

DRUG DEALING AND THE INTERNAL MORALITY OF MEDICINE

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INTRODUCTION

Which practices qualify as “medical” in nature? This question has important legal implications. Every state has laws prohibiting the “unauthorized practice of medicine.”¹ Health insurance policies generally limit coverage to procedures that are “medically necessary.”² And physicians can be prosecuted as drug traffickers if they prescribe controlled substances without a “legitimate medical purpose.”³ Each of these questions—and many others—hinge on how medicine is defined.

As with many common terms, we all have a general understanding of what medicine is and this heuristic suffices to carry us through our daily lives without complication. Yet when called on to produce a precise definition that captures all practices we think of as “medical,” while excluding those we do not, that task proves exceptionally challenging.⁴ This problem is further complicated by the fact that what qualifies as “medical” may vary across different contexts. Prescribing Botox to mitigate frown lines may qualify as a “medical” intervention for purposes of laws regulating doctors but may not qualify as “medically necessary” for purposes of insurance reimbursement.

Yet despite the difficulty of defining medicine and the weighty legal consequences that can hinge on these definitions, courts, regulators, and legal scholars have given little consideration to these challenges in the context of regulating physician prescribing. Instead, they have often relied on “commonsense” definitions that fail to grapple with the complexity of the issue.⁵ As a result, legal standards that govern prescribing are often unclear and inconsistently applied, leaving physicians without a clear understanding of which conduct they must avoid.⁶ Given multiple opportunities to resolve this issue definitively, the United States Supreme Court has repeatedly demurred, including most recently in its 2022 opinion in *Ruan v. United States*.⁷

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1. Glenn Cohen, *Protecting Patients with Passports: Medical Tourism and the Patient-Protective Argument*, 95 IOWA L. REV. 1467, 1540 (2010).

2. NAT'L ASS'N INS. COMM'RS, *Understanding Health Care Bills: What is Medical Necessity?*, <https://content.naic.org/sites/default/files/consumer-health-insurance-what-is-medical-necessity.pdf> [<https://perma.cc/SF2Y-HUDH>]. (last visited Mar. 10, 2023)

3. 21 C.F.R. § 1306.04(a) (2020).

4. See Peter H. Schwartz, *Reframing the Disease Debate and Defending Biostatistical Theory*, 39 J. MED. & PHIL. 572, 572-89 (2014) (critiquing attempts to use conceptual analysis to define concepts such as “health” and “disease”).

5. Matt Lamkin, *Legitimate Medicine in the Age of Consumerism*, 53 U.C. DAVIS L. REV. 385, 392, 395 (2019).

6. *Id.* at 385, 388, 392, 395, 397, 401, 435.

7. *Ruan v. United States*, 142 S. Ct. 2370 (2022).

By contrast, philosophers of medical ethics have wrestled with the complexity of determining medicine's proper scope for at least half a century.⁸ Drawing on this more rigorous debate could help refine and clarify legal standards governing prescribing. However, such an effort would have to contend with the fact that the philosophical literature on this question is strikingly inconclusive.

Some prominent bioethicists contend medicine is defined by an "internal morality" that defines its scope. For example, some claim the essence of medical practice is healing, so that actions taken for other purposes, such as enhancing one's physical appearance, do not qualify as medical in nature and are therefore improper for physicians to perform.⁹ Others deny medicine's scope is limited by any internal morality, instead insisting that judgments regarding the propriety of physicians' conduct must be governed by considerations external to the practice of medicine.¹⁰ In this view, as long as cosmetic surgery is ethical in general (e.g., under universal moral principles), it is ethical for physicians to engage in that practice. There is no essential nature of medicine that physicians would transgress in so doing.

Happily, this debate need not be resolved in order for the law to benefit from it. Rather than seeking to determine what medicine's "true" nature is, it may be useful to examine the various conceptions offered by these observers and seek an account that is consonant with existing legal standards while also helping refine them. Not every account of medicine's proper scope is equally suitable for informing the legal standards governing prescribing. "Internal" accounts that reject nontherapeutic practices as "non-medical" are flatly inconsistent with existing law, which countenances cosmetic surgery, vasectomies, and other nontherapeutic practices as within medicine's ambit. Conversely, external accounts that deny the existence of an internal morality of medicine without providing an alternative definition of medicine's scope are of little use when specifying which acts doctors can lawfully perform.

What is needed is a standard that is broadly consistent with existing legal standards, but that helps clarify them. An account of medicine's scope offered by philosopher Christopher Boorse meets these criteria. Although Boorse takes no position regarding whether medicine is governed by an internal morality, he argues that if such a morality exists, it is a broad one.¹¹ Rather than limiting the practice of medicine to treating illnesses, in this view doctors can provide a wide range of interventions as long as they are seeking to use their expertise and skill

8. See, e.g., Leon R. Kass, *Regarding the End of Medicine and the Pursuit of Health*, 40 THE PUB. INT. 11, 42 (1975).

9. See, e.g., Edmund D. Pellegrino, *The Internal Morality of Clinical Medicine: A Paradigm for the Ethics of the Helping and Healing Professions*, 26 J. MED. & PHIL. 559 (2001).

10. See, e.g., Tom Beauchamp, *Internal and External Standards for Medical Morality*, 26 J. MED. & PHIL. 601 (2001); Robert M. Veatch, *The Impossibility of a Morality Internal to Medicine*, 26 J. MED. & PHIL. 621 (2001).

11. Christopher Boorse, *Goals of Medicine*, in NATURALISM IN THE PHILOSOPHY OF HEALTH: ISSUES AND IMPLICATIONS 163 (Élodie Giroux ed., 2016).

to benefit the patient.

At first blush, this standard may seem both too indeterminate and too permissive to inform legal questions regarding when a physician has prescribed without a “legitimate medical purpose.” In fact, however, Boorse’s approach helps focus this inquiry and clarifies the kinds of evidence that support the conclusion that a doctor has abused their prescribing authority. In particular, rather than asking whether a doctor prescribed “too much” of a painkiller or negligently allowed patients to divert their medications, claims that a physician violated federal prescribing laws should focus on the doctor’s motivations.¹² While a physician can face a range of legal consequences for harmful prescribing practices, such as loss of license and civil liability, not every bad doctor is a drug trafficker. As long as the physician was seeking to benefit the patient, rather than seeking to profit from dispensing drugs without regard for the patient’s wellbeing, the doctor should be deemed to have acted with a “legitimate medical purpose” under federal drug laws.

Of course, just because a particular account of medicine’s scope is well suited to resolving certain legal questions does not mean it is the best account of what is ethical for doctors to do. The law merely sets a floor of minimally acceptable conduct, not an ethical standard to which every doctor should strive. There may be many practices that should not be punishable by criminal law but may still be condemned as unethical for doctors to perform. A different account of medicine’s proper scope may be better suited to resolving bioethical controversies. But criminal liability for transgressing medicine’s proper bounds should be limited to narrow and clearly defined circumstances.

I. FEDERAL LAW GOVERNING PHYSICIAN PRESCRIBING LACKS A COHERENT ACCOUNT OF MEDICINE’S SCOPE

The federal government regulates the manufacture, sale, and possession of many drugs through the Controlled Substances Act (CSA).¹³ To prevent “the diversion of drugs from legitimate to illicit channels,” the act controls who may prescribe drugs and for which purposes.¹⁴ The act provides that many drugs can only be dispensed pursuant to a prescription issued by a “practitioner,” meaning a physician or other person who is legally permitted to dispense a controlled substance “in the course of professional practice or research.”¹⁵ Regulations

12. Diane E. Hoffmann, *Treating Pain v. Reducing Drug Diversion and Abuse: Recalibrating the Balance in Our Drug Control Laws and Policies*, 1 ST. LOUIS U. J. HEALTH L. & POL’Y 231, 306 (2016).

13. 21 U.S.C.A. § 812.

14. *Gonzales v. Raich*, 545 U.S. 1, 12-13 (2005).

15. 21 U.S.C.A. § 802(21) (Westlaw through Pub. L. No. 118-13) (defining “practitioner”); 21 U.S.C.A. § 829(a)-(b) (Westlaw through Pub. L. No. 118-13) (authorizing “practitioner[s]” to prescribe controlled substances); *United States v. Rosenberg*, 515 F.2d 190, 193 (9th Cir. 1975); *See* 21 U.S.C.A. § 841(a)(1) (Westlaw through Pub. L. No. 118-13) (criminalizing distribution of

promulgated by the Drug Enforcement Administration (DEA) provide that a prescription is valid only if it is “issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice.”¹⁶ If a physician prescribes a drug without a legitimate medical purpose, she is deemed not to have acted as a “practitioner,” and has therefore violated the act’s provisions that prohibit non-practitioners from dispensing controlled substances.¹⁷ In other words, under these circumstances the doctor has ceased to act as doctor and has instead acted as a drug trafficker.

Accordingly, whether a prescription has a “legitimate medical purpose” carries significant legal consequences for a physician. Yet the Controlled Substances Act does not define the phrase “legitimate medical purpose” or “the usual course of professional practice.” Nor have courts, prosecutors, or the DEA supplied useful definitions of these concepts. Indeed, in 2006 the DEA released a policy statement insisting that “it is not possible to expand on the phrase ‘legitimate medical purpose in the usual course of professional practice,’ in a way that will provide definitive guidelines that address all the varied situations physicians might encounter.” The agency further declared that “one cannot provide an exhaustive and foolproof list of ‘dos and don’ts’ when it comes to prescribing controlled substances for pain or any other medical purpose.”¹⁸

Courts have fared no better. In one early case, a court stated with apparent confidence that the phrase “‘in the course of professional practice’ . . . clearly means that a doctor is not exempt from the statute when he takes actions that he does not in good faith believe are for legitimate medical purposes.”¹⁹ Despite the vacuousness of this “definition,” the Court insisted “it is difficult to see how the language can be made more precise and at the same time ban the undesirable conduct on the part of physicians which Congress intended to make illegal and subject to sanctions.”²⁰

In a more recent case, a court concluded that no “specific set of facts had to be present in order to find that a physician stepped outside of his role and issued prescriptions without a legitimate medical purpose.”²¹ Rather, to convict a physician as a drug trafficker, courts simply “looked to the facts in the record to

controlled substances “[e]xcept as authorized by this subchapter”).

16. 21 C.F.R. § 1306.04(a) (2020).

17. *Rosenberg*, 515 F.2d at 193 (“[A] doctor who acts other than in the course of professional practice is not a practitioner under the Act and is therefore not authorized to prescribe controlled substances. Such a physician is therefore subject to the criminal provisions of the Act contained in section 841(a)(1).”).

18. Dispensing Controlled Substances for the Treatment of Pain, 71 Fed. Reg. 52,716, 52,717, 52,719 (Sept. 6, 2006) <https://www.federalregister.gov/documents/2006/09/06/E6-14517/dispensing-controlled-substances-for-the-treatment-of-pain> [<https://perma.cc/KBR6-LRSL>].

19. *Rosenberg*, 515 F.2d at 197.

20. *Id.* at 198; *Id.* at 204 (Ely, J., dissenting) (concluding that “Congress has, without doubt, used language that is ‘. . . so vague that men of common intelligence must necessarily guess as to its meaning and differ as to its application.’”).

21. *United States v. MacKay*, 715 F.3d 807, 823 (10th Cir. 2013).

conclude enough facts existed for a fact finder to affirmatively determine that the physician issued the drugs for an improper purpose.”²² This analysis, such as it is, seems to amount to little more than “we know it when we see it.” It is useless to physicians in determining what conduct they must avoid in order to comply with the law.

The United States Supreme Court has repeatedly declined opportunities to bring clarity to this issue. In *Gonzales v. Oregon*, the State of Oregon challenged the United States Attorney General’s threat to revoke the prescribing privileges of physicians who prescribed lethal drugs to certain terminally ill patients at their request, in compliance with the state’s Death with Dignity Act.²³ The federal government argued hastening a patient’s death was not a legitimate medical purpose, so prescribing drugs for that purpose violated the Controlled Substances Act. Although the Court rejected the government’s argument, it sidestepped the question of how to define the legitimate scope of medical practice. Instead, the Court simply concluded that since committing suicide was not the kind of “drug abuse” the Act aimed to combat, prescribing drugs for that purpose did not violate the law.²⁴ While this reasoning was sufficient to resolve the case, it did little to clarify the scope of legitimate prescribing outside the context of assisted suicide.

In the absence of a clear definition, courts have applied radically different standards to determine whether a physician prescribed drugs without a legitimate medical purpose. Several courts have insisted that physicians can only be convicted under the Act if they act outside the course of professional practice by *intentionally* acting as a drug dealer.²⁵ As one court explained, “[a] practitioner becomes a criminal not when he is a *bad* or *negligent* physician, but when he ceases to be a physician *at all*.”²⁶

However, as the federal government has cracked down on physician prescribing in response to the opioid epidemic, prosecutions have ensnared

22. *Id.*, see also *United States v. August*, 984 F.2d 705, 713 (6th Cir. 1992) (“there are no specific guidelines concerning what is required to support a conclusion that an accused acted outside the usual course of professional practice. Rather, the courts must engage in a case-by-case analysis of evidence to determine whether a reasonable inference of guilt may be drawn from specific facts.”).

23. *Gonzales v. Oregon*, 546 U.S. 243 (2006); OR. REV. STAT. ANN. § 127.800 *et seq.* (West 2003).

24. *Gonzales*, 546 U.S. 243, 273-74.

25. See, e.g., *United States v. Feingold*, 454 F.3d 1001, 1007-08 (9th Cir. 2006) (“we agree with Dr. Feingold’s contention that a practitioner who acts outside the usual course of professional practice may be convicted under § 841(a) only if he does so intentionally. . . . Simply put, to convict a practitioner under § 841(a), the government must prove . . . that the practitioner acted with intent to distribute the drugs *and with intent to distribute them outside the course of professional practice*. In other words, the jury must make a finding of intent not merely with respect to distribution, but also with respect to the doctor’s intent to act as a pusher rather than a medical professional.”).

26. *Id.* at 1011 (emphasis in original).

physicians who may have over-prescribed medications, but who seemed to be trying to treat patients with genuine ailments.²⁷ Rather than requiring prosecutors to show that these physicians intentionally distributed drugs with no legitimate purpose, several courts have allowed juries “to convict based on an ex post facto ‘he should have been more careful’ theory or to convict on mere negligence.”²⁸

These conflicting standards reached the Supreme Court in 2022 in *Ruan v. United States*. In hearing appeals by physicians who were convicted for violating the CSA by writing improper prescriptions, the Court rejected the idea that doctors could violate the act simply by prescribing in ways that do not conform to common practices.²⁹ Instead, the Court held that “the Government must prove beyond a reasonable doubt that the defendant *knowingly* or *intentionally* acted in an unauthorized manner.”³⁰

In reaching this conclusion, the Court emphasized that the requirement that prescriptions must have a “legitimate medical purpose” was “‘ambiguous,’ written in ‘generalit[ies], susceptible to more precise definition and open to varying construction.’”³¹ Yet the Court did not attempt to resolve this ambiguity by supplying a more precise definition of the conduct physicians must avoid. Although the Court held that prosecutors must show that an accused doctor “knowingly or intentionally acted in an unauthorized manner,” it made no attempt to specify which conduct is “unauthorized” under the act.³²

Thus, while *Ruan* settled a circuit split regarding the government’s burden of proof when prosecuting doctors under the CSA, the opinion did little to clarify what a doctor must do to act outside of (or remain within) the legitimate scope of professional practice. Bringing clarity to that question would benefit physicians, courts, and regulators alike.

II. THE BIOETHICS DEBATE CAN INFORM AND CLARIFY LEGAL STANDARDS

Although courts have failed to acknowledge the complexity of defining medicine’s scope, philosophers have debated the issue for decades. The question of what qualifies as “medical” underlies bioethics debates regarding the propriety of physicians helping patients commit suicide, performing nontherapeutic abortions, and providing cosmetic surgery.³³ Some have argued it is unethical for physicians to engage in these practices, even if it would be ethical for others to perform these same acts, because medical practice is limited to promoting patients’ health. Others claim that if the acts themselves are ethical, it is permissible for physicians to perform them.

27. See Hoffmann, *supra* note 12.

28. *Id.* at 305.

29. *Ruan v. United States*, 142 S. Ct. 2370, 2376 (2022).

30. *Id.* (emphasis added).

31. *Id.* at 2377, 2382.

32. *Id.* at 2377.

33. John D. Arras, *A Method in Search of a Purpose: The Internal Morality of Medicine*, 26 J. MED. & PHIL. 643, 650 (2001).

The fact that “equally perceptive observers of the medical scene could have come to such diametrically opposed conclusions about the most fundamental methodological question in medical ethics” reveals the true complexity of the issue.³⁴ Yet despite the “near-total disagreement about the existence and scope” of an internal morality of medicine,³⁵ the bioethics literature can still be useful in informing legal questions regarding medicine’s scope. That task entails identifying a standard that is generally consistent with existing legal standards and practices but offers a definition of medical practice that is clearer and more coherent.

A. Narrow Essentialism

Proponents of an internal morality of medicine claim “the nature of medicine, its internal goods and virtues, are defined by the ends of medicine itself, and therefore, ontologically internal from the outset.”³⁶ In this view, certain acts are improper for doctors to perform in their professional capacity because they do not qualify as “medical” in nature, regardless of whether those practices would be wrong for non-medical professionals to perform.

A prominent advocate of this view, Edmund Pellegrino, argues the ethics of medical professions “has its source in the nature of these professions, in what is distinctive about them and the good at which they aim.”³⁷ Specifically, he claims the good at which medicine aims is healing, arguing that “[m]edicine exists because being ill and being healed are universal human experiences, not because society has created medicine as a practice.”³⁸ Pellegrino’s central claim is that practices that do not aim at “the return of physiological function of mind and body” or “the relief of pain and suffering” are not truly “medical” in nature, and are therefore outside the scope of legitimate medical practice.³⁹ In this view, while considerations external to medicine may *constrain* physician conduct (e.g., a physician cannot heal a patient against her will), those considerations cannot *justify* the physician performing, in her professional capacity, acts that do not aim at healing.

For purposes of specifying when a prescription has a legitimate medical purpose, this approach has the benefit of offering a clear standard. In this view, practices that do not promote healing are not medical in nature. Accordingly, a physician who prescribes drugs for any purpose other than promoting healing has ceased to act as a physician.

34. *Id.* at 644.

35. Boorse, *supra* note 11, at 152.

36. Pellegrino, *supra* note 9, at 563.

37. *Id.* at 560.

38. *Id.* at 563; LEON R. KASS, TOWARD A MORE NATURAL SCIENCE: BIOLOGY AND HUMAN AFFAIRS, 198 (The Free Press, 1985) (offering a similar essentialist account: “Medicine violates the body only to heal it.”)

39. Pellegrino, *supra* note 9, at 569.

But while this approach has the benefit of clarity, it is unhelpful in setting a legal standard governing prescribing because it would condemn practices that are clearly legal and commonly performed by physicians. Under this standard, prescribing drugs for purposes of contraception or erasing frown lines would be outside medicine's scope when they are not aimed at treating or preventing any illness. Given the ubiquity of such interventions, it seems clear such practices fall squarely within "the usual course of professional practice" under federal prescribing laws. As this legal standard suggests, it is derived from physicians' customary practices, rather than from any abstract notions regarding medicine's essential nature.

Indeed, the United States Supreme Court rejected this narrow essentialist standard in *Gonzales*.⁴⁰ In that case, the federal government argued that assisting suicide is not a legitimate medical purpose because it does not aim to promote patients' health:

The ordinary meaning of the term "medical" is "[p]ertaining or related to the *healing art* or . . . to 'medicine,'" and the term "medicine" refers to "[t]hat department of knowledge and practice which is concerned with the *cure, alleviation, and prevention of disease* in human beings, and with the *restoration and preservation of health*" Assisting an individual's suicide does not fit within the ordinary meaning of the phrases "legitimate medical purpose" or "usual course of professional treatment," because it does not aim to preserve the patient's health or to cure, alleviate, prevent, or "treat" the disease or its symptoms in the patient.⁴¹

The Court disagreed. In concluding the Controlled Substances Act did not prohibit physicians from prescribing drugs to help a patient commit suicide in accordance with state law, the Court implicitly rejected the claim that legitimate medicine is limited to prescribing drugs for the purpose of healing.⁴² Hence, whatever the merits of this narrow essentialist account as a matter of medical ethics, this approach does not help clarify the scope of legitimate medical practice

40. *Gonzales v. Oregon*, 546 U.S. 243 (2006).

41. Brief for the Petitioners at 18-19, *Gonzales v. Oregon*, 546 U.S. 243 (No. 04-623), 2005 WL 1126079, at *18-19. *See also* Letter from Henry J. Hyde, Chairman, Committee on the Judiciary, U.S. House of Representatives, and Orrin G. Hatch, Chairman, Committee on the Judiciary, U.S. Senate, to Thomas A. Constantine, Administrator, Drug Enforcement Administration (July 25, 1997), *reprinted in* S. REP. NO. 105-372, at 7 n.6 (1988) (emphasis added) (discussing a similar position previously taken by several members of Congress, writing that "assisting in a suicide by prescribing or filling a prescription for a controlled substance cannot be a 'legitimate medical purpose' under DEA regulations, especially when *the practice is not reasonable and necessary to the diagnosis and treatment of disease and injury, legitimate health care, or compatible with the physician's role as healer.*").

42. *Gonzales*, 546 U.S. at 270 ("Congress regulates medical practice insofar as it bars doctors from using their prescription-writing powers as a means to engage in illicit drug dealing and trafficking as conventionally understood.").

when construing the Controlled Substances Act.

B. External Morality

Other observers deny the existence of an internal morality of medicine and instead argue that “all judgments in bioethics must be guided and ultimately justified by ethical norms external to the practice of medicine.”⁴³ “Only by looking outside of medicine,” Robert Veatch argues, “can a health professional or anyone else know what the proper ends of medicine are and therefore know what constitutes the ethical practice of the profession.”⁴⁴ In this view, since the physician is charged with benefiting the patient (and what counts as a benefit depends on the patient’s social context and debates regarding what constitutes human flourishing), determining which practices are ethical for doctors to perform always requires invoking considerations that are external to the medical profession.⁴⁵ “[I]n order to know what the ends of medicine are, one must first know what the ends of living and social functioning are and . . . this, in turn, requires turning outside of any conception of medicine to determine.”⁴⁶

Veatch illustrates his argument with a colorful hypothetical example of a society in which priestly *castrati* play an important and honored cultural role.⁴⁷ Preserving the soprano voices of male cantors requires castrating them at puberty. Veatch argues it is impossible to determine whether physicians in such a society could ethically perform these castrations on healthy boys simply by reflecting on the essential nature of medicine. “The rightness or wrongness of the surgeons’ actions depends not on any goals of medicine,” Veatch claims, “but rather on the correctness of the society’s broader cultural beliefs and rituals.”⁴⁸ In other words, if the castrations themselves are ethical, it is ethically permissible for physicians to perform them. No morality internal to the profession would bar them from doing so.

A real example may further illustrate this argument. Consider prescribing hormone-blockers to a transgender woman to help her express her gender identity. Does this intervention promote the patient’s health? Hormone blockers do not heal the patient’s body; in fact, they disrupt the body’s normal processes. Yet even if one were to limit legitimate medicine to healing, presumably physicians could still ethically prescribe this intervention if transgenderism itself were considered an illness. Views on that question have shifted over time in response to shifting social mores and norms—norms that are themselves external to medicine.⁴⁹ As Veatch argues, “[t]hat the purpose of medicine is health or

43. Arras, *supra* note 33, at 644.

44. Veatch, *supra* note 10, at 623.

45. *Id.*

46. *Id.* at 628.

47. *Id.* at 625-26.

48. *Id.* at 634.

49. Jodie M. Dewey & Melissa M. Gesbeck, *(Dys)Functional Diagnosing: Mental Health*

healing tells us nothing more than that the purpose of medicine is to solve what is (properly) perceived to be a problem in the medical realm without telling anything whatsoever about what would constitute such a problem and what would count as a solution.”⁵⁰

In terms of informing legal questions regarding which practices count as “medical,” an external account is appealing because the regulation of medicine is inherently an exercise in applying external (legal) standards to the profession. The external approach seems to view the medical profession as a tool society uses to produce certain benefits. In this view, it is appropriate for society to place within medicine’s lawful domain any problem for which physicians’ skills and expertise may be beneficial. As Tom Beauchamp argues:

If beneficence is a general moral principle (and it is), and if physicians are positioned to supply many forms of benefit (and they are), then there is no manifest reason to tie physicians’ hands or duties to the single benefit of *healing*. Patients and society may, with good reason, regard cosmetic surgery, sleep therapies, assistance in reproduction, genetic counseling, hospice care, physician-assisted suicide, abortion, sterilization, and other actual or potential areas of medical practice as important benefits that only physicians can safely and efficiently provide. These activities are not forms of healing⁵¹

Accordingly, Veatch concludes that “[i]f the society is justified in condoning the behavior, it is potentially justified in expecting those in health professional roles to engage in them when these are the only people who can perform them.”⁵²

Yet although this approach avoids narrow essentialism’s rejection of common nontherapeutic practices, it does little to help answer questions regarding what falls within the legal scope of medicine. While the standard proposed by many essentialist accounts may be too cramped to encompass the full range of legitimate medicine, proponents of externalist accounts do not offer an alternative standard of their own. They merely argue that these questions cannot be answered simply by reflecting on medicine’s purposes. Instead, resort must be made to external accounts of what is ethical in general.⁵³

While this may be a valid way of assessing whether a particular practice is ethical, it offers little help in determining whether that practice qualifies as “medical” in nature. For example, one could believe it is unethical to prescribe hormone blockers to transgender patients without believing that a physician who does so is not practicing medicine. Moreover, the laws regulating physician

Diagnosis, Medicalization, and the Making of Transgender Patients, 41 HUMAN. & SOC’Y 37 (2017).

50. Veatch, *supra* note 10, at 636.

51. Beauchamp, *supra* note 10, at 603.

52. Veatch, *supra* note 10, at 635.

53. *See, e.g.*, Beauchamp, *supra* note 10, at 612 (offering a defense of externalism that “appeals to universal moral principles that are valid independent of the perspectives of particular communities and traditions of medical practice and ethics.”).

prescribing are expressly predicated on the idea that legitimate medicine is defined by certain “purposes.”⁵⁴ Since external accounts seem to reject that premise, they are not helpful in distinguishing acts that are distinctively medical from those that lie outside that scope.

C. Evolutionary Dialogue

Another camp has sought to strike a middle ground between the internal and external views. These theorists endorse a hybrid approach, insisting that an internal morality does limit the proper goals of medicine, while also arguing that these goals can evolve in response to shifting social contexts.

A consensus report produced by the Hastings Center illustrates this approach. The report argues “medicine has essential ends, shaped by more or less universal ideals and kinds of historical practices, but its knowledge and skills also lend themselves to a significant degree of social construction.”⁵⁵ Hence, while the aims of medicine may have traditionally been limited to healing, over time—in dialogue with a changing society—the boundaries of the practice have expanded to include additional objectives that are now central to medicine. According to the authors, today the “goals of medicine” include: (1) “the prevention of disease and the promotion of health,” (2) “the relief of pain and suffering,” (3) “the treatment of disease and the care of those who cannot be cured,” and (4) “the avoidance of a premature death and the promotion of a peaceful death.”⁵⁶

Miller and Brody propose a similar compromise. These authors purport to endorse an internal morality of medicine while arguing that “the goals of medicine are not timeless and unchanging; of necessity they evolve along with human history and culture.”⁵⁷ Miller and Brody believe that “healing, promoting health, and helping patients achieve a peaceful death” traditionally have been central to the practice of medicine.⁵⁸ But they argue that medicine’s scope cannot be limited to healing alone, because traditional goals can be reinterpreted to permit new practices and “social forces” can result in new goals being added to medicine’s purview.⁵⁹

In this view, there are goals that are “core” or “central” to medicine because they have been recognized as an appropriate part of medical care for a long time.

54. 21 C.F.R. § 1306.04(a) (2020).

55. Daniel Callahan, *The Goals of Medicine: Setting New Priorities*, in 26 HASTINGS CTR. REP. (SPECIAL SUPPLEMENT) 1 (1996), reprinted in *THE GOALS OF MEDICINE: THE FORGOTTEN ISSUES IN HEALTH CARE REFORM 1*, 17 (Mark J. Hanson & Daniel Callahan eds., Geo. Univ. Press 1999).

56. *Id.* at 17.

57. Franklin G. Miller & Howard Brody, *The Internal Morality of Medicine: An Evolutionary Perspective*, 26 J. MED. & PHIL. 581, 585 (2001).

58. Franklin G. Miller & Howard Brody, *Professional Integrity and Physician-Assisted Death*, 25 HASTINGS CTR. REP. 8, 12 (1995).

59. Miller & Brody, *supra* note 57 at 585.

But those goals can also evolve via “responsive adaptation to the circumstances of the present.”⁶⁰ When a particular practice becomes accepted in the broader society, it may be appropriate for the goals of medicine to expand to encompass these practices. Answering that question, the authors argue, that it requires determining “whether the proposed alteration would represent a possibly positive evolution in the nature of medicine, or whether the degree of violence done to traditional medical values is simply too great to allow the change.”⁶¹ Ultimately, Miller and Brody settle on a list that they claim reflects the range of goals that are properly within medicine’s domain:

1. Reassuring the “worried well” who have no disease or injury;
2. Diagnosing the disease or injury;
3. Helping the patient to understand the disease, its prognosis, and its effects on his or her life;
4. Preventing disease or injury if possible;
5. Curing the disease or repairing the injury if possible;
6. Lessening the pain or disability caused by the disease or injury;
7. Helping the patient to live with whatever pain or disability cannot be prevented;
8. When all else fails, helping the patient to die with dignity and peace.⁶²

By identifying specific goals that define medicine’s proper scope, these evolutionary accounts offer potential tools for evaluating whether a physician acted with a legitimate medical purpose in prescribing a drug. Under such an approach, if the physician’s purpose in writing a prescription is to pursue one of these specified purposes, the physician has acted within the legitimate scope of medicine. If not, the physician has not acted as a practitioner in writing the prescription.

That benefit proves illusory, however, because the proponents of these lists do not claim that the goals they identify are the only objectives physicians may properly pursue. While the Hastings Center’s consensus report identifies four goals as the legitimate aims of medicine, they conclude it is sometimes permissible for physicians to engage in “nonmedical” practices as well.⁶³ For example, they argue that although contraception and cosmetic surgery “fall outside the traditional goals of medicine,” it is still acceptable for physicians to provide these services in pursuit of “social and individual purposes” besides promoting health.⁶⁴

Miller and Brody likewise assert that “[b]esides medical activities which are

60. *Id.* at 586.

61. *Id.* at 585.

62. Howard Brody & Franklin G. Miller, *The Internal Morality of Medicine: Explication and Application to Managed Care*, 23 J. MED. & PHIL. 384, 386-87 (1998).

63. Callahan, *supra* note 55 at 31.

64. *Id.* at 30.

fully consistent with medicine's internal morality, and those which violate that morality, there may be a third category: activities which are considered morally permissible for physicians, but which occupy a borderline status in relation to internal morality."⁶⁵ For example, the authors argue contraception "arguably fails to promote any medical goal, since fertility is not a disease," and conclude that physicians prescribing contraception cannot be justified "on a principled basis."⁶⁶ Yet in their view this does not mean it is unethical for doctors to do so, because physicians' expertise and skill make them uniquely qualified to provide this important service:

[w]e could envision a hypothetical negotiation between the medical profession and the larger society. Imagine that everyone agreed that contraception and sterilization are social goods, everything being equal. When push comes to shove, there seem to be two ways to provide this good. Either physicians will stretch a point and agree to provide this service despite the potential compromise of their professional integrity Or, society will somehow create a new set of professionals or technicians who will learn these skills All might readily agree that the first course of action is a much wiser use of all sorts of social resources than the second.⁶⁷

Accordingly, in this view some practices that do not aim at the traditional medical goals of promoting health, such as contraception or cosmetic surgery, can still be properly performed by physicians. The authors "suggest a normative mapping of medicine that encompasses a core of legitimate medical practice, consistent with the goals and internal duties of medicine, a periphery of more or less acceptable procedures and practices outside the core, and a range of violations beyond the pale of medical legitimacy."⁶⁸

Thus, rather than offering a clear principle that can help determine when a physician has ceased acting as a physician, this approach posits that legitimate medical practice includes traditional goals, such as healing, as well as many other practices society has enlisted doctors to perform. As Boorse notes, in the evolutionary view nontherapeutic practices such as cosmetic enhancement or assisted suicide "if they are in patients' best interests, will either be genuine medicine, or something besides medicine that physicians can permissibly do – in either case acceptable."⁶⁹ Such a standard appears of little use in seeking to determine when a physician has exceeded the scope of legitimate practice.

65. Howard Brody & Franklin G. Miller, *The Internal Morality of Medicine: Explication and Application to Managed Care*, 23 J. MED. & PHIL. 384, 390 (1998).

66. *Id.* at 391.

67. *Id.* at 392.

68. Franklin G. Miller et al., *Cosmetic Surgery and the Internal Morality of Medicine*, 9 CAMBRIDGE Q. HEALTHCARE ETHICS 353, 356 (2000).

69. Boorse, *supra* note 11, at 173.

D. Broad Essentialism

For purposes of construing federal prescribing rules, the external and evolving accounts are unhelpful for the same reasons: they do not help decide concrete cases that hinge on whether a physician ceased acting as a physician. By contrast, Pellegrino's essentialist account provides a clear standard for making this determination—namely, that acts not aimed at healing do not qualify as medical in nature—but this narrow definition of medicine's scope is flatly inconsistent with existing law. An internal standard that articulates a principle for determining which acts are "medical" would be useful, but that principle must be broad enough to embrace the wide range of legal, nontherapeutic practices that medical practitioners commonly perform. An analysis offered by Christopher Boorse provides such a standard.

Boorse argues that if medicine is governed by an internal morality, it is a broad one. He rejects the narrow form of essentialism that seeks to confine medicine to the aim of healing, finding that "[a]s a matter of history, whenever one supposes the Western medical tradition began, physicians from the start have done things other than to fight disease and promote health."⁷⁰ Noting that Hippocratic doctors routinely provided both contraceptive and abortion interventions for no health-related purpose, Boorse argues medicine has embraced non-therapeutic aims from the dawn of the profession.⁷¹ For those who instead trace modern medicine's origins to the rise of germ theory circa 1865, Boorse notes that Victorian-era physicians quickly embraced obstetrical anesthesia as ethical, despite the fact that pain caused by labor is normal rather than pathological.⁷²

Having rejected the view that medicine can be limited to healing alone, Boorse argues that other proposed lists of medicine's goals, such as those offered by the Hastings Center and Miller and Brody, can be consolidated under the headings of (1) "[p]reventing pathological conditions," (2) "[r]educing the severity of pathological conditions," and (3) "[a]meliorating the effects of pathological conditions." But because these authors also claim physicians may also use their skills to provide nontherapeutic interventions, such as contraception and plastic surgery, the list of physicians' permissible goals must also include a fourth goal: "[u]sing biomedical knowledge or technology in the best interests of the patient."⁷³ And once one acknowledges this fourth item as a permissible goal for physicians, this objective subsumes the other three: "[f]or it is undisputed that the pursuit of all the other goals is justified only when it is in the patient's interest."⁷⁴

In sum, Boorse concludes that if medicine is governed by an internal

70. *Id.* at 146.

71. *Id.* at 166.

72. *Id.* at 148, 170.

73. *Id.* at 170 (Boorse also identifies a list for medical goals regarding the development of scientific knowledge, but those are inapplicable here).

74. *Id.* at 172.

morality, that morality does not limit doctors to specific practices but rather to a broadly-stated end: using their special expertise and skills to promote the patient's well-being. By framing the goal of medicine at this level of abstraction, this approach goes a long way toward reconciling the essentialist, evolutionary, and external accounts. It offers an essentialist account that acknowledges a morality at the core of medicine that constrains its practitioners. But it defines that core principle broadly enough to encompass the ways in which what constitutes "benefit" hinges on external considerations: the morality of the broader society, shifting social contexts, and individual preferences. Thus, for example, under this standard, physicians could not ethically participate in executions even if performing executions were justifiable according to external moral principles, because killing would violate the internal morality of medicine that commits doctors to benefiting their patients.

At first blush, this standard may seem too broad and abstract to be useful in evaluating the propriety of a physician's prescriptions. Like the external and evolutionary accounts, this approach does not identify specific practices doctors should abstain from performing. But unlike those accounts, Boorse provides a principle for determining when a physician has ceased acting as a physician. This standard also focuses attention on the factors that are relevant when undertaking that assessment: in engaging in certain conduct, was the physician trying to use her skills and expertise to benefit the patient? Or did the doctor have some other aim, such as profit-seeking, irrespective of whether it benefited the patient? In other words, rather than focusing on whether a physician prescribed too much, too frequently, or in other ways that might deviate from the standard of care, the inquiry into whether a physician had a legitimate medical purpose should focus on the physician's motivations—in particular—whether the doctor was reasoning like a fiduciary.

III. A FIDUCIARY PRESCRIBING STANDARD

From its inception, benefiting patients has been at the core of the medical profession. According to one translation of the Hippocratic Oath, a doctor pledges to "follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous."⁷⁵ Plato observed in the *Republic* that "[n]o physician, insofar as he is a physician, considers his own good in what he prescribes, but the good of his patient; for the true physician is . . . not a mere money-maker."⁷⁶ Millenia later, the preamble to the American Medical Association's (AMA) Principles of Medical Ethics observes that the profession's ethical principles were "developed

75. OATH OF HIPPOCRATES, *reprinted in* Allan H. McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549, 549 (1959).

76. Sam F. Halabi, *Against Fiduciary Utopianism: The Regulation of Physician Conflicts of Interest and Standards of Care*, 11 U.C. IRVINE L. REV. 433, 445 (2020), (quoting PLATO, THE REPUBLIC 17 *in* COSMIO CLASSICS (Benjamin Jowett trans., 2008) (1888)).

primarily for the benefit of the patient.”⁷⁷

Thus, although physicians are compensated for their work, they are situated differently than providers of most other services. When laypeople enter into economic transactions, they are generally free to maximize their own benefit from those exchanges. It is incumbent on the other party to the transaction to look out for her own interests.⁷⁸ But members of certain professions, such as lawyers and financial advisors, are considered fiduciaries who are required by both ethical standards and legal restrictions to prioritize the wellbeing of their clients.⁷⁹

Fiduciary duties are often imposed on professionals who “have specialized knowledge or expertise.” Their work requires judgment and discretion. Often the party that the fiduciary serves cannot effectively monitor the fiduciary’s performance. The fiduciary relationship is based on dependence, reliance, and trust.⁸⁰ Because the doctor-patient relationship fits all these criteria, it has frequently been characterized as a fiduciary relationship. As several legal scholars have observed, this is not strictly accurate—the law does not treat physicians as fiduciaries in every respect.⁸¹ At a minimum, however, doctors do owe ethical duties to act as fiduciaries in some respects, including by prioritizing patients’ well-being above their own financial interests.

An AMA report on conflicts of interest asserts that “a physician must exercise medical judgment independently of his own . . . financial interests.” The report states that conflicts between the physician’s and the patient’s interest “must be resolved to the patient’s benefit.” These benefits derive, according to the AMA, from the “physician’s role as a fiduciary, i.e., a person who, by his undertaking, has a duty to act primarily for another’s benefit.” The American College of Physicians declares that the physician is “the advocate and champion of his patient, upholding the patient’s interests above all others.” They add that “[t]he physician must avoid any personal commercial conflict of interest that might compromise his loyalty and treatment of the patient.”⁸²

In other words, although physicians are paid for their services—and in that sense

77. *AMA Principles of Medical Ethics*, AMA CODE OF MED. ETHICS, <https://code-medical-ethics.ama-assn.org/principles#:~:text=The%20medical%20profession%20has%20long,health%20professionals%2C%20and%20to%20self.> [https://perma.cc/3KEC-W7V9]. (last visited Mar. 6, 2023)

78. Justin Sevier & Kelli Alces Williams, *Consumers, Seller-Advisors, and the Psychology of Trust*, 59 B.C. L. REV. 931, 940 (2018).

79. Halabi, *supra* note 75 at 438-40.

80. Marc A. Rodwin, *Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System*, 21 AM. J. L. & MED. 242, 244 (1995).

81. Rodwin, *supra* note 79, at 247; Halabi, *supra* note 75 at 452.

82. Rodwin, *supra* note 79, at 246-47 (quoting AM. MED. ASS’N, REPORT OF THE COUNCIL ON ETHICAL & JUD. AFF., REPORT A (I-86): CONFLICTS OF INTEREST 11 (1986)); American College of Physicians, Ad Hoc Committee on Medical Ethics, *American College of Physicians Ethics Manual, Part 1*, 101 ANNALS INTERNAL MED. 129, 134 (1984).

commonly “prescribe for profit”—when the patient’s interest runs counter to the physician’s, the physician is obligated to prioritize the patient’s wellbeing. According to the AMA’s Code of Medical Ethics, “[u]nder no circumstances may physicians place their own financial interests above the welfare of their patients . . . Physicians should not provide wasteful and unnecessary treatment . . . solely for the physician’s financial benefit.”⁸³

This description of physicians’ duties matches Boorse’s account of what is distinctive about the physician’s role: the application of the physician’s special skills and knowledge to benefit the patient.⁸⁴ It is also consistent with an approach to defining the scope of medicine that has sometimes, though not always, found purchase among courts and legal scholars construing federal rules governing prescribing.

Most notably, Diane Hoffmann has argued that in determining whether physicians prescribed without a legitimate medical purpose, the key inquiry should be whether they used their prescribing power to seek personal profit, irrespective of whether the patients would benefit or be harmed.⁸⁵ Courts, too, have sometimes explicitly endorsed this standard. Noting that “[i]mplicit in the registration of a physician is the understanding that he is authorized only to act ‘*as a physician*,’” the United States Supreme Court concluded the Controlled Substances Act’s criminal penalties are aimed at doctors “who sold drugs . . . ‘primarily for the profits to be derived therefrom.’”⁸⁶ More recently, an appellate court concluded that conviction under the Controlled Substances Act required proving that the physician’s “authority to prescribe controlled substances was being used not for treatment of a patient, but for the purpose of assisting another in the maintenance of a drug habit or of dispensing controlled substances for other than a legitimate medical purpose, *i.e. the personal profit of the physician*.”⁸⁷ At one point even the DEA sought to allay doctors’ concerns about the vague and shifting standards governing prescribing by insisting that the agency only targeted physicians who “knowingly and intentionally prescribe opioid medications *for profit or other personal gain*.”⁸⁸

However, the DEA subsequently disavowed the document that contained that

83. Am. Med. Ass’n, *Opinion 11.2.2: Conflicts of Interest in Patient Care*, AMA CODE OF MED. ETHICS, <https://www.ama-assn.org/delivering-care/ethics/conflicts-interest-patient-care> [<https://perma.cc/U9R3-Q5FK>]. (last visited Mar. 6, 2023)

84. Boorse, *supra* note 11, at 172 (noting that “[i]ndeed, the limitation to action in the patient’s interest is not unique to medicine: it also restricts every other profession, such as law or investment management, that includes a fiduciary duty to clients.”).

85. See Hoffmann, *supra* note 12.

86. *United States v. Moore*, 423 U.S. 122, 135, 141 (1975) (quoting H.R. Rep. No. 91-1444, 10).

87. *United States v. Katz*, 445 F.3d 1023, 1028 (8th Cir. 2006) (emphasis added).

88. Drug Enforcement Administration et al., *Prescription Pain Medications: Frequently Asked Questions and Answers for Health Care Professionals and Law Enforcement Personnel*, 19 J. PAIN & PALLIATIVE CARE PHARMACOTHERAPY 71, 93 (2005) (emphasis added).

statement,⁸⁹ and courts have not always applied this standard to prosecutions of physicians under the Controlled Substances Act.⁹⁰ Boorse's account offers support for consistently applying this fiduciary-based standard to prosecutions of physicians for unlawful prescribing.

This standard also focuses attention on the kinds of evidence that should be relevant in prosecutions of doctors for abusing their prescribing powers in violation of federal drug laws. Because courts have not been consistent in applying this standard, many prosecutions of physicians have focused on whether the physician prescribed in accordance with prevailing medical standards (i.e. whether the physician met the standard of care).⁹¹ An expert witness looks through the physician's prescribing history and expresses the opinion that the doctor prescribed too frequently or in excessive dosages, or that the doctor should have detected that patients were diverting their prescribed medications.⁹²

While this evidence is clearly relevant to whether a physician was acting as a drug trafficker, it should not be sufficient on its own and should not be considered the ultimate issue. Instead, evidence of this sort is relevant only insofar as it helps establish that the physician's prescriptions were motivated by a desire to profit from drug trafficking, irrespective of patient benefit.⁹³ As Leib and Galoob note, the fiduciary duty of loyalty demands that fiduciaries "have or form certain attitudes and that [they] think or deliberate in certain ways."⁹⁴ Harmful prescribing may be a breach of the duty of care, but it is only a breach of the duty of loyalty if the physician's motivations were not "shaped by the beneficiary's interests."⁹⁵

Cases involving convictions of doctors for violating the CSA provide examples of the kinds of behavior that evidence a breach of this duty. For example, the conviction of Dr. Permaeshwar Singh was supported not merely by the large volume of drugs he prescribed, but by the fact that he prescribed some 76,000 pills without even being present at the office—a feat achieved by pre-signing blank prescriptions and allowing non-medical office personnel to

89. Dispensing of Controlled Substances for the Treatment of Pain, 69 Fed. Reg. 67170, 67170 (Nov. 16, 2004).

90. See discussion *infra* Part I.

91. Hoffmann, *supra* note 12, at 286.

92. *Id.*

93. *Id.* at 306 (physicians should not be convicted for violating the CSA on the basis of poor prescribing practices unless the record also includes evidence that "the physician received a tangible benefit (in excess of ordinary fees) for his prescribing." Granted, a physician prescribing amounts of addictive drugs wildly in excess of professional standards may be very strong evidence that the physician was acting as a drug trafficker. But the fact that the physician's practices violated customary practices should not be considered the ultimate inquiry. It is merely evidence that bears on the physician's motivations.)

94. Ethan J. Leib & Stephen R. Galoob, *Fiduciary Political Theory: A Critique*, 125 YALE L. J. 1820, 1829 (2016) (citing GEOFFREY BRENNEN ET AL., EXPLAINING NORMS 193, 245 (2013)).

95. *Id.*

complete them for patients upon request.⁹⁶ Another convicted physician, Dr. Thomas Moore, prescribed drugs as frequently as his patients requested without even examining them and charged them based on the volume of drugs prescribed.⁹⁷ And in an administrative action to revoke the DEA registration of Dr. Robert Smith, the accused physician wrote prescriptions to individuals he had not examined, charged patients a \$65 fee for each office visit plus an additional \$100 for prescriptions, and asked one patient for sexual favors in exchange for prescriptions. These are indications that these physicians were not prescribing for the purpose of benefitting patients, and therefore were not acting as physicians in so doing.⁹⁸

By contrast, clarifying the legal standard to focus on physicians' motivations rather than mere negligence could exonerate physicians like Dr. Robert Ignasiak. The evidence showed Dr. Ignasiak examined his patients before prescribing medications for them, treated them for a broad range of conditions with a variety of non-narcotic medications, and took steps to protect against addiction and abuse.⁹⁹ The physician's patients suffered from "illnesses or conditions that caused them pain, anxiety and/or depression, ailments that could well have justified the use of controlled substances within the range of discretion accorded physicians."¹⁰⁰ Moreover, Dr. Ignasiak's prescriptions never exceeded the dosages or amounts listed in the Physician's Desk Reference ("the leading drug reference among physicians"¹⁰¹).¹⁰² Nevertheless, the court determined he could be convicted under the Controlled Substances Act merely because he was "on notice" that his prescriptions were harming patients and, based on some of his patients' abuse of the narcotics he prescribed, he should have known "that perhaps there was something wrong with the way that he was prescribing controlled substances."¹⁰³

It may well be that Dr. Ignasiak was engaging in harmful prescribing practices that did not conform to professional standards, or that he was negligent

96. United States v. Singh, 390 F.3d 168, 176 (2d Cir. 2004).

97. Moore, 423 U.S. at 142-43.

98. See generally United States v. Rosen, 582 F.2d 1032, 1035-36 (5th Cir. 1978) (noting that in many cases affirming convictions of physicians under the CSA, courts have seized on the fact that the defendant did not conduct any examination of her patients before prescribing controlled substances); Katz, 445 F.3d at 1027-28 (in affirming the defendant's conviction under the CSA, the court emphasized the physician's practice of prescribing narcotics without first examining patients).

99. United States v. Ignasiak, 667 F.3d 1217, 1220-1221, 1223, 1226 (11th Cir. 2012).

100. *Id.* at 1228.

101. Jay S. Cohen, *Dose Discrepancies Between the Physicians' Desk Reference and the Medical Literature, and Their Possible Role in the High Incidence of Dose-Related Adverse Drug Events*, 161 ARCHIVES INTERNAL MED. 957, 958 (2001) (last visited Dec. 20, 2023), <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/647832> [<https://perma.cc/4EZ6-E2LJ>].

102. *Ignasiak*, 667 F.3d at 1228.

103. *Id.* at 1236.

in failing to detect that his patients were diverting their medications. But the standard applied in evaluating his conduct, and the evidence emphasized in supporting his conviction, seemed to suggest such violations of professional standards, by themselves, constituted prescribing without a legitimate medical purpose. Consistently applying a standard focused on the physician's motives for prescribing could change outcomes in prosecutions under the Controlled Substances Act.

CONCLUSION

Whether a practice or intervention is considered "medical" can carry important legal consequences. Yet the law has not always been rigorous in defining which practices meet this description, yielding standards that are unclear and inconsistent. The law can benefit from drawing on the philosophical debate that has engaged with the complexity of this question.

In the context of prescribing laws, Boorse offers a useful standard for determining when a physician is acting within the legitimate bounds of medicine. This fiduciary standard is acceptable because it embraces the full range of practices that physicians routinely perform and that are widely accepted as legal. And it is a useful standard because it focuses attention on the key inquiry: whether, in writing a prescription, the doctor was seeking to benefit the patient or to profit irrespective of the patient's wellbeing. While courts have sometimes asserted that a similar standard governs cases involving unlawful prescribing, Boorse's account offers support for consistently applying this standard to all cases.

Yet even if Boorse's account helps clarify the appropriate legal standard, that does not mean the application of that standard will be clear in every case. The practice of medicine involves unavoidable financial conflicts of interest.¹⁰⁴ Since physicians are generally paid for their services—and often earn more for prescribing more therapy—profit motive will be present in many prescribing decisions. Determining whether a physician has pursued that profit motive without regard for the patient's benefit is a fact-intensive inquiry that will not always yield obvious answers. But conflicts of interest are not unique to medical practice, nor is it unusual for legal standards to require case-by-case application by factfinders. The standard offered by Boorse offers value by clarifying the central question those factfinders must answer and by specifying the kinds of evidence that are relevant to that inquiry.

Nevertheless, the utility of Boorse's standard for assessing conformity with the Controlled Substances Act does not necessarily suggest this would be the most useful standard for resolving other questions regarding the definition of medicine. As Arras notes, whether it is useful to specify an internal morality that governs legitimate medical practice may hinge critically on "[w]hat . . . an internal morality of medicine [is] *for*."¹⁰⁵ For example, while this standard tells

104. Halabi, *supra* note 75, at 461-62.

105. Arras, *supra* note 33, at 650 (emphasis in original).

us that a doctor who prescribes Botox is providing a “medical” service, it seems to offer little help in determining whether Botox is “medically necessary” for purposes of insurance reimbursement.

Nor does the utility of this standard in assessing compliance with federal prescribing laws mean it is the best approach to resolving ethical issues regarding permissible physician conduct. The question of what physicians can lawfully do without violating federal drug laws is distinct from the question of what practices physicians can ethically undertake. The fact that prescribing drugs to help a patient commit suicide does not violate the CSA does not mean doctors should do so. And in resolving that ethical question, it may be that Boorse’s emphasis on benefitting the patient offers little help, because it does not attempt to specify what should count as a benefit to the patient.

Finally, it is important to emphasize that limiting the scope of physicians’ liability under federal drug laws does not mean physicians cannot face other legal consequences for harmful prescribing practices. Doctors can face discipline from state medical boards when they violate professional standards.¹⁰⁶ They can also face civil liability when that conduct harms patients.¹⁰⁷ These are appropriate remedies for physicians who practice medicine poorly. But criminal penalties for unlawful prescribing should be reserved for doctors who abandoned their professional roles altogether in favor of profiting from drug trafficking.

106. Lamkin, *supra* note 5, at 432-33.

107. *Id.*