Criminal Law -- Controlled Substances -- North Carolina Adopts a Novel View of Physician Punishment Under Controlled Substances Act

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economic efficiency. An employer or union that successfully defends its labor practices against unreasonable attack confers a substantial benefit on commerce and vindicates the strong Congressional policy of efficient employment of labor.

Denying prevailing Title VII defendants the benefit of section 706(k), except when subjected to suits brought in bad faith, is inappropriate. The "reasonableness" standard, which would exclude all suits brought in bad faith or upon unreasonable or meritless (though perhaps colorable) grounds, more properly implements the policies of Title VII, and reflects more accurately the equities of Title VII litigation. 89

SAUL LOUIS MOSKOWITZ

Criminal Law—Controlled Substances—North Carolina Adopts a Novel View of Physician Punishment Under Controlled Substances Act

One of the major concerns of state and federal legislation in the past decade has been the illicit diversion of controlled substances from legitimate channels of distribution. 1 While courts interpreting this legislation generally

89. The reasonableness of a Title VII suit should, of course, be resolved by the trial court by reference to the policies underlying Title VII and the equities of each case. Some factual considerations are of particular relevance. The court should determine to what extent the EEOC procedures were used to obtain settlement of the claim. A prior EEOC finding of no reasonable cause, though not dispositive of the reasonableness issue, should be accorded heavy weight, if based upon extensive investigation. Similarly, a conciliation agreement that was refused by the plaintiff-complainant, if fair and reached by the EEOC and defendant in good faith, should operate to thrust upon the plaintiff a greater risk of an adverse § 706(k) award. The court can thereby promote the full and effective involvement of the EEOC in Title VII disputes. Substantial abuse of the EEOC or court processes, including "bad faith" suits, seems to be patently unreasonable. Abuse of less egregious sorts can be balanced along with other considerations. Other considerations should be given weight. For example, did defendant prevail on the merits or on procedural grounds? An award of attorneys' fees for prevailing on procedural grounds does not further the policy of efficient allocation of labor for no labor practices have been approved.

In weighing relevant factors, the benefits foreseeably flowing from a successful complaint should be weighed according to the probability that success would have been realized. In the instant case, the probability of success by the EEOC was low, because the argument that its power to sue eo nomine was retroactive to 1965 was untenable in view of the wording of § 14. See note 5 supra. If interpretation of that section had not been an issue of first impression, but had been previously construed in a manner hostile to the EEOC position, the probability of success would have been even lower. The probability of success turns, then, on what strength the case of both parties could reasonably have been said to have at the outset of the litigation.

have concluded that physicians who dispense drugs for invalid purposes are subject to the same penalties as ordinary street traffickers, the North Carolina Supreme Court recently gave a different interpretation to North Carolina’s statutory scheme. In *State v. Best,* a case in which a physician was accused of the illegal sale and delivery of controlled substances, the court ruled that a dual system of punishment, based on the status of the offender, exists in North Carolina.

Dr. Best’s arrest resulted from a statewide crackdown on physicians conducted by a small investigative squad specifically constituted to probe the diversion of prescription drugs. He had prescribed Ritalin, a Schedule II controlled substance, on three separate occasions to an agent who claimed that she worked nights and "needed something to stay awake."

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2. 292 N.C. 294, 233 S.E.2d 544 (1977). The indictments charged that "on or about the 19th day of March, 1975, in Pitt County Andrew Arthur Best unlawfully and wilfully did feloniously sell and deliver a controlled substance . . . not within the normal course of his professional practice . . . ." Record at 13-14, State v. Best, 31 N.C. App. 250, 229 S.E.2d 581 (1976). In addition to the charges discussed here, defendant was accused of selling a Schedule II substance to two other State Bureau of Investigation agents on March 18, 1975 and March 6, 1975. Defendant was acquitted on these latter charges. 292 N.C. at 301, 233 S.E.2d at 549.

3. A "controlled substance" is a drug or other substance described in Schedules I through VI of the Controlled Substances Act. It does not include distilled spirits, wine or tobacco. 21 U.S.C. § 802(6) (1970); N.C. GEN. STAT. § 90-87(5) (1975); see notes 6, 8 & 82 infra. The North Carolina Controlled Substances Act was amended seven times during the most recent legislative session. For a comprehensive list of those amendments, see note 35 infra. Amendments are cited elsewhere only when pertinent to the statutory language under discussion.

4. Police stated that the charges against Dr. Best resulted from a four month undercover operation by local officers and State Bureau of Investigation agents. Raleigh, N.C., News and Observer, Mar. 27, 1975, § A, at 1, col. 6.

5. North Carolina is one of the first states to concentrate enforcement efforts against medical professionals who engage in the indiscriminate dispensing or issuing of prescriptions for controlled substances. For a discussion of this program, see Davis, *Drug Abuse Control: Prescribing Controlled Substance Drugs,* 6 CUM. L. REV. 331 (1975); Weir, *Legitimate Drugs: A Coordinated Effort to Prevent their Diversion into the Black Market,* 4 CONTEMP. DRUG PROb. 483, 485 (1975).

6. A Schedule II controlled substance is one characterized by "a high potential for abuse; currently accepted medical use in the United States, or currently accepted medical use with severe restrictions; and the abuse of the substance may lead to severe psychic or physical dependence." N.C. GEN. STAT. § 90-90 (1975 & Supp. 1975). Examples are methadone, morphine, cocaine and amphetamines. Unless dispensed directly by a practitioner other than a pharmacist to an ultimate user, these substances may be dispensed only on written prescription except in certain emergency situations in which case an oral prescription must be reduced promptly to writing. 21 U.S.C. § 829(a) (1970); N.C. GEN. STAT. § 90-106(a), (b) (1975), as amended by Law of June 22, 1977, ch. 677, § 3(8), 1977 N.C. Adv. Legis. Serv. 267 (Pamphlet No. 10, Pt. 1).

7. 292 N.C. at 295, 233 S.E.2d at 546. On her first visit to Dr. Best’s office, the agent gave a medical history and the receptionist weighed her and took her temperature and blood pressure. Dr. Best, after conversing with the agent, issued the prescription for 36 pills. The agent saw Dr. Best briefly on her second visit; she testified that she did not see him on her third visit. Dr. Best testified that he did talk with her on her third visit and that he told her "she could not stay on this medication forever." Id. at 299, 233 S.E.2d at 548. Each refill also was for 36 pills.
also dispensed Phenobarbital, a Schedule IV controlled substance,\(^8\) to her when she complained of nervousness. The State maintained that such activities were outside the usual course of a doctor’s professional practice in this state and were not for a legitimate medical purpose.\(^9\) Dr. Best insisted that he had used proper diagnostic procedures and was prescribing small, carefully monitored quantities of Ritalin to treat intermittent narcolepsy.\(^10\) Dr. Best also claimed that he dispensed the Phenobarbital to combat side effects from the Ritalin after the agent told him that she had stopped taking the stimulant drug.\(^11\)

Dr. Best was convicted of two counts of sale and delivery of Ritalin.\(^12\) The court of appeals upheld the convictions.\(^13\) The North Carolina Supreme Court reversed on the ground that Dr. Best had been charged under North Carolina General Statutes section 90-95(a)(1)\(^14\) for the felonious “sale and delivery” of a controlled substance while he should have been indicted under section 90-108 for “distributing or dispensing” the drug.\(^15\) The court

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8. A Schedule IV controlled substance is one with “a low potential for abuse relative to the substances listed in Schedule III of this Article; currently accepted medical use in the United States; and limited physical or psychological dependence relative to the substances listed in Schedule III of this Article.” N.C. GEN. STAT. § 90-92 (Supp. 1975). An example is tranquilizers. Except when dispensed directly by a practitioner to an ultimate user, Schedule IV drugs must be dispensed by a prescription and oral prescriptions shall be reduced promptly to writing. Limits are placed on the time and number of refills allowed. 21 U.S.C. § 829(b) (1970); N.C. GEN. STAT. § 90-106(c) (1975).

9. See 292 N.C. at 302, 233 S.E.2d at 549.

10. Id. at 299, 233 S.E.2d at 548. Narcolepsy is a sleeping disorder and is one of the conditions for which Ritalin has a legitimate use. Id. at 298, 233 S.E.2d at 547. Dr. Best testified that he issued the two refills because his receptionist said that the agent had not reported any side effects from the medication. Id. at 299, 233 S.E.2d at 548.

11. Id. at 299, 233 S.E.2d at 548.

12. The convictions were for the two refill prescriptions. Id. at 301, 233 S.E.2d at 549.

13. 31 N.C. App. 250, 229 S.E.2d 581 (1976). The court of appeals dismissed Dr. Best’s argument that the North Carolina Controlled Substances Act, N.C. GEN. STAT. §§ 90-86 to -113.8 (1975 & Supp. 1975), was so imprecise as to be unconstitutionally vague. He had argued that the standard applied to him under id. § 90-87(22)(a) (1975), “within the normal course of professional practice,” did not give adequate guidance to enable a physician to know when his activities were outside the standard and therefore illegal prescriptions under the Act. The court found the phrase not unacceptably vague because it gives the practitioner fair notice of the standard he must follow to legally prescribe controlled substances under the statute. Id. at 264, 229 S.E.2d at 589. This conclusion follows that of the federal courts interpreting the similar federal statute, e.g., United States v. Rosenberg, 515 F.2d 190 (9th Cir.), cert. denied, 423 U.S. 1031 (1975); United States v. Collier, 478 F.2d 268 (5th Cir. 1973).


15. N.C. GEN. STAT. § 90-108(a)(2) (1975) states that “[i]t shall be unlawful for any person who is . . . a practitioner to distribute or dispense a controlled substance in violation of G.S.
explained that because a physician is authorized to write prescriptions for controlled substances, he is not subject to the constraints of section 90-95(a)(1). If he writes a prescription "outside the normal course of professional practice in North Carolina and not for a legitimate medical purpose," however, the physician violates section 90-108. The court concluded that "while the indictments follow the language of G.S. 90-95(a)(1), the evidence discloses a violation, if at all, of G.S. 90-108" and that because of this "fatal variance," the court of appeals erred in not dismissing the action.

The North Carolina Controlled Substances Act is patterned after federal legislation that originated with the Harrison Act in 1914. The federal statute, initially designed as a tax measure, had a primary purpose of bringing "the domestic traffic in narcotics into the open under a licensing system, so that sloppy dispensing practices of the day could be checked." The Harrison Act provided an explicit statutory exemption for the physician who prescribed or dispensed narcotics "to a patient . . . in the course of his professional practice only." As abuses in the drug area increased, Congress passed numerous laws dealing with various aspects of the problem. Finally, in 1970, in an effort to coordinate the plethora of drug legislation

90-105 or 90-106." Id. § 90-105 states that "[c]ontrolled substances included in Schedules I and II of this Article shall be distributed only by a registrant or practitioner, pursuant to an order form." Id. § 90-106 (1975 & Supp. 1975), as amended by Law of June 22, 1977, ch. 667, § 3(8), 1977 N.C. Adv. Legis. Serv. 267 (Pamphlet No. 10, Pt. 1), sets forth the prescription and labeling requirements for the various schedules of controlled substances. See, e.g., notes 6 & 8 supra.

16. 292 N.C. at 310, 233 S.E.2d at 554.
17. Id.
18. Id.
19. Id. at 311, 233 S.E.2d at 554.
20. The Narcotic Drug Act of Dec. 17, 1914, ch. 1, 38 Stat. 785. This was the first significant legislative attempt to control drugs and drug traffic.
23. The Narcotic Drug Act of Dec. 17, 1914, ch. 1, § 2(a), 38 Stat. 786. This phrase has since been interpreted to mean that the physician who dispenses the narcotic drugs mentioned in the Act is protected from prosecution under the Act only when he does not depart from the usual course of medical practice. See Jin Fuey Moy v. United States, 254 U.S. 189, 194 (1920). Note 13 supra discusses North Carolina's comparable phraseology. In United States v. Moore, 423 U.S. 122 (1975), the Supreme Court cited Jin Fuey Moy and its progeny as proof that the Harrison Act, predecessor of the Controlled Substances Act, 21 U.S.C.A. §§ 801-996 (West 1972 & Cum. Supp. 1977), contemplated conviction of physicians who acted outside the usual course of medical practice under the same terms as applied to nonmedical traffickers. 423 U.S. at 132. The Moore Court added that there was no indication that Congress, in passing the 1970 Act, intended to change this treatment of doctors. Id. at 131-33, 139.
and to devise a more flexible penalty structure that would strengthen law enforcement, Congress passed the Controlled Substances Act (the Act). In prosecutions under the Act, the overwhelming majority of federal courts that have considered the matter have upheld convictions of physicians for violations under the general provision of the Act, which makes it unlawful for "any person knowingly or intentionally to manufacture, distribute, or dispense . . . a controlled substance." Technical violations, such as improper use of drug order forms or failure to employ a written prescription when required, were punished under separate portions of the Act. The courts based their interpretation on the overall legislative purpose of the Controlled Substances Act to strengthen enforcement and on the notion that doctors who are also traffickers should be subject to the same penalties as other drug offenders.

25. 21 U.S.C. §§ 801-996 (West 1972 & Cum. Supp. 1977); see House Report, supra note 1, at 1, reprinted in [1970] U.S. Code Cong. & Ad. News at 4566. Harrison Act prosecutions were based on the nature of the drug involved and a single penalty applied to all narcotic drugs. In revising the penalty structure, Congress classified controlled substances into five categories based on their potential for abuse, value for treatment and resulting psychological and physical effects. Provisions were made for adding or removing drugs from the five schedules as new medical evidence suggests. Thus, the legislative history of the Act shows that Congress has continued to be concerned with the nature of the drug in the transaction rather than with the status of the defendant. United States v. Moore, 423 U.S. 122, 133-34 (1975).


27. 21 U.S.C. § 841(a)(1) (1970) (emphasis added). The section more fully states that "[e]xcept as authorized by this subchapter, it shall be unlawful for any person knowingly or intentionally to manufacture, distribute, or dispense, or possess with intent to manufacture, distribute, or dispense, a controlled substance." Compare North Carolina's version quoted in note 14 supra.

Some of the factors that courts have considered relevant to convictions of physicians under § 841 include lack of a physical examination before prescribing a controlled substance, knowledge by the doctor that his patients are prone to trade or otherwise dispose of the drugs, use of slang terms for the drugs by patients and/or doctor, telling patients to get their prescriptions filled at different stores to prevent suspicion by the Bureau of Narcotics and Dangerous Drugs, billing patients based on the quantity of drugs prescribed rather than on the medical services performed, lack of supervision of administration of the drug, no precautions against misuse or diversion, no known health complaints by patients and actual increases in drug usage by patients while under the doctor's care. See United States v. Moore, 423 U.S. 122 (1975); United States v. Rosenberg, 515 F.2d 190 (9th Cir.), cert. denied, 423 U.S. 1031 (1975); United States v. Bartee, 479 F.2d 484 (10th Cir. 1973). State courts, construing their own versions of the Federal Controlled Substances Act, have applied the equivalent of § 841 to doctors. E.g., State v. Vinson, 298 So. 2d 505 (Fla. Dist. Ct. App. 1974); Anderson v. State, 231 Ga. 243, 201 S.E.2d 147 (1973).

28. E.g., 21 U.S.C. § 842(a)(1) (1970) provides "[i]t shall be unlawful for any person who is subject to the requirements of part C to distribute or dispense a controlled substance in violation of section 829 of this title." Persons, including doctors, who are required to register in order to dispense controlled substances are subject to the requirements of part C. 21 U.S.C. § 829 (1970) outlines the proper procedure for issuing prescriptions. See notes 6 & 8 supra.

In *United States v. Moore*, the United States Supreme Court unanimously endorsed the view that physicians could be prosecuted under the main felony provision of the Act. Stating that the legislative history of the Act showed a Congressional concern with the nature of the drug transaction rather than with the status of the defendant, the Court held that the relevant inquiry was whether the activity itself fell within legitimate channels. The Court noted that Congress expressed a particular concern because physicians have the greatest access to controlled substances and had been responsible for a large part of the illegal drug traffic. It concluded,

We think it immaterial whether Dr. Moore also could have been prosecuted for his violation of the statutory provisions relating to dispensing procedures. There is nothing in the statutory scheme or legislative history that justifies a conclusion that a registrant who may be prosecuted for the relatively minor offense of violating § 829 [prescription requirements] is thereby exempted from prosecution under § 841 for the significantly greater offense of acting as a drug “pusher.”

The same concerns that led Congress to pass comprehensive federal drug legislation prompted many states, including North Carolina, to pass their own versions of the Act. The model for state legislation was the

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30. 423 U.S. 122 (1975), rev'g 505 F.2d 426 (D.C. Cir. 1974).  
31. Before its reversal, the District of Columbia Circuit was the sole court of appeals applying a lesser standard of punishment for a physician under the federal act. Dr. Moore was charged in multiple counts with the unlawful distribution and dispensing of methadone, a Schedule II substance, without obtaining the special authorization required for conducting a maintenance program. 423 U.S. at 124. Among the most damaging testimony was that the doctor's fees were based on the quantity of the drug prescribed rather than medical services rendered and the fact that several patients dramatically increased their usage of drugs while under his care. The doctor also felt the necessity of having armed guards at the entrance to his office and kept a revolver on his desk. The court of appeals based its decision on the overall statutory framework of the law to “strongly suggest” that “Congress intended to deal with registrants primarily through a system of administrative controls, relying on modest penalty provisions to enforce those controls, and reserving the severe penalties provided for in § 841 for those seeking to avoid regulation entirely by not registering.” 505 F.2d at 430. For a discussion of this case, see Recent Developments, *supra* note 21.  
32. 423 U.S. at 135.  
33. *Id.*  
34. *Id.* at 138; accord, United States v. Liddy, 542 F.2d 76 (D.C. Cir. 1976) (defendant does not have constitutional right to demand prosecution exclusively under the statute prescribing lesser penalties); see, e.g., notes 6 & 8 *supra*.  
Uniform Controlled Substances Act, a set of provisions with the stated purpose of supplying "an interlocking trellis of Federal and State law to enable government at all levels to control more effectively the drug abuse problem." North Carolina's Controlled Substances Act, passed in 1971, retains the primary attributes of the federal and uniform statutes.

With the exception of the Best opinion, all federal and state courts that have considered the position of physicians in statutory schemes covering drug offenses have found United States v. Moore dispositive of the matter. In justifying its contrary position, the North Carolina Supreme Court asserted that "several aspects of the North Carolina Controlled Substances Act differ from both the Uniform Controlled Substances Act and the Federal Controlled Substances Act and lend credence to the view which we have taken." Thus, an examination of the differences among the acts and their

37. Id., Prefatory Note.
41. 292 N.C. at 308, 233 S.E.2d at 553. In explaining its interpretation of the North Carolina Act, the court said:

In skeletal form the present system of control over physicians operates as follows: (1) All transactions with controlled substances are prohibited by G.S. 90-95 except as authorized. (2) Under G.S. 90-101 a physician who meets established objective criteria is authorized to make certain transactions with controlled substances and thus is exempted from the proscriptions of G.S. 90-95.

significance to North Carolina's regulatory scheme is essential to an understanding of the court's holding in *State v. Best*.

In *Best*, the North Carolina Supreme Court placed great emphasis on a 1973 amendment to section 90-95 that changed the wording of the prohibited activity from "manufacture, distribute or dispense" to "manufacture, sell or deliver." From this action the court concluded:

> By the use of "sell or deliver"—words of the street—rather than "distribute or dispense"—which have technical medical connotations and which are used extensively in those sections relating to regulation of registrants and practitioners—the Legislature intended to clarify and emphasize the dual nature of the regulatory scheme.

The new statutory language on which the North Carolina Supreme Court relies has also been subject to interpretation by other courts. In discussing whether a physician can properly be charged with the "sale" of a controlled substance, the United States Supreme Court has maintained that there is "no necessary repugnance between prescribing and selling." In reaching that conclusion, the Court relied heavily on the concept of the physician as a principal who aids the patient in procuring an item that would not otherwise be available to him.

The North Carolina Criminal Code contains a section comparable to the federal statute regarding aiding and abetting. This section, it would seem, provides an analogous statutory

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41. See 292 N.C. at 303-04, 233 S.E.2d at 550.
42. Id. at 309-10, 233 S.E.2d at 554.
43. Jin Fuey Moy v. United States, 254 U.S. 189, 192 (1920). Defendant argued that the act of selling or giving away a drug and the act of issuing a prescription are so essentially different that to allege he sold the drug by prescribing it amounts to a contradiction of terms and this repugnance renders the indictment fatally defective. The Court, dismissing the argument, explained that "one may take a principal part in a prohibited sale of an opium derivative . . . by unlawfully issuing a prescription to the would-be purchaser." Id.
45. Compare 18 U.S.C. § 2(a) (1970) with N.C. GEN. STAT. § 14-5 (1971), which states that "[i]f any person shall counsel, procure or command any other person to commit any felony . . . the person so counseling, procuring or commanding shall be guilty of a felony . . . ."
One of the many cases interpreting this statute provides that "[a]ll who are present," either actively or constructively, "at the place of a crime and are either aiding, abetting, assisting, or advising in its commission, or are present for such purpose," are principals in the crime. State v. Dawson, 281 N.C. 645, 655, 190 S.E.2d 196, 202 (1972); accord, State v. Ball, 270 N.C. 25, 153 S.E.2d 741 (1967); State v. Spears, 268 N.C. 303, 150 S.E.2d 499 (1966); State v. Jarrell, 141 N.C. 722, 53 S.E. 127 (1906); State v. Gaston, 73 N.C. 93 (1875); State v. Torain, 20 N.C. App. 69, 200 S.E.2d 665 (1973), cert. denied, 284 N.C. 622 (1974).
framework within which to interpret the Act. The North Carolina Supreme Court, however, in arriving at a different conclusion from the United States Supreme Court, provided no explanation for the variation in interpretations.

Similar problems in statutory interpretation arise in concluding that a physician cannot be properly indicted for the "delivery" of a controlled substance. In drafting the Uniform Act's primary felony section, the Commissioners deliberately chose the term "deliver" because it encompasses both distributing and dispensing activities. Thus, it is reasonable to conclude that the North Carolina General Assembly did not merely substitute a street term for a medical one, but that it chose the most comprehensive word to describe a physician's activity in providing controlled substances to others. Generally, the correct method of statutory interpretation is that enunciated by the North Carolina Supreme Court: "In the construction of any statute . . . words must be given their common and ordinary meaning, nothing else appearing. . . . [W]hen the statute itself, contains a definition of a word used therein, that definition controls, however contrary to the ordinary meaning of the word it may be." Therefore, the "street" connotation of "deliver" must be discarded in favor of the Act's definition, which is "the actual, constructive, or attempted transfer from one person to another of a controlled substance, whether or not there is an agency relationship." "Constructive delivery" has been held to include the issuing of a

46. Uniform Controlled Substances Act § 401, Commissioner's Note. Since the passage of the Federal Act in 1970, a battle has raged in the courts over whether a physician "distributes" or "dispenses" a drug. Courts holding that the proper term is "dispense" include United States v. Green, 511 F.2d 1062 (7th Cir.), cert. denied, 423 U.S. 1031 (1975); United States v. Leigh, 487 F.2d 206 (5th Cir. 1973); United States v. Bartee, 479 F.2d 484 (10th Cir. 1973). See also United States v. Hicks, 529 F.2d 841 (5th Cir.), cert. denied, 429 U.S. 856 (1976). Those maintaining that "distribute" is the correct term are United States v. Eillezey, 527 F.2d 1306 (6th Cir. 1976) (per curiam); United States v. Rosenberg, 515 F.2d 190 (9th Cir.), cert. denied, 423 U.S. 1031 (1976); United States v. Badia, 490 F.2d 296 (5th Cir. 1973) (per curiam); United States v. Collier, 478 F.2d 268 (5th Cir. 1973). Helpful discussions of this distinction may be found in United States v. Fellman, 549 F.2d 181, 182 (10th Cir. 1977) (per curiam); Commonwealth v. Comins, — Mass. —, 356 N.E.2d 241 (1976), cert. denied, 97 S. Ct. 1582 (1977); People v. Alford, 73 Mich. App. 604, 251 N.W.2d 314 (1977).

Moore did not resolve the dispute. In that case the indictment charged both distribution and dispensing. 423 U.S. at 124; see note 31 supra. One court has condemned this argument as being based on a "hyper-technical distinction" between the two terms even though there is no "functional difference" in the context of the physician cases. United States v. Fellman, 549 F.2d at 182. Cf. Commonwealth v. Comins, — Mass. —, 356 N.E.2d 241 (1976), cert. denied, 97 S. Ct. 1582 (1977) (choice of words should not be permitted to become crucial).

47. One factor supporting this view is the Uniform Act provision that it is to be "so applied and construed as to effectuate its general purpose to make uniform the law with respect to the subject of this Act among those states which enact it." Uniform Controlled Substances Act § 603. See generally Barton, Controlled Substances Act of 1971, 52 Mich. St. B.J. 617, 621, 623 (1973).


Moreover, the terms "dispense" and "distribute," as identically defined in the North Carolina, Federal and Uniform Acts, are described in terms of the "delivery" of a controlled substance. Thus, it is extremely doubtful that a legislative intent to restrict the application of section 90-95 solely to street traffickers can be inferred from the change of language.

The Best court also distinguished the North Carolina Act from its federal and uniform counterparts on the basis of section 90-101(c)(4), which exempted "practitioners licensed in North Carolina" from having to register with the North Carolina Drug Authority in order to possess, distribute or dispense a controlled substance. The court discerned from this provision a

50. State v. Vinson, 298 So. 2d 505 (Fla. Dist. Ct. App. 1974). The Vinson Court interpreted the Florida law, which is phrased in the same terms as the North Carolina one: "It is unlawful for any person to sell, manufacture, or deliver . . . a controlled substance." FLA. STAT. ANN. § 893.13(1)(a) (West 1976). The court specifically addressed the question whether delivery of a drug could include the issuance of a prescription and relied on the definition of "delivery" identically contained in the federal, uniform, Florida and North Carolina statutes. The court concluded that the issuance of a prescription by a physician was a form of "constructive" delivery and it was no defense that the actual transfer of the drug would be made by a pharmacist pursuant to the order of the prescription. 298 So. 2d at 507; accord, King v. State, 336 So. 2d 1200 (Fla. Dist. Ct. App. 1976); People v. Alford, 73 Mich. App. 604, 251 N.W.2d 314 (1977).

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51. "'Dispense' means to deliver a controlled substance to an ultimate user or research subject by or pursuant to the lawful order of a practitioner, including the prescribing, administering, packaging, labeling, or compounding necessary to prepare the substance for that delivery." N.C. GEN. STAT. § 90-87(8) (1975); UNIFORM CONTROLLED SUBSTANCES ACT § 101(g). 21 U.S.C. § 802(10) (1970) is identical in the pertinent parts.


52. In support of its view, the North Carolina Supreme Court states that the words "distribute or dispense" are terms confined to "technical medical connotations." 292 N.C. at 309, 233 S.E.2d at 554. This is an arguable proposition. A number of other state and federal courts have convicted street pushers of "dispensing" and/or "distributing" drugs. Those that have convicted street pushers of "distributing" include United States v. Joseph, 533 F.2d 282 (5th Cir. 1976), cert. denied, 97 S. Ct. 1698 (1977); United States v. Garcia, 528 F.2d 580 (5th Cir. 1976); United States v. Oquendo, 505 F.2d 1307 (5th Cir. 1975); United States v. Visuna, 395 F. Supp. 352 (S.D. Fla.), aff'd, 524 F.2d 1231 (5th Cir. 1975). Other courts have convicted nonmedical people of "dispensing," e.g., People v. Fenninger, — Colo. —, 552 P.2d 1018 (1976); People v. Dinkel, — Colo. —, 541 P.2d 898 (1975). One commentator has suggested that the primary purpose of the amendment was to alter provisions of the Act concerning the use of prior convictions under the Act and to change the statutory presumption concerning possession as it relates to intent to sell. Interview with Michael Crowell, Associate Professor, Institute of Government, University of North Carolina at Chapel Hill, in Chapel Hill (Aug. 29, 1977). Since no legislative intent to attach such significance to the change in wording appears from the available documentation describing the history of the amendment, it seems that the court's reliance on the legislature's intentions is suspect. See NORTH CAROLINA SOLICITORS' ASS'N, RECOMMENDATIONS TO THE 1973 GENERAL ASSEMBLY FOR LEGISLATION AFFECTING CRIMINAL LAW 34 (1973) (distributed to each legislator); Crumpler, CONTROLLED SUBSTANCES ACT, POPULAR GOV'T, June 1973, at 13 (summary of legislative action on Controlled Substances Act).

legislative intent to exempt the practitioner from the provisions of section 90-95 by virtue of his status as a doctor. This distinction, however, appears to have a weak substantive foundation. Although the Federal Act does require yearly registration by all physicians who dispense controlled substances, such registration is pro forma—the Attorney General has no discretion to refuse the registration of any physician who is properly licensed by a state authority. Moreover, physicians who do not dispense regulated drugs from their offices but who merely administer or prescribe them are subject to no federal registration requirements. Thus, the minimal registration requirements placed on doctors by the federal government reflect only a minor difference in the attitudes of the Federal and North Carolina Acts toward the treatment of doctors and appears insufficient to justify a difference in application of the primary felony provisions of the respective Acts.

In addition, the North Carolina Supreme Court justified its interpretation of the North Carolina Act on the basis that, unlike the Federal Act, it provides “essentially the same” penalties for both medical and nonmedical offenders. The court added that, while “minor penalties” are provided in the federal counterpart of section 90-108, there are “potentially stiff penalties” under the North Carolina section, thereby indicating that “the Legislature felt that the unlawful acts proscribed ... were more than minor ‘technical violations’ ...”

Although the court stated that the penalties for medical and nonmedical offenders are “essentially the same,” the latter are subject to a maximum penalty for a first offense of illegally distributing a Schedule II substance of ten years imprisonment and a $10,000 fine. In contrast, physicians who

N.C. GEN. STAT. § 90-101(c)(4) (1975)). This section was repealed by Law of July 1, 1977, ch. 891, § 4(2), 1977 N.C. Adv. Legis. Serv. 517 (Pamphlet No. 11, Pt. 2).
54. 292 N.C. at 305, 233 S.E.2d at 551.
56. United States v. Moore, 423 U.S. at 140-41. 21 U.S.C. § 823(f) (1970) states that “[p]ractitioners shall be registered to dispense or conduct research with controlled substances in schedule II, III, IV, or V if they are authorized to dispense or conduct research under the law of the State in which they practice.” The only restriction applied by the Federal Act is that special registration with the Attorney General is required to authorize a physician to deal in Schedule I drugs, those controlled substances that have no accepted value for medical treatment. See id. § 823 (1970 & Supp. V 1975); HOUSE REPORT, supra note 1; Recent Developments, supra note 21, at 184.
57. Davis, supra note 5, at 344.
58. In drafting the Uniform Controlled Substances Act, the Commissioners, believing that such matters should be left to the discretion of the states, included no penalty provisions. UNIFORM CONTROLLED SUBSTANCES ACT, Prefatory Note.
59. 292 N.C. at 308-09, 233 S.E.2d at 553.
60. Id. at 309, 233 S.E.2d at 553.
dispense a Schedule II substance outside the course of their professional practice are subject to a maximum penalty of five years imprisonment and a $5000 fine.\textsuperscript{62} Although all convictions for sale or delivery under section 90-95 are classified as felonies, physicians are considered guilty of only a misdemeanor unless it is established that they committed the offense intentionally.\textsuperscript{63} Thus, a higher burden of proof is required to convict a physician of a felonious drug offense than to convict a street dealer of the same type of offense. Although there may be merit to lesser punishment of physicians for such transgressions, comparison of sections 90-95 and 90-108 refutes the argument that the penalties for violations are "essentially the same" for both groups.

This difference is magnified upon subsequent violations of the Controlled Substances Act. If the \textit{Best} decision is interpreted as meaning that the practitioner is totally "exempted from the proscriptions of section 90-95,"\textsuperscript{64} then he would receive no additional punishment for subsequent offenses, since section 90-108 makes no provision for additional penalties under such circumstances.\textsuperscript{65} In contrast, for a conviction under section 90-95 following conviction for two or more felonies under the same section, a defendant can receive up to thirty years in prison and a $30,000 fine.\textsuperscript{66}

In addition, the federal penalties referred to as "minor" by the North Carolina Supreme Court are not without substance.\textsuperscript{67} Substantial sanctions are provided for commercial type offenses (a maximum of one year imprisonment and $25,000 fine)\textsuperscript{68} and for fraudulent offenses committed intentionally or knowingly (a maximum of four years imprisonment and $30,000 fine).\textsuperscript{69} The maximum penalty in North Carolina for similar offenses is the section 90-108 sanction of five years imprisonment and $5000 fine for an intentional offense.\textsuperscript{70} In view of the lack of a major difference in the federal and state penalties for such violations, it is difficult to discern a definitive

\textsuperscript{62} Id. § 90-108(b).
\textsuperscript{63} Id.
\textsuperscript{64} 292 N.C. at 303, 305, 233 S.E.2d at 550, 551.
\textsuperscript{65} N.C. GEN. STAT. § 90-108(b) (1975).
\textsuperscript{66} Id. § 90-95(e)(2).
\textsuperscript{67} Ironically, Judge Ely in his dissent to \textit{United States v. Rosenberg} used the stiff punishments prescribed under the federal counterpart of § 90-108 to justify treatment of doctors solely under those sections. 515 F.2d 190, 201 (9th Cir.) (dissent), \textit{cert. denied}, 423 U.S. 1031 (1975). Even though he was convinced that the federal law established a separate system for punishing physicians who prescribe Schedule II through V drugs outside the course of accepted medical practice, however, Judge Ely thought it significant that the Act confers no authority on registered physicians to deal in Schedule I controlled substances. Therefore, he maintained that a physician may illegally dispense Schedule I controlled substances and be prosecuted under § 841, the primary felony provision, for so doing. \textit{Id.} at 202.
\textsuperscript{69} Id. § 843(c).
\textsuperscript{70} N.C. GEN. STAT. § 90-108(b) (1975).
legislative intent to regard these violations in North Carolina in any different light from their federal counterparts.71

Finally, the court emphasized that "[i]t is apparent that the North Carolina Drug Commission . . . views [the Act] as establishing a parallel system"72 and added that "[w]here an issue of statutory construction arises, the construction adopted by those charged with the execution and administration of the law is relevant and may be considered."73 It is difficult, however, to perceive such an interpretation from the publications of the Commission. Their Physicians' Reference on Drug Laws and Emergency Treatment,74 cited by the court in support of its analysis,75 states that practitioners are "primarily concerned" with the prohibitions of section 90-108.76 Clearly, the vast majority of doctors need only ensure compliance with the technical aspects of dispensing controlled substances since they routinely confine the issuance of such drugs to the accepted course of professional practice. The use of the word "primarily," however, suggests that other provisions may be of secondary concern to the physician.77 There is no suggestion that physicians who violate a provision of the Controlled Substances Act should be charged under any language other than the "manufacture, sale or delivery" of the drug—at least in situations where their conduct is comparable to that of a trafficker.

The interpretation by the North Carolina Supreme Court of the state's Controlled Substances Act represents a radical departure from the view taken by the United States Supreme Court and the federal and state tribunals that have considered legislation substantially similar to the North Carolina scheme. If the North Carolina court's opinion is read broadly, it opens the way for unscrupulous practitioners to sell drugs "primarily for the profits to be derived therefrom"78 without being subject to the same severe criminal

71. This regulatory structure could also be viewed as enacting substantial penalties for acts such as fraudulent practices, improper use of order blanks and illegal issuance of prescriptions in order to deter such conduct while retaining even harsher penalties for conduct that is equivalent to that of the street trafficker.
72. 292 N.C. at 308, 233 S.E.2d at 553.
73. Id.
74. NORTH CAROLINA DRUG AUTHORITY, PHYSICIANS' REFERENCE ON DRUG LAWS AND EMERGENCY TREATMENT (1972).
75. 292 N.C. at 308, 233 S.E.2d at 553.
76. NORTH CAROLINA DRUG AUTHORITY, supra note 74, at 11-12.
77. Another publication of the Commission, which provides sample arrest warrant forms, only sets forth language paralleling the wording of § 90-95, the primary felony section. NORTH CAROLINA DRUG AUTHORITY, DRUG LAWS OF NORTH CAROLINA (INCLUDING REGULATIONS) 155-66 app. (1975).
penalties that apply to their nonmedical counterparts. Another consequence of the court’s opinion is that prosecutors must be extremely careful in wording their indictments. If medical practitioners are charged with “selling or delivering” or street traffickers with “dispensing or distributing,” a fatal variance will result.  

It is unfortunate that the North Carolina Supreme Court chose to interpret the entire Controlled Substances Act in a manner that is not supported by either logic or precedent. The court could have avoided the massive statutory interpretation it undertook and reached the same result by ruling that the evidence was not sufficient for a conviction under the Act. The physician who employs controlled substances in treatment of his patients is faced with very real and very serious problems: because it is acknowledged that all controlled substances except those in Schedule I have useful and legitimate medical purposes, he must be given the flexibility 

79. The concern felt by the courts that refused to find a dual system of regulation was voiced by the Rosenberg opinion in that since registration is pro forma for the most part, the physician would be able to "stand on [any] street corner and sell prescriptions to passersby" with impunity because he would not be writing prescriptions but personally delivering controlled substances. 515 F.2d 190, 194 (9th Cir.), cert. denied, 423 U.S. 1031 (1975). Under a dual system the penalties for violations of 21 U.S.C. §§ 842 and 843 would be triggered by a violation of § 829, which requires a written-prescription "[e]xcept when dispensed directly by a practitioner . . . to an ultimate user." Thus, directly dispensing a drug without a prescription would not be a violation under those two sections. For a further exposition on this shortcoming of a dual system of regulation, see Recent Developments, supra note 21, at 190. Furthermore, the same deleterious effects are felt by the addict and society whether or not the source of supply is a medical one, especially in light of statistics estimating that physicians, pharmacists and other professionals are currently the source, intentionally or not, of as much as 90% of the dangerous drugs found in the illicit market. Weir, supra note 5, at 484.  

80. Because of the acceptance by other courts of indictments charging physicians with the sale or delivery of a controlled substance, it is questionable whether there was a fatal variance in this indictment. The indictments that charged Dr. Best, although they tracked the "sell and deliver" language of § 90-95, stated no violation of any particular section of the North Carolina Act. See text accompanying notes 18 & 19 supra. The controlling factor should be that argued by the State in Best:  

[In reaching a determination as to whether or not there is a fatal defect in an indictment, the primary consideration is whether or not the indictment informed the defendant of the charges against him in order that he might prepare a defense and protect himself from another prosecution for the same offense. New Brief for the State at 20 (citations omitted). There would seem to be no question here that Dr. Best was made fully aware of the crimes with which he was charged. Accord, United States v. Fellman, 549 F.2d 181, 182 (10th Cir. 1977) (per curiam).  

81. One only needs examine the facts of the Moore case and others to recognize that Dr. Best’s alleged conduct falls far below the level of abuses that have resulted in convictions for substantive violations of the Controlled Substances Acts. See text accompanying notes 26-28 supra.  

to use them in a manner that will most effectively help his patients without the worry of being second-guessed by a jury. 83

By the time the North Carolina legislature passed its version of the Act and subsequent amendments thereto, other similar acts had been interpreted by a number of state and federal courts. The North Carolina Supreme Court has in effect changed the legislative history of the Act and denied the legislature the insight that comes from studying and evaluating similar statutes.

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83. Also, the ongoing updating of drug schedules requires constant attention by the busy practitioner. Compounding this problem is the fact that often, "detailmen," employees of drug companies, are a major source of ... information regarding new drugs or developments concerning drugs already on the market. It is highly improbable that this source or the advertisements in medical journals keep the physician abreast of what the drug culture has discovered for new "highs" or what group is abusing what drug.

Davis, supra note 5, at 360.

There are compelling policy reasons for punishing doctors differently than other persons for violations of the controlled substances laws. In United States v. Moore, the Supreme Court noted that

Congress understandably was concerned that the drug laws not impede legitimate research and that physicians be allowed reasonable discretion in treating patients and testing new theories. . . .

In enacting the Comprehensive Drug Abuse Prevention and Control Act of 1970 . . . Congress faced the problem directly. Because of the potential for abuse it decided that some limits on free experimentation with drugs were necessary.

423 U.S. at 143. The Court added that Congress required the Secretary of Health, Education and Welfare, in consultation with the Attorney General and national professional organizations, to determine the appropriate professional standards for treating addicts in order to provide clarification for the medical profession. Id. at 144. Prior to this time many doctors were afraid to take addicts as patients because of the uncertain state of the law.

In arguing for a new approach to the problem by legislatures, courts, medical schools and the medical profession, Professor Davis observes that

Drug abuse is not confined to the narcotic addict nor to the user of hallucinogens. Medicine cabinets across the country are filled with stimulants and depressants prescribed by overworked physicians catering to an uptight, overweight populace. As real and tragic as this situation is, one must, nonetheless, question whether the criminal sanctions imposed upon the medical community are really the answer. Perhaps the underlying problem and the ultimate solution lie in the areas of professional responsibility and medical ethics.

Davis, supra at 359.

The same system of punishment, however, should apply to all who dispense or distribute Schedule I drugs. The North Carolina Supreme Court seems to support this view. Although it says that transactions that are exempted from the proscriptions of § 90-95 are those that involve drugs authorized by other provisions of the Act, such transactions would not include the dispensing or distributing of Schedule I drugs by practitioners. Thus, it is arguable that if faced squarely with the question, the court would hold physicians who sell or deliver heroin, LSD or other Schedule I substances subject to the penalties under § 90-95.