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ACTIVE VERIFICATION AND VIGILANCE: A METHOD TO AVOID CIVIL AND CRIMINAL LIABILITY WHEN PRESCRIBING CONTROLLED SUBSTANCES

By Michael C. Barnes and Stacey L. Sklaver*

INTRODUCTION

On June 25, 2009, tragic news broke that the King of Pop, Michael Jackson, had died. Jackson had suffered a sudden and fatal cardiac arrest due to a prescription-drug overdose.1 Jackson’s personal physician, Dr. Conrad Murray, had prescribed the fatal medication dosage in an attempt to relieve Jackson from an insomnia-ridden state.2 Subsequently, a jury found Murray guilty of involuntary manslaughter, and he received the maximum sentence of four years in prison.3

Following Murray’s sentencing on November 29, 2011, Los Angeles District Attorney Steve Cooley signaled that, going forward, he would continue to be aggressive in holding physicians criminally liable for their roles in patient deaths4 resulting from prescribed controlled substances.6

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4. Although the legal suggestions in this paper apply to all prescribers, the focus will be on physicians. See Who Can Prescribe and Administer Rx in Washington State?, WASH. ST. DEP’T HEALTH (Aug. 2012), at http://www.doh.wa.gov/portals/1/Documents/Pubs/690158.pdf (discussing which licensed professionals can write prescriptions.).
6. See 42 U.S.C. § 802 (2006). The Controlled Substances Act defines “controlled substances” to mean “drugs or other substances” as found in schedules I through V. These schedules contain drugs that have a high potential for abuse. 42 U.S.C. § 812 (2006). Such drugs include diazepam (Valium), propofol (Diprivan), hydrocodone (Vicodin), carisoprodol (Soma), oxycodone (OxyContin), oxycodone with paracetamol/acetaminophen (Percocet, Tylox), propoxyphene (Darvon), hydromorphone (Dilaudid),
Less than a year later, Cooley stayed true to his word. On March 1, 2012, Dr. Hsui-Ying “Lisa” Tseng was arrested. Mr. Cooley charged Dr. Tseng with second-degree murder for the deaths of three of her patients that had suffered fatal overdoses of prescription medications that she had prescribed. Although it is more common for physicians to face civil liability, the homicide charges against doctors Murray and Tseng, and against many physicians throughout the United States, demonstrate the increasingly varied, yet severe, forms of legal liability that physicians may face for improperly prescribing controlled substances.

According to the Centers for Disease Control and Prevention (“CDC”), prescription drug abuse in the United States is an epidemic that is gaining widespread recognition. Accompanying the rise in abuse is a rise in the number of deaths associated with prescription drug overdoses. In 2010, seven people died each day from prescription drug overdoses in Florida alone. As a result, states understandably have

lorazepam (Atvan), midazolam (Versed), alprazolam (Xanax), morphine sulfate (MS Contin), and meperidine (Demerol). This Article refers to prescription medications by their generic names.

11. See National Prescription Drug Abuse Prevention Strategy, CTR. LAWFUL ACCESS & ABUSE DETERRENCE, 7 (2010), available at http://claad.org/downloads/2010_National_Strategy.pdf. “Prescription Drug Abuse” is “the intentional self-administration of a medication for a nonmedical purpose such as ‘getting high.’” This definition “includes all degrees of medication use with the intention of experiencing a high, from teens swallowing pills from medicine cabinets to inveterate addicts ‘shooting’ morphine. Abuse and nonmedical use are synonymous” for the purpose of this Article. It includes all controlled substances, whether they be benzodiazepines, stimulants, or opioids—both long and short acting.
12. See Glossary, CTR. FOR DISEASE CONTROL AND PREVENTION, http://www.cdc.gov/vaccines/about/terms/glossary.htm#. The CDC defines “epidemic” as “[t]he occurrence of more cases of disease than expected in a given area or among a specific group of people over a particular period of time.”
14. See id.
moved to interrupt the supply of prescription medications to drug abusers.16

Although drug abusers may acquire prescription medications through illicit channels, many others obtain prescriptions directly from prescribers.17 Although at the fringe, some physicians operate pill mills, acting as little more than drug dealers.18 However, the vast majority of physicians prescribe controlled substances in good faith, legitimately trying to manage patients’ medical ailments, such as a chronic pain, anxiety, or insomnia.19 Yet, states, such as Florida,20 are simultaneously imposing stronger legal duties upon physicians and seeking criminal sanctions against physicians who improperly prescribe controlled substances.21

Prior to the epidemic, many scholars and courts alike had opposed the imposition of criminal liability on physicians for improper prescribing, fearing that such liability would create a chilling effect: physicians would refrain from properly treating patients who legitimately needed certain prescription medications out of fear of criminal sanctions if a patient died from an overdose.22 However, the issue for physicians is more nuanced than just whether or not to prescribe controlled substances, and the belief that that physicians should be held criminally liable when their patients die from prescription drug overdoses, is gaining traction.23

16. See Deutsch & Risling, supra note 9; War on Pill Mills, supra note 9.
17. See War on Pill Mills, supra note 9.
20. See H.R. 7095, 113th Cong. (2011). Florida House Bill No. 7095 requires physicians to actively verify patients’ suitability for the use of controlled substances and remain vigilant in ensuring controlled substances continue to be appropriate for their patients, a model used by this article.
When a patient dies of a prescription drug overdose, the physician may face legal actions ranging from civil liability to first-degree murder. As more prosecutors bring charges against physicians, these physicians willing to prescribe controlled substances may not be able to accurately predict when they could face criminal liability. Additionally, courts have begun to reject long-standing defenses that physicians have used in the past.

Moreover, controlled substances are not appropriate for certain patients, even when such patients have a legitimate medical need for the medication, especially if the patients have previously abused or exhibit signs that they are likely to abuse controlled substances. This article establishes that physicians who prescribe controlled substances must, on a case-by-case basis, actively verify that treatment via controlled substances is an appropriate option for their patients, diligently ensure that the patients remain suitable candidates after the physicians have prescribed such medication, and willingly change the course of treatment if the patients exhibit any signs of abuse—a method that this paper deems "active verification and vigilance." This method, when thoroughly documented in medical records, helps to satisfy physicians' duties under civil law, the Controlled Substances Act ("CSA"), state controlled substances acts, and state homicide laws. Therefore, to protect patients from foreseeable harm and to make both civil liability and criminal convictions less likely, physicians must adequately and diligently employ the method of active verification and vigilance when prescribing controlled substances.

Prosecutions of physicians, from just 15 convictions in 2003 to 43 in 2008.

24. See infra Part IV.A-B.
25. See Frank L. Sapienza, Abuse Deterrent Formulations and the Controlled Substances Act (CSA), 70 DRUG & ALCOHOL DEPENDENCE S23, S30 (2012) (stating that "... differentially scheduled products, formulations and substances could also lead to confusion regarding appropriate criminal charges, penalties and sentencing issues" in a discussion of the CSA).
26. See infra Parts IV, V and Table 1 (discussing the good faith, contributory negligence, calculated risk, and willful ignorance defenses).
27. See Stewart B. Leavitt & Gary M. Reisfield, Introducing "Understanding UDT in Pain Care," PAIN TREATMENT TOPICS (Aug. 27, 2012), available at http://updates.pain-topics.org/2012/08/introducing-understanding-udt-in-pain.html?m=1. The concept of "vigilance" in this article is based on the definition of pharmcovigilence, which is defined as the science and activities related to the "detection, assessment, understanding, and prevention of adverse effects or other problems related to medication prescribing and use" in order to "enhance the care and safety of patients."
29. See infra Part III.
30. This article defines "active verification" as (1) verifying a patient's medical history, (2) checking prescription monitoring program databases, (3) determining whether other treatments that did not involve controlled substances were tried and failed by using drug tests before first prescribing, and (4) continuing to
This article serves as a guide to physicians and their legal counsel to help them better determine when physicians can be held civilly and criminally liable if their patients die from improperly using controlled substances while under the physicians’ care. It analyzes both civil and criminal case law at both the state and federal levels, determines which defenses are no longer viable, and makes recommendations as to what steps physicians should take to avoid liability. Part I first explores the problem of prescription drug abuse in the United States, and the resulting increase in legal proceedings involving physicians. Part II provides an overview of the medical standard of care, the CSA test as well as state controlled substances act tests for criminal liability, and various homicide doctrines. Part III establishes that physicians must, to the best of their ability, actively verify patient suitability for controlled substances before beginning treatment and must remain vigilant throughout the course of treatment to better comply with legal requirements imposed by civil law, the CSA, state controlled substances acts, and state homicide statutes. Part IV discusses civil cases in which courts have held physicians liable for their patients’ deaths due to overdoses of controlled substances. Part V discusses how physicians may be held criminally liable for failing to actively verify patient suitability before beginning treatment and remain vigilant throughout the course of treatment. It reviews federal and state criminal cases in which courts have held physicians liable when improper prescribing practices resulted in patient deaths. It highlights defenses on which physicians may no longer rely, further emphasizing the need for physicians to actively verify patient suitability for controlled substances before beginning treatment and remain vigilant throughout the course of treatment. This article concludes by asserting that, if physicians properly adhere to the method of active verification and vigilance, they have a better chance of providing adequate care for their patients and avoiding civil and criminal liability at state and federal levels.

I. THE GROWING PROBLEM OF PRESCRIPTION DRUG ABUSE

Whitney Houston, Michael Jackson, Heath Ledger, and Anna Nicole Smith are just a few of the many modern-day celebrities whose prescription drug-related deaths have highlighted the national problem of test and monitor patients throughout their treatment to ensure the patients do not use the controlled substance improperly.

31. This article addresses liability faced solely by physicians. However, physician extenders and other practitioners may also be held liable if they practice on their own, and could still be required to defend themselves even if they were acting under the direct supervision of physicians. This is an issue of agency relationships, and is beyond the scope of this paper.
prescription drug abuse. According to the Centers for Disease Control and Prevention, "prescription drug abuse is the fastest growing drug problem in the United States." In 2010, approximately 16,651 people in the United States died as result of unintentional overdoses involving prescription opioid pain relievers.

Several classes of prescription medications are prone to abuse. One such class is the aforementioned opioid pain relievers. Since 2003, deaths due to prescription opioid overdoses have outpaced deaths due to heroin and cocaine overdoses combined. Prescription opioids include hydrocodone, oxycodone, morphine, hydromorphone, and meperidine. Physicians prescribe such medications because opioids can "effectively change the way a person experiences pain," making the pain more tolerable. Yet, opioids may also result in a heightened sense of pleasure, making such medication prone to abuse.

Central nervous system ("CNS") depressants are another class of prescription medications that patients often abuse. CNS depressants are sedatives that enhance the effect of gamma-aminobutyric acid in the brain, subsequently slowing brain activity. CNS depressants include propofol, barbiturates, and benzodiazepines, like alprazolam and diazepam.

34. Press Release, Ctr. for Disease Control & Prevention, Opioids drive continued increase in drug overdose deaths, (Feb. 20, 2013), available at http://www.cdc.gov/media/releases/2013/p0220_drug_overdose_deaths.html; See Stewart B. Leavitt, Drug Overdose Deaths Still Rising in U.S., PAIN TREATMENT TOPICS (Feb. 19, 2013), available at http://updates.pain-topics.org/2013/02/drug-overdose-deaths-still-rising-in-us.html (stating that of those 16,651 deaths involving opioids, 4,903 were the result of opioid use alone and the rest of the deaths involved a combination of opioids and alcohol, other prescription medications, or illicit drugs).
36. See id.
41. Id.
42. Id.
43. Id.
Abusers often mix CNS depressants with other prescription medications, such as stimulants like amphetamines.\textsuperscript{44} A third class of highly-abused controlled substances is stimulants, which includes methylphenidate, dextroamphetamine, and pemoline. Individuals tend to abuse stimulants because doing so may result in many of the same euphoric effects as cocaine.\textsuperscript{45} Yet, stimulants also have other negative effects. High doses of stimulants can lead to an increased risk of addiction, cardiovascular complications, increased blood pressure, headaches, panic episodes, aggressive behavior, suicidal or homicidal tendencies, and overdose-related deaths.\textsuperscript{46}

When a physician improperly prescribes a controlled substance, he can face professional responsibility, civil, and criminal legal proceedings.\textsuperscript{47} For example, the Osteopathic Medical Board of California alleged that Dr. Lisa Tseng improperly prescribed drugs to a number of patients, eventually leading to Dr. Tseng’s voluntary surrender of her license.\textsuperscript{48} Dr. Tseng also settled civil suits for the wrongful deaths of five of her patients who died of prescription drug overdoses.\textsuperscript{49} Soon after, Los Angeles County District Attorney Steve Cooley brought second-degree murder charges against Dr. Tseng.\textsuperscript{50}

Criminal charges are becoming more frequent as states attempt to crack down on so-called pill mills and the rogue prescribers who operate out of them. Pam Bondi, Florida’s Attorney General, describes such physicians as “drug dealers in white coats.”\textsuperscript{51} As states enact tougher laws to deter improper prescribing, physicians who legitimately prescribe...
controlled substances face greater scrutiny and risk of civil and criminal liability.\textsuperscript{52} They must know and abide by the proper standards of care.

II. THE MEDICAL STANDARD OF CARE, THE ANALOGOUS CSA STANDARD, AND HOMICIDE DOCTRINES

When prescribing medications, physicians have a legal duty to abide by the medical standard of care or face liability for breaching such standard.\textsuperscript{53} Courts use various tests to determine the medical standard of care.\textsuperscript{54} Additionally, the CSA imposes a criminal duty on physicians that draws from the medical standard of care, and all states have their own controlled substances acts, which are typically modeled after the CSA.\textsuperscript{55} This Part provides an overview of the standard of care and physicians' duties under the CSA and under state laws.

A. Tests for the Medical Standard of Care in Civil Cases

Courts rely on a medical standard of care in medical malpractice cases to determine physicians' legal duties to their patients.\textsuperscript{56} Although there is no widely accepted definition for the standard of care that governs the medical community, state courts tend to use one of two tests to determine the standard: the "medical customs" test and the "reasonable, prudent physician" test.\textsuperscript{57} Courts that apply the medical customs standard of care evaluate a defendant physician's conduct by comparing such conduct with that of his peers in the medical community.\textsuperscript{58} The party


\textsuperscript{54} Id. The duty of care is one element of the medical malpractice test, which is a type of professional negligence. The four elements include the following: (1) the physician owed a legal duty to the patient by undertaking care or treatment of the patient; (2) the physician breached his duty to the patient by failing to conform to the relevant standard of care; (3) the breach caused an injury; and (4) the patient suffered damage. See Budd v. Nixen, 491 P.2d 433, 436 (Cal. 1971).


\textsuperscript{57} Id.

\textsuperscript{58} Id.; Simon, supra note 56.
seeking to establish a customary practice in court typically does so by presenting evidence in the form of expert testimony.\textsuperscript{59}

According to the Supreme Court decision, \textit{Daubert v. Merrell Dow Pharmaceuticals Inc.},\textsuperscript{60} a proponent presenting expert testimony must prove that the expert has scientific knowledge and that such knowledge is valid.\textsuperscript{61} Courts determine validity by considering various factors.\textsuperscript{62} Such factors include whether:

1. Scientists have tested the theory or technique and deemed it valid;

2. Peers have reviewed the idea or it has been published in scientific journals;

3. The relevant scientific community has generally accepted the theory or technique as valid; and

4. Standards have been circulated, usually in the form of consensus statements or clinical guidelines, to govern the operation of the technique and the known or potential rate of error involved in the technique.\textsuperscript{63}

The factors focus on methodology and principles rather than simply the ultimate conclusions generated.\textsuperscript{64}

However, many other courts throughout the United States have expressly rejected deference to medical customs, reframing the medical standard of care in terms of the “reasonable, prudent physician” test.\textsuperscript{65} In fact, the courts of at least twenty-one states have applied a form of the

\textsuperscript{59} See, e.g., Raines v. Lutz, 341 S.E.2d 194, 196 (Va. 1986) (holding that expert testimony is normally required on the standard of care, deviation from standard of care, and causation); Walski v. Tiesenga, 72 Ill. 2d 249, 256 (1978) (holding that the plaintiff must establish the standard of care for medical malpractice through an expert witness).

\textsuperscript{60} Daubert v. Merrell Dow Pharmaceuticals, 509 U.S. 579 (1993).

\textsuperscript{61} Id. at 589.

\textsuperscript{62} Id.

\textsuperscript{63} Id.

\textsuperscript{64} Id.; see also Strauss, supra note 56, at e193.

\textsuperscript{65} See, e.g., Philip G. Peters, Jr., \textit{The Quiet Demise of Deference to Custom: Malpractice Law at the Millennium}, 57 WASH. & LEE L. REV. 163, 164 (2000) (noting that twelve states have expressly rejected giving deference to medical customs, and nine more states have rephrased their standard of care to address the reasonable, prudent physician rather than customs in the medical community); Leonard J. Nelson III, et al., \textit{Medical Liability and Health Care Reform}, 21 HEALTH MATRIX 443, 453 (2011) (noting the trend toward replacing the traditional medical standard of care with the reasonable prudent physician standard of care).
reasonable, prudent physician test. Even if 99 of 100 physicians perform the same inadequate technique or ascribe to a certain theory, a court can still find the physicians negligent if such technique or theory caused harm to patients. Courts have held that negligence cannot be-excused just because other physicians use similar practices or the medical community widely accepts such practice. As such, the reasonable, prudent physician test is more stringent than the medical customs test, focusing more on whether a physician's action or omission could cause the patient harm, rather than customary acceptance. Therefore, physicians must protect themselves by not only taking into account what is customary, but also what any reasonable, prudent physician would do in a like situation to prevent harm to a patient.

B. The CSA's and State Controlled Substances Acts' Criminal Duties

Physicians must also adhere to standards and duties imposed by the CSA and state controlled substances acts. In response to a growing illicit drug problem in the U.S., Congress passed the CSA, which granted the U.S. Drug Enforcement Administration ("DEA") authority to investigate and prosecute prescribers. The Act created five schedules that classify


67. Simon, supra note 56.

68. Id.

69. See, e.g., The T. J. Hooper, 60 F.2d 737, 738 (1932); Helling v. Carey, 519 P.2d 981, 983 (1974); Simon, supra note 56.

70. See, e.g., Gilbert v. Sycamore Mun. Hosp., 622 N.E.2d 788, 795 (Ill. 1993) (stating that the standard of care is "the authority which a reasonably prudent person, exercising diligence and discretion, in view of the principal's conduct, would naturally suppose the agent to possess."); McPherson v. Ellis, 287 S.E.2d 892, 895 (N.C. 1982), stating:

[a] physician or surgeon who undertakes to render professional services must possess the degree of professional learning, skill and ability which others similarly situated ordinarily possess; he must exercise reasonable care and diligence in the application of his knowledge and skill to the patient's case; and he must use his best judgment in the treatment and care of his patient . . . . He is held to the standard of professional competence and care customary in similar communities among physicians engaged in his field of practice.

Helling v. Carey, 519 P.2d 981, 983 (Wash. 1974) (citing The T.J. Hooper, 60 F.2d 737 (2d Cir. 1932)) (describing the reasonable, prudent physician test and stating that courts must set their own standards rather than leaving it up to the medical community because "there are precautions so imperative that even their universal disregard will not excuse their omission").

controlled substances based on considerations, such as degree of actual or relative potential for abuse, scientific evidence of pharmacological effect, public health risks, and psychic or physiological dependence liability.\textsuperscript{72} Schedule I contains substances that lack any accepted medical use in treatment.\textsuperscript{73} Schedules II through V contains controlled substances that state-licensed physicians may prescribe as long as they have registered with the DEA to do so.\textsuperscript{74}

The CSA also imposes upon physicians duties regarding receiving and maintaining records of controlled substances, writing or faxing prescriptions, providing refills, transferring a controlled substance to another registered prescriber, providing proper security for storage of controlled substances, and reporting and completing the proper paperwork for theft or significant loss of controlled substances.\textsuperscript{75}

In addition to the CSA, each state has statutes that regulate physicians’ ability to prescribe controlled substances.\textsuperscript{76} Such statutes typically fall under the states’ own controlled substances act, which are usually modeled after the CSA.\textsuperscript{77} State statutes can impose additional duties on physicians who prescribe controlled substances.\textsuperscript{78} Thus, physicians must also be aware of the controlled substances act that applies in their state.

Federal courts applying the CSA and many state courts applying their own controlled substances acts determine criminal liability based on a three-step test. The court must determine whether (1) the physician knowingly and intentionally furnished a prescription for a controlled substance; (2) the physician’s behavior serves a “legitimate medical purpose;” and (3) the physician acts within “the usual course of medical practice.”\textsuperscript{79}

\begin{footnotes}
\item[77] Id.
\item[78] Id.
\item[79] See, e.g., 21 U.S.C. § 841(a)(1) (2006); State v. Moody, 393 So. 2d 1212, 1214-5 (La. 1981); United States v. Rosenberg, 515 F.2d 190, 196-7 (1975) (holding that the phrases “in the usual course of professional practice” and “legitimate medical purpose” have the same meaning); see also United States v. Moore, 423 U.S. 122, 141-2 (1975); see also Deborah Hellman, \textit{Pushing Drugs or Pushing the Envelope: The Prosecution of Doctors in Connection with Over-Prescribing Opium-Based Drugs}, 28 PHIL. & PUB. POL’Y Q. 7 (2008), available at
\end{footnotes}
Physicians can meet these duties under CSA by abiding by the medical standard of care. Although the CSA test is used for criminal liability, it is consistent with the medical standard of care, and courts have applied both the reasonable, prudent physician and medical customs tests in CSA cases. For instance, in *United States v. Alerre*, the defendant physicians faced criminal charges for drug distribution, drug conspiracy, and money-laundering. The lower court had allowed an expert physician to testify that the defendants had issued prescriptions that were "inconsistent with the dosages that a prudent physician in the state of South Carolina would give [under] the standard of care." The lower court permitted the jury to consider but not necessarily convict based on what a "reasonable physician would have done," i.e., the same civil test used for the medical standard of care. The appellate court upheld the lower court's decision to permit the jury to consider the medical standard of care. It stated that a showing of breach of the medical standard of care—a civil standard—is relevant to establish that the physician breached his duties to the patient under criminal law as long as the jury was also properly instructed on the criminal standard for liability.

Similarly, in *United States v. Chube*, the Fourth Circuit upheld the lower court's convictions of Dr. Randall Chube and Dr. David Demaret Chube II for unlawful distribution of a controlled substance, which the physicians argued that they used to treat their patients' chronic pain. The circuit court noted that the government was required to show that the defendant "knowingly and intentionally acted 'outside the course of professional practice' and without 'a legitimate medical purpose'". The court further stated that it was "impossible sensibly to discuss the question of whether a physician was acting outside the usual course of professional practice without a legitimate medical purpose without mentioning the..."
usual [medical] standard of care.”

Thus, the medical standard of care and the CSA test often contain the same requirements, and a physician can meet his duties to his patients under the CSA by complying with the medical standard of care.

C. Homicide Doctrines

When a patient dies due to a prescription drug-related overdose, prosecutors can choose to charge the physician and apply state homicide laws. Although some courts have been reluctant to find physicians criminally liable for breaching the standard of care due to such physicians’ benign motives in inflicting injury on patients, many other courts are less apprehensive when such breach results in a patient’s death. When physicians violate the CSA or state law regulating controlled substances, state medical boards typically suspend physicians’ medical licenses temporarily or place physicians on probation. However, if a physician is convicted under a state homicide statute, his license can be permanently revoked, making such charge a more enticing option for prosecutors aiming to deter improper prescribing in particularly egregious cases.

Some prosecutors, in states such as California, have charged physicians with involuntary manslaughter and second-degree murder. Other prosecutors, in states such as Georgia, have charged physicians with felony-murder. Florida prosecutors have gone so far as to charge physicians with first-degree murder. Given that the distinctions between these legal doctrines are so nuanced, it is helpful to provide a quick and simplified overview. This section will use California terminology to discuss involuntary manslaughter and second-degree murder, Georgia terminology to discuss felony-murder, and Florida terminology to discuss first-degree murder.

90. Id. at 698.
92. See infra, Part III; see also Laura D. Seng, Legal and Regulatory Barriers to Adequate Pain Control for Elders in Long-Term Care Facilities, 6 N.Y. CITY L. REV. 95, 101 (2003) (stating that “criminal prosecution[s] of physicians are unfortunately a necessary evil” in a discussion of prescription drug abuse).
93. Trachtman, supra note 23.
94. States have the power to revoke physicians’ licenses to practice medicine if the physicians have been found guilty of improper or unlawful conduct. See, e.g., Younge v. State Bd. of Registration for Healing Arts, 451 S.W.2d 346, 347 (Mo. 1969). The purpose of such action is to protect the public rather than to punish the physician. Id. One study found that 69% of physicians convicted of murder, manslaughter, or involuntary manslaughter convictions had their licenses revoked. Paul Jung, et al., U.S. Physicians Disciplined for Criminal Activity, 16 HEALTH MATRIX 335, 349 (2006).
95. See infra Part V.B.
96. Id.
97. Id.
first-degree murder. Each of these states—California, Georgia, and Florida—have adjudicated cases against physicians using these criminal doctrines respectively, as discussed below.  

1. Involuntary Manslaughter

Involuntary manslaughter is an unintentional, unlawful killing committed without malice aforethought but committed with criminal negligence. To be convicted of involuntary manslaughter, the defendant must have either committed a killing "in the commission of an unlawful act, not amounting to a felony; or in the commission of a lawful act which might produce death, in an unlawful manner, or without due caution and circumspection." Criminal negligence is defined as the reckless or grossly negligent commission of a highly dangerous act. A person acts with criminal negligence when he should be, but is not, aware of the substantial and unjustifiable risk to human life. The conduct is such a departure from the reasonable, prudent person’s conduct under the same circumstances that it shows “disregard of human life or an indifference to consequences,” thus establishing the objective, reasonable, prudent physician standard in the criminal context.

2. Second-Degree Murder

Second-degree murder is a lesser-included offense of first-degree murder. Case law defines second-degree murder as a murder that is committed with malice aforethought. A court will presume malice aforethought exists if (1) an assailant deliberately performs an unlawful act resulting in death, (2) the assailant knows that his conduct endangers the life of another, and (3) the act is executed without provocation or sudden passion.

In order to act with malice, the defendant must have known that his act threatened a life, but continued to act with conscious disregard of that threat regardless of his knowledge. In other words, it requires a
conscious disregard for life where the accused actually appreciated the risk involved.

Malice may be express or implied.108 Express malice murder requires an actual intent to kill.109 According to the California Penal Code, second-degree murder with implied malice requires the following:

(1) [The defendant] intentionally committed an act;

(2) The natural and probable consequences of the act were dangerous to human life;

(3) At the time [the defendant] acted, [he] knew [his] act was dangerous to human life; and

(4) [He] deliberately acted with conscious disregard for [human] life.110

Therefore, a state court will find a physician guilty of second-degree murder for knowingly and intentionally committing an act dangerous to human life where the physician appreciated the risk.111

There is a subtle distinction between second-degree murder with implied malice and involuntary manslaughter. Second-degree murder with implied malice requires the defendant to actually realize the risk to human life created by the conduct and to act with conscious disregard.112 Involuntary manslaughter requires that the defendant’s conduct endanger a life, but the defendant does not objectively realize the risk and acts without conscious disregard.113 In other words, unlike criminal negligence, which is determined by the objective standard of the reasonable person, second-degree murder with implied malice requires a determination that the accused was aware of the risk to life that his actions created and consciously disregarded that risk.114

110. CALCRIM § 520 (2012).
114. Id.
3. First-Degree Murder; Felony-Murder

First-degree murder is defined as (1) the unlawful killing of a human being with premeditation or (2) felony-murder.\textsuperscript{115} Felony-murder occurs when, in the commission of a felony, the defendant causes the death of another human being irrespective of malice.\textsuperscript{116} In some states, defendants can only be charged with felony-murder if they commit certain, specific felonies.\textsuperscript{117} However, in Georgia, a defendant can be charged for felony-murder for any felony resulting in death if the felony is dangerous per se, or if the felony creates a foreseeable risk of death by attendant circumstances.\textsuperscript{118} The prosecutor must show a direct, causal connection between the commission of the felony and the death.\textsuperscript{119} The court will not find that legal cause existed if (1) a coincidence occurs that was not reasonably foreseeable; or (2) an abnormal response occurs.\textsuperscript{120} Although the defendant need not act with malice or intent to kill another human being, he must possess the criminal intent to commit the underlying felony.\textsuperscript{121} The sentence for felony-murder in Georgia is life imprisonment or death.\textsuperscript{122}

III. THE METHOD OF ACTIVE VERIFICATION AND VIGILANCE

Controlled substance prescribers should actively verify patient suitability for treatment before beginning such treatment and remain vigilant throughout the course of treatment to help meet their legal duty under civil law, the CSA, and state homicide laws.\textsuperscript{123} By taking and properly documenting steps to comply with this method, physicians can significantly improve their likelihood of satisfying the medical standard of care and of avoiding homicide charges in the event of a patient overdose. This Part discusses the steps that physicians can take to satisfy this method

\textsuperscript{115} FLA. STAT. ANN. § 782.04 (2012).
\textsuperscript{116} GA. CODE ANN. § 16-5-1(c) (2012).
\textsuperscript{117} See, e.g., ALA. CODE §§ 13A-6-2 (2012); FLA. STAT. § 782.04 (2012); KAN. STAT. ANN. §§ 21-5402, 21-2515 (2012); VA. CODE § 18.2-32 (2012).
\textsuperscript{119} See State v. Crane, 279 S.E.2d 695, 696 (Ga. 1981) (refusing to hold the defendant liable for the victim’s death because someone other than the defendant caused the death).
\textsuperscript{122} GA. CODE ANN. § 16-5-1(d) (2012).
and how taking and documenting these steps can help physicians avoid both civil and criminal liability.

A. Approaches to Active Verification and Vigilance

When contemplating prescribing controlled substances, physicians should first actively verify the suitability of such treatment and then remain vigilant by continuously monitoring whether such treatment is still appropriate. Physicians can meet these tasks in a number of different ways.

1. Approaches to Active Verification

Physicians should actively verify that their patients are suitable for treatment with controlled substances to help comply with the medical standard of care, and to meet the “legitimate medical purpose” and “usual course of medical practice” prongs of the CSA test. For examples of tasks used to actively verify, physicians can look to Florida Statute § 456.44, which imposes a legal duty on physicians to meet certain “standards of practice.” Florida’s mandatory standards of practice include (1) completing a medical history and physical examination before beginning any treatment and documenting such medical record; (2) developing an individualized treatment plan for each patient that states objectives to be used to determine treatment success; and (3) changing treatment for patients with signs or symptoms of substance abuse.

Physicians can also satisfy this method of active verification in other ways. For instance, a physician can verify that the patient has a disorder that calls for treatment with controlled substances and that the patient tried other treatments, such as taking non-controlled substance medications or attending therapy sessions, before resorting to controlled substances. A physician can also verify by speaking with other physicians who treated the patient in the past, by reviewing reports of the patient’s medical history, and by utilizing prescription monitoring programs (“PMPs”).

127. See, e.g., Use of Controlled Substances for the Treatment of Chronic Pain, AZ. STATE MED. BD., available at http://www.azmd.gov/statutes-rules/7_policy.aspx (stating that physicians must conduct an evaluation before prescribing controlled substances, which includes “corroboration of medical history by reviewing patient’s medical records and/or speaking with patient’s former physicians”).
128. Id.
129. PMPs are electronic databases that function as depositories for information about controlled substances.
Physicians can use PMPs to identify factual circumstances that suggest prescription drug diversion, abuse, or addiction. At the onset of treatment, a physician can check the state PMP before prescribing a controlled substance. Physicians must always obtain informed consent from the patient before beginning any treatment.

Physicians can also verify through drug testing, which is an objective clinical tool used to assess whether patients are taking prescribed medications, taking the prescribed dosage, taking unauthorized controlled medications, using illicit substances, or taking combinations of medications and illicit substances that may induce adverse drug interactions at any given point in time. Drug testing usually includes both a preliminary screening test and a confirmatory test to ensure accuracy, reliability, and specificity.

Taking all of these measures into account, the physician can then make an informed decision as to whether treatment using controlled substances is appropriate for the patient based on an individual, case-by-case assessment. If the physician determines that the patient may not be able to comply with the physician's usage instructions or has a past history of abuse, the physician must adjust treatment in order to avoid foreseeable harm to the patient. This method can be scaled up or down, at the

130. Some believe that a physician's duty is solely to the patient rather than society, and therefore, do not have a duty to prevent diversion. See, e.g., Victor R. Fuchs, The Doctor's Dilemma—What is "Appropriate" Care?, 365 N. ENGL. J. MED. 585-7, (Aug. 18, 2011), available at http://www.nejm.org/doi/full/10.1056/NEJMp1107283. However, this is not true. Pursuant to the CSA, physicians have a duty to both protect the patients' health and safeguard society against diversion of controlled substances. 21 C.F.R. § 1301.71(a) (2006).


132. Barth L. Wilsey, et al., Prescription Opioid Abuse in the Emergency Department, 33 J.L. MED. & ETHICS 770, 772, 775 (2005) (stating that patients taking controlled substances require monitoring, and examinations "must be supplemented with toxicology screening in order to detect the true incidence of prescription drug abuse").


134. Leavitt & Reisfield, supra note 27 (also noting that such tests are useful because patients are expected to test positive for prescribed medications that otherwise might be considered substances of abuse and to test negative for non-prescribed controlled medications and illicit drugs).

135. Id.

prescriber’s discretion, according to the anticipated risk. Physicians should also properly document every tool they use while practicing the method of active verification so that they may later use such documentation as evidence of their legitimate efforts to prevent foreseeable harm, should harm ultimately result. By utilizing these approaches, the physician may be able to meet his duty under civil law, the CSA, and state homicide statutes by actively verifying that the patient is suitable for treatment using controlled substances.

2. Approaches for Vigilance

Active verification is only the first step; physicians also should remain vigilant in order to reduce the risk of diversion, misuse, and abuse\textsuperscript{137} of controlled substances under civil law, the CSA, and homicide laws. This means that once the physician has determined that treatment with controlled substances is suitable, he must continue to monitor the patient in order to ensure that such treatment remains suitable, and if the patient shows signs of risk, the physician must change the treatment. Physicians can do this by taking certain steps, which may include requiring follow-up appointments periodically to assess the efficacy of treatment and consider adverse drug effects; and requiring monitoring of medication usage by performing drug tests and checking the PMP to ensure patient compliance.\textsuperscript{138}

If a physician discovers that the patient has begun to abuse the medication or determines that treatment using controlled substances is no longer suitable for the patient, then he must change the course of treatment in order to prevent foreseeable harm to the patient.\textsuperscript{139} The physician should properly document the steps he has taken to change the course of treatment in order to protect himself should harm ultimately arise. By remaining vigilant throughout the patient’s course of treatment, the physician is more

\textsuperscript{137} Ctr. for Disease Control & Prevention, Policy Impact: Prescription Painkiller Overdoses (Nov. 29, 2012), available at http://www.cdc.gov/homeandrecreationalsafety/rxbrief/. Misuse is distinguishable from abuse. Abuse, as defined above, is “the intentional self-administration of a medication for a nonmedical purpose such as ‘getting high.”’ In contrast, misuse is “the use of medication for a medical purpose other than as directed or indicated, whether willful or unintentional, and whether harm results or not. Misusing medications includes behaviors such as self-medicating without a prescription, using the medication for another indication than that for which it was prescribed, and increasing the dose of a prescribed medication.” See also Ctr. for Lawful Access & Abuse Deterrence, National Prescription Drug Abuse Prevention Strategy, (2010), available at http://claad.org/downloads/2010_National_Strategy.pdf.

\textsuperscript{138} H.R. 7095, 113th Cong. (2011)

\textsuperscript{139} Leavitt & Reisfeld, supra note 27 (noting that courts usually find that routine testing is a standard of responsible practice, also noting that all major federal guidelines for Kentucky, New York, and Washington state that physicians should use drug tests when prescribing controlled substances).
likely to meet his duty under civil law, the CSA, and state homicide statutes because he is truly making a legitimate effort to prevent foreseeable harm.

B. Active Verification and Vigilance to Prevent Civil and Criminal Liability

This section discusses the rationale for why active verification and vigilance will protect physicians from liability.

1. Meeting the Physicians’ Duty Under Civil Law: Medical Customs Test

As discussed above, when determining whether a certain practice is customary in the medical community, proponents of evidence will offer expert testimony to establish validity under the five-part Daubert test.\(^{140}\) Active verification and vigilance meet this test. Although such methods can sometimes be subjective or imprecise, various members of the medical community have tested and deemed the technique of active verification and vigilance valid through the use of scientific studies.\(^{141}\) Additionally, multiple peers in the medical community have reviewed the technique of active verification and vigilance, have published articles in various scientific journals, and have acknowledged that such techniques are accepted by the scientific community.\(^{142}\) They have also been established as standards in clinical guidelines.\(^{143}\) In fact, fifteen states have adopted the

\(^{140}\) Daubert v. Merrell Dow Pharmaceuticals, 509 U.S. 579, 589 (1993) (holding that factors establishing validity include (1) whether the technique has been tested and deemed valid, (2) whether it has been submitted for peer review or publication, (3) whether it has been accepted in the scientific community, (4) whether standards were circulated to govern the operation of the theory or technique, and (5) whether the potential rate of error involved is known.)


Federation of State Medical Boards “Model Guidelines for the Use of Controlled Substances for the Treatment of Pain.”\textsuperscript{144} The guidelines include approaches consistent with the method of active verification and vigilance, such as evaluating patients’ medical history to determine suitability; developing treatment plans; periodically reviewing the course of treatment and the patients’ compliance with such plan; and adjusting treatment if patients show signs of abuse.\textsuperscript{145} Additionally, the error rates of certain active verification and vigilance techniques are known.\textsuperscript{146} Therefore, active verification that a patient is suitable for treatment with controlled substances and remaining vigilant throughout the course of treatment is consistent with the medical customs test established in Daubert.\textsuperscript{147}

2. Meeting the Physicians’ Duty Under Civil Law: Reasonable, Prudent Physician Test

Under the reasonable, prudent physician test, physicians must act with the caution that a reasonable physician in similar circumstances would exercise in providing care to prevent harm to a patient.\textsuperscript{148} It is reasonable and prudent for a physician to actively verify patient suitability for controlled substances before treatment and remain vigilant throughout the course of treatment because controlled substances are dangerous by nature, requiring additional caution when prescribing. By actively verifying and remaining vigilant, a physician can avoid improperly prescribing controlled substances to a patient with a history of abuse, and the physician can detect abuse if the patient develops dangerous habits. Therefore, active verification and vigilance can help a physician prevent patient overdoses and other harm, which is consistent with the reasonable, prudent physician test.

3. Meeting the Physicians’ Duty Under The CSA

Moreover, physicians should actively verify and remain vigilant to meet the requirements of the CSA. As discussed above, physicians

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\textsuperscript{144} State-by-State Opioid Prescribing Policies, supra note 21.


\textsuperscript{146} See, e.g., L.R. Webster, et al., Predicting Aberrant Behaviors in Opioid-Treated Patients: Preliminary Validation of the Opioid Risk Tool, 6 PAIN MED. 432-442 (2005) (providing statistics on the accuracy of screening tools that predict which individuals may develop aberrant behavior when prescribed controlled substances).

\textsuperscript{147} See supra Part I.B.; see also Daubert, 509 U.S. at 589.

\textsuperscript{148} Strauss & Thomas, supra note 56.
prescribing controlled substances must not knowingly and intentionally prescribe controlled substances without a legitimate medical purpose or outside the usual course of medical practice under the CSA. Actively verifying the suitability of treatment with controlled substances and remaining vigilant prevents the physician from acting “without a legitimate medical purpose,” because it requires the physician to verify whether the patient has a need for the prescription and to act accordingly. It prevents a physician from acting “outside the usual course of medical practice” because it requires the physician to verify whether a controlled substance prescription is appropriate for the patient, to periodically verify that the patient is not using the prescription improperly, and to change the course of treatment if the patient exhibits dangerous behaviors. Failure to actively verify and remain vigilant may result in criminal liability under the CSA. In fact, one study identified thirty-two cases in which federal and state prosecutors found that physicians were prescribing controlled substance outside the usual course of medical care, sometimes simply for writing prescriptions to patients who then diverted the medication. Therefore, physicians should actively verify a patient’s suitability for controlled substances before beginning treatment and remain vigilant throughout the course of treatment to better comply with the CSA.

4. Meeting the Physicians’ Duty Under State Statutes

Active verification and vigilance, and, in particular, certain approaches of which physicians can use to comply with this method, are explicit in some states’ controlled substance acts and implicit in others. For example, Delaware, Nevada, New York, and Tennessee have statutes that explicitly state that physicians must check the PMP before prescribing controlled substances. Kentucky and Tennessee also require physicians to check the PMP at monthly intervals to ensure that patients who have been prescribed controlled substances are properly refilling their

149. See, e.g., 21 U.S.C. § 829 (2006); United States v. Rosenberg, 515 F.2d 190, 196-7 (9th Cir. 1975) (holding that the phrases “in the usual course of professional practice” and “legitimate medical purpose” have the same meaning); Moore, 423 U.S. at 141-2; Rosenberg, 515 F.2d at 193; Hellman, supra note 79.
150. See 42 U.S.C. § 841(a)(1); see also Rosenberg, 515 F.2d at 193; see also David L. Robinson, Bridging the Gaps: Improved Legislation to Prohibit the Abuse of Prescription Drugs in Virginia, 9 APPALACHIAN J. L. 281, 294 (2010); see also Steven Dubovsky, Big Brother May Be Watching What You Prescribe, J. WATCH PSYCHIATRY, (2007) (stating that physicians prescribing controlled substances must “document a careful history, examination, and treatment plan; schedule appropriate follow-up visits; and resist patients’ pressures to prescribe risky medications” in order to comply with the requirements of the CSA).
151. Dubovsky, supra note 150.
prescriptions in compliance with instructions and are not "doctor-shopping." Other states, such as Kentucky and Ohio in addition to Delaware and Nevada require physicians to check the PMPs when they believe that patients are seeking controlled substances for reasons other than treatment of existing medical conditions, therefore ensuring legitimate medical need before prescribing. Arizona, Kentucky, Tennessee, Utah, and Vermont require all licensed prescribers and dispensers to register with, but not necessary use, the PMP database.

Additionally, the Boards of Medicine in Florida, New York, and various other states have issued legislative guidelines that instruct physicians to create treatment plans, perform drug tests, and engage in periodic review of patients who are prescribed controlled substances. Although such guidelines are not mandatory, the Boards will consider such guidelines when they make determinations at physician hearings.

Louisiana, New Jersey, and Massachusetts require physicians to schedule check-ups every six weeks, three months, and six months, respectively, in order to assess the appropriateness of controlled substance treatment. Eighteen states require physicians to obtain patients' informed consent before prescribing controlled substances. Iowa requires physicians to adopt effective treatment plans, engage in periodic reviews and consultations, and terminate pharmacotherapy if necessary. As such, physicians are required to take steps to actively verify and remain vigilant under many state-controlled substances acts.

153. KY. REV. STAT. ANN. § 218A.172(2) (2012) (requiring practitioners to review the PMP no less than once every three months for all available data on patients prescribed controlled substances); TENN. COMP. R. & REGS. § 1200-34-01-.07(1)(a)(7) (2012) (requiring health care providers to access and review patient information in the PMP upon each new admission and once every six months thereafter).

154. DEL. CODE ANN. tit. 16, § 4798(12)(e) (West 2012); KY. REV. STAT. ANN. § 218A.172(1) (2012); NEV. REV. STAT. § 639.23507(A) (2012); OHIO REV. CODE ANN. § 4731.11 (West 2012). See also States that Require all Licensed Prescribers and/or Dispensers to Register with PMP Database, NAT'L ALLIANCE FOR MODEL STATE DRUG LAWS (2012), available at http://www.namsdl.org/documents/StatesThatRequirePractitionertoRegisterorHaveAccessstoPMPO7312012.pdf (Providing a list of the rest of the states that require physicians to check the PMPs in certain situations).

155. States that Require all Licensed Prescribers and/or Dispensers to Register with PMP Database, supra note 154.

156. FLA. ADMIN CODE ANN. 64B8-9.013 (2010); Leavitt & Reisfield, supra note 27.


159. These states include Arizona, Arkansas, District of Columbia, Iowa, Kansas, Maine, Michigan, Minnesota, Nebraska, New Hampshire, South Carolina, South Dakota, Texas, Utah, Vermont, Virginia, Washington, and West Virginia. Id.

160. Id.

161. Although the website is limited to opioids, rather than all controlled substances, Medscape provides a state-by-state summary of prescriber requirements consistent with and containing many tools used in the method of active verification and vigilance. State-by-State Opioid Prescribing Policies, supra note 21.
5. Meeting the Physicians’ Duty Under State Homicide Statutes

Physicians must actively verify and remain vigilant under state homicide statutes as well. As mentioned above, involuntary manslaughter is an unintentional, unlawful killing with gross negligence, a disregard for human life, or indifference to consequences.62

Second-degree murder is an unlawful killing in which the defendant knowingly and intentionally commits an act dangerous to human life with appreciation of the risk.63 The element of “knowledge” is imputed on every physician who prescribes controlled substances. As defined by the CSA and adopted by many state-controlled substance acts,64 controlled substances have high potential for abuse.65 Such medications can lead to severe psychological or physical dependence and have limited medical uses.66 For that reason, the DEA requires physicians who plan to prescribe controlled substances to register before doing so,67 and certain states require additional education and training before the physicians can prescribe controlled substances.68 Given the extent of the prescription drug epidemic and present-day resources available for prescriber education, physicians cannot legitimately claim that they are unaware of the risk of death to patients for whom they prescribe controlled substances. Therefore, involuntary manslaughter is no longer the most appropriate charge in controlled substance homicide cases. With knowledge of the dangers of controlled substances, if a physician does not actively verify patient suitability for controlled substances and remain vigilant throughout treatment, the physician is acting with conscious disregard and can be charged with second-degree murder.69

First-degree murder includes felony-murder, or a death caused while the defendant was in the commission of the felony, irrespective of malice.70 In a few states, it is a felony for physicians to dispense, prescribe, or administer controlled substances outside the scope of

162. Developments in California Homicide Law, supra note 102, at 1443-4.
163. See supra Part II.C.2.
164. E.g., FLA. STAT. § 893.02 (2012); PA. CODE § 25.72(c) (2012); TEX. HEALTH & SAFETY CODE ANN. § 481.033(c) (West 2012).
166. Id.
170. FLA. REV. STAT. § 782.04 (2012); GA. CODE ANN. § 16-5-1(c) (2012).
practice, similar to the CSA test.\textsuperscript{171} If a physician improperly prescribes a controlled substance, and such behavior results in his patient’s overdose-related death, then he can be found guilty of felony-murder. However, if the physician actively verifies and remains vigilant, he will be complying with the medical standard of care and can prevent patient overdoses and the resultant felony-murder charges.

Therefore, physicians must actively verify and remain vigilant to prevent and interrupt risky behavior in their patients who they treat with controlled substances. By practicing and properly documenting steps to actively verify and remain vigilant, physicians likely can satisfy the medical standard of care and avoid liability under the CSA, state-controlled substance acts, and state homicide statutes.

IV. CIVIL LIABILITY FOR FAILURE TO ACTIVELY VERIFY AND REMAIN VIGILANT

As shown above, physicians can face civil liability if they improperly prescribe controlled substances without actively verifying and remaining vigilant.\textsuperscript{172} To further illustrate this fact and to point out defenses that are no longer viable in light of evolving case law regarding medical practice, this Part provides cases in which physicians have and have not been held liable for improperly prescribing controlled substances. It shows how physicians who actively verify and remain vigilant have not been held liable, and physicians who typically exhibit a pattern of failing to practice such technique have been held liable.

One such case is \textit{Taglieri v. Moss}.\textsuperscript{173} In \textit{Taglieri}, the New Jersey Superior Court affirmed a lower court’s partial summary judgment that a physician was civilly liable for his patient’s abuse of controlled substances.\textsuperscript{174} The plaintiff in \textit{Taglieri} alleged that his former physician, Dr. Albert Moss, was the proximate cause of his prescription drug addiction.\textsuperscript{175} Dr. Moss began treating the plaintiff with oxycodone and carisoprodol after a laminectomy failed to cure the patient of chronic back pain.\textsuperscript{176} In order to facilitate prescription refills, Dr. Moss gave the plaintiff
post-dated and undated prescriptions.\textsuperscript{177} Dr. Moss testified that he "provided prescriptions for a larger supply to accommodate [the plaintiff], for whom it was difficult to make frequent trips to the doctor's office."\textsuperscript{178} Despite Dr. Moss's testimony that he believed his prescribing behavior was acceptable, the court found that, by so prescribing, Dr. Moss violated the reasonable, prudent physician test for the medical standard of care.\textsuperscript{179} The court took note of the fact that Dr. Moss only saw the plaintiff once every three months,\textsuperscript{180} despite the New Jersey law that forbids a physician from prescribing Schedule II controlled substances in more than a thirty-day supply, with limited exceptions, one of which being a requirement that the physician must evaluate the patient's continued need for the prescription at least every thirty days.\textsuperscript{181}

This suggests that the court felt Dr. Moss had provided inadequate oversight of the plaintiff's prescription medication use. Dr. Moss had breached the standard of care by failing to actively verify patient suitability for controlled substances before prescribing such medication and to remain vigilant throughout the course of treatment because he had not taken steps to ensure that treatment with controlled substances was still appropriate for his patient. As a result, his good faith defense failed.

In \textit{Argus v. Scheppregrell},\textsuperscript{182} a Louisiana court upheld a finding that Dr. William Scheppregrell violated his duty of care by prescribing controlled substances to a patient for weight control.\textsuperscript{183} The 18-year-old patient was 5'6" tall and weighed ninety-seven pounds.\textsuperscript{184} Yet, Dr. Scheppregrell continued to prescribe the medication in increased dosages even after the patient's mother informed him that the patient had become addicted.\textsuperscript{185} As a result, the patient died of an overdose. The court found that Dr. Scheppregrell's prescribing was the proximate cause of the patient's death, stating that Dr. Scheppregrell had blatantly disregarded his duty of care.\textsuperscript{186} Dr. Scheppregrell defended by claiming that the patient was contributorily negligent, but the court held that the patient's negligence could not be both a foreseen risk that imposes a duty on the physician and, at the same time, a defense to an action for damages for breach of that

\begin{thebibliography}{99}
\bibitem{177} Id. at 282-3.
\bibitem{178} Id. at 284.
\bibitem{179} Taglieri, 842 A.2d at 286.
\bibitem{180} Id. at 284.
\bibitem{181} N.J. ADMIN. CODE § 13:35-7.6(c) (2004).
\bibitem{182} Argust v. Scheppregrell, 472 So.2d 573 (La. 1985).
\bibitem{183} Id. at 574.
\bibitem{184} Id.
\bibitem{185} Id.
\bibitem{186} Id. at 576-77.
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Thus, contributory negligence was not a valid defense, and active verification of the patient’s suitability for controlled substances before prescribing them and vigilance throughout the course of treatment on the part of Dr. Scheppegrell could have prevented the death of his patient.

In Ballenger v. Crowell, a North Carolina court also held that contributory negligence was not a valid defense. There, a physician breached his duty of care by continuing to prescribe controlled substances to a patient who had developed an addiction and died from an overdose. The court held that the fact that a patient becomes addicted to a medication, continues treatment under the physician’s care, and the patient knowingly continues her addiction will not make her contributorily negligent unless the patient does something wrong or unless the patient knows her doctor is negligent. Here, the plaintiff believed she would be addicted for the rest of her life because the defendant physician told her so. Therefore, neither wrongful conduct nor knowledge of the physician’s negligence was present, and the court ruled that the fact that the plaintiff knew she was an addict and actively sought the medication did not make her contributorily negligent.

In contrast, in Posner v. Walker, a Florida court threw out a jury verdict that a physician had negligently caused a patient’s death from overdose. The court went on to enter judgment in favor of the physician. In Posner, the court described the great lengths to which the physician, Dr. Ira Posner, had gone in order to wean the patient off of controlled substances. Dr. Posner suggested that the patient seek alternative pain management. Additionally, over the years, he treated the patient with a variety of approaches, including anti-inflammatories, physical therapy, steroid injections, non-opioid medications, and surgery. The court noted that the patient failed to tell Dr. Posner that she

187. Id. at 577.
188. Id.
190. Id. at 291.
191. Id. at 293.
192. Id. at 294.
193. Id. at 291.
194. Id. at 291-2.
196. Id. at 668.
197. Id.
198. Id. at 665-6.
199. Id. at 665.
200. Id.
had met with other physicians and received prescriptions while Dr. Posner was treating her. When Dr. Posner discovered other physicians were also prescribing the patient medications, he asked them to stop. Dr. Posner also had the patient meet with a pain management team that included himself and multiple other specialists, and he denied her more medicine until she agreed to detoxification.

In contrast to Judge Pastor who sentenced Dr. Murray in Michael Jackson’s death, as discussed below, the court in Posner was willing to shift responsibility from Dr. Posner to the patient. Unlike Dr. Murray, Dr. Posner had tried nearly every available treatment, from physical therapy and injections to biofeedback and anti-inflammatory medications, to control his patient’s pain and wean her off of pain medications. The court was sympathetic to Dr. Posner, noting that, “[a]s a physician, Dr. Posner [could not] make his patients do exactly as he tells them.” Dr. Posner had remained active and vigilant, and as a result, he was not found liable.

Therefore, physicians must assert and document efforts to verify patient suitability for controlled substances before prescribing them and remaining vigilant throughout the course of treatment to avoid civil liability, as Dr. Posner did. They cannot rely on certain defenses, such as good faith and contributory negligence, but complying with this method can help protect physicians from liability.

V. HOMICIDE CHARGES FOR FAILURE TO ACTIVELY VERIFY AND REMAIN VIGILANT

Civil law, which is aimed at compensating the victim, sometimes does not go far enough when a physician could have prevented a patient’s controlled substance-related death through active verification and vigilance. First and foremost, the victim has already died, making the survivor’s civil proceeding too little and too late. Physicians also carry medical malpractice insurance, covering costs that they may incur from civil liability and obstructing much of the deterrent effect that litigation

201. Posner, 930 So. 2d at 667.
202. Id. at 666.
203. Id.
204. See supra Part V.B.1.a.
205. Id.
206. Id.
207. Id.
208. Sawicki, supra note 47 (noting civil law is aimed at victim compensation and criminal law is aimed at punishing wrongdoers).
may have. The decedent’s survivors may be compensated, but the physician may continue the same dangerous acts that he had committed in the past. The case of People v. Tseng exemplifies this point. In People v. Tseng, which is discussed at length below, five separate families sued Dr. Tseng for wrongful death after their family members died from overdoses. Dr. Tseng settled with all five families and continued her dangerous prescribing practices, which caused an additional seven deaths. The civil suits did not deter her.

Criminal proceedings, which are specifically aimed at punishing the wrongdoer and preventing repeat offenses, are sometimes necessary. In recent years, courts increasingly have been willing to find physicians criminally liable when a patient dies due to controlled substance overdose and the physician had prescribed the fatal medication. In fact, the DEA has reported a steady rise in successful criminal prosecutions of physicians, from just fifteen convictions in 2003 to forty-three in 2008.

Physicians can avoid homicide charges through active verification and vigilance. For instance, it is an absolute defense to both civil and criminal liability for improper prescribing or dispensing in West Virginia if a physician makes a good faith reliance on the information contained in the PMP database when he prescribed or refused to prescribe a controlled substance. Yet, by failing to actively verify patient suitability for controlled substances and remain vigilant thereafter, a physician exposes himself to homicide charges.

This Part discusses federal and state criminal cases in depth. It focuses on states that have been particularly aggressive in prosecuting

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209. See Addressing the Medical Malpractice Insurance Crisis: Alternatives to Damage Caps, 26 N. ILL. U. L. REV. 413, 431 (2006) (noting that under the current system, “the deterrent effect of the tort system is blunted by malpractice insurance”).

210. See id. ("Although there is some deterrent effect in the loss of reputation associated with a malpractice claim, the majority of the deterrence, primarily economic cost, is absorbed by the insurance company.")


212. See infra Part V.B.2.

213. Hernandez, supra note 49.

214. Id.; AP Staff Writer, CA Doctor Ordered to Trial in 3 Drug Deaths, THE EXAMINER (June 26, 2012), available at http://washingtonexaminer.com/ca-doctor-ordered-to-trial-in-3-drug-deaths/article/feed/2006561#.UD5xT8FISxs (noting that prosecution offered testimony about a total of twelve of Tseng’s patients who died of drug overdoses, although the prosecution only brought charges for three of those deaths).

215. Hernandez, supra note 213; CA Doctor Ordered to Trial in 3 Drug Deaths, supra note 216.

216. Trachtman, supra note 23.

217. Id.


219. See supra Part III.B.
physicians for improperly prescribing controlled substances repeatedly or to extreme levels. It also establishes that physicians may be able to avoid criminal liability through active verification and vigilance.

A. Federal Controlled Substances Act Cases

At the federal level, prosecutors frequently charge physicians for crimes under the CSA. Successful federal prosecutions have paved the way for state prosecutors to become more aggressive and to do away with the “good faith” defense. This section discusses some of those federal cases.

_Moore v. United States_ 221 was groundbreaking for the prosecution of physicians under the CSA. There, the United States Supreme Court held that physicians “can be prosecuted [for improperly prescribing controlled substances despite being licensed and registered to do so] when their activities fall outside the usual course of professional practice.”222 The Court found Dr. Moore guilty of knowingly and unlawfully distributing and dispensing a controlled substance because Dr. Moore prescribed medication in large quantities to patients at their requests, in the requested amount, and at a price based on the number of pills.223

Since _Moore_, lower courts have struggled with defining what physician conduct falls in or out of “the usual course of professional practice” in improper prescribing cases.224 _Moore_ provided little guidance on this issue because the case involved a physician who abdicated all professional responsibility.225 The Court further complicated matters by upholding the lower court’s jury instructions that, for a guilty verdict, the jury had to conclude that the defendant physician had prescribed the medications “other than in good faith,” making good faith an element of the liability test for the first time.226 Later courts held that a jury instruction

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221. 423 U.S. 122 (1975).
222. Moore, 423 U.S. at 124.
224. Robinson, _supra_ note 150, at 294 (stating that “defining the bounds of ‘legitimate’ medical practice is a subjectively vague and somewhat obscure concept, which inevitably results in vast amounts of physician discretion”).
226. Id. at 138-9 stating:

The trial judge assumed that a physician’s activities are authorized only if they are within the usual course of professional practice. He instructed the jury that it had to find beyond a reasonable doubt that a physician, who knowingly or intentionally, did dispense or distribute [methadone] by prescription, did so other than in good faith for detoxification in the usual
to determine whether a physician had acted in good faith was sufficient to
guide the jury in finding whether a physician had the “intent to act as a
pusher rather than a medical professional.”

In United States v. Feingold, the Ninth Circuit affirmed the
conviction of a physician for the unlawful distribution of a controlled
substance under the CSA. The government indicted Dr. Jeffrey Feingold
on 185 counts of illegal distribution of controlled substances, including
diazepam, hydrocodone, oxycodone, and oxycodone with
paracetamol/acetaminophen. Dr. Feingold authorized refills of his
prescriptions at rapid rates, sometimes within a day or two. Two
undercover DEA agents visited Dr. Feingold, posing as patients. Dr.
Feingold prescribed controlled substances to both, without even examining
the agent-patients.

In his defense, Dr. Feingold argued that he was “merely an
incompetent doctor” that had always prescribed medications in good faith
and had genuinely, if naively, believed patients when they requested
pills. He explained his excessive prescription-writing as a lack of
training, in both managing opioid medications and in identifying opioid
seekers, but that he always prescribed in the genuine belief that such
medication was necessary to treat his patients’ legitimate and serious
medical conditions. However, the court explained that good faith was
not merely having good intentions towards a patient, but “an honest effort
to prescribe for a patient’s condition in accordance with the standard of
medical practice generally recognized and accepted in the country.”

Dr. Feingold argued that he lacked the proper mens rea, or guilty
mind. The court noted that, to find a physician guilty under the CSA, a
practitioner must act with intent to distribute controlled substances outside


2013] ACTIVE VERIFICATION AND VIGILANCE 123

course of a professional practice and in accordance with a standard of medical practice gen-
erally recognized and accepted in the United States.
227. United States v. Feingold, 454 F.3d 1001, 1008 (9th Cir. 2006).
228. Id. at 1001.
229. Id. at 1013. The CSA makes it unlawful for any person to knowingly or intentionally distribute or
dispense a controlled substance without proper authorization. 21 U.S.C. § 841(a). Furthermore, a
prescription for a controlled substance is only allowed if it is “issued for a legitimate medical purpose by an
individual practitioner acting in the usual course of his professional practice.” 21 C.F.R. § 1306.04(a)
(2006). In Moore, the Supreme Court held that a physician who prescribes outside of the usual course of his
professional practice is subject to criminal liability. Moore, 423 U.S. at 124.
230. Feingold, 454 F.3d at 1004-5.
231. Id. at 1005.
232. Id.
233. Id.
234. Id. at 1006.
235. Id. at 1006.
236. Feingold, 454 F.3d at 1006.
the course of professional practice, acting as a "pusher rather than a medical professional." And although Dr. Feingold argued that he was simply an incompetent physician who honestly tried to help his patients manage their pain, the court still found that he had the requisite intent, upholding the conviction. The court noted that he prescribed drugs "to people whom he knew to be addicts, to people whom he never examined, to people whom he never met, and to undercover law enforcement officials" who essentially told him they wanted narcotics, and he dispensed controlled substances in extreme. He did not determine whether such patients had a legitimate medical need, and if so, whether they were suitable for treatment with controlled substances. Nor did he remain vigilant throughout the course of treatment to ensure patients were properly using their medications, instead choosing to act outside the usual course of medical practice, and as a result, the court affirmed his convictions.

In the same year that the Ninth Circuit decided Feingold, the Fourth Circuit decided United States v. Hurwitz and United States v. McIver under the CSA. Dr. William Hurwitz, a physician who operated a pain clinic in Virginia, managed pain with controversially high doses of various opioid medications, including methadone, oxycodone, and hydromorphone. After several of Dr. Hurwitz’s patients were arrested for attempting to sell prescription drugs, they cooperated with federal investigators and identified Hurwitz as the source of such medication. A jury convicted Dr. Hurwitz of "50 counts of illegal drug distribution, including conspiracy to distribute controlled substances, and charges related to drug trafficking that resulted in one death and serious bodily injury to others." Dr. Hurwitz received a sentence of twenty-five years in prison.

Dr. Hurwitz appealed the district court’s decision, in part because Judge Leonard Wexler barred the jury from considering whether Dr. Hurwitz had prescribed the medications in good faith in their verdict.

237. Id. at 1008.
238. Id. at 1010.
239. Id. at 1005.
242. Hurwitz, 459 F.3d at 466.
243. Id. at 466-7.
245. Id.
determination. Dr. Hurwitz argued that, despite the controversy of his treatment plans, they had a valid medical purpose. Dr. Hurwitz later suggested that a small segment of his patients had taken advantage of his practice. He argued that problems arose because he was ill-equipped to deal with drug-seeking patients.

The government argued that Dr. Hurwitz's treatment plans were outside the usual course of professional practice, even for physicians who provide high-dose opioid therapy. An expert for the prosecution testified that high-dose therapy generally entailed about 200 milligrams of morphine a day to a patient. In contrast, Dr. Hurwitz prescribed a median of 2,000 milligrams of morphine or its equivalent a day to his individual patients.

The Fourth Circuit held that the jury should have been able to consider whether Dr. Hurwitz prescribed in good faith. It vacated Dr. Hurwitz's conviction and remanded the case for a new trial. At his second trial, on July 13, 2007, the jury convicted Dr. Hurwitz on sixteen counts of drug trafficking. U.S. District Court Judge Leonie Brinkema sentenced Dr. Hurwitz to less than five years, a substantial reduction from his vacated twenty-five year sentence. In her ruling, Judge Brinkema indicated that she believed Dr. Hurwitz had helped more patients than he had harmed. In fact, one patient testified that Dr. Hurwitz's treatments allowed her to regain her life and live in considerably less pain. Judge Brinkema concluded that "the mere prescription of huge quantities of opioids [did not necessarily] mean anything." Moreover, she did not find Dr. Hurwitz's high dose therapy to be outside the usual course of practice.

246. Hurwitz, 459 F.3d at 466.
247. Id.
249. Id.
250. Hurwitz, 459 F.3d at 467.
251. Id.
252. Id.
253. Id. at 481-2.
254. Id. at 482.
255. Markon, supra note 248.
256. Id.
257. Id.
258. Hurwitz, 459 F.3d at 468.
noting that "an increasing body of respectable medical literature and expertise supports those types of high-dosage, opioid medications." 

The court also held that although good faith generally is relevant when determining whether a physician violated the CSA, the district court had not erred by refusing to allow Hurwitz to present the injury with instructions to find him not guilty if he subjectively acted in good faith. The court noted that "allowing criminal liability to turn on whether the defendant-doctor complied with his own idiosyncratic view of proper medical practices" is inconsistent with prior case law. It went on to say that "to permit a practitioner to substitute his or her views of what is good medical practice for standards generally recognized and accepted in the United States would be to weaken the enforcement of our drug laws in a critical area." As such, Hurwitz received a multi-year prison sentence. Thus, physicians should follow standards generally recognized and accepted in the medical community when prescribing controlled substances. The approaches to active verification and vigilance summarized in Part III, section A above will likely satisfy this requirement.

In McIver, the Fourth Circuit affirmed the convictions of Dr. Ronald McIver. Dr. McIver operated a pain management clinic in South Carolina and prescribed oxycodone, methadone, and morphine, among other controlled substances, to his patients. Like Dr. Hurwitz, Dr. McIver managed his patients' pain with high-dosage opioid therapy. The court cited numerous ways that Dr. McIver's prescribing history did not accord with the usual course of professional practice. For example, Dr. McIver rarely offered non-drug pain therapy. He also continued to prescribe after he suspected patients were addicted. In one case, he continued prescribing after finding a syringe in a patient's possession and after the patient told Dr. McIver he only used the syringe for fishing. Interestingly, Dr. McIver had written to the South Carolina Health

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261. Hurwitz, 459 F.3d at 476-80.
262. Id. at 478.
263. Markon, supra note 248.
265. Id. at 553, 557-8.
267. McIver, 470 F.3d at 554.
268. Id.
269. Id.
270. Id. at 554-5.
Department about his suspicions that the patient was selling his prescription medication. However, given that Dr. McIver continued to prescribe medications to the patient, and therefore, failed to be vigilant in the course of treatment by changing his treatment methods, the court gave little weight to Dr. McIver’s letter.

In United States v. Merrill, the Eleventh Circuit affirmed the conviction of Dr. Thomas Merrill, after five of his patients died of drug overdoses while under his care. A jury had found Dr. Merrill guilty of a litany of violations under the CSA, including four counts stating that the deaths resulted from the use of the prescribed medications. The jury rejected Dr. Merrill’s argument that there was no way he could have “foreseen the deaths of patients who did not follow proper dosage instructions.” As shown above, physicians have imputed knowledge of the dangers of prescribing controlled substances, so his patients’ improper usage should have been foreseeable. He also argued that his only fault was that he trusted his patients too much. Yet, trust alone is not appropriate. A physician has a duty to do more than trust a patient; he must make a legitimate effort or use best practices in an attempt to determine whether the patient has an actual medical need for the controlled substance, and, if so, that the patient properly uses it. It is never possible to be fully confident that the patient is doing what the physician directed, but this method protects the physician in addition to the patient. When properly documented, it can show that the physician has taken appropriate steps to avoid foreseeable harm.

Dr. Merrill appealed the jury’s verdict, arguing, among other things, that there had been insufficient evidence for the jury to convict him. The Eleventh Circuit rejected a good faith standard of intent and instead focused solely on whether the physician objectively acted in accordance with the usual course of professional practice. The court found that there had been sufficient evidence against Dr. Merrill to affirm the jury’s

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271. Id. at 555.
272. Id.
273. United States v. Merrill, 513 F.3d 1293 (11th Cir. 2008).
274. Id. at 1309.
277. Id.
278. Merrill, 513 F.3d at 1298-9.
279. Id. at 1306.
It noted that the evidence had shown that Dr. Merrill had written multiple prescriptions for similar medications to the same patient during one visit; performed few, if any, physical examinations; maintained poor records of the medications he had prescribed patients; did not run any toxicology screens; and ignored warnings from other medical professionals that a patient was addicted to prescription medications.

Good faith was not a viable defense because, before prescribing, Dr. Merrill failed to ensure that his patients had a legitimate medical need and were suited for treatment involving controlled substances. After beginning treatment, he failed to be vigilant.

B. State Cases

States throughout the country have increased their enforcement efforts in order to curb prescription drug abuse. In many of those states, homicide cases are currently pending against physicians due to improper prescribing of controlled substances. This section focuses on cases from aggressive states such as California, Florida, Georgia, and Nevada.

1. California

Over the past decade, California courtrooms have hosted some of the most highly publicized homicide trials of physicians who improperly prescribed controlled substances. This section focuses on cases from aggressive states such as California, Florida, Georgia, and Nevada.

a. People v. Murray

Dr. Conrad Murray met pop icon Michael Jackson in 2006, when he treated Jackson and his children for the flu. In the spring of 2009, Jackson asked Dr. Murray to serve as his personal physician during a

280. Id. at 1297-8.
281. Id.
ACTIVE VERIFICATION AND VIGILANCE

series of concerts in England, and Dr. Murray subsequently started treating Jackson for insomnia. On June 25, 2009, Jackson died of cardiac arrest. Later, forensic tests revealed that a drug overdose caused the cardiac arrest. The Los Angeles County Coroner named the cause of death as "acute propofol intoxication" and "intravenous injection by another."

Propofol is a powerful medication, most often given to surgical patients as a sedative. While propofol produces a sleep-like loss of consciousness, the anesthetic's effect is actually closer to a coma. FDA-approved labeling provides that propofol "should be administered only by persons trained in the administration of general anesthesia."

Dr. Murray administered propofol, among other prescription medications, to Jackson on a nightly basis over the course of two months, in an effort to treat Jackson's insomnia. Dr. Murray had become concerned that Jackson had grown dependent on propofol to sleep. Yet, on June 25, 2009, after administering doses of diazepam, lorazepam, and midazolam to Jackson, who still could not fall asleep, Murray reluctantly acquiesced to Jackson's requests and once again administered propofol. Shortly thereafter, Jackson was non-responsive and later pronounced dead.

The court instructed the jury to find Dr. Murray guilty of involuntary manslaughter if he "committed a lawful act but acted with criminal negligence," and such act caused Jackson's death. The court defined

286. Id.
287. See Michael Jackson's Amended Death Certificate, supra note 1.
288. Id.
289. The DEA has issued a proposed rule to place propofol into schedule IV of the CSA. 21 C.F.R. § 1308 (2010).
293. Sentencing Memorandum, supra note 2.
"criminal negligence" as a reckless action "that creates a high risk of death or great bodily injury and a reasonable person would have known that acting in that way would create such a risk." It further instructed the jury that the defendant was charged with involuntary manslaughter based upon the theory of criminal negligence stemming from the failure to perform a legal duty. It explained that a physician "who assumed the responsibility to treat and care for a patient has a legal duty to treat and care for that patient," and that a physician fails to perform a legal duty if he causes the patient's death. The death must be the direct, natural, and probable consequence of the act or the failure to perform a legal duty, and the death would not have happened without the act or the failure to perform a legal duty.

The court found that Murray acted with an extreme callousness for Jackson's safety and with a strong disregard for the risk of death, rather than with due caution. Murray breached the standard of care simply by treating Jackson's insomnia with propofol. The prosecution called expert witnesses to testify on the standard of care in the medical community. One such witness, Dr. Nader Kamangar, testified that Dr. Murray's treatment of Jackson's insomnia with propofol was "beyond comprehension" and "disturbing." The court found that Murray "had repeatedly subjected Jackson to a dangerous, unprecedented pharmaceutical experiment" by administering propofol on a nightly basis for over two months, in addition to benzodiazepines; that Murray failed to provide the proper monitoring equipment or additional personnel that would have been able to save Michael Jackson's life; and that Murray personally failed to monitor Jackson. Thus, Dr. Murray breached his duty of care by failing to determine whether Jackson was suited for treatment using propofol. The jury found Murray guilty of involuntary manslaughter on November 7, 2011.

Superior Court Judge Michael Pastor found Dr. Murray's treatment of Jackson's insomnia with propofol to be outside the bounds of the

298. Id.
299. Id.
300. Id. at 7-8.
301. Id.
302. Sentencing Memorandum, supra note 2, at 2.
303. Id.
305. Id.
307. Id.
standard of care, calling it "experimental."\textsuperscript{308} Dr. Murray had defended himself by claiming that Jackson engaged in doctor-shopping.\textsuperscript{309} Judge Pastor rejected the defense's "criminal contributory negligence" argument that Jackson should bear responsibility for his own death because he sought prescription medications.\textsuperscript{310} Even so, it was no excuse because Dr. Murray could have consulted with Jackson's previous physicians, could have used the state's PMPs, could have drug tested Jackson, or, as Judge Pastor noted, could have "walked away and said 'no' as countless [other physicians] did."\textsuperscript{311} As a result of this lack of verification of the appropriateness of the treatment, Judge Pastor sentenced Dr. Murray to four years in prison without probation, the maximum possible sentence.\textsuperscript{312}

\textit{b. People v. Tseng}

At a conference following Dr. Murray's conviction, a member of the press asked District Attorney Cooley whether "he had filed the case just because the alleged victim was Michael Jackson."\textsuperscript{313} Cooley said no, indicating that Jackson's celebrity status did nothing more than raise the media interest in the case.\textsuperscript{314} Given the relative rarity of homicide charges against prescribing physicians, some may have been skeptical; however, in March 2012, Cooley charged Dr. Lisa Tseng with second-degree murder.\textsuperscript{315} Following her arrest, Cooley made his position clear, releasing a statement that noted that "prescription drug overdose deaths have reached epidemic proportions" and "[e]nough is enough. Doctors are not above the law."\textsuperscript{316}

The DEA began to investigate Dr. Tseng in 2007.\textsuperscript{317} During a three-year investigation, the DEA found that Dr. Tseng had written an average of twenty-five prescriptions a day.\textsuperscript{318} Additionally, an L.A. Times investigation in 2010 linked Dr. Tseng to eight patient deaths.\textsuperscript{319} Federal
prosecutors considered charging Dr. Tseng under a federal drug-dealing statute.\textsuperscript{320} However, in the end, federal prosecutors left Dr. Tseng’s case in the hands of Cooley.\textsuperscript{321} Cooley subsequently charged Dr. Tseng for the deaths of three of her patients—Joey Rovero, Vu Nguyen, and Steven Ogle.\textsuperscript{322} In addition, Cooley charged Dr. Tseng with twenty-one other felony counts for prescribing controlled substances, such as oxycodone and alprazolam, without a medical purpose.\textsuperscript{323}

Cooley’s choice of second-degree murder rather than involuntary manslaughter, of which Dr. Murray had been convicted, was a bold decision. Not only had few physicians been convicted of second-degree charges, but also a second-degree murder conviction in California carries a much heavier sentence.\textsuperscript{324} An involuntary manslaughter conviction carries a maximum sentence of four years.\textsuperscript{325} In contrast, a second-degree murder conviction carries a minimum of fifteen years.\textsuperscript{326}

Cooley charged Dr. Tseng under a different theory than that under which he charged Dr. Murray. Cooley charged Dr. Murray under the theory that Dr. Murray had been criminally negligent in his administration of controlled substances to Jackson.\textsuperscript{327} Cooley charged Dr. Tseng under the theory of implied malice.\textsuperscript{328} In Dr. Tseng’s case, malice could be implied because Dr. Tseng knew some of her other patients had died from overdoses.\textsuperscript{329} Therefore, she should have known that her prescriptions were potentially deadly.\textsuperscript{330} Yet, she did not alter her prescribing approaches.\textsuperscript{331}

Following a preliminary hearing, Superior Court Judge M.L. Villar de Longoria decided that Dr. Tseng would indeed stand trial for the murders of Rovero, Nguyen, and Ogle.\textsuperscript{332} The gravity of the charges, combined with the rarity of attempting to hold a physician criminally liable for the death of a patient, undoubtedly contributed to the extensive

\textsuperscript{320} Id.
\textsuperscript{321} Id.
\textsuperscript{322} Branson-Potts, supra note 7.
\textsuperscript{323} Deutsch, supra note 48.
\textsuperscript{325} CAL. PENAL CODE §193(c) (West 2012).
\textsuperscript{326} CAL. PENAL CODE § 190(b) (West 2012).
\textsuperscript{327} Sentencing Memorandum, supra note 2, at 4.
\textsuperscript{328} Deutsch & Risling, supra note 9.
\textsuperscript{329} Id.
\textsuperscript{330} Id.
\textsuperscript{331} Id.
nature of the preliminary hearing. Over a three-week period, forty witnesses testified, including "members of law enforcement, the coroner’s office, former staff members at Tseng’s clinic, expert witnesses, former patients and family members of patients." The prosecution also presented over 100 pieces of evidence. Witnesses testified that Dr. Tseng prescribed them controlled substances with very little examination or, in some cases, with no examination at all.

One of the patients who died under Dr. Tseng’s care was Joey Rovero, a 21-year-old college student. Dr. Tseng prescribed Rovero oxycodone, alprazolam, and carisoprodol after he came to her office complaining of a sore wrist and feelings of anxiousness. Dr. Tseng did not identify which wrist was bothering Rovero, nor did she probe why Rovero was feeling anxious. Rovero later died “from a mixture of alcohol and moderate to trace levels” of the drugs that Dr. Tseng had prescribed to him. She did not actively verify that the use of controlled substances was appropriate for him. Nor did she try an alternative approach to treatment with controlled substances first, even though she could have simply prescribed aspirin for his sore wrist.

In order to establish implied malice, the prosecution asserted that Dr. Tseng had ample notice that her prescribing methods were dangerous, given that three other patients had died of overdoses during 2007 and 2008. Moreover, the prosecution argued that Dr. Tseng received notice through other means. For example, one patient’s father had called Dr. Tseng in 2010 and implored her to stop writing prescriptions for his son.

According to the defense, Dr. Tseng wrote each prescription in good faith and for the purpose of helping her patients cope with their pain. Dr. Tseng’s five-attorney team tried to shift the blame from Dr. Tseng to her

333. Id.
334. Id.
335. Id.
337. Deutsch & Risling, supra note 9.
338. Id.
339. Id.
340. Id.
341. Deutsch, supra note 332.
343. Id.
344. Deutsch, supra note 332.
patients. For instance, on cross-examination of one of Dr. Tseng’s patients, who served as a witness for the prosecution, the defense pressed the patient to admit that she was aware she was addicted to controlled substances and was abusing the prescriptions Dr. Tseng wrote for her. Some patients acknowledged that they mixed their medications with alcohol. Dr. Tseng’s defense argued that Dr. Tseng could not know which patients were abusing drugs, nor could she be blamed if patients did not follow her dosing instructions. Dr. Tseng stated that if a “patient decides to take a month’s supply in a day, then there’s nothing I can do about that.” Yet, Dr. Tseng could have taken steps to actively verify patient suitability for controlled substances before prescribing them, and then remained vigilant throughout the course of treatment. She could have tried treatments using non-controlled substances first. She could have checked California’s PMP to determine whether her patients were doctor shopping to divert or abuse medications. Periodic urinalysis tests could have alerted her to disqualifying conditions, such as alcohol use, addiction, and non-compliance with dosage instructions.

In deciding that Dr. Tseng would stand trial for murder, Judge Villar de Longoria accepted the prosecution’s theory of implied malice. During his ruling, Judge Villar de Longoria said, “[Dr. Tseng] continued to prescribe these narcotics in high doses even after she was told something was terribly wrong and young men were overdosing and dying.” He made particular note of the high number of patients who died of overdoses while under her care.

Dr. Tseng was arraigned on August 7, 2012, where she pleaded not guilty to three counts of second-degree murder, one felony count of prescribing drugs using fraud, and twenty felony counts of prescribing drugs without a legitimate purpose. If convicted, she faces a maximum prison term of forty-five years to life.

345. See Hernandez, supra note 213.
346. Id.
347. Deutsch, supra note 332.
348. Id.
349. Deutsch & Risling, supra note 9.
351. Id.
352. Id.
353. Id.
355. Id.
c. People v. Fisher

Dr. Frank Fisher operated a California pain clinic from 1995 to 1999. In February 1999, Dr. Fisher was arrested and charged with prescribing excessive amounts of controlled substances and five counts of first-degree murder based on the prescription overdoses of his patients. Prosecutors claimed that Dr. Fisher overprescribed pain medications such as oxycodone, causing five overdose deaths, that he ran a drug mill, and that he was billing for treating patients with no legitimate medical need. The charges were later reduced to involuntary manslaughter due to inadequate evidence. At trial, the prosecution mainly argued that Dr. Fisher was the largest prescriber of Oxycontin in the state. In his defense, Dr. Fisher showed that he adhered to the accepted standards of care, fulfilling the duty of the active verification of patient suitability for controlled substances before prescribing them and vigilance throughout the course of treatment by providing the following treatment:

- Rigorous pre-treatment screening to exclude potential abusers of pain medications;
- Mandatory mental health evaluations of all chronic pain patients by a licensed professional;
- Ejection of patients caught lying, diverting medication, or ingesting non-therapeutic doses; and
- Regular and frequent blood and urine testing for medication serum levels, as well as for illegal substances.

These steps established that Dr. Fisher had abided by the standard of care. The court acquitted Dr. Fisher of all charges, and four wrongful death suits that were brought against him were all dismissed. The case highlighted the importance of establishing active verification and vigilance as an effective defense for physicians.
2. Florida

Florida, a state particularly impacted by the prescription drug epidemic, currently has two cases pending in which physicians have been charged with first-degree murder. In March 2010, Dr. Sergio Rodriguez was indicted for three counts of first-degree murder for the overdose deaths of three of his patients, and his trial is still pending. The criminal complaint alleged that Dr. Rodriguez caused the deaths of his patients “through the unlawful prescription of a controlled substance, oxycodone, by means of prescription issued in bad faith and not in the course of his professional practice.” He knowingly distributed controlled substances outside the scope of his professional medical practice without legitimate medical purposes. Although Dr. Rodriguez operated a pediatric office, he saw adult patients and prescribed them controlled substances without examining them.

In August 2011, a state grand jury indicted Dr. Gerald Klein, a physician who worked at a pain clinic, with first-degree murder, and his trial is also currently pending. Dr. Klein’s patient died of a prescription drug overdose after obtaining a single prescription from Dr. Klein for more than 200 pills at one time without determining a legitimate medical need. The patient died of combined drug toxicity the day after receiving the prescription. Three board-certified pain management doctors all agreed that no medical reason existed for Dr. Klein to prescribe such large

method may still end up on trial. Even if the result of the trial is a finding of no liability, which is more likely for physicians who practice verification and vigilance, the mere fact the case is brought can damage a physician’s reputation, insurability, and finances. This problem could likely be reduced by ensuring that prosecutors obtain adequate education and training on how to recognize dangerous prescribing practices and when to refer such cases to licensing authorities versus pursuing them as criminal matters.

365. Deutsch & Risling, supra note 9; see also Michael LaForgia, Doctor Charged with Murder in Overdose Deaths of 3 Men, PALM BEACH POST, March 13, 2010, at 1A.
367. FL Dep’t of Law Enforcement, Palm Beach County Doctor Indicted on Murder Charges (Mar. 12, 2010), available at http://www.fdle.state.fl.us/Content/News/March-2010/Palm-Beach-County-Doctor-Indicted-on-Murder-Charge.aspx.
369. Dahl, supra note 10; see also Michael LaForgia, Feds Hope to Crush Pill Czars, PALM BEACH POST, August 24, 2011 at 1A.
370. Dahl, supra note 10; see also Death on Owners’ Hands, PALM BEACH POST, August 24, 2011 at 10A.
doses of controlled substances.\textsuperscript{372} Dr. Klein's attorney told Circuit Judge Joseph Marx that he plans to present evidence that the patient had been doctor-shopping at the time of his death and ignored Dr. Klein's orders not to take pills that a relative had given him, a defense that this Article has shown will likely fail.\textsuperscript{373}

3. Georgia

Georgia is another state that has pursued murder charges in improper prescribing cases.\textsuperscript{374} In Georgia, a physician can be charged with felony-murder if the death of a patient results from controlled substance use.\textsuperscript{375} Felony-murder, as defined by Georgia law, occurs when the defendant commits the offense of murder in the commission of a felony, and the defendant causes the death of another human being irrespective of malice.\textsuperscript{376} The sentence for felony-murder is life imprisonment or death.\textsuperscript{377} In \textit{Hulme v. State},\textsuperscript{378} the court stated that felony-murder was appropriate in controlled substance homicides:

In Georgia, although we have no controlled-substance homicide statute, a person may be convicted of felony murder in this State when, in the commission of a felony, he causes the death of another human being irrespective of malice. The only limitation on the type of felony that may serve as an underlying felony for a felony murder conviction is that the felony must be inherently dangerous to human life. For a felony to be considered inherently dangerous, it must be dangerous per se or it must by its circumstances create[ ] a foreseeable risk of death.\textsuperscript{379}

In \textit{Chua v. State},\textsuperscript{380} the jury found the defendant-physician guilty of not only violating Georgia's controlled substances act, but of felony-murder.\textsuperscript{381} In \textit{Chua}, the patient died of an overdose of a mixture of controlled substances, including morphine, oxycodone, and methadone,
which Dr. Noel Chua had prescribed. Dr. Chua had prescribed oxycodone on November 28, 2005 and then distributed methadone to the patient days later on December 9 and December 12, 2005. Dr. Chua had obtained the patient’s previous medical records, which showed a pattern of prescription drug abuse, but failed to adjust the patient’s treatment plan, therefore failing to verify the appropriateness of treatment with controlled substances and to remain vigilant to prevent foreseeable patient harm.

Dr. Chua also ignored a nurse who warned him that the patient had an addiction, and he continued to provide the patient with controlled substance prescriptions, again failing to act after learning facts that typically necessitate a change in the treatment plan. The defense argued that Dr. Chua treated the patient in the usual course of practice, and that the pain medications were necessary to help relieve the patient’s chronic pain and headaches. In affirming Dr. Chua’s conviction, the court stressed Dr. Chua’s inaction despite evidence that the patient was addicted to prescription medications.

When prescribing controlled substances, verifying the patient’s history to ensure the patient’s suitability for treatment with controlled substances is vital, but is not enough; a physician must also be vigilant and change the course of treatment when the physician finds out that treatment using controlled substances is not appropriate for the patient.

4. Nevada

In Nevada, a physician may be convicted of first-degree or second-degree murder, if “the death of a person was proximately caused by a controlled substance which was sold, given, traded, or otherwise made available to him.” Depending on whether the prosecutor decides to charge the physician with first-degree or second-degree murder, the physician can receive a minimum sentence of twenty-five years in prison and a maximum sentence of the death penalty.

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382. Id.
383. Id.
384. Id.
385. Id.
387. Chua, 710 S.E.2d at 544.
In 2011, Dr. Richard Teh was arrested, pursuant to this statute, on a second-degree murder charge for prescribing “inappropriate doses” of schedule II-IV controlled substances to a patient who subsequently died.\textsuperscript{390} Although the prosecution charged Dr. Teh with acting with malice aforethought,\textsuperscript{391} Dr. Teh’s attorney argued that Dr. Teh never intended to harm the patient by prescribing the pain medication.\textsuperscript{392} He further stated, “there was no malice, no intent to kill,” and yet, prosecutors were willing to bring the charge anyway.\textsuperscript{393} However, the prosecutors ultimately dropped the case when the coroner’s office changed its ruling on the cause of death.\textsuperscript{394}

In 2008, a Nevada jury convicted Dr. Harriston Bass of second-degree murder\textsuperscript{395} along with forty-nine counts of selling a controlled substance and nine counts of possession with the intent to sell, after one of his patients died from taking hydrocodone prescribed to her by Dr. Bass.\textsuperscript{396} Dr. Bass ran a mobile medical service called “Docs 24-7,” through which he made house calls to patients at their homes and hotel rooms.\textsuperscript{397} His car was outfitted with a portable refrigerator that he used as his mobile pharmacy.\textsuperscript{398} Although he was not certified as a pharmacist and was not authorized to sell or dispense controlled substances, Dr. Bass routinely dispensed the medications for money.\textsuperscript{399} The prosecution had accused Dr. Bass of selling the decedent 900 hydrocodone pills.\textsuperscript{400} However, only trace amounts of the medication were found in the decedent’s toxicology report, suggesting the decedent was diverting the medications.\textsuperscript{401} The Nevada Supreme Court affirmed his convictions and a sentence of twenty-five years to life.\textsuperscript{402}

\textsuperscript{391} Criminal Complaint, supra note 390, at 1.
\textsuperscript{392} Harasim & Blasky, supra note 390.
\textsuperscript{393} Criminal Complaint, supra note 390, at 1.
\textsuperscript{394} Francis McCabe, \textit{Murder Charge Against Doctor to be Dropped, Memo Shows}, LAS VEGAS REV. J., Apr. 3, 2011, at 1B (changing the case of death to pneumonia rather than an overdose).
\textsuperscript{395} Second-degree murder in Nevada is almost anything besides a “willful, deliberate and premeditated killing.” NEV. REV. STAT. § 200.030 (2012).
\textsuperscript{397} Harasim & Blasky, supra note 390.
\textsuperscript{398} Id.
\textsuperscript{399} Vogel, supra note 396.
\textsuperscript{400} Id.
\textsuperscript{401} Id.
\textsuperscript{402} Harasim & Blasky, supra note 390.
C. What Do These Cases Tell Physicians?

There are a few common threads in these cases. Mainly, they demonstrate the defenses on which physicians can no longer rely in light of the need to actively verify a patient’s suitability for controlled substances before beginning treatment and to remain vigilant throughout the course of treatment. This section provides a discussion of such defenses. Additionally, please see Table 1 for a list of defenses and cases in which such defenses have been rejected.

1. The Good Faith Defense

As established in Tseng, Feingold, Hurwitz, and Merrill, physicians cannot rely on the good faith defense, in which a defendant argues that he prescribed based on his belief that such prescription was appropriate, to protect themselves against criminal liability. Although a patient may have a condition that can be treated with controlled substances, the physician must determine that the patient has a legitimate medical need for treatment with controlled substances rather than another type of treatment. When a physician simply prescribes controlled substances without verifying that the patient is suited for such treatment, he may have good intent, but mere intention likely will not save him from liability based on the imputed knowledge of the dangers of prescribing controlled substances.

2. Willful Ignorance and Calculated Risk

Good faith standards may encourage “willful ignorance,” which occurs when a physician continues to prescribe, despite his awareness of a number of red flags, as in the cases of Dr. Tseng and Dr. Chua. The physician deliberately avoids learning the facts that, if known, would require the physician to change his prescribing actions.

It is questionable whether a physician could continue to prescribe controlled substances despite his awareness of red flags, but still act in good faith, especially because courts have looked unfavorably at physicians when they disregarded warnings. However, defenders of such conduct argue that physicians can use the “calculated risk” defense, in which the physician believes that any benefit derived from the treatment,

403. See supra Part V.A-B.
404. Id.
405. See Hellman, supra note 79.
406. See, e.g., Chua, 710 S.E.2d at 540 (2011).
such as cessation of pain, would outweigh negative consequences, such as possibility of addiction to the controlled substance. 407

This calculated risk argument is weak because proper medical practice requires that the physician evaluate, manage, and, if necessary for patient safety, respond to the risks of prescribing controlled substances. If the physician takes steps to actively verify patient suitability for controlled substances, he will have a greater likelihood of knowing, before writing the first prescription, whether the patient could be seeking to divert or abuse controlled substances. 408 For example, if the patient has a history of abuse, the physician will know that the risk requires a specialized approach to treatment. 409 Even if the physician preliminarily determines that the controlled substance is appropriate for the patient, if the physician is properly following the calculated risk theory, then certain red flags, such as PMP data or urinalysis results can alert him that the risk of the controlled substance has begun to outweigh its benefit and that a different method of treatment is now necessary. 410

Moreover, the CSA test, which requires a physician to prescribe to patients with a legitimate medical need and inside the course of usual medical practice, prevents certain risk-taking. 411 Many states require physicians to undergo training pertaining to controlled substances to learn what is within the usual course of medical practice. 412 Other practices, such as prescribing large dosages of controlled substances without properly verifying the patient’s suitability for the medication, as doctors Hurwitz, McIver, and Merrill had done, violate the first part of the CSA test because the physician has not determined whether the patient has a legitimate medical need for such treatment. Risky practices, such as providing rapid refills without knowledge of the patient’s proper use of the medication, as

407. Id. (noting that “it isn’t reckless to risk a harmful action, even if it is very likely to occur, if the harm is significantly smaller than the harm that inaction may cause” and that a physician “is obligated to care more about alleviating the suffering of his patient than he cares about avoiding harm to society”).

408. See H.R. 7095, supra note 20; see also STEVEN D. WALDMAN, PAIN REV. 674-5 (2009); see also Scott, supra note 123.

409. See Hellman, supra note 79.

410. See id.

411. See, e.g., Feingold, 454 F.3d at 1008; Merrill, 513 F.3d at 1309; People v. Tseng, (Super. Ct. L.A. County, 2012, No. 394495).

Dr. Feingold had done, violate the second part of the CSA test because such method is outside the usual course of medical practice.

Therefore, physicians should not rely on the willful ignorance or calculated risk defenses even if they believe that using controlled substances adequately treats their patients’ symptoms, as doctors Chua, Feingold, Hurwitz, McIver, Merrill, and Moore had attempted to do.413

3. Trusting the Patient

Similarly, trusting a patient is not enough to protect a physician against criminal liability. Dr. Feingold, Dr. Merrill, and Dr. Tseng all argued unsuccessfullly that they simply trusted their patients to a fault.414 Yet, the courts still found them guilty.415 Although a physician’s trust in his patient is important to help the patient feel respected,416 physicians are still required to determine whether their patients have a legitimate medical need for treatment with controlled substances and to then prescribe within the usual course of medical practice. Blindly accepting a patient’s word that he experiences sharp pains or strong headaches, as in *Feingold, Merrill,* and *Tseng,* is not sufficient to prescribe controlled substances. A physician must legitimately attempt to verify the need for such treatment and ensure that such treatment is, and remains, necessary and appropriate. However, with respect to active verification, a physician can never be certain of such need because many disorders or symptoms of disorders for which controlled substances are prescribed do not present significant physical or measurable manifestations, and can only be assessed and reported by the patient himself. Examples are pain, anxiety, and adult Attention Deficit Disorder.

When active verification and vigilance are consistently carried out when prescribing controlled substances, the stigma of not relying upon trust alone is removed. Although some patients can find testing offensive or intimidating, it is a practice that can help ensure a physician’s compliance with the standard of care.417 When a physician checks a PMP or incorporates drug testing into treatment plans regardless of what the patients say, the physician can rightly state that he is not taking such actions because he does not believe his patients. Rather, the physician

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413. See Hellman, supra note 79.
414. See supra Part V.A-B.
415. Id.
416. See Hellman, supra note 79.
417. Leavitt & Reisfield, supra note 27.
takes these actions because he is required to do so for medical and legal reasons.

4. Lacking Foreseeability

Lacking foreseeability is also no longer a valid defense. Dr. Tseng, Dr. Murray, and Dr. Merrill all argued that they had no way to foresee whether patients would follow the proper dosage instructions.\(^{418}\) The foreseeability defense is similar to arguing contributory negligence. For example, Dr. Murray defended that Jackson self-administered the propofol when Dr. Murray had left the room.\(^{419}\) Dr. Murray also argued that he did not know that, the night before Jackson's death, Jackson had taken other medications that Dr. Murray prescribed.\(^{420}\) Yet, the courts found all of these physicians liable regardless.\(^{421}\) Like contributory negligence, lack of foreseeability is not a valid defense because the physicians have imputed knowledge of the risks involved in prescribing controlled substances. They become aware of this risk at the moment they are required to register with the DEA to prescribe controlled substances, a step that alerts physicians to the seriousness of prescribing such medication.

Additionally, lack of foreseeability is a weak argument because physicians have methods of assessing the likelihood of adverse events at their disposal, as discussed above. If they make efforts to verify patient suitability for controlled substances and remain vigilant throughout the course of treatment, they likely will be able to spot signs of diversion, misuse, or abuse before it is too late. Therefore, unique risks associated with each patient's controlled substance use are increasingly foreseeable.

5. Risky Prescribing

Risky prescribing without actively verifying patient suitability for controlled substances and without remaining vigilant throughout the course of treatment can result in a breach of duty under civil law, the CSA, and state homicide statutes. Physicians can no longer rely on the defenses of good faith,\(^{422}\) willful ignorance,\(^{423}\) trusting the patient,\(^{424}\) calculated

418. See supra Part V.A-B.
419. See supra Part V.B.
420. Id.
421. See supra Part V.A-B.
422. Feingold, 454 F.3d at 1008; Hurwitz, 459 F.3d at 466; Merrill, 513 F.3d at 1309; Deutsch, supra note 332 (discussing the rejection of Dr. Tseng's good faith defense).
423. See Chua, 710 S.E.2d at 544; Stepzinski, supra note 386 (discussing how the court rejected Dr. Chua's argument that he prescribed high dosages of controlled substances to properly treat his patient's pain); Branson-Potts, supra note 342 (noting that Dr. Tseng ignored her patient's father when he told her about his son's abuse of controlled substances).
risk, or lack of foreseeability. Thus, as these defenses are not viable, physicians who prescribe controlled substances without actively verifying patient suitability for controlled substances before prescribing and remaining vigilant throughout the course of treatment are more exposed than ever to criminal liability.

CONCLUSION

Prescription drug abuse is a well-known and widespread epidemic. When physicians claim that they do not know that controlled substances are dangerous and perhaps deadly to their patients, it does not ring true. Similar skepticism shrouds claims that they do not know what dosages their patients are taking, that their patients had been doctor-shopping, or that the patients had a history of controlled substance abuse. Physicians must determine the appropriateness of prescribing controlled substances through active verification and vigilance. When physicians fail to take these steps, they are knowingly breaching the reasonable, prudent person standard of care and the CSA test by placing their patients at risk of harm. As such, breaching physicians can be charged with anything ranging from a civil fine to first-degree murder. As case law evolves, physicians should no longer rely on certain, long-standing defenses. Thus, if physicians actively verify and remain vigilant, while properly documenting the tools used to practice such method, they can improve their likelihood of avoiding both civil and criminal liability at the federal and state levels. More importantly, they can help protect their patients from unnecessary and preventable adverse events, including death.

424. See Feingold, 454 F.3d at 1006; see supra note 277 and accompanying text; see supra note 345 and accompanying text.
425. See Chua, 710 S.E.2d at 544; Hurwitz, 459 F.3d at 466 (choosing to prescribe his patients high dosages of controlled substances to treat their pain after obtaining the patients' medical records and being told of patients' addictive behavior); Stepzinski, supra note 387 (discussing how the court rejected Dr. Chua's argument that he prescribed high dosages of controlled substances to properly treat his patient's pain).
426. See Merrill, 513 F.3d at 1309; Nelson, supra note 276 (discussing how the court rejected Dr. Merrill's foreseeability defense); Deutsch, supra note 332 (discussing the prosecution's rejection of Dr. Tseng's foreseeability defense).
### TABLE 1

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<tr>
<th>Defense</th>
<th>Definitions</th>
<th>Cases that rejected this defense</th>
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| Good Faith                             | A state of mind denoting honesty of purpose, freedom from intention to defraud, and generally speaking, means being faithful to one’s duty or obligation.  


| Contributory Negligence / “Criminal” Contributory Negligence | The act or omission amounting to want of ordinary care on the part of the plaintiff, which, concurring with the defendant’s negligence, is the proximate cause of injury.  

428. Id. at 1033. |

| Trusting the Patient | Physician’s reliance on the information that a patient tells him without properly verifying whether such information is accurate.  


| Calculated Risk | A chance of failure or success whose degree of probability has been estimated before some undertaking is entered upon.  

430. BLACK’S LAW DICTIONARY, supra note 428 at 649. |

| Lack of Foreseeability | Lack of reasonable anticipation that harm or injury is likely to result from certain acts or omissions.  

430. Id. |

Taglieri v. Moss, United States v. Tseng, United States v. Feingold, United States v. Hurwitz, & United States v. Merrill

Argus v. Scheppregrell, Ballenger v. Crowell, People v. Murray, & People v. Tseng

United States v. Feingold, United States v. Merrill, & United States v. Tseng


United States v. Tseng, United States v. Murray, & United States v. Dr. Merrill