HEALERS OR DEALERS: THE EFFECT OF DOCTORS COMMITTING HEALTH CARE FRAUD ON THE OPIOID EPIDEMIC

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I. INTRODUCTION

Victoria Ross was a healthy woman running a business and supporting her family. When Ross developed back pain, she went to see Dr. Webb who prescribed her more opioids than necessary for the pain. Before Ross met Dr. Webb, she was a loving mother, a wife and a business woman, but that all changed after she began seeing Dr. Webb.[1] After Dr. Webb started prescribing her OxyContin—a highly addictive opioid medication prescription for moderate to severe pain—Ross stopped caring after her family, she even lost her business. She became addicted to the oxycodone (another name for OxyContin) Dr. Webb was prescribing.[2] Dr. Webb was aware of his patient's addiction, pharmacists began refusing to fill his prescriptions, they even told him that his prescription practices might be contributing to Ross's misuse of the drugs, and yet he continued to write her prescriptions for this highly addictive drug.[3] Once she was addicted, Ross was no longer seeing Dr. Webb because of her pain, she was going to him because he was the only doctor who would continue to write her these prescriptions. On August 27, 2004, Ross died of "acute oxycodone intoxication."[4] Put simply, she died of a drug overdose—direct result of Dr. Webb's prescriptions for an illegitimate medical purpose.

A person in pain goes to their doctor because they believe their doctor can help them. They believe that they can trust their doctor to do what is best for them. They believe their doctor will make them better. But what happens when a trusting patient goes to an untrustworthy doctor? When the person who was supposed to help them, harms them? These doctors who run fraudulent medical practices—often referred to as "pill mills"—are creating a new class of drug dealers. By fraudulently prescribing opioids for the purpose of getting more money from insurance companies, the doctor is essentially dealing drugs. However, as physicians they are held to higher standards than 'street dealers.' When physicians enter the practice of medicine, they swear to "[f]irst, do no harm."[5] A physician who fraudulently prescribes narcotics for their own personal gain

1 United States v. Webb, 655 F.3d 1238, 1244 (11th Cir. 2011).

2 *Id*.

3 *Id*.

4 *Id*. at 1245.

5 United States v. Volkman, 797 F.3d 377, 382 (2015).

violates this principle. By writing unnecessary opioid prescriptions these doctors are causing their patients harm. They get their patients addicted to opioids, often prescribing such large and unnecessary quantities of pills as to cause a potentially dire harm. An addict who goes to a drug dealer on the street to buy heroin assumes the risk, but a patient going to their doctor assumes only that their doctor will help them.

While ethical health care providers attempt to fight the growing opioid epidemic, unethical actors, such as the doctors described in this note, pose a continuing threat. Although much of the talk around the opioid epidemic concentrates on how drug users are manipulating the system, physicians also play a vital role in the opioid epidemic. Recently the drug companies and manufacturers of these drugs are receiving attention and being prosecuted for their large role in this epidemic. The next step needs to be holding these doctors accountable by prosecuting them to the full extent of their crimes. Policies such as state Prescription Drug Monitoring Programs ("PDMPs") focus on how to prevent patients from misusing controlled substances but are not effective in preventing doctors from committing Medicaid Fraud.[6] When physicians write unnecessary prescriptions to patients for the purpose of receiving reimbursement from insurance companies, they are directly contributing to the ongoing epidemic.[7] If a physician is involved in fraud, they are not going to consult a PDMP or following proper protocol.

Since this epidemic was labeled a national health care crisis, the focus has been divided between what is causing it and what can be done to end it. However, little attention is being paid to the fact that health care, a federal program such as Medicaid is contributing to the crisis. Although healthcare fraud is not a sole cause of this crisis, its role in this growing epidemic needs to be acknowledged. It is indisputable that there are many contributing factors in the opioid epidemic. However, this Note focuses on the role of the doctors committing fraud, and the resulting opioid addictions and opioid related deaths that follow. This Note discusses what happens when doctors abuse their positions, when they put their own greed before the well-being of their patients, and in doing so fan the flames of the opioid crisis. In the following cases discussed here are examples of doctors who are taking advantage of people suffering, either from real

6 Joanna Shepherd, *Combating the Prescription Painkiller Epidemic: A National Prescription Drug Reporting Program,* 40 AM. J. L. & MED. 85, 86 (2014).

7 *Id*.

pain or drug addiction, to line their pockets. These crimes not only threaten patients, but the entire health care system. Section II of this note discusses the background of the epidemic followed by the current regulations in place at both the states and federal levels. Section III describes the doctor exception to the Controlled Substance Act ("CSA"). Section IV of this note discusses the standards of criminal liability applied to the CSA. Section V follows, connecting the criminal liability standards to doctors committing healthcare fraud. These doctors are held to a higher duty of care than a drug dealer, and therefore should be found criminally liable for their patients who die of opioid overdose.

Healthcare fraud touches every corner of the United States. This massive fraud scheme not only costs tax-payers money, but it also has deadly consequences. Unfortunately, these cases are severely under prosecuted. More often than not, a doctor writing fraudulent prescriptions can get away with their crimes by paying back the money they stole. In some cases, their licenses are revoked. But in very few cases are the doctors, who write fraudulent prescriptions that lead to patient deaths, being charged for the death. There are steps being made towards the right discussion which are described further on in this note. However, these steps are not enough. There needs to be more focus on the doctor's role in the ongoing opioid epidemic. More specifically, doctors who write unnecessary opioid prescriptions with the intent to commit health care fraud should be held responsible when their fraudulent actions lead to their patients' deaths.

II. BACKGROUND

A. The opioid epidemic is responsible for more deaths than either traffic fatalities or gun violence in the United States

From 1999 to 2018, the Center for Disease Control ("CDC") estimated that more than 450,000 people in the United States died from an overdose involving an opioid.[8] Of those, more than 232,000 people died from overdoses related to *prescription* opioids.[9] 42,000 of

8 *Understanding the Epidemic*, CDC, https://www.cdc.gov/drugoverdose/epidemic/index.html (last updated Mar. 19, 2020).

9 *Prescription Opioid Overdose Data*, CDC, https://www.cdc.gov/drugoverdose/data/prescribing/overview.html (last updated Mar. 19, 2020) (emphasis added).

those deaths happened in 2016 alone.[10] In 2017, the number of overdose deaths increased by about 10%, resulting in more than 72,000 deaths in the United States.[11] Close to two-thirds of all drug overdose deaths are opioid overdose deaths.[12] A Drug Enforcement Agency ("DEA") report noted that as of 2015, more Americans died from drug overdoses than from either traffic fatalities or guns.[13] Moreover, the CDC estimates that for every 100 Americans, about 58 opioid prescriptions were written in 2017.[14] Finally, Opioid Use Disorders ("OUDs") is now the second most common drug use disorder in the United States.[15]

On October 26, 2017, President Donald Trump declared the United States opioid crisis a national public health emergency.[16] Subsequently, in July of 2017, 412 people were charged in healthcare prosecutions and were accused of "collectively defrauding the government of $1.3 billion."[17] Of those charged, about one-third were accused of opioid related crimes.[18] Acting director of the F.B.I., Andrew G. McCabe, said that "[s]ome of the doctors wrote more prescriptions for controlled substances in a single month than entire hospitals wrote in that time."[19]

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10 *U.S. Charges Hundreds in Major Health Care Fraud, Opioid Crackdown*, REUTERS (June 28, 2018), https://www.nbcnews.com/news/us-news/u-s-charges-hundreds-major-healthcare-fraud-opioid-crackdown-n887436.

11 Erin Durken, *US Drug Overdose Deaths Rose to Record 72,000 Last Year, Data Reveals*, THE GUARDIAN (Sept. 28, 2018), https://www.theguardian.com/us-news/2018/aug/16/us-drug-overdose-deaths-opioids-fentanyl-cdc.

12 German Lopez, *In One Year, Drug Overdoses Killed More Americans than the Entire Vietnam War Did*, VOX (Sept. 28, 2018), https://www.vox.com/policy-and-politics/2017/6/6/15743986/opioid-epidemic-overdose-deaths-2016.

13 Nicholas Eberstadt, *Our Miserable 21st Century*, COMMENTARY MAGAZINE (Mar. 2017), https://www.commentarymagazine.com/articles/nicholas-eberstadt/our-miserable-21st-century/.

14 *U.S. Opioid Prescribing Rate Maps*, CDC, https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html (last updated Mar. 5, 2020).

15 James M. DuBois, *Between a Rock and a Hard Place: Can Physicians Prescribe Opioids to Treat Pain Adequately While Avoiding Legal Sanction?*, 42 AM. J.L. & MED. 7, 10 (2016).

16 Gregory Korte, *Trump Orders Public Health Emergency for Opioids, A Partial Measure to Fight Drug Epidemic*, USA TODAY (Oct. 26, 2017), https://www.usatoday.com/story/news/politics/2017/10/26/exclusive-trump-declare-public-health-emergency-opioid-crisis- partial-measure-figh/796797001/.

17 Rebecca R. Ruiz, *U.S. Charges 412, Including Doctors, in $1.3 Billion Health Fraud*, N.Y. TIMES (July 13, 2017), https://www.nytimes.com/2017/07/13/us/politics/health-care-fraud.html.

18 *Id.*

19 *Id.*

B. Doctors are abusing the system set up to help patients for their own greed

As of July 2018, Medicaid provides health coverage to 66.7 million people.[20] Medicaid is administered to states, according to federal requirements, and is funded jointly by states and the federal government.[21] Since the adoption of Medicaid in 1996, it has on its own "covered almost twenty to thirty percent of the overall pool of spending for opioids in the country."[22] In 2012, $7.4 billion was spent on opioid painkillers alone, with insurers paying 82% of that amount.[23] A recent report found that insurers spend, on average, $3,453 a year on an individual patient; however, that amount jumps to $19,333 for individuals with an opioid dependence or abuse diagnosis. [24] "[P]rescription painkillers are often lawfully prescribed by physicians and paid for by health insurers."[25] Insurance covers office visits, tests done on patients, and the drugs themselves.

Physicians who commit fraud take advantage of this by billing for everything that should be done to lawfully write a prescription for a controlled substance without actually completing any of the necessary medical exams or tests. Yet these doctors write the prescriptions anyway.[26] These physicians will see patients for as little as two to five minutes enabling them to see between sixty to one hundred patients in a single eight-and-one-half-hour day.[27] While in reality all they are doing in this time is writing prescriptions, they bill for each of these patient services as if they have done the necessary exams.

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20 MEDICAID, https://www.medicaid.gov/medicaid/index.html (last visited Nov. 17, 2018).

21 *Id*.

22 Valerie K. Blake, *Engaging Health Insurers in the War on Prescription Painkillers*, 11 HARV. L. & POL'Y REV. 485, 495 (2017).

23 Julia Appleby, *Insurance Data Show a Surge in Spending on Opioid Treatment and Testing*, NPR (Sept. 12, 2016), https://www.npr.org/sections/health-shots/2016/09/12/493618415/insurance-data-show-a-surge-in-spending-on-opioid-treatment-and-testing%20.

24 *Id*.

25 Blake, *supra* note 22, at 485.

26 *Id*. at 494.

27 *Id*.

Some physicians take it a step further by billing for procedures they do not actually perform. They instead perform unnecessary treatments in order to bill and receive more reimbursement from the insurance companies. For example, in *United States v. Martinez*, Dr. Martinez advised his patients to receive nerve-block injections every one to two weeks.[28] Dr. Martinez would not write his patients prescriptions for oral pain medications unless they were willing to receive these injections.[29] The government argued that this was because Medicare, Medicaid, and other insurance companies reimbursed these procedures at higher rates than other injections and office visits.[30] To support this argument, the Government presented evidence showing that Martinez gave each patient an average of sixty-four nerve-block injections per year, while the state average for pain treatment patients was only 2.5 injections per year.[31] Additionally, Martinez did not inform his patients of the optional nature of the injections or of the potential risks and side effects.[32] In cases such as this the only reason for a doctor to carry on such illegitimate medical practices is for their own self-seeking purposes, namely, money. Doctors like Martinez see dollar signs where they should see their patients.

C. The President's Commission on Combating Drug Addiction

In November 2017, the President's Commission on Combating Drug Addiction (the "Commission"), issued a report listing over 50 recommendations to help combat the opioid crisis.[33] These recommendations included coordinating electronic health records, increasing prescriber education, more screenings, and responses to overdoses.[34] This report, however, underestimates the role doctors play in the epidemic. Like so many, they focus primarily on how to prevent patients from abusing the system. This is clear when the report states "[t]hese recommendations help doctors . . . fight opioid abuse and misuse."[35] Additionally, the report lists guidelines and protocols for doctors to follow to avoid being manipulated by patients into

28 United States v. Martinez, 588 F.3d 301, 306 (2009).

29 *Id*.

30 *Id*. at 307.

31 *Id*.

32 *Id*.

33 WHITE HOUSE, THE PRESIDENT'S COMMISSION ON COMBATING DRUG ADDICTION AND THE OPIOID CRISIS (2017).

34 *Id*.

35 *Id*. at 6.

prescribing unnecessary medications.[36] However, programs requiring doctors to keep better records, giving guidelines to follow with patients, or attempting to better educate doctors may prevent patients from manipulating the system, but they do not prevent a doctor from committing fraud. The patients are the victims here, and it is the doctors who are abusing the system.

III. CURRENT REGULATIONS

A. The Controlled Substances Act ("CSA")

The CSA is a federal criminal drug law that prohibits illegal drug manufacturing and distribution. The term "controlled substance" as defined by the CSA, is "a drug or other substance, or immediate precursor, included in schedule I, II, III, IV, or V."[37] Under the CSA, drugs are placed into one of five schedules based on their medical utility as well as the potential for abuse, misuse, physical and psychological dependence. Schedule I drugs have no acceptable medical use and have a high potential for abuse.[38] Schedules II-V have accepted medical uses with the potential for abuse and dependence ranging from high ("Schedule II") to progressively less potential for abuse through Schedule V.[39] Most opioids are Schedule II drugs.[40]

A prescription for a controlled substance must be issued "for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice."[41] It is "unlawful for any person to knowingly or intentionally . . . manufacture, distribute, or dispense, or possess with intent to manufacture, distribute, or dispense a controlled substance."[42] Conspiracy to do so is also a crime.[43] However, practitioners are excepted under the CSA, and as such are permitted to "distribute, dispense, conduct research with respect to [and] administer . . . a controlled substance" so long as such conduct

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36 *Id*.
37 21 U.S.C.A. § 802(6) (West 2016).
38 21 U.S.C.A. § 812(b)(1)(A-C) (West 2012).
39 21 U.S.C.A. § 812(b)(2-5) (West 2012).
40 21 U.S.C.A. § 812 Schedule II (West 2012).
41 21 C.F.R § 1306.04 (2018).
42 21 U.S.C.A. § 841(a) (West 2010).
43 *Id*.

is done "in the course of professional practice."[44] Under the CSA, a physician qualifies as a 'practitioner.'[45]

1. Penalties under the CSA

Generally, for schedule I or II controlled substances, the CSA imposes sentences ranging from ten years to life imprisonment for large-scale distributions,[46] from five to forty years for medium-scale distributions, [47] and no more than twenty years for smaller distributions.[48] These sentences do not apply when "death or serious bodily injury results from the use of [the distributed] substance."[49] Instead, the sentence "shall be not less than 20 years or more than life," a substantial fine, or both.[50]

2. Physician Exception

The CSA prohibits a person from dispensing or distributing a controlled substance.[51] However, a physician is exempt from this prohibition as long as he is registered and acting as authorized.[52] As an exception under the CSA, practitioners are permitted to "distribute, dispense, conduct research with respect to [and to] administer . . . a controlled substance" so long as such conduct is done "in the course of professional practice."[53] A physician qualifies as a "practitioner."[54] Any person or entity who "handle[s], prescribe[s], or dispense[s]" controlled substances is required by the CSA to register with the DEA.[55] A controlled substance in Schedules II through V used as a prescription drug may not be dispensed without a prescription.[56]

A "prescribing practitioner" accepts responsibility for the "proper prescribing and dispensing of controlled substances" such as

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44 21 U.S.C.A. § 802(21) (West 2016).

45 Alyssa M. McClure, *Illegitimate Overprescription: How Burrage v. United States is Hindering Punishment of Physicians and Bolstering the Opioid Epidemic*, 93 NOTRE DAME L. REV. 1747, 1755 (2018).

46 21 U.S.C.A. § 841(b)(1)(B) (West 2010).

47 *Id*.

48 21 U.S.C.A. § 841(b)(1)(C) (West 2010).

49 21 U.S.C.A. § 841(b)(1)(A)-(C) (West 2010).

50 21 U.S.C.A. § 841(b)(1)(A)-(C) (West 2010).

51 21 U.S.C.A. § 841(a)(1) (West 2010).

52 21 U.S.C.A. §§ 802(21), 822(b) (West 2016).

53 21 U.S.C.A. § 802(21) (West 2016).

54 *Id*.

55 21 U.S.C.A. §822(a)-(b) (West 2018).

56 *See* 21 U.S.C.A. § 829 (West 2016).

opioids.[57] To be lawful, the prescription for a controlled substance "must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice."[58] If a physician's conduct falls outside "the usual course of professional practice" they may be prosecuted (found criminally liable for any injuries or deaths that occur) for improperly prescribing controlled substances, despite being licensed and registered to do so.[59] The Supreme Court adopted this standard in *United States v. Moore*, where a physician was convicted for knowingly and unlawfully distributing methadone (a Schedule II controlled substance), in violation of 21 U.S.C. § 841(a)(1).[60] The Supreme Court held that "registered physicians can be prosecuted under § 841 when their activities fall outside the usual course of professional practice."[61] Moreover, "any distribution or dispensing by a registrant that is not within his 'professional practice' is not authorized and is therefore illegal."[62]

B. Regulations at the Federal Level

The Drug Enforcement Agency ("DEA"), is a law enforcement agency within the Department of Justice that is responsible for the CSA. "The Attorney General, through the DEA, authorizes providers to prescribe controlled substances through a certificate of registration. That authority is limited to the prescription of controlled substances 1) for a legitimate medical purpose and 2) in the usual course of professional practice."[63] The DEA can investigate providers and prescribers for any reason.[64] The DEA reported "a steady rise in successful criminal prosecutions of physicians from just 15 convictions in 2003 to 43 in 2008."[65] These numbers have continued to increase, and in 2016, the DEA took action against 479 doctors.[66] It

57 21 C.F.R. § 1306.04(a) (2005).

58 *Id*.

59 United States v. Moore, 423 U.S. 122, 123 (1975).

60 *Id*.

61 *Id*.

62 *Id*.

63 Kelly K. Dineen, *Addressing Prescription Opioid Abuse Concerns in Context: Synchronizing Policy Solutions to Multiple Complex Public Health Problems*, 40 L. & PSYCHOL. REV. 1, 50 (2016).

64 *Doctors Increasingly Face Charges for Patient Overdoses*, CNN (Sept. 28, 2018), https://www.cnn.com/2017/07/31/health/opioid-doctors-responsible-overdose/index.html.

65 McClure, *supra* note 45, at 1748 (internal citations omitted).

66 *Doctors Increasingly Face Charges for Patient Overdoses*, *supra* note 64.

is the belief of the DEA that the types of cases in which physicians are found to be dispensing controlled substances improperly under federal law "generally involve facts where the physician's conduct is not merely of questionable legality, but instead is a glaring example of illegal activity."[67]

In addition to the DEA, the Food and Drug Administration ("FDA") is a federal public health agency that is responsible for regulating the safety and effectiveness of drugs in the United States. Unlike the DEA, the FDA "is primarily a consumer protection agency and does not directly regulate physicians' prescribing practices."[68]

C. Regulations at the State Level

The State Medical Practice Act legislation created regulations known as State Medical Boards ("SMBs").[69] These agencies regulate physicians through oversight of medical practices. Further, SMBs regulate entry to practice as well as investigate and discipline providers who act contrary to professional standards as defined by state practice and regulations.[70]

Additionally, forty-eight states have established PDMPs. State laws require prescribers to register prescription opioids and select other drugs with the PDMP.[71] However, prescribers often do not consult the database before prescribing, nor do they always report their prescriptions. These state PDMPs are aimed toward regulating the behavior of patients than that of physicians. If properly consulted, the PDMP can prevent patients from receiving multiple opioid prescriptions from more than one doctor. However, if a physician is intentionally misprescribing a controlled substance, they are going to be ignoring a PDMP since it is their conduct, not that of the patient, which is improper.

IV. CRIMINAL STANDARDS FOR LIABILITY

Physicians may face criminal charges under the CSA at both the state and federal level. Violations under criminal law require both a criminal act (actus reus) and a criminal intent or mental state (mens

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67 21 C.F.R. § 1306 (2006).

68 Kelly K. Dineen & James M. DuBois, *Between a Rock and a Hard Place: Can Physicians Prescribe Opioids to Treat Pain Adequately While Avoiding Legal Sanction?*, 42 AM. J. L. & MED. 7, 28 (2016).

69 *Id*. at 23-24.

70 *Id*. at 24.

71 Shepherd, *supra* note 6, at 105.

rea).[72] To violate the CSA there must be a knowing or purposeful mens rea accompanied by the act of distributing, dispensing, possessing, or manufacturing controlled substances.[73] Because physicians can be lawful distributors under the CSA, there is a higher standard of criminal liability. For liability to attach to physicians they must prescribe controlled substances "(1) knowingly; (2) without a legitimate medical purpose; and (3) outside the course of professional practice."[74] When imposing criminal liability on physicians, the context of the physician-patient relationship is critical.[75] Moreover, the physician must have had either "actual knowledge of the illegal activity or deliberately failed to inquire about it before taking action to support it."[76]

The Model Penal Code states that "[c]onduct is the cause of a result" if "it is an antecedent but for which the result in question would not have occurred."[77] The Code further explains this subsection as representing "the minimum requirement for a finding of causation when a crime is defined in terms of conduct causing a particular result."[78] The level of causation required for a conviction under the enhanced penalty section of the CSA has been discussed in length by Circuit Courts. This is due to the fact that the "results from" language of § 841 is not defined by the CSA. The statute imposes an enhanced penalty whenever "death or serious bodily injury *results from* the use of" the controlled substance.[79] Several circuits have held that this statute's enhanced penalty requires "only proof that the death resulted from the victim's use of a controlled substance dispensed by the defendant."[80]

A. The necessary causation required to apply an enhanced sentence under the Controlled Substances Act is "but-for" causation

The Supreme Court in *Burrage v. United States*, addressed the issue of "whether the mandatory-minimum provision applies when the

72 Model Penal Code § 2.02 (West 2018).
73 21 U.S.C.A. § 841 (West 2010).
74 Dineen & DuBois, *supra* note 68, at 30 (citing 21 C.F.R. § 1306.04).
75 *Id*. at 32.
76 *Id*. at 30-31.
77 Model Penal Code § 2.03(1)(a).
78 Model Penal Code § 2.03, Explanatory Note.
79 20 U.S.C. § 841(b)(1)(C) (2020) (emphasis added).
80 United States v. Webb, 655 F.3d 1238, 1250 (11th Cir. 2011).

use of a covered drug supplied by the defendant contributes to, but is *not* a but-for cause of, the victim's death or injury."[81] In *Burrage*, Banka, "a long-time drug user," died of a drug overdose the day after purchasing one gram of heroin from a drug dealer, Burrage.[82] Count 2 of the indictment "alleged that Burrage unlawfully distributed heroin . . . and that 'death . . . resulted from the use of th[at] substance'—thus subjecting Burrage to the . . . mandatory minimum of § 841(b)(1)(C)" (206-207).[83] At trial, two medical experts testified regarding the cause of Banka's death. A forensic toxicologist testified that multiple drugs were present in Banka's system at the time of his death, but heroin was the only drug present at a level above the therapeutic range.[84] Although the toxicologist could not say whether Banka would have lived had he not taken the heroin, he concluded that the heroin was a "contributing factor" in Banka's death.[85] The State Medical Examiner came to similar conclusions; testifying that the heroin played a "'contributing' role" in Banka's death. However, she could not say whether Banka would have lived had he not taken the heroin.[86]

The jury instructions given at trial stated that the Government must prove, beyond a reasonable doubt, "that the heroin distributed by the Defendant was a contributing cause of Joshua Banka's death.[87] A contributing cause is a factor that, although not the primary cause, played a part in the death."[88] The jury convicted Burrage and the court sentenced him to two concurrent twenty-year terms.[89] When the case got to the Supreme Court, the Court ruled in favor of Burrage. The majority wrote that "[w]here there is no textual or contextual indication to the contrary, courts regularly read phrases like "results from" to require but-for causality."[90] Because the CSA does not define "results from," the Court gives it its ordinary meaning.[91] Thus, the Court "adopted a but-for test in proving causality for purposes of section 841(b) enhancement."[92] Nonetheless, a defendant's conduct

81 Burrage v. United States, 134 S.Ct. 881, 885 (2014).
82 *Id*.
83 *Id*.
84 *Id*.
85 *Id*. at 885.
86 *Id*.
87 134 S.Ct. at 885.
88 *Id*. at 886.
89 *Id*.
90 *Id*. at 888.
91 *Id*. at 887.
92 McClure, *supra* note 45, at 1759.

will qualify as a but-for cause even if it "combines with other factors to produce the result, so long as the other factors alone would not have done so—if so to speak, it was the straw that broke the camel's back."[93]

Although the defendant in *Burrage* was not a doctor, but instead, a "street dealer," this but-for causation standard was adopted for all cases attempting to satisfy the enhanced punishments of § 841(b). However, *Burrage* is distinguishable from the cases discussed in this note that find doctors to be the but-for causes of their patients' overdoses. Whereas in *Burrage*, the use of the controlled substance was a "contributing cause" of the death[94] in most cases involving physicians, although there were mixed drugs found in the decedents' system, the controlled substances prescribed by these doctors were found to be sufficient causes of death.

Prior to *Burrage*, the Eleventh Circuit in *United States v. Webb* held that "the plain and unambiguous language of § 841(b)(1)(C) contains no foreseeability or proximate cause requirement."[95] Instead, under § 841(b)(1)(C), "the Government must prove only that death results from' the victim's use of a controlled substance charged in the indictment."[96] This "results from" language was interpreted to require a cause-in-fact connection between the victim's ingestion of the drugs and death.[97] In this case, the doctor was not only convicted on counts charging that a patient's death resulted from the use of controlled substances dispensed by Dr. Webb ("Webb"), but also on one count of a patient's death that resulted from his health care fraud violation.[98] At trial, evidence was presented showing that Webb's prescription practices were "done in a way that was inconsistent with the usual course of medical practice and [were] done for other than legitimate medical purpose."[99] Practices included seeing patients for less than 15 minutes before prescribing medications, routinely granting patients' requests for early refills, ignoring pharmacy and staff when notified of patients' drug abuse, Dr. Parran, the government's expert witness in drug and alcohol dependency, testified that these practices "constitute[ ] knowingly doing harm to a patient in an ongoing way."[100] For a

93 134 S.Ct. at 888.
94 *Id*. at 208, 886.
95 United States v. Webb, 655 F.3d 1238, 1254 (11th Cir. 2011).
96 *Id*. at 1255.
97 *Id*.
98 *Id*.
99 *Id*. at 1243.
100 *Id*..

doctor to be knowingly harming their patients is a clear violation of their oath. The effect of these harms do not affect only one person but create a trickle-down effect, thus causing the opioid epidemic to grow.

More recently, in *United States v. Volkman*, the Sixth Circuit applied the Supreme Court's holding in *Burrage* and found the defendant physician to be the but-for cause of death.[101] The court convicted the defendant for "unlawful distribution of a controlled substance leading to death" on four counts.[102] Volkman, however, contended that his prescriptions were not the but-for cause of death.[103] For each count, experts testified that there was no legitimate medical purpose for the combination of drugs Volkman prescribed to his patients.[104] Moreover, Volkman unnecessarily prescribed these drugs to patients who were already at risk based on prior physical and mental health conditions.[105] Each of these patients died within days of filling prescriptions from the defendant and each with high enough levels of opiates in their system to find Volkman to be a but-for cause of death.[106] Based on the evidence presented, the court found that "(1) Volkman issued a prescription; (2) that had no legitimate medical purpose; (3) which was the but-for cause [of] the victim's death.[107] Thus, the Government satisfied its burden of proof under the CSA as interpreted by the Supreme Court in *Burrage*."[108]

Such cases make clear that whenever death or serious injury is a consequence of a victim's use of a controlled substance that was distributed by the defendant, a defendant is exposed to a more severe minimum sentence. The point of the penalty enhancement of § 841 (b)(1)(C) is to more severely punish conduct that results in the loss of life. The catch is that for this to apply the controlled substance must be found to be an independently sufficient cause of the death. Although critics argue that this stringent but-for standard will prevent doctors from being held responsible for their patients' deaths,[109] it is important to acknowledge that the case of *Burrage* did not involve a physician. Whereas the Supreme Court in *Burrage* addressed only the requisite causation, the courts in cases where a physician is involved

101 United States v. Volkman, 797 F.3d 377, 383 (2015).

102 *Id*. at 392.

103 *Id*.

104 *Id*.

105 *Id*.

106 *Id*. at 393-98.

107 797 F.3d at 393-98.

108 *Id*. at 393.

109 *See* McClure, supra note 45, at 1760.

look also to whether the controlled substance prescribed was done so knowingly, without a legitimate medical purpose and outside the course of professional practice, which was the but-for cause of the victim's death. Even in cases where the patient was found to have several substances in their system at the time of death, when combining all relevant factors, the courts may still find a physician to be the but-for cause of death.

1. Proximate cause is not required under the court's analysis of the statute

When a crime requires "not merely conduct but also a specified result of conduct," a defendant generally may not be convicted unless his conduct is "both (1) the actual cause, and (2) the 'legal' cause (often called the 'proximate cause') of the result."[110] However, the district court in *Webb*, instructed "there was no foreseeability or proximate cause requirement, and that instead the government must prove that 'but for' . . . the victim's ingesting of the drugs charged in the indictment [drugs prescribed by the defendant], the victim would not have died."[111] The defendant, Webb, argued that the jury had to find "'proof of actual cause and effect' between Webb's own conduct and his patients' deaths."[112] The Eleventh Circuit, along with other Federal Circuit Courts, rejected this interpretation.[113] The court in *Webb* held that "§ 841(b)(1)(C)'s enhanced penalty require[d] only proof that the death resulted from the victim's use of a controlled substance dispensed by the defendant."[114] Additionally, "[t]he statute puts drug dealers and users on clear notice that their sentences will be enhanced if people die from using the drugs they distribute."[115] Doctors present an even more profound case of this; you know you are taking a chance with drug-dealers, but these are doctors. Drug users are sustaining their denial by going to doctors they know are running pill mills. These pill mills provide a place where patients can go to a doctor who they know will write them a prescription regardless of the medical necessity of it.

110 WAYNE R. LAFAVE, SUBSTANTIVE CRIMINAL LAW, § 6.4 (3d ed. 2018).

111 United States v. Webb, 655 F.3d 1238, 1249 (11th Cir. 2011).

112 *Id*.

113 *Id*.

114 *Id*. at 1250.

115 *Id*. at 1251 (quoting United States v. Patterson, 38 F.3d 139 (4th Cir. 1994)). A doctor acting as a drug dealer is put on the same notice as a street dealer.

2. Although the patient is the one taking the drugs, the causal chain is not severed by that act, and doctors may be found responsible for their patients' deaths

These cases require a finding of an act that was purposely or knowingly committed. Therefore, the result must be within the "purpose or contemplation" of the actor.[116] If the result cannot be established as such, then the causation element is not satisfied.[117] Moreover, the causality element is established only if the actual result involves the same kind of injury as the contemplated result and the actual result is not too remote or accidental in its occurrence to have a just bearing on the actor's liability or the gravity of his offense.[118]

The counter-argument is that even though the physician prescribed the pills, the causal chain is severed by the patient's intervening act that results in death. "An intervening act is a *coincidence* when the defendant's act merely put the victim at a certain place at a certain time, and because the victim was so located it was possible for him to be acted upon by the intervening cause,"[119] but[120] where "intervening events are foreseeable and naturally result from a defendant's criminal conduct, the chain of legal causation is unbroken.[121] Therefore, if it is proven that the death is a result of a controlled substance dispensed by the defendant, the causal chain is not severed, and the doctor can be held responsible for the patient's death.

V. HEALTH CARE FRAUD

A. A doctor may be found responsible for the death of their patient as a result of their fraudulent prescription practices

Health care fraud is not only a betrayal of vulnerable patients, it is a robbery of taxpayers. Section 1347(a) provides for an enhanced penalty for health fraud "if the violation results in death," as follows:

> (a) Whoever knowingly and willfully executes, or attempts to execute, a scheme or artifice—

116 MODEL PENAL CODE § 2.03.

117 *Id*.

118 *Id*.

119 LAFAVE, *supra* note 110, at § 6.4(f)(3).

120 *Id*.

121 United States v. Martinez, 588 3d 301, 319 (2009) (quoting United States v. Guillette, 547 F.2d 743, 749 (1976)).

> (1) to defraud any health care benefit program; or
> (2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program,
>
> in connection with the delivery of or payment for health care benefits, items, or services, shall be fined under this title or imprisoned not more than 10 years, or both . . . . [I]f the violation results in death, such person shall be fined under this title or imprisoned for any term of years or for life, or both. [122]

To obtain a conviction for health care fraud under 18 U.S.C. § 1347, the Government is required to prove beyond a reasonable doubt that a defendant[123]: "(1) knowingly devised a scheme or artifice to defraud a health care benefit program in connection with the delivery of or payment for health care benefits, items, or services; (2) executed or attempted to execute this scheme or artifice to defraud; and (3) acted with intent to defraud."[124]

Similar to § 841(b)(1)(C), there is not an express foreseeability or proximate cause requirement in § 1347(a)'s penalty enhancement. In *United States v. Webb*, the court interpreted the "results in" language of § 1347(a) as indistinguishable from the "results from" language in § 841(b)(1)(C).[125] Moreover, that Congress includes express language requiring foreseeability or proximate cause in other criminal statutes but not here is telling. The Federal Courts have emphasized that "[w]here Congress knows how to say something but chooses not to, its silence is controlling."[126] The court in *Webb* also recognized that "the cause-in-fact connection in § 841(b)(1)(C) is between the use of the controlled substance and the death, and in § 1347(a), between the defendant's conduct and the death."[127] Additionally, § 1347(b) states that "[w]ith respect to violations of this section, a person need not have actual knowledge of this section or specific intent to commit a

122 18 U.S.C § 1347.

123 *Id*. A defendant may be anyone who satisfies the requirements as listed in 18 U.S.C. § 1347.

124 588 F.3d at 314.

125 United States v. Webb, 655 F.3d 1238, 1257 (11th Cir. 2011).

126 *Id*. (quoting In re Griffith, 206 F.3d 1389, 1394 (11th Cir. 2000)).

127 *Id*.

violation of this section."[128] Therefore, an enhanced penalty under § 1347(a) does not require proximate causation and may apply "regardless of whether Defendant knew or should have known that death would result."[129]

In *Webb*, the physician was charged with a death resulting from health care fraud in violation of 18 U.S.C. § 1347.[130] The court opined that similar to § 841(b)(1)(C), Congress did not insert a foreseeability or proximate cause requirement into § 1347(a)'s penalty enhancement. The cause in fact connection here was between the defendant's conduct and the death of the patient.[131] The court held that there was "overwhelming evidence (1) that the type of health care fraud involved Webb's prescribing controlled substances for other than legitimate medical purposes, and having pharmacies submit claims for reimbursement to health insurers on the basis of his prescriptions; and (2) that Ortega's death stemmed from taking those prescribed drugs for which reimbursement was sought."[132]

In *United States v. Martinez*, Dr. Martinez was an anesthesiologist who regularly prescribed controlled substances.[133] In 2002, the Federal Bureau of Investigation ("FBI") began investigating Martinez for health care fraud.[134] The Government's theory at trial was that "Martinez engaged in fraud and endangered his patients by omitting physical examinations, ignoring 'red flags' of painkiller addiction, giving appreciably more injections than were medically necessary or advisable, and providing at-risk patients with treatments that would leave them dependent on him for pain-suppressant prescriptions." [135] Martinez would only prescribe oral pain medications if patients were willing to visit his office to receive rather frequent nerve-block injections.[136] These injections are reimbursed at higher rates than other injections and office visits. It was also argued that Martinez's fraud resulted in the death of two patients.[137] Martinez saw anywhere from sixty to over one hundred patients in a given

128 18 U.S.C. § 1347(b).
129 655 F.3d at 1257.
130 *Id*. at 1255-57.
131 *Id*.
132 *Id*.
133 United States v. Martinez, 588 F.3d 301, 307 (6th Cir. 2009).
134 *Id*.
135 *Id*.
136 *Id*.
137 *Id*.

day.[138] Significantly more patients than any other Ohio doctor. To do this he would spend only two to five minutes with patients at their appointments and perform minimal or no physical examination of patients. However, Martinez continued to bill the visits under billing codes used for more extensive office visits.[139]

At trial, an expert witness, a pain-management specialist, testified that Martinez's practices were neither appropriate nor medically necessary. [140] He concluded that "Martinez's prescriptions for controlled substances could not have been for legitimate medical purposes and that such prescriptions were outside the bounds of accepted medical practice."[141] Moreover, the expert witness testified that as a result of his practices there was not a true doctor-patient relationship between Martinez and his patients.[142] The Government also argued that Martinez's techniques were outside the bounds of accepted medical practice.[143] Finally, they presented evidence that Martinez's course of treatment for these two patients led to their death.[144]

The Court determined that the evidence presented was sufficient to show that Martinez (1) knowingly devised a fraud scheme when he billed for procedures that were not medically necessary; (2) by submitting the bills he was executing his scheme to defraud; and (3) by performing procedures and prescribing medications that experts deemed medically unnecessary, it could be inferred that he knowingly devised his scheme with the intent to defraud.[145] However, Martinez argued that there was not enough evidence to prove beyond a reasonable doubt that this fraud caused the deaths in question.[146] But because the parties in this case did not challenge the lower court's determination that proximate cause was the appropriate standard of causation, the circuit court made their decision based on the principles of proximate cause. [147] The court stated that "[t]he concept of proximate cause incorporates the notion that an accused may be charged with a criminal offense even though his acts were not the

138 *Id*.
139 588 F.3d at 307.
140 *Id*. at 308
141 *Id*.
142 *Id*. at 308.
143 *Id*. at 316
144 *Id*.
145 588 F.3d at 316.
146 *Id*.
147 *Id*.

immediate cause of the victim's death or injury."[148] The court went on to conclude that "even if Martinez did not intend for his two patients to die, he can be held responsible for their deaths if there was sufficient evidence that it 'reasonably might or should have been foreseen . . . that [his fraudulent conduct] would be likely to create a situation which would expose another to the danger of . . . death.'"[149] However, even with a foreseeability requirement, the cases discussed in this note are likely to meet either standard.

B. What is (or is not) being done to combat this health care fraud moving forward

More often than not, when a doctor commits health care fraud that results in patient deaths, the emphasis in the charges and following case against them focuses on the health care fraud only. Even with mention of deaths resulting from the fraudulent prescribing, the focus remains on the health care fraud on the money.[150] In an Indiana case, an investigation of OB-GYN, Dr. Paul Kelty, found that this fraudulent prescribing went so far it effected not only a mother, but her newborn baby.[151] After being prescribed opioids by Dr. Kelty, when the mother's baby was delivered, "the newborn had to be placed in the NICU for approximately 2-1/2 months to receive methadone for detoxification." [152] During that same investigation the Indiana Attorney General learned that from 2009 to 2012 Dr. Kelty wrote 31,490 prescriptions, totaling 1.08 million pills. [153] It was also indicated from the investigation that this doctor's behavior resulted in *at least* six fatal overdoses (emphasis added).[154] However, despite these facts, these deaths, Dr. Kelty got off with only four years of home incarceration and $22,000 in restitution[155] and additionally, he lost his license.[156] As a result of a plea deal, the original 22 charges

148 *Id*. at 319 (quoting U.S. v. Guillette, 547 F.2d 743, 749 (2d Cir. 1976)).

149 *Id*. at 319.

150 *See generally* Alan Stewart, *OB-GYN Faces 22 Charges*, THE CORYDON DEMOCRAT (June 5, 2013), http://www.corydondemocrat.com/Articles-News-i-2013-06-04-226056.114125-OBGYN-faces-22-charges.html.

151 *Id*.

152 *Id*.

153 *Id*.

154 Marissa Alter, *Bond Lowered for Doctor Accused of Sex Abuse, Medicaid Fraud*, WLKY (May 31, 2013), https://www.wlky.com/article/bond-lowered-for-doctor-accused-of-sex-abuse-medicaid-fraud-1/3743889#.

155 *Id*.

156 *Southern Indiana Doctor Sentenced for Medicaid Fraud, Corrupt Business Practices*, LOUISVILLE BUSINESS FIRST (Aug. 7, 2015),

were dropped and, instead, Dr. Kelty plead guilty only to charges involving "Medicaid fraud and corrupt business practices."[157]

On June 28, 2018, there was the largest national healthcare fraud takedown.[158] This resulted in charges against 601 individuals responsible for over $2 billion in fraud losses. Of these charges 84 were opioid cases involving more than 13 million illegal dosages of opioids.[159] However, of all these charges, only one made mention of unlawful distribution of controlled substances resulting in death.[160] With approximately 115 Americans dying every day of an opioid-related overdose, how is it only one death was found to be a result of 13 million illegal dosages of opioids? Like the focus of these doctors in committing the fraud, the focus of the takedowns was money. These doctors essentially robbed Americans of billions, and this fact should not be taken lightly. However, these doctors not only robbed people of their money, they robbed people of their lives. These doctors stole people's loved ones. The idea is that "[a]ggressively pursuing corrupt medical professionals not only has a deterrent effect on other medical professionals, but also ensures that their licenses can no longer be used to bilk the system."[161] However, the penalty for these charges are fines or a maximum of 10 years in prison.[162] Additionally, a suspended license does not guarantee a doctor will no longer abuse the system. There are even cases where doctors are allowed to continue practicing at a 'limited capacity' pending their trial and resulting sentence.[163] Moreover, it seems clear that these doctors care more about themselves than anyone else. Even without a license, they find ways to "bilk the system." If these things were real deterrents, then the opioid crisis would be shrinking, not growing.

Recently, it has received increasingly more attention. However, the attention is focused on the companies manufacturing the drugs,

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https://www.bizjournals.com/louisville/blog/morning_call/2015/08/southern-indiana-doctor-sentenced-for-medicaid.html.

157 *Id*.

158 *National Health Care Fraud Takedown Results in Charges Against 601 Individuals Responsible for Over $2 Billion in Fraud Losses*, U.S. DEPT. OF JUSTICE - JUSTICE NEWS (July 28, 2018), https://www.justice.gov/opa/pr/national-health-care-fraud-takedown-results-charges-against-601-individuals-responsible-over.

159 *Id*.

160 "In the Western District of Oklahoma this *one* case marked the district's *first* time charging unlawful distribution of controlled substances resulting in a death." *Id*. (emphasis added).

161 *Id*.

162 18 U.S.C § 1347.

163 Stewart, *supra* note 150.

much less so on the doctors. While it is important that the drug companies be held responsible for their creation and mass distribution of opioids, these companies are not the ones giving the drugs directly to consumers.

VI. CONCLUSION

Although the law exists to prosecute doctors on behalf of their dead patients, and the precedent to succeed with these claims is available, most of these cases settle for indictments only on the health care fraud claim, without mention of the deaths that likely resulted. It is unclear if this is because having to pay the fines is seen as the greater consequence, or if the thought is still that it can't be the doctor's fault, only the person taking the pills is at fault, or maybe those prosecuting are simply not aware that they have a chance with a case like these. As long as money is put before people, these misconceptions will continue to be perceived as realities. There are even guidelines doctors are supposed to use when prescribing opioid pain medications. However, these guidelines are aimed more towards preventing patients from manipulating doctors into writing unnecessary prescriptions. They do not prevent doctors from manipulating the health care system if that is their intention. Without adequate consequences being enforced for these doctors they will not be deterred from violating their oaths, defrauding healthcare, and putting their patients at risk for opioid addictions, and potential deaths.

It is hard to say what it will really take to turn the opioid crisis in the opposite direction. This issue is affecting more and more people every single day. Yet, there is not enough focus on significant roles such as those of the doctors described in this note. It is not enough to focus solely on the patients, the addicts, they are only one piece of this expanding crisis. Nor is it enough to attempt to regulate the insurance without more strongly regulating the doctors, the prescribers. That a medical professional takes an oath does not and should not make them immune from scrutiny. There is an assumption that these people are professionals, they have taken time to earn medical degrees and so they must know best, they are the healers. However, this trust has enabled these doctors to go from being healers, to drug dealers. Thus, they should not be treated as exceptions to the rule, but as the criminals they are—murderers.