain overdoses.<sup>33</sup> At 12:21 p.m., an ambulance was called to Jackson’s home.<sup>34</sup> Jackson was pronounced dead at 2:26 p.m. on June 25, 2009 at UCLA Medical Center.<sup>35</sup> During a police search of Jackson’s rented mansion in suburban Los Angeles, which took place in the days after his death, large quantities of propofol were found.<sup>36</sup> Law enforcement

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26. *Coroner’s Preliminary Finding*, *supra* note 17.

27. *See id.*

28. *See id.*; *Coroner Rules Jackson’s Death a Homicide*, MSNBC.COM (Aug. 24, 2009, 7:49 PM EDT), <http://www.msnbc.msn.com/id/32542682/ns/entertainment-music/>.

29. Valium is a Schedule IV controlled substance. *See supra* note 6.

30. *Coroner’s Preliminary Finding*, *supra* note 17.

31. *Id.*; *Coroner Rules Jackson’s Death a Homicide*, *supra* note 28. Murray contends that he resisted Jackson’s pleas for six hours out of fear that Jackson had become addicted to propofol. *See* Kimi Yoshino et al., *Jackson Pleaded with Doctor for Powerful Anesthetic, Records Show*, L.A. TIMES (Aug. 25, 2009), <http://articles.latimes.com/2009/aug/25/local/me-michael-jackson25>.

32. *Coroner’s Preliminary Finding*, *supra* note 17; *Coroner Rules Jackson’s Death a Homicide*, *supra* note 28.

33. *See Coroner’s Preliminary Finding*, *supra* note 17; *see also Flumazenil*, DRUGS.COM, <http://www.drugs.com/ppa/flumazenil.html> (last visited Oct. 8, 2010) (indicating that flumazenil is an antidote that is used to reverse the side effects of benzodiazepines). Flumazenil is not a controlled substance pursuant to the DEA’s classification schedules. *See* U.S. DRUG ENFORCEMENT ADMIN., *supra* note 6.

34. *Michael Jackson Dead at 50 After Cardiac Arrest*, CNN.COM, <http://www.cnn.com/2009/SHOWBIZ/Music/06/25/michael.jackson/> (last visited Oct. 8, 2010).

35. *Id.*

36. *See* Gottlieb & Lin II, *supra* note 21; *Source: Powerful Sedative Propofol Found at Michael Jackson’s Mansion*, FOXNEWS.COM (July 3, 2009), <http://www.foxnews.com/entertainment/2009/07/03/source-powerful-sedative-propofol-michael-jacksons-mansion/>.

officials also found numerous prescription drugs at the scene, many of which “were dispensed under various patient names and doctors, leading investigators to believe aliases were used to obtain the drugs.”<sup>37</sup>

Two months after his death, the Los Angeles County Coroner concluded that Jackson’s death was a homicide.<sup>38</sup> Forensic tests revealed that a lethal combination of prescription drugs present in Jackson’s body caused his death.<sup>39</sup> Specifically, the coroner’s office determined that Jackson’s death was caused by “acute propofol intoxication.”<sup>40</sup>

Experts say that there is “no surprise” that death could result from the combination of drugs administered to Jackson.<sup>41</sup> Even though Dr. Murray administered a relatively small dose of propofol to Jackson on the morning of his death,<sup>42</sup> the likelihood of having an adverse reaction with the other sedatives administered earlier that morning was high.<sup>43</sup> It is reported that Jackson approached three medical professionals in the months before his death requesting propofol because he “liked how the drug knocked him out fast and allowed him to sleep for hours longer than he could naturally.”<sup>44</sup> All three refused,<sup>45</sup> as propofol is intended only for in-hospital or office sedation during surgical procedures and is not intended to treat insomnia.<sup>46</sup> Further, due to the nature of the drug,

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37. Source: *Powerful Sedative Propofol Found at Michael Jackson’s Mansion*, *supra* note 36.

38. Alan Duke, *Michael Jackson’s Death Was a Homicide, Coroner Rules*, CNN.COM (Aug. 28, 2009, 7:50 PM EDT), <http://www.cnn.com/2009/SHOWBIZ/Music/08/28/jackson.autopsy/index.html>; Russell Goldman & Sarah Netter, *Jackson Death: Arrest of Dr. Conrad Murray Seems Imminent*, ABCNEWS.COM (Aug. 25, 2009), <http://abcnews.go.com/Entertainment/MichaelJackson/story?id=8405922>.

39. See Duke, *supra* note 38. Jackson was administered sedatives five times over a six-hour period. See *Michael Jackson Died of ‘Acute Propofol Intoxication,’ Coroner Says*, L.A.TIMES: L.A. NOW (Aug. 28, 2009, 11:52 AM), <http://latimesblogs.latimes.com/lanow/2009/08/michael-jackson-3.html>.

40. Duke, *supra* note 38 (internal quotation marks omitted); *Jackson’s Death Officially Ruled a Homicide*, *supra* note 13. According to the Los Angeles County Coroner, the two drugs primarily responsible for Jackson’s death were propofol and lorazepam. Duke, *supra* note 38.

41. *Coroner Rules Jackson’s Death a Homicide*, *supra* note 28 (quoting Dr. David Zvara, anesthesia chairman at the University of North Carolina at Chapel Hill).

42. *Jackson’s Death Officially Ruled a Homicide*, *supra* note 13; see *supra* text accompanying notes 17-20, 28, 31.

43. *Jackson’s Death Officially Ruled a Homicide*, *supra* note 13; Source: *Powerful Sedative Propofol Found at Michael Jackson’s Mansion*, *supra* note 36.

44. *Jackson’s Death Officially Ruled a Homicide*, *supra* note 13.

45. *Id.*

46. See *supra* note 18. Dr. Selena Calmes, an outside consultant hired to review the coroner’s findings stated that, “propofol is not supposed to be used for insomnia relief.” Corky Siemaszko, *Michael Jackson Autopsy Report Confirms Singer Suffered from Vitiligo, Wore Wig, Had Tattooed Makeup*, NYDAILYNEWS.COM (Feb. 10, 2010, 11:00 AM), [http://www.nydailynews.com/gossip/2010/02/10/2010-02-10\\_michael\\_jackson\\_autopsy\\_report\\_confirms\\_singer\\_suffered\\_from\\_vitiligo\\_wore\\_wig\\_h.html](http://www.nydailynews.com/gossip/2010/02/10/2010-02-10_michael_jackson_autopsy_report_confirms_singer_suffered_from_vitiligo_wore_wig_h.html) (internal quotation marks omitted). The only reports of propofol use in the home are related to suicide, fatal drug abuse, and murder. See *id.* It is “completely crazy” to treat

the FDA requires that propofol be administered by only those physicians trained in general anesthesia<sup>47</sup> and in the presence of readily available emergency medical equipment.<sup>48</sup>

On February 8, 2010, after months of investigation and speculation, Los Angeles County prosecutors charged Dr. Murray with involuntary manslaughter.<sup>49</sup> Dr. Murray is actively practicing medicine at his offices in Las Vegas, Nevada and Houston, Texas, and has been back to work since November 2009.<sup>50</sup> If convicted of involuntary manslaughter under California law, Dr. Murray faces up to four years in prison.<sup>51</sup>

Why is it that so many celebrities lose their lives to prescription drug abuse?<sup>52</sup> One likely explanation is that rich celebrities are willing to pay large sums of money to physicians to support their drug addiction.<sup>53</sup> Referred to as “concierge doctors,”<sup>54</sup> these physicians may be kept on the payroll of a rich celebrity patient, schedule appointments with the patient at home, and sometimes travel with the patient on the road for business or personal engagements.<sup>55</sup> The abuse of prescription

insomnia with propofol; it is like “swat[ting] a fly with a bomb.” Ryan & Leonard, *supra* note 17 (quoting Vesna Maras, a former Los Angeles County prosecutor). Using propofol to treat insomnia is “like using a shotgun to kill an ant.” *Source: Powerful Sedative Propofol Found at Michael Jackson’s Mansion*, *supra* note 36 (quoting Dr. Howard Nearman, department chairman of anesthesia at University Hospitals Case Medical Center in Ohio).

47. FOOD & DRUG ADMIN., *supra* note 18, at 14.

48. *Id.* Dr. Murray did not have the recommended equipment for patient monitoring, precision dosing, and resuscitation available at Jackson’s home while administering propofol. Siemaszko, *supra* note 46.

49. Dr. Murray’s arraignment was presided over by Superior Court Judge Keith Schwartz at a courthouse near Los Angeles International Airport. *See Jackson’s Doctor to Return to Court in April*, MSNBC.COM (Feb. 9, 2010, 09:16 AM EDT), <http://today.msnbc.msn.com/id/35298192>. He was released on \$75,000 bail, ordered to surrender his U.S. Passport, and instructed not to use any anesthetic agent in the course of his medical practice. *See id.* Dr. Murray is due back in court on October 26, 2010 for a status hearing. Kevin Hayes, *Hearing Delayed for Conrad Murray, Doctor Charged in Michael Jackson’s Death*, CRIMESIDER (Aug. 24, 2010, 10:41 AM EDT), [http://www.cbsnews.com/8301-504083\\_162-20014527-504083.html](http://www.cbsnews.com/8301-504083_162-20014527-504083.html). This is a step in the right direction; however, physicians should routinely face this type of criminal liability for causing a patient to die as a result of a prescription drug overdose. *See infra* Part IV.B.

50. *See Ritter*, *supra* note 12.

51. *Jackson’s Doctor to Return to Court in April*, *supra* note 49.

52. Dr. Drew Pinsky, substance-abuse expert, observed that young celebrities are dying of addiction every day. Stateman, *supra* note 11. Specifically, Pinsky states that they are all dying from pharmaceuticals that come from his “peers.” *Id.*

53. Patrice O’Shaughnessy, *Michael Jackson’s Death Puts ‘Concierge Doctors’ in the Spotlight*, NYDAILYNEWS.COM (July 5, 2009, 4:27 AM), [http://www.nydailynews.com/entertainment/michael\\_jackson/2009/07/05/2009-07-05\\_concierge\\_doctors\\_for\\_the\\_rich\\_famous.html](http://www.nydailynews.com/entertainment/michael_jackson/2009/07/05/2009-07-05_concierge_doctors_for_the_rich_famous.html); *Questions Swirl Around Jackson’s Doctor*, MSNBC.COM (June 27, 2009, 08:22 PM EDT), <http://today.msnbc.msn.com/id/31587382>.

54. O’Shaughnessy, *supra* note 53 (internal quotation marks omitted).

55. *See GOLDMAN*, *supra* note 10, at 56-57 (alleging that Elvis’s drugs were his life, and that toward the end of his life, he spent close to one million dollars each year on drugs and doctor’s



medication, however, is not solely synonymous with the rich and the famous.<sup>56</sup> According to the Center for Disease Control, more than 33,000 people in the United States died from drug overdoses in 2005.<sup>57</sup>

While it is common for physicians to face civil liability for the death of a patient, it is rare for them to face criminal charges.<sup>58</sup> However, when a patient dies as a result of a prescription drug overdose, physicians are regularly convicted under various sections of the federal Controlled Substances Act (“CSA”),<sup>59</sup> or a state’s adopted version of that Act.<sup>60</sup> It should be noted that many scholars oppose holding physicians criminally liable under the CSA or the state penal laws for the death of a patient out of fear that this will discourage physicians from providing palliative treatment to patients suffering from chronic pain.<sup>61</sup>

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fees); Debra C. Cascardo, *Boutique Medicine: A New Concept Based on Traditional Ideals*, MEDSCAPE TODAY (Sept. 9, 2003), <http://www.medscape.com/viewarticle/460881>; *Dream Job Turns to Tragedy for Jackson Doctor*, *supra* note 13; O’Shaughnessy, *supra* note 53; David Rosenfeld, *Jackson Case Highlights Medical Ethics*, MILLER-MCCUNE (July 22, 2009), <http://miller-mccune.com/health/jackson-case-highlights-medical-ethics-1362>; David E. Williams, *Boutique Medicine: When Wealth Buys Health*, CNN.COM (Oct. 20, 2006, 12:39 PM EDT), <http://www.cnn.com/2006/US/10/19/bil.healthy.wealthy/index.html>.

56. Douglas J. Behr, *Prescription Drug Control Under the Federal Controlled Substances Act: A Web of Administrative, Civil, and Criminal Law Controls*, 45 WASH. U. J. URB. & CONTEMP. L. 41, 43 (1994).

57. HSIANG-CHING KUNG ET AL., CTR. FOR DISEASE CONTROL, NATIONAL VITAL STATISTICS REPORTS DEATHS: FINAL DATA FOR 2005, at 10, available at [http://www.cdc.gov/nchs/data/nvsr/nvsr56/nvsr56\\_10.pdf](http://www.cdc.gov/nchs/data/nvsr/nvsr56/nvsr56_10.pdf).

58. See *United States v. Ramnath*, 533 F. Supp. 2d 662, 675 & n.21 (E.D. Tex. 2008). *But see* Amy J. Dilcher, *Damned If They Do, Damned If They Don’t: The Need for a Comprehensive Public Policy to Address the Inadequate Management of Pain*, 13 ANNALS HEALTH L. 81, 92 (2004) (asserting that the number of DEA actions against health care providers are on the rise); Deborah Hellman, *Prosecuting Doctors for Trusting Patients*, 16 GEO. MASON L. REV. 701, 701 (2009) (asserting that an increasing number of physicians are being prosecuted under drug trafficking laws in connection with prescribing controlled substances). At one time, “physicians . . . were thought to be immune from criminal punishment.” Alessia T. Bell, *Criminal Law/Medical Malpractice: Court Strikes Down Murder Conviction of Physician Where Inappropriate Care Led to Patient’s Death*, in *Recent Developments in Health Law*, 28 J.L. MED. & ETHICS 194, 195 (2000). There is, however, a growing trend toward prosecuting physicians for fatal mistakes. *See id.*

59. See generally 21 U.S.C. §§ 841–865 (2006) (articulating criminal offenses and penalties for persons acting in violation of the CSA).

60. See Dilcher, *supra* note 58, at 86; Sharon B. Roberts, *All “Pushers” are Not Created Equal! The Inequities of Sanctions for Physicians Who Inappropriately “Prescribe” Controlled Substances*, 23 NOVA L. REV. 881, 883-84 (1999). For information on state CSA statutes, see *infra* note 166.

61. See, e.g., Rob McStay, *Terminal Sedation: Palliative Care for Intractable Pain*, *Post Glucksberg and Quill*, 29 AM. J.L. & MED. 45, 73, 75 (2003); Beth Packman Weinman, *Freedom from Pain: Establishing a Constitutional Right to Pain Relief*, 24 J. LEGAL MED. 495, 508, 513-16 (2003); Stephen J. Ziegler & Nicholas P. Lovrich, Jr., *Pain Relief, Prescription Drugs, and Prosecution: A Four-State Survey of Chief Prosecutors*, 31 J.L. MED. & ETHICS 75, 75-76 (2003). Fearing criminal liability, physicians may undertreat their patient’s pain, which may also result in criminal charges brought against the physician for the patient’s pain and suffering. *See* Jacob B.

It is true that prescription drugs and/or controlled substances, when prescribed for a legitimate medical purpose and in the course of ordinary patient care, do effectively manage and treat severe pain, which improves the quality of life for many patients.<sup>62</sup> Furthermore, a great deal of scholarship exists regarding the relative healing effects high levels of prescription drugs have on individuals with different tolerance levels,<sup>63</sup> and successful responses to the drugs as a result of proper titration.<sup>64</sup> That discussion, however, exceeds the scope of this Note. The arguments in this Note are predicated upon the existence of a specific factual scenario: a patient is regularly prescribed a wide variety of prescription drugs, a practice known as polypharmacy,<sup>65</sup> none of which serve a legitimate medical purpose, all of which are contrary to the best interests of the patient, and she inadvertently dies. This Note seeks to generate awareness throughout the legal and medical communities that certain practices of physicians relating to the prescription of controlled substances<sup>66</sup> are proscribed, and these practices should be routinely punished by imposing harsh criminal sanctions.

Physicians have rarely been convicted under state homicide laws for causing the death of patients in the previously articulated manner.<sup>67</sup> For example, in *Pennsylvania v. Youngkin*,<sup>68</sup> a physician who wrote seven prescriptions for Tuinal<sup>69</sup> for a seventeen-year-old girl in the seven

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Nist, Commentary, *Liability for Overprescription of Controlled Substances: Can it Be Justified in Light of the Current Practice of Undertreating Pain?*, 23 J. LEGAL MED. 85, 85, 87-88 (2002).

62. See Jane C. Ballantyne & Jianren Mao, *Medical Progress: Opioid Therapy for Chronic Pain*, 349 NEW ENG. J. MED. 1943, 1943 (2003); Dilcher, *supra* note 58, at 82, 91, 96, 98; Weinman, *supra* note 61, at 506.

63. See, e.g., Ballantyne & Mao, *supra* note 62, at 1944-45; Dilcher, *supra* note 58, at 116-17; Myra Glajchen, *Chronic Pain: Treatment Barriers and Strategies for Clinical Practice*, 14 J. AM. BOARD OF FAM. PRAC. 211, 213-14 (2001).

64. See Dilcher, *supra* note 58, at 98-99, 116-17. Titration refers to the gradual increase of the amount of an opioid (a narcotic in the morphine class) until a balance is reached between pain relief and the adverse side effects of the medication, i.e., sedation or respiratory depression. *Id.* at 98-100. When properly titrated, opioids are entirely safe. *Id.* at 116. Further, because opioids have no ceiling effect, the appropriate dose is one that relieves the patients' pain while causing the least side effects. *Id.* at 116-17.

65. See, e.g., GOLDMAN, *supra* note 10, at 2-11 (describing Elvis' struggles with drug addiction). The concurrent use of multiple prescription drugs is commonly referred to as polypharmacy. See *What is Polypharmacy?*, NAT'L PRESCRIBING SERV. NEWSL. (Nat'l Prescribing Serv., Australia), Dec. 2000 (noting that polypharmacy is associated with the prescription and use of superfluous medicines at high dosages or frequencies).

66. See *supra* note 5.

67. Murder charges for physicians acting in an emergency situation to provide medically indicated treatment are rare. See Bell, *supra* note 58, at 195 (discussing *United States v. Wood*, 207 F.3d 1222 (10th Cir. 2000), as an example). For further discussion on *Wood*, see *infra* text accompanying notes 72-76.

68. 427 A.2d 1356 (Pa. Super. Ct. 1981).

69. Tuinal is part of the class of drugs known as barbiturates. See *Barbiturates (Systemic)*,

weeks preceding the girl's death was convicted of involuntary manslaughter.<sup>70</sup> Although the court found that the actual cause of death was asphyxiation from aspiration of the contents of her stomach due to a depression of her gag reflex, the physician was deemed liable due to the presence of high amounts of Tuinal in the girl's stomach.<sup>71</sup>

Years later in *United States v. Wood*,<sup>72</sup> an attending physician who intravenously administered a dose of potassium chloride to a surgical patient was convicted of involuntary manslaughter.<sup>73</sup> Although his conviction was reversed and remanded for further proceedings by the Tenth Circuit, the court found that, based on all of the evidence, a reasonable jury could convict Dr. Wood of involuntary manslaughter.<sup>74</sup> The record evidence, according to the court, was sufficient to demonstrate that Dr. Wood administered a quantity of potassium chloride at a speed that exceeded the consensus as to the maximum beneficial dosage and thus acted recklessly, without "due cause and circumspection."<sup>75</sup> The court noted that while potassium is essential to life and heart functioning, it could be lethal when administered via injection at a high concentration over a short period of time.<sup>76</sup>

In light of *Youngkin*, *Wood*, and the cases discussed in Part III, in addition to the criminal charges available under both the federal CSA and the states' versions of the Act, physicians who cause the death of a patient in the above-circumscribed manner should be concurrently indicted under state criminal homicide statutes.<sup>77</sup> The physician should

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DRUGS.COM, <http://www.drugs.com/cons/tuinal.html> (last visited Oct. 8, 2010). Barbiturates act as central nervous system depressants and are used for, among other things, their tranquilizing and anti-seizure effects. *See id.* Barbiturates may become habit forming. *See id.*

70. *Youngkin*, 427 A.2d at 1359-60. The county coroner opined that the pills prescribed by the physician were double the normal pill size, and that it was a questionable decision to prescribe Tuinal to an outpatient. *Id.* at 1361.

71. *Id.* at 1359-60.

72. 207 F.3d 1222 (10th Cir. 2000).

73. *Id.* at 1227. Dr. Wood was charged with first-degree murder with a lesser-included offense of second-degree murder and involuntary manslaughter. *Id.* Wood's motion for a judgment of acquittal on the murder charges was denied at the trial level; this was reversed on appeal, as the Tenth Circuit found that no juror could have found Wood guilty beyond a reasonable doubt. *See id.* at 1229, 1234. The court concluded that Wood was denied a fair trial as a result of cumulative error and reversed and remanded to the lower court for a new trial on the involuntary manslaughter charge. *Id.* at 1226. However, the court asserted that there was sufficient evidence for a jury to conclude, beyond a reasonable doubt, that the manner in which Dr. Wood performed the injection was reckless. *Id.* at 1234.

74. *Id.*

75. *Id.*

76. *Id.* at 1230.

77. There are few instances where prosecutors have brought these charges concurrently. *See United States v. Millen*, 594 F.2d 1085, 1086 (6th Cir. 1979). A physician was convicted of twenty counts of unlawful distribution under 21 U.S.C. § 841, and one count of involuntary manslaughter

be charged with the state's equivalent of the federal involuntary manslaughter charge.<sup>78</sup> Under federal law, the crimes of murder and manslaughter are based on whether or not "malice" was present in the mind of the actor.<sup>79</sup> Each state defines criminal homicide differently; some use the "malice" standard, and others look at various culpable mental states of the actor to determine the level of homicide committed.<sup>80</sup> When physicians prescribe controlled substances in excessive doses and/or varieties to their patients for an unarticulated medical purpose (enabling drug dependency or recreational use) which ultimately results in that patient's death, it is likely that this behavior will rise to the level of involuntary manslaughter under both federal and state homicide laws.<sup>81</sup> This Note argues that physicians are more likely to be deterred from committing these proscribed acts if they are put on notice of the additional criminal liability they will face in light of a patient's death.

Part II of this Note will describe the evolution of the concierge medical industry and the impact it has had on its patients. Part III will

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for writing twenty-three prescriptions for Demerol, a Schedule II controlled substance, for a close friend. *See id.* at 1086; U.S. DRUG ENFORCEMENT ADMIN., *supra* note 6. On appeal, the involuntary manslaughter conviction was reversed and remanded as a result of prosecutorial misconduct. *See id.* at 1086-88.

78. *See* 18 U.S.C. § 1112 (2006) ("Manslaughter is the unlawful killing of a human being without malice. It is of two kinds: [v]oluntary—[u]pon a sudden quarrel or heat of passion; and [i]nvoluntary—[i]n the commission of an unlawful act not amounting to a felony, or in the commission in an unlawful manner, or without due caution and circumspection, of a lawful act which might produce death."). For the purposes of this Note, the criminal homicide statutes of California and New York will be analyzed. This Note suggests that the proper charge is involuntary manslaughter because the above behaviors do not rise to the level of murder under the federal law and the laws of California or New York. *See id.* § 1111 (requiring a showing of malice for a murder conviction); CAL. PENAL CODE § 187 (West 2008) (same); N.Y. PENAL LAW §§ 125.25, 125.27 (McKinney 2009) (defining second degree murder and first degree murder, respectively). For a discussion on the applicable manslaughter statutes, see *infra* Part V.

79. *See* 18 U.S.C. § 1112. "Malice" is not defined under the U.S. Code; however, the federal courts have interpreted it to mean:

[A]n intent to do bodily harm, a formed design, and deliberate intent to kill. It does not necessarily imply any ill will, spite, or hatred towards the individual killed, but includes a case of a depraved, wicked, and malicious mind, and a will deliberately bent on murder, or doing some great bodily harm. It implies premeditation, which is a period of time for prior consideration, but as to the duration of that period the limit cannot be arbitrarily fixed. The time in which to form a design varies as the minds and temperaments of men differ, according to the circumstances in which they may be placed, and an interval of time between the forming of the intent to kill and the execution of such intent sufficiently long for the defendant to be fully conscious of what he intended, is sufficient to support a conviction for murder.

*United States v. Hart*, 162 F. 192, 195 (N.D. Fla. 1908). For a further discussion on the term "malice," see *infra* notes 287-89 and accompanying text.

80. *See infra* Part V.

81. *See infra* Part V.

explore the evolution of the federal drug laws, and articulate distinctive types of criminal liability that may be, and have been, pursued by prosecutors as a result of a patient's death by overprescription. Part IV will examine the relative deterrent effects of the CSA and state homicide laws on physicians participating in this prescription scheme. This Note will argue that prospective charges under the state homicide law acts as a superior deterrent for physicians. Part V will break down the requisite mental states of California and New York's criminal homicide laws. Part V will also argue that the mental state of physicians who overprescribe cocktails of prescription drugs to their patients satisfies the requirements under various state manslaughter statutes. Finally, Part V will articulate why Dr. Murray, and others similarly situated, should be charged under various sections of the CSA and with involuntary manslaughter for causing the death of a patient.

## II. CONCIERGE MEDICAL SERVICES: ITS IMPACT ON THE PHYSICIAN-PATIENT RELATIONSHIP

The concept of the physician-patient relationship dates back to fifth-century ancient Greek civilization.<sup>82</sup> Hippocrates, dubbed the "Father of modern medicine,"<sup>83</sup> was a central figure surrounding the creation of the physician-patient relationship.<sup>84</sup> It was Hippocrates' belief that physicians should study their patients before making any determinations about the state of their health and any subsequent treatment plan.<sup>85</sup> One of Hippocrates' greatest contributions to modern medicine was the Hippocratic Oath.<sup>86</sup> This Oath was comprised of Hippocrates' teachings on the moral and ethical requirements that should be reflected in every physician's professional service ideology.<sup>87</sup> Over the years, the original version, which was written in Greek, was

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82. See HENRY OSBORN TAYLOR, GREEK BIOLOGY AND MEDICINE, at xiv-xv, 7, 10 (1963) (discussing the theoretical relationship between the medical practitioner and the autonomous living being).

83. Alex Sakula, *In Search of Hippocrates: A Visit to Kos*, 77 J. ROYAL SOC'Y MED. 682, 682 (1984) (internal quotation marks omitted).

84. See *id.* at 686 (discussing Hippocrates' holistic approach to medicine).

85. Philip C. Grammaticos & Aristidis Diamantis, Editorial, *Useful Known and Unknown Views of the Father of Modern Medicine, Hippocrates and His Teacher Democritus*, 11 HELLENIC J. NUCLEAR MED. 2, 2 (2008) ("[M]edicine should stand on detailed observation, reason and experience in order to establish diagnosis, prognosis and treatment.").

86. See TAYLOR, *supra* note 82, at 34; Sakula, *supra* note 83, at 687.

87. See Sakula, *supra* note 83, at 687 (noting the strong moral and theological undertones of the first few words of the Oath).

translated<sup>88</sup> and modernized to reflect the practice of medicine in the twentieth and twenty-first centuries.<sup>89</sup>

This oath of ethical professional behavior is taken and sworn by most new physicians upon the completion of a medical program.<sup>90</sup> The Hippocratic Oath instructs physicians to respect the work of other physicians and the privacy rights of their patients, as well as to prevent disease and overtreatment.<sup>91</sup> Despite the existence of differing views on the purpose of the modern Hippocratic Oath,<sup>92</sup> its principles are regarded as sacred by medical professionals today.<sup>93</sup>

In 2008, it was reported that there were over 660,000 physicians practicing medicine in the United States.<sup>94</sup> Today, more and more medical students are pursuing higher-paying specialties and thus, endangering the future of primary care practices.<sup>95</sup> However, the concierge medical industry,<sup>96</sup> despite the trend toward specialty practices, is doing well.<sup>97</sup>

Concierge medicine is a form of private medical care in which patients pay a physician directly for increased time and access to that physician.<sup>98</sup> This concept—originally developed in Seattle,

88. *Introduction to HIPPOCRATES, THE GENUINE WORKS OF HIPPOCRATES*, at vi (Francis Adams trans., 1939).

89. See Sakula, *supra* note 83, at 687. To read a modern version of the Hippocratic Oath which is used in many medical schools today, see Peter Tyson, *Doctors' Diaries: The Hippocratic Oath Today*, NOVA, <http://www.pbs.org/wgbh/nova/doctors/oath.html> (follow "The Hippocratic Oath: Modern Version" hyperlink) (last visited Oct. 8, 2010).

90. See Tyson, *supra* note 89.

91. See *id.*

92. See David Kestenbaum, *Why We Have the Hippocratic Oath*, NPR (Aug. 20, 2009, 7:40 AM), [http://www.npr.org/blogs/money/2009/08/why\\_we\\_have\\_the\\_hippocratic\\_oa.html](http://www.npr.org/blogs/money/2009/08/why_we_have_the_hippocratic_oa.html) (citing a paper written by Nobel economist Kenneth Arrow, which suggests that the Hippocratic Oath is administered to "enforce a culture of professionalism among doctors . . . because they have this financial incentive not to act in our best interests"); Tyson, *supra* note 89 (noting that some physicians feel that the Oath is not adequate to address the realities of the twenty-first century medical world, and that the administration of the Oath is merely ritualistic).

93. See Tyson, *supra* note 89.

94. See BUREAU OF LABOR STATISTICS, U.S. DEP'T OF LABOR, OCCUPATIONAL OUTLOOK HANDBOOK, 2010-11 EDITION 2 (2009), available at <http://www.bls.gov/oco/pdf/ocos074.pdf>.

95. Parija B. Kavilanz, *Family Doctors: An Endangered Breed*, CNNMONEY.COM (July 18, 2009, 7:58 AM ET), [http://money.cnn.com/2009/07/16/news/economy/healthcare\\_doctors\\_shortage/index.htm](http://money.cnn.com/2009/07/16/news/economy/healthcare_doctors_shortage/index.htm). In the last ten years, only ten percent of medical school graduates have chosen primary care as their specialty due to the vast differences in the potential salaries. *Id.* ("A specialist can earn \$500,000 or more a year and work 20 hours a week versus a family doctor who earns on average \$120,000 a year and works more than 60 hours a week." (internal quotation marks omitted)). See also Kevin Sack, *Despite Recession, Personalized Health Care Remains in Demand*, N.Y. TIMES, May 11, 2009, at A12 (asserting that the concierge medical industry has "exacerbated the shortage of primary care physicians").

96. See *infra* notes 98-128 and accompanying text.

97. See Sack, *supra* note 95.

98. See STEVEN D. KNOPE, CONCIERGE MEDICINE: A NEW SYSTEM TO GET THE BEST

Washington<sup>99</sup>—arose as patients demanded more face time and services from their physicians.<sup>100</sup> In return for payment, concierge patients receive premium service and amenities.<sup>101</sup> Such amenities include: around-the-clock care and access to their physician; access to the physician's private phone numbers and e-mail; same-day appointments; longer, more thorough, and more frequent visits with the physician; nicer and less crowded offices; house calls; access to the top specialists in the country; visits to a specialist, if needed, accompanied by their physician; and individualized nutrition and fitness counseling.<sup>102</sup>

In order to provide these services, physicians have to cut their patient base substantially.<sup>103</sup> Being responsible to a smaller number of patients allows physicians to practice more preventative healthcare instead of simply treating sick patients each day.<sup>104</sup> Also, physicians develop better relationships with their patients when they spend more time with them during exams,<sup>105</sup> which helps to better assess their long-term health goals and needs.<sup>106</sup>

Celebrity patients use concierge medical services primarily for the availability, personalized attention, convenience, and discretion of the physician.<sup>107</sup> Generally, a concierge physician will devote herself primarily (or entirely) to the celebrity.<sup>108</sup> Although it is a concept that

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HEALTHCARE 10 (2008); Sack, *supra* note 95. Typically, patients pay an annual fee in exchange for highly-personalized medical care. See Anthony J. Linz et al., *Impact of Concierge Care on Healthcare and Clinical Practice*, 105 J. AM. OSTEOPATHIC ASS'N 515, 515 (2005); Williams, *supra* note 55.

99. KNOPE, *supra* note 98, at 12; Linz et al., *supra* note 98, at 515; Sack, *supra* note 95.

100. See Linz et al., *supra* note 98, at 516; Sack, *supra* note 95; Angela Gonzales, *More Docs Offering Concierge Medical Services for Annual Fees*, PHOENIX BUS. J., Feb. 22, 2008, <http://phoenix.bizjournals.com/phoenix/stories/2008/02/25/story12.html>.

101. See KNOPE, *supra* note 98, at 10; Linz et al., *supra* note 98, at 515; Sack, *supra* note 95.

102. See Pam Belluck, *Doctors' New Practices Offer Deluxe Service for Deluxe Fee*, N.Y. TIMES, Jan. 15, 2002, at A1; Linz et al., *supra* note 98, at 515; Sack, *supra* note 95; Gonzales, *supra* note 100.

103. See Belluck, *supra* note 102; Elizabeth Cohen, *Is Boutique Medicine Worth the Price?*, CNNHEALTH.COM (Sept. 19, 2008, 11:15 AM EDT), <http://www.cnn.com/2008/HEALTH/09/18/ep.concierge.medicine/index.html>; Gonzales, *supra* note 100; Williams, *supra* note 55.

104. See Linz et al., *supra* note 98, at 518; Gonzales, *supra* note 100; Williams, *supra* note 55.

105. See News Desk, *Concierge Doctors—The Future of Primary Care?*, INDENVERTIMES, (Apr. 12, 2009), <http://www.indenvertimes.com/concierge-doctors-the-future-of-primary-care/>.

106. See Linz et al., *supra* note 98, at 515, 518.

107. See *id.* at 515; O'Shaughnessy, *supra* note 53; Williams, *supra* note 55.

108. See Carol Costello, *Doctors and Celebrities—Money Over Ethics?*, CNN AMFIX BLOG (June 30, 2009, 6:37 AM ET), <http://amfix.blogs.cnn.com/2009/06/30/doctors-and-celebrities-money-over-ethics/>; O'Shaughnessy, *supra* note 53.

has deep roots in the lifestyles of the rich and famous,<sup>109</sup> concierge medical services are available for non-celebrities and families alike.<sup>110</sup>

The annual fee for concierge physicians can run anywhere from \$900 to \$20,000 per patient, per year.<sup>111</sup> Today, there are more than 5000 physicians who are engaged in full or partial concierge practices.<sup>112</sup> There are various private companies that specialize in concierge medical care, such as PinnacleCare,<sup>113</sup> MyMD,<sup>114</sup> and MDVIP.<sup>115</sup>

While there are benefits to concierge medical practices,<sup>116</sup> many have criticized the industry as being saturated with tough ethical questions.<sup>117</sup> Physicians who have opted out of their general practice to pursue concierge care have been accused of enacting their own brand of health reform.<sup>118</sup> Some concierge physicians are not only opting out of using insurance companies altogether, but are encouraging their patients to pay service fees in cash.<sup>119</sup>

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109. See GOLDMAN, *supra* note 10, at 17-18 (discussing the attractiveness of being the physician of a celebrity); O'Shaughnessy, *supra* note 53.

110. See Belluck, *supra* note 102; O'Shaughnessy, *supra* note 53; Williams, *supra* note 55 (describing MD2, a concierge healthcare firm that caters specifically to families).

111. Linz et al., *supra* note 98, at 515.

112. JoNel Aleccia, *Patients Face Bitter Choice: Pay Up or Lose Care*, MSNBC.COM (Nov. 23, 2009, 8:23 AM ET), [http://www.msnbc.msn.com/id/34019606/ns/health-health\\_care/](http://www.msnbc.msn.com/id/34019606/ns/health-health_care/) (suggesting that the number of doctors who practice concierge medicine could quadruple in the coming years).

113. See Linda K. Wertheimer, *Firms Give Health Advice for a Price*, BOSTON.COM (June 23, 2008), [http://www.boston.com/news/health/articles/2008/06/23/firms\\_give\\_health\\_advice\\_for\\_a\\_price](http://www.boston.com/news/health/articles/2008/06/23/firms_give_health_advice_for_a_price) (stating that PinnacleCare typically caters to wealthy clients as their fees can surpass \$100,000 a year; however, the standard family plan starts at \$10,000 per year). PINNACLECARE, <http://www.pinnaclecare.com/> (last visited Oct. 8, 2010).

114. MYMD, <http://www.mymd.com/> (last visited Oct. 8, 2010).

115. MDVIP, <http://www.mdvip.com/patient/default.aspx> (last visited Oct. 8, 2010); see Williams, *supra* note 55. MDVIP also provides instruction and support to practicing physicians about how to build a successful concierge practice. See KNOPE, *supra* note 98, at 13.

116. See *supra* text accompanying notes 98-107; see also Linz et al., *supra* note 98, at 516, 518-19 (postulating that this model of care will allow physicians to avoid the restraints of managed healthcare and defer considering early retirement or alternative employment opportunities).

117. See Aleccia, *supra* note 112; Costello, *supra* note 108. "[T]he growth of limited-caseload practices could exacerbate today's already-severe shortage of primary-care physicians." Lori Calabro, *At Your Beck and Call*, CFO MAG. (Sept. 1, 2007), [http://www.cfo.com/article.cfm/9678384/1/c\\_9747262?f=magazine\\_alsoinside](http://www.cfo.com/article.cfm/9678384/1/c_9747262?f=magazine_alsoinside). Further, because the concierge plans exclude so many patients, experts feel that there are "community and societal issues" involved for practitioners. *Id.* (quoting Professor Joseph Restuccia of Boston University School of Management). There are no studies that suggest concierge medicine results in healthier patients; however, based on readily available statistics, ninety-five percent or more patients in a given concierge practice reenroll annually. See *id.*

118. Aleccia, *supra* note 112 (stating that physicians are "opting out of the system, with some doctors dumping insurance companies altogether and others forcing patients to pay thousands of dollars in cash to keep the care they're accustomed to").

119. See *id.*; Devon Herrick, *Concierge Medicine: Convenient and Affordable Care*, NCPA (Jan. 19, 2010), <http://www.ncpa.org/pub/ba687>.



Additionally, concierge physicians, who focus their practices on a few high-profile clients, as in the case of Dr. Murray, have been criticized as creating a situation that goes beyond the bounds of a physician-patient relationship.<sup>120</sup> According to the Code of Medical Ethics, the governing ethical doctrine adopted by the American Medical Association (“AMA”), the relationship between patient and physician is “based on trust and gives rise to physicians’ ethical obligations to place patients’ welfare above their own self-interest.”<sup>121</sup> The best interests of the patient are paramount in every physician-patient relationship.<sup>122</sup> As a concierge physician, if your income depends primarily on a practice centered on providing care to a few high-profile patients, the temptation to please your patients becomes too great.<sup>123</sup> The ability to treat the patient diminishes as the patient becomes more demanding.<sup>124</sup> Particularly with regard to prescription drugs, this temptation may lead the physician to become a personal pharmacy for the patient, which is in contravention to the AMA’s Code of Ethics and the physician’s promise to avoid overtreatment pursuant to the Hippocratic Oath.<sup>125</sup> The physician will feel inclined to acquiesce to the patients’ prescription drug requests because the patients are paying vast sums of money for the physician’s care.<sup>126</sup> Further, a concierge physician has a large interest in maintaining a positive rapport with his high-profile patients so that these patients will continue to re-enroll with the physician’s concierge practice.<sup>127</sup> Based on the previously cited instances, the traditional physician-patient relationship may be reversed, thus putting the patient in control of her medical treatment.<sup>128</sup>

Despite the fact that the concept of concierge medicine evolved from an altruistic desire to spend more face time with patients in order to

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120. See Costello, *supra* note 108.

121. AMA CODE OF MED. ETHICS § 10.015 (2001).

122. See *id.*

123. See Costello, *supra* note 108. It is very easy to cross the line of “giving good, objective care” to overprescribing at times. Stateman, *supra* note 11.

124. See Stateman, *supra* note 11.

125. See *supra* text accompanying notes 90-91. This practice, “seemingly as old as Hollywood itself,” in which a patient can buy anything they want, is highly dangerous for all parties involved. Stateman, *supra* note 11 (noting the ability of celebrity substance abusers to find doctors to “give them the medicines and care they crave, even if it goes against proper medical practice”); see *Doctor: Michael Jackson was an Addict*, *supra* note 23.

126. See Stateman, *supra* note 11; see also Wertheimer, *supra* note 113 (noting that concierge physicians cater to patients willing to pay upwards of \$100,000 per year for personalized care).

127. See Calabro, *supra* note 117.

128. See Stateman, *supra* note 11 (“[W]hen a doctor is treating a famous individual, the traditional relationship is reversed and boundaries are blurred, with the celebrity dictating what drugs or care they want and using their allure, threat of banishment and lucrative pay as means to get their way.”); *supra* notes 123-27 and accompanying text.

provide them with superior care, the physician may become concerned more with her personal well-being and less with making medical decisions in the best interest of the patient. As in the relationship between Dr. Murray and Jackson, when ethical guidelines are not adhered to, the physician's actions may result in the death of a patient. A physician's ethical misguidance, which ultimately results in the patient's death, should be criminally sanctioned.

### III. THE LEGAL BASES FOR PROSECUTING PHYSICIANS

At the turn of the twentieth century, the federal government determined that certain regulations had to be put in place for various medicinal drugs in order to protect the health and welfare of citizens and to regulate the conduct of physicians administering these drugs.<sup>129</sup> Over the years, Congress found that certain drugs do serve useful and legitimate medical purposes and are necessary to maintain the health and general welfare of the American people.<sup>130</sup> While Congress's primary objective in enacting legislation was to prevent illegal drug trafficking and distribution, their focus wasn't initially on practicing physicians.<sup>131</sup> It was not until the late 1960s that Congress began to crack down on physicians.<sup>132</sup>

Prescription drugs consist of a vast array of psychotherapeutic drugs<sup>133</sup> that are used to treat many medical and psychological health problems.<sup>134</sup> Prescription drugs include narcotic analgesics or pain relievers, tranquilizers, sedatives, and stimulants.<sup>135</sup> Before being prescribed by a physician, these drugs have been developed, tested, and approved for legitimate medical uses and are regularly used throughout the country to treat an array of medical and psychological issues.<sup>136</sup>

The federal government first established controls over prescription drugs in the early 1900s.<sup>137</sup> The Pure Food and Drug Act ("PFDA"),

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129. See *infra* text accompanying notes 137-42.

130. See 21 U.S.C. § 801(1) (2006).

131. See *infra* notes 137-48 and accompanying text.

132. See *infra* text accompanying notes 156-58; *infra* Part III.A.

133. *Psychotherapeutic Drugs*, THE FREE DICTIONARY, <http://medical-dictionary.thefreedictionary.com/psychotherapeutic+drugs> (defining "psychotherapeutic drugs" as "drugs that are prescribed for their effects in relieving symptoms of anxiety, depression, or other mental disorders") (last visited Oct. 8, 2010).

134. See CAL. STATE TASK FORCE ON PRESCRIPTION DRUG MISUSE, SUMMARY REPORT AND RECOMMENDATIONS ON PRESCRIPTION DRUGS: MISUSE, ABUSE AND DEPENDENCY 1-2 (2009), available at [http://www.adp.ca.gov/Director/pdf/Prescription\\_Drug\\_Task\\_Force.pdf](http://www.adp.ca.gov/Director/pdf/Prescription_Drug_Task_Force.pdf).

135. See *id.* at 2.

136. See *id.*

137. Behr, *supra* note 56, at 45; Roberts, *supra* note 60, at 883.

enacted in 1906,<sup>138</sup> made it illegal to manufacture, sell, or transport in interstate commerce any adulterated,<sup>139</sup> misbranded,<sup>140</sup> poisonous, or deleterious foods, drugs, medicines, or liquors.<sup>141</sup> Section 9 of the PFDA provided an exemption to dealers who inadvertently violated the statute by obtaining a proscribed item so long as the requisite signed records were kept.<sup>142</sup>

Congress later passed the Harrison Narcotic Act (“HNA”) in 1914,<sup>143</sup> which was the first attempt by the federal government to regulate the then-rampant drug consumption in the United States, specifically opium and cocaine.<sup>144</sup> The HNA made it illegal to dispense or distribute narcotic drugs without a “written order of the person to whom such article is sold, bartered, exchanged, or given, on a form to be issued in blank for that purpose by the Commissioner of Internal Revenue.”<sup>145</sup> Physicians and pharmacists were exempt from prosecution under the HNA so long as they met certain requirements.<sup>146</sup> Section 2 of the HNA allowed physicians to dispense or distribute otherwise prohibited drugs so long as the physician was registered under the HNA, kept a record of all dispensed and distributed drugs, and prescribed the drugs “in the course of his professional practice only.”<sup>147</sup> Pharmacists were able to sell, dispense, and distribute otherwise illegal narcotics pursuant to a written prescription issued by a registered physician.<sup>148</sup> However, the U.S. Supreme Court, in *Webb v. United States*,<sup>149</sup> held that

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138. Pure Food and Drug Act, ch. 3915, 34 Stat. 768, 772 (1906), *repealed by* Food, Drug, and Cosmetic Act, ch. 675, § 902, 52 Stat. 1040, 1059 (1938) (current version at 21 U.S.C. § 331 (2006)).

139. *Id.* § 7, 34 Stat. at 769-70.

140. *Id.* § 8, 34 Stat. at 770.

141. *Id.* § 7, 34 Stat. at 770; *see* Behr, *supra* note 56, at 45-46.

142. If a dealer could produce a guaranty signed by the party she purchased the substance from, which provided the name and address of the seller and stated that the substance was not adulterated or misbranded within the meaning of the statute, the dealer was off the hook. *See* Pure Food and Drug Act § 9, 34 Stat. at 771.

143. Harrison Narcotic Act, ch. 1, 38 Stat. 785 (1914), *repealed by* Controlled Substances Act, Pub. L. No. 91-513, 84 Stat. 1242 (1971) (codified as amended in scattered sections of 21 U.S.C.).

144. *See* C.E. Terry, Editorial, *The Harrison Anti-Narcotic Act*, 5 AM. J. PUB. HEALTH 518, 518 (1915).

145. Harrison Narcotic Act, ch. 1, § 2, 38 Stat. at 786; *see* Behr, *supra* note 56, at 46.

146. *See* Behr, *supra* note 56, at 46.

147. *See* Harrison Narcotic Act, ch. 1, § 2(a), 38 Stat. at 786; *see* Behr, *supra* note 56, at 46. The HNA did not define the phrase “in the course of his professional practice.” Thus, physicians at the time got the benefit of a per se exemption. Critics argued that physicians should not be exempt from liability since it was common knowledge at the time that physicians were the “greatest single factor in drug addict formation.” Terry, *supra* note 144, at 518.

148. Harrison Narcotic Act, ch. 1, § 2(b), 38 Stat. at 786; *see* Behr, *supra* note 56, at 46.

149. 249 U.S. 96 (1919).

physicians were prohibited from supplying drug addicts and drug dealers with the proscribed drugs.<sup>150</sup>

In 1938, after a legally marketed toxic elixir killed over one hundred people,<sup>151</sup> Congress enacted the federal Food, Drug, and Cosmetic Act (“FDCA”), which required prescriptions for all habit-forming drugs, such as narcotics and barbiturates.<sup>152</sup> This Act established a class of drugs that could be dispensed only by prescription.<sup>153</sup> Based on the language of the statute, which focused on the “dispensing” of the illegal drugs,<sup>154</sup> many of the prosecutions under this Act did not involve physicians, but pharmacies and their employees.<sup>155</sup> Congress later amended the FDCA to hold physicians liable for dispensing illegal drugs, thus relieving the heavy burden previously placed upon pharmacists.<sup>156</sup> The 1965 Drug Abuse Control Amendments (the “Amendments”) to the FDCA placed further limitations on physicians.<sup>157</sup> Notably, the Amendments applied to physicians acting in the course of professional practice, and limited the dispensation and distribution of stimulants and depressants to the ordinary and authorized course of business, profession, occupation, or employment.<sup>158</sup>

In 1970, Congress repealed portions of the HNA and the Amendments by enacting the Comprehensive Drug Abuse Prevention and Control Act of 1970 (“CDAPCA”).<sup>159</sup> The CSA, found in Title II of CDAPCA, is the primary vehicle through which physicians who

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150. *See id.* at 97-100; *see also* *Jin Fuey Moy v. United States*, 254 U.S. 189, 192-94 (1920) (holding that issuing prescriptions for morphine without a written order and not in the ordinary course of professional practice to known morphine users for the purpose of enabling such persons to further their drug habit or to sell it to another was a violation of the HNA).

151. *See Regulatory Information: Legislation*, FDA, <http://www.fda.gov/RegulatoryInformation/Legislation/default.htm> (last visited Oct. 8, 2010).

152. Food, Drug, and Cosmetic Act, ch. 675, §§ 501-502, 503(b), 52 Stat. 1040, 1049-50, 1052 (1938), *amended by* Controlled Substances Act, Pub. L. No. 91-513, 84 Stat. 1242, 1281-83 (1971); *see* Behr, *supra* note 56, at 46.

153. *See* Behr, *supra* note 56, at 46-48.

154. *See id.* at 48.

155. *Id.* at 48 & n.35.

156. *Brown v. United States*, 250 F.2d 745, 745-47 (5th Cir. 1958) (upholding a conviction under section 353(b)(1) of the FDCA for a physician who sold illegal drugs to two undercover federal agents without a valid prescription).

157. *See* Behr, *supra* note 56, at 48-49.

158. Drug Abuse Control Amendments of 1965, Pub.L. No. 89-74, § 3(b), 79 Stat. 226, 227-29 (1965), *repealed by* Controlled Substances Act, Pub.L. No. 91-513, § 701(a), 84 Stat. 1242, 1281 (1971); *see* *White v. United States*, 399 F.2d 813, 815, 825 (8th Cir. 1968) (upholding the conviction of a physician who sold and delivered depressants and stimulants in violation of 21 U.S.C. §§ 331(q)(2) and 360a(b)(1), which prohibit the “sale, delivery, or other disposition of a drug” to any other person).

159. Comprehensive Drug Abuse Prevention and Control Act of 1970, Pub. L. 91-513, 84 Stat. 1236 (codified as amended in scattered sections of 21 U.S.C.).

illegally administer,<sup>160</sup> deliver,<sup>161</sup> dispense,<sup>162</sup> or distribute<sup>163</sup> controlled substances<sup>164</sup> are prosecuted today.<sup>165</sup> This Act retained the standard of “professional practice” found in both the HNA and the Amendments.<sup>166</sup>

#### A. *The Controlled Substances Act*

The CSA established controls over the manufacture, wholesale and retail distribution, and dispensation of drugs.<sup>167</sup> Under the CSA, physicians are exempted from liability so long as the prescription for a controlled substance is issued for a legitimate medical purpose and falls within the scope of the physician’s professional practice.<sup>168</sup> The guidelines for prescribing and dispensing controlled substances<sup>169</sup> are predicated on the five different “schedules,” or classes, of various controlled substances, which are codified under 21 U.S.C. § 812.<sup>170</sup> Each schedule differs according to the drug’s potential for abuse, currently accepted medical use, and effects of abuse.<sup>171</sup> Schedule I drugs are considered to be the highest schedule with the highest potential for abuse

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160. To “administer” a controlled substance pursuant to the CSA, a practitioner must directly apply the substance to the “body of a patient.” *See* 21 U.S.C. § 802(2) (2006).

161. “[D]elivery” refers to the “actual, constructive, or attempted transfer of a controlled substance or a listed chemical.” *Id.* § 802(8).

162. To “dispense” means “to deliver a controlled substance to an ultimate user . . . pursuant to a lawful order of, a practitioner.” *Id.* § 802(10).

163. Distributing refers to the delivery of a controlled substance of listed chemical other than by administering or dispensing. *See id.* § 802(11).

164. *See infra* notes 169-81 and accompanying text.

165. *See* Roberts, *supra* note 60, at 883-84. More than thirty states have adopted their own versions of the CSA. *See, e.g.*, CAL. HEALTH & SAFETY CODE § 11000 (West 2007); KAN. STAT. ANN. § 65-4101 (West 2003); LA. REV. STAT. ANN. § 40:961 (2001); N.Y. PUB. HEALTH LAW § 3300 (McKinney 2002). Prosecutors have the option to charge physicians under the state or federal version of the CSA. *See, e.g.*, Scotland v. Attorney General, 342 F. App’x 851, 854 (3d Cir. 2009) (holding that a conviction under New York penal law was analogous to an offense under the CSA); Cadet v. Attorney General, 339 F. App’x 273, 275 (3d Cir. 2009) (per curiam) (arguing that New Jersey generally proscribes the same conduct as the federal analog). *See generally* OFFICE OF DIVERSION CONTROL, U.S. DEP’T OF JUSTICE, CASES AGAINST DOCTORS, [http://www.deadiversion.usdoj.gov/crim\\_admin\\_actions/doctors\\_criminal\\_cases.pdf](http://www.deadiversion.usdoj.gov/crim_admin_actions/doctors_criminal_cases.pdf) (last updated Aug. 13, 2010) (containing arrest and conviction information of physicians registered with the DEA from the last seven years).

166. *See* 21 U.S.C. § 844(a); Drug Abuse Control Amendments § 3(b), 79 Stat. at 227-29; Harrison Narcotic Act, ch. 1, § 2(a), 38 Stat. 785, 786 (1914); Behr, *supra* note 56, at 49.

167. *See* 21 U.S.C. §§ 823, 825-30, 841(a)(1), 842(a)(1)-(3), 843(a)(1); Behr, *supra* note 56, at 51.

168. *See* 21 U.S.C. § 822(b); 21 C.F.R. § 1306.04(a) (2010).

169. *See* 21 U.S.C. §§ 802(6), 821-30.

170. *See id.* § 812(a)-(c).

171. *See id.* § 812(b). A list of factors to be determinative of control or removal from a schedule is found at 21 U.S.C. § 811(c).

and no currently accepted medical use.<sup>172</sup> Examples of Schedule I drugs include heroin, marijuana, ecstasy, and methamphetamine.<sup>173</sup> Substances falling under Schedules II through IV have decreasing abuse potential and increasingly accepted medical usage.<sup>174</sup> Demerol, morphine, and Ritalin are all examples of Schedule II drugs.<sup>175</sup> Examples of Schedule III drugs include Tylenol with codeine and Vicodin.<sup>176</sup> Xanax and Valium are common Schedule IV drugs.<sup>177</sup> Last, Schedule V drugs consist of compounds and mixtures containing limited amounts of certain narcotic drugs appearing in both prescription drugs and over-the-counter drugs.<sup>178</sup> Compounds and mixtures under Schedule V have a very low potential for abuse and have currently accepted medical use in the United States.<sup>179</sup> A common example of a Schedule V drug is cough syrup with codeine.<sup>180</sup> Pursuant to §§ 811 through 814 of the CSA, the Attorney General has the ultimate authority on the scheduling of controlled substances.<sup>181</sup>

Under the CSA, physicians who wish to handle controlled substances are charged with certain responsibilities in order to avoid criminal liability. First, physicians seeking to handle controlled substances are required to register with the Drug Enforcement Administration (“DEA”).<sup>182</sup> The Attorney General<sup>183</sup> shall grant the registration application of a physician unless she determines that such registration is inconsistent with the public interest.<sup>184</sup> Physician applicants may register for one or all schedules in their entirety except

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172. *See id.* § 812(b)(1); Behr, *supra* note 56, at 52.

173. *See* U.S. DRUG ENFORCEMENT ADMIN., *supra* note 6.

174. 21 U.S.C. § 812(b)(2)–(4).

175. U.S. DRUG ENFORCEMENT ADMIN., *supra* note 6.

176. *Id.*

177. *Id.*

178. *See* Behr, *supra* note 56, at 52.

179. *See* 21 U.S.C. § 812(b)(5).

180. *See* U.S. DRUG ENFORCEMENT ADMIN., *supra* note 6; Behr, *supra* note 56, at 52.

181. *See* 21 U.S.C. §§ 811–814.

182. *See id.* § 822(a). Physicians are required to register each principle place of business or professional practice where they administer, distribute, or dispense controlled substances or Schedule I chemicals. *See id.* § 822(e); 21 C.F.R. § 1301.12 (2010).

183. Under the CSA, the Attorney General “is authorized to promulgate rules and regulations . . . relat[ed] to the registration and control of the manufacture, distribution, and dispensing of controlled substances.” 21 U.S.C. § 821.

184. *Id.* § 823(a)–(e). The factors to consider in whether it is in the public interest to approve a registrant’s application are: (1) the maintenance of effective controls against diversion of certain controlled substances; (2) compliance with state and local laws; (3) promotion of technical advances in manufacturing the substance(s); (4) prior convictions relating to the manufacture, distribution, or dispensing of controlled substances; (5) any relevant past experience in the manufacture or distribution of controlled substances; and (6) any other relevant factors consistent with public health and safety. *See id.* § 823(d)(1)–(6).

Schedule I.<sup>185</sup> A registrant must keep records to track controlled substances from manufacture to wholesale distribution to ultimate user pursuant to statutorily-imposed guidelines.<sup>186</sup> Registrants may also be required to report to the Attorney General periodically with respect to their records.<sup>187</sup>

Registrants are required to adhere to certain procedures when prescribing controlled substances in accordance with the CSA.<sup>188</sup> In order for a prescription to be valid under the CSA, it “must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice.”<sup>189</sup> Notably, under the CSA, a practitioner may not prescribe narcotic drugs to an addict<sup>190</sup> unless a separate registration<sup>191</sup> is approved, and specific guidelines are followed thereafter.<sup>192</sup> According to the CSA, a practitioner may order one day’s

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185. See 21 C.F.R. §§ 1301.13(e)(1), 1301.22(c). A practitioner who is an agent or employee of a hospital may administer, dispense, or prescribe Schedule I controlled substances under the registration of the hospital so long as she is acting in the normal course of business or employment, she is permitted to prescribe controlled substances within the prescribing jurisdiction, the hospital has verified the practitioner’s registration status and knows that she can prescribe controlled substances, and the hospital has authorized her to prescribe controlled substances under their registration. See *id.* § 1301.22(c)(1)–(6).

186. See 21 U.S.C. §§ 827–30; Behr, *supra* note 56, at 58.

187. 21 U.S.C. § 827(d).

188. See *id.* §§ 822–30; 21 C.F.R. §§ 1306.01–.09.

189. 21 C.F.R. § 1306.04(a).

190. “[A]ddict” is defined as “any individual who habitually uses any narcotic drug so as to endanger the public morals, health, safety, or welfare, or who is so far addicted to the use of narcotic drugs as to have lost the power of self-control with reference to his addiction.” 21 U.S.C. § 802(1).

191. See *id.* § 823(g)(1). A physician who wishes to dispense narcotic drugs to addicts for narcotic treatment must obtain a separate registration on an annual basis. See *id.* The Attorney General shall approve registration for this purpose if the requirements of subsection 1 are met. See *id.* § 823(g)(1)(A)–(C).

192. A physician, pursuant to the requirements of §§ 802 and 823, may administer either detoxification or maintenance treatment on an addict. Maintenance treatment is “the dispensing, for a period in excess of twenty-one days, of a narcotic drug in the treatment of an individual for dependence upon heroin or other morphine-like drugs.” *Id.* § 802(29). Detoxification treatment is:

[T]he dispensing, for a period not in excess of one hundred and eighty days, of a narcotic drug in decreasing doses to an individual in order to alleviate adverse physiological or psychological effects incident to withdrawal from the continuous or sustained use of a narcotic drug and as a method of bringing the individual to a narcotic drug-free state within such period.

*Id.* § 802(30). Additionally,

A practitioner may administer or dispense directly (but not prescribe) a narcotic drug listed in any schedule to a narcotic dependant person for the purpose of maintenance or detoxification treatment if the practitioner meets both of the following conditions: (1) [t]he practitioner is separately registered with DEA as a narcotic treatment program[; and] (2) [t]he practitioner is in compliance with DEA regulations regarding treatment qualifications, security, records, and unsupervised use of the drugs pursuant to the [CSA].

dose of medication under emergency circumstances to relieve an addict's acute withdrawal symptoms.<sup>193</sup> Such order may not exceed three days, and it may not be renewed or extended.<sup>194</sup>

Specific prescription guidelines must be adhered to under the CSA.<sup>195</sup> Each prescription for a controlled substance must be dated and signed on the date it is issued.<sup>196</sup> The full name and address of both the patient and the prescribing practitioner along with the practitioner's registration number must also be present.<sup>197</sup> A "prescription" that does not conform to these requirements is not a prescription under the CSA, and thus is a violation pursuant to the statute.<sup>198</sup> Further, there are additional restrictions placed upon prescriptions of various controlled substances depending on which schedule the drug fits into.<sup>199</sup>

If a physician violates any section of the CSA, she may be found criminally liable, and thus subject to substantial fines and/or imprisonment.<sup>200</sup> One of the first significant cases involving the scope of the CSA was *United States v. Moore*.<sup>201</sup> *Moore* dealt with the issue of whether or not a registered physician could be prosecuted under § 841 of the CSA.<sup>202</sup> The physician, who lost his authorization to conduct a drug maintenance program, prescribed methadone, a Schedule II controlled substance,<sup>203</sup> to patients pursuant to a drug treatment program.<sup>204</sup> The Court held that a practicing physician registered under the CSA could be held liable under its various subsections, so long as the physician's activities fell outside of the usual course of professional practice.<sup>205</sup> Dr.

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21 C.F.R. § 1306.07(a)(1)–(2).

193. See 21 C.F.R. § 1306.07(b).

194. See *id.*

195. See 21 U.S.C. §§ 828–29.

196. 21 C.F.R. § 1306.05(a).

197. *Id.*

198. See Behr, *supra* note 56, at 62.

199. See *id.* at 62–64. For example, a valid prescription of a Schedule II controlled substance must be in writing. See 21 C.F.R. § 1306.11(a). Although, in the case of an emergency, the controlled substance may be dispensed pursuant to an oral authorization so long as the quantity is limited to the amount needed to treat during the emergency period, the prescription is immediately reduced to writing by the pharmacist, the pharmacist makes a good faith effort to identify the prescribing practitioner, and a written prescription signed by the prescribing practitioner is delivered to the pharmacy within seven days. See *id.* § 1306.11(d). Valid prescriptions of Schedule III, IV, and V controlled substances may be transmitted in either written or oral form. See *id.* § 1306.21(a). If transmitted orally, the pharmacist must promptly reduce the prescription to writing. See *id.*

200. See 21 U.S.C. § 841–65.

201. 423 U.S. 122 (1975).

202. See *id.* at 124.

203. See U.S. DRUG ENFORCEMENT ADMIN., *supra* note 6.

204. See *Moore*, 423 U.S. at 125–26.

205. *Id.* at 124. The legislative history of the CSA "indicates that Congress was concerned with the nature of the drug transaction" and not the status of the defendant. *Id.* at 134; see also *id.* at 140



Moore unsuccessfully argued that physicians were exempt from certain provisions of the CSA because of their authorization to prescribe controlled substances under the Act.<sup>206</sup>

After *Moore*, courts began to affirm convictions of physicians pursuant to various provisions under the CSA. A violation under § 841(a)(1)<sup>207</sup> was a predominant criminal charge.<sup>208</sup> For example, a practitioner may be found to have issued an illegal prescription in violation of the CSA when: the physician sells prescriptions;<sup>209</sup> the prescriptions are issued without any prior, or an inadequate, physical examination of the patient;<sup>210</sup> the prescription is written by physician to a fictitious patient or to a patient not present at the time the prescription was written;<sup>211</sup> the physician is aware that the medication is not or will not be used for a medical purpose;<sup>212</sup> the physician writes prescriptions

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(noting that the legislative history “reveals an intent to limit a registered physician’s dispensing authority to the course of his ‘professional practice.’”).

206. *See id.* at 131. “Congress intended the CSA to strengthen rather than to weaken the prior drug laws.” *Id.* at 139. The Court went on to say that the purpose of exempting physicians from criminal liability was to enable those physicians who act lawfully to further their medical practice and patient care. *See id.* at 131-33.

207. “[I]t shall be unlawful for any person knowingly or intentionally . . . to manufacture, distribute, or dispense, or possess with intent to manufacture, distribute, or dispense, a controlled substance . . .” 21 U.S.C. § 841(a)(1) (2006).

208. To prove a violation under this section, the government has the burden to prove: “(1) that [the physician] distributed or dispensed a controlled substance, (2) that he acted knowingly and intentionally, and (3) that he did so other than for a legitimate medical purpose and in the usual course of his professional practice.” *United States v. Rosen*, 582 F.2d 1032, 1033 (5th Cir. 1978) (citing *United States v. Bartee*, 479 F.2d 484 (10th Cir. 1973)).

209. *United States v. Rottschaefer*, 178 F. App’x 145, 146 (3d Cir. 2006) (upholding conviction for unlawful distribution of controlled substances in exchange for sexual favors); *United States v. Word*, 806 F.2d 658, 660, 662-67 (6th Cir. 1986) (upholding conviction of physician for selling prescriptions for Dilaudid in exchange for large sums of money); *United States v. Andrew*, 666 F.2d 915, 916, 920-22, 924-25 (5th Cir. 1982) (upholding conviction of physician for knowingly, intentionally, and unlawfully dispensing controlled substances in exchange for cash payments).

210. *Jin Fuey Moy v. United States*, 254 U.S. 189, 193 (1920) (upholding conviction of physician for failing to perform a physical examination of patients in some cases and failing to perform an adequate evaluation in other cases).

211. *Word*, 806 F.2d at 663-64 (upholding conviction of physician for knowingly prescribing controlled substances to persons under false names); *United States v. Stump*, 735 F.2d 273, 274, 276 (7th Cir. 1984) (upholding conviction of physician for issuing a large number of prescriptions; some to knowingly fictitious persons); *United States v. Larson*, 722 F.2d 139, 140-42 (5th Cir. 1983) (upholding conviction of physician for knowingly and intentionally prescribing drugs to persons under false names); *United States v. Potter*, 616 F.2d 384, 385-87 (9th Cir. 1979) (upholding conviction of physician for using fictitious names for prescriptions for Quaaludes for several patients).

212. *United States v. Warren*, 453 F.2d 738, 740-41 (2d Cir. 1972) (physician prescribed methamphetamines for a patient knowing that the patient used the drug solely to boost his performance as a musician).

for a patient too frequently;<sup>213</sup> and the physician writes prescriptions for a large amount of controlled substances to an individual patient.<sup>214</sup>

Concierge physicians certainly are more likely to violate the CSA based on the inherently dangerous relationship shared with the patient.<sup>215</sup> Concierge physicians may violate the CSA by failing to have a legitimate medical purpose for prescribing a particular drug(s) and thus, are not acting in the usual course of professional practice. Those rich patients who have unfettered access to their physicians ultimately get what they want as a result of the financial objectives of concierge physicians.<sup>216</sup>

Recently, the former boyfriend and former concierge physicians of the late Anna Nicole Smith were charged under California's CSA.<sup>217</sup> Among the charges are prescribing, administering, and dispensing controlled substances to an addict;<sup>218</sup> unlawfully prescribing a controlled substance;<sup>219</sup> obtaining a controlled substance by fraud, deceit, or misrepresentation;<sup>220</sup> obtaining a controlled substance by false name or address;<sup>221</sup> and issuing a prescription that is false or fictitious.<sup>222</sup> Despite these egregious allegations, these three defendants are not being charged with Smith's death.<sup>223</sup> The trial in connection with Smith's death began on August 4, 2010.<sup>224</sup>

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213. *United States v. Kaplan*, 895 F.2d 618, 620-21 (9th Cir. 1990) (physician convicted of writing nineteen and twenty-one prescriptions, respectively, to two different undercover federal agents within the period of one month).

214. *See id.*; *Potter*, 616 F.2d at 386-87.

215. *See infra* notes 217-22 and accompanying text.

216. *See supra* notes 120, 123-28 and accompanying text.

217. *See* Felony Complaint for Arrest Warrant at 1-3, *California v. Kapoor*, No. BA353907 (Cal. Super. Ct. Mar. 13, 2009), available at [http://ag.ca.gov/cms\\_attachments/press/pdfs/n1699\\_complaint\\_ans.pdf](http://ag.ca.gov/cms_attachments/press/pdfs/n1699_complaint_ans.pdf); *Anna Nicole Smith's Boyfriend, Doctors Charged*, CNN.COM (Mar. 13, 2009, 6:33 PM EDT), <http://www.cnn.com/2009/CRIME/03/13/anna.nicole.charges/index.html>; *Stern Faces More Charges in Anna Nicole's Death*, N.Y. POST (Sept. 23, 2009, 1:38 PM), [http://www.nypost.com/p/news/national/item\\_xIN48UdnnrOJVjyMKkNvYO](http://www.nypost.com/p/news/national/item_xIN48UdnnrOJVjyMKkNvYO).

218. CAL. HEALTH & SAFETY CODE § 11156(a) (West 2007); Felony Complaint for Arrest Warrant, *supra* note 217, at 1-3.

219. CAL. HEALTH & SAFETY CODE § 11153(a); Felony Complaint for Arrest Warrant, *supra* note 217, at 1-3.

220. CAL. HEALTH & SAFETY CODE § 11173(a)-(b); Felony Complaint for Arrest Warrant, *supra* note 217, at 1-3. On September 29, 2010, a Los Angeles Superior County judge "threw out a charge against Stern of obtaining drugs for Smith by fraud and deceit." *Judge Dismisses 2 Charges in Anna Nicole Drug Trial*, ABC NEWS (Sept. 29, 2010), <http://abcnews.go.com/Entertainment/wireStory?id=11761598>.

221. CAL. HEALTH & SAFETY CODE § 11174; Felony Complaint for Arrest Warrant, *supra* note 217, at 1-3.

222. CAL. HEALTH & SAFETY CODE § 11157; Felony Complaint for Arrest Warrant, *supra* note 217, at 1-3.

223. Felony Complaint for Arrest Warrant, *supra* note 217, at 1-3; Mike Von Fremd & Sarah Netter, *Anna Nicole Smith Trial: Doctors Say They Were Trying to Help Outlandish Reality Star*,

### B. State Homicide Prosecutions

In the last seven years, there have been few criminal prosecutions of physicians subsequent to the death of a patient caused by a prescription drug overdose under the state penal laws.<sup>225</sup> According to information compiled by the DEA's Office of Diversion Control over the past seven years,<sup>226</sup> only four registered physicians have been indicted and subsequently convicted under various state homicide laws.<sup>227</sup> The list contains arrest and conviction information for over two hundred physicians across the country, ten of which are said to have caused the death of an unknown number of patients.<sup>228</sup>

In Montana, Dr. James Bischoff pled guilty to, and was convicted of, negligent homicide at the age of forty-eight.<sup>229</sup> He was sentenced to ten years in prison on the negligent homicide charge, and six years in prison on other charges, which were to be served concurrently.<sup>230</sup> Dr. Bischoff's registration with the DEA was revoked in 2005.<sup>231</sup>

The state of Georgia convicted Dr. Noel N. Chua of violating its version of the CSA, which is a felony offense.<sup>232</sup> As a result of the patient's death while in the commission of a felony, Chua was convicted of felony-murder and sentenced to life in prison.<sup>233</sup> According to a local commentator, Dr. Chua's reputation in the community was irreparably harmed as a result of the felony-murder indictment and conviction.<sup>234</sup>

Dr. Jesse B. Henry was convicted under New Mexico's involuntary manslaughter statute for causing the death of three of his patients.<sup>235</sup> Dr.

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ABCNEWS.COM (Aug. 5, 2010), <http://abcnews.go.com/GMA/anna-nicole-smith-trial-doctors/story?id=11330552>.

224. See Von Fremd & Netter, *supra* note 223.

225. See generally OFFICE OF DIVERSION CONTROL, *supra* note 165 (detailing the arrest and subsequent convictions of prescribing physicians).

226. See *id.*

227. See *infra* notes 229-42 and accompanying text.

228. See OFFICE OF DIVERSION CONTROL, *supra* note 165.

229. See *id.*

230. See *id.*

231. See *id.*

232. See GA. CODE ANN. §§ 16-13-20, 16-13-43(b) (2007) (noting that a violation of Georgia's CSA is a felony offense, and providing minimum mandatory terms of sentence for violators); OFFICE OF DIVERSION CONTROL, *supra* note 165.

233. OFFICE OF DIVERSION CONTROL, *supra* note 165. According to court documents, Dr. Chua prescribed multiple controlled substances for the victim, and none were issued for a legitimate medical purpose or in the usual course of professional practice. See *id.*

234. Philip S. Chua, *A Victim of Southern Injustice*, FAR E. U., <http://www.feualumni.com/justicenoel.pdf> (last visited Oct. 8, 2010). Dr. Noel Chua himself lamented that even if he were exonerated of the charges, his face and name had been plastered all over the world wide web as a murderer, which had ruined his reputation as a physician permanently. *Id.*

235. See OFFICE OF DIVERSION CONTROL, *supra* note 165.

Henry prescribed quantities and combinations of methadone, hydrocodone, OxyContin, alprazolam, and diazepam<sup>236</sup> to his patients, which were found to be the causes of death.<sup>237</sup> Dr. Henry was known as “Doctor Feelgood” among his patients.<sup>238</sup> He was sentenced to five years of probation and has paid \$50,000 in fines to date.<sup>239</sup>

Finally, a physician in the state of Nevada, Dr. Harriston Bass, was charged and convicted of second-degree murder for prescribing controlled substances to minors absent a legitimate medical purpose.<sup>240</sup> According to court documents, Dr. Bass prescribed controlled substances at the minors’ homes and at hotels and casinos in Las Vegas.<sup>241</sup> Dr. Bass was convicted on forty-nine counts of drug-related offenses and is serving ten years to life in prison.<sup>242</sup>

Several other physicians were not indicted on penal charges; however, each received lengthy prison sentences as a result of abundant convictions under various sections of the CSA.<sup>243</sup> Further, some physicians convicted under state or federal CSA provisions were able to continue to practice medicine after paying a fine.<sup>244</sup> The fact that

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236. *See id.*

237. *See id.*

238. Joe Cantlupe & David Hasemyer, *Pills at Will: Deception, Incompetence and Greed Can Lead to Over-prescribing*, SIGNONSANDIEGO.COM (Sept. 27, 2004), <http://legacy.signonsandiego.com/news/health/20040927-9999-lz1n27report.html> (internal quotation marks omitted).

239. *See* OFFICE OF DIVERSION CONTROL, *supra* note 165.

240. *See id.* The prescribing and dispensing patterns of Dr. Bass caused the overdose of several young adults and juveniles. *See id.*

241. *See id.*

242. *See id.*

243. *See id.* It is likely that these physicians received long prison sentences because each of them were convicted of violating numerous provisions of the CSA resulting in the death of a patient. For example, Dr. Robert Ignasiak was found guilty on twelve counts of healthcare fraud and thirty-one counts of unlawfully dispensing controlled substances under the CSA, and he was sentenced to 292 months in prison. *See id.* Dr. Jorge Martinez was found guilty by a federal jury on two counts of healthcare fraud resulting in death, twenty-one additional counts of healthcare fraud, ten counts of wire fraud, fifteen counts of mail fraud, and eight counts of distribution of controlled substances. *See id.* He was sentenced to life in prison. *See id.* Dr. Thomas Merrill was convicted of eighteen counts of wire fraud; five counts of defrauding health care benefit programs, including two counts that charged that death resulted from the violation; and seventy-five counts of dispensing or distributing controlled substances including oxycodone, morphine, hydrocodone, fentanyl, alprazolam, and diazepam. *See id.* Four out of the seventy-five counts of dispensing and distributing controlled substances included charges that death resulted from the use of the drugs. *See id.* He was sentenced to life in prison, and concurrent twenty-, ten-, and five-year terms on the four charges that resulted in the death of a patient. *See id.*

244. *See id.* For example, in 2004, a Pennsylvania physician delivered thousands of prescription drug samples to a pharmacist who sold the drugs to patients. *Id.* The patients’ insurance companies reimbursed the pharmacist, and the physician was paid \$10,000 for the drug samples. *Id.* The physician was sentenced to two years probation, ordered to pay a fine of \$10,000, and has an active registration with the DEA. *Id.* In 2005, another Pennsylvania physician pled guilty to the illegal sale of prescription drug samples. *Id.* Although ordered to pay a \$20,000 fine, his DEA

celebrities, among others, are consistently falling victim to drug overdoses is evidence that concierge physicians participating in prescription drug cocktail schemes do not fear being indicted under the CSA. Put another way, the penalties under the CSA are not harsh enough, as they do not adequately prevent physicians from engaging in proscribed practices. The following Part illustrates the relative deterrent effects of concurrent indictments under the CSA and the penal laws.

#### IV. HOW THE CSA AND CRIMINAL HOMICIDE STATUTES DETER PHYSICIANS

The U.S. Supreme Court recognized in *Harmelin v. Michigan*<sup>245</sup> that there are four penological goals of the criminal justice system: deterrence,<sup>246</sup> rehabilitation,<sup>247</sup> retribution,<sup>248</sup> and incapacitation.<sup>249</sup> These goals are the result of a mixture of the two classical theories of punishment, utilitarianism and retributivism.<sup>250</sup> The American criminal justice system has placed different emphasis on these four goals over time.<sup>251</sup> When seeking criminal charges for physicians whose patients overdose as a result of prescription drug cocktails, prosecutors should be primarily concerned with deterrence and retribution. Physicians who

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registration remains active. *See id.* A physician in California pled guilty to issuing prescriptions of controlled substances to patients without a legitimate medical purpose. *See id.* She was sentenced to “one day in jail, three years probation, 120 hours of community service, and ordered to pay restitution in the amount of \$18,204.11.” *Id.* Her license to practice medicine remains active.

245. 501 U.S. 957 (1991).

246. BLACK’S LAW DICTIONARY 481 (8th ed. 2007) (“The act or process of discouraging certain behavior, particularly by fear; [especially], as a goal of criminal law, the prevention of criminal behavior by fear of punishment.”); HERBERT L. PACKER, *THE LIMITS OF THE CRIMINAL SANCTION* 39 (1978) (describing deterrence as “the inhibiting effect that punishment, either actual or threatened, will have on the actions of those who are otherwise disposed to commit crimes”).

247. BLACK’S LAW DICTIONARY, *supra* note 246, at 1311 (“The process of seeking to improve a criminal’s character and outlook so that he or she can function in society without committing other crimes . . .”).

248. *Id.* at 1343 (“Punishment imposed as a repayment or revenge for the offense committed; requital.”).

249. *Id.* at 775 (“The action of disabling or depriving of legal capacity.”); *see Harmelin*, 501 U.S. at 999 (Kennedy, J., concurring).

250. *See* JOSHUA DRESSLER, *UNDERSTANDING CRIMINAL LAW* 22 (3d ed. 2001) (arguing that the criminal law system that has developed in the United States is not philosophically consistent, as “some rules of criminal responsibility are primarily retributive in nature, whereas others are utilitarian in character”); Caprice L. Roberts, *Ratios, (Ir)rationality & Civil Rights Punitive Awards*, 39 AKRON L. REV. 1019, 1033 (2006).

251. *See Harmelin*, 501 U.S. at 999. Prior to 1970, the American criminal justice system considered the principal goals of punishment to be rehabilitation and incapacitation. *See* James Q. Whitman, *Equality in Criminal Law: The Two Divergent Western Roads*, 1 J. LEGAL ANALYSIS 119, 127 (2009). However, beginning in the early 1970s, there was a dramatic shift toward determinative sentencing guidelines, which resulted in the restriction of judicial discretion. *See id.* at 127-28. Today, retribution seems to be the principal focus of the criminal justice system. *See id.* at 128.

cause the death of a patient should be punished accordingly, and their punishment should serve as a warning to other physicians as to what consequences they will face if they act in the same manner.

The foundation of utilitarian theory rests upon the principle that all laws are to “maximize the net happiness of society.”<sup>252</sup> Utilitarians are concerned primarily with the future of society.<sup>253</sup> A person balances the expected benefits of the criminal conduct with its risks, such as detection and punishment, and will avoid criminal activity if the perceived potential pain outweighs the expected potential pleasure stemming from the rewards of committing the criminal conduct.<sup>254</sup> Although utilitarians believe that both crime and punishment are unpleasant, the infliction of pain in the form of punishment is justifiable if it is expected to result in a net reduction of societal pain (crime) that would otherwise occur.<sup>255</sup>

Retributivists, on the other hand, focus on punishing the past acts of wrongdoers who perform criminal acts based on the belief that punishment is deserved when the wrongdoer freely chooses to violate rules enacted by society.<sup>256</sup> Wrongdoers must be punished regardless of whether this punishment will result in the future reduction of crime because society has a duty to punish morally culpable individuals pursuant to the concept of “just desert.”<sup>257</sup> Despite the American system being controlled primarily by utilitarian theory,<sup>258</sup> the retributivist concept of moral blameworthiness, as a primary justification for punishment, must be accounted for in a criminal justice system.<sup>259</sup> As such, a morally blameworthy individual is punished and thus, stigmatized by his offense.<sup>260</sup>

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252. Joshua Dressler, *The Wisdom and Morality of Present-Day Criminal Sentencing*, 38 AKRON L. REV. 853, 853-54 (2005).

253. See DRESSLER, *supra* note 250, at 14-15.

254. See *id.*

255. See *id.*; Dressler, *supra* note 252, at 853-54.

256. See DRESSLER, *supra* note 250, at 16.

257. See *id.* “Just desert” stems from retributive theory, and refers to the mandatory punishment of a morally culpable wrongdoer. See Joshua Dressler, *Hating Criminals: How Can Something That Feels So Good Be Wrong?*, 88 MICH. L. REV. 1448, 1451 (1990). Retributivists believe that it is morally wrong to punish an innocent person even if society might benefit from the action, and would rather have a guilty man go unpunished than an innocent man pay his “just deserts” for a crime that he did not commit. See *id.*

258. Stephen F. Smith, *Proportional Mens Rea*, 46 AM. CRIM. L. REV. 127, 146-47 (2009); William L. Barnes, Jr., Note, *Revenge on Utilitarianism: Renouncing a Comprehensive Economic Theory of Crime and Punishment*, 74 IND. L.J. 627, 630 (1999).

259. See Smith, *supra* note 258, at 146.

260. DRESSLER, *supra* note 250, at 16-18.

A. *The Deterrence Principle of the American Criminal Justice System*

As illustrated above, the American criminal justice system is primarily influenced by the tenets of utilitarian theory.<sup>261</sup> One of the most basic principles of the utilitarian theory is the deterrence of future acts.<sup>262</sup> Both general and specific deterrence exist under utilitarian theory, and each achieve a different end result.<sup>263</sup>

The desired end of general deterrence is a net reduction in crime.<sup>264</sup> General deterrence calls for the punishment of the wrongdoer, with the hope that the general community will be convinced to forego criminal conduct in the future.<sup>265</sup> By making an example of the wrongdoer, the expectation is that members of society will be inhibited from acting like the wrongdoers in the future by the threat of being punished themselves.<sup>266</sup> The existence of a threat helps to create patterns of conforming behavior throughout society, and “reduce[s] the number of occasions on which the choice of a criminal act presents itself.”<sup>267</sup> This concept seeks to instill fear into the general community and puts potential violators on notice of what conduct is prohibited.<sup>268</sup> It is likely that feelings of shame resulting from the effect of the potential punishment, such as social disgrace of being labeled as a criminal, contribute to the success of the general deterrence model.<sup>269</sup>

Conversely, specific deterrence seeks to punish the wrongdoer so that the punishee behaves lawfully in the future.<sup>270</sup> Specific deterrence focuses on an after-the-fact effort by the criminal justice system to condition an individual to avoid future conduct that she knows is likely to again result in punishment.<sup>271</sup> Specific deterrence is obtained by incapacitation—the imprisonment of the wrongdoer—and intimidation of future incapacitation if she returns to a life of crime after being released from prison.<sup>272</sup>

Law enforcement officials should be primarily concerned with the general deterrence of physicians for a number of reasons. It is commonly recognized that an individual who has served a prison sentence is subject

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261. See *supra* note 258 and accompanying text.

262. See DRESSLER, *supra* note 250, at 15-16.

263. See *id.* at 15.

264. *Id.*

265. See *id.*

266. See *id.*; PACKER, *supra* note 246, at 39.

267. PACKER, *supra* note 246, at 43.

268. See DRESSLER, *supra* note 250, at 15; PACKER, *supra* note 246, at 42.

269. See PACKER, *supra* note 246, at 42.

270. See DRESSLER, *supra* note 250, at 15; PACKER, *supra* note 246, at 45.

271. See PACKER, *supra* note 246, at 45.

272. DRESSLER, *supra* note 250, at 15.

to a high rate of reconviction.<sup>273</sup> Thus, focusing on specifically deterring individuals may not be an effective means to accomplish the important ends of a safe and healthy society. The punishment of previous offenders serves as a general deterrent in this situation: treating physicians who aspire to engage in the same proscribed behaviors are put on notice of their own possible punishment.<sup>274</sup>

*B. How Criminal Charges Under Both the CSA and Penal Laws Deter Future Criminal Acts*

The CSA was enacted with punitive and deterrence purposes in mind.<sup>275</sup> However, the conviction of a physician under the CSA carries little to no general deterrent effect.<sup>276</sup> Although many of the provisions under the CSA provide for long prison sentences if violated,<sup>277</sup> a physician will only get a long sentence if evidence sufficient to sustain a conviction is presented.<sup>278</sup> The number of physicians who engage in similar drug practices each day is staggering.<sup>279</sup> If physicians believe that they are immune to criminal penal liability, they will continue to engage in illegal practices and violate the CSA.<sup>280</sup> While individual physicians may have been specifically deterred by a punishment, general deterrence is the ideal end result so that less harm can befall society.

Conversely, homicide charges deter both generally and specifically by putting society on notice of what acts are proscribed and by punishing after the fact. Imposing homicide charges upon an individual devastate his or her reputation in society, as it is nearly impossible to avoid the

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273. See PACKER, *supra* note 246, at 46.

274. See Kirk R. Williams & Jack P. Gibbs, *Deterrence and Knowledge of Statutory Penalties*, 22 SOC. Q. 591, 591, 593 (1981).

275. See 116 CONG. REC. 1662-68 (1970).

276. See generally OFFICE OF DIVERSION CONTROL, *supra* note 165 (illustrating that physicians are regularly convicted under the federal CSA or a state's equivalent). Physicians are not generally deterred under the CSA because there is no inherent stigma associated with a CSA violation. See Theodore G. Chiricos et al., *Inequality in the Imposition of a Criminal Label*, 19 SOC. PROBS. 553, 562-64 (1972) (noting that defendants that pled "guilty" and are represented by private counsel are more likely to avoid the stigma attached to a criminal conviction; however, those defendants accused of a personal offense, such as homicide, are least likely to avoid the criminal stigma).

277. See 21 U.S.C. §§ 841, 848 (2006) (potential prison term of twenty years for life for engaging in a continuing criminal enterprise). See generally OFFICE OF DIVERSION CONTROL, *supra* note 165 (punishments ranging from probation to life in prison).

278. See *supra* Part III.B.

279. See generally OFFICE OF DIVERSION CONTROL, *supra* note 165 (listing over two hundred DEA investigations of physician registrants that resulted in the arrest and prosecution of the physician).

280. Some physicians are charged under the CSA for the death of a patient. See *supra* text accompanying notes 228-42.



criminal stigma associated with this personal offense.<sup>281</sup> A physician is likely to be cognizant of behaviors that may give rise to a criminal homicide charge, as she will be wary of risking her professional reputation.

Additionally, if a physician violates the AMA Code of Medical Ethics,<sup>282</sup> the state medical board should take action as necessary.<sup>283</sup> A study conducted in 2006, which surveyed disciplinary actions between 1990 and 1999, found that state medical boards imposed more severe punishments on physicians convicted of murder, manslaughter, or involuntary manslaughter than physicians convicted of various, unidentified prescribing violations.<sup>284</sup> Typically, state medical boards revoked a physicians' license to practice medicine if the physician was previously convicted under a state homicide statute.<sup>285</sup> However, violations under the state or federal CSA resulted in the temporary suspension of licenses, probation, or, as in most cases, no serious action taken at all.<sup>286</sup> In addition to the inherent general deterrent effect of a potential involuntary manslaughter charge, the tendency of state medical boards to revoke medical licenses of physicians convicted under state homicide statutes should act as a further deterrent of criminal behavior. If a physician knows that, if convicted of criminal homicide, she may lose her license to practice medicine, she will be generally deterred from engaging in proscribed prescription practices with patients.

#### V. WHY AN INVOLUNTARY MANSLAUGHTER CHARGE IS APPROPRIATE

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281. See Chiricos et al., *supra* note 276, at 564.

282. See *supra* text accompanying notes 121-22.

283. See Paul Jung et al., *U.S. Physicians Disciplined for Criminal Activity*, 16 HEALTH MATRIX 335, 336, 343-44 (2006).

284. See *id.* at 340, 348-49 tbls.2 & 3. The study considered the following six orders of the state medical boards to be severe (in descending order of severity): "revocation, surrender, suspension, emergency suspension, probation, and restriction of licensure." *Id.* at 338. Almost ninety-five percent of physicians convicted of murder, manslaughter, or involuntary manslaughter received severe punishments, while less than sixty-five percent of physicians convicted of prescribing violations received severe punishments. *Id.* at 348 tbl.2. Notably, close to ninety percent of physicians convicted of manslaughter had their medical licenses revoked, surrendered, or suspended. *Id.* at 349 tbl.3. In comparison, less than twenty percent of disciplined physicians convicted of a prescribing violation had their licenses revoked. See *id.* Close to forty percent of physicians convicted of a prescribing violation did not face disciplinary action. See *id.*

285. See *id.* at 349 tbl.3. A manslaughter conviction acted as the catalyst for revocation, while a prescribing violation was consistently not reprimanded. See *id.*

286. See *id.* at 342, 349 tbl.3.

Under California law,<sup>287</sup> as a prerequisite to a criminal homicide conviction, there must be a showing of malice,<sup>288</sup> either express or implied.<sup>289</sup> In the situation where a physician overprescribes a prescription drug cocktail to a patient, it is likely that the mental requirement of malice is absent. However, California penal law provides a charge of involuntary manslaughter—not requiring a showing of malice—under which such a physician may be tried.<sup>290</sup> Pursuant to California law, involuntary manslaughter involves the commission of: (1) an unlawful act that does not amount to a felony, or (2) a “lawful act, which might produce death, in an unlawful manner or without due caution and circumspection.”<sup>291</sup> It is likely that this behavior would meet the second prong of the statute. Although the actor may have engaged in a lawful physician-patient relationship while authorized to prescribe controlled substances, providing her patient with a cocktail of drugs in excessive quantities may be regarded as an unlawful act in the absence of due cause and circumspection.

New York penal law determines culpability pursuant to four mental states: intentionally, knowingly, recklessly, and negligently.<sup>292</sup> New York law does not have an involuntary manslaughter provision; instead it provides criminal liability for manslaughter in the second degree.<sup>293</sup> An actor is guilty of manslaughter in the second degree when she “recklessly causes the death of another person.”<sup>294</sup> A person acts “recklessly” within the meaning of section 125.15(1) when she is “aware of and consciously disregards a substantial and unjustifiable risk that such result will occur or that such circumstance exists.”<sup>295</sup> Further, “[t]he risk must be of such nature and degree that disregard thereof constitutes a gross deviation from the standard of conduct that a reasonable person would observe in the situation.”<sup>296</sup>

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287. *See supra* note 78.

288. CAL. PENAL CODE § 187 (West 2008). “Malice” is a common law mens rea term that generally refers to intentionally or recklessly causing a prohibited social harm. *See* DRESSLER, *supra* note 250, at 133.

289. Malice is express when “there is manifested a deliberate intention unlawfully to take away the life of a fellow creature.” CAL. PENAL CODE § 188. It is implied when “no considerable provocation appears, or when the circumstances attending the killing show an abandoned and malignant heart.” *Id.*

290. *See id.* § 192(b).

291. *Id.*

292. N.Y. PENAL LAW § 15.00 (McKinney 2009).

293. *See id.* § 125.15(1).

294. *Id.*

295. *Id.* § 15.05(3).

296. *Id.*

The application of the aforementioned criminal homicide statutes can be seen in the case of Dr. Murray. A prosecutor who is confronted with an overprescription case should utilize the law in the following manner. First, Dr. Murray should be charged under various provisions of California's Uniform Controlled Substances Act ("CUCSA"). The CUCSA requires that physicians who wish to furnish controlled substances in the state of California register annually with the state Department of Justice ("DOJ").<sup>297</sup> It is reported that Dr. Murray is not registered with the California DOJ and, more importantly, was not registered at the time of Jackson's death.<sup>298</sup> As such, furnishing a controlled substance—or as in Dr. Murray's situation, a plethora of controlled substances<sup>299</sup>—to a patient absent a permit would constitute a misdemeanor or felony violation of the CUCSA.<sup>300</sup> Dr. Murray could also be charged with unlawful transport and administration of a controlled substance,<sup>301</sup> and prescribing, furnishing, or administering a controlled substance to an addict.<sup>302</sup>

If convicted under the CUCSA, it follows that Dr. Murray should subsequently be convicted of involuntary manslaughter, as both disjunctive prongs of the statute are met.<sup>303</sup> If the CUCSA violations are classified as misdemeanors, section 1 is met;<sup>304</sup> conversely if the violations are felonies, section 2 applies and its requirements are met.<sup>305</sup> Even if Dr. Murray could successfully argue that his acts were in fact lawful under the CUCSA, it follows that his actions were "without due

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297. CAL. HEALTH & SAFETY CODE §§ 11106(a)(1)(A), 11106(i) (West 2007).

298. Jana Winter, *DEA Raids Pharmacy Believed to be Source of Jackson's Alleged Drug Death*, FOXNEWS.COM (Aug. 11, 2009), <http://www.foxnews.com/entertainment/2009/08/11/dea-raids-pharmacy-believed-source-jacksons-alleged-death-drug/>; Jana Winter, *Michael Jackson's Doctor Not Licensed to Prescribe Controlled Drugs in California*, FOXNEWS.COM (July 6, 2009), <http://www.foxnews.com/entertainment/2009/07/06/michael-jacksons-doctor-licensed-prescribe-controlled-drugs-california/>.

299. Even though propofol was not classified as a controlled substance at the time of Jackson's death, the other drugs administered to Jackson were controlled substances. *See supra* note 18, text accompanying notes 25, 28-30.

300. CAL. HEALTH & SAFETY CODE § 11106(j).

301. Unless issued pursuant to a valid prescription, it is illegal to transport and administer a controlled substance in the state of California. *Id.* § 11352(a). Any violation is punishable by three to five years imprisonment. *Id.*

302. *Id.* § 11210. The CUCSA does provide physicians with the ability to prescribe controlled substances to addicts with certain exceptions and pursuant to strict regulation. *See id.* § 11217.5 (a licensed medical physician may administer controlled substances to an addict for rehabilitation and treatment purposes so long as the medications are deemed *medically necessary* by the physician). There is no evidence to show that administering propofol to Jackson in any dosage or amount was medically necessary. *See supra* text accompanying notes 18, 44-46.

303. *See supra* notes 291, 299-300 and accompanying text.

304. *See supra* notes 291, 299-300 and accompanying text.

305. *See supra* notes 291, 299-300 and accompanying text.

caution and circumspection.”<sup>306</sup> At the time of Jackson’s death, Dr. Murray had been practicing medicine for twenty years.<sup>307</sup> According to several expert opinions, it is common knowledge among physicians that the combination of prescription medications administered to Jackson on the morning of his death would likely cause respiratory depression.<sup>308</sup> Since Dr. Murray did not monitor Jackson and had no emergency equipment available over the course of the time period he treated Jackson, he did not act with due caution and circumspection, thus likely satisfying an involuntary manslaughter conviction.<sup>309</sup>

Had this situation taken place within the jurisdiction of New York, the New York State Controlled Substances Act<sup>310</sup> (“NYSCSA”) would be implicated. Dr. Murray could be charged with prescribing, administering, or dispensing a controlled substance to an addict.<sup>311</sup> Additionally, Dr. Murray’s behavior likely rises to the level of recklessness<sup>312</sup> required to obtain a conviction of manslaughter in the second degree. Dr. Murray admits that he was fully aware of the dangers of propofol<sup>313</sup> and was in the process of trying to wean Jackson off of the drug.<sup>314</sup> Dr. Murray should be aware of the effects of various combinations of controlled substances and how propofol, a drug he had administered to Jackson for six weeks, could interact with other prescription drugs. Also, Dr. Murray admitted to police that he acquiesced to Jackson’s demands for propofol,<sup>315</sup> which further supports the notion that Dr. Murray knew the risk propofol posed, but consciously decided to administer the drug. It is likely that Dr. Murray was aware of and consciously disregarded a substantial and unjustifiable risk that death could result.<sup>316</sup> Pursuant to the multitude of expert opinions with regard to propofol,<sup>317</sup> it is likely that Dr. Murray’s failure to monitor Jackson and failure to have emergency resuscitation equipment present

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306. CAL. PENAL CODE § 192(b) (West 2008). “Without due caution and circumspection” has been held to be equivalent to criminal negligence. *California v. Stuart*, 302 P.2d 5, 9 (Cal. 1956).

307. See Dan Fletcher, *Michael Jackson Doctor Conrad Murray*, TIME (Aug. 26, 2009), <http://www.time.com/time/nation/article/0,8599,1918722,00.html>.

308. See *supra* note 18, text accompanying notes 41-43.

309. See *supra* note 48 and accompanying text.

310. See N.Y. PUB. HEALTH LAW § 3300 (McKinney 2002).

311. See, e.g., *id.* § 3350 (McKinney 2002). Since Dr. Murray was in California at the time of the prescribing violation and is not licensed to practice medicine in New York, further analysis under the NYSCSA is futile for the purposes of this Note.

312. See *supra* text accompanying notes 296-97.

313. See *supra* notes 18, 21-22, 24, 46-48 and accompanying text.

314. See *supra* text accompanying note 24.

315. See *supra* text accompanying notes 28, 31.

316. See *supra* text accompanying notes 41-48, 296.

317. See *supra* text accompanying notes 41-48.

is a “gross deviation from the standard of conduct that a reasonable person would observe in the situation.”<sup>318</sup> Dr. Murray would likely be found guilty of second-degree manslaughter if tried under the laws of New York.

## VI. CONCLUSION

Inherent in the nature of a concierge medical practice is the temptation to forgo ethical rules and fulfill every articulated desire of a patient, whether legal or illegal. The concierge medical industry, although innovative and designed with the intent to have a positive impact on the physician-patient relationship, is saturated with legal and ethical dilemmas, decided upon daily by physicians.

While the decision by the Los Angeles County prosecutor to indict Dr. Murray on charges of involuntary manslaughter is clearly a step in the right direction, this practice must become uniform across the country to adequately deter physicians from participating in illegal, and often times lethal, prescription drug practices. A concierge physician like Dr. Murray will be effectively deterred from participating in polypharmacy if she knows that she will face concurrent CSA and criminal homicide charges if a patient dies as a result of a prescription drug overdose. Although the CSA or a state’s adopted version of that Act specifically deters, when seeing the rapid rate in which CSA indictments are passed out among physicians, it is apparent that concierge physicians do not fear criminal liability under this Act, and thus criminal charges under the CSA alone are not effective. Conversely, due to the inherent stigma attached to a criminal homicide conviction, an involuntary manslaughter indictment has been shown to destroy the reputations of physicians in their communities, and among their families and friends. Ultimately, the prospective social damage a concierge physician may face will result in successful general deterrence and a reduced number of prescription-drug-related deaths.

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318. N.Y. PENAL LAW § 15.05(3) (McKinney 2009).

\* J.D. candidate, 2011; Hofstra University School of Law. This Note is dedicated to my parents. Thank you for teaching me the value of hard work and perseverance, and for your unequivocal love, support, and encouragement in my every endeavor. This Note would not have been completed without the help and thoughtful suggestions of many. Thank you Professor Eric Lane for your suggestions and guidance; Laurel Harris, Lauren Manning, and Alysa Koloms for your careful and thoughtful editing; Nick for helping me stay focused; and Stephen for being my unconditional support system throughout the Note-writing process. I would also like to thank Michael de Matos, Rachael Ringer, and Alison Sablick for their leadership and friendship, and the

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