SOME LEGAL CONSIDERATIONS IN THE PRACTICE OF ADDICTION MEDICINE

As practitioners of addiction medicine, you are fighting an opioid epidemic that is killing thousands of people every year. Last year alone, 72,306 people died from opioid overdose in the U.S. alone – that's more people than America lost in combat deaths from Vietnam to the present.[1] And while you fight this epidemic, the political and public climate can make it feel like you're walking through a mine field. I hope to give you some insights that might make you a bit more comfortable taking care of your patients.

I. BACKGROUND

First, let me give you a brief history of the federal controlled substances law. Before 1914, druggists could sell narcotics over-the-counter – no prescription needed. This led to widespread abuse. Then Congress passed the Harrison Narcotic Drug Act, which required a physician's order for a druggist to dispense narcotics.[2] The Harrison Act was later amended to regulate physicians, but with the stated intent that it not prevents a registered physician from prescribing narcotics in the normal course of his practice for a legitimate medical purpose.[3] The Act has been amended many times since and is now the Controlled Substance Act, 21 U.S.C. §801 et seq. For over a hundred years, Congress has tried to eliminate drug addiction by making it illegal and increasing the regulation of physicians

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1 National Center for Health Statistics CDC Wonder database.

2 Webb v. U.S., 249 U.S. 96, 99 (1919), the Court considered the question of whether, "a practicing and registered physician issued an order for morphine to a habitual user thereof, the order not being issued by him in the course of professional treatment in the attempted cure of the habit, but being issued for the purpose of providing the user with morphine sufficient to keep him comfortable by maintaining his customary use, is such a physician's prescription under exception (b) of §2?" Id. at 99. The Webb Court found such a "prescription would be so plain a perversion of the meaning that no discussion of the subject is required." Id.

3 Linder v. U.S., 268 U.S. 5, 15 (1925).

E. J. Saad, Esq., 6207 Cottage Hill Rd, Suite G, Mobile, Alabama 36609. Telephone: Phone: 251-660-0888, Email: ejsaad@ejsaadlaw.com

who prescribe narcotics. This has been a long and frequently confusing journey for physicians and patients alike. However, the fundamentals of the law are not so complex. In order to stay within the bounds of federal law, a physician must follow five basic steps:

1. Be licensed to practice medicine in one or more States;
2. Be registered by the Drug Enforcement Administration to prescribe and administer controlled substances;
3. The physician must prescribe or dispense the controlled substance in the usual course of his or her medical practice;
4. Prescribe only for a legitimate medical purpose; and
5. Finally, the physician must properly keep records, including medical records.

See, United States v. Merrill, 513 F.3d 1293, 1301-02 (11th Cir. 2008). See, also, 21 U.S.C. §841.

The prescribing of controlled substances is further complicated by the practice of "off-label usage". The United States Supreme Court has recognized that physicians may legitimately prescribe a drug for a purpose different from that approved by the Food and Drug Administration, (FDA). See, Buckman Co. v. Plaintiffs' Legal Comm., 531 U.S. 341, 351 (2001). Under federal law, opioids can be prescribed for an off-label use that meets a legitimate medical purpose just like other drugs and medical devices. See, The Travelers Indemnity Co. v. Cephalon, Inc., 2015 U.S. App. LEXIS 13949 (3rd Cir. 2015). But, be aware that it is State law, not federal law, that controls and regulates the practice of medicine. Gonzales v. Oregon, 546 U.S. 243, 270-71 (2006). For instance, in some States, such as Tennessee, there are limits for the use of buprenorphine in treating addiction and its off-label use in treating pain. In Tennessee, if a physician, even with an X-Number, wants to prescribe more than 16 mg per day of buprenorphine for a patient, he or she must

meet requirements imposed by law rather than sound medical judgment. I could find no similar laws in Alabama.

So, given this legal terrain, how does a physician avoid running afoul of the Controlled Substances Act? Where is the line between appropriate prescribing of narcotics and being dubbed a "pill-mill"? On this point, I and any other lawyers would be on dangerous ground to tell you we know absolutely where the line is set. But I can tell you what I think is the best path to follow.

First, do the obvious: keep your State medical license and your DEA registration in good standing. Second, only prescribe controlled substances for patients you see in the usual course of your medical practice. When I was young, a family doctor might write a prescription in his office, at the patient's home or even in the parking lot at the local supermarket if need be. He could and would write prescriptions as his medical judgment deemed fit. Such informality is a thing of the past and is definitely not advisable when dealing with controlled substances today. You should write prescriptions for controlled substances only in the usual course of your professional medical practice. 21 U.S.C. §841. No prescriptions for controlled substances to friends, family or co-workers unless you are seeing them as a patient in your regular practice.

The Controlled Substances Law requires a legitimate medical purpose for every prescription. You should always keep proper medical records on patients, but especially on patients who receive controlled substances and the medical notes should include enough information to allow you to recall the medical reason for the prescription. 21 U.S.C. §841. A sound medical purpose that is well considered and well documented will be your best

E. J. Saad, Esq., 6207 Cottage Hill Rd, Suite G, Mobile, Alabama 36609. Telephone: Phone: 251-660-0888, Email: ejsaad@ejsaadlaw.com

protection if there is ever an inquiry. You don't have to be perfect, but it is important to be consistent. One undocumented prescription, even a few, can likely be explainable and be understood by the authorities. However, a pattern of irregular prescriptions for controlled substances will eventually be a problem – and one you don't need.

When narcotics are involved, the medical purpose can never be to satisfy the habitual use of a drug addict. Unless the physician has an X-Number, the medical purpose cannot even be to treat a patient's addiction. Only physicians with DATA-2000 waivers may legally use buprenorphine or any controlled substance to treat addiction or provide detoxification treatment or maintenance treatment for a patient. See, 21 U.S.C. §823 and 21 CFR 1306.04. Even with an X-number, however, a patient should only be prescribed controlled substances for legitimate and well-documented medical purposes. If the addicted patient is dealing with a documented cancer or post-operative pain, the legitimacy of the medical purpose will not likely be an issue. If the medical purpose is not that clear, from a legal standpoint, prescribing narcotics should only be done with careful and well-documented consideration of the medical need and the alternatives to narcotics. If you have doubts whether the patient's condition justifies a prescription for a narcotic, it probably does not.

With that said, let me also tell you that my review of the cases suggests that a physician, who tries to practice sound medicine, has little to fear. In all the criminal cases that I found involving physicians, based on the facts in the reported cases, there was no doubt that the accused physician had crossed the line of legal practice. As one judge stated, it is illegal to "cloak drug deals under the guise of a professional medical practice." See,

United States v. Alerre, 430 F.3d 681, 691 (4th Cir. 2005). All the cases I could find involved physicians who were knowingly writing prescriptions to patients under highly questionable or totally improper circumstances such as patients with assumed names, patients trading prescriptions for sex or other favors, or physicians writing excessive prescriptions to a single patient, (such as many patients of one doctor who received prescriptions for seven or eight narcotics to a single patient in a single visit). None of these cases were close calls. None left any doubt that the practitioner had strayed far outside accepted professional standards.

What this tells me is that law enforcement is not going after physicians who are legitimately practicing medicine. Rather, they are focused on the situation in which a prescriber is shamming the system for gain and violating the medical standards each of you uphold. My guess is that the people who are doing that know full well they are over the line. So long as you practice sound medicine, you can do so with confidence and without fear of unwarranted prosecution.

II. CREATING THE PATIENT RELATIONSHIP - THE PATIENT AGREEMENT.

Let's talk about the legal basis underpinning the relationship with your patient. This relationship is created and governed by the normal rules of contracts. Before you see a patient, your engagement should be set out in a written patient agreement that is signed by the patient. Whether your agreement is one-page or a more extensive document, if a problem arises, you will be glad to have a written agreement to protect you and your facility. A patient agreement should cover at least these areas:

1. Identify the Parties. The agreement must identify the parties, including your facility and it should include the verified name of the patient. Get a copy of his or her photo identification if possible. Make sure the patient is identified by his or her full name - no abbreviations, no nick names. Get contact information on the patient for notice purposes. Historically, the DEA and U.S. Attorneys look closely at whether the provider is knowingly prescribing controlled substances to fictitious patients. A patient agreement, with an identified and verified person, is your first proof that the patient is a real and is a legitimate patient.

2. The Patient Engages the Provider. The agreement should clearly state that the patient is engaging you and your facility to provide medical services in the treatment for addiction. It is important to clearly state that the patient is engaging you to provide medical care and judgment and there is no expectation that he or she will receive a prescription for medication. If your sound medical judgment results in prescriptions being needed, that's part of the service, but there is no quid pro quo - no promise or assurance that the patient will receive a prescription of any kind. This will be helpful when you encounter the patient who later wants to argue that he or she is entitled to a prescription when your medical judgment says otherwise. This is evidence of compliance with the Controlled Substances Act requirement that prescriptions are issued only for legitimate medical purposes. Set this out in the patient agreement so the patient knows the parameters of your relationship. Some of you may provide services on a fee-for-service basis or private-pay – if so, set that out clearly. If your office accepts third-party payments, you

may best address those payment terms in a separate agreement tailored to the particular types of third-party payment arrangement(s) you offer.

3. Set Out the Patient's Obligations. The patient agreement should include a section setting out the patient's obligations in the physician/patient relationship. This may include:

a. The patient's obligation to keep appointments and be on time. Discuss your cancelation policy or any charge for failure to appear.

b. The patient's obligation to give a complete and accurate history, including his or her medical history, social history, family history and history of drug use.

c. The patient should agree that you can have access to the patient's medical records from any other provider, whether in the past or in the future. The patient should consent for you to communicate with his or her other providers, including other physicians, hospitals or pharmacies. This is important because of the enhanced privacy law under the Drug Addiction Treatment Act of 2000. 21 U.S.C. §823 and associated regulations.

d. The patient's obligation to take any prescribed medication only as directed and to safeguard the medication from use by or dissemination to others. The patient agreement should state plainly that the patient's relationship with your facility will end if he or she diverts drugs obtained by your prescriptions to any use other than that prescribed.

e. The patient's commitment not to use any illegal drugs while in treatment. (Recognizing that there may be occasions when your patient fails in this obligation, but it is best that the patient knows you expect him or her to avoid other drugs as part of the relationship.)

f. If applicable to your facility's operation, the patient's obligation to submit to urine or blood testing and pill counts.

Such a list of patient's obligations demonstrates to the patient and, if needed, to investigators or regulators, that your patient is expected to cooperate in addiction treatment and avoid diversion of medications.

4. Explain the Confidentiality of Drug Abuse Patient Records. You should include a section in your patient agreement concerning the confidentiality of the patient's

identity and medical records. Federal law, 42 C.F.R. Part 2, sets out the federal rules governing patient confidentiality and release of medical records. These requirements overlap with and are in addition to the rules set by the Health Insurance Portability and Accountability Act, HIPPA. Upon admission to a Part 2 addiction program or as soon as the patient's mental status allows understanding, the patient must be informed of his or her rights to confidentiality. See, 42 C.F.R. 2.22. You may consider putting a statement in your patient agreement or giving a similar written notice to each patient as follows:

> "The confidentiality of alcohol and substance use disorder records maintained by this program is protected by federal law and regulations. Generally, the program may not say to a person outside the program that a patient is involved in the program or disclose any information identifying a patient as an alcohol or drug abuser unless:
>
> (1) The patient consents in writing;
>
> (2) The disclosure is allowed by a court order; or
>
> (3) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.
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> Violation of the federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations. Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against a person who works for the program or about a threat to commit such a crime. Federal laws and regulations do not protect any information contained in patient medical records about suspected child abuse or neglect from being reported or subpoenaed under State law for consideration by appropriate State or local authorities."

This is based on the requirements of 42 C.F.R. §2.22. Although it is not required by federal regulations, you might also want to inform the patient that your office may try to contact him or her by telephone, text or email and give the patient the opportunity to "opt-out" in

order to avoid unintentional breach of patient confidentiality to members of the patient's family that may not know of his or her involvement in treatment.

5. Provide for Arbitration of Disputes. I strongly recommend that your patient agreement include a requirement for arbitration of any dispute that arises between the patient and either the facility/medical office, a treating physician or any staff member, or all of these. Under the Federal Arbitration Act, arbitration agreements in patient agreements are valid, irrevocable and enforceable. See, 9 U.S.C. §2. Arbitration agreements assure privacy for your patient and for the physician, facility or clinic. Unlike court proceedings, arbitrations are not public. The matter is not handled in the courthouse. There usually is no lawsuit or public disclosure of the existence of a dispute. The documents associated with the arbitration are not made public and, if the matter is actually tried, it is by an arbitrator, rather than a jury. Because the process is private, the public is excluded, which includes the news media. This is particularly helpful since the patient's identity and treatment is confidential by federal law and a public trial would, of necessity, expose those facts to public scrutiny. In like manner, the privacy of the accused physician, facility or clinic is protected by arbitration. This can be helpful because, whether the result is for or against the provider, great harm can be done merely by the accusation.

There is also a benefit to arbitration because of the quality of the decision-makers. Arbitrators are almost always former judges or very experienced attorneys, who know the law and will apply it dispassionately. They are usually better able to understand complicated issues and, because they have seen many cases, they can usually sort out fact from fiction better than a typical jury.

In drafting the arbitration agreement, your lawyer will know to pay special attention to the selection of the arbitrator. The arbitrator must be neutral, unbiased and have no allegiance to any parties. The law allows the arbitrator to be selected by the parties or appointed by an identified third-party. Some lawyers include a provision that calls for an arbitrator from a private arbitration company such as the American Arbitration Association or "Triple A". Other lawyers call for the arbitrator to be named by the presiding judge of a designated county. This latter approach has gained more acceptance as a means of cost containment and speed of resolution. Arbitration is an important tool that should be included in your patient's agreement. If your patient does not want to sign a patient agreement with arbitration, you probably don't want that patient.

6. Set the Terms for Termination of the Patient Relationship. The patient agreement should contain provisions for ending the physician/patient relationship. The patient agreement can simply state that either party can end the relationship at any time. Most often, you will know the patient has ended the relationship because he or she simply does not return. But if the physician or facility seeks to end the relationship, it should be with a notice of the termination to the patient that is noted in the patient's medical records. By having the termination procedure in the patient agreement, the provider is in a better position to defend the decision.

7. Signing the Patient Agreement and Keeping a Copy. The patient agreement should be signed by the patient before the physician sees the patient on the first visit or at the time of admission if it is an in-patient facility. If the patient is a minor, the patient agreement should be signed by the patient's parent or guardian. It should also be signed by

a representative of the facility or medical office; especially if it contains an arbitration provision so as to fully invoke the arbitration requirement. The patient should be given an opportunity to read the patient agreement and to ask questions about its terms. I know some facilities in Tennessee that go so far as to have a short video presentation explaining the patient agreement and the typical events that occur during a patient visit. That seems to have proven helpful for them and you may find it a workable idea for your facility or office. When the patient leaves your office, he or she should have a copy of the patient agreement. The office should retain the signed agreement for its records. If there is a change in the terms of the patient agreement, or a later edition, have the returning patient sign a fresh agreement on his or her next visit and provide the patient a copy. The most recently signed agreement will control. With a properly constructed patient agreement in place, your relationship with the patient is on firm ground and you are ready to undertake treatment.

III. WHAT HAPPENS IF THE RELATIONSHIP SOURS - ENDING THE PATIENT RELATIONSHIP.

We have thus far discussed what happens when the doctor/patient relationship proceeds without difficulty and is beneficial to both the patient and doctor. But, inevitably there will be patients that strain the limits of the relationship to the breaking point. There will likely be times when the physician, facility or office must end the doctor/patient relationship. Of course, the patient may end the relationship without notice by simply not returning to the facility or office; assuming that his or her participation is voluntary and not court ordered. If the patient ends the relationship, there is no issue of abandonment of care

by the physician, facility or office. When the physician, facility or office elects to end the patient relationship, the medical provider must be careful to do so in a manner that does not improperly cause harm to the patient. Abandonment may occur in many circumstances, but here we will concern ourselves with ending an office treatment relationship without committing the civil wrong of "abandonment of a patient." A provider abandons a patient when the provider ends the relationship with the patient without giving the patient notice and opportunity to procure the services of another provider. Generally, the notice to the patient may be given verbally or in writing and it should be copied into the patient's record. There must be a period of time during which the patient's medical needs are served in order to allow him or her to engage an alternative provider. If the patient is receiving medication, that period should be at least 30 days during which the medication is prescribed and the patient is directed to seek another provider. The grounds for discharging the patient need not be stated, but it is helpful to make a note of the reason that termination was deemed appropriate. If the patient agreement contains a provision for termination of the relationship, it should be followed. In most situations, ending the relationship can be accomplished without further complications. If a problem develops or if you anticipate that termination of a patient relationship will raise legal problems, consult your lawyer; preferably before ending the relationship. If the problem turns into a dispute, you will be in a better position if there is an arbitration agreement so the dispute can be decided privately and on the merits.

IV. PATIENT PRIVACY - PRODUCTION OF MEDICAL RECORDS TO THIRD-PARTIES.

Patient confidentiality is extraordinarily tight under DATA 2000 and associated federal regulations of 42 CFR Part 2. Federal case law generally holds that there is no private cause of action under federal law for a mistaken release of records. See, Ellison v. Cocke County, 63 F.3d 467, 471-72 (6th Cir. 1995), Waldrep v. Albright, 2014 U.S. Dist. LEXIS 131789 (N.D. Ala. 2014). However, some States, including Alabama, allow a private cause of action for the unauthorized release of medical records by a medical provider. See, Hollander v. Nichols, 19 So.3d 184, 190 (Ala. 2009). While there is no case so far, it may be that the increased obligations of confidentiality imposed by 42 C.F.R. Part 2 could raise additional concerns for addiction practitioners, facilities and offices. I can give you an overview, but you would be well advised to speak with your organization's attorney about these regulations and consult anytime there is any doubt about how to proceed in responding to requests or orders requiring disclosure of patient medical records.

The patient is permitted access to his or her own medical records and is entitled to a copy on request. See, 42 C.F.R. §2.23. Patient records may also be disclosed to outside medical personnel if necessary to meet a bona fide medical emergency when the patient's consent cannot be obtained. If this happens, the disclosure must be noted in the patient's medical records setting out a summary of the release, including to whom the records were released and why. See, 42 C.F.R. §4.51. Patient's medical records may also be disclosed to individuals within the criminal justice system in order to monitor the patient's progress or compliance; for instance, parole officers, child welfare officers, judges and the like. See, 42 C.F.R. §2.35. These disclosures may be made with or without the patient's consent.

Under federal regulations, a patient may consent to release of medical records by signing a written authorization that contains the following:

a. the name of the patient;

b. the specific name or general description of your facility or medical office, (For instance, the XYZ Medical Office, PC might be described generally as "XYZ Medical", so long as the facility's identification is generally descriptive enough to identify the organization it will suffice.);

c. a description of the kind of information to be disclosed, including an explicit description of the substance-use disorder information that may be disclosed;

d. the name(s) of the individual(s), organization or entity to whom the disclosure is to be made;

e. the purpose of the disclosure;

f. a statement that the consent is subject to revocation at any time except to the extent that the part 2 facility or other lawful holder of the patient's indentifying information has already acted in reliance on the authorization at the time of revocation (if you have already released the records prior to revocation, your actions are "grandfathered" under the authorization;

g. the date, event or condition upon which the consent will expire, which must be no longer than is reasonably necessary to serve the purpose for which it is provided (Open ended authorizations are not valid. Usually one-year is the longest period a release may be open.);

h. the signature of the patient or, if the patient is a minor, the signature of his or her parent or legal guardian; and

i. the date of signing.

42 C.F.R. §2.31. With each release of records, whether by consent or court order, federal regulation, 42 C.F.R. §2.32(a), requires a written Notice to the recipient, which states:

WARNING NOTICE REQUIRED BY FEDERAL LAW

> The following warning notice is required by 42 C.F.R. §2.32. There are potential criminal punishments for violation. "This information has been

> disclosed to you from records protected by federal confidentiality rules (42 C.F.R. part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 C.F.R. part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65."

42 C.F.R. §2.32. Fortunately, a recent amendment to 42 C.F.R. §2.32 would simplify this warning notice to "42 CFR Part 2 prohibits unauthorized disclosure of these records." If patient records are delivered by mail, express delivery, or by hand, it is advised that the records be sent in a sealed envelope, addressed to the recipient organization but with no information on the outside that could identify the patient or associate him or her with a substance-abuse program. See, 42 C.F.R. §2.12. I suggest that the responding organization make a permanent note in the patient's records memorializing the facts of the medical record release, logging a copy of the authorization and a statement that a Section 2.32 warning notice was included with the disclosure. Some organizations elect to voluntarily maintain a centralized medical records release log for the benefit of the organization in order to confirm compliance with federal confidentiality requirements.

While many requests for medical records will be fairly straightforward, with patient authorization and to a fellow medical provider, your organization will and probably already has faced more murky requests, as in cases of litigation or various requests presented from third-parties as being with the patient's consent. For instance, your organization likely

receives requests for medical records, with patient's consent, from workers compensation providers, attorney's offices, social security evaluators, insurance companies issuing policies of life or health insurance and even, in rare cases, from prospective or current employers. You likely also have or will receive subpoenas or orders to disclose medical records in various court proceedings. You are also permitted to release patient records or to allow viewing of these records by members of the Food and Drug Administration, (FDA), the Drug Enforcement Agency, (DEA), Medicare, Medicaid, or other Federal, State or local government agencies for regulatory or payment purposes. 42 C.F.R. §2.53. None of these requests are prohibited by federal law with the patient's consent. See, 42 C.F.R. §2.33. The intricacies of medical records in a Part 2 organization is enough to challenge even a lawyer working with these issues daily. The vast majority of requests, subpoenas or court orders for release of records will be in compliance with federal regulations. But, if you have any doubts, check with your attorney - let his or her advice be your guide and keep a copy of it in your records to show you were acting on advice of counsel.

V. PATIENTS' AND PROVIDERS' RIGHTS UNDER THE AMERICANS WITH DISABILITIES ACT.

It has been my experience as a lawyer that discrimination is not uncommon against drug addiction patients and the medical facilities that treat them. Cities and counties, frequently under pressure from local citizens, refuse business licenses, impose zoning requirements to block the opening of clinics, allow or even order their police departments to harass the patients, both coming and going. I have even seen situations in which physicians were pulled over by police, harassed and urged not to return. Discrimination

can be just as prevalent in the private sector - landlords that won't lease to drug addiction clinics or harass the clinic once open or threaten termination of the lease because of dislike for the patients. Perhaps you have heard patients complain of some misguided pharmacists who refuse service or belittle patients in front of other customers for seeking to fill a Suboxone prescription. These are just some examples of the widespread discrimination against patients and providers involved in the treatment of drug addiction, and every one of them is a violation of federal law.

Drug addiction is considered an impairment under the Americans with Disabilities Act, (ADA). Individuals in treatment for or recovering from drug addiction are considered disabled and protected under the ADA. See, Caron Found of Fla., Inc. v. City of Delray Beach, 879 F. Supp 2d 1353 (S.D. Fla. 2012). Federal law forbids discrimination against a drug addict who is in treatment for his or her addiction and it also protects the medical providers involved in treatment. This is a civil rights matter of high priority to the federal courts based on Congress' recognition that persons in treatment for drug addiction face discrimination and are entitled to protection under the ADA. Statutory protection against such discrimination is specifically provided by the Americans with Disabilities Act (42 U.S.C. §12101 et seq) or ADA and the Rehabilitation Act of 1973, (29 U.S.C. §701 et seq). The Americans with Disabilities Act states:

> (a) General Rule. No individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation.

42 U.S.C. §12182. This language is similar to the Rehabilitation Act of 1973, which prohibits discrimination against persons with disabilities by entities that receive federal funds, which include any city, county and state that accept federal funds - and virtually all of them accept federal funds. 29 U.S.C. §794(a).

Federal law takes particular notice of the discrimination that is exercised by cities, counties and other governmental agencies against medical providers who treat drug addiction. In a Kentucky case, a methadone clinic sued when the City of Covington passed zoning ordinances that made it virtually impossible for MX Group to open a facility anywhere in the city. See, MX Group, Inc. City of Covington, 293 F.3d 326 (6th Cir. 2002). The Court noted that medical providers have the right to sue for themselves and on behalf of their patients to prevent discrimination in violation of both the Rehabilitation Act and the ADA. Id. at 355. Federal protection is extended to residential facilities, out-patient facilities, physicians, employees and patients alike to shield them from discrimination in zoning and unfounded police activities.

In the private sector, both providers and patients frequently encounter discrimination by actual or potential landlords. Where a person owns, leases (or leases to), or operates a place of public accommodation, that person is forbidden from discriminating against any individual on the basis of a disability. 42 U.S.C. §12182. Some "places of public accommodation" specifically defined by Congress include commercial facilities, retail establishments, shopping centers, pharmacies, professional offices of a health care provider, hospitals or other similar service establishments and lawyers' offices. There are many more places described in the law, and each is a place of public accommodation, with

E. J. Saad, Esq., 6207 Cottage Hill Rd, Suite G, Mobile, Alabama 36609. Telephone: Phone: 251-660-0888, Email: ejsaad@ejsaadlaw.com

duties not to discriminate. See, 42 U.S.C. §12181. Under the law, a landlord of commercial space, who refuses to rent space to an addiction-treatment facility because of the clientele, is subject to injunctive relief or even damages under the ADA.

I believe the same is true of a pharmacy that refuses to fill prescriptions for an addict-in-treatment based on a discriminatory bias against Medically Assisted Drug Treatment (MADT). However, the question is more complicated with pharmacies because of provisions in the Controlled Substance Act that place responsibility on pharmacists to avoid filling potentially illegal prescriptions. When the pharmacy's employees or the pharmacist personally goes so far as to harass patients, it is pretty clear the line is crossed and ADA action is justified. Additionally, I have seen cases in which a pharmacy actually informed the patient that it would not fill prescriptions for an out-patient treatment facility but would fill the same medication from a different specified physician. Assuming that the out-patient facility was following recognized standards of practice, this type of action might well be actionable as either impermissible discrimination or some other civil wrong. I have used these laws to reason with pharmacies, city councils and police departments and, fortunately, in each case we have been able to reach accommodations without the need to litigate - only with the possibility of litigation and the federal law as inducement. I do not encourage litigation, but I think and hope that you will be mindful that you, as physicians treating addicted patients, have the federally protect right not to be discriminated against or harassed and your patients also have the right to be free of such discrimination.

VI. CONCLUSION.

E. J. Saad, Esq., 6207 Cottage Hill Rd, Suite G, Mobile, Alabama 36609. Telephone: Phone: 251-660-0888, Email: ejsaad@ejsaadlaw.com

I hope this makes you a bit more comfortable with some of the issues you face in the field of addiction medicine. I have this last bit of advice: Recognize that the law is an integral part of any practice involving the treatment of addicted patients. Your best course is to practice medicine without undue concern. If you have a question – before there is a problem – call your lawyer. Do an annual review of your documents to make sure you are following changes in the law. Consider your attorney to be an asset in building and protecting your practice.

E. J. Saad, Esq., 6207 Cottage Hill Rd, Suite G, Mobile, Alabama 36609. Telephone: Phone: 251-660-0888, Email: ejsaad@ejsaadlaw.com